The Nuffield Trust
FOR RESEARCH AND POLICY
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BEYOND PRACTICE-BASED COMMISSIONING: THE LOCAL CLINICAL PARTNERSHIP 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).

Key points

- Practice-based commissioning (PBC) has been a cornerstone of the Government's health service reforms in England since it was introduced in 2005, but it has so far struggled to deliver significant changes to services for patients, or financial savings.
- There is little appetite, politically or within the NHS, for further large-scale policy upheavals but further thought is urgently needed as to how to develop clinically-led commissioning, as the NHS enters a period of financial constraint.
- There are different ways that PBC could be developed. This report considers one broad model: that of multi-specialty groups of clinicians – GPs as well as specialists based in the community and in hospitals – coming together in new organisations ('local clinical partnerships') and taking responsibility for designing, delivering and commissioning local health services.
- Developed and owned by clinicians, these partnerships would hold real budgets and have responsibility for the health outcomes of their local communities. In most cases they would be led by doctors, although nurses from primary and community care, pharmacists and allied health professionals would be actively involved.
- The organisational form of the partnerships would not be a rigid one and would vary, with foundation trusts, social enterprise options and multi-professional partnerships appearing to show particular promise.
- Ideally, they would be based on a geographical community but the crucial factor is that they develop locally as independent collectives of clinicians who are committed to working together.
- The partnerships would require the alignment of organisational and personal incentives to ensure the active engagement of GPs and specialists. This would be vital, given the general disenchantment of GPs with PBC.
- The report concludes that this model holds the promise of re-engaging clinicians in reform and delivering a health service that is affordable, centred on the needs of patients and led by clinicians.

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.

Beyond Practice-based Commissioning: The local clinical partnership, published jointly by The Nuffield Trust and the NHS Alliance, focuses specifically on how PBC can be developed to help face some of the challenges outlined above.

While there may be many ways that PBC could be developed (see Lewis and others, forthcoming), this report considers one broad model – that of multi-specialty groups of clinicians – GPs as well as hospital-based specialists – taking responsibility for the provision and commissioning of a range 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 further 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 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 to describe how these groups could operate within the NHS in England.

Key features of a local clinical partnership

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, while 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 to 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
- 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
- development of an incentive package for specialists becoming part of an LCP – the portability of the NHS pension is a key issue
- 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
- reshaping 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 or PMS organisation 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 LCP 'deal'

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
- 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.

REFERENCES

Lewis RQ, Rosen R, Goodwin N and Dixon J (forthcoming) *Integrated Care – The future for primary care-led commissioning?* London: The Nuffield Trust and The King's Fund.

Smith JA, Curry N, Mays N and Dixon J (forthcoming) *Where Next for Commissioning in the English NHS?* London: The Nuffield Trust and The King's Fund.

The full report *Beyond Practice-based Commissioning: The local clinical partnership*, by Judith Smith, Julie Wood and Jo Elias, published November 2009, is available at www.nuffieldtrust.org.uk/publications or www.nhsalliance.org

The report forms part of the Trust's wider programmes of work on commissioning and the future organisation and delivery of care, which are examining how commissioning can be strengthened to ensure the NHS is prepared for the efficiency and healthcare challenges ahead.

ABOUT THE NUFFIELD TRUST

The Nuffield Trust is a charitable trust carrying out research and policy analysis on health services. Our focus is on the reform of health services to improve the efficiency, effectiveness, equity and responsiveness of care. Current work themes include new forms of care provision, commissioning, efficiency, international comparisons and competition policy. For more information on our work programme and to sign up to receive our regular e-newsletter, visit **www.nuffieldtrust.org.uk**

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The NHS Alliance champions, supports and represents NHS primary care and all those working in it. The Alliance brings together PCTs with practices, clinicians with managers and board members. It is independent of government and is fully multi-professional: its members include PCT chief executives and other senior managers, doctors and practice managers, nurses, pharmacists and allied health professionals, along with board chairs and members.
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