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BEYOND PRACTICE-BASED COMMISSIONING: THE LOCAL CLINICAL PARTNERSHIP

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EXECUTIVE SUMMARY

Significant challenges face the NHS. In the short to medium term, funding levels will be severely constrained. Pressure on health services to be far more responsive to, and engaging of, the individuals using them will grow. Traditional providers of healthcare, hospitals and general practices will be forced to improve the efficiency and quality of care, as well as offer new forms of care that are more convenient for the public. These pressures are seen universally across the developed world.

Those responsible for commissioning care using tax funds must become more skilled and proactive in helping to shape desired forms of care that offer greater value. If not, the quality and availability of care, and along with it public support for the NHS, will diminish.

Yet commissioning in the NHS by primary care trusts (PCTs) has not delivered nearly as much impact as expected (Smith and others, forthcoming). Practice-based commissioning (PBC), a policy designed to engage doctors, in particular, to be more conscious of cost, quality and patient choice in commissioning hospital and community care, has not in many cases been able to bring about the significant change nor widespread clinical engagement that was anticipated in policy.

There is little appetite, politically or within the NHS, for further large-scale policy upheavals. Yet with PBC apparently unfit for purpose in its present form, and PCT commissioning frequently cautious and tentative, further thought is urgently needed as to how to boost commissioning, and specifically how to nudge or evolve clinically-led commissioning into life.

How commissioning has developed to date, and what might be the appropriate next steps in its evolution, are the subjects for discussion in two forthcoming joint monographs by The Nuffield Trust and The King's Fund (Smith and others, forthcoming; Lewis and others, forthcoming). This paper focuses specifically on how practice-based commissioning can be developed to help face some of the challenges outlined above.

While there may be many ways that practice-based commissioning could be developed (see Lewis and others, forthcoming), this paper considers one broad model – that of multi-specialty groups of clinicians – for example general practitioners (GPs) as well as hospital-based specialists – taking responsibility for the provision and commissioning of local healthcare. A 'local clinical partnership' (LCP) is examined as a means of bringing together the known benefits of involving clinicians in NHS resource management, with an incentive structure that could engage them in local service redesign aimed at improving the quality of care, and securing greater efficiency of service provision.

The report has been informed by a series of interviews and two workshops held with clinicians and managers active within practice-based commissioning, academics, and policy-makers expert in this area. In these interviews, people were asked about their views of the role and potential for groups of clinicians to assume responsibility for health provision and commissioning in the NHS. As context to the study, a review of the research and policy literature on physician groups, multi-specialty groups and primary care organisations was undertaken, including material from the UK, USA, Australia and New Zealand. A presentation of the draft conclusions from the report were delivered at a workshop session at the NHS Alliance annual conference in October 2009, and the feedback was used to inform this final report.

In a number of international health systems, clinicians form themselves into organisations to manage and develop the provision of local health services and/or the commissioning of healthcare. These groups are variously known as physician groups, independent practitioner associations, divisions of general practice, or primary health organisations. For the purposes of this study, the authors considered such groups as 'clinical collectives' that bring together mainly (but not exclusively) doctors into organisations that take responsibility for the funding and provision of a range of local health services, and are accountable for local health outcomes. The report uses the term 'local clinical partnership' (LCP) to describe how these groups could operate within the NHS in England.

Key features of a local clinical partnership might include:

- **Responsibility** – for the provision and commissioning of a range of local primary, community health and 'office medicine' services.
- **Clinical involvement** – the LCP would comprise a group of clinicians, and in most cases would be doctor-led, although it would have the active involvement of nurses from primary and community care, pharmacists and allied health professionals. As well as generalists, it would include specialists who would be contracted to the organisation from local foundation trusts/other acute trusts or community provider agencies, employed by the LCP, or engaged in the organisation as partners.
- **Geography** – an LCP would ideally be based on a geographical community, thereby enabling it to assume a population-based budget and focus on delivering health outcomes for that population. However, a strict geographical focus should not override the need for LCPs to develop 'bottom-up' as independent collectives of clinicians who are committed to working together in managing budgets and sharing the associated risk.
- **Size** – evidence suggests that to maintain a sense of 'localness' for the clinicians forming the group, whilst having sufficient critical mass for managing clinical and financial risk, organisations need to have a population base of at least 100,000. LCPs will need to be of sufficient scale to keep management and transaction costs under control and be effective commissioners.
- **Ownership** – the organisational form of an LCP would be determined by local clinicians. The precise nature of 'ownership' would vary according to the history and context of the particular collective of clinicians. Factors to be considered would include whether they want to be purely provider organisations, entities that assume both provider and commissioning responsibilities, and how 'multi-specialty' they intend to be.
- **Budget** – LCPs would have a population-based, real, capitated and risk-adjusted budget, assumed on the basis of taking responsibility and accountability for local health outcomes, patient experience, and financial performance. The LCP should be able to take 'make or buy' decisions.
- **Accountability** – LCPs would be accountable to PCTs and regulators for health outcomes, patient experience and financial performance.

It is clear that if clinician groups with real budgets and responsibility for population health outcomes are to play a key role in the next phase of development of the NHS, a phase that entails possibly the greatest management and financial challenges known to the NHS for a generation, then radical change will be necessary. The report outlines the potential role of multi-specialty groups of

clinicians in taking responsibility for and leading such change at a local level. The main changes needed are:

- enabling LCPs to adopt an organisational form relevant to their scope, size, and organisational history – foundation trust, social enterprise models, and multi-professional partnerships show particular promise
- the crafting of a sophisticated set of incentives for GPs engaging in an LCP, including a renewal of the General/Personal Medical Services (GMS/PMS) contracts
- the development of an incentive package for specialists becoming part of an LCP – the portability of the NHS pension is a key issue
- the use of robust methodology in allocating population-based and risk-adjusted budgets
- development of a framework for assessing the outcomes of LCPs
- finding ways of ensuring public accountability within LCPs, through public membership or other advisory and consultative arrangements
- examining the potential of offering people a choice of LCP
- a reshaping of the role of the PCT, towards one focused on being the steward and governor of a (probably larger) health community.

A migration path is suggested for the move from current PBC consortia towards becoming an LCP. This is set out as a series of possible models that different local groups might adopt, depending on the willingness and readiness of local clinicians to assume certain levels of financial and service commissioning responsibility.

The paper concludes by outlining the essential requirements for putting in place an LCP, as viewed from the perspective of local clinicians, and the PCT. This 'deal' is suggested as a checklist of critical issues that might guide the further development of policy for multi-specialty clinician-led organisations beyond PBC.

The key elements of the 'deal' could be:

- budgets must be real, with financial risk handed over and assumed
- savings could be kept by the organisation and used in a not-for-profit way
- LCPs must be developed and owned by clinicians
- experimentation and innovation must be encouraged
- 'make or buy' decisions must be possible
- governance must be robust and proportionate, and accountability clear
- responsibility for health outcomes must be taken
- radical service improvements must be possible.

As the NHS enters a time of financial challenge that calls for significant changes to the delivery of care in primary, community and hospital settings, clinical leadership and engagement will be needed as never before. Experience of primary care-led commissioning, service line management and other approaches to involving clinicians in resource management and service change highlight the potential of harnessing clinical knowledge and enthusiasm with strategic service change. We suggest that a multi-speciality local clinical partnership, with full responsibility for a population's health outcomes and funding, holds real promise as a way of developing more efficient and higher-quality care beyond practice-based commissioning.

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POLICY CONTEXT

Improving productivity and quality

After a period of significant and extended real growth in resources, averaging nearly seven per cent per year until 2010/11 (Appleby and others, 2009), the National Health Service in England is facing a severe curb in the rise of its overall funding, suggested as being in the order of £8–10 billion (NHS Confederation, 2009) or even £15–20 billion (Nicholson, 2009) over the three years from 2011, and the curbs could possibly extend beyond that.

This financial forecast is set against a backdrop of an NHS where there have been some significant improvements in the quality of services over the past decade, most notably in respect of reduced waiting times for treatment or specialist consultation, an increase in choice of provider of care, and the development of a comprehensive approach to quality assessment and assurance in primary care. This means that as the NHS contemplates how to meet the financial challenge ahead, the traditional approaches of letting waiting lists grow and quality reduce should be avoided (NHS Confederation, 2009).

Furthermore, the presence of stronger regulation of health and social care services will make it evident where attempts to improve productivity have a negative impact on service quality. The Care Quality Commission's routine assessment of the quality of local services, together with increasing use of patient-reported outcomes and other user survey data, will provide a check on NHS and social care provision that was not present in previous economic downturns.

Department of Health policy-makers have responded to this financial and service quality challenge by setting out four key priorities: quality, innovation, productivity and prevention (QIPP). This QIPP approach is intended to focus the NHS on driving up service quality while improving productivity. Commentators have noted the importance of addressing the design and organisation of health services as a critical way of dealing with the quality/productivity challenge: "The big gains are most likely to come from the redesign of clinical services. These are difficult areas and need to be done on a sufficiently large scale to release savings" (NHS Confederation, 2009: p6).

Evidence on implementing change within health systems points to the vital importance of engaging clinicians in the planning and delivery of such service redesign (Baker and others, 2008). This evidence base has underpinned previous attempts to involve clinicians in budget-holding and resource management in the NHS, as explored in the next section of this paper.

Improving primary and secondary care integration

NHS policy focuses on improving service integration across primary and secondary care, underpinned by a belief in the need for better coordination of community-based services for people living with long-term conditions (especially the frail elderly), and in the potential of extracting efficiencies by reducing the use of expensive hospital care and managing people's care in a more appropriate manner in the community. This vision was articulated in *Our Health, Our Care, Our Say* (Department of Health, 2006), and is now being progressed through the Transforming Community Services programme (Department of Health, 2008), which asserts a desire to increase productivity in this sector by ten to 20 per cent. However, recent Audit Commission analysis of NHS productivity noted that "PCTs made little or no in-roads in 2008/09 to transferring care from hospitals into the community or in dampening demand, either in investment or activity." (Audit Commission, 2009: p1).

Improving health and social care integration

In addition to calling for improved productivity and service quality within the NHS, the Department of Health is urging the NHS to work more closely with local government in seeking to commission and deliver better integrated health and social care services. The recent Green Paper *Shaping the Future of Care Together* (HM Government, 2009) calls for more joined up working across health and social care, a focus on rights and entitlements for service users, and reform of the funding of social care within a new National Care Service.

Other cross-government policy initiatives such as Total Place (HM Treasury, 2009) encourage local public bodies to work together to examine how they could align funding and provision of local services for a geographical area and hence improve efficiency and ensure a more streamlined experience for users. The services being examined within Total Place pilots include mental health, children and older people, thus emphasising the importance of NHS involvement in this type of funding, planning and service redesign activity.

Developing commissioning

These challenges of finance, quality and service integration fall to local commissioners – primary care trusts (PCTs) and their practice-based commissioners (PBCs) – to address. The QIPP programme is particularly targeted at commissioners, yet evidence on the performance of NHS commissioning is equivocal at best (Smith and others, forthcoming). In 2008 the Audit Commission, in a review of progress with NHS system reform, noted that more work was needed to strengthen commissioning to "provide the necessary balance between primary and secondary care" (Audit Commission, 2008: p5) and called for more effective engagement of general practitioners (GPs) in commissioning, and PBC in particular.

Practice-based commissioning (Department of Health, 2005) has been a key plank of government policy, predicated on a belief that engaging GPs in the planning and funding of local services will enable PCTs to manage their risk better and encourage the design of improved care and better use of resources. Within PBC, PCTs continue to be responsible for funding and contracting with providers, and devolve indicative budgets to practices, or groups of practices.

Research and policy analysis of PBC concludes that the policy is at best underdeveloped (Audit Commission, 2007a; Curry and others, 2008; Coleman and others, 2009; Smith and others, forthcoming), at worst in need of a major overhaul. This critique focuses on:

- the relative lack of engagement of grassroots clinicians in assuming budgets and working to redesign services
- the often limited scope of PBC activity, which appears to focus mainly on extending primary care provision rather than commissioning services from secondary care or other providers
- the complexities of a commissioning arrangement that is virtual rather than real, and requires PCT approval of PBC groups' plans.

This reinforces one of the key messages from an earlier review of evidence on primary care-led commissioning (Smith and others, 2004); that groups of primary care clinicians are unlikely to be able to wield any considerable power in respect of commissioning acute care services, something that has been judged difficult for even the most sophisticated of health purchasers in the international context (Mays and Hand, 2000; Ham, 2008).

Summary

In thinking about how to meet the challenges faced by commissioners, a conundrum is faced in respect of the role of PBC. Should it be abandoned, with a retreat from the concept of GPs holding budgets and playing a role in wider health commissioning, or is there an alternative 'beyond PBC' where primary care and other clinicians could work together in organisations, playing an active role in the transformational service redesign work needed in the next five years?

PROJECT APPROACH

In July 2009, a workshop of clinicians and managers active within practice-based commissioning, together with academics and policy-makers expert in this area, spent time scoping questions to be examined in the study. This resulted in a decision to examine:

- why 'clinical collectives' might be needed in the NHS
- what their role might be
- the scope and scale of such groups
- who would be involved
- why clinicians might get involved
- the principles by which groups might operate
- the support they would need
- how the success of such groups would be measured.

A set of interviews was carried out with 12 key informants drawn from policy, practice and national organisations. In these interviews, people were asked about their views of the role and potential for groups of clinicians to assume responsibility for health provision and commissioning in the NHS, and the issues set out above as research aims were examined in depth. As context to the study, a review of the research and policy literature on physician groups, multi-specialty groups, and primary care organisations was undertaken, including material from the UK, USA, Australia and New Zealand.

In September 2009, a further workshop of expert clinicians, managers and academics was held, with the purpose of discussing emerging findings. A presentation of draft project conclusions was made at a workshop session at the NHS Alliance annual conference in October 2009, and the feedback from these two workshops was used to inform this final paper.

Individuals involved in the two expert workshops have had an opportunity to comment on a draft of this report, reflecting the interactive nature of this study which has sought constantly to test its approach and conclusions with practitioners, policy-makers and managers.

In presenting our analysis, we propose the term 'local clinical partnership' (LCP). We begin by outlining the rationale for using groups of physicians to manage budgets and develop services, both in relation to UK and international experience. This analysis is then used as the basis for suggesting evolution of PBC towards LCPs – multi-specialty groups of doctors who will take responsibility for the funding and development of a range of local health services, and possibly for the commissioning of other services, as the NHS moves 'beyond practice-based commissioning'.

Particular attention is given to examining how LCPs might be put into practice, and a proposal for policy-makers of potential migration paths towards a health service with effective clinically-led health organisations.

THE RATIONALE FOR PHYSICIAN ORGANISATIONS

Involving clinicians in management

Before the 1980s, doctors played a lead role in decision-making about the distribution of resources and the day-to-day control of health organisations. Doctors as 'medical superintendents' managed hospitals, using their professional autonomy to achieve what they believed to be the best outcomes for local services (Davies and Harrison, 2003). There was therefore no need to examine how to engage clinicians in management, for they were the managers, supported by a matron and an administrator within a triumvirate arrangement where there was a desire to seek consensus in terms of strategic and operational directions.

The Griffiths Management Inquiry of 1983 called for 'general managers' who would be personally accountable for NHS organisational direction and performance, and concluded that clinicians should be more closely involved in management decisions, holding a management budget and being provided with necessary support for this (Department of Health and Social Security, 1983). It was at this point in the development of the NHS that the importance of securing clinician engagement in management and budget-holding appears to have its roots.

The resource management initiative

One consequence of the Griffiths Inquiry was the Resource Management Initiative of the 1980s, which sought to strengthen the management of NHS resources by improving information systems and engaging clinicians in holding budgets for services. The rationale for having clinical budget-holding was that clinicians and managers working together would be better able to control NHS resources to maximum effect. In Guy's Hospital in London, the initiative was interpreted in the adoption of a 'clinical directorate' model of resource and general management, where triumvirates of doctor, nurse and manager worked together to manage the budget and service of a specific clinical area of the hospital. In this model, the clinical director (usually a doctor) was typically accountable for overall directorate performance (Rivett, 1998).

The clinical directorate model remains widespread in the NHS some 25 years later, and there is now a renewed focus on critical analysis of resource use by clinicians at directorate, clinical service, and even patient level, through initiatives such as service line management. Service line management is an approach that has been used extensively by Monitor with NHS foundation trusts, entailing detailed reporting and analysis of financial, activity and patient experience data at a clinical service level, these data then being analysed within portfolio matrices that highlight good and poor performance. These analyses provide a basis for clinical leaders and operational managers to review and refocus services, and hence improve both patient experience and financial performance (Ham, 2009). In a study of clinical engagement in financial management in the NHS in 2007, the Audit Commission concluded that it was vital for organisations to seek to engage clinicians in financial planning and management, noting that:

> There are real benefits to be gained if engagement can be achieved, in terms of efficiency savings that can be reinvested in improved services for patients. Good financial management and greater efficiency go hand in hand with better patient care.
>
> (Audit Commission, 2007b: p2)

Budget-holding by primary care clinicians

In the 1990s, the concept of NHS resource management by hospital clinicians was extended to primary care in the guise of GP fundholding, followed by an extension to fundholding known as total purchasing. GP fundholding enabled GP practices to opt to hold a budget with which they could purchase a specific range of community health, outpatients, and elective hospital care, together with assuming financial responsibility for their prescribing activity. Total purchasing pilots, established in 1994, enabled practices or groups of practices to assume a real delegated budget from their host health authority (the precursor of a PCT) with which to purchase potentially all services for their registered population. Although total purchasing was abandoned once Labour came to power in 1997, the evidence from evaluation of the pilots continues to be a useful guide to how GPs might respond to any extension of budget-holding 'beyond PBC'.

Analysis of the behaviour of GPs within fundholding suggests that doctors changed their behaviour in response to the particular set of incentives presented by the scheme. For example, Croxson and others (2001) reported on research that showed how fundholders increased their elective referrals in the year prior to fundholding (as a way of inflating their initial budget) and then reduced them as soon as they became fundholders, making savings that could be invested in their practice and its services. There was also evidence of more development of community-based clinics by fundholders, compared with non-fundholders. Other research (Dowling, 1997; Propper and others, 2002) pointed to the fact that fundholders' patients benefited from shorter waiting times for elective treatment, and a review of the evidence on fundholding suggested that these GPs constrained their prescribing and referral rates, and increased levels of generic prescribing (Gosden and Torgerson, 1997).

What is clear is that the structure of the fundholding scheme enabled GPs both to protect their practice business (involving funds for General Medical Services (GMS)), while having responsibility for Hospital and Community Health Services (HCHS) funds that could be rerouted into GMS services (for example, by relocating clinics or undertaking minor surgery in general practice) and hence into their own business to produce a profit. Such direct financial incentives appear to have influenced GPs' clinical behaviour in areas that were policy priorities for the NHS: seeking to reduce referrals to secondary care; reducing waiting times; and controlling prescribing costs.

Total purchasing pilots demonstrated that they were able to reduce emergency-related bed days by significantly more than comparable local practices, this being achieved through innovative discharge schemes and community-based service development. However, they were generally unable to persuade acute providers to alter contract volumes and hence release resources for the future (Mays and others, 2001). This suggests that the enthusiasm and innovation demonstrated through fundholding could be extended into emergency care, but they lacked the purchasing clout, clinical, managerial and contracting expertise to reshape hospital care and thus release resources to invest in other local services.

Alternatives to fundholding that emerged in the 1990s demonstrated that they too were able to bring about changes in primary care and community health services provision, although research evidence is lacking in relation to whether or not they were able to impact on waiting times and referrals (Smith and Goodwin, 2006).

How this compares with practice-based commissioning

What is critical to our analysis of how the NHS might move 'beyond PBC' is the apparent lack of financial or other incentives for GPs within PBC. They are unable to redirect resources for commissioning hospital and community health services into their practices, they hold 'notional' and not 'real' budgets, the level of savings kept must be negotiated with the PCT, and PBC groups typically struggle to make significant and timely changes to local services.

Both the financial and governance structures of PBC, designed in part to avoid what were seen as problems with fundholding (transfer of NHS resource into personal profit for GPs, adverse effect on equity of access to care as fundholders' patients gained advantages in terms of waiting times and extended services) appear to have significantly compromised its effectiveness. This, on top of a lucrative GP contract, has meant that the financial incentives at least for GPs to be involved in PBC are practically non-existent.

Physician organisations based in primary care appear to hold significant promise in relation to developing an extended range of community-based services, but much less so in terms of an ability to commission care beyond the primary or community health sector.

INTERNATIONAL EXPERIENCE OF PHYSICIAN ORGANISATIONS

Physician groups are defined here as collectives of clinicians who come together in an organisational arrangement in order to manage health services and resources. These groups have their roots in the development of managed care in the early 20th century in the United States. Historically they developed to serve unionised workforces for large employers, for which funding was typically capitation-based, such as Kaiser Permanente (California), Group Health (Seattle) and the Henry Ford Clinic. The group of clinicians took responsibility for the funding and provision of health services for an enrolled population and overall capitated budget.

In countries with a nationally capitated health funding arrangement, together with a firm base of (largely) publicly funded general practice, such as the UK, New Zealand and Australia, physician groups have however tended to emerge from within that general practice community. In all four countries, the drivers for forming physician groups have at different times included:

- a defensive measure against some wider system threat, such as a new public contract for general practice (New Zealand independent practitioner associations (IPAs))
- a response to new budget-holding and health purchasing arrangements for GPs (UK GP fundholding groups)
- a desire by government to establish some entities through which some development and planning of primary care services could be undertaken (Australian divisions of general practice)
- the taking up of an opportunity to contract for extended primary care services across a number of practices (Personal Medical Services (PMS) pilot projects and subsequent provider organisations in the English NHS)
- a requirement for a large-scale entity capable of contracting with health funders in a market-based system (US managed care organisations and IPAs).

What these groups share is a collective arrangement that draws together previously independent small or solo practices, an arrangement that is deemed by the members to confer individual and collective benefits. The benefits reported from the establishment of physician groups include:

- developing new services on a group basis to which practices can refer
- establishing peer review and clinical governance
- developing core service standards and protocols across member practices
- sharing financial risk for pharmaceuticals, diagnostic tests, and specialist outpatient advice (and sometimes for acute care)
- joint management and technical support.

As noted in the previous section, it is the engagement of clinicians with responsibility for health funding and service development that appears to continue to tempt policy-makers to consider physician groups. Furthermore, evidence on high-performing healthcare systems (Baker and others, 2008) underlines the vital importance of having strong clinical leadership and engagement in health organisations. Physician groups appear to be an effective way of securing such engagement in sectors or systems where practitioners have traditionally been disparate and isolated, such as general practice in New Zealand, Australia and the UK, and internal and family medicine in the US.

In the US, many physician groups are 'multi-specialty' in nature, drawing together primary, community and specialist practitioners. This reflects the fact that compared with the UK, New Zealand and Australia, physicians in the US are much less likely to be employed by, or based in, hospitals. A challenge for these other health systems is to try and develop physician groups that go beyond primary care, especially in view of the ever-increasing pressure to develop community-based services for people with long-term and complex conditions. This is problematic however, for where institutional and funding arrangements bind specialists to hospitals, there are immense organisational, cultural and policy challenges in reframing the physician community into one that is organised in groups in non-hospital settings.

Issues faced by physician groups fall into a common pattern, irrespective of the wider health system context within which they operate. All groups appear to face a challenge in respect of how far to 'make or buy' services, and develop arrangements for shared services across the organisation and into practices, as well as seeking to get 'better deals' with specialists and others on behalf of the collective. A further challenge relates to the alignment of incentives and risk – as in the example of how to manage a pharmaceutical or other care budget across a large number of practitioners and develop acceptable arrangements for sharing financial risk, peer-reviewing practitioner performance, incentivising expected good practice, and dealing with poor performance.

The need to connect financial and clinical performance across a network of providers calls for integrated data-sharing and IT support, and this often presents a particular challenge to physician groups. Yet it can serve to prompt the development of the collective into something that makes a real difference to individual and group practice.

The issue of 'ownership' of clinician groups is a vexed and complex one. Within the US, UK, Australia and New Zealand, groups adopt different organisational forms depending on local circumstances, the purpose of the group, and the wider policy settings of the health system. For example, ownership arrangements have been a key concern for the New Zealand IPA movement, where the adoption of a limited liability partnership as the common form for an IPA served to protect the organisations from being dis-established by a Labour government that spent a decade trying to replace them with community-governed public health organisations (Smith and Mays, 2007).

In this paper, our thinking about what we conceptualise as a 'local clinical partnership' has been informed by our reading and understanding of international experience of physician groups. Of particular note is the potential of such groups to assume budgets to develop community-based services for a defined population, (sometimes) enact 'make or buy' decisions, develop ownership arrangements that enable them to 'last the distance', and operate extended networks of clinical practice and organisation across primary (and sometimes secondary) care.

LOCAL CLINICAL PARTNERSHIPS FOR THE NHS

Holding faith with physician groups

The time is now ripe to pause and consider what lies 'beyond PBC'. In this paper we assert that there is sufficient international and UK evidence about the benefits of physician groups to merit an examination of how such groups might be strengthened in order to unleash the evident innovation and energy that clinicians have for service design and development where they are appropriately incentivised, supported and given proper responsibility for decision-making. The issues identified in our analysis of the current policy context cry out for effective clinical engagement and leadership at a local level, and for that leadership to be able to enact decisions about how services will be designed and delivered.

A critical question to be addressed before exploring how such groups might be recast is that of whether clinician organisations should be construed primarily as providers who assume a contract for managing and developing local primary and community health services, or as commissioners seeking to purchase care on behalf of a local population. From our reading of the research evidence, and observation of the experience of PBC, it would appear that there is more promise in regarding clinician groups as being first and foremost concerned with community-based provision but, critically, using their responsiblity as commissioners with a global budget and the power of taking 'make or buy' decisions as a lever for re-designing services closer to home. In this sense, the term 'practice-based commissioning' could be argued to have been a misnomer from the outset, given what we know about where most PBCs have actually made progress.

Indeed, in those places where groups of PBC clinicians are 'champing at the bit' to assume real budgets, it appears that a primary driver is typically a desire to assume more responsibility for designing and delivering new approaches to care in those areas of highest morbidity and cost, namely long-term conditions, and unscheduled care for frail (mainly elderly) people, but achieving this through their broader-based commissioning responsibilities. Examples of such organisations are shown in Table 1.

The local clinical partnership

We suggest in this paper a 'local clinical partnership' as the next, more radical and advanced incarnation of NHS clinicians' primary care-based commissioning and provider development activity – that is, life beyond PBC. The intention is to build on what has worked in PBC, drawing on evidence from international experience to develop a more vibrant and innovative form of clinician group that is fit for the purpose of playing a core role in redesigning local services to improve health outcomes and ensure greater cost efficiency.

The LCP would comprise a group of clinicians, and in most cases would be doctor-led, although with the active involvement of secondary care doctors, nurses from primary and community care, and pharmacists. As well as generalists, it would include specialists who would be contracted to the organisation from local foundation trusts/other acute trusts or community provider agencies, employed by the LCP, or engaged in the organisation as partners. It would develop in a 'bottom-up' manner, for evidence from research suggests that where PBC and its antecedents have worked to best effect, the groupings have been developed from practice level, and not as 'top-down' PCT-imposed configurations.

An LCP would ideally be based on a geographical or registered population. If however LCPs are to develop as independent collectives of clinicians who are committed to working together in managing budgets and sharing the associated risk, it can be argued that willingness to work together in an organisation is more important than a strict geographical focus.

The size of an LCP is an important issue to be considered. Experience would suggest that to maintain a sense of 'localness' for the clinicians forming the group, while having sufficient critical mass for managing clinical and financial risk, organisations need to have a population base of at least 100,000 (Smith, 1999; Martin and others, 1998). The right size of population to cover, and services to commission, to be able to manage financial risk can now be tested empirically using person-based risk adjusted resource allocation models that have been recently developed (Dixon and others, forthcoming). Having an organisation of this scale is important not only to manage financial risk, but also to reduce management

TABLE 1: EXAMPLES OF COMMISSIONING ORGANISATIONS

Nene Commissioning	A commissioning-only community interest company (CIC) covering a population of 657,000 (NHS Northamptonshire) Currently taking direct commissioning responsibility for certain care pathways, such as end-of-life care One of the Department of Health integrated care pilots, focusing on long-term conditions and populations at high risk of admission, integrating primary care with acute, community and social services provision
Sutton Horizon Consortium/NHS Merton and Sutton	PCT developing framework for local integrated care pilots taking on hard budgets focusing on long-term conditions Developing an incentive scheme for the management of risk around a population-based risk-adjusted budget Exploring how community staff can be engaged within the local integrated care organisation (ICO) to ensure appropriate local service delivery
NHS Cambridgeshire/ Cambridgeshire Association to Commission Health	Exploring making PBC budgets real to see if this resuscitates the interest of GPs in commissioning, and incentivises them to take on the radical redesign of services that is needed The vision is for a cluster of practices to pool their budgets and work together in a health management model for a defined population The health community is also interested in integrating the social care budgets
NHS Cumbria/Westmorland Primary Care Collaborative	Practices covering a population of 110,000 are federating and will assume responsibility for a global and real budget, taking 'make or buy' decisions for the health of their population Over the last three years, in response to a financial crisis, a new PCT team has moved clinicians to the heart of decision-making processes and brought the PCT into financial balance. The federation is being established as a trailblazer for the rest of the PCT, to integrate commissioning with the provision of primary care and community services A social enterprise form is being used, with no one profession in the majority, and they are looking to assume greater responsibility for commissioning primary care. Governance and accountability arrangements for this are being developed

costs and transaction costs, and have the right level of expertise, such as clinical skills, management and analytic skills.

The clinicians in an LCP would be established as a formal organisation or entity, which they feel that they 'own'. The precise nature of 'ownership' would be likely to vary according to the history and context of the particular collective of clinicians. The forms adopted for this would build on what is already in place or what feels to be a natural next step for groups of GPs (and in some cases GPs plus specialists); factors to be considered would include whether they want to be purely provider organisations, or entities that assume both provider and commissioning responsibilities. These forms might include:

- a company limited by guarantee
- a multi-professional partnership across practices, and including specialists, within a GMS contract
- a virtual network of practices that devolves up its commissioning/budget-holding activity to a social enterprise organisation, community interest company or similar entity
- a foundation trust
- a consortium-based PMS contract.

International evidence highlights the value for clinicians of establishing a more formal and enduring entity for collective service development and budget-holding. For example, IPAs in New Zealand have in most cases found that being set up in a truly independent and formally clinician-owned manner has provided a robust buffer against any government attempt to reorganise or requisition their primary care-based work (Smith and Mays, 2007). This suggests that having LCPs that are literally owned by local clinicians, while entailing the bearing of personal and practice risk, also offers the potential of a degree of robust independence from wider health service (re)organisation.

The LCP would have a real risk-adjusted and capitation budget, assumed on the basis of taking responsibility and accountability for local health outcomes, patient experience, and financial performance. The LCP should be able to take 'make or buy' decisions, and be held to account for these decisions in relation to the health outcomes delivered as a result. The extent of the budget would depend on how far it elected to 'buy as well as make' and the LCP would need to be of sufficient scale to manage the risk associated with that budget.

The LCP would take responsibility for a selected range of health outcomes of its population, those over which it could reasonably have control through its provider and any commissioning activity. The extent to which it would assume responsibility for commissioning beyond local primary and community health services would depend on the preferences of the member clinicians, its overall objectives and aspirations and its readiness and desire to take on direct commissioning responsibilities for a broader range of care pathways, conditions or services. The organisation would be clearly accountable to its PCT and its local population, and to its constituent clinician members/owners, for its decisions and the health outcomes resulting from those commissioning decisions.

The LCP would differ significantly from how PBC is operating in practice. In Table 2, we summarise these differences. In the next section, we examine how local clinical partnerships might be put in place in the NHS, setting out the policy and management challenges that would need to be addressed.

TABLE 2: PRACTICE-BASED COMMISSIONING AND LOCAL CLINICAL PARTNERSHIPS – A COMPARISON

	EXISTING PBC CONSORTIUM	LOCAL CLINICAL PARTNERSHIP
Budget	Virtual, devolved from PCT and often excluding major spending areas Practice-based and only aggregated to consortia by agreement	Population-based, real, capitated and risk-adjusted
Scope of services	Some primary and community services	Most or all primary and community health services, and some specialist advice, diagnostics and care Starting point is all-important but the LCP would give authority to others to commission on its behalf – either other LCPs or the PCT
Membership	Mainly GPs	GPs, other local generalists and specialists, other primary care and community professionals
Ownership	Usually informal consortia working on behalf of the PCT, although some are independent entities	A form determined by the clinician members
Accountability	To the PCT for financial performance and achievement of service objectives, through a PBC agreement, compact and/or governance framework	For health outcomes, patient experience and financial performance, through a formal contract with the PCT
Risk	Borne by the PCT as the legal contracting agency. Freed up resources gained by the consortia. Overspends borne by PCT	Assumed by the members of the organisation, for finance (upside and downside), service quality, and health outcomes
Leadership	Shared clinical and managerial, typically under the umbrella of the PCT	Clinical, supported by high-quality management employed by the LCP

PUTTING IT INTO PRACTICE

Determining the scope of an individual LCP

Within a more plural approach, LCPs would vary in size and scope, with the range of services assumed depending on the interests of the group of clinicians, their sense of local health priorities, and the maturity of the organisation. Some LCPs would grow out of clinician organisations that have been in place for many years through PMS, PBC and its antecedents, and local medical associations. Decisions about scope would be critical, for they would inform how far the LCP chose to carry out a commissioning as well as provider role, the nature and extent of its population-based budget, the management support it would require, and the range of other primary care clinicians (beyond GPs) and specialists it will engage. A policy framework that tolerated plurality of LCP scope and function, but ensured that all the population was covered by the new arrangements, would have implications for the role of PCTs as the overall local health system architect and steward, a topic explored in more detail below.

Determining form

LCPs could develop an organisational form appropriate to their particular scope, size, and history, as was the case with fundholding and GP commissioning consortia in the 1990s, and with PMS and some PBC groups in recent years. With a greater range of financial and service responsibilities and accountability, one might anticipate that LCPs would elect to have more formal arrangements than has often been the case with PBC. Thus there might be more use of social enterprise-type organisations, community interest companies (CIC), limited liability partnerships, and perhaps foundation trusts. These offer a range of potential benefits, for example how pension arrangements for staff transferring in might be handled and the ability to handle 'profit/not-for-profit' issues and the opportunities to raise capital investment. If the integration of specialists within a single organisational form was important to deliver the functions of the LCP, then the pension arrangements and continuity of service would probably be critical factors to be addressed.

Within some of these arrangements, LCPs might seek to extend 'membership' beyond the clinicians forming the original group, operating a mutual or employee ownership model whereby all staff might share in the running and governance of the organisation. For example, clinicians might form a multi-specialty partnership, for as noted by Ellins and Ham (2009: p75): "The freedoms possessed by FTs [foundation trusts] provide an opportunity to give staff greater control.... The development of a multi-professional 'chambers'-type arrangement... would be consistent with the development of service line management in NHS foundation trusts."

Engaging GPs

The most critical issue to be addressed when seeking to develop clinician groups with real budgets is 'Why on earth would they do it?' Critical to the successful development of clinician groups beyond PBC would be the aligning of personal and organisational incentives. GPs would need to be able to see the direct benefit of engaging fully in budget-holding and service development beyond their immediate practice. They would want to have the right to reinvest any savings made, albeit that they would also have to commit to sharing in financial overspends. It is likely that there would be a need to renew the GMS and PMS contracts, in order to connect the work of a general practice team with the collective activity and priorities of a budget-holding group such as an LCP. The issues associated with a renewal of the GMS and PMS contracts are explored in the next section of this paper.

A key incentive for GPs might be that the LCP was able to enact its decisions about service development and commissioning in a timely manner and without needing to seek external permission. They would be likely to want the LCP to have properly devolved responsibility for 'make or buy' decisions and to be able to negotiate directly with primary care, community health and specialist providers for services it wishes to commission, or decommission, for its population. For many clinicians, developing improved services for patients would be an incentive in itself, especially where they can secure new and more rapid access to specialist advice and diagnostics within the LCP. Other incentives might include opportunities for shared educational and development across practices and specialists in the

organisation, shared arrangements for out-of-hours care for patients, pooling of resources to enable better cover for staff absences, career development for practice clinicians and managers through taking up leadership roles within the multi-speciality group, and seeing clear benefits for patients through improved access to services such as specialist diagnostics and advice.

Reimbursement of clinical time spent on management and commissioning work with the LCP would also be regarded by GPs as a critical feature. It will however be challenging to design incentive structures that can entice back the clinical budget-holding and GP commissioning enthusiasts of the 1990s, some of whom have become disillusioned through their experience of PBC, and ignite the interest of a generation of clinicians who have never taken responsibility for this type of budget-holding and service development.

A new GMS/PMS contract

If LCPs were to assume a real population-based budget for their registered patients, with a clear mandate to take 'make or buy' decisions about primary care and community health services, one possibility would be to give the LCP responsibility for managing GMS/PMS resources alongside those for community health and (at least some) secondary care services. This would however represent a significant departure from how the GMS/PMS contracts are currently managed, whereby a largely national contract is administered locally by the PCT, but with relatively little local variation of the contract and its performance indicators to suit local priorities and services. This would require the PCT to establish very clear governance arrangements, given the potential for conflicts of interest if a GP-led organisation managed its own contracts. Furthermore, it is hard to see why many GPs would want to put their GMS/PMS funding at risk by pooling it with hospital and community health services resources, especially in financially challenged times.

Another, perhaps more realistic, possibility would be to include 'beyond-PBC activity' – that is, fully-fledged responsibility for a capitated and risk-adjusted budget for a range of local health services – within the GMS/PMS contracts, where GPs are content to take such responsibility. In this way, budget-holding and commissioning activity could be properly valued and mandated as an extension to GPs' provider work.

A practice might opt to manage its own budgets within the framework of the LCP, or could 'block it back' to be managed on its behalf by the LCP or other 'lead practices'. Or the LCP might contract with a third-party organisation to manage the budget and help commission.

Within the GMS and PMS contracts, there would be a need for a clear set of incentives to reward effective 'beyond-PBC activity', including some potential for a share of any savings, or money to reward evidence of improved patient satisfaction and health outcomes connected to PBC to come to the practice. Arrangements for financial risk-sharing in relation to the LCP budget would similarly need to be articulated in the contract and, as mentioned above, the relationship between GPs' GMS/PMS funds and their commissioned HCHS resource would need to be very carefully considered prior to any review of the GMS and PMS contracts.

If GMS/PMS resources were to be managed within LCPs, it might make sense to move to a national framework for these contracts, including specification of a currency for payment (to avoid repeated and protracted negotiations between LCPs and GP representatives on local medical committees). This would entail the setting out of certain national requirements in respect of core health priorities, desired health outcomes, and financial management, and adherence to NICE and other guidance, but would leave considerable room for LCPs to contract with practices to deliver services in accordance with overall local health service plans and priorities.

Engaging specialists

In order to reshape health services in ways that will enable more efficient, higher-quality, and more community-based care, LCPs would need to have rapid access to specialists who could provide timely diagnosis, advice and support to community-based clinical teams. In particular, specialists whose work is increasingly community-oriented, such as diabetologists and dermatologists, would be ideal candidates for being formally part of LCPs. This reflects the trend within some specialties to operate on an 'office medicine' basis, where specialists are community-based, focusing mainly on giving advice, undertaking diagnosis and prescribing treatments,

typically reserving admitting rights to one or more hospitals for the minority of patients in that specialty requiring inpatient care.

There are different ways in which an LCP might engage specialists, and the details of these would depend on local clinical networks and relationships. For example, a well-established local diabetes network with high levels of trust between generalists and specialists is likely to be more open to aligning consultants with practices and an LCP, at least on the basis of the LCP contracting with the consultants' employing trusts for a number of sessions (something that already happens in some PMS organisations). Transfer of consultant employment into an LCP is harder to envisage until such time as LCPs have demonstrated their organisational competence and sustainability, given the tendency for frequent restructuring of primary care-led organisations in the NHS. The issue of LCP sustainability connects to the form that the LCP selects for its organisation. If it were to be set up as a multi-professional partnership of several practices plus perhaps pharmacists and other local clinicians, a possibility for consultants would be to join the partnership. This idea was mooted by Ellins and Ham (2009) in their examination of the potential of employee-ownership in the NHS.

This is not just about an LCP calling all the shots about how community-based clinical services will be organised in future. It is possible that PCTs, faced with a huge financial and service reconfiguration challenge, might specify contracts with LCPs and foundation trusts/other acute trusts that expect delivery of 'office medicine' and multi-specialty care, thus exerting additional leverage over providers and encouraging the development of better integrated service responses across primary and secondary care. Given the evidence about the scale of unnecessary outpatient appointments in the NHS, taken together with concern about primary care diagnosis of cancers and other conditions, a lead from commissioners in this area would seem to be essential, and the LCP as a community-based provider network could be lead in putting this into practice. Similarly, an LCP might manage a local network for urgent care, drawing together generalists and specialists in an organisation holding a PCT contract.

Critical to fuller engagement as a contractor, employee or partner would be the offer that an LCP could make to a specialist. This would need to be attractive from both an economic and professional perspective, covering issues such as pay, pension, and continuing professional education. They are also likely to want to have admitting rights to one or more local hospitals, rapid access to specialist diagnostic services, and opportunities to provide a service across a significant population base in order to ensure an appropriately broad and stimulating mix of cases. An examination would also need to be made of the collective incentives at play within an LCP. If GMS resources were to be protected (still contracted directly by the PCT or ring-fenced in some other way) and hence offering GPs the potential of 'profit', what would be the equivalent for specialists joining the LCP? Incentives for specialists might include greater autonomy away from a large institution, lower frustration levels when working in a clinical partnership, and being able to share in any gains made by the LCP.

Arrangements to engage specialists within LCPs raise the possibility of greater diversity of models of working for specialists. For example, while some specialists might elect to become fully part of LCPs, others might form 'barristers' chambers' and contract their services to local clinical partnerships, and foundation trusts might offer their consultants' services via contracts with LCPs. It is also possible that a foundation trust might virtually or vertically integrate with an LCP in order to form a multi-specialty group. While this might offer advantages in terms of service integration, it raises the possibility of local service monopolies and a lack of incentives to change service patterns and improve productivity, and would be subject to likely challenge from the NHS Cooperation and Competition Panel.

A portable NHS pension

In order for community and secondary care specialists to want to become formally part of an LCP, the issue of the portability of NHS pensions must be addressed. Certain organisational forms that would be available to LCPs lend themselves more favourably than others in this respect. The latest Department of Health guidance (Department of Health, 2009) enabling new patterns of provision of community services, details the organisational forms that are most beneficial in terms of pensions and defers 'acceptable' status for registered charities, community interest companies and industrial

and provident societies, while conferring 'direction employers' status for social enterprise organisations. This might influence the precise organisational form that would be most beneficial for an LCP.

Setting risk-adjusted person-based budgets

If LCPs are to assume real budgets with which to provide and commission care for a population on a fully accountable basis (including for health outcomes), there would be a need for robust methods for allocating budgets. History suggests that the issue of resource allocation to clinician groups is typically fraught and contested, as groups often mistrust the methods used, and suspect that they are being short-changed. These are likely concerns if LCPs were established around 2011, when NHS funding increases halt and the squeeze on public expenditure really begins to take effect.

Current work being undertaken by a consortium led by the Nuffield Trust (Dixon and others, forthcoming) proposes a method of resource allocation that is predictive, using linked primary and secondary care records at a person-level to categorise groups of patients and hence predict more accurately future health costs. The resulting model is being proposed as the basis for making financial allocations at a GP practice or PBC group level, based on the morbidity observed for individuals within the particular local population. In this way, the allocation of a budget to a local clinical partnership could be clearly linked to the current and predicted level of illness in the registered population of individuals in constituent practices. Risk adjustment of this nature would be essential if LCPs were to assume a global budget for a wide range or all local services.

The importance of robust methods for allocating resources to LCPs is also a reminder of the need for high-quality integrated data and IT systems within such new organisations. If an LCP was to be responsible for population health, based on an aggregate of practice patient lists, it would need to be able to link the contacts each person has with different elements of the primary, community, and specialist health system (and ideally with social care as well). This would enable its clinicians to properly coordinate and plan care for individuals and populations, and the organisation to account for activity, health outcomes and financial performance.

There might be a need for caution in the early years of allocating risk-adjusted capitated budgets, for some LCPs might receive windfall financial gains. Hence an initial cap on savings that could be made by an LCP might be appropriate. There would need to be central scrutiny of levels of surpluses within an LCP type approach, in order to assure proper stewardship of public resources at a time of transitional funding arrangements.

Accountability

A key feature of an LCP would be its focus on accountability for a specific population and its health outcomes, via the assuming of a real and risk-adjusted budget. Critical to such an approach, as explored in discussion in the US about the concept of an 'accountable care organisation' (Fisher and others, 2007) would be the development of benchmarks that could be used to measure progress by the LCP in relation to service quality, health outcomes, and financial performance. Again, this reinforces the importance of sophisticated data and IT support for LCPs, and also of robust contracting and performance assessment by reshaped PCTs.

The precise nature of LCP accountability would depend on their scope. If holding hospital and community services and/or GMS/PMS funds, they would have to account to the PCT and be performance-managed by them for the extent of their commissioning and provision responsibilities, or, if constituted as a foundation trust, by Monitor. If an LCP were to be a foundation trust and subject to regulation by Monitor, careful thought would need to be given to the regulation of commissioning as well as provider performance.

Performance management of HCHS funds held by an LCP would be a similar process to that currently used by PCTs and Monitor when assessing performance of providers. PCTs would also need to hold the LCP to account for the delivery of its primary care services, as the overall commissioner, including its decisions in relation to the services it decided to 'make' rather than 'buy' (making sure that it was not simply directing patients to its own services for profit motives, in preference to other local providers). The PCT would need to use whatever range of contractual mechanisms it had in place to do this, (for example

GMS/PMS contracts, including enhanced services and the Quality and Outcomes Framework (QoF)) and it would require a more sophisticated approach to the commissioning of primary care than has hitherto been in existence across all PCTs. In summary, an LCP would need to demonstrate to its PCT how it was ensuring accountability to its local population for its decisions in relation to both commissioning and provision, and the assurance of proper choice and contestability.

The possibility of LCPs assuming foundation trust status means that local people might become members of an LCP. Indeed, the issue of public and patient involvement is a critical element of accountability, and the relative lack of such involvement was a frequent criticism of primary care-led organisations in the 1990s and early 2000s (Dowling and Glendinning, 2003; Smith and others, 2004). While foundation trust status would require engagement of local people in the governance of the LCP, other potential forms, such as partnerships and companies limited by guarantee would have no requirement to do so, and hence the LCP would need to explore how it would ensure this. One approach to developing lay governance of a primary care organisation operating as a social enterprise is Principia Partners in Health in Nottingham, where the board is elected by patients from constituent practices and has a majority of lay members, alongside community services and GP members. Other arrangements for an LCP to adopt might include a patients' or public council, an arrangement that is used by some New Zealand IPAs as a means of developing and testing out plans for service design and development.

From a regulatory perspective, there would be a need for appropriate national and local measures to be applied in order to assess LCP performance, but it would be important for the extent of the regulation to be proportionate. This would need to include a mix of assessment by existing regulatory bodies such as the Care Quality Commission, Monitor (if foundation trust status were adopted), the Audit Commission and the National Patient Safety Agency. Performance against national targets would be determined through the LCP's contract with the PCT, and locally-developed measures deemed relevant to population health priorities, designed by the LCP and negotiated with the PCT.

Choice of LCP

An important policy question to be addressed 'beyond PBC' is whether people should be able to choose their LCP. How this might be enacted would depend on the extent of take-up of an LCP approach by local clinicians, and also on the number of LCPs in a particular area. However, it would be possible for people to be offered the choice between becoming a member of an LCP that would manage their primary and wider care in an 'office medicine' approach, with the alternative being to remain with the PCT as health funder (which people are arguably members of at present). In reality, choice of LCP would be likely to be guided very much by choice of GP practice, for one would expect practices to join a particular LCP and hence 'take their patients with them'. Consideration needs to be given to how practice enrolment would operate in future in respect of LCP-type arrangements, especially if people were to elect for dual membership of practices (for example, one near work and one near home), and the connection between a patient and a practice became more diffuse.

Raising public awareness of LCPs, their potential 'service offer' and why one LCP might be preferable to another, could be a key challenge. On the one hand, the public might need a convincing narrative about the purpose and value of a new tranche of NHS organisations, at a time when 'NHS bureaucracy' is being questioned once again within political debate. On the other, multi-specialty group practice might easily be understood as an extension of the concept of multi-partner general practice. While there is evidence that people have a high degree of trust in doctors and nurses to run health organisations, they are likely to struggle to understand changes to service patterns such as the relocation or termination of some outpatient clinics. In such cases they may suspect financial restraint, rather than clinically-led service innovation, as the motivation. Choice of LCP would also call for careful attention to be paid to risk adjustment within financial allocations, to minimise any selection bias on the part of LCPs; there would be a need, as in the Dutch system of competing health insurers, of a right to join any LCP irrespective of health status (Bevan and van de Ven, forthcoming).

A reshaped role for the PCT

The development of LCPs would have inevitable implications for the role of the PCT, which would become primarily a funder, setter of priorities, and allocator of risk-adjusted budgets to LCPs, especially if the trend for PCTs to divest themselves of managing community health services continues. The PCT would have a key role in designing, implementing and monitoring LCP contracts, and in devising and assuring robust assessment of financial performance, health outcomes and patient experience. This role as steward and governor of the local health economy has been described as being the 'brain' (setter of priorities) and 'conscience' (performance manager) in a more plural provider market (Smith and Mays, 2005).

Some LCPs might choose to source their management and infrastructure support from PCTs, but this could not be assumed, for the independence of LCPs (independence necessary to secure clinician engagement) will require that they are able to design and source support on a competitive basis, including perhaps from private sector organisations. LCPs would be likely to access specialist procurement and contracting support from the NHS-based or commercial hubs that are being developed at strategic health authority (SHA) or supra-PCT level, a development that reduces the dependence of an LCP-type organisation on PCTs.

There might therefore be a natural move towards fewer PCTs that assume a more 'pure' commissioning role, holding the ring of contracts with LCPs, foundation trusts/other acute trusts (and LCPs may be foundation trusts in some cases), and other providers. In this sense, setting up LCPs might entail PCTs 'doing themselves out of a job', although it remains to be seen how far GPs and LCPs will want to assume extensive commissioning, as well as provider, responsibility. Evidence about reorganisation and restructuring in the NHS (Dickinson and others, 2006; Fulop and others, 2002) would support an approach whereby PCTs would evolve into new larger entities as and when new clinically-led LCPs were in place, and would warn strongly against a wholesale, centrally-imposed reconfiguration of PCTs which would risk holding back some health economies, distracting others, and destabilising places where LCPs would take much longer to nurture.

Summary

It is clear that if clinician groups with real budgets and responsibility for population health outcomes are to play a key role in the next phase of development of the NHS, a phase that entails possibly the greatest management and financial challenges known to the NHS for a generation, radical change will be necessary.

Issues such as developing a new incentive structure for primary and secondary care clinicians, renewing the GMS/PMS contracts, setting up new local organisations that make sense to local people, and reshaping the role of PCTs entail significant organisational and cultural change. A summary of these changes is set out in Box 1 overleaf.

Box 1: Summary of changes needed for putting local clinical partnerships into practice

- To tackle the financial and health challenges ahead, LCPs would need to become multi-specialty in nature, including generalists and specialists.
- LCPs would vary in size and scope, both in relation to the range of services covered and how far they elect to commission as well as provide services.
- The organisational form of LCPs would likewise differ, with foundation trusts, social enterprise options and multi-professional partnerships appearing to show particular promise. The ability to raise capital for new developments would be crucial.
- The crafting of incentives for GPs would be the most critical issue, given their general disenchantment with PBC.
- A move to more collective management by GPs of local services might require consideration of renewing the GMS and PMS contracts.
- Careful work would be required to design organisational and personal incentives for specialists to engage closely with LCPs.
- The portability of the NHS pension would be a critical issue to be resolved when determining the form of an LCP; social enterprise or foundation trust options may hold most promise here.
- Robust methods for allocating risk-adjusted budgets would be critical.
- A framework for measuring and assessing the outcomes of LCPs would be required, taking account of national, PCT and local regulatory standards.
- Public accountability of LCPs would need to be assured, through public membership or other consultative and advisory arrangements.
- Consideration chould be given to offering patients a choice of LCP.
- The PCT role would move to become more focused on being steward and governor of a (probably larger) local health economy.

CONCLUSIONS

A critical question to be addressed is the path by which current PBC and other existing clinician organisations might develop into a local clinical partnership model as proposed in this paper.

One possibility would be a 'big bang' reform requiring redesign of local health systems across the country, supported by policy changes outlined in the previous section such as a new GMS contract, reform of resource allocation, and restructuring of PCTs. This would however bring forth the known hazards and consequences of structural reorganisation and would impede progress with improvements to NHS efficiency and service development over the exact two- to five-year time period when the service has to adapt to a radically different fiscal context. There is no appetite, in the NHS or politically, for an upheaval of this sort.

The alternative is to adopt an approach whereby a policy context is shaped that enables existing and emerging clinician groups to grasp opportunities to build new devolved and accountable local clinical partnerships. Such a context would need to be permissive, avoiding the temptation to dictate organisational form, clarifying desired overall outcomes, and establishing a set of principles for LCPs that would ensure that this opportunity was available to all willing and able clinician groups.

One possibility would be to adopt a phased approach, whereby LCPs could select different models of resource management and organisational form, according to their willingness and/or readiness, but with a clear expectation (that would be performance-managed by the SHA) on the part of the PCT that LCPs must be enabled and allowed to develop and progress to the most advanced level at which they wish to operate. For example, models could include:

- The LCP with ring-fenced GMS budgets maintained at practice level, taking on a capitated real HCHS budget for the locality, using this to deliver an increased range of primary and community based services (possibly by contracting with some specialists to deliver it) and to commission a range of services across a set of care pathways.
- The LCP with ring-fenced GMS budgets maintained at a practice level, taking on a capitated real HCHS budget and delivering as above, but also perhaps using it to employ some specialists directly within the LCP, as well as contracting for other services.
- Foundation trusts with doctors in certain community-oriented specialties used to managing their department via service line reporting, migrating the specialty to the LCP, which has budgets organised as above.
- Personal Medical Services (PMS) and Alternative Providers of Medical Services (APMS) organisations joining with foundation trusts along clinical pathways or departments (such as the care of older people, diabetes, dermatology) to form an LCP.
- The LCP is developed from current ICO pilots, but taking on the essential features of an LCP as outlined above.
- The most advanced model might entail an LCP taking on a global capitated risk-adjusted budget for the locality (including primary care resources committed via GMS/PMS) and using this to deliver an increased range of primary and community services through a range of individual practices, and groups of practices, operating in a federal model, as well as integrating delivery with a range of other specialist providers. The services the LCP did not 'make', it would 'buy' from a range of other providers and commission these, either by itself or with another LCP, or by the PCT acting on its behalf.

The extent of HCHS budget assumed by groups could vary according to local readiness and priorities. Some of the budget might be 'blocked back' to the PCT or to other LCPs to manage financial risk and service commissioning. For PCTs, there would be a challenge in relation to managing a 'mixed economy' of LCPs with varying levels of commissioning responsibility, and they would play a critical role in ensuring that patient care was not compromised.

An initial move in this direction might be to invite pilot groups of clinicians wanting to assume total or partial real budgets for a population (which, as noted earlier, is already happening in some areas), with a commitment

to suspend certain policy requirements for such pilots where local stakeholders were willing and that was deemed necessary – for example, shaping a different approach to the management of GMS, bundling payments 'beyond payment by results', and sharing of financial risk. The local PCT, SHA and the Department of Health would need to encourage bold innovation of this type.

In this way, LCPs could be shaped by local clinician groups working with PCTs, foundation trusts and other stakeholders, and those who are already close to being LCPs could make rapid progress and be used as experience from which others could learn. This has the attraction of 'working with the willing' and avoiding the inevitable 'lowest common denominator' approach of enforcing a single national approach.

We conclude this paper by summing up, in Table 3, what we consider to be the essential requirements of developing robust local clinical partnerships, the 'deal' that could guide the development of policy beyond practice-based commissioning.

TABLE 3: THE 'DEAL' FOR LOCAL CLINICAL PARTNERSHIPS

THE 'DEAL'	FOR CLINICIANS, THE LCP MUST:	FOR THE PCT, THE LCP MUST:
Budgets must be real, with risk handed over and assumed	Have a budget that is set using robust person-based and risk-adjusted methodology	Be able to manage the risk associated with a global budget and ensure that sound financial management and governance arrangements are in place between LCPs and the PCT
Local clinical partnerships must be developed and owned by the clinicians	Have an organisational form that is owned by the clinicians and protected (as far as possible) from any attempt by the NHS to impose structural reorganisation Facilitate closer working with their peers (other GPs, primary and community care clinicians, and secondary care specialists) on the issues that are critical for their population, based on its health needs, overall NHS priorities, and health outcomes Support local practices and providers, seeing these as vital building blocks and 'front of house' service delivery points within the overall LCP Enable sufficient managerial and technical support to be provided by the PCT or other management service organisation so that the LCP can operate in an efficient and productive manner, including sophisticated data linkage and analysis	Encompass the whole population within a local health community, ensuring that there are no exclusions of vulnerable groups and/or high-cost patients Be of sufficient scale to enable financial risk to be borne and economies in transaction costs to be realised Demonstrate clear and sustainable clinician leadership Avoid an overly medical focus, being concerned with improving local population health and involving all local health and social care professionals necessary

THE 'DEAL'	FOR CLINICIANS, THE LCP MUST:	FOR THE PCT, THE LCP MUST:
Experimentation and innovation must be encouraged	Foster a spirit of innovation and experimentation in the commissioning and delivery of services, linked to clear responsibility for health outcomes	Enable a focus to be made on improving the quality and productivity of primary and community care, as well as on the quality of services commissioned from others
'Make or buy' decisions must be possible	Align the incentives for taking on responsibility for a global risk-adjusted real budget, with those associated with making service change and improving quality of patient care, including issues of clinical governance, education and training, and peer review	Provide an efficient system within which clinicians can take 'make or buy' decisions that are properly and proportionately governed
Governance must be robust and proportionate and accountability must be clear	Provide the 'headroom' to enable swift and responsible decisions to be taken about services to be delivered within a primary care setting, and those to be commissioned from elsewhere, coupled with clear accountability	Demonstrate progress against agreed local and national outcome measures, including those set by bodies such as the Care Quality Commission and National Patient Safety Agency Demonstrate adherence to national and European standards of procurement
Responsibility for health outcomes must be taken	Ensure that the 'holy trinity' of patient experience, financial performance, and health outcomes are brought together in a robust accountability framework for the LCP	Create an environment within which primary care and other clinicians will take real responsibility for the health outcomes of a given population and for utilising the associated health budget to best effect, and be held to account for doing so
Radical service improvements must be possible	Enable improved access to and coordination of care across formal organisational boundaries that will deliver real improvements to services for patients. Result in effective service change that is deemed to make a positive difference to patients, and address the concerns of clinicians	Enable a focus to be made on improving the quality and productivity of primary and community care, as well as on the quality of services commissioned from others Result in improved patient experience of local services, especially in relation to those focused on long-term conditions, unplanned admissions, and care of the frail elderly

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