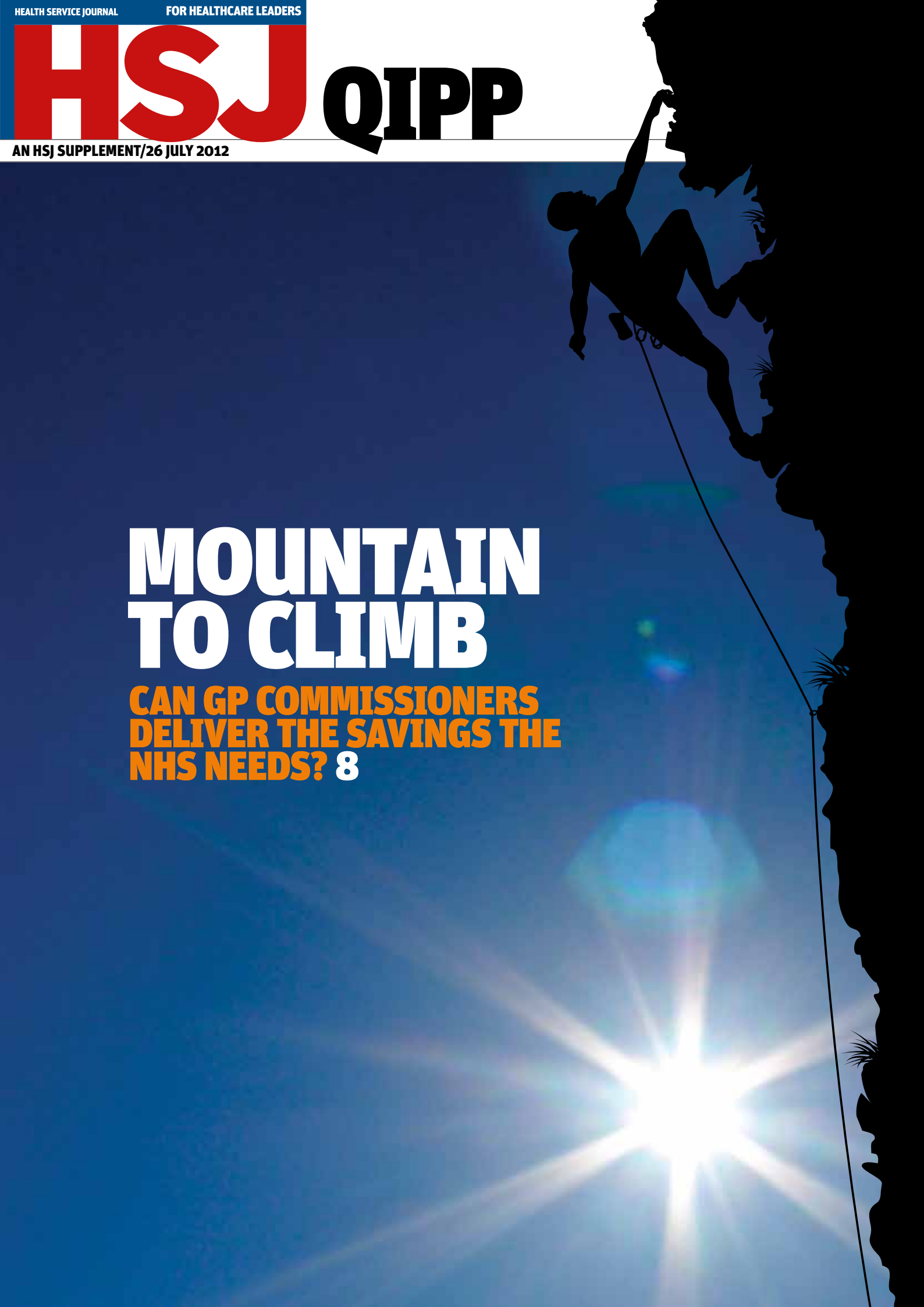
HEALTH SERVICE JOURNAL FOR HEALTHCARE LEADERS

HSJ QIPP

AN HSJ SUPPLEMENT/26 JULY 2012



MOUNTAIN TO CLIMB

CAN GP COMMISSIONERS DELIVER THE SAVINGS THE NHS NEEDS? 8

Supplement editor
Rebecca Creamer

CONTENTS

MEDICINES MANAGEMENT

Put it in the recycling bin

How Leicester hospitals invested in dedicated staff to tackle drug waste – and saved £400k. By Alison Moore

Wasted medicines are a part of life in most healthcare settings. But they are costly, sometimes in short supply and needed for other patients, and disposing of medicines and their packaging can be an added expense.

A QIPP scheme at University Hospitals of Leicester Trust has enabled medicines to be reused safely, saving the trust around £400,000 a year.

Nearly two years ago, the trust realised there could be savings from looking at how it approached medicines reuse. Like a lot of trusts, it had invested in a robotic dispenser for its main pharmacy. This had many advantages but the robot could only dispense full packs of medicines – usually as calendar month packs. Potentially, this meant the hospital throwing away more medicines – when a patient went home after a short time or drugs were changed and the old ones no longer needed.

So a scheme was set up to allow the three hospitals within the group to recycle medicines. Elizabeth McKechnie, medicines safety lead pharmacist, says: "We employed three members of staff, one on each site, and their whole remit was to do the recycling and redistribution of medicines."

Ward staff put unused medicines into green bins on the ward. These are designed to be secure and can only be opened with a key, which the pharmaceutical assistant has.

These bins are regularly emptied by the pharmaceutical assistant who then logs what has been deposited and sifts through it.

Some drugs can't be recycled – for example where a patient has brought them in from home the trust can't reuse them for another patient – and must be disposed of, if the patient can no longer take them. But there are others which are suitable for reuse. Typically these are part-used packs of hospital dispensed medicines (part-used blister packs are discarded). Oral oncology drugs – which are notoriously expensive – are among many which can be reused as long as strict criteria are met.

These are then issued to satellite pharmacies within the hospitals – which don't use robotic dispensers – or directly to wards which keep a stock of some medicines. Short dated medicines are usually sent to wards which keep a stock of the same drug – indicating they have a quick turnover.

Refrigerated medicines have to be treated differently as the "cold chain" has to be unbroken if they are to be recycled. Ward staff return them to fridges on wards but leave a note for the pharmaceutical assistant on the fridge door, indicating unused drugs that can be taken. These are then processed and reissued quickly – so they can be back in a fridge as quickly as possible.

Patients' own medicines can be used in hospital – if appropriate – which helps staff establish which drugs a patient is taking and reduces waste and cost for the hospital. "They may only be in hospital for a day and may have stacks and stacks of drugs with them," says Ms McKechnie.

And the trust is also careful about supplies sent home with patients: there is no use providing them with extra drugs if they already have adequate supplies at home. These extra drugs may just be wasted and have the potential to confuse patients.

In the first year, the scheme saved around £400,000, after the cost of extra staff at bands two and three was deducted. The scheme has now been devolved to the trust's individual business units who have adopted slightly differing approaches to staffing. However, savings are still substantial – £156,000 a year before staffing costs in the cardiorespiratory department, for example. In the children's services unit a band three worker has been employed both to recycle and dispense medicines. And there will also be savings on waste disposal – unused medicine and packs are treated as clinical waste and are expensive to dispose of.

So is the system replicable elsewhere? Ms McKechnie believes so. She identifies some keys to success. Dedicated staff are important – if general pharmacy staff are used, they may be moved to other work when the department is under pressure. Security and storage of unwanted medicines is also important. And organisations must be prepared to "invest to save" – although in the Leicester project, the cost of extra staff was quickly paid back. ●

Falling through the cracks

Femur fracture patients at one trust were spread across two sites and faced long delays and poor outcomes. A single dedicated service and multi-disciplinary team has changed all that. By Alison Moore

Patients with fractured neck of femur are often some of the oldest and frailest in hospital. They may also be at risk of poor outcomes with delays in operating, long length of stay and little forward planning for when they leave hospital.

A few years ago this was the case at East and North Hertfordshire Trust. Patients with fractured neck of femur were spread over the trust's two main hospitals and could face a long delay in treatment. Outcomes were poor with the average length of stay hitting 32 days and higher than expected mortality. Other indicators such as falls and pressure ulcers also caused concern.

What has happened since then shows that QIPP is not just about saving money but also about offering patients real improvements in care.

Consultant in elderly medicine Emma Lines, who joined the trust in 2010, says: "The first thing we did was realise there was a really big problem." The team found they were not meeting all the guidelines on care from the British Orthopaedics Society all of the time. They also "walked the pathway" to discover what was going wrong for patients, examined the cases of patients who had died and looked at what other providers were doing – including visiting Addenbrooke's Hospital in Cambridge.

The reorganisation of the trust – which is centralising some acute services to the Lister Hospital in Stevenage – offered an opportunity. The space was available to concentrate all fractured neck of femur patients at the Queen Elizabeth II Hospital in Welwyn Garden City on a dedicated ward with theatre access – which would stop patients being "bumped" down the operating list.

"It was a unique opportunity to try to identify the service we wanted within this space that we would not have had available otherwise," says Nick de Roeck, clinical director for trauma and orthopaedics and an orthopaedic surgeon.

But this vision needed to be communicated with the other staff who would be affected and would have to deliver the service. And the board had to be persuaded as well. "Senior leadership buy-in was vital," says divisional nursing services manager for surgery Karen Cameron. The vision of this dedicated service needed key skills in place: a nurse specialising in fractured neck of femur and an orthopaedic consultant carrying out the more complex surgery. As well as nursing staff, therapy staff needed to be involved as early as possible in mobilising patients and planning for discharge.

Multi-professional approach

Having patients in one place has transformed care with a truly multi-professional approach. "We have daily meetings of our multi-disciplinary team to discuss patients," says Ms Lines.

Patients are usually admitted through Stevenage A&E but transferred to the QEII as soon as possible. They are then assessed and any necessary tests done. Hip fracture operating lists run every morning and patients are generally operated on within 36 hours, and mobilised as soon as possible after that. Therapists and social workers are involved in planning discharge: many patients will need support after they go home.

What has been the results? The length of stay has reduced by more than a third to 19 days, around the national average. Mortality has improved: deaths are now lower than expected. Patients are generally operated on within 36 hours of admission and the proportion of patients discharged to home has increased. And on softer measures – compliments about the quality of care and number of complaints, for example – the trust has also improved.

'Patients are generally operated on within 36 hours, and mobilised as soon as possible after that'

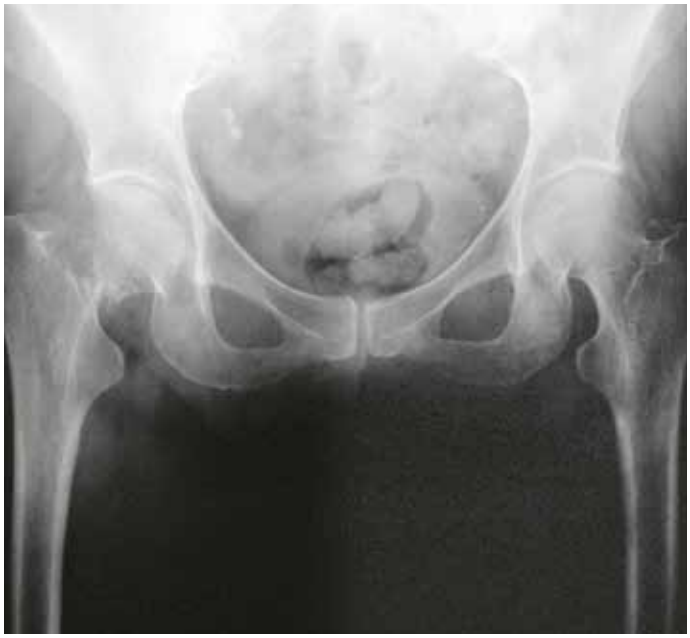
And, although the project was not about saving money, there could be some financial benefits. The reduction in length of stay has allowed five beds to be closed. The improvement in the package of care given patients has opened the way for more income through an enhanced tariff scheme which is dependent on meeting five indicators for the care of patients with fractured neck of femur.

Dedicated staff

Against this, providing quality care does mean some extra costs – for example, through a dedicated nurse.

"We are providing better care and getting more money per patient," says Ms Lines. "But we are ploughing that money back into improving quality of care."

The journey of improvement is continuing: one of the challenges of the next two years will be moving the service into the revamped Lister Hospital and continuing to provide the dedicated service. But Mr de Roeck is hopeful and believes the team working is what has enabled the trust to deliver a radically improved service. ●



Time to operate: a fracture of the neck of the femur

ALAMY

JONATHAN SHEFFIELD WHY THERE SHOULD BE AN 'R' IN QIPP

Quality, innovation, productivity and prevention is not a new concept for the NHS. However, ever since the launch of the NHS chief executive's innovation report last year, there has been a welcome new focus placed on the "I" of innovation, previously – I believe – the least developed and least practised part of QIPP.

In some ways, delivering the innovation element of QIPP is our biggest challenge. The NHS is largely run on rules, targets and protocols – things that refine activity, constrain variation and standardise the way we work. This mindset sits well with quality, prevention and productivity. But if we want to deliver innovation, we need to encourage a different culture that encourages more creative thinking and acknowledges that not every innovation will be adopted. As all innovative organisations know, not every idea will work, but those that do can be transformational.

Two things are notable in the latest discussions about innovation. The first is there is more emphasis on driving innovation through partnership – particularly with the life sciences industry. The second is that innovation alone is not enough. We also need dissemination, an area where we have been weak in the past.

That is why NHS trusts should be looking at clinical research as a vital component of QIPP.

With the number of commercial clinical trials in the NHS on the rise, research can help trusts build relationships with pharma, med-tech and bio-tech companies, and develop the trust and understanding essential to any partnership.

'Without research to prove what works, we risk wasting money'

That leaves dissemination. One of the reasons why innovative practice does not get rolled out is that new ideas constitute a risk. There is the risk that the innovation is too embedded in local context to be more generally applicable. There is the risk that an idea hasn't been properly thought through or tested. Again, this is where clinical research comes in. Through research we can produce robust evidence to determine which innovations are worth disseminating, and which are not.

At this year's NHS Confederation conference, a speaker claimed that innovation is for all, while clinical research is the province of a rarefied few. This was wrong on two counts. With 99 per cent of trusts now doing some research, it is hardly rarefied – and we should be grateful for that. Without research to provide validation, and prove what works, we risk wasting time, money and effort innovating to no purpose. Research is the invisible "R" in QIPP, and we forget it at our peril.

Dr Jonathan Sheffield is chief executive of the National Institute for Health Research clinical research network

INNOVATION

SWITCHED ON

Trusts must be alert to new treatments – and use research to help them decide what to adopt. By Ingrid Torjesen

Real innovation is needed to improve treatments and the way services are delivered to ensure money is spent in the most effective way possible if the NHS is to achieve the £20bn in efficiency savings that must be found through the quality, innovation, productivity and prevention agenda.

Unfortunately innovation is the least well developed element of QIPP. The Department of Health has recognised this and NHS chief executive David Nicholson's report *Innovation health and wealth*, published in December last year, was an attempt to accelerate adoption and diffusion of innovation.

"We have a habit in the NHS to not pull technology through but to wait and have it pushed to us," says Mike Farrar, chief executive of the NHS Confederation.

He recalls seeing a revolutionary technology in 2000 in Oxford and in Doncaster that involved barcoding blood products – and complains that it took nearly 10 years for this system to become standard across the NHS. "Over the course of that time it has cost us money because we have mistransfused and then got into problems, or, worse still, just think about the patients who have received poor quality care," he says. "It is not only just the cost saving that we miss, it is also the improved quality and the outcomes for patients that we miss by not implementing and innovating and using these technologies faster."

The long time frame it takes for commercial suppliers who innovate to move products from proof of concept to a critical mass of market penetration, where they start to get a return on their investment, means these products end up more expensive than they would have been if the NHS had supported faster adoption, he explains.

The mindset of NHS leaders needs to be challenged to encourage them to adopt best practice earlier, because it makes sense both commercially and for patients, Mr Farrar says. "We need really good mechanisms to communicate with them so that they can get the best and quickest knowledge of new products and new developments and can work with their clinicians in implementing the change – because simply having the technology without the proper context for its implementation very often ... doesn't deliver the anticipated benefits."

Dr Jonathan Sheffield, chief executive of the NIHR clinical research network, says that sound evidence is needed to prove that change is beneficial and providing such evidence will also speed uptake elsewhere of the change across the NHS.

Not only does an overall benefit for the NHS need to be demonstrated, but it is also important to make it clear where these savings will be seen, Dr Sheffield emphasises. "A good research study makes it absolutely clear where and what the savings you can make, and what improvements you can make to patient outcomes, so there is very clear evidence as to why an innovation should be implemented universally."

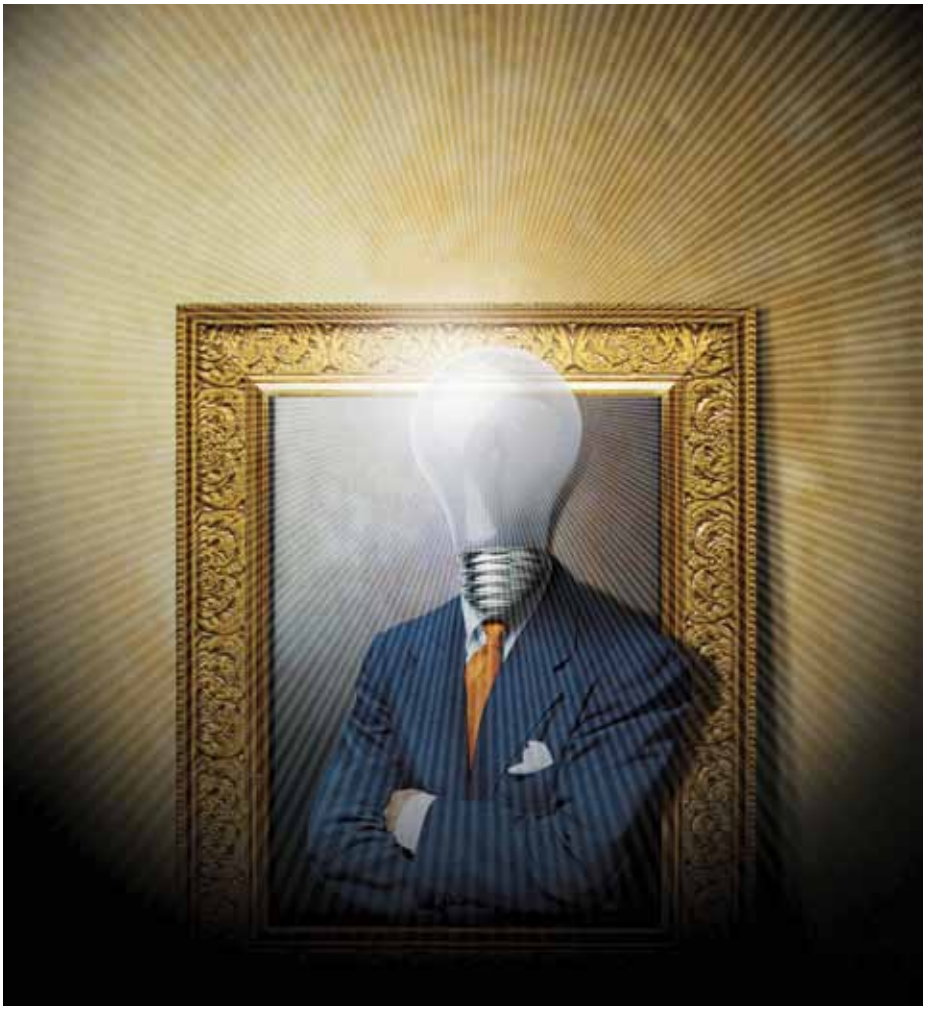
Double blind randomised controlled clinical trials are the current gold standard for new drugs, demonstrating efficiency while improving the quality of outcomes for patients. This delivers a more efficient and productive treatment that can reduce length of stay and complications, which means patients return to a more productive life in the community more quickly.

While such formal trials may not always be necessary for non-drug interventions, Professor Gary Ford, director of the NIHR stroke clinical research network, says that some systematic assessment is essential, because many initiatives which sound sensible do not deliver.

In the area of stroke, for example, trials were done to assess the impact of introducing family support workers. "Everybody thinks they must be good idea, but actually trials showed they make little difference to how patients or families felt in the long run," he says.

Another example was the upgrading of response to suspected strokes from category B (19 minute response) to category A (eight minutes), with the aim of getting patients to

CASE STUDIES OVERLEAF ▶



ALAMY

hospital faster so they would be more likely to receive clot busting drugs. Again, while this seemed a good idea, Professor Ford says the change did not take into account the fact that only half of patients with stroke are recognised as such when the ambulance is called, so other interventions were needed for ambulance dispatchers to identify a higher proportion of stroke patients from 999 calls. Additionally, the wider impact of the upgrade on the response to other life-threatening conditions was not fully considered.

In England, 98 per cent of trusts are currently conducting research and last year half a million patients were recruited into clinical trials. But Dr Sheffield points out: "What is not so clear is how the evidence produced by the trials is being used to change the way that we manage patients."

"The next stage is how to get trusts to engage in looking at that evidence base in a systematic way and making sure that they implement the changes," he says, because even some of the strongest NICE guidance is not implemented consistently by trusts.

Mr Farrar says organisations need to learn that they can import effective solutions and do not always have to develop them from scratch. The NHS Confederation has been working in partnership with the Association of the British Pharmaceutical Industry and the Association of British Healthcare Industries to run showcase events for NHS managers where they can learn how other organisations are using innovative techniques and products to address problems. And it is a successful approach: follow-up of the attendees three months after the first event revealed that between 50 and 60 per cent had adopted one of the technologies seen.

'Organisations need to learn that they can import solutions and do not always have to develop them from scratch'

The NHS Confederation also plans to start an innovation collaborative to bring together stakeholders together on a regular basis, and is working with 14 large NHS hospitals to try and source joint equity funding to help promote innovative products. "This idea is about bringing equity funds alongside NHS funds so that the NHS gets capital investment and ... a return if it promotes and spread best practice of particular technologies and products," Mr Farrar says. "We create commercial ventures and commercial deals where the NHS benefits itself from adoption financially because it's done some risk sharing."

Sir Muir Gray, lead of the QIPP right care workstream, says value-based decisions need to be made on whether an intervention is implemented for individuals and populations, which means looking at the relationship between effectiveness, quality and value.

"Not all effective interventions are of high value, and even if you do something at high quality then it may not be of high value of your population," he explains. "Even when there is evidence that something does more good than harm, you then have to say 'is it right for this patient?', 'is it right for this population?'"

He says part of that depends on resources but that it is also dependent on prevalence and severity. For example, Hong Kong decided not to introduce breast screening because prevalence of the disease was so low.

Research is something that patients like to see the clinicians treating them involved in and want to participate in themselves. Last year, a survey by the Association of Medical Research Charities found that over 90 per cent of the public felt that the NHS should be involved in research and over 70 per cent would like to be involved personally. Furthermore there is evidence that research active centres provide higher quality care across the board than is delivered by organisations not active in research.

The NIHR clinical research network collates information on how active trusts are in research and in which particular fields, and is working to share this information with the Care Quality Commission. Dr Sheffield explains: "By sharing this information we put ourselves in a stronger position to raise the profile of research engagement throughout the NHS."

Most organisations list provision of the highest quality care among their strategic aims. "Unless you know what the research evidence is and unless you are using innovation to implement that best research evidence, how do you make that claim?" Dr Sheffield asks.

"An organisation has to be seen not only to be involved with research but to be interpreting research findings into their everyday practice to be really demonstrating that they are giving the very best quality of care to patients, which is a significant part of the QIPP agenda." ●

INNOVATION: CASE STUDIES

TRIALS IN THE REAL WORLD

Gathering evidence to support innovation – including a study that confirms the NHS as an ideal environment for testing if treatments will work outside controlled trials

Looking at the outcomes of clinical research studies provides an insight into the impact of innovation and why it needs to be a fully developed element of the QIPP agenda. Two of the following studies demonstrate how clinical research can improve NHS productivity and patient outcomes. The third, the Salford lung study, also highlights unique characteristics of the NHS as a research environment – showing how it can continue to put the UK at the forefront of global innovation in healthcare.

START BACK STUDY

The STarT Back study has used a stratified care model to deliver care according to a patient's needs to improve outcomes for patients and save money for the NHS.

Researchers at Keele University designed a tool to help clinicians determine whether patients were at low, medium or high risk of long term back problems and were referred to physiotherapists who delivered a specific package of treatment, according to that risk.

Patients in the low risk group attended a single session with a physiotherapist and a package of advice to support self management. Patients in the medium risk group received a standardised package of exercise and manual physiotherapy, while the high-risk group were seen by physiotherapists trained to address their concerns and unhelpful beliefs about back pain – a bio-psycho-social approach.

The results showed patients experienced less pain and disability and improved treatment satisfaction and quality of life. It also saved the NHS money – £34 per patient – because low risk patients were discharged more quickly. In addition, there was an estimated £675 saving per patient in society costs because patients in medium and high risk groups took less time off work.

The study took place in 10 GP surgeries across Staffordshire and involved more than 850 patients. Every time an eligible patient consulted, a pop-up reminder would come up on the GP's computer screen to enrol the patient in the study.

A real world sister study called Impact Back has subsequently taken place in Cheshire. The results have yet to be published, but show a comparable NHS saving. In this study both GPs and physiotherapists could choose to enrol patients or not, as they would in normal care.

Keele University has encouraged adoption of the approach in other parts of the UK. In February, a meeting was held to disseminate the findings to the local NHS across Staffordshire, Shropshire and Cheshire, and in April 150 people from across the UK attended a free meeting to hear about the approach and its success.

The Royal College of General Practitioners and the British Pain Society have incorporated the tool into their pain management guidelines and the British Association of Spinal Surgeons has included it on its national spine registry.

Helen Duffy, manager of the primary care musculoskeletal research consortium at Keele University says: "The beauty of the STarT Back study and its sister study is that it showed clear improvement, clear benefits in terms of clinical outcomes – the pain function – in terms of patient satisfaction and cost effectiveness.

"There were NHS savings of £34 per patients in the STarT Back and then in its sister study it was £33 per patient. To be able to state that we know it will save £34 per patient, we know it will reduce secondary care referrals, we know it will reduce requests for images – that's quite amazing."

SALFORD LUNG STUDY

Formal randomised double blind clinical trials are a prerequisite for demonstrating a new drug therapy is effective and does not cause unacceptable adverse events. Such trials have rigid inclusion and exclusion criteria and conform to strict protocols to demonstrate clinical effects under controlled conditions in a narrow group of patients.

But once a drug is licensed, its use will be extended to a wide variety of patients, such as the elderly, patients with several comorbid conditions or those who smoke or are significantly overweight – people unlikely to have been included in the trial. The effectiveness of the drug may be different in these groups. Compliance with treatment may also be lower in patients left to their own devices compared with those encouraged to take the drug in clinical trials.

As a result pharmaceutical companies are increasingly looking to assess new therapies in real world settings to understand how effective the treatment will be in actual use, likely patient compliance, and wider benefits for patients taking it and the wider health system which will be valuable for commissioners but were not investigated by the formal trials.

One of the first of these "real world" studies is the GSK Salford Lung Study. Taking place in addition to formal clinical trials, it is assessing a new inhaled therapy for asthma and chronic obstructive pulmonary disease.

Real results: an asthma sufferer. The Salford study tests treatments in real world settings

GSK searched globally to find an environment with a database that recorded healthcare events that occurred in both primary and secondary care in as close to real time as possible. The NHS offered this and Salford staff have been enthusiastic partners. NHS Salford and Salford Royal Foundation Trust were eager to be involved. Every pharmacy in the area has also signed up and almost every GP practice.

Dr Dave Leather, medical director at the GSK Respiratory Centre of Excellence in Uxbridge, Middlesex, says: "It is the sort of thing you can do in UK which would be very difficult to do elsewhere."

Inclusion guidelines for both studies are straightforward. To be enrolled in the COPD study patients must be over 40 and have a GP diagnosis of COPD, and for the asthma study patients must be over 18 and have a GP diagnosis of asthma. The COPD study has begun recruiting and the asthma study is still undergoing ethics approval. The aim will be to have 4,000 patients enrolled in each study.

Both studies are looking at detailed aspects of healthcare utilisation and meaningful endpoints for commissioners – in COPD the endpoint will be exacerbations and in asthma it will be asthma control. For COPD hospitalisation, oral steroid use or antibiotic use for chest reasons will be the surrogate markers.

'It is the sort of thing you can do in the UK which would be difficult to do elsewhere'

For patients the only difference to their usual care is likely to be an occasional phone call to check on their lung function or asthma control because a team of 45 hospital and community based nurses oversee collection of the data and need to ensure completeness and check it for accuracy. Dr Leather said: "As far as the patients are concerned it's almost as if they're not in trial, but behind the lace curtain there's a frenetic level of activity."

The drug being tested has some features which suggest that it may work more effectively in the real world. "Typically if a medicine has those characteristics in a double-blind randomised controlled trial you don't see any benefit," Dr Leather says. For example poor compliance would be seen in a real world study of a medicine with a bad taste, whereas it would not be so evident in a double blind randomised controlled trial because patients would be encouraged to take the drug regularly despite the taste.

TXT2STOP

A free service that sends motivational text messages to smokers attempting to give up, and has doubled their quit rates, is being rolled out across England – within a year of research results being published.

The txt2stop study recruited 5,800 smokers attempting to quit through GP surgeries, with the assistance of the NIHR primary care research network. The group were randomly assigned to the txt2stop programme or the standard NHS support package. The txt2stop group received five text messages per day for the first five weeks, then three per week for the next 26 weeks. There was also the option of texting the word "crave" or "lapse" to receive an instant message of support. After six months smokers who claimed they had stopped received a saliva test to confirm that.

The results showed that the success rate in the txt2stop group was more than double that of the group receiving the standard smoking cessation package – 10.7 per cent compared with 4.9 per cent. The average age of participants was 35 but their ages ranged from 16 to 79.

Dr Caroline Free, of the nutrition and public health intervention research unit at the London School of Hygiene and Tropical Medicine, who led the research, has worked with the DH tobacco control team to roll out the service and it has been available across England since January. Of the 5,000 people who have so far joined the programme, 1,000 claimed to have quit at four weeks.

The National Institute for Health and Clinical Excellence is contemplating adding the service to its guidance if a demand for it is demonstrated.

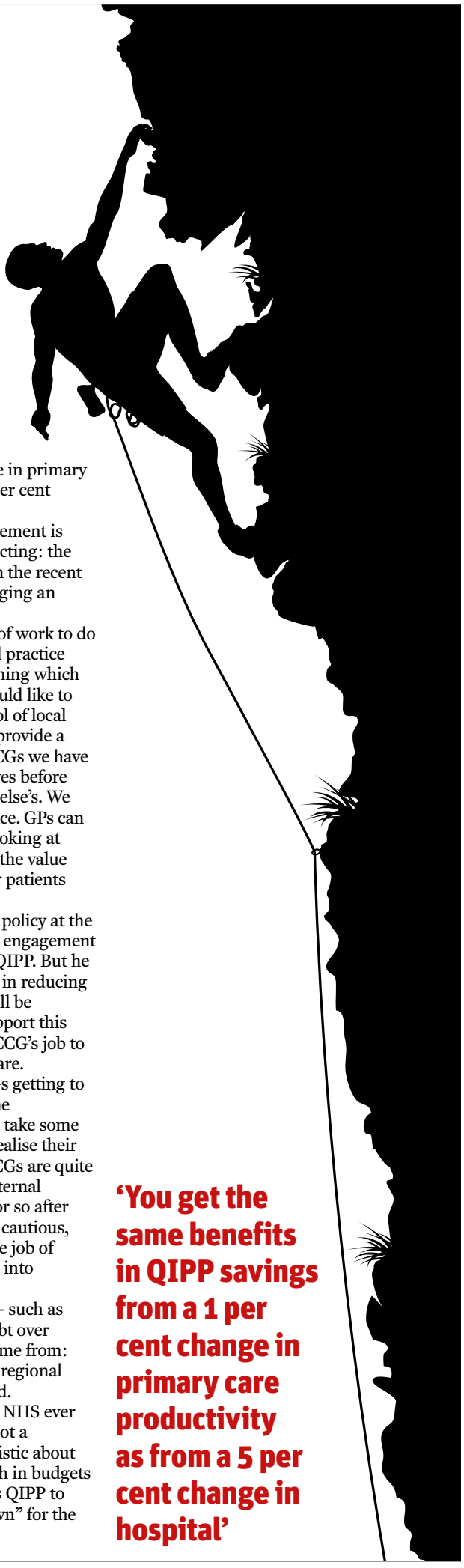
Dr Free says: "I haven't done a great deal about promoting the service, but still people have joined it." Information about the service is available at www.smokefree.nhs.uk and in "Quit Kits" which have been available through pharmacies since January. "Getting stuff from being available to being implemented is quite a challenge, I think," she says. "As more people got to hear about it, we found recruiting to the trial was a kind of exponential curve, so I imagine that's what will happen with the service but we will have to wait and see.

"It was something that worked and worked well and something that has been implemented quite quickly really. It would be great to see it implemented in Scotland and Wales." ●

ALAMY

Now for the hard bit

With the easy QIPP savings made, new CCGs are under pressure to design more efficient models of care. Alison Moore reports on the huge challenge they face



REFLESTOCK

Delivering cost savings through the QIPP agenda will be a key part of clinical commissioning groups' agendas for the coming years.

As primary care trusts increasingly devolve budgetary control to CCGs, they are acutely aware their ability to manage and deliver QIPP will be under scrutiny as part of the authorisation process. With many health economies looking to make significant savings in this financial year, that will be a challenge.

Many CCGs have well developed QIPP plans, which are being closely monitored and signed off by PCT clusters. Often these plan to make savings far above what is likely to be needed – in some cases 50 per cent above – to allow for slippage in year. Inevitably, not all of these savings are yet allocated to specific areas but that is not unusual at this point in the year.

But, with many of the easy savings already made in the early days of QIPP, will CCGs be able to release more savings? There is optimism that the greater involvement of clinicians will enable them to look beyond quick administrative savings to longer term redesign of care systems. National Association of Primary Care chair Dr Johnny Marshall says: "CCGs will be looking at how they can transform models of care."

He identifies local tariffs, the right investment in primary and community services and even new ways of commissioning such as alliance commissioning as ways in which this will be facilitated – and says ultimately this will lead to "less requirement for hospital beds and less hospitals".

"A sense I'm picking up is that this is not something that CCGs can do as commissioners on their own and they want a more collective approach to this," he adds.

North East Essex CCG chief executive and NHS Alliance spokesman Dr Shane Gordon says the big savings in the future are likely to come from prevention, early intervention and secondary prevention – all areas where primary care and community settings are likely to be crucial, as they come into contact with so many more people than secondary care.

"You get the same benefits in QIPP savings from a 1 per cent change in primary care productivity as [from] a 5 per cent change in hospital," he says.

But he believes clinical engagement is also having an impact on contracting: the focus on quality has increased in the recent contracting round. "We are bringing an added dimension to it," he says.

But he suggests there is a lot of work to do to optimise the model of general practice over the next few years – something which is not always recognised. He would like to see CCGs confirmed as in control of local enhanced services which could provide a lever to change practices. "As CCGs we have to take the log out of our own eyes before looking at the mote in someone else's. We have a lot to fix in general practice. GPs can do the same sort of process of looking at leanness in their services and ... the value they are trying to deliver to their patients and how they are doing that."

Chris Naylor, fellow in health policy at the King's Fund, agrees that clinical engagement could have positive impacts on QIPP. But he thinks the involvement of CCGs in reducing variation within GP practices will be contentious – some GPs will support this while others will not see it as a CCG's job to performance manage primary care.

The biggest challenge to CCGs getting to grips with QIPP is likely to be the organisational upheaval. "It will take some time before many of the CCGs realise their full potential. At the moment CCGs are quite rightly focusing on their own internal development. For the first year or so after authorisation they may be quite cautious, making sure they can do the core job of commissioning, without getting into complex service redesign."

With other parts of the NHS – such as SHAs – being axed, there is doubt over where the strategic input will come from: National Commissioning Board regional offices will have to be established.

But, looking forward, will the NHS ever be in a position where QIPP is not a challenge? Dr Gordon is pessimistic about the chances of significant growth in budgets in the years to come and expects QIPP to remain "the biggest game in town" for the rest of his career. ●

'You get the same benefits in QIPP savings from a 1 per cent change in primary care productivity as from a 5 per cent change in hospital'