

## SUBMISSION TO THE HEALTH SELECT COMMITTEE INQUIRY INTO COMMISSIONING

1. The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

### Summary

2. The previous Health Committee strongly criticised the current commissioning regime, concluding that, unless it is able to demonstrate better value for money, the purchaser/provider split may need to be abolished. It highlighted a number of weaknesses including:
  - primary care trusts (PCTs) remain largely passive commissioners and do not challenge providers sufficiently regarding the quality and efficiency of their services
  - PCTs lack essential data analytic skills, clinical knowledge and high-quality managerial talent
  - the skills deficit in PCTs has been worsened by 'constant reorganisations and high turnover of staff'.
3. Since the publication of the Committee's report, the latest world class commissioning assessments have been made available, and we have published new research focusing on the use of external support for commissioning by PCTs. Both highlight marked improvements in the quality of commissioning over the past year, although many of the weaknesses identified by the Committee remain.
4. The new government's White Paper *Equity and Excellence: Liberating the NHS* proposes replacing the current arrangements with a new system of (GP) commissioning led by GPs and their practice teams (GP commissioning), abolishing PCTs by 2013. Our evidence to this inquiry draws on our response to the White Paper to make the following key points.
  - Giving budgets to GPs provides a significant opportunity to improve commissioning in the NHS. However, the government's approach risks undermining the benefits it could bring. We recommend a more measured approach that enables those who are ready to pilot the new arrangements to do so, with the learning used to support a flexible, staged national roll-out that enables consortia to take on increasing responsibilities as and when they are ready to do so.
  - Although we do not endorse abolishing the purchaser/provider split, there is a strong argument for sticking less rigidly to a separation of the two functions. The needs of some patients, for example, older people and people with long-term conditions, may be better met by organisations that bring together commissioning and some or all aspects of provision. Now is the time for policy-makers to explore the role that such integrated systems could play in the NHS.
  - While we acknowledge the case for some reform, we question the need to embark on a fundamental reorganisation of the NHS at this time. Streamlining NHS structures over time as the new commissioning arrangements are implemented, rather than abolishing all PCTs and strategic health authorities (SHAs) by a set date, would ease the transition and minimise instability as the NHS also confronts the most significant financial challenge in its history.
  - It will be vital that the consortia include a range of clinicians and professionals as well as GPs.
  - While we welcome the enhanced role that local authorities will play under the government's proposals, the relationships between the NHS Commissioning Board, local health and wellbeing boards and GP commissioning consortia need to be clarified. The loss of co-terminosity between local authorities and commissioners risks undermining collaborative working.

- An overly restrictive management allowance could make it difficult for consortia to build or buy in the range of skills they will need to commission effectively.
- More thought needs to be given to how consortia will collaborate to commission specialist services that cannot be effectively commissioned by individual consortia. Allowing this to happen organically may not be sufficient.

### **Clinical engagement in commissioning**

5. Limited use of clinical expertise remains a key weakness in commissioning. Practice-based commissioning (PBC) has not succeeded in securing sufficient clinical engagement, in part because the incentives to engage are weak, and in part because many GPs feel it does not give them enough power or control over commissioning decisions (Curry *et al* 2008). Devolving power down to consortia level and replacing the notional commissioning budgets used in PBC with real budgets can be expected to improve this.
6. The evidence from clinical commissioning groups in other countries, particularly the USA, makes it clear that involving doctors from a range of specialties, not solely GPs, is crucially important for success (Ham 2010a). Engaging other professionals such as nurses, pharmacists and social care professionals is also important. With real multidisciplinary involvement, commissioning consortia can 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 historic divisions between different parts of the health service, and in particular between primary and secondary care.
7. The government's intention to make membership of commissioning consortia mandatory will go some way to encouraging a minimum level of clinical engagement in commissioning. However, it will also be important for GPs and other professionals to feel they have ownership of these new organisations. The government will need to develop a clear operational policy on how GP consortia will work with their constituent GP practices to ensure due process and transparent decision-making. Rules governing conflicts of interest should not, however, become a rigid barrier that prevents consortia from commissioning services from their constituent practices. This would risk making it difficult for GPs to use their commissioning powers to develop new services in primary care, which for many GPs is likely to be one of the main attractions of engaging with commissioning.

### **Implementing the proposed reforms**

8. The research evidence suggests that clinical commissioning is most successful when the scope of services commissioned is adjusted according to the size and skills of each commissioning group (Ham 2010a). We do not, therefore, endorse the proposed single model for GP commissioning, in which all consortia bear full risk for commissioning a near-comprehensive range of services, as described in the government's White Paper (Department of Health 2010).
9. However, if this approach is implemented, we urge the government to adopt a more flexible, staged process in which consortia are not exposed to full budgetary risk in the first years of their existence, and take this on only as and when they are ready for it. Experience from other countries suggests that a gradual transfer of budgetary responsibility is required as GP commissioners learn how to manage budgets effectively. This would allow (a) some consortia to take on responsibilities before others, and (b) responsibilities to be transferred incrementally rather than transferring full financial risk from the outset. The NHS Commissioning Board could have the power to limit windfall gains or unavoidable losses during this period, or until there is general confidence in the accuracy of the formula used to allocate resources between consortia.
10. The readiness to take on greater responsibilities for commissioning currently varies markedly between different groups of GPs. Some practice-based commissioning groups are ready to make a start as soon as possible. Supporting them to be early adopters by using 2011/12 as a shadow year for introducing GP commissioning would enable testing and evaluation to take place to inform national implementation.

11. Building the necessary capabilities within consortia will be a key challenge in implementing the proposed reforms. Commissioning is a complex and multi-faceted task, and doing it effectively requires a broad range of skills. These range from very specific, technical skills (eg, data analysis and interpretation) to more generic but no less important skills in leadership and management (eg, influencing, negotiation and relationship management). Highly specialist skills are also needed in areas such as accountancy and contract management.
12. While it will not be necessary for consortia to develop all these skills internally, they will as a minimum need to quickly develop a clear understanding of the different elements of high-quality commissioning and the support they may need in order to do it effectively. They will also need strong leadership and communication skills, in order to establish an effective dialogue with colleagues in primary and secondary care about quality and productivity and to influence professionals who are not directly accountable to them.
13. Other more technical skills may be bought in or built over time by working with commissioners in PCTs and local authorities, or with private sector companies offering commissioning support services. Our research found that while external support can help improve commissioning processes, PCTs have not always been effective users of the services available (Naylor and Goodwin 2010). GP consortia will not necessarily have experience of using external support and are likely to be operating with more restrictive management allowances. They will therefore need to learn from PCTs' experience of using external support to avoid repeating past mistakes.
14. If management allowances are too restrictive, there is some risk that consortia will not be able to either buy in the skills they need or build them in-house.
15. The results of the 2010 world class commissioning assessment process indicate that commissioning skills within some PCTs have improved considerably since 2009 (Gainsbury *et al* 2010). An immediate priority must be to support existing commissioning and managerial talent in PCTs, SHAs and elsewhere during the transition period, to prevent the accumulated knowledge and skills from being lost. If the rapid changes currently being seen in PCTs continue and lead to a major scaling back in their activities before consortia are fully operational, there is a serious risk of losing financial control in the interim period.

### **Accountability arrangements for GP commissioning**

16. The White Paper proposes that GP consortia are held accountable by the NHS Commissioning Board, using a commissioning outcomes framework. The Board will have a very wide-ranging remit, including calculating how resources will be allocated between consortia, holding them to account, developing commissioning guidelines and model contracts, and directly commissioning services not commissioned by consortia. Despite the intention set out in the White Paper for it to be a 'lean and expert body', the NHS Commissioning Board is likely to need a substantial workforce and a presence at the regional level to discharge these varied responsibilities effectively.
17. The proposed framework focuses principally on the outcomes consortia will be expected to achieve for the population they serve. We are concerned that focusing just on outcomes will leave the NHS Commissioning Board poorly equipped to assess the performance of consortia, since outcomes measures used in isolation can be insensitive to difference, slow to detect change over time, and will be influenced by multiple external factors beyond the consortia's control. While we would not advocate the creation of an assessment process as burdensome as world class commissioning for GP consortia, we believe the Board should complement outcome measurement by also assessing consortia in terms of a small number of essential commissioning processes or competencies, particularly during the first years while consortia are still developing their skills.
18. Particular accountability arrangements should be put in place with regard to the use of external support. If some consortia choose to outsource their responsibilities and transfer the financial risks involved in commissioning onto private sector organisations, arrangements will be required to safeguard public accountability and ensure the organisations involved are capable of taking on these risks.

## **Integration and the role of local authorities**

19. Local authorities will be given a number of new roles under the proposed reforms. In addition to taking on responsibility for commissioning public health services, new health and wellbeing boards will be established with responsibility for:
- co-ordinating and integrating the commissioning of health and social care services
  - assessing population health needs and leading, or at least overseeing, health improvement activities
  - scrutinising consortia's plans for service redesign.
20. Transferring public health commissioning to local authorities creates a welcome opportunity to integrate the planning of public health interventions with decision-making around broader factors that influence population health, such as education, housing and transport. However, it is important that the NHS remains closely involved in health improvement and prevention and that the many opportunities that exist for health professionals to promote health and wellbeing are not lost. Further thinking is needed on how responsibilities in this area will be divided between consortia, local authorities and the new Public Health Service.
21. GP commissioners will have a central role in developing integrated models of care which span organisational boundaries. The case for collaboration in the delivery of high-quality care for people with long-term conditions and for older people who have complex co-morbidities is compelling. Many of these people are frequent users of NHS and social care services who could be supported to live independently if primary care teams worked more effectively with specialist teams based in hospitals. Integrated service provision has the potential to deliver more care closer to home and avoid the inappropriate use of hospitals as is already being demonstrated in areas like Torbay, with emerging evidence suggesting that working in this way also delivers savings to the NHS (Ham 2010b; Ham and Smith 2010). Given the severe pressure on health and social care budgets over the next few years, it will be essential that NHS organisations and local authorities do more to work together to pool resources and align services in this way.
22. The impact of the reforms on the integration of health and social care may depend largely on the interface between health and wellbeing boards and GP consortia. This is currently unclear and it remains to be seen whether health and wellbeing boards will have any real power over consortia's decisions. If the boards do not have formal powers with regard to GP consortia's commissioning decisions, their role in integrating the provision of health and social care may be limited. If, on the other hand, they do have statutory powers, this would create a dual chain of accountability for consortia, with tensions potentially arising between the demands of local health and wellbeing boards on the one hand and the national NHS Commissioning Board on the other.
23. One serious concern is that the loss of the geographical co-terminosity that currently exists between PCTs and local authorities may make collaborative working considerably more difficult. Although the shape consortia will take is as yet undetermined, some are likely to straddle local authority boundaries, and many local authorities will need to forge relationships with multiple consortia. In addition to challenges regarding relationship-building, the loss of co-terminosity introduces significant practical barriers resulting from having different local partners working with data flows and commissioning plans which cannot be aligned in terms of their geographical coverage. The impact of this would be heightened further if consortia are formed on the basis of affinity rather than geography.
24. To facilitate the development of integrated models of provision, policy-makers should avoid sticking rigidly to a separation of commissioning and provision. GP commissioners must be supported in developing services that overcome barriers between primary and secondary care, between health and social care and between practices themselves. Regulations concerning conflicts of interest arising from being both a provider and commissioner should ensure transparency in decision-making without preventing GPs and other professionals from innovating in this way.

## **Health inequalities**

25. Tackling the stark and avoidable inequalities in health that exist between different groups and areas of the country requires a cultural change in which GP commissioners accept greater responsibility for protecting and promoting population health as well as for the immediate needs of individual patients. It is important that the commissioning outcomes framework includes strong incentives for GP consortia regarding health improvement and the reduction of health inequalities.
26. The interface between consortia and local authorities will again be critical for delivering on this agenda. Consortia will need to build close relationships with local authorities and the new Public Health Service in order to work collaboratively on tackling health inequalities.

### **Specialised commissioning**

27. The previous Committee's report on commissioning identified particular issues regarding the commissioning of specialised services, with many PCTs giving this low priority and wide variations existing between local areas. Under the new proposals, the most highly specialised services will be commissioned by the NHS Commissioning Board rather than by GP consortia. Securing the necessary clinical engagement in specialised commissioning under these arrangements will be important.
28. There are a number of services that are not specialised enough to be commissioned by the NHS Commissioning Board, but that could not be commissioned effectively by individual consortia acting in isolation. Cancer, stroke care, trauma and high-risk complex surgery are examples of services that fall into this category. To ensure quality and safety, these services are best delivered by concentrating services in specialist centres, and the commissioning of them needs to occur across a larger geographical area or population.
29. To commission such services successfully, consortia will need to aggregate and commission collaboratively. It may not be sufficient to allow such collaboration to happen organically. The Department of Health will need to give careful thought to what structures or guidance may be needed to allow inter-consortia commissioning to be undertaken effectively.

### **Conclusions**

30. Although there have been recent improvements in the quality of commissioning in the NHS, many of the shortcomings highlighted by the Health Committee's last report on commissioning still exist, and the characterisation of commissioning as the 'weak link' remains fair. International experience indicates that other countries face similar challenges and there is no health care system in which commissioning is done consistently well (Dixon 2010).
31. The government's proposed reforms aim to address some of the shortcomings in commissioning. However, they do so at the expense of considerable disruption to the operation of the NHS over the next three years, and while they may succeed in tackling some longstanding problems, they also introduce some considerable new risks. We would question whether the scale and pace of the reforms are necessary, particularly given the evidence that both the NHS generally and the commissioning function specifically have been on a path of gradual improvement over recent years (Thorlby and Maybin 2010). Unresolved questions raised by the proposals include:
  - where will the much needed local and regional system leadership reside in the absence of PCTs and SHAs?
  - will consortia be able to carry the financial risks associated with random fluctuation in population health needs?
  - will organisational upheaval distract from the productivity challenge that the NHS needs to be focusing on over the next five years?
  - will the proposed constraints on management allowances make it difficult for consortia to access the management support they will need?
32. As policy continues to be developed and refined, we hope that this inquiry will help bring greater clarity to these difficult but important questions.

## References

Curry N, Goodwin N, Naylor C, Robertson R (2008). *Practice-based Commissioning: Re-invigorate, replace, or abandon?* London: The King's Fund.

Department of Health (2010). *Equity and Excellence: Liberating the NHS*. London: TSO.

Dixon A (2010). 'Purchasing health care in a cold climate' . Editorial. *Journal of Health Services Research and Policy*, vol 15, pp 3-4.

Gainsbury S, Taylor A, Lewis S (2010). 'World class commissioning: PCTs raise the bar in final assurance test.' *Health Service Journal*, 12 August 2010. Available at:  
[www.hsj.co.uk/topics/world-class-commissioning-scores-2010/world-class-commissioning-pcts-raise-the-bar-in-final-assurance-test/5018158.article](http://www.hsj.co.uk/topics/world-class-commissioning-scores-2010/world-class-commissioning-pcts-raise-the-bar-in-final-assurance-test/5018158.article)

Ham C (2010a). *GP Budget Holding: Lessons from Across the Pond and from the NHS*. Birmingham: Health Services Management Centre.

Ham C (2010b). *Working Together for Health: Achievements and challenges in the Kaiser NHS beacon sites programme*. Birmingham: Health Services Management Centre.

Ham C, Smith J (2010). *Removing the Policy Barriers to Integrated Care in England*. London: Nuffield Trust.

Naylor C, Goodwin N (2010). *Building High-Quality Commissioning. What role can external organisations play?* London: The King's Fund.

Thorlby R, Maybin J (2010). *A High-performing NHS? A review of progress 1997-2010*. London: The King's Fund.