‘Liberating the NHS: Commissioning for patients’

This response draws on research evidence, and our wider experience, in setting out the views of the Nuffield Trust about ‘Commissioning for Patients’ (Department of Health, 2010).

We use the five themes from ‘Commissioning for Patients’ to set out our response: responsibilities; establishment of GP consortia; freedoms, controls and accountabilities; partnerships; and implementation and next steps.

Consultation response

11 October 2010

1. Responsibilities

Research evidence points to the significant potential of GP commissioning consortia holding real, as opposed to indicative, capitated budgets for the purchasing of local health services, and for these groups to be held to account for health outcomes, patient experience of services, and financial performance. GP consortia offer the promise of a more 'real' form of primary care-led commissioning that is likely to engage at least some GPs in health planning, funding and service development in a very active manner, and to enact changes without facing some of the bureaucratic hurdles that proved a frustration with practice-based commissioning (Nuffield Trust and NHS Alliance, 2009).

To have consortia focused purely on commissioning (and not with a combined commissioner-provider role) does however raise questions about (a) how real this separation of commissioning and provision can be in practice and (b) if it is real, the extent to which consortia will be able to lever desired changes both from their colleagues across primary and secondary care, and about the bureaucracy and transaction costs that may ensue. One of the strengths of primary care-led commissioning is its ability to enable 'make or buy' decisions where clinical commissioners deliver as much care as possible within practice-based settings, and then purchase other services that maximise the possibility of more integrated care for patients (Nuffield Trust and NHS Alliance, 2009).

Evidence on the performance of NHS commissioning would suggest that it may prove challenging for GP consortia to control expenditure any more successfully than PCTs before them, at least in the short to medium term. Research evidence on structural reorganisation (Dickinson et al, 2006) and the development of primary care-led commissioning (Dowling and Glendinning, 2003; Smith and Goodwin, 2006) suggests that consortia will, for at least two years, be in a process of organisational development and hence struggle to have a significant impact on the shape of local service provision. This is a critical issue, given the financial context into which GP commissioning is being introduced, and the scale of the challenges ahead in respect of developing new forms of urgent care, and services for people living with long-term conditions.

It appears quite possible that consortia will look to the NHS Commissioning Board (NHSCB) for guidance, approval, management, and direction – especially in the challenging economic climate. Given the NHSCB's proposed range of functions, it seems likely that it will become large and need to operate through regional outposts. Indeed, it may fall in part to the NHSCB to provide effective local system management, along with GP consortia. To enable this effective local system management, the relationship between the NHSCB and local consortia will need careful development, to avoid it becoming focused on hierarchical performance management, but instead defined by mutual respect, support, and constructive challenge.

The NHSCB will need to develop a failure regime for GP commissioners, and the relationship of this with the General Medical Services contract will be critical. The NHSCB will hold the individual general practice contracts for GPs as providers, and GP commissioning consortia to account. This poses a question as to whether and how these two areas of general practice activity will be jointly overseen at national level, considering the progress that has been made by many PCTs in managing locally tailored practice contracts.

A key challenge within the new arrangements is how hard choices will be made, and who will be held responsible for these. Drawing on previous (Edwards, 2007) and current (Coster, forthcoming) Nuffield Trust analysis of the role and function of national independent health boards, two key questions arise. First, whether the NHSCB will be able to remain truly independent of the Secretary of State and the Department of Health when faced with difficult local rationing decisions. There is likely to be a need for formal circumscription of the scope of the Secretary of State and the Department of Health to intervene in the work of the NHSCB, albeit there will need to be arrangements for the NHSCB to account to Parliament in an appropriate and transparent manner. Second, there is likely to be a need for careful consideration of how patients will respond to their GP if and when they know that s/he is responsible for deciding what services are or are not funded locally.

2. Establishment of GP consortia

Given the focus on GP rather than wider clinical commissioning in the White Paper there will be a need to explore how consortia can be incentivised to find ways of working closely with specialist colleagues in community, mental health, and secondary care services to develop new and more integrated services for patients. The main challenges faced by GP commissioners (Dixon, 2010) will be in the areas of managing demand for hospital care, reducing avoidable admissions (Blunt et al, 2010) addressing large and unaccountable variations in clinical practice, and developing better co-ordinated care for people living with long-term conditions. Research evidence shows that primary care commissioners in the past have focused mainly on extending primary and community care services, and on marginal improvements in elective care, and have struggled to have any significant or strategic impact on wider secondary care services. If consortia are to be able to concentrate on the development of more integrated services across sectors, this suggests that the composition of consortia should be guided not only by local geography, but also by the ability of secondary and primary care to relate to one another so as to better serve a local population.

Research evidence on primary care led commissioning points to the importance of such groups not being seen as 'other' or as belonging to the state, but as being clearly owned and run by GPs (Smith and Walshe, 2004; Locock et al, 2004; Smith and Mays, 2007; Nuffield Trust and NHS Alliance, 2009; Casalino, 2010). In the absence of PCTs, the extent of financial responsibility to be placed in the hands of GPs makes the statutory nature of such consortia appropriate and inevitable. It needs to be borne in mind however that research evidence suggests that the formality and extent of such responsibility (in particular in a period of financial austerity) may compromise the engagement of front-line practitioners, inhibiting the achievement of the benefits of GP commissioning (Smith and Walshe, 2004; Locock et al, 2004; Smith and Mays, 2007).

The success of GP consortia will depend upon sufficient numbers of GPs feeling enthusiastic about, and engaged in, the idea of becoming the main NHS commissioners. Research (e.g. Curry et al, 2008) suggests that practice-based commissioning struggled to engage GPs in a significant manner, and even GP fundholding in the 1990s, with clear and personal incentives for GPs, only reached 50% take-up after seven years. It is not yet clear what the incentives will be for GPs to participate actively in the new and extended form of GP commissioning. The current suggestion is to link a proportion of practice income to commissioning performance. This will need to be carefully crafted to provide direct personal incentives for GPs whilst avoiding undesirable conflicts of interest.

Research also highlights the importance, and the transactions costs, of commissioning consortia spending time and energy in staying connected with constituent practices and staff (Dowling and Glendinning, 2003; Smith and Goodwin, 2006; Locock et al, 2004). This will be particularly challenging if consortia are large in size, and even more so if they seek to engage in an active manner other primary care contractors such as pharmacists, optometrists and dentists.

3. Freedoms, controls and accountabilities

The move to GP commissioning may give people a clearer sense of connection to their health commissioners than is currently the case with PCTs, the latter largely lacking local legitimacy and profile (Glasby et al, 2010; Thorlby et al, 2008). Most people are registered with, and use, GP services, with 80% of people having contact with their GP in any one year. A focus on clinical, rather than purely GP commissioning is worthy of consideration by the consortia, enabling groups of primary, community and secondary care clinicians to work together in new consortia, taking responsibility for the health and services of a defined population.

The removal of the PCT as the local system manager raises important issues. Previous analysis by the Nuffield Trust suggests that commissioning is most effectively undertaken at different levels of the population, in order to manage financial risk, for economies of scale, and to concentrate necessary skills (Smith et al, 2010). There does not appear to be a 'one size fits all' solution to the conundrum of what size a commissioning consortium should be and in the post-White Paper world, services will be commissioned through: personal health budgets; practice networks; GP consortia; joint commissioning with local authorities; multi-consortia networks; and the NHS Commissioning Board. There is a need to determine who, in the absence of PCTs, will co-ordinate the local 'continuum of commissioning' (Smith et al, 2004), and hold large, powerful, providers to account. This will also be important to ensure that services, and more significantly patients, do not 'fall through the cracks' between organisations.

4. Partnerships

In the short to medium term, the process of transition from PCT to GP commissioning risks undermining vital work to promote the integration of health and social care. Joint working across the NHS and local government requires the nurturing of long-term relationships between managers and professionals. The restructuring of NHS commissioning (Dickinson et al, 2006; Glasby et al, 2010) typically entails changes in key personnel, and the need for local government to get to know new NHS leaders and to reorganise some of its own boundaries and governance arrangements in order to work in an effective manner with NHS bodies.

In the medium to longer term, the move of public health from the NHS to local government should enable public health specialists to focus more firmly on the wider health agenda. There is however a parallel risk of public health becoming divorced from NHS service planning and provision, and of GP commissioners finding it hard to access essential and timely public health expertise in needs assessment, priority setting, service evaluation, and the monitoring of health outcomes.

The proposal to establish local health and wellbeing boards (LHWBs) suggests a potentially enhanced role for local authorities in health commissioning, with public

health and local government coming together to provide overall scrutiny of the work of GP commissioners. GP commissioning consortia will need to develop relationships with Health Watch, the public health service, and LHWBs, yet research evidence suggests that this may prove challenging, at least in the short to medium term. GP commissioners have typically preferred to focus on clinical service commissioning reflecting their training and experience and have historically been less willing to engage with broader population health commissioning or to develop patient engagement mechanisms (Dowling and Glendinning, 2003; Smith and Goodwin, 2006).

5. Implementation and next steps

It will be important for the Department of Health and SHAs to ensure that extremely robust local system management is in place during the period of transition, especially in relation to financial control, clinical governance and the meeting of the many statutory requirements currently located with PCTs. The evidence on health system reorganisation points to the difficulties associated with maintaining financial control and proceeding with service developments, when managers and clinicians within organisations are distracted by the process of change (Dickinson et al, 2006; NHS Confederation, 2010).

The allocation of resources to GP commissioning consortia will form a key element in determining the acceptability of the new approach to GPs. Resource allocation for GP commissioning will entail the balancing of incentives for more efficient care against the need to ensure that sufficient funds are available to tackle local health needs. This will be particularly challenging where consortia do not align with historical geographic boundaries. The current person-based approach for allocating resource from PCTs to practices (developed by a consortium led by the Nuffield Trust) is based on predicting future use of hospital care by exploiting information on primary and secondary care at the person level. This approach has shown that it is possible to estimate a risk-adjusted capitated budget that is driven by the individuals within a registered population base. As such it offers a way of setting budgets for commissioning consortia in a way that does not depend on aggregating geographic areas.

Policy decisions will need to be made as to which methods should be used for allocation of funding to GP commissioning consortia, and the extent to which the NHSCB thinks it appropriate to direct the method of allocation *within* each consortium.

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