Work Stream 2

Understanding the new commissioning system in England: contexts, mechanisms and outcomes

Work Stream 2 – tracer short report: *Orthopaedic Services*

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Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter 'HSCA12'). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area ('tracers') in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of orthopaedic services. This 'tracer' was chosen because it represents an area likely to be relatively unaffected by the changes introduced in the HSCA12.

Orthopaedics is a specialism focused on the treatment of issues arising with the musculoskeletal system (MSK), which is comprised of bones, joints, ligaments, tendons, muscles and nerves. Orthopaedic services provide treatment for long-term conditions (e.g. osteoarthritis) and traumatic injuries (e.g. fractures). MSK disorders command an NHS budget of around £10bn, the third-highest after mental and cardiac health (Briggs, 2015), and this figure is expected to rise as an ageing population brings increasing demand for orthopaedic care (Murray et al., 2013). Orthopaedic referrals from GPs to secondary care providers are increasing by around 8% per year, and 25% of all surgical interventions are carried out by trauma and orthopaedic surgeons (Briggs, 2015). Orthopaedic service provision therefore represents a substantial portion of NHS activity and expenditure.

In order to explore the impact of HSCA12 upon the commissioning of orthopaedic services, we conducted interviews with a range of commissioners and service providers in two English Areas corresponding to NHS England Area Team footprints (as originally conceived):[1]

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core.
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million and a large central city.

Orthopaedics was discussed in the majority of the 78 Work Stream 1 interviews, which primarily involved individuals from Clinical Commissioning Groups (CCGs) and NHS England (NHSE). On the basis of this data, we found little evidence of pre and post HSCA12 variation, or variation between Areas, in terms of orthopaedic commissioning and provision. Consequently,

[1] Area Teams were absorbed into the four existing regional teams when NHS England was reorganised in April 2015.

we conducted three orthopaedic focused Work Stream 2 interviews (a CCG commissioner, and two Providers) in Area 1 only.

Pre-HSCA12

Prior to the HSCA12, Primary Care Trusts (PCTs) were responsible for commissioning routine and specialised orthopaedic treatments. Specialised services were those that covered a planning population (catchment area) of more than a million people, and PCTs worked in collaboration with others close by to provide for populations at broader footprints and pool financial risk (National Audit Office, 2016). See 'Specialised Services' tracer report for more details.

Most treatments were paid for from PCT funding allocations under the standard NHS tariff, with a small amount paid for by central government.

Post-HSCA12

Following the introduction of the HSCA12 and the abolition of PCTs, the commissioning responsibility for routine treatments passed to the newly-created CCGs, with NHSE taking over responsibility for specialised orthopaedic care, including major trauma services.

The HSCA12 introduced a statutory duty for NHSE to conduct an annual assessment of CCGs. This assessment includes use of a framework to ensure that CCGs are meeting certain targets, which for orthopaedic-related activity includes the 18-week referral-to-treatment time established as a patient right in the NHS Constitution.

There was little within the HSCA12 which specifically focused upon orthopaedic services. However, the Act as a whole was underpinned by the **programme theory (Weiss, 1998) that GP-led CCGs would be more efficient and effective commissioners than PCTs because of their enhanced clinical leadership, with clinicians assumed to have a greater understanding of population needs** (Checkland et al., 2014). The other main change arising from the HSCA12 is the role for NHSE in the commissioning of specialised orthopaedic services. This role is part of changes to the commissioning of specialised services as a whole, which are explored in the 'Specialised Services' tracer short report.

To explore the impacts from the HSCA12 upon orthopaedic services commissioning, this report presents findings from interview data organised into two themes: (1) Orthopaedics as "bread and butter" routine commissioning activity; (2) Controlling orthopaedic activity.

Theme 1: Orthopaedics as "bread and butter" routine commissioning activity

More so than any other tracer, **orthopaedics was perceived by interviewees as largely unaffected by the HSCA12**. It is an area of commissioning that has continued *"in the old vein..."* [2623, Area 1 CCG, Apr 2015] with a relatively straightforward handover of responsibility. From a provider perspective, a surgeon reported: *"On the coal face there's been no change. In fact you can't see any difference at all"* [15845, Area 1, provider, Aug 2016]. In particular, there was no obvious change towards a more clinically-focused approach to commissioning. One interviewee stated that she had observed an increase in bureaucracy in relation to service procurement since the HSCA12 – describing it as a *"bureaucrats' party"* – but could not say whether this was a consequence of the HSCA12 or would have developed in this way regardless of it [12580, Area 1, provider, May 2016].

Commissioners tended to describe orthopaedics using terms such as *"bread and butter"* [2388, Area 1, CCG, Mar 2015] and *"transactional"* [6010, Area 2, CCG, Aug 2015], a traditional or even stereotypical commissioning activity: *"…you do demand and capacity modelling, it's actually what quite a lot of people think commissioning is about, you know, how many of these, I'll buy them from there, what's the price and let's get it…"* [6010, Area 2, CCG, Aug 2015]. However, interviewees identified that there was **considerable variation in terms of orthopaedic treatment activity both within their Area and nationally** [4095, Area 1, CCG, Jun 2015], and this had not changed post-HSCA12. Several commissioners commented on the historical tendency for orthopaedics to focus on the surgical procedure as mechanistic and discrete, and how orthopaedic care needed to better take account of the individual and their broader social context for the good of the patient and the health and social care system:

> "…say for arguments sake, you have a hip replacement, you can't get up and down the stairs and you say, I'd like a stair lift, well you can have one in two and a half years, well, say no more and if somebody needs a chair lift to leave them at home, why doesn't health prescribe them? Why does it have to be social care? Because actually, if we kept them in the home and not in a hospital or somewhere, that's cheaper. So you may spend £2,000 on a stair lift or you can spend £2,000 a week keeping them in a hospital and all the infrastructure costs and you don't release to home and you make people more dependent, you've lost their health and wellbeing. So we need to think wider about the individual rather than about, well, that's health money, that's the problem, the mind set has to change." [4246, Area 1, CCG, Jun 2015]

> "You can continue to give people new knees but if you don't help them to exercise and live more healthily they'll just knacker the new knee that's been put in. If you don't tell them that they've got to do ten minutes exercise at least a day to get the benefit of having a new knee there's no point in putting a new knee in." [4519, Area 1, CCG, Jun 2015]

There was **no notable difference between Areas 1 and 2** in terms of the dominant issues in orthopaedic commissioning and provision. However, interviewees reported a number of issues and arrangements specific to local CCGs and the providers that they interacted with. For example, two CCGs, one from each Area, noted that their local hospital providers had a lack of capacity for orthopaedic procedures, leading to unsatisfactory waiting times for patients [3271, Area 1, CCG, Apr 2015; 6120, Area 2, CCG, Aug 2015]. In Area 1 there was a footprint, encompassing multiple CCGs, where there had been a pre-existing Clinical Assessment and Treatment Service (CATS) run by a private provider. This was commissioned pre-HSCA12 by the Department of Health. This contract was then transferred to NHSE, and CCGs were committed to funding it for several years before the provider was notified that the contract would not be extended further. An interviewee from one of the relevant CCGs noted that this arrangement had constrained the degree of financial control they enjoyed as commissioners and that all of the CCGs were now able to re-procure these services, which was positive [2623, Area 1, CCG, April 2015].

Theme 2: Controlling orthopaedic activity

Commissioner **interviewees perceived orthopaedics to be an attractive domain of activity for providers and a strong source of revenue**. One stated:

> "That's the most difficult arena because orthopaedics is a burgeoning… it's lovely if you're a provider. It's a huge area of income generation. And the challenge in orthopaedics is, is it effective use of your resources. So there are a lot of procedures that are being done in orthopaedics which are of limited clinical benefit. It's an area where demand is growing very rapidly. And those that provide those services drive up the demand as well, and there's a procedure for everything" [4144, Area 1, CCG, Jun 2015].

This extract highlights a key challenge perceived by commissioners: how best to make judgements about the relative value of orthopaedic procedures, and the allocation of funding to those procedures. One commissioner in Area 1 reported that his CCG, which has a large specialist orthopaedic provider Trust within its footprint, had received a request to fund *"some sort of bionic wrist replacement"* at a cost of approximately £30,000. The surgeons were keen to secure funding for the procedure in part because *"they want to keep pushing themselves to do the next fantastic thing"*, but the CCG had to weigh up the cost of this procedure and the potential benefit for the patient with the potential benefit for the CCG population at large from a range of other health care services [4519, Area 1, CCG, Jun 2015].

However, with the majority of **orthopaedic contracts being Payment by Results, commissioners do not always have the levers to control the activity of providers** and, consequently, the size of the bills that they receive from them. This was an issue in Area 1. An acute hospital, located within the boundaries of a CCG, undertook a significant expansion of its orthopaedic service capacity without consulting the CCG first. The business model for this expansion involved increasing activity from commissioners outside the local area. The hospital did not attract the desired levels of activity and began running 'education' events for local GPs (the CCG members) to try and encourage them to refer patients for treatment earlier. This generated more income for the hospital and caused a spike in surgical activity paid for by the CCG. The following year the CCG implemented an MSK pathway based closely on the Department of Health model CATS service (Department of Health, 2006). This reduced the CCG's spend with the provider significantly, actually lowering it below the level they were paying before the hospital's expansion, and the CCG and hospital entered into discussions to decide on arrangements that would meet the needs of both organisations without adverse effects.

Commissioner concern about a lack of control over provider activity levels was often coupled with a **concern that referrals by GPs were not always appropriate**: *"I think we've struggled to control it and we're struggling to control the way GPs refer as well"* [3391, Area 1, CCG, May 2015]. Increasing control over orthopaedic activity and, therefore, spending was frequently cited by commissioners as a reason for introducing or developing systems that involved **triaging and filtering GP referrals and/or screening the procedures** carried out by providers to ensure that they were being charged appropriately. There were numerous examples of these systems in place in Area 1 and Area 2 referred to by a range of titles such as "referral gateways" [4095, Area 1, CCG, Jun 2015]. These orthopaedic **specific services were often conceived as part of a broader "MSK pathway"**, and when interviewees were asked about orthopaedics they often responded by talking specifically about MSK and allied services, which indicates how they were seen as inseparable. MSK pathways frequently involved the provision of rheumatology and pain services, and the relocation of orthopaedic activity from hospital

settings into the community. The intention behind these schemes was to reduce the number of handovers between different providers and services (including local authority and third sector), and better co-ordinate linkages between them, to make the experience of accessing care less fragmented for patients and to reduce costs by reducing unnecessary hospital based care. Crucially, the planning and enactment of these was in some cases carried out by PCTs, pre-HSCA12, and the schemes were continued unchanged or developed further by CCGs.

A CCG in Area 1 had a particularly well-established MSK pathway. The CCG commissioned what was referred to by interviewees as both an "integrated provider hub" and a "holistic community based MSK service." This was orchestrated by a non-profit "honest broker" organisation, staffed by orthopaedic experts. This broad service was primarily provided in community settings where patients could have initial consultations with consultants as well as access a range of other related services. The service was originally commissioned by the PCT but proved successful in controlling orthopaedic spending and so the CCG had extended its contract and expanded the remit of the service. The CCG was very positive about its benefits and had allocated their entire orthopaedic budget for management by the non-profit provider organisation [7412, Area 2, CCG, Oct 2015].

In Area 2, two CCGs each commissioned referral "triage and assessment" services that were primarily community based and involved physiotherapists. Interviewees from both CCGs expressed dissatisfaction with these services due to duplication and cost, and both were at different stages of tendering for an MSK pathway service [7290, Area 2, CCG, Oct 2015; 7679, Area 2, CCG, Oct 2015]. An interviewee from one of these CCGs stated that the CCG had found itself in a significantly worse financial position than the PCT before it, and the financial pressures upon them had contributed to a less constructive and collaborative relationship with their main local provider of orthopaedic services. His perception was that senior figures from the provider organisation were unhappy that the CCG was tendering for a new MSK service, in the interests of making savings, because they might not win the contract [7679, Area 2, CCG, Oct 2015].

Summary

- Little change in the landscape of orthopaedic commissioning and provision reported as a result of the HSCA12. Commissioning responsibility was passed from PCTs to CCGs, with little obvious change related to greater clinical involvement in CCGs
- Commissioners commonly referred to orthopaedic activities as straightforward, "bread and butter," and "transactional"
- Some commissioners were concerned about a lack of control over activity, with demand and costs rising, and perceived that some providers were motivated to increase demand because of the profitability of orthopaedic procedures
- The majority of CCGs operated, or were in the process of developing, a musculoskeletal (MSK) pathway with orthopaedics rolled into a suite of linked service including rheumatology and pain management, commonly involving local authority and third sector organisations, with a greater proportion of delivery in community settings
- Whilst it might be thought that CCGs, as 'membership organisations', would have a greater ability than PCTs to control the activity of their GP members, in practice we saw no evidence of this. Control of referral activity generally focuses upon "referral gateways" or consultant led triage systems run by an independent, non-profit organisation to act as an "honest broker". Such mechanisms were, in many cases, instigated by PCTs before the establishment of CCGs.

Actionable messages

The main issues that arose in studying this area of commissioning are familiar ones: the need to control costs whilst maintaining an effective and accessible service. Our interviewees suggested that:

- Strict separation of activity into 'commissioning' and 'provision' is not necessarily the most effective approach. Those CCGs which had managed to control costs had usually done this by working closely with local providers in order to set up a system which effectively triaged patients to the most appropriate service, and which provided access to lower-level and less costly services such as pain management and physiotherapy
- Incentives built into the payment by results system can be unhelpful.

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