House of Commons Health Committee follow-up inquiry into commissioning

Evidence submission from The King's Fund

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Summary

- Many GP commissioning consortia will need considerable support from the NHS Commissioning Board, particularly during the first years after formal establishment. Unless there is a robust process of self-assurance and an accompanying developmental programme, the Board may be drawn into top-down performance management.
- The Secretary of State retains considerable powers of intervention under the Health and Social Care Bill. The pressure to use these will be intense unless consortia and the NHS Commissioning Board perform consistently highly.
- Consortia must be given stronger requirements to involve other professionals in commissioning, and in doing so should be encouraged to work with clinical networks.
- The Bill creates insufficient mechanisms and incentives for integrating commissioning across health and social care. Monitor should be given a specific duty to promote collaborative working as well as competition.
- Commissioning processes must be transparent if consortia are to manage conflicts of interest without creating unnecessary bureaucracy.
- Stronger obligations are needed to guarantee adequate patient and public involvement in commissioning.
- We remain very concerned that it will be difficult for commissioning consortia to drive much-needed large-scale reconfiguration within secondary care.
- Choice of 'any willing provider' may be appropriate in some clinical areas but not in others, and should not be allowed to undermine commissioner purchasing power.

The assurance regime for consortia

1. The Committee's previous report on commissioning highlighted the critical importance of creating a sufficiently robust assurance regime for GP consortia, and we would strongly endorse this point. Consortia will be held to account principally by the NHS Commissioning Board through an annual performance assessment, and rewarded for good performance with a 'quality premium' incentive payment.

2. The Health and Social Care Bill allows some flexibility in terms of how the NHS Commissioning Board interprets its relationship with consortia. Its most direct powers of intervention can be deployed in only two circumstances:

   - when a consortia is failing to discharge any of its functions
   - when a consortia is at 'significant risk' of failing to do so.

3. However, the Bill also confers broader powers that could see the NHS Commissioning Board become much more than a safety net for isolated cases of failure, and it is highly likely that it will need to do so. For example, it has powers to issue commissioning guidance that consortia would be legally bound to have regard to. David Nicolson has indicated his preference for the NHS Commissioning Board taking a wider role in offering proactive support, writing in a recent letter to the NHS that the Board 'will offer a spectrum of support, from empowering and facilitating success, to intervening to support consortia in difficulty'.

4. While we believe the overall relationship between the NHS Commissioning Board and consortia should be 'supportive' rather than managerial, it may be necessary and appropriate for the Board to assume a more hands-on role in the first few years after consortia formally take on their responsibilities, potentially working with or through PCT clusters. This could include directly commissioning those services that consortia are not yet ready to accept financial responsibility for. It is likely that there will be a substantial number of consortia that perform relatively poorly but that do not meet the threshold for formal intervention by the NHS Commissioning Board. There will need to be an appropriate developmental programme in place to help these consortia make improvements, perhaps including 'mentoring' from more advanced consortia.

5. The annual performance assessment process developed by the NHS Commissioning Board, along with any commissioning guidance it publishes, must be designed to be of use to consortia themselves. The assessment should be a developmental aid more than a performance management tool, the aim being to help consortia to clearly identify what their weaknesses are and what developmental support they might need to address these weaknesses. Consortia must be able to translate their performance in the annual assessment into practical action. Focusing the assessment process exclusively on outcomes may not be sufficient to give consortia a detailed diagnosis of how they need to change. An assessment of core commissioning competencies would be of much value to consortia, particularly in the early years when they are developing skills and capacity.

6. If the assurance regime fails to enable consortia to assess and respond to their skills gaps and organisational weaknesses themselves, a return to top-down performance management may be inevitable. Our view is that a wholesale reversion to performance management would be regrettable – but that there are some functions that the NHS Commissioning Board should be performing on an ongoing basis, such as the development of national standards and template contracts.

7. The authorisation process for consortia will be a key part of quality assurance for GP commissioning. Getting this process right will be an early challenge for the NHS Commissioning Board. In stark contrast to the authorisation process developed by Monitor for aspiring foundation trusts, consortia will be new organisations with no track-record they can be judged against. The skills they need will also be new – and different to those required in the past by primary care trusts (PCTs). This leads to the conclusion that for some consortia, authorisation may need to be a phased process rather than a one-off event, with responsibilities being transferred incrementally over time.

8. Given the relatively small scale of many consortia, it is highly likely that some services will need to be commissioned collaboratively by inter-consortia partnerships, potentially at multiple co-existing levels. This introduces another element of complexity into assurance arrangements. It is not clear how the quality of inter-consortia commissioning

will be assured, and how good or poor performance will be attributed to actions taken at this level versus the individual consortia level.

9. A priority for the NHS Commissioning Board will be to develop a clear failure regime for consortia whose performance is poor enough to warrant intervention. The Bill gives the Board power to intervene in a range of ways, including ultimately the power to dissolve a consortium and pass its functions to other consortia or take them on itself. The Board will need to establish a rules-based system describing with greater precision how and when its various powers will be used.

Accountability at the national level

10. The Committee raised concerns about the potential for conflict between the NHS Commissioning Board, Department of Health and Secretary of State, and the need for clear lines of accountability to prevent this.

11. Under the Bill, the Secretary of State retains considerable powers over the NHS. For example, in the annual mandate between the Secretary of State and the NHS Commissioning Board, the former is able to specify not only the objectives that the NHS Commissioning Board should seek to achieve, but also 'any requirements that the Secretary of State considers it necessary to impose on the NHS Commissioning Board for the purpose of ensuring that it achieves those objectives'. The Bill also allows for secondary legislation that would allow the Secretary of State to set a number of other requirements relating to the operation of the NHS Commissioning Board, and with parliamentary approval could require the Board or consortia to do anything considered 'necessary for the purposes of the health service'.

12. The Bill therefore leaves room for the relationship between the Secretary of State and the NHS Commissioning Board (as well as that between the Board and consortia) to have managerial elements. The Department of Health has indicated that some of the powers granted to the Secretary of State would be used only in exceptional circumstances. However, if consortia or the NHS Commissioning Board do not perform consistently well, the pressure on the current or future Secretary of State to use the powers invested in them could be very strong. In such a circumstance, the removal of the intermediate tiers of NHS management (PCTs and strategic health authorities (SHAs)), leaving national bodies interacting directly with (potentially weak) local bodies, could result in increased centralisation – in spite of the prevailing political preference for the opposite.

13. Just as there is a potential for these arrangements to lead to tensions between the NHS Commissioning Board and Secretary of State, there is also a lack of clarity in the relationship between the Care Quality Commission and Monitor. The two regulators are charged with safeguarding different aspects of system performance, and it is not yet clear what the pre-eminent consideration will be in situations where these diverge – for example, where promoting competition and contestability is at odds with promoting quality. Greater clarity is needed on how the two organisations will relate to each other in the new system – and how both will relate to the NHS Commissioning Board. There may be a risk of confusion in some circumstances over whether the Secretary of State should turn to Monitor or to the Board to deal with performance issues, with no single organisation holding responsibility for overseeing the NHS as a whole, in terms of both provision and commissioning.

Multidisciplinary involvement in commissioning

14. We are concerned that the requirement in the Bill for consortia to 'obtain appropriate advice' from other health professionals will not guarantee sufficient multidisciplinary involvement in commissioning. The government must set out clear expectations that consortia will fully involve hospital specialists, other clinicians and health and social care professionals in their work; this could be through a legal duty to involve such professionals, or a duty to report annually on how they have been involved.

15. With real multidisciplinary involvement, commissioning consortia could become the focus for improved collaboration and closer working between services and professionals. If, however, commissioning is seen principally as the prerogative of GPs, there is a risk of it widening the divisions that already exist. Research shows that practice-based commissioning had exactly this effect in areas where specialists and other professionals were not adequately involved (Curry *et al* 2008).

16. Consortia should be encouraged to work closely with existing clinical networks created as forums for multidisciplinary work. These broker care across providers for patients with particular conditions, for example, in cancer, cardiac and stroke care (Curry and Ham 2010). Evaluations have demonstrated that such networks can succeed in supporting professionals to build collaborative relationships across organisational and professional boundaries (Guthrie *et al* 2010). The NHS Commissioning Board could set out expectations for how consortia should work with multidisciplinary networks in core clinical areas.

17. Over time, some consortia may choose to go further than this and develop into multi-professional organisations, which span the divide between commissioning and provision, on a similar model to multi-specialty medical groups in the US. Some of these groups have successfully taken on a budget for a defined population, on behalf of the insurance companies with whom the patients are enrolled. The groups consist of a network of specialists and primary care doctors who are either directly employed by the group, or contracted to work with them. The experience of these groups suggests that multidisciplinary commissioning could only succeed in the UK if payment mechanisms were re-designed to support such collaboration (Thorlby *et al* 2011, Ham and Smith 2010).

18. If consortia are to have sufficient focus on the health of their local population as opposed to individual clinical encounters, it is essential that public health specialists are involved in their commissioning activities. We are concerned that health & wellbeing boards will have limited powers over GP consortia, and that there may not be sufficiently close relationships between consortia and public health specialists based in local authorities. The lack of co-terminosity between local authority and consortia boundaries will introduce a further barrier here, making it harder for consortia to get access to the high quality public health data they will need to commission effectively.

Integration with social care

19. The Bill places duties on the NHS Commissioning Board and health and wellbeing boards to promote integration between health and social care and includes provisions to enable the NHS Commissioning Board or consortia to establish pooled funds. These provisions are welcome and should encourage joint working across health and social care. We would encourage the definitions of 'health-related services' and 'social care services' in

clause 179 to be widened to capture the full range of health and well-being services. There should also be an equivalent duty on GP consortia to promote integration.

20. However, integration across health and social care will be compromised if the policy drivers of choice and competition produce an increasingly fragmented array of competing public and private providers (see also our response to the *Greater Choice and Control* consultation). There is a duty on Monitor to promote competition 'where appropriate'; the definition of 'where appropriate' will be critical to ensuring that promoting competition does not impede efforts to advance integration. Monitor should also be given a specific duty to promote collaborative working across health and social care.

21. The NHS, social care and public health outcomes frameworks need to go further to support integration between the sectors. Further work is needed to ensure that the outcomes frameworks align. In the longer term, the creation of a single outcomes framework across the three sectors would more effectively support integrated working.

22. Under the current arrangements, PCTs and local authorities have developed numerous ways of working in partnership, resulting in better co-ordination of services. Ensuring good practice is carried forward through the transition will be critical, but it is unclear how realistic it will be to achieve this given the speed and scale of the reforms. The loss of the co-terminosity between local authorities and commissioners may create practical barriers to joint working (see our response to the *Information Revolution* consultation) and we fear that progress made to date in improving integration could be reversed.

23. It is difficult to interpret what impact the changes to the legislation on care trusts (clause 184) will have on integrated working. However, we caution against any provisions that might lead to dissolution of arrangements in those places where care trusts have worked well, such as Torbay. The benefits of such arrangements are described in a recent report from The King's Fund (Thistlethwaite 2011).

Conflicts of interest

24. The Bill requires that consortia include in their constitution details on managing the conflicts of interest that will inevitably arise from GPs' dual position as commissioners and providers of services. What should be included in this is not specified in the Bill, although the government's response to the Committee's previous inquiry suggests that there is likely to be secondary legislation and/or guidance on consortia's internal governance arrangements in due course (paragraph 68).

25. It would not be in patients' interests for regulations/guidance on conflicts of interest to be unduly restrictive. A major benefit of GP involvement in commissioning is the potential for GPs to design and commission innovative forms of expanded primary care provision and new models of care in the community. An appropriate balance needs to be struck that does not risk stifling this potential for creativity under the burden of highly bureaucratic processes or complex procurement and tendering rules.

26. What is imperative is that the arrangements that are developed maximise transparency. Transparent reporting of the commissioning decisions taken, and how these are reached, will provide the strongest safeguard to ensuring public money is used appropriately. There are several practical ways this could be implemented (see Ham *et al* 2011):

- requiring consortia to have public representation in their boards or other management structures
- a requirement to publish commissioning decisions above a defined value
- application of open-book accounting principles
- establishing processes through which aggrieved parties can ask for commissioning decisions to be reviewed
- a requirement for GPs to declare financial interests in provider organisations
- development by the NHS Commissioning Board of a list of enhanced services that consortia are able to commission from practices without using tendering processes.

27. In the context of this need for transparency, the limited requirements being placed on consortia are a cause for concern. The Bill requires that consortia publish their constitution, commissioning plans and remuneration arrangements, and that they hold an annual general meeting open to members of the public. These requirements are helpful but do not go far enough – particularly with respect to patient/public involvement (see below).

Patient/public involvement in commissioning

28. Arrangements for patient/public involvement in commissioning are already weak under the existing system, and there is a significant risk that the reforms will weaken them further. By placing no specific obligations on consortia, the Bill fails to give patients and members of the public meaningful powers within the commissioning system. Consortia are to have a duty to involve patients in decision-making, but involvement here can mean as little as 'being consulted or provided with information'. The power of local HealthWatch groups over consortia will be limited to a scrutiny function, and local authorities' ability to refer reconfiguration decisions to the Secretary of State is to be restricted to designated services.

29. The Bill does permit the NHS Commissioning Board to publish further guidance on patient involvement, to which consortia will be obliged to have regard. The NHS Commissioning Board should be encouraged to do so and, as stressed above, the most important principle in such guidance should be that of transparency. Patients and members of the public must be able to see how and why decisions relating to the commissioning of services in their area are reached.

30. Without meaningful accountability to local people, we can anticipate many legal challenges being made to commissioning decisions. This situation could be pre-empted, and the associated expenses reduced, through effective patient/public involvement from the outset.

31. Patient/public involvement should build on examples of good practice developed by practice-based commissioning consortia. For example, the constitution of Principia Partners in Health in Nottinghamshire guarantees that half of the members of the company's board of directors are members of the public and lay members have voting rights at the annual meeting (Parsons *et al* 2010). The community membership models developed by foundation trusts may provide further examples of good practice (Ham and Hunt 2008). Involving local condition-specific groups and community organisations in the commissioning process may also provide an effective mechanism for giving patients and members of the public a stronger voice (NHS Alliance 2010).

Service reconfiguration

32. We remain concerned that it will be difficult for commissioners to drive major reconfiguration within secondary care in the absence of PCTs and SHAs or equivalent local system leadership. The importance of the system leadership role (currently provided principally by SHAs) is underlined by new research on the reconfiguration of hospital services in south-east London. The research shows that the necessary changes are unlikely to happen if left to market forces alone, or if local commissioners are not supported by bodies with wider strategic oversight (Palmer 2011).

33. The Bill enables consortia to collaborate in order to address issues too large for any one consortium to tackle alone. However, there is a danger that allowing such collaboration to happen organically will mean that the pressing need to reconfigure hospital provision in some areas will not be addressed quickly enough, if at all. A related concern is that consortia will pursue commissioning strategies that make financial sense from their own perspective, but could represent very poor value for money for the local health economy as a whole. This could risk derailing crucial efforts to improve productivity in the NHS.

34. The government's response to the Committee's previous inquiry indicates that there may be a role for the NHS Commissioning Board in supporting consortia in service reconfiguration (paragraph 93). It is possible that regional tiers of the NHS Commissioning Board will provide the local system leadership that currently appears to be lacking in the proposals. In the more immediate future, it seems likely that reconfiguration will be driven principally by secondary care providers themselves, seeking to make efficiencies in response to the intense financial pressure they are under.

35. The designation process, by which Monitor will ensure the continuity of certain 'essential' services, may complicate attempts to reconfigure hospital services. The financial and practical interdependency of different service clusters means that designation can be expected to have knock-on effects on other services, whose removal would make the designated services unsustainable. Designation is expected to be led by consortia, which will apply to Monitor for local services to be granted designated status. This process could have a major impact on the range of services available in local areas, again underlining the importance of giving patients and members of the public a strong voice within consortia. Both consortia and Monitor will need to strike a careful balance between maintaining access to essential services and avoiding creating a system with undue barriers to beneficial change.

Tensions between patient choice and commissioning

36. Giving patients choice of 'any willing provider' has the potential to weaken commissioners' hands in negotiations with service providers. A commissioner's power is based to some extent on their ability to negotiate and selectively contract with certain providers to deliver services under defined terms. Under the any willing provider model, a provider's income is determined by the sum of individual patients' choices rather than by agreements with commissioners (which could not specify contract volume or expected income). There is some risk that this could weaken commissioners' ability to influence provider behaviour or specify innovative service models. Patient choice could also compromise the commissioner's ability to control their budget. There is therefore a need to strike a balance between commissioning and patient choice as two alternative means of driving service improvement.

37. We recognise the benefit of offering greater choice to patients in elective care and would like to see greater choices being offered to patients with long-term conditions, as well as in mental health, maternity and end-of-life care services. We would recommend that the extension of choice in these areas is managed carefully by the NHS Commissioning Board and Monitor, and have suggested ways that this could be achieved in our response to the *Greater choice and control* consultation. However, we also stress that complex services such as those for trauma or cancer need a co-ordinated approach across providers. Quality has been demonstrably improved by focusing care within centres of excellence and creating networks of providers – an approach that necessarily reduces the extent of choice for patients. A market that encouraged multiple new entrants to offer such services would not be good for patients, or financially beneficial for commissioners. GP consortia should be supported to develop integrated care networks with acute and community providers. Patients could then be offered choice between integrated delivery systems – although this scenario may take some years to develop (Curry and Ham 2010).

38. The devolution of commissioning budgets to GP consortia, combined with free choice of GP, will mean that for the first time in the NHS patients will have de facto choice of commissioner. If consortia make significantly different decisions about their clinical and financial priorities, patients may decide to register with a different practice in order to access a different range of treatment options. It is unclear whether this will impact positively or negatively on equity of access, or on health inequalities – there is a risk that those who are more able to navigate the system may be able to get greater access to their preferred treatment options. Choice of commissioner could also have other implications such as the potential for adverse selection or 'cream skimming'.

39. An additional dimension to this debate relates to GP consortia assuming the drug rationing responsibilities previously held by National Institute for Health and Clinical Excellence. There is a risk of the patient–doctor relationship being compromised by this arrangement if a patient suspects their GP is making prescribing decisions based on financial rather than clinical considerations. There is a strong argument for retaining a central mechanism for evaluating the cost-effectiveness of interventions and issuing guidance on this, on the grounds that devolving all rationing decisions to the local level would be inefficient, impose significant burdens on consortia, and could exacerbate the 'postcode lottery' in availability of treatments.

References

Curry N, Goodwin N, Naylor C, Robertson R (2008). *Practice-based Commissioning. Reinvigorate, replace or abandon?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/pbc.html

Curry N, Ham C (2010). *Clinical and Service Integration. The route to improved outcomes.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/clinical_and_service.html

Guthrie B, Davies H, Greig G et al (2010). *Delivering Health Care through Managed Clinical Networks (MCNs): Lessons from the North*. Report for the NIHR SDO programme.

Ham C, Imison C, Ashton R (2011). 'Should GPs make or buy?' *Health Services Journal*, vol 121, pp 12–13.

Ham C, Hunt (2008). *Membership Governance in NHS Foundation Trusts: A review for the Department of Health.* Available at: www.mutuo.co.uk/wp-content/shared/nhs-ft-review.pdf

Ham C, Smith J (2010). *Removing the policy barriers to integrated care in England*. London: The Nuffield Trust.

NHS Alliance (2010). *Whose NHS is it Anyway? Sharing the power with patients and the public*. Available at: www.nationalvoices.org.uk/sites/default/files/Whose_NHS_is_it_anyway.pdf

Palmer K (2011). *Reconfiguring Hospital Services. Lessons from south-east London.* London: The King's Fund. Availableat: www.kingsfund.org.uk/publications/reconfiguring.html.

Parsons S, Winterbottom A, Cross P, Redding D (2010). *The Quality of Patient Engagement and Involvement in Primary Care*. London: The King's Fund. Available at: www.kingsfund.org.uk/document.rm?id=8722

Thistlethwaite P (2011). *Integrating health and social care in Torbay: Improving care for Mrs Smith*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/integrating_health_1.html

Thorlby R, Rosen R, Smith J (2011). *GP commissioning: insights from medical groups in the United States*. London: The Nuffield Trust.

The King's Fund's responses to the NHS White Paper consultation documents are available at:
www.kingsfund.org.uk/press/parliamentary_activities/consultations/index.html