The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff
The current staff of the Committee are Dr David Harrison (Clerk), Martin Gaunt (Second Clerk), David Turner (Committee Specialist), Lisa Hinton (Committee Specialist), Frances Allingham (Senior Committee Assistant), Julie Storey (Committee Assistant) and Gabrielle Henderson (Committee Support Assistant).

Contacts
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Memorandum by the Department of Health (COM 01)

TERMS OF REFERENCE

— “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?
— The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?
— Commissioning and “system reform”: how does commissioning fit with Practice-based commissioning, “contestability” and the quasi-market and Payment by Results?
— Specialised commissioning.
— Commissioning for the quality and safety of services.

EXECUTIVE SUMMARY

1. World class commissioning (WCC) sets out a new approach to commissioning for health and care services, and is one of the underpinning delivery vehicles for current health policy. The programme seeks to deliver a step change in commissioning capacity and capability, ultimately improving the quality of care, health and well-being outcomes, and reducing inequalities.

2. WCC is increasing the momentum of NHS reforms that began with The NHS Plan1 in 2000 (see key stages of NHS reform set out in Figure 1, page 10). This set out a 10-year programme of reform for the NHS, focussing principally on secondary care provision.

3. Commissioning a patient-led NHS2 (2005) recognised the need to strengthen commissioning and empower commissioners to drive change, initially largely through alterations to structure and process. The document signalled a large (but necessary) reorganisation of PCTs and SHAs.

4. In 2005, having taken stock of the progress of implementation of the NHS Plan, it was decided that momentum could best be increased, and ownership built, through a more holistic approach to NHS reform, framed around the four main elements of demand, supply, transactions and system management. This reflected the need to take a more cohesive approach, seeking to enable major change by intervening to improve the management and development of both demand (commissioning) and provision, and modernising and aligning the NHS’s approach to transactions and system management, recognising the interdependencies between them.

5. To deliver substantial improvements in service quality and value for money, embed personalisation, and secure a much greater focus on prevention and well-being, the Department was aware that the commissioning capability of PCTs needed to be enhanced substantially and assured to reduce unacceptable variation.

6. The PCT Fitness for Purpose exercise (May 2006—March 2007) set out the required capabilities underpinning effective PCTs and provided a framework against which to assess them.

7. In May 2007, the Department conducted a joint review of commissioning capability with the Prime Minister’s Delivery Unit. This highlighted challenges around commissioning capability, and recommended actions that needed to be taken to drive a step change in commissioning capability. The new PCT organisational structures had taken some time to embed and this had some impact on the ability of PCT’s to deliver the improvements required in the commissioning function in response to Fitness for Purpose assessments.

8. The WCC programme responds to these issues and is designed to raise ambitions for a new form of commissioning which does not exist in a consistent way in any developed healthcare economy anywhere in the world.

9. World Class Commissioning (WCC), addresses directly both the need to create a strong, shared vision for commissioning and build commissioning capability, capacity and leadership. It is a national programme, developed in partnership with the NHS, implemented locally and is widely accepted and supported by the NHS. It has been built on the evidence base of commissioning best practice internationally, reflecting our aspiration to develop “world class” commissioners of NHS-funded services.

10. WCC creates the framework through which PCTs can focus on improving the health of local people. It sets out the skills and capabilities of highly-skilled commissioners and articulates the management arrangements and characteristics of a world class organisation.

11. It is not an end in itself, but a way for commissioners to develop different approaches that are long term, strategic and outcomes focused in order to improve outcomes for their local population, and that involves all partners including patients, the public, local authorities, clinicians and providers.

12. Some elements of commissioning (but not accountability) are devolved to third parties. Examples would be through practice-based commissioning (PBC) agreements, where consortia of primary care practitioners act on behalf of PCTs, and Specialised Commissioning Groups (SCGs) where PCTs come together at Strategic Health Authority (SHA) level to collectively commission specialised services.

13. The WCC process has already started a process of real behaviour change which will deliver long term health improvements for patients. All PCTs have identified a clear path to help them become world class organisations and have concentrated on commissioning for long-term health gain for their local communities with a greater focus on prevention and early intervention.

14. Results from the first year of assurance demonstrate how PCTs are making satisfactory, and in several PCTs excellent, progress in their journey to become world class commissioners. From here onwards, the pace of development in PCT commissioning capability is expected to be rapid, with effects on locally identified health outcomes to become visible in the next three to five years.

15. The current economic climate has sharpened the focus on how we are going to go further in seeking step-change improvements in quality, and innovation, and make more effective and efficient use of resources. Great importance is placed on WCC as a key enabler to drive improvements in these areas.

16. WCC will have an increasing direct impact on the health and well-being of the population, delivering better services which are more closely matched to local needs, resulting in better care, driving unprecedented improvements in patient outcomes, reducing health inequalities across the community and ensuring the NHS remains one of the most progressive and high-performing health systems in the world.

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

17. To accelerate the momentum and ownership of reform, in 2005 the Department formulated a more holistic, cohesive approach to NHS reform, built around the four main elements of demand, supply, transactions and system management. A key element of this was to state much more clearly the aims of commissioning and to clarify the key roles and contribution of commissioners. This was done through two publications: a Commissioning Framework included in Health Reform in England: update and commissioning framework (2006) and—to reinforce the growing importance of prevention, health and wellbeing—Commissioning framework for health and wellbeing (2007). What this did not do, however, was address the underlying issue of commissioning capacity, capability and leadership—hence the strategic importance of the WCC assurance and development programme.

18. The two fundamental roles of a health service commissioner are:

(i) to be the advocate for patients and communities—securing a range of appropriate high-quality health and healthcare services for people in need, which provide care which is safe, effective and a good experience. Patients must have good access to primary, community, mental health, local hospital and specialised services. Standards must be reliable and constantly improving, and reliable and relevant information about health and services must be freely available to patients.

People rightly expect greater choice and personalisation, with services tailored to meet their needs and aspirations. Commissioners have a key role to play in enabling this. To address the strategic challenges of rising demand highlighted by Derek Wanless (see Figure 1), commissioners increasingly need to be advocates for health and wellbeing, encouraging and enabling individuals, families, and communities (including employers) to take greater and shared responsibility for staying healthy and managing their health and conditions. This means understanding better the determinants of health, effective engagement and enablement of people and populations and strengthened partnership working (eg with local authorities, community groups and employers) to improve health and wellbeing. As a result, the role of commissioners has grown from a traditional fairly narrow base of needs assessment and contracting. The challenges to commissioning capability and leadership have risen accordingly.

(ii) to be the custodian of tax-payers money—this brings a requirement to secure best value in the use of resources. Budgets must be optimised, and resources must be used where they will generate the greatest benefit. Challenging how the NHS spends its money and ensuring that the best outcomes are achieved are at the core of the commissioning role. To do this requires comprehensive health needs assessment, understanding the evidence for effective interventions and which are likely to give the best return on investment, effective prioritisation, as well as strong financial management, negotiation and commercial skills.

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3 Health Reform in England: update and commissioning framework, published July 2006:
4 Commissioning framework for health and wellbeing, published March 2007:
19. Experience from local authorities and the NHS had shown that neither of these roles were likely to be exercised effectively without a clear separation of the responsibility for commissioning from provision, allowing “commissioners” to focus on securing the best value for patients and taxpayers without being conflicted by having responsibility for provision. Without this separation, it is more difficult for PCTs to commission those services their populations actually need, rather than what has been provided historically.

20. The Audit Commission’s report Healthy Competition, published in 2007, examined how councils can use competition and contestability to improve services, highlighting their importance as components of public service reform. It found that in the councils that made the best use of competition and contestability, officers across the council had sound service definition, procurement and contract management skills. Where competitive exercises were less successful, the issue was compounded by poor commissioning. The research showed that councils needed to be clear about what they wanted before they could procure it, regardless of how the service was to be delivered.

21. Has the purchaser-provider split worked? At the time that the health reforms were being developed in 2005, it was recognised that, whilst commissioning had been in place for some time, it was not having the intended impact. The underperformance reflected a variety of factors, principally that:

   (i) there had not been sufficient investment in developing the capability and capacity of commissioners to carry out their role;
   
   (ii) commissioning had often been seen within the NHS as a less attractive career option and of lower status than managing acute NHS Trusts, and consequently the calibre of leadership was often weaker, particularly at middle management level; and
   
   (iii) the necessary system levers and enablers were not in place to support, resulting in unbalanced relationships and influence between providers and commissioners.

22. The responsibility for both supply and provision, particularly the management of significant provider arms, had also distracted some PCT boards from their core commissioning role. The conflict of interest for PCTs as commissioners if they continued to provide community health services also put at risk their ability to obtain the best services for their populations.

23. Nevertheless, there is growing evidence (see the examples provided in Annex A) that commissioners are delivering substantial improvements in services, commissioning new, innovative services, provided closer to people’s homes and with a stronger focus on prevention and maintaining independence.

**World Class Commissioning—what does this tell us about how effective commissioning by PCTs is**

24. Some PCTs (see examples provided at Annex A) are commissioning more effectively, delivering improved quality, responsiveness and effectiveness for patients, and better value for taxpayers. Some PCTs, however, have yet to fully transform themselves as commissioners and become active health investors for their population.

25. The reorganisation of PCTs in 2006 was intended to strengthen the capability and capacity of PCTs to commission more effectively. However there is limited evidence that reorganisation resulted in PCTs using their commissioning powers to redesign services, in order to secure better patient outcomes and value for money.

26. World Class Commissioning was developed in response to this and is designed to ensure that PCTs invest their £100 billion budget to improve health outcomes and reduce health inequalities.

27. WCC was developed in partnership with the NHS and other stakeholders. This extensive engagement of people across the system created a crucial sense of ownership and co-production and commitment to implement change locally following the launch of the programme in December 2007.

28. WCC brings a different approach to PCT commissioning: one that is focused on outcomes and that involves all partners including patients, public, local authorities, clinicians and providers in making tough choices about local priorities and how to deliver them.

29. The Committee may wish to refer to the WCC update paper provided in October 2008 which set out the background and aims of the WCC programme. 

30. WCC will help PCTs ensure delivery of better services which are more closely matched to local needs. It will result in better quality of care, which is safe, effective and a good experience; improved health and well-being; and a reduction in health inequalities across the community.

31. WCC does this by creating the framework through which PCTs can focus on improving the health of local people. Improving health outcomes will be key to success. However, at this stage in the commissioning journey of PCTs, it is too soon to focus on outcomes on their own as many health outcomes have long lead periods before improvement is evident e.g. cancer mortality. WCC therefore also sets out the competencies

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(the characteristics that an organisation needs to become world class) and their governance arrangements. The latter recognising the importance of PCT Board buy-in to the behavioural and cultural change needed for success.

32. A range of guidance, tools and support have been developed to help PCTs rise to the challenge.

33. Every PCTs progress on WCC is assessed through an annual “assurance” process. This aims to help PCTs assess their performance and build a development plan to help them become world class commissioners.

34. The process is developmental but rigorous. PCTs are assessed in three areas: health outcomes (the priorities for health improvement in the local area), competencies (the characteristics that an organisation needs to become world class) and their governance arrangements.

35. Through the assurance process, the programme is providing the first ever systematic approach to measuring commissioning performance and ensuring health outcomes are improving.

36. Ultimately, through the Commissioner Performance regime (to be introduced from 2010), those PCT commissioners who persistently under-perform for the people they serve risk having part or all of their commissioning functions franchised to high-performing PCTs or commercial organisations.

Figure 1

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<td>The NHS Plan(^7) set out a 10 year programme of reform for the NHS, focussing principally on secondary care provision, detailing a comprehensive approach to increase capacity and investment, together with underpinning transactional changes (eg Tariff) and action to strengthen the management of provision (Foundation Trusts).</td>
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<td>February 2004</td>
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<td>The Wanless report Securing good health for the whole population(^8) emphasised the increasingly urgent strategic need to begin to move away from a focus on hospital based provision—treatment and cure—and towards prevention, health promotion and well-being, and proactive, rather than reactive, responses to care.</td>
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<td>July 2005</td>
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<td>Commissioning a patient-led NHS(^9) recognised the need to strengthen commissioning and empower commissioners to drive change, initially largely through alterations to structure and process. This began to move the emphasis from spending on services to investing in health and well-being outcomes. The document signalled a large (but necessary) reorganisation of PCTs and SHAs.</td>
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<td>May 2006—March 2007</td>
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<td>The PCT Fitness for Purpose exercise (May 2006—March 2007) set out the required capabilities underpinning effective PCTs and provided a framework against which to assess them. Fitness for Purpose included organisational and commissioning capability diagnostic assessments which indicated significant areas of weakness in commissioning capability.</td>
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<td>May 2007</td>
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<td>Following Fitness for Purpose, a joint review conducted by DH and the Prime Minister’s Delivery Unit (PMDU) further highlighted the need to strengthen commissioning capability. This identified similar challenges around commissioning capability, and recommended actions that needed to be taken to drive a step change in commissioning capability.</td>
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<td>June 2008</td>
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<td>High Quality Care For All: the Next Stage Review Final Report,(^10) continued the journey towards an improved NHS which is fair, personalised, effective and safe, and which is focused relentlessly on improving the quality of care, ensuring that services are safe, effective and provide a good experience for patients. Improving commissioning is at the heart of delivering this agenda.</td>
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PCT Commissioning Performance

37. Results from 2008–09, the first year of WCC assurance have demonstrated that PCTs are making satisfactory, and some PCTs excellent, progress in their journey to become world class.

38. Every PCT now has—for the first time—a five year strategic commissioning plan setting out the priorities and outcomes agreed with partners, clinicians and patients as being the most relevant to their population, setting a baseline to measure improvement in subsequent years. These plans are underpinned


by rigorous financial, operating and organisational development plans. The rigorous preparation required to develop these strategies and plans should place all PCTs in a much stronger position to address the financial challenges ahead.

39. PCTs are clearly focused on improving the health outcomes of their populations, and focusing their energy towards commissioning for long term health gain. In addition to the two mandatory priorities—reducing health inequalities and improving life expectancy, there was much consensus on local priorities—the same 10 outcomes were identified in 60% of PCTs. These were:

- smoking quitters;
- rate of hospital admissions per 100,000 for alcohol related harm;
- CVD mortality;
- percentage of all deaths that occur at home;
- under 18 conception rate;
- Cancer mortality rate;
- Diabetes controlled blood sugar;
- infants breastfed;
- percentage of stroke admissions given a brain scan within 24 hours; and
- Clostridium difficile infection rate.

40. PCTs’ ambition and enthusiasm for improving their commissioning was clearly demonstrated in year one. Their capabilities as local leaders of the NHS, working with community partners, engaging with the public and patients and collaborating with clinicians was evidenced.

41. Following an assessment against a range of competencies, PCTs were identified as being strongest at working with community partners. This greater cooperation and joint working between PCTs and local government will ensure they have a more holistic view of their population’s health and social care needs, leading to better integration of services.

42. PCTs are also focusing more on developing their knowledge management skills in order to develop greater understanding of their populations, their health needs, behaviours and experience of the NHS, and enable them to design services around those needs. Increased management of data by PCTs is better informing them about where care is being delivered, when it is most effective and where there might be opportunities for improved outcomes.

43. In the first year of WCC, PCT capabilities were assessed as being less strong in the more technical competencies, such as shaping and managing the capacity and supply structure and securing procurement expertise. These are areas where there is a range of practical support available to enable PCTs to make progress quickly. Progress in these areas is expected to be evidenced in this second year.

44. Robust governance arrangements were seen in most PCTs, with the grip of Boards on their respective organisations and their ownership and control of the commissioning agenda locally, coming out most strongly.

45. WCC has created a step change in the way the NHS views commissioning. Many PCTs have stated that they found the process transformational. A comprehensive evaluation was undertaken after the conclusion of this first year of the assurance process. This included over 300 responses to an online survey (including over approximately 200 PCT colleagues, 70 panel members and 30 SHA colleagues); interviews with SHA colleagues and panel members, an in-depth review of the assurance website, a working group on the data and metrics used in the system as well as a national evaluation event. Nearly 90% of participants in the process are agreed that WCC will lead to an improvement in commissioning capability and governance. Overall, we heard that the assurance process had been successful and the WCC Framework was good with only fine-tuning required.

**World class commissioning Year 2**

46. Refinements have been made to the assurance framework and process for year 2 which reflect:

- the above evaluation and feedback from year 1, supplemented by extensive consultation across the NHS;
- wider contextual challenges that PCTs are facing, particularly the challenge of improving quality in the current and future climates; and
- expected changes in commissioning skills and behaviours as the definition of world class continues to develop.
47. The following key changes have been made to year 2:

**Outcomes:** Improving health outcomes and reducing health inequalities remain the focus and overall goals of WCC assurance. In year 2, PCTs will be asked to describe how they will demonstrate improvements to date and to set year-on-year aspirations for the next 5 years. The outcome metrics list has been revised in response to evaluation.

**Competencies:** Competencies have been revised to increase clarity and ensure relevance to current context and what is required of PCTs to deliver in these challenging times. The revised criteria for all the sub-competencies provide greater clarity on the specific skills, knowledge and processes that are required, and ensure there is a greater differentiation between each level. Competency 11, focusing on efficiency and effectiveness, will also now be assessed as part of the core competencies (rather than in the governance section as in year 1). Competency 6 has been revised in light of this and also requires PCTs to prioritise investment in different financial scenarios.

**Governance:** The board self-certification has been developed so PCTs will now self-assess against all three aspects of governance to allow a more informed debate with the panel. The strategy section has been strengthened to reflect feedback and the increasing challenges PCTs are facing. The board element has been enhanced with greater emphasis on board ownership and responsibility for managing risk and for strategic development and delivery.

**Process:** The process for this year has been streamlined and simplified wherever possible, with the aim of helping PCTs focus their time and efforts on the core activities that underpin assurance such as the strategic plan and embedding core capabilities and skills.

48. Year two of assurance was launched on 16 September. In summary, this has an increased focus on improvement in health outcomes, and PCTs having a clear strategy for delivering improved quality, whilst at the same time, demonstrating increased efficiency and effectiveness. PCTs are encouraged to set aspirational goals that will challenge and stretch their capabilities and performance.

49. In July 2010, following the completion of the second year of WCC assurance, the panel reports for each PCT will be published nationally. The panel report and scorecard for Year 2 will be used to determine the PCTs whose performance will be rewarded and those which will be under greater scrutiny. PCTs that are at the upper end of performance will be rewarded with a range of incentives. This is in keeping with the commitment made in High Quality Care for All. The measure of success will be based on a combination of outcomes, competency and governance.

50. PCTs which are at the lower end of performance will be subject to increased SHA intervention. This will be in line with the principles set out in the NHS Performance Framework and the NHS Transactions Manual. The NHS Performance Framework will be applied to PCT commissioners from April 2010. The Framework will set clear thresholds for intervention in underperforming organisations and a rules-based process for escalation, including defined timescales for demonstrating performance improvements to ensure the NHS is consistently delivering high quality care.

51. Key touchstones going forward will be partnerships, clinical engagement and use of information to drive improvement. For example, PCTs must consult and work collaboratively with a variety of partners, including local government, healthcare providers, third sector organisations, clinicians and clinical partners such as practice-based commissioners and specialist consortia. In addition to commissioning healthcare, they also need to consider the wider determinants of health and the role of other partners in improving the health outcomes of their population. For example, PCTs also share responsibility for undertaking a joint strategic needs assessment (JSNA) with local authorities. Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design.

52. Whilst the WCC programme is designed for and focused on NHS commissioning practices, the principles of ‘good’ commissioning practice can be applied in a social care setting. We are working to develop closer joint working between PCT and social care commissioners and providers locally so that these principles apply across whole health and care pathways.

53. From here onwards, the pace of development in PCT commissioning capability is expected to be impressive. Improvements in commissioning competencies are anticipated in the next two to three years, and effects on locally identified health outcomes to become visible in the next three to five years.

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Practice-based commissioning

54. At the heart of world class commissioning is clinical engagement and leadership. This is a recognition that commissioning is at its strongest and most effective when it is the product of a partnership between local clinicians and health service managers working in tandem to enhance the quality of services and improve health outcomes. Practice-based commissioning (PBC) provides the means for this partnership to take place and thrive. Fundamentally, PBC is about the clinical leadership of commissioning and driving service quality & innovation.

55. PBC is a way for clinicians to influence the way existing services are provided, by assessing the health needs of local populations and addressing them through proposing new services, or re-designing existing ones to better meet patient needs. Practice-based commissioners are able to shift care into more local community based settings that provide more convenient, integrated care for patients, and can reduce the need to refer to secondary care and therefore keep people out of hospital.

56. We do not accept that—as some commentators have suggested—that there is an inherent conflict or tension between WCC and PBC. PCT commissioning and practice-based commissioning should work together as part of an integrated system, where the strategic health investment plans for the wider population dovetail with the health investment plans for local practice populations. Clinical Commissioning: our vision for Practice-Based Commissioning13 (2009) sets out how strong partnerships between PCTs and their clinical communities are fundamental to effective commissioning, with both drawing on respective strengths to drive better health, better care and better value for local patients.

57. Clinical Commissioning sets out the support and entitlements that practice-based commissioners can expect to underpin successful implementation and provides a clear focus for PCT investment in clinicians as commissioners. In addition, for year 2 of WCC, we have strengthened competency 4 to add emphasis to the PCT fulfilment of PBC responsibilities and to add an explicit reference to engaging clinicians from all relevant sectors and demonstrating that local clinicians support PCT strategic priorities.

Case Study: PBC group creating improved services for patients in Croydon

Norbury women’s health clinic is working with PBC Croydon to deliver a one stop GP-led service for women with menstrual problems with a senior clinical input at an early stage.

This initiative was established with the purchase of a £25,000 ultrasound scanner, paid for by the PCT with the PBC consortia bringing in a consultant in gynaecology, a GPwSI in gynaecology, a sonographer, nurse and healthcare assistant to staff the service.

To date, the average waiting time to see a senior clinician has been reduced from between eight to 10 weeks to two weeks, with less than 10% of patients seen by the clinic being referred to secondary care.

Commissioning for the Quality and Safety of Services

58. The overall vision set out in High Quality Care for All is to make quality the organising principle of the NHS by developing a system-wide focus on quality. It sets out a definition of quality covering three specific domains: patient safety, effectiveness of care and patient experience. Improving the quality of care demands a system-wide effort, with WCC is a key enabler. It requires a broad range of actions in organisational leadership, commissioning, performance improvement and clinical engagement. PCTs will have a key role in delivering this vision, given their focus on commissioning for better health, better care and better value. Their relationship with providers should be open, honest, challenging and focussed on improving the quality of care. As part of WCC, PCTs will demonstrate their approach to improving quality by evidencing how they measure outcomes both objectively, ie clinical outcome, as well as patients own reported experience.

Tools for Commissioners

59. The CQUIN (Commissioning for Quality and Innovation) payment framework is one of a range of levers designed to support the cultural shift to put quality at the heart of the NHS. Introduced in High Quality Care for All, the framework makes a small proportion of provider income conditional on locally agreed goals for quality improvement and innovation, and aims to ensure that quality considerations are embedded within the commissioner-provider dialogue. CQUIN goals are intended to be ambitious and about continuous improvement beyond minimum standards, going further than the quality provisions in the NHS standard contracts for NHS-funded services.

60. High Quality Care for All tasked NICE with the production of quality standards. These will set out a set of specific, concise statements acting as markers of high quality, cost effective care across a pathway or a clinical area. They will be produced collaboratively with the NHS and its partners, and derived from the best available evidence.

61. The first four pilot quality standards will cover Venous Thromboembolism (VTE) prevention, diabetes, stroke and neonatal care. The National Quality Board (NQB) will work to scope the library and sequence the development of quality standards.

62. Standard Contracts are essential to provide transparency, empower commissioners by providing them with the levers they need to improve services for the communities they serve, incentivise providers to greater efficiency and better, more consistent quality, ensure fair, consistent treatment and simplify transactions.

63. A Standard NHS Contract for Acute Hospital Services was introduced through the Operating Framework in December 2007 for agreements between PCTs, as commissioners, and NHS Trusts and NHS Foundation Trusts as providers. Its use will be extended to cover acute independent sector providers following changes to legislation relating to the Contributory Negligence Scheme for Trusts (CNST).

64. Contracts have since been developed for ambulance, mental health and community health services and were published with the Operating Framework in December 2008 for use from April 2009 along side a refreshed acute services contract. The set of contracts are being reviewed and strengthened for use from April 2010. All the Contracts are based upon similar principles and requirements that first appeared in the standard acute contract. The non acute hospital setting contracts have been amended to take account of the different service and organisational contexts.

65. Indicators for Quality Improvement (IQI) is an assured menu of provider-based indicators which can be benchmarked across different providers. These will provide commissioners with useful information on indicators they should consider for example, as the basis of their contracts and CQUIN schemes. The development of IQI is being overseen by the National Quality Board (NQB).

66. Significant event auditing (SEA) is being embraced, but should be re emphasised. Because of the one-to-one personal contact between the patient and the GP in primary care services, there is significant scope for learning from thorough audit of events that have led to harm or where there has been a “near miss”. The use of SEA is incentivised through the organisational domain of the Quality and Outcomes Framework (QOF) for primary medical care.

67. Never Events—serious patient safety events that are largely preventable—should be defined, identified and monitored. The development of a national set of Never Events aims to strengthen the patient safety focus in commissioning for reducing serious incidents and improving transparency. Never Events will be monitored as part of the contract between commissioners and providers. In the first phase, it is proposed that PCTs will report on the incidence of Never Events in the services they commission. Implementation will firstly focus on promoting clear reporting and management systems for Never Events, then the NHS and the Department of Health will work to define whether linkages to payment regimes would be appropriate and effective.

68. Empowering patients—patients, through the exercise of choice (see “System Enablers”), can help to drive-up quality. The Department and Commissioners have a key role to play in enabling this, both through the provision of accessible, relevant and reliable information on quality and safety for patients and referrers (for example, through the NHS Choices website) and ensuring that patients are aware of their right to choose, and can access appropriate advice and support.

Specialised commissioning

69. Although most services in the NHS are commissioned by PCTs, there are different arrangements for commissioning specialised services. A specialised service is defined in legislation (SI 2002 No. 2375) as a service covering a planning population (catchment area) of more than a million people. Most specialised services are high-cost low-volume services that are provided in fewer than 50 hospitals/providers.

70. Specialised services are commissioned on a collective basis to:
   — ensure equitable access to care;
   — spread the financial risk amongst PCTs; and
   — ensure concentration of clinical expertise.

71. Sir David Carter led an independent Review of Commissioning Arrangements for Specialised Services14 in 2006. Implementation of the review’s 32 recommendations was designed to strengthen arrangements for commissioning specialised services. As a result of the review, the following bodies were established:
   — 10 Specialised Commissioning Groups (SCGs). These are coterminous with the Strategic Health Authorities and commission specialised services for their regional populations, which range in size from 2.5 million people to 7.5 million people.
   — The National Commissioning Group (NCG). This group commissions about 50 highly specialised services, which generally affect fewer than 400 people or involve services where fewer than 400

highly specialised procedures are undertaken per annum. It has an annual budget for services of approx £480 million. The group advises Ministers on which NHS services are best commissioned nationally.

— *The National Specialised Commissioning Group (NSCG)*. This group oversees the national commissioning function; and facilitates collaborative working at a pan-SCG level.

72. The NCG operates a cycle of annual applications from local services to consider new applicants for national commissioning against common criteria. Ministers continue to have a final decision on the designation (and de-designation) of nationally commissioned specialised services, based on recommendations from the NCG and NSCG.

73. PCTs can delegate their commissioning responsibilities to SCGs through formal governance arrangements and the effectiveness of these commissioning arrangements are assessed through WCC Assurance. Therefore, SCGs are responsible for significant commissioning budgets.

74. The assurance tool which has been developed specifically for SCGs, reflects all the elements of the PCT WCC assurance system, however it has been adapted to reflect the respective roles and responsibilities of PCTs, SHAs and SCGs. The assurance tool for SCGs is not mandatory for 2009–10, although it should be used across the country as a developmental tool, helping to inform the PCT assurance process and assess the effectiveness of PCT’s relationships with their SCGs. The outcomes of the SCG assurance tool will be evaluated to inform its use for 2010–11.

**System Enablers**

75. As a result of the NHS reforms, there is now greater clarity about the roles of different parts of the NHS, who provides services and who commissions them. On the supply-side the move to NHS Foundation Trusts (FTs) has strengthened governance and has given local communities a greater say about how health services are run. Payment by results is helping to deliver better value for money. New standard national contracts help to ensure transparency and hold providers to account for improving quality and value for money. The demand-side has been strengthened through giving patients greater choice and strengthening commissioning, particularly through the WCC programme and the evolution of practice-based commissioning. Commissioners are able to deliver better services for patients by using the additional capacity in the system and making full use of the levers (standard contracts, choice, contestability, more freedom for providers and better financial systems) available to them.

76. Since April 2009, all PCT direct provider organisations (mainly community services) have been required to work within a contractual relationship with the PCT commissioning function so that the PCT can commission and procure transparently and fairly, securing choice and value for money and avoiding conflict of interests.

**Competition**

77. PCT commissioning and procurement takes place within an overarching system of national rules designed to ensure transparency and fairness, and that the interests of patients and taxpayers remain paramount. These rules include the Operating Framework and the *Principles and Rules for Cooperation and Competition in the NHS (PRCC)*,15 published in December 2007.

78. The PRCC provide simple, workable guidance for system managers, commissioners, and providers on the expected behaviours and rules governing cooperation and competition, in the provision of NHS services. This guidance is being reviewed and will be updated for 2010–11, with a stronger focus on promoting co-operation. SHAs exercise strategic oversight and hold PCTs to account. SHAs are also responsible for resolving disputes relating to PCT commissioning and procurement activities. Where disputes cannot be resolved locally, the Cooperation and Competition Panel (CCP) has a role in adjudicating in procurement disputes referred on appeal. The CCP assesses compliance with the PRCC when a case is brought to it and makes appropriate recommendations to SHAs, the Department and Monitor.

**Choice**

79. Choice is fundamental to a truly patient-centred NHS. It can empower patients so that they are able to make informed choices about their healthcare. Patient choice incentivises providers to tailor services to the needs and preferences of patients, and give attention to service quality.

80. Free choice was introduced on 1 April 2008; it allows individuals, when referred for elective care, to choose services from any hospital provider in England that meets NHS standards and costs including FTs, NHS acute hospitals and many independent sector providers. NHS patients now have a much greater choice of provider—at June 2009, patients could choose between 170 acute trusts and 149 independent sector sites.

The NHS Constitution\(^{16}\) includes a right to choice: “You have a right to make choices about your healthcare and the information to support you in making those choices”. From 1 April 2009 there has been a legal right to choose the provider of your care when you are referred for your first outpatient appointment.

81. Choice is being extended to include key aspects of maternity care by December 2009. As part of the phased introduction of individual care plans for people with long-term conditions, PCTs are expected to increasingly offer appropriate choice, of treatment, support and where individuals receive services. This is integral to empowering individuals to play a more active role in managing their conditions.

Foundation Trusts

82. In 2008–09, over 50 percent of acute and mental health NHS trusts had been authorised as NHS FTs, giving them greater autonomy as to how best to organise and manage their organisations to deliver high-quality, cost-effective care. During 2009–10, there will be further progress with increasing the number of FTs. Plans will also be drawn up for the minority of trusts that are judged unlikely to be to be able to secure authorisation to become FTs in their present form so that their services can be delivered through the FT model.

83. FT autonomy, their rigorous regulatory regime operated by Monitor and increasingly stronger commissioning is creating the conditions for constantly improving performance to the benefit of patients. Evidence shows that the FT model is delivering strong organisations that can improve quality of care, maintain their finances very well, deliver efficiencies and build surpluses to invest in improvements to healthcare.

84. FTs set their own strategies and make their own investment decisions within the framework of their legally binding contracts with commissioners to deliver improved services to patients, informed by their unique membership governance model. The relationship between FTs and their commissioners is a key determinant to the success of FTs. With responsibility for service design and using their contracts to secure constantly improving quality from providers, commissioners manage overall affordability in the health system, determine the practical availability of choice and will play an increasing quality management role in FTs.

85. WCC provides the necessary counterweight to strong autonomous providers. South Central, London and North West, for example, are introducing collaborative commissioning approaches whereby PCTs in a region/sub-region aggregate their commissioning capacity in order to collectively commission a service pathway or manage a particular provider. Their aim is to achieve economies of scale, and streamline negotiations and performance management to enable more energy to be focused on service improvement, with greater leverage. This is particularly important where PCTs may currently be too small to exert effective influence over large secondary care providers. Through the new sector arrangements, the NHS in London expects to improve performance against acute targets and CQC Annual Health Check ratings, improve patient choice and access, and reduce healthcare costs and redistribute spend from acute to primary and community care.

Financial Strategy

86. Payment by Results (PbR) is an overarching term for a programme where payment is linked to clearly defined activity by type (casemix) and volume. Within the programme there is a mandatory national tariff which covers about £26 billion of services commissioned by PCTs, representing about one-third of PCT revenue allocations in 2009–10. Commissioners generally use the national tariff when securing services from the NHS or for other types of services where that service is the same as an existing hospital service and is within the scope of PbR. However, local tariffs can be negotiated.

87. PbR is a more transparent and fair rules based system than the locally negotiated funding arrangements that preceded it. It has:

- enabled commissioners and providers to refocus discussions from disputes over price to the volume, quality and mix of pathways and services that best meet population need and the pathway of care for patients;
- it has supported choice and plurality, by enabling funds to go the services chosen by patients and to any provider, whether NHS or independent sector, who can treat patients at tariff and to NHS standards. Funds follow patients;
- it has facilitated the “dehosting” of A&E and other services, so that the responsible commissioner rather than the host commissioner bears the financial risk of these services;
- it has improved efficiency and value for money, as both commissioners and providers can retain and invest surpluses where services are delivered at less than tariff;
- increasingly, it is supporting the emphasis on quality and innovation in *High Quality Care for All* as from 2010–11 best practice tariffs for some high volume areas of care will be designed around best practice rather than average cost.

\(^{16}\) The NHS Constitution for England, published January 2009:
88. The Audit Commission has tracked the NHS’s experience with PbR in a series of reports since its introduction in 2003–04. In *The right result? Payment by Results 2003–07* (February 2008) they state that PbR is now firmly mainstreamed within the NHS and has given PCTs a clear financial incentive to strengthen their commissioning function. The Department’s WCC programme, along with support from SHAs, is helping PCTs to manage the risks and take advantage of the opportunities that PbR has to offer.

*Department of Health*

*22 September 2009*

**Annex A**

**Is Commissioning Making a Difference?**

*Oxfordshire PCT—Joint Commissioning of Primary Child and Adolescent Mental Health Services (PCAMHS)*

The PCT and local authority have jointly commissioned a ground-breaking community-based early intervention children’s multi-agency health service. It works with 1,200 children a year and supports children’s agencies and professionals to respond to children with emotional and mental health concerns, including the voluntary sector. It is the single point of access for all countywide referrals for both CAMHS and Specialist Learning Disability services.

The, service has led to:

— a 30% fall in the numbers of children being seen by Tier 3 CAMHS;
— the eradication of waiting lists for specialist treatment (over 95% of children are now given appointments within four weeks);
— a reduction in inappropriate referrals to Specialist Mental Health services; and
— high satisfaction ratings with the service (eg 88% for young children, 91% for older children, 90% for patients).

*Somerset PCT—Chronic Obstructive Pulmonary Disease service*

Commissioners led the design and procurement of an innovative comprehensive community COPD service, following consultation with patients and local clinicians. Procurement was by competitive tender and a three year contract was awarded to BUPA Home Healthcare and local GP-led Avanaula Systems Ltd.

This is a flexible, equitable community service designed by patients and professionals, providing care closer to people’s home and providing the opportunity for patients to take control of their COPD and achieve better health outcomes. Benefits include a reduction in the rate of emergency admissions to hospital of 50%, improved patient-reported wellbeing and satisfaction, more equitable access to pulmonary rehabilitation and support, and increased value for money by ensuring that oxygen therapy is optimised.

*NHS Rotherham—Improving health by using evidence to target interventions*

Rotherham has significant variation in life expectancy and health between its wards. It therefore uses the results of detailed analysis of current and projected needs of its population to target its efforts at those most in need. It also shares the analysis done with other partners (eg local authority), providers and with patient/public representatives such as local assemblies.

An example of the targeted action that is commissioned is NHS Rotherham’s work to reduce incidence of teenage pregnancy. While rates had reduced in line with the national figures, the PCT wanted to accelerate reductions amongst under 16 years. It launched a project in Maltby, where teenage pregnancy rates are higher than the town’s average. Girls assessed as most at risk are referred for targeted support such as one-to-one sessions, group work or peer support. Since its launch pregnancy rates have virtually been eliminated amongst those taking part. It has also resulted in improved mental health and smoking cessation, reduced drinking and anti-social behaviour and fewer participants not in education, employment or training. The project is now being rolled out to other areas of Rotherham.

NHS Rotherham also uses its analysis to support clinical benchmarking between GP practices in its area for three key disease areas—diabetes, cardiovascular disease and chronic obstructive pulmonary disorder, enabling clinical practice to be compared and improved. By comparing actual prevalence with indicative prevalence levels, the PCT can work with GPs to identify conditions where ill-health is not being identified and opportunities to improve outcomes for patients missed.

17 *The right result? Payment by Results 2003–07, published February 2008: http://www.audit-commission.gov.uk/nationalstudies/health/pbr/Pages/therightresult_copy.aspx*
South Central

In the South Central region, PCTs are working together to review patient pathways and make changes to improve outcomes for patients and potentially achieve better value for money. An example of this is the work being done on stroke services. Detailed analysis of current and future need and existing service provision has allowed PCTs to identify growing demand for stroke services between now and 2020, disproportionate to population growth, particularly for those aged over 69 years. Analysis of existing services along the patient pathway identified differing actions required, from working with existing providers to improve and develop services, to bringing in new providers to introduce new services and significantly expand rehabilitation capacity:

- Prevention—work with least healthy to reduce vascular risk through funded weight management support provided through contract with independent sector. GPs incentivised to identify cases.

- Diagnosis and Intervention—Rapid treatment for high risk patients (those who have had a Transient Ischemic Attack (TIA)) to prevent a full stroke and extension of thrombolysis and provision of packages of care. Working with existing providers to expand capacity, resulting in 71% of TIA patients receiving service and also in improvements in thrombolysis provision.

- Rehabilitation Improve outcome for all Hampshire residents by expanding capacity through open tender, having done detailed work to develop a clear service specification and approach to market development.

The above work is still in progress, and is reviewed by commissioners on an ongoing basis for evidence of effectiveness and to ensure that the right incentives are in place to deliver the desired levels of activity and improvement in outcomes. The work is also the basis of a forthcoming procurement pack for stroke rehabilitation services, which will be available to all PCTs looking to deliver similar improvements.

*NHS Wirral—Service improvement through pathway redesign*

NHS Wirral is delivering improved services for patients through collaborative, innovative, pathway redesign. Intensive clinical engagement and leadership (eg through practice based commissioning), patient involvement in pathway redesign, and integrated partnership working with local authority partners are key to its success. Quality, patient satisfaction and cost are regularly monitored to assess effectiveness of service provision and prioritise service improvement and investment. Care pathway redesign resulted in demonstrable improvement in service, including shift in expenditure, reduced spend per procedure, improved access and increased patient satisfaction.

The Map of Medicine is used to engage local health community staff and clinicians to drive pathway redevelopment. The Map is used to review, redesign and find gaps in existing pathways and services.

An example of recent pathway improvement is wet age-related macular degeneration (AMD). Rapid redesign of the service pathway was enabled by use of the Map. As a result waiting times were cut from 10 weeks to 10 days, spend per procedure was reduced and patient satisfaction improved.

*Collaborative commissioning in London*

In London, new organisational arrangements are being put in place to strengthen acute sector commissioning. London PCTs have divided into six sectors, with each establishing a Joint Committee of PCTs (JCPCT) and appointing a JCPCT Chair and sector Chief Executive with responsibility for the commissioning, performance management and configuration of acute services.

The rationale for doing this is to achieve transformational change in commissioning to drive improvements in health and health outcomes for Londoners through improved acute trust and PCT performance. PCTs are currently too small to exert leverage over secondary care providers with the average London PCT being 27% smaller in population terms than English average and many carrying director-level vacancies. Through the new sector arrangements, the NHS in London expects to improve performance against acute targets and CQC Annual Health Check ratings, improve patient choice and access, and reduce healthcare costs and redistribute spend from acute to primary and community care.
Each sector is in the process of establishing a sector acute commissioning unit (SACU) to perform acute commissioning and performance management on behalf of the PCTs within the sector. Every sector expects to have completed this assurance process and to be commissioning and performance managing acute services by October.

Memorandum by Richard Lohman (COM 02)

I am writing to you as an individual and not in my capacity as member of the Oxfordshire Links steering group. I am employed by a primary care trust in a specialist GP practice for people experiencing homelessness in Oxford City and am a qualified social worker.

The problem with bringing business models such as “world class commissioning” into health and social care is one of striking the correct balance between being cost effective whilst not reducing the quality of care and I do wonder where the safeguards are to ensure that quality of care is not being relegated to second place behind cost.

Bringing not for profit organisations such as social enterprises and charities into the NHS provider fold is I think a good thing as it will encourage innovation and importantly any savings made will be ploughed back into the business. It is surely however an entirely different matter when private health providers are encouraged into providing NHS services, simply because all the profits are not put back into the business.

A large part of the “product” that the NHS sells are the skills of it’s highly trained workforce, this training is not inexpensive and I do fear that in the medium to long term our NHS will suffer (in terms of the quality and scope of it’s provision) due to private health providers being encouraged to supply NHS healthcare.

World class commissioning almost forces PCTs to spend copious amounts of monies on consultants to teach them how to purchase “effectively”: in business speak this means cutting costs on the largest bill, this is of course stunting costs, both wages and pensions.

There are also real concerns about the huge increase in transaction costs, fragmented patient pathways, distortion of health priorities caused by providers responding to the PBR incentives, issues of accountability and transparency resulting from much NHS information being “commercially sensitive information” and therefore unavailable to staff, public, councillors and MPs and too much competitive rather than co-operative pressures in the system in too short a space of time (changes in organisational culture require five years).

I urge the commission to critically reflect on all the evidence it gathers and I place trust in its conclusions in regard to providing guidance to government that will ensure the best healthcare for the public that is free at the point of access and critically requires financial profits being put straight back into the system.

September 2009

Memorandum from Mary E Hoult (COM 03)

INTRODUCTION AND AIM

This submission is being made by a member of the public. Please remember that it is not being made by a PR savvy organisation or department. As a consequence it may lack polish. However, it compensates by perspective. It is written by someone who is not only a member of the public but also a patient and a carer. As an observer, mostly silent, I have attended many local NHS bodies up close and personal.

Having a keen interest in the inequalities agenda I have followed the NHS reforms since late 1990s to date. The main part of my involvement was in attending SHA/Local Trust and PCT meetings held in public as a member of the public. I have experienced both highs and lows from this experience and would like to present a lay person’s perspective for consideration by your enquiry.

OBSERVATIONS

The government plan was to offer patients who may require healthcare in an acute setting, a choice of four or five providers. This choice is integral to the introduction of world class commissioning. However I do not believe that this choice is available to ophthalmology NHS patients in my area of East Leeds.

Leeds has been slow to introduce and accept the Choose and Book system with Yorkshire and Humber SHA reporting utilisation has dropped and they remain below the England average, experiencing much higher levels of slot unavailability (Patients unable to get appointments). A special report was commissioned and published by the Leeds PCT in 2008 as to the reasons.
Reported activity by Leeds Teaching Hospitals NHS Trust (outpatient and inpatient attendances) for Ophthalmology has shown an increase year on year, ie:

<table>
<thead>
<tr>
<th>Year</th>
<th>Attendances</th>
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</thead>
<tbody>
<tr>
<td>2004</td>
<td>69,224</td>
</tr>
<tr>
<td>2006</td>
<td>76,831</td>
</tr>
<tr>
<td>2009</td>
<td>85,381</td>
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</tbody>
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Staffing levels have remained the same since about 2005, with 14.70 wte Consultants, one of which covers community and public health. Only last week the LTHT passed a business case to close the only ophthalmology inpatient ward and reduce staffing levels further, despite reporting the biggest monthly increase in total numbers of patients on inpatient waiting lists of about 23% and an acknowledged backlog of follow up patients.

This information leads on to a question tabled by at least two of the key players responsible for the strategic direction both at LTHT and in community and public health, when they attended the Royal College of Ophthalmologists Annual Congress, in May 2009.

**Ophthalmology in the community—are we facing extinction?**

This is a good question considering the recent reported backlog of 5,000 follow up patients waiting to be seen. A question the patients themselves may well be asking!

We in Leeds do not appear to be able to establish a provider/commissioner split and appear to have only been given one choice, which is Leeds Teaching Hospital Trust. This is especially true for the provision of eye care, so the system reforms re quasi markets etc. do not apply.

The specialised services element also appears to be struggling with large deficits which it is reported will take a year or two to resolve, by LTHT’s own admission. LTHTs CEO is a key advisor/player for PBR (payment by results) which is being handled nationally and appears to operate by just passing the problems back to the PCT? Large acute trusts have a lot of power which they use to their best advantage. It is very hard for any organisation to manage change when this is the situation. The risk profile for July 2009 stated the city’s main provider of healthcare has no strategic plans in place with a recorded risk 20! Hence the need for the current Strategic Services Review. We await the outcome.

The promised strategy to shift care out of the hospital and into primary care appears to be being lost and is preventing patients being able to choose from the service most appropriate to their needs.

This takes me to my final point/observation, the safety of patient services.

Ophthalmology patients have been the only group to attend the Leeds Teaching Hospital Trusts AGM for the last three years in order to express their concerns. Last year as the LTHT minutes will confirm, patients had extreme difficulty with the choice of venue several needing porter assistance. They complained bitterly as the Trust did not seem to consider the needs of the disabled or other vulnerable patients wishing to attend. I did highlight this to the National Patient Safety Agency who took about 10–11 months to reply with an apology.

When capacity to see patients both new and follow up is far outstripped by demand, patients have to wait longer for appointments thus placing them at greater risk of sight loss and/or further complications.

**Conclusion**

The terminology, world class commission is used frequently but it is really hard so see any evidence of it happening on the ground here in Leeds. Blind and elderly people risk what we all fear the most, loss of independence and dignity.

One of the government’s main planks of the reforms is “a patient led NHS”. My experiences have revealed little evidence of this. My attendance at meetings should be an opportunity for engagement. Sadly this is rarely the case. Indeed one of the impressions I get is that the NHS has fallen into a predictable bureaucratic trap. Its primary purpose is to protect its own. Unfortunately its own being its staff rather than its patients.

The more astute cum worried well can overcome some of these barriers to engagement. They are articulate and have access to information through the internet etc. Their voice can be heard and a response made. Many do not have this ability, technology or confidence. These are often the most vulnerable and needy of what the NHS can offer. The recent NICE guidelines on glaucoma will further increase the number of referrals, and the system is in danger of becoming overwhelmed. If the culture is right (WCC) world class commissioning promised much and now is the time to deliver. Our ageing population needs good eyecare.

If you could consider this as part of your enquiry it might just prevent the inequalities gap widening even further.

*September 2009*
Memorandum by Dr Peter Davies (COM 04)

"World-Class Commissioning": what does this initiative tell us about how effective commissioning by PCTs is?

1. It tells us that commissioning by PCTs is very ineffective. It is not clear how commissioning can be made more effective in an NHS that has provided a bare minimum of facilities for too many years. Commissioning is about choice between alternatives, but the NHS has had too few alternatives for a long time.

2. Mark Britnell’s move away from the commissioning brief suggests central loss of confidence in the project.

3. The term “world class commissioning” is hubristic. It asks for nemesis.

4. The link between world class commissioning (WCC) and practice based commissioning (PBC) is unclear. As a GP and so a primary care provider am I allowed to function as both a provider and a commissioner of care? If so can I choose to move resources/contracts from secondary care to my own practice and provide them myself? This is currently being encouraged as “entrepreneurial and innovative general practice” and “moving services closer to patients”, to me it smacks of insider trading.

5. The commissioning scenario is “Win/Lose.” One part of the system wins at the expense of another.

6. The time and expense spent on commissioning is of doubtful efficacy and value, both for GPs, and as far as I can tell for PCTs.

7. As a GP PBC is an unwelcome distraction from my core job, and I have yet to see it help any patients. If it is going to work I think some GPs will have to specialise in it—it should not be a role that everyone is obliged to fulfil.

8. I know of no evidence that management consultants know any more about WCC and PBC than I, or PCT staff, do. No doubt they will present themselves well and plausibly as knowing more than the natives, but when pressed for evidence will produce nothing more substantial than a coloured pie chart.

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

9. The purchaser/provider split has been a failure. It has been used to divide primary care from secondary care. This increasing gap between two care sectors is bad for patients as they experience radical discontinuity as they move between the sectors. I gave examples in a BMJ article published 4 July 2008.18

Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

10. As far as I can see this random jumble of parts and acronyms is incoherent, and does not build into any form of whole. The result is loss of focus, wasted money and resources, and circular reorganisations. All the while the service puts patients last as James Gubb and I describe in our book Putting Patients Last: How the NHS follows the 10 commandments of business failure. http://www.amazon.co.uk/Putting-Patients-Last-Commandments-Business/dp/1906837090/ref = sr_1_l_1?ie = UTF8&s = books&qid = 1250545891&sr = 1-1

Specialist commissioning

11. I have no idea what this is about. Nor would I know what “generalist commissioning” was either.

Commissioning for the quality and safety of services

12. I do not see how commissioning helps with quality and safety issues.

13. This adds another layer of complexity to an already opaque process.

14. For most PCTs and Acute Trusts the priorities in reality are:

   (i) stay within budget;

   (ii) buff the figures to make it appear we have met central government targets; and

   (iii) avoid any major clinical incidents or other bad publicity.

I am sorry that I cannot be more positive about what is supposed to be a major plank of both Labour and Conservative plans for the NHS. I think the whole scheme is utterly flawed in design and implementation. Both parties, and the service itself, need to come up with better than this if the NHS is to improve.

September 2009

18 Peter Davies, The great NHS communication breakdown BMJ 2008;337:a664, doi: 10.1136/bmj.a664
http://www.bmj.com/cgi/content/full/337/jul04_1/a664
Memorandum by Abbott UK (COM 06)

Introduction

1. Abbott is pleased to have the opportunity to respond to the Health Committee’s inquiry into commissioning.

2. Abbott is a global, broad-based health care company devoted to the discovery, development, manufacture and marketing of pharmaceuticals and medical products, including nutritional, devices and diagnostics. The company employs more than 72,000 people and markets its products in more than 130 countries.

3. In addition to Abbott’s expertise in the health sector, we have also been particularly active over the past few years in supporting research into the relationship between health and work. We have sought to address key policy questions such as how to build a more “work-focused” NHS and ensure that patients’ health needs are well supported in the workplace.

4. Specific to this area of health and work, Abbott’s particular interest is in the field of musculoskeletal disorders (MSDs) such as rheumatoid arthritis (RA) and ankylosing spondylitis (AS) as well as obesity. MSDs are one of the most common causes of work-limiting health problems and long-standing illness, and the second biggest cause of sickness absence. In 2007 Abbott supported a Work Foundation study into the effect of MSDs on labour market participation—a project which is now being rolled-out across Europe.

5. It is believed that obesity can be both a cause and effect of workforce difficulties and unemployment, and that obesity can result in increased sickness and absence from work. For example, there were around 15.5–16 million days of certified incapacity directly attributable to obesity in 2002, which represents £1,300–1,400 million in lost earnings as a consequence and the Health Select Committee reported on 10 May 2004 (Page 128) that “around 45,000 attributable working years of working life (are) lost through obesity.

6. The health and work debate poses a number of questions for commissioning. Commissioners are expected to deliver “more for less”, by securing ambitious savings to the health budget, whilst driving up quality and using their resources “for the benefit of the whole community”. Budget holders are being challenged to deliver both improved clinical outcomes, and “patient-centred” outcomes which take into account the impact of services on other factors—such as ability to work, socialise, and maintain independence. These issues are now more important than ever given the pressing need to reduce the cost of ill-health to the public purse, and to retain valuable skills and knowledge within the workforce to help drive the UK’s economic recovery.

7. Within the health sector Abbott also has substantial expertise in managing obesity and under-nutrition as well as specialised commissioning for RSVirus for neonates.

Executive Summary

— Outcome indicators for the World Class Commissioning programme should be reviewed annually to ensure that they reflect the commissioning priorities of PCTs.

— It is essential that outcomes for adult obesity should be added to the World Class Commissioning programme to reflect the significant impact that it has on public health and as a risk factor for other conditions.

— Complex and specialist conditions would benefit from greater use of collective commissioning and decision-making arrangements.

— Commissioners hold many of the keys to driving provision of efficient and effective health services and delivering on both clinical and cost-effective outcomes.

— Further efforts should be made to tackle inequalities in access to quality healthcare.

— Commissioners should receive more support in the implementation of authoritative national guidelines.

— All national guideline development should meet the strict standard of consultation and transparency that NICE operates within.

— Local commissioners must have the right tools to commission services.

— The 2010–11 Operating Framework needs to prioritise rheumatology and MSDs due to their significant impact on incapacity benefit—one of the key drivers of public spending.

— The new NHS Indicators for Quality Improvement should include greater reference to the treatment of MSDs—especially on achieving earlier intervention to increase productivity, in line with the findings of the NAO report on RA.

— We urge the Government to appoint a “clinical champion” for MSDs to ensure widespread implementation at a local level.
— We call on the Government to accept the Health Select Committee’s own recommendation that NICE should be empowered to look beyond health economic outcomes and consider broader societal and productivity costs and benefits when assessing new techniques.
— We believe it is vital to provide continued support for patients at home which may help prevent unnecessary readmissions to hospital thus supporting patient care and cost saving to the NHS.

Our Response:

“World-Class Commissioning”: What does this initiative tell us about how effective commissioning by PCTs is?

8. Abbott’s work in the health and work arena has led us to support the inclusion of wider societal costs when assessing the benefits of treatment and technology. As such, we believe that PCTs are currently not commissioning services as effectively as they could, as wider societal costs are often not taken into account. We welcomed the recent announcement of social value commissioning pilots, which aim to develop a framework within which the social value of commissioning and procurement activity can be captured and articulated. We also support wider use of social value concepts in commissioning to allow commissioners to “manage” social value across a whole system, and to work more effectively with their partners to deliver social value outcomes, for example, helping a patient stay in, or return to work. 4

9. However, despite these positive developments, we were disappointed by Professor Ian Kennedy’s review for the National Institute for Health and Clinical Excellence (NICE) that concluded that social benefits should not currently be taken into account by NICE in its appraisals, as it would be too difficult to calculate these benefits without discriminating against other groups. 5 However, we would urge the Government to learn from the Swedish model, which successfully takes into account the benefits that new technologies would have for the individual, the employer and the state. 6 Professor Kennedy’s report did, however, recommend that NICE commissions research to determine whether such benefits could be included in the future. Indeed, the Department of Health is also undertaking its own research into this area, and we await both reports with interest.

10. Integrated public service delivery, which aims to reduce costs and increase efficiency, must also examine costs and benefits which go beyond the NHS. The 2009 National Audit Office report, Services for people with rheumatoid arthritis, estimated that RA alone costs the NHS around £560 million a year in healthcare costs, and that the additional cost to the economy of sick leave and work-related disability is £1.8 billion a year. 7

11. The NAO report found that at present only 10% of patients with RA are treated within three months of symptom onset. Its economic modelling suggested that an increase to 20% could result in productivity gains of £31 million for the economy due to reduced sick leave and lost employment and could, on average, increase a patient’s quality of life (QALY) by four per cent over the first five years. 8

12. Abbott is concerned about the mechanisms by which the Department of Health select the outcome indicators for use in World Class Commissioning. Obesity provides an example of an area not included in the World Class Commissioning programme by the Department of Health, but which Primary Care Trusts themselves have chosen to prioritise and yet according to Dawn Primarolo, the then Minister for Public Health, obesity is now the “biggest health challenge” facing the UK. In England alone, almost two-thirds of adults and one-third of children are either overweight or obese. 29

13. Obesity increases the risk of a variety of chronic diseases, including: type 2 diabetes, high blood pressure, coronary heart disease and stroke, osteoarthritis and some forms of cancer. On average, obesity reduces an individual’s life expectancy by between three and 13 years. 29 Despite this data the fact is that no obesity measurements were included in the outcome indicators list, almost half of PCTs (73 out of 152) chose to use their own locally defined indicator on obesity. 9 It is therefore clear that this is a key area where commissioners want to improve their abilities, and aim to be measured and benchmarked on their journey to becoming “world class”. 10

14. We believe that it is essential that the Department of Health include an outcome measure on adult obesity in the World Class Commissioning programme in time for PCT assessment in 2010. This would help make national priorities link more clearly with local decision making and could stimulate better commissioning of obesity services to tackle this serious public health problem.

15. Abbott believes that outcome indicators for World Class Commissioning should be reviewed annually to ensure that they reflect the commissioning priorities of PCTs.

Specialist Commissioning

16. For some disease areas, such as the management of RespiratorySyncytial Virus (RSV), significant regional variation in clinical management and access to treatment exists. In such cases, Abbott does not believe that existing commissioning structures accurately reflect the needs of individual health economies and exacerbate inequalities. Abbott would welcome a mechanism such as that of the National Specialised Commissioning Group, whereby local commissioners can come together on a national level to ensure that appropriate services can be provided.
17. The commissioning of specialist paediatric services provides an example of how this approach is necessary. Many children will have serious or complex needs which require treatment by specialist paediatric services, working across discipline and organisational boundaries. The complexities of these arrangements necessitate flexible models to be established to meet individual patient needs.

18. It is important to recognise that conventional reimbursement and commissioning models may not adequately reflect the complexities of delivering pediatric care, and therefore it is right that such services should remain under the specialised commissioning umbrella.

19. Abbott welcomes the recent recognition in *Improving access to medicines for NHS patients*\(^{11}\) that complex and specialist conditions can benefit from greater use of collective commissioning and decision-making arrangements.

**Commissioning for the Quality and Safety of Services**

20. NHS Chief Executive David Nicholson has stated that delivering the Quality, Innovation, Productivity and Prevention agenda in the current economic climate is one of the most important challenges facing the NHS. He has also highlighted the need to take an evidence-based approach.\(^{12}\) However, the NAO report noted that although World Class Commissioning envisages that PCTs will commission evidence-based services, the majority of PCTs lack epidemiological evidence to commission services for people with RA effectively.\(^{13}\) We would like to see how initiatives such as the Commissioning for Quality and Innovation (CQUIN) payment framework might encourage PCTs to gather data on MSD prevalence and assess patient needs in order to more effectively design and commission services.

21. While we support the aim that people with a long-term condition should be able to feel independent and in control of their condition, there must be a greater focus on MSDs in the list of Indicators for Quality Improvement, especially with regard to the percentage of patients treated within three months. Without a specific indicator for MSDs, for example, one which ensures quick referral to a specialist or consultant, PCTs are not currently incentivised to improve patient care. The NAO report similarly argued that there is a lack of impetus or incentive for changing the way services are currently configured.\(^{14}\)

22. Commissioning guides such as those produced by NICE are a useful resource to help commissioners implement NICE guidance and Abbott supports greater patient and public involvement in their development. Abbott welcomed the 18-week commissioning pathway for inflammatory arthritis (IA) launched in June 2009 by the Department of Health and the Rheumatology Futures Project. This draws on work commissioned from the King’s Fund on perceptions of patients and professionals on RA care and underlines the importance of early presentation to primary care and onward referral. The 18-week pathway recognised the need for education of the general public, pharmacists and other frontline staff into the signs and symptoms of IA in order to facilitate this early intervention.\(^{15}\) Abbott also developed, in collaboration with clinicians and managers across primary and secondary care, a commissioning guide in 2008 which aims to provide a complete integrated care pathway for the management of MSDs such as RA and AS, which we would be happy to submit to the Committee as further evidence. We look forward to the publication of the new NICE commissioning guide on RA, expected later in 2009.

23. National standards exist to ensure that Primary Care Trusts (PCTs) are meeting the needs of patients while also delivering value to the NHS. These should be central to efforts to drive quality. Commissioners hold many of the keys to driving provision of efficient and effective health services and delivering on both clinical and cost effective outcomes. They should be looking to the national standards set by the National Institute for Health and Clinical Excellence (NICE) guidance as the bedrock for improving quality, incentivising implementation of guidelines and holding services to account if they fail to meet them.

24. Further efforts should be made to tackle inequalities in access to quality healthcare—a major barrier to improving health. There has been a considerable level of debate about variations in implementation of national guidance on the use of medicines on the NHS (“postcode prescribing”).

25. Commissioners should have due regard to NICE guidelines in the commissioning of services. For example, NICE has issued Clinical Guideline 43, *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*.\(^{16}\) The guideline outlines key priorities for implementation covering the prevention of overweight and obesity, and management of overweight and obesity in adults and children. The management of obesity is split into four distinct phases: assessment and classification, lifestyle changes, drug treatment, and surgery. All of these phases of management are important to reduce the numbers of people becoming overweight and obese. All treatment for obesity should be in line with the guideline.

26. Abbott also welcomes the recommendation from the Health Committee that PCTs should receive more support in the implementation of NICE guidelines.\(^{17}\)

27. Abbott is concerned that national implementation guidelines set by the Joint Committee on Vaccination and Immunisation (JCVI) are not developed to the same standard as those set by NICE. For example, in the case of access to immunotherapy for RSV, in a recent meeting some members of the JCVI expressed concern that the recommendations may be hard to implement.\(^{18}\) The JCVI should be producing workable recommendations with proper consultation and transparency.
28. For people requiring home enteral tube feeding, timely discharge from hospital and patient safety through the provision of training for patients and carers should be paramount.

29. We believe it is vital to provide continued support for patients at home which may help prevent unnecessary readmissions to hospital thus supporting patient care and cost savings to the NHS.

**THE RATIONALE BEHIND COMMISSIONING: HAS THE PURCHASER/PROVIDER SPLIT BEEN A SUCCESS AND IS IT NEEDED?**

30. Whilst Abbott broadly supports the principles behind the purchaser/provider split, a recent audit from the Arthritis and Musculoskeletal Alliance (ARMA) showed poor implementation of the Government’s 2006 Musculoskeletal Services Framework, noting that spending on MSDs per patient between different areas of the country fluctuated significantly. At the same time, the King’s Fund report found that patients and professionals perceive an “unacceptably wide variation” in the level and quality of care currently available. As such, the ARMA audit called for enhanced strategic direction and oversight through the creation of a new National Clinical Director for MSDs—a call endorsed by a House of Commons EDM and one supported by Abbott.

31. It is vital that local commissioners have the right tools to commission effective services. Commissioners and service providers should work together to identify models and services which are important to the local health economy.

**COMMISSIONING AND “SYSTEM REFORM”: HOW DOES COMMISSIONING FIT WITH PRACTICE-BASED COMMISSIONING, “CONTESTABILITY” AND THE QUASI-MARKET, AND PAYMENT BY RESULTS?**

32. Abbott believes that GP-led commissioning has the potential to move decision-making closer to patients and improve outcomes through measures such as increasing early intervention, but that sufficient support should be made available. Without adequate training for GPs, patients with RA will continue to suffer delays in diagnosis. For example, the NAO report recommended that PCTs should improve awareness in primary care, in particular GPs, of how to recognise the symptoms of inflammatory arthritis and the need to refer suspected cases promptly, so that any delay from onset to treatment is minimised. The Work Foundation report on Musculoskeletal Disorders and Labour Market Participation found that up to 30% of GP consultations concern musculoskeletal complaints. We welcome projects such as the National Education Programme for GPs, announced in May 2009, that aim to drive up professional standards in the area of health and work, but believe that more needs to be done in this field which has a crucial role in driving economic recovery.

33. Obesity also has a detrimental impact upon the UK economy. If current trends continue, the direct healthcare costs (NHS and personal social services) of obesity alone could cost up to £3.9 billion by 2015, with the combined NHS costs of elevated BMI coming in at £6.4 billion. The effects of obesity and overweight also generate significant indirect costs, including absence from work, reduced productivity, and morbidity, not treated in the NHS. Taking these into account, the total wider costs of elevated BMI (including disease related to BMI) could be £27 billion by 2015 (Foresight Tackling Obesities: Future Choices—Modelling Future Trends in Obesities and Their Impact on Health. 2nd Edition.)

34. In the case of obesity management, services should incorporate a broad weight management programme (including advice and classes covering lifestyle, exercise, diet and nutrition), moving on to pharmacotherapy for those for whom it is appropriate, and delivered by dedicated weight management clinics.

35. Commissioners should be open to commissioning services from a range of providers, allowing for innovation in the development of new services. In the case of obesity management, there is considerable opportunity for commissioning services from a variety of areas of primary care, such as pharmacies, dietetics departments and specialist clinics, so that overweight and obese people are able to experience a holistic service.

36. Whichever service model is chosen, the service must be able to offer evidence-based guidance and support. Abbott is currently developing a toolkit as a practical resource for anyone wanting to commission or provide obesity-management services for their local health economy. The toolkit draws together recent policy and clinical guidance and outlines a four-step approach to aid the development of local obesity services:

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- Assessing local need and agreeing local goals;
- Developing a local service strategy;
- Securing the service; and
- Monitoring and evaluation.
CONCLUSION AND KEY RECOMMENDATIONS

37. While the Department of Work and Pensions has committed itself to reducing the flow of people out of work due to ill-health, the current NHS operating framework is noticeable for the lack of priority given to tackling MSDs. The 2010/11 Operating Framework needs to prioritise rheumatology and MSDs due to their significant impact on incapacity benefit—one of the key drivers of public spending.

38. The new NHS Indicators for Quality Improvement should include greater reference to the treatment of MSDs—especially on achieving earlier intervention to increase productivity, in line with the findings of the NAO report on RA.

39. Implementation of the 2006 Musculoskeletal Services Framework (MSF) has been patchy, as shown by the recent ARMA audit, and we urge the Government to appoint a “clinical champion” for MSDs to ensure widespread implementation at a local level.

40. In the current economic climate, the wider costs of ill health and the need to reduce public spending are now more important than ever. As such, we call on the Government to accept the Health Select Committee’s own recommendation that NICE should be empowered to look beyond health economic outcomes and consider broader societal and productivity costs and benefits when assessing new technologies.

41. Outcome indicators for World Class Commissioning should be reviewed annually to ensure that they reflect the commissioning priorities of PCTs.

42. Outcomes for adult obesity should be added to the World Class Commissioning programme to reflect the significant impact that it has on public health and as a risk factor for other conditions.

43. The Care Quality Commission (CQC) should be charged with the inspection of PCTs success, or otherwise, in commissioning services compliant with the NICE Clinical Guideline 43, Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Follow up audits should be completed every three years to map progress against the Guideline.

44. Complex and specialist conditions would benefit from greater use of collective commissioning and decision-making arrangements.

45. Further efforts should be made to tackle inequalities in access to quality healthcare through the use of national standards.

46. All national guideline development should meet the strict standard of consultation and transparency as NICE operates within.

47. Commissioners should receive more support in the implementation of authoritative national guidelines.

48. Local commissioners must have the right tools to commission services.

Abbott UK
August 2009

REFERENCES:
2. Data on File: Abbott UK.
7. NAO, p 5.
8. NAO, p 8.
22. NAO, p 9.

Memorandum by Dr Jon Orrell (COM 07)

EXECUTIVE SUMMARY

Progress has been made in spite of the new and ever changing national schemes rather than because of them. A period of stability with any system at all, whatever its contents, is preferred. The blizzard of ill considered and untested initiatives or reorganisations is not a helpful base on which to build new services. Professional Nurses and Doctors have dedicated their lives to improving patient care and will do so more easily without the interference of ignorant management consultants with fat fees, 5 minutes experience and zero commitment to long term patient care.

“World-Class Commissioning”: What does this initiative tell us about how effective commissioning by PCTs is?

1. This is initiative has further confused the local implementation of practice based commissioning. The preceding plan that had not been properly embedded before world class commissioning arrived.
2. World class commissioning has skipped its proposed initial steps of engagement, clinical or public, and missed genuine health needs assessments, and jumped to markets.

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

1. The split is half baked. The Hospitals have all the power and are paid by activity rather than by results. Bournemouth Hospital, for example, can ignore PCT commissioning intentions and appoint cardiologists to insert stents for stable angina, where the evidence shows no advantage over drug treatment, then fill in the blank cheque book provided by payment by results.
2. The GP side of the split is hamstrung but the lack of a genuine budget, or the ability to dynamically and effectively challenge individual bills. No business could really run without examining expenses.
3. In reality it is not needed. The system before the split was not broken, just chronically under funded. There was no need for the split and reform. This only served to waste the new money on contracts, coding clerks, management consultants and profits.
**Commissioning and "system reform": how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?**

1. The blizzard of initiatives means that GP practice based commissioners are sometimes the good guys, developing new services and sometimes the bad guys, pilloried for delivering their contract and assaulted by Darzi centres and new private providers.

2. Despite the relentless chaotic system reform we have been able to develop new local services for patients, despite the initiatives, rather than because of them.

3. The unfettered market has no place in banking or healthcare. Regulation is required in the former and rational planning in the latter. Blind markets lead to health inequalities with death for the poor, and over investigation and over treatment of the rich (USA) with crippling costs to provide profit for corporations.

**Commissioning for the quality and safety of services**

1. Each successive Health Minister or incoming government seems determined to leave its mark by reforming the management of the NHS. This is easier than actually improving services for patients, which takes more time, thought and effort by engaged frontline clinicians.

2. The quality and safety of services would be develop faster if one could resist the temptation to constantly meddle and reform.

3. The Peninsula SHA is a powerful example of how planned and firmly managed control by a strong central figure can ride out the relentless change and chaos through all the waste of re disorganization, and hold onto key relationships by recycling individuals through each reform disruption. The all pervasive planning and monitoring permits the illusion of markets whilst limiting their devastation and damage.

4. The best of the NHS is driven by the passion and commitment of nurses and doctors who feel their vocation to public service. The market place will undermine this and lead us to American waste, cost and inequality. Markets will deliver profits for corporations, not public benefit. Profit despite human cost is build into the very fabric of corporations whose responsibility is to their shareholders, not the public good. There is no unseen hand, only a grasping fist that needs the long arm of the law or public servant to direct it.

**Dr Jon Orrell**

*September 2009*

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**Memorandum by David Elliott (COM 08)**

**EXECUTIVE SUMMARY**

1. From my recent experiences I believe that the commissioning of Paediatric Intensive and High Dependency Care in the Midlands region is not sufficient and, despite the best efforts of medical and nursing staff, this situation has led to the premature death of infants in the area.

2. Following the recent death of my grand daughter, Elizabeth Sargeant, due to a hospital acquired infection, reports produced by Birmingham Children’s Hospital NHS Foundation Trust (BCH) in conjunction with University Hospitals of Leicester NHS Trust (UHL) and University Hospital North Staffordshire NHS Trust (UHNS) (the providers of paediatric intensive care facilities for the Midlands region), clearly show:

   (a) There is no regionally commissioned and co-ordinated paediatric high dependency care service for the Midlands region.

   (b) Paediatric intensive care facilities in the Midlands region are often operating above their deemed safe capacity.

   (c) Paediatric intensive care facilities in the Midlands region are sometimes under utilized due to funding shortages (a commissioning issue) leading to a lack of trained and experienced specialist staff.

**INTRODUCTION**

3. I am submitting this evidence as an individual following the recent death of my grand daughter and the subsequent investigations into her death due to a hospital acquired infection.

4. I am not a health professional nor employed by the National Health Service and my evidence is base on my actual experiences of the service provided by the National Health Service.

**FACTUAL EVIDENCE**

5. BCH has confirmed that there is no regionally commissioned and co-ordinated paediatric high dependency care service for the Midlands region. This can lead to infants being discharged from intensive care facilities back to local hospitals rather than to dedicated high dependency facilities where the appropriate care can be administered.
6. UHNS have confirmed that their intensive care unit has 8 physical beds but that they are funded to provide 13 care levels (level of dependency of the children ranges from level 1 to 4). This means that if three children have dependency of four then the care level is 12, one below the deemed safe level of operation. This leaves five beds empty because UHNS is only funded to provide 13 care levels.

7. UHNS have confirmed that they sometimes function above the deemed safe capacity based on the staff available at the time.

8. The West Midlands Specialised Commissioning Services (WMSCS) have confirmed that further work is required to continue to develop paediatric intensive care facilities across the Midlands region.

RECOMMENDATIONS FOR ACTION

9. WMSCS conducts an urgent review into the provision of intensive care facilities in the Midlands region and provides adequate funding to ensure that the current facilities are fully utilised. A report should then be provided to the Health Committee.

10. WMSCS conducts an urgent review into the provision of high dependency paediatric care in the region and then provides adequate funding to ensure that sufficient facilities are in place and are adequately staffed. A report should then be provided to the Health Committee.

September 2009

Memorandum by NHS Dorset (COM 09)

1. EXECUTIVE SUMMARY

1.1 NHS Dorset has developed programme based commissioning to ensure clinical input and leadership are at the heart of the commissioning process, ensuring high quality services for our population.

1.2 NHS Dorset has been very proactive in its commissioning of services for its public and patients. These initiatives include a North Dorset Referral Management Scheme, Dental Services for Homeless People, a DVT service, a Christchurch Proactive and Integrated Nursing Service, Cancer and End of Life services, a 24/7 Thrombolysis service, Policy Custody Health Care, Dorset Orthopaedic Treatment Service, Staying Health Initiatives and a Homelessness Primary Care Outreach Project. Details of these initiatives are listed within the paper.

2. PRIMARY CARE PROGRAMME

Practice Based Commissioning

2.1 NHS Dorset has established practice based commissioning with strong locality involvement. These localities work closely with the programmes to support care closer to home and link with the Transforming Community Services programme.

2.2 Examples of PBC-level World Class Commissioning are:

North Dorset Referral Management Scheme

2.3 GP practices in the North Dorset PBC Consortium decided to establish their own reflective and collaborative approach to referral management. Drawing on previous local approaches to managing prescribing expenditure, the group decided that they would review systematically all elective referrals, specialty by specialty with orthopaedics. Each practice was asked to hold a monthly referral review meeting, where referrals were reviewed and any issues/actions/trends identified. The detail of all referrals were then fed into a central locality team, whose role was produce control charts of referrals at practice and locality level and to provide feedback to practices about referral rates, and to take up any issues identified. On a quarterly basis, the locality meets as a group to reflect on the learning, consider options for improvement, including agreeing referral criteria and identifying/addressing service gaps to inform future commissioning plans. The locality also contacted all patients who had had an A&E attendance to find out why they had attended A&E, and, where this was for an issue that could have been addressed in primary care, providing them information about alternatives. This information is also being collated to identify any service gaps. To date, locality data is demonstrating that referral rates are remaining stable and, in some practices, falling against a picture of rising referrals across the rest of the PCT.

Dental Service for Homeless People

2.4 Following discussion with a number of groups that work with homeless people in Dorchester, the PBC group recognised that, whilst primary medical services for homeless people in the town had been tailored to meet their needs, access to dentistry was still poor. The practices decided to use their PBC reward funding to commission a mobile dental service that will outreach into settings frequented by homeless people. This has been set up on a pilot basis with an existing provider to test out the service model, before being included in a formal tender for general dentistry in the area.
DVT Service

2.5 A review of preventable and avoidable emergency admissions identified that there are high levels of patients being admitted with query DVT in both West Dorset and Weymouth and Portland PBC localities. West Dorset is a primarily rural area with dispersed populations, whilst Weymouth and Portland is the PCT’s most densely populated and deprived urban community. Both populations access secondary care services, including emergency care, in Dorchester, which necessitates significant travelling, particularly for the follow up care. Having talked to patients who had experienced treatment for DVT, it was decided that this was an opportunity to locate care closer to home to the benefit of patients. Reflecting the diversity of the populations, two different service models have been developed. In Weymouth and Portland, patients will be seen and treated in the new GP-led health centre which is located in the community hospital. In the rural areas of West Dorset, the service will be practice-based and delivered.

Christchurch Proactive Management and Integrated Nursing Services

2.6 Christchurch locality has one of the oldest populations in England, and, in response, the locality has developed a number of innovative services which aim to identify and manage proactively those patients who are frail, vulnerable and at risk of emergency admission. For example, the SMILE (Self-Management in a Local Environment) Team was set up to test out the benefits of targeted self-care support for vulnerable and frail elderly people. After the first seven months and an investment of just £40,000, 220 patients had already benefited from the scheme, with an estimated net saving to the NHS of £60,000. More importantly, patients reported feeling more confident and less anxious, and were less likely to need hospital-based care.

2.7 In developing these approaches, it became apparent that the practice and community nursing teams and the community matrons were working in isolation from each other, partly because of conflicting priorities communicated by the different management structures (practices and PCT) and a history of tense relationships at management level. It was agreed that the solution was to develop an integrated nursing team, with a clear service specification that would enable the delivery of both PCT and locality level objectives. This developed into a significant piece of organisational development, involving, as it did, staff and managers from two different organisations. It was recognised that there were barriers to bringing all staff into one employing organisation because of costs associated with harmonising terms and conditions, so it was decided to develop a virtual team with a management board drawn from both the PCT and the locality group. The outcomes of this piece of work are yet to be evaluated but feedback from staff suggests that the integrated team is working well.

Pharmacy Services

2.8 Enhanced Services have been commissioned from Community Pharmacy for Smokestop, Chlamydia testing and treatment and Weight Management, these have improved availability and access to these services.

Cancer and End of Life Programme

Support for End of Life Care

2.9 The end of life programme has, through effective commissioning, promoted close collaborative working between NHS Dorset, Dorset Social Services, third sector providers including Weldmar/Marie Curie, and primary/community/secondary NHS providers. The plan to improve end of life care in line with the End of Life Care Strategy was developed collaboratively and is being implemented collaboratively with a large emphasis on education and training for all staff who may care for end of life patients.

2.10 Development of an education and training package for Residential and Nursing Homes and a plan to support them in enrolling for Gold Standards Framework will improve their ability to support patients in their homes that are nearing end of life rather than needing to admit them to NHS secondary care.

2.11 The appointment of two End-of-Life Care (EOLC) facilitators for NHS Dorset who lead on many aspects of the EOLC plan has ensured good progress as this is a dedicated resource to support the commissioning process.

Chemotherapy

2.12 A pilot project to provide chemotherapy treatments at Victoria Hospital, Wimborne, began in April 2008. It incorporated a weekly treatment clinic and was provided and supported by the community cancer nursing team employed by Bournemouth and Poole Primary Care Trust. Treatments included blood products, supportive therapies and some chemotherapy regimes.

2.13 The pilot project followed an independent review which had concluded that providing chemotherapy treatments in the community closer to patients’ homes would be beneficial and that community hospitals are ideally placed to provide some of the more simple cancer treatments.

2.14 Evaluation of the project was very positive. A patient satisfaction survey showed that the needs of individual patients had been met and in any cases their experience of care was improved. Equally, quality of care had not been compromised. As a result, this model is likely to be extended to other sites across Dorset to meet local needs in suitable sites.
Vascular Programme

24/7 Stroke Thrombolysis

2.15 Through the Dorset Stroke Network commissioners in NHS Dorset and NHS Bournemouth and Poole have worked with acute trust providers to identify a pan-Dorset solution for 24/7 stroke thrombolysis. The service model involves collaborative working with a single on-call consultant rota to cover all three acute trusts in Dorset out of hours, using telemedicine to make this a realisable solution.

2.16 This commissioning model has promoted collaborative working across the acute trusts in Dorset, driven by the Stroke Network through strong clinical leadership. Agreement with the proposed service model would not have been reached without strong unified leadership from the commissioners of the two PCTs.

Mental Health Programme

Police Custody Healthcare—National NHS Commissioning Pilot

2.17 Police Custody Healthcare does not have an NHS focus or input and concerns have been expressed nationally regarding the quality of custody healthcare services and the lack of integration with NHS, Social Care and Voluntary Sector providers of health and social support.

2.18 NHS Dorset were a first wave pilot site for the NHS to commission healthcare to prisons and from 1 April 2004 have demonstrated the improvement in quality and cost effectiveness of healthcare provision through the local NHS. The broad range of skills and expertise available in the local NHS has transformed services which were isolated and restricted in scope. In particular, the highly developed infrastructure for healthcare governance provides a comprehensive framework for quality and safety of service provision and staff development and performance.

2.19 As a result the successful implementation of the new model of prison healthcare, NHS Dorset was approached to work in partnership with the police to jointly develop an NHS commissioned model of police custody healthcare. The aim of the pilot is to test NHS Commissioning and Governance process in police custody healthcare as part of the national strategy for “end to end” offender health. This is an innovative service delivering healthcare advice assessment and treatment, where appropriate, to detainees and victims of crime. It promotes a pioneering advance in integrated healthcare across agencies, which informs development of the National Offenders Strategy. The aim is to ensure anybody entering Dorset custody suites with an identified need has timely access to healthcare provision. Custody suites receive a diverse range of people and can include on occasions individuals where this is the only contact the individual has with a healthcare professional.

2.20 The model is now being promoted as the model to be rolled out in other police forces.

Musculoskeletal

2.21 The purpose of the Dorset Orthopaedic Treatment Service (DOTS) is to provide education, self help direction and evidence based primary intervention of a high quality which is cost effective for the medical management of adults who have a musculoskeletal condition. This will enable patients to achieve their optimum health and reduce the impact of their problem on their overall wellbeing gaining a positive clinical and social outcome.

2.22 The development of this service reduces the health inequalities across the population of Dorset whilst improving the speed and convenience of access to diagnosis and treatment ultimately improving the quality of patient experience to ensure dignity, respect and responsiveness. It has aided the extension of choice of providers, treatments and care options so that individuals can select those that best fit their needs and personal circumstances as well as improving services to maximise the independent living of vulnerable groups and people with specific diseases, including long-term conditions and disabilities.

2.23 The pathway objective for the service maintains these areas of function:

2.24 The effective interaction and collaboration among all agencies, services, and people involved in the pathway who provide assessment, treatment and rehabilitation of individual musculoskeletal patients in a locality or region; planned specialist input with patients, their carers and other appropriate health and social care professionals; promotion and the use of an organised and standardised approach in each facility and component of the system; identification of performance measures (both process and outcomes) and includes a mechanism for evaluating effectiveness through which the entire system and its individual components continue to evolve and improve.

2.24.1 Regular and systematic audit is co-ordinated and undertaken to evaluate the following outcomes:

2.25 An improvement in patient education; an improvement on the self-assessment by the client of their needs and improved quality of life as audited by the Euro Qol questionnaire; fewer unnecessary referrals to outpatients in secondary care; fewer unnecessary admissions to secondary care; improved quality of life for patients, increased mobility and sustained or increased independence; high levels of satisfaction expressed by patients and carers as well as other stakeholders including referring GPs; and the achievement of service targets.
2.26 The development of this service has been achieved by collaboration between clinicians, local leadership and the driver of high quality care and better value for money. Partnership working between the commissioner and the provider has led to a service which is achieving its aims and objectives.

2.27 The service has significantly reduced activity into secondary care by the redesign of the patient pathway.

Staying Healthy

2.28 NHS Dorset Public Health directorate identified that the issue of adult obesity is an ongoing challenge to population health both nationally and locally. In 2006, Dorset developed a Local Area Agreement target to tackle adult obesity. The target is for 1,200 service users to have lost at least 2.5 kg of weight after a quality assured intervention and then maintained at least 2.5 kg weight three months post intervention.

2.29 Following a review of existing initiatives it became evident that existing services were not attracting any significant numbers of participants and very few demonstrated sustained weight loss, hence there was a significant risk of not reaching the LAA target. To address the service gap and to minimise this risk, the Commercial Weight Management on Referral Pilot (Healthy Choices) has been developed with NHS Dorset’s Public Health directorate, Procurement Team Dorset County Hospital NHS Foundation Trust, commercial providers Weight Watchers, Rosemary Conley and Slimming World, and third sector not-for-profit social enterprise Healthy Living Wessex. Healthy Choices was commissioned as a year long pilot and contracts have recently been extended for a further eight months to allow for a comprehensive and detailed analysis of results.

2.30 The Healthy Choices service has now been functioning for a year and during this year has been developed as a result of feedback from service users and to help address health inequalities. There have been regular quarterly meetings with all providers to ensure the development, refinement and smooth running of the pilot programme to ensure excellent service provision. The most significant development in response to feedback from primary care and service users has been the extension of the scheme which entitles patients to a further set of “free” 12 week vouchers if the appropriate criteria are fulfilled.

2.31 The programme has been highly popular since it was launched in September 2008 with just short of 1,000 referrals being made. Weight loss results are looking promising.

3. Additional Commissioning Achievements

Choose and Book

3.1 NHS Dorset has been successful in implementing Choose and Book through its commissioning process. There are two main reasons behind the growth of usage for Choose and Book in Dorset. Firstly, GPs and other clinicians were quick to see the potential benefits for patients so they pioneered the systems despite the inevitable teething troubles. Secondly, patients across Dorset have been flexible in adapting to use Choose and Book to arrange their hospital appointments to fit in with their other plans and commitments.

3.2 More than eight out of 10 patients across Dorset now use Choose and Book to select and arrange hospital appointments which means that we can help provide healthcare services which fit in with our patients rather than make appointments which require our patients to fit in with the NHS.

3.3 In order to support and broaden choice for patients who live in a rural area, NHS Dorset works proactively to commission appropriate local services at NHS Dorset community hospitals through the primary care menu on Choose and Book. NHS Dorset is one of the highest performing PCTs in the country which means all NHS Dorset patients can choose to be treated based on location and quality of services from a list which includes all secondary care services nationwide, as well as PCT commissioned services.

3.4 As Choose and Book is the standard method of referral for GP practices in Dorset the information collected for elective referrals can be used to inform commissioners. Dorset and Somerset are unique in that they operate local Booking Management Services (Bridgwater and Poole) for Choose and Book. The information tool initially developed by NHS Somerset to analyse Somerset referrals has recently been adapted for NHS Dorset and now provides a referral picture for all 59 Dorset practices. This information is used to inform discussion and raise awareness amongst Practice Based Commissioners. It highlights any increases or decreases in referral trends, maps a practice’s referral patterns against either a benchmark for all Dorset practices or a locality benchmark and can measure each practice’s referrals by specialty over specified periods of time. The use of this information has been further adapted by NHS Dorset through application of a baseline statistical tool to measure standard deviation and upper and lower control limits, and seeks to identify points of “special cause” in sets of trend data.

3.5 Information provided from Choose and Book nationally is also used to report on the availability of appointment slots for directly bookable services at secondary care trusts. This is provided to PCTs weekly by the SHA and informs NHS Dorset commissioners which providers and specialties need to change and improve services.
A Homelessness Primary Care Outreach Project

3.6 It is a sad fact that in 2009 there are still a significant number of people living in Dorset without a home and the basic facilities to support their health needs on a daily basis. Until recently there have been no health services that have specifically sought to meet the needs of this often extremely vulnerable group of people.

3.7 In 2007 NHS Dorset worked together with The Hub, a homeless day-care centre in Dorchester, and two local GP practices, to establish two primary care outreach clinics in Weymouth and Dorchester.

3.8 The Hub was initially funded through the Pfizer Foundation, an organisation which supports community based projects that tackle health inequalities. Two nurse practitioners were employed by the Royal Crescent Surgery in Weymouth and the Prince of Wales Road Practice in Dorchester to run generic primary care clinics out of Soul Food (a church-based homeless support service) and The Hub respectively.

3.9 In 2008 NHS Dorset took on the commissioning of the project, with The Hub providing a coordinating role and sub-contracting with the two local surgeries for clinical services and supervision.

3.10 Fifty-one homeless people went to the Weymouth clinic during 2008 and 38 to the Dorchester Clinic. Altogether there were 259 patient contacts over the year.

3.11 Clinical activities ranged from the routine (‘flu vaccines, health screening, medication reviews and prescription requests), through to problems often associated with sleeping rough (bruising and injury as a result of accidents or violence, sunburn, musculoskeletal problems, self-harming, substance misuse, mental health problems, hygiene care, pneumonia).

3.12 There are challenges associated with serving people with multiple and complex health needs, and difficulties with making effective referrals and arranging appropriate and timely care.

3.13 In 2009, there are plans to extend the service further by increasing capacity for immediate support for those patients with mental health problems and by improving access to much needed dental health services.

3.14 By building trust with people, responding to immediate needs and facilitating access to more mainstream health services, this project is an example of how the NHS needs to diversify in response to population health need and become more outward and patient-focused.

Dorset PCT Network
September 2009

Memorandum by NHS Tower Hamlets (COM 10)

In response to the Health Select Committee’s inquiry into Commissioning NHS Tower Hamlets is providing evidence of our progress and achievements as a commissioning organisation in recent years. Please find below five examples:

1. Self care education for diabetes patients.
2. Developing a District Nursing Tariff.
3. Improving access to GP appointments.
4. Improving Chlamydia screening rates.
5. Improving A&E performance against the four-hour wait.

1. Self Care Education for Diabetes Patients

Issues to be addressed:

1. Tower Hamlets is one of the most deprived and ethnically diverse areas in the country with high prevalence rates of diabetes, with almost 53% of people with diabetes of Bangladeshi origin. Local residents are almost 15% more likely to be diabetic than the rest of the nation.

2. In January 2008, there were approximately 11,140 people with diabetes in Tower Hamlets, a prevalence rate of 4.4% The residents of the borough are almost 15% more likely to be diabetic than the rest of the nation.

3. In 2006, a Healthcare commission survey of people with diabetes found that 86% of people with diabetes in Tower Hamlets who responded said they had never participated in education or training to help them better manage their diabetes, and of these 84% said they had never been offered it.

4. An external review of diabetes education for people with type 2 diabetes in 2008 showed there was a low referral rate, high attrition rates, no patient choice and high cost per patient attending diabetes education.

5. As a result of this we commissioned a comprehensive review which segmented patients across a number of criteria. This highlighted the need to commission diabetes education to individuals, based on their need and learning style in a much more flexible way to improve access and uptake. It also highlighted that segmentation-based provision of education is imperative in controlling diabetes in Tower Hamlets.
6. Based on this a portfolio of tailored educational interventions were commissioned in response to each of the five segments identified. Based on patients attitudes and behaviours towards learning styles, the segments identified were:

(a) Proactive.
(b) Confident but with knowledge gaps.
(c) Confused and anxious.
(d) Ignorant and unconcerned.
(e) Resigned/passive.

Commissioning response

7. Non-recurrent investment in 2008–09 was made into Diabetes education, with the overall aim of providing diabetes education to a minimum of 7,000 people with diabetes and a “Day to Day Diabetes Education” project was set up which ran from January–May 2009.

8. The diabetes education programme was established to provide tailor made diabetes educational interventions based on population segmentation.

9. Six education interventions were developed and provided. These were: HAMLET, a revised structured diabetes education course that consisted of four three hour sessions, a two hour key message diabetes courses, exercise and cooking classes (Healthy Moves) which consisted of six exercise sessions and one cookery session, drop in sessions and production of an educational DVD and workbook and drop in sessions for general advice, blood pressure and blood sugar checks.

10. The investment was used to commission the following to ensure the success of the programme:

(a) Day to day programme management and administration, team of educators.
(b) Telemarketing company to invite people to attend the programme.
(c) A media/marketing company to coordinate promotion and marketing of the programme, design and production of resources.
(d) British Dietetic association to provide educators for the programme.
(e) X-PERT programme to train the educators and provide quality assurance of HAMLET and the two hour key message sessions.
(f) Community voluntary sector to provide venues and also one of the educational interventions.
(g) Interpreting services for translation of written materials

Improvements achieved:

11. 6,640 people (60% of the diabetes population) with diabetes accessed at least one of the educational interventions during the programme, which ran for 17 weeks.

12. There were 9,940 attendances at educational interventions.

13. 100% of people on the diabetes register received a DVD and workbook.

14. 2,346 people accessed HAMLET, 5,335 accessed a key message course, 2,259 accessed Healthy Moves.

15. Educational interventions were offered at 52 venues across Tower Hamlets, seven days a week between 7 am–8 pm.

16. The key message course was provided in eighteen different languages.

17. HAMLET, the self management structured course, was provided in 10 different languages.

18. High levels of patient satisfaction were recorded, this will be substantiated through an academic review which is currently out for tender.

19. Academic evaluation of the effectiveness of the educational interventions and assessment of clinical outcomes is in the process of being commissioned. Key outcomes we expect include improvement in levels of controlled diabetes and reduction in complications and the need to access secondary care.
2. Developing a District Nursing Tariff

Issues to be addressed:

20. District nursing is a key community health care service. But there was a lack of clarity as to the details and quantity of the health care interventions offered.

Commissioning response

21. The programme outlined below was met within current budgets.

22. With the assistance of external experts in healthcare currencies commissioners oversaw a process being rolled out to develop an activity based payment for work carried out.

Improvements achieved:

23. Detailed information available for first time on the health care the service is providing against cost.

24. This information will now allow commissioners to benchmark the Tower Hamlets service against this in other areas to see where improvements are possible—and allow for alternative procurement routes to be followed if required in order to deliver improved health outcomes.

25. This has allowed for efficiencies to be made without compromising patient safety or quality of care. Notably it was established that certain procedures were regularly being carried out by nurses at a higher grade than was clinically necessary for that procedure. A re-alignment of care procedure with level of qualification required has released significant savings to be re-invested in patient care.

26. The commissioning model trialled with community nursing is now being extended to cover other community health services within Tower Hamlets.

3. Improving Access to GP Appointments

Issues to be addressed:

27. In 2007 the first GP Patient Survey showed that access to GP appointments in Tower Hamlets was the worst in England and that there was huge variation in performance across the borough.

28. Reasons for this poor performance given by providers included deprivation, ethnicity, disease prevalence, low levels of health literacy and English usage, all of which did contribute to making it a challenging target to meet.

Commissioning response

29. Commissioners set up a multi disciplinary Access Strategy Group, and a Community Engagement and Dialogue group which to ensure that clinician, managers and community representatives all drove the process.

30. Commissioners looked at each of the stated external factors and correlated them with access performance and demonstrated that the best performing practices in Tower Hamlets were not operating in demonstrably different circumstances to those that were experienced at the lowest performers.

31. Four management tools were developed which enabled practices to better understand their access issues and enabled the PCT to utilise data driven performance management processes with its GP contractors concentrating on demand, supply and quality of care.

32. Commissioners have stopped talking about WTE GPs and started to talk about number of appointments per 1,000 patients per week. This has driven change in service provision to meet the needs of the patient at each practice.

33. Practices now provide regular data which that maps access, appointment supply and patient satisfaction performance.

34. Commissioners have set benchmarks in these areas and in communicating success to patients.

35. Practices were performance managed using a RAG methodology. Each practice has been categorised as a red (more than 10% below London average), amber (within 10% of London average) or green (above London average). Each practice has been performance managed in line with its RAG status with some red practices being visited on a weekly basis.

36. The PCT has also created an access LES which rewards practices in line with their GP Patient Survey performance.

37. We have also communicated directly to patients through leaflets, posters, radio and external media the level of performance that they should expect from their GP practice.
Improvements achieved:

38. In 2008 patient satisfaction in Tower Hamlets increased by 6%, (more than anywhere else in England) to 74%. In 2009 Tower Hamlets increased by 8% to an average of 82%. An improvement of 14% in two years. It is now above the London average of 81% for 2009.

39. The variation in performance across the borough was significantly reduced, with the poorest access rate improving by 18%.

40. Patients have also expressed high satisfaction with their ability to book appointments ahead.

41. External reporting through the MORI poll has assisted in bringing greater transparency and improvement in care.

42. In 2007 there were 22 “red” practices. In 2009 there are only five.

4. IMPROVING CHLAMYDIA SCREENING RATES

Issues to be addressed:

43. In 2007–08 Tower Hamlets Women and Young Peoples service (WYPS) were commissioned to deliver the Chlamydia Screening Programme (CSP) via a competitive tendering process.

44. Quarter 1 & 2 performance monitoring by commissioners highlighted that although WYPS was responsible for delivering the Chlamydia screening programme they would not have the capacity to deliver all of the screens required to hit the target.

Commissioning response

45. Commissioners tendered for additional capacity and utilised voluntary organisations well placed to contact young people in larger groups.

46. Two third sector organisations were selected based on a number of criteria:

47. Expertise in areas like focused outreach work with difficult-to-reach groups.

48. Evidence of past achievements in sexual health work.

49. Submitted plan of action for testing.

50. Cost of screening the required number of people within the set period of time.

51. Robust action plan for treating positives and partner notification.

52. These organisations were given tough targets and had performance related bonuses built into their contracts.

53. The contract for both providers was subcontracted through WYPS service to maximise the collaborative provider relationship and reduce providers competing for the same target audiences.

54. This led to an extremely productive but competitive arrangement between providers. Each provider had individual targets, but WYPS was ultimately accountable for overall performance.

Improvements achieved:

55. In 2007–08 the 15% target was met, in 2008–09 the 17% target was exceeded (21% achieved).

56. It is recognised that additional investment has made Tower Hamlets an outlier in comparison to the investment other PCTs have made. WYPS are therefore commissioned to provide additional screens year on year within the same financial envelop.

57. A different third sector provider has been commissioned 2009–10 as repeat tendering has driven the cost per screen down from £50 in 2007–08 to £20 per screen in 2009–10.

58. Economies of scale are now being explored via pan-London procurement of test kits and diagnostics.

5. IMPROVING A&E PERFORMANCE AGAINST THE 4-HOUR WAIT

Issues to be addressed:

59. Barts and The London NHS Trust A&E department were consistently failing to meet the 4hr waiting time standard

Investment and response

60. The PCT developed a clear data-set to be reported against for breaches, previously primarily anecdotal data was used. Breaches were then analysed daily, this showed that one-third of breaches were due to delays in A&E assessment and one-third were due to bed availability.

61. A discharge project designed to ensure consultants did ward rounds early in the day and nurse led ward rounds allow three daily ward rounds are keeping bed managers informed and free to release beds. Discharge plans on admission or earlier are now required.
62. The high number of delayed discharges, due to residential care, inefficient use of community based beds, and that neuro patients utilise alternative providers when no bed is available, are being reduced through processes to ensure patients are transferred as soon as an appropriate bed becomes available.

63. Recurrent funding has been made into GPs streaming in A&E, these GPs conduct a very brief primary care assessment of all ambulatory, adult patients between 10am-10pm. Many patients are therefore appropriately streamed away from A&E eg to Walk in Centre, own GP, or home with self care advice.

64. To ensure that the system is able to cope with the pressures of the winter and the potential impact of a second wave of swine flu a winter plan has been jointly developed between the PCT and the Acute provider, in this service leads have been asked to demonstrate increased capacity to deal with surges and insure alternative care pathways for patients with chronic diseases and vulnerable groups.

Improvements achieved:

65. The number of breaches due to bed availability has been reduced from 33% to 12%, discharges are now averaging 431 per week compared to 388 in 2008–09.

66. All patients now have an expected discharge date on admission or earlier and are clear that where appropriate they will be transferred to the community hospital whilst they wait for a bed in their residential facility of choice.

67. The GP streaming team streams away 50% of patients that they see. This means that between 10 and 15% of the total volume previously seen by A&E are now streamed to other appropriate services.

68. At month five progress towards the four hour A&E target is 98.54%. The outturn position in 2008–09 was 96.92%.

69. In 2009–10, the average number of breaches has been more than halved to 56.

4hr breaches at the Royal London Hospital A&E

Tower Hamlets PCT Network
September 2009

Memorandum by National Pharmacy Association (COM 11)

1. THE NATIONAL PHARMACY ASSOCIATION

1.1 The National Pharmacy Association (NPA) is the body which represents the entire spectrum and vast majority of community pharmacy owners in the UK. We count amongst our members nationwide pharmacy multiples, regional chains and independent pharmacies. This spread of members, our UK-wide geographical coverage, and our remit for NHS and non-NHS affairs means that we are fully representative of the community pharmacy sector. In addition to being a representative voice, we provide members with a range of commercial and professional services to help them maintain and improve the health of the communities they serve.
1.2 The NPA is currently conducting research into pharmacy contractors’ perspectives on the nature of local commissioning of pharmacy services. NPA would be pleased to share the results with the Committee when they become available.

2. EXECUTIVE SUMMARY

2.1 What follows is a perspective on commissioning from independent contractors to the NHS. We believe community pharmacy’s experience of commissioning is instructive in relation to other primary care contractors and indeed for providers of many shapes and sizes.

2.2 Community pharmacies in England have expanded their clinical role in recent years. The Pharmacy in England white paper (Pharmacy in England—Building on Strengths, DH 2008) is intended to progress community pharmacy towards a sustainable clinical role, and local commissioners need to perform their role competently in order to effect this change, in partnership with providers.

2.3 There is good commissioning practice in areas across England, plus comprehensive and up to date guidance on commissioning of pharmaceutical services. Nevertheless, NHS commissioning of pharmacy services is highly variable. Differentials in local investment are only partially accounted for by population need. The Department of Health admits that “many PCTs work hard at fostering a vibrant community pharmacy service, with dedicated staff supporting the expansion of choice and services, (but) that commitment is variable” (ref: Pharmacy in England).

2.4 From an independent contractor perspective, factors in combination that seem to be significant in achieving effective commissioning are: Leadership, relations, accountability, stability, investment and risk share, awareness and understanding, staff capacity and contained administrative burden (both for commissioner and provider).

We wish to draw special attention to the idea that PCTs can release energy from providers by addressing “mundane”, routine matters of administration, as well as having a mind to the gains to be had from “strategic” improvements and service redesign (paragraphs 6.3-6.7).

3. COMMUNITY PHARMACY

3.1 Pharmacists are experts in the use of medicines to treat disease. They undertake five years pharmacological and medical training and work within a code of ethics that requires them to continuously develop their professional knowledge and competence relevant to their field of practice.

3.2 There are around 10,000 community pharmacies in England, situated in high street locations, in supermarkets and in the heart of deprived communities. Community pharmacies, like GP practices, are independent contractors and an integral part of the NHS family. Pharmacists are responsible for the supply of most medicines available to the public. They advise the public and other professionals on the safe and effective selection and use of medicines and other health-related matters. In recent years, pharmacy has expanded its role, and now supplies a wide range of NHS services such as minor ailments schemes, stop smoking counselling and help for people to get off illegal drugs.

3.3 Pharmacies provide services in the heart of neighbourhood communities where they are within reach of the people who need them most—poorer people, older people and people with a disability or chronic condition. The Government has recognised community pharmacy as “perhaps the biggest untapped resource for health improvement . . . a resource for reducing health inequalities, especially for vulnerable and deprived population” (ref: A Vision for Pharmacy in the New NHS, DH 2003).

4. COMMISSIONING OF PHARMACEUTICAL SERVICES

4.1 Publicly funded community pharmacy services in England are provided across three tiers of a community pharmacy contractual framework. “Essential” services, which all pharmacies are expected to provide, such as support for self care, signposting and advice on health living, can improve health and reduce demand on local services. Through medicines use review (an “Advanced” tier service), pharmacists can identify problems that people may have with their medicines usage and help resolve them before they become serious, preventing unnecessary hospital admissions. The “Enhanced” service tier enables pharmacists to be commissioned locally to supply NHS services such as minor ailments schemes and a wide range of public health services including smoking cessation, emergency hormonal contraception and substance misuse support.

4.2 There are many examples of successful schemes (see Maximising Health Gain Through Community Pharmacy: NHS Alliance, CCA, AIMp, NPA, PSNC, RCGP, 2009). Nevertheless, there are still locations in which pharmacy is not delivering such services within the NHS. In addition, the types of services that could be part of radical service re-design within the development of patient pathways—including point of care testing, hospital follow up and the management of long term conditions, although popular where they do exist, are still scarce.

4.3 NHS commissioning of pharmacy services is highly variable. Differentials in local investment are only partially accounted for by population need. The Department of Health admits that “many PCTs work hard at fostering a vibrant community pharmacy service, with dedicated staff supporting the expansion of choice and services, (but) that commitment is variable” (ref Pharmacy in England). Pharmacy in England is intended
to progress community pharmacy towards a sustainable clinical role, and local commissioners need to perform their role competently, indeed excellently, in order to effect this change, in partnership with providers. The efficient operation of the NHS “market” requires that no provider group should expect commissioners to cosset them. Nevertheless, commissioners should not be bystanders to the fortunes of its key providers. World Class Commissioning states that PCTs should “give providers direct support for innovation and change where necessary”. Pharmacy in England tells PCTs that they have a central role in “aligning pharmacy as part of the fabric of patient centred NHS services”. Only with the active engagement of PCTs will pharmacies grow into the healthy living centres envisaged by the Department of Health.

5. COMMISSIONING IN CONTEXT

5.1 There is a “challenge of alignment” to be met if community pharmacy is to step up to the sustainable, service based future at the spearhead of health improvement envisaged in Pharmacy in England. The intentions and capabilities of various groups need to be brought into alignment: in other words, commissioners/funders need to be willing and able to commission services at the same time as pharmacy providers are willing and able to provide those services, at the same time as patients are willing and able to access them, at the same time as fellow providers such as GPs who share the service pathway are willing and able to interface efficiently, at the same time as there is an enabling regulatory and legislative framework.

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<th>PCT willingness to commission</th>
<th>Pharmacy willingness to provide</th>
<th>Patient/public willingness to access the pharmacy service</th>
<th>Fellow provider willingness to cooperate along the care pathway</th>
<th>Government/Regulators’ willingness to set the right conditions</th>
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<td>Awareness and understanding</td>
<td>Business case and strategic alignment</td>
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<td>Awareness of shared gain to patients and all parties</td>
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<td>Obligation/accountability: inc performance monitoring of commissioners</td>
<td>Confidence that funding will be sustained</td>
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<td>Finances</td>
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6. FACTORS IN ACHIEVING EFFECTIVE COMMISSIONING

6.1 From an independent contractor perspective, factors in combination that seem to be significant in achieving effective commissioning are: leadership, relationships, accountability, stability, investment and risk share, awareness & understanding, staff capacity and contained administrative burden (both for commissioner and provider).

6.2 PCTs looking to get maximum value from community pharmacy should pay careful attention to High Quality Care for All: Improving Pharmaceutical Services, which DH published in April 2009 as part of its suite of Primary Care & Community Services guides. The guide suggests 15 questions for PCT Boards to ask themselves, many of which slot into the leadership, awareness and staff capacity categories listed in paragraph 6.1 above:

Leadership: Is there a named Board member with responsibility for pharmaceutical services?

Awareness: Do non-executive Board members have a good understanding of the relationship between PCT and its providers of pharmaceutical services? Does the PCT have a good understanding of pharmacy as a provider of public health and health improvement services? Does the PCT have a good picture of how current investment in pharmaceutical services is deployed and the levels of access, quality and health improvement this provides?

Staff capacity: Does the primary care commissioning team have appropriate capacity, skills and support from Directors in respect of pharmaceutical services?
6.3 However, we wish to draw particular attention to the importance of administrative processes. Data from recent and current NPA surveys of our members suggests that PCTs can release more energy from pharmacists by addressing “mundane” and routine matters of administration, as well as having a mind to the gains to be had from service redesign.

6.4 Independent contractors, in particular those operating as “small businesses” face a sometimes insurmountable administrative challenge, when it comes to tendering for NHS work locally. Even incumbent contractors delivering demonstrable benefits through local enhanced services have been excluded from continuing provision when their service has been subsequently “bundled” into a larger service tender. In certain such instances, the incumbent may fail even to pass through the Pre Qualifying Questionnaire stage.

6.5 PCTs should therefore pay more attention to the PCT Procurement Guide for Health Services (NHS, 2008) which emphasises proportionality—“making procurement processes proportionate to the value, complexity and risk of the services contracted, and critically no excluding potential providers through overly bureaucratic or burdensome procedures.”

6.6 The administrative burden must also be minimised further on in the commissioning cycle, including performance monitoring and transactional matters such as payment.

6.7 Unnecessary administration also stands in the way of the roll-out of proven schemes. Well established and already widely commissioned pharmacy services, such as NHS minor ailments schemes and numerous public health services could be commissioned on an SHA-wide or national basis, so that all service users may enjoy the benefits.

7. CONCLUSION

7.1 The national representative bodies for pharmacy recently published research into Making Commissioning Effective in the Reformed NHS in England (Health Policy Forum 2006). Our collective close interest in health service commissioning precedes that report and continues to this day, because ineffective commissioning will perpetuate a position in which the pharmacy profession’s considerable potential to improve health outcomes is not fully realised.

7.2 We believe community pharmacy’s experience of commissioning is instructive in relation to other primary care contractors and indeed for providers of many shapes and sizes. We trust therefore that our written submission will be useful for your inquiry and we should be delighted to give more detail in verbal sessions.

NPA

September 2009

Memorandum by CLIC Sargent (COM 12)

1. SUMMARY

CLIC Sargent is the UK’s leading children’s cancer charity, providing care and support services to children and young people with cancer across the UK.

We welcome the opportunity to participate in the select committee’s inquiry into commissioning. CLIC Sargent believes that commissioning needs to ensure a more holistic approach to delivering services, with better links between the commissioning of specialist and generalist services across hospital and community settings. In particular, consideration should be given to the role that PCTs play in this, and whether practice-based commissioning has any relevance to people with rarer conditions like childhood and adolescent cancer. These points are explored further below in addressing the inquiry’s key questions.

2. “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

CLIC Sargent welcomes the progress which has been made by PCTs in developing effective commissioning. However, PCT commissioning is not yet effective enough at taking a holistic approach to the needs of children and young people with long term illnesses.

For children and young people with cancer, their treatment and care in hospital tends to meet their clinical needs well. But both for those who need palliative support services, and for those who go on to survive cancer for many years, there is also a complex set of emotional, social, educational and clinical needs which must be balanced in the planning commissioning process.

The provision of care and support for sick children and young people must now move beyond health service commissioning and instead take a wider perspective, planning an integral care pathway from diagnosis, through treatment, and beyond, addressing the range of needs for children and young people.
More Than My Illness, our report on community based care and support for children with cancer, proposes a model of delivering a whole pathway approach to meeting the full needs of these children. This includes the following elements:

— Assessment and care planning—full assessment of both clinical and non-clinical needs at the outset. This helps with transition out of hospital, into home, into education, and into independence.

— A key worker to ensure care is coordinated across all clinical and non-clinical services for children with cancer, acting as a main contact person for families through health, social care, education and other elements. This person should be a trained children’s cancer nurse.

— Appropriate support for children, young people and their families to promote their well being across social, emotional, educational and financial aspects in addition to clinical care.

— A Community Multi-Disciplinary Team (CMDT). A fully integrated community team of professionals including social care, a GP, community nursing, education support and other specialisms as needed would ensure a genuinely holistic approach to commissioning and service provision.

3. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

The split between the purchasers and providers of services is needed, as it enables commissioning bodies to look at what is needed objectively, without having the partiality of being a service provider at the same time as making purchasing decisions. The purchaser/provider split means that there is a choice of service providers, and offers the opportunity to seek out expertise in delivering different services.

4. Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

For childhood and adolescent cancer, practice-based commissioning is not effective in fully meeting their needs. There is an inherent tension with practice-based commissioning where a GP is only likely to see one case of adolescent cancer in their entire career. It is therefore unlikely that the needs of people with rarer conditions like these would be considered at practice level when assessing the overall needs of the wider population.

A truly holistic service is vital to children and young people with cancer and other illnesses, but this is unlikely to be achieved by practice-based commissioning where these patients are a small factor in a wide, generalist population base.

5. Specialist commissioning

With 20 Principle Treatment Centres (PTCs) providing specialist treatment and care for children with cancer across the UK, it is vital that commissioning is adequately coordinated across the area covered by each PTC.

In addition, specialist commissioning must better connect with the whole range of community services, including health, social care, information, and education in order to provide the holistic, community based service that sick children and young people need. As detailed in point seven below, CLIC Sargent knows of several areas where children with cancer and their families feel that their needs in the community are not being met. In particular, there should be more specialist paediatric and/or young people oncology nurses available to perform a key worker role for these patients, and to provide the appropriate support to community nurses so that more cancer care can be delivered locally.

This requires integrated commissioning which addresses both specialist health care and other needs. It is very important for children and young people living with and beyond cancer that different commissioning bodies do not work in isolation from each other, but instead work within a whole care pathway. It is also crucial that the social, emotional, educational and mental health needs of these children and young people are not neglected in the commissioning process.

The existing commissioning of local health, social and education services is unlikely to take into account the particular needs of this relatively small cohort of children within local authorities. Currently it is near to impossible to influence local commissioning of community based services effectively because of the numbers of authorities and PCTs.
6. Commissioning for the quality and safety of services

Care and support should be delivered as close to a child’s home as possible. And NICE’s *Improving Outcomes for Children and Young People with Cancer* guidance is also clear that delivering care at or near to a child’s home must always be clinically safe and effective.

CLIC Sargent believes that improvements are needed to community based care and support services, to ensure that all children and young people can have safe, specialist and quality treatment, and are able to go home wherever possible. These children and young people also need support to continue their lives at home, at school, at work, and in every sphere of life. We want to see an end to the current inequity in community services for children with cancer and other serious illnesses.

Community based care and support is important for sick children and young people, and the Government has recognised the need for providing care closer to home in several of its key strategies:

— High Quality Care for All: NHS Next Stage Review;

— Our Health, Our Care, Our Say;

— Healthy Lives, Brighter Futures: the strategy for children and young people’s health; and

— The Independent Review of Palliative Care Services for Children and Young People in England.

In order to achieve these ambitions, commissioning needs to ensure a more holistic approach to delivering services, with better links between the commissioning of specialist and generalist services, as outlined above.

7. Additional materials

7.1 A review of community based care and support

As part of a wide review of community based services for children and young people with cancer, CLIC Sargent has spoken with parents, children and siblings to find out their experiences. We found that:

— Children and young people with cancer need to go home during their treatment in order to maintain a normal family life and continue with their education. 97% of children with cancer in the CLIC Sargent sample tell us that it’s important for them to be able to return home during their treatment, but these children need to be fully supported in order for this to happen safely.

— A lack of children’s community nurses and social workers means parents aren’t experiencing the level of support they feel they need when their child is at home. As a result, children are spending more time in hospital—staying longer in hospital before they can go home, or ending up back in hospital for minor treatment unnecessarily.

— CLIC Sargent is concerned that access to community services is not equitable across the UK and the expertise of community nurses to support and care for children undergoing cancer treatments is variable. A majority of parents in the CLIC Sargent sample identify the need for clinical support when at home, in and out of normal working hours. This includes visits from a community nurse, tests and treatment at home, and explanations about side effects of treatment. Nearly 50% of these families felt that key elements of clinical support at home was lacking.

— Families are not getting all the support they need to maintain an ordinary life during their child’s treatment. For example, more than two thirds of parents who feel they need counselling say they can’t access it for them or their child with cancer. Worryingly, about half of children who want help in keeping up with their education, like accessing home tutoring, are not getting it or they find it is insufficient.

Smarter, cross-service commissioning would help to ensure that the above gaps are addressed and that care and support runs more consistently between health, social care, education and other services, as highlighted above.

7.2 More Than My Illness: delivering quality care for children with cancer

This key report, which is the result of collaboration of experts across the children’s and health fields, outlines the case for community based care and support for children with cancer, and proposes a model for effectively commissioning this care pathway. The report is included as part of CLIC Sargent’s submission to this inquiry.
7.3 More Than My Illness—a focus on teenagers and young adults

A second report which focuses on the community needs of teenagers and young adults with cancer is anticipated later this year and will be forwarded to the Committee at this time.

September 2009

Memorandum by NHS Norfolk (COM 13)

1. **EXECUTIVE SUMMARY**

1.1 NHS Norfolk welcomes the opportunity to contribute to the Health Select Committee’s Inquiry into commissioning.

1.2 In our response we have provided an overview of how independent commissioning and system management is effective in shaping the future for local service delivery and improvement, culminating in the production of a system wide agreed Strategic Plan.

1.3 NHS Norfolk considers the role of commissioning as essential in managing a health system which focuses on the needs of the local population.

1.4 The commissioning role, balancing competing local priorities and national targets, is a complex one. There have been many changes to the commissioning regime, but the development of World Class Commissioning has improved focus, confidence and overall impact of PCTs as the local leaders of the NHS.

1.5 More recently NHS Norfolk has been successful in challenging providers when services are falling below expectations to ensure effective use of the public resources and deliver services aligned with patient needs.

1.6 To continue this focus on service improvement, NHS Norfolk plans to tender £55m of services over the next two years, using the market to promote cost effective services and high quality service provision, aligned with the latest needs of the community we serve.

1.7 One of the key responsibilities of the PCT as commissioners is to set the strategic framework for commissioning decisions. NHS Norfolk has just launched its “Bold and Ambitious” Strategic Plan for 2009–14, following comprehensive consultation with patients, communities, practice based commissioners and partner organisations. The legitimate independent commissioning role of NHS Norfolk has facilitated the open dialogue with all parties, balancing the competing priorities to produce a locally agreed plan which focuses on reducing health inequalities, promoting prevention and providing care closer to communities.

1.8 In relation to the other specific areas covered by the Health Committee’s Inquiry, we fully support the response submitted by the Primary Care Trust Network, but are grateful for the opportunity to highlight local areas of specific commissioning actions that will improve patients services’ locally.

2. **LOCAL COMMISSIONING EXAMPLES**

Below is sample of commissioning changes NHS Norfolk has made as we embark on the delivery of the strategy:

2.1 **Assistive Technology**

An innovative partnership between NHS Norfolk, social care and individuals themselves has significantly improved the lives of patients with long term conditions such as COPD and heart failure. Together with Norfolk County Council, NHSN recognised scope to pilot a Telehealth system. 20 remote units were placed with 40 patients with long term respiratory and heart conditions. They were able to measure their own vital signs using specific monitoring equipment and input the resulting data themselves via a touch screen. The results were then sent directly to nursing staff for analysis of trends. In many cases this enabled early intervention, directly improving the patients’ lives, reducing the number of hospital admissions and making significant cost savings for the NHS. It also led to a substantial improvement in the individual patients’ understanding of their disease process and they in turn were able to make decisions about their day to day activities. The results were confirmed in a post-trial study carried out by the University of East Anglia.

2.2 The scheme is now being rolled out further, involving practice based commissioners in both identifying the framework for sustainability and also the type of technologies best suited to the individuals. The tendering process was unique in that it involved patients and clinicians in analysing bids by the service providers and helping NHSN to score them, eventually determining the supplier of choice.
2.3 Comments about this service:

“Referral to Mr C’s GP enabled prompt therapy, hence stopping deterioration of his condition. Mr C successfully managed his condition at home with the support of the heart specialist nurse and Telehealth. He was able to drive his car, visit friends and expressed his gratitude for this assistance and the ability to have a better quality of life.”

Heart Specialist Nurse, James Paget University Hospitals NHS Foundation Trust, Norfolk.

“It’s great to see Mum up and about smiling again. Telehealth has freed up time for me to spend with my own children and also given me peace of mind that Mum’s health is being better managed by both herself and the NHS”

Daughter of Telehealth recipient

2.4 There is now established a Joint Commissioning Forum for Assistive Technology, a multi-agency group tasked with continuous improvement of driving the technology agenda forward.

2.5 Telehealth has also been trialled for multi-users, enabling patients in a care home setting to send details of their conditions and requirements to their GP via the internet, including a live link to their GP. It has substantially improved access to NHS services by patients who would otherwise find it difficult to travel.

3. STROKE SERVICES

3.1 Soon after it was established in 2007, NHS Norfolk set up a working group with clinical representation and service user/carer involvement to look at stroke care in Norfolk in light of the recommendations contained in the national strategy for stroke care in England. The group developed a service specification to meet the needs of this strategy. NHS Norfolk then embarked upon a procurement to market test for providers to deliver the new pathway of care.

3.2 There are three phases to the new pathway:

— Acute phase:

A major improvement in stroke treatment this year has been in the piloting and subsequent launch of a Thrombolysis treatment programme at Norfolk and Norwich University Hospital (NNUHFT) in Norwich and Queen Elizabeth Hospital (QEHKLT) in King’s Lynn.

NNUH is already running a 24/7 service, while QEH is running a nine to five service, with plans to shift to a 24/7 service in coming months.

NHSN worked closely with the Anglia Stroke Network, which has clinical membership from all the acute hospitals in the region looking at innovations in telemedicine to support the roll out of 24/7 thrombolysis across the region.

— Acute rehabilitation phase:

On 24 August 2009 construction began on NHS Norfolk’s new dedicated stroke and general rehabilitation unit based at Norwich Community Hospital on Bowthorpe Road. Costing £8million, it is NHS Norfolk’s single biggest capital investment, demonstrating NHS Norfolk’s commitment to improvements in treatment for stroke patients. This will result in 24 dedicated beds for the acute rehab phase for stroke patients in Norfolk.

— Community rehabilitation phase:

An early supported discharge team has been established to focus on getting patients home, providing in-reach services to support independent living.

3.3 Through practice based commissioning, a new trial fibrillation screening service has been agreed which will be launched across more than 40 GP practices in west and north Norfolk to coincide with the annual influenza vaccination programme. The North Norfolk and West Norfolk PBC consortia identified the need for screening to reduce cardio-vascular illness and stroke among patients—an outcome which is anticipated to generate health improvements and cost savings in the future. Patients over the age of 65 are given pulse checks and if there are irregularities they are offered follow-up examinations, including ECGs within the practice. This is being carried out in close co-operation with acute specialists.

4. INTEGRATING CARE IN NORFOLK

4.1 NHS Norfolk is one of the largest PCTs in England in terms of its population (740,000) and geographical area. Its population is significantly older than the average for England with 20% over age 65 (16% nationally) and 10% over 75 (7.8% nationally). The population of older people is also growing at a rate faster than the rest of England.

This context poses significant challenges to health and social care services which require innovative and flexible responses to avoid reliance on traditional interventions such as admission to hospital and long term residential care.
4.2 NHS Norfolk, Norfolk County Council (NCC) and groups of General Practices engaged in Practice Based Commissioning are establishing a series of fully integrated, local health and social care teams comprising GPs, community health staff and adult social care staff to provide cohesive, pro-active and personalised care for patients, blurring the traditional boundaries between practices, organisations and professions. This project is a part of the Department of Health’s Integrated Care Pilot Programme.

4.3 Six pilot locality teams covering slightly different populations and geographical areas across the county are aiming to deliver the following core objectives which support NHS Norfolk’s Strategic Plan 2009–14 and the County’s Strategic Partnership’s Local Area Agreement:

— to achieve an increase in user satisfaction;
— to reduce current levels of unplanned admissions to secondary care;
— to reduce levels of placements into long term residential care;
— to increase support available to carers;
— to support more people to live at home utilising personal health and social care budgets;
— to reduce waiting times for assessment; and
— to achieve an increase in staff satisfaction.

Each of the pilot sites will also be encouraged to supplement these core objectives with local ones, which reflect the needs of the communities in which they serve.

4.4 From a World Class Commissioning perspective the project has drawn on a number of the competencies:

— Engaging the public and partners:
  The project is being driven by six pledges agreed with a panel of patients and carers.
— Work with community partners:
  A partnership between NHS Norfolk and Norfolk County Council is at the heart of the project.
— Collaborate with clinicians:
  The project is led by GPs and other community clinicians.
— Promoting innovation and improvement:
  The teams are being given scope to innovate and improve delivery through challenging current ways of working.

5. DENTISTRY

5.1 NHS Norfolk has seen an increase in funding into dental services by £3 million per annum over two successive years enabling significant commissioning of new services.

5.2 Identification and rectification of primary care under-provision:

Following the change of responsibility for commissioning dental services in April 2006, we commissioned research which identified geographical gaps in provision, partly due to the rural nature of the county. In the first phase we identified two hotspots via PALS responses and questioning of existing dentists—North Walsham in north Norfolk and East Dereham in the centre of the county. NHS Norfolk was able to rectify this under-provision by tendering for services and put in place new NHS dental practices in both towns, one with five dentists and the second with two dentists.

5.3 Further under-provision is addressed through commissioning extra dental services from existing practices where it would be uneconomical to commission new services and practices. By monitoring UDAs geographically throughout the county, NHS Norfolk is able to commission this extra capacity where required.

5.4 Assessments into the needs for dentistry services in Norfolk care homes and also in the areas surrounding RAF Marham are currently underway. Once this information has been fully established, NHS Norfolk will look to provide appropriate services to these patients.
5.5 Orthodontics:

Via dental needs assessments, NHS Norfolk recognised an under-provision in orthodontics. NHS Norfolk invested an additional £720,000 per annum into primary care orthodontic services, funding an extra 600 cases each year. By July 2008 it had also formed a central Orthodontic Referral Management Service in a further step to better manage waiting lists, reduce waiting times for treatment and increase patient choice. By summer 2008 NHS Norfolk commissioned a new practice in Norwich to expand treatment choices for patients. This practice has seen 500 new patients.

NHS Norfolk is currently commissioning a local provider to clear a backlog of cases.

5.6 Local Access Standards:

An Ipsos Mori poll commissioned by NHS Norfolk in the summer of 2008 gathered an important body of data from the general public on their dental needs and expectations. We achieved a generally high level of satisfaction with access standards and we have aimed to improve the satisfaction levels further though a Board approved Local Access Standard scheme.

5.7 Interactive Website:

In April 2009 NHS Norfolk launched an interactive map on its website, guiding the public to their nearest NHS dental service: http://www.norfolk.nhs.uk/dentalmap/dentalmap.html

By hovering the cursor over their area the patient is told where the service is located and what services are offered, making access to dental services simpler to understand and therefore easier to access.

6. IAPT

6.1 Improving Access to Psychological Therapies (IAPT) is vital to improving the mental well-being of Norfolk’s population and will radicalise the treatment of mental health. The project has been to recruit 100 psychological therapists in Norfolk over a two year period. The service has been designed to address mental health problems in a holistic and flexible way whilst being based in a localised setting. Instead of a traditional health model the new IAPT services have been set in a community model, giving people choice and control over where and how they access services. This community model was designed to address the stigma that is associated with many existing mental health services.

6.2 Demonstrate Health Improvement:

— NHS Norfolk is working with Practice Based Commissioners in each of the four Norfolk localities to ensure that IAPT addresses the needs of each locality. These plans will include opportunities for the wider improvement of mental health and in addressing issues of stigma.

— The Public Health Directorate has identified mental wellbeing as a key driver for improving the health of the population and is working through the Programme Board to deliver initiatives. Further work will be undertaken to identify specific pieces of work that will focus on mental health and how IAPT can assist in their delivery. On the basis that “there is no health without good mental health”, these approaches are likely to include access to existing programmes around smoking, weight management and physical activity referrals.

— Preliminary discussions have been held with some Local Strategic Partnerships to understand how IAPT may deliver on objectives shared across the wider local system. Whilst these discussions are at a very early stage the feedback has been very positive with a high level of sign-up by partners. Specific approaches are still to be developed but may include the offer of an outreach service to employing organisations to improve the mental wellbeing of their workforce.

6.3 Service Improvement:

— Primary Care based mental health services in Norfolk prior to IAPT were not universally available for the population in Norfolk. Based on the learning from a series of cross-stakeholder events, several key quality outcomes were established to facilitate a vision for IAPT. This community based vision supports IAPT to be localised, enable patient choice, address stigma and undertake mental health promotion.

— Utilising this learning NHS Norfolk has led the implementation of various improvements:

— there is no upper age barrier in Norfolk, unlike elsewhere in the UK;

— self-referral will be available to all people in Norfolk;

— GP involvement is at the heart of service delivery;

— there are four locality based IAPT teams, creating a support network for both clinicians and patients;

— the team’s design is based on a community model where all aspects of a person’s mental well-being are assessed;

— service implementation and innovation is administered through local steering groups;
— public and patient involvement is constantly sought through local and county networks to validate the implementation process;
— NHS Norfolk has led on the creation of a cross-agency Norfolk Employment Strategy Group to address the holistic issues that affect people during this economic crisis; and
— data collection software was procurement in collaboration with users, clinicians and technical experts. This has considerably eased the efficient implementation of IAPT.

7. REDUCTION IN HEALTH INEQUALITIES

7.1 The majority of IAPT therapists needed to be trained and recruited over two years due a shortage of skilled staff and limited number of University places. Therefore, IAPT services in Norfolk have been designed to actively target the neediest populations. The four IAPT locality teams have been part of a roll out plan to target the GP practices with most need. This has been achieved through the use of mental health need data, deprivation indices, consultation with practice based commissioners and the information gathered from stakeholder events. This process has directly impacted on the variable mental health provision that has historically existed in Norfolk. This is coupled with the fact that IAPT services are by and large newly funded and therefore no resource had existed before their development.

September 2009

Memorandum by IMPRESS (COM 14)

1. EXECUTIVE SUMMARY

This is the response from the two leading clinical societies representing clinicians who care for people with respiratory symptoms and lung disease. It describes the importance of clarifying the roles of networks, leadership, audit, education and training in improving care and how these relate to commissioning. It highlights some of the problems and tensions of the procurement process and the crucial role of good coding as a first step towards payment by results.

2. INTRODUCTION

This response is from IMPRESS, a joint British Thoracic Society (BTS) and General Practice Airways Group (GPIAG) initiative (www.impressresp.com). This aims to provide the clinical leadership to drive high quality patient-centred care across the traditional boundaries of secondary and primary care to integrate and improve the services for people with respiratory disease. Therefore this response draws on the experience of commissioners (PCT and practice-based commissioning and social care), and clinicians in primary and secondary care with a particular interest in people with prevalent long term conditions such as asthma and chronic obstructive pulmonary disease (COPD).

3. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

3.1 Networks

Firstly, we want to make the point that IMPRESS believes system-wide approaches are necessary to achieve improvements and strongly recommends the formation of networks. These cross the purchaser/provider split recognising that expertise and knowledge needs to be shared. These networks would be along the line of managed clinical networks in Scotland, that agree on local needs and aim to raise standards through local discussion and agreement about the evidence and about the best way to implement it given local need. However, networks can be seen to be anti-competitive, and there are challenges about how to fairly involve all providers (including the private sector for example). There are also challenges about intellectual property: is it acceptable for the commissioners to seek expert advice from local providers for free, and then to use it to write a specification for services that it may award to a private sector provider? It would be good to have clarification about the roles of networks and markets. See http://www.impressresp.com/Networks.aspx for our main messages about networks.

3.2 Procurement

We think that there is a lot to learn about using competitive approaches and to ensure they work effectively. We attach a paper Commissioning a community COPD service: Lessons for the NHS based on a case study in Somerset PCT also found at http://www.impressresp.com/Portals/0/IMPRESS/CommissioningCOPDservicev.pdf

We have drawn out the main lessons here: http://www.impressresp.com/Commissioning/Procurement/Dosanddontsofprocurement.aspx

Since then, we have kept a watching brief on other tenders for COPD care. There have been eleven so far. A recent tender, in West Herts, was allocated to a community trust. In terms of dos and don’ts, we would reinforce a few points.
The competitive dialogue phase is important as it enables a detailed analysis of costs and services, and, if the commissioner has clearly specified the outcomes it wants, enables providers to make suggestions about other services that might be appropriate.

Adjudication of bids is extremely difficult. Most local experts may be conflicted because they may also be bidders in competition. It is difficult for an external expert to find the time, or the inclination to judge their peers. Yet there is a crucial responsibility to confirm whether the services proposed are safe, effective and within clinical guidelines. There needs to be guidance and a national coordinated approach to finding expert clinical adjudicators.

3.3 Alternatives: leadership, audit, education and training

There are alternatives to competitive procurement to raise standards: strong clinical leadership, audit, and education and training. We strongly encourage commissioners to invest in these. IMPRESS promotes the options of an Integrated Care consultant http://www.impressresp.com/Portals/0/IMPRESS/ConsultantPhysinRespCare.pdf and also a practitioner with a special interest.

4. Coding and tariff

Payment by Results (or activity) requires a financial language which can be understood and trusted by both providers and commissioners. This is one of the major challenges that need to be achieved before the current model of an NHS marketplace can evolve with confidence.

Correct coding is critical as the first step and the PbR data assurance framework 2007–08 (www.audit-commission.gov.uk), “provides the first comprehensive national picture of the quality of the data which underpin not only financial, but also clinical and commissioning information”. An average HRG error of 9.4% (range 0.3–52%) translated in to a gross financial error of £3.5 million in that sample. They noted that the net financial impact was close to zero in most cases (making gaming a less likely issue) but the wide range of error will result in financial risk in some individual units. The main areas that needed to be addressed were poor documentation, clinician involvement in coding and training and development of the clinical coding profession.

In an attempt to better define clinical activity and casemix severity there have been a number of new procedure codes and HRG revisions developed over the last two years. These additions don’t always “ripple out” efficiently to the front line clinicians, coders and finance departments and as a result when reference costs are being generated some of the newer HRGs are very poorly populated due to a lack of relevant clinical data entry. Reference costs may then be based on such small numbers as to be very unreliable. This is particularly true in the case of one day interventions and experience so far has demonstrated that there may be very wide variations in the reference costs for some HRGs. The concerns raised by such findings and the perceived risk of financial destabilisation has led to a tendency to restrict many HRGs to non-mandatory and rely on local provider/commissioner negotiations. Such negotiations have not proved to be straightforward, presumably as a result of the many competing financial pressures within the different organisations. It is possible that providers may not have the same commitment to coding for the newer HRGs when there is no firm mandate for reimbursement. This in turn results in a further year of poor representation of these interventions in coding terms and once again results in a lack of sufficient data for the HRG to be approved as a mandatory reimbursable activity. The same cycle has the potential to continue on an annual basis and bearing in mind the built in lag before reference costs are translated in to published tariffs this can mean that a new HRG with important relevance both in resources, epidemiology and clinical pathways may not play a full part in financial flows for many years.

The development of Patient Level Information and Costing Systems (PLICS) which is now being piloted for some interventions “represents a change in the costing methodology in the NHS from a predominantly ‘top down’ allocation approach, based on averages and apportionments, to a more direct and sophisticated approach based on the actual interactions and events related to individual patients and the associated costs”. A guide can be found at:


This will offer the opportunity for healthcare professionals, in liaison with coders, finance and their specialist societies to generate bottom up costs for individual interventions which may reduce the wide variation in reference costs which are currently being generated and have the potential to destabilise health economies.

Although the DH mission statement is a move towards care closer to home and patient choice, it is still not possible to record and reimburse for specialist activity out in the community which will potentially act as a disincentive for such initiatives. We have been arguing the case for a new discharge code for Hospital at Home so that national data and benchmarking can be derived for this form of standardised pathway which studies have shown to be safe and highly appreciated by patients. However, the cost (using current HRG) is around £500 which is a considerable underestimate bearing in mind that the patient may be reviewed at home on a daily basis for a week. This provides a further disincentive for a healthcare package which fulfils all the DH’s criteria for quality care.
It is perhaps understandable that when the drivers for NHS financial reform are based on a market place format there is a natural tendency to tread carefully in order to avoid serious financial instability but the concepts of PbR have moved rather more rapidly forward when compared with the sophistication and uptake of the coding building blocks upon which the financial language is based.

September 2009

Memorandum by Wolverhampton City PCT (COM 15)

The Health Committee (HSC) has announced an enquiry into commissioning in the NHS, focusing on the following points:

1. “World Class Commissioning (WCC)”: what does this initiative tell us about effective commissioning by PCT’s is?
   1.1 Although this initiative was designed as a developmental process for PCT commissioning it is inevitable that the results are used as an assessment of the current performance of PCTs as Commissioners.
   1.2 In effect World Class Commissioning complements the Transforming Community Services and Foundation Trust Programmes.
   1.3 The results from the first year of the WCC Assurance process show that PCTs in general are stronger on the first five competencies than on the second five competencies. This is not unexpected as PCTs have received clear and consistent messages on their responsibilities in relation to need to lead the health agenda locally involving public, patients and professionals.
   1.4 However clarity over time with respect to whether PCTs are operating in a market, and the nature of this market has been less clear. Most PCTs have been slow to grasp the need to operate and manage a market, within a formal contractual framework.
   1.5 The WCC process arguably indicates the potential direction for PCTs as commissioners, and the basis for the assessment of their performance, in the future rather current performance.

2. The rationale behind commissioning: has the purchaser / provider split been a success and is it needed?
   2.1 Commissioners given that they are effective have an important role in ensuring that services meet the needs of the local population, promoting choice and holding providers to account for their performance. Without this counterbalance to the professional and organisational interests of providers, significant imbalances occur in local health systems. These imbalances were at the most extreme in the C20th with World Class teaching hospitals surrounded by populations with very poor health outcomes and poor primary and community services.

3. Commissioning and “System reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?
   3.1 Commissioning as envisaged by WCC has a clear fit with the model described by “contestability” and the quasi market and Payment By Results.
   3.2 The “fit” of PBC with this model is less clear, based on experience to-date; more work is required to thoroughly align the incentives and checks/balances for PBC with the wider model. The current scope of responsibilities and effectiveness of Practice Based Commissioners is still highly variable.
   3.3 In practice, it is important to improve incentives and information to all of the key stakeholders in the health care system.

3.3.1 A more flexible and comprehensive system than the current PBR system is required to ensure the incentives to improve efficiency are optimised across Primary, Community and Hospital Services.
   3.3.2 Clarity on the nature of the market and the relative importance of competition or cooperation is required to avoid wasted effort and a clear focus on outcomes and objectives rather than processes.

4. Specialist Commissioning
   4.1 West Midlands PCTs have developed over a number of years robust specialist commissioning arrangements which are effective in commissioning these services.
   4.2 However they are a number of issues which need to addressed:

   — the rate of increase of the overall cost of specialist services which is not sustainable in the current economic climate;
   — the variation between PCTs on what services are commissioned on a specialist basis; and
   — the level and nature of engagement between specialist commissioning teams, PCT commissioners and practice Based commissioners.
5. Commissioning for the quality and safety of services

5.1 This area presents a significant challenge for PCTs, in recent years PCTs have begun to develop more robust approaches for both primary and secondary care providers, but much more still needs to be done. There is still a lack of clarity of what approaches PCTs should take, particularly in relating to hands on monitoring and how this relates to the Standards for Better health and the role of the CQC and Monitor.

September 2009

Memorandum by HEART UK (COM 16)

EXECUTIVE SUMMARY

1. This response concentrates on the issue of the effectiveness of commissioning and on the role of specialist commissioning.

2. HEART UK—The Cholesterol Charity—supports everyone at risk of cardiovascular disease and especially those individuals and families who are at increased risk due to an inherited cholesterol condition, of which the most important is familial hypercholesterolaemia (FH). Affected patients have a substantially increased risk of premature death from coronary heart disease, even in the absence of other risk factors. The estimated prevalence of FH is 1 in 500, suggesting at least 120,000 affected individuals in the UK. Despite the ready availability of diagnostic tests and excellent prognosis with preventive statin therapy, the condition remains under diagnosed, with only some 15% of cases having been identified and treated.19

3. In August 2008 the National Institute for health and Clinical Excellence (NICE) published a clinical guideline on FH, citing a cost per Quality Adjusted Life Year (QALY) of £2,700,20 comparable to the national NHS Health Checks programme. One year on, however, little or no progress has been made with the implementation the guideline in England.

4. The failure to develop services to identify and treat FH on the scale warranted illustrates problems at the heart of localised commissioning. Three particular concerns impede the commissioning of FH services:
   (i) Despite being based on evidence-based medicine, there is no requirement to implement the NICE programme.
   (ii) There is no additional or designated funding to support that programme.
   (iii) There is a lack of understanding/knowledge about FH among commissioners.

5. While commissioning can be an effective means of tackling issues at the local level, the current system can lead to some health conditions (such as FH) being missed. The present commissioning system can also lead to inequalities—for example, a cascade testing programme is being funded in Wales, but not in England, which will lead to poorer opportunities for FH detection in England.

HEART UK RESPONSE TO THE COMMISSIONING INQUIRY

6. HEART UK—The Cholesterol Charity—supports everyone at risk of cardiovascular disease and especially those individuals and families who inherit an increased risk due to a cholesterol condition. The estimated prevalence of familial hypercholesterolaemia (FH) is 1 in 500, suggesting 120,000 affected individuals in the UK. The condition is under diagnosed, with only some 15% of cases diagnosed.21 Critically, FH patients have a substantially increased risk of premature coronary heart disease. Some 50% of men and 30% of women with FH will have developed coronary heart disease by the age of 55 years.22 The disorder has an autosomal dominant mode of inheritance, with children and siblings of a person with FH having a 50% chance of inheriting the condition. Importantly, most people do not show outward symptoms that they have FH. However, an effective means of diagnosing FH is cascade testing, using a combination of DNA and cholesterol testing to screen for the likelihood of FH in relatives.

7. In August 2008, the National Institute for Health and Clinical Excellence (NICE) published a clinical guideline for the Identification and management of familial hypercholesterolaemia (FH). NICE has produced further information to help the NHS implement this guideline locally including audit support, a slide set, a costing template, and a costing report.23

21 Ibid.
8. Recommendations from the NICE guideline include:
   — cascade testing using a combination of DNA testing and LDL-C concentration measurement to identify affected relatives of those index individuals with a clinical diagnosis of FH; and
   — the use of a nationwide, family-based, follow-up system to enable comprehensive identification of people affected by FH.24

9. One year since the publication of the NICE guideline, as far as HEART UK is aware, no programmes have been commissioned in the whole of England. A pilot audit carried out by the Royal College of Physicians (RCP) demonstrates that there remains a serious gap in the provision of systematic family cascade testing.25 This is despite numerous successful pilots studies approved and funded by the Department of Health itself and the commitment of lipid specialists, clinical genetics services and Cardiovascular Networks.

10. In the case of England, the NICE guideline provides the best clinical and economic evidence to support the development of FH services. However, without a requirement to implement the guideline, and without additional, ring-fenced funding, the commissioning system simply does not support the further development of FH services. Indeed, one of the recommendations of the RCP audit is that NHS Trusts will need additional resources to find the undiagnosed cases, and funding to pay for DNA diagnosis of possible FH patients.26

11. The situation in England is contrasted with Wales, where funding has been designated by the Welsh Assembly and the British Heart Foundation to pay for a family cascade screening programme. Similarly, in Scotland, the Better Heart Disease and Stroke Care Action Plan is calling for a national forum for FH to be established by the Scottish Government Health Directorates. The strategy has supported the Aberdeen molecular genetics laboratory to undertake a pilot project of cascade testing for FH.27

12. The commissioning process can help local people determine needs and commission responses to meet those needs. However, without some central injection of funding and requirements to deliver a programme, certain services can be left behind, with inequalities emerging across the countries of the UK.

13. At present, the commissioning process does not facilitate straightforward progress on conditions like FH. Specialist commissioning is applicable to services with low patient numbers, though requiring a critical mass of patients to make treatment centres cost effective. In the case of FH, the numbers of people affected by it are currently considered too large to warrant specialised commissioning. However, we also know from the RCP audit that primary care trusts (PCTs) are not commissioning FH services. This may be, in part, due to a lack of knowledge about the condition and the implications of undiagnosed FH as a future burden on the health system. The lack of awareness of FH is compounded by the fact that symptoms of the condition rarely manifest themselves until it is too late and an episode (such as a heart attack) has already occurred. In the absence of short-term payback, commissioners see investment in future disease prevention as an unattractive option.

14. The House of Lords Science and Technology Committee recently published a report on genomic medicine. The Committee recommended the need to review the commissioning structure as genetics spreads further into the mainstream NHS, including measures to ensure that new genomic technologies and knowledge are integrated into the national health system.28 This is consistent with the RCP audit’s calls for the NHS to be appropriately resourced to provide for DNA diagnoses of possible FH patients. At present, that infrastructure simply is not available.

15. The problem for FH commissioning is that it does not sit comfortably within the current commissioning paradigms. The result is that, unless PCT commissioners are given clear directives, adequate funding and systems infrastructure for diagnosing and managing the condition, FH will continue to remain undiagnosed at great cost to the health service and families across the UK.

September 2009

APPENDIX

HEART UK is the nation’s cholesterol charity, committed to preventing premature deaths caused by high cholesterol and cardiovascular disease.

This submission is from the HEART UK Healthcare Committee and members of the HEART UK Familial Hypercholesterolemia (FH) Guideline Implementation Team.

24 Ibid.
26 Ibid.
Members of the HEART UK Health Care Committee:

Dr Sarah Jarvis, Chairman;
Professor John Betteridge;
Dr Alan Begg;
Ms Marian Byrt;
Mr Michael Livingston;
Mrs Linda Main;
Ms Michaela Nuttall;
Mrs Suzanne Watkins; and
Mr Richard Evans.

FH Guideline Implementation Team Members:

Dr Jonathan Morrell, Chairman;
Dr Dermot Neely; and
Dr Alan Rees.

Memorandum by NHS South Birmingham (COM 17)

NHS South Birmingham supports the response submitted by the NHS Confederation.

Supplementary views and supporting evidence are provided below.

1. Executive Summary

1.1 NHS South Birmingham believes that commissioning is accelerating in its' development and offers real opportunities for commissioners to be the advocate of the patient and the system manager. We can identify tangible improvements in care for patients as a result of a commissioning led approach.

2. World Class Commissioning—What does this tell us about how effective commissioning by PCTs is?

21. We are strongly of the view that the competencies do reflect a good overview of the things we need to do really well to deliver effective commissioning. Many of the concepts in WCC are not new, however, never before have we clearly articulated the standard to which we will need to deliver in all these areas to really do the best job for our local population. The process focussed PCT’s attention in the right areas and supported us as organisations to be ambitious in delivering for our populations. The assurance process was a good start, however, the challenge, as ever is to ensure the assessment is truly evidence based. We look forward to the focus on delivery in the coming year’s assurance process, rather than presentation.

3. Has the purchaser/provider split been a success and is it necessary?

3.1 The role of the commissioner is as the payer in the system and the system manager. We strongly believe that this is the right role for PCTs, acting as advocates for the population. We are well advanced in separation of our provider function and have been in the pilot phase for Community Foundation Trust status. This has allowed the PCT Board to focus on commissioning in a way which would not otherwise be possible. There have been tangible benefits, both in terms of the focus of the Board and the progress we have made as a consequence of really thinking of ourselves as commissioners.

3.2 We have had a robust approach with our provider organisation and have worked with the local population to redesign services. Service redesign is collaborative but it has been commissioner led with clearly developed service specifications for community nursing and therapies which challenge the status quo.

3.3 The role of the PCT is also to shift investment in the system. Over the last year as a PCT, we have shifted circa £20 million into preventative services to deliver our strategy. This includes obesity management, falls prevention services, risk assessment and screening and a big expansion in self care programmes. Without a commissioning organisation, there would be no incentive for existing providers to achieve this level of change.

3.4 Along with shift in investment, we can demonstrate areas eg diabetes redesign where significant change has been achieved by our leading clinical dialogue across organisational boundaries.
4. Commissioning and System Reform—How does it all fit?

4.1 The tension between competition and co-operation is a constant challenge and the boundaries ever changing, however, PCTs are becoming quite sophisticated at achieving this balance. We have a clear procurement strategy that guides our decision making in this area.

4.2 As commissioners, it is difficult to manage the system when there is not always the required flexibility in Payment by Results. Nevertheless there are contractual levers which we are increasingly using. We support the concept of choice, not just as a market lever, but as a fundamental human right. We support the development of individual budgets and recognise the further challenge this brings in terms of managing the market.

4.3 We see practice based commissioning or clinical commissioning as a key strand of our delivery. Primary care clinicians commit a significant proportion of NHS resources and so it is only by working together, we can successfully fulfil our commissioning role. We have significant service areas eg the development of community based outpatient clinics in dermatology, heart failure and ophthalmology where leadership from practice based commissioners has been key to successful service change.

5. Specialist Commissioning

5.1 We have good working arrangements for specialised commissioning in the West Midlands.

6. Commissioning for Quality and Safety

6.1 This is an area where the commissioning focus has really helped us in terms of taking a system wide view. We have developed a “Share to Care” programme to agree patient experience metrics and share them across the health economy. We are developing systematic ways of capturing patient experience data.

6.2 We have robust monthly quality meetings with providers where we review quality and safety including NICE compliance, audit programmes, serious untoward incidents and complaints. The PCT will use the contractual levers where necessary.

6.3 All specifications are signed off as clinically safe by a Quality Advisory Committee and we have a robust Medicines Management Strategy

6.4 We have developed clear mechanisms for monitoring primary care quality with a scorecard for primary care performance.

7. Summary

In summary, we strongly support the concept of commissioning and have tangible examples of where it has delivered significant change which has benefited local people. This involves a historic shift in emphasis away from the big acute hospitals towards a system where population health, prevention, primary care and management of long term conditions in the community become the drivers of local health care systems. Commissioning offers a clear way forward in terms of having a system manager focussed on the needs of the population with no self interest in any one provider organisation.

September 2009

Memorandum by the Association of Greater Manchester Primary Care Trusts (COM 18)

1. Background

1.1 The Health Committee has decided to undertake an inquiry into Commissioning, the terms of reference of which are as follows:

— “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

— The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

— Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

— Specialist commissioning; and

— Commissioning for the quality and safety of services.

1.2 This submission is made on behalf of the Association of Greater Manchester Primary Care Trusts (PCTs).
2. The Association of Greater Manchester PCTs

2.1 The Association is the vehicle supporting collaboration and joint working across the 10 PCTs in Greater Manchester. The Greater Manchester PCTs are:

- Ashton, Leigh & Wigan
- Bolton
- Bury
- Heywood, Middleton & Rochdale
- Manchester
- Oldham
- Salford
- Stockport
- Tameside & Glossop
- Trafford

2.2 The Association is not an organisational entity but an ethos of collaboration. The principle of collaboration across the 10 PCTs is strongly supported by the Chairs, PEC Chairs and Chief Executives as providing a mechanism by which PCTs can achieve economies of scale where that adds value but also retain an organisational structure that supports local engagement and local sensitivity. The Association is established to:

(i) Support the sharing of information and good practice across local health economies;

(ii) Support joint work across the PCTs to reduce unnecessary duplication of effort; and

(iii) Provide a properly constituted forum to support collective leadership of the GM health system.

2.3 The Greater Manchester PCTs work together when clear benefits for collaboration can be described, such as:

- Increasing effectiveness by joint working eg through reducing duplication or combining expertise
- Addressing specific issues/services spanning several or all PCT boundaries
- Where a single approach to implementation of initiatives across the whole of Greater Manchester is essential
- Where there is a mandatory requirement to work collectively
- Where other Greater Manchester stakeholders (local authorities, Police, Fire Service etc) might be supported through the delivery of consolidated and accessible NHS leadership.

2.4 Importantly, we would assert that the very existence of the Association represents a sign of increasing maturity in the commissioning system. This recognises clinical and service interdependencies across organisational boundaries and provides appropriate governance to manage them.

2.5 This submission may be seen as a supplement to written evidence provided by any individual Greater Manchester PCT.

3. Executive Summary

3.1 We believe it is important to encourage a maturing of the discussion on the organisation of the commissioning function acknowledging evidence of tangible developments in PCTs’ approaches to delivering the breadth of their responsibilities.

3.2 The establishment of a separate commissioning function we believe makes issues around prioritisation and accountability for resource allocation more transparent and explicit. This is essential in the context of the NHS constitution and the future challenges the NHS faces. The World Class Commissioning framework provides a useful basis for PCT assessment and records clear areas of success in PCTs across the competencies.

3.3 Our evidence points to progress in Greater Manchester of the PCTs delivering against a commissioning prospectus operating at a number of levels.

- A focus at community level—with clinical commissioning from practices to allow that to respond to highly local, known patient needs;
- A focus at the borough level—developing a population view and strategic plan across communities and generations to build a responsive and accessible local system across health and social care. This is the key footprint of integrated commissioning at the borough level in partnership with local government.
- A focus at the pan-PCT level—organising services for populations extending beyond those of the PCT through commissioning partnerships and Specialised Commissioning arrangements.

3.4 PCTs have been challenged to facilitate commissioning at the community level through clinicians, at the borough level with local authorities and at the pan-borough level in partnership with each other. In a remarkably short space of time, and against a backdrop of long established supply side dominance and further reconfiguration, PCTs can point to tangible examples of progress. The PCT role at each level is the only way to avoid otherwise inevitable disintegration according to institutional interest and fractured pathways of care. We hope our evidence provides a useful illustration of some of the key areas of note.

29 www.agmpcts.nhs.uk
4. “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

4.1 The national framework provided by the Department of Health has articulated the fundamental approaches and activities that make up “world class commissioning”—a framework that the NHS now looks to in assessing its management, development and delivery of care. We believe the establishment of an assurance process against recognisable core commissioning functions represents a positive step. In particular it supports local efforts to clarify the scope and complexity of the commissioner role to the public and local stakeholders, not least the providers of NHS services.

4.2 The experience of and learning from the first assurance round has also been positive, confirming significant areas of success and progress as well as emphasising quite clear development needs. We have, therefore, an opening position against which to drive and track the development of the commissioning function.

4.3 A summary of panel assessments for Greater Manchester PCTs offers clear recognition of success in PCTs’ engagement with partners and local leadership of the NHS. This is something we would have anticipated and would recognise to a significant degree as a consequence of coterminosity with the 10 local authorities in Greater Manchester following the most recent reconfiguration. Coterminosity on such a scale has allowed the Greater Manchester PCTs to accelerate integration and joint working with local government to a degree not often seen elsewhere. Critically, it has also facilitated engagement at the sub-regional level with AGMA representing the 10 local authorities collectively. The PCTs are therefore, fully engaged with, and appropriately represented in, the developing city region governance arrangements arising from Greater Manchester’s designation as a pilot statutory city region. The opportunities presented by the aggregation of leadership at the city region level of the NHS and local government serving a population of nearly 3 million people are considerable. This in itself is worthy of recognition in the context of any future assessment of PCT leadership capability and application.

4.4 The competency areas where PCTs showed greatest development need, are largely those which are newer to the organisations and those which challenge health systems internationally. In particular these included skills around market stimulation, procurement and contracting. The Greater Manchester PCTs took an early step to establish a shared service organisation, the Commissioning Business Service (CBS), to provide the skills, capabilities, and capacity to achieve optimum care outcomes and ensure value for money in procuring required services. The Commissioning Business Service concept, conceived by the Association in December 2004, recognised the need to strengthen business competencies that underpin the commissioning of health services for the NHS. Today, the CBS provides the largest network of commissioning expertise in the North West.

4.5 In the baseline year (2008/09) the Greater Manchester PCTs demonstrated evidence of international standard practice in a number of competencies (clinical engagement, local leadership and working with partners). The Greater Manchester PCTs also achieved amongst the highest scores nationally for governance. Significant steps have also already been taken to build skills in areas where we scored less well. The Greater Manchester PCTs have, therefore, established the foundations of strong leadership, effective partnerships and robust governance to ensure future assurance rounds will track an upward trajectory.

5. The rationale behind commissioning: has the purchaser / provider split been a success and is it needed?

5.1 There exists a clear rationale behind the separation of commissioner provider functions which has been described elsewhere:

- Improving technical efficiency by allowing purchasers to secure best value from a range of public, private and third sector providers;
- Allowing providers to concentrate on optimising provision, and commissioners to discharge their functions unburdened by the need to manage large organisations;
- Ensuring that services are designed around the needs of communities and individuals rather than service providers and professionals;
- Improving allocative efficiency by permitting purchasers to negotiate a new balance of services with providers;
- Encouraging more responsive provision by making clear the providers’ need to compete for the right to provide care;
- To clarify providers’ costs and the amount spent in each service area by comparing the services and costs of each provider; and
- To make accountabilities for prioritisation and resource allocation decision more explicit.

30 www.gmecbs.nhs.uk
5.2 The English NHS is challenged to balance high quality, clinically appropriate care with finite resources whilst delivering improved health outcomes for patients. This provokes a complex interplay between elements of the health system but emphasises the importance of the commissioners as custodians of the tax-payers interest, as advocates for individuals navigating a complex system of care and as accountable bodies for decisions on resource allocation and competing priorities.

5.3 The development of a clear commissioning function makes these elements more transparent and more explicit. We believe a retreat to a consolidated commissioner/provider function would fatally undermine the quality, clarity and depth of public debate on the relationship between individuals and the NHS at a time when that public discussion is most pressing.

5.4 More pointedly, the recent evidence is that the separation produces better management of care if we compare achievement of the 18 referral to treatment target across England and Scotland and Wales.

5.5 However, we would recognise risks which might clearly be associated with the split. In particular there is potential for high translation costs to negotiate, challenge, resolve and assure against service issues across organisational boundaries. This requires a maturity of approach which recognises and manages this risk. We would assert that PCTs are quickly developing the skills and processes to lead complex and ambitious system reform against this backdrop. The Greater Manchester PCTs would offer a number of examples in support of this assertion:

(a) Integrated Acute Stroke Care

The Greater Manchester PCTs have acted in concert since 2007 to reform the emergency response to stroke across the 10 PCT areas, developing a networked model of care across 10 acute trusts serving 2.5 million people. The model will ensure that all Greater Manchester stroke victims have 24 hour access to CT scanning with profusion and thrombolysis (if appropriate).

(b) Improving Outcomes Guidance for Cancer

Greater Manchester PCTs recognise the importance of “holding the ring” on system discussions to consolidate surgical activity in certain cancer services, applying clear designations to ensure that such activity serves a sufficiently broad population base. Whilst a negotiated arrangement across trusts is conceptually possible, a managed and transparent procurement exercise is more often necessary to ensure resolution.

(c) Reconfiguring Children’s and Maternity Services

The establishment of a formal joint committee of PCTs in 2004 oversaw what was at the time the largest public consultation in the NHS’s history to generate proposals to reshape children’s and maternity services across Greater Manchester. The Joint Committee also provided sufficiently robust governance to deliver a set of decisions to drive that reconfiguration across the affected PCT area.

6. Commissioning and “system reform”: how does commissioning fit with Practice Based Commissioning, “contestibility” and the quasi-market, and Payment by Results

6.1 The levers of system reform represent a mixed picture of development, application and impact. The overall judgement should recognise structural challenges for commissioners seeking, from a standing start, to influence change in local economies shaped largely by monopoly providers with little or no sizeable competition from the independent or third sector. The equivalent challenge to local government to stimulate and manage mixed markets of provision for example applied to a much broader range of services making up a much smaller proportion of overall spend.

6.2 However, recent illustrations across Greater Manchester in Tier 2 services, Clinical Assessment and Treatment Services and enhancing approaches to commissioning with the third sector, represent substantial progress in developing a more plural market with positive impacts on services to patients.

6.3 It is important to recognise that the technical levers available to support commissioners’ system reform intentions are always likely to be relatively limited. System reform rests on a process of clinical behaviour change and, subsequently, PCTs are developing more refined and subtle means of influencing change. For example, with a view to encouraging radical thinking on urgent care reform the Association held a Greater Manchester wide Urgent Care Clinical Congress to build a shared understanding of the case for change to optimise the delivery of urgent care services for local people. The event attracted over 100 clinicians to identify priorities for action on urgent care.

6.4 We have emphasised the fundamental importance of clinical leadership to drive system reform. We would add that clinical commissioning at the practice level is a highly desirable step in handing the service design page to the clinicians with the most developed sense of the needs of local communities. The associated responsibility for resource management is key to proactive pathway management to secure that balance in cost effectiveness and clinical appropriateness we emphasise above.

6.5 We would emphasise, therefore, the importance of the PCTs’ leadership and influencing role in driving system reform and positive service change whilst acknowledging current efforts to develop the technical competencies around contracting and system management. However we would also highlight the extent to which national policy can confound local economy efforts to balance supply and demand. NHS provider
organisations tend to have a high fixed-cost base and are rewarded for increased volumes under the NHS financial regime payment by results. They therefore have a major incentive to increase activity in order to secure increased tariff income at full cost, running directly counter to the objectives of commissioners.

6.6 The GM PCTs have taken tangible steps to develop the local provider market and position clinical commissioning at the heart of system leadership. We would also point to growing maturity in developing the influencing skills necessary to facilitate clinical leadership across disciplines. However, we would also emphasise the role national policy has in supporting local efforts across both providers and commissioners in tackling perverse incentives which are to some degree driven by PbR.

7. Commissioning for Quality & Safety of Services

7.1 We would recognise that the principal responsibility for quality and safety rests with clinical staff. However, recognising the role of PCTs to act as the custodian of public finances and as advocate for patients receiving care, PCTs have a clear stakeholding in efforts to drive and sustain quality and safety. PCTs would, therefore, point to realised efforts to challenge and enhance care quality of care, and to lead quality focussed system reform.

7.2 In this context the GM PCTs collectively developed an early Never Events list learning from international best practice to ensure patient safety lessons are learnt and implemented. The list includes the most serious events we want to be sure are prevented as far as possible. Healthcare providers are required to ensure that they have taken all reasonable steps to implement evidence-based control systems to prevent such events. This includes all healthcare providers (not just hospitals).

7.3 Across the NW, PCTs have worked with trusts and the SHA to develop Care Indicators in parallel with the regional Advancing Quality Programme and are included in the Regional CQUIN. The five pilot sites in the NW have shown some significant improvements in the quality of care provided for patients and there has been further development work undertaken to adapt the indicators to the urgent care, paediatric and midwifery services. The NPSA is intending to use the indicators developed in the North West, roll them out nationally and incorporate the indicators within their patient safety programmes.

7.4 A number of GM PCTs are also spearheading efforts to optimise local systems of care through programmes such as Triple Aim. The Triple Aim is a framework to optimise the health system and that requires participating organisations to structure their strategic drive through the three Triple Aim dimensions of improving the health of a defined population, the experience of the individual, and the per capita cost for the population.

7.5 We would emphasise the importance of a role in quality and patient safety for commissioners which is often under-recognised or simply not acknowledged. Recent experience in mid-Staffordshire emphasises the importance of whole system vigilance on quality and safety and we would encourage recognition of the commissioners’ role in relation to the development of provider Quality Accounts and local Quality Observatories.

8. Specialised Commissioning

8.1 Greater Manchester PCTs have a long history of collaborative commissioning for specialist and tertiary services. Whilst the list of services within the remit of Specialised Commissioning Groups are subject to national designation, the Greater Manchester PCTs are practised in, and have the governance to support co-ordinated commissioning for rarer services which nonetheless fall outside this designation.

8.2 The formation of the North West Specialised Commissioning Group (NWSCG) harmonises the work plans of the three former Specialised Commissioning Groups within the North West: Cheshire and Merseyside, Cumbria and Lancashire, and Greater Manchester. The NWSCG has been set up as a sub committee of the 24 North West Primary Care Trusts with the delegation of powers and lines of accountability clearly detailed in the Establishment Order of the NWSCG which has drawn on the best practice advice given in the Department of Health Review of Commissioning arrangements for Specialised Services May 2006.

8.3 Following recent review and engagement with member PCTs, the NWSCG is developing a revised governance approach which will strengthen non-executive involvement and challenge to specialised commissioning. Additionally, focussed work is now underway to analyse in detail activity across a range of NW services to address issues of demand management and service configuration.

8.4 We welcome the specific reference and intent to embed specialised commissioning arrangements in the second World Class Commissioning assurance process. This reflects our acknowledgement of PCT’s end to end responsibilities to deliver against a commissioning prospectus across the whole continuum of care.

8.5 We believe the step change improvements that have been delivered within the Greater Manchester healthcare system have only been made possible by the collective commissioning activities of the 10 Primary Care Trusts who have provided leadership throughout the service improvement described within this document.

September 2009
1. The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives and for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established of all clinical disciplines.

2. This submission has been prepared based on the input from our members, commissioners of maternity services who have no professional background in midwifery, and independent consultant Dr Suzanne Tyler. Whilst most RCM members work as clinicians or providers within provider units, there are a small but growing number of midwives who are working within PCTs advising and supporting the commissioning of maternity services. The different experiences of these groups have informed this evidence. Whilst commissioning clearly applies across to a full range of health services, our submission is focused on issues relating to the commissioning of maternity services specifically.

EXECUTIVE SUMMARY

3. The RCM welcomes the rigour and challenge that the commissioning process can add to the organisation and delivery of maternity services. However, we believe that it may be too early to accurately evaluate whether this approach to health care delivery has been effective. Further review and monitoring needs to be undertaken over the coming years in order to more clearly ascertain its impact.

4. Overall, we are of the view that:

4.1 Regardless of “who” leads the commissioning of maternity services, it has to focus on what is “right” for the woman;

4.2 Commissioners need to have a full understanding of the demographic and other factors associated with good/poor outcomes in maternity and their distribution in the local community. This will allow commissioning decisions to be made on the basis of an assessment of population need;

4.3 The application of Payment by Results to maternity services needs to be made more consistent, so that models of care are based on clinical effectiveness and evidence of impact on health outcomes, rather than by financial incentives. In practice this means that national tariffs need to apply to the whole maternity package, rather than only to specific elements;

4.4 There is a need to adopt a national minimum data set for maternity services, meaning that all providers record the same key elements of activity. This would achieve greater consistency in national data collection, as well as allowing PCTs to benchmark local provision in terms of quality and value for money; and

4.5 There needs to be open and constructive engagement between key players within commissioner and provider organisations. This includes systematic engagement between clinical staff, management, managers and those in contract negotiation roles, such as finance staff.

World Class Commissioning: How effective has PCT commissioning of maternity services been?

5. The RCM is generally supportive of the principle of World Class Commissioning (WCC) and welcomes the rigour and challenge that the commissioning process can add to the organisation and delivery of maternity services. This is reflected in the objective for commissioning outlined by one PCT, whereby "any activity is designed to ensure that maternity services are those judged to be the best possible to meet women’s needs, consistent with available resources and priorities, and are not just those which have been provided in the past or which have developed in an ad hoc or uncoordinated way”.

6. However, it is too early to judge whether WCC has had a lasting impact on maternity services. Many commissioners are only now beginning to get to grips with the complexities of maternity care, given it is a service which crosses acute, community and primary care and which can not be planned in the same way as much elective care.

7. Whilst maternity care has enjoyed high political and public attention over many years (including a number of Health Committee inquiries since the Winterton Report in 1992), it has rarely been a priority for NHS providers or commissioners. Only more recently, with the announcement of an additional £330 million in funding above tariff for service development and more particularly with the inclusion of required maternity outcomes within PSA targets and the last three NHS Operating Frameworks, have we seen maternity become a higher priority for PCTs and acute trusts in a systematic way. Given these multiple drivers, it is therefore difficult to assess whether it is the above imperatives or the impact of WCC that is delivering change in maternity services.

8. Given WCC implementation is still only in the early stages of implementation, there appears to be very little in the way of formal evaluation. However, what we can say is that there are still too many PCTs which do not yet possess the knowledge, expertise and skills in maternity services to commission robustly, nor is there adequate systematic engagement between key personnel within commissioner and provider organisations to ensure that the right information is reaching the right people. In particular:

8.1 Maternity services are often only a small part of a commissioner’s brief, meaning that it can be overshadowed by other areas of commissioning, and it can be difficult for providers to identify a PCT’s maternity commissioning lead;

8.2 We are aware of situations where lead commissioners and heads of service may have developed constructive working relations, but the main negotiations and decisions about contracts are taken by finance and contracting staff in both organisations, without any reference to the plans, intentions and priorities being discussed by those with service knowledge. Such disconnects represent a significant barrier to effective implementation of WCC.

8.3 We are aware of particular problems arising in London, where there are many small PCTs who each commission services from a number of providers. This includes multiple and inconsistent data requests from different commissioners to the same provider. That said, we understand that in the last six months networked commissioning arrangements are beginning to take shape; and

8.4 Based on the experiences of our members, the wider consideration of social care and public health in the commissioning process for maternity services is patchy.

The rationale behind commissioning: the experience of the purchaser/provider split in maternity services

9. Whilst the purchaser/provider split is by now an established structural element of the NHS, the mechanism for commissioning has developed more slowly, with the size, function and remit of PCTs continually evolving. It appears that commissioning of maternity services has lagged behind other acute services and, until recently, most Service Level Agreements were vague and unspecified, with many PCTs actually unaware of what and how much they really commission. On this basis, rather than proactively commissioning on the basis of understood population need, strategic priorities and analysis of value for money, it appears many PCTs have merely rolled over existing expectations year after year.

10. That said, over the last year, we have become aware of more PCTs approaching commissioning of maternity services in a more systematic fashion, involving the rigour of conducting a needs assessment and developing a service specification.

11. In our view, key obstacles to effective commissioning of maternity care are:

11.1 A lack of robust information on activity, cost and outcomes. There is no national or regional data set for maternity with providers all keeping information in different formats and PCTs having different information requirements;

11.2 A lack of clinical engagement with commissioning. In many NHS trusts, the Head of Midwifery post holder no longer occupies a strategic position, which means those with the most detailed expertise and experience are often not included in discussions with commissioners; and

11.3 Inadequate relations between the individuals leading negotiations. Without good structural requirements the effectiveness of much commissioning seems to come down to personalities. This includes whether individuals in both organisations are: interested; committed to negotiation; have the ability to make decisions; and are willing to engage. Unfortunately, based on the experiences of our members, there appear to be many examples of PCTs and provider organisations having combative rather than collaborative relationships.

12. In this context, we would argue that moving to more effective commissioning requires:

12.1 Each PCT having a full understanding of the demographic and other factors associated with good/poor outcomes in maternity and their distribution in the local community. This can be determined by undertaking a full maternity needs assessment or by working with colleagues in public health and child information to collate existing data;

12.2 Providers and PCTs being able to describe “what” is currently being commissioned in terms of antenatal, intrapartum and postnatal care, including the role of GPs, midwives and obstetricians and to accurately quantify “how much” is currently being commissioned including the aggregate number of contacts, the different professional contributions and the location of care; and

12.3 Open discussions and agreement between PCTs and Providers about the relative priority of ‘hard’ outcomes such as infant mortality, low birth weight, breastfeeding rates etc and the “soft” outcomes of choice and satisfaction.
Commissioning and system reform: the impact of Payment by Results and Practice Based Commissioning in maternity services

13. The RCM recognises that Payment By Results (PbR) is now a central part of health care funding and has invested considerable energy in assisting members to develop a clear understanding of this system and its implications for maternity care.

14. However, we do note that PbR was originally designed for elective surgery—with a focus on short-term acute-based episodic care. This means that it is not necessarily the most appropriate funding mechanism for maternity care on the basis that maternity care is often: over a longer time-frame; occurs in a range of care settings (including acute, primary and community); can cross geographical boundaries; and also frequently involves multiple inputs from different professionals.

15. The difficulties in developing accurate PbR tariffs for maternity were in part recognised this year when maternity received an 8% uplift on tariff price to compensate for previous under-funding. Whilst we are pleased that this need for higher tariffs has been recognised, we remain concerned that building accurate reference costs for maternity is still not achievable within many acute trusts, meaning that tariffs continue to be a poor reflection of the actual cost of the service.

16. The factors identified in paragraph 13 also contribute to another key area of concern—namely the inconsistent application of PbR across the maternity care pathway. Specifically, a number of key elements of maternity care (including antenatal and postnatal care outside of clinical settings) are not subject to a national tariff. Whilst local tariffs for these services can be negotiated between individual PCTs and providers, in the vast majority of cases these aspects of care are still included under block community contracts, making it very difficult for commissioners to gain an accurate picture of what services, and how much, is being provided. This approach can result in confusion during service negotiations, particularly if a PCT does not understand the different elements of maternity care. The fact that a significant number of women have antenatal and postnatal care near their homes but actually give birth out of area further complicates matters.

17. This use of different funding mechanisms for maternity care inside and outside of clinical settings can also inhibit service development and introduce perverse financial incentives. For example, under the current approach, providers will receive specified payments for each episode of care provided in clinical settings but only a set amount (ie. the community block contract amount) for care provided in the community (no matter how much is provided). On this basis, it is in a provider’s financial interest to shift antenatal and postnatal care from women’s homes to clinics either in primary or acute settings. Whilst this may be more straightforward (and generate more income) for providers, such a direction has the potential to limit innovation in maternity care as well as significantly reduce the degree of choice provided to women in relation to their maternity care. This is contrary to the choice guarantees under Maternity Matters and the direction of maternity care set by the National Service Framework.

18. On this basis, we strongly believe that the current approach to funding maternity care needs to be amended, so that all elements are funded on the basis of cost and volume, with a national tariff for all elements of the maternity care pathway. This would ensure that models of care are based in clinical effectiveness and evidence of impact on health outcomes, rather than being shaped by financial incentives.

19. On a more positive note, we recognise that that implementation of PbR has stimulated the collection of more robust activity data and hard evidence that begins to link ‘inputs’ to outcomes. This means that some PCTs are beginning to be able to explore activity levels and clinical outcomes, giving them the ability to challenge practice on an informed basis.

20. To make such collection more systematic and of broader application, we firmly believe there is a need to adopt a national minimum data set for maternity services, recording the key elements of activity. This would allow PCTs to benchmark local provision in terms of quality and value for money. There also needs to be national guidelines or benchmarks developed, so when variations in PbR activity levels are visible, commissioners are able to judge what constitutes the “right” level of activity.

21. An integral step in this process will also be ensuring that there are adequate infrastructure and data recording and collection systems in place. For many providers it has been a challenge to engage midwives in routine data collection given the lack of IT hardware (particularly for community midwives) and the inadequacy of most information systems. Adequate resources also need to be allocated to collection of data itself, both in terms of recording what clinicians are doing and then coding it correctly. We understand that it is often the clinicians themselves who do the recording and coding, which can often take-up significant amounts of time that could be directed towards providing more clinical care if there were dedicated staff for the recording and coding tasks.

22. In relation to Practice-based commissioning (PBC), the RCM is unaware of any serious developments within Practice based Commissioning to include maternity services to date. However, we are aware that some GPs have opposed recent strategic developments such as relocation of antenatal clinics to Children’s Centres and Direct Access to Midwifery care (both key elements of Maternity Matters and the NSF). We would be extremely concerned if these GPs were to use PBC as a way of undermining these developments by “opting-out” of some elements of the maternity pathway and making their own in-house arrangements. PBC must maintain integration and continuity of care to maintain quality and avoid increased costs.
**Commissioning for quality and safety of maternity services**

23. Whilst commissioners are fairly new to proactively specifying quality outcomes for maternity care, we are aware that there is increasing interest in ensuring both value for money and linking inputs to outputs. In particular a number of PCTs have used the new CQUIN targets as a way of prioritising improvements in maternity services, tying resources to a range of local priorities including: improvements in continuity of carer, reductions in C-section, improved satisfaction and reduced unit closures.

24. Many maternity providers would argue strongly that they live with the legacy of historic underfunding of their services, and certainly our members’ experiences of block contracts indicate that such contracts should not have been judged as adequate for the level of activity they supposedly included.

25. Whilst the RCM is pleased that maternity services are now a higher priority for some commissioners than in recent years; the experiences of midwife managers suggests there is a paradox to increased attention. Whilst PCTs and providers share ambitions to improve services, even where money is available, this can be difficult: the national shortage of midwives means many units are failing to fill funded vacancies and thus service developments are frozen. Equally, the establishment of specific maternity related targets can both act as a lever for raising the profile of maternity services and mean that only specific aspects of the maternity pathway may receive attention, such as breastfeeding initiation, rather than the whole care package.

26. For the future, the RCM’s hope is that more PCTs and providers, commissioners and maternity leads will engage in mature collaborative relationships, setting challenging but realistic projections for service development. Whilst it has been fairly simple to agree outcome measures for intrapartum care, less attention has been given to outcome measures in antenatal and postnatal care. Clearly outcomes need to be measurable, but they also need to be relevant to raising quality standards.

27. The overall commissioning aims of maternity services should be defined in relation too providing safe, flexible and accessible support for local women, babies and families in planning pregnancy, during pregnancy and labour, and in the period following the baby’s birth. Services should explicitly target inequalities in health, and aim to meet the needs of vulnerable or excluded groups of service users.

28. In our view, regardless of “who” leads the commissioning of maternity services, we believe there are certain key principles, embedded in WCC, that must be adhered to:

28.1 Commissioning has to focus on what is “right” for the woman, not for any one professional interest or organisation;
28.2 Commissioning decisions should be made on the basis of an assessment of population need;
28.3 Any local commissioning strategy has to be a translation of nationally accepted standards, guidelines, priorities and requirements; and
28.4 The maternity pathway has to be protected in order that women are able to move easily from antenatal care through intrapartum to postnatal care.

**September 2009**

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**Memorandum by Dr N D R Luscombe (COM 20)**

1. **INTRODUCTION**

1.1 Barnsley PCT seems proud that they ranked at number 4 out of 152 in the World Class Commissioning (WCC) league table in the Health Service Journal 5/03/09.

1.2 The criteria used were I believe strategy, finance and board.

1.3 Nowhere in this league table is the quality of healthcare mentioned.

1.4 Genuine world-class medical care is denied to Barnsley patients by a combination of under funding and PCT management incompetence not because of a lack of medical knowledge or ability.

1.5 The same managers who are rated as 4th in the WCC league table have been in post for years and healthcare for Barnsley patients is poor.

1.6 To protect patients we frequently divert them away from local services to ensure adequate but nowhere near genuine world-class medical care as one would expect in the USA or leading UK teaching hospitals.

1.7 Several of our patients have gone abroad for treatments because of the poor local WCC services. Many will use private medicine to circumvent local services which would delay, or deny them, decent treatment.

1.8 What is even more damning, following the influx of immigrants from the former Eastern Bloc countries, is their comments regarding access to local services and they contrast how much quicker and better services are in their native countries.
2. **Practice Based Commissioning (PBC) The Local Experience**

2.1 For about a year I went as the Practice’s representative to local PBC consortium meetings. It took only two meetings for me to realise that PBC locally was 2 different entities that would collectively produce nothing.

2.2 In my opinion, nothing has changed since. We have regular feedback about PBC and the same issues and problems are being discussed as before.

3. **The Local PCT View of Commissioning (PBC)**

3.1 It is clear to me that the commissioning process is seen by the local PCT as a means of reducing costs by devolving, or “commissioning” patient care to Primary Care which the local PCT sees as cheap compared with the Payment by Results tariff where they have no control over costs as these are fixed centrally.

3.2 The local managers feel that commissioning enables them to come up with “commissioning plans” to devolve work to local GPs for things currently done by local hospitals.

3.3 Barnsley has 35 GPs less than it should and even with the Darzi centres is still under doctored. An undermanned work force is being used to reduce PCT costs, not improve patient care, via PBC.

4. **Commissioning (PBC) the Local GPs’ Perspective**

4.1 Local GPs regarded PBC as a means to redesign and improve local services (designed by the same managers in charge of current commissioning) to benefit patients.

4.2 GPs are required to go through a very bureaucratic process in order to get anything done. This discourages innovation because of the time involved. It allows managers the opportunity to block or insist on changes to any proposal submitted.

4.3 The GPs involved are working full time as GPs and PBC is extra work. In contrast managers doing PBC do it as part of, not in addition to, their day job. Initially this was heavily stifled by a lack of funding for things like administrative support.

4.4 GPs have been coerced into participating in PBC through the threat of sanctions.

5. **The Result Locally**

5.1 Meetings inevitably stalled as managers adopted a top down approach and said this is what we want you GPs to do.

5.2 Decision making was impossible due to the fact that those managers sent to PBC meetings were junior and merely relaying the decisions of those more senior.

5.3 There was a clear agenda set by the PCT as to what they felt commissioning was namely “commissioning” GPs to do extra work to save the PCT money.

5.4 It was clear that GP (active) commissioning was not the way the PCT thought “commissioning” should work.

5.5 Former fundholding GPs quickly realised that there was to be no GP commissioning only GPs being “commissioned”.

5.6 While local manager numbers have increased, GP numbers have remained static. Our staff joke that every week in the local paper there are job adverts for more commissioners.

5.7 The local approach to commissioning in the number 4 WCC PCT that Barnsley PCT claims is best summarised in the diagram below:
6. **Some Examples of Local “Commissioning” and “Commissioning Plans”**

7. **A&E Attendances**

   7.1 One of the most “academically” qualified managers attending PBC meetings came up with the idea that if GPs spoke to patients this would reduce repeat A&E attendances by a small group of patients.

   7.2 This ill informed idea took almost two years to knock on the head. The manager was convinced that this would reduce unnecessary A&E attendances.

   7.3 A local teaching hospital consultant thinks that talking to patients leads to a 2% reduction in smoking. Talk to 100 patients about abusing A&E and 2 might not. 100 GP consultations @ £20 a time to save a few A&E attendances at £65 per patient per attendance.

   7.4 The audit of our practice’s patients revealed one alcoholic who attended every time an ambulance was called when they were unconscious, a chronic hypochondriac and a severely mentally ill patient with no insight.

   7.5 This was an example of local PCT WCC ideas.

8. **Orthopaedics**

   8.1 Local managers feel that physiotherapists are more qualified to treat patients than doctors. They have redesigned the orthopaedic referral process.

   8.2 Under the old system a GP would write to an orthopaedic consultant who would allocate an appointment based on the letter.

   8.3 The new system has 3 physiotherapists and 2 GPs with a special interest in orthopaedics (GPwSIs) screening all orthopaedic referrals. They try to send patients to see a physiotherapist or to the community musculoskeletal service run by GPwSIs rather than see a consultant.

   8.4 “Choose” and Book is used to redirect where possible all orthopaedic referrals to a referral management centre (RMC) whose role appears to be to send patients to community rather than hospital based services. We are told that the aim is to keep the money within the PCT and local hospital.

   8.5 When the referral letters have been screened the patients have to ring a call centre to be given their “choice”.

   8.6 Using Choose and Book to deny choice seems to be to reduce costs as part of WCC by ensuring that a referral to an orthopaedic surgeon (expensive) is replaced by seeing a physiotherapist or GPwSI (cheaper) regardless of what the patient/GP wanted (Choice).

   8.7 When I as a GP refer a patient I am asking for a more qualified opinion than mine, not a less qualified opinion and investigation to exclude a cause of back pain which might be surgically treated.
8.8 Under the current system in Barnsley most cases of back pain are assessed and treated by a physiotherapist. Some, after assessment, are referred for a MRI scan but this takes a couple of months.

8.9 The rationale for this is that only 25% of orthopaedic referrals result in surgery. It would appear that local commissioners thought if only 25% need surgery then it is cheaper for the 75% who don’t to see a physio who can screen out the 25% cheaper than an orthopaedic surgeon.

8.10 Unfortunately the commissioners cannot see the small but potentially dangerous side of this which is that:

1) physios cannot, and never have, operated. They do not know who is, or is not, likely to need or benefit from surgery.

2) physios have only seen a screened population of patients. They are very good at treating these who have been screened by orthopaedic surgeons or GPs.

8.11 I have seen several cases of sciatica caused by a slipped disc which in any first world country should, and would, have had an urgent MRI scan.

8.12 All of these were referred to see an orthopaedic surgeon and all referrals went via “Choose” and Book. All were redirected to see a physiotherapist who made things worse.

8.13 When they got the MRI scan results after two months of “treatment” it was clear that surgery was required which is what was asked for in the first place. WCC had delayed and, attempted to deny, them the correct treatment and subjected them to unnecessary pain.

8.14 To treat these patients as they would be in the first world I had to refer again to a local teaching hospital to see a surgeon to get the surgery.

8.15 If our secretaries make referrals for orthopaedics other than to Barnsley they are told not to do this by the local “Choose” and Book monitors.

8.16 Local managers seem happy with the system as it saves money.

8.17 This is not world-class medicine where an urgent MRI would be de rigueur for back pain with evidence of nerve compression. It is, however, local “world class” commissioning.

9. Coronary Care Provision

9.1 Barnsley has high rates of coronary heart disease (CHD). If one were in the first world the treatment of a heart attack (myocardial infarction MI) would be primary angioplasty.

9.2 At a recent meeting with a local cardiologist we were told that, at some point, Barnsley patients with a suspected MI would be diverted to Sheffield for primary angioplasty.

9.3 The cardiologist said the only thing holding it up was “the commissioners”.

9.4 I have been aware of this treatment for a while as it occurs in London and more recently Sheffield hospitals have been providing it on a 24 hour 7 day a week basis.

9.5 Unfortunately the “commissioners” in an area of high CHD deny Barnsley patients’ world-class care while they engage in WCC.

9.6 They do not treat life threatening heart attacks by investing in coronary angioplasty services but instead draw up “commissioning plans” to get GPs to screen large numbers of well patients to try and identify those at risk of CHD.

9.7 While prevention is good medicine and may pay dividends in 20 years time it is no good if you have your heart attack now and are denied world-class medical care while “world-class” commissioning occurs.

9.8 This was in one of the first commissioning plans I encountered and was so well drawn up that it took 8 months from proposing it until we knew what we should be doing. I still do not know exactly what we are supposed to be doing as despite a long meeting with the person in charge the plan was changed the next week.

10. Local Provision of Radiology Services to GPs

10.1 GPs need to access investigations for example blood tests and x-rays to help treat patients.

10.2 A few years ago, due to a local shortage of radiologists, the same managers that now provide WCC, felt that it was acceptable to send x-ray images electronically to Barcelona to be reported on. This meant x-ray reports were received by GPs 3 months after the x-ray was taken.

10.3 This system resulted in a patient with a persistent cough returning 3 months after their x-ray being told that it showed something on their lung. The Spanish x-ray report suggested antibiotic treatment and a repeat x-ray afterwards another 3 month wait.

10.4 The nature of the report and the patient’s symptoms made me refer him urgently to see a consultant who diagnosed his lung cancer.

10.5 I spoke to a consultant radiologist for an opinion on an x-ray and he asked did I know that we could get x-rays on our desktops?

10.6 We did not and we agreed to trial electronic delivery of x-rays to a GP’s desktop PC.
10.7 This has been an excellent addition to our diagnostic armoury. We now see x-rays, CT, MRI and ultrasound scans.

10.8 This has resulted in GPs spotting things that have been missed. For example, a lady sent home from A&E with a painful foot was told nothing was wrong. She had requested a home visit because of the pain but a look at her x-ray suggested 3 broken bones so a return trip to A&E was more appropriate.

10.9 In my opinion access to x-rays has been of great benefit to me as a GP and I believe from talking to colleagues that this is available else where in the country.

10.10 When I spoke again to the consultant radiologist and asked him how the roll out was going he told me the managers had blocked this. I asked him why? He told me because of “confidentiality”.

11. IT SUPPORT

11.1 One of the biggest obstacles to commissioning locally is the inability of the PCT to provide our consortium with information. Barnsley PCT has very backward IT provision.

11.2 The biggest stumbling block appears to be a reluctance of those in charge to provide information they have to PBC consortia and a failure to allow consortia to use software that the PCT has in their possession.

12. REFERRALS

12.1 The local PCT say 60% of referrals to the local hospital are not from GPs but from consultant to consultant. Consultant to consultant referrals bring no income under Payment by Results and they have commissioned a protocol that prevents this.

12.2 This means a consultant identifying a problem has to send the patient back to see their GP to ask for a referral.

12.3 This delays patient care and creates extra work for GPs. It depends on a patient coming back to see a GP or a GP picking up from a letter that the consultant wants a referral doing.

12.4 Often hospital letters will say they have referred a patient but that referral is in effect “blocked”. The first we find this out is when a patient says “I saw Dr X at the hospital 6 months ago who said they would refer me but I haven’t heard anything”.

12.5 GPs then have to waste time tracking a referral which, because it attracts no money, has been ignored. Usually another referral has to be done to ensure Payment by Results for the hospital but more importantly the treatment of the patient.

13. COMMISSIONING OF DISTRICT NURSING AND HEALTH VISITING: COMMON FAILINGS

13.1 Commissioning locally has been disastrous for patients by the removal of district nurses (DNs) and health visitors (HVs) from being practice based to working in teams. This, we are told, is Department of Health policy.

13.2 The removal of these has resulted in the loss of daily face to face communications.

13.3 Referrals now take longer.

13.4 What used to be care by a limited and accountable group of DNs/HVs is now replaced by an unaccountable morass of unidentifiable individuals.

14. SPECIFIC PROBLEMS: DISTRICT NURSING

14.1 Feedback is non existent. Any preventative intervention has been replaced by a purely reactive approach.

14.2 Local managers insist that all messages are sent to a central communications centre which shuts for lunch for an hour. It takes at least an hour to get through and messages are corrupted as a result.

14.3 Of the five district nurses in our practice team only one nursing auxiliary remains. The others have voted with their feet.

14.4 The unaccountability means work avoidance eg being told a nurse could not get blood after 2 attempts. A surgery health care assistant went out and got blood first time to be told that no one had been. This is not an isolated case.

14.5 An attempt to “improve” things has meant the big team (there were 3 to start) is now two teams one of which covers our patients as a practice but not based here.
15. **SPECIFIC PROBLEMS: HEALTH VISITING**

15.1 The current model for health visiting is I believe the highly successful Doncaster model and has taken 3 years of PCT planning.

15.2 Instead of HVs being responsible for Practice registered patients, they are now responsible for a particular geographical area. In some areas this might mean there is just one GP Practice but in others it might mean them covering 20 separate GPs’ patients.

15.3 Communication is now a central telephone number with an answer machine with the default message on it. No one is happy to leave patient details on an unidentifiable answer machine. For the system to work and identify who the responsible HV is it would mean giving the child’s details including their address.

15.4 The system is complicated for patients who may have a HV who sees them at home based but might receive their immunizations at their surgery which is covered by another set of HVs due to its location.

15.5 It is not difficult to see how follow up will be affected. If a baby misses health checks at a surgery under the old system the same HVs would follow them up. Under the new system this could be missed as 2 separate HVs are involved who may be separated geographically and not meet.

15.6 Several of us complained about the inherent safety failings in this system in January this year. We were promised a review and have heard nothing. Lord Laming was able to review Haringey and publish a report in 4 months.

16. **SUMMARY**

16.1 I hope I have given an objective account of some aspects of commissioning in Barnsley.

16.2 It appears to be being used locally as a mechanism to save money not improve patient care.

16.3 I think that the House of Commons has recognized this previously in paragraphs 38-44 of NHS Next Stage Review Health Committee Contents 3. Key Issues.

16.4 I doubt any local commissioner is aware of these paragraphs for if they were they would not have had to spend £ 50,000 on management consultants to tell them why PBC and WCC is not working locally.

16.5 World-class care for our patients should be the aim of all those in healthcare not WCC which denies world-class care.

16.6 Cost and care effectiveness are one thing. Cost cutting and care reduction is all that seems to be achieved locally by WCC.

*September 2009*

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**Memorandum by the National Rheumatoid Arthritis Society (COM 21)**

The National Rheumatoid Arthritis Society is now recognised as the leading charity in terms of support for Rheumatoid Arthritis. The charity was founded in 2001 and supports patients, their carers and healthcare professionals in delivering care and support to people living with this debilitating disease.

RA is a progressive autoimmune disease which attacks the joints, resulting in long-term damage and therefore early diagnosis and referral to specialist care is key for this group of patients. However, there is significant evidence that RA patients often experience delays in being diagnosed with the disease and referred onwards for specialist care.

1. The nature of RA as a disease means that strong commissioning is vital to ensure patients are identified early in primary care and referred quickly to specialist services for treatment and care in order to keep their disease under control.

2. PCTs currently do not have an accurate understanding of the RA needs of their population in order to commission RA services effectively and in many cases; they are not talking directly to the frontline staff involved in delivering the care.

3. Although commissioning is essential for establishing the process for referring patients to specialist care, primary care practitioners also need to be aware of the disease in order to spot its symptoms. The NAO Report and the Kings Fund Report show that the education gap is very wide across the Country.

4. The development of the Inflammatory Arthritis commissioning pathway is a welcome step, but significant variations remain in access to timely specialist care and treatments for patients and just because the Pathway exists, it does not mean that it will be adopted, especially if the knowledge amongst Commissioners and PCTs is lacking in terms of disease complexity.

5. Many commissioners are currently failing to ensure that key policy recommendations, such as the Musculoskeletal Services Framework and the NICE Guidelines for Adults with RA, are being effectively implemented in local health economies.
6. RA and wider musculoskeletal services appear to have been deprioritised through the World Class Commissioning assurance processes. Only three PCTs prioritised a musculoskeletal outcome indicator and the programme receives a disproportionately low level of prioritisation compared overall NHS spend. This is not helped by the lack of education and understanding of the disease, the risk factor associated with CHD for example is on a par with Type 11 diabetes. This is often not known and certainly not prioritized in the same fashion for RA patients as it is with diabetic patients.

7. Accurate information needs to be collected on patient outcomes in order to inform future commissioning and to potentially realize the cost savings that are noted in the NAO Report.

1. The nature of RA means strong commissioning is needed to ensure early identification, referral and monitoring of patients

1.1. RA is a progressive autoimmune disease which attacks the joints, resulting in long-term damage. Early diagnosis and referral to specialist care is key for this group of patients. There is however, significant evidence that RA patients often experience delays in being diagnosed with the disease and can experience long delays in referral onwards for specialist care. The recent National Audit Office report found that people with the condition visit a GP on average four times before being referred to a specialist for diagnosis, and 18% of patients visit their GP more than eight times. These delays in onward referral are often exacerbated by patients delaying seeking medical help about their symptoms; around a fifth of patients delay seeing their GP for a year or more.33

1.2. It is therefore essential that we have an effective commissioning process to ensure that once patients have presented to their GP with possible symptoms of RA, they can be swiftly diagnosed and put on appropriate treatment. The recent clinical guideline published by the National Institute for Health and Clinical Excellence (NICE) states that the sooner a patient is diagnosed with RA and treated with Disease-Modifying Anti-Rheumatic Drugs (DMARDs), the better the long-term outcome through reduced damage to the joints.34 This three month window of opportunity, also recognised in the 18 Week Commissioning Pathway for Inflammatory Arthritis,35 from the onset of symptoms to first treatment means that strong commissioning is needed to ensure GPs are able to refer patients in a timely way for diagnostic testing, such as imaging and blood tests, and then for specialist care and treatment as appropriate.

2. PCTs need accurate assessments of local demand for RA services in order to commission effectively

2.1. In spite of the evidence for this “window of opportunity” for maximising potential health outcomes for the patient, commissioning of appropriate RA services does not currently meet the evidence base that supports rapid referral or the demands of patients at early onset of the disease. Only 10% of people with RA are currently treated within three months of symptom onset, and the average time from GP referral to first visit with a consultant has remained constant at around six weeks since 2003.36

2.2. Although the IA Pathway provides commissioning guidance for RA services, there is evidence that the split between purchasers and providers has created barriers to the highest standards of treatment and care for RA patients across the country. Variations in access remain, often because some PCTs, as purchasers, have an inadequate assessment of local health needs, and therefore are not commissioning effectively from providers. We have had many phone calls from members that have actively taken part in patient participation. Services for people with rheumatoid arthritis, within their localities, commenting that rheumatologists have not been present at service redesign meetings as well as Rheumatologists themselves calling to inform us of redesign of their local services without any consultation with them around the clinical needs and priorities of IA patients, whose needs are very different to those of osteo arthritis for example.

2.3. Weak commissioning of appropriate services stem from inaccurate purchaser understanding of the RA health needs of its local population. The National Audit Office (NAO) found that Primary Care Trusts (PCTs) are currently not commissioning RA services based on accurate assessments of demand, as only 11% of PCTs responding to its census reported that they had compared the number of people in their area against the expected number of cases.37 This means that most PCTs do not know if they are effectively identifying patients with the disease, this means that they do not know whether they are commissioning sufficient capacity in the system to treat them. As the NAO states, this is in spite of the development of the World Class Commissioning framework which requires PCTs to commission evidence-based services. Moreover, it is critical that specialist understanding of the needs of RA patients is sought in order to commission services effectively, given RA patients’ needs for ongoing support and monitoring of their complex condition.

33 National Audit Office, Services for people with rheumatoid arthritis, July 2009, page 5.
34 National Collaborating Centre for Chronic Conditions, NICE clinical guideline 79, Rheumatoid arthritis: The management of rheumatoid arthritis in adults, February 2009.
2.4. There is also evidence that barriers exist for patients in accessing ongoing specialist care once they have had a first appointment with the consultant. RA patients require ongoing monitoring of their condition in order to manage flare-ups and ensure that treatment is appropriate for their disease on an ongoing basis. However, research suggests that the focus on commissioning services to meet the 18-week target between GP referral and specialist appointment is having a detrimental impact on patients who have already been diagnosed with the disease. The new NICE Guidelines state that a newly diagnosed RA patient should be monitored monthly until their Disease Assessment Score (DAS score) is under control. The centres that could provide this type of service would be few and far between.

2.5. A recent report by the Rheumatology Futures Group found that rheumatology health professionals are reporting greater delays in seeing patients with existing disease because of the focus on the ratio between new and follow-up patients. Moreover, anecdotal evidence suggests that clinicians may have to “play the system” by registering patients as new diagnoses, even when they have been identified with the disease and already had an initial appointment with a consultant, in order to ensure that patients have the opportunity for follow-up specialist care. This is not effective use of NHS resources as hospital consultants are reimbursed for a new diagnosis, which is more costly than for a follow-up appointment.

3. Commissioners are not currently ensuring that key policy recommendations are being effectively implemented in local health economies

3.1. Recent research has highlighted that commissioners at PCT level are currently failing to implement fully national policy recommendations on RA services. The Musculoskeletal Services Framework was published in July 2006, there was no formal funding to develop and improve service capacity, and a lack of national clinical leadership. Recent analysis by the Arthritis and Musculoskeletal Alliance (ARMA) has found that there is poor implementation of the framework’s recommendations: only 16% of PCTs which responded to ARMA’s Freedom of Information requests had mapped their current resources and their use by people with musculoskeletal conditions, and there is considerable variation in spending on musculoskeletal conditions between different areas of the country. Moreover, in spite of the framework’s focus on Clinical Assessment and Treatment Services for musculoskeletal conditions as a “keystone” in this area, more than one in five PCTs do not operate these.

3.2. It is clear that existing national policy is not being implemented fully at local level, if this were to be the case; we would not see significant variations in access to high quality services for RA patients around the country.

4. RA is under prioritised by PCTs, resulting in a lack of commissioning focus on improving services

4.1. A recent analysis of the priorities developed by PCTs as part of the World Class Commissioning process found a worrying lack of focus on RA or indeed wider musculoskeletal services. Only three PCTs selected an indicator relating to musculoskeletal conditions and this related to falls prevention in all three cases, rather than an indicator which can impact on RA. This is despite the high prevalence of musculoskeletal conditions and their significant impact on NHS budgets.

4.2. The result of the first year of the World Class Commissioning assurance process is that when compared to overall NHS spend, musculoskeletal conditions such as RA have been significantly under prioritised. This is quite remarkable, given that Musculoskeletal conditions are the sixth highest overall area of NHS spend. This lack of focus is even more worrying given the imminent slowdown in increases in NHS expenditure. The NAO report identified that significant savings could be made through more effective management of RA, and more needs to be done to ensure that PCTs are prioritising improvement in RA services.

5. Greater public and professional awareness of the disease is needed to assure effective commissioning for RA services

5.1. While appropriate commissioning mechanisms are needed to allow GPs to refer patients promptly for diagnostics and specialist care, there also remains a broader challenge concerning education that needs to be addressed. Current levels of public and professional awareness of RA are low, so patients often get confused around the term “arthritis” and do not associate their symptoms with the possibility that they could have an autoimmune disease and may delay seeking medical help. GPs may not have a detailed understanding of the symptoms of RA, given that they are likely to see less than one new case of RA a year, and therefore they may not recognise the patients’ symptoms as a possible indication of RA. A public

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campaign/education programme would tackle low professional awareness and would enable GPs to consider the possibility of RA earlier, and therefore refer patients onwards more quickly for testing and appropriate support. Patients would also then be aware that arthritis comes in many forms and that they should seek medical advice at the onset of their symptoms.

6. **There should be comprehensive implementation of the IA commissioning pathway to reduce variations in access to treatment and services**

   6.1. RA is a complex disease and hence a complex service area and commissioners have historically lacked the expertise to effectively performance manage expert providers. Therefore, it is particularly important that commissioning support tools and resources are developed for RA and that frontline staff are actively engaged in the commissioning process.

   6.2. There have been some welcome developments with regard to evidence this year towards strengthening commissioning of RA services. These offer significant opportunities for tackling the problems associated with early diagnosis and secondary referral identified above. The publication of the IA commissioning pathway offers clear direction to PCTs about the appropriate mechanisms required for effective care and support for RA patients. Combined with the NICE Clinical Guideline also published this year, there is now a comprehensive commissioning plan in place for PCTs to follow to ensure high quality RA services. NRAS will also be overlaying the IA Pathway with a Patient Pathway. This will provide a complete, comprehensive picture of the RA journey for patients, their carers, healthcare professionals and commissioners.

7. **Accurate information on patient outcomes should be collected to inform future commissioning decisions**

   7.1. It is vital that information is not only collected on the demand for RA services of the local population, but also gathered on RA patient outcomes to inform the future commissioning of services. This would allow PCTs to make the best use of resources and enable them to plan effectively for the future. It includes PCTs’ considering more innovative configuration of services in order to meet patients’ needs, such as moving care into community settings, through specialist nurse visits and telephone-based outpatient consultations. Care must be taken however, to not fragment services. The treatment of RA requires the expertise of a multi-disciplinary team that is Consultant led, it is not important to the patient if this team is not in a big hospital setting, as long as the team is accessible and in one place.

   7.2. Cost savings to the NHS can be made by reducing unplanned emergency admissions when flare-ups may occur, and support patients to self-manage their condition without repeated specialist appointments. This brings benefits to patients by providing care in a setting more convenient, closer to home and comfortable for them, and which improves the overall patient experience. By collecting accurate data on patient outcomes, commissioners will have a better understanding of the impact of a range of services on RA patients.

**Recommendations**

In order to support more effective commissioning of RA services, NRAS believes that:

- A national strategy for RA should be developed by the Department of Health which would reflect the high burden of disease and the significant cost implications. The strategy should set out the outcome metrics which PCTs should use to monitor improvements in the service delivery and performance management of its providers.

- We would ask that a national clinical director should be appointed in order to provide clinical leadership and support PCTs in effectively commissioning RA services. This should build upon the successful model established for cancer in the form of clinical networks and other high priority conditions.

- The national strategy should also set out the role for SHAs in providing strategic oversight of PCT commissioning decisions.

- There should also be a national strategy that includes plans for a comprehensive programme to improve public and professional awareness of RA; this would encourage earlier presentation and diagnosis of the disease.

- Tools should be developed to support the commissioning process. PCTs need to effectively benchmark the performance of the services they commission against those of comparable health economies.

We would welcome the Committee’s consideration of these recommendations.

*August 2009*
Memorandum by Weight Watchers UK (COM 22)

EXECUTIVE SUMMARY

1. Commissioning of weight loss services for adults does not appear to be offering equality of access

Over the last five years Weight Watchers (WW) has invested significant resources in developing, refining and evaluating an effective weight loss intervention which the NHS can commission for overweight and obese adults. Currently, over half of the Primary Care Trusts (PCTs) in England engage with the Weight Watchers Referral Scheme (WWRS) which consists of a pack for 12 weeks’ worth of WW meetings. Whilst most PCTs offer this intervention free of charge to patients, individual access varies. Each PCT sets its own criteria for eligibility, choosing to focus on treatment and/or prevention of overweight and obesity. Many PCTs purchase packs on a pilot basis (less than 250). Five PCTs purchase on a larger scale (over 3,000) and proactively publicise referral to WW, amongst a range of weight management services, in their local communities.

2. Referral to WW through GP practices does appear to help many patients lose weight with significant health benefits

Preliminary analysis in 2007 of 1058 referrals drawn from 21 PCTs suggested that 55% of patients attended every meeting of the 12 week intervention. Amongst these patients the average weight loss was 5.2kg. GP practices seemed to favour referring obese rather than overweight patients (median BMI was 35.2 kg/m²) and 88% of those referred were women. Furthermore, recent forecasting conducted by the Foresight team indicated that this realistic 12 week intervention, which achieves a modest weight loss, could, if maintained for life, result in a 20% reduction in individual risk of diabetes and a saving of over £200 per intervention person to the NHS budget.

3. There are no criteria to evaluate effective weight loss interventions

There are a number of commercial providers (both potential and current) of weight management interventions for adults to the NHS. Commissioners do not have clear guidance on which of these interventions are deemed effective. Some have been researched, yet there is a wide spectrum of quality and hierarchy in such evidence. All of this constitutes a central issue for commissioners. There needs to be transparency and consistency in the criteria for evaluating weight loss interventions most likely to be effective, culminating in an approved list of providers.

4. In-house and commercial capacity—the WWRS offers industrial scale commissioning opportunities with clear economic benefits for NHS commissioners

Potentially, over half the adult population in the UK needs access to some sort of weight management service. The NHS has limited capacity to tackle this rising epidemic of obesity. In contrast WW has the operational capacity to deliver an industrial scale of service, with over 6,000 meetings per week, across all regions of the UK, facilitated by over 1,700 leaders trained in helping people adopt healthier behaviours. There is a strong cost effective argument for commissioning commercial providers such as WW to provide the resource-intensive weekly support deemed essential for effective weight loss, on the required industrial scale, in order to spare the highly specialised care provided by health professionals for more complex cases of obesity.

5. World-Class commissioning: shining examples

Two examples of world class commissioning of the WWRS: Walsall PCT has been proactive and forward thinking, working on a large scale in its approach to tackling the obesity challenge; South Staffordshire PCT, whilst working on a smaller scale, has developed a robust and effective way to achieve effective results with the weight loss challenge in its area.

6. Current commissioning processes for weight management services inhibit world-class commissioning

The current NHS commissioning process for weight management services is increasingly unwieldy, and the tendering processes are time-consuming, over-complicated and lack flexibility.

7. Next steps

We propose four clear steps for improving the commissioning of weight management services for adults:

1. To improve equality of access and avoid the current postcode lottery:
   (a) funding for weight management services within each PCT should relate directly to levels of overweight and obesity within that population;
   (b) standard criteria should be agreed nationally for eligibility for weight management interventions.

2. The DoH and the cross Government Obesity Unit should develop an approved list of providers of weight management interventions for adults based on transparent criteria for safe and effective weight loss services for adults.
3. The DoH and the cross Government Obesity Unit should facilitate the sharing of best practice in commissioning weight loss services for adults between all PCTs. This should include ensuring higher awareness amongst front line staff of available weight management services and better skills and services to “match patient to service” to maximise potential outcomes.

4. PCTs should engage with providers pre-tender, to develop service level agreements for weight management services to ensure the specificity and sensitivity to local needs appropriate for effective weight loss.

EVIDENCE

1. The Weight Watchers Referral Scheme—an example of specialist commissioning that does not appear to be offering equality of access

1.1 Currently more than half of all PCTs in England have commissioned the WWRS. Following extensive piloting the scheme was introduced in 2005 (Poulter and Hunt 2007). It enables health professionals to refer their overweight and obese patients for 12 weeks’ worth of WW meetings. PCTs buy this subsidised service and most offer it to their patients free of charge. Patient progress is recorded centrally by WW and evaluation reports with compliance and weight change information are fed back to PCTs.

1.2 Currently there is a clear lack of equality of access to the WWRS both between and within PCTs, creating a postcode lottery situation.

1.3 The funds available for commissioning weight management services vary enormously between PCTs. There does not appear to be a direct and consistent relationship between levels of overweight and obesity within a population, and funding for weight management services. In addition, each PCT sets its own criteria for eligibility. Some PCTs focus commissioning on treatment and/or prevention of overweight and obesity. For example, some PCTs offer the scheme only to patients with a BMI over 30kg/m², whilst some offer the scheme to those with a BMI over 26kg/m².

1.4 At the moment, many PCTs purchase packs on a pilot basis (less than 250). A small number of PCTs purchase on a larger scale and proactively publicise referral to WW, amongst a range of weight management services, in their local communities. Some PCTs offer the intervention to all, and some to a select few.

1.5 In order to improve equality of access:

— funding for weight management services within each PCT should directly correlate to levels of overweight and obesity within that population; and

— standard criteria should be agreed nationally for eligibility for weight management interventions.

2. The efficacy of WW’s programme and methods—central to the quality, safety and effectiveness of the service it offers to PCTs

2.1 There is strong evidence underpinning both the WW programme and its methods, which are based on weekly group support and healthy behavioural change. WW meets the best practice standards issued by the National Institute of Health and Clinical Excellence (NICE 2006—see Appendix 2). WW controls the quality and credibility of its programme delivery by centrally producing core and weekly programme materials that are approved by a qualified Health Professions Council registered health professional, and standardised training for leaders.

2.2 WW is committed to ongoing independent evaluation, both qualitative and quantitative, to ensure the quality of its service and effective weight loss outcomes. For example:

— A two year randomised controlled trial study in the USA (Heshka et al 2003), involving 423 overweight and obese adults, showed significantly greater weight loss outcomes at one and two years in the WW group compared to the self help group.

— Follow up studies of WW members who met their target weight five years previously showed that over half of these had maintained at least a clinically significant 5% loss from their starting weights (Lowe et al 2001; Lowe et al 2004).

— An initial audit of 1,058 WWRS patients from 21 PCTs was carried out in 2007 by Dr Susan Jebb's team at the Medical Research Council in Cambridge. Results suggested that 55% attended every meeting of the 12 week intervention and amongst these patients the average weight loss was 5.2kg. GP practices seemed to favour referring obese, rather than overweight patients (median BMI was 35.2kg/m²) and 88% of those referred were women (Poulter and Hunt, 2007).

— A two-year randomised controlled trial has been commissioned to compare outcomes (weight change and clinical indicators) between patients referred to WWRS and the usual care provided by GP practices in three countries including the UK. This trial is due to report in 2010.
3. Commissioning for the quality and safety of services—criteria needed for effective weight loss interventions

3.1 The quality, safety and effectiveness of commercial weight management services and products vary enormously. Whist commissioners have clear guidance from NICE (2006) on evaluating the safety and quality of weight loss interventions, there are no comparable criteria for evaluating effectiveness. In other words there is no clarity on the level of evidence above which commissioners can deem weight loss interventions effective. In WW’s case:

— The NICE (2006) review recognised WW as the only commercial programme with a good quality randomised controlled trial published in a high impact scientific journal demonstrating its efficacy.

— WW has conducted a wealth of evaluative studies to investigate the effectiveness of the WWRS.

3.2 The NHS should procure evidence based services. However most services, including in-house NHS-developed weight management interventions, are lacking evidence to support their efficacy. There should be a level playing field for all, with clarity and transparency over the evidence requirement for the NHS commissioning of weight management services, culminating in an approved list of providers for adult weight management services.

4. WW offers much needed opportunities for “industrial scale” commissioning of weight management services

4.1 By 2050, nearly 60% of the UK population could be obese. Without action, obesity related diseases could cost the Government an extra £50 billion per year (Foresight, 2007). The cross government strategy “Healthy Weight; Healthy Lives” has identified primary care as one of the key channels to deliver personalised advice and support to people who are already overweight (HM Government, 2006). Yet surveys have identified that capacity for obesity management within GPs practices is limited (Dr Foster 2005). Additionally the Darzi review recommended that “systematic and industrial scale” interventions are needed to tackle obesity and the resultant long term conditions such as diabetes and coronary heart disease (CHD). In his view the NHS is required to commission obesity management services on a national scale to make any meaningful impact on this rising epidemic (DH, 2008).

4.2 Research has repeatedly shown that different weight loss approaches suit different people (Truby et al, 2006, HDA, 2003). In addition, the overweight/obese population is a mixed group, some with highly complex issues. As a consequence the service needs of this population are diverse. Relatively small numbers of obese patients with complex health problems require specialised treatment from multidisciplinary teams of health care professionals. Others require one:one style interventions from health professionals such as dieticians, practice nurses or GPs. Then there is a large group of the overweight/obese population which is likely to respond well to group support interventions.

4.3 The WWRS encourages cost effective use of NHS resources because it spares the very skilled input which qualified health professionals provide and means that PCTs do not have to develop their own group interventions, helping to maximise the cost effectiveness of obesity treatments at PCT level. With the WWRS model, the referring healthcare professional continues to maintain ultimate clinical responsibility for the patient, whilst WW delivers the intensive regular service considered necessary to achieve effective weight loss and maintenance.

4.4 An economic analysis of WW was undertaken by the Health Economics Consortium at York University, to assess the relative costs and benefits (in health terms) of WW methods. The study suggested that WW is a cost effective intervention for the NHS to help prevent and manage obesity. The cost effectiveness ratio of WW generated by this economic model (£1.022 per QALY) is towards the lower end of the range of those for other interventions (Trueman et al, 2006). The authors concluded that referral to WW is more cost effective than “doing nothing” and stressed that the continuing burden of obesity is continuing to escalate.

4.5 In March 2008 WW commissioned an independent modelling exercise to harness the forecasting capability developed for the Foresight review to examine the potential impact of wider implementation of NHS referral to WW (Foresight, 2007, Brown and McPherson, 2009). The exercise used the Foresight computer programme to simulate virtual referrals in the English population from 2010 to 2030 and national health and economic outcomes were predicted up to 2080. Assuming the typical BMI loss of 1.5 units is sustained over the participant’s lifetime, this micro simulation estimated savings in healthcare costs of £1,860 per intervention person. Health outcomes in participants appeared similarly significant (see Appendix 3).

4.6 WW has the operational capacity to deliver national scale weight management services with over 6,000 meetings per week spread across all regions of the UK at convenient times (mornings, afternoons, evenings and weekends) and in accessible venues which are familiar to local communities. These meetings are facilitated by over 1,700 trained leaders.

4.7 The above demonstrates a cost effective argument for “siphoning” off clinically suitable overweight and obese patients, who are ready to change, to services such as WW.
5. **World Class Commissioning: shining examples**

5.1 Theoretically the WWRS is a perfect match for the World Class Commissioning vision to deliver:
   - Better health and well being for all
   - Better care for all
   - Better value for all

5.2 Walsall Teaching PCT

Walsall Teaching PCT has been proactive and forward thinking, working on a large scale in their approach to tackling the obesity challenge. The PCT launched a campaign called ‘Weight’s Over’ in spring 2008. In addition to in-house NHS services, commercial services are commissioned to broaden service choices for local communities and there is equality of access for all overweight and obese adults within the PCT.

A social marketing model is used to introduce weight management services including free access to the WWRS, access to physical activity, on line weight management services and NHS health trainers.

Advertising is displayed on bus-sides, bus shelters and in local newspapers.

There is effective matching of patient to service to maximise compliance and potential weight loss outcomes through a central telephone line to health advisers.

5.3 South Staffordshire PCT

South Staffordshire PCT, whilst working on a smaller scale, has developed a robust and effective way to achieve weight loss results in its area, with a flexible purchaser-provider relationship using Service Level Agreements (SLAs):

- GPs undertake initial screening that qualifies the patient for eligibility
- Patients call a WW Hub Centre and are assessed for readiness to change
- If patients are ready to change and to engage with WW, WWRS packs are sent to them
- WWRS patients are supported by Health Trainers to motivate and monitor weight loss progress.
- Further WWRS packs can be awarded to patients who achieve 5% weight loss during their 1st pack, have attended regularly and are committed to continuing to lose weight.

6. **Current commissioning processes for weight management services inhibit world-class commissioning**

6.1 Against a landscape where the NHS needs support to tackle the obesity burden, the NHS commissioning process for weight management services is increasingly unwieldy and lacks flexibility.

6.2 There is repetition of commissioning processes between PCTs, involving commissioners investing huge amounts of time in going through the same steps with little apparent sharing of best practice.

6.3 In the development of a WWRS pilot, meetings are held with obesity leads and equivalents to discuss the scheme and how WW could best support service needs for the local community. This dialogue is key to sharing best practice, achieving success and maximising weight loss results.

6.4 However, when the size of the contract increases, an official tender process comes into play. Often the request for tender and the Pre Qualifying Questionnaire (PPQ) stage are delivered via the internet by the procurement or the commissioning arms of the NHS. Once this process is in place WW is not able to meet face to face with local teams to discuss local needs, query elements or share best practice experience accrued from working with other PCTs.

6.5 The tender process sets an extremely formal tone for the interface between the purchaser and provider and in practice this means that, often, there is no opportunity for a pre-tender dialogue. As a result, PCTs often set rigid rules for provision of services and there is no opportunity to discuss or negotiate. Without a dialogue some tenders are unrealistic and, due to operational constraints, WW may take the decision not to bid for a tender if the exact requirements cannot be fulfilled.

6.6 This process does not encourage the vibrant, effective and responsive partnerships essential to World Class Commissioning.

6.7 The NHS should allow PCTs to engage with providers pre-tender, to develop service level agreements for weight management services. This will facilitate the discussion of practicalities and realistic operational deliverables, and is likely to ensure the specificity and sensitivity to local needs appropriate for effective weight loss.

7. **What needs to happen to improve the commissioning of weight management services**

7.1 To improve equality of access:

   (a) funding for weight management services within each PCT should relate directly to levels of overweight and obesity within that population;

   (b) standard criteria should be agreed nationally for eligibility for weight management interventions.
7.2 The DoH and the cross Government Obesity Unit should develop an approved list of providers of weight management interventions for adults based on transparent criteria for safe and effective weight loss services for adults.

7.3 The DoH and the cross Government Obesity Unit should facilitate the sharing of best practice in commissioning weight loss services for adults between all PCTs. This should include ensuring higher awareness amongst front line staff of available weight management services, and better skills and services to ‘match patient to service’ to maximise potential outcomes.

7.4 PCTs should engage with providers pre-tender, to develop service level agreements for weight management services to ensure the specificity and sensitivity to local needs appropriate for effective weight loss.

Weight Watchers UK Ltd

September 2009

APPENDIX 1

REFERENCES


Dr Foster (2005) Primary Care Management of adult obesity


HOW WW MEETS NICE BEST PRACTICE STANDARDS

<table>
<thead>
<tr>
<th>NICE “Best Practice” Standards</th>
<th>WW</th>
<th>How WW meets NICE standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helping people to decide on a realistic healthy target weight (usually 5-10% of their starting weight)</td>
<td>✓</td>
<td>Generally leaders encourage members to aim to lose 10% of their starting weight. With referral scheme members a 5% initial goal option is discussed.</td>
</tr>
<tr>
<td>Aiming for a maximum weekly weight loss of 0.5—1kg</td>
<td>✓</td>
<td>WW healthy eating plans are designed to achieve a daily calorie deficit of 500kcal, which will result in about a 1kg weight loss per week. Leaders encourage members to go for slow but sustained weight loss over a long period of time.</td>
</tr>
<tr>
<td>Focusing on long term lifestyle changes</td>
<td>✓</td>
<td>Both the programme material and leader training focus on using a behavioural approach. This empowers members to develop their own coping strategies for long term lifestyle changes. Leaders are equipped with communication strategies, a working knowledge of the stages of change model and an understanding of the importance and confidence realisations to drive and sustain motivation.</td>
</tr>
<tr>
<td>Addressing both diet and physical activity, and offering a variety of approaches using a balanced, healthy eating approach</td>
<td>✓</td>
<td>Group leaders and programme materials provide a framework for healthy eating, physical activity and lifestyle change. Healthy eating plans are based on consensus scientific advice (COMA, 1984, 1991).</td>
</tr>
<tr>
<td>Offering practical safe advice about being more active</td>
<td>✓</td>
<td>Physical activity is a central part of the WW programme both in boosting everyday activity and reducing sedentary behaviours WW own research suggests that many overweight and obese people are chronically disengaged with physical activity and initially are far more likely to build effort into everyday activity than take part in formal exercise sessions.</td>
</tr>
<tr>
<td>Including some behaviour-change techniques, such as keeping a diary and advice on how to cope with ‘lapses’ and high risk situations</td>
<td>✓</td>
<td>Leaders use an array of practised behavioural techniques and tools with members within meetings. For example members use food and activity diaries to reflect upon their week, set goals and evaluate their progress. Lifestyle assessment questionnaires completed periodically, help members set their priorities for action.</td>
</tr>
<tr>
<td>Providing ongoing support</td>
<td>✓</td>
<td>Members attend weekly meetings where they receive input and support from their leaders as well as their peers. WW believes that such support is key to keeping people on track in the long term and research appears to confirm this (Truby et al 2006, Poulter and Hunt 2007).</td>
</tr>
</tbody>
</table>

FORESIGHT MODELLING EXERCISE

In March 2008 WW commissioned an independent modelling exercise to harness the forecasting capability developed for the Foresight review to examine the potential impact of wider implementation of NHS referral to WW (Foresight, 2007, Brown and McPherson, 2009). At that time of the modelling, the WWRS had been operating for three years involving over one third of Primary Care Organisations who had referred over 8,000 patients for 12 weeks worth of WW meetings.

The first stage of the modelling exercise mapped key characteristics of the referral patient population and indicated that most are female (over 88%), between 40–70 years and tend to be obese with one third between BMI 30–35, one third between BMI 35–40 and one third over BMI 40. Analysis of weight loss distributions suggested an average BMI loss of 1.5 units (equivalent to a loss of 4.6kg) in participants who completed the 12 week intervention.
This information was subsequently entered into the Foresight computer programme to simulate virtual referrals in the English population from 2010 to 2030 and national health and economic outcomes were predicted up to 2080. Assuming the typical BMI loss of 1.5 units is sustained over the participant’s lifetime, this micro simulation estimated savings in healthcare costs of £1,860 per intervention person. When theoretical allowances were made for a 50% drop out rate and a 25% success rate in maintaining weight loss over a lifetime then the UK Government would make a saving in direct health care costs of about £230 (at today’s prices) per participant of the WW intervention and £1,600 per head on full economic costs.

Health outcomes in participants appeared similarly significant. A 20% reduction in risk for diabetes was estimated and 5% reduction in the likelihood of developing other BMI related diseases including cardiovascular disease and arthritis. In addition a small but measurable increase in life expectancy was estimated (an additional 4-months/participant). The authors concluded that this modelling exercise confirms that large scale application (to a significant proportion of the eligible population with BMIs ≥ 30) of a modest single weight loss intervention could result in considerable savings to Government and improvement in health outcomes for individuals.

Memorandum by the Cystic Fibrosis Trust (COM 23)

1. Introduction

1.1 The Cystic Fibrosis Trust was concerned about the commissioning of Cystic Fibrosis (CF) services following the NHS plan of 2000, as there were no clear indications as to how specialist conditions, of which CF is one, were to be commissioned. It seemed that with the abolition of the regional health authorities, the specific responsibilities for overseeing the commissioning of the specialist conditions had been lost, and not recreated in the revised plan.

1.2 When the representatives of the various conditions drew this to the attention of the Department of Health, the situation was reviewed by John Hutton, then Minister for Health, and at his request various organisations, including the Cystic Fibrosis Trust, made submissions. However, the revised arrangements which resulted from this consultation were opaque, confused and did little to improve matters.

1.3 It is important to note that even prior to the NHS plan and the abolition of the regional health authorities, commissioning for conditions like CF was very unsatisfactory. The old block contract system did not adequately provide for appropriate CF care, and certainly did not recognise and resource the improvements in treatment both in terms of the multidisciplinary team necessary to look after those with CF and the relatively high drugs budget they incur.

1.4 The CF Trust was pleased when Lord Warner initiated a further review of specialist services, chaired by Professor Sir David Carter. Of the dozens of Government reviews to which the Cystic Fibrosis Trust has submitted evidence, the Carter Review stands out as one where submissions were understood, taken on board and reflected in the recommendations. These were then endorsed and implemented almost in their entirety by Lord Warner.

1.5 These arrangements for the commissioning of specialist conditions such as CF in England have been the bedrock of a considerable amount of development in the CF service since then. They form a very solid foundation for the appropriate commissioning of CF care.

2. Regional Implementation

2.1 Although overall the new arrangements for commissioning CF care in England are sound and appropriate, they have been taken up and implemented in quite different ways by the ten Specialist Commissioning Groups who are co-terminus in geographic boundary with the Strategic Health Authorities. The CF Trust is in contact with nine of the lead commissioners for CF in the ten Specialist Commissioning Groups. The fact that we can communicate with a named individual with responsibility for CF is extremely helpful. The area where we have not been able to engage with a named individual for the last two years is London.

2.2 Most of the specialist commissioners are interested and, to a varying degree, engaged. They include:

- Rob Lusuardi (West Midlands);
- Clare Jones (North West);
- Theresa Warr (South Central);
- Nicky Coffey (South East);
- Diana Cargill (South West);
- Kim Cox (Yorkshire & The Humber);
- Peter Dixon (Yorkshire & The Humber);
- Jon Currington (East Midlands); and
- Patrick Hobbs (East of England).
2.3 It would be fair to say that they tend to view their roles differently and some take their responsibilities seriously whilst one or two seem less interested or less effective.

2.4 The problems in London seem to stem from the re-organisation that has been in progress for over two years now. Sue McLellen was initially the lead for CF and in that capacity took a considerable interest and was helpful in our attempt to understand the funding arrangements for the CF service in London. However, since she became overall director of the service in London, we have found it very difficult to identify who is now responsible for CF and have received no reply to correspondence. We were pleased to learn a few months ago that an appointment had been made, and were about to make contact, when we heard that the individual concerned was due to retire in July. We hope to meet with the recently appointed CF commissioner in the near future. This has caused particular concern, as it is estimated that roughly one third (ie 2,000 or so) of the estimated 6,000 patients with CF in England come to one of the London hospitals for some or all of their care. These hospitals include the Royal London Hospital, the London Chest Hospital, Great Ormond Street, the Royal Brompton Hospital, Kings College Hospital, and Lewisham Hospital. There are other district general hospitals (DGH) in the London area who offer some care for those with CF in conjunction with one of the aforementioned hospitals.

2.5 The level of engagement and nature of interest in each region differs somewhat. For example, the South East Coast Specialist Commissioning Group are in the process of carrying out a complete review of all CF services in their area, which has been going on for around 18 months, with a view to planning appropriately for the future.

2.6 The North West service is focusing on specific “hot spots” of need; they are working to identify a hospital to develop an additional adult CF centre to alleviate the pressure on Wythenshawe Hospital, which is significantly over-subscribed with CF patients. This need for additional adult centres is marked in several other parts of the country, because whilst paediatric CF numbers are relatively stable, the adult numbers are increasing nationally by approximately roughly 100 each year. The upper limit of being able to cope adequately with a large cohort of CF patients is being challenged, both in the level of care the CF multidisciplinary team is able to provide and the infrastructure of the host hospital. It is estimated that most hospitals and their infrastructure can provide a good service for up to 250 adults, but when the numbers start to exceed this, compromises are made and standards sacrificed. There are several other areas throughout the UK where an additional CF centre is desperately needed, and the CF Trust applauds the North West Commissioning Group for being pro-active in this respect.

2.7 The Cystic Fibrosis Trust offers a peer review service to CF specialist centres and CF specialist clinics throughout the UK. These are comprehensive reviews by a team of specialist doctors, nurses, dietitians and physiotherapists, along with patient or parent representation who spend a day with the CF team in their hospital to review their service. This follows the completion of a comprehensive proforma and a treatment and outcomes questionnaire by the service being reviewed and a questionnaire to the patients of that service. The reports from these reviews are detailed, comprehensive and focused, and include key recommendations. They are routinely sent to the Chief Executive of the hospital, the clinical director of the CF service and the specialist commissioner for the area. We have found most of the commissioners to be interested and keen to engage and address some of the relevant issues, sometimes where necessary, as a matter of urgency. One example is the service at the University Hospital of North Staffordshire, in Stoke on Trent, where the commissioner, Rob Lusuardi, responded immediately to the identified shortcomings.

2.8 The drawbacks of this system of commissioning are in the areas of implementation. For example, following a recent peer review of the Oxford Paediatric CF Service, key recommendations were made as to the necessary increased resources not only to enable the CF team to look after their full care patients appropriately, but also to enable them to ensure that the care offered to those patients in a network service with a number of other clinics in DGHs is of an equally high standard. The specialist commissioner, Theresa Warr, referred a modest request for additional funding to go a limited way to meet this identified need to the PCTs in question who refused extra funding. The fact that the funding for specialist conditions such as CF still has to come from the PCT, but without any apparent obligation on their part to release it, creates a problem. It also creates inequality in service. The CF Trust strongly recommends that once a clear price is identified for the care of a particular condition, the money is top-sliced before it goes to the PCTs.

2.9 A further area of concern is that there is no ring-fencing of money made available by the commissioners and the PCTs for a specialist service. For example, the CF Trust has peer reviewed services which seemed on paper and to the specialist commissioners, to be very adequately resourced, but has found that the money made available to the hospital has not reached the frontline of the CF service, or at least only in very small quantities. In one centre, the amount allocated for CF, but used for other purposes exceeded £2 million, and in many other areas we have identified significant sums of money allocated to the hospital specifically for CF care, but with little indication that this has been received by the CF team to improve the level of service. A particular example is the Birmingham Children’s Hospital. These shortcomings could be resolved by appropriate implementation of a Payment by Results system.
3. **Payment by Results**

3.1 When the Department of Health embarked on the Payment by Results initiative, with payments being agreed on an episodic basis for each condition, the CF Trust was keen to co-operate, but could not see how this would work for CF. At any time, there may be several aspects of the body affected by this complex condition, including the lungs, gastro-intestinal system, liver, bones and sinuses. In addition, many adults with CF develop CF related diabetes. CF is present from birth until death, and in episodic terms, it seems impossible to work out where one episode starts and ends and how much it should cost.

3.2 The CF Trust therefore devised a package based on current practice in some forward thinking hospitals using a tariff based on an annual banded package of care, reflecting (a) the severity of the condition in each patient and (b) the amount of treatment necessary to keep that patient as well as possible. Point (b) is particularly relevant in paediatrics, where a great deal of medication is used to keep children well, rather than waiting until they become ill, when available treatment will be far less effective. As a result of its submission, the CF Trust was invited to take part in a pilot study for Payment by Results early in 2008.

3.3 We engaged with this exercise and initially enlisted fourteen specialist CF centres in England to collect and submit comprehensive data for the cost of a full year of CF treatment including all staffing costs, ranging from doctors, nurses, physiotherapists, dietitians, play therapists, data clerks, microbiologists, etc. as well as the drugs involved in each patient’s care. It reflected out-patient, in-patient and home care. Eventually ten of the fourteen hospitals were able to submit data by the agreed deadline. The other four were keen to be involved, but for various practical reasons were not able to produce the data in time. It should be stressed that there was no extra funding, either for the CF Trust or for the hospitals concerned, to complete this exercise. The CF Trust employed an individual to lead this initiative, and we have been extremely grateful for the support of the clinical teams and finance departments of the hospitals taking part for the hard work they have put in to make this possible.

3.4 The first tranche of data has been submitted to the Department of Health and analysed. We are grateful for the support of Peter Howitt (Payment by Results Development Manager, Department of Health) and Peter Donnelly (Head of Clinical Classification and Costing, Payment by Results Development Team, Department of Health), who have been very helpful throughout this exercise. We understand that an independent evaluation of progress to date, carried out by PricewaterhouseCoopers, was positive although there are a number of areas that still need to be addressed and a number of gaps which we are currently addressing, including using some of the data from the four hospitals who were unable to produce their data set in time for the initial deadline.

3.5 This work will enable an annual banded tariff to be agreed for each category of CF patient. We have outlined five main categories, two with sub groups. Band 1 is the mildest and Band 5 is the most severe. Bands 1 and 2 are divided into 1a, 1b, 2a and 2b. In each of these bands, patients will have a similar level of health, but patients in category (a) will need a much lighter treatment regime to keep them well than those in category (b), who may have a similar lung function and body mass index but receive a great deal more treatment to achieve this.

3.6 One of the recommendations in the Carter Report, which was not implemented by Lord Warner was that there should be a clinical database for each of the specialist conditions. This was simply a pragmatic decision as the Department of Health’s IT programme is struggling with its current workload. The CF Trust funds and resources a CF Registry and as we have this well respected clinical database, we asked the then national commissioner for specialist conditions, Adrian Pollitt, if databases already in existence and of a suitable standard could be used instead, and were told they could. It is therefore proposed that our clinical database is used to band all CF patients in England in Bands 1 to 5 (or whatever the final banding structure may be) and that this should determine the amount of funding each specialist centre receives for the care of each CF patient for a year.

3.7 The CF Trust feels strongly that CF patients should be able to choose the centre where they have their care. The vast majority will go to the centre nearest to their home, but a minority travel further afield for personal reasons. The CF Trust supports patient choice, and as long as patients are going to a recognised CF Centre, feels that the money should follow the patient to their chosen centre. This should make no difference to their PCT, other than the PCT’s natural desire to support their local hospital. However, given the relatively small numbers of CF patients, this would not be a large consideration.

3.8 The CF Trust has invested a great deal of time and energy in developing an appropriate tariff for those with CF, and although it is currently called Payment by Results, what we have calculated is really payment by activity. Eventually, it would be important to ensure that centres delivering CF care are achieving appropriate outcomes, which again can be done by our clinical database.

3.9 This would put funding for CF care on a firmer, more robust and more realistic footing than has ever been the case to date. It would also remove the necessity for tiers of committees and bureaucracy to decide what funding should be made available. Clinical teams would be spared the problem of having to write endless letters to GPs, PCTs and hospital managers requesting the funding for what is recognised as appropriate and safe CF treatment.
4. Designation

4.1 A further aspect of commissioning is the process of designation. CF care has mostly been provided in large city hospitals where interested paediatricians and adult physicians have taken responsibility for developing and providing a service. For adults, full specialist centre care is recommended, as it is at this stage that their condition becomes more complex. For paediatrics, a network of care is recognised as being appropriate where the centre oversees care, some of which may be delivered by DGHs in an outreach specialist centre clinic. Centres provide a significant proportion of care for each patient within the network, which is likely to take the form of a combination of visits from the specialist centre team to the DGH and of patients to the specialist centre.

4.2 In a good paediatric network service the centre will provide 50%—80% of care to patients in outreach clinics, or in some cases 100% where the local facilities of the hospital are used but there are no local clinicians or multidisciplinary team members involved, where the network arrangement is simply to minimise the travelling demands on the families. Many paediatric specialist centre teams visit each DGH with whom they have a network or shared care service anything from between once a month to twice yearly. It is strongly recommended that those patients in Bands 1 to 3 see the specialist centre team at least twice a year, and those in Bands 4 and 5 should receive all their care from a specialist centre team.

4.3 Although this system has evolved to work quite well, there are certain problems, not least where some patients are still cared for in a DGH without appropriate reference to a specialist centre and where the local team may have limited experience of Cystic Fibrosis. The CF Trust therefore welcomes the planned process of designation to ensure that CF care is only offered where it can be delivered to a recognised safe standard.

5. Summary

5.1 The improvements the Cystic Fibrosis Trust would like to see in the commissioning process are therefore as follows:

(a) A clearer brief to each of the ten Specialist Commissioning Groups, to clarify their level of responsibility in relation to each specialist condition, including Cystic Fibrosis.

(b) The CF Trust would like to see a fair and realistic national tariff agreed for each CF patient, reflecting the severity of their condition and the amount of treatment needed to keep them as well as possible. The Payment by Results initiative in which we are currently involved would be an ideal vehicle to deliver this.

(c) Once a tariff is agreed, we would like payment to be mandatory and not left to the discretion of a PCT. We would prefer the money for specialist conditions such as CF to be top-sliced before being allocated to PCTs. Failing that, we would like to see the PCTs being given no choice as to whether this payment was made. The money should follow the CF patient to a centre of their choice as long as it is a designated centre.

(d) We would also like to an agreement as to the proportion of this funding that should be retained by the hospital for overheads, with the remainder going directly to the CF service.

September 2009

Memorandum by NHS Ealing and NHS Harrow (COM 24)
INTEGRATED CARE ORGANISATION

1. Summary

1.1 Introduction

This paper describes a proposal, to bring together the services currently provided by Ealing Hospital NHS Trust (EHT) and the Ealing and Harrow provider arm (the community services historically provided by Ealing and Harrow Primary Care Trusts). Ealing Hospital NHS Trust would be used as the “shell” Trust, but the process would create a new organisation dedicated to providing care as an integrated organisation focused on delivering local services to local people.

1.2 The Need for Change

Healthcare for London outlined changes that need to happen to healthcare across the capital. This identified that care should be local where possible and central where necessary. The likely financial constraints on the NHS over the coming years mean that care needs to be organised in the most efficient way possible, whilst providing better quality outcomes for patients. In parallel, the policy shift away from Primary Care Trusts providing care directly to focus on commissioning means that the way community care is organised needs to change. Likewise the policy directive that acute care should be delivered from Foundation Trusts, means that EHT cannot continue in its present form (as it has been characterised as unable to achieve Foundation Trust (FT) status in the current London environment).
1.3 *A modern network of care*

The new organisation therefore needs to provide local services for the people of Ealing and Harrow in settings that are as local as possible, embodying the aspiration: “right care, right time, right place”. It will integrate services that are currently described as acute and community, using as a framework the principles that form part of the DH Transforming Community Services agenda:

- Health, well being and reducing inequality.
- Rehabilitation services.
- End of life care.
- Services for people with long term conditions.
- Children, young people and families.
- Acute care closer to home.

1.4 *Proposed service model and the need for a joint venture*

The proposed service model is to join together the services currently provided by EHT and by the Ealing and Harrow provider arm. The new organisation will then be able to offer integrated provision, eg for diabetes, services for older people, and COPD.

In the first year of operation the service model will simply see a bringing together of the existing services. However, over time services will be increasingly integrated. The advantage of the joint venture will be both vertical integration and scale. Specialist services, such as home chemotherapy, can be provided over a wider area enabling expertise to be developed & retained in an efficient manner.

The organisation will have links with other provider organisations, and the more specialist acute services will be reviewed to ensure models of provision that are cost effective and meet modern care standards. This will include some services being provided directly by the new organisation, some being provided in partnership with a secondary or tertiary care organisation, some being provided on local sites by other secondary or tertiary care organisations and some very specialist services only being available at central locations, as is already the case for cardiac surgery, for example.

These points are expanded in the notes below.

2. **Benefits**

Establish a locally-led organisation focussed on the provision of local services.

Ensure responsiveness of local services to local needs through links with PBC groups and locality service models.

Bring together services that are currently provided differentially in acute and community settings to offer integrated provision (eg for diabetes, older people, COPD) to the people of Ealing and Harrow.

Use vertical integration and scale (services across more than one borough) to:

- Improve the effectiveness of local services, eg. by providing specialised services over a wide area (example: home chemotherapy);
- Increase efficiency and release resources for service development;
- Innovate in developing more responsive local services.

3. **Key Points**

**Provision**

The new provider’s mission will be to provide local services to the people of Ealing and Harrow in settings that are as local as possible—“right care, right time, right place”.

The new provider will integrate services that are currently described as “acute” and “community”—see illustrative diagram—through clinical leadership across a large element of the new care pathways.

It will enhance the opportunities for borough-based provision linked to local authority services, while developing strong clinical leadership because of its scale (multi-borough, across settings).

It will be responsible for local urgent care services 24/7.

It will include bedded services as required on a number of sites.

These sites may or may not be owned by the new organisation.

There will be potential for clinicians to have links with other NWL providers of local “acute” services (eg Hillingdon Hosp, NWLHT) and with tertiary providers.

The new organisation will operate in the context of HfL’s polysystems policy, ensuring care is delivered in a range of settings from beds through polyclinics to homes. Nb. the APO is already host to one of London’s polyclinics (Alexandra Avenue) and is in a good position to bid entrepreneurially to run other polyclinics.
Commissioning and Contracting

The PCTs will need to commission and contract with the new organisation differently from the current commissioning arrangements with the APO and EHT.

Commissioning, and therefore models of provision, will increasingly be for pathways of care and support, rather than using tariff for specific HRGs or block for community or non-PbRS services.

Contracting will increasingly be outside of current acute tariffs—bedded services will be priced in new ways as part of the new pathways.

Commissioning and contracting will incentivise the new provider to provide services without hospital admission as much as possible, minimising length of stay when admission required.

Commissioning will move the system to a model similar to a health maintenance organisation (HMO).

Partners

The new arrangements for the local health communities will encompass primary care clinicians.

The new provider will not itself initially provide registered, list-based services but may provide other services currently described as primary care.

Better commissioned pathways will increase clarity about responsibilities for elements of provision and promote new ways of joint working with independent primary care contractors.

The new arrangements will integrate practice-based commissioners into pathway design and management.

Interfaces will be developed with local authority social services and other LA services (eg housing) appropriate to each borough.

There may be scope in time for the new organisation to provide some social care services.

Similar interfaces will be developed with mental health services.

Implementation

The new organisation will be established [in April 2010] with all the services and assets of the predecessor organisations.

It will have a high level of corporate viability, starting with a turnover of approx £150 million pa and having sufficient scale and capability to flex its portfolio over time:

— it may acquire new services (the APO has just won its first tender to another PCT); and
— it may float off services (to acute providers or small social enterprises) without jeopardising its business model.

A commissioning strategy, agreed in advance and consistent with the NWL Collaborative Commissioning Intentions, will direct a staged transformation of services and financial flows.

September 2009

Memorandum by The Children’s Trust, Tadworth (COM 25)

Summary

— Our submission to this inquiry focuses on specialist commissioning.
— Improvements are needed in the commissioning of specialist health services for disabled children. Local decision making often leads to inadequate servicing in cases of exceptional need.
— PCTs and local authorities need to work together and adopt a whole-system approach to commissioning for children with severe disabilities and complex health needs. They also need better data about the population of disabled children in their areas.
— Commissioning at the level of individual PCTs for high-cost services for children with low-incidence conditions will inevitably lead to difficulties. The NHS should consider developing a national specialist commissioning group for these cases.
— Some PCT commissioners do not have the skills and knowledge to commission adequately the most appropriate and effective services for children with complex needs.

The Children’s Trust, Tadworth

1. The Children’s Trust, Tadworth is a national charity that provides care, education, therapy and rehabilitation to children and young people with multiple disabilities, complex health needs and acquired brain injury (ABI). Our services include short breaks, continuing care, transitional care, special education and the UK’s largest rehabilitation centre for children with ABI.
2. The children to whom we provide services are amongst the most severely disabled in the country: most cannot walk or talk, many are fed by a tube and some are dependent on artificial ventilation to help them breathe. The majority receive health funding (sometimes jointly with education and/or social services funding), but in addition our services are significantly subsidised by voluntary income, which contributes enormous value in the form of new buildings, special equipment and specialist staff, as well as supporting the introduction of new services.

3. Improvements in medical care have resulted in an increase in the number of children living long-term with severe disabilities and complex health needs (for example, evidence would suggest that more children are surviving premature births). They are “new survivors”—children and young people who would probably not have survived for any length of time 10 or 15 years ago. For many of them, the complexity and/or rarity of their condition means that specialist services are the only health services they will access. Many may never see a GP. Though this group is still relatively small, the systems for planning and commissioning appropriate services for them are failing to keep pace with need.

4. In recent years there have been a handful of Government policy initiatives that we hope will make a significant, positive impact on the lives of disabled children and their families. But while these programmes commit new money to developing vital services such as short breaks, there are still structural obstacles to disabled children accessing the specialist health services they need. We have recently supported and contributed to a significant piece of work that looks at this very issue. *Disabled Children and Health* is a report published in June 2009 by the Every Disabled Child Matters (EDCM) campaign.43 The report features a list of recommendations for Primary Care Trusts urging them to develop, in partnership with their local authorities, more holistic and child-focused commissioning practices for disabled children.

5. The formation of local authority children’s trusts over the last five years was intended to improve the commissioning of services for children with complex needs by enabling greater joint working and the pooling of budgets between agencies, but we have yet to see that happening to any great degree in practice. Certainly The Children’s Trust has never received a direct referral from a local authority children’s trust, yet the type of children we cater for are precisely those who most need local agencies to pull together. In February the Government’s Child Health Strategy “Healthy Lives, Brighter Futures” made further recommendations to local authorities, more holistic and child-focused commissioning practices for disabled children.

6. Commissioners must recognise the importance of adopting a holistic and long-term view of services for disabled children—a whole system approach. A pathway leading to better health outcomes for disabled children and young people must take account of very diverse needs including education, housing, various equipment needs, short breaks and training for employment where appropriate. For example, we have experience of costly residential care placements being extended unnecessarily because of avoidable delays in rehousing families following a child’s acquired brain injury or because social services did not become involved early enough to plan a seamless package of community care. In EDCM’s *Disabled Children and Health* briefing, one mother talks about her family’s need for a joined-up approach from all agencies:

“My son has an acquired brain injury and has a tracheostomy fitted to enable him to breathe. He has been staying at The Children’s Trust, Tadworth whilst he receives rehabilitation, and we want him to come home and live with us and his twin sister. We are fighting the local authority to agree the funding and plans for our home to be adapted and until this is agreed he can’t come home. In the meantime the PCT has spent many more times that amount on keeping my son in residential care. The local authority and PCT need to work together to plan for my son’s future!”—Disabled Children and Health, p 16.

7. Many of the problems disabled children face in accessing specialist services can be traced to financial decisions within PCTs. While the conditions that affect the children we see at The Children’s Trust are relatively uncommon, it is expensive to meet the needs of those children who are affected. Unfortunately, the devolved system of commissioning health services for children with these low-incidence, high-cost conditions often fails in the most complex cases. In our experience there is sometimes great resistance by a local PCT to meeting such costs, particularly when decisions about services for a single child can “bust the budget” held by individual commissioners.

8. The answer may be for more PCTs to consider pooling budgets regionally for low-incidence, high-cost conditions or for these cases to become a national specialist commissioning group. It is quite feasible to imagine, for example, a regional consortium for very vulnerable, technology-dependent children commissioning services from regional centres of excellence for all complex cases in its catchment area. By spreading their financial risk in this way, PCTs would be better able to cope with occasional, unexpected spikes in demand for their resources.

9. Pooling responsibility is not just about reducing financial risk. PCTs’ budgetary limitations are exacerbated by a lack of expertise amongst some commissioners in what services will best meet a complex child’s needs. Commissioners are often not sufficiently aware of and sensitive to the needs of families where a child has multiple disabilities and really complex health needs, nor in sympathy with the factors which

influence the cost of meeting those needs. There needs to be more expertise applied to the commissioning of highly complex cases and a national/regional commissioning structure would help to accumulate experience, leading to better outcomes and better value for money.

10. In our experience, it is not the commissioners who are leading the way in obtaining the best outcomes for children with complex needs. Children are referred to us by clinicians or parents, never by commissioners, and it is the clinicians and parents who seek out the most beneficial care pathway. Commissioners meanwhile are pre-occupied with managing budgets and are rarely proactive in finding innovative solutions in the best interests of the child. This is clearly a long way from “World Class Commissioning”.

11. There is a final important point to be raised about population data. Specialist commissioning for disabled children will never approach “World Class” status until PCTs and local authorities are fully aware of the number of disabled children in their area and the extent of their needs. Early evidence from the implementation of “Aiming High for Disabled Children” and the tendering for provision of short breaks suggests that knowledge of the numbers of disabled children, let alone any reliable classification of severity or complexity of need, is at best sketchy in some areas. How can commissioners budget properly for service provision if their chief reference point for responding to need is “what we spent last year”? Much more effort needs to be made to improve local data about the population of disabled children.

12. In conclusion, we do not shy away from the fact that providing children with multiple disabilities and complex health needs with the specialist services that they deserve is expensive, but if PCTs are to meet the vision of World Class Commissioning the needs of these children and their families must not be ignored. It is our belief that the skills, capacity and funds to deliver a world class standard of care already largely exist within the current system, but that this is prevented by the inflexibility of the commissioning structure and a lack of epidemiological data.

13. We would welcome members of the Health Committee to visit us to see our services in action and to discuss the issues raised above.

September 2009

Memorandum by the Royal College of Radiologists (COM 26)

1. The Royal College of Radiologists (RCR) has approximately 7,800 members and Fellows worldwide representing the disciplines of clinical oncology and clinical radiology. All members and Fellows of the College are registered medical or dental practitioners. The role of the College is to advance the science and practice of radiology and oncology, further public education and promote study and research through setting professional standards of practice.

2. This response outlines the impact and implications commissioning has had and will have on clinical oncology services and diagnostic and interventional radiology services.

3. “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

World class commissioning is meant to encourage and promote innovation and deliver the services patients need locally. However, many Primary Care Trusts (PCTs) have been ignoring and discouraging innovation and failing to recognise the infrastructure that underpins commissioned services. An example might be the commissioning of dialysis services which, though now being delivered locally, has failed to recognise the vital role that diagnostic and interventional radiology plays in this service. Radiological innovations underpin dialysis services yet receive little or no funding for doing so. This has resulted in failed fistulae, long waiting lists and femoral and other lines being left for too long in patients, which has contributed to infection rates. Oncology services, such as radiotherapy, are often ignored by commissioners since referral to these services are from secondary care and not primary care.

If commissioning is to be truly world class, there will need to be a much better understanding of the services being commissioned and what they entail.

4. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

While the internal market has made NHS hospitals more efficient and less complacent, it has not been a success for “service specialties” such as radiology or tertiary referral services such as oncology. The natural tendency of market forces to drive down costs works only superficially, as it leaves the infrastructure underfunded and inefficient. This became apparent once targets were introduced and led, for example, to the need for massive investment in radiology to bridge the gap. There are national and international inequalities in the provision of Interventional Radiology and PET CT and specialised radiotherapy as a result of this.
5. Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

When Payment By Results was first discussed as a concept it appeared attractive as a solution to the funding issues radiology and oncology faced. However the failure to unbundle high cost in-patient and transferred patients whilst GP work was unbundled caused departments to lose staff and money. Innovative ways of working are already being considered and implemented by many Trusts to try to get around these problems. For instance by not imaging or providing interventional therapies on in-patients but having them sent home and readmitted for imaging/procedures, departments will take advantage of the out-patient unbundling situation. This is not in the patient’s best interests.

Radiotherapy services are still not in tariff and this creates problems with the introduction of improved techniques such as intensity modulated and image guided radiotherapy.

6. Specialist commissioning

Many of the low volume yet vital Interventional Radiology (IR) services cannot be delivered in every hospital Trust. If they are to be available 24/7, the National Specialist Commissioning Advisory Group (NSCAG) will need to recognise that networked IR systems will have to be commissioned.

In clinical oncology specialist commissioning needs to look more closely at the specialised services such as paediatric oncology, sarcoma services and specialised radiotherapy techniques.

7. Commissioning for the quality and safety of services

In order to ensure the quality and safety of services, Radiology and Oncology departments are going to have to produce evidence that their radiologists and oncologists have enough time in their job plans for audit, Morbidity and Mortality meetings, discrepancy meetings and submission to national databases and registries where appropriate. However, there seems to be a trend at present for Trusts to decrease the amount of SPA (Supporting Professional Activity) sessions in job plans, which would leave little time for the above mentioned activities.

September 2009

Memorandum by Health Mandate (COM 27)

1. Executive Summary

1.1 Health Mandate is a specialist health policy and communications consultancy, advising a range of NHS, voluntary sector and commercial organisations on some of the highest profile health issues of the day.

1.2 The publication of the first year of the World Class Commissioning Panel Reports provided a unique opportunity to investigate patterns in Primary Care Trust (PCT) commissioning. In recent years our consultants have become increasingly focused on how best to translate national policy priorities into comprehensive local delivery. Although national priorities will remain central to the health improvement agenda, politicians of all parties are progressively more convinced about the importance of local autonomy and performance management. We therefore decided to undertake an analysis of the outcome indicators selected by PCTs in England, which was published in a report, National priorities, local action? An analysis of Primary Care Trusts’ World Class Commissioning policies in July 2009. All statistics used in this submission are from this report unless otherwise referenced.

1.3 Our report, which is included as supplementary material to this submission, enables scrutiny of the areas on which commissioners are focusing, as well as the extent to which PCTs are measuring local performance on national priorities. It also identifies ways in which the World Class Commissioning assurance process could evolve to meet the emerging challenges facing the NHS, including the need to deliver more efficient services, as well as improving the quality and consistency of patient care. We have made a number of recommendations which the Committee may wish to consider:

— The Department of Health should publish regular national analyses of the World Class Commissioning priorities adopted by PCTs and the progress made on improving these service areas. This would have the benefit of ensuring transparency and national accountability for the World Class Commissioning programme.

— In order to facilitate better engagement and to help PCTs meet the third competency of the World Class Commissioning programme (“World class commissioners proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health”), PCTs should be required to clearly explain to local populations the rationale for their priorities.

— The Department of Health should develop nationally-defined indicators for issues which have frequently been the subject of locally-defined indicators.
— The Department of Health should decommission nationally-defined indicators that were not selected, or that were rarely selected, by PCTs.
— The Department of Health should ensure that future national disease or service strategies are explicit in their links to World Class Commissioning, establishing nationally defined indicators which PCTs can adopt.
— The Department of Health should clarify the relationship between the national performance management processes and the World Class Commissioning outcome indicators, ensuring that there is greater consistency in whether Vital Signs are translated into nationally-defined indicators.
— The balance of World Class Commissioning indicators should evolve so that they more accurately reflect the overall impact of different service areas on overall NHS expenditure.
— In order to assist PCTs in managing the challenges posed by a slowdown in NHS spending, the Department of Health’s newly appointed National Director for Improvement and Efficiency should be tasked with identifying efficiency indicators as a matter of priority.

1.4 We warmly welcome the decision of the Committee to conduct an inquiry into the effectiveness of commissioning. Our comments are restricted to the impact of the World Class Commissioning programme, as well as what it tells us about the effectiveness of PCTs. In developing National priorities, local action? we collated a wealth of information, which we would be happy to share with the Committee. We would also welcome the opportunity to provide further oral evidence.

2. Impact of World Class Commissioning

2.1 It is clear that the World Class Commissioning programme has raised the profile of commissioning, giving it a new level of priority within the Department of Health’s wider agenda. By requiring PCTs to make explicit choices about the health outcomes on which they focus, it has given an insight into the issues which most exercise commissioners and therefore provides an overview of the issues on which local action can be expected to deliver. However, no national analysis had been published assessing the issues on which PCTs have chosen to focus, which is why Health Mandate published National priorities, local action?

2.2 The Committee may wish to consider recommending that the Department of Health should publish regular national analyses of the World Class Commissioning priorities adopted by PCTs and the progress made on improving these service areas. This would have the benefit of ensuring transparency and national accountability for the World Class Commissioning programme.

2.3 The World Class Commissioning assurance process is intended to assess the progress made by PCTs in implementing robust commissioning strategies. As part of the process, each PCT is required to select up to eight outcome measures that are reflected in their strategic plan priorities and that have been agreed with partners, including the public and patients, community organisations and clinicians. Progress towards achieving these objectives is monitored through the assurance process. PCTs can select indicators from a national list of 54 centrally defined outcome measures. In addition, up to three indicators can be locally defined. All PCTs are also measured against mandatory health inequalities and life expectancy indicators.

2.4 Figure 1 shows the 10 most commonly selected indicators by PCTs. It is clear that PCTs have chosen to focus on prevention issues, with smoking cessation and reducing alcohol-related harm the two most commonly selected indicators. This finding is of particular relevance to the Committee’s previous work on public health and health inequalities.

![Figure 1: Indicators Most Commonly Selected by PCTs](image-url)
3. Extent to which PCTs are focussing on the outcomes most relevant to their population

3.1 A key aspect of high quality commissioning is identifying particular areas of local health need and prioritising action accordingly.

3.2 It is not clear, however, that all PCTs are using the World Class Commissioning process to focus on the health issues which are most pressing for their population. For example:

— Smoking—a number of PCTs with high smoking populations have failed to select the “smoking quitters” outcome measure, including Hull, which has the highest rates of smoking in the country, at 40.9% of the adult population smokers.\(^{44}\)

— Alcohol—nearly half of England’s PCTs (49%) are focused on reducing the number of hospital admissions caused by alcohol. However, the list excludes a number of PCTs which have high rates of hospital admissions due to behavioural disorders of alcohol, including Hampshire, which had the fifth highest number of admissions in the country in 2007-08 for such disorders.\(^ {45}\)

— Teenage pregnancy—53 of England’s 152 PCTs (35%) are prioritising reducing teenage pregnancy rates, although a number with high teenage pregnancy rates chose not to prioritise this, including Halton and St Helen’s PCT, which has the highest teenage pregnancy rate in the country (70.3 per 1,000 female population aged 15–17).\(^ {46}\)

3.3 Overall, most PCTs are focusing on issues where their performance is below the national average, although a third have chosen to focus predominantly on areas where performance is above average.

3.4 It is not always clear why PCTs elected to focus on the areas they do. The Committee may wish to recommend that, in order to facilitate better engagement and to help PCTs meet the third competency of the World Class Commissioning programme (“World class commissioners proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health”), PCTs should be required to clearly explain to local populations the rationale for their priorities.

3.5 Some strategic health authorities (SHAs) appear to be exercising significant influence on local commissioning processes as part of their system oversight responsibilities, with PCTs in their health economy opting to focus on common themes. For example, PCTs in NHS East of England have all opted to prioritise four locally-defined indicators (childhood obesity, GP access, patient experience and access to dentistry). All four of these issues feature as priorities in the East of England’s regional NHS Next Stage Review vision, Towards the best, together.\(^ {47}\) It is clear that NHS East of England has identified commissioning as a key lever for implementing its vision. Overall, at least half of all PCT priorities in the East of England were collectively determined.

3.6 Spearhead PCTs broadly appear to have the same priorities as other PCTs. However, they give disproportionate priority to alcohol-related admissions and less to smoking cessation and the proportion of deaths which occur at home.

3.7 PCTs have the opportunity to develop their own indicators, reflecting issues of particular local concern. In total, 127 PCTs elected to focus on at least one locally-defined indicator. Overall, 23% of all indicator selections were locally-defined. This may also reflect the absence of significant health issues from the Department of Health’s list of nationally-defined indicators. For example, childhood obesity, talking therapies and dementia were all frequently developed local indicators.

3.8 The Committee may wish to consider recommending that the Department of Health should develop nationally-defined indicators for issues which have frequently been the subject of locally-defined indicators.

3.9 Similarly there were three nationally defined indicators which were not selected by any PCT: uptake of pneumococcus vaccinations by over 65s; HIV prevalence; and proportion of patients waiting no more than 31 days for cancer treatment. This indicates that PCTs do not currently believe that the commissioning of services to tackle these areas is a priority.

3.10 The Committee may wish to consider recommending that the Department of Health should decommission nationally-defined indicators that were not selected, or that were rarely selected, by PCTs.

4. Translation of national priorities into local action

4.1 If the transition towards local autonomy through the commissioning process is to be successful and sustained, then national policymakers will have to be confident that it provides an effective mechanism for securing progress on nationally-identified priorities. National priorities, local action? reveals that that the service or disease areas on which PCTs are focusing do broadly reflect national priorities.

4.2 It can therefore be assumed that national policy does influence local commissioning prioritisation. Perhaps the best example of this is end of life care. The most commonly-selected indicator which relates to a specific area of service provision is “percentage of all deaths that occur at home”. This is a key finding


because end of life care has traditionally been seen as a “Cinderella” area of NHS provision, attracting a low public profile and too little focus from policymakers. However, 49% of PCTs adopted an indicator for end of life care, demonstrating the impact that the Department of Health’s End of Life Care Strategy has made.

4.3 The early success of the End of Life Care Strategy shows how national strategies can be translated into local prioritisation. The Committee may wish to consider recommending that the Department of Health ensure that future national disease or service strategies should be explicit in their links to World Class Commissioning, establishing nationally defined indicators which PCTs can adopt.

4.4 It is also clear that there has not been a consistent approach to translating national priorities—such as those contained in all three tiers of the Vital Signs contained within the NHS Operating Framework or the national indicator sets used to measure performance against the Department of Health’s Public Service Agreements—into nationally-defined World Class Commissioning metrics. The implication of this is that either some PCTs are effectively “double counting” by choosing indicators which are already prioritised through other performance management mechanisms or that some national priorities are effectively disadvantaged by their lack of inclusion within the nationally-defined indicators.

4.5 Only 21 of the 40 metrics included in the Vital Signs were included in the nationally-defined indicators. For example, childhood obesity which is included within a Public Service Agreement and tier 2 of the Vital Signs, does not appear in the list of nationally-defined metrics for the first year of the assurance process. This is particularly concerning as tier 2 indicators are defined as “national priority for local delivery” and tier 3 as “local action”.

4.6 The Committee may wish to recommend that the Department of Health should clarify the relationship between the national performance management processes and the World Class Commissioning outcome indicators, ensuring that there is greater consistency in whether Vital Signs are translated into nationally-defined indicators.

4.7 Some of the nationally-defined indicators do not appear in any other form of national performance management mechanism. There is also little consistency in whether PCTs are selecting indicators which are also included in other forms of performance management. Overall, 52% of all indicators selected are the same or very similar to those included in the Vital Signs.

4.8 There is also an imbalance between the distribution of nationally-defined indicators and overall NHS programme spend. For example, no nationally-defined indicators relate to musculoskeletal services and NHS dentistry, despite the high overall level of expenditure incurred in these areas.

4.9 The Committee may wish to consider recommending that the balance of indicators should be evolved so that it more accurately reflects the overall impact of different service areas on overall NHS expenditure.

5. Delivering on the Efficiency Agenda

5.1 The Department of Health has made clear that the World Class Commissioning programme is expected to play a major role in delivering the efficiency savings necessary for the NHS to withstand the slowdown in the growth in health spending. This was reflected in Budget 2009.

5.2 The NHS Confederation has argued that PCTs should plan for a real terms reduction of at least 2.5–3% in the resources available to them from 2011. This changed environment means that commissioners have less than two years to deliver efficiency improvements in preparation for lower budgets.

5.3 Although the preventative measures prioritised by many PCTs will ultimately reduce demand for healthcare, it is likely that many of the priorities will only deliver savings in the medium to long term. Shorter term efficiency savings will also be required to meet the challenges of the economic downturn.

5.4 Although the importance of using the commissioning process to deliver efficiency savings is reflected in other areas of the World Class Commissioning programme, efficiency improvements can also be encouraged through the design of health outcome indicators, ensuring that the attention of commissioners and providers is focused on delivering both clinically and cost-effective services. It is therefore concerning to note that only six of the 54 nationally-defined indicators relate to improving service efficiency or reducing ineffective spend:

- Percentage of live births delivered by caesarean section.
- Delayed transfers of care.
- MRSA infection rates.
- Clostridium difficile infection rates.

53 NHS Confederation, Commissioning in a cold climate, June 2009.
— Rate of hospital admissions per 100,000 for alcohol-related harm.
— Percentage of all deaths that occur at home.

5.5 The Committee may wish to consider recommending that, in order to assist PCTs in managing the challenges posed by a slowdown in NHS spending, the Department of Health’s newly appointed National Director for Improvement and Efficiency should be tasked with identifying efficiency indicators as a matter of priority.

5.6 PCTs established 16 further locally-defined indicators relating to service efficiency. However, only 18% of all indicator selections could be considered to focus on delivering short to medium term efficiency savings. By far the most common of these were alcohol-related harm and percentage of all deaths that occur at home.

September 2009

Memorandum by the Medical Practitioners’ Union (COM 28)

1. SUMMARY

1. Commissioning identifies the health needs of a population, turning it into services that the population requires.

2. We support replacing market-based commissioning with locality commissioning, the policy on which the Government was elected in 1997.

3. Markets haven’t succeeded—large amounts of money have achieved less than if invested in the old system.

4. An NHS resource strategy requires immediately using participative LEAN methodologies to improve quality and reduce cost and a longer term strategy reducing need by lifestyles and healthy ageing. Tariffs cannot deliver either of these. Clinical engagement involving GPs, consultants and public health is essential to deliver these changes.

5. Paras 28-33 and 41-43 give practical examples of the market system not meeting current NHS circumstances.

2. “WORLD-CLASS COMMISSIONING”

6. World class commissioning is as good as its criteria.

7. We welcome criteria on assessing the health of local populations and setting objectives based on health outcomes. We argued for locality commissioning in a detailed document in the early 1990s. We support replacing the market with locality commissioning on which the Government was elected in 1997.

8. We welcome criteria on public involvement. In the 1980s we produced papers advocating democratic popular involvement in the local NHS through Neighbourhood Health Committees.

9. We welcome criteria on clinical engagement—essential to the redesign of services.

10. Criteria on market development are foolish (paras 15-33)

11. The new criterion on financial stability is unachievable under the tariff system and should be replaced by two new criteria:
   — immediate use of LEAN participative methods to provide better services at lower cost; and
   — a medium term resource strategy reducing need through lifestyle change and healthy ageing.

12. The criterion on governance achieves little.

3. HAS THE PURCHASER/PROVIDER SPLIT BEEN A SUCCESS AND IS IT NEEDED?

13. Commissioning is identifying the needs that a defined population has for health care and translating that into the services the population receives.

14. Commissioning, so defined, is essential to any health care system planned to meet need.

15. The creation of a market nexus between commissioners and providers is not an essential part of commissioning. Nor is it particularly useful. With growing expenditure where the main problem for commissioners is to turn the additional funding most efficiently into services, there is an argument that markets will be the most effective way to achieve that. We don’t agree with that view, but we can understand it and we accept that it will be seen as axiomatic to those who have a strong faith in markets.

16. However markets have not proved themselves. The NHS has improved dramatically (before this Government came to power waiting lists were measured in years not in weeks) but a system would have had to be appallingly inefficient not to achieve improvement with the large amount of money spent. The old system would have achieved more with the same money.
17. Even if markets had proved themselves in this dramatic growth of expenditure they will not cope with the future situation (paras 21-33)

18. Purchaser/provider separation has limited the scope for clinicians to cooperate in the planning of care across the GP/consultant boundary. Some NHS Trusts have forbidden consultants from negotiating service changes with GPs. This growth in managerial power is not in the interests of patients.

19. Commissioning should take place to geographical populations—Neighbourhood Health Committees elected to represent natural communities should be coordinated by elected Health & Social Services Board at social services authority population level which would also have a degree of direct control over provider organisations. This reorganisation should be organic not disruptive (see Appendix 1).

20. There will however be some patients who choose to cross the boundaries. It should be possible to handle cross boundary flow without markets (see Appendix 2)

4. COMMISSIONING AND "SYSTEM REFORM"

(a) Resource Strategy

21. We would be delighted if current growth trends in NHS spending were maintained as they should be.

22. However even smaller levels of growth may represent considerable prioritisation of the NHS in expenditure scenarios that many wrongly regard as unavoidable.

23. Growing NHS demand can currently only be accommodated by considerable above-inflation funding growth.

24. If society will fund that there is no problem.

25. If it won’t (and even current plans beyond 2011 would not) we need to reduce that financial demand.

26. This requires:
   — collaboration between primary and secondary care, with public education, reducing unnecessary service use;
   — service redesign providing care more efficiently;
   — industrial-scaling of lifestyle services reducing morbidity and hence need (timescale five years—two to achieve lifestyle change and 3 to reflect that in morbidity); and
   — a healthy ageing strategy reducing dependency in the elderly population and the gap between healthy life expectancy and life expectancy (likely timescale 10 years, when those now in their 50s will be in their 60s, those in their 60s will be in their 70s and those in their 70s in their 80s).

(b) Can The Market Deliver This Strategy?

27. The present system cannot achieve this. Eliminating unnecessary use of services is difficult when providers have perverse incentives to encourage activity. Competitive models undermine planned service redesign. Funds for lifestyle services are squeezed by growth in tariff-based demand. A healthy ageing strategy requires higher expectations of old age, steps to avoid treatable disease being missed with premature acceptance of dependency, changes in society (in culture, leisure, work and transport) to help older people live a normal independent life and active rehabilitation to maintain independent function. These can’t be turned into a tariff.

(c) An Example of This Failure

28. We are grateful to the BMA for the following example.

29. In district A the cost of providing the services which the population receive is some 3% above the funding currently available to the PCT. The hospital has a surplus which Monitor regards as dangerously small in comparison to its turnover. The reason this situation has arisen is that the hospital has failed to achieve the 3% Treasury efficiency savings and the PCT has underestimated the growth in demand for services. The hospital is under pressure and has difficulty meeting waiting list targets.

30. To bring this system into balance requires reduced costs of care. It would be possible to do this by the PCT taking harsher rationing decisions, the PCT funding community services to ease the pressure on the hospital by facilitating earlier discharge, clinicians cooperating to avoid some unnecessary use of services, and lean health care being used to reduce costs. By these approaches the system should save considerably more than 3% and fund growth.

31. However if the hospital increases the activity it carries out it can earn more money and avoid harsh decisions about costs. It has set up information systems to code activity more effectively and business models aimed at persuading GPs to refer more patients more people to come to A&E. This will worsen pressures on the hospital and the financial state of the health economy but nonetheless it is a rational decision for the hospital as it can treat more patients at marginal cost (lower than the tariff as its overheads are already met)

32. The PCT can route patients into an intermediate care system to monitor referrals and save money and incentivises its GPs to reduce referrals. It spends money on these systems.
33. The activities of the two organisations are both rational in market terms but do nothing to solve the problems of the system. The PCT cannot provide community services to ease the pressure on the hospital by facilitating discharge because it will cost money and will not save on tariffs unless precisely (and clinically inappropriately) focussed on break points when length of stay triggers extra payment. The hospital cannot turn away referrals because it will lose income. The hospital has a theoretical solution to its problems but only by making its pressures worse and earning entitlement to money that doesn’t exist (a classic toxic asset). The PCT has a theoretical solution to its problem but only by destabilising its hospital. If they realise this and work together to solve their shared problem in an intelligent way they will breach competition principles.

(d) Clinical engagement

34. We must involve GPs, consultants and public health doctors fully in service redesign. Our proposals for Neighbourhood Health Committees and locality commissioning envisage a major role for GPs. Our proposals for LEAN participative efficiency measures require full involvement of consultants. Service redesign, lifestyle changes and healthy ageing require the skills of public health doctors.

35. Consultants are often not involved in commissioning at present. Managers often feel that their income stream would be endangered if consultants discuss individual patients or clinical protocols with GPs. This disempowerment is deeply resented and lowers morale.

36. GPs are deeply involved in commissioning but often feel that their role is that of scapegoat. They hold budgets and gatekeep but many admissions, especially those through A&E, by pass them and many commissioning decisions are made by bodies like NICE. Patients are told to expect choice. Attempts to enforce effective use of resources policies can damage the doctor/patient relationship and hence the doctors’ score on patient surveys. Service redesign is undermined by providers who create capacity knowing that patients will use it. This system can only work if we are willing to spend a GDP percentage not only equal to that spent in America but with extra to make the American system universal. GPs are then expected to contain its costs within European levels of funding.

37. Public health professionals often feel that they are seen as backroom information providers away from the main focus of decision with their skills in resource optimisation and prevention undervalued.

38. Power should shift back from managers to health professionals, whilst finding effective ways to hold the system to democratic account. We are grateful to the BMA for the phrase “shift power from bureaucrats and bean counters to Parliament, the professions and the people”.

5. Specialist Commissioning

39. Effective commissioning requires epidemiological stability of need within the financial accounting period. For tertiary care services this can be achieved by extending the accounting period, by risk sharing or by commissioners acting together. Collaborative commissioning is the obvious choice to help bring commissioners and providers closer together.

40. Tertiary commissioning faces the problem of funding medical advances. In our view this can only be tackled by a new approach to pharmaceutical pricing (see Appendix 3)

6. Commissioning for the Quality and Safety of Services

41. In district B the proportion of patients X rayed in A&E has risen dramatically. The commissioner is concerned because:

— it wastes NHS resources;
— this is magnified on the commissioner’s books because it alters the tariff level of the individual case;
— it exposes patients to unnecessary X rays. The risk to each individual patient is small but the cumulative effect is a definite additional number of cases of cancer; and
— it is contrary to recognised professional good practice.

42. The cause is an increasingly risk averse medical practice driven by complaints and litigation. Managers are unconcerned as it adds to their income.

43. How in the current system is the commissioner to deal with this? By detailed contractual specifications of when X rays are to be done? By limiting the number of X rays? By appointing a doctor to sit in A&E second guessing every X ray request?

44. The current system as designed is uniquely inept at commissioning for quality and safety. Those who operate it know this but are undermined by the system they are required to operate.

September 2009
APPENDIX 1

ORGANIC REORGANISATION

<table>
<thead>
<tr>
<th>Current Model</th>
<th>Organic Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everything happens on a fixed day</td>
<td>There is a gradual process</td>
</tr>
<tr>
<td>Old organisations are disbanded</td>
<td>Functions shift to a different operational model</td>
</tr>
<tr>
<td>New organisations are founded</td>
<td>When functional shift is complete it may be recognised in organisational form</td>
</tr>
<tr>
<td>New organisations then devise their structures</td>
<td>New organisations come into being because structures have come into place which need them</td>
</tr>
<tr>
<td>There is a pause in strategic work whilst old organisations are lame ducks</td>
<td>Continuity between old and new</td>
</tr>
<tr>
<td>Another pause whilst new organisations develop strategy</td>
<td>New organisations are created because a strategy exists which requires them</td>
</tr>
<tr>
<td>So for about 12 months everybody concentrates on reorganisation and no strategic work happens</td>
<td>No such gap</td>
</tr>
<tr>
<td>Vacancies are held (or filled temporarily) until reorganisation to maximise flexibility for new organisation</td>
<td>Vacancies are used to reshape in the new direction</td>
</tr>
<tr>
<td>People then apply for new jobs in the new organisation</td>
<td>No such problem</td>
</tr>
<tr>
<td>This freezes career progression for one to two years</td>
<td>Existing jobs are reshaped</td>
</tr>
<tr>
<td>Enthusiasts are held back until the system is ready</td>
<td>No such problem</td>
</tr>
<tr>
<td>Doubters have to come along with the rest</td>
<td>Doubters move more slowly watching what is happening</td>
</tr>
<tr>
<td>Mistakes happen everywhere at once and are denied</td>
<td>Mistakes happen in pilot areas and are learned from. There is time for this</td>
</tr>
<tr>
<td>Alternative models are suppressed</td>
<td>Alternative models are tested. There is time for this</td>
</tr>
<tr>
<td>Isolated good practice remains isolated because everybody else has already finished the process</td>
<td>Good practice is tested, learned from and copied. There is time for this</td>
</tr>
<tr>
<td>Those who make rapid progress are seen as the best</td>
<td>Those who make rapid progress are seen as the reconnaissance unit</td>
</tr>
<tr>
<td>Those who make slow progress are seen as being laggards</td>
<td>Those who make slow progress are seen as being careful</td>
</tr>
<tr>
<td>The centre decides how and what to devolve to the front line and controls the devolution process</td>
<td>The front line decides what central support it needs and controls the devolution process</td>
</tr>
<tr>
<td>Every NHS body has a full management team, a set of support functions, a Board and a complex financial system and is a large self sufficient organisation</td>
<td>An NHS body has a coherent purpose, a budget to achieve that purpose, one or more people to run it, a relationship to the system of political accountability, and access to the support systems it needs. It could be very small</td>
</tr>
<tr>
<td>Organisations are large to achieve economies of scale</td>
<td>Organisations are small to avoid diseconomies of scale. Functions needing centralisation to achieve economies of scale are shared</td>
</tr>
</tbody>
</table>

APPENDIX 2

THE ISSUE OF CROSS BOUNDARY FLOW

The following table shows how cross boundary flow could be accommodated by a system without markets.

<table>
<thead>
<tr>
<th>Planned cross boundary flow</th>
<th>built into the normal flow of funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergencies, workplace services, school health services and walk in facilities</td>
<td>funded by commissioners for those present within their boundaries not just their own population. Funding allocations would take account of working populations, school populations, evening populations and holiday populations negotiated directly between neighbourhoods and practices/social enterprises/adjoining neighbourhoods</td>
</tr>
<tr>
<td>Cross boundary FHS registration and cross boundary availability of community facilities and community hospitals</td>
<td>direct SLA between a Neighbourhood and a neighbouring health board</td>
</tr>
<tr>
<td>Planned usage of community health specialist services and secondary care services across Health Board boundaries</td>
<td>SLA between Health Boards</td>
</tr>
<tr>
<td>— where a neighbourhood receives its main hospital services cross-boundary</td>
<td></td>
</tr>
<tr>
<td>— other situations</td>
<td></td>
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</tbody>
</table>
Planned cross boundary flow

<table>
<thead>
<tr>
<th>Planned usage of tertiary care services</th>
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<td>— within SHA boundaries</td>
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<td>— across SHA boundaries</td>
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<td>Unplanned cross boundary flow</td>
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<th>built into the normal flow of funds</th>
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<td>knock for knock basis. Health and Social Services Boards should account for care they provide on this basis and care they receive. In general this should balance out. Fluctuation year on year should be dealt with by a degree of flexibility in carrying forward surpluses or deficits. Persistent imbalance may need to be reflected in some form of financial adjustment.</td>
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If a Board is a persistent unplanned exporter of patients this may imply:
(a) inadequate local volume of provision;
(b) poor quality leading to patients choosing other providers; and
(c) unrecognised natural flows of patients

If a Board is a persistent unplanned importer of patients this may imply:
(a) excessive capacity;
(b) high quality attracting patients; and
(c) unrecognised natural flows of patients

APPENDIX 3

COMMISSIONING PHARMACEUTICALS

We should reform the pharmaceutical market so that rewards for innovation and development are based on health gain and separated from price at the time of use by a national payment to the company that developed them. This would allow the NHS to use all new drugs as extensively and quickly as clinical need requires since their price at the point of use would no longer pay for research and development. This would not save money—money saved at the point of use would be spent nationally in licence fees. R&D has to be paid for somehow.

There would be changes in the pattern of R&D. With licence fees based on health gain it would no longer be profitable to produce “me too” drugs or drugs merely replacing drugs going out of patent.

There would be changes in manufacturing—with R&D as a distinct profit centre pharmaceutical companies could develop a drug but leave manufacturing to generic manufacturers.

With licence fees rather than sale of drugs being the main source of profit marketing would decline. The NHS could take over the marketing departments of drug companies and use them to promote good practice.

Drug companies would bear more of a risk on R&D and would more often make losses. However there is no free lunch—losses on drugs which achieve limited health gain would be offset by more profit on drugs that were a genuine advance.

Memorandum by Professor Stephen Harrison, Dr Kath Checkland and Dr Anna Coleman (COM 29)

PRACTICE-BASED COMMISSIONING IN THE ENGLISH NATIONAL HEALTH SERVICE: EXPERIENCE AND PROSPECTS

EXECUTIVE SUMMARY

1. Practice-based Commissioning is a policy designed to increase the engagement of front-line primary care physicians with the commissioning of services for their populations.

2. Most GPs have undertaken PBC as part of local groups rather than as single practices.

3. Our research has demonstrated that there is considerable engagement with PBC amongst GPs. Such engagement requires that local PBC arrangements should be perceived as legitimate by GPs. Tight control by PCTs and concern that the policy will be abruptly changed or abolished both act to reduce this perception of legitimacy.

4. Positive impacts of PBC included: development of new services; engagement in the redesign of patient pathways; the development of systems to review and reduce hospital referrals; and a new willingness amongst GPs to engage in peer-review of performance.
5. Areas of difficulty or contention include: calculation of budgets and savings; managerial and information support; integration of PBC into the wider commissioning agenda of the PCT; and patient and public involvement. We found some engagement with the notion of health inequalities, but some confusion as to how this might be approached through commissioning.

6. We conclude that, if these areas of difficulty are addressed, PBC has the potential to contribute significantly to the effectiveness of commissioning.

BACKGROUND

7. The National Primary Care Research and Development Centre is a multi-disciplinary, academically independent centre, established at the University of Manchester by the Department of Health in 1995 to undertake a programme of policy related research in Primary Care. Research into aspects of organisation of the NHS is one of NPCRDC’s major programmes of investigation.

8. In this evidence, we draw on our own research into Practice-based Commissioning (PBC) (Coleman et al 2009—available online at www.npcrdc.ac.uk/r5.82) conducted between 2007 and 2009 in order to assess its progress and potential future value. Our research included interviews with a small number of civil servants, close examination of official documentation, and a questionnaire survey of Primary Care Trusts (PCTs), but our most extensive and in-depth data was derived from intensive qualitative fieldwork in 14 PBC consortia in 8 PCTs. Our fieldwork sites were varied in terms of numbers of PBC consortia within the PCT, numbers of registered patients, services covered by the PBC budget, management and governance arrangements, and stated reasons for pursuing PBC. Our fieldwork comprised over 130 interviews and some 325 hours of observation, mainly of meetings.

9. This evidence focuses specifically on PBC, gradually introduced to the English NHS from 2004 onwards. The essence of PBC is that PCTs provide general medical practices with an “indicative budget” from which to commission services for their patients, with the majority of any resulting savings being available to the general practices to invest in improved patient services. It is important to note that “PBC” is something of a misnomer, since it is clear both from our own research and from our ongoing contacts with the NHS that the majority of PBC is in fact undertaken by groups of general practices organised into what have been variously termed “consortia”, “localities”, “clusters” and similar terms (we employ the term “consortia” hereafter), with few general practices conducting PBC on a “standalone” basis. The term “clinically-led” commissioning has in some quarters come to be substituted for PBC, though here we use the latter term throughout.

10. The Government has recently committed itself to “revitalise” PBC as part of the NHS reforms resulting from the Darzi review (Department of Health 2008:13).

THE RATIONALE FOR PRACTICE-BASED COMMISSIONING

11. Neither formal objectives nor a detailed blueprint for PBC were officially specified, so that its logic and rationale are open to various interpretations. As might be expected, our research found a range of differences in local arrangements, some of which we outline in later sections. However, official guidance (Department of Health 2006) made two potentially key suggestions. First, it was expected that PBC indicative budgets should cover:

(a) services subject to the “payment-by-results” (PbR) system,
(b) prescribing;
(c) community services, and
(d) mental health services.

Second, it was expected that (other than in exceptional circumstances) not less than 70% of savings resulting from PBC should be available to general practices for reinvestment in services.

12. Examination of official documentation and discussions with relevant Department of Health staff suggested that PBC would allow greater “engagement” by primary care clinicians in service design, resulting in services that would be more varied, more responsive and more convenient for patients than their predecessors.

13. However, the same sources revealed two broad sets of assumptions about how PBC might “work”. One set of assumptions centred on the idea that PBC would encourage practice-based commissioners to review and redesign services, especially in the form of local “patient pathways” agreed with relevant local providers and followed by local referrers. The second set of assumptions was that the desired changes would come about through increased contestability amongst a greater number of providers, and indeed that PBC might lead to the market entry of new providers. Although these two sets of assumptions are not wholly incompatible, there is a potential tension in that local co-operation between primary and secondary care clinicians in the development of (say) new patient pathways might well be inhibited if it were believed that this might result in an increase in contestability of services.
14. One rationale for PBC that was not prominent in official documents but was clearly articulated in our interviews within the Department and the NHS was the management of demand for health care. In the present PbR system, the means available to PCTs to maintain expenditure within budget are relatively limited (Checkland et al 2009), so that the potential of PBC to affect the behaviour of GP referrers is logically very important.

RESEARCH FINDINGS

15. By 2008–09, we found substantial engagement by GPs with PBC across all our sites, in the sense that both the overall PBC project and the actions taken in its name were generally seen by GPs to be legitimate. This legitimacy was helped in our study sites by: formal “sign-up” arrangements to the consortium; a sense amongst “rank and file” GPs that they were being kept fully informed about PBC and its processes; systems that ensured that GPs were aware of and able to use new services and/or pathways as they were developed; a financial incentive scheme perceived to reward work appropriately; and perceptions that progress was being made. Factors that seemed to undermine the perceived legitimacy of PBC were: concern that national policy might substantially alter or abolish PBC at any time, and excessively tight control by PCTs, with overly bureaucratic processes or a failure to support innovation. We also noted that much of the progress made had depended on co-operative work between PBC consortia and local providers.

16. The degree of engagement by individual GPs in the day-to-day activities of PBC varied from participation in PBC governance, through communication of PBC decisions and services to colleagues, to practice-level action such as internally reviewing referral decisions and utilising new patient pathways and services resulting from PBC.

17. Budget setting was often a source of contention. The extent of the budget devolved under PBC plays a part in determining the scope of the action possible. Our questionnaire survey (Coleman 2007) showed that by 2007, only about one-third of consortia had been given indicative budgets of the scope suggested in official guidance. In only two of the PCT areas that we studied in our detailed fieldwork had consortia received budgets that extended beyond prescribing and PbR, and we found an appetite amongst PBC consortia for greater access to community or mental health budgets, as these are areas that have a very direct impact on the work of GPs. Transparency about budget setting processes was important to participants.

18. We found a large number of new services set up in the name of PBC. These ranged from local, small scale practice-level innovations (eg ECGs) to much larger schemes (eg new clinics across localities). Not all of these services were established solely as the result of PBC, but PBC provided a convenient vehicle for their ongoing development, management, governance and financing. We found that such services and pathways usually resulted from active co-operation with local providers and that there was little apparent appetite amongst our sites for extending the range of providers. Indeed, all our PBC groups were keen to provide services themselves. Some had established or were planning a formal “provider arm” as a social enterprise or other type of company. This generated disquiet amongst many PCT officers, who were concerned about potential conflicts of interest. However, in many cases the provision of services by GPs seemed successful, utilising existing premises and expertise, and providing services that integrated well with existing practice services.

19. All our study sites had developed systems to try to reduce overall demand for hospital services; these included peer-reviewing of referrals and auditing of specific service areas. These arrangements were more likely to be implemented at practice level if GPs accepted the overall legitimacy of PBC. PBC consortia often complained that they had insufficient support in analysing and responding to detailed hospital activity statistics. However, GPs were also often unclear as to exactly what they wanted from their data analysts.

20. Many of the PBC consortia had made savings. However, there was no overall consensus about how such savings should be calculated, or about whether or not it was meaningful to regard savings as “planned” or “unplanned”. The absence in some sites of consensus about how savings should be calculated, or whether or not it was meaningful to regard savings as “planned” or “unplanned” led to uncertainty and contention about the possibilities of reinvestment. Sites which had made formal agreements in advance about how such savings should be calculated, or whether or not it was meaningful to regard savings as “planned” or “unplanned” led to uncertainty and contention about the possibilities of reinvestment. Sites which had made formal agreements in advance about how savings were to be calculated and used were less likely to report conflict.

21. Importantly, and unexpectedly, we found a new willingness by GPs to engage in peer review and performance management of each others’ work, although some preferred to talk about this as “levelling up” general practice or “education”. Mechanisms observed included: practice visits to discuss performance against budgets; publication of named performance data; open discussion of such performance data in meetings; and the use of PBC as a mechanism to implement an unrelated performance assessment framework.

22. We found no agreed definition of “health inequalities” or agreement about which social groups should be of concern in this respect. We also found no overall agreement about how any inequalities might be addressed by PBC and some concern that PBC might exacerbate inequalities if some consortia developed better services for their own patients. Nevertheless, in a small number of our sites there were some plans to use PBC to invest extra resources in practices in areas of deprivation. This was more likely to occur in areas where the PBC project as a whole was seen as legitimate and successful.

23. Patient and public involvement was limited in all our sites and, although some were seeking to develop this, there was no overall consensus about the form or timing of such involvement.
24. We found some evidence of engagement with Local Authorities, but this was much more difficult in areas where PBC boundaries do not coincide with local authority boundaries. Integration of PBC with the wider commissioning agenda of the PCT was variable between sites; it was most likely to be successful where structures existed to enact integration on the ground, and GPs were engaged with both PCT priority-setting processes and with local public health specialists. Such integration was easier to achieve where there were a smaller number of groups undertaking PBC within a PCT.

25. Adequate management resources were found to be important in all our sites. We found a variety of models, including staff seconded from the PCT, staff directly employed for the PBC consortium, and the employment of external consultants. Importantly, none of these models was in itself better or worse than others. Rather, the most important factors were: clarity over roles and responsibilities; willingness by the GPs to engage in organisational development and to think more widely about the nature of PBC; and a belief by GPs that associated managers were working on their behalf. Precise contractual arrangements for managerial support were less important than the provision of adequate managerial time, with a clear remit and lines of responsibility.

Policy Implications of the Research

26. PBC is a policy still in its infancy and requires time and resources to develop its full potential. Our data do not point to any ‘one best way’ of organising PBC. Factors such as historical legacies or geographical features can have important local effects (Coleman et al., in press), and imposing a “top down” model of PBC in the face of these would risk being counter-productive. We found that the relationship between PBC groups and their PCT was the single most important factor affecting progress. Tight control of PBC by PCTs risks undermining the legitimacy of PBC. An approach that is flexible and supportive of innovation, whilst incorporating adequate governance safeguards, is most likely to be successful.

27. It is neither necessary nor desirable for all GPs to be involved in governance and planning activities for PBC. Rather, the most important factor in ensuring clinical engagement with PBC (at both consortium and practice level) is that the local PBC project should be seen as legitimate by the mass of GPs. Formal “sign-up” arrangements to consortia enhance both legitimacy and clarity surrounding PBC.

28. Communication strategies seemed to be most successful if they both ensured that GPs felt fully informed and also provided easy to use information about available new services and pathways. In particular, clarity about budgets and how savings will be calculated, allocated and used is vital, and formal “sign-up” arrangements both within PBC consortia and between the consortia and the PCT may facilitate this.

29. The scope of the budget devolved enables or constrains the action possible through PBC, so that possible developments in community or mental health may remain constrained by PCT views about the difficulty of devising indicative budgets for such services.

30. If provider competition intensifies, the level of engagement necessary to underpin co-operation between PBC clinicians, local secondary care colleagues and PCT contracting staff involved in effective PBC might be at risk.

31. Peer review of general practice performance under PBC is a significant positive outcome, but there is a danger that the legitimacy of PBC will be undermined if this is not done sensitively or if external performance regimes are attached to PBC without GPs’ agreement.

32. The perceived impact of PBC in “tacking inequalities” depends upon how these “inequalities” are defined. PBC could increase some forms of inequality whilst simultaneously reducing others. Greater clarity about official aspirations in this regard is required before any judgement can be made.

33. PCTs and PBC groups may need to adopt different mechanisms for involvement of patients and the public for different areas of service development, and performance regimes should be flexible enough to allow a degree of local diversity to exist.

34. GP acceptance of the PCT’s wider commissioning and health and wellbeing agenda is most likely where the PCT itself respects local ambitions of PBC. It may also be easier for GPs to understand the wider agenda where a single PBC consortium covers the whole PCT area.

35. Hiring external consultants to provide management support for PBC consortia is not of itself a shortcut to success. Irrespective of the means by which such support is provided, clarity over mutual roles and responsibilities and the perception by GPs that associated managers are working on their behalf, alongside willingness by GPs to engage in organisational development and to think in greater detail about information requirements are essential.

Concluding Comments

36. In the present system of commissioning NHS care, the means available to PCTs to maintain expenditure within budget are somewhat limited. The potential of PBC to influence expenditure by providing an opportunity and incentive for GPs to reconsider and modify existing patterns of referral, and to participate in the redesign of local services may be important in an era of budgetary restraint.
37. Overall, our results suggest that the potential longer term impact of PBC in affecting the pattern and delivery of local services depends upon the extent to which PBC becomes integrated with the wider commissioning agenda of the PCT. This requires PCT managers to be prepared to cede some control and to provide managerial resources, and GPs to engage beyond their traditional comfort zones, addressing wider population health needs and taking managerial responsibility. However, tackling these difficult questions could bring significant rewards, including, for example: a general raising of standards in general practice using peer-surveillance and the spread of good practice; better informed commissioning and demand management, as GP practices provide ground-level intelligence that can be used in negotiations with hospital trusts; and a general improvement in service planning and integration, as those with first-hand knowledge of patient experiences engage alongside PCT managers and hospital colleagues to develop better clinical pathways.

REFERENCES


University of Manchester National Primary Care Research and Development Centre September 2009

Memorandum by the fpa (COM 30)

1. EXECUTIVE SUMMARY

1.1 fpa (Family Planning Association) is one of the UK’s leading sexual health charities. Our mission is to help establish a society in which everyone has positive, informed and non-judgmental attitudes to sex and relationships; where everyone can make informed choices about sex and reproduction so that they can enjoy sexual health free from prejudice and harm.

1.2 We have restricted our comments to issues associated with commissioning sexual health services.

1.3 fpa is concerned that Primary Care Trusts do not currently have sufficient expertise to commission the high quality sexual health services required. Many sexual health commissioners have competing demands and have not been in post for long. It is vital that each PCT has a full-time sexual health commissioner.

1.4 Sexual health is often a hidden issue about which few people are willing to speak. Consequently, assessing the actual need for sexual health services is difficult and problems achieving this can have an adverse effect on the commissioning of sexual health services.

1.5 The fact that different elements of sexual health services are funded in different ways has undermined the possibility of commissioning integrated sexual health services.

1.6 Many sexual health services are open access and a significant number of people will travel to a different PCT to access services. This poses particular problems for PCTs who pay for those services and can act as a deterrent to service improvements.

2. COMMISSIONING EXPERTISE

2.1 fpa is concerned that Primary Care Trusts do not currently have sufficient expertise to commission the high quality sexual health services required.

2.2 The Review of the National Strategy for Sexual Health and HIV, which was commissioned by the Independent Advisory Group on Sexual Health and HIV and carried out by MedFASH,54 highlighted particular issues around commissioning.

2.3 The Review found that a quarter of sexual health and HIV commissioners had been in their posts for less than a year and 11% of posts were vacant. In addition, commissioners responsible for sexual health at PCT level were often not sufficiently senior to have influence and many had responsibility for a range of competing commissioning roles.

2.4 A survey of PCTs carried out on behalf of the All Party Parliamentary Pro-Choice and Sexual Health Group found similarly worrying results with only 22% of those who responded stating that there was a commissioner within the PCT with full-time responsibility for sexual health.

2.5 Commissioning sexual health services can be extremely complex given the range of conditions, services and providers involved as well as the difficulties with assessing the true need for services (see below). Therefore fpa believes it is crucial that there is a suitably trained full-time sexual health commissioner who has appropriate seniority in each PCT to ensure that sexual health is afforded the priority it requires.

2.6 In addition, information on which to base sexual health commissioning decisions can be difficult to access. In part this is because some data, such as conception data, can take a significant amount of time to compile. Added to this is the fact that many sexual health services do not have adequate access to IT. Although the Department of Health has invested some money to pump-prime procurement of IT systems in community contraceptive clinics there is still a lot of progress to be made to ensure that commissioners have high quality information on which to base their decisions.

2.7 It is also vital that commissioners are able to interpret the data they receive correctly. This can be a particular issue with sexual health services. For example, a rising rate of diagnoses of Chlamydia could be a negative result because more people are being infected. However, it could also be seen as a positive result as more people are aware of and able to access testing services. Commissioners will have to be able to make such assessments to ensure they commission the right services.

2.8 We are aware that the Department of Health is in the process of developing a sexual health commissioning framework. However, it will require commissioners to have the necessary skills and seniority to implement the framework properly to see any improvement in services.

3. PUBLIC AND PATIENT INVOLVEMENT

3.1 Issues associated with sexual health, contraception, sexually transmitted infections and abortion continue to be surrounded by stigma and embarrassment. As a result very few people are willing to talk about their experiences and the services they need. This can make it incredibly difficult for commissioners to assess the need for services.

3.2 The Review of the National Strategy for Sexual Health and HIV found that needs assessment has not consistently been part of the commissioning process for sexual health services and instead provision was generally commissioned according to historical patterns rather than assessed need.

3.3 An important distinction has to be made between “demand” and “need”. Given the nature of sexual health services the vocal demand for services is likely to be significantly lower than the actual need for services. This is in part because of stigma and embarrassment but is also affected by the fact that many people accessing sexual health services, for example contraceptive services, will not think of themselves as a patient because they are not ill. Consequently, they are unlikely to engage in “patient involvement” exercises.

3.4 In some cases, PCTs use anonymous feedback and surveys of service users. However, these will only capture the views of those who are actually accessing services. A true assessment of need will also include people who are no longer using services and people who have never used them. PCTs need to develop innovative measures to ensure they have accurate and timely assessments of the need for sexual health services.

4. DIFFERENT MODES OF FUNDING

4.1 Different sexual health services are funded using different payment mechanisms. Payment by Results tariffs have been developed for HIV inpatient treatment, GUM outpatient treatment and abortion services delivered in NHS hospitals. Tariffs are not currently available for services delivered in the community, including contraceptive services or for social or community care for HIV and the tariff for abortion services does not necessarily apply for independent sector providers. In addition, a significant amount of contraceptive advice is provided as an additional service in general practice under the GMS contract.

4.2 These disparate funding mechanisms have undermined efforts to develop fully integrated sexual health services as they are commissioned from different budgets, and sometimes even by different people. The review of the National Strategy for Sexual Health and HIV found that: “Partial implementation of Payment by Results (PhR) for sexual health and HIV services, with the introduction of tariffs for some services and some settings, but not for others, has led to further disjunction between hospital and community services, presenting barriers to commissioning across whole pathways of care”.

4.3 This has been a particular issue for contraception and abortion services. Abortion services are usually commissioned from secondary care budgets, and increasingly are delivered by independent sector providers. This has meant that many PCTs have not always commissioned abortion service providers to offer the full

55 Ibid.
range of contraception after an abortion. Poor links between abortion services and community contraceptive services, which are commissioned from community budgets, usually on block contracts, have meant that significant numbers of women who have had an abortion have not been able to access the contraception they need leaving them at risk of further unintended pregnancies.

4.4 fpa has welcomed the fact that since April 2009, PCTs have been expected to commission the full range of contraceptive methods from abortion providers but it is not clear whether this is yet in place across the country. It is also not clear whether the professionals involved in delivering services will receive adequate training to talk about all methods of contraception or have sufficient time to discuss all of the options with the women they see. The change to the contract also does not resolve the issue of links between abortion and contraception services which continue to be commissioned separately.

4.5 Piloting of some new and some reviewed tariffs for sexual health services is underway, which is to be welcomed. However, it is vital that these reflect the full range of activities carried out in sexual health services, including training. For example, the vast majority of contraceptive training takes place in community contraceptive clinics and this needs to be taken into account in the development of tariffs. In addition, it is not clear whether these tariffs will support the integration of sexual health services or perpetuate the divisions between GUM, contraception and abortion services.

5. OPEN ACCESS SERVICES

5.1 The vast majority of sexual health services operate on an open access basis. This means that many people visit services in a different PCT to where they live. This can cause problems for the PCT which is paying for the service as it is covering the cost of treatment for residents of another area.

5.2 This situation creates a deterrent to improving sexual health services in both the PCT which hosts the service and also the PCTs from where people are travelling. The PCT which hosts the service will not want to invest further in services which people from other areas benefit from and the PCTs that people travel from will not see the need for investment in services if large numbers of people travel elsewhere.

5.3 To resolve this situation some areas impose strict residency criteria to ensure that only people from the local area are able to access services. This poses a number of problems including deterring even local people from accessing services because they are concerned about their confidentiality when they have to provide lots of information about themselves. It can also leave people from other areas without access to services either because they are not delivered in their area or because they are too concerned about their confidentiality in their own area. It is important to recognise that some people prefer to travel long distances to access sexual health services because of concerns about confidentiality. In addition, in some cases a service in another PCT can actually be closer to a service user than one in their own area.

5.4 Improved tariffs for sexual health services could go some way to resolving this issue as it would enable PCTs to engage in a process of de-hosting and cross-charging to ensure that all PCTs were paying for their own residents. This highlights the importance of commissioners assessing fully the needs of their populations. De-hosting and cross-charging are likely to be complex. However, they are crucial to ensuring that high quality sexual health services are available to all.

September 2009

Memorandum by NHS Sheffield (COM 31)

1. EXECUTIVE SUMMARY

1.1 NHS Sheffield was formed in October 2006; the result of the merger of four primary care trusts in the city.

1.2 It inherited an historic debt of £30 million, cleared by the end of the financial year 2007–08 and which put the PCT in a position to invest in enhancing city wide services.

1.3 Its performance has improved year on year. In 2006, the PCT had a rating of Weak and Weak (Health Care Commission and Use of Resources); in 2007 Fair and Fair and it is projected to receive Good and Good for 2008–09.

1.4 In 2008, after extensive public and stakeholder consultation, it launched its strategy, Achieving Balanced Health—which set out plans to save 400 lives by reducing the health inequalities that exist in Sheffield and in doing so make it the healthiest city in England.

1.5 This submission offers four areas where NHS Sheffield considers it has driven local health and health service improvements and can demonstrate its impact. These are:

1.5.1 delivery of national and local priorities;

1.5.2 Practice Based Commissioning;

1.5.3 public health initiatives with deprived communities; and

1.5.4 engagement and consultation.
2. DELIVERY OF NATIONAL AND LOCAL PRIORITIES

2.1 NHS Sheffield has led delivery of key national and local priorities across the Sheffield community through a robust contractual process with providers, clear strategies for responding to public health priorities and clear accountability of service contributors across the health, social care and third sector community. These include:

2.2 Meeting of the 18 week national standard and the clinical pathway reforms that underpin this— the PCT set up a city wide clinical reference group to allow clinical staff to review care pathways and set out alternatives to traditional referral to secondary care.

2.3 Managing delays of older people in acute hospital—the Sheffield health and social care community has worked to provide more comprehensive out of hospital intermediate and rehabilitative care. In conjunction with Local Authority colleagues there has been increased investment and revised working arrangements that have contributed to a weekly average of acute delays of less than 12. 18 months ago this was as high as 120.

2.4 Smoking Quitters—Sheffield has identified smoking as one of its key Public Health Priorities and through increased investment and focus on delivery has achieved its smoking targets during the last financial year and is now on track to deliver this year’s from a position of underperformance.

2.5 Providers of healthcare in Sheffield—were all rated as Excellent for Quality of Services in the last HCC ratings. This underpins the priority and focus of the commissioning and contracting process that the PCT and its providers undergo.

2.6 Chlamydia Screening—the PCT initiated a number of key innovations in increasing uptake, ranging from pharmacists undertaking screening through to small incentive schemes. This resulted in the community achieving its national target and evidence to date indicates that this progress is continuing.

3. PRACTICE BASED COMMISSIONING

3.1 Practice Based Commissioning (PBC) in Sheffield has changed and evolved considerably since its launch by the Department of Health (DH) in 2006. In Sheffield in 2008–09 the consortia consolidated from seven to four and there is only one practice (out of 93) not yet signed up to PBC.

3.2 The DH commissions a national survey of practices which monitors engagement in PBC quarter-by-quarter. Over the last 12 months we have achieved a consistent improvement in our local results and the latest show Sheffield benchmarks favourably: 80% of the Sheffield sample reported positive relationships with NHS Sheffield, compared with 59% in the Yorkshire and Humber region and 62% across England (February 2009).

3.3 Good relationships have been established between PBC managers, strategy and specification managers and clinical colleagues where they are working together on redesigns. The following are among those already completed:

3.3.1 Local Enhanced Service (LES) for Care Homes—A two-year pilot to test if improved GP cover could reduce avoidable admissions had a successful first year. Across 14 homes, admission costs were down £145k (10%) covering the £125k cost of the LES and creating a 20k net saving.

3.3.2 Dermatology—An estimated 9,000–15,000 people in Sheffield (17%–29%) suffer from dermatological problems and more than 8,300 were referred to dermatology last year. However there are a number of conditions that can now be managed by a dermatology service in the community and in January 2009 we tendered for this. Sheffield Teaching Hospitals Foundation Trust won the contract and is identifying suitable new community venues, for a late summer start.

3.3.3 Orthopaedics—Sheffield GPs made nearly 7,400 referrals to orthopaedics, up 34% on the year before. A series of musculoskeletal pathways have been completed to help tackle the rise in hospital demand, including foot and ankle, back pain, knee and shoulder.

3.3.4 Primary Eye Care Acute Referral Service (PEARS)—Nearly 6,000 referrals were made to ophthalmology last year and there is evidence that referrals would reduce by having high street opticians see patients first. A pilot with seven PEARS-trained opticians has run in West and Hallam consortia areas for six months. Nearly 150 patients have been seen by opticians, only 25% of who ended up referred to hospital. Previously all of these patients would have been referred to hospital. Patient feedback is very positive.

3.3.5 Case-finding—Emergency admissions of older patients results in major hospital spend. 28 practices are establishing “at risk” registers, using tools to identify the 75 years + at risk of emergency admission and have started undertaking the 15,000 risk assessments.
3.4 *PBC focus 2009–10*

The PBC Local Incentive Scheme (LIS) is essential to supporting the costs of engagement in demand management and redesign and therefore securing the £40 million savings to deliver our strategic aims. While the headline achievements in 2008–09 were good, both consortia and NHS Sheffield are looking to scale up in 2009–10 and beyond, so that there is more focus on citywide reforms to realise greater patient and financial benefits.

3.4.1 The Local Enhanced Service (LES) for care homes, PEARs and case-finding will be scaled up, to citywide where possible and are three of the series of reforms identified on NHS Sheffield’s Improved Programme for Clinical Services (IPCS).

3.4.2 The return in investment for PBC in 2009–10 will be assessed by:

3.4.3 Effective demand management with consortia achieving referral targets.

3.4.4 The completion of relevant IPCS redesigns with savings realised.

3.4.5 Increased numbers of clinicians actively engaged, as a result of the Development Programme.

3.4.6 Sustaining and improving engagement, as measure by the quarterly national DH PBC survey.

3.4.7 NHS Sheffield is clear that in order to enhance our World Class Commissioning assessment we must ensure our investment in PBC is develop consortia’s commissioning competence.

4. **Public Health Initiatives**

4.1 In Sheffield, mortality rates have fallen dramatically in recent years. As a result, life expectancy for both males and females has increased. However, enormous disparities remain and there is still a ten year difference in life expectancy between our better off and worse off neighbourhoods. There are similar differences in ill health and early death between some of our more vulnerable communities (such as black and minority ethnic communities) and the rest of the local population.

4.2 For these reasons, both our Joint Strategic Needs Assessment and our “Achieving Balanced Health” strategy prioritise the need to reduce inequalities in life expectancy by targeting action to improve health and access to healthcare services in the most deprived parts of the city.

4.3 The Enhanced Public Health Programmes (EPHP) have been developed to cover the one third of the city with the worst health and deprivation levels and are focused on 15 geographical neighbourhood clusters, covering a total population of approximately 185,600 which is approximately 34% of the Sheffield population.

4.4 For each EPHP area, a plan has been developed and delivered in partnership with the local community. The plans are focused on tackling the wider determinants of health (such as providing skills development, training and employment opportunities), promoting healthier lifestyles (for example, providing stop smoking support, weight management services and alcohol interventions) and increasing access to and uptake of appropriate health services (particularly in relation to people most at risk of developing conditions such as coronary heart disease, stroke, chronic obstructive pulmonary disease, diabetes, and cancer).

4.5 All our evidence this year points to health improving faster in the enhanced public health programme areas than anywhere else in the city.

5. **Engagement and Consultation**

5.1 We are committed to listening to and creating an ongoing dialogue with the city’s population. We actively work with patients, the public and staff to design and take forward services—engaging at all stages of the commissioning process and creatively engaging with groups and communities who are seldom heard. In addition to our routine engagement activity, we have:

5.1.1 Launched the Advisory Forum—a representative group of 35 people from across Sheffield to advise the Board on strategic issues.

5.1.2 Listened to and talked with the people of Sheffield on a range of issues—including intermediate care services, dermatology services, the NHS Constitution and our strategy.

5.1.3 Developed our brand and helped the people of Sheffield to start to understand why they should get involved with us.

5.2 **Advisory Forum**

5.2.1 Central to our engagement agenda is a group of Sheffield people from all backgrounds who meet four times a year to help steer our strategic direction. We made history and changed forever how we listen and engage with Sheffield people when we launched the Advisory Forum in September 2008. This group of around 35 people from the city now advise our Board on future plans and help ensure that patients and the public are listened to. Members are representative of the city’s population and include seldom heard voices in the community. The meetings are chaired by the chair of NHS Sheffield.
5.2.2 One of the most significant actions the group has taken since its launch was to allocate £250,000 to projects concerning improvement in compassion, dignity, privacy and respect in patient care. Following a two-stage assessment process the Forum recommended to the NHS Sheffield Board that 12 new projects receive funding. Community organisations as well as statutory partners, such as Sheffield Teaching Hospitals, were allocated funding for projects ranging from £600 to £50,000.

5.3 Consulting and engaging

5.3.1 We have asked the people of Sheffield for their views on a range of subjects, including how they would like intermediate care (short term rehabilitation and care between hospital and home) services to be developed, a new city centre GP practice, dermatology services, the NHS Constitution, maternity services and second and third year refreshes of our five year strategy. This latter consultation was called the Big Health Conversation.

5.3.2 We are increasingly becoming more sophisticated in our work in this area, and the most recent consultation informed nearly one million people it was happening (this figure includes double, triple or higher counts of the same person who will have been informed in more than one way—eg postcard, listened to the news on the radio, read the newspaper, saw a bus advert etc). We actively had conversations with nearly 2,500 Sheffield residents on the issue.

5.4 Developing brand recognition

5.4.1 Strategic development of communications and engagement work in the last 18 months has taken NHS Sheffield from scant public understanding of what it did (perception survey results 2007) to year on year public perception improvement (NHS PCT perception poll results for 2009 evidence this). In addition, NHS Sheffield scored the highest in the region (Yorkshire and the Humber) for its favourable media coverage.

September 2009

Memorandum by Beating Bowel Cancer (COM 32)

KEY POINTS

— There have been welcome developments at national level in improving bowel cancer services, including the national screening programme.

— Greater local prioritisation of bowel cancer and stronger commissioning by PCTs will improve services for patients throughout the care pathway.

— There should be scrutiny of the implementation of changes to processes for ensuring access to cancer treatments for patients, particularly for those at the end of their life.

— Commissioners should act upon the recent report by the National Chemotherapy Advisory Group to improve quality and safety for bowel cancer patients.

1. The national bowel cancer screening programme should improve rates of early diagnosis, but stronger commissioning should support this further

1.1 2009 should see the completion of the roll-out of the national bowel cancer screening programme for all men and women aged 60 to 69. Evidence on the uptake of the programme so far indicates that nearly 2,000 cancers have been detected, and almost 1.3 million kits have been returned. While these figures indicate the success of the programme in improving rates of diagnosis in patient populations at higher risk of the disease, commissioning will be an important tool to address the challenges that remain.

1.2 Local NHS organisations are being measured according to the quality improvement indicator, launched as part of the NHS Next Stage Review, on the “percentage of 60–74 year-old adult population screened for bowel cancer in the previous two years”. This aims to deliver an “optimum” uptake rate of 60%, although this may be exceeded.

1.3 It will be critical that PCTs are scrutinised on their responsibility to commission services to meet this standard, and to ensure that the success factors for the programme are not based on absolute numbers of invitations sent out, but on the proportion of returned kits. This will support efforts to drive participation in the programme amongst more hard to reach populations.


1.4 It is also significant that there is currently no nationally-defined indicator on bowel cancer screening included in the World Class Commissioning framework for PCTs. This is in spite of indicators for breast and cervical cancer screening. As the UK’s second biggest cancer killer, bowel cancer should be included as an indicator in order to ensure that action to tackle the disease through screening is given more priority by PCTs.

2. **PCTs should give greater prioritisation to bowel cancer in local commissioning decisions.**

2.1 Bowel cancer is one of the most curable cancers if caught early: 93.2% of people diagnosed with the earliest stage of disease survive five years from diagnosis, compared to only 6.6% of people with advanced disease which has spread to other areas of the body at diagnosis.\(^58\)

2.2 However, only 13% of patients are currently diagnosed at the earliest stage of the disease as people are often reluctant to discuss their bowel symptoms with their GP because of embarrassment.

2.3 At local level, however, there is evidence that PCTs are failing to prioritise efforts to address low rates of early diagnosis in bowel cancer patients. Recent research has shown that only one PCT has developed locally defined indicators on uptake of the bowel cancer screening programme under the World Class Commissioning framework.\(^59\)

2.4 The measures being introduced by the National Awareness and Early Diagnosis Initiative, set up following the Cancer Reform Strategy in 2007, are a welcome step to improve rates of early diagnosis of bowel cancer, in addition to the national bowel cancer screening programme.

2.5 The World Class Commissioning framework offers an opportunity for PCTs to demonstrate how they intend to raise awareness of bowel cancer, beyond efforts to drive uptake of the screening programme.

2.6 PCTs should set out how they will increase awareness of bowel cancer signs and symptoms amongst their local populations, based on an assessment of local health needs.

3. **There should be greater scrutiny of changes to improve access to bowel cancer treatments for patients**

3.1 As well as prioritising prevention and early detection measures, commissioning has a significant impact on the quality and range of treatments available to patients.

3.2 There have been a number of innovative medicines developed in the last few years to treat bowel cancer. However, patients have often had to campaign for access to these on the NHS as some have not been approved by the National Institute for Health and Clinical Excellence (NICE).

3.3 The Department of Health has recognised the difficulties which cancer patients can face in obtaining treatments which their clinician may recommend, but which may not be available on the NHS. The government’s steps to address this issue, particularly through the recommendations from Professor Mike Richards, the National Cancer Director, are therefore welcome.\(^60\)

3.4 It will be important to scrutinise fully PCTs’ implementation of these recommendations, particularly to ensure that where patients have had to use exceptional case procedures to request a specific drug, that decisions on funding are made in a transparent, rational and consistent manner in accordance with Professor Richards’ recommendations. The extent to which PCTs implement these recommendations should be seen as a key test of the World Class Commissioning programme as it touches on a number of the competencies:

(i) The PCT engages with and understands the views and priorities of local NHS organisations and is respected as the local leader of the NHS.

(ii) The PCT works collaboratively with partners.

(iii) The PCT leads and seeks continuous and meaningful engagement with people, patients and communities to shape services and improve health.

(iv) The PCT leads continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation.

(v) The PCT undertakes robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements.

(vi) The PCT prioritises investment according to local needs, service requirements and the values of the NHS.

(vii) The PCT influences provision to meet demand and secure required clinical and health and wellbeing outcomes.

(viii) The PCT promotes and specifies continuous improvements in quality and outcomes through clinical and provider innovation and configuration.

(ix) The PCT deploys procurement skills that ensure robust and viable contracts.

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58 National Cancer Intelligence Network, *Colorectal Cancer by Stage NCIN Data Briefing*, June 2009.


60 Professor Mike Richards, *Improving access to medicines for NHS patients*, November 2008.
(x) The PCT performance manages providers to ensure contract compliance and continuous improvement in quality and outcomes.

(xi) The PCT demonstrates excellent financial management.

3.5 Effective commissioning also supports bowel cancer patients to access high quality interventions, such as laparoscopic surgery. There has been welcome progress in meeting the Cancer Reform Strategy’s commitment to increase the use of this type of surgery for bowel cancer, and it will be important that PCTs meet their responsibilities to commission appropriate laparoscopic surgery capacity once teams have received training, so that patients can benefit from this new development.

4. **Commissioners should ensure that providers of bowel cancer services adhere to the highest standards of quality and safety**

4.1 There are a number of sources of guidance for commissioners which set out the care quality and safety standards according to which cancer services should be provided.

4.2 Commissioners have a vital role in ensuring the quality and safety of services provided for the population they serve. Beating Bowel Cancer is keen to see greater scrutiny of the way in which PCTs are applying this guidance through their commissioning processes. For example, significant concerns have been raised about the safety and quality of the chemotherapy provided to a small minority of cancer patients. The National Chemotherapy Advisory Group (NCAG) has therefore recently recommended changes to improve the quality and safety of chemotherapy services. If implemented, these should bring significant improvements for bowel cancer patients, including better information, support and advice for patients on the implications of their treatment.

4.3 Patients should also be better supported should they need to attend hospital as an unplanned emergency as a result of complications from their chemotherapy; acute oncology services will be introduced for urgent specialist oncological advice in every hospital with an emergency department. However, driving implementation will be a key task for commissioners.

4.4 There are tools available to support commissioners in working with providers to plan chemotherapy capacity. (eg the Chemotherapy Planning Online Resource Tool (CPORT)). Planning chemotherapy capacity is particularly important for bowel cancer as there have been significant developments in new treatments for the disease in recent years, which have had a considerable impact on demand for chemotherapy.

5. **Recommendations**

5.1 There should be scrutiny of the uptake rates of the national bowel cancer screening programme to ensure that as many eligible people as possible participate in the programme, leading to improvements in the rate of early diagnosis of bowel cancer.

5.2 Bowel cancer screening should be included as a national indicator in the World Class Commissioning framework so that PCTs have clear responsibility to commission services to improve uptake of the programme in their local area.

5.3 PCTs should set out through the World Class Commissioning framework how they are meeting their responsibilities to raise awareness of the signs and symptoms of bowel cancer.

5.4 The Department of Health should scrutinise PCTs’ progress in implementing the relevant recommendations of Improving access to medicines for NHS patients as part of the World Class Commissioning assurance process.

5.5 Given its importance to patient safety, the extent to which commissioners are able to ensure service providers implement the NCAG recommendations in full should be reviewed by the Care Quality Commission.

*September 2009*

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**Memorandum by Roche (COM 33)**

1. **EXECUTIVE SUMMARY**

1.1 Roche is closely involved in supporting NHS commissioners as part of our everyday work. We have collected a wealth of anecdotal examples and data on the quality of commissioning and the impact that it has on service provision.

1.2 In this submission we make a number of recommendations which the Committee may wish to consider, including:

   — The Department of Health should make clear that PCTs should predominantly focus on outcomes where performance is relatively poor;

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— The Department of Health should develop nationally-defined metrics for hitherto underprioritised programme areas, such as musculoskeletal services;
— The Department of Health should commission research to ascertain why the End of Life Care Strategy has been so successful in influencing PCT prioritisation;
— The Department of Health should ensure that future national disease strategies are explicit in showing PCTs how the World Class Commissioning competencies should be applied to the disease area in question;
— The approach adopted for cancer should be emulated in other disease areas, with a comprehensive set of commissioning tools being developed to support PCTs;
— Every area of high programme spend should have a national strategy, overseen by a national clinical director whose remit should include supporting PCTs in the effective commissioning of high quality, efficient services;
— The Department of Health should develop outcome metrics which are more closely linked to delivering short term efficiency savings;
— The Department of Health should consider the case for developing clinical networks to advise and support commissioners for other conditions, such as musculoskeletal or hepatitis C;
— The Cancer Commissioning Toolkit model should be emulated for other areas of programme spend, ensuring that PCTs have access to accurate and contextualised information on the outcomes, quality and efficiency delivered by services they commission;
— The Department of Health’s World Class Commissioning programme should review the process made by PCTs in implementing the guidance issued by the National Prescribing Centre on supporting rational local decision-making about medicines and treatments;62, 63
— The Department of Health should consider how the commissioning process could be improved for “near label” treatments. The recommendations made by the Rarer Cancers Forum should be used as the starting point for this consideration;
— The Department of Health should keep tariffs under review, ensuring that any unintended perverse incentives are identified and eradicated. In order to assist the effective commissioning of efficient, high quality services, tariffs should be calculated on the basis of the cost of delivering good practice;
— Given the position of NICE guidance within the NHS Constitution, the Care Quality Commission should assess the extent to which PCTs commissioning according to NICE guidance; and
— NICE should be provided with a similar level of resource to encourage implementation of its guidance as it has for developing it in the first place. The Department of Health should also ensure that adequate support is given to the recently announced implantation team within the Office of the Strategic Health Authorities.

2. INTRODUCTION

2.1 Roche is a leading manufacturer of innovative medicines in a variety of different disease areas, including oncology, musculoskeletal, virology and transplantation. As such, we are continuously engaged with NHS organisations at every level. We therefore experience the impact of effective and poor commissioning from both a purchaser and a provider perspective. Our personnel have been closely involved in a number of leading commissioning initiatives, including the development of the Cancer Commissioning Toolkit, jointly developed by the NHS and the POI, and supporting the London Renal Modernisation Team in developing commissioning metrics for renal services.

2.2 In this submission we use examples from three major disease areas as illustrations of our wider observations on the current status and capability of NHS commissioning:
— Cancer—which has a relatively well developed infrastructure to support commissioners, including cancer networks, effective national clinical leadership and comprehensive and contextualised data provision;
— Musculoskeletal conditions—which collectively are very common, constitute one of the largest causes of illness-related work absence, encompass a range of conditions which vary according to severity and complexity and account for one of the fastest growing areas of NHS programme spend; and
— Hepatitis C—which is a major and growing public health issue which has hitherto received little attention from policymakers or commissioners.

2.3 We welcome the opportunity to submit written evidence to this inquiry and would be happy to provide follow-up information if this would be helpful.

63 National Prescribing Centre, Supporting rational local decision-making about medicines (and treatments)—a handbook of good practice guidance, February 2009.
3. The Impact of World Class Commissioning

Prioritisation of health issues

3.1 The World Class Commissioning programme has had a welcome effect in raising the profile and status of commissioning functions within the NHS. Although the programme remains at a relatively early stage, there is evidence from the assurance process that PCTs are taking seriously their responsibilities to commission according to the health needs of local populations.64

3.2 However, a recent analysis found that approximately one third of PCTs have opted to focus on more outcomes where their performance is already better than the national average than where it is below.65 This calls into question the extent of the ambition shown by some PCTs and casts doubt upon whether the World Class Commissioning agenda will in itself address inequalities in performance.

3.3 The Department of Health should make clear that PCTs should predominantly focus on outcomes where performance is relatively poor.

3.4 It is also instructive to note that there are significant differences in the extent to which PCTs are focussing on implementing the NHS Next Stage Review vision for their Strategic Health Authority area. For example, PCTs in NHS East of England have universally opted to focus on issues prioritised in the SHA's Next Stage Review vision, Towards the Best, Together, whilst others have taken a much autonomous approach.66

3.5 Overall, the outcome indicators selected by PCTs do not reflect the health impact of some conditions, nor their contribution to overall NHS expenditure. For example, despite musculoskeletal services accounting for over £3.5 billion of NHS expenditure in 2006-07, making it the sixth highest overall area of programme spend, only three of 152 PCTs chose to prioritise a musculoskeletal measure.67 This may be in part due to the fact that the Department of Health’s list of nationally-defined outcome metrics does not reflect the balance of programme spend.68

3.6 The Department of Health should develop nationally-defined metrics for hitherto underprioritised programme areas, such as musculoskeletal services.

Local delivery on national priorities

3.7 In an era of increasing devolution of power and control in the NHS, effective commissioning will be critical to delivery on national policy priorities. However, evidence of its effectiveness in doing so is variable.

3.8 A clear early success story has been the implementation of the End of Life Care Strategy which, despite being traditionally a low profile area, has been prioritised by nearly half of all PCTs.69 This shows that local commissioning priorities can effectively support national policy.

3.9 The Department of Health should commission research to ascertain why the End of Life Care Strategy has been so successful in influencing PCT prioritisation.

3.10 Although the World Class Commissioning competencies set out a general overview of what should be expected from an effective commissioner, many of them have little relevance to the challenges faced in commissioning for particular disease areas. It would therefore be helpful if national disease strategies explicitly set out how the competencies translate for the disease area in question. A good example of this approach is the Cancer Reform Strategy, which sets out how the competencies can be applied to improving cancer services.70

3.11 The Department of Health should ensure that future national disease strategies are explicit in showing PCTs how the World Class Commissioning competencies should be applied to the disease area in question.

3.12 Cancer commissioners have also been supported through the development of a range of mechanisms to enable effective commissioning:

   — The Cancer Commissioning Guidance sets out the standards that commissioners should be expecting from services, as well as the data sources that can be used to measure improvement;71
   — The Cancer Commissioning Toolkit brings together disparate sources of information so that commissioners can track performance and benchmark against other comparable health economies;
   — The National Cancer Peer Review Programme assesses the extent to which service providers are complying with core guidance and makes this information available to commissioners; and

64 Health Mandate, National priorities, local action? An analysis of Primary Care Trusts’ World Class Commissioning priorities, July 2009, page 29.
66 Ibid.
C-PORT enables commissioners and providers to work together to simulate the financial and capacity implications of changes to service models, so helping them plan how best to deliver safe, effective and financially sustainable chemotherapy services which meet the needs of local populations.

3.13 The contrast with musculoskeletal services and hepatitis C is stark. In both cases, national strategies were developed but before the advent of World Class Commissioning. This means that the commissioning agenda was not adequately reflected in these strategies, nor have PCTs been supported in applying the competencies to each disease.

3.14 Independent audits have found that implementation of the Musculoskeletal Framework and the Hepatitis C Action Plan have been patchy at best:

— Repeated surveys by the Hepatitis C Trust have revealed that many PCTs are failing to address the actions set out in the Hepatitis C Action Plan,72 and

— A recent audit by ARMA found poor implementation of the Musculoskeletal Framework, with 16% of PCTs having mapped their available services for musculoskeletal conditions. Furthermore spending per patient by PCTs fluctuates wildly, from £95 per head per year in Lewisham PCT, to £1,379 per head per year in Western Cheshire PCT.73 The findings of this audit support the conclusions a recent National Audit Office study into rheumatoid arthritis which found that more could be done to mitigate the impact of the condition.74

3.15 The approach adopted for cancer should be emulated in other disease areas, with a comprehensive set of commissioning tools being developed to support PCTs.

3.16 Challenges in delivering these national strategies have been compounded by the absence of national clinical leadership and support for local NHS organisations. It is instructive that neither musculoskeletal conditions nor hepatology have a national clinical director, despite the high levels of incidence, burden of disease and programme spend.

3.17 Every area of high programme spend should have a national strategy, overseen by a national clinical director whose remit should include supporting PCTs in conducting needs assessments and effectively commissioning high quality, efficient services.

Commissioning for efficiency

3.18 The Government has made clear that it expects the World Class Commissioning programme to deliver significant efficiency savings,75 helping the NHS withstand the impending reduction in real terms resources. There is, however, greater scope for PCTs to demonstrate through the assurance process how they will work with providers to deliver these savings. For example, outcome metrics more closely linked to efficiency could be developed.

3.19 The Department of Health should develop outcome metrics which are more closely linked to delivering short term efficiency savings.

4. The impact of the purchaser/provider split

Ensuring commissioners have access to appropriate expertise and information

4.1 A key challenge for commissioners is that expertise on complex services is usually located within provider services. This is compounded by the fact decisions which incur significant amounts of expenditure, for example the decision to prescribe a high unit cost medicine, are actually taken by providers and not commissioners. This makes it challenging to exercise effective and independent oversight of service delivery and can result in commissioning becoming an exercise in seeking to limit cost rather than improving quality. This challenge will be exacerbated by trends to devolve commissioning responsibility still further, for example through practice based commissioning.

4.2 One way to mitigate this impact of the purchaser-provider split is through the development of clinical networks which can serve as expert advisors to commissioners. The leading example of this approach is cancer networks which bring together primary and secondary care professionals, as well as commissioners, to support PCTs and SHAs in planning and commissioning cancer services. Although the quality of cancer networks remains variable, Roche’s experience is that they add value to commissioning decisions in a particularly complex and challenging disease area. Cancer networks have also helped mitigate the disruption caused by structural reorganisation, ensuring some continuity.

4.3 The Department of Health should consider the case for developing clinical networks to advise and support commissioners for other conditions, such as musculoskeletal or hepatitis C.

72 Hepatitis C Trust, Hepatitis C: out of control— an audit of Strategic Health Authority hepatitis C governance, July 2009, page 5.
74 National Audit Office, Services for people with rheumatoid arthritis, July 2009, page 8.
4.4 Alongside expert commissioning support, access to high quality, relevant and contextualised information on service performance is essential if the imbalance in expertise created by the purchaser-provider split is to be mitigated. The Cancer Commissioning Toolkit presents a useful model in this respect, enabling PCTs to gain access to a wide variety of data sources, including on incidence, prevalence and mortality, screening uptake, waiting times, medicines utilisation, emergency admissions, inpatient bed utilisation and expenditure. Unfortunately services areas such as musculoskeletal have experienced little development in this respect. This can lead to the use of inappropriate performance measures which have no link to outcomes.

4.5 The recent publication of 18 week commissioning pathways for conditions such as inflammatory arthritis or osteoporosis are encouraging developments but commissioners will require much more focused support if these pathways are to make a significant difference and move beyond the 18 weeks agenda.

4.6 The Cancer Commissioning Toolkit model should be emulated for other areas of programme spend, ensuring that PCTs have access to accurate and contextualised information on the outcomes, quality and efficiency delivered by services they commission.

**The role of national support in mitigating the impact of the purchaser-provider split**

4.7 Roche has received feedback that PCTs often welcome national support and guidance in discharging commissioning duties in complex service areas, utilising economies of scale to commission better delivery models. This approach can ameliorate the relative absence of expertise from commissioning bodies. An example of this is the way in which PCTs make local funding decisions on the reimbursement of different treatments.76

4.8 *Improving access to medicines for NHS patients* found that PCTs usually have to make such in three scenarios:77

— where NICE has yet to issue guidance;

— where NICE has declined to recommend a treatment for use in the NHS but a clinician nonetheless wishes to prescribe it; and

— where NICE will never be able to issue guidance because a treatment is used outside its licensed indication.

4.9 Work by the Rarer Cancers Forum has revealed that PCTs have struggled to make rational, consistent and transparent decisions in these situations.78 Many of the problems experienced by PCTs have been fundamentally due to fact that expertise of the appropriateness of a treatment has resided solely with those who are making the request. As a result, PCTs have often inappropriate processes such as “exceptional cases” to determine funding instead of seeking to develop collaborative commissioning arrangements.79

4.10 The guidance issued by the National Prescribing Centre is therefore extremely welcome and its implementation will be critical to improving commissioning decisions and reducing inequalities in access across the country.

4.11 The Department of Health’s World Class Commissioning programme should review the process made by PCTs in implementing the guidance issued by the National Prescribing Centre on supporting rational local decision-making about medicines and treatments.80, 81

4.12 However, the Rarer Cancers Forum has also demonstrated in its recent report, Off limits: An investigation into how NHS organisations determine requests for the use of off-label treatments for cancer patients, that problems remain in the way in which the NHS handles requests for the use of medicines in a disease outside their licensed indication but which nonetheless has a similar biology to that for which it is licensed—a group the charity has described as “near-label” treatments.82

4.13 Off limits found that significant variations still exist in access to “near-label” treatments, despite them being widely recognised as an important part of cancer care, without which patient outcomes would be diminished.83

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81 National Prescribing Centre, *Supporting rational local decision-making about medicines (and treatments)—a handbook of good practice guidance*, February 2009.
83 Ibid.
4.14 Requests for “near-label” are likely to occur in very small numbers, making it impossible for PCTs to develop an expertise on different forms of treatment for rare disease. Also, requests are typically made by specialists from providers, but the funding for them needs to come from commissioners who are typically non-specialist in the disease area. The split between purchasers and providers in this area—and the competition between them—therefore frustrates the delivery of the most effective care to patients.

4.15 These difficulties create a vicious circle in which funding for treatments is not made available because there is little published evidence in support of them, which itself perpetuates the paucity of information. This will impede judgements made by commissioners on a particular treatment’s effectiveness, meaning that the decision often collapses into an assessment of raw cost, rather than a more considered assessment of clinical and cost-effectiveness.

4.16 The Rarer Cancers Forum has made a number of recommendations about how a different commissioning process could be developed for “near label” treatments. This revolves around replacing the existing commissioning process for ‘near label’ treatments with a more collaborative decision-making approach which combines the skills of hospital specialists and PCT commissioners.84

4.17 The Department of Health should consider how the commissioning process could be improved for “near label” treatments. The recommendations made by the Rarer Cancers Forum should be used as the starting point for this consideration.

5. COMMISSIONING AND SYSTEM REFORM

5.1 The effectiveness of commissioning will inevitably depend in part on other areas of system reform. The development of the tariff significantly influences service development and therefore the ability of commissioners to exercise oversight and control.

5.2 A tariff which rewards an inefficient model of care will make it difficult for commissioners to effectively work with providers to improve the efficiencies and effectiveness. An example of this would be the perverse incentivisation of the delivery of chemotherapy in a hospital setting even if more efficient alternatives exist. The recently published National Chemotherapy Advisory Group Report states, “inpatient delivery of chemotherapy should be kept to a minimum. This can be achieved by maximising the use of oral medicines (eg capcitabine in place of fluorouracil).”85 However, Roche has received feedback from some providers that they are unwilling to make greater use of oral therapies because they fear a loss of income under the tariff.

5.3 The commitment made in the NHS Next Stage Review to evolve tariffs so that they are calculated on the basis of good practice rather than NHS averages is extremely welcome. The economic downturn should not be used as a rationale for moving away from this approach.

5.4 The Department of Health should keep tariffs under review, ensuring that any unintended perverse incentives are identified and eradicated. In order to assist the effective commissioning of efficient, high quality services, tariffs should be calculated on the basis of the cost of delivery good practice.

6. COMMISSIONING FOR QUALITY AND SAFETY

6.1 A fundamental duty for all commissioners should be to ensure that services are delivered in an effective and safe manner. In fulfilling this function, PCTs will need to pay due regard to the work of Care Quality Commission, as well as guidance produced by NICE.

6.2 In relation to NICE, it is clear that commissioners have a mixed record in ensuring implementation. In addition to well-rehearsed variations in the uptake of guidance on cancer medicines,86 Roche has recently undertaken research on the implementation of technology appraisals relating to the treatment of hepatitis C. This reveals that:87

— no SHA area has managed to fully implement NICE guidance and, on average only 29% of diagnosed patients were treated with NICE approved antiviral therapy;
— for those SHAs which have managed to improve their diagnosis rates, treatment levels remain significantly below that recommended in NICE guidance; and
— England is failing to contain hepatitis C infections, as a result of the treatment rate being lower than that estimated for infection.

6.3 It is clear that the commissioning process is failing to deliver hepatitis C services, resulting in a sub-optimal quality of care and the lack of delivery on the Hepatitis C Action Plan. This is particularly concerning given that the legal right to NICE-approved treatment was recently reaffirmed within the NHS Constitution.88

84 Ibid. pages 8–11.
86 For an example see: Department of Health, Uptake of NICE approved cancer drugs 2007–08, May 2009.
87 Data published in Hepatitis C Trust, Hepatitis C: out of control—an audit of Strategic Health Authority hepatitis C governance, July 2009, page 12.
6.4 Given the position of NICE guidance within the NHS Constitution, the Care Quality Commission should assess the extent to which PCTs commissioning according to NICE guidance.

6.5 In addition to NICE’s focus on producing high quality guidance, it is clear that there is a need for an equal focus on implementation, ensuring that PCTs commission services according to nationally-defined standards.

6.6 NICE should be provided with a similar level of resource to encourage implementation of its guidance as it has for developing it in the first place. The Department of Health should also ensure that adequate support is given to the recently announced implantation team within the Office of the Strategic Health Authorities.

September 2009

Memorandum by UNISON (COM 34)

Executive Summary

UNISON is concerned that the implementation of World Class Commissioning has become too focused on marketisation rather than service improvement, with insufficient trade union involvement and potential for major conflicts of interest within the FESC aspect of WCC. The intensification of the purchaser/provider split since 2005 has led to time and resources being wasted on facilitating the market rather than being dedicated solely to improving care. The split also serves to contradict other government policy that favours more integrated services and joint working across traditional boundaries.

World Class Commissioning

3. UNISON has significant reservations about the way in which World Class Commissioning is being implemented by commissioners that are pursuing market based routes to the provision of services, rather than focusing on service improvements by existing NHS providers. This is a common theme across other areas of commissioning and health service reform, explored further below. The assumption that has been built into the system is that the NHS is unable to improve itself and services need to be subjected to market-testing and competitive tender in order to produce better results.

4. This situation is exacerbated by the fact that there is insufficient reference to trade unions and partnership working in the WCC competencies. There is considerable evidence to support the argument that unions can play an important role in helping deliver efficiency improvements,89 and the NHS Social Partnership Forum has demonstrated the role that partnership working can play in increasing productivity and transforming service delivery.90 PCTs stand to gain from engaging with unions about service improvement and yet UNISON members report a lack of understanding by commissioners of how to involve unions in the process of commissioning services. Members report practical difficulties with engaging with the process as well, with roadshows or engagement events held at times when staff cannot leave wards or clinics, with night staff or those working in the community (such as district nurses) excluded. Another barrier to involvement reported by members is the vast amount of new contractual and legal jargon that has been produced by WCC and other new initiatives. The policy-by-soundbite approach of WCC (“Adding life to years and years to life”) is no match for one that is rooted in meaningful staff involvement and proper partnership working.

5. The stated reason for the introduction of WCC was a perception that the quality of commissioning in the NHS was not up to scratch. However, NHS commissioning will not improve if responsibility is handed over to private sector commissioners. The Framework for procuring External Support for Commissioners

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89 For example, Department for Business, Enterprise and Regulatory Reform, Workplace representatives: a review of their facilities and facility time, 2007.

90 www.socialpartnershipforum.org/PartnershipWorkingInTheNHS/CaseStudySection/Pages/CaseStudies_Homepage.aspx
(FESC) potentially does exactly that. The idea is that once companies have been brought in to advise commissioners they should ensure that there is a transfer of skills back to the NHS, but it remains doubtful that this is taking place or will do in the future. Given that these same companies are also hoping to secure a bigger piece of the healthcare market it is counter-intuitive to suppose that they will pass on any acquired knowledge and then move on. UNISON has yet to see any evidence of the experience these companies have of commissioning healthcare for large and diverse populations.

6. At a time when spending is tight it is impossible to justify the amount being spent by the NHS on the FESC. To date, £15 million has been spent on it with no discernible achievements. Apparently the FESC suppliers have committed to guaranteed savings of £18 million, but at Hillingdon primary care trust, where the first FESC contract was awarded to Bupa, the experience has not been a happy one. In August 2008 the chair of the PCT said he “could not see how these projects would result in value for money”.

7. Perhaps most importantly, the FESC includes potential for conflict of interest. The majority of firms on the approved list of fourteen FESC suppliers are consultancy groups, but the list also includes organisations such as UnitedHealth Europe, who deliver provider services in the UK. The Department of Health have attempted to allay fears by ensuring that FESC commissioners are not working in areas where they also provide services. It would still be possible, however, for a FESC supplier to advise a PCT on its commissioning decisions in advance of making a future bid to provide services in that area. Moreover, once a commissioner has successfully recommended a service for outsourcing that service must be open to competition at a later date in order to abide by procurement and competition law, thus opening up a healthcare market for these same companies to come back and provide services in. Given these issues, it is striking that there is so little reference to avoiding conflicts of interest in the FESC documents for PCTs; for example, there is no mention of it at all in the main Practical Guide to the FESC.

8. Further conflicts of interest loom in the way that some companies are involved in the whole fabric of the system. KPMG feature as one of the approved list of FESC suppliers, but it transpires that they were also paid to provide “assistance in developing some elements of the generic template document” for the FESC. If this was not enough, the Department of Health’s own architect of WCC—director general for commissioning and system management Mark Britnell—left the DH to take up a new job with KPMG in July 2009. The Health Committee has already helpfully raised concerns about the amount spent on management consultancy and the failure to test for value for money, but there is a need to explore wider issues of professional conduct and probity in English healthcare commissioning.

THE PURCHASER/PROVIDER SPLIT

9. UNISON welcomed the decision to end the NHS internal market in 1997 and the subsequent increased funding for the health service, but since 2002 there has been a change in direction. UNISON was highly critical of Commissioning A Patient Led NHS in 2005 that threatened to relieve PCTs of their provider functions, leading to some hasty back-peddling by the government. Since then, however, this process has been quietly intensified, culminating in 2009’s Transforming Community Services (TCS) programme, in which the split between PCTs’ commissioning and provider arms is to be rigidly enforced. This has been compounded by the establishment of a Cooperation and Competition Panel (CCP) to ensure the development of health markets, and by a new commercial operating model, Necessity Not Nicety, that will see an extra £20 million leaking out of the NHS in order to set up new structures, such as Commercial Support Units, that will pave the way for greater private sector involvement in healthcare.

10. It is important to contrast the English experience with that of the devolved nations. In both Scotland and Wales the purchaser/provider split has been found wanting and disposed of. In Scotland, successive administrations have used NHS Boards and Community Health Partnerships to move away from competition and towards partnership. In Wales, more recently, the One Wales coalition has removed the purchaser/provider split in favour of a more structured central planning system.

11. UNISON welcomes renewed engagement by health ministers with unions through the NHS Together coalition and the NHS Social Partnership Forum. The union also welcomes the recent letter from NHS chief executive David Nicholson that seeks to refocus TCS on service improvement rather than organisational form and permits some flexibility in what was otherwise a very tight timetable for separation of commissioner and provider sides.

12. However, this does not detract from UNISON’s main concerns about intensifying the split between commissioner and provider. These are amply demonstrated by responses from UNISON members who are consistent in their rejection of the purchaser/provider split. Responses point out the waste of time and resources that result from protracted arguments and negotiations between commissioning PCTs and providing NHS trusts, making it harder for trusts to plan their services. The recent international wrangling
over the success or otherwise of the NHS compared to American healthcare has allowed commentators in the UK (including UNISON) to point out the lower transaction costs in this country, precisely because the UK has been traditionally a more integrated system. 98 But the further we move away from this, the greater the amount of money that is drained away from the frontline. UNISON members point out that the pressure from TCS to enforce separation is costing PCTs money before the split has come fully into operation, with provider sides set up to run in shadow form before separation becomes a reality.

13. In terms of the effect on patients, members point to the fragmentation of patient pathways as a result of having to use competing providers. Responses also stress that money would be better spent on frontline services than enforcing the split, and emphasise the time that may be taken away from clinicians if they are called upon to bolster their organisation’s submissions when bidding for contracts. Perhaps the most concerning are responses that suggest there are inadequate processes to evaluate whether the tendering or outsourcing of a service is actually in the best interests of patient care (for example, by analysing an organisation’s approach to a particular disease area or whether a change in service provider will lead to greater innovation). Too often competition is being pursued as an end in itself rather than the means to improved outcomes.

14. Other responses focus on the lop-sided nature of the commissioning process, with ill-equipped PCT provider arms forced to compete against private contractors with more time and resources to plan for the open tendering process.

COMMISSIONING AND SYSTEM REFORM, OTHER ISSUES

15. Concerns about the purchaser/provider split also relate to another major problem with healthcare reform in England: the fact that different initiatives contradict one another. One of the more welcome aspects of reform, at least at the structural level, has been the desire to provide more integrated services and joined-up work across traditional boundaries. For example, Integrated Care Organisations working across health and social care, and new clinics allowing services traditionally delivered in hospitals to be more readily available in the community. But the purchaser/provider split runs contrary to this, despite a wealth of international evidence supporting the need for closer integration across healthcare. For example, the research of Professor Chris Ham, previously director of strategy at the Department of Health, has pointed out that “there are major obstacles to the efficient operation of systems in which the roles of commissioners and providers are separated”. This is due to the “intractable transactions” involved in healthcare, with services tending to be complex, hard to define in contractual terms, and often depending on long term relationships between patients and professionals. 99 (This follows much earlier research demonstrating that the introduction of market mechanisms doubled the administrative costs to the NHS). 99 The latest report from the New York-based Commonwealth Fund also points to a high degree of integration (including vertically between commissioners and providers) amongst high performing health organisations in the US. 101

16. In terms of the interaction of commissioning with Payment by Results, in a separate study of clinically integrated systems in England, Ham reports concerns about PbR also hindering integration. In some areas “the introduction of payment by results was reported to have set back attempts to integrate care, as hospitals focused on maximising the benefits to them from this system of payment rather than continuing efforts to achieve closer integration” .102 Responses from UNISON members confirm the way in which aspects of system reform have skewed priorities, with PbR providing perverse incentives and with commissioners encouraging a greater focus on quantitative data, potentially to the detriment of the quality of clinical services—something which runs directly contrary to Lord Darzi’s recent focus on quality.

17. In terms of contestability, UNISON members have pointed out the problems this causes for accountability. There is an increasing demand for foundation trust boards to meet in public—prompted both by the Mid Staffordshire scandal and by a more general feeling that transparency is needed. For example, West Sussex PCT has now told the boards of two of its foundation trust providers to meet in public.103 It will be hard to enforce this, however, when foundation trusts, as with other parts of the NHS, are set up against rivals from within the NHS and outside who are in direct competition to provide services. The legacy of greater contestability is likely to be greater secrecy and organisations increasingly seeking to use “commercial sensitivity” as a reason to block MPs, councillors, staff and the public from accessing information.

98 For example, UNISON, Why we love the NHS, August 2009, www.unison.org.uk/file/US_factsheet.pdf
103 Health Service Journal, Make NHS board meetings public, foundation trusts told, 26 August 2009.
18. The question about accountability is also a wider one where commissioning in the NHS is concerned. The vast majority of market-based health reform in recent years has taken place with very little Parliamentary scrutiny. TCS and the CCP are good examples, where the first specific references to these important developments in the House of Commons came from written questions from MPs to health ministers.104

19. UNISON members also report a number of other issues around commissioning. Some pass on findings from staff surveys that demonstrate commissioning directorates with higher levels of harassment and higher staff turnover rates. Others refer to the stress and anxiety teams are exposed to as they work through lengthy periods of uncertainty about whether their services will retain the right to provide services, with a corresponding negative impact on the services they are currently delivering. This is to say nothing of the amount of extra time union stewards are now obliged to spend overseeing such processes to ensure fairness and that members are supported throughout.

UNISON Policy Unit and Healthcare Service Group

September 2009

Memorandum by Dr Jonathan Howell (COM 35)

Executive Summary

1. World-Class Commissioning (WCC) is to be welcomed as a structured approach. Commissioning in the NHS is a complex activity that requires sophisticated team working. There are not the numbers of trained and experienced public health specialists to support the commissioning teams in the developments that are needed.

2. It is still relatively early in terms of strengthened commissioning to see whether some of the strands, such as contestability, are necessary. Foundation trusts can be too focused on their own needs to the detriment of the wider NHS.

3. From a public health perspective specialised commissioning cannot be separated from wider commissioning issues and the linkages with PCTs. You cannot commission at the higher levels without understanding the pressures affecting PCTs and ensuring that values are shared. This is particularly important as the SCGs and the NCG commit PCT money.

4. The Carter report of 2006 on specialised services has strengthened SCGs by producing more consistent and shared working and has also started to change the relationship between the DH, SCGs and PCTs. The roles of the new NSCG and its sub committee, the NCG, are taking time to become established and there have been tensions between the NSCG and DH.

5. It is argued, with evidence on high profile issues such as orphan drugs and cancer initiatives, that one of the key underlying issues is the difficulty around making consistent decisions in prioritising new developments and technologies. This needs good policy linkage between the DH (Department of Health) and the NHS as well as structured public engagement. Prioritising expensive healthcare developments needs to be part of a whole systems approach with the appropriate decision making powers given to those NHS bodies accountable for budgets on a statutory basis. This may help to remove the high level politics in some of these decisions and to support public understanding.

Background Information about Dr Jonathan Howell

6. I am a Consultant in Public Health working for the West Midlands Specialised Commissioning Group (WM SCG). I have a medical background and have worked in specialised services for almost five years. I worked as a GP for eight years before retraining in public health. My previous post was as Director of Public Health at Cannock Chase PCT.

7. I am a member of the National Commissioning Group (NCG) and was a member of its predecessor, the National Specialised Commissioning Advisory Group (NSCAG), together for over four years. In the last year I have established the SCG Public Health Network as a formal committee of public health specialists working in SCGs to provide advice and support to the National Specialised Commissioning Group (NSCG), which represents the ten regional SCGs in England. I am also a member of the Faculty of Public Health’s Healthcare Committee and have strong links to the UK Public Health Commissioning Network.

104 HoC, written answers from Phil Hope to Joan Walley, NHS: Conditions of employment, 2 June 2009; HoC, written answer from Mike O’Brien to Dave Anderson, Co-operation and Competition Panel, 6 June 2009.
WORLD-CLASS COMMISSIONING

8. World Class Commissioning (WCC) is an initiative from the DH that has been developed in a structured manner. The most important aspect is that it recognises commissioning as a complex activity and a key task for PCTs.

9. The range of tasks as illustrated by the competencies specified for WCC needs sufficient people to make then work. This should give PCTs a strong understanding of what they commission for what they spend and what standards of care they expect for their population.

10. The NHS spends a large proportion of its funds on healthcare. As the Wanless reports illustrated, it is important to achieve a reasonable balance between the resources for health improvement for the population and the proportionately greater spend on healthcare. The evidence base for the latter tends to be stronger but its funding can also be driven by commercial interests. PCTs (and public health specialists) need a perspective on the whole care pathway for patients and to support a balance in the funding of health services.

11. Good commissioning needs a team approach between commissioning managers, finance personnel and experience public health specialists supported by good information analysis. At least 6 of the original 11 WCC competencies need input from trained public health people.

12. There are not enough public health personnel with the right experience coming though the training system to provide 152 PCTs and 10 SCGs in England with the required support. The emphasis in the last few years for public health has been on the “Choosing health” initiative and to some extent on health protection. It is important that the Faculty of Public Health as the standard setting body for public health recognises commissioning as a separate discipline that needs sufficient experienced public health specialists.

THE PURCHASER/PROVIDER SPLIT

13. Although PCTs hold the budgets for their populations they have often not been in a strong enough position to counter the demands of acute trusts for increases in clinical services when the trusts want to fund new technologies and developments. This may be changing with the emphasis on WCC and the recent quality initiatives.

14. Good commissioning cannot operate without good information and we still seem to be some way from getting to grips with this although there are continuing efforts to improve this. This will need support from trained analysts and epidemiologists although there is a shortage in this area.

15. Commissioners have started to strengthen their control of providers through better formal arrangements since the last NHS reorganisation. However, the increased independence of foundation trusts has again widened the gap between NHS organisations that should share common values. New technologies have often been introduced in trusts in a way that assumes that PCTs will automatically pay for them. Rather than a negotiated service development some apparent innovations are requested inappropriately with individual patients caught in the middle and adverse publicity for the NHS.

16. The weakness of commissioning is illustrated by the lack of specific policies for many services. These sorts of policies need to be developed across PCTs both to share resources and to ensure greater consistency. The South Central Health Policy Unit is an example of this and it also helps to address the gaps not filled by advice from NICE.

17. There is a recent example that illustrates how commissioners can help to control the appropriate funding of new technologies in the context of uncertainties around safety and the clinical and cost effectiveness. This is the replacement of aortic heart valves through a catheter (given the acronym TAVI) rather than open heart surgery and costing upwards of £20,000 per procedure. The procedure developed about five years ago but came to the fore when the manufacturers started marketing the valves to clinicians. The clinical rationale seems good but without randomised controlled trials (RCTs) we do not know the overall benefits of TAVI, which patients to target and what the value is for the NHS. The specialist cardiologists initially started requesting funding for individual patients. As commissioners we resisted this approach saying that TAVI looked promising but that we would only commission as part of an RCT so as to ensure that we obtained the best results for patients and the NHS. We are moving towards an RCT after negotiations involving the cardiac professional societies. The media has hardly picked up on this issue and so has not driven the agenda.

COMMISSIONING AND SYSTEM REFORM

18. I have limited experience of practice-based commissioning (PBC) as this has been supported by PCTs. It is unlikely that PBC consortia have any understanding of specialised services or the amount of resource that is spent in this area on behalf of the PCTs. As such it may be difficult for PBCs to make informed decisions about prioritising aspects of clinical services or reinvesting resources to make the care pathway more effective. There is a danger that services may sometimes be reorganized from a PBC perspective and undermine the care pathway. Understanding the work of SCGs and overseeing all aspects of the care pathway is a PCT role. Enough influence needs to be left with PCTs to ensure that commissioning decisions do not lead to fragmented health care services.
SPECIALIST COMMISSIONING

19. Specialised commissioning is regarded as being one part of commissioning that has worked well although it should always be seen as a subset of PCT commissioning. PCTs are the statutory budget holders with overall responsibility for population healthcare and the key principle should be that commissioning decisions should only be delegated with good reason. If you fragment commissioning too much then the overall coherence and balance will be threatened.

20. The Carter review of 2006 introduced a coherent set of changes and reforms to introduce more consistency to the commissioning of specialised services. This has seen all 10 regions start to converge in terms of SCGs and commissioning. Some regions with new SCGs may take three to four years to establish a good understanding with their local PCTs of the structures, processes and resources that are needed. Within the West Midlands the 17 PCTs generally have a good understanding of the relationship with the SCG and that the SCG is a subcommittee with formally delegated responsibilities and accountability operating on their behalf. This is reflected in formal establishment agreements that ensure a common commitment.

21. Ideally the key principle should be that services are commissioned as close to the statutory budget holder as possible. As PCTs have the responsibility for a defined population they are in the best position to take into account all the factors that go into good commissioning. To move commissioning decisions elsewhere should only be done with good reasons and ideally the input of politics should be at a strategic level and not in operational decisions.

22. One part that has caused frustration and much work without the long term outcomes being clear is the Specialised Services National Definition Set (SSNDS). This list of services is currently being reviewed, which is taking considerable resource. I think it unlikely that we will use the SSNDS to any worthwhile effect in the West Midlands and it is not clear that the objectives of the SSNDS will lead to actions that affect the practicalities of specialised services commissioning.

23. The current DH definition of a specialised service is too limited and does not reflect the subtleties that may make it beneficial to take a service away from being commissioned in a PCT. The current definition from the NSCG website is too simplistic: “A specialised service, as defined in law (Statutory Instrument (SI) No. 2375), is a service with a planning population of more than one million people”. There is a difference between planning across a wide population and specifically commissioning and funding a service for a population. As an example a planning population of one million has been interpreted in terms of screening to mean that this should be commissioned as a specialised service when most screening is commissioned and delivered at a PCT level. The broad planning may occur across a large population but the number of recipients or patients is way beyond the numbers who would be treated in other specialised services.

24. The role of the National Commissioning Group (NCG) is well established and is clear in its remit of commissioning highly specialised services across all 152 PCTs in England. This is a valuable role that needs to be closely linked to decisions in SCGs and PCTs as it is money from PCT budgets that is being spent.

25. With the implementation of the Carter Review the NCG has changed from its previous role as the NSCG when it was primarily accountable to the Minister for Health through the DH. However, at times, the DH still feels it should influence NHS commissioning in a way that undercuts the rationale of the Carter review (Recommendation 1 and paragraph 45, which states that putting the national commissioning function into the NHS would “ensure better alignment with NHS processes and funding priorities”). There are examples when the DH has forced a decision on the NHS. This undermines a reasonable approach to joined-up commissioning in the NHS and has the effect of driving PCT priorities in an unreasonable way. It is not helped by a fear of adverse publicity that can make politicians take decisions that cut across due process and undermine the roles and integrity of NHS statutory bodies such as PCTs.

26. An example from the NSCG was a unilateral decision in 2007, outside of the agreed processes, to increase PCT funding of the Enzyme Replacement Therapies (ERTs), a group of orphan drugs. There have also been related issues at the NCG with another orphan drug, called Eculizumab, where the NSCG commissioning decision was overturned by the DH / Minister of Health using a lower level of evidence to justify this. These examples are explained in more detail below. Underlying this is some uncertainty about the role of the SHAs in commissioning. The SHAs have been given a role in overseeing the NSCG that is not considered in the Carter report and is not defined. It is unclear whether this role is about governance or about making sure that the NSCG does not make politically unpopular commissioning decisions.

27. The ERTs are currently funded through the NCG to the order of £100 million per year across England. Several of these drugs cost around £250,000 per patient per year and are for rare genetic diseases. Commissioning was agreed through NSCAG for a limited period and this was unilaterally extended to five years by the DH not using the appropriate NSCAG processes.

28. Subsequently the DH negotiated a highly unusual “donation” of £7 million from Genzyme, a leading company in the ERT field, to the NHS over three years (see press release, Appendix I). This donation was supposed to have been agreed under the auspices of the NCG although the NCG had no part in the negotiations. The reason for this donation and what the company got in return is not clear. It has been reported that the DH subsequently allowed Genzyme to limit the payment as the company was unhappy with the restrictive Pharmaceutical Price Regulation Scheme (PPRS) agreement.
29. Another orphan drug, Eculizumab for 100 patients with Paroxysmal Nocturnal Haemoglobinuria, came to the NCG for commissioning in 2007. This drug had been priced comparable to the ERTs so would cost the NHS about £25 million per year. Whilst Eculizumab was probably an improvement for some patients on the existing treatment a Health Technology Assessment suggested its clinical effectiveness had limitations and it was considerably out of line with the cost effectiveness levels used to justify other new technologies. Its cost per life year gained was estimated to be of a much greater magnitude than the cost per QALY used by NICE.

30. After due consideration and the development of robust commissioning policies by SCGs, such as the West Midlands where all 17 PCTs agreed the policy, the NSCG turned down commissioning through the NCG as not being cost effective. The NSCG decision was taken to a meeting of the SHAs but not endorsed one way or the other. After some debate within the DH, which was not allowed to go outside, the Minister overturned the NSCG decision and decreed that it would be commissioned by the NSG. This decision was largely justified on the grounds of clinical effectiveness whilst no mention was made of the cost effectiveness. The NHS cannot afford to make future decisions on expensive technologies or service developments without proper consideration of the financial case or the cost effectiveness. Not to do this will lead to poor commissioning and the opportunity cost will be to patients elsewhere in the system without a strong voice.

31. A more recent example is the directive by the minister to the NHS to effectively commission a new proton beam therapy centre for the NHS. This despite the large financial commitment and the NCG still considering the information for this potential development. The missing element here is any adequate financial review of a technology with expensive capital costs (estimated to be £100–£150 million for one centre) and uncertain treatment costs but thought to be in the region of £20,000 per patient. The clinical case suggested that the evidence was good to treat 400 patients with cancer but the ministerial statement has extended this to 1,500 cases. What sort of company in the commercial sector would commission such an expensive development without fully understanding the business costs and the uncertainties? At times there is a perception that the NHS is a money-free zone where the political imperative can over ride good business sense and the ability of NHS commissioners to make reasoned and prioritised decisions.

RECOMMENDATIONS

32. That the Department of Health clarifies the role of itself and of the SHAs in the NHS structures established by the Carter Review. These bodies, such as the SGs, the NSCG and the advisory NCG, should be allowed to develop commissioning policies for new technologies and developments that are consistent with the values across the wider NHS.

33. There should be an active national policy and debate on prioritisation that recognises the population values of the NHS and the need to engage the public in the difficult decisions that are made on their behalf. There is an increasing use of evidence based policies to determine commissioning decisions. Inevitably when this is within the fixed NHS budget then there will be prioritisation decisions that exclude certain new developments.

34. The Department of Health should clearly separate the roles that generate a conflict of interest by its need to support the NHS and to support a UK-based pharmaceutical industry.

September 2009

APPENDIX 1

NATIONAL COMMISSIONING GROUP FOR HIGHLY SPECIALISED SERVICES

PRESS RELEASE—5 NOVEMBER 2007

GENZYME AND NHS NATIONAL COMMISSIONING GROUP FORM A £7 MILLION PARTNERSHIP TO SUPPORT WORLD CLASS COMMISSIONING FOR RARE DISEASES

As a result of successful negotiations between DH and the biotechnology company, Genzyme, the NHS National Commissioning Group today announced that they will join together in a £7 million partnership to support a specialised system of care for patients with Lysosomal Storage Disorders (LSDs).

LSDs are rare, progressive, and often severe metabolic diseases that require specialised multidisciplinary expertise. The National Commissioning Group (NCG) has designated seven hospitals in England for the care of these patients: Royal Free Hospital, Great Ormond Street Hospital, The National Hospital for Neurology and Neurosurgery in London, Addenbrooke’s Hospital in Cambridge, Birmingham Children’s Hospital, Royal Manchester Children’s Hospital and Hope Hospital in Salford. The Partnership will support the ongoing development of these centres to meet the needs of patients with LSDs such as Gaucher disease, Fabry disease, Pompe disease, and the MPS group of disorders.
Announcing the Partnership, Dawn Primarolo, Minister of State for Public Health said:

“We are delighted that we have been able to join in this Partnership with Genzyme for patients with lysosomal storage disorders and that we can jointly support patients living with these debilitating diseases. This Partnership will aid in sustaining our ‘world class’ commissioning of services for rare diseases through the NCG.”

Professor Tim Cox, Professor of Medicine in the University of Cambridge, who was one of the first European physicians to treat patients with these diseases at Addenbrooke’s Hospital, warmly welcomed the partnership. He said:

“These are not simply orphan diseases; they are equally marked by the pain and alienation associated with every longstanding medical condition. Without partnerships like this one, such rare diseases would remain marginalised in medical textbooks and patients suffering from them, forever neglected.

Paul Drohan, General Manager of Genzyme UK and Ireland said:

“Genzyme believes that the NHS has developed a highly effective model of care for patients with lysosomal storage disorders (LSDs) and that this is one of the best examples in the world of a universal healthcare system managing rare diseases. As enzyme replacement therapies are a key element of successful treatment of patients with LSDs, Genzyme is excited to have an opportunity to work closely with the NHS to support this service now and into the future.”

LSDs are categorised as orphan diseases since they are rare: they affect a small number of individuals, approximately less than 1 in 2000 population. In consequence they have had few options developed to treat them in the past. They are also difficult to recognise and diagnose.

To ensure equitable access the NHS in England has, since 2005, developed this “world class” NCG commissioning structure, a commissioning model that is attracting interest internationally. Through this commissioning structure, the NHS has been able to meet the needs of patients with LSDs in England. Genzyme recognises the success of the LSDs Service and is committed to providing support for this model now and in the coming years.

Contact for press enquiries: Adrian Pollitt, Director of National Specialised Commissioning on 020 7932 3940

NOTES TO EDITORS

1. Lysosomal storage disorders (LSDs) are inherited metabolic diseases that are characterised by an abnormal build-up of various toxic materials in the body’s cells, as a result of enzyme deficiencies. These disorders affect different parts of the body—including the skeleton, brain, skin, heart, and central nervous system—and can lead to significant morbidity and, in some cases, death. Genzyme has developed enzyme replacement therapies for four lysosomal storage disorders, these products being imiglucerase (Cerezyme®), agalsidase beta (Fabrazyme®), laronidase (Aldurazyme®) and alglucosidase alpha (Myozyme®)

2. The National Commissioning Group (NCG) advises Department of Health Ministers on which NHS services are best commissioned nationally, to ensure high quality of clinical care, equity of access for patients and value for money. The NCG is hosted by NHS London but works on behalf of the NHS England.

3. For the financial year 2007–08, the budget for English patients with Lysosomal Storage Disorders is £79 million.

4. The grant will run for three years from January 2007 to December 2009 and will total about £7 million.

5. One of the world’s leading biotechnology companies, Genzyme is dedicated to making a major positive impact on the lives of people with serious diseases. Genzyme in the UK is a fully integrated business with manufacturing (Haverhill, Suffolk and Maidstone, Kent), research (Cambridge, Cambridgeshire) and commercial capabilities (Oxford, Oxfordshire and Maidstone, Kent/Diagnostics), employing over 500 employees in the four UK sites. Based in Cambridge MA, since 1981, the company has grown from a small start-up to a diversified enterprise with more than 10,000 employees in locations spanning the globe and 2006 revenues of $3.2 billion. In 2007, Genzyme was chosen to receive the National Medal of Technology, the highest honour awarded by the President of the United States for technological innovation. In 2006 and 2007, Genzyme was selected by FORTUNE as one of the “100 Best Companies to Work for” in the United States. With many established products and services helping patients in nearly 90 countries, Genzyme is a leader in the effort to develop and apply the most advanced technologies in the life sciences. The company’s products and services are focused on rare inherited disorders, kidney disease, orthopaedics, cancer, transplant, and diagnostic testing. Genzyme’s commitment to innovation continues today with a substantial development program focused on these fields, as well as immune disease, infectious disease, and other areas of unmet medical need.
FOOTNOTES

Information about Adverse Event reporting can be found at www.yellowcard.gov.uk. Adverse events on Genzyme medicines should also be reported to Genzyme Therapeutics on 00-31-35-699-1299, or pharmacovigilancesafety@genzyme.com

Summary of Product Characteristics for Genzyme therapies are available at http://emc.medicines.org.uk

Genzyme Ref: LSD-UK-11/07, date of prep 5 November 2007

1. INTRODUCTION

1.1 Local Improvement Finance Trusts (LIFT) are a Government-endorsed finance scheme based on long term joint ventures at national and local level to improve investment in primary and social care services in England. Already around £1.8 billion of funding has been injected into GP premises and community facilities across the country in this programme, with over £1 billion in the pipeline. To date, over 260 LIFT buildings are either in construction or open to patients. LIFT facilities often co-locate a wide range of services, including GP practices; podiatry services; occupational therapy; physiotherapy; multi-purpose diagnostic and treatment clinics; and mental health services. In addition, Children’s Centres, libraries, leisure facilities and social care facilities including residential, day-care and nursing supported housing schemes are just some of the premises that have been built through Local Authorities under LIFT.

1.2 Each local joint venture company (the LIFTCo) is owned by representatives of the local Primary Care Trust (PCT), Community Health Partnerships and a private sector partner. Projects are overseen by a Strategic Partnering Board, comprising representatives of stakeholders from the local health economy including in some areas Local Authorities. Unlike Private Finance Initiative (PFI) deals, LIFT schemes are based on the local LIFTCo owning and maintaining the new premises and leasing space to PCTs, General Practitioners (GPs) and other social care or voluntary sector tenants, offering a real partnership approach between the public and private sectors. LIFT was first introduced by the Department of Health (DH) in 2000 with the aim of attracting a total of up to £1 billion of private investment by 2010; a level of primary care investment unprecedented in the history of the NHS.

1.3 The LIFT Council (formerly LIFT LOBI) is the representative trade body for private sector investors in LIFT schemes. Our membership comprises 13 organisations; over 95% of the private equity investors in LIFT ventures around the country. The LIFT Council acts as a forum for debate and decision-making for members on all issues relating to LIFT and represents the interests and consensus opinion of its members. We welcome the opportunity to feed into the Committee’s commissioning inquiry and this submission addresses the issues in the terms of reference. In particular, The LIFT Council believes that much more can be made of role LIFTCos can play in assisting PCTs to discharge their commissioning function and that it is more important than ever that PCTs draw on this support given the strong link in the Government’s Transforming Community Services programme between commissioning strategy and estates management.

2. SUMMARY

2.1 The LIFT Council believes that whilst there has been some progress around improving commissioning at the local level, there is still some way to go. To really ensure reform bites on the ground, any Government must ensure that LIFT is positioned as a central resource for PCTs. Whilst LIFT is a clear success story, it is largely an unsung one in many parts of the country. Where PCTs have existing LIFTCos, they must be encouraged to see it as the delivery vehicle for joining up commissioning strategy and estates management—a message that must be strongly reflected in DH guidance. For those PCTs without an existing LIFTCo, the new Express LIFT framework offers PCTs and local authorities who have not yet conducted their own procurement the opportunity to select a pre-approved LIFT partner more quickly and cost effectively from a pre-approved list. With the NHS currently in a state of uncertainty over future funding, it is more vital than ever that PCTs are encouraged to make use of established models such as LIFT which offer huge potential in assisting them with the effective management of their estate and aligning this with commissioning strategy. Working with established partners whose success is totally linked with the success of the relevant NHS organisation offers a win/win solution. Wise partnering between public and private sectors is therefore an essential feature of success for the NHS.

2.2 The other side of the same coin is that Government must ensure the LIFT model is able to work effectively and should actively remove barriers that are facing commissioners on the ground, particularly around prioritising the integration of care; developing commercial acumen in the NHS; ensuring a strong link between commissioning and outcomes, potentially through an extension of patient surveys; clarifying and streamlining the role of SHAs to one based on light-touch regulation; and encouraging the extension

Footnotes

105 Community Health Partnerships (CHP)—known until autumn 2007 as Partnerships for Health (PfH)—is an independent company, wholly owned by the Department of Health. Its main activity has been to deliver the Local Improvement Finance Trust (LIFT) Initiative which provides clean, modern, purpose-built premises for health and local authority services in England.
of PBC (practice-based commissioning). In light of the current financial situation, getting more from existing resources and improving commissioning will be a fundamental requirement on all parts of the NHS; success in achieving this goal will be a key differentiator between successful and failing NHS bodies. In addition, improving commissioning also has a key part to play in addressing the challenges of Quality, Innovation, Productivity and Prevention (QIPP), key priorities for the NHS.

3. World Class Commissioning (WCC)

3.1 Despite the mixed results of the first round of the assurance system, The LIFT Council considers the aspirations of the WCC programme to be a step in the right direction and our members report increased evidence of expertise and increased competency from their PCT partners as well as an increased awareness of the issues surrounding commissioning. The Council further hopes the recent publication of the DH’s new commercial operating model, Necessity—not nicety, will contribute towards an increased focus on the development of commercial skills within NHS organisations as this can only contribute to the ongoing success of the LIFT model.

3.2 The LIFT Council would, however, like to see a more robust management structure in place and a more systematic review process at PCT level to assist the DH to audit the direction of travel of PCTs on commissioning. The current system is too dependent on self-assessment and providers (“the commissioned”) should also have a say in the process.

3.3 In addition, there is some additional concern that there is a tendency for PCTs to be over-reliant on the use of external consultants which can potentially compromise the learning process for PCT staff. Indeed, Pulse magazine recently reported that PCT spending on management consultants has more than tripled in the last two years, with each PCT now spending an average of £1.217 million on external consultants and the Health Select Committee itself recently published a report on this same issue. Relationships with external consultants are not based on this same partnership approach as LIFT, shared goals and linked financial success and can potentially contribute to higher costs, confused strategy and delay in delivery. Whilst there will always be inherent challenges with a “tick-box” based assessment process, the LIFT Council does believe this change needs to be driven from the centre to encourage a change of culture within PCTs with a view to realising effective commissioning and creating a system with encourages PCTs to behave courageously.

4. The Provider/Commissioner Split

4.1 The LIFT Council supports the separation of PCT provider and commissioner functions which was set out in the NHS Operating Framework for 2008–09 and further addressed in the Transforming Community Services guidance published in January 2009. Transforming Community Services required all PCT direct provider organisations to have moved into a contractual relationship with their PCT commissioning function using the national contract for community services in 2009–10. In addition, PCTs are required to agree with their SHAs a clear and realistic strategy for the future of the estate that will ensure that the estate’s fitness for purpose is assessed in the light of current and future commissioning intentions, exploring options to ensure that the estate is managed on an efficient and flexible basis to accommodate future changes in need.

4.2. Despite this move, The LIFT Council believes the guidance should have gone further and required a full separation of PCT provider and commissioning functions. If responsibility for making a commissioning decision is linked to responsibility as a service provider for implementing a service change then compromise in the commissioning decision is a frequent result. It is only through total separation of the commissioning decision from the resultant action that commissioners will truly be able to focus on their primary goals of improving the health care of the population and improving productivity and value for money. Indeed, the influential health think-tank, the King’s Fund, has argued that “the management of significant provider arms has distracted PCT boards from their core commissioning role . . . The commissioning role of PCTs is now rightly taking precedence over that of provision”.

4.3 It is The LIFT Council’s position that commissioning should fundamentally be a locally-led process, to be taken forward by expert commissioners within PCTs. Service provision should be entirely separate from the commissioning process with commissioners setting financial targets, leading on informatics and setting the overall strategic direction for commissioning based on service needs. The LIFT Council further believes that a migration towards a total split between PCT provider and commissioning functions is an inevitable result of the initial moves in this area. In a model such as this, LIFTCo can align with the commissioner to ensure the estate is linked to the commissioning strategy, with services to be provided through a partnering arrangement with providers. With LIFTCo assisting PCTs in ensuring the estate is fit for purpose, the commissioner is able to focus on ensuring quality in the service delivery of providers. This

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split is therefore the best way in which to ensure high quality service delivery, increased productivity and value for money, and challenge mediocrity in the NHS. In addition, commissioning in this way is likely to lead to cost savings for PCTs through the introduction of market pressures and incentives.

5. COMMISSIONING AND SYSTEM REFORM

5.1 Competition and the private sector

5.1.1 There is a significant role for the private sector to play both in continuing to provide investment in the NHS, in stimulating competition but also in assisting PCTs to derive maximum value from their entire health infrastructure, with the presumption as part of Transforming Community Services that that responsibility for the provision of estate will remain with commissioners; a role certainly likely to become increasingly important as the NHS is faced with squeezed budgets. Indeed, all the main political parties have acknowledged the vital role the private sector has played in the support and delivery of healthcare and this was a clear message in the recent DH publication Necessity—not nicety which set out a new commercial operating model for the NHS and the DH. The document sets out that the reasoning behind the publication of this new model was to address the NHS’s commissioning weaknesses, to stimulate the market and to help it deal more effectively with the private sector. The LIFT Council believes that wise partnering between public and private sectors will enable the NHS to get more from existing resources.

5.1.2 In addition, the DH recently published further guidance to support PCTs with Transforming Community Services and in developing what is now termed the Commissioners’ Investment and Asset Management Strategy (CIAMS). Central to CIAMS is the alignment of estate configuration with service need. One of the key policy steers of Transforming Community Services was that responsibility for the provision of estate should not pass to providers and should instead be controlled by commissioners with a view to ensuring that:

- Estates requirements are aligned with commissioning plans;
- Commissioners are more easily able to obtain their desired outputs from providers; and,
- A level playing field is created for existing providers and potential market entrants.

5.1.3 This approach is fundamentally in line with the wider objectives of driving up quality, with PCTs more able to focus on the quality of provider services, and transforming local commissioning.

5.1.4 Despite this intention the current system is characterised by fragmentation and even in LIFT areas assets are owned and managed by a myriad of organisations, all of whom deliver services to the NHS. In non-LIFT areas ownership structures are even more complicated. This acts as a real drag on synchronising the system since service providers can hold the commissioner hostage whilst the commissioner is unable to decommission services or appoint new providers due to a lack of estate.

5.1.5 The guidance explicitly states that PCTs should view the LIFTCo option as their delivery vehicle of choice in terms of forming a strategic partnership to realise CIAMS. This builds on the announcement in November 2008’s Pre-Budget Report that LIFTCos would be enabled to extend their management to the entire PCT estate which was widely welcomed by the LIFT Community. It will be important to ensure PCTs receive guidance as soon as is practically possible on how best to use LIFTCo as part of its CIAMS and estates strategy. The LIFT Council has proposed a model whereby the PCT and the LIFTCo work together to develop an estate survey, aligned with the PCTs commissioning strategy, to identify where the existing estate is holding back quality and cost improvements in clinical service delivery and improved value for money. The review will include all facilities whether owned or leased by the PCT, GPs or LIFTCo. Working closely with the PCT the LIFTCo would then work up a strategy which would have a number of objectives:

- Developing a comprehensive picture of actual usage as well as condition and suitability.
- Proposing ways in which any gaps in provision could be filled, either through new developments or the redevelopment of existing estate.
- Developing options to free the NHS from poor quality service providers who retain contracts due to their ownership of particular assets.
- Identifying target areas for quality and productivity improvements.

5.1.6 As a meaningful partnership between the public and private sectors, our members identify a key role for LIFT in enabling the NHS to deliver world class commissioning and improved outcomes for patients. With expertise in commissioning, contracting and performance-management, we believe LIFTCo is ideally placed to support commissioning at the local level. This role is likely to become increasingly important as the Transforming Community Services programme develops and as LIFTCos across the country work with PCTs to ensure their commissioning strategy is strongly linked to the management of their primary care estate. Indeed, there is already evidence from our members that they are already starting to assist their PCT partners in delivering CIAMS. In addition, there are many examples of schemes where...
LIFTCo has helped PCTs realise a more efficient use of resources—for example, the 2,000 sq m Oak Park Children’s Services Centre in Havant was specially designed to relocate a wide range of services previously provided from eight different sites across the area into one purpose-built facility.

5.2 Practice-based commissioning and Payment by Results

5.2.1 It is widely acknowledged that the Government’s practice-based commissioning (PBC) scheme has not been as successful as was hoped. Indeed, the results of the DH’s own quarterly GP practice survey which is designed to give a picture of national implementation of PBC revealed that 69% of practices had been given an indicative budget and only 64% had agreed a commissioning plan.

5.2.2 It is the LIFT Council’s position that a system of “earned autonomy” would be preferable where high-performing commissioning groups could be delegated increased autonomy and power. Such a system should be based on robust measures of financial capacity and patient satisfaction. Indeed, the concept of earned autonomy has the potential to be rolled-out more widely across the NHS; the recently published New Guidance on Approving Investments in LIFT that DH was considering the extension of a system of earned autonomy to those PCTs and LIFTCos that can demonstrate a good working relationship, appropriate competitive tension, value for money and a mature approach to risk. These PCTs and their partners will be accredited and will earn significantly higher delegated capital expenditure limits.

5.2.3 Given that a huge amount of NHS expenditure is already directed by GPs by way of their gatekeeper role, The LIFT Council believes it is critical to place more responsibility on GPs to commission services whilst ensuring that the conflict of interest issue is appropriately addressed. Whilst the current Government has taken some steps around reinvigorating PBC, The LIFT Council believes this reform must go further and particularly in terms of using LIFTCo to realise the benefits of PBC.

5.2.4 In light of the focus on ensuring commissioning has a strong local basis, The LIFT Council would support the commissioning of regular primary care services to take place at GP level, with appropriate oversight from the PCT based on a system of earned autonomy. The LIFT Council believes that it is important that clinicians are given the freedom to determine service provision for their local area as they are best qualified to make decisions based on local need. For more specialist services, defined as only accessed by small proportion of the local health economy, the PCT should retain responsibility for commissioning, given their access to aggregate figures and the fact that such services will need to cover larger geographical areas. The LIFT Council believes this system would lead to better quality care pathways being developed, better value for money as well as a strong local link between commissioning and local needs. Local LIFTCos will be able to play a clear supporting role in realising strategic local commissioning. The LIFT Council therefore believes that the renewed vision for PBC and its implementation will be an important test in enabling more strategic commissioning to take place at the local level.

5.2.5 As identified by a recent King’s Fund report, a key barrier to success in PBC is the lack of national guidance on the respective roles and responsibilities of GPs and PCTs around PBC. Indeed, our members would also point to attempts by SHAs to claw-back some powers in this area which moves PBC away from being a locally-driven initiative. It is imperative that any programme of renewal for PBC ensures that local commissioners have the confidence to take forward initiatives to improve local care as well as ensuring they have the power to do so. It is also important to ensure that the Payment by Results system is better integrated with PBC by continuing to unbundle the tariff to free up resources so that more care can be delivered in the community, as well as considering how the system might be extended to cover a broader range of primary and community based services, including potentially those carried out by GPs. There are also obvious benefits with the care in the community approach in identifying cost savings, a key challenge for the NHS over the next few years.

5.2.6 It is the view of The LIFT Council that LIFT can facilitate and enable a better take-up of PBC as it delivers purpose-built facilities, designed to meet local needs, which can be used as a springboard to think creatively about the delivery of more services in the community. One example is the Clifton Cornerstone facility which delivers a huge range of services in the community, including multi purpose diagnostic and treatment clinics for a range of conditions; mental health services and counselling rooms; children’s clinics; and physiotherapy, occupational therapy and speech and language therapy; dental surgery; and podiatry. With expertise in commissioning, contracting and performance-management, LIFTCo is ideally placed to support PBC at the local level. The new Express LIFT framework will also enable the benefits of LIFT to be realised at an increased number of PCTs across the country.

5.2.7 Whilst the issue of indicative vs real budgets is a particular discussion point in relation to PBC, it is worth considering more generally where commissioning budgets should sit particularly given the myriad of organisations involved in commissioning in the NHS. For PBC specifically, it has been argued that giving real budgets to GPs might empower more GPs to become engaged in the system. Clearly though, if real budgets are to be introduced for PBC, the PCT must play a role in policing the system and ensuring that the system remains focused on value for money and what is best for patients. Indeed, an “earned autonomy” system might work well in this area.
6. Commissioning for Quality

6.1 There has been much debate around what actually constitutes commissioning for quality, with the general consensus pointing to strong links to improved patient outcomes—a strong theme in Lord Darzi’s review of the NHS, *High Quality Care for All*. In his report, Lord Darzi envisaged putting quality at the heart of everything the NHS does and saw a particular role for Patient Reported Outcome Measures (PROMs) as a way for patients themselves to assess effectiveness of care with PROMs now having been introduced for patients undergoing certain procedures. Linking this issue to commissioners, The LIFT Council considers there may be a role for PBC groups, for example, to survey patients on their quality of care and for payments to be clearly linked to quality measures, another emerging area of work. Many of our members already have in place robust processes to measure the level of patient satisfaction and to allow them to act upon suggestions both as part of the planning process and once the facility is in use. For example, NHS Oldham, together with Oldham Council and supported by Community 1st Oldham, undertook a Health Impact Assessment (HIA) to assess the potential positive and negative health impacts of the Royton LIFT project and to enable the LIFT project to enhance positive health benefits and minimise negative ones. Despite some progress in this area, it is clear that health outcomes are somewhat difficult to measure, particularly in a primary care setting, and so this area certainly merits further debate and discussion.

6.2 The LIFT Council also believes that, in line with its position that commissioning must have a strong local link, PCTs need to play an active role in setting and achieving local priorities, potentially based on a set of 4–5 key performance indicators. Clearly this approach is the principle behind the Local Area Agreement (LAA) process; given that as of June 2008, LAAs are in place for all 150 upper-tier local authority areas in England, the evolution of this process will be critical in terms of assessing the progress local partners make towards locally-determined priorities. The LIFT Council’s position is that there is a potential role for LIFTCo to play in linking in with such local processes as LAAs and the related Joint Strategic Needs Assessment, and in ensuring that the PCT is taking a strategic view with regards to local needs and the services that are being deployed to meet this need.

6.3 Whilst it is clear that there is potentially some role for SHAs to play in monitoring and assessing the development of PCTs’ CIAMS, The LIFT Council maintains that commissioning decisions should take place at the local level with SHAs only able to intervene in the case of failure. In addition, SHAs might potentially play a role in monitoring a system of earned autonomy whereby high performing commissioning groups are given greater autonomy. SHAs should also play a role in supporting the development of a regional market and The LIFT Council is keen that the SHAs’ role lies in closely with the new regional Commercial Support Units (CSUs) announced as part of the new commercial operating model. As soon as the CSUs are operational, The LIFT Council will seek to ensure they are aware of the benefits of drawing on the commercial knowledge of LIFTCo and are actively promoting this through their PCT networks, both for those areas with existing LIFTs and as part of the new Express LIFT framework. Despite this, The LIFT Council does support the position that SHAs often introduce an additional layer of bureaucracy and that their role should be based much more on the principles of light-touch regulation and much more clearly defined.

6.4 The LIFT Council believes commissioning for integrated care will also lead to high quality care and improved patient outcomes and that it is therefore incumbent on PCTs to take more of a lead in this area with commissioners clearly specifying clear service integration in service specifications rather than simply co-located services. There is a clear benefit in using the LIFT model to achieve better integrated services as facilities are purpose-built and many schemes are enabling the design of integrated care pathways to the benefit of patients. For example, the Mary Potter Centre in Nottingham provided an opportunity to modernise day care and rehabilitation services by providing accommodation for the new Acorn Resource Centre (physical and sensory impairment services) as well as including the only Children’s Centre nationally to be located outside of a school campus. This should be more achievable in the context of the *Transforming Community Services* programme whereby commissioning strategy is to be explicitly linked with estates management.

September 2009

Memorandum by the West Midlands Specialised Commissioning Group (COM 37)

EXECUTIVE SUMMARY

1. World-Class Commissioning (WCC) is a development whereby the Department of Health (DH) has recognized the need to strengthen commissioning in PCTs from a low base to support the better delivery of healthcare. Commissioning in the NHS is a complex activity and SCGs act as commissioners of delegated PCT resources of a considerable amount (about 5% of the total PCT budgets). As such the SCG needs to reflect and be closely linked to PCT priorities.

2. Strong commissioning will support the concept of contestability. This may help to strengthen the outcomes from commissioning and an example of improved procurement for mental health services is given. However, it may also be divisive in terms of relationships with organisations within the NHS. This is also
seen with the independence of foundation trusts where relationships are sometimes competitive to the detriment of the wider values in the NHS. This may mean that commissioners find it more difficult to achieve the right balance of services to reflect patient needs.

3. From a Specialised Commissioning Group (SCG) perspective commissioning has generally been well structured within the West Midlands SCG. However, WCC, along with the Carter reforms, has helped to highlight how commissioning can be improved.

4. The Carter Review of 2006 on specialised services has strengthened SCGs by producing more consistent and shared working and has also started to change the relationship between the DH, SCGs and PCTs. The roles of the new NSCG and its sub committee, the NCG, are taking time to be established.

5. The development of robust governance policies and procedures has been a priority for the WM SCG, in particular looking at Serious Untoward Incident (SUI) reporting and lessons learnt, and this work will continue to support the NHS policies on improving patient safety. Consideration has been needed as to how to report and manage SUIs when more than one commissioner is involved.

6. Some acute services providers have more than one specialised services commissioner, particularly across regional boundaries. This needs good arrangements, and possibly further development, to ensure that the commissioning arrangements and accountability are consistent across the different commissioners without undue bureaucracy for the provider trust.

**BACKGROUND INFORMATION ABOUT THE WEST MIDLANDS SPECIALISED COMMISSIONING GROUP**

7. The West Midlands SCG was established in 2007 following a review by the 17 PCTs of the West Midlands on how they should commission specialised services. This followed the publication of the Department of Health Carter Review in 2006. Prior to 2007 the forerunner of the SCG had been established before 2000 as the West Midlands Regional Specialties Team. The population of the West Midlands is about 5.4 million.

8. The West Midlands SCG had a budget of £838 million for 2008 -2009 covering both regional commissioning services and those on a collaborative basis across local groupings of PCTs. Total management costs were £3.5 million. 0.4% of the total annual budget managed by WM SCG. The expenditure on specialised mental health services was £146 million or about 20% of the total portfolio. Specialised cancer, cardiac, renal and neonatal services were the largest acute services by expenditure.

**WORLD-CLASS COMMISSIONING**

9. World Class Commissioning (WCC) is an initiative from the DH that has been developed in a structured manner. Perhaps the most important aspect is that it recognizes commissioning as a key task for PCTs. It has encouraged investment in the support that is needed to make commissioning in the NHS successful.

10. The development of robust working relationships with the SCG’s many partner organisations has been instrumental in raising the profile of specialised commissioning and is important for good governance, control and accountability. As the SCG is not a statutory body Establishment Agreements setting out the formal accountability arrangements between the SCG and the PCTs continue to be important. These agreements and the working structures of the SCG have helped everyone to gain a better understanding of organisational needs. The role of the PCT that hosts the WM SCG is also important within the specialised commissioning arrangements as it helps to assure all PCTs in the region that there is robust governance in place for the work of the team.

11. Public Health skills are vital for the SCG as it moves towards being a WCC organisation. The commissioning process is often described as a cycle and public health activities are integral for this commissioning process to be effective. The competencies identified as those required for WCC are closely aligned with the public Health competencies as defined by the UK Faculty of Public Health. This underlines the important role that public health professionals play in supporting NHS organisations in their commissioning role. Collaborative working is key to much of the work of the public health team, who works with colleagues from providers and PCTs, and with a range of clinical staff both within the West Midlands and further afield. However, it is not clear that there are sufficient public health specialists experienced in commissioning coming through the system to provide the support that WCC needs.

12. Priority setting and policy development are important roles where public health contributes to commissioning and needs to work closely with finance and managerial colleagues. A substantial development has been the contribution to the National Prescribing Centre’s handbook on rational local decision making for PCTs, and this helps to support the NHS Constitution. A set of generic commissioning policies have been developed with a local PCT and these sorts of policies need to be adopted widely across the NHS to support consistent commissioning. The SCG has also devised and gained support from all 152 PCTs to establish a NICE liaison unit. This aims to improve PCT engagement with NICE’s technology appraisal programme, improve relations and dialogue between NICE and PCTs and ultimately increase PCTs and commissioners influence with NICE.
13. An example of acute service working is where the West Midlands has a regional Cardiac Steering Group to co-ordinate cardiac developments across the local cardiac and stroke networks so that clinicians, provider trusts and commissioners work closely together. One piece of work that has also been worked on collaboratively at a national level is to ensure that the development of new cardiac valves (with the acronym TAVI), inserted via a catheter rather than during major surgery, is only supported in the context of more detailed evaluation and research trials. This is an example of working across commissioners (both PCTs and SCGs) and with leading clinicians to ensure that new developments are properly evaluated with respect to the benefits and safety for patients.

14. The WM SCT also plays a role in collaborative commissioning. That is where services need commissioning or support across more local groupings of PCTs and where commissioning as a regional specialised service is not felt to be appropriate. There are five of these local groupings across the 17 PCTs in the West Midlands. This also helps to maintain PCT communication and input as well as allowing more sensitivity to local needs and care pathways. In particular it allows policy co-ordination for national initiatives such as the developments in radiotherapy services.

Specialised Mental Health Services

15. Specialised Mental Health Services has a regional portfolio which covers:

- high, medium and low secure inpatients, mental health and learning disabilities services,
- personality disorders services, and
- Child and Adolescent Mental Health Services (CAMHS) Tier 4. As recommended by the Carter Review, there have been significant moves towards consistency across the NHS although this still needs ongoing work in this sensitive area. There has been a best practice specification for medium secure services and a similar guidance is being refined for low secure services.

16. Procedural and structural improvements are being made and there are substantial changes in the NHS relationship with the criminal justice system, which will continue with the recommendations from the recent Bradley Review. One aspect that needs more understanding is the metrics around secure mental health services and the information to support this needs considerable development.

17. The West Midlands has led a major project to put in place improved contractual arrangements with Independent Sector providers, as these providers play a substantial role in providing services to secure mental health patients. This led to a collaborative working arrangement with the Commercial Directorate to provide procurement, contracting and legal expertise for areas of mental health and learning disability commissioning, specifically medium and low secure and Tier 4 CAMHS. This improved procurement not only identified savings to the West Midlands of £3.8 million but should also improve the quality of service delivery through better specification and accountability.

18. The SCG’s mental health team has led major reviews to develop strategies for adult secure services and CAMHS Tier 4. What these reviews have demonstrated is the need for good linkage with the part of the care pathway for mental health services commissioned by PCTs so that these patients with complex problems can more easily move through the pathway as necessary. To ensure that patients receive the appropriate level of treatment and the NHS manages its resources in the best way it is important that PCTs give commissioning for mental health services a similar priority to that for acute clinical services.

Recommendations

19. World Class Commissioning as a means to support the complexities of NHS commissioning should continue to be supported and developed.

20. Specialised services commissioning needs to be more widely recognised as commissioning delegated from PCTs and to be supported to enable joined-up commissioning both with PCTs and at the national commissioning level.

21. Priority setting within commissioning budgets continues to be a difficult issue. This area needs a national debate to support public engagement and the understanding of the difficult decisions that need to be made on the public’s behalf.

22. Mental health services need to be given a higher commissioning priority to improve the services and outcomes for patients.

September 2009
1. EXECUTIVE SUMMARY

1.1 Bayer Schering Pharma is one of the ten largest speciality pharmaceutical companies in the world. We have a particular heritage in female contraception and manufacture a number of different forms of contraception, enabling women to choose a method which best meets their preferences and reflects their lifestyle.

1.2 We welcome the Committee’s decision to begin an inquiry into Commissioning. This submission focuses on the commissioning of contraceptive services in primary care and addresses the impact of World Class Commissioning as well as issues relating to how commissioning can improve the quality and safety of services.

1.3 We make a number of recommendations which the Committee may wish to consider:

— The Committee should consider recommending that the Department of Health establish an outcome indicator based on the all-age abortion rate in the World Class Commissioning programme.

— The Committee should consider recommending that the Department of Health should include, within the NHS Operating Framework, that every PCT should undertake and publish an audit of access to, and usage of, all contraceptive methods; including the methods and brands used by women, removal and insertion rates for LARCs and the percentage of women provided with information about LARC methods.

— The Committee should consider recommending that the World Class Commissioning assurance process should require for PCTs to set out the steps they are taking to ensure that the services they commission are delivered in accordance with the recommendations of NICE Clinical Guidelines on LARC.

2. THE DELIVERY OF CONTRACEPTIVE SERVICES

2.1 Contraceptive services will be of relevance to most people at some point in their lives. However, there is clear evidence that contraceptive services do not meet the needs of all women as the rate of unintended pregnancy is not declining.

2.2 Whist it is difficult to measure rates of unintended pregnancy, it is possible to estimate the amount of unintended pregnancies based on abortion rates. In 2008, there were 195,296 NHS and NHS agency abortions in England. NICE has estimated that 40.6% of unintended pregnancies end in abortion. This implies that in 2008 there would have been approximately 481,025 unintended pregnancies. Whilst tackling teenage pregnancy is rightly a key Government priority, it is worth noting that over half of all abortions in England and Wales are for women in their 20s, 27.9% are for women of 30 years and over, whilst only 21.8% are for women under 20 years.

2.3 Also it is clear that unintended pregnancy is not a problem confined to young single women without families. 16% of women having abortions are married, 48% have already given birth to one or more children and 33% have had a previous abortion.

2.4 The prevention of unintended pregnancy through NHS services may save over £2.5 billion per year, with the cost to the NHS of an unintended pregnancy estimated at £1,235 based on assumptions made in the NICE Long-acting reversible contraception guideline. There are a variety of different methods of contraception, including a range of oral contraceptives, the male and female condoms, the intrauterine system (IUS), the intrauterine device (IUD), the contraceptive injection, the implant and the emergency contraceptive pill. Therefore the accurate and successful use of contraceptives, in a way which fits the lifestyle and personal preferences of individual women, can play a key part in reducing unintended pregnancy, improving health outcomes and minimising NHS expenditure.

3. IMPACT OF WORLD CLASS COMMISSIONING

3.1 The World Class Commissioning programme has resulted in an unprecedented focus from the Department of Health on supporting the effectiveness of commissioners, which is extremely welcome. A key element of effective commissioning is identifying and responding to the needs of local communities. The assurance process has undoubtedly introduced greater transparency into local priority setting. By analysing the outcome indicators selected by PCTs, it is possible to gain an insight into their priorities, as well as the extent to which these align with local health needs.

3.2 A recent analysis of outcome indicator selections found that the under 18 conception rate was the fifth most commonly selected nationally-defined indicator by PCTs, demonstrating that PCTs have responded to the Prime Ministerial Teenage Pregnancy report and targets. Figure 1 shows the PCTs that

115 Health Mandate, National priorities, local action? An analysis of Primary Care Trusts’ World Class Commissioning policies, July 2009.
have selected the *under 18 conception rate* World Class Commissioning indicator as one of their outcome measures to be measured against. Just over one third (53 out of 152) of PCTs have decided to focus on this indicator.\(^{117}\) However by comparing the areas that have prioritised *under 18 conception rate* in the World Class Commissioning programme with the actual teenage pregnancy rate, shown in Figure 2, it is possible to see that many of the areas where teenage pregnancy poses the biggest problem have not selected the World Class Commissioning outcome indicator.

3.3 Although reducing teenage pregnancy is a policy priority of the Department of Health, it is not an indicator for the quality of overall contraceptive services. As outlined in point 2.2 above unintended pregnancy is an issue for all women, and in particular those in the 18–34 age bracket. Figures 3 and 4\(^ {118}\) show the difference in abortion rates in those under 18—where the World Class Commissioning outcome indicator is focused—and the abortion rates for older women, were there is no Government attention. This disparity demonstrates that the contraceptive needs of women of all age groups are not being met.

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\(^ {117}\) Health Mandate, data on file.

**Figure 1:** Primary Care Trusts that selected *under 18 conception rate* as a World Class Commissioning outcome measure

**Figure 2:** Under 18 conception rate per 1,000 female population, upper-tier local authority level

**Figure 3:** under 18 abortion rate per 1,000 women

**Figure 4:** 18-34 abortion rate per 1,000 women
3.4 Given the impact that people’s experience of contraceptive services will have on their wider experience of NHS care, as well as the clear policy priority of reducing the abortion rate, we believe that it would be appropriate to develop an outcome indicator for the World Class Commissioning programme linked to the abortion rate. This would provide a better mechanism for enabling PCTs to assess the quality of the contraceptive services they commission for women of all ages.

3.5 The Committee should consider recommending that the Department of Health establish an outcome indicator based on the all-age abortion rate in the World Class Commissioning programme.

4. COMMISSIONING HIGH QUALITY CONTRACEPTIVE SERVICES

4.1 The importance of commissioning contraceptive services was recognised in the NHS Next Stage Review, which identified sexual health as one of the six priority areas for PCTs to commission. The NICE guideline clearly stated that "women requiring contraception should be provided with information and offered a choice of all methods, including LARC methods." The importance of commissioning contraceptive services was recognised in the NHS Next Stage Review, which identified sexual health as one of the six priority areas for PCTs to commission. The NICE guideline clearly stated that "women requiring contraception should be provided with information and offered a choice of all methods, including LARC methods."

4.2 There are a number of very useful resources to assist PCTs in commissioning high quality, safe and cost-effective contraceptive services.

4.3 For long-acting reversible contraceptives (LARC) the NICE Clinical Guideline No 30: long-acting reversible contraception, published in 2005 provides comprehensive and evidence-based advice on the forms of contraception which should be offered, as well as the way in which services should be delivered. The NICE guideline clearly stated that "women requiring contraception should be provided with information and offered a choice of all methods, including LARC methods."

4.4 Despite societal shifts and attitudes to contraception, as well as other contraceptive options becoming available, in 2007/08 the oral contraceptive pill was still the most popular contraceptive method in the UK. However different contraceptive pills are not all alike. Today there are 25 different types of oral contraceptive pill available. They differ in the type and dose of the hormones used.

4.5 Over time, there has been a focus on improving formulations to improve use and compliance and reduce side effects. Anecdotally we know that some PCTs are restricting access to the newer brands of contraceptive pill. New additions to the range of combined oral contraceptives provide extra choice to more women, essential to meet diverse user needs and preferences. In one study it has been shown that choice in contraceptive pill available, in 2007/08 the oral contraceptive pill was still the most popular contraceptive method in the UK. However different contraceptive pills are not all alike. Today there are 25 different types of oral contraceptive pill available. They differ in the type and dose of the hormones used.

4.6 Since April 2009 the GP Quality Outcomes Framework has included indicators to support increasing choice in contraceptive method and increasing awareness of LARC methods. The new indicators are:

- The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year.
- The percentage of women prescribed an oral or patch contraceptive method in the last year who have received information from the practice about long acting reversible methods of contraception in the previous 15 months.
- The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription.

4.7 Despite this it is clear that many PCTs are not following offering the full range of contraceptive choice to all women. A survey carried out in 2005 showed that up to 30% of PCTs restrict access to some forms of contraception. A Department of Health audit found that 20% of PCTs reported that they had policies

123 Qlaira®: Summary of Product Characteristics.
126 Faculty of Family Planning and Reproductive Health Care, Sexual health in the UK: Protecting our future, 2005.
in place which restricted access to LARC methods.\textsuperscript{127} The same survey revealed that only 5\% of PCTs had undertaken a comprehensive audit of LARC methods, with a further 31\% indicating that they had undertaken a limited or minimal level of audit. We believe that it is impossible for PCTs to argue that they are effectively commissioning for quality and safety if they have failed to undertake even a basic level of mapping or needs analysis.

4.8 The Committee should consider recommending that the Department of Health should include, within the NHS Operating Framework, that every PCT should undertake and publish an audit of access to, and usage of, all contraceptive methods; including the methods and brands used by women, removal and insertion rates for LARCs and the percentage of women provided with information about LARC methods.

4.9 We believe that this is particularly important given that access to choice of contraceptive methods appears to be decreasing despite the Department of Health’s patient choice agenda. Research by Bayer Schering Pharma has found that the number of women being offered a choice in contraception has declined by approximately one third in the last two years.\textsuperscript{128} A GP magazine investigation has also identified restrictions to NHS contraceptive services.\textsuperscript{129}

4.10 The cost-benefit ratio of contraception is estimated to be £11 saved for every £1 spent.\textsuperscript{127} Therefore PCTs should be commissioning comprehensive contraceptive services which allow women to use the contraception which suits them. By enabling women to make better contraceptive choices this will lead to down-the-line savings including reducing the rate of unintended pregnancy.

4.11 Unfortunately NICE Clinical Guidelines do not have the same level of enforceability as Technology Appraisals. There is little point in NICE devoting significant time and resources to developing such guidelines if commissioners do not intended to use them as basis for commissioning services.

4.12 The Committee should consider recommending that the World Class Commissioning assurance process should require for PCTs to set out the steps they are taking to ensure that the services they commission are delivered in accordance with the recommendations of NICE Clinical Guidelines on LARC.

September 2009

Memorandum by the Royal College of Physicians (COM 39)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

1. Summary

1.1 The following submission develops the argument that any evaluation of commissioning policy, centrally and locally, cannot be disentangled from the wider NHS reform agenda. On paper, seemingly cross referenced initiatives like Care Closer to Home, Practice Based Commissioning, World Class Commissioning are unobjectionable. But there is a danger of unintentionally confused messages and competing interests coming into play on the ground. Clinicians wish to see the NHS using resources wisely and achieving the best outcomes for all patients. The RCP is of the firm belief that to do this, heath professionals and managers should be empowered to use the better policy initiatives as necessary, and to reject those that are barriers to change.

2. Has the purchaser/provider split been a success, and is it needed?

2.1 The experience here is mixed. Some specialities, such as Palliative Care report that moves towards a purchaser/provider split were initially beneficial. It enabled clinicians to plan clearly across their districts and formalised the contribution of each service; NHS and voluntary. In respect of the latter group, such as hospices, by forcing them to define more clearly what they were doing, they were able to seek a proper NHS contributions towards their costs.

2.2 However, we are uncertain whether a genuine purchaser/provider split is possible or even desirable in the present day. The provider arm, necessarily, has to draw on clinical input and leadership. However the clinicians advising on PCT boards are also often providers of commissioned health care services themselves, or professionally linked to those who do. The issue that needs to be grappled with here is whether the potential conflict of interest is necessarily problematic.

\textsuperscript{128} Bayer Schering Pharma, data on file.
\textsuperscript{129} GP magazine, 12 June 2009.
2.3 This is an especially pertinent question when one considers the changing reality of need in the NHS. There is an emerging consensus that the only way to reconcile the increasingly complex needs of our patients, with policies geared towards ensuring that they see the right person, at the right time, and in the right setting is through the development of integrated models of care, whereby multi-professional teams work in a managed network across the traditional primary/secondary care interfaces. There is good evidence that integrated working practices of this kind lead to improved patient satisfaction, greater efficiency, and improved health outcomes.

2.4 However, we know that some commissioners are worried about the threat of clinical integration leading, effectively, to monopolies. And it is true that the conditions required for such work to flourish can be inimical to internal market ideas. Specifically, 2007 RCP survey of new models of care in the community identified a number of elements that promote success. These were:

- clinical Leadership and involvement;
- high-quality partnership between clinician and professional manager;
- primary and secondary care partnerships;
- committed commissioners willing to innovate and fund flexibly;
- clear patient focus for a defined group;
- clear governance arrangements; and
- agreed measures and standards to improve the quality and quantity of work.

2.5 The converse is equally true. For instance, the setting up of independent treatment centres to increase competition (even in areas where the existing healthcare provider supplied a good service and offered adequate capacity) can cause considerable disillusionment thereby discouraging quality clinician engagement. Policy makers need to decide what is more important—general and hospital practitioners aligning their work so that patients are at the centre of everything they do, or fragmented, inefficient local health economies whose main redeeming feature is their acknowledgement of competition policy.

3. “World class commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

3.1 Members who contributed to our consultation appear sceptical about the usefulness of the WCC programme. Persistent complaints were that it has slowed down the introduction of key local strategies as staff got to grips with its requirements. The problem, in some areas appears to be compounded by a high turnover of commissioners which makes engagement with the process difficult.

4. Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, contestability, the quasi market, and Payment by Results?

4.1 We’ve already touched on how the principles that would make commissioning fit for the NHS’s likely future purpose sit uncomfortably with “contestability” and the quasi market. Turning now to the present day and immediate past, there is also evidence that PBC and PbR can have harmful and unintended effects on the commissioning cycle.

4.2 Practice-based commissioning, as a tool to transfer more care from secondary to primary care settings could be an effective mechanism for initiating clinical integration. For it to work, PBC needs to involve clinicians using local knowledge and expertise to assess the needs of practice populations, reviewing resource use and service delivery, identifying gaps and opportunities to deliver quality improvement. However, a number of specialties report that in reality, it poses difficulties for their members.

4.3 There are two main concerns. Firstly, when clusters of practices decide to offer differentiated services, it can make it harder to introduce new district wide services that require a critical mass. Secondly, there have been instances where GPs and consultants become opponents in a bidding war, rather than working cooperatively as colleagues with different areas of complementary competence. Finally, the creation of models commissioned, and potentially provided by GPs could undermine the futures of the specialist, hospital-based component of such services. Without adequate dual provision, community-based services will have fewer places to turn for training, continuing professional development, and the diagnosis and management of patients with less mild diseases.

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131 An aging population will mean an increasing focus on the management of long-term conditions. Already, patients with long-term conditions move between primary and secondary care at different times of their lives. As they get older or more unwell, these moves have a tendency to become frequent and complex, requiring the additional involvement of social, voluntary and sometimes mental health services.
4.4 Turning now to PbR, it is clear that its effects differ from specialty to specialty. In some cases such as palliative care (where much of the service delivery occurs in hospices and as such remain outwith the PbR regime), there has been no significant impact. Other specialties report that where services are unprofitable, many are being neglected or run down. In the case of Foundation Trusts, which are not obliged to reveal financial information to commissioners for commercial reasons, the commissioners appear to have little or no role in procurement.

4.5 More profoundly—for Care Closer to Home advocates—PbR may create perverse incentives, so that it appears financially easier to admit the patient rather than manage them outside the hospital or to commission separate specialist services in primary care, thus avoiding the fully tariff price of a consultant-delivered service in an outpatient clinic.

5. CONCLUSION AND RECOMMENDATIONS

5.1 The Next Stage Review has raised the spectre of quality, but does so in the context of now structurally embedded policies that can militate against its main precepts and principles. Despite this there are many clinicians and commissioners who, across the country and clinical specialties are delivering innovative services that meet the needs of their local populations. The question is how do we create the right culture to encourage further integration along best practice lines? In our opinion, the following measures would help:

— promotion of the idea that engaging doctors in a spirit of collaboration is required for successful commissioning;
— official repudiation of unhealthy forms of competition, and encouragement of jointly commissioned models of integrated health services, underpinned by primary and secondary care working together; and
— the incentives/disincentives of Payment by Results need to be rebalanced to bring integrated generalist and specialist care closer to the patient’s home.

September 2009

Memorandum by Which? (COM 40)

EXECUTIVE SUMMARY

Which? believes that world class commissioning could potentially deliver benefits to patients. However, our research into consumers’ experiences of GP and dental services show that there are unacceptable levels of variation between PCTs in how effectively they currently commission services.

A key theme emerging from our research was the sense of being “lucky” if people manage to get an NHS appointment or a convenient GP appointment. Clearly ease of access should not be a question of luck based on which PCT you happen to live in and how effectively they commission their services.

More creative and innovative commissioning is needed to serve the needs of different populations. All PCTs need to provide consistently high-quality services which meet the needs of patient groups in their local area and are responsive to their demands.

INTRODUCTION

1. Which? is an independent, not-for-profit consumer organisation with over 700,000 members and is the largest consumer organisation in Europe. Which? is independent of Government and industry, and is funded through the sale of Which? consumer magazines, online services and books.

2. Which? has a longstanding and strong interest in patients’ experiences of NHS care and we welcome this opportunity to submit evidence to the Health Select Committee’s Inquiry into Commissioning. In this submission we have used access to GP and NHS dental services as two case studies of how commissioning of primary care services affects a huge number of consumers and their experience of health care.

PATIENT PERSPECTIVE ON THE COMMISSIONING OF GP SERVICES

Huge variation in availability of appointments outside GPs contracted hours

3. Our research into consumers’ experiences of GP services found that the ability to get a GP’s appointment outside their contracted hours varied considerably between PCTs:

— The proportion of surgeries offering appointments before 9 am varied from four in 10 to nine in 10 depending on the PCT.

139 Which? carried out an online survey of 2,454 UK adults aged 16+ in March 2009 about their experiences of GP services. Weighting was applied to ensure the sample was representative of adults in the UK. Which? also carried out “situation research”, posing as consumers to contact 497 GP surgeries across the 10 SHAs in England in March 2009 asking them questions about accessing their services. We then repeated the exercise among 481 surgeries in May–June 2009 to ask specifically about online and telephone contact.
— A quarter of GPs in one PCT did not offer appointments after five, whereas in several other PCTs all GPs provided those.
— The percentage of surgeries in any given area in PCTs offering Saturday appointments varied from 5% to 73%.

4. This variation in the level of provision at individual surgeries is backed up by research by the Department of Health. For example, Cornwall PCT has a GP practice in both the 10 highest and 10 lowest rated practices in the country in terms of access experience. Such variation in the behaviours of individual practices is unacceptable and must lead to the conclusion that not all services are meeting the needs of patients.

Use of Technology

5. Our research found huge variation across the country in terms of the technology being used to enhance and improve access to GPs. At SHA level striking disparities exist. GP practices in the South Central SHA are more likely to offer a website, online appointment booking systems and email access to GPs than any other SHA. Email access to surgeries for administrative queries was the second highest of any SHA in the country.

6. Consumers told us that they found online appointment services very helpful:

"My husband and I are registered online with our local GP surgery and it is brilliant. You get issued with security details and off you go. I managed to get an appointment within 10 minutes of going online. As long as you are happy with seeing anyone, the selection and times are vast."

7. In contrast to South Central SHA, the South East SHA scored consistently badly in terms of offering alternative routes of access to GPs. The percentage of GP practices who offered the services mentioned above was often worse than any other SHA. Email access to surgeries for administrative queries was the third lowest of any SHA in the country.

<table>
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<tr>
<th>Service</th>
<th>South Central SHA %</th>
<th>South East SHA %</th>
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<tbody>
<tr>
<td>Website</td>
<td>77</td>
<td>6</td>
</tr>
<tr>
<td>Online appointments booking system</td>
<td>47</td>
<td>6</td>
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<td>Email access for admin</td>
<td>54</td>
<td>10</td>
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<tr>
<td>Email access to GP</td>
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8. We recognise that it may not be reasonable or proportional to expect all GP practices to offer all these services—for example, single handed practices, or those in socially deprived areas where fewer people have access to computers. However, this variation is unacceptable and demonstrates that there is much that could be done in some areas to improve access via the use of technology. For commissioning to be successful it needs to take account of the local population and circumstances of the range of practices in the PCT as a whole.

9. On average, 39% of surgeries offer email contact between them and the patient. Again the likelihood of this varies considerably from PCT to PCT: our research found that in one area nine in ten surgeries offer it, whereas in another, none do. While some PCTs are clearly early adopters of technology others are seriously lagging behind.

Access to GP surgeries via telephone

10. In terms of access to GP surgeries via the telephone, our situation research found wide disparities between different areas when we called at off peak times. For example, in the South West and South East SHA, a fifth of callers got a frustrating busy tone and had to ring back, compared to less than 1 per cent in the North West SHA.

11. For those consumers who simply cannot get through to someone who could help them this is frustrating and hard to justify:

"I am registered with a very good GP practice. The receptionists are helpful and efficient and the GPs first class. However, there are major problems getting an appointment to see them; you have to ring from 8 am for an appointment that day. It is virtually impossible to get through on the telephone—I redialed without pause 102 times from 8 am to 8.35 am before being connected, to be told all appointments had gone. Therefore the whole process must be repeated the following day. This is unsatisfactory and frustrating."

140 Department of Health (2008) Report of the National Improvement Team or Primary Care Access and Responsiveness.
12. On average 21% of GP surgeries have online booking systems. However, the surgeries in some PCTs seem to be ahead of others in offering this as an alternative to telephoning the surgery to make an appointment. In one PCT half of surgeries offered it, whereas in another no surgeries did.

Recommendations

13. The variation between SHAs and PCTs described above leads us to the conclusion that not all PCTs are using their commissioning powers effectively or robustly enough.

14. A key theme emerging from Which? research was the sense of being “lucky” if people were registered at a GP practice which was easy to access:

“We have lived here 16 years and have never failed to get a GP appointment, usually with our own doctor. We are very lucky!"

Ease of access should not be a question of luck based on which PCT you happen to live in.

15. Routes to accessing GPs remain largely inflexible and too firmly rooted in a one-size fits-all approach. We appreciate local populations can vary and might need different solutions but more creative commissioning is needed which some PCTs are already delivering. PCTs and via them GP surgeries need to provide for needs of all patient groups in their local area and be responsive to their demands.

16. The most common form of contract used by GPs is the General Medical Services contract but PCTs could commission more creatively, using Alternative Provider Medical Services contracts, Personal Medical Services Agreements, or by using more Local Enhanced Services backed up by CQUIN payments.

17. PCTs could incentivise good GPs better via Practice Based Commissioning. Proposals to have locally based QOF indicators (if agreed) would go hand in hand with this. Good collaboration with and monitoring by the PCT would be essential.

PATIENT PERSPECTIVE ON COMMISSIONING OF NHS DENTAL SERVICES

Access overall is actually fairly good but problems are acute and localised

18. 68% of our survey sample had tried to get an NHS appointment, and around nine out of 10 of them were successful, with relatively little difference between SHA areas. Whilst this might sound positive, it still means that three million people had tried to find an NHS dentist in the last two years and failed. Furthermore, our survey estimated that 4.5 million people have stopped trying to find one, having had problems in the past. PCT commissioning must take these disengaged potential patients into account.

19. Our situation research found a wide variation in the number of dentists open to new NHS patients across the SHAs. The average was 43%, with 78% in the West Midlands open for new NHS business but only 12% in Yorkshire and the Humber.

20. The stories we collected from consumers indicated that the minority who cannot access NHS services are severely affected, whether by an actual lack of NHS dentists or the failure of local PCTs to route people to existing services effectively:

“There are no NHS dentists where we live . . . If the news is to be believed constant stories of 100+ queues outside new dentists are common . . . I cannot afford to go to a dentist as I am aware that I have other cavities and the dentist will want to treat them as well leaving me with a massive bill. So I just live in the hope that the pain won’t get worse. I am stunned that the government still thinks there is no problem; they clearly are not living in the same country as me.”

21. Although there was little difference in ease of accessing an NHS dentist across SHAs, those who lived in rural areas and did not have an existing dentist were more likely to have had to call more than one dentist to get an NHS appointment. SHAs may comprise both rural and urban areas, so commissioning at a PCT level must be sufficiently agile to meet all local needs.

22. As our situation research identified, 57% of dental practices across England were not taking on new adult patients. Those who would only take certain types of patient were mainly taking on children—in four in five cases (78%)—or adults on benefits only in one in four cases (27%). Only one practice offered to take


In our quantitative survey 9% of the sample had tried to get an NHS dental appointment in the past two years but were unsuccessful. The three million figure is a simple estimate that multiplies the number of adults aged 16+ in England (from ONS 2007 mid-population estimates) by the percentage from the survey: 41 million x 8%. A 95% confidence interval on this calculation gives a value between 2.8 million and 3.6 million, with a mid point of 3.2 million (rounded to three million). 7% of our sample had gone private the last time they went to the dentist in the past two years. These two groups combined make up 11% of the sample. Using the same calculation as above gives a value between 4 and 5 million, with a mid point of 4.5 million.
the caller but not their child, and over half of those who would not take an adult on the NHS (55%) would take a child. This figure seems surprisingly high given that the Department of Health has stated that child-only contracts for dentists are “undesirable” and should be “managed out”.143

23. Which? is concerned that some adults may feel “forced” to sign up for private treatment so that their children receive NHS care:

“In order for my two children to continue as NHS patients with their current dentist I had to register as a private patient on a monthly dental plan . . . There is no such thing as free dentistry any more—why doesn’t the NHS let us all take out dental plans and give us tax relief on this.”

24. The dental surgeries we spoke to were not effective enough at signposting patients to other sources of help, with around three in 10 (31%) giving nothing but the most minimal assistance to callers who could not be taken on as NHS patients, and 32% suggesting another practice, which may or may not have been useful.

25. This represents a wasted opportunity to educate the public about how to navigate the system, and, crucially, to engage them in that system. As a minimum, we would like to see contracts that contractually oblige dentists to signpost enquirers who cannot be taken on back to the PCT so that they can effectively measure and respond to demand for NHS dental services.

26. Consumers reported extreme variability in the ease of accessing dental services. Some PCTs were proactive in signposting dental services and provided a good example of what joined-up health services might look like:

“Fortunately, our local Primary Care Trust runs a system for finding patients an NHS dentist. There was a poster up in our local GP surgery telling us who to contact and we applied accordingly. After only a couple of weeks we had letters from the dental surgery that had been found for us, offering us appointments to register and have an examination.”

However, consumers also told us about long waiting lists and frustrating issues with poor communication, demonstrating unacceptable variability in the ways that PCTs are administrating their dental services.

Access to NHS treatments

27. The reality for some people may be that although NHS dental services are theoretically available, it is at the individual dentist’s discretion whether or not they offer NHS treatments. The greater range of treatments now available may also threaten the relationship of trust between dentist and patient, with the financial transaction coming to the fore for some consumers:

“It used to be that you would trust a dentist like a doctor to tell you what was wrong and what needed to be fixed to set things right. The current situation with dentists trying to sell you private treatment feels more like being sold a pair of shoes and then being persuaded to buy cleaning treatments that are not necessary.”

28. Access to NHS dentistry must therefore not be the sole measure of whether consumers are getting access to the right treatments. Consumers should know that the “deal” offered by the local NHS dentist includes all NHS services, and PCTs commissioners should be ensuring that their contracting arrangements make this crystal clear to dentists.

Recommendations

29. Filling the remaining gaps in NHS dentistry must be made a top-level priority at Chief Executive and Board Level of PCTs to ensure resolving access problems is a key priority for those PCTs who are failing to provide good-quality dental services to the local population.

30. PCTs must be able to pinpoint which local areas are most in need of extra dentistry. This could be achieved for example by using geographic information and data mapping techniques as used by Bristol Primary Care Trust.144

31. Finding an NHS dentist must be made easy for consumers. At a minimum those dentists not taking on new patients should be obliged to signpost callers back to their local PCT.

144 Bristol PCT pinpointed the five areas of the city most in need of extra dentistry services by using geographic information and data mapping techniques. The Trust already had plenty of data such as population numbers, level of expected demand and how many people already had access to dental services. The geographic information and data mapping services were able to translate this data into a map of the city which was detailed precisely where need for dental services was greatest. As a result, the trust was able to commission dental services to fill this demand.
32. PCTs should be much more innovative in their approach to signpost patients to an NHS dentist. For example, Tower Hamlets PCT works together with the local authority to ensure when new people move into the area they are informed by the Council about how to find a local NHS dentist taking on new patients. In Telford and Wrekin PCT, a perception that it was difficult to find NHS dental care was tackled through promotion of services but also initiatives such as online booking and a “tracker” which collected patient feedback on the ease of making an appointment.

33. PCTs already have some tools that they can use to commission dental services more innovatively within the existing contract. The Department of Health should play a more active role in ensuring best practice is spread consistently across PCTs.

34. We believe that PCTs should look much more closely to the data on recall intervals to assess whether any additional capacity in the system could be found by eliminating unnecessary recalls of patients when there is no clinical need. There are already existing mechanisms in the GDS contract and PDS agreement which would allow PCTs to police this more closely.

35. PCTs should phase out child-only contracts.

36. PCTs should make strategic use of collected data, including patient feedback, to identify patterns that suggest poor quality or inappropriate treatments, or that dentists are misinterpreting the NHS 

37. The Government should mandate PCTs to analyse the data from inspections and make proactive use of the results when commissioning services.

September 2009

Memorandum by the Urology Trade Association (COM 41)

The Urology Trade Association (UTA) represents up to 95% of manufacturers and service providers who supply the urology appliance market.

Our aim is to:

— act as a forum for discussion and a vehicle for collective action on all issues relating to the urology product manufacturing and/or distributing sector;

— represent the interests and consensus opinion of our members;

— promote the contribution to NHS patients of the urology manufacturing sector and its products;

— communicate the benefits of high quality, innovative urology appliances to key stakeholders; and

— work in collaboration with Healthcare Professionals bodies and patient organisations.

Executive Summary

Due to the nature of their business, UTA member companies deal extensively with PCT commissioners, as well as NHS procurement agencies. As a result, UTA members deal with the NHS and PCTs on a daily basis. Through this experience and work, the UTA has, as a trade association, become increasingly concerned about the use of certain procurement initiatives to save costs in commissioning as we feel they will ultimately be to the detriment of patients.

The commissioning landscape in the NHS has evolved rapidly and has resulted in varying levels of success across treatment areas and geographical localities. The UTA is concerned that this has resulted in uncertainty and a lack of clarity on behalf of commissioners and participating companies about the NHS’ commissioning process in general and how individual PCTs’ commissioning practices fit with this direction of travel. The UTA is concerned by the increasing tendency to focus on cutting costs as this risks being done on the expense of patient-centred decision making within commissioning.

In this response, the UTA will focus on two areas of concern within specialist commissioning: PCTs which tender their urology products and services to be supplied by only one company, and secondly the use of “activity based income” by collaborative procurement hubs to fund their work.

145 Presentation given by Andrew Ridley, Deputy Chief Executive of Tower Hamlets PCT on Innovative commissioning in practice: Exploring the outcomes in terms of access rates and quality of provision, HSJ Seminar on Transforming NHS Dental Provision, 30 June 2009.

146 Collete Bridgeman, Consultant in Dental Public Health in NHS Manchester has developed innovative ways, such as evidence based commissioning to deliver NHS dental services within the existing contract framework to drive access and quality to meet needs of the local population.


148 Ibid.
First, PCTs which choose to only use one company through a tendering process seriously risk limiting patient choice. Not being able to access the full spectrum of unique and tailored urology products may force a patient to use an inferior or unsuitable product, resulting in health complications that will ultimately require more clinical care and create extra costs for that PCT and NHS. Second, the UTA find it worrying that some collaborative procurement hubs have started using a system whereby they charge suppliers an extra percentage fee for all contracts. This commissioning tool is called “activity based income” and is used to fund the procurement hub. However, this practice is increasing costs for manufacturer and suppliers which in the long run will result in either a price increase for products or a decrease in product quality. Both outcomes will ultimately result in a negative effect for patients.

The UTA recommends that the Department of Health strongly address these two areas of concern by issuing strict guidance to PCTs and collaborative procurement hubs advising against the use of tenders as well as activity based income in urology.

**Commissioning**

The UTA noted with interest that this inquiry will look at the progress which has been made in improving NHS commissioning services under the benchmarking and assurance scheme initiated by “World Class Commissioning”. The commissioning landscape in the NHS has evolved rapidly over the past three years and continues to do so at differing speeds and with varying levels of success across treatment areas and geographical localities. Moreover, the skill set and professional experience of those holding commissioning posts also varies considerably between individual PCTs. In particular, the increased use of external consultants has hampered efforts to develop PCTs’ commercial acumen and a commissioning knowledge bank across the NHS.

The UTA is concerned that this has resulted in uncertainty and a lack of clarity on behalf of commissioners and participating companies about the NHS’ commissioning process in general and how individual PCTs’ commissioning practices fit with this direction of travel. The fractured commissioning landscape has at times encouraged a lack of focus by commissioners on clinical considerations, patient choice and patient control. The UTA has observed the tendency to focus on cutting costs over patient care and quality with concern, and we believe that this has at times been at the expense of patient-centred decision making within commissioning and is ultimately to the detriment of patient care. In this respect, we have observed some PCTs to contravene the Standards laid down in the Ethical Standards Code for the NHS (November 2002).

The UTA’s remit covers wider commissioning issues as the association represents member companies that have interests in NHS procurement for urological care items as well as the services associated with this. As such, we would like to comment on some areas of concern to the urology industry relating to the general direction of travel towards generic commissioning of continence care services. We would in particular like to comment on the following aspects of the inquiry:

**Specialist commissioning**

1. Urological care and continence management not only require clinical prescription of medical devices but also the provision of related care services and support, including access to advice and help with specific products and appliances as well as the opportunity to provide feedback to the manufacturer.

2. Over six million people, both children and adults, are affected by continence problems resulting from a wide range of complex medical diagnoses including cancer, stroke, spinal cord injury, multiple sclerosis, spina bifida, CVA and other neurological conditions such as Parkinson’s disease.

3. Medical diagnoses which require continence management are therefore often long term conditions that require specialist commissioning services. This is essential for urology patients to not only improve their clinical health but also support their independence, dignity and quality of life. These patients rely on effective continence management in order to ensure that they remain free from infection, lead independent lives and are able to work.

4. In order to deliver effective specialist commissioning for urology care, PCTs must recognise the complexity of the wide range of medical conditions which require continence management, and commission services which provide for an individual patient’s specific condition and needs. This entails ensuring that patients can access the full range of products and services which are listed on Part IX of the Drug Tariff.

5. A key principle of the World Class Commissioning framework is to offer patients choice and control over which services they use to manage their own conditions. This stance has been widely reiterated in numerous policy statements from the Department for Health and most notably is enshrined as a core patient right in the NHS Constitution. It was also a strong theme in Lord Darzi’s NHS Review that effective commissioning would demonstrate improved patient outcomes, placing quality at the heart of all NHS activity.

6. The UTA is concerned by the direction of travel in the commissioning and procurement in urology as we have been made aware of examples where individual PCTs tender out their provision of services and/or products to one company as well as the introduction of activity based income being used by procurement hubs. Both could potentially have negative effects on the NHS and patients.
7. First, the UTA is concerned by the increasing use of tenders to deliver integrated continence services as it risks negatively affecting patient choice. Although the UTA recognises that this may be a cost-effective commissioning procedure, restrictive tenders which are designed to give one company the right to supply all urological medical devices and services to patients in a PCT have serious adverse implications on quality of care, product variation and patient choice.

8. Limiting the provision of continence care items to one supplier risks leaving the PCT and its patients in a situation where the PCT does not provide adequate access to the full range of products and services which the market has to offer. As a result, urology users are inevitably restricted from accessing urology care items that should be available to them under the Department of Health’s Part IX arrangements. Tendering urology services and products to one company often force patients who have been using a different company’s products to switch supplier no matter how effective, appropriate or comfortable their existing product is. Additionally, it restricts new urology patients from accessing a wide range of products to find the medical device that is best suited to their clinical and lifestyle requirements.

9. However small the differences in product material, design or service may seem to procurers, for urology users they can often impact severely on their ability to manage their own conditions. Given the high incidence of related dexterity and mobility problems of many urology users, not all products are suited to facilitate an independent lifestyle. Far from enabling an independent lifestyle, a less than optimum product can create further respite care needs causing over reliance on carers. This neither delivers effective commissioning of quality care nor enhanced patient outcomes.

10. A successful tendering company will automatically be in a privileged position as they will be the only company with access to information about patients and the products they use. Reduced competition will additionally threaten research, innovation and development programmes. These measures do not allow for the specialist commissioning of niche products and services, which are vital for children’s integrated continence care.

11. Furthermore, these measures remove a patient’s sense of ownership over their own care. It also relies on patients to be fully knowledgeable of the whole range of care items, devices and services which should be available to them under the Part IX arrangements and feel confident challenging medical guidance.

12. Such examples of a tendency towards the generic commissioning of services in urology do not improve health outcomes for patients as demanded by the World Class Commissioning principles. The incorrect prescription of invasive medical devices such as catheters considerably heightens the risk of infection for patients, creating additional clinical care needs and dependency.

13. The average cost for the admission of emergency urethral catheterisation resulting from infection, is estimated in the region of £1,500 per patient, per visit. In addition, if patients are forced to change products, they must first be clinically assessed before being prescribed with alternatives. In specialist care, the associated and potential costs of such procurement initiatives are a considerable expense for PCTs and could potentially far outweigh any initial savings.

14. Tenders also lead to the creation of a postcode lottery system for urology care, since the provision of care items will not be based upon local care requirements but on the competitive advantages and cost savings of a particular manufacturer or supplier.

15. The second issue of concern to the UTA is the activity based income system which is being implemented by procurement hubs. The UTA is concerned that a new commercial operating model is emerging for some collaborative procurement hubs and that is has become a vehicle of choice for PCTs to channel procurement activities. Acknowledging this, the UTA is concerned by the willingness of some hubs to switch the costs of funding what is envisaged as a core NHS service from PCTs to suppliers themselves. Through using activity based income, these hubs are charging the suppliers a higher fee to fund their work.

16. One specific procurement hub has implemented this new funding mechanism requiring suppliers to pay an additional charge of 1.5% on top of every contract which is made through the hub. The costs of such a proposal are significant for any commercial supplier and imply considerable ongoing costs for industry, especially considering that no service is being offered to the supplier in return. We fear that these increased costs for industry will simply be transferred to the NHS and patients.

17. We urge the government to support the effective commissioning of specialist services for urology care, by ensuring that procurement initiatives designed to generate efficiency savings do not impact negatively upon either the provision of high quality care, innovation or patient control by restricting patient choice.

RECOMMENDATIONS

1. The government should encourage adequate clinical input in all commissioning decision making to ensure that the inclination of commissioners to cut costs is balanced against clinical needs as well as both product and service suitability.

2. Measures should be put in place to ensure that patient focus and patient experience remains at the centre of all decision making and that commissioning decisions are consulted on locally or subject to patient and/or stakeholder scrutiny at various points whether through local expert patient groups, or LINKs. We also feel that there should also be a level of consistency in the necessary experience or training undertaken for those individuals holding commissioning positions.
3. In relation to urology, three more specific recommendations can be made in connection to commissioning which would ensure a focus on patient choice and quality of products and services. First, it is important that the role of tenders in specialist commissioning are examined to ensure that those procurement initiatives for long term conditions which require continence management do not restrict the range of care items available for patients and the ability for users to choose the most suitable products and service for their specific condition.

4. Second, the Department of Health should also take steps at a central departmental level to ensure that PCTs’ procurement activities do not undermine the world class commissioning principles to deliver enhanced patient outcomes by restricting patient control over how to manage their own condition.

5. Third, the Department of Health must realise that increasing costs for suppliers and manufacturers through activity based income will in the long term, put these cost back on patients and the tax payer. It must therefore issue strict guidance to collaborative procurement hubs against this practice.

September 2009

Memorandum by the Assura Group (COM 42)

1. INTRODUCTION

The Assura Group (“Assura”) partners with GPs and other healthcare professionals to deliver high quality medical care, innovative property solutions and consumer responsive pharmacy services. It is fully listed on the London Stock Exchange, has a strong balance sheet and substantial asset backing.

Assura and its three business divisions—Medical, Pharmacy and Property—work together to deliver solutions to meet local primary care needs. We believe that this strategy is what sets us apart from other healthcare providers through our:

— collaborative model of working with GPs;
— competitive advantage in the pharmacy market;
— business model built on a strong asset backed portfolio of property;
— synergies between the three divisions in delivering integrated care; and
— relationships and reputation with individuals from all levels of the NHS value chain and particularly within Primary Care Trusts (PCTs).

2. EXECUTIVE SUMMARY

The importance of effective commissioning, particularly in the current financial environment, cannot be overstated. If PCTs can become genuine world class commissioners, then there is scope for significant cost savings and improved care. There remains some way to go, however, before this vision can be realised.

Assura’s position is that the Department of Health needs to consider what more it can do to ensure PCTs are stimulating the market and, by utilising existing bodies such as the Cooperation and Competition Panel and the regional Commercial Support Units, delving deeper into their performance and encouraging a greater sense of urgency and depth to commission services from a wide range of providers including the independent sector.

In addition, the Department urgently needs to consider how to reverse the gradual decline of Practice Based Commissioning and look again at how budgets are allocated and clinical input is applied. This latter point is crucial since alongside poor commercial acumen, PCTs struggle with understanding the clinical aspects of the services which they are commissioning. A coherent system with aligned incentives and transfer of budget risk is the real prize for the NHS as it faces up to the financial challenges of the coming years. This can only be achieved if PCTs become clearer that their role is to commission for outcomes and then regulate the system to deliver these outcomes.

3. WORLD-CLASS COMMISSIONING

3.1 World Class Commissioning (WCC) is a laudable programme and a valuable statement of intent from the government about how PCTs should be commissioning high quality services for patients. With PCTs spending £200 million per day it is crucial, particularly in light of the wider economic climate, that this significant sum of money is spent wisely and effectively.

3.2 In the two years that WCC has been operational, it has helped to highlight areas of weakness across the country, most notably the fact that PCTs lack the necessary commercial acumen to design, tender, negotiate and monitor the performance of contracts with independent sector providers.
3.3 The major weakness of WCC, however, is that it is largely comprised of self-assessment reports from the PCT with little or no input from the wider provider market. PCTs are not incentivised by being given targets to commission from a plural market and hence there are inconsistent approaches regionally and clinically. This system needs to change to give the process more credibility, economies of scale, pace of delivery and ensure that wider stakeholders have confidence in the system.

3.4 An additional problem with WCC is the fact that it is based on a league table system. Simply being in the top 10% of PCTs across the country does not automatically mean that a PCT is an effective commissioner and this system ought to be reviewed. Instead, like the BBC where 25% of programme making was required by legislation to come from outside the BBC, PCTs should be given minimum targets on budget spend to commission via a fair and open tender process. This would help stimulate the market and allow providers (NHS, independent and voluntary) to innovate and build real scale of operations.

3.5 There is a need for the Department of Health to develop examples of what good commissioning looks like and use these as the benchmarks against which PCTs are judged. Using the gold-standard as the example of “world-class” it should then be possible to see how far away any given PCT is from that position.

4. THE RATIONALE BEHIND COMMISSIONING

4.1 Effective commissioning is aligned to effective system management and it is therefore imperative that PCTs are strong at discharging this function.

4.2 To date, too few PCTs have shown they are capable of becoming effective commissioners. Via Assura’s GPCos, which serve three million patients throughout England, Assura comes into contact with many PCTs and the standard of commissioning is variable and weak in far too many cases.

4.3 Given that the UK still lags behind many other countries on key health indicators, with life expectancy and infant mortality well below the average of other developed nations, the effectiveness of the system has a real bearing on the health of the population. With more overweight and obese people than all but two other developed nations, a smoking rate above that of the United States and a rapidly ageing population the service is likely to come under ever greater strain in the coming years.

4.4 To squeeze the most out of the system, therefore, high quality commissioners are needed who can act courageously and foster a culture of innovation and creativity. The pace of change needs to be sped up and an understanding needs to be developed at PCT level of how to contract with the independent sector.

4.5 As a way of achieving this we propose that the government introduces a requirement on all PCTs that they tender for a minimum number of services (or a minimum percentage of their budget) per year. Currently PCTs tend to contract with the same providers that they have always worked with and are reluctant to decommission services and market test for value for money. A centrally imposed target of how many services to commission would focus attention on this issue with PCTs supported by the newly created Commercial Support Units at regional level.

4.6 To that end the purchaser/provider split, which the government has been encouraging for the last four years, is a misnomer. The most important thing for commissioners to ensure, even if the commissioner is also the provider, is an understanding as to what the service is trying to achieve, ensuring value for money for the taxpayer in its contract awarding and regulating the service to guarantee ongoing quality.

4.7 Finally, it is crucial that the role of the Cooperation and Competition Panel, established in early 2009, is examined and where necessary expanded to ensure that it is able to scrutinise not just those PCTs that have tendered for services in an uncompetitive manner but also those PCTs that have been too timid in their commissioning. Bullet 4.5 would help with this but even if a minimum target is not set then the Panel needs to be permitted to become proactive in its evaluation of market stimulation.

5. COMMISSIONING AND SYSTEM REFORM

5.1 Commissioning and system reform fit together and the various instruments set out by the government form an important part of this overall package.

5.2 The government has put a great deal of commitment behind Practice Based Commissioning, the process of involving GPs and other frontline clinicians in the commissioning of services for patients. However, progress has been slow with only 69% of Practices having indicative budgets in 2008–09, a 3% reduction on the figures for the previous year. Coupled with the fact that only 64% of Practices have a commissioning plan it is clear there is a long way to go before Practice Based Commissioning can be said to have worked.

5.3 To improve this situation Assura proposes handing real budgets to GPs and allowing those GP clusters to identify support in acting as proper commissioning bodies. It must also be the norm that GPs can reinvest any savings made so that they are incentivised to act efficiently and make the best use of limited resources. Currently Practice Based Commissioners can only reinvest savings for their patients in the unlikely event of the wider local NHS having also made savings.

148 OECD Health Data
5.4 In addition to these changes the PCT ought to make better use of local clinical knowledge and draw in local GPs and other healthcare professionals to advise them on their own commissioning work. PCTs too often lack the clinical knowledge required to commission for particular services.

September 2009

Memorandum by NHS Stockport (COM 43)

1. **Summary**

1.1 Commissioning has created some benefits however it has created a system whereby the levers to control spend are predominantly in the hands of those who have no real incentive to do so. Pigou’s Theorem is used extensively in the transport sector however it has relevance to health economies. It states that allocative efficiencies cannot be achieved by a market in situations where there is a downward cost curve and high entry costs. A brief summary of Pigou’s theorem is included at the end of this paper.

1.2 Providers may wish to engage with Commissioners for the good of the Health Economy however their own governance processes and structures give other measures priority. The nature of competition between providers from both public and private sectors means that any efforts by an individual provider to limit provision may just hand market share to a competitor and not actually assist the Health Economy in gaining maximum effectiveness.

1.3 Practice based commissioning and the role of the GP as gate keeper is essential. However the existing GP contract does not create any imperative for the GP to engage and patient choice and satisfaction agendas create perverse incentives. The role of GP as commissioner and provider has created an almost unmanageable conflict of interest.

2. **Roles within the Current Market System**

2.1 Patients have been given choice but insufficient information on which to base their choice.

2.1.1 For service aspects such as such as being treated with respect and dignity patient choice can be very effectively used to drive up standards.

2.1.2 Patient choice in areas requiring clinical expertise can drive up costs without necessarily linked health gain.

2.1.3 A focus on patient choice has served to increase demand which does not necessarily address need. The demand tends to come from the more affluent areas which takes spend away from the areas which need the most focus.

2.2 PCTs have limited control at best they can seek to influence, at worst merely spectate and evaluate consequences.

2.2.1 Price is fixed nationally for many aspects.

2.2.2 NICE set guidelines on what patients can expect.

2.2.3 Availability of supply does drive its own demand as things can be done quickly removing the watchful wait time that may deem intervention unnecessary. Things can be done “just in case”.

2.2.4 Data can be used to facilitate conversations intended to influence however it is a proxy and relies on commitment from parties such as GPs and Providers. When it used to distribute resources it becomes distorted particularly as population sizes decreases.

2.2.5 Is the commissioning role therefore effectively unenforceable? Quantity x Price = Cost

2.3 Providers have fixed costs to cover and multiple providers increase the fixed cost and overhead base.

2.3.1 The focus on access and waiting times has increased the capacity in the market place permanently, often through expensive PFI schemes which will leave significant finance costs in health economies for many years to come.

2.3.2 Providers have perverse incentives to increase demand. The “commercial” position of Foundation Trusts in particular creates a continuous drive for growth.

2.3.3 Targets such as 18 weeks and 4 hours can be met by putting on more capacity which PCTs have no choice but to pay for, removing the need for any real drive towards productivity or creative solutions.
2.4 **Role of GPs**

2.4.1 GPs gate keep referrals but do not suffer consequences if they do not manage them to be as low as possible.

2.4.2 They have perverse quality incentives not to manage down use of resources when faced with patient demand.

2.4.3 Measures to ensure GPs deliver a contractual minimum are not sufficiently robust. Data on appointments made available, patients seen, etc does not need to be shared with PCTs.

3. **Proposed Alternatives**

3.1 PCTs continue with overall accountability for the local health economy but have levers to pull to deliver against that accountability.

3.1.1 GP contract which gives accountability for budget with enforceable consequences, GPs must manage patient costs and therefore choosing to deliver services within the GP surgery is rewarded through incentives for hitting targets not through LESs and DESs which drive significant administration and create the conflict of interest.

3.1.2 Assets in the estate are owned by PCT.

3.1.2.1 This was picked up by Transforming Community Services as being necessary to have competition in the market as the costs of entry were prohibitive otherwise; costs of start up in secondary care are even greater.

3.1.2.2 The PCT can then contract for the market to deliver the required service from that location for a fixed period rather than have continuous competition in an open market.

3.1.2.3 Independent sector is brought in on a locally contracted basis when needed rather than have a right to list on choose and book.

3.2 **PCTs are broken up**

3.2.1 Secondary care budget is given directly to each NHS provider and they are tasked to manage within the budget.

3.2.2 Patient choice would be removed and IS providers would be brought in as needed by the NHS provider.

3.2.3 Public Health and preventative matters could be managed by local authorities.

3.2.4 GPs have accountability for managing spend for their practice which can be monitored through a PBC organisation which controls GP contracts and areas such as prescribing and referrals.

3.3 **Within either alternative**

3.3.1 **Role of PbR**

3.3.1.1 PbR can continue to have a role however as a denominator rather than a multiplier.

3.3.1.2 IE The provider is given a block contract and the activity of the provider is costed at tariff. The effectiveness of the provider is measured according to how that costed activity compares to the block payment that was made, with providers delivering more or less than expected for the money received. Incentives and consequences are associated with this performance.

3.3.2 **Targets**

3.3.2.1 The 18 week target does need to be reworked as the current target measures what is actually carried out and this does not encourage a treat in turn policy once a backlog has arisen. A better measure would be the number of patients who have waited over 18 weeks at any point in time.

3.3.2.2 A&E Four hours does not differentiate on the basis of need and many patients are arriving at A&E as a quick alternative to seeing their GP. One possible approach to this to understand if this is a genuine preference of the population and if so trial radical reforms of primary care.

3.3.2.2.1 For example GPs manage long term conditions and all one offs are dealt with on the hospital site via a primary care triage. This would reduce the numbers of GPs in practice and place some in a hospital setting. Patients would know that any escalation of the condition would be dealt with promptly as they are on the hospital site.

3.3.2.2.2 Obviously consideration would need to be given to the geography and spread of the areas covered. This may only be a possible solution in areas of concentrated population.
4. **Response to Individual Questions**

4.1 **World Class Commissioning: what does this initiative tell us about how effective commissioning by PCTs is?**

4.1.1 On the positive side, World Class Commissioning signals a move towards quality and patient involvement, however it does so only after prolonged energy and resource have been invested into access and capacity, meaning there is over supply. This is driving down thresholds, which is making current levels of elective care unaffordable.

4.1.2 A consistently poor score across PCTs is in the area of market management raises the question of are PCTs not skilled in this area, or is it actually that within the current operating framework it cannot be done? It is the opinion of Stockport PCT that it cannot be done, as PCTs have accountability for matters over which they have little or no control. The opportunities the current operating framework gives providers is outlined in the next bullet and the lack of consequences for GPs is outlined in response to the PBC question.

4.1.3 High WCC scores do not guarantee success as a PCT, as issues within the system can hamper delivery of PCT accountabilities.

4.2 **Purchaser/Provider Split**

4.2.1 The purchaser/provider split has led to divergent strategies between purchaser and provider, which is then exacerbated by the different performance regimes particularly where the provider is a foundation trust. The SHAs’ ability to act as co-ordinator of a regional health economy is severely compromised by Monitor’s position outside of SHA.

4.2.2 Price is fixed at an average cost, therefore there is no competition between providers where benefit is passed on to the commissioner. The benefits of efficiency remain with the provider and only if steps are taken out of a pathway does the benefit accrue to the commissioner.

4.2.3 Poor performers do not need to move to best practice, they only need to move to the average (whilst mathematically this will eventually move the average, it is a slow process).

4.2.4 Good performers can deliver larger surpluses, which allows them to invest but this just becomes additional capacity driven by what the provider wants to deliver not what the purchaser believes is necessary.

4.2.5 Providers have no incentive to manage demand. In fact they have a perverse incentive to drive up demand.

4.2.6 There are no nationally recognised thresholds for referral into secondary care and the many too many relationships between PCTs and Providers makes it difficult to manage. As the decision is a clinical one it is difficult to challenge lowering of thresholds from trend data, as trend data is at best a proxy for appropriate clinical behaviour.

4.2.7 There is a feeling amongst clinicians that the purchaser/provider split has made for a less effective working relationship between GPs and consultants as everything must be paid for and what used to be a request for an opinion has become a referral, at which point GPs feel the patient is taken out of their hands.

4.2.8 Administrative costs have increased as each organisation manages the transactions between purchaser and provider.

4.3 **PBC, Contestability, Quasi-Market, Payment by Results**

4.3.1 GPs acting as gatekeeper do not suffer consequences for excessive and unnecessary referrals into secondary care, or A&E attendances by their patients. PBC relies on incentive and not all GPs want to engage in incentive schemes. The effectiveness of the “carrot” in an incentive scheme is to encourage people to do more than they “have to”, it only works effectively in conjunction with a “stick” to ensure that the start point is doing the minimum.

4.3.2 PBC has thrown into sharp contrast the conflict of interest of GPs as Purchasers and GPs as Providers.

4.3.3 Tariff does not recognise the significant level of fixed costs in provision.

4.3.4 New entrants into the market are faced with significant set up costs and therefore will only enter with guaranteed volume which it may not be possible to fill without the ability to direct patients. Multiple suppliers in an economy drive up the fixed costs without providing genuine competition between providers; it merely grows supply.

4.3.5 Patient choice limits the commissioner ability to manage and challenge providers. Patient choice was not supported by sufficient education of patients to understand the consequences of the choice they make. As patients have no direct accountability for the costs they drive they do not have an incentive to self manage or take accountability for their own health. Focus has become service not need and patients may demand things which are not needed and not actually in their best interests. By definition this will increase costs without consequent health gain. Most patients do not make the connection between service and cost to them via taxation.
4.3.6 GPs are concerned that current plans to measure quality through patient feedback will favour the GPs who do not attempt to manage resources. For example should a patient demand a referral to a consultant when one is not necessary, their opinion of a GP who refers will be higher than one who refuses no matter what the clinical need or how much time is spent explaining that need.

4.4 Specialist commissioning

4.4.1 The management of costs for PCTs becomes more difficult the more remote the contract is, eg National costs are felt to be imposed on PCTs.

4.4.2 Regionally specialist commissioning has been provider led according to what could be done rather than needs led by commissioners. This is being addressed in the North West at the moment.

4.4.3 The role of specialist commissioning should be to define pathways including threshold management, negotiate best price and provide appropriate and timely data.

4.4.4 Specialist areas currently experience many similar issues to non specialist services in that availability can lead to a drop in thresholds without any health benefit.

4.4.5 PCTs are one step further removed from controlling volume of referrals and information flows and the ability to address any behaviour changes needed is made more difficult and slower as a result.

4.5 Quality and Safety

Repeating comments noted above in WCC

4.5.1 Initially targets were aimed at access and speed.

4.5.1.1 We are now moving toward quality and safety at a time when increased access and speed has made affordability an issue.

4.5.1.2 Targets can often have unintended consequences and the pressure is to hit the targets not necessarily do the right things. This is of course a difficult area to police and some targets and controls are necessary, but all bring unintended consequences.

5. Summary of Pigou’s Theorem

5.1 Pigou’s Theorem considers markets which have high entry costs and significantly lower costs associated with incremental activity once the capacity is in place.

5.2 It is used most extensively in the transport industry, in areas such as road pricing, public transport subsidies and railway and airline pricing.

5.3 Markets operating in this manner clear at a point where there is spare capacity.

5.4 In some situation this spare capacity is sold at a reduced price in order to use it and drive financial benefit, such as air and train fares. However if this price becomes the norm it would not be sufficient to meet the fixed cost base and therefore the reduced price is made available in limited circumstances often with major inconveniences or restrictions in place.

5.5 In some situations the spare capacity is left spare such as toll roads. This is most likely where it is not possible to differentiate benefit between users by choice paying a premium rate and those who would use spare capacity if offered it at a reduced rate.

5.6 The relevance to health care is driven by the high entry costs and the creation of fixed capacity as a result of expansion.

5.7 Applying the toll road solution is excluded due to patient choice. If an appointment is available a patient can take it and the availability of supply will serve to reduce waiting times or reduce thresholds. Whilst this is excellent service it does not allow any form of control over spend.

5.8 Applying the railway/airline rate reduction approach is excluded due to tariff which fixes the rate. Even if rate negotiation were possible patient choice would again prevent implementation as patients have no incentive to take an “inconvenient” or “restricted” option when full service options are available free of charge.

September 2009

Memorandum by Wakefield Local Pharmaceutical Committee (COM 44)

1. Executive Summary

1.1 The LPC appreciates the magnitude of the change that is facing all PCTs with local commissioning and has some sympathy with their ability to cope. This is especially so in consideration of the proliferation of bureaucracy which is so often out of proportion to the size of the service to be established.

1.2 A few PCTs have been proactive in commissioning services from community pharmacies, but the LPC feels that this is inconsistent thus creating inequalities and confusion for the public.
1.3 While acknowledging that commissioning Stop Smoking Services successfully included pharmacies, the LPC remains both frustrated and disappointed at the general level of engagement.

1.4 Devolution from the centre is intended to facilitate response to local need, but it is the LPC’s experience that this does not happen. Many PCTs seem unable or unwilling to commit the necessary resources to the tasks of undertaking robust pharmaceutical needs assessments, developing strategies and above all commissioning pharmaceutical services.

1.5 PCTs in general seem to have failed to develop their infrastructures and invest in resources to manage the changes needed to capitalise on pharmacy’s potential. Delays in payments for Stop Smoking Services and Antiviral Distribution are examples of how the PCT is not even able to manage the few services that it has commissioned.

1.6 LPCs wish to work in collaboration with PCTs to develop the pharmacy agenda in keeping with the Pharmacy White Paper. However, the engagement of some PCTs with the LPCs is inadequate to the extent that some services have been introduced without any consultation. This is both unacceptable and inefficient.

1.7 Whilst it is recognised that a few PCTs have embraced the opportunities available to them via better commissioning from community pharmacy, most have failed to do so and it is unlikely that this situation will change without firm direction.

1.8 National services are much easier to establish since they prevent the need for each PCT to separately develop service specifications and negotiate fees etc. which often results in conflict with the LPCs. They also prevent inequalities for patients by improving access for all and standardising the service specification whilst also benefiting from the free publicity that new nationally based services receive from the media.

2. INTRODUCTION

2.1 This submission is made by Wakefield Local Pharmaceutical Committee (LPC) which is the professional representative committee for 67 community pharmacies in an area of West Yorkshire.

2.2 This report is based on the experiences encountered in commissioning with the local PCT and also draws on knowledge from networking with colleagues elsewhere.

3. ENGAGEMENT

3.1 It is notable that there is no pharmacist member on the local PCT’s Clinical Management Committee that replaced the Professional Executive Committee (PEC) and so the profession’s contact with that committee is reduced to a 20 minute presentation that the LPC is invited to make each year.

3.2 Good commissioning did occur with the establishment of a Stop Smoking Service and a Nicotine Replacement Therapy Access Service. Pharmacists were able to provide the Stop Smoking Service using the same LES specification as other primary care professionals. Furthermore, the fee structure was common to all professionals and was a Payment by Results (PBR) system, being made only for successful “quits”. This enabled the PCT to achieve its smoking cessation target which without the community pharmacy involvement, it would have failed to do. Ironically, this service was developed prior to World Class Commissioning even though it encompassed many of the WCC competencies.

3.3 In an attempt to be proactive, the LPC organised a Pharmacy White Paper workshop to which PCT officers were invited. The date was changed to accommodate the Chief Executive and Directors, but none of them subsequently attended although several middle management officers were present. The PCT officers’ poor understanding of the community pharmacy business culture, let alone what the profession has to offer, surprised even the LPC. However, several potential Enhanced Services were identified although progress in establishing them has been slow or non-existent.

3.4 At the Pharmacy White Paper workshop, a McMillan nurse spoke passionately of the need for an On Demand Availability of Palliative Care Drugs Service in keeping with neighbouring PCTs. The service had been planned in this PCT, but had been blocked by the commissioners on the grounds that it was necessary to quantify the need and calculate costs even though the LPC had agreed to no fees being payable with the only financial burden being payment for unused out of date stock which was estimated to be less than £1,000 per year. Subsequently, the PCT agreed to establish the Enhanced Service which was due to commence on May Day 2009. However, at the beginning of September, the service has still not been commissioned. The LPC is frustrated by what appears to have been bureaucratic filibusters to the detriment of patient care.

4. PRACTICE BASED COMMISSIONING

4.1 There has been no involvement of community pharmacy in the local PBC agenda.

4.2 It is understood that the number and configuration of local PBC groups has changed, but the LPC is not even aware of which ones are now in existence let alone how to contact them.

4.3 It is the opinion of the LPC that PCTs and SHAs should be required to do far more to ensure that PBC groups work with LPCs in a meaningful way.
5. **Purchaser Provider**

5.1 The LPC proposed a Prescription Optimisation and Not Dispensed Service (PONDS) and submitted a Business Case as required by the PCT. The service was designed to reduce wastage by optimising dosages and ensuring that the patient still needed items prescribed on repeat prescriptions. Although a similar pilot service established by the previous PCT was (and still is) running, the service was rejected due to the fact that the PCT’s Medicine Management Department provide a service involving a team of their own pharmacists and technicians who visit GP surgeries to review repeat medicines.

5.2 This raises several important issues. Firstly, there would appear to be a conflict of interest within the PCT which is acting as both commissioner and provider. Secondly, it is questionable whether the pilot established by the previous PCT some years ago should still be running without appraisal. Finally, the PCT seems to have ignored the fact that the service was to be established on a PBR basis, so no fees would have been generated unless pharmacists were able to identify things that had escaped the attention of the PCT staff and would have produced a financial saving.

5.3 These latter points lead the LPC to question whether PCTs have the resources or commitment to manage the pharmacy contract or commission services at a local level.

6. **World Class Commissioning**

6.1 The LPC has considered “High Quality Care For All. Primary Care & Community Services: Improving pharmaceutical services” (Dept Of Health, 31 March 2009) and whilst recognising that WCC is still in its early days, is disappointed to note that there are few competencies where it is felt that the PCT achievement has risen above Level 1.

6.2 The paper *Pharmaceutical Needs Assessments (PNAs) as part of world class commissioning. Guidance for primary care trusts* (NHS Employers, January 2009) listed competencies 2, 4, 5 and 7 as being most important to pharmacy, but again, the LPC feels that there is little evidence of progression beyond Level 1. This is perhaps not too surprising considering that the PCT has never had a PNA. It is understood that work commenced on a PNA last year and a baseline assessment was undertaken, but the LPC has not been invited to work with the PCT on this and it has not been published. Some recent delay could have been due to the announcement that new criteria will be needed when PNAs become mandatory.

6.3 A few months ago, the PCT was criticised in an appeal report from the NHS Litigation Authority for not having a Minor Ailment Service due to the fact that it had granted an application in a deprived housing estate with no GP surgery, partly on the grounds that it would provide access to over the counter medicines. The LPC has approached the PCT on many occasions about commissioning such a service and as far as the LPC is aware, no decision to do so has yet been taken.

6.4 Commissioning of pharmaceutical services for Pandemic Flu has also been far from “world class”. The LPC had met with the PCT and decided in January that in the event of a flu pandemic pharmacies would not be used as antiviral distribution points, largely due to the fact that they would be too busy maintaining the normal medicine supply and responding to requests for self help. However, when the pandemic arrived, the PCT was not prepared and so a few pharmacies were pressurised into agreeing to distribute antiviral medication. Although supply started in April, the pharmacists had still not received any fees in September—some five months later.

6.5 Towards the end of the last financial year, the PCT announced the availability of a grant of £3,000 for the provision of a consultation room in any pharmacy that did not have one. Another grant was made available for the provision of portable hearing loops. In both of these cases, such practice penalises the proactive pharmacies that have already provided such facilities at their own expense and so creates inequalities. Furthermore, the grant was not made available to pharmacies that may have considered a second (ie additional) consultation room which would have encouraged greater innovation and expansion of Enhanced Services.

7. **Recommendations**

7.1 There is a real need for PCTs to adequately invest in resources to manage the changes if community pharmacy’s potential is to be realised.

7.2 PCTs must be required to consult with LPCs and work in a collaborative meaningful manner.

7.3 To capitalise on pharmacy’s potential, there should be more Essential and Advanced Services, the national level establishment of which benefits from economies of scale.

7.4 More Directed Enhanced Services should also be introduced with ring fenced funding.

7.5 The LPC considers that SHAs also need to communicate with LPCs especially with reference to monitoring PCTs’ engagement with community pharmacy which should be mandatory.

*September 2009*
Memorandum by East of England PCTs (COM 45)

The PCT Network will suggest that progress in developing commissioning is well underway, within the framework provided by World Class Commissioning. Challenges remain in system terms, not always assisted by the national tariff. Initiatives to improve quality and safety are underway.

1. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

1.1 Separating the commissioning side of the PCT from provision allows each organisation to focus on assessing the health needs of its population and securing the range of health and well-being services required to address these needs. Maintaining a link with providers might lead to commissioners either being unduly influenced by providers' needs, or the operational distraction of managing services.

1.2 Although purchasers have always prepared strategies to support their work, the ability to turn such strategies into commissioning plans, grounded in the needs of their populations, produces far better outcomes for patients. This move to strategic commissioning requires commissioners to take a broader view of commissioning priorities and focus on outcomes rather than the inputs associated with a particular provider. They can also view the whole of a healthcare market in an objective way.

1.3 Separating commissioners and providers also allows the former to be held accountable more transparently. This is increasingly important as difficult decisions about priorities have to be taken.

1.4 In the case of community health services, PCTs will contest their community health services once there is clarity about their objectives for services. PCTs are rightly considering how their plans for divesting themselves of direct provision will address service redesign and QIPP before moving through a contestability process.

1.5 Most other public sector bodies have also seen a separation of their commissioning from their provider functions, with many local authorities outsourcing service delivery as well as back office functions. Consistency in approach across public sector commissioners is essential. This is particularly important when PCTs join with local authorities to commission services for vulnerable people, or initiatives to address the broader determinants of health.

2. “World Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

2.1 There needs to be a recognition that most of the effort in developing organisations, almost since the inception of the NHS, has related to providers, not those who commission care.

2.2 World Class Commissioning acknowledges that insufficient attention has been paid in the past to the development of commissioning skills within the NHS. The results from the first round of assurance contain few surprises, with PCTs providing more evidence of their competence in partnership working (in its broadest sense) that the more commercial competences. On a scale of 1–4, three of the PCTs in the East of England scored “3s” for elements of partnership. Most PCTs scored only “1” in competence 7 (stimulate the market).

2.3 Whilst PCTs have developed greater awareness of some of the “commercial” skills through capital schemes, there is less experience of applying some of the competences to clinical services. With the support of the Commercial Team at NHS East of England, a number of initiatives to benefit patients have taken place, using better specification of outcomes, early engagement with potential providers and rigorous contract negotiation. An example would be the selection of the consortium to run services at the new Braintree Community Hospital, which brings together independent sector providers with the PCTs provider arm, at a competitively negotiated price. This will be one of the first community hospitals procured using the new national contract for community services. PCTs are involved in an East of England Commercial Advisory Board, which aims to support both commissioners and the independent sector in understanding how to work effectively together. PCT commissioners across the East of England met with existing and potential providers of mental health services in a market stimulation event, where commissioning priorities could be shared with providers, and examples of best practice identified which could feature in future service specifications. New services have been introduced through competitions for enhanced access to primary care, or psychological services.

2.4 It is important to state that using tools and techniques from the commercial sector does not mean a move towards privatisation of the NHS. All commissioners are committed to the NHS principles and standards of care. However, more robust processes can only support the optimum use of public resources and the delivery of patient-focused services.

2.5 In considering the relationship between SHAs and PCTs, it is worth reflecting on the need to separate World Class Commissioning development from assurance. Both are important activities, but require different skills as well as adequate resourcing.

2.6 A critical factor in allowing PCTs to continue their development as commissioners is organisational stability. If it is acknowledged that significant change is required before PCTs truly become World Class Commissioners, then they must be allowed to grow and embed new skills and business processes without the threat of another reorganisation.
2.7 Even with organisational stability, it needs to be recognised that the time and investment required to become a World Class Commissioning PCT is significant. PCTs need to be adequately resourced for the organisational development required, within realistic timeframes.

3.  **Commissioning and “system reform”: how does commissioning fit with Practice-based commissioning, “contestability” and the quasi-market, and Payment by Results?**

3.1 Practice-based commissioning is central to the development of commissioning and a sustainable NHS. It is essential that clinicians are actively engaged in reviewing current patterns of care to ensure that their patients receive the right care in the right place at the right time. PCTs, looking at the whole population, need to set the strategic framework within which groups of primary care clinicians can commission. PCTs ought not to define the detail of how services are delivered, so that clinicians can use their clinical skills and dialogue with patients to identify innovative ways of meeting patient need. Clinicians involved in practice-based commissioning do, however, need to accept that they operate within the framework established by their PCT, and support drives to manage demand and deliver other national imperatives. Strong governance mechanisms are also needed to ensure that clinicians do not confuse commissioning with provision.

3.2 There is a need to reach a common understanding of the term “contestability”. Contestability covers a spectrum from establishing a robust, outcome-based specification (with appropriate metrics) and ensuring that providers are held to account for delivery, through to tendering for a service in the open market. The ability to look across this spectrum is important for more rural areas such as Norfolk, where the healthcare market is less developed and a tendering process may not lead to new providers. In such a PCT, other tools for provider management will be important. There is a potential policy conflict when seeking to expand the market, as an increased range of providers (offering greater choice to patients) will ultimately receive smaller shares of an existing patient base and a commissioner’s leverage will decrease.

3.3 PCTs in the East of England are increasingly looking to other, non-NHS providers to promote improvements in quality and responsiveness. Despite the adverse incentives within the national tariff, it does facilitate negotiations with other providers by setting a maximum financial envelope within which PCTs can negotiate. The national contracts do, however, need to be applied in a proportionate way, so that smaller organisations (notably the third sector) can respond to tenders.

3.4 Whilst the rationale behind payment by results appears sound by allowing money to follow the patient, it regrettably acts as a perverse incentive. The drive behind *High Quality Care for All* is to redesign the pattern of healthcare delivery. However, there is no incentive for providers to work with commissioners to reduce the numbers of admissions or attendances where a safe and efficient alternative is available in the community. Changes to lengths of stay also result in any benefit being retained by the provider, if this is within the average length of stay used to formulate the tariff. Unless and until this is addressed, commissioners will find it hard to reshape services.

3.5 Although it is suggested in this paper that most of the emphasis in development terms has been on the provider side, and that this needs to be redressed, there is also a need to consider how we develop “World Class Providers” within local health systems. Foundation Trusts remain part of the NHS, but in some instances prove to be less co-operative in implementing service change with their commissioners. This must change if we are to address the challenges arising from future financial projections.

4.  **Commissioning for the quality and safety of services**

4.1 Commissioners need to assemble a range of intelligence about the quality and safety of the services they commission. This requires them to specify the metrics they will use, drawing on both the national indicators and local ones to reflect PCT priorities. The use of CQUIN and PROMS schemes is of key importance.

4.2 PCTs will need to consider new ways of capturing intelligence from patients and their carers. NHS SW Essex is a pilot site for the summary care record and is looking at ways of using HealthSpace to allow patients to record real-time information on their experience of using services. Other PCTs are examining patient experience tracker from Dr Foster.

4.3 The advent of Quality Observatories will support PCTs in developing metrics and standards for inclusion in contracts. This is to be welcomed, but must address the current imbalance in the national quality metrics between acute services and other sectors, particularly primary care.

4.4 At the same time, PCTs will need to work with local patients and their carers to ensure that they are able to use this range of information about quality and safety in making choices about service models and providers.

4.5 PCTs will also need to enter into robust working arrangements at a local level with regulators, especially Monitor, to embed the commissioning of quality and safety into their mainstream activities. Commissioners must devise ways of measuring quality and safety which may mirror those used by regulators as they cannot afford to exclude themselves from proactive monitoring, as the Mid Staffordshire experience shows.
4.6 One area where more emphasis may be needed is in PCTs commissioning of primary care services. Many PCTs are developing balanced scorecards to reflect the complex nature of modern primary care, but such initiatives need to be built into the same sort of contract monitoring arrangements which apply to secondary care providers, with appropriate action being taken when necessary.

4.7 In seeking to relocate services from secondary to primary care settings, PCTs need to consider how they market the quality and safety of such services. Patients, GPs and clinicians in secondary care all need to be assured that such services can deliver at least the same level of care, otherwise new pathways will be implemented with difficulty.

5. **Specialist commissioning**

5.1 The Specialist Commissioning Groups (SCGs) established as a consequence of the Carter Review are sub-committees of their constituent PCTs. In many cases, the budgets devolved to specialist commissioning are larger than an individual PCTs. As such, it is essential that the principles of World Class Commissioning are applied to each SCG. PCTs need to work with their SCGs to ensure that the competences required for non-specialist services are applied with the same rigour to specialised commissioning.

5.2 Whilst SCGs have less of a market within which to tender services, they must demonstrate that they are managing contracts with the same rigour that is being applied to local contracts. As commissioners focus on care pathways (from primary through to tertiary services), specialist commissioners must be aware of and support their contribution to patient and outcome-based commissioning—how is communication maintained between tertiary, secondary and primary care services? How effective is discharge planning?

5.2 SCGs are evidence of PCTs being able to commission together, to secure a greater benefit for their populations. There will be an increasing requirement for PCTs to collaborate, sharing scarce resources and capabilities.

**CONCLUSION**

We would argue that the purchaser/provider split does bring benefits to patients by facilitating a more strategic approach to commissioning, with more transparency in the use of resources. World Class Commissioning is acknowledged to provide the focus for development of robust commissioning, but it does need to be seen as a development programme requiring investment. System change sits alongside this, and offers many benefits, but the adverse incentives within PbR need to be addressed. Quality and safety are central to commissioning, but again, further development can only add to our ability as commissioners. We also need to apply the rigour of World Class Commissioning to specialist commissioning.

*September 2009*

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**Memorandum by the Company Chemists’ Association and the Association of Independent Multiple Pharmacies (COM 46)**

1. **INTRODUCTION**

1.1 The Company Chemists Association (CCA) and the Association of Independent Multiple Pharmacies (AIMp) are the two representative organisations for pharmacy businesses, speaking with one voice to policymakers and decision-makers on behalf of over 55% of the UK pharmacy market. Membership of both organisations ranges from the largest chains of pharmacies, to much smaller pharmacy companies with between five and 300 branches. Together, the two organisations represent over 7,000 pharmacies.

1.2 CCA and AIMp welcome the Committee’s Inquiry into Commissioning. The findings and conclusions of the Committee will assist the Department of Health, the NHS, and other Government departments and agencies in ensuring that commissioning is undertaken in the most efficient and effective way, to ensure that people using NHS services receive the best care possible.

1.3 CCA and AIMp believe that the effective commissioning of community pharmacy can improve the experience of service users, engage hard to reach groups and is a cost-effective use of NHS resources, and would like to provide evidence in support of this for the Committee’s attention.

2. **EXECUTIVE SUMMARY**

2.1 Commissioning of community pharmacy must be something on which PCTs are measured in the World Class Commissioning programme. Community pharmacy is an important component of primary care and must not be ignored simply because it is a contracted service rather than a direct part of the NHS family.

2.2 Every PCT should have an identified board member with direct responsibility and accountability for pharmaceutical services.

2.3 Shared best practice in designing national templates for services would reduce significant variations across PCTs and remove the possibility of developing 152 solutions for the same problem.
2.4 It is estimated that some 57 million GP consultations each year involve minor ailments, which could be dealt with at a pharmacy.\textsuperscript{149} The average GP surgery consultation last 11.7 minutes and costs £32.\textsuperscript{150} The same 11.7 minute consultation in pharmacy would cost £17.75.\textsuperscript{151} If these patients could be moved to pharmacy then over £812 million (£812,250,000) could potentially be saved.

2.5 Community pharmacies are easily accessible. 99% of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. Therefore stronger commissioning of services from community pharmacy gives people choice of service provider and ensures that hard to reach groups (including rural communities) have easy access to primary care health professionals.

2.6 To improve commissioning processes, there must be better dialogue with all stakeholders to design and agree outcomes before going to tender. If services were commissioned for at least 2-3 years, customers, providers and commissioners would experience and be able to choose services on the basis of quality, consistency and value.

3. PHARMACY IN ENGLAND

3.1 The Government White Paper, \textit{Pharmacy in England}, published on 3 April 2008 built on previous government commitments to, “build on pharmacy’s strength”, ensuring that community pharmacies “are commissioned based on the range and quality of the services they deliver”.\textsuperscript{152} The White Paper includes several welcome sections looking at the importance of strengthening the commissioning of pharmacy services, all aiming to achieve a more personalised health service which promotes health and wellbeing, prevents ill health and reduces health inequalities.

3.2 The White Paper stated that the Government does not yet believe that PCTs are in a position to take full responsibility for contracting pharmacy services as their commissioning function is not adequately defined and understood. As such, it was proposed that PCTs should be given a much wider role in commissioning, but that the Department of Health would identify certain services which have to be provided by PCTs, to ensure their local implementation. These Direct Enhanced Services (DES) will cover areas that are needed at a local level throughout the country and will include measures like the proposed Minor Ailment Service and NHS Health Check.

3.3 The White Paper called for commissioners to ensure that community pharmacists are involved in health needs assessments, to ensure that they are included in local planning processes and to incorporate them into Joint Strategic Needs Assessments (JSNAs) allowing them to be included in the patient’s integrated care pathway.

4. WORLD-CLASS COMMISSIONING

4.1 The World Class Commissioning programme provides an opportunity for PCTs to develop their commissioning skills to become more effective commissioners of services, including those which can be provided by community pharmacy.

4.2 Following the publication of the first year of the World Class Commissioning assurance process, CCA and AIMp have undertaken an analysis of the Panel Reports of the 30 PCTs ranked “most competent” by the Health Service Journal.\textsuperscript{153} The purpose of this analysis was to determine how PCTs are commissioning pharmacy as a route to making themselves “world class” and to identify how the effective commissioning of pharmacy can contribute to PCTs becoming world class in their commissioning going forward.

4.3 Effective commissioning of pharmacy did not appear to be a priority in the first year of the World Class Commissioning programme. The role of pharmacy was only mentioned by five out of the 30 top performing PCTs in their Panel Reports. This was a disappointing result because in order to provide a truly world class service to the populations that they serve, commissioners should contract a variety of providers to ensure that services are responsive to local needs and accessible to all. We would like to see information about how PCTs are commissioning community pharmacy in all Panel Reports during the next World Class Commissioning assurance process.

4.4 Following the first round of assurance reports the Department of Health launched \textit{Primary Care and Community Services: Improving pharmaceutical service}\textsuperscript{154} in April 2009, as a further resource to improve commissioners’ ability in commissioning high class pharmaceutical services. It is unfortunate that this supplementary guidance was not launched in time to have an impact on the first year of World Class Commissioning, but now that it has been launched it should be fully implemented and PCTs should be held to account against its recommendations in future rounds of the World Class Commissioning programme.

\textsuperscript{149} Joint paper submitted to the Department of Health by the PSNC and the Proprietary Association of Great Britain, December 2007.

\textsuperscript{150} Personal Social Services Research Unit, \textit{Unit Costs of Health and Social Care} 2008, 23 December 2008.

\textsuperscript{151} Personal Social Services Research Unit, \textit{Unit Costs of Health and Social Care} 2008, 23 December 2008.


\textsuperscript{153} Health Service Journal, \textit{World Class Commissioning League Table}, 5 March 2009.

\textsuperscript{154} Department of Health, \textit{Primary Care & Community Services: Improving pharmaceutical services}, April 2009.
4.5 This guidance explains how commissioning is distinctive in pharmaceutical services, and outlines the levers and tools available to make change in these services happen. Important inclusions in the guidance are mapping the base line of the services which currently exist in each PCT and developing a clear vision for pharmaceutical service provision.

4.6 It is encouraging that the guidance states that PCTs must ensure that there is appropriate pharmacist input at board level whenever decisions about commissioning pharmaceutical services are taken and that PCTs should have a named board member with responsibility for pharmaceutical services to support strong and effective leadership for pharmacy. The named PCT board member must be the accountable person for ensuring that guidance including the PNA and JSNAs are properly implemented to support new regulations and effective World Class Commissioning. Strategic Health Authorities must ensure that all PCTs in their area comply with this guidance to ensure that the people with the right skills are involved in the commissioning of pharmaceutical services.

4.7 Commissioning services from pharmacy can also help PCTs achieve the eight outcomes measures which they select as local priorities. According to a recent report, smoking quitters is the most commonly selected of the World Class Commissioning outcome indicators. Pharmacy has a key role to play in smoking cessation and therefore commissioning pharmacy effectively in these specific areas can assist PCTs in becoming world class. Many of the outcome measures, particularly in the “staying healthy” and “long term conditions” categories, could be supported by the effective commissioning of pharmacy.

4.8 It is vital that in the next round of the World Class Commissioning assurance programme, commissioning of community pharmacy is scrutinised by the Department of Health to ensure that PCTs are capitalising on the benefits that can be provided by using pharmacy effectively. Community pharmacy is an important component of primary care and must not be ignored simply because it is contracted service rather than a direct part of the NHS family.

5. The Purchaser/Provider Split

5.1 The purchaser provider split has driven efficiencies across all health care settings since its introduction. However it does suffer from the weakness that many on the purchasing side do not have expertise or experience of services provided in community pharmacy. This may impede the commissioning of services in this setting. In order to overcome this, mechanisms to involve community pharmacists in the process should be strengthened. Any further devolution of commissioning to a GP level will exacerbate this.

6. Services that Community Pharmacy can Deliver

6.1 Community pharmacies are offering an ever expanding variety of services to promote the health and wellbeing of local communities including NHS Health Checks, smoking cessation, heart disease management and prevention, diabetes screening and management, blood pressure services, weight management services, and alcohol screening and interventions. Among the services that community pharmacy can offer are:

6.1.1 NHS Health Checks—these need to be provided in a variety of settings in order to reach those groups who are not frequent users of healthcare (particularly men), and those who cannot normally visit other healthcare settings, such as GP practices, during the day. The delivery of the NHS Health Checks programme in community pharmacy is, therefore, critical to its success.

6.1.2 Smoking cessation—the healthcare benefits in relation to cardio and vascular disease of stopping smoking are irrefutable, as are the benefits of offering stop smoking services in community pharmacy; every year, for example, at least 20% of all attempts made by smokers to quit—100,000 people a year—are as the result of the services offered by community pharmacies.

6.1.3 Weight management—pharmacists can provide vital additional services, on people’s doorsteps, to help tackle obesity (with the resultant beneficial effect on cardio and vascular problems) in the population through innovative weight management programmes. In Coventry, for example, a pilot programme running from January to August 2007 saw 70 patients complete at least four follow up pharmacy appointments, during which time their waist circumference reduced by an average of 3.37cm.

6.2 These services should be considered by commissioners as simple and cost effective ways to ensure that they are able to reach world class standards for commissioning as quickly as possible. It is estimated that some 57 million GP consultations each year involve minor ailments, which could be dealt with at a

155 Health Mandate. National priorities, local action? An analysis of Primary Care Trusts’ World Class Commissioning policies, July 2009.

156 Brock, Taylor & Wuliji, Ending the Global Tobacco Pandemic. London School of Pharmacy, 2007.

157 Malson Pharmacies win as patients lose weight via PCT-funded services. PJ Online, October 2008 http://www.pjonline.com/news/pharmacies_win_as_patients_lose_weight_via_pctfunded_services
pharmacy. The average GP surgery consultation last 11.7 minutes and costs £32. The same 11.7 minute consultation in pharmacy would cost £17.75. If these patients could be moved to pharmacy then over £812 million (£812,250,000) could potentially be saved.

6.3 Community pharmacies are easily accessible. 99% of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. Therefore stronger commissioning of services from community pharmacy gives people choice of service provider and ensures that hard to reach groups (including rural communities) have easy access to primary care health professionals.

6.4 National tenders and local level service agreements are a useful way of procuring services and ensure that there are timelines and frameworks for services. However, there are a number of challenges currently facing community pharmacy which are a result of the current tender processes used by PCTs to commission services. For example, there can be significant variations in services specification, few pilots progress to formal contracts, and completing a tender process can become overly burdensome.

6.5 To improve commissioning processes, there must be better dialogue with all stakeholders to design and agree outcomes before going to tender. Ongoing dialogue must continue when the service is implemented to amend and adapt activity according to local need.

6.6 Shared best practice in designing templates for services would reduce significant variations across PCTs and remove the possibility of developing 152 solutions for the same problem. This will also ensure that people accessing services are assured that this will be to the same standard and include the same things regardless of where they live. As soon as a successful service evaluation is produced for a model service, the service specification should be reviewed to produce a “best practice model” and this should become the national template to enable high quality services to be spread efficiently fulfilling QIPP (quality, innovation, productivity, and prevention). This national template should be made available to local PCT commissioners in a timely and planned way so that they do not unknowingly duplicate or waste resources. Standardisation of good and innovative services allows better focus on supporting delivery and on continuously improving quality.

6.7 If services were commissioned for at least 2–3 years customers, providers and commissioners would experience and be able to choose services on the basis of quality, consistency and value. Longer contracts will encourage additional providers to make the investments in resources, people, locations and premises needed to create the conditions to effect substantial change.

7. CLOSING REMARKS
CCA and AIMp look forward to reading the Committee’s report and its recommendations.

September 2009

Memorandum by the Muscular Dystrophy Campaign (COM 47)

EXECUTIVE SUMMARY

Three years on from the publication of the Carter Review, we strongly believe that the new commissioning arrangements in the majority of the English regions are failing patients living with rare and very rare conditions. Many of the regional Specialised Commissioning Groups are failing to commission services on the National Definition Set for Specialised Services, and to plan and commission services for rare conditions across their whole region. We have further uncovered serious structural failings in the relationships between Specialised Commissioning Groups, Primary Care Trusts and Strategic Health Authorities. These failings in the commissioning structure can have a devastating impact on the life expectancy and quality of life for patients with muscle disease.

INTRODUCTION

1. The Muscular Dystrophy Campaign represents the 60,000 people in the UK with muscular dystrophy or a related neuromuscular condition. There are more than 60 different types of muscular dystrophy and related neuromuscular conditions which affect approximately 1,000 children and adults for every one million of the population.

2. Many neuromuscular conditions are low-incidence, orphan conditions and indeed some are very rare and are regarded as ultra orphan. Neuromuscular conditions can be genetic or acquired and, with the exception of a couple of acquired conditions, there are no known effective treatments or cures.

159 Personal Social Services Research Unit, Unit Costs of Health and Social Care 2008, 23 December 2008.
3. As these are rare conditions, it is the remit of regional Specialised Commissioning Groups to commission services for this patient group. Over the last six months, the Muscular Dystrophy Campaign have met separately with each of the 10 Specialised Commissioning Groups in England to discuss the commissioning of services for people with muscular dystrophy and related neuromuscular conditions.

**The Carter Review**

4. The Carter Review was published in May 2006, following a seven month review commissioned by Lord Warner, the then Minister of State for NHS Reform, and led by Professor Sir David Carter. The review investigated how the NHS commissions specialised services and makes proposals for improvement.

5. The Carter Review recommended the creation of a regional Specialised Commissioning Group for each Strategic Health Authority area, which would also be a member of a National Specialised Services Commissioning Group.

6. The Carter Review highlights the need for the Primary Care Trusts to work collectively to plan and share the costs of specialised services as the patient numbers are too small per PCT area.

   "The risk to an individual PCT of having to fund expensive, unpredictable activity is reduced by PCTs grouping together to collectively commission such services and share financial risk."[^63]

**Specialised Commissioning Groups**

7. Evidence from our meetings and discussions with SCGs across the country have highlighted a number of serious concerns with the commissioning of specialised services for patients with rare conditions:

   (a) The majority of the SCGs refuse to commission services for this group of patients. This is despite the fact that the SCGs have a responsibility to commission these services—muscular dystrophy and related neuromuscular conditions are included in the Department of Health’s National Definition Set, under the new Neurosciences definition (Definition number 8).[164]

   (b) This raises a further issue regarding the purpose and use of the Specialised Services National Definition Set. We have repeatedly been told by SCGs that they are not “supposed” to commission all or even a majority of the services listed on the National Definition Set. This seems to contradict the original aims of Carter as reflected in the 2008–09 NHS Operating Framework which stated:

   “For that reason, we expect SCGs to create pooled budgets and to commission the majority of specialised services on their patch this year, extending this to all specialised services in 2009–10.”[^65]

   (c) This aim has clearly not been met, and appears to have disappeared from the next NHS framework—seemingly shelved without comment, despite the devastating impact for people with rare conditions who face a postcode lottery as to whether their local SCG will decide to commission services for their condition.

   (d) Furthermore, despite their inclusion on the National Definition Set, a number of SCGs have told the Muscular Dystrophy Campaign that patients with neuromuscular services are “not a priority”.

   (e) We have found that in practice, the Specialised Commissioning Groups have no authority over the Primary Care Trust in their regions. We have been told time and time again that the SCGs work “on behalf of the PCTs” and that they will only concentrate on those services important to the PCTs. As Committee Members will recognise, this is completely inappropriate for rare conditions affecting small numbers of patients within PCT catchment areas—and indeed it was for this reason that the Specialised Commissioning Groups were set up. We have been instructed by SCGs, who have absolved themselves of their responsibility to commission collectively, to speak to each PCT individually to ask them to take action to improve services for their small numbers of patients with a neuromuscular condition.

   (f) There is no clear structure or chain of command for working between Strategic Health Authorities and Specialised Commissioning Groups. This has resulted in completely dysfunctional relationships in some regions—and leaving some SHAs in the impossible position of having the ultimate responsibility for supervising overall healthcare in the region, but having no power to improve health outcomes for people with devastating muscle wasting and weakening conditions—some of which are life-limiting. For example, there is no functioning relationship or communication between the SHA and the SCG in the NHS South Central region, where the offices are located some 37 miles apart.

   (g) Many SCGs do not commission services for the whole region, preferring in some places to stick with outdated commissioning boundaries—for example, people with rare condition in Cumbria.


have their services commissioned by the North East SCG, despite falling within the boundaries of the North West SHA area. In other regions the SCG refuses to work to the new regional boundaries, preferring to commission in only small clusters of PCTs—as has been found in the North West SHA. Again this fails to accept the need to plan services for rare conditions on a regional basis because of the small numbers of patients—as recognised by Carter. This is the case with the North West Specialised Commissioning Group.

(h) There is no accountability for the actions of the SCG. Patients have no arena for PPI—local LINk groups are simply an inappropriate forum for questions of specialised services for people with rare conditions, due again to the small numbers of patients. Further there is no transparency within the Specialised Commissioning Group network, with SCG meetings closed to the public and patient groups, and the minutes rarely shared widely.

THE NATIONAL SPECIALISED COMMISSIONING GROUP

8. The National Specialised Commissioning Group (NSCG), created on 1 April 2007, is meant to have overall responsibility for the oversight of specialised commissioning. However, we believe their authority over the SCGs is extremely limited and the NSCG is unable to instruct the SCGs to prioritise certain services and conditions.

COMMISSIONING OF SPECIALISED SERVICES IN WEST MIDLANDS AND SOUTH WEST

9. Specialised commissioning arrangements for neuromuscular services can work—and there is evidence of this in the South West and West Midlands regions. In the South West, the SCG undertook a thorough review of neuromuscular services, led by Louise Tranmer, which involved patients, clinicians and the Muscular Dystrophy Campaign. This has resulted in real improvements for people in the South West living with neuromuscular conditions, and the Muscular Dystrophy Campaign has encouraged other SCGs to follow suit.

10. The West Midlands SCG is currently conducting a similar review. This was kick started when Parliamentarians on the APPG for Muscular Dystrophy recently questioned Eamonn Kelly, Director of Commissioning for the West Midlands SHA, as part of their Inquiry into access to specialist care. The Muscular Dystrophy Campaign is shocked that this level of pressure is required before the SCGs and SHAs realise that they have a responsibility to commission specialist services for this vulnerable group of patients.

11. It is important to note that in both the South West and the West Midlands the SCG works closely with the SHA and the priorities of the two have been closely aligned. This has allowed the SCG to plan services for a whole region while also meeting the SHA’s aim of improving health for the region as a whole.

THE WALTON REPORT

12. The All Party Parliamentary Group for Muscular Dystrophy published their final report—The Walton Report166—in August this year following a nine month inquiry into access to specialist neuromuscular services. The Walton Report highlighted the difficulties experienced by patients trying to access specialist services and the lack of planning of these services. One of the main recommendations of the report called for:

The responsibility for ensuring that access to specialised, multi-disciplinary neuromuscular services is available for all patients should lie with a named individual postholder in the National Specialised Commissioning Group and with a named individual in each of the English regions.

We echo this call, and believe it would be one of the steps necessary for the recommendations of Carter to be implemented in practice and to provide better services for people with rare and very rare conditions.

RECOMMENDATIONS

1. The National Specialised Commissioning Group should be resourced and empowered to identify and press priority commissioning areas.

2. Relationships between regional Specialised Commissioning Groups and their constituent PCTs should be strengthened to ensure that collective commissioning arrangements are not governed by the interests of individual PCTs.

3. The relationship between each Specialised Commissioning Group and their respective Strategic Health Authority should be standardised with clear lines of responsibility and accountability.

4. The National Specialised Commissioning Group should provide guidance as to the use of the Specialised Services National Definition Set for SCGs in order that these services are commissioned.

September 2009

Memorandum by NHS Bristol (COM 48)

COMMISSIONING FOR THE PEOPLE OF BRISTOL

1. PURPOSE

1.1 The purpose of the paper is to provide the Health Select Committee with information about how local commissioning is bringing about positive change for patients. The emphasis of the submission is upon change that would not have occurred without commissioner involvement.

2. BACKGROUND

2.1 NHS Bristol commissions services for a diverse population of just over 400,000 residents. It has a mixed profile of health need and a significant life expectancy gap of around 9 years between the best and worse off within the City. The strategic priorities of the PCT are centred around our aspiration to reduce this gap in life expectancy through improving outcomes for the least advantaged populations within the city.

3. IS THE PURCHASER/PROVIDER SPLIT NEEDED?

3.1 In the experience of NHS Bristol the purchaser / provider split has been a necessary part of the service reform required to ensure the NHS responds to the needs of the population as a whole and is not configured around the needs of health services and the professionals who work within them. Commissioners are uniquely placed to fulfil a number of critical roles that provider organisations have not and are unlikely to embrace.

3.2 The first is the oversight of the whole system across both health and social care to ensure that patients are cared for in the most appropriate setting and can flow through a system in a fashion appropriate to their needs and not the needs of individual providers. An example of particular success in whole system management within the Bristol system is evidenced by the very low levels of Delayed Transfers of Care with our acute hospital settings which can be attributable to PCT leadership in galvanising and performance managing a system towards a system goal. This has been achieved by working closely with Bristol City Council to develop comprehensive and highly integrated “intermediate care” services which offer early discharge and admissions avoidance services for older people.

3.3 Secondly commissioners are uniquely placed to plan and organise services across patients’ whole pathway of care. This not only increases the likelihood of patients experiencing services in a joined up manner but it enables emphasis to be placed on parts of the pathway which would otherwise not have been developed adequately. Inevitably this may mean individual providers ceasing to provide services or experiencing down turns in demand for services where commissioners emphasise “up stream” interventions within a pathway but it is these impacts of good pathway design that make commissioners well placed to bring about this change.

Case Study 1—Commissioning Improved Heart Attack and Stroke Care

From June 2009, NHS Bristol implemented new care pathways for heart attack and stroke for the 800,000 residents of Bristol, North Somerset and South Gloucestershire. This allows the population to benefit from improved services including primary angioplasty for heart attacks, same day TIA clinics (for transient ischaemic attacks, or mini-strokes) and the development of a hyper-acute stroke centre to offer 24/7 stroke thrombolysis. These evidence based approaches were recommended by Lord Darzi. NHS Bristol has introduced them two years ahead of the national timetable.

Without strong commissioner leadership to mandate new ways of working, the local NHS Trusts would be unlikely to relinquish their overlapping and less optimal historical patterns of service provision. More than 250 people per annum in Bristol could have reduced chance of mortality from their heart attack as a result of the new pathway and more than 70 people suffering from stroke could have significantly reduced levels of disability through improved early acute management of the condition.

Case Study 2—Commissioning IVF Services

From April 2009, NHS Bristol has commissioned “single embryo transfer” for IVF to reduce the high level of twin pregnancies associated with this intervention and thus reducing the high burden of morbidity and service utilisation associated with multiple births. This good practice change was resisted by providers and would not have been secured without the commissioners exerting their influence and leverage because of the way in which the benefits and dis-benefits of current practice fall across the health system. Commissioners as guardian of the whole pathway are uniquely placed to consider the unintended consequences of clinical practice in other parts of the system such as increased rates of neonatal intensive care usage and increased morbidity and disability associated with premature births.

Currently between 40–60% of IVF neonates are transferred to intensive care, compared with 20% of single IVF infants; around 20% of women carrying IVF twins suffer high blood pressure compared with only 1–5% of those carry a single baby and the risk of life threatening pre-eclampsia is 30% for twin pregnancies compared to 2–10% for those carrying one baby. All these
3.4 Health service providers by their nature are largely concerned with the individual patient. Examples of providers working proactively with the well public are lacking and commissioners have embraced the need to address the burden associated with ill health as demographic changes and other factors threaten to undermine the future of a tax based health system. NHS Bristol can cite many examples of the work it is doing, in partnership with other agencies and notably Bristol City Council, to improve the health status of the wider population. A specific example is the creation of the Community Development Worker role to work with communities who do not readily access services to promote their mental health and wellbeing. It is entirely unclear which provider market would respond to such a population need without commissioner intervention.

**Case Study 3—Commissioning for Improvements in Health**

Through the joint Healthy Schools Programme between NHS Bristol and Bristol City Council, we have introduced a pioneering anti-smoking initiative into all secondary schools in the city. “ASSIST” is led by 12 and 13 year old students who are trained as “peer supporters” to promote anti-smoking messages in their everyday conversations with their classmates. ASSIST has been developed by the Universities of Bristol and Cardiff and its early positive evaluation is being tested through a £1.5 million grant from the Medical Research Council.

This programme is quoted as an example of good practice in the recently published children and young people’s health strategy “Healthy Lives, Brighter Futures” 2009.

3.5 The significant emphasis on improving the patient experience of health services users and providing individuals with choice over how and where their care is delivered is perhaps one of the most recent and powerful examples of commissioner influence. NHS Bristol has an extensive service redesign programme covering areas such as cardiovascular disease, cancer, mental health, sexual health and many others. Clinicians, managers, service users and public representatives work together to create and implement improved pathways of care.

**Case Study 4—Community Child Health—realising the benefits of partnership**

During 2008/9 NHS Bristol led a procurement exercise to re-commission all its community child health and child and adolescent mental health for the City and for South Gloucestershire PCT. Children and young people are a key health target group in Bristol where differences in educational attainment, teenage pregnancy and emotional and mental health are stark. Previously provision of these services had been fragmented between several NHS providers and access to services had been variable.

From April 2009 these services will be provided by North Bristol Trust in partnership with Barnardo’s. This partnership combines the extensive clinical and governance experience of an established NHS Trust with the responsiveness, innovation and local knowledge of a respected, national voluntary organisation.

The new contract worth £100 million a year has a comprehensive quality and outcomes framework which is orientated towards addressing health inequalities, acting on service user experience and building cultural competence into the workforce.

**Case Study 5—Offering the choice to have Chemotherapy at Home**

In NHS Bristol we are piloting a wide scale approach to offering cancer patients the choice of receiving their chemotherapy at home rather than in hospital. Feedback from patients receiving their chemotherapy at home has been overwhelmingly positive. This is delivered through a public private sector partnership and an initiative that one provider had been trying to progress for many years with no success. Commissioning leadership enabled this pilot to move from concept to patient delivery in nine months and is attracting national interest. Since March 2009, 377 chemotherapy regimens have been delivered to patients in their own home, transforming the experience of 85 patients and their families.

**Case Study 6—Equipment for Disabled Children**

In response to a growing number of concerns from parents about the delays in accessing essential equipment for their children, commissioners led a review of how equipment was provided not only across health service providers but other agencies involved in the care of children. These concerns were not new and many agencies were very well versed on the nature of the problem however, the solution lay outside their sphere of influence and as such had remained unresolved. As a result of the review, commissioner transferred budgets for equipment to those agencies best placed to rapidly assess a child’s equipment needs and provide equipment directly eliminating previously lengthy application and approval processes involving at least two and often three organisations. This has led to a reduction in waiting times for equipment from a typical wait of six months to a no wait model with the only delay being the week for the supplier to deliver the equipment to the child.
3.6 Finally, the role of commissioners as performance managers cannot be underestimated when assessing the relative contributions of commissioners and providers to improved performance. The setting of clear standards by commissioners and the rigorous follow through of providers’ actions to ensure delivery of those standards has undoubtedly led to improved performance in areas where poor performance has been longstanding. The most obvious example would be the significant reduction in waiting times that has been achieved in recent years, recognising that the employment model of NHS consultants and the role of private practice created perverse system incentives that commissioners have overcome through the use of alternative providers and the introduction of competition. A specific example in Bristol would be the use of the independent sector to clear audiology backlogs and increase service capacity reducing waiting times for assessment from over 12 months to 6 weeks. These waits had hitherto been intractable with no local provider able (or willing) to create the necessary capacity despite available resources.

4. Conclusions

4.1 NHS Bristol believes the role of commissioners as the guardian of the population interest, and in the context of a system constrained by finite resources, is fundamental and underpins much of the transformation of the NHS that has taken place in the last decade. Further consideration should be given to looking at the ways in which the transactions costs associated with the provider/commissioner split can be further minimised and how some of the perverse incentives that have flowed from system reforms such as Payment by Results can be countered for the benefit of the whole system, particularly as we move to challenging financial times.

September 2009

Memorandum by the South West Specialised Commissioning Group (COM 49)

COMMISSIONING SPECIALISED SERVICES IN THE SOUTH WEST

1. Purpose

1.1 The purpose of the paper is to provide the Health Select Committee with information about how specialist service commissioning is being taken forward in the South West.

2. Background

2.1 The South West Specialised Commissioning Group was formed in May 2007 following the Carter review. Over the last two years the SCG has been working to fully establish its commissioning function by investing in a multi-disciplinary commissioning team and establishing collaborative commissioning arrangements for the majority of specialist services.

2.2 The group comprises the 14 PCT chief executives in the South West, supported by the Director of Specialised Commissioning and her team. It is accountable to each Primary Care Trust Board.

2.3 The specialist commissioning group commissions £400 million of specialist services on behalf of the PCT in the South West.

3. Achievements since 2007

3.1 Neuromuscular Services—Addressing service deficits and strengthening networks of care

3.1.1 The South West Specialised Commissioning Group reviewed services within the South West for adults and children and comparing them to best practice standards and service models elsewhere. As a result a Neuromuscular Service Development Strategy was developed, consulted upon widely and approved. This will lead to £1m investment in new services and the establishment of a Clinical Network to support further improvements to patient care.

3.2 Mental health—Improving cost efficiency and contract management

3.2.1 The South West Specialised Commissioning Group reviewed all individual, specialist, mental health placements, outside of our main service providers in order to better understand where these patients are being cared for and the nature of the services they receive, and how these are commissioned. Following the review the SCG undertook a procurement process to secure services according to a service specification targeted at the needs of the patient groups identified. The process has established expected quality standards for patient care, mechanisms for performance management, streamlined contractual processes, released savings of £2 million and will provide valuable information for longer term strategic planning within the South West. These savings have been reinvested in health care across the region.
3.3 **Designation of Bariatric surgery providers—Improving Quality and Access**

3.3.1 The South West Specialised Commissioning Group has recently completed a process designating Bariatric Surgery providers across the South West. As a result, the number of NHS providers within the South West has been increased from two to six making access easier for patients within a region that has a large physical geography.

3.3.2 The service model was developed through a range of engagement meetings with patients, PCTs and Trust managers and clinicians (surgical and medical). Similarly the service specification was developed with clinical input from across the South West. A cost card was developed using Health Resource Group4 Payment by Results codes for the most common procedures. This created a costed package of care which the SCG would expect to pay for. This is a powerful tool since it clearly sets out what the SCG is and is not commissioning from service providers.

3.3.3 The designation involved competitive tender and included visiting ten potential providers. The designation visit team included a patient representative who committed to attended all visits. The criteria which were scored by the patient were agreed before the events and support given throughout by our Patient and Public Engagement Lead.

3.4 **System audit for neonatal services—Tracking care and monitoring pressures**

3.4.1 The care of neonatal babies is one of the most expensive services commissioned by the Specialised Commissioning Group. Until recently the information about transfers of babies between hospitals was of variable quality and consistency. The SCG now requires all neonatal providers across the SW to use the same clinical and commissioning database which will help us to track baby transfers across the SW and support system modelling. This database has been augmented by a detailed one month audit, involving all sixteen providers tracking reasons for transfers on and out of units. Once this is collated, this information will be used to model cot capacity at the right level of care to limit the number of babies moved from their birth units.

3.5 **Designation of burn care providers—Creating sustainable supra-regional services**

3.5.1 The South West Specialised Commissioning team has been leading the work of the South West UK Burns Network in preparation for the designation of burns care services for children and adults in South Wales, the South West and South Central England. This process concerns the most complex care for people with severe burns and relates to approximately six children a year and around 30 adults.

3.5.2 The importance of “designating” these small volume, highly complex services is to ensure that they are sustainable and affordable in the future in terms of quality of care, which encompasses clinical outcomes, recruitment and retention of specialist staff, and research and development.

3.5.3 In order to ensure a robust body of evidence was available for the decision making process, detailed work has been undertaken as follows:

3.5.3.1 Each provider has assessed themselves against the 2006 burn care standards and been visited to validate their returns; members of the public were included within the visiting teams.

3.5.3.2 All activity data has been reviewed and validated by matching local systems with information on the national burn care database.

3.5.3.3 A review of clinical outcomes, including mortality rates, has been completed for the providers across the South West.

3.5.3.4 A formal patient transport and access study has been completed, including road and air transport, together with public and private transport access for relatives and carers.

3.5.3.5 An engagement programme including several events for patients, carers, families, members of the public and staff across the South West as well as an on line questionnaire has been carried out to inform people about our proposals and gather their views and ideas about the services.

3.5.4 The South West UK Burn Care Network is now undertaking final preparations prior to the launch our final formal engagement process with the pubic, with a view to designating our burn care services by the beginning of April 2010–11 and concluding this long running process.

3.6 **Patient and Public Engagement—Enabling patients, families and the public to shape care**

3.6.1 The South West Specialised Commissioning Group has developed a very inclusive approach to engaging with patients and the public. During 2008–09 we developed an approach to service specific stakeholder days which shares information about services and gathers views and opinions about that service and specialised health care in general which is then formally analysed and written up as an appendix to service development plans. This summary is also posted on our website. For large development processes we often have several stakeholder days in different parts of the South West to ensure maximum opportunity for access. At stakeholder
days, attendees can register to be on our database for invite to future events and can complete questionnaires on line via our website. In addition, we have established a formal policy for managing large service improvement programmes that involve all of our PCTs and their Health Overview and Scrutiny Committees.

4. CONCLUSIONS

4.1 Despite being relatively new, the South West Specialised Commissioning Group has demonstrated a number of clear success and added value to specialised commissioning and commissioning generally including:

4.1.1 Establishment of robust governance arrangements to support collaborative commissioning that will increasingly be seen as World Class.

4.1.2 The ability to identify issues that need addressing and develop processes to support service improvement.

4.1.3 The gathering of powerful data and information that will inform collaborative commissioning across the South West and with partners where appropriate.

4.1.4 Ability to improve the quality and consistency of services while also increasing value for money.

4.1.5 Demonstrating good practice in engaging with patients and the public through our service designation processes.

4.1.6 The use of detailed clinical and outcome data to inform decision making.

4.2 However, we recognise that we have much to do in terms of consolidating current progress and further strengthening our commissioning in order to improve outcomes for patients and achieve commissioning that is regarded as World Class.

September 2009

Memorandum by the South of England Spinal Injuries Board (COM 50)

COMMISSIONING SPINAL CORD INJURY SERVICES

1. CONTEXT

1.1 The review by Sir David Carter on the commissioning arrangements for specialised services in 2006, made clear recommendations to PCTs to collaboratively commission specialised services across larger populations, to ensure good quality and cost effective services, and minimising risk to individual PCTs through financial risk sharing of low volume and high cost services.

1.2 All services delivered by spinal cord injury centres are defined as specialised. There are eight spinal cord injury centres in England (Appendix 1) of which three are located in the South of England, spinal cord injury centres provide care for newly injured patients and the long-term needs of people with para or tetraplegia.

1.3 The significant work that has been delivered through the commissioning these services collaboratively across the South of England is an excellent example of implementation of the Carter Review’s recommendations.

2. COMMISSIONING ARRANGEMENTS

2.1 The spinal cord injury services in the South of England have been collaboratively commissioned through the South of England Spinal Cord Injury Board, since September 2003. The Board now represents 6 Specialised Commissioning Groups (SCGs), across London, South East Coast, South Central, South West, West Midlands and East of England.

2.2 The Board working together with SCGs and key stakeholders, including the Spinal Injuries Association, lead clinicians and members of the multidisciplinary teams lead on collectively delivering the commissioning strategy for Spinal Cord Injury care.

2.3 The South of England Consortium since April 2008 has delivered on collaborative procurement by implementing the South of England Spinal Cord Injury Board agreed strategy. The consortium members are from the London, South East Coast and South Central SCGs. In 2010 the South West and the East of England SCGs are expected to join. This will make the South of England consortium the largest collaborative procurement arrangement for specialised commissioning outside of the National Commissioning arrangements.
2.4 The South of England Spinal Cord Injury Board and consortium is chaired by Deborah Evans, Chief Executive of Bristol PCT, Chair of the South West SCG and the management support is through Stephanie Newman Director of Specialised Commissioning, South East Coast Specialised Commissioning Group, (SEC SCG), and the SEC SCG team.

2.5 The structure of the South of England Spinal Cord Injury Board and consortium is described in appendix 2.

3. THE SPINAL INJURIES COMMISSIONING WORK PROGRAMME

3.1 The South of England Spinal Cord Injury Board work programme has included:

3.1.1 The production of Standards for Spinal Cord Injury care in 2003, which have been revised in 2009, following two audits. The three spinal cord injury centres are assessed against these quality standards.

3.1.2 Support of the development of National classifications and costing, by leading on the PbR development pilot. The outcome of this work will be to create a single national system of contract “currencies” for spinal injury services which will allow a consistent approach to pricing services and contracting for them. At present the centres have a variety of differing ways of pricing and charging for their work. Specialised services are at a disadvantage compared to general acute hospital services in not having a standard, national approach.

3.1.3 Developing a commissioning dataset and a South of England database.

3.1.4 Supporting an “Outreach” project to review a best practice models to build educational and professional links between A&E and other Hospital departments that receive patients with a spinal cord injury and the relevant Spinal Cord Injury Centre.

3.1.5 Developing a common referral dataset and collation of referrals.

3.1.6 Facilitating effective discharge programmes, working with discharge coordinators across the three services, reviewing successful reintegration of patients and addressing the barriers, for example housing and social care issues.

4. FUTURE ARRANGEMENTS

4.1 It has been agreed, following a meeting on 14 August, that the 10 SCGs with partners in Scotland and Wales will establish a National Spinal Cord Injury Strategy Board.

4.2 This new Board will be Chaired by Deborah Evans, Chief Executive of Bristol PCT, Chair of the South West SCG and Chair of the South of England Spinal Cord Injury Board.

4.3 The SCGs and partners are establishing the terms of reference for the National Board at present but broadly have agreed to:

4.3.1 Develop National Standards for the service, and work jointly to continuously improve performance against the National Standards.

4.3.2 Work in partnership with other planning or commissioning groups, such as trauma networks, so as to ensure the best interests of patients with spinal cord injury are represented.

4.3.3 Facilitate the most efficient use of bed capacity, through measures to prevent avoidable complications and delayed discharges, and by the development of payment for outcomes.

4.3.4 Develop consistent service specifications, outcome measures and quality indicators for use in procurement at all specialised centres treating patients with Spinal Cord Injury.

4.3.5 Agree the criteria for Designation as a Specialised SCI Centre, and as a Specialised Spinal Surgery Centre (for surgery on people with spinal cord injury).

4.3.6 Develop a work programme to ensure implementation and delivery of the agreed strategy.

4.3.7 Oversee the establishment of a national commissioning patient database for the service, with the aims of improving commissioning, procurement, service improvement and research, based on the pilot of the South of England model.

4.3.8 Influence the development of new commissioning currencies through the DoH PbR Development Site, and approve the programme for shadow monitoring of contracts in the new currencies. It is hope that the new tariff should be published in December 2010 and will be in operation by 2011–12.

5. CONCLUSION

5.1 The South of England Spinal Injuries Commissioning Board demonstrates the value of a collaborative to improve access to specialist spinal injury care, establish and validate quality standards and facilitate the discharge of patients to local settings.

September 2009
APPENDIX 1

SPINAL CORD INJURIES CENTRES ACROSS THE UK

Belfast
Spinal Cord Injuries Centre
Musgrave Park Hospital

Dublin
National Medical Rehabilitation Hospital
Rochestown Avenue

Glasgow
Queen Elizabeth National Spinal Injuries Centre
Southern General Hospital

Middlesbrough
The North of England Spinal Injuries Centre
The James Cook University Hospital

Oswestry
The Midlands Centre for Spinal Injuries
The Robert Jones & Agnes Hunt Orthopaedic Hospital

Rookwood
Welsh Spinal Injuries and Neurological Rehabilitation Centre
Rockwood Hospital

Salisbury
The Duke of Cornwall Spinal Treatment Centre
Salisbury Foundation Trust Hospital

Sheffield
The Princess Royal Spinal Injuries Centre
Northern General Hospital

Southport
The Regional Spinal Injuries Centre
Southport and Formby General Hospital

Stanmore
The London Spinal Injuries Centre
Royal National Orthopaedic Hospital
Stanmore

Stoke Mandeville (Buckinghamshire Hospitals NHS Trust)
National Spinal Injuries Centre
Stoke Mandeville Hospital

Wakefield—Pinderfields
Yorkshire Regional Spinal Injuries Centre
Pinderfields General Hospital
APPENDIX 2

South of England Spinal Cord Injuries Board Structure

Input

PROVIDERS (SCICS)

Buckinghamshire Hospitals (Stoke Mandeville)

Royal National Orthopaedic (Stanmore)

Salisbury Foundation Trust

COMMISSIONERS

Planning:
South East Coast SCG
London SCG
East of England SCG
South West SCG
South Central SCG
West Midlands SCG

Procurement Consortium:
South East Coast SCG
London SCG
South Central SCG
South West & East of England SCG (to review entry in 2010/11)

Others as co-opted

PATIENT GROUPS

Spinal Injuries Association

OTHERS AS CO-OPTED

Output

COMPLETED WORK

South of England Standards for Spinal Cord Injury Care 2003

Re-audit of standards 2006

Information standards

Outreach Project Manager Appointment

ON-GOING WORK

Development of Commissioning arrangements

Development of National Documentation for Designation of SCI Centres

Designation

Development of links to DGHs, Education for Staff and Outreach to patients unfit or unable to access SCIC bed

Strategy

National Group developing packages of care and commissioning currencies

Revision of Standards

Continuous work programme

Rationalisation and expansion of consortia

CQUIN Scheme in Progress

SUB GROUPS

Services and Standards Sub Group

Commissioning Currencies Sub Group

Discharge Planning Sub Group

FUTURE

Development of Annual Report

Service specification

Development of common referral proforma and protocol for prioritisation for admission
Memorandum by Smokefree South West (COM 51)

COLLABORATIVE COMMISSIONING FOR HEALTH IMPROVEMENT

1. PURPOSE

The purpose of the paper is to provide the Health Select Committee with information about how local commissioning is bringing about positive change for population health gain. The emphasis of the submission is upon change that would not have occurred without commissioner involvement.

2. BACKGROUND

2.1 The 14 Primary care Trusts in the South West region commission services and health improvement for a diverse population of just over £5.2 million residents. It has a mixed profile of health need and a significant life expectancy gap between the best and worst off within the region. The strategic ambitions of the region are centred around our aspiration to reduce this gap in life expectancy through improving outcomes for the least advantaged populations across the region and within individual localities.

2.2 There is clear evidence that investing in more effective programmes to tackle smoking related disease and conditions can have a major impact on improving the health of the population. The impact is large. Over 80,000 people still die prematurely each year from tobacco related causes in England as a whole. Estimates from ASH suggest that smoking costs the NHS £2.7 billion a year and there are substantial potential gains for the health community in supporting staff to stop smoking which will contribute to efficiency savings in working days lost.

2.3 A business case setting out the compelling rationale for collective commissioning of a more ambitious tobacco control programme to significantly accelerate and amplify effective action to reduce smoking prevalence was considered by the regions’ PCT Chief Executives on 1 May 2008 resulting in common agreement to fund Smokefree South West, as a regional body to lead on driving down smoking prevalence.

3. IS THE PURCHASER/PROVIDER SPLIT NEEDED?

3.1 In the experience of South West Primary Care Trusts, the purchaser/provider split has been a necessary part of the service reform required to ensure the NHS responds to the needs of the population as a whole and is not configured around the needs of health services and the professionals who work within them. In terms of significant public health programmes where there is a clear need to engage smokers, especially those who are currently asymptomatic, in making a decision to quit, there is a particular need to ensure there are appropriate mechanisms in place both at local and regional level to maximise implementation of all effective interventions. Commissioners are uniquely placed to fulfil a number of critical roles that provider organisations have not embraced and are unlikely to do so.

3.2 Primary amongst these is the oversight of the whole system to ensure that patients who are smokers are identified and referred to the most appropriate setting and can flow through a system in a fashion appropriate to their needs and not the needs of individual providers. Increased awareness of local NHS Stop Smoking Services and how to access them is also a key factor in ensuring effective uptake of the services on offer.

Case Study 1—Region-wide campaigning to recruit smokers to use the SW NHS Stop Smoking Services

The NHS Stop Smoking Service is the most effective way to stop smoking however research identified that whilst almost half of all smokers are likely to make a quit attempt in a 12 month period, only a small minority, about 6% of smokers in the South West, chose to use the support of an NHS Stop Smoking Service in their quit attempt.

A clear objective was identified—to increase the number of smokers using the NHS Stop Smoking Service. A pan region, multi intervention campaign themed “Around the Corner” was developed and delivered in the period September 2008 to March 2009. The campaign addressed two identified barriers to use of the NHS Stop Smoking Service:

1. Saliency of the service
2. Invisibility of the service

“Around the Corner” referred to 1,000 service access points across the South West

Through collective commissioning of pan-regional promotional campaigns and recruitment activities the health community is able to lever in significant economies of scale through region wide procurement. Savings of up to 49% are to be gained by commissioning regional advertising through the Central Office of Information (COI). Such savings are achievable because the focus of ownership of local media (98 local newspapers in the South West are owned by just four publishers, 16 commercial radio stations in the South West are owned by just two groups) so buying across the portfolio offers better opportunity for negotiation.
Case Study 2—Primary Care Trust NHS Stop Smoking Services

Smokefree South West provides active support to Primary Care Trust NHS Stop Smoking Services to achieve and exceed all key service targets, such as those agreed under the Operational Plan and Local Area Agreements. This is done through approaches such as enhanced social marketing, organising training and development to fast track adoption of evidence-based interventions, and facilitating best practice sharing. All the NHS Stop Smoking Services in the South West region achieved target in the financial year 2008–09.

There is now significant emphasis on improving the patient experience of health services users and providing individuals with choice over how and where their care is delivered. This is perhaps one of the most recent and powerful examples of commissioner influence. This is particularly important where “patients” are not ill and there is a need to offer support to stop in a variety of forms which appeal to their different motivations for stopping and thereby reduces the barriers to making the “healthy” choice.

Smokefree South West works with the PCTs to strengthen and extend NHS Stop Smoking Services to better meet the needs of all smokers in the region. Support is provided to encourage Services to broaden their provision such as by the establishment of out of hours services and drop in groups. This will increase accessibility for treating priority groups, including routine and manual workers. Smokefree South West has undertaken work to increase regional awareness and take up of the full range of effective cessation interventions and of national stop smoking telephone support, through regional media campaigns such as “One Way Street”. Successful work was undertaken through the Around the Corner campaign to publicise the breadth of locations where smokers in the South West can access NHS services raising awareness that services are now available in over 1000 locations’ across the region.

Case Study 3—Whole Systems Approaches

Smokefree South West has been instrumental in rolling out regional programmes to increase referral to the regions NHS Stop Smoking Services by working with all health service providers and professional groups to ensure that all patients seen in the health care system are screened for tobacco use, have their smoking status regularly recorded and, as a first step, receive brief interventions to help them quit. Training and support is provided on an ongoing basis to implement the Stop Smoking Interventions in Primary Care (SSIPC) whole systems approach to improving engagement across primary care settings.

Enhanced engagement from the acute hospital sector is being facilitated by Smokefree South West through the Stop Smoking Interventions in Secondary Care (SSISC) approach. With support from Smokefree South West, four of the region’s acute trusts were engaged in the first tranche of the SSISC which launched in June 2009. A further nine trusts are engaging with the second tranche which rolls out in late September. The approach aims to engage with smokers at every point of their journey though both planned and unplanned admissions. For planned admissions, referrals are made to the local NHS Stop Smoking Service for pre-elective surgery cessation support whilst for unplanned admissions, support is provided during their stay. In line with current evidence, a strong link is being developed between that provided during hospitalisation and community or primary care based support on discharge.

3.3 A key element of any tobacco control programme is helping to prevent young people from starting to smoke. This is also an essential component of any programme aiming to reduce overall smoking prevalence.

Case Study 4—Commissioning for Health and reducing uptake of smoking by children.

Through Smokefree South West work is underway to build on the innovative work commissioned jointly through the Healthy Schools Programme and both NHS Bristol and Bristol City Council. This locality introduced a pioneering anti-smoking initiative (ASSIST) into all secondary schools. ASSIST is led by 12 and 13 year old students who are trained as “peer supporters” to promote anti-smoking messages in their everyday conversations with classmates. ASSIST has been developed by the Universities of Bristol and Cardiff and its early positive evaluation is being tested through a £1.5 million grant from the Medical Research Council. Through Smokefree South West there is now agreement with both universities to create regional capacity to enable all other South West PCTs and Local Authorities to draw down the ASSIST programme to suit local priorities. Seven areas have already expressed interest in taking this forward and work is underway to recruit a Coordinator to deliver Train the Trainer courses from the summer term of 2010.

3.4 Reducing access to illicit tobacco is a key component of any tobacco control policy.

Case Study 5—Partnership working with key stakeholders around Illicit Tobacco

Price is one of the most effective tobacco controls, with every 10% rise in price reducing smoking prevalence by 4%. Cheap and illicit tobacco undermines price (tax) and other tobacco control measures such as age of sale regulations. The criminal activities of smuggling, and increasingly, counterfeiting, lead to the availability of tobacco at less than half the tax-paid price in many
deprived areas. This maintains smokers in their habit, undermines quitting and encourages young people to start smoking. Since 2000, HM Revenue and Customs, the lead enforcement agency, has been successful in reducing levels of tobacco crime, working overseas, at the borders and inland.

There is much potential for tackling illicit trade through collaborative working between HMRC and other agencies at a regional and local level including local authorities, the police, the NHS, local tobacco alliances, local businesses and community leaders. This work needs to dovetail with the activity at international and national levels. This sort of collaboration can be ineffective at a local level, which is a clear example of the need to engage in this work regionally at first.

Smokefree South West is working closely with HMRC Inland Detection lead officers and Trading Standards colleagues, including the regional co-ordinating organisation, SWERCOTS, police, Department of Health and NHS to support more effective partnership work and the creation of an action plan to tackle cheap and illicit tobacco all can sign up to deliver against. The aim of this action plan is to improve the health of the population through reducing smoking prevalence. Action will be directed towards reducing the availability (supply) of cheap and illicit tobacco, thus keeping prices high and reducing demand for it, using appropriate and effective tools.

4. **Conclusions**

4.1 In collectively commissioning Smokefree South West, the 14 PCTs of the South West region have taken the tobacco control programme for the region to a more ambitious level commensurate with the regional aspiration to reduce the gap in life expectancy through improving outcomes for the least advantaged populations across the region and within individual localities. This collective commissioning is fundamental to the region’s ability to accelerate and amplify effective action to reduce smoking prevalence.

*September 2009*

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**Memorandum by the Terrence Higgins Trust (COM 52)**

**Executive Summary**

Terrence Higgins Trust (THT) is a voluntary sector provider which delivers a range of sexual health and HIV services across England. In THT’s experience, there is significant variation between PCTs in terms of their approach to commissioning. The continuing power imbalance between commissioning and providing organisations makes it difficult for PCTs to innovate and modernise services, and decommissioning is often more of a challenge than commissioning. Commissioners need a defined career pathway and accredited training to attract the best people to the profession and support is needed to ensure the best use is made of tools such as needs assessment. Good commissioning can change the way in which services are delivered, open up the possibilities for innovation and partnership working and make the best use of limited resources. Poor commissioning will make it impossible to improve services and health outcomes.

1. **Introduction**

1.1 Terrence Higgins Trust (THT) is the UK’s largest HIV and sexual health charity, with 36 service centres across England, Wales and Scotland.

1.2 In addition to campaigning on behalf of people living with or affected by HIV or poor sexual health, THT contracts with a number of PCTs across England to provide sexual health and HIV services. These range from clinical services offering STI and HIV testing, to health promotion and health support services. THT is the largest non-NHS provider of the National Chlamydia Screening Programme in England.

1.3 For the last seven years, THT has undertaken a joint survey of sexual health and HIV commissioners and specialist clinicians to determine how national policy is implementing on local work. The most recent *Disturbing Symptoms* report was published in May 2009. A total of 41 commissioners responded to this year’s survey, which gave a snapshot of various issues across the UK.

1.4 THT’s submission to the Committee is drawn from our experience of working with a range of PCT commissioners to deliver HIV and sexual health services and the responses we received from commissioners to this year’s *Disturbing Symptoms* survey.

2. **The Role and Status of Commissioners**

2.1 In developing its World Class Commissioning framework the Department of Health have acknowledged that commissioners require more support if they are to improve local services and also improve health outcomes for local populations.

2.2 Strong commissioning is vital in sexual health and HIV. In recent years, the desire for more patient choice, accessibility and the resulting need to offer services in a range of settings have made the redesign and modernisation of services increasingly important.
2.3 THT’s experience is that commissioners face a number of challenges in working to modernise and improve sexual health and HIV services. There is a wide spectrum of skills and ability amongst commissioners and there is little training that is specific to the role.

2.4 In some areas, sexual health and HIV is only one element of a commissioner’s workload, which means they may not have the opportunity to develop specific skills around commissioning for these areas. In Disturbing Symptoms 7 (BASHH/BHIVA/THT, May 2009) almost a fifth of PCTs and Health Boards responding to the survey indicated that they did not have a lead commissioner specifically for HIV and sexual health. Commissioners juggling a large portfolio of responsibilities are unlikely to have the capacity to spend a lot of time on specific issues, which may impact on local work in complex areas of public health.

2.5 While length of service is no guarantee of ability, in a rapidly changing environment, experienced commissioners will be vital to PCTs hoping to improve and redesign services. In the last two years of the Disturbing Symptoms survey, between 24% and 30% of responding PCTs indicated that the lead commissioner for sexual health and HIV had been in post for less than one year. Good commissioners can make a huge impact on the health service, but they need time, support and stability in order to develop their skills and implement change.

2.6 More broadly, the relative status of commissioners in comparison to providers is an ongoing issue in sexual health and HIV and across other areas of the health service.

2.7 For example, in one area where THT works, commissioning for sexual health services is undertaken by one commissioner on behalf of a small group of PCTs. The commissioner is based in PCT A and the main provider for all local sexual health services is PCT B. The commissioner is subject to strategic influence from all the local PCTs and is not as senior as the manager of the very large sexual health service provided by PCT B. The power imbalance between the commissioner and the provider PCT has led to a virtual monopoly in sexual health service provision, making it very difficult to reconfigure funding in order to develop new and innovative approaches and plurality of choice. There is no indication that the implementation of World Class Commissioning will affect the status quo in this PCT grouping. Although the current provider does deliver some excellent services, where a single provider is not subject to the challenge of competition and where commissioning is not strong, it will be more difficult to reduce inefficiencies and develop better services.

2.8 Commissioners will only be able to impact on service development if their role has the status and seniority to carry through changes. THT would recommend development of better career pathways for sexual health and HIV commissioners, including accredited training.

3. Planning and Needs Assessment

3.1 Effective commissioning requires an in-depth understanding of the needs of a local population. Managing knowledge and assessing needs are core components of World Class Commissioning.

3.2 Responses to the Disturbing Symptoms surveys in recent years have indicated that regular sexual health and HIV needs assessment may not be taking place consistently across England. In 2009’s survey, 44% of respondents said their PCT had undertaken such an assessment within the past year, with a further 32% saying this had last taken place between one and three years ago. Almost a quarter of this year’s responding commissioners either could not say when a needs assessment had last taken place, or indicated that it had taken place over four years ago.

3.3 Without regular needs assessments, commissioners will be unable to plan local work effectively, so it is essential that this element of World Class Commissioning is implemented as a priority.

4. Managing the Process

4.1 World Class Commissioning rightly places an emphasis on outcomes. For HIV and sexual health this is particularly important as these are areas in which prevention, health promotion and long term behaviour change are as important as treatment and care.

4.2 However, in THT’s experience, commissioners do not always focus on outcomes and can sometimes become very involved in process and administrative details. This is perhaps easier for contracts with the third sector, where costs and methods of service delivery are very transparent. On occasion, this contributes to disproportionate scrutiny of and micro-management of voluntary sector contracts, with an undue focus on process.

4.3 In addition, managing a market with multiple providers can also present difficulties after a contract has been awarded. For example, some initial contracts for coordinating Chlamydia screening programmes included a requirement that the co-ordinating provider (THT) would be responsible for ensuring all other local providers such as GP surgeries, sexual health services and pharmacies delivered enough Chlamydia screens to meet a local target. However, in most circumstances, THT had no authority to ensure this happened. In addressing this issue, commissioners eventually decided to implement Service Level Agreements and Locally Enhanced Service contracts with other local providers and worked in partnership with THT to bring other providers on board through incentivisation.
4.4 In another area, a PCT commissioned the clinical and outreach elements of an STI testing contract separately but unfortunately did not bring the two elements together in the most effective way. The successful achievement of outcomes for both parts of the contract were interdependent, but the two providers have developed the services based on goodwill and local relationships, rather than formal management by the commissioner.

4.5 These examples illustrate some of the challenges for both commissioners and providers in managing the new commissioning landscape and implementing the contract management process in the most effective way.

5. **JOINT COMMISSIONING**

5.1 Given the cost and population sizes involved in HIV services, collaborative commissioning is more likely to be resource-effective for PCTs. In sexual health and HIV, patients may often seek treatment and care across nominal PCT boundaries. Similarly, prevention and sexual health promotion work can be more effective when coordinated across an area bigger than one PCT.

5.2 Almost a third of commissioner respondents to this year’s *Disturbing Symptoms* survey said they had not been involved in joint commissioning activity. This may be due to administrative or bureaucratic barriers.

5.3 In one area that THT works in, a number of PCTs are working to reduce undiagnosed HIV through use of fixed and mobile clinics and assertive outreach. The commissioners have a constructive relationship with local providers and through this relationship, have developed a good understanding of the local population. The commissioners recognise the range of skills of the various providers and have contracted with different providers to deliver different elements of the work. However, despite having an excellent understanding of the needs of the local population and working well with multiple providers, the PCTs did not manage the local commissioning framework in the most effective way. This was mainly due to administrative and bureaucratic barriers and a very narrow focus on their own population. Although a joint-commissioning model across a number of local PCTs would have enabled more cost-effective management and delivery of the service, the PCTs chose not to implement this and instead contracted as separate organisations with the local providers. The very intense focus on achieving the necessary outcomes and outputs for their own residents prevented them from commissioning collaboratively.

5.4 Whilst it is important that PCTs focus on local residents, this should not prevent them from commissioning together across a region to provide a more efficient and effective service.

6. **STRATEGIC COMMISSIONING**

6.1 THT’s most positive experience of commissioning has been where PCTs work collaboratively with the provider to find solutions, think strategically about long-term aims and get the most out of a service.

6.2 In one area where THT delivers Chlamydia screening, the commissioner has a particularly good understanding of the needs of the local population and has commissioned accordingly. Performance against the contract is managed in a constructive, rather than a punitive way and where there are problems, the commissioner works with THT to improve the service. The focus is on achieving the desired outcomes, rather than commissioner involvement in the day-to-day running of the service. With the final objective of mainstreaming Chlamydia screening within the PCT and embedding it as part of all work with young people, the commissioner worked with THT as the main provider to develop a capacity-building worker role. The role’s main function would be to work with GP surgeries, pharmacies and Further Education colleges to train staff around opportunistic offers of screening. This will undoubtedly be beneficial to the PCT in the longer term, as Chlamydia screening will become a part of mainstream services, enabling more efficient and effective delivery and wider coverage.

6.3 This example illustrates an innovative use of an outcome target as a local lever and real consideration of how to make delivery against a target sustainable.

7. **CONCLUSION**

7.1 The environment in which PCTs operate is still relatively new and it is not surprising to find various challenges and difficulties in commissioning. Good practice definitely exists and hopefully the World Class Commissioning framework will help to support this more widely. However, issues relating to skills, status, capacity and the relative status of commissioners urgently need to be addressed if the implementation of World Class Commissioning is to be successful.

*September 2009*
Memorandum by Bliss (COM 53)

1. Bliss is the UK charity that cares for premature and sick babies. For thirty years Bliss has been dedicated to ensuring that these babies survive and go on to have the best possible quality of life. We provide practical and emotional support to families during an extremely difficult time, so they can give the best care to their babies. Our specialist study days and training supports doctors and nurses to develop their skills and we fund research to improve the care of all sick and premature babies. We also raise awareness of the issues affecting special care babies and fight for essential change within government and the NHS.

2. Bliss welcomes this inquiry into commissioning. This submission will focus on the impact commissioning has upon neonatal care services that care for sick and premature babies.

3. Neonatal care is provided in three levels of care (Special Care, High Dependency and Intensive Care) that are coordinated by managed clinical networks. Until now, these levels of care have not been commissioned by the same bodies. Intensive Care and High Dependency Care are generally commissioned by Specialist Commissioning Groups whereas Special Care is generally commissioned by Primary Care Trusts. A baby’s condition may alter frequently meaning that the level of care they require also alters. A baby can receive these differing levels of care in the same place while being cared for by the same team of health professionals. However, their care during this time is actually being commissioned by different bodies. Maternity services, of which neonatal care is an integral part, are also commissioned separately.

4. These separate commissioning arrangements complicate what is already a highly specialised area of care. The National Audit Office report, Caring for vulnerable babies, details the commissioning arrangements for neonatal care and some of the variations that exist from one hospital to another.167

5. Bliss believes that neonatal care must be commissioned in a coordinated manner across managed clinical networks with close links to maternity services.

6. Payment by Results (PbR) has not yet been introduced for neonatal care. This is due to the complicated nature of the service and the need to define specific tariffs for each aspect of neonatal care. One significant problem with developing these tariffs is that current services are under-resourced and underfunded. The shortages facing neonatal services are also detailed in the National Audit Office report. If the tariffs are based on current levels of service provision, this will only serve to reinforce the current problems.

7. Commissioning the entirety of the service on a network basis would result in a smoother patient pathway, and would ease confusion with the introduction of Payment by Results.

8. Bliss would like to draw attention to the work of the NHS Neonatal Taskforce.168 The Taskforce comprised of a group of senior experts in the fields of neonatology, nursing and commissioning as well as representatives from Bliss and the Department of Health. The Taskforce process was initiated as a result of the National Audit Office report on neonatal care. This report was critical of various aspects of neonatal services, including the way in which they are commissioned. As such, the Taskforce has produced a comprehensive commissioning framework for neonatal care. This document is currently being finalised and will be released in the autumn of 2009 along with the rest of the Taskforce recommendations. Bliss would commend the inquiry to look at this piece of work as an example of overcoming the challenges of commissioning an extremely complex area of care.

September 2009

Memorandum by NHS North Somerset (COM 54)

North Somerset PCT was established in April 2002 and covers an area over 145 square miles. It serves a very diverse population of 205,000, ranging from communities in the wealthy suburbs of Bristol to rural villages and the communities of the popular seaside towns. The PCT shares its boundaries with North Somerset Council and works with a diversity of health care providers. The PCT has three key functions:

— To engage with its local population to improve health and wellbeing and reduce inequalities.
— To commission a comprehensive and equitable range of high quality responsive and efficient services with allocated resources.
— To directly provide high quality responsive and efficient services where this gives best value.

NHS North Somerset’s mission is “working together for your health and well being”. The core vision is about “making it right for you”. The core strategic objectives are:

— To improve quality and meet all necessary targets.
— Meet our challenges through innovative service design to meet identified need.
— Reduce health inequalities and promote health and well being.

— Be a world class commissioner and ensure a ‘fit for purpose’ provider service.
— Be a good partner to work with—building public, stakeholder and staff confidence.

NHS North Somerset has also identified four primary goals, which are as follows:
— Reduce health inequalities in all areas of our work, by targeting effort in the areas and population with greatest deprivation.
— Address the interrelated issues of care for older people, long term conditions, cardiovascular disease, cancer, self care and increasing independent living at home.
— Work across boundaries to improve joint working between primary and secondary care, with other agencies, and with carers, in order to find new radical solutions to systematic problems.
— Get it right first time—deliver safe, effective care, by ensuring that systems and processes are efficient and reflect best practice.

We welcome the opportunity to participate in the Select Committee inquiry into commissioning and set out below a selection of recent local health and health service improvements. We believe this provides you with some tangible examples of how commissioning processes are improving services for the local population.

Rehabilitation Service

The new service started in June 2009 as a replacement for the rehabilitation service provided at Bristol General Hospital. It includes an enhanced rehabilitation service at Clevedon Hospital and at home including nine rehabilitation beds alongside the GP admission beds that still remain. The new service has been very successful to date providing rehabilitation closer to home, continuity of care between the hospital environment and home follow up, an integrated service from a multi-disciplinary team, an increased number of clinical staff both in the hospital and the community including very effective new generic support workers. The project has also led to the redevelopment of the hospital with a new patient therapy room, new equipment for the gym and improved facilities such as shower rooms. It is expected that the improved service will also be 2% more efficient.

End of Life Care Programme

This is overseen by the North Somerset Strategy Group and takes in the work produced by the Marie Curie “Delivering Choice” programme and the Bristol, North Somerset and South Gloucestershire End of Life Service Design Group. Having assessed what is needed to develop proposals, new approaches are now being piloted. This includes for example education, liaison and mentoring for care homes using SHA training money. Detailed work is also underway on a 24 hour care pathway (including workforce requirements) to care for people dying in their own home. The advance care planning documentation has been disseminated to all organisations for adoption and is available on the website.

Screening for Atrial Fibrillation

This project saw NHS North Somerset working with Woodspring GP Practices to provide opportunistic screening for atrial fibrillation. The project found the screening led to a greater chance of the patient being optimally treated and the avoidance of a number of strokes that would otherwise have happened. We have agreed to promote opportunistic screening through practice based commissioning in all our practices. This will include further education for GPs, improved dialogue with secondary care cardiologists, practice information system prompts and a promotion of atrial fibrillation management guidelines and information to patients. The promotional work will be linked with other initiatives such as anticoagulation testing and vascular checks.

Intravenous Antibiotic Therapy in the Community

The new service will mean all GP prescribed IV antibiotic therapies can be provided within the community as a safe alternative to hospital admission or to help timely discharge from hospital. Patients will be provided with all the education and information they need as will nurses in the community. This will reduce the need for patients to go to hospital and ensure patients can be discharged more quickly. This makes our services up to date and in line with many other PCT areas in the country.

Urology Assessment and Diagnostic Service

This new service is being piloted in a particular area of the PCT. This follows useful work with the providers (GP care and Bristol Urology Associates) to ensure that clinical governance arrangements are in place to secure the quality and safety of the service.
Primary Care Enhanced Services

We have agreed to commission 33 enhanced services mostly from GP practices (one from pharmacists) to increase the range of services available to patients. Recent successes have included extended hours, choose and book, vulnerable older people (Woodspring) and nursing homes (Weston). An enhanced service also incentivised the development of practice based commissioning. Enhanced services for nursing homes, vulnerable older people and the community anticoagulation service will be maintained and developed in the coming year. A new cardiovascular risk screening service will target people in South and Central wards in Weston to reduce health and inequalities.

Crossroads Care North Somerset

A key part of our joint carers’ strategy is to support Crossroads and its services for carers. It is vital to support carers who do so much (often more than formal carers) to help keep their loved ones at home. Crossroads (yes, it is named after the soap opera) provides a range of services to give carers breaks, support, information and relaxation, a service for young carers and arranges bespoke services that will make a difference to the carers ability to support the person in need. These range from counselling, ironing, reflexology through to sitting services and piano lessons!

Lymphoedema Service

The service for North Somerset, Bristol and South Gloucestershire is hosted by North Somerset PCT’s Provider Service. Now with a permanent team leader in post, the service re-launched during national lymphoedema week in April and in the past year has exceeded its target caseload. A new patient information leaflet, patient assessment and treatment record, service guideline for professionals, referral form and service framework are in production and due to be published soon. The three local PCTs invest £230,000 in the service and this has been supplemented over the past three years by a Macmillan grant for training and equipment.

Now it is fully established, the team is able to provide expert treatment for patients requiring manual lymphatic drainage (MLD) who previously had to be sent to private treatment. A patient survey shows that patients’ understanding of their condition improves with half feeling their quality of life has improved. A quarter felt they had visited their GP less since being managed by the service. Almost all respondents said they had been treated with dignity and respect. Patients would like more local clinics and one clinic has recently moved into the Marina Healthcare Centre. However due to the specialist nature of the work, it is unlikely that we could spread the number of clinics more widely at this stage.

Self Care Programme

This puts people in charge and helps them deal with the impact for a long term condition on them and their family. With proper support for self care, research shows that visits to GPs can reduce by up to 69%, outpatient visits by 76%, A&E attendance by 54% and hospital admissions and days in hospital may be halved. The use of medicine is improved and days off work can be reduced by up to 50%. This is a major area of work for us with an immediate ambition to ensure that all people with long term conditions have an action plan supporting their self management by 31 March 2010. We have adopted a model that ensures patients have the right information when they want it, support for making positive changes to lifestyle (eg suitable exercise), helps patients learn from each other how to manage their condition (expert patient programme) and how to get the right support from local groups and help professionals such as community matrons together with the right equipment.

Primary Care Services

Two new GP Health Centres have been commissioned and opened in North Somerset in the past year, as part of addressing the under-doctoring in the county. Both the Marina Healthcare Centre and the new Weston GP Healthcare Centre (based in Weston Hospital) opened in the spring and the walk in service linked to the latter will open in the centre of Weston late this year. A new GP practice in Worle is due to open by Christmas.

New Pathways for Stroke, Acute MI and TIA

The pathways mean that primary angioplasty will be provided 24 hours a day, 7 days a week at the Bristol Heart Institute at the Bristol Royal Infirmary. Patients with the appropriate condition will be identified early so that they can be brought directly to the institute. A comprehensive stroke centre for our area will operate from North Bristol Trust 24 hours a day, 7 days a week providing stroke thrombolysis and a daily TIA assessment clinic. University Hospitals Bristol Trust will provide a primary stroke centre with stroke thrombolysis 9.00 am to 5.00 pm and TIA clinics during weekdays. Weston General Hospital will not initially provide thrombolysis and TIA clinics will be provided three days a week. We are looking at the possibility of stroke thrombolysis being provided at Weston. All three hospitals will have a dedicated stroke unit and team.
Hopefully, these examples will help the Select Committee in completing the inquiry and help to demonstrate the real changes that local commissioning arrangements are making to health and wellbeing services. Should you require further information, please do not hesitate to contact us.

Otherwise, thank you for giving NHS Somerset the opportunity to make a submission and we look forward to the Select Committee report conclusions in due course.

September 2009

Memorandum by NHS South of Tyne and Wear (COM 55)

EXECUTIVE SUMMARY

NHS South of Tyne and Wear covers the three PCTs within Sunderland, South Tyneside and Gateshead. The integrated management team which commissions on behalf of the three PCTs are supportive of the NHS Confederation response to the Terms of Reference for the Health Select Committee inquiry. In particular we support the need for a separate commissioning function within a tax funded public healthcare system to ensure the system is designed around the needs of communities rather than providers and to balance the clinical needs of patients with the finite resources available.

The Confederation also recognises the development of the commissioning function and that there is much yet to be done, however it is keen to provide tangible examples of such development and the impact on local health improvement. Three examples are provided from NHS South of Tyne and Wear overleaf:

— Commissioning Alcohol Services.
— Commissioning Vascular services.
— Commissioning acute health services for children.

These examples demonstrate our commissioning response to local health need, following prioritisation with local stakeholders including local people. Our focus is on reforming strategic pathways on an industrial scale and at a pace which is possible for a commissioning organisation which commissions for a population of 750,000 with a budget of £1.2 billion. This approach relies upon using market principles, increasing choice to drive up quality and enables us to address the longer term as well as take shorter term tactical action.

COMMISSIONING SERVICES FOR PEOPLE WITH ALCOHOL PROBLEMS

The three PCTs in NHS South of Tyne and Wear all have rates of alcohol related admissions to hospital in the worst national quartile, with Gateshead in the worst decile and Sunderland and South Tyneside in the worst quartile. We therefore have agreed that one of our key health outcomes should be to reduce such admissions. Improving outcomes for people who misuse alcohol is therefore one of our 12 strategic objectives in our Strategic Plan. The target is also part of the Local Area Agreements. The impact on actual hospital admissions will take time to be realised, however, a lot of effort has this last year, gone into developing capacity, capability and managing the system to support delivery of the targets over the next few years. For example:

— The PCT has taken the lead on the commissioning of alcohol treatment services working in partnership with all the responsible authorities to develop alcohol strategies.
— Stakeholder events were organised to consult and work with partners prior to developing the commissioning plans.
— An annual alcohol needs assessment is undertaken linking into the joint strategic needs assessment.
— Based on the needs assessment and consultation with stakeholders, the available resource/investment has been prioritised.
— New alcohol investment has provided commissioners with new opportunities to further enhance the existing provider/commissioner relationships resulting in innovative practice from providers eg a hospital based project inclusive of brief intervention staff and specialist nurses was established. A new Alcohol Education Service working at local events and supporting employers was also established. A service user led service for advocacy and mentoring was commissioned.
— Service User involvement has been ongoing and prior to developing commissioning plans eg Research was commissioned into hard to reach and vulnerable groups’ including older people and carers. A media campaign has been based on the views of service users.
— A Local Enhanced Service has been developed with input from local GPs. Clinicians sit on the Alcohol Commissioning Group and a GP led social enterprise has been commissioned to deliver brief intervention training to GPs.
— An independent consultant was commissioned to do analysis which has helped us understand the market, analysing gaps within service provision. As a result, pump priming was made available for business development grants and a separate grant system to encourage community groups to address alcohol local issues.
— Outcome based commissioning training has been provided to commissioning staff and rolled out to all providers.
— Formal contract reviews take place with providers and regular informal dialogue.
— Investment has been made in Performance Accelerator, a database which will enable both providers and commissioners to update and access reports on progress.
— The Commissioning board has received progress reports to support their assurance role.
— An independent consultant was commissioned to evaluate the alcohol commissioning process to gather lessons learned and areas for improvement to support the commissioning of all services.

COMMISSIONING SERVICES FOR PEOPLE WITH VASCULAR DISEASE

The three PCTs within NHS South of Tyne and Wear all have poor life expectancy rates with all three PCTs in the worst decile for both males and females. The need to bridge this gap has been recognised and as a result improving outcomes for people with vascular disease is one of our key 12 strategic priorities. Key related health outcome targets have been agreed for hypertension, smoking in pregnancy, life expectancy and health inequalities. Whilst it will take time to see improvement in these rates, the integrated management team have put a lot of effort into understanding the need, current services, reviewing the pathways and commissioning new services which will be better placed to meet the needs identified over the next few years. For example:

— We have taken a clear role in leading the approach to vascular disease across the three PCTs, based on analytical work to identify how the gap in life expectancy at a local level could be reduced.
— This has been accompanied by significant investment and is co-ordinated by the Bridging the Gap Strategic Commissioning group with input from PBC.
— Vascular disease has formed a key part of the locally developed JSNA and the LAA targets. Investment has been targeted at the NHS Health Checks programme, support services for obesity and tobacco control and stroke rehabilitation.
— A proactive approach to commissioning from the third sector has been undertaken eg brief intervention for stop smoking and grant agreements for the NHS Health Check Programme.
— We have the DoH Test Bed status for the NHS Health Checks social marketing approach, to ensure services and materials are targeted to greatest effect.
— Clinicians take an active role in leadership of the local programme eg the Strategy Group is chaired by a local GP and member of the Clinical Executive. Task groups for Heart Failure and Arrhythmia are chaired by local clinicians.
— A CVD performance dashboard has been developed to share performance with GPs across the patch.
— Predictive modelling is being used in the NHS Health Check Programme to predict further service needs. Geodemographic tools including mosaic are helping to drill down to small population groups and to target CVD services.
— Stakeholder events have been held to stimulate the market and have led to commissioning services from private slimming clubs, community pharmacists, GPs and occupational health departments of Local Authorities. In addition a grants process to stimulate the 3rd sector is underway.
— Collaboration is taking place with Newcastle University in relation to a risk communication tool for NHS Health Checks.
— Week long Rapid Process improvement workshops using the north east transformation methodology have been held for NHS Health checks and improvement (Kaizen) events for lifestyle referral services.
— The Commissioning Board have received progress reports to support their assurance role.

COMMISSIONING SERVICES FOR THE ACUTELY SICK AND INJURED CHILD

Admissions of children who are acutely sick or injured are higher than the national average and the pathway leading to these admissions has been an area of concern for a number of years. As a result this area was prioritised through the strategic planning process and is now one of the key 12 strategic objectives for the three PCTs in NHS South of Tyne and Wear. The WCC assurance process will measure our progress on key health outcomes, which include targets to reduce emergency admissions for ambulatory care sensitive conditions. Whilst it will take time to see an improvement in this outcome, we have been focusing on understanding the current state and defining the future state working with existing providers and families. We are at the point of developing a clear plan to move from the current to the future state over the next two years. Examples of progress include:

— Leading the development of a Children’s’ Acute Clinical reference and steering group, chaired by the Director of Commissioning and Reform. This has become a key forum for engaging relevant stakeholders in reforming the existing pathway.
— Ongoing dialogue with parents and young people using a range of methods eg comment cards, focus groups, engaging with youth parliaments and local secondary schools. For example, young people came up with ideas for promoting health services to other young people including a self adhesive format to be included in every lesson planner.

— Strong clinical engagement with paediatricians, nurses and GPs attending the steering group and the rapid process improvement workshops.

— A range of information has been collected, analysed and reviewed during the reform process including research evidence and expert opinion. This work is linked to the NHS III rapid improvement programme for children’s emergency care and this has been very beneficial in understanding what is happening in other areas, and has included site visits.

— A proposed future pathway which invests in community based services has been agreed eg enhanced role for children’s community nursing services, Walk in Centres and Minor Injury Units.

— Early modelling work has begun to understand the change in activity on the current pathway, using the NHS II Scenario Generator.

— The existing pathway has been proactively reviewed, with a detailed review of two high volume conditions—bronchilitis and acute abdominal pain to test the future pathway.

— The changes are likely to be secured through contract variation rather than procurement.

— Opportunities have been identified to maximise efficiency and effectiveness of spend via the new pathway eg reduction in number of inpatient beds/units.

— Pump priming has been identified to develop community services but overtime savings linked to the reduced use of inpatient beds will support the longer term investment needs.

September 2009

Memorandum by the Royal College of Nursing (COM 56)

1. EXECUTIVE SUMMARY

1.2 The RCN believes that the NHS in England is not yet able to prove that it has world class commissioners of healthcare services, but there is, without doubt huge commitment to achieving progress.

1.3 It remains far easier for Primary Care Trust (PCT) commissioners to continue to contract for the provision of services in the same way as they have always been commissioned.

1.4 The RCN is concerned that the separation should not become a “Berlin Wall” which prevents appropriate sharing of intelligence, a free exchange of views on future developments, and proportionate involvement in performance management of the service in question.

1.5 We need to give commissioning organisations suitable time to bed down and become better placed to commission according to the actual health needs of local people, rather then contract for what has always been done.

1.6 Broadly, Practice Based Commissioning (PBC), Payment by Results (PbR) and the introduction of regulated competition are designed to reduce the negative consequences of monopoly provision of services through structured pricing, transparent or shared decision making and a notion of market testing even where a market does not exist. However, the RCN is concerned to ensure that quasi market solutions are not the only response to the challenges faced by the NHS.

1.7 Without the voice of nursing, the public and patients, commissioning risks slipping into a market orientated contracting process focused predominantly on controlling costs, with little modernisation or achievement of other perhaps more socially orientated policy goals.

1.8 The RCN is pleased to see that lessons have been learnt from the development of PbR and that within Transforming Community Services (TCS) there is some attention being paid to using best practice patient care pathways to build pricing models which will help commissioners purchase evidence based care. However, the desire to make progress must be tempered with a thorough and methodical approach to gathering the evidence required and thoroughly testing assumptions before more powerful financial incentives are unleashed in community care.

1.9 The RCN believes that the nursing workforce holds the key to quality and safety in healthcare and can take a leading role in commissioning and providing services.
2. **Introduction**

2.1 With a membership of 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2.2 The RCN welcomes this opportunity to submit evidence to the Health Select Committee investigation into Commissioning.

2.3 This submission will be formed by the questions set by the Health Select Committee’s terms of reference. These questions will appear as italic text.

3. **“World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?**

3.2 The RCN believes that the NHS in England is not yet able to prove that it has world class commissioners of healthcare services, but there is, without doubt huge commitment to achieving progress. Training is in place and resources are being committed to equipping commissioners to move to the position that could be defined as “world class” however more time needs to be given and proper evaluation carried out to establish the breadth and depth of the transformation.

3.3 The current commissioning process is many steps away from the traditional notion of contracting. The ambition is to commission services which result in the redesign of services—in line with Transforming Community Services—and long term improved health status of the population.

3.4 While use of the term “commissioning health services” is now more common in the language of the NHS than “contracting”, the RCN’s perception is that commissioning which truly stimulates innovative models of care in partnership with the public and professionals continues to be in its early stage of development and it is unclear how targeted or successful the investment to date has been in enabling commissioners to undertake this new and challenging role.

3.5 It remains far easier for Primary Care Trust (PCT) commissioners to continue to contract for the provision of services in the same way as they have always been commissioned.

3.6 Part of the reason for this is that it is actually extremely difficult for commissioners to decommission services, in order to commission new and possibly more innovative models of care. There are two possible causes for this difficulty.

3.7 Firstly, evidence about the clinical effectiveness of the service concerned is often scarce. Evidence based benchmarks for new services are frequently hard to come by.

3.8 Secondly, in the absence of clearly communicated objectives for reform at a local level and a lack of public engagement in tackling the problems, the subject for debate becomes the perceived loss of a service rather than the opportunity to create a new model altogether. Within this issue there is an apparent reticence to engage the public in difficult conversations about what services need to be provided and why.

3.9 One of the critical factors in failing to engage the public seems to be the erosion of public trust about the objectives of change which is not helped by increasing commercial sensitivity in the re-design process.

3.10 Radical redesign and innovation will only be achieved through a much more open and cooperative approach—competition and market forces can only deliver on a limited range of policy objectives.

3.11 The RCN is clear that for the public to benefit from world class commissioning, resources need to be unlocked from traditional patterns of activity. This in turn needs to be invested in a new multi-agency, co-operative focus on the prevention of illness and the reduction of health inequalities. But this will only occur where commissioners are equipped with appropriate resources to develop effective communication and engagement strategies; where there is an open and transparent decision making process; and where there is clear clinical and professional leadership.

4. **The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?**

4.1 In any healthcare system, a model is needed to identify population need, design a response, allocate resources, and evaluate the effect. There are a range of models that work to deliver the above process but there is little international consensus on which model is universally most effective. In the context of a clear policy objective in England to deliver universal health care available to all free at the point of delivery we would suggest that a successful system should:

   - Efficiently allocate limited resources for the best clinical outcomes.
   - Be sufficiently flexible and responsive to meet the rapidly changing needs of populations.
   - Have sufficient coverage to ensure maximum coverage and thus maximise population health and deal with inequality of access.
4.2 The RCN would argue that in some instances it is too early as the model has had very little time to work in reality.

4.3 One rationale frequently cited for the purchaser provider split is that those who are in the business of providing services are likely to have a vested interest in promoting their particular model of service so it would be inappropriate for them to be involved in resource allocation decisions. In that sense it would seem appropriate to separate commissioning and provider functions.

4.4 However, the RCN is concerned that the separation should not become a “Berlin Wall” which prevents appropriate sharing of intelligence, a free exchange of views on future developments, and proportionate involvement in performance management of the service in question. In that sense, the RCN supports models of distinct and separate governance rather than a complete divestment of provision from commissioning organisations.

4.5 An over use of competitive tendering and mixed market provision is likely to lead to a breakdown in the shared vision for integrated health and social care and is likely to make the patient journey more complex.

4.6 In terms of to what extent the purchaser provider split assists or inhibits proper and proportionate performance management, anecdotally the RCN is aware that it remains a challenge for many to manage poor performance in a provider despite the contractual and regulatory tools available.

4.7 For example, we are aware of one PCT having significant difficulties holding a Foundation Trust to account in terms of its concerns about the quality of care and staffing issues. It took six months and a huge amount of effort on their part to see any improvement from what they described as “a very aggressive FT”. Another example we are aware of concerns a PCT wanting to challenge an acute provider over its standards of delivery only to find that the contracts they have in place with the acute provider will not enable them to do that to any meaningful degree.

4.8 At the practice level, independent assessment of the early impact of Practice Based Commissioning (PBC) has highlighted a number of potential problems and obstacles to achieving improved services for local people. The Audit Commission has previously noted that although progress had been made in setting up processes and policies related to the organisation of PBC, many crucial aspects of financial management were still to be developed.

4.9 In terms of avoiding the potential for a conflict of interest within organisations like PBCs who commissioning and provide services, the RCN is aware that there is still a concern for the development of good governance arrangements especially where practices purchase services from themselves; and in terms of ensuring shared ownership of decisions on strategic objectives between practices and the PCT (Healthcare Commission and Audit Commission, 2008).

4.10 The NHS needs to learn lessons from the past. Historically it has failed to invest in the systems and people required to deliver world class purchasing—for example, high quality integrated IT systems for tracking delivery, staff learning and development in service design and contracting, and clinical engagement in service specification.

4.11 An unfortunate consequence of a forced divestment of provider services is that most of the people with clinical expertise and experience of service delivery models have been shifted towards the provider end of the system. This gap has left many commissioning bodies having to bring in expertise from the private sector often at great expense to compensate for the loss of clinical input.

4.12 In that sense there has been little information forthcoming about the hidden costs of commissioning. It remains incredibly difficult to find out exactly how much it has cost in real terms to set up the market and the associated structures that are required and whether that investment represents value for money for the public purse in terms of its success in achieving a range of policy objectives.

4.13 Despite the above concerns, we do need to give commissioning organisations suitable time to bed down and become better placed to commission according to the actual health needs of local people, rather then contract for what has always been done. In addition, the following practical steps could be taken:

— Ensure every commissioning arm has a clear structure which provides for executive nurse leadership at Board level and a clear clinical engagement strategy in order to inform both commissioning and de-commissioning at all levels.

— Retain a focus on developing good quality practice level governance processes and increased transparency for spending decisions at practice level especially where a practice commissions services that it provides.

— Champion innovative public patient engagement strategies and apply contractual incentives for adopting more transparent approaches to decision making and governance in general.

— A thorough evaluation of the effectiveness of this approach should be undertaken which takes into account the costs of setting up the market.
5. Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

5.1 Broadly, PBC, PbR and the introduction of regulated competition are designed to reduce the negative consequences of monopoly provision of services through structured pricing, transparent or shared decision making and a notion of market testing even where a market does not exist.

5.2 However, the RCN is concerned to ensure that quasi market solutions are not the only response to the challenges faced by the NHS. For example, whilst there are some risks in monopoly provision, there are also some benefits (for eg critical mass of skills and resources, potential for lower costs, etc).

5.3 In policy terms, the mixed market economy approach is sold as best suited for driving innovation and quality improvement although the precise impact of this policy in healthcare is far from proven.

5.4 The concern with mixed market provision in health care is that the range of provision is only increased to the degree the market will bear (ie pay for). In the context of NHS England, unless the incentives are right, there may be insufficient market entry to meet diverse need; or such a range of services and options that quality and outcomes are hard to compare leaving the public (and perhaps clinicians) confused about what model is best suited for their needs.

5.5 One potential way forward being explored by some PCTs is to conduct a thorough analysis of the local markets. Specifically by reviewing what services already work; which need improving; and the examining the potential risks of bringing to bear certain competitive pressures such as tendering. The focus then becomes about the available evidence on the gaps rather than a debate on ideological models for delivery.

5.6 One of the other dangers of an over reliance on market mechanisms is that relationships between commissioners and providers may become too market orientated and so miss opportunities for collaboration and sharing objectives. In reality, relationships need to be underpinned by trust, continual open dialogue and an understanding of each others perspectives, which will be different, but of equal value—something which the NHS has not always achieved but needs to pay constant attention to.

5.7 For example, at practice level, GPs and community nurses (including practice nurses) have local knowledge and experience of the people they work closely with gained over many years. The registered list of patients to each general practice means that a number of practices within the same part of the PCT can easily form clusters and agree how local services need to be redesigned in accordance with Transforming Community Services. That local knowledge has grown through a long term relationship with the community served, something which might be hampered by commercial sensitivities and short term contractual cycles.

5.8 The RCN does see a role for market style incentives where perhaps there is a need for innovation in models of care or where quality has become a concern. For example, the increasing prevalence of long term conditions needs to be addressed in a very different way to how the NHS has previously operated.

5.9 In order to encourage NHS clinicians to engage in innovating and competing to deliver alternative models, serious consideration will need to be given to the level of ongoing support and development new models of care will require and what steps need to be taken to equip “NHS” nurses to set up outside of the relative security of the NHS employer model.

5.10 In summary, commissioning and provision is likely to be enhanced through constructive dialogue between local people, providers, and commissioners working at all levels through a range of different approaches.

5.11 Redesigning services for patients with long term conditions, implementing the end of life strategy and moving forward on the public health agenda are challenging activities. Without the voice of nursing, the public and patients, commissioning risks slipping into a market orientated contracting process focused predominantly on controlling costs, with little modernisation or achievement of other perhaps more socially orientated policy goals.

6. Commissioning for the Quality and Safety of Services

6.1 The RCN believes that this has to be the overriding objective for any further reform in commissioning. Whilst accepting the economic reality of public sector finances, the progress that has been made in driving high quality care risks being lost with a draconian or ill informed withdrawal of investment at such an important junction.

6.2 The RCN is pleased to see that lessons have been learnt from the development of PbR and that within Transforming Community Services there is some attention being paid to using best practice patient care pathways to build pricing models which will help commissioners purchase evidence based care. However, the desire to make progress must be tempered with a thorough and methodical approach to gathering the evidence required and thoroughly testing assumptions before more powerful financial incentives are unleashed in community care.

6.3 The RCN believes that the nursing workforce holds the key to quality and safety in healthcare and can take a leading role in commissioning and providing services. The key contributions that nursing can make are:

— years of frontline experience of delivering care to the population in a variety of settings;
— an inherent practice of multidisciplinary communication and coordination; and
— a broader definition of health and care inherent within pre-registration preparation and education of nurses.

6.4 Despite the many benefits, more progress could be made to enhancing the nursing contribution. All clinicians will need to develop a range of skills including an ability to influence at a strategic organisational level to ensure that the reality of clinical practice and patient experience is translated into practice, PCT or SHA level commissioning objectives.

6.5 In addition, more work needs to be done to generate the tools which will help nurses and others translate clinical knowledge, expertise and experience into meaningful information and data which will inform commissioners and help patients understand the service on offer relevant to their individual needs.

6.6 It is important that nurses are more fully engaged in the debate about the future of world class commissioning, and that competence in continuous improvement of the quality of care, based on knowledge and understanding of the patient experience, is seen as essential as good procurement and financial skills.

6.7 Whilst achieving this engagement requires nurses’ own efforts to get to grips with the breadth and depth of the commissioning agenda, it will also require strong political messages which recognise the added value of the nursing contribution at the commissioning table.

September 2009

Memorandum by Northamptonshire PCT (COM 57)

1. EXECUTIVE SUMMARY

1.1 The Health Select Committee Inquiry into Commissioning has the following as its terms of reference:
— “World Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?
— The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?
— Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?
— Specialist Commissioning.
— Commissioning for the quality and safety of services.

1.2 Northamptonshire PCT is responding to this inquiry by contributing two practical examples of our achievements as commissioners, and particularly what the impact has been in terms of outcomes for patients.

1.3 We have supplied two examples of the impact of world class commissioning in Northamptonshire. Both are initiatives that have already been implemented, and therefore the outcomes can be identified. The first example illustrates improved health outcomes for sex workers (SWAN Partnership). The second example outlines improved outcomes for children and adolescents in receipt of mental health services (CAMHS) as the result of a patient care pathway redesign.

1.4 Outcomes from the SWAN partnership include: Established the first managed area nationally, reduced crime by 30% in the last year, helped sex workers into drug treatment (two-thirds now in treatment) and helped them to leave the industry (reduced from 240 to less than 50). SWAN estimates that 90% of sex workers are now accessing a GP.

1.5 Outcomes from the CAMHS patient pathway redesign will include: Improved quality and safety within the service and more robust monitoring of service delivery. It will improve access and service user choice and control. The new specification has detailed service standards, outcome measures and data requirements to ensure effective monitoring. A reduction in costly in-patient provision outside the County should be achieved with the provision of a wider and more patient centred range of services providing care closer to home.

2. ROLE OF COMMISSIONERS

2.1 Excellent health service commissioning is about knowing the needs and wishes of our customers, and planning ahead to meet those needs in a way that provides high quality services, that offer value for money, in plenty of time, at a place of choice, with which customers are satisfied and which achieve agreed outcomes.

2.2 Many Government initiatives are helping us to reach this goal, but the impact of World Class Commissioning should not be underestimated. It is a powerful tool that is facilitating a large scale cultural shift in terms of strategy and operations, commissioning and provision.
2.3 The purchaser/provider split is important for the purposes of transparency, probity, contestability and market management, but whether it “works” or not is down to the way in which relationships between commissioners and providers are managed and the understanding each has of the others position. Northamptonshire adopts a collaborative approach, working in partnership with providers to actively improve outcomes. The examples supplied in this document demonstrate this commitment.

2.4 World Class Commissioning is only in its second year, and many targets have a three to five year lifespan. However clear gains can already be demonstrated. The examples supplied here are two of many that we could have included. Commissioning practice is changing and the competencies have been instrumental in affecting this change.

3. Impact of World Class Commissioning in Northampton—Examples of Local Achievements

3.1 We have supplied two examples of the impact of world class commissioning in Northamptonshire. Both are initiatives that have already been implemented, and therefore the outcomes can be identified. The first example illustrates improved health outcomes for sex workers (SWAN Partnership). The second example outlines improved outcomes for children and adolescents in receipt of mental health services (CAMHS) as the result of a patient care pathway redesign.

3.2 SWAN Partnership

3.2.1 SWAN Partnership is an example of the PCT being a leader nationally and working collaboratively with community partners—it is a PCT led scheme delivered with partners (including drug/alcohol, police, probation, local authorities) addressing health inequalities in sex workers by reaching out to women in the sex industry.

3.2.2 A dedicated team of staff plus volunteers provide a safe, female only premises, outreach and drop in sessions, and individual client work. Each member of the partnership contributes by providing mainstream posts, management support or grant funding as appropriate. Service user input is important to the partnership. SWAN have begun a focussed outreach programme working into off street sex working premises, with monthly visits to 80% of the parlours in the County. SWAN’s help provides sexual health materials, health advice and support as well as links into substance use treatment and housing support.

3.2.3 Achievements: Established the first managed area nationally, reducing crime by 30% in the last year, helping sex workers into drug treatment (two-thirds now in treatment) and helping them to leave the industry (reduced from 240 to less than 50). SWAN estimates that 90% of sex workers are now accessing a GP. Knowing that a woman with minimal service provision and previously limited choices in all areas will achieve the same choices and services as everybody else, and as a result has hope for a positive future is what the team is ultimately proud of.

3.2.4 The scheme has received Health and Home Office Awards, and has informed Home Office planning. The two awards it has received are:

- NHS Institute for Innovation and Improvement, 2008 Health and Social Care awards, category winner in Regional (East Midlands) Awards, and finalist in National Awards, in the Improving Health and Reducing Inequalities Category.

3.3 Child and Adolescent Mental Health Services (CAMHS)—Patient care pathway redesign

3.3.1 Mental Health is a strategic priority for the PCT. Practice Based Commissioning colleagues have identified the proportion of people with depression and/or anxiety disorders who are offered Psychological Therapies as a priority. This is because GPs recognise they are usually the first point of contact for disorders of this nature and they believe they are better able to intervene at an early stage if they can offer the provision of psychological therapies including cognitive behaviour therapy. Improved access to Psychological Therapies is a priority for the PCT.

3.3.2 Currently about 20% of the population of Northamptonshire (150,000) are children and young people under the age of 18. This figure is predicted to increase by 2021 to around 165,000. Large scale UK studies suggest that as many as 1 in 10 young people under the age of 18 may experience mental health problems at some stage during their childhood.

3.3.3 Locally the PCT and other agencies in Northamptonshire want to ensure that they are working to develop comprehensive CAMHS services which are able to respond with services available at the right time, delivered in the most appropriate way and targeted upon those who need them most. In order to achieve this the CAMHS partnership developed a strategy which identified local priority areas for investment and development. This was based on local needs analysis. An aim of the strategy was to reduce expenditure on, and improve the patient experience of, very costly independent specialist hospital admissions for a few young people by building and developing local specialist services. The pathway redesign for CAMHS arose from this strategy which highlighted a number of gaps and inefficiencies. The redesign aimed to address these and to improve the whole pathway for CAMHS from preventative services through to services to meet the most complex mental health needs.
3.3.4 In order to redesign the whole pathway it was necessary to specify fully the requirements of the service, to pool resources across the County Council and the PCT and to re-tender through a competitive tendering process. The NSF for Children and Maternity Services provided the baseline for where the service needed to be.

3.3.5 In order to achieve a comprehensive service it was recognised that all universal services have a part to play eg teachers, health visitors, social workers, school nurses, GPs, voluntary groups. These staff need to be supported by the staff within specialist CAMHS services and these specialist services also need to offer services targeted upon more vulnerable groups and young people with more complex mental health needs.

3.3.6 The service redesign was achieved with full engagement of local clinicians and key partners. The CAMHS multi-agency partnership members led work streams which were multi-disciplinary and multi-agency in nature and were set up to develop the optimum pathways for service users. The service specification developed was subject to a three month consultation process with all key stakeholders including young people, patients and carers. Feedback was obtained in a variety of ways including open forums. The pathway will be delivered by clinical and professional teams involved in the development.

3.3.7 As part of the roll out of the new service a full workforce reform programme will be put in place to ensure specialist CAMHS staff have the requisite skills and expertise to deliver the new service specification.

3.3.8 A key aim of the redesign was to reduce expenditure on, and improve the patient experience of, costly inpatient admissions for a few young people, often placed a long way from home, by investing in local inpatient, crisis and home intervention services for young people with the most complex needs. Greater investment will be made in delivering support to universal services and to ensuring that specialist services are delivered close to home with localised and community delivery where possible. Services to more vulnerable groups will be delivered in a flexible responsive way. Cost effectiveness is being achieved by the development of local services to prevent the need for costly inpatient admissions and by streamlining two services into a single countywide service, thereby avoiding duplication.

3.3.9 The pathway will be sustainable in the longer term and it is planned to build upon the service model in an incremental fashion. The four tiers of the new integrated CAMHS services will ensure consistency across the County:

- Specialist CAMHS services tier 4: A Northamptonshire inpatient unit and a crisis intervention and home treatment service providing intensive support in the home as an alternative to inpatient provision. This will be a new service that did not previously exist.
- Specialist CAMHS services tier 3: A community based multi-disciplinary CAMH service focused on those children and young people who need specialist input
- Specialist CAMH services tier 2: Specialist Mental Health support to universal services offering support to other professionals.
- Targeted specialist CAMH services: A service for looked after and adopted children and a children and young people’s learning disability service.

3.3.10 A new and detailed service specification has been developed and the tender for the new service is now complete. The redesigned pathway will improve quality and safety within the service and enable more robust monitoring of service delivery. It will improve access and service user choice and control. The new specification has detailed service standards, outcome measures and data requirements to ensure effective monitoring. A reduction in costly in-patient provision outside the County should be achieved with the provision of a wider and more patient centred range of services providing care closer to home.

September 2009

Memorandum by the Medical Technology Group (COM 58)

INTRODUCTION

1. The Medical Technology Group (MTG) is a coalition of patient groups, research charities and medical device manufacturers working to improve access to medical technologies for everyone who needs them.

2. Appropriate use of medical technology gives value for money to the NHS, patients and taxpayers. It improves clinical outcomes and supports the wellbeing and personal development of individuals, and can achieve savings to the NHS and in other areas of public spending. The uptake of medical technology is not as good as it should be in our country, and people need more and better information about such technologies.

3. There are a number of entrenched barriers to the uptake of medical technology. These include a lack of awareness among patients and clinicians of the benefits of a particular intervention (which can be compounded by the rapid cycle of medical innovation); a conservative culture which upholds traditional treatment techniques, and a commissioning framework which can hinder the procurement of effective medical technology.
EXECUTIVE SUMMARY

4. In July 2009 the Office of Life Science (OLS) published a “Life Sciences Blueprint”. Among the aims of the Blueprint is to ensure, “... the uptake of groundbreaking and cost-effective medicines and technologies”. However, the Blueprint recognised that, “The adoption and uptake of new medicines and technologies in the NHS is variable and in some cases, far behind that of other European countries.”

5. Improving uptake of medical technology in the NHS presents unique and complex challenges for commissioners. Budget holders are expected to make ambitious savings, and at the same time deal with the pressures of demographic change, increasing patient expectations and unprecedented public health challenges. The “World Class Commissioning” programme, challenges commissioners to work across both health and social care to address not only the clinical needs of patients, but to consider wider outcomes such as independence, and ease of participation in education and in work.

6. David Nicholson recently articulated his vision for NHS managers, in which better quality and innovation are characterised as the main drivers of efficiency savings. Uptake of medical technology provides an important case in point. Resolving the key obstacles that inhibit innovation and access to the best technology can help us to make further progress towards a 21st century NHS that is both cost-effective and provides high quality care to every patient.

CHALLENGES FOR THE NHS

Commissioning for the Quality and Safety of Services

7. In his letter to NHS leaders of 10 August 2009, David Nicholson noted that the Quality, Innovation, Productivity and Prevention (QIPP) agenda is “the most important challenge facing the NHS in the foreseeable future”. The challenge falls in large part to commissioners working in a closer partnership with health professionals and patients to achieve the necessary step-change in NHS provision.

Quality

8. Medical technologies deliver improvements in patient care. This can mean reducing the invasiveness of surgical and diagnostic interventions; speeding recovery and reducing pain; supporting greater patient independence through accurate, remote monitoring of conditions; or using techniques which increase the longevity or efficacy of the procedure. In addition to delivering improvements in patient care and quality of life, appropriate use of medical technology can at the same time result in cost advantage, by increasing patients’ productivity in the economy, reducing days in hospital, reducing the need for repeat interventions and enabling clinicians to maximise their time.

9. For example, infections are a major cost to the NHS leading to longer hospitalisation and complications. Medical technology manufacturers work to address infection control in a number of ways, including hospital-based systems that reduce the risk of infection for all patients, and devices with local anti-bacterial properties that promote rapid healing, and provide longer wearing time, with less maintenance from nursing staff. One example is a sealant for surgical sites which forms a protective layer immobilising bacteria that survive prep and is not washed off by irrigation or bodily fluids during surgery.

10. Similarly, improvements in artificial joints increase longevity of the joint replacement, supporting patient independence, more rapid return to work, and reduced acute costs to the NHS. Commissioners could better realise these benefits by including more sophisticated quality requirements of medical technologies in their contracts with providers. This is especially true of commissioning for specialised services, where there is often a lack of expertise and knowledge of advanced medical technology, as used by specialist providers on the part of those commissioning the service. This conspires to deny patients and the NHS with the clinical and cost effectiveness benefits that medical technologies can offer, including those from devices that have been appraised by NICE.

Innovation

11. The UK is a hub for innovation in medical technology. Around 50,000 people work in this fast-paced, highly innovative sector, often in research roles, and around 7% of turnover is reinvested in research and development. The medical technology industry’s focus on research and development enables patients to benefit both from key refinements of existing treatments as well as cutting edge products such as deep brain stimulation used to treat Parkinson’s disease. Unlike pharmaceuticals, medical device technology is strongly engineering based and continuous improvement at pace is normal business.

12. Despite our strengths on the supply side, adoption of medical technology in the UK is not as good as it should be. While pockets of innovation exist, widespread uptake of new techniques at the local service level still lags behind other countries. Heart disease, for example, is the biggest killer in this country. In
2008, implantable cardioverter-defibrillator (ICDs), which can lead to a 50% reduction in cardiac deaths,\textsuperscript{173} were implanted in Germany at over three times the UK rate.\textsuperscript{174} ICDs have been recommended by NICE as a clinically and cost-effective use of NHS resources and set a target of 100 implants per million population. There are thousands of patients who are able to benefit from medical technologies that have been approved by NICE—ICDs and insulin pumps are just two examples. We urgently need to address the barriers to uptake, by tackling the key challenges for commissioners, which are discussed further in paragraphs 15–26 below.

**Productivity**

13. Medical technology can allow the NHS to make significant productivity gains. An example of this is the minimally invasive surgery (MIS) technique for total hip arthroplasty (THA). The initial cost of such equipment is more than that for conventional surgery. Yet the newer procedure can cost almost a third less than its predecessor when implant costs are excluded. In part this is due to MIS requiring shorter stays in hospital; whereas conventional THA necessitates an average admission of 15.11 days, this falls to 10.46 days for MIS THA. In addition, shorter operating times are required and less post operative care is needed. What is needed is a better focus on this kind of benefit as it improves long term savings. Because of the way in which budgets are organised in the NHS, the short term costs, for which cost of procurement is often a proxy, dominate the discussion. Meanwhile the long term benefit—cost of ownership and impact on overall resource use and patient outcomes—frequently goes unrecognised.

**Prevention**

14. Medical technology can prevent ill health and hospital admission in numerous ways, and such a discussion is beyond the scope of this document. However, to cite just two examples, telecare and telemedicine devices allow clinicians to monitor and treat patients in their homes and prevent frequent routine trips to hospital. This means less disruption in patients’ daily lives and reduced hospital workloads. In some cases, the term “prevention” conveys not the prevention of the disease itself, but rather stabilizing the patient’s condition to keep more dire consequences at bay. Examples of this type include ICDs, which can prevent life threatening complications by correcting abnormal heart rhythms before blood supply is compromised, and insulin pumps, which in many instances provide more consistent and effective management of diabetes. Many medical technologies have the ability both to monitor disease progression and prevent future acute episodes. Devices currently available for heart disease and diabetes are capable of adjusting the therapy delivered to ensure patients remain in a stable condition and prevent avoidable hospitalisations. The technologies can also allow routine follow up to take place remotely, reducing pressure on hospital outpatient departments, car parks and the ambulance service.

**Challenges for Commissioners**

“World Class Commissioning” what does this initiative tell us about how effective commissioning by PCTs is?

15. The “World Class Commissioning” agenda has sought to professionalise commissioning and to build the competencies of NHS managers to procure more effectively, and deliver more patient-centred health services. World Class Commissioning aims to improve specific skills sets which support local health provision, and drive up the effectiveness of commissioning in the following ways:

16. **Locally lead the NHS**—as described above, new technologies can give professionals opportunities to expand their skills, provide innovative patient care, and encourage best practice among their peers. Commissioners should use examples of pioneering work to drive service improvement in different clinical areas, and share improvements, include wider social benefits, to key partners such as local authorities and community organisations.

17. **Work with community partners and manage the local health system**—appropriate use of medical technologies can support the independence of patients, and the provision of care closer to home. A reduction in the need for acute services can mean that community partners play a greater role in providing services. A number of the MTG’s 20 patient group members are involved in providing care outside of traditional settings, such as the Lindsay Leg Club Foundation, which allows leg ulcer patients to be treated in community settings. By improving their communication with local partners, commissioners can play an important role in sharing best practice in the use of medical technology and gaining a closer insight into the kind of interventions which best support patients close to their homes.

18. **Engage with public and patients**—given the rapidly expanding range of new treatments available to patients, health professionals should look to engage their patients more thoroughly in the different options available. In some instances, we need to look to commissioners to help initiate this dialogue. It may be that clinicians are not in a position to offer an adequate level of advice and guidance about new treatments and technologies. This requires targeted investment in training and infrastructure which supports clinicians to up-skill and embrace new methods. Many patients would benefit from treatment by uterine fibroid

\textsuperscript{173} NICE Technology Appraisal, Implantable cardioverter defibrillators for arrhythmias, p8 http://www.nice.org.uk/nicemedia/pdf/TA095guidance.pdf

\textsuperscript{174} Eucomed http://www.eucomed.org/abouttheindustry/~/media/E60CE28CFAFE4E30AE3575BDE9A4FEB2.ashx
18. **Collaborate with clinicians**—use of medical technology can require systems and behaviour change, so it’s important that commissioners engage with clinicians to re-design pathways of care. This is evidenced within specialist diabetes services providing insulin pumps, which free type one diabetics from multiple daily injections, and limit episodes of hypoglycaemic and hyperglycaemic attacks. Best practice pump provision is currently delivered through a limited number of “pump clinics”, where specialists including diabetologists, diabetes specialist nurses and nutritionists work together to provide diabetics with the support they need to use pumps safely and effectively.

20. **Manage knowledge and assess needs**—NICE approved technologies should have a clear route into the NHS which is accepted by all stakeholders based on a robust local business case which delivers appropriate levels of investment in infrastructure and training. NICE’s “Commissioning Guides” are a positive step forward, providing information to commissioners to help them to deliver services in line with NICE clinical guidance. They include a benchmarking tool to enable commissioners to assess local need for a particular disease area. Tools like this are becoming more important as the commissioning environment becomes more complex, and the variation in provision across the country continues to increase. The commissioning guides do not normally focus on a particular technology, with the exception of the insulin pump guide. The MTG believes that NICE’s commissioning guides are a valuable tool which should be developed for more technologies with a proven benefit to patients.

21. **Prioritise investment**—budget restrictions across all government departments mean that in order to avoid cuts to services, investments will need to generate ever greater returns. One way of achieving this would be for commissioners to look at the societal benefits of interventions. For example, spinal cord stimulation can alleviate chronic pain, estimated by the Chief Medical Officer to lead to 25% of sufferers losing their jobs. A full picture of spinal cord stimulation’s benefit would involve looking at its ability to keep people in work and prevent spending on incapacity benefit. If such social benefits were taken into account for all treatments, a fuller picture would be developed of investment returns, and spending could be better prioritised. To expedite this, further encouragement should be given to joint commissioning across local health, social and other relevant services.

22. As noted by Sir Ian Kennedy in his July 2009 NICE study on “Valuing Innovation”, the assessment of societal costs and benefits is complex. However this should not discourage further research into evaluation models which would allow this. MTG is working with York Health Economics Consortium to research evaluation methods which can accommodate wider societal costs; and to substantiate the holistic budgetary impact of appropriate use of medical technology. This should form part of a wider cohort of research into the subject.

23. **Stimulate the market and promote improvement and innovation**—Britain is a world leader in the development of medical technologies. Yet these improvements do not always reach British patients. This may mean that research is not always commissioned with input and engagement with patients and clinicians at the outset or that uptake mechanisms for innovative technology are stronger in other markets. Commissioners who increase their focus on the end-user can become more intelligent purchasers of medical technology, and in so doing help ensure that innovative treatment reaches UK patients.

24. **Secure procurement skills**—procurement of effective medical technologies is not as good as it should be, partly because the focus is on the short term cost rather than on long term benefits—means rather than ends (see also paragraph 12). This is in part due to a lack of evidence (the kind of evidence that is required to commission pharmaceutical drugs for example) to support provision within the NHS. However, as part of their innovation duty, SHAs should look to oversee the quality of procurement practice including an “innovation indicator” which rewards excellence. Underperforming commissioners should be encouraged to undertake training and recruitment which supports the development of improved procurement skills.

25. **Make sound financial investments**—Investments in procedures can only be made effectively if there is accurate data regarding the resources required to treat a particular episode of disease or disease state. Tariffs must reflect the true cost of the best intervention, rather than lesser clinical alternatives. MTG welcomes David Nicholson’s review of the Payment by Results structure which should consider how tariff setting can best accommodate new medical technology. We also support the use of the “exclusion mechanism” as an effective way to foster innovation and reap the benefits of rapidly evolving technologies. Even where the HRG adequately captures high cost technologies, the rapid change of new technologies can undermine the accuracy of a tariff that is never able to “catch up or keep up”. Exclusion allows at least an annual review of the latest iterations and the potential to support managed entry of new technologies into local health economies. We are also concerned that there is a disconnect between the operational imperatives of the PbR programme and wider system reform aimed at increasing innovation in the NHS. The approach taken to coding and classification for example is technical, to support the system, rather than focused on the NHS’s need to accommodate continuous development in clinical practice; this threatens to make PbR blind to innovation.
26. Investments should of course take account of the costs and benefits associated with a treatment—it's overall value over the entire episode of care rather than just its price. Some medical technologies may involve a higher upfront cost but result in savings over the longer term, and improve the quality of patient care as well. Medical devices have a different value proposition to pharmaceuticals. A patient with familial hypercholesterolemia for example, could be treated with statins and other medicines costing over £100 a month for many years. But if the inherited condition was a cardiomyopathy, the upfront cost is around £15,000 for an ICD. Despite the long term value of the intervention compared to multiple repeat prescriptions, an upfront investment presents a conundrum for commissioners who are focused on managing budgetary pressures in the immediate term.

COMMISSIONING IN THE FUTURE

27. Commissioning must adapt and enhance its rigour to meet the challenges of a complex health environment and resource restrictions. This will require some vigilance—to ensure that current financial pressures do not result in short-term decisions, which ignore long-run benefits, and which will prove to be more costly over time.

28. Improvement in incorporating a calculation of long term health benefits and savings into commissioning will require commissioners to have appropriate information on which to base their decisions. Three changes could help to achieve this. Firstly, the success of the first tranche of NICE Commissioning Guides should be emulated to provide commissioners with in-depth knowledge about a greater range of technologies, and how to procure them effectively to meet local need.

29. Secondly, the scale of societal costs and benefits must be properly evaluated if such information is to feed into commissioning judgements. MTG believes that such calculations should form part of NICE guidance. This would allow an accurate assessment of the effects on all government expenditure to be made, resulting in more efficient investment.

30. Finally the tariff price should be based on a fair and accurate assessment of a technology’s long term value. This will support commissioners in making better purchasing decisions based on genuine value.

September 2009

Memorandum by Baxter Healthcare Ltd (COM 59)

EXECUTIVE SUMMARY

1. Baxter is a global, diversified healthcare company that develops products and therapies to make a meaningful difference in the lives of people with life-threatening conditions such as haemophilia, kidney disease, immune disorders and other chronic and acute conditions.

2. With this focus on chronic and acute conditions, we have significant experience in dealing with specialist commissioners. It is in this area of commissioning that we have focused this evidence, particularly in relation to the specialist commissioning of haemophilia services.

3. In our experience, specialist commissioning for haemophilia has been a success. Overall, treatment has improved for patients with improved consistency of care and a greater focus on the very specific needs of haemophilia patients. One area where we believe however, that the independence and ability of specialist commissioners to fulfill their role is threatened, is by the use of e-auctions to procure the medicines and services used to treat haemophilia. We believe this threatens the future independence of commissioners to provide informed choice of care for patients and is an inappropriate mechanism to use for both efficacy and safety reasons.

BACKGROUND TO HAEMOPHILIA

4. Haemophilia is primarily an inherited blood clotting disease that affects thousands of people in the UK. It can cause internal bleeding into muscles and joint cavities, arthritis, joint disease and loss of muscle mass. It can also result in extreme physical, psychological and social disabilities.

5. A large number of patients with haemophilia contracted HIV and Hepatitis C from their treatments in the 1970s and 1980s. Over half of those infected have died and the emotional cost to bereaved families is a tragedy.

6. The Archer Inquiry provided a comprehensive review of the circumstances that led to what Lord Robert Winston described as, “the worst treatment disaster in the history of the NHS.” The Government’s response to the inquiry has gone some way to compensate patients and their families for the contaminated blood products they received.
SPECIALIST COMMISSIONING

7. There are many examples of improved patient care having been delivered through specialist commissioning for haemophilia. As an example, the Pan-Thames Consortium provides specialist commissioning for haemophilia treatment on behalf of 48 Primary Care Trusts across London and the South East. The Consortium has a strong record of liaison with patient groups and industry and has successfully introduced ways of treating patients closer to their home. It has created a hub and spoke model which keeps services locally while centralising complex specialised care. It has also piloted a scheme that enables patients who require emergency treatment to take them directly to their specialist centre, rather than their general A&E location. The Consortium has also developed recommendations for services for particular groups of patients, for example paediatric care and has developed a peer review mechanism for treatment decisions of patients with Haemophilia.

8. Regional commissioning teams have also widely supported the provision of home delivery services for haemophilia patients, which enables people to maintain as normal a life as possible while reducing costs. Research has demonstrated that this is very popular with patients (Cox Market Research 2008).

9. A further example of strong specialist commissioning can be found in the North East, where the North East Specialised Commissioning Group undertook a full service review into its haematology services. Following the review, improvements were made to the haemostasis laboratory including the funding of reverse e-auctions for patients with haemophilia, and ultimately improve the management of patients within the system.

REVERSE E-AUCTIONS

10. The national contract for medicines for patients with haemophilia uses “reverse e-auctions” (the next auction is due later in 2009), which is similar to an e-bay auction in reverse; where manufacturers offer lower prices rather than higher ones. This can play a vital part in effective procurement for the NHS, particularly in relation to certain commodities such as plastic aprons or toilet rolls. The process can encourage competition and reduce the overall costs to the NHS. When the commodities that are being tendered can be safely interchanged, the process is a win-win situation for the NHS.

11. However, when this procurement process is also used for medicines designed to treat chronic conditions, such as haemophilia, which are not interchangeable, it can have a negative impact on scientific innovation and patients’ access to quality treatments that ensure the highest level of safety.

12. Reverse e-auctions can play a part in effective procurement but, as the Archer Inquiry emphasised, patient involvement in clinical decisions is important and should not be overlooked. The design of e-auctions needs to be re-considered to ensure innovation and patient safety are not undermined by simply focusing on the cheapest drug and that patient choice should be taken into account. Any tender process should ensure that both cost and safety are reviewed on an equal basis.

13. PASA’s award criteria for the tender for clotting factors in 2006 weighted cost as 40% and safety as 25%. To ensure the utmost safety for patients, we believe that the criteria for the 2009 re-tender should give both cost and safety equal importance in the decision making. Baxter Healthcare would recommend that both cost and safety are given 30% weighting each.

SPECIALIST COMMISSIONING AND REVERSE E-AUCTIONS

14. For specialist commissioning to work effectively, commissioners need to be able to recommend treatments and medicines that are both safe and have a proven efficacy. We believe that the national contract for haemophilia medicines might create a situation in which certain medicines become limited due to the reverse e-auction process and therefore limit the ability of specialist commissioners to make the recommendations they might otherwise have made. Clear examples of where reverse e-auctions have not worked and have directly affected the commissioning of care have recently been outlined in the east of England. Companies who were granted contracts post e-auctions (based on lowest price) to provide facilities/care around dementia, have now been struck off suppliers list for providing below standard patient care. In our view, national procurement decisions need to be taken with closer involvement of specialist commissioners to ensure this is not the outcome.

September 2009

Memorandum by Professor Rod Griffiths CBE (COM 60)

NATIONAL SPECIALISED COMMISSIONING FOR VERY RARE DISEASES

INTRODUCTION

1. This paper is written from a personal perspective, reflecting on more than 15 years’ association with Regional and National Commissioning. From 1992 until 2004 I was Regional Director of Public Health and for part of that time Deputy Chief Executive of the West Midlands. In 2004 I was elected President of the Faculty of Public Health, the part of the Medical Royal College system responsible for Public Health. In
2004 I was also appointed chairman of the National Specialised Commissioning Advisory Group (NSCAG) and I have been Chair of the National Commissioning Group since its inception, following the report of the Carter Committee, of which I was a member.

EXECUTIVE SUMMARY

2. Very rare diseases present challenges to almost every part of the NHS and to the assumptions that lie behind the way it is organised and run. This paper explores those challenges and suggests some areas where solutions may lie. In particular, rarity means that knowledge and evidence are often scarce and the patient often knows more that the health care professionals treating them. Costs are often disproportionate and uncertain.

3. By very rare diseases I mean those with an incidence of 10–20 cases or fewer per million of the population. If the NHS is not able to deliver a response that meets patients’ needs, then the challenge from these diseases will always tend to end up with an ad hoc political decision. Solutions that emerge from political “fixes” may be based on short-term pressures and are not always the best thing either for the patients with a particular disease or for the NHS as a whole. It is particularly unfortunate when these solutions create precedents on costing or other grounds that then tend to be applied to other diseases with less consideration than they deserve.

THE CHALLENGE TO PRIMARY CARE AS A GATEKEEPER

4. Strong primary care, acting as a gatekeeper to specialist services, is very cost effective in most cases. Very rare diseases challenge this simply because most general practitioners will know very little of the disease concerned. If the disease presents in an unusual way then it is likely that the patient will be referred to a specialist, but it may be the wrong specialist. If the presentation is similar to other more common diseases then there may be considerable delay before the patient sees the right specialist.

5. Patients with very rare diseases often have stories to tell of long periods seeing different doctors where different treatments are tried, but nothing works out as expected.

6. For most diseases the doctor knows more than the patient, even when the patient trawls the Internet at length the doctor knows the range of possibilities with that disease, and thus knows what to look out for and knows when the treatment is working. GPs see cases all the time and also benefit from letters from specialists and from continuing professional education.

7. In contrast a patient with a very rare disease who trawls the Internet is likely to quickly overtake what the GP knows. Furthermore he or she is likely to quickly find other patients with the same disease, even though they may be scattered across the globe, such is the power of search engines. If a GP sees an article in a journal about a very rare disease, he or she is likely to ignore it, thinking, quite rightly, that they are unlikely to ever see a case. The knowledge relationship between GP and patient is reversed and the patient is more likely to have the time and the motivation to determine the right specialist centre for their condition. We cannot blame GPs for spending little time keeping themselves informed about diseases that most GPs will never see.

RARITY AND COSTS

8. It is widely assumed that drugs and treatments for very rare diseases are bound to be more expensive. The rationale for drugs is that the laboratory costs of development will be the same, but the cost must be recovered from far fewer prescriptions. On the other hand the cost of trials may well be less because there will be very few patients, and marketing and post market surveillance costs will be miniscule. We have no idea how these different costs balance out because the drug companies are simply not transparent.

9. Further down the line the developer is less likely to have their market threatened by a generic producer because with so few patients there is little to be gained from creating a generic product.

10. Very rare diseases thus challenge every assumption that is made about costs and hence this challenges assumptions about the fairness of allocation of costs. We do not insist that all government departments put the same value on human life—the cost of saving a life by building safer roads, for instance is very much greater than that for saving a life through health care. We know it costs a lot to build roads and we accept different allocations and different metrics because the circumstances are very different. The questions we need to ask about very rare diseases are “Are they sufficiently different to justify different metrics?” If we add up the sum total of decisions that ministers have made about previous funding then the answer must be yes, because they have funded some very expensive treatments; but the issue has not been examined rigorously, perhaps it should be.

11. In the UK we exert some control over drug prices by capping overall profits. Whilst this may be effective as a whole it fails the patient with a rare disease because the price rather than the profit determines availability in the NHS. If a drug company re-allocated their overheads so that the prices of all of their drugs came under the NICE cost effectiveness cap they could increase accessibility without diminishing their profit. They don’t do this because the UK price would then undermine the price they can charge in other systems where NICE does not hold sway. It is the patient with a rare disease who is the greatest loser in this accounting game. The example of Eculizumab is explored in Appendix 1.
Rarity and Evidence

12. Many assumptions about the evidence to support therapeutic decisions are also challenged. There may well be no randomised trials, simply because there are too few patients to mount a trial with enough statistical power. There is even less likelihood of meta-analyses of multiple trials.

13. Less powerful sources of evidence and the views of small numbers of experts have to be relied on. Because there are very small numbers of patients there will also be very small numbers of experts who take an interest in each disease. The usual, and quite proper, scepticism about conflicts of interest is harder to justify if there are very people who are experts. It is hard to discount the knowledge of the one person who knows on the grounds that he or she is the one person who knows and is therefore biased.

Designation versus Market

14. It is a common assumption that markets, through competition, improve both cost and quality. This too is turned on its head by rare diseases. There is no market because there are not enough patients to make competition viable. Quality has to be driven by different factors. If any individual practitioner is allowed to treat rare diseases then many cases will be treated sub optimally. The Calman-Hine review of cancer services and other studies since then have provided evidence to support specialisation, and the same concepts apply to very rare diseases. Following ministerial decisions taken on NCG advice particular providers and specialist teams can be designated as the only places where the treatment of certain conditions will be funded. Whilst other providers could take cases, the lack of funding for what are usually expensive treatments is enough to restrict treatment to a small number of centres that have appropriate experience. Designation by the NCG also allows those providers to advertise their services so that the chances of patients speedily finding their way to the right specialist are increased. The combination of improved referral pathways and secure funding gives providers sufficient assurance to continue to invest in specialist staff and facilities.

Geographical Inequities

15. Many rare diseases are the result of particular genetic problems. They may run in families and in particular ethnic groups and are thus distributed unevenly. Patients with chronic rare diseases will often choose to move to be nearer particular specialist centres.

16. On the other hand it is also the case that specialists in particular areas are more likely to be able educate local non-specialists and thus establish referral streams.

17. It is thus likely that patients will be clustered unevenly across the country and it may be impossible to be sure why that is. The challenges providers with the necessity of providing a national solution, but there will always be PCTs who note that they have no patients with a particular disease, yet the cost of the national commissioning is still shown against their budget.

The European Perspective

18. The European and international perspective is also important. Rarity requires that we study and gather information from larger populations. Normally it is difficult to compare the experience of patients across different health care systems because the system differences get in the way. For common diseases much is known and progress is often dependant on understanding small changes that make a big difference when multiplied up across a large number of patients. These small differences are dwarfed by the differences in cultures, health beliefs and health systems, so cross-country learning adds little and there is no difficulty in doing good science within any one system. For very rare disease the issues are reversed. It is hard to do good science in a single system because the patient numbers are too small and there are relatively greater gains from working across systems. The number of treatments available is likely to be small and hence the variation between systems and cultures is reduced.

Learning in General

19. Very rare diseases thus challenge all our major assumptions and also contribute little to learning as a whole. Many conclusions that can be drawn about the state of health care that are based upon the experience of patients with rare diseases are almost bound to be irrelevant to health care for more common diseases. Inevitably that means that sometimes patients with rare diseases will feel as though their complaints are ignored and that can damage the whole system.

20. The media latch onto good stories and a tale about a patient who needs a heart transplant provides more drama than one who needs a hernia repaired; but when a patient with a hernia reads that the NHS has allowed a patient who needed a transplant to die he or she will tend to think, “Well if they can’t deal with someone who is as ill as that, then what chance do I stand?”

The Rule of Rescue

21. There is of course no such rule set out in law, but it is a convenient label for a set of arguments that often arise over rare diseases. An identifiable patient with a tragic story is likely to evince public sympathy. There will be pressure to “rescue” them which may well override priorities given to less visible cases, even though they may be more deserving or better value for money.
22. Such rescues are sometimes justified because we all feel better for knowing that we live in the sort of society where such rescues are possible. Summing the small gain for each member of the population can make the intervention appear cost effective. Cases may concern actual rescues, or just unique problems and the costs of rescue may be huge. The cost is regarded as part of a civilised society, and indeed the final wording, after a major consultation, of the NHS Constitution could be argued as supporting such efforts.

23. Those who have to find the funds for, and prioritize, more run of the mill health care are bound to resent the Rule of Rescue being used as a trump card.

24. Unless we can find a more coherent system that recognises and takes account of the particular challenges presented by very rare diseases we are likely continue to bounce from one “rescue” to the next, undermining the rationale of the health service in general and providing a less than optimum service for patients with rare diseases.

**The Carter Formulation**

25. The Carter committee attempted to develop a more comprehensive system of specialised commissioning. Prior to Carter very rare diseases that required a national approach were commissioned directly by the Department of Health. Ministers were advised by a committee that contained the presidents or representatives of the relevant Royal Colleges sitting with a number of other specialist advisors on Commissioning, Finance etc., drawn from the NHS. They advised ministers who decided whether a particular proposal for the diagnosis and or treatment of a very rare disease should be commissioned nationally. Ministers did not always accept the advice they were given, at least in part because they were also able to bring a political perspective to bear.

26. For example, let us imagine a rare disease with perhaps 100 patients across the country that it proposed to treat with a new drug that costs £300,000 per patient per year. NHS interests would probably advise the minister that the total cost was excessive. On the other hand a patient group representing these patients can go to the minister and say, “The NHS spends a 100 billion and for a mere 30 million you could save all of our members. How could you possibly be so mean and heartless as to refuse funding something that costs such a tiny proportion of the whole?” (Despite the changes following Carter this still happens, see Appendix 1 for a specific example) Seen against the possibility of watching patients suffer on the TV and on the front pages of newspapers, it is easy to see why a minister might make a political decision that refusal to fund such a scheme might undermine confidence in the whole system.

27. Carter also examined regional commissioning and concluded that approaches varied widely across the regions, each choosing to commission a slightly different list at the regional level.

28. Carter proposed bringing the national commissioning team into the NHS and creating a working relationship with the regional tier of commissioning. Ministers still had the ability to impose a political solution, but it was hoped that bringing all the levels of specialised commissioning into a coherent system would allow learning and lead to a more consistent approach across the country.

29. It was hoped that the regions would gradually come into line so that a patient with a particular rare disease in any region would receive roughly the same approach and that the even rarer diseases commissioned nationally would also be approached in a similar, consistent manner.

30. Has it worked? The answer has to be—not yet. There is little sign that the different regions have used the experience of others to examine their own practice. There are still big differences between regions as to what they handle at regional level. National commissioning has benefitted from the challenge of the regional tier but it is still the case that all too often regional commissioners would rather say “no” to a national scheme than try to save an equivalent amount of money by challenging their own services.

31. The regional tiers are in most part accountable to local PCTs and it seems clear that they have done little to inform PCTs about national commissioning or to educate them about the large regional variations across the country. PCTs themselves would rather challenge regional and national decisions than their own services. PCTs inevitably think that it is their money. In fact it is taxpayers money, previously part of the DH budget, and simply shown against each PCT as an accounting device. PCTs are not asked to endorse what they see as a top slice, but making the allocation visible in this way causes resentment and opposition without any examination of the plight of the patients concerned.

32. It could be argued that Carter should be given more time to work, some things that were recommended by Carter have been achieved. What is not clear is who is accountable for delivering Carter, particularly in those areas where it is in no-one’s individual interest but in the common interest.

**Where might Solutions Lie?**

33. If we are to avoid a situation where rare diseases create precedents that damage the NHS as a whole, then we need solutions that are clearly seen to be bespoke for rare diseases and outside rest of the NHS envelope. There is a risk in too much separation because commissioning of rare diseases benefits from the experience and pressure for cost effectiveness found in the NHS. In a completely insulated system this would be absent.
34. The solution might be to designate a budgetary target for very rare diseases that was based on a European comparator. Tony Blair committed the NHS to a spend level that was comparable with the European average. Working with EU partners, using the accepted competence of the EU in rare diseases it should be possible to arrive at a budget target that was comparable with the rest of the EU. That could be used to set a cap on spending by the NCG. Within that cap decisions could still be scrutinised by the NSCG as they are at the moment but decisions on rare diseases would be protected from negation simply on the grounds of cost.

35. Within the NCG mechanism it is necessary to both develop clinical expertise in rare diseases and at the same time to challenge it. The NCG has begun to use specialist advisory groups, as for instance with Proton Beam Therapy, and advice from such groups is challenged by Presidents of Royal Colleges who are represented on the main committee. In the same way we could make more use of disease-specific patient groups, who could be challenged by lay members appointed though a competitive process. At the moment the NCG and the NSCG have one such patient member. There might be some benefit in more.

36. Outside the specific commissioning mechanisms there is a strong case for the UK to use its considerable experience in assessing pharmaceuticals and in research to press for an EU-wide pricing mechanism for very high cost drugs. Such a mechanism would need to strike a fair deal both for manufacturers and for the patients, insurance companies and governments who pay for the drugs.

37. At the EU level it would also be possible to explore whether current patent law creates the right incentives in this area. The EU is as well placed as any organisation in the world to deliver such a package.

**CONCLUSION**

38. Because we have failed to get to grips with the unique challenges presented by rare diseases, and because we keep trying to shoehorn them into the formulations that work for common diseases, we miss opportunities and end up with inferior solutions.

It is time to think more deeply.

September 2009

**APPENDIX 1**

**ECULIZUMAB**

The Carter formulation of relationships did not deliver a coherent policy, in part because it is no one’s job to see that it does. No one is in a position to speak for the greater good of the system and patients, so each part of the system presses their individual interest. The story of Eculizumab presents a good example of lost opportunities. Eculizumab (brand name Soliris) is a drug which treats a rare condition called Paroxysmal Nocturnal Haematuria (PNH).

The NCG considered the drug and concluded that it was an effective treatment for a very debilitating and ultimately fatal condition. However the price was so high (as much as £300,000 per patient per year, depending on the patient and dose) that the NCG concluded that they did not have the financial and commissioning expertise to evaluate the impact of commissioning such an expensive drug. It might set precedents that could not be sustained, and PCTs might well feel that it was so far outside their value for money assumptions that it could not be afforded.

The NSCG discussed the problem on two occasions and found that the majority of SCGs were against commissioning the drug. The NSCG therefore recommended that the drug not be commissioned.

The hierarchy determined by Carter meant that the decision was then passed to the SHA chief executives meeting with the Chief Executive of the NHS. This group declined to make a decision and passed the matter on to the relevant minister, who then decided to overturn the NSCG view and ruled that the NCG should commission the drug.

Whilst this was good news for the 120 patients, many PCTs concluded that it set precedents that would make it much more difficult for them to say “no” to other expensive drugs.

In my view the problem that was presented to the minister in the case of Eculizumab was the wrong one. In effect she was asked, “Should we fund this or not?” The right question would have been, “What is the best way of serving the interests of the patients and the country in relation to this new therapy for a very rare condition.”

If the question was put in that way, a quite different formulation emerges. The drug does a good job for patients with a very debilitating disease who face a long drawn out path to death in late middle age, but the drug costs too much.

The drug company set an arbitrary price, far in excess of what was expected and with no evidence of the real costs. Across Europe they were able to play one country off against another. PNH is the first disease that the drug has been shown to improve but it is being tested on some kinds of asthma. If it had worked for asthma, then its development costs would have been set against trying to treat asthma, rather than loaded onto the cost of treating one very rare disease. Without transparency from the drug company we have no
idea which of the costs of the drug really relate to PNH and which relate to other research that the company is undertaking. The drug is their only product thus far and whilst there is no doubt that they have spend many millions on research we do not know in any detail what that research was.

Tackling very rare diseases is an EU competence, yet no attempt was made to use the Europe wide market muscle to negotiate a lower price. Why not? Presumably because the wrong minister was asked the wrong question.

The European market is so large that the drug company would be bound to listen and negotiate. This opportunity was missed and as a result a decision was taken which could undermine PCTs ability to make cost effectiveness stick.

The graph below shows Alexion’s stock price on the NASDAQ index following the various funding decisions across the EU and USA.

Alexion make no mystery about their interest in exploiting the commercial possibilities of orphan drugs, as the following statement from their 2007 annual report makes clear.

Aptitude in Rare Disease

Through our experience with Soliris (ECULIZUMAB) and PNH, Alexion has developed exceptional expertise in the highly promising field of rare disease, an area of medicine where serious clinical needs are commonly unmet, competition among pharmaceutical companies is limited, and orphan drug status can provide a period of additional exclusivity as a meaningful economic incentive. We intend to continue exploring the potential for developing and delivering treatments for patients with other rare disorders—a commitment reflected in our research and development programs.

Very rare diseases risk becoming a battleground where drug companies seek additional profits and health systems are held to ransom unless we can find new approaches that recognise the unique challenges presented by these conditions.

Memorandum by the National Specialised Commissioning Group (COM 61)

SPECIALIST COMMISSIONING

INTRODUCTION AND EXECUTIVE SUMMARY

1. This paper is written on behalf of the National Specialised Commissioning Group, which has responsibility for overseeing regional and national specialised commissioning in England. I have been the Chair of this group since its creation in April 2007 and have experienced first hand the changes in specialised commissioning since Sir David Carter’s independent Review of Commissioning Arrangements for Specialised Services in 2006. This note sets out some of the key developments since that review and the challenges regional and national commissioners face going forward.
COMMISSIONING SPECIALISED SERVICES

2. The NHS works to meet the health and healthcare needs of everyone and through specialised commissioning ensures that the needs of those with less common conditions or who require specialised services, not provided in all local hospitals, are met effectively. By ensuring appropriate high quality specialised services are in place, specialised commissioning helps improve the quality of life of those with specialised healthcare needs.

3. A specialised service is defined in legislation (SI 2002 No 2375) as a service covering a planning population (catchment area) of more than a million people. There is a Specialised Services National Definition Set of 34 definitions of services that are considered specialised. Whilst these services tend be high-cost low-volume services, and tend to be provided by fewer than 50 specialist centres in England, it is important to note that they are an integral part of the overall patient continuum/pathway of care.

4. Whilst most NHS services in England are commissioned by Primary Care Trusts, some specialised services are commissioned either regionally or nationally. This enables the NHS to:
   — Ensure the provision of high quality care through concentrating clinical expertise.
   — Ensure equity of access.
   — Spread the financial risk across PCTs.

5. The National Specialised Commissioning Group has responsibility for overseeing specialised commissioning in England. It facilitates collaborative working between the Specialised Commissioning Groups, for example through national programmes such as the national paediatric cardiac surgery and paediatric neurosurgery programmes, which are currently underway. It also oversees the national commissioning function. Its voting members are 10 PCT Chief Executives representing the 10 regional Specialised Commissioning Groups.

6. The 10 Specialised Commissioning Groups in England, coterminous with the 10 Strategic Health Authorities, commission services on behalf of their constituent PCTs. They plan and commission those services from within the Specialised Services National Definition Set that their PCTs direct them to commission. Together they have an annual budget of about £4.5 billion; approximately 5% of NHS spend. This does not represent all spending on specialised services as some services continue to be commissioned locally by PCTs. The Strategic Health Authorities are responsible for the performance management of the Specialised Commissioning Group in their region.

7. The National Commissioning Group is a standing sub committee of the NSCG. It is predominantly a clinical group and commissions over 50 services nationally for England (and in some cases for Wales, Northern Ireland and Scotland) with an annual budget of about £480 million.

8. The National Specialised Commissioning Team commissions services on behalf of the National Commissioning Group and supports the work of the National Specialised Commissioning Group, such as the national paediatric cardiac surgery and paediatric neurosurgery programmes. The Team also helps facilitate collaborative working between the Specialised Commissioning Groups.
9. Figure 1 below shows the accountability arrangements of the National Specialised Commissioning Group.

**Figure 1**

**NSCG ACCOUNTABILITY ARRANGEMENTS**

![Diagram showing accountability arrangements of the NSCG](image)

THE CARTER REVIEW OF SPECIALISED COMMISSIONING

10. Sir David Carter’s independent *Review of Commissioning Arrangements for Specialised Services* in 2006 made 32 recommendations for strengthening the commissioning of specialised services. The review led to the establishment of the National Specialised Commissioning Group, the Specialised Commissioning Groups and the National Commissioning Group. The recommendations also included:

- Strengthening arrangements for commissioning secure mental health services.
- Designation of specialised services providers.
- Mapping and costing specialised services.
- Annual prioritisation processes for SCGs and the NCG.
- Strengthening the Specialised Services National Definitions Set.
- Ensuring robust patient and public engagement processes.

PROGRESS TO DATE

**National Specialised Commissioning Group**

11. Since the establishment of the National Specialised Commissioning Group in April 2007, members agreed work plans for 2008–09 and 2009–10 that included national programmes for paediatric cardiac and paediatric neurosurgery and a national policy on pulmonary hypertension, which has led to equity of access for the high cost drugs associated with this condition.

12. Following ministerial agreement, in May 2008 the National Specialised Commissioning Group became accountable and responsible for the commissioning of high secure services via the National High Secure Commissioning Team.

13. The National Specialised Commissioning Group reviews the National Commissioning Group and Specialised Commissioning Groups’ Public and Patient Engagement strategies on an annual basis. The National Commissioning Group and National Specialised Commissioning Group have both appointed lay members.
Specialised Commissioning Groups

14. Progress has been made in developing evidence-based regionally commissioned services. Examples include the South Central Specialised Commissioning Group, which has developed and agreed a framework for commissioning bone marrow transplants across the South Central region. This ensures equity of access and appropriate provision according to the indicated need. The East of England Specialised Commissioning Group has tackled the issue of IVF access and has developed a common policy, compliant with NICE guidance, across their Region.

15. Identified Specialised Commissioning Groups are leading on the development of designation standards and implementing them. Designation material has now been agreed for eight services:
   - Adult congenital heart disease services.
   - Cleft lip and palate services.
   - Clinical genetics and genetics labs service.
   - HIV services for children.
   - Medium secure mental health services.
   - Morbid obesity services.
   - Positron emission tomography services.

16. Work on developing designation material for a further six services identified by the National Specialised Commissioning Group as high priority is underway and further material should be agreed in autumn 2009. Specialised Commissioning Groups have agreed standard templates for designation materials and a process to assure the quality of the material produced. Decisions are made by individual Specialised Commissioning Groups about the services prioritised for designation locally and the timetable for implementation. This enables the programme of designation to reflect local requirements and priorities.

17. West Midlands Specialised Commissioning Group has developed designation material on behalf of all Specialised Commissioning Groups for medium secure mental health services. Nine of the 10 Specialised Commissioning Groups commission medium secure services. The National High Secure Commissioning Team, which takes its lead and is actively supported by the National High Secure Commissioning Group which is inclusive of Health Commission Wales, has been established as a standing committee of the National Specialised Commissioning Group to help strengthen commissioning arrangements for high secure services.

18. The 10 Specialised Commissioning Groups are sub-committees of their constituent PCT Boards and reflect the geography and the populations they serve. Their priorities also reflect the geographical pattern of provision and the live issues within local communities. However, as part of the overall development of specialised commissioning, Specialised Commissioning Groups have identified 10 service areas for service mapping and benchmarking. This work programme has been endorsed by the National Specialised Commissioning Group and is being led by the Specialised Commissioning Group Finance Network, chaired by the Director of Finance from the South West Specialised Commissioning Group. It is also anticipated that this “top 10” list will be used in other pan-SCG discussions, for example on developing CQUIN goals.

19. The Specialised Commissioning Groups have broadly implemented an annual prioritisation process and the National Specialised Commissioning Group agreed a 2009–10 National Specialised Commissioning Group Business Plan. The Specialised Commissioning Groups are now working to further develop annual prioritisation processes for the 2010–11 Operational Planning round and have agreed key elements of the national work programme for 2010–11.

20. Good progress is being made on reviewing the Specialised Services National Definition Set. This work is strengthening the clarity of definitions which will help to support commissioning processes such as service reviews and strategic planning and making comparisons on activity levels and spend. 21 definitions have now been updated and a further 13 will be available by February 2010.

21. The 10 Specialised Commissioning Groups are sub-committees of their constituent PCT Boards and are very different organisations with different priorities and this has sometimes made it difficult for them to agree priorities for joint working. However, as noted above, the National Specialised Commissioning Group has now endorsed a list of 10 priority areas for looking at service mapping to facilitate costing and the Specialised Commissioning Groups’ Finance Network will be taking work forward on these areas.

22. The majority of Specialised Commissioning Groups have patient and public engagement strategies and are reporting on progress in their annual reports. Specialised Commissioning Groups are actively engaging patients and the public. For example, the North West Specialised Commissioning Group has worked with patients to produce a newsletter aimed at individuals receiving dialysis. The East Midlands Specialised Commissioning Group has involved families of children with cancer through the region’s new integrated cancer service, working on a one to one basis with parents and children to ensure that the service meets their expectations and aspirations. Specific service improvements are now being implemented as a direct result of this involvement.
National Commissioning Group

23. The National Commissioning Group have developed standards for many national services, and outcome reporting is a central part of the annual review process for these services. For example, the National Specialised Commissioning Team has developed standards for liver and pancreas transplant and lysosomal storage disorders. Patient level outcome reporting is in place for almost all nationally commissioned services.

24. The National Commissioning Group has an annual process for considering new applications for nationally commissioned services. The National Specialised Commissioning Team is developing an ethical framework to support decision-making and prioritisation for these services from 2010–11 and is working closely with Specialised Commissioning Groups to prioritise applications for national commissioning.

25. For very rare diseases commissioning through the National Commissioning Group has enabled the NHS to commission services for a range of rare diseases concentrating expertise and sharing financial risk. The designation of specialised services and providers can sometimes feel at odds with the move within the NHS to a greater plurality of providers enabling competition to drive up quality. For many very specialised services there is a need to concentrate clinical expertise in a small number of centres to ensure patients receive high quality care. This is particularly true of services for patients with very rare diseases where there may only be one or two expert clinical teams in England.

26. This is widely recognised by clinicians and patient groups. Organisations representing patients with lysosomal storage disorders were hugely supportive of national designation and commissioning. Clinicians in all nationally commissioned services emphasise the benefits of centralisation and England has shown international leadership in the treatment of choriocarcinoma, severe combined immune deficiency (including gene therapy), epidermolysis bullosa (EB) and pseudomyxoma peritonei surgery.

27. Ministers continue to designate nationally commissioned services and providers. The National Specialised Commissioning Team is developing a process for the renewal of designation of nationally commissioned services, which will aim to review all services as part of a five-year rolling programme. This programme is expected to begin in April 2010.

CHALLENGES AND OPPORTUNITIES

28. There are inevitable challenges for commissioners who have to make difficult decisions to ensure the maximum benefit from available resources. These decisions need to be made in a way that takes account of local circumstances as well as of national policy. There can be tension between local priorities and calls for regional or national consistency with regard to specific treatments, drugs and targets. The challenge for specialised commissioners will be to strike a balance between local determination and national consistency.

29. The Specialised Commissioning Groups will need to continue to work together if they are to deliver national programmes; develop and implement designation standards across England; and develop consistent performance management metrics and understanding of costs and variations in patient pathways. The National Specialised Commissioning Group and National Specialised Commissioning Team will continue to facilitate this collaborative working.

30. Specialised services offer real opportunities for developing innovative services within the NHS. The process of designation allows for the controlled introduction of high-cost new technologies ensuring that they are properly tested as part of their introduction to use in the NHS. Examples include islet transplant, proton beam therapy and pulmonary thromboendarterectomy (PTE). Innovation needs to be supported appropriately in a move towards a period of tighter financial constraints within the NHS.

31. The introduction of the Commissioning for Quality and Innovation (CQUIN) framework and a clear focus within the NHS on quality is welcomed by the National Specialised Commissioning Group. This is an opportunity for specialised commissioners to build on existing outcome measures and ensure that they continue to improve the quality of the services they commission. The National Specialised Commissioning Team is working closely with the Department of Health to ensure that specialised commissioning maximises the benefits that CQUINS can offer. Several Specialised Commissioning Groups are using the CQUIN framework to ensure providers comply with national databases and the East of England Specialised Commissioning Group is seeking a reduction in MRSA bacteraemia incidents for renal dialysis patients.

32. The cost of treatment for some very rare diseases continues to be a challenge for the NHS. Some enzyme replacement therapies for very small groups of patients, and high secure mental health patients, can cost £300,000 per year for a single patient. As the NHS prepares for a period of greater financial constraints than in recent years, more must be done to ensure transparency in decision-making about specialised services and the balance of interests between individual need, cost-effectiveness and the demands faced by the NHS.

33. High-cost low-volume services often fail to meet the same cost-effectiveness criteria as more local NHS treatments for far more people are asked to meet. For specialised forensic mental health services, the issue is further compounded in that the flexibility which can be afforded most NHS contracts in activity is limited. For example, high secure mental health services capacity is subject to Ministerial agreement.

34. The challenge faced is deciding if the same criteria should be applied to all NHS services or if in some situations different criteria such as rarity, the value of innovation and affordability to the NHS should be considered. The National Specialised Commissioning Team is developing an ethical framework for the National Commissioning Group and National Specialised Commissioning Group that should help with
these decisions for nationally commissioned services and some Specialised Commissioning Groups are also
developing such framework. For example the South Central Specialised Commissioning Group has an
ethical framework in place that is helping ensure that robust and transparent decision-making about
specialised services takes place.

35. Specialised Commissioning Groups and the National Commissioning Group work hard to ensure
that they keep up to date with policy changes and best practice but it would greatly assist in the ongoing
development of special commissioning if Specialised Commissioning Directors and the Director of the
national Specialised Commissioning Team were routinely included in significant policy document and letter
 circulation from the Department of Health.

36. Specialised Commissioning Groups and the National Commissioning Group welcome the
introduction of World Class Commissioning and the development tool for Specialised Commissioning
Groups that the Department of Health has produced. They are keen to maximise the potential benefits of
World Class Commissioning for specialised commissioning.

September 2009

Memorandum by the British Society for Rheumatology (COM 62)

EXECUTIVE SUMMARY

1. The British Society for Rheumatology (BSR) exists to promote excellence in the treatment of people
With arthritis and musculoskeletal conditions and to support those delivering it. As a professional
association representing those with an interest in musculoskeletal conditions, BSR aims to improve
standards of care in rheumatology and secure a high priority for rheumatology services. With over 1500
members, including clinicians, scientists, academics, trainees, and allied health professionals, it seeks to
enhance the skills of the rheumatology team through education and professional development
opportunities. It also aims to ensure that those with an interest in rheumatology can access and contribute
to the most up-to-date evidence base.

2. The BSR notes that it is crucial that all PCTs move to world class commissioning as soon as possible,
both for the future of the NHS and in order to ensure that rheumatology patients receive the best possible
treatment.

3. The purchaser-provider split has begun to succeed in ensuring that patients are seen as customers
whose views are taken into account. However it has also resulted in many instances of needless barriers to
the provision of local services between primary and secondary care. These services need to be integrated and
cannot be adequately developed if short term contracts for care with different potential providers are
established.

4. On balance, rheumatology has been helped by the split; separating commissioning and providing
ensures a more balanced view of priorities.

5. Some aspects of the split however are not popular with many rheumatologists, who see it as leading
to a market driven system of providing healthcare by competitive tendering. Moreover short term market
contracts can break down multi-disciplinary teams.

6. The commissioner’s role is to balance patients’ desires with sensible healthcare resource allocation.
Practice-based commissioning should work in partnership with the PCTs so that GPs are equipped with up-
to-date information on the quality of local hospital services. Currently there appears to be no clear division
of resource and responsibilities between existing commissioning mechanisms and Practice-based
commissioning.

7. The great majority of rheumatic diseases can be adequately managed through secondary care
rheumatology units. Specialist commissioning is however vital for a small part of rheumatology services.
Decisions on how to provide such care should be taken in a balanced and fair way, ensuring that, where some
services are withdrawn, this does not happen until the new services are in place.

8. It is vital that commissioners have effective mechanisms to reward those who provide safe, good quality
services and penalise those who don’t.

9. Levels of service for individuals with rheumatic disease are not uniform across the country and in many
areas need to be strengthened. Commissioners in many circumstances need to facilitate robust liaison
between primary and secondary care providers to improve quality of care.

“World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

10. World-class commissioning is rightly regarded by the Government and the NHS Executive as vital
for the future of the NHS in the UK.
11. For many BSR consultant members commissioning is perceived in general to be of poor quality and to often not take adequately into account the views and advice from secondary care. This perception seems to correspond to evidence from the Healthcare Commission/Care Quality Commission Performance rating showing variable rates of PCT success.

12. The BSR notes that it is crucial that all PCTs move to world class commissioning standards as soon as possible to ensure rheumatology patients are being treated, and health professionals are working, in the most effective and appropriate environment.

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

13. The purchaser-provider split has begun to succeed in ensuring that patients are seen as customers whose views are taken into account (for example in prioritising rapid access to care which was not regarded by many clinicians as important compared with “clinical priorities”).

14. However it has also resulted in many instances of needless barriers to the provision of local services. Many patients with rheumatic diseases such as Rheumatoid Arthritis require long term treatment strategies for their care and the development of strong local services with input from several agencies such as physiotherapy, occupational therapy, often social services and sometimes psychologists. There need to be appropriate links to specialists in orthopaedics and pain management. These services need to be integrated and cannot be adequately developed if short term contracts for care with different potential providers are established.

15. For more effective care and efficient use of resources, barriers need to be broken down between primary and secondary care, building links to enable as much care as possible to be undertaken in primary care but with no restriction to secondary care when needed.

16. The purchaser/provider split has the potential to ensure that only good services are commissioned in future through patient choice, competition on access and quality initiatives such as CQUINS and Quality Accounts but there is a long way to go.

17. Separating commissioning and providing ensures a more balanced view of priorities, raising the profile of less fashionable issues such as long term condition management and prevention. Without a purchaser/provider split we would return to the days when hospitals and clinicians determined what was provided with little attempt at formal prioritization or evidence based choices.

18. On balance, rheumatology has been helped by the split (higher priority for long term condition care and the provision of TNF inhibitors according to national guidance not hospital budgets are the most obvious examples).

19. Some aspects of the split however (notably the commissioning of community Musculoskeletal (MSK) services) are not popular with many rheumatologists, who see it as leading to a market driven system of providing healthcare by competitive tendering. Examples include outsourcing of services (such as MSK services) often to private providers and sometimes with guaranteed income streams whether they do the work or not (eg ISTCs). This ultimately could move away from universal provision to a situation where the NHS is left only with the complex, difficult and less remunerative patients.

20. Finally, short term market contracts can break down multi-disciplinary teams. There is a specific point here (made in point 8) about competitive commissioning between GPs (Practice-based commissioning, PBC) and secondary care so that PBC is used to provide limited quality services in primary care (one local PBC group set up a clinic for “dry needling” painful soft tissue musculoskeletal conditions, an evidence free treatment, but one favoured by—and in fact undertaken by—a GP important in the PBC group). There can also be conflicts of interest where local GPs commission and also provide services which enhance their practice income.

Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

21. Practice-based commissioning assumes a level of knowledge, time commitment and interest in commissioning which many if not most GPs don’t have yet. Practice-based commissioning should work in partnership with the PCTs so that GPs are equipped with up-to-date information on the quality of local hospital services. A positive example of this partnership in Practice-based commissioning is the creation of a local MSK service (in NHS Lewisham, where the GPs prioritised better access to musculoskeletal care for more minor conditions. Here rheumatologists in the Trust successfully won the tender to keep work within rheumatology rather than losing it to external providers.

22. Moreover, there currently appears to be no clear division of resource and responsibilities between existing commissioning mechanisms and Practice-based commissioning. This leads to needless barriers, frustrations and lack of uniformity of approach to service provision.

23. Contestability and Payment by Results are essential cornerstones of the split and couldn’t exist without it.
24. The quasi-market refers to the fact that not all healthcare (especially for rare conditions or those requiring vast investment) can be provided sensibly on a pure market basis otherwise you finish up with a hospital on every street corner with its own trauma centre or every patient with backache seeing a neurosurgeon. The commissioner’s role is to balance patients’ desires with sensible healthcare resource allocation which is not a conflict but the necessary tension for their role.

**Specialist Commissioning**

25. The great majority of rheumatic diseases can be adequately managed through secondary care rheumatology units.

26. Specialist commissioning is however vital for a small part of rheumatology services such as paediatric rheumatology, complex connective tissue diseases, inherited MSK diseases and so on where the demands are relatively low and the services need to be provided on a networked basis across many providers or provided by only a few providers. For a few specialised conditions such as severe vasculitic diseases referral to tertiary care centres may be needed.

27. This mechanism should be supported in appropriate areas, ensuring that decisions on how to provide such care are taken in a balanced and fair way and that, where some services are withdrawn, this does not happen until the new services are in place. There needs to be good rapport between centres and historically most rheumatology units have developed appropriate links. Commissioning must take these links into account when making appropriate contracts.

**Commissioning for the Quality and Safety of Services**

28. The enhanced emphasis on quality in the final report of the Next Stage Review, Healthcare for All, is the vital next step in developing a really good NHS now that access and some element of patient choice has been introduced.

29. It is vital that commissioners have effective mechanisms to reward those who provide safe, good quality services and penalize those who don’t—the financial penalty of CQUINS is one such mechanism and no longer commissioning low quality services is another.

30. For Rheumatoid Arthritis, recent NICE guidance for management and the development of the commissioning pathway for inflammatory arthritis provide vital standards for levels of care.

31. In addition it is apparent from reports such as from the Rheumatology Futures Group and the National Audit Office census that levels of service for individuals with this disease are not uniform across the country and in many areas need to be strengthened.

32. Commissioners in many circumstances need to facilitate robust liaison between primary and secondary care providers to improve quality of care for individual with rheumatic diseases which are not only a major cause of disability and loss of earnings to the individual and to the economy in general, but are also associated with other co-morbidities and reduced life expectancy.

September 2009

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**Memorandum by Bupa (COM 63)**

1. **About Bupa**

1.1 Bupa is an international leader in health and care. We exist solely for the benefit of our customers as we have no shareholders. This allows us to reinvest our profits to provide more and better healthcare for our members. With our international reach, serving customers in 190 countries, we can benchmark the care we provide against best practice across a range of markets. As the second largest commissioner of care in the UK we can complement our international experience with 60 years of procuring and delivering care in the UK, and a framework of clinical understanding, based on owning and managing hospitals, all of which we seek to bring together to support the NHS commissioning agenda.

1.2 Bupa entered the NHS commissioning space in 2007 in response to the Department of Health’s introduction of the Framework for External Support for Commissioning (FESC). Following our acquisition in 2008 of Health Dialog Inc., a leader in the field of disease management in the United States, we merged Health Dialog UK and Bupa Commissioning to create Bupa Health Dialog Ltd. (BHD) to better support NHS commissioning.

1.3 BHD partners with a broad range of NHS commissioners including Practice Based Commissioning Groups, Primary Care Trusts and Strategic Health Authorities. Our range of clinically-led services, underpinned by a sophisticated analytical service, takes a “system-wide” approach to commissioning, encompassing both primary and secondary care. This ensures our clients can measure, monitor and evaluate the interaction and impact of their current decisions and then prioritise, design, plan and deliver future commissioning actions across the whole of their health economy.
1.4 BHD’s proposition is relevant to the NHS’s focus on better balancing supply and demand by improving the efficiency and effectiveness of commissioning. Our emphasis is on supporting the better allocation of resources to deliver higher quality health outcomes and we root all we do in measurable outcomes and savings. We advise PCTs how to better manage the need of their health populations and we add value by drawing on our international expertise and by using data driven decision methods.

Executive Summary

— We believe the intent behind World Class Commissioning (WCC) to be correct; any framework weaknesses we perceive are with the lack of execution and implementation support, focus and guidance.

— Key challenges facing commissioners at the “coal face” include the lack of data, tools, delivery frameworks and the specific skill sets to deliver actual commissioning actions. WCC tends to deal with the aims of commissioning and the “how” (process) not the “what” (the actual doing).

— To address this issue, there needs to be more emphasis on data and information acquisition to give commissioners the tools they need to manage demand more effectively.

— This data also needs to be in an appropriate, user friendly format. One area where companies like Bupa can add value is in ensuring that current NHS data is brought together in easy to access and relevant formats.

— Despite being highlighted as one of the 10 core WCC competencies, our experience is that greater up front clinical involvement in core day to day commissioning activity could result in more appropriate care being delivered more consistently.

— The patient choice agenda could also be enhanced by greater emphasis on educating doctors and patients about how to have a more informed conversation about the medically evidenced alternative care choices available to the patient, not just the care setting.

— We also perceive a wider role for complementing existing primary care services with greater nurse delivered health coaching especially support for the chronically ill to more effectively manage their conditions and to therefore avoid unnecessary hospital admissions.

We have focused our answers in response to questions 2, 3 and 4 in the call for evidence, where we feel we have the greatest insights to add:

2. World Class Commissioning: what does this initiative tell us about how effective commissioning by PCTs is?

2.1 Our international experience reinforces our view that the majority of public health systems face similar challenges: medical inflation, an ageing population, an increase in lifestyle related chronic conditions, increasing expectations of the level of service and an increase in public sector pension burdens. The intent, therefore, of WCC to improve productivity and better align resources as a response to tackling these cost trends was correct, but the challenges have been around building execution capability to meet the framework expectations.

Context

2.2 In our view, the original impetus behind the Framework for Support for External Commissioners (FESC) was an attempt to provide more delivery mechanisms and to bring more commercial skills to the management of PCTs by bringing in major private sector healthcare companies to manage primary care commissioning directly. This initiative marked a parallel to the introduction of Independent Sector Treatment Centres (ISTC) on the provider side. Whilst the independent sector managing whole geographies did not materialise, the Framework has mutated to a useful tool for PCTs to tender large scale bundles of commissioning support services to enable them to “upskill” themselves and improve delivery against the WCC agenda.

2.3 The mantra of WCC has been a movement from “diagnose and treat” to “predict and prevent”—in other words to ensure that the system effectively looked at the pinch points in the current NHS market and tackled them before they developed into more costly outcomes. The most quoted example is, of course, how better commissioning can reduce costly, and unnecessary, hospital admissions. However, it quickly became apparent that the NHS lacked the core skills to effectively “predict” the needs now—and in the future—of any given locality. This gap was partly a consequence of the lack of analytical data, which is where Bupa’s skills and expertise can help.

An example of a service procured under FESC which enhanced a PCT skill set, engaging resource to improve patient care and value for money

Bupa is delivering a collaborative care programme in West Kent implementing predictive risk modelling at PCT and GP level.

Our analytics target patients, including those with chronic conditions, who are missing recommended care; people at risk of hospital or accident and emergency admission; those facing selected surgeries; and people who have high future predicted health needs.
The Care Call programme uses BHD’s NHS trained nurses to deliver intensive non-directional whole-person health coaching which is designed to influence the behaviours of the most targeted patients.

This supports the PCT to deliver a long term condition care management programme, reduce high cost avoidable hospital admissions, commission more relevant services in the community and improve the patients care, support and improve health outcomes.

The programme has so far enrolled 233,000 people with less than 4.5% of the population not taking up the service and is being managed within tight return of investment criteria by the PCT.

Challenges facing commissioning

2.4 The key PCT performance measures are national health outcome measures, national and local targets, delivering break-even and World Class Commissioning scores. The question is, how can these assessments be improved and how can PCTs become more effective commissioners? We believe a number of system changes could be made, which are explored in more detail below.

2.5 Bupa believes that commissioning intentions are in the right direction but the areas to further focus on are execution and delivery. Implementation effectiveness depends on commissioners having the data and experience to enable them to truly assess local health needs, reduce avoidable hospital admissions and ensure the availability and the right supply of care. WCC tends to focus on the “how” (process) not the “what” (actually doing). More, consideration needs to be been given to the specific skill sets required to be an effective implementers of change along specific care pathways.

2.6 A starting point for improving implementation and delivery would be more emphasis on the standard of data in assessing population health needs and targeting care. Without a good level of underpinning data, it is difficult to see how the optimal resource allocation decisions can be made. Bupa’s recommendation would be that there needs to be more emphasis on requiring PCTs to link existing GP, social care and national patient data to support practice based commissioners.

2.7 This data also needs to be in an appropriate, user friendly format. There is an abundance of data within the NHS but where companies like Bupa can add real value is in ensuring that it is brought together in easy to access and use formats designed with the actions commissioners and GPs need to take account of in mind.

An example of how managing data more effectively can improve commissioning

BHD is currently working with West Midlands SHA to develop an innovative set of predictive models and whole population applications of evidence based clinical informatics.

This model will unite GP and hospital data across all of the participating PCTs within the SHA and each PCT and Practice Based Commissioning Group will have a patient risk profile and likely expected future risk based on a unique Patient Profile for every patient.

This allows the PCT and the GPs to understand and manage patient journeys across the health care system, rather than episodes of care and provides for the integration of primary and secondary care data at the patient-level.

Importantly, it also provides for coordinated interventions across PCTs, practices, providers and social care and allows GPs to prioritise workload in resource constrained times, as well as reach patients in need they may not be aware of.

2.8 Despite being highlighted as one of the 10 core WCC competencies, our experience is that greater up front clinical involvement in core day to day commissioning activity could result in more appropriate care being delivered more consistently. Our work indicates that clinical involvement in assessing the validity of clinical encounters can double the savings identified from transactional invoice validation, a core commissioning task. Moreover, the discovery of referral patterns opens the possibility for care pathway redesign allowing for system reform not just tighter care costing.

2.9 There also needs to be greater emphasis on educating doctors and patients about how to have a more informed conversation about their care choice and the medically evidenced alternatives available for much elective care. Our evidence from the US tells us that where patients have greater choice, often revealed via closer collaboration, they tend to choose less invasive procedures, which in turn reduces the cost of care. For example, in a UK trial involving potential hysterectomy patients, the standard care pathway resulted in average costs of £2,053 per patient, while a path including decision aid videos and nurse coaching resulted in an average cost of £1,169 per patient.175

2.10 We also perceive a wider role for complementing existing primary care with greater nurse delivered health coaching—especially support the chronically ill to more effectively manage their conditions and to therefore avoid unnecessary hospital admissions.

175 Cited in Health Affairs and other publications.
Case Study—the role of coaching

The appeal of the Bupa Care Coaching programme for our partner PCTs and SHAs is partly based on the analytic underpinning of the programme, where the individuals generating the highest costs can be identified and targeted with the most appropriate care, but also the level of patient engagement it creates and the empowerment of patients to manage their chronic conditions.

BHD in the UK provides, through its 24/7 NHS trained nurse coaches’, intensive non-directional whole-person health coaching which is designed to influence the behaviours of the most at risk patients.

Norfolk Health and Social Care Economy invited Bupa to develop and deliver a Long-Term Condition (LTC) management model. Using predictive risk modelling, individuals were identified along the whole continuum of risk (not just those who have experienced a recent hospital admission) to touch those migrating across segments of need.

Patient surveys have shown the following results:

— 73% were satisfied with Health Coaching input.
— 83% would recommend the programme.
— 96% felt they acted on the outcome of the call.

— This pilot programme demonstrated a 1.9 to 1 return on investment for the PCT.

3. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

3.1 The major reform of the last 20 years has been the creation of an NHS market. Fundamental to this innovation has been the split between the commissioning organisations that purchase care on behalf of patients, and oversee GPs to manage demand and prevent illness and hospital admission; and the providers, especially acute care providers, who deliver care. Commissioning has split the provider/commissioning roles to increase competition in the system, and to empower the NHS, used to delivering block contracts, to better analyse the needs of the local community. So one of the benefits of the purchaser/provider split is that it has emphasised the specialist requirements of each side.

3.2 Today, 90% of all funding flows from PCTs as they buy care on behalf of patients. PCTs oversee GPs, manage provider arms which deliver community services, commission acute care and ensure the standard of care is delivered. GPs prescribe patient care which, when delivered in the acute sector, is booked through the “Choose and Book” system which is meant to provide patients with multiple choices for the location of their care. GPs advise the patient on the outcomes, service levels and proximity of each choice. However, the physical location of services, tradition, training and the existence of an established care pathway in reality mean that most patients attend the same facility as when care was block purchased and choice was limited.

3.3 Given the broad political alignment over the provider/commissioner split the major commissioning tools or levers to drive down costs and improve quality over the next few years will, on the primary care side of the system, be:

— preventing and reducing admissions—especially keeping the chronically ill out of hospital;
— better management of the patients’ journey through the care system, as well as reducing access to inappropriate or out of date services;
— providing cheaper services in the community and closer to people’s homes; and
— better integration of health and social care.

This pressure will mean that commissioners will require an increased skill set to deal with the challenges posed by the purchaser/provider split—and ultimately more specialism introduced into the system to complement the work that is already taking place.

4. Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

4.1 Given the importance we attach to greater collaboration between clinicians and commissioners, we support the principles of Practice Based Commissioning, because it brings the commissioning decisions as close as possible to the GP and the patient. It also gives the GP a greater responsibility for ensuring that appropriate of care is procured and the result is that the GP has greater visibility of the patient journey. In order for GPs to be more effective commissioners, however, they need the right level of data about their patient population to empower them to do their job and, importantly, change the patient pathway to benefit the patient. To this end, Bupa believes that GPs need to get a clearer picture of the care in their locality, by combining their own data with hospital data. This in turn enables GPs to reach out to those most in need—usually those with long term conditions—and ensure they are treated in the right way in the right location.
4.2 Payment by Results highlights the need for greater collaboration between GPs and commissioners and should reflect the care a patient receives, not the setting in which it is delivered. Once again, data is required to enable commissioners to spot referral pattern trends that indicate delivery of inefficient or sub optimal care as well as inappropriately costed care. Only by ensuring clinicians are part of assessing a medical encounter can these patterns be revealed.

Case Study—Payment by Results

Milton Keynes PCT and Milton Keynes Foundation Trust reached agreement on the financial year, although at significantly higher than budgeted performance levels exceeding the plan by several million.

Based on high level productivity benchmarks, the PCT believed one specific area for over-performance was due to unnecessary admissions of emergency patients. The FT maintained that the benchmarks were not applicable and that all emergency admissions were warranted.

Bupa Health Dialog was asked to advice on how to resolve the situation.

BHD and the PCT identified that the largest anomaly was likely to be found in patients admitted for less than one day, as many of these patients could be treated in A&E or Assessment Units rather than being admitted to wards.

As a first validation, BHD reviewed data for all emergency admissions over the past six months, amounting to 5,000 spells. Every spell was manually reviewed by BHD’s experienced clinicians, who found that 75% of the spells were potentially unwarranted or lacked support in the data to justify admission. BHD outlined an audit methodology which was agreed by all parties.

Additional evidence supporting admission was found in only 16% of the audited cases—leaving 84% emergency ZLOS admissions without sufficient clinical rationale to admit the patient. BHD estimated that the additional cost for reimbursing a full admission rather than A&E or an Assessment Unit was estimated to be up to £4 million per annum.

BHD made recommendations on appropriate levels of reimbursement for emergency admissions, and the PCT and FT agreed to review admission and reimbursement practices. These negotiations are progressing without BHD participation.

5. Conclusion

5.1 Bupa is delighted to be able to respond to this timely inquiry into commissioning. From our experiences, we believe that much progress has been made since the launch of World Class Commissioning in the UK and real efficiency savings are being made that are of genuine benefit to the NHS and patients alike. However, as we have outlined in this paper, more work needs to be done to ensure that outstanding challenges are overcome, particularly around ensuring commissioners have the right tools and skills sets to effectively deliver at a local level. There are a number of lessons that can be learnt from the case studies we have included in this paper and we believe that WCC can truly become world class if an effective dialogue is orchestrated between Government, commissioners and the private sector. We look forward to playing our part in this exciting and ongoing debate.

September 2009

Memorandum by NHS Hammersmith and Fulham (COM 64)

EXECUTIVE SUMMARY

NHS Hammersmith and Fulham is supportive of the World Class Commissioning initiative as a means to facilitate the development of commissioning expertise to ensure the delivery of better health outcomes for our local residents. In addition, our integration programme with the council is enabling a greater commissioning focus on the local community to ensure that the health and social care needs of residents are being met in a collaborative manner. Our work in leading the local health economy has been evident in the recent opening of two hospital based polyclinics which include GP led urgent treatment at the front end of A&E, Fulham Centre for Health at Charing Cross Hospital and Hammersmith Centre for Health at Hammersmith Hospital.

1. NHS Hammersmith and Fulham has found the World Class commissioning a useful framework to enable us to determine a baseline for the PCT’s commissioning expertise and as a comparator to other PCTs. The framework helps us to describe the aspiration of what excellent commissioning looks like. It enables PCTs to respond by referencing the competencies in the planning stages of the commissioning cycle to support better commissioning. The development of the PCT has been aligned to achievement of the competencies and in order for the initiative to embed, it is important to keep it in place for several years in order to monitor and measure improvements against the competencies.

2. World Class Commissioning has also shifted commissioning focus to a more outcome based approach. This is enabling PCTs to commission for the quality and safety of services.
3. The purchaser provider split in Hammersmith and Fulham has happened in shadow form from 1 March 2009 and it is still too early to assess its impact. However, it has enabled the commissioning organisation to be much more focussed on its commissioning responsibilities. This development along with integration of the commissioning arm with the Local Authority (we have a joint Chief Executive) is helping to pool commissioning expertise and focus attention more sharply on commissioning services that meet the needs of the residents of the borough in a collaborative manner.

4. As a commissioner we are now better able to respond to new initiatives such as polysystems and there is less of a conflict of interest when it comes to commissioning new and innovative services which require provision by what was our provider arm.

5. In addition, the setting up of Sector Acute Commissioning Units is providing greater leverage when commissioning acute services and has meant that the borough based PCT (integrated with the council) can focus more on out-of-hospital care in line with Healthcare for London and shifting activity from acute setting to community settings (where this is clinically appropriate and in line with patients' needs).

6. Examples of commissioned work that is helping to deliver improved outcomes are:

   (a) Implementation of heightened quality programme with GPs (Quality and Outcomes Framework + (QOF +)) to improve the quality of services to patients.
   (b) Commissioning of primary care led “front-ends” to Hammersmith Hospital and Charing Cross Hospital.
   (c) Stimulating the market for smoking cessation services to encourage greater competition and encouraging entry into the market of a new provider as well as increasing the number of smoking quitters.
   (d) Development of a joint commissioning plan with the council (including focus on deprived families, social housing, services for young people and those with long term conditions).

7. Practice Based Commissioning is at an early stage in the borough but as a concept, it helps to ensure greater clinical input into commissioning decisions. By working closely with practice based commissioners and other GPs, through the Professional Executive Committee and outside of this structure, commissioning work has been strengthened, with a focus on the patient pathway. A recent example has been the commissioning of new musculoskeletal services.

   NHS Hammersmith and Fulham is proud to be at the forefront of new initiatives in London with both integration with the council and as one of two exemplar sites in London for the polysystems programme as key parts of our strategy to strengthen the commissioning of services for local residents.

   September 2009

Memorandum by the Federation of Specialist Hospitals (COM 65)

1. Executive Summary

   The Federation of Specialist Hospitals has been formed to provide a shared voice for the few remaining specialist hospitals in the UK.\(^{176}\)

   These hospitals, with their extensive experience of high volumes of complex procedures, can provide the type of multidisciplinary teams and leading-edge treatment that are the only, and sometimes last, hope for patients with a range of very rare conditions or serious complications.

   We are of the view that patients with highly complex conditions or complications are sometimes either suffering because they cannot access the right treatment or worse are suffering at the hands of inexpert treatment. A good example is the thoroughly unsatisfactory situation regarding the numbers of patients who require breast reconstruction revision surgery following mastectomy after being treated by surgeons who have not been trained in the latest techniques and technology.

   The failure to date to push through the Carter Report proposals for Specialised Commissioning, has led to a situation whereby commissioners are less interested by low volume procedures/treatments and in many cases neglect them—this leads to a fractured national service for many highly complex conditions—for example the provision of paediatric scoliosis surgery in the UK is in complete disarray.

   We believe that there needs to be a national vision for super specialist hospitals—one that combines specialised commissioning and strategically commissioned out-reach models, such as hub and spoke and satellite models, to extend access to super specialists and raise standards throughout the country. Successful examples include:

   — The burns service provided by Queen Victoria Hospital in East Grinstead which uses live video links to swiftly assess patients in the community and avoid losing vital time.

\(^{176}\) See Appendix 1 for list of UK Specialist Hospitals.
— The hub and spoke model based at the Nuffield Orthopaedic Centre that delivers care to paediatric rheumatology patients across the region.

— The satellite model used by Moorfields Eye Hospital, which set up its first satellite at Northwick Park Hospital 14 years ago and now operates from 12 sites across London and the South East.

— The Walton Centre’s role as the sole provider of neurology services in 14 different District General Hospitals with a catchment population of 3.5 million (across Cheshire, Merseyside, the Isle of Man and North Wales). This has been in action for the past 15 years and involves hospitals up to 80 miles away. They also provide elective tertiary services to PCTs across the country.

In our view the only way to improve the quality of care received by this vulnerable group of patients is to make the next editions of the National Commissioning Groups Definitions Sets wholly mandatory on either a national or regional level, from a nationally vetted group of specialised providers.

The current process of involving clinicians and the Royal Colleges in creating robust definitions of what should be specially commissioned and then not obliging commissioners to adopt these does patients a disservice. We are not proposing the wholesale removal of specialist treatment from District General Hospitals—but rather the removal of a very small number of “super specialist” procedures in order to protect patients.

In summary—more lives can be saved if super specialist services are strategically commissioned and provided by super specialist hospitals.

2. INTRODUCTION

This memorandum of evidence is offered in response to the Committee’s call for evidence on commissioning and, given the nature of our member organisations, focuses on specialised commissioning.

The Federation of Specialist Hospitals works with many of the few remaining specialist hospitals in England: a list of specialist hospitals is contained in Appendix 1. Please note that the comments in this review are a composite view from the trusts involved with the Federation and may not represent exactly either the views or situation of every trust.

These hospitals currently play a major role within the English NHS in their specialist areas in respect of patient care, training and research. Patients travel large distances to access their services regionally or nationally, particularly those that are not available to patients locally. These hospitals are very highly rated by patients, for example in the 2008 in-patient hospital survey specialist hospitals were in the top 10 in all categories.

These hospitals play a major role in training the national specialist workforce. Their status as national centres of expertise ensures unrivalled experience for trainees in all medical disciplines, who gain experience of a rich variety of rare and difficult problems, unmatched in other centres. They are also important centres of research and innovation, developing new treatments that are subsequently adopted in the rest of the NHS and in other health systems.

As the proportion of elderly patients increases and the range of treatments and drugs available grows, the role of specialists will be vital in ensuring the appropriate treatment is available for increasing numbers of complex cases.

3. BENEFITS OF SPECIALIST HOSPITALS

3.1 Improved clinical outcomes

These hospitals, with their extensive experience of high volumes of complex procedures, provide the type of multidisciplinary teams and leading-edge treatment that are vital for patients with a range of serious complications or rare conditions. For example:

— In a recently published European trial, Moorfields NHS Foundation Trust’s success rate in retinal detachment surgery was 84% compared with 64% for similar patients elsewhere. In another recent study, Moorfields’ rate of significant complications following glaucoma surgery was 3% compared with 20% nationally.

— St Mark’s Hospital in London, a national and international referral centre for intestinal and colorectal disorders, is unique in the UK in providing a blend of subspecialist multidisciplinary practice that allows the management of virtually all complex colorectal disease and complications. It is also the only national centre for polyposis syndromes, one of two national intestinal failure centres, the only endoscopy unit in the UK recognised by World Organisation of Digestive Endoscopy as a World Centre of Excellence, a Cancer Network designated anal cancer centre, national bowel cancer screening hub and centre and a national laparoscopic surgery training centre. This level of expertise is borne out in statistics such as St Mark’s screen detection rate of colorectal cancer (adenoma), which is 62.65 against a national target of 35.
— The 2008 report of the Myocardial Ischaemia National Audit Project (MINAP) showed that patients taken to Harefield for primary angioplasty—in which a catheter is used to unblock arteries and a stent used to keep the arteries open—are treated within 23 minutes of arrival at the hospital. The national average is 56 minutes. Time is critical when giving heart attack treatment as the longer an artery remains blocked, the greater the damage. The service at Harefield’s Heart Attack Centre is used as a model by healthcare professionals establishing similar services around the country, and staff frequently run training sessions and conferences.

— Surgeons from Harefield have become the first in Europe to successfully use a new procedure known as ex-vivo lung perfusion (EVLP) which improves the condition of donor lungs, making them suitable for transplantation. It is estimated that over 80% of donor lungs are currently not suitable for transplant and EVLP can increase the retrieval rate by around 50%—something that is critical when the shortage of donor organs means that patients still die on transplant waiting lists.

3.2 Low infection rates

Most specialist elective units have significantly lower infection rates, something that is particularly important when dealing with some of the most fragile patients. For example, in the UK’s five specialist orthopaedic hospitals infection rates run at 0.2% for primary hip and knee replacements (many of these complex cases)—against a national infection rate of 1%-4%. This pattern is repeated across the specialist hospitals with significantly lower infection rates across the specialties. This, of course, reduces both suffering and cost.

3.3 Value for money

Understanding what is appropriate treatment for complex cases and patients, and thereby ensuring that they are treated by appropriate providers, not only ensures better outcomes for patients, it also saves the hard pressed public purse.

Furthermore, specialist hospitals provide care of the highest quality and “get it right first time”; for example avoiding the need for correction surgery, and long term dependence on social care, reducing costs and allowing patients to experience a better quality of life. Indeed, we are strongly of the view that many initially more expensive treatments save thousands of pounds over the longer term. Examples include properly managed rheumatism, or successfully treated sight disorders.

3.4 Research and development

Groundbreaking research is carried out throughout these specialist centres, as a part of a focus on improving the understanding and treatment of common and rare diseases of all types, by placing the clinical needs of patients at the heart of a drive for scientific advancement and innovation. This is because the most talented medical experts are rarely content with using tried and tested methods to treat their patients. The opportunity to influence the course of modern medicine by developing new treatments is a prospect which attracts clinicians and academics to specialist centres, where research opportunities are a fundamental part of delivering patient care, for example:

— For example, the Royal Brompton and Harefield NHS Foundation Trust is responsible for carrying out the world’s first heart/lung transplant, and first percutaneous heart valve replacement for aortic incompetence; the UK’s coronary angioplasty. They also set up the first adult congenital heart disease unit in Europe.

— The Royal Brompton and Harefield also host the world’s largest trial of gene therapy for cystic fibrosis. The trial is being conducted by the UK Cystic Fibrosis Gene Therapy Consortium, made up of approximately 80 clinicians and scientists in the UK, from the Royal Brompton/Imperial College and Oxford and Edinburgh Universities.

4. The Issues

In 2006 the Carter Review of commissioning for specialised services found that problems identified in earlier reports from the Clinical Services Advisory Group and the Audit Commission had not been fully addressed. Commissioning and financial arrangements were still unsatisfactory.

Despite the findings of these authoritative reports, the measures necessary to optimize and support specialist hospitals (and specialist centres that form parts of other trusts) have not been taken. As a result, serious problems remain which threaten their long term future and therefore the continuing provision of high cost specialist services.

First, although recent changes, such as those introduced with HRG 4 to the national tariff for hospital services, have been helpful, they have not gone far enough in funding highly specialised care sufficiently. Some procedures continue to be loss making. Local purchasers typically devise ad hoc solutions to ensure current services are maintained, but these do not provide a sound basis for long term service planning and development. In addition this poses an unfair burden on the “host” PCT.
Second, the changes recommended by the Carter Review for the organisation of commissioning of specialist services have not been fully implemented. Strategic Health Authorities have not universally adopted the Carter Review proposals. Commissioners at PCT level do not have the necessary expertise and higher level commissioning remains poorly organised in many parts of the country.

As a result, in some parts of the country patients do not have access to the treatments they need. For example the provision of paediatric scoliosis surgery is in complete disarray and the provision of services for people with genetic eye disorders is very uneven: some parts of the country have very limited services available and treatment rates are much lower than the national average.177

Furthermore, some patients are being treated by surgeons without the necessary expertise; for example many patients who would benefit from a particular type of specialist breast reconstruction surgery are not even made aware of the treatment that they should, and could, be receiving and suffer as a result of inadequate treatment.

5. What Should be Done

The Federation supports the current arrangements for specialist commissioning at national level: some of the services its members provide are contracted for in this way. It also supports the current arrangements for defining which services should be categorised as specialist. The procedures followed are rigorous, involve a wide range of clinical opinion and therefore command respect across the NHS as a whole.

The need now is to ensure that these services are properly commissioned at a regional level by the regional Specialised Commissioning Groups—and solely from approved specialist providers. The proposals made in the Carter Review point the way forward. The need now is to implement them. It should be made mandatory that the treatments defined in the National Commissioning Groups Definition Sets are specially commissioned at regional level. It is certain that patient outcomes will improve if these most complex cases are treated only by specialist providers.

The second requirement is for a change in the way that the tariff is set for specialist procedures. How this should be done depends on the organisation of commissioning but at the most basic level requires an overhaul of the coding system that enables providers to claim for specialised work. An improved coding system should make use of coding combinations and both diagnostic and procedural codes. The current system leaves many specialists simply unable to claim for complex work. These types of improvements will only be possible if the Department allows experts from specialist organisations to become very closely involved—as it is unreasonable to expect departmental staff to be au fait with this level of specialism.

At a strategic level there is a need for some/all specialist treatments to be planned at national level. We propose that for each specialty a “task and finish” group should be established to estimate current and future patient needs and the capacity need to treat them. This would provide the essential foundations to support regional commissioning. The work carried out by the PHG Foundation178 in relation to genetic eye disorders provides an excellent example of what is required.

We consider that patients, or their representatives, should be included in this work and that steps should be taken, eg through NHS Choices, to ensure that patients are properly informed about the treatments available for their condition.

6. Conclusion

Lord Darzi’s report Next Steps sets a new agenda for the NHS focused on quality of care. The Federation believes that ensuring the availability of high quality, strategically planned and appropriately funded specialist services to patients in all parts of the country is a key part of that vision. It hopes therefore that the Committee will support the proposals set out above.

September 2009

APPENDIX 1

LIST OF UK SPECIALIST HOSPITALS

Wrightington Hospital (part of Wrightington, Wigan and Leigh NHS Foundation Trust)
Royal National Orthopaedic Hospital NHS Trust
Nuffield Orthopaedic Centre NHS Trust
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
Royal Orthopaedic Hospital NHS Foundation Trust
Royal Brompton and Harefield NHS Trust

177 Genetic Ophthalmology in Focus, Tony Moore and Hilary Burton, Report for the UK genetic testing network It is published by the PHG Foundation, Cambridge.

178 PHG Foundation is an independent not-for-profit public health organisation focusing on the translation of science and biomedical innovation to improve health; especially genome-based science and technologies and the actions needed to change healthcare policies and services to deliver the benefits of research to populations worldwide.
Memorandum by the NHS Sickle Cell and Thalassaemia Screening Programme (COM 66)

SUMMARY

This paper sets out details of the influence and impact commissioning has on the screening of sickle cell and thalassaemia; highlighting issues that raise questions for all screening programmes and “specialist” disease areas. The specific problem areas addressed are:

— The difficulty of commissioning a joined up patient journey across disparate health settings.
— The challenge of ensuring due attention is paid to “specialist” disease areas like sickle cell and thalassaemia.
— Enabling effective commissioning and uniform standards of care in both high prevalence and low prevalence areas.

1. INTRODUCTION: ABOUT THE NHS SICKLE CELL AND THALASSAEMIA SCREENING PROGRAMME AND THE DISEASES

1.1 Sickle cell and thalassaemia (SC + T) are serious inherited disorders affecting the capacity of red blood cells to carry oxygen around the body. In England, sickle cell is one of the most common inherited conditions affecting some 14,000 people. Together there are some 240,000 genetic carriers for these conditions in England.

1.2 The NHS Sickle Cell and Thalassaemia Screening Programme (the Screening Programme) is the first in the world to offer a linked antenatal and newborn screening service. It is also now working closely with a range of clinical, policy and patient stakeholders to develop a network of managed clinical care.

1.3 The conditions predominantly affect people from black and minority ethnic populations. Hence addressing these conditions not only fulfils important health priorities but also addresses other key government agendas including health inequalities and diversity.

1.4 There are lessons from our programme that apply to other screening programmes, to genetic conditions and, more broadly, to the management of long term chronic conditions.

2. SPECIALIST COMMISSIONING AND VARYING PREVALENCE

2.1 Effective specialist commissioning is critical for SC + T, it is the only way to guarantee that patients across the country will have access to services. The SC + T Programme has had some success in establishing national commissioning protocols. The Specialised Services National Definition (SSNDS) for sickle cell and thalassaemia was agreed in December 2008 by the Specialist Commissioning Group.
2.2 However not all Specialised Commissioning teams have taken on board commissioning for these services, nor is it mandatory for them to do so. The sickle cell and thalassaemia SSNDS was number thirty-eight on a list of priorities. We understand that many Specialised Commissioning teams have only commissioned up to about number twelve. Hence provision of care is uneven across England, further exacerbating health inequalities.

2.3 The varied prevalence of SC+T, like other genetic diseases, presents a particular challenge to commissioners: commissioning at a local level needs to reflect the particular needs of that community. Nevertheless, SC+T screening is a national programme and there are patients in lower prevalence areas who still need access to quality and accessible care. Commissioning systems need to clarify how standards of care and screening will be delivered in the context of the local situation.

2.4 While acknowledging the need for prioritisation in specialist commissioning, there needs to be effective incentives to reward the effective commissioning of specialist services where it is relevant for specific local communities. Sickle cell and thalassaemia are not a priority for every Trust but there is evidence that relative impact and importance of the disease can be underestimated; sickle cell is one of the most common inherited diseases in England (more common than the much more widely known cystic fibrosis).

3. Commissioning a Joined up Journey Across Disparate Services

3.1 Screening programmes, especially those where screening is directly linked to clinical care, epitomise one of the key challenges of effective commissioning. Patients can make a journey that cuts across different health specialties and settings—and hence commissioning systems. So, in the case of SC+T, this journey can involve primary care, community and hospital-based midwifery, laboratory services, genetic counselling, obstetrics, paediatrics, haematology, child health, and care in community, general hospital and specialist hospital settings.

3.2 The key challenge for commissioning is to enable a joined up service. This applies both to the experience that patients have, and to the effective management of services—for example clarity of payment, data capture, quality management, failsafe systems and effective referrals. This is a particular issue for the SC+T Programme as the responsibility to link antenatal and newborn screening (which have different commissioning systems) is a fundamental to our remit.

3.3 At the moment, the key problem is a lack of clarity about who commissions what, where and in what timescale. Commissioning across the screening journey means dealing both at PCT level across the country and with specialist commissioning structures working at SHA level.

3.4 As the Screening Programme has sought to navigate the pathway, we have sometimes struggled to identify the correct decision-makers at each level in order to ensure that appropriate levels of care are provided.

3.5 A particular example of how this lack of clarity has a real impact on patients has been the commissioning of Pre-Natal Diagnosis (PND). When both parents are identified through screening as genetic carriers, they are offered PND. This is a diagnostic test for the baby that reveals whether s/he has sickle cell or thalassaemia. The timing of this test is critical because termination is one option if the baby is affected. Clearly, the earlier a termination is offered, the less invasive and distressing it is likely to be.

3.6 It proved difficult to establish who was responsible for paying for PND. In many cases this led to delays in offering the test which caused great distress to patients. It was ultimately necessary to appeal directly to the Department of Health who have now issued specific guidance (Gateway reference: 12529) with a clear statement affirming that PCTs are responsible for funding PND tests. This is a clear example of how confused commissioning systems are having a direct adverse impact on patients—this is not an abstract administrative issue.

4. Recommendations

4.1 Clear incentives are required to reward the effective commissioning of specialist services where it is relevant for specific local communities. Sickle cell and thalassaemia are not (and should not be) a priority for every Trust but for those who face a high prevalence of these diseases there should be clear benefits for their Specialist Commissioning teams to take the lead on developing a local strategy.

4.2 The varying prevalence of SC+T also means that providing a quality service to people in low prevalence areas raises a very different challenge; commissioning systems need to be adaptable enough to support these shifting needs.
4.3 Ensuring clear delineation between the various commissioning systems will take time. The publication of clear guidelines on where responsibility resides is urgently required. In the meantime, opportunities to work with commissioners to promote a better understanding of entire patient journeys would be welcomed.

September 2009

Memorandum by the Genetic Interest Group and Rare Disease UK (COM 67)

EXECUTIVE SUMMARY

1. A world class health service can only be provided with excellence at every level of its planning process, which requires cooperation, world class expertise and world class tools. Services must be planned based on good quality evidence, and commissioners should be equipped to obtain this.

2. Planning and funding of care is now carried out in a hierarchy; at GP, PCT, Regional and National level. This layered approach is necessary for the provision of high quality postcode-blind tertiary and specialised services. Communication between commissioning structures is essential to ensure that coordinated care can be provided at all levels.

3. Following changes made by devolved governments to their health services, commissioning is now solely and English and Northern Irish discipline. These changes provide a unique opportunity to examine which structures provide efficiency and which are wasteful; and to compare the intricate with the streamlined to establish whether intricacy is necessary to deliver health care to all of the population, whatever their health need.

INTRODUCTION

4. The Genetic Interest Group (GIG) is the UK national alliance of families and all those affected by genetic conditions. GIG works to raise awareness and improve the health service provision available to those living with and at risk from inherited conditions. Our membership represents 138 voluntary organisations working for a wide range of conditions, many of which are rare and/or pose complex health and social care needs. Many of the organisations and families which GIG represents are affected by conditions that require specialised and tertiary services. It is vitally important that patients can access good quality health services that provide timely and accurate diagnosis; and effective and best practice management from clinicians and health professionals who have the knowledge and expertise in each particular condition.

5. Rare Disease UK (RDUK) is an alliance for people with rare diseases and all who support them. It is a joint initiative of the Genetic Interest Group and other key stakeholders including patient organisations, clinicians, academics, industry and interested individuals bought together in response to the unmet care needs of the 3.5 million people who struggle to access integrated care and support from the NHS.

6. GIG and RDUK welcome this inquiry and the opportunity to provide evidence.

SPECIALIST COMMISSIONING

7. Commissioning care and treatments for many of the patients that our organisations represent can be complicated and/or expensive. Our organisations therefore have a strong interest in the existence of a commissioning framework which is capable of planning and funding many differing types of care: complex therapies for which there will be very few patients; good quality, timely, expert diagnosis of complex rare conditions for patients approaching primary care; and multi-disciplinary care from various specialities for patients with multifactorial conditions, are three examples.

8. A particular concern for those that our organisations represent is that services that require the cooperation of multiple specialities within the NHS are facilitated. The commissioning process should be flexible enough to fund integrated care between secondary care specialities for patients with multifactorial conditions and accommodate patient’s needs in this complex area. This flexibility should allow for novel entry-points as diagnosis of a multifactorial disease is possible from many angles and healthcare provision for patients such as these should allow for this, and provide a service that looks the same from any angle.

SERVICE PLANNING

9. Services should be planned using good quality evidence and with proper communication and coordination between different levels of the commissioning framework, to prevent gaps in service provision. The changing rate of demand for services must also be identified as part of a horizon scanning process. Mechanisms need to be developed to ensure that as the demand for a service increases then the planning for the service takes this into consideration.

10. Horizon scanning should also take account of other changes, for example: improvements in healthcare have led to life expectancies rising for many conditions. Conditions that were once solely cared for in the paediatric setting now have patients progressing into adulthood. This has led to young adults sometimes being cared for in paediatric environments, a situation which is not ideal for any party. There is
little incentive from commissioners for the development of adult services, and the level of specialisation in adult medicine is such that there is no obvious point from which to develop an adult service for these young adult patients.

**Levels of Commissioning**

11. Currently, funds in the English NHS follow a convoluted pathway, with commissioning taking place at many levels. The budget is top-sliced to provide funds for the National Commissioning Group, it is then distributed between PCTs, who then top-slice the funds again for Strategic Healthcare Authority level planning (Regional Commissioning), and use the remainder for commissioning of services within their area of remit, including the possibility of another layer of commissioning: practice based commissioning.

12. It becomes necessary to concentrate on recalling that this is a single health service. Whilst on inspection the benefits and reasoning behind planning and funding care at different levels is clear, better communication is perhaps necessary to remind all of the parties of this reasoning. Regional Commissioning can sometimes be regarded as a drain on PCT’s resources. In fact the system is in place because decisions are best made at this level for this kind of care provision and the risk of individual PCTs having to fund potentially expensive and unpredictable activity is reduced by commissioning services collectively. Regional Commissioning should be seen as a mechanism which assists PCTs to discharge their obligation to all of their patients, and prevents potentially unfair drains on resources being presented to single PCT.

13. That commissioning should be carried out at more than one level is not in dispute, evidence for the necessity of commissioning at national level is amply provided by the progress made by the National Commissioning Group in safeguarding treatments for some of those with the rarest of conditions. Commissioning of services such as these would be impossible at a local or even regional level.

14. Many patients with a rare disease are already heavy users of NHS resources, but these resources are provided without any strategy, often in a fragmented and uncoordinated manner, that is not always appropriate to the patient’s needs. SCGs can provide solutions to patients’ needs and enable health gain by ensuring that adequate structures are put in place to deliver integrated care strategies for patients. This should not be seen as a distraction from the day to day business of providing healthcare to the “average” citizen. Specialist services should be considered complimentary to local services as opposed to a threat to local services, and commissioners should be in a position to facilitate coordination between these areas.

15. Understanding between levels of commissioning in England is necessary to foster cooperation between national, regional and local commissioning. There are over 6,000 rare diseases, not all rare diseases are so complex that the day to day management needs to be delivered through specialised services. The patient will always begin their pathway at the local level, they may need to progress to a nationally commissioned service for a diagnosis, but treatment thereafter will involve a combination of specialist and local care.

16. Good quality communication and understanding between the levels is necessary on both the clinical side and the financial side. There should be no barrier to referrals outside of a particular funding area. Referrals to a service outside of a PCT should be just as seamless as those made within the organisation. A clear framework should be in place which allows clinicians to make appropriate referrals with no unnecessary bureaucratic hurdles. Investment is needed to foster a culture of co-operation and allow integrated solutions to emerge.

_The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?_

17. With the advent of devolution and the changes made by devolved governments to their health services, commissioning is now solely an English and Northern Irish discipline. This direction of travel from Scotland and Wales raises questions; and the evidence which will accumulate as the new system in Scotland and the soon to be new system in Wales become mature has the potential to provide answers. Should policy formation be so far removed from funding decisions in the English NHS? Does the purchaser/provider split generate efficiency and choice or does it waste money and discourage cooperation within the English NHS?

_Wales—the new structure_

19. The structure of the NHS in Wales that will be adopted on October 1st 2009 is simple in comparison to that of NHS England. The healthcare budget for Wales will be divided between seven Local Health Boards (LHBs), each responsible for healthcare provision in their constituency. These funds will then be top-sliced, and pooled for tertiary and specialised services. Governance of the spending of this top-slice pool will be from the Welsh Health Specialised Services Committee (WHSSC), composed of LHB Chief Executives. All planning and fund allocation for healthcare in Wales will therefore be carried out by the LHBs.

20. This model, when compared to the structure of the NHS in England is straightforward, and gets funds to primary and secondary care at an appropriate level for the population size in a streamlined manner. This plan does bring concerns for the community of patients that our organisations represent. Our concerns are that the top-sliced funds should be distributed by a dedicated body, which is perhaps further removed than the LHBs than is currently the plan.
21. This point illustrates a facet of the structure of the NHS in England which we particularly appreciate and support, top-sliced funds for specialised and tertiary services, are governed by the National Commissioning Group, a dedicated group who provide expert guidance on the types of services that can be funded in this way and provide support for those services once founded. Details of the role that the WHSSC will fill and how they will interact with commissioners in the English NHS to facilitate cross-border access to specialised care is yet to emerge.

22. The purchaser/provider split was originally implemented to encourage efficiencies and deliver cost savings. The advent of Payment by Results, Practice Based Commissioning, Foundation Trusts, Regional Commissioning and National Commissioning creates an altogether more complicated landscape. Planning and funding of care is now carried out at many levels, GIG and RDUK believe that, for the patient communities that we represent: those requiring tertiary and specialised care, this layered approach between Regional Commissioning and National Commissioning is necessary for the provision of high quality postcode-blind care and services.

23. The specific question “has the purchaser/provider split been a success and is it needed?” can only be answered with comparison between the four health services of the United Kingdom.

“World-Class Commissioning”: What does this initiative tell us about how effective commissioning by PCTs is?

24. World Class Commissioning is essentially an initiative aimed at providing a world class health service at a local level. This is a laudable aim and one to be supported, at least until the initiative just entering its second year is in a position to be judged. However, the initiative does aim to provide a world class health service to all; we hope that this response has demonstrated that commissioning at a Primary Care Trust level, even when overseen at a Strategic Health Authority level, is not enough to provide a world class service to all patients.

25. Commissioning must take place at appropriate levels matching the population and complexity of the health care need, sharing risk and ultimately ensuring that no one misses out from treatment because their condition is rare. A world class health service can only be provided with excellence at every level of its planning process, which requires cooperation, world class expertise and world class tools.

26. NHS England can provide a lead, not only for the Home Nations, but for the rest of the developed world as health care systems struggle to cope with rising demand and constrained resources.

27. The Genetic Interest Group and Rare Disease UK are grateful for the opportunity to comment and welcome further communication on the issues discussed here.

September 2009

Memorandum by the Pharmaceutical Services Negotiating Committee (COM 68)

1. The Pharmaceutical Services Negotiating Committee (PSNC) welcomes the opportunity to contribute to the Health Select Committee’s inquiry into NHS commissioning. PSNC represents and promotes the interests of almost 11,000 pharmacy contractors in England and Wales. It is PSNC’s responsibility to liaise with the Department of Health and to negotiate the contractual terms for the provision of NHS community pharmacy services.

2. This submission is informed by contributions from Local Pharmaceutical Committees (LPCs) and pharmacy contractors, who were asked to provide information on their experience of PCT commissioning of pharmacy services across England. LPCs represent pharmacy contractors in their respective areas, and are responsible for discussing and negotiating pharmacy services with PCTs. The observations and recommendations that follow are based upon these LPCs’ experiences of PCT commissioning of pharmacy services in recent years.

EXECUTIVE SUMMARY

3. PCT commissioning of enhanced (local) pharmaceutical services is regrettably patchy. 2008’s Pharmacy in England White Paper argues that providers should be commissioned “based on the range and quality of the services they deliver”. Whilst there are strong examples of best practice in commissioning, in too many areas pharmacists’ potential as highly qualified and accessible healthcare providers is not being effectively harnessed.

4. The most common problems that our consultation identified were a lack of PCT engagement with providers around planning or commissioning processes; inadequate communication between PCTs and LPCs; inconsistent and unclear responsibility for commissioning pharmacy services; a failure to adequately remunerate contractors for providing services; and imperfectly designed pilot schemes.
5. We recommend that enhanced pharmacy services with undeniable value to all communities (such as Minor Ailments Services and support for patients with long term conditions) are reclassified as advanced services or Directed Enhanced Services (DESs), which PCTs are centrally directed to commission. Too many enhanced pharmacy services with undeniable value to all areas are not being provided as a result of inadequate commissioning.

6. We also recommend that the Department of Health should seek to ensure that PCTs implement fully the guidance on pharmacy commissioning recently published.\(^\text{179}\)

7. We further recommend that all PCTs should be encouraged to build service evaluation into the commissioning of all new services. Enhancing the evidence base for all primary care services, including community pharmacy, is critical to supporting PCTs in effective commissioning.

**BACKGROUND**

8. The 2005 National Pharmacy Contract distinguishes between three classes of pharmacy services: essential, advanced, and enhanced (local). All NHS pharmacy contractors provide essential services including the dispensing of medicines; repeat dispensing; and signposting patients to the most appropriate health provider. PCTs are obliged to commission advanced services where a pharmacy on their list has the relevant accreditation. However, PCTs hold full responsibility for commissioning enhanced services. It is the inconsistent quality of the commissioning of these services upon which we focus in this submission.

9. Enhanced services should be commissioned by PCTs in response to the health needs of the local population. These services include Minor Ailments Schemes (MAS), substance misuse services; Emergency Hormonal Contraception (EHC) services, stop smoking services and needle exchange schemes.

**CURRENT COMMISSIONING OF ENHANCED PHARMACY SERVICES**

10. The message we receive from LPCs is that PCT commissioning of enhanced services is regrettably patchy. The Pharmacy in England White Paper, published in 2008, highlights the Government’s calls for a shift in pharmacy’s emphasis from dispensing prescriptions to providing clinical services; an increase in the range of services available through pharmacies; exploitation of pharmacies’ convenient locations and extended opening times; and greater use of the clinical skills of pharmacists and the talents of other pharmacy staff. The White Paper argues that pharmacy services should be commissioned “based on the range and quality of the services they deliver”. Whilst there are strong examples of best practice in commissioning, these are sadly more the exception than the rule, and in too many areas pharmacists’ potential is being sadly neglected.

11. The most common problems that were identified were a lack of PCT engagement with providers around planning or commissioning processes; inadequate communication between PCTs and LPCs; inconsistent and unclear responsibility for commissioning pharmacy services; a failure to adequately remunerate contractors for providing services; and imperfectly designed pilot schemes for innovative enhanced services.

**ENGAGEMENT OF LPCS AND PROVIDERS IN THE COMMISSIONING PROCESS**

12. PSNC recognise that the building of positive working relationships and strong lines of communication is the joint responsibility of both PCTs and LPCs. However, the responses we received from LPCs indicated that in many areas they were not involved in discussions around the development of pharmacy services or wider primary care developments and were often not informed of significant changes in service provision arrangements. Transparency and collaborative planning are crucial to effective commissioning—in many areas this has been lacking.

13. A number of LPCs complained of their local PCT dictating changes to arrangements at short notice with little to no consultation with the LPC or contractors. One LPC in the North East experienced serious problems in providing stop smoking services resulting from a restructuring of PCTs in their area. They told us that they “have been promised . . . an area-wide service for about a year, but we have had little input into the process and I expect, as usually happens, someone will turn up to a meeting with printed copies of a hefty document and expect us to rubber-stamp the process. We have found the smoking cessation service consistently fail to appreciate they must not only consult the LPC but cannot change the procedure when they wish. They decided recently to withdraw free gym passes for smoking cessation clients but failed to inform the pharmacies issuing the passes”.

14. A West Midlands LPC experienced a number of problems building relationships with one of their PCTs. “Over the course of last year, the trust undertook a series of “Next Stage Reviews” with stakeholders and patient groups; the 2009–10 report, however, failed to identify pharmacy as a stakeholder or as a service provider. Service submissions do not get considered and for the one that did, the Medicines Management Team wrote a report to the board but the pharmacy PEC member was excluded from the discussion of the report or the right of response from a community pharmacy perspective”.

\(^{179}\) World Class Commissioning: Primary Care and Community Services: Improving Pharmaceutical Services, DH April 2009: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_097408
15. An LPC in Yorkshire told us that “as an LPC, we held a White Paper briefing event to which the PCT was invited. The date was changed to accommodate the CEO and Directors, none of whom subsequently attended”. The LPC’s assessment was that “there is enormous inconsistency and the PCT’s ability or desire to commission in an equitable manner is to say the least questionable. The track record is dismal, especially in relation to working with the LPC”.

16. Despite having provided a needle exchange service for a number of years, in December 2008 one LPC was sent a policy for the service that was generic for all providers. They wrote that “despite several requests for a pharmacy based specification and the PCT pharmacy clinical governance lead developing a specification based on the PSNC templates, and meetings about the same, no progress has been made”. There has also been “no negotiation with the LPC about the service requirements and the fee structure”.

17. It is clear that many LPCs are not being effectively consulted or informed on commissioning decisions. We believe that high quality commissioning involves engaging providers and using their expertise to plan and design the best possible services for patients. Unfortunately, poorly coordinated commissioning is too often leading to a top-down approach to service planning and provision.

COMMISSIONING RESPONSIBILITIES

18. LPCs who have attempted to engage with the commissioning process have often found their efforts hindered by a lack of clearly defined roles and responsibilities within the PCT’s commissioning functions. This has greatly hindered their efforts to work with PCTs to plan the best possible services for patients. It has often led to delays in services being put in place, and barriers to their effective delivery once they have commenced.

19. Another Yorkshire based LPC found that when it came to the commissioning of new services “no-one ever wants to take responsibility. Commissioning thinks its Medicines Management’s responsibility and Medicines Management think it is the commissioners’ responsibility. Communication between the two is especially poor”.

20. An LPC in the South West also experienced problems as a result of unclear responsibilities around commissioning at the PCT. An LPC representative said that whilst working with the PCT to commission a Chlamydia treatment and testing service, they found that “nobody knew who had access to what budget and who was authorised within the PCT to make a commissioning decision. As a pharmacy enhanced service did responsibility lie with the Medicines Management team, or as a sexual health service did responsibility lie with the public health team?”

21. A North East LPC’s representative echoed the opinion that responsibility for commissioning was fractured and ill-defined. They told us that “exactly who actually handles commissioning is unclear and the existing services continue to be handled by several departments with varying results”.

22. We believe that a greater degree of consistency in responsibilities for commissioning enhanced services is needed. Commissioning structures and processes are far too variable, and disparity between high quality organisations and those that do not meet the necessary standards is all too clear. We feel that only through greater guidance and hands-on Department of Health support for local commissioning will this level of consistent quality be achieved.

RENUMERATION AND SUPPORT OF CONTRACTORS

23. Many LPCs argued that their local PCT failed to fully appreciate the financial and time costs of providing the services they were commissioning, thus failing to incentivise contractors to opt in to new schemes, and leaving those who did without adequate resource or support. Much of this is due to a lack of engagement with the providers themselves, who are in the best position to communicate their needs.

24. When pharmacists in the South West were commissioned to provide stop smoking programmes, the LPC felt that “there was no value put on the amount of time, input and effort taken to provide the service, despite this being a recommendation in NICE guidelines. It was the view of the LPC and contractors that the fee structure did not truly remunerate for the length of time pharmacists and their staff spend with clients and there needed to be an incentive scheme for pharmacists”.

25. A West Midlands LPC told us that having agreed that pharmacists in the area would provide antivirals at short notice as an interim measure to address the spread of pandemic flu, the PCT “refused to listen to LPC concerns and refused to negotiate an appropriate service fee suggesting that pharmacy is profiteering in an emergency . . . all work within the PCT relating to pharmacy is directed to the Medicines Management Lead who whilst claiming to support pharmacy is constantly alleging potential for fraud, poor quality of service and wants all services to be at the lowest possible price and opposes all elements of profit within any service”.

26. Greater engagement with LPCs would go a long way to improving commissioners’ understanding of contractors’ needs in terms of support and remuneration. However, the ability to assess such needs should be a core capability of commissioners’ work.
TARGETS

27. LPCs found that despite being able to deliver high quality enhanced services that could deliver real outcomes for patients, some PCTs were unwilling to commission these once they had met their set targets for health improvement.

28. A South West LPC encountered this problem with the stop smoking service delivered by pharmacies in their area (which had achieved quit rates of 60%, above the national average of 53%). A representative of the LPC told us that “incentivising pharmacists to support clients for a longer period of time would improve quit rates; however the PCT continues to commission on outputs (ie four week quitters) rather than outcomes for patients”. She added that “It is quite a common approach...for the PCTs to say that once they have reached their target the service will stop. This is another disincentive to put much time and effort into investment of premises or into staff”.

29. Another West Midlands LPC told us that they were keen to provide a Chlamydia screening service, which pharmacists were specifically trained to provide. However, “(the) commissioner refused as targets were now being met, so all effort went to waste”.

30. We understand the need for PCTs to rigorously assess the benefits of the services they provide. However, we feel that enhanced pharmacy services can have real and significant benefits for patients that are seen over long periods of time and result in long term improvements in population health. These are not necessarily effectively measured by PCT targets, which are not intended as a benchmark for the benefits of pharmaceutical services. Commissioners would benefit from guidance in more comprehensively assessing the usefulness of enhanced pharmacy services.

PILOTS AND TEST SCHEMES

31. A number of LPCs raised the concern that enhanced services were commissioned as short pilot schemes; however, a lack of support from the PCT and less than ideal conditions for the pilot led to a relative lack of success. Unfortunately, this resulted in the PCT commissioning other providers to deliver the service.

32. One LPC experienced problems when commissioned to offer postal Chlamydia screening kits for young people in December 2007. An LPC representative wrote that “The pilot ran for three months with no associated marketing or promotional activities, hence there was a low uptake for the service and pharmacy has been labelled as being a poor provider because there are few or no screens coming through pharmacy...the PCT is reluctant to invest any more money in pharmacy because it ‘doesn’t deliver’ yet it is making this judgment based on a pilot that was poorly thought out and managed over 15 months ago”.

33. One pharmacy contractor noted that significant improvements could be made if services were commissioned “for two to three years, so that customers, providers and commissioners can experience and choose services on the basis of quality, consistency and value”. They also argued that “longer contracts will encourage additional providers to make investments in resources, people, locations and premises, and effect sustainable change”.

34. Whilst piloting pharmacy services before they are introduced is a cost-effective way of testing their suitability and quality, these pilots should be conducted over a long enough period of time to reasonably assess their long-term effectiveness. This assessment cannot always be made over a three or six-month period. Support from the commissioning PCT, including effective promotion of the service, can be invaluable at the start of programmes like those described above. We recommend that all PCTs should be encouraged to build service evaluation into the commissioning of all new services.

RECOMMENDATIONS

35. Too many enhanced pharmacy services with undeniable value to all areas are not being provided as a result of inadequate commissioning. We recommend that such services are reclassified as advanced services or Directed Enhanced Services (DESs), which PCTs are centrally directed to commission. Whilst we recognise that commissioning should consider the varied health needs of local populations, services such as support for patients with long term conditions and MASs are consistently and indisputably valuable to all communities. This value should be recognised and PCTs should be obligated to commission them where possible.

36. PSNC is currently in discussions with NHS Employers around necessary changes to the pharmacy contract and both organisations will present emerging recommendations to the Department of Health in the coming months. A restructuring of the pharmacy contract to ensure the wider commissioning of key pharmacy services is essential to the effective implementation of the Pharmacy in England White Paper, and this point should be recognised as the Department considers the joint recommendations.

37. We recommend that the Department of Health should seek to ensure that PCTs implement fully the guidance on pharmacy commissioning recently published.

38. Good practice in the commissioning of pharmaceutical services should include:

(i) Early consideration of providers’ perspectives into commissioning plans;

(ii) The systematic organisation of engagement between commissioners and providers, with systems put in place for regular communication and cooperation;
(iii) Clear responsibility assigned within PCTs for the commissioning of pharmacy services, with a named Board member taking overall responsibility for this work;
(iv) Communication of commissioning intentions, as well as changes in relevant personnel or commissioning structures and procedures, to providers and their representatives by PCT commissioners; and
(v) Incorporation of effective evaluation into all newly commissioned services.

39. A joint document produced by the NHS Alliance and a collaborative of pharmacy bodies proposes further methods by which PCTs can maximise health gain through high quality community pharmacy commissioning.

September 2009

Memorandum by the Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic & Dispensing Opticians (COM 69)

1. EXECUTIVE SUMMARY

1.1 Together the Association of British Dispensing Opticians (ABDO), the Association of Optometrists (AOP) and the Federation of Ophthalmic & Dispensing Opticians (FODO) represent over 12,000 optometrists, 5,600 dispensing opticians and 5,500 optical businesses in the UK who provide high quality and accessible eye care services to the whole population.

1.2 Currently there is a huge amount of choice amongst providers of community eye care services. The eye care market is incredibly competitive which has resulted in no waiting times for patients and good access to optical practices at a time convenient to the patient and at a convenient location, near to where they work or live. Uniquely in the NHS, funding for sight tests and treatment already follows the patient in the most direct way, namely if they do not satisfy the patient, they do not get paid.

1.3 Commissioning of enhanced eye care services which is undertaken by PCTs, for example diabetic retinopathy screening, glaucoma referral schemes and post operative care services for cataract patients, is in need of improvement, with wide variations across the country.

1.4 We have also included structured feedback gathered recently from Local Optical Committees—the statutory committees representing NHS community eye care providers—on PCT performance where this is relevant.

2. “WORLD-CLASS COMMISSIONING”: WHAT DOES THIS INITIATIVE TELL US ABOUT HOW EFFECTIVE COMMISSIONING BY PCTS IS?

2.1 We believe that World-Class Commissioning is an ideal that the NHS should be aspiring to. However the current system of commissioning is some way off that gold standard. We believe that primary care commissioning and in particular, the commissioning of enhanced eye care services could be improved through the following measures:

2.1.1 Commissioning should be based on local need and services commissioned to meet that need. Our research demonstrates that only 6% of PCTs had carried out an eye health needs assessment so far, with only a further 6.25% planning to carry out such an assessment.181

2.1.2 Localism is fine but the Department of Health has not yet got the balance right between services that should be commissioned at PCT level and those that should be commissioned at supra-PCT/national level to minimise transaction costs, bureaucracy and waste; this is currently not right, wasting vital health care resources.

2.1.3 PCTs should have a greater role in consulting with at risk and hard-to-reach groups where take up of services is low. We believe this is an important part of the commissioning role. Only a small number of PCTs (8%) have an Eye Health Forum in place (despite this being recommended in Department of Health sponsored guidance several years ago) and not all include patient representation.

2.1.4 PCTs should also consult local clinicians when designing and planning local eye care services. Only 11% of Local Optical Committees report being always involved in the design and planning of eye care services and 60% report never being consulted when specifications are being drawn up for hospital ophthalmology contracts.

2.1.5 PCTs should include public health messages about regular sight testing to prevent blindness and visual impairment in their wider health communication strategies.

2.1.6 Pleasingly 17% of PCTs are reported as developing local plans in line with the government supported UK Vision Strategy with one noble PCT reported as promoting the importance of regular sight testing to local people and 3% more carrying out specific awareness campaigns for eye diseases such as glaucoma and age-related macular degeneration (AMD).

2.1.7 PCTs should promote greater joint working between the four contractor professions and community staff on eye health improvement at local level, especially with GPs and community nurses who tend not to react to eye health issues until visual impairment impacts on the patient by which time it is often too late.

2.1.8 There needs to be a better system of identifying and sharing best practice amongst pathways as a basis for tailoring to local requirements wherever possible. For example, having multiple pathways for, say glaucoma and ocular hypertension, increases clinical risk, inhibits staff mobility and adds unjustifiably to NHS transaction costs.

2.1.9 Commissioners should consider commissioning a wider range of non-optical services, from optometrists and dispensing opticians which are currently providing eye care services in convenient locations in the community at a minimal cost to the NHS. (The NHS does not fund the capital expenses.) These premises and highly trained staff could also provide other health services such as case finding high blood pressure in hard to reach groups, diabetes detection, obesity and smoking cessation services—smoking already severely damages eye health and reducing smoking is a major prevention measure—or annual health checks.

2.1.10 PCTs should develop a far better understanding of markets and market mechanisms and move away from their traditional ignorance, suspicion and fear of the NHS care which is provided in the retail sector such as optics and community pharmacy.

2.1.11 There should be greater assessment of PCTs’ performance by stakeholders. There needs to be much more systematic feedback from patients and service providers when rating PCTs against World-Class Commissioning standards to help them develop and improve.

3. THE RATIONALE BEHIND COMMISSIONING: HAS THE PURCHASER/PROVIDER SPLIT BEEN A SUCCESS AND IS IT NEEDED?

3.1 Yes but there are some services, such as essential sight testing and eye care services, which are best commissioned on a national basis because of the relatively small size of the service (£400m nationwide), the standardisation of the sight test and the unacceptably high transaction costs that local commissioning would impose.

4. COMMISSIONING AND “SYSTEM REFORM”: HOW DOES COMMISSIONING FIT WITH PRACTICE-BASED COMMISSIONING, “CONTESTABILITY” AND THE QUASI-MARKET, AND PAYMENT BY RESULTS?

4.1 There are sadly low levels of understanding about markets and how they operate to bring service improvement amongst both NHS commissioners and providers. This ignorance and overreliance on bureaucratic rather than market or risk-based solutions is holding back the development of high quality, accessible services for local people. Commissioning is a grown-up art and needs greater boldness and ambition if the Government’s aims for Quality, Innovation, Productivity and Prevention (QIPP) are to be achieved.

September 2009

Memorandum by NHS East & North Hertfordshire and NHS West Hertfordshire (COM 70)

1. EXECUTIVE SUMMARY.

1.1 This paper attempts to provide the Inquiry with a summary of views from a large commissioning organisation on the questions posed. We have attempted to give some examples of where commissioning has improved service delivery and quality as well as identifying some barriers or constraints to improved delivery.

1.2 An over-arching comment would be that we have seen a lot of structural and policy change across the NHS and it is important to give organisations enough time to develop and embed policy & delivery before changing systems again. Major changes such as World Class Commissioning assessment need more than one year of operation to assess whether or not they are making a difference to outcomes.
2. “WORLD-CLASS COMMISSIONING”: WHAT DOES THIS INITIATIVE TELL US ABOUT HOW EFFECTIVE COMMISSIONING BY PCTs IS?

2.1 The World Class Commissioning framework was published in December 2007, with the first round of assessments acting as a baseline exercise. It is too soon to fully assess whether or not this initiative is substantially improving the way in which all PCTs are commissioning services. What it has given us as commissioners for the first time is a very clear framework against which to measure and benchmark our performance.

2.2 The assurance framework for year 2 was launched in 16th September and it is only after this assurance round is complete in March of next year, that there will be a national opportunity to assess improvement and effectiveness.

2.3 The process has encouraged us at a local level to question existing practice and long held assumptions, to re-shape our organisational structure and to develop a clear commissioning cycle with well defined stages, which we are now developing much more detailed standards and policies to support. It has also encouraged us to look at and share good practice with other PCTs including the development of joint training for staff and the setting up of an East of England wide acute invoice validation project. This uses external non-NHS expertise to systematically analyse and challenge acute Trust activity.

3. THE RATIONALE BEHIND COMMISSIONING: HAS THE PURCHASER/PROVIDER SPLIT BEEN A SUCCESS AND IS IT NEEDED?

3.1 A purchaser/provider split is vital if in a nationally funded system we are to ensure that the provision of healthcare and its delivery is designed around the needs and priorities of local populations rather than those of service providers and health care professionals. It is also a very difficult area to assess success in and commissioners are still developing the full range of skills & knowledge they need to become truly effective local leaders of the NHS and challenge long held existing practice.

3.2 The role of a commissioner is not easy as it needs to balance the wishes local populations against the national and local agenda. For example as technology advances some services require minimum patient numbers to meet professional quality & safety requirements, leading to consolidation of specialised surgery in smaller numbers of sites. This often creates local tension over the removal of what are viewed as local services. A recent operational example of this is the implementation of Improving Outcome Guidance (IOG) cancer guidance in gynaecology and oesophagi-gastric services, where commissioners played a key role in working with the public and providers to ensure that as much of the pathway as possible was retained in local hospitals via a network approach, whilst still delivering the national quality standards.

3.3 There are many local examples of where we as commissioners have had a positive impact on the range, quality and accessibility of services for our local population. Specific examples include: The development of the 2 local GP led health centres, the prison healthcare service, the development of urgent care centres, the reduction of waiting times, improvements in the provision of sexual health services and the strengthening of primary care mental health services.

3.4 As commissioners we also recognise the importance of working in partnership with other commissioners to improve and develop local services. For example for over 5 years the commissioners of NHS health care and the commissioners of social care at the County Council have worked as a joint commissioning team, hosted by Adult Care Services, covering mental health services (older people & adults of working age), learning disabilities, and substance misuse services. We hold a joint contract with the main local provider of NHS services and the team are accountable to a Joint Partnership Board comprising of senior staff members for each partner organisation, voluntary agency representatives, local councillors and PCT non-executive members. This approach has allowed us to commission integrated pathways of care and to fully utilise good practice and specialised expertise from both health and social care.

3.5 In the last 12 months the development of the Transforming Community Services agenda and the work to clearly split the providing and commissioning function at a PCT level, has caused us to review the community portfolio. We now have a clear commissioner/provider split with our provider function operating as an arms length organisation, whilst it works to become a community FT. There is a contract in place, which no longer operates at a block level for many services. We have started to develop and implement revised service specifications in a number of areas, for example district nursing which has lead to increased clinical patient contact time by key front line staff and extension of the hours which the service is available in some areas.

4. COMMISSIONING AND “SYSTEM REFORM”: HOW DOES COMMISSIONING FIT WITH PRACTICE-BASED COMMISSIONING, “CONTESTABILITY” AND THE QUAS-MARKET, AND PAYMENT BY RESULTS?

4.1 The structure and remit of commissioner organisations has been subject to frequent re-organisation and changing and sometimes conflicting expectations. Traditionally commissioning has focused very much on the relationship with NHS providers and the national contracting mechanism with large block contracts made it difficult for commissioners to identify levers to push change. Mechanisms have now become more sophisticated, however implementing change can still be very difficult and the balance of power often remains with providers. For example where there is limited competition, or where the PCT is not a major commissioner.
4.2 The new national contracts have helped to shift the balance of power, allowing for tighter specification of pathways, expected outcomes and strengthening information requirements & timeliness from a commissioning perspective. The introduction of the national quality framework has also enabled us to start developing more accessible information about service quality & patient experience, which can then be used to inform new service specifications, to either drive up quality with existing providers or test the market for new providers. For example in West Hertfordshire we have recently re-specified the COPD pathway and are engaging in a procurement exercise to re-commission the service.

4.3 The implementation of the national choice agenda has significantly extended the options available to patients but has added to the complexity of the system from a commissioning perspective. Large especially specialist providers often provide for their catchment areas by their lead commissioners, thereby leading to unforeseen consequences, for example increased costs for the same level of activity with no improvement in outcome and the threat by some providers to stop delivering certain procedures which they saw as becoming unprofitable whilst wishing to significantly increase their use of other clinical procedures which could be considered more profitable. This resulted in the need for an SHA wide negotiated solution.

4.4 In Hertfordshire we have been working with PBC groups and the local population to increase the range and choice of services offered. For example as part of our Delivery Quality Healthcare in Hertfordshire strategy we are developing urgent care centres in a number of settings to allow care closer to home and add choice within the urgent care arena. A centre has already opened in Hemel to replace an A&E service, with further centres opening in a community hospital in Hertford & a health centre in Cheshunt in the autumn.

4.5 PbC groups have been a strong catalyst in driving change and challenge in the system. This includes a range of approaches including commissioning additional or targeted services in line with the needs of their local populations (for example additional family planning services accessible for young people in an area with higher rates of teenage pregnancy). We have also issued a number of Any Willing Provider tenders at a PbC group level to increase the availability of community services to local populations, for example counselling & physiotherapy. We have also developed closer working and contractual arrangements with two of the main Independent sector healthcare providers, with facilities within the patch (Spire & Ramsey) leading to increased choice and enabling us to challenge some existing traditional pathways.

4.6 To date the challenges to increased competition and contestability that we have encountered are that it is a steep learning curve, with much relatively new legislation, TUPE, Indemnity issues, information system connectivity for 3rd party organisations and how to demonstrate and deliver good value for money. We are working at a local level and with other PCTs to address these issues where we can but recognise some have wider national implications.

4.7 The induction of Payment by Results and in particular the recent changes for HRG4, have generated a range of negative and positive impacts. The system does create an incentive for providers to generate activity and income, rather than help manage demand for secondary care services or implement new pathways to streamline patient journeys. This significantly impacts on a PCT’s ability to manage and control over performance and will need to be addressed nationally as we move forward. The late final publication of HRG4 and the significant swings in pricing for some specific procedures especially in orthopaedics has lead to unforeseen consequences, for example increased costs for the same level of activity with no improvement in outcome and the threat by some providers to stop delivering certain procedures which they saw as becoming unprofitable whilst wishing to significantly increase their use of other clinical procedures which could be considered more profitable. This resulted in the need for an SHA wide negotiated solution.

4.8 Practice based commissioning is integral to the delivery of the World Class Commissioning agenda. It is an important element of retaining local ownership, and ensuring sound clinical leadership in the commissioning process. It is key to prioritising local need, driving up service quality, and ensuring value for money is delivered. We must however recognise that primary care staff needs support and time to develop the range of skills and competencies needed to deliver the commissioning agenda. To support this we have utilised the national FESC call off contract to establish a PbC development programme with the Centre for Innovation. We have also encouraged clinical staff to take part in the SHA clinical leadership programmes and our PbC groups play an active role in the regional PbC development network.

4.9 One of the challenges to PbC development and sometimes to wider clinical engagement is the conflict of interest in being both a commissioner and provider. This needs to be clearly recognised by all parties and we have established clear rules round conflict, service development and procurement. We also use clinical reference groups to test wider service change where possible utilising external clinical expertise and challenge.

5. Specialist Commissioning

5.1 We have worked collaboratively on the commissioning of specialised services over a number of years. A collaborative approach has allowed us to pool budgets with others and spread the financial risk of commissioning expensive or unpredictable services and develop a pool of expert commissioners. It has also allowed us to test and implement the development of new pathways and services where a critical mass in excess of the local population is required.
5.2 The current structure, with an East of England team, has been in place since 2008. A dedicated team of commissioners is in place, hosted via a PCT, but acting as a sub-committee of the 14 PCTs involved and is accountable to Board made up of the PCT Chief Executives and an SHA senior representative. There have been a number of governance and information challenges to work through particularly when consultation is required.

5.3 This joint approach has been vital to moving forward a number of services, for example last year the specialised commissioning team lead an East of England process to procure a NICE compliant specialist infertility service, leading to increased choice for patients, improved quality and competitive pricing. This is not something that individual PCTs would probably have been able to deliver on their own.

5.4 The challenges for PCTs in this area are how to deal with competing and conflicting priorities and ensure that new technologies are adopted and best practice followed.

5.5 The Carter Review in 2006, defined the services 32 services, to be within the remit of specialised commissioning, the detail of these definitions is variable across the identified areas, ranging from very specific health care resource groups or procedure level codes to general service headings. This does still present some difficulties in agreeing the commissioning responsibility between individual organisations and specialised commissioning groups.

5.6 Definitions are periodically reviewed but this does not always result in greater clarification. For example some pathways at specialised centres will end up with split funding between PCTs and specialised commissioning, potentially increasing administrative costs or the risk of duplicate charging. Further work is also required to ensure that as services become more routine within the NHS and embedded in local providers that commissioning responsibility passes back to local PCTs. For example a number of procedures in the original definition set for specialised cardiology can now be provided at a local hospital level. Similarly, we need to question if specialised services can be provided more locally in a cost effective way, for example in Hertfordshire we have a population of around 1 million and have worked with the specialised commissioning team over the last 12 months to develop a local specialist seating & specialist wheelchair service to meet our population needs based within the county, rather than the previous service which was commissioned via a consortium and provided in North London.

6. COMMISSIONING FOR THE QUALITY AND SAFETY OF SERVICES

6.1 The national change in focus & emphasis on driving up quality and improving patient safety has been welcomed by the PCTs, although along side this it remains very important that we continue to drive for value for money in the services provided and continue to work with all providers to improve data quality and timeliness.

6.2 The introduction of CQUIN and PROMs is still relatively new to the NHS and we have not as yet had the opportunity to see how they work through a full commissioning cycle. However early indications are that a focus by commissioners on areas such as better quality & timely discharge summaries and proactive visits and auditing of mixed sex accommodation is driving change at a speed quicker than that previously seen. In developing our CQUINs for use with the main local FT provider of mental health and learning disabilities, we used our local public engagement forums to shape the potential quality indicators and are now using them to help us monitor process on delivery. This is an approach we hope to extend into other contract areas next year.

6.3 Compiling and presenting the mixture of hard and soft data on service quality is complex and challenging, particularly if you wish to use to both inform and engage the public in a wider debate and use as a driver to improve quality. This is currently an area of very focused work PCT. There are so local examples of intervention to address commissioner concerns, including the new born hearing & audiology service at a local provider.

6.4 We are also beginning to look at proactive work in this area, for example joint visits to services with the local LINKs groups, broader adult safeguarding checks as part of continuing care reviews and better scrutiny of local Trust mortality data, but as yet it is too early to assess what the wider impact may be and if there is any good practice to share with other commissioners.

6.5 On a wider policy note, there remains from a PCT perspective duplication and inefficiency created by having so many regulatory and auditing bodies acting as watchdogs over so many of the areas for which PCTs are responsible or contribute to. As commented by one of our non –executives, a recently shared report showed how the 35 different regulators, auditors, inspectorates and accreditation agencies who oversee the
various Standards for Better Health were largely duplicating each other, with as many as 25 of these agencies in some cases all separately monitoring the same item. We recognise that some steps are already in place to address this but in the current national context there is potentially scope for further streamlining.

_August 2009_

**Memorandum by the British Medical Association (COM 72)**

1. **Executive Summary**

1.1 The commissioning or planning of patient care and services is a key function of a National Health Service seeking to balance the population's health needs with the finite resources that society is prepared to make available via general taxation. Associating commissioning with ideological reforms or policies dilutes and subverts its core purpose, ultimately to the detriment of patient care.

1.2 The BMA has opposed the purchaser-provider split (or internal market) in the NHS from its inception for a number of reasons:

— It has proved expensive, leading to poorer cost containment, higher administrative and transactional costs182 and ineffective purchasing;

— It inhibits clinician involvement in planning services as there is little opportunity or incentive for commissioners and providers to work together in the design and delivery of healthcare;

— It makes integrated patient care much more difficult to provide, the end result being an increasingly fragmented and more difficult-to-navigate service; and

— The internal market relies heavily on competition as the driving force around which the NHS operates. A number of studies have shown that competition appears to be associated with lower quality (higher death rates)183 and that on balance the relationship between competition and quality of care appears to be negative.184

1.3 We consider the stability of the NHS to be under threat from dogged pursuit of a market, as such a system undermines the spirit of cooperation, which we believe is central to the NHS' success. As such we do not believe that the rigid purchaser-provider split has or will deliver significant benefit to patients and wish to see in its place a system that promotes greater integration and collaboration.

1.4 Contestability and patient choice in its current form could inhibit commissioners from investing in innovative clinical practice that seeks to put in place new or redesigned services that better meet the needs of patients. Similarly, these policies provide no incentive for potential providers to invest in the development of such new services.

1.5 Moves to create a plurality of providers in primary and secondary care to date have not only proved expensive, but have opened up new opportunities for the private/commercial sector to provide NHS services; it is likely therefore that a similar effect will be seen in community services in due course.

1.6 In the present difficult financial conditions, it is more important than ever that NHS funding is used to best effect, rather than being wasted on the pursuit of ideologically-driven reforms.

2 “World-Class Commissioning”: What does this initiative tell us about how effective commissioning by PCTs is?

2.1 The commissioning or planning of patient care and services is a key function of a National Health Service seeking to balance the population's health needs with the finite resources that society is prepared to make available via general taxation. Most importantly, effective commissioning has the potential to improve the range and quality of health services available to patients.185 It is important to clarify at this stage that we see a clear distinction between purchasing and commissioning; the former being predominantly a means of contracting for services with providers as opposed to the more complex and considered process of commissioning.

2.2 The design and introduction of the World Class Commissioning (WCC) programme indicates acknowledgement by the Department of Health (DH) that Primary Care Trust (PCT) commissioning capabilities need to be systematically improved. The fact that WCC focuses specifically on PCTs however is not in keeping with the emphasis on clinicians leading the commissioning agenda bottom-up.


183 Propper, C, Burgess, B, Green, K (2002) Does Competition Between Hospitals Improve the Quality of Care? Hospital Death Rates and the NHS Internal Market, unpublished mimeo, University of Bristol, CEPR & CMPO.


185 The paper “BMA principles for effective and successful commissioning” can be found online: www.bma.org.uk/employmentandcontracts/independent_contractors/commissioning_service_provision/bmaeffectcomm.jsp
3. **The Rationale Behind Commissioning: Has the Purchaser/Provider Split Been a Success and is it Needed?**

3.1 The purchaser-provider (PP) split takes a very different form today than when originally conceived in the early 1990s. The move that originally established the internal market in the NHS was the introduction of a new funding system that ended the direct financing of all hospitals/providers and instead allocated funding to Health Authorities who then selectively purchased care from hospitals through large, block contracts. Although both the specific arrangements and terminology have moved on since then, the PP split and internal market still prevails today, taking the form of PCT commissioners who, within an allocated budget, purchase care from providers, such as hospitals, using the relatively new national tariff under the system of payment by results (PbR). GPs are involved in PCT commissioning through practice based commissioning (PBC). Whilst PCTs hold the budget and remain responsible for contracting with all providers, GP practices are expected to manage their indicative budget within the annual cycle and either not exceed it or, ideally, spend under it.

3.2 The BMA has opposed the PP split in the NHS from its inception for a number of reasons. Firstly, it inhibits clinician involvement in planning services as there is little opportunity or incentive for commissioners and providers to work together in the design and delivery of healthcare. The PP relationship is dominated by two opposing aims—cost containment for commissioners and income generation for providers—creating artificial divisions between different parts of the health service, establishing inherently adversarial relations and the potential to strain relationships between primary care doctors and their secondary care colleagues. The current system compels organisations to formulate and pursue their own strategy in isolation and there is an absence of a shared strategic vision for how services will develop and work together as part of a system of care. This service model makes integrated patient care much more difficult to provide; the end result being an increasingly fragmented and more difficult-to-navigate service.

3.3 A system of commissioning that is based on division and that actively discourages collaboration can never be truly effective, nor can it develop co-ordinated services that deliver the best care for patients. Commissioning should enable cross-sector collaboration and co-operation and ensure an appropriate balance between cost-effectiveness, quality and long-term sustainability of the health economy.

3.4 The PP split has also proved expensive for the NHS, leading to poorer cost containment, higher administrative and transactional costs and ineffective purchasing. The BMA is concerned that continuing with this policy will lead to further valuable time and money being spent on simply managing the market itself rather than delivering care to patients. In the USA the proportion of health funds devoted to administration has risen by 50% in the past 30 years and now stands at 31% of total health spending. The US experience is not unique and all markets necessarily have transaction costs; the development of markets in other health systems shows a related sharp rise in administrative costs including earlier attempts in the UK and in New Zealand.

3.5 The main problem however is that the success of a PP split and the internal market relies heavily on competition as the driving force around which the NHS operates. This is particularly worrying given that available evidence suggests that where patients’ care is bought and sold, and where hospitals, doctors, nurses and carers have to compete with one another like businesses, this is associated with poorer health outcomes for patients, lower quality care and rising bureaucracy together with the erosion of professional relationships where cooperation is replaced with competition. A number of studies have shown that competition appears to be associated with lower quality (higher death rates) and that on balance the relationship between competition and quality of care appears to be negative. Commentators suggest that competition in health care too often works to the detriment of improving patient care with restrictions to patient access to care, ‘gaming’ (using the system to generate maximum income for providers or minimum costs for purchasers), the shifting of costs on to fellow providers and the stifling of innovation.

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186 A resolution passed at the 1998 BMA Annual Representative Meeting called for “…any commissioning system … [to] involve doctors in both primary and secondary care”.
191 Propper, C, Burgess, B., Green, K (2002) Does Competition Between Hospitals Improve the Quality of Care? Hospital Death Rates and the NHS Internal Market, unpublished mimeo, University of Bristol, CEPR & CMPO.
3.6 We consider the stability of the NHS to be under threat from dogged pursuit of a market, as such a system undermines the spirit of cooperation, which we believe is central to the NHS’s success. As such we do not believe that the rigid PP split has or will deliver significant benefit to patients and wish to see in its place a system that promotes greater integration and collaboration. Moreover, in the UK’s current financial climate, effective collaboration becomes imperative; without proper service integration the transaction costs of a system will grow, consuming a greater proportion of the healthcare budget and reducing funding available for delivery of actual patient care.

3.7 In the BMA discussion paper A Rational Way Forward for the NHS in England, we advocated a more mature form of commissioning. We are currently exploring ideas around a new financial regimen that would simultaneously support the clear need for (i) a cross-sector, collaborative approach to the planning of services, given that the NHS is a funding-limited system and the populations’ health needs are both complex and evolving, (ii) greater stability for providers to allow them to put in place long-term strategies to develop their services and (iii) appropriate levels of flexibility to enable local health economies to meet the specific needs of their local patient populations. Our approach is predicated on the principles that the NHS is publicly provided and that cooperation replaces competition as the driving force in the NHS.

3.8 In brief, the financial regimen would comprise a large part of funding to be determined nationally as informed by local, commissioner intelligence and allocated to providers directly. In addition, a smaller proportion of funding would be allocated directly to commissioners, the use of which would be locally determined. These arrangements would be in-built with a greater emphasis on the meaningful involvement of patients and the public in the design and running of local services. As already stated, this model represents the Association’s early thinking rather than established policy.

4 COMMISSIONING AND “SYSTEM REFORM”: HOW DOES COMMISSIONING FIT WITH PRACTICE-BASED COMMISSIONING, “CONTESTABILITY” AND THE QUASI-MARKET, AND PAYMENT BY RESULTS?

Practice based commissioning (PBC)

4.1 The BMA supports the principle of PBC as a means to use primary care doctors’ and other clinicians’ unique position and experience in order to plan/commission NHS services more effectively. However as stated above, the fact that PBC—which encourages GPs to use secondary care less or more appropriately—and Payment by Results (PbR)—which encourages hospitals to treat more—are fundamentally opposed, creates numerous problems. Demand management is an important aspect of any funding-limited health system, however, the effective reduction of commissioning to a demand management or “rationing” mechanism in many areas acts as a major disincentive to primary care clinicians from becoming more heavily involved in the process. There are of course many other barriers to improved take up of PBC, such as lack of clarity over management costs and freed up resources; results from the latest DH quarterly PBC survey of GP practices shows that practices that rate the PCT managerial support they receive as poor (48%) continue to outweigh those who rate it as good (44%).

4.2 In addition, the design of PBC and its built-in incentives inhibits the involvement of other doctors in the commissioning process. Close cross-sector collaboration and dialogue between secondary and primary care clinicians, including public and community health doctors, is necessary in order for clinician-led commissioning to achieve its full potential. Using negative incentives to drive engagement of secondary care—such as fear of destabilisation—is both inappropriate and ineffectual. Consultants and other hospital doctors as providers of secondary care have expert knowledge and should be brought into the commissioning process, rather than excluded on the assumption that they are self-interested generic providers rather than an integral part of local health services. In areas where collaboration and productive dialogue between secondary and primary care doctors has been achieved, this has been a result of the sheer determination of individuals rather than because this has been facilitated by the system. Whilst there has been acknowledgement from the DH that PBC should seek to involve secondary care doctors, there have been no moves to address this or that the system itself is prohibitive of such an approach.

4.3 The BMA has produced a paper on the involvement of secondary care doctors in the commissioning process, which cites examples that highlight the benefits of such an approach. It also provides practical suggestions as to how PCTs can involve consultants in the process, for example through Professional Executive Committees (PECs), and thereby going further to satisfy three of the WCC competencies: “Collaborate with clinicians”; “Promote improvement and innovation” and “Manage the local health system”.

References:
Contestability

4.4 As part of the government’s reforms, contestability and a plurality of providers have been promoted as means to stimulate further competition in the NHS; the BMA’s view on this market approach has already been expanded upon above. The “any willing provider” policy/model, whereby any number of providers are on stand-by to treat patients as and when referred to them, is one which has the potential to create further instability and threaten continuity of care, notwithstanding that it may lead to fragmentation of the NHS. Further, it could inhibit commissioners from investing in innovative clinical practice that seeks to put in place new or redesigned services that better meet the needs of patients. Similarly, contestability provides no incentive for potential providers to invest in the development of such new services.

4.5 The government’s push to create a plurality of providers began in secondary care, principally with the introduction of Independent Sector Treatment Centres (ISTCs). The central procurement of ISTCs saw the NHS enter into hugely expensive contracts with third party providers, largely the private/commercial sector. The contracts featured start-up payments, enhanced payments for non-NHS providers, and closing “parachute” payments. This together with many instances of providers failing to complete their contracted numbers of cases, despite receiving full payment, provided very poor value for taxpayers’ money. In fact, it has recently been estimated that up to £927m could have been wasted on unused operations in ISTCs nationally.

4.6 The next focus was primary care with a major programme of new procurements (GP-led health centres) announced in 2007 as part of the NHS Next Stage Review. Again, this will prove very costly to implement and put added financial pressure on already-stretched PCT budgets. It should be noted that many areas have no identified need for these new services.

4.7 The latest focus is on the reform of community services through the Transforming Community Services (TCS) programme, which principally instructs PCTs to separate their commissioning and provider functions. Moves to create a plurality of providers in primary and secondary care to date have not only proved expensive, but have also opened up new opportunities for the private/commercial sector to provide NHS services; it is likely therefore that a similar effect will be seen in community services in due course. In the present difficult financial conditions, it is more important than ever that NHS funding is used to best effect, rather than being wasted on the pursuit of ideologically-driven reforms. Furthermore, the BMA believes that the NHS should be publicly provided and publicly accountable, using public money for quality healthcare, not profits for shareholders.

Patient choice

4.8 Current “patient choice” policies are designed to stimulate and intensify competitive forces in the NHS. As is the case with contestability, choice in its current form has the potential to inhibit commissioners from investing in innovative clinical practice as well as providing no incentive for providers to invest in the development of such new services.

4.9 At the same time, choice in its current form suffers as a result of other reform policies. For example, choice conflicts with demand management, which has lead the way for local initiatives such as referral management centres (RMCs), Capture Assess Treat and Support (CATS) centres and Integrated Clinical Assessment & Treatment Service (ICATS) to be put in place. These systems subvert patient choice by undermining the decisions made by patients with their GPs. Choice is further subverted by the existence of non-NHS providers in the area—for example ISTCs—who have under-used contracts that the PCT is keen to see more heavily utilised. Patients are directed to these services rather than to their original preference.

4.10 Introducing choice to health care is a complex process with potentially unpredictable results. The aim of choice should be to empower patients, improve outcomes and contribute to reducing inequity. As such, a choice agenda, which is driven principally by a desire to stimulate competition between providers is unlikely to achieve these aims. In fact, the available evidence around choice in its current form is not encouraging and suggests that choice is likely to increase costs, is probably more likely to increase than decrease inequalities and may or may not increase efficiency.

Payment by results (PbR)

4.11 Underpinning the whole system of reform is the national tariff, which facilitates the existence of a multiplicity of providers and means that patients’ choices have a financial impact on providers. By its very design, PbR fragments care since the provision of care is seen as a series of episodes that attract payment rather than as a long-term commitment to the provision of care for an individual. In addition, increasing numbers of uncomplicated cases are provided outside of the traditional NHS hospital setting; these are cases

199 See the BMA’s briefing on ISTCs lookafterournhs.org.uk/wp-content/uploads/independent-sector-treatment-centres-01062.pdf
201 Fotaki et al. What benefits will choice bring to patients? Literature review and assessment of implications J Health Serv Res Policy Vol 13 No 3 July 2008,
that are likely to be both predictable in respect of in-hospital stay, costs and profit and as a result are relatively low-risk for the provider. The removal of uncomplicated cases from NHS hospitals both disadvantages and destabilises them since they, as providers of care for more complex and expensive cases or as providers of comprehensive care, are left with cases that are less predictable and with smaller associated profit.

The framework for external support for commissioners (FESC)

4.12 Commissioning seeks to balance the clinical needs of patients with the finite resources that society is prepared to make available via general taxation. Patient care and the overarching ethos and ethics of a publicly provided health service should therefore be at the heart of this process. Whilst we recognise the need to improve the commissioning capabilities of many PCTs in England, we believe that commissioning is a key function of the NHS and its future does not lie within the private sector.

5. SPECIALIST COMMISSIONING

5.1 The BMA does not have specific or detailed policy on this particular area, however the general principles articulated in this response also relate to specialist commissioning.

6 COMMISSIONING FOR THE QUALITY AND SAFETY OF SERVICES

6.1 The DH has recently introduced the Commissioning and Quality and Innovation (CQUIN) payment framework, which takes the form of an overlay to the national tariff. PCTs have been instructed to agree with NHS acute and community providers how to link payment to quality within contracts in 2009–10, with locally agreed CQUIN targets attracting 0.5% of the overall tariff or contract price this year. A higher and rising value will be attached to CQUIN targets in subsequent years.

6.2 If this initiative is used as a mechanism to bring providers and commissioners together to jointly analyse the specific needs of the local population or clinical areas requiring improvement, and to set local objectives accordingly, then it could well be a positive development. If however it is used purely to intensify competition between providers, in terms of what targets they will agree to deliver in order to attract the CQUIN payment, we do not support such a move.

6.3 Providers’ performance against Patient Reported Outcome Measures (PROMs) will contribute to CQUIN payments, signalling the first time in secondary care that patient experience will determine (a portion of) providers’ income. It is worth noting here that 2009–10 is the first year that the NHS is using PROMs systematically across the service; we would question therefore whether the move to link patient experience with provider income is being taken too soon. Furthermore, patient experience is already measured in general practice and attached to specific payments through the annual Patient Experience Survey; the experience in primary care so far is that this is a questionable way of funding NHS providers.

September 2009

Memorandum by Cancer Research UK (COM 73)

EXECUTIVE SUMMARY

Cancer Research UK welcomes the opportunity to submit a response to this inquiry. The findings and recommendations of the Committee will no doubt assist the Department of Health, the NHS and other bodies in ensuring that commissioning is undertaken in the most effective way. This will hopefully ensure that NHS patients receive the best care possible and have a positive impact on outcomes.

We believe that strong cancer commissioning is vital if we are to ensure that high quality services are delivered. Commissioning for cancer is complex. There are many different types of cancer, each with a different care pathway involving clinical teams in the community, in acute general hospitals and in specialist centres. Some aspects of the diagnosis and treatment of cancer are rare and require highly specialised commissioning at a national or regional level. Other aspects of cancer are common and overlap with non-cancer services and should therefore be commissioned at a local level.

This submission makes a number of recommendations that the Health Select Committee may wish to consider:

— the role of cancer networks as commissioning “advisers” to Primary Cancer Trusts (PCTs) should be supported;
— the Department of Health should publish regular analyses of the World Class Commissioning priorities listed by PCTs and capture the progress made towards improving these service areas;
— all Spearhead PCTs should be encouraged to include “smoking quitters” amongst their priorities;
— the Department of Health should clarify the process used for developing nationally-defined indicators. There is an urgent case for developing national indicators on childhood obesity and bowel cancer screening;
— the Department of Health should encourage PCTs to take full advantage of the opportunities the Cancer Commissioning Toolkit offers;

— the Department of Health to undertake a review of the progress made by PCTs in improving exceptional case processes; and

— commissioners should act on the recommendations of the National Chemotherapy Advisory Group report to improve quality and safety for cancer patients.

CANCER RESEARCH UK

Cancer Research UK\textsuperscript{202} is the world’s largest independent organisation dedicated to cancer research. Our vision is that together we will beat cancer. We funded £333 million of research in 2007–08. We carry out world-class research to improve our understanding of cancer and to find out how to prevent, diagnose and treat different types of the disease.

MAIN POINTS

There has been much progress at the national level in improving cancer services since both the Cancer Plan in 2000 and the Cancer Reform Strategy (CRS) in 2007. The success of the CRS depends largely on how it is implemented at a local level. Stronger commissioning by PCTs will undoubtedly improve services for patients throughout the care pathway.

World Class Commissioning and Cancer

The World Class Commissioning (WCC) programme delivers both a long-term and strategic approach to commissioning. It provides welcome clarity about the competencies commissioners will need to demonstrate if they are to be successful. However, how these competencies apply to different disease areas will vary noticeably. The Cancer Reform Strategy, launched in 2007, sets out what the World Class Commissioning competencies mean for cancer:\textsuperscript{203}

1. The PCT engages with and understands the views and priorities of local NHS organisations and is respected as the local leader of the NHS.

PCTs working collectively through networks will engage with all organisations contributing to cancer care pathways.

2. The PCT works collaboratively with partners.

For cancer it is essential that clusters of PCTs across a network work effectively together, as care pathways frequently cross boundaries.

Partnership with Local Authorities is also vital.

3. The PCT leads and seeks continuous and meaningful engagement with people patients and communities to shape services and improve health.

Network partnership groups can facilitate this.

4. The PCT leads continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation.

Network clinical groups can facilitate this.

5. The PCT undertakes robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements.

The network executive team can provide crucial information to assist the PCT in doing this.

6. The PCT prioritises investment according to local needs, service requirements and the values of the NHS.

Cancer networks can make recommendations on prioritisation.

7. The PCT influences provision to meet demand and secure required clinical and health and wellbeing outcomes.

The network can engage with providers on behalf of the PCTs.

8. The PCT promotes and specifies continuous improvements in quality and outcomes through clinical and provider innovation and configuration.

The cancer network can promote service innovation and redesign.

9. The PCT deploys procurement skills that ensure robust and viable contracts.

Procurement remains a key responsibility of individual PCTs.

\textsuperscript{202} Registered charity no. 1089464.

10. The PCT performance manages providers to ensure contract compliance and continuous improvement in quality and outcomes.

    The network can act on behalf of and advise the individual PCTs where appropriate while ultimate responsibility lies with individual PCTs.

11. The PCT demonstrates excellent financial management.

    Networks can help to identify opportunities for managing budgets more effectively.

The way in which cancer networks support Primary Care Trusts in carrying out their commissioning responsibilities is still developing. However, as recommended in the Cancer Reform Strategy (CRS), the role of cancer networks as commissioning advisors should be supported. As cancer is such a complex and multi-faceted disease area, providers often have more specialist expertise than purchasers. The CRS tried to address this by recommending that networks should act as commissioning advisors so that specialist expertise is available on both the purchaser as well as the provider side.

It is also vitally important that the WCC priorities adopted by PCTs—and any progress made—are reported on at a national level. This would help ensure transparency and accountability and should be carried out by the Department of Health.

The Impact of World Class Commissioning on Health Inequalities

Some of the submissions to the Health Select Committee’s inquiry into Health Inequalities raised concerns that WCC would not have a noticeable impact on health inequalities. However, recent research has shown that commissioners do recognise the significant health benefits that can be realised by improving preventative services. The most commonly selected indicators by PCTs were “Smoking quitters” followed by “Reducing alcohol related harm” with over two thirds of all PCTs opting to focus on the smoking indicator and around half choosing the alcohol indicator. Worryingly however, “smoking quitters” is prioritised less frequently by Spearhead PCTs than the national average.

Cancer Research UK believes that because of the pivotal role smoking plays when it comes to health inequalities all Spearhead PCTs should prioritise “smoking quitters”.

Nationally-defined indicators for World Class Commissioning

The World Class Commissioning assurance process is intended to enable PCTs to focus on priority issues for their local population. To assist PCTs, the Department of Health has developed a set of 54 nationally-defined indicators. However there appear to be inconsistencies in the way these indicators have been developed. For example:

    — Research has shown that the most commonly developed local indicator (those not listed as national indicators) is childhood obesity. Given the amount of national policy attention the issue of childhood obesity has been given it seems odd that it was not included in national list of indicators. This results in PCTs having to devote time and effort in to developing local indicators on issues for which there is a clear national interest.

    — Although indicators for breast and cervical screening have been included, there is no equivalent indicator for bowel cancer screening. This omission could result in PCTs not giving sufficient priority to bowel cancer screening, which is a relatively new programme and therefore should be a particular focus of attention.

We would like the Department of Health to clarify the process used for developing nationally-defined indicators. There is an urgent case for developing national indicators on childhood obesity and bowel cancer screening.

Cancer Commissioning Toolkit

Launched last year, the Cancer Commissioning Toolkit is a web-based tool which supports commissioners and cancer service providers, helping them to understand and apply data to assist the planning and delivery of world class cancer services for their communities. The CCT is a “one-stop” library of key cancer information and data which can be easily accessed by commissioners and will be a critical tool in strengthening the quality of cancer commissioning.

205 Health Mandate, National priorities, local action? An analysis of Primary Care Trusts’ World Class Commissioning policies, July 2009 http://www.yourmandate.com/content/world-class-commissioning-choices-under-spotlight
206 Ibid
By using the CCT, commissioners should be able to make informed comparisons about a variety of service issues including: incidence, mortality and survival rates; uptake of screening; waiting times; levels of inpatient bed utilisation; emergency admissions from cancer, etc.

We recommend that the Department of Health encourages PCTs to take full advantage of the opportunities the Cancer Commissioning Toolkit offers.

**COMMISSIONING THE LATEST CANCER TREATMENTS**

There has been much controversy in the last 18 months about access to the latest effective cancer treatments. The Government and the National Institute for Health and Clinical Excellence (NICE) have taken a number of actions to address this issue including accepting in full the recommendations made by Professor Mike Richards in his report on “top ups” in November 2008 and NICE’s supplementary advice on appraising life-extending, end of life treatments in January 2009.

These measures should support PCTs in making commissioning decisions on new treatments. However, the extent to which PCTs implement the recommendations on exceptional case processes will be a crucial test of their quality as commissioners. As Cancer Research UK said at the time, when patients have to use exceptional case procedures to access a particular drug, it is essential that decisions on funding are as transparent and consistent as possible.

We would like the Department of Health to undertake a review of the progress made by PCTs in improving exceptional case processes.

**QUALITY AND SAFETY**

Commissioning can play an important role in improving the quality and safety of NHS services for cancer patients. Last month’s National Chemotherapy Advisory Group report made 26 recommendations aimed at improving the safety and clinical governance of chemotherapy services. If acted upon, these recommendations should result in significant improvements for cancer patients including better information, support and advice for patients on their treatment. The proposal that ‘all hospitals with an Accident and Emergency (A&E) department establish an “acute oncology service” (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy’ is something we strongly support. Many people with undiagnosed cancer either don’t recognise or choose to ignore signs and symptoms of the disease for so long that they eventually end up being admitted to hospital in an emergency.

Cancer Research UK and the Department of Health have established the National Awareness and Early Diagnosis Initiative (NAEDI) to encourage people to be aware of symptoms and visit their family doctor with concerns early enough. But we need to have in place adequate systems for people who leave it too late, so we welcome this new initiative.

*September 2009*

**Memorandum by the NHS Alliance Pharmacy Services Commissioning (PSC) Network (COM 74)**

**BACKGROUND**

The NHS Alliance Pharmacy Services (PSC) Network is delighted to submit evidence to the Health Select Committee Inquiry on commissioning.

The NHS Alliance is the only independent body that brings together primary care trusts’ chief executives and other senior managers, doctors and practice managers, nurses, pharmacists and allied health professionals, along with board chairs and members. We are a value-driven organisation, with no political affiliation. We work in partnership with various bodies associated with the NHS to create a progressive health service that is free from the traditional tribalism of single interest groups.

The PSC network is one of a number of networks provided as part of the NHS Alliance’s support programme. Any PCT manager can join, but this network specifically focuses on the day to day challenges faced by:

- Board members responsible for PSC.
- Directors who oversee PSC delivery.
- Front line executives and managers responsible for delivering world class PSC.
- PCT pharmaceutical advisors and medicines management leads who advise on PSC and input into pharmaceutical needs assessment (PNA) development.

The network has three key objectives:

- To connect its members and share best commissioning management practice;

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209 Professor Mike Richards, Improving access to medicines for NHS patients. November 2008.
— To identify opportunities, challenges and solutions from the front line of pharmacy commissioning; and
— To influence future commissioning policy development.

The PSC network has only recently been launched (9 September 2009). As we are only just up and running, this submission is limited in its scope. However, we felt it was important to put down a marker with The Health Select Committee on an issue that is so core to our reason for being.

Clearly the network approaches this issue from a specific pharmacy perspective; although many of our members are responsible primary care commissioning more generally. This response is thus focused first and foremost on WCC within the context of pharmacy service commissioning.

What does WCC tell us about how effective commissioning by PCTs is?

We believe the competencies are the right overarching principles. Guidance, scoping what WCC of pharmacy services encompasses was published earlier this year. Since then, primary care trusts have been working towards implementation.

Our instinct is that since the guidance was published, PCTs have started to focus more on pharmacy services commissioning as a specific challenge; although we have no concrete evidence to back this up.

We are seeing clearer delegation of responsibility for pharmacy commissioning to specific managers; and often they are commissioning managers rather than pharmacist advisors. Furthermore, the need to produce a pharmaceutical needs assessment and to have it in place by March 2010 to comply with changes in legislation is focusing commissioning teams’ minds on undertaking this “must do” thoroughly.

We do know that until now, the commissioning of enhanced pharmacy services has been patchy. We also know that pharmacy services are often not integrated with wider PCT commissioning and strategic planning processes.

We believe that undertaking a robust PNA may help to integrate pharmacy commissioning with the broader primary care agenda, but this is not a given. There is still a lot of work to be done to integrate needs assessment processes and strategic service planning across primary care. Some of our members feel that because the PNA’s scope is by its very nature limited, it may inadvertently marginalise pharmacy services from wider primary care needs assessment and commissioning strategy development. PNAs need to tick the box as a tool for controlling entry to the pharmacy market, but also need to sit within a broader strategic context. This dual role may prove difficult to reconcile. Our early experience suggests that the PNA may need to be viewed as a subset of primary care needs assessment. We will be exploring how the process of integrating PNA is working in practice, and will provide insights from our network to policy makers over the coming months.

2009–10 will be the first year when pharmacy service commissioning can be included in the WCC assurance process. This should further highlight the need for a more joined up approach; and will help Government and PCTs themselves to assess and evaluate if WCC is indeed impacting on health outcomes as a result of changing commissioner behaviours as we believe it is starting to do.

Furthermore, we think that pharmacy service commissioners are still getting to grips with how some WCC competencies such as the following apply and translate into management competencies and organisational capability:

— Proactively builds continuous and meaningful dialogue with the public and patients to shape services and improve health.
— Leads meaningful engagement with a broad range of professionals to inform strategy, drive quality and service design and assure efficient and effective use of resources.
— Effectively stimulates the market.

We will be supporting our members to share their experiences around this.

Commissioning for Quality and Safety

Because the pharmacy contract is not a contract between the PCT and the provider; rather a contractual framework negotiated at national level, PCT competencies relating to contract management; and promoting and specifying quality improvements through clinical and provider innovation are challenging as PCTs have few effective levers at their disposal, and little control over provider activity. For instance, the regulations that govern the pharmacy contract lay down quality measures and in effect, these are the only things that a PCT can assess quality on.

As a minimum, the PNA must become embedded within the PCT commissioning cycle so that each year the commissioners review the quality of service provision and pharmacy service providers should submit an annual quality report (precursor to quality accounts), measuring predefined criteria.

A PCT’s right to cancel contracts with pharmaceutical services providers is likely to be enabled through legislation. This will provide a stick, but the current contractual framework has no equivalent to QOF or CQUIN and so few incentives to fine tune nationally specified provider activity in line with local needs.
Experience at PCT level suggests it is difficult to persuade providers to focus on improving the health needs of local people voluntarily. There have been a number of calls for a pharmacy QOF; and at least 2 PCTs have introduced a local one already (NHS Doncaster, Nottingham). Whether it is a local or national one, a pharmacy QOF could pull together a commissioning dataset and create opportunities to measure quality improvement, coupled with financial incentives to improve quality.

As the current financial climate necessitates improved productivity and quality achieved within current expenditure—or more likely a reduced financial envelope—it is clear that more effective contractual levers are going to be needed at PCT level to drive quality and greater efficiency and effectiveness from management of the pharmacy contract.

How does commissioning fit with Practice-based Commissioning (PBC), “contestability” and the quasi-market, and Payment by Results?

Getting PBC working is a key performance indicator within world class commissioning, with PCTs who fail to deliver PBC limited to a score of 2. However, there is no clear policy or steer from the Department of Health on how it sees PBC dovetailing with pharmacy service commissioning. This is also true of the development of integrated care organisations; the likely next phase in the evolution of PBC.

This deficit in current policy thinking is something that we as a network have identified. In response, we have entered into productive discussions with the national clinical directors for PBC and primary care and community pharmacy about how this might be addressed. We see this alignment as a significant gap within current programmes to reinvigorate PBC and explore integrated care organisations. We believe that this issue should be scoped and explored through a series of pilots. We are happy to provide more details about our thinking on this.

Scoping this alignment requires very clear delineation between commissioning and provision of services.

In their capacity as service commissioners, PBC groups will need to work with their PCT pharmacy commissioning team to integrate and join up PBC with pharmacy commissioning strategies.

In their capacity as providers, GPs have the opportunity to work collaboratively with pharmacy service providers to join up and improve patient care and drive efficiencies in primary care service delivery. We know that where PCTs have invested in facilitating such collaborative working between GPs and pharmacists, great progress has been made. Within PSC and primary care commissioning more generally, we see facilitating collaboration between pharmacists and GPs as an essential part of WCC (market stimulation, provider development and clinical engagement). We believe investment in supporting such collaboration can reap great benefits for patients, and should be prioritised. What is more, if collaboration focused on driving prescribing cost efficiencies, it would also achieve measurable budget savings. Collaboration could also be incentivised in both the pharmacy and GMS/PMS contracts through jointly provided enhanced services to improve medicines management—especially in those with long term conditions.

We think an equivalent of Payment by Results (PBR) in primary care might drive contestability across primary care contractors for certain enhanced primary care services; but that the funding formula would need to recognise that services would be liable to cherry picking; and therefore cannot be seen in isolation from core primary care service contractual arrangements.

Unless these change significantly, the unintended consequence of PBR in primary care might be an increase in unit cost of delivery of the core services. An example illustrates this point. If GMS practices lost income for certain services to a pharmacy provider, unless the support provided to the GMS practice in relation to staff, premises, IT and superannuation were also proportionately reduced, the cost of the services remaining in general practice would rise—and the overall cost to the NHS would be higher.

That said, we believe that services should be provided where possible by a range of providers, and that competition can drive quality and improve service experience. PBR might create greater competition between incumbent and new providers; and this may well increase choice, convenience and improve quality and the service experience as perceived by patients. But we doubt that this would improve cost effectiveness; unless primary care contracts were radically redesigned.

Specialist Commissioning

Specialist commissioning teams should have access to pharmaceutical advice; and when scoping the potential market for specialist providers, pharmacy service providers need to be included.

September 2009

Memorandum by NHS Somerset (COM 75)

ROLE OF COMMISSIONERS AND IMPACT OF WORLD CLASS COMMISSIONING

EXECUTIVE SUMMARY

NHS Somerset’s view is that the role of the commissioner is to lead the local health system by:

— implementing Government policy in a way that is appropriate to local circumstances;
— developing services which meet the needs of the population, meet high quality standards and provide value for money;
— ensuring that public funds are invested appropriately;
— managing the provider market, and holding providers to account; and
— working in partnership, particularly with practice based and local authority commissioners.

In Somerset, World Class Commissioning has helped to provide focus and structure to the development of our commissioning skills and programmes, and encouraged our more proactive market management approach. NHS Somerset can now point to several examples of service redesign where effective commissioning has resulted in improved services for patients.

1. This paper provides evidence on behalf of NHS Somerset to the House of Commons Health Select Committee Inquiry into Commissioning.

2. NHS Somerset is committed to implementing the vision for World Class Commissioning in Somerset, in a way that ensures that the needs and priorities of the local population are met through commissioning better services and delivering better outcomes based on local priorities, within a self improving system. With a focus on delivering stretching outcome targets and providing a pro-active, rather than a re-active, health service, the Primary Care Trust is seeking to build on its position within the local community, developing closer relationships with key partners and taking a leading role in shaping and defining local services.

3. NHS Somerset has a good track record of innovative and effective commissioning which involves assessing and prioritising population needs, focusing on strategic outcomes, procuring services and managing providers to deliver the required outcomes. It draws on the skills and expertise of its staff and partners in all elements of the Commissioning Cycle to deliver its ambitions for improving health outcomes.

4. One of the key NHS reforms is the introduction of market-style incentives to providers of NHS services as a lever for service improvement. As a result, the NHS is in transition, with an increasing range of more autonomous providers operating as part of a system which demonstrates greater competition and contestability. These changes will continue to increase choice and ensure services are patient centred. NHS Somerset has embraced this market development approach locally, and two examples are described at the end of this paper.

5. A major commissioning responsibility for the Primary Care Trust is now to manage the local NHS market, creating incentives or removing barriers to encourage new providers to enter a service area to increase competition and contestability, securing value for money and offering incentives that drive up quality and service delivery. Over the next five years, the Primary Care Trust will be the lead commissioner in a dynamic market, shaped by the forces of patient choice and value for money with a mixed economy of existing NHS, independent and third sector providers.

6. While increasing competition and encouraging additional providers to enter the market can be a powerful tool to improve health outcomes and efficiency, it is not the right approach for all services or circumstances. Effective market management must also include working with our current providers to establish more commercial relationships, strengthening performance management and improving the quality of care provided. Locally we are very mindful of this and give careful consideration to our commissioning approach for individual pathways, in terms of whether to opt for a strategic collaborative, or market tender route.

7. Our approach to commissioning and market management is focused on ensuring that how we commission and from whom we commission addresses any system failures which contribute to reductions in patient health and wellbeing, such as health inequalities, failures of access, unmet needs and failures in service capacity and quality.

Practice Based Commissioning

8. An important strength of the Somerset health system is a coherent countywide approach to practice based commissioning. All 76 practices in Somerset have combined to form a practice based commissioning consortium called WyvernHealth.Com. They are led by a Board of General Practitioners elected from across the localities in Somerset. A local GP chairs the Board, and they have a full time General Manager and a team of implementation managers.

9. The practices recognised the value of acting as a consortium so that care pathways could be redesigned across Somerset and influence with local NHS Foundation Trusts and the Primary Care Trust increased. The consortium also acts as a resource to support practices in developing plans for local services.

10. A significant benefit of the development of practice based commissioning in Somerset has been a step change in the level and impact of clinical leadership. This has strengthened the ability of NHS Somerset to redesign services and deliver improvements in quality.
Examples of Service Improvement through Commissioning

11. NHS Somerset is presenting two examples of service developments where effective commissioning has resulted in improved services for patients:

— Community COPD Services: Care closer to home, using competitive procurement to drive quality improvement.

— Drug and Alcohol Service: Improving access for substance misusers through service redesign and competitive tendering.

CARE CLOSER TO HOME—USING COMPETITIVE PROCUREMENT TO DRIVE QUALITY IMPROVEMENT

Over 1,000 people with COPD in Somerset are now benefiting from a community COPD service, designed by patients for patients, a culmination of work that began in 2006. In the first year, the service has seen roughly 50% of its target registered population, which represents 18% of people registered with COPD.

Prior to the Service’s introduction in 2008, it was acknowledged by GPs that access to services was inequitable and fragmented across the county. Consequently, patients frequently found that if their health deteriorated they were admitted to hospital.

The practice based commissioning consortium, WyvernHealth.Com worked with NHS Somerset and the local Clinical Advisory Group to build a vision for a new community service to prevent emergency admissions and to improve patient outcomes.

Comprehensive patient engagement included a patient questionnaire, in-depth interviews. Overall, the feedback exercise showed that people wanted more specialised clinics available in their local area that would minimise the need for hospital admission. Patients were an integral part of the commissioning process.

Procurement was by competitive tender and a three-year contract was awarded to the partnership of BUPA Home Healthcare and local GP led Avanaula Systems Ltd.

This service is one of the first in the country to deliver a comprehensive community based COPD service designed around the needs of the patient, and delivered through a partnership between the public and private sector.

What has been achieved is a flexible, equitable community service designed by patients and professionals that brings care closer to the patient’s home and provides opportunity for patients to take control of their COPD and to achieve better health outcomes.

MAIN OUTCOMES

— early data indicates a reduction in the rate of emergency admissions by 50%;
— improvement in patient reported wellbeing and service satisfaction;
— equitable access to pulmonary rehabilitation and support for optimal self care; and
— improved value for money by ensuring oxygen therapy is optimised.

BENEFITS FOR PATIENTS

— improved access to specialist support for all patients in Somerset;
— community based care, including home care to reduce hospital admission;
— 24/7 access to specialist nursing support and advice;
— individually tailored management plan focussed on optimising self care;
— increased access to information through telephone advice, literature and comprehensive pulmonary rehabilitation programme; and
— access to urgent nebuliser assessment and replacement service in and out of hours

IMPROVING ACCESS FOR SUBSTANCE MISUSERS THROUGH SERVICE REDESIGN AND COMPETITIVE TENDERING

In its first year of operation Somerset’s new integrated drug and alcohol service has exceeded its target for numbers in treatment and met national performance requirements for waiting times and retention in treatment.

A key factor in the successful treatment of drink and drug problems is the recognition that motivation to change fluctuates and therefore rapid engagement and retention in treatment are crucial to good outcomes.

The previous configuration of services was fragmented; there were difficulties in accessing the service, waiting list problems and minimal provision for people with alcohol problems.

Somerset Drug and Alcohol Action Team (DAAT) is a strategic partnership of NHS Somerset, Somerset County Council, Avon and Somerset Police and Avon and Somerset Probation Area. The DAAT engaged consultants and led a process of extensive stakeholder consultation including service users and carers, general practitioners and provider staff to review existing provision and make recommendations.
Through this process an open access model was developed where barriers to access were minimised. The patient’s journey through treatment became the focus of service design and alcohol services received greater emphasis.

Following full public consultation and market testing the service was put out to competitive tender and awarded on a 5 year contract to Turning Point, one of the country’s leading third sector providers in the substance misuse field. The service started in April 2008.

Somerset now has a very accessible service with a wider range of provision for both drug and alcohol problems. These include specialist medical treatment and joint working with general practitioners and clear care pathways to a wide range of health and social care services.

**After 1 Year These Additional Services are Available**
- Alcohol service now county wide.
- Home detoxification service.
- Testing and vaccination service for blood borne viruses.
- “One stop” bases in Yeovil, Taunton, Mendip and Bridgwater accessible five days per week.
- Continued expansion of shared care treatment with general practitioners.
- Carers assessment and support service.
- Service user forums in each area.

**Outcomes (as at 31 March 2009)**
- 1143 problem drug users in treatment 12% above target.
- 88% retained in treatment for over 12 weeks.
- 95% waited less than 3 weeks.

*September 2009*

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**Memorandum by South East Coast PCT Alliance (COM 76)**

**Summary**
1. This response has been made by the South East Coast (SEC) PCT Alliance and has been configured around the five points that make up the terms of reference for the Committee.
2. The content of this paper reflects points noted against the terms of reference and includes examples of recent commissioning achievements.

**Introduction to the South East Coast**
3. Within the South East Coast area reconfigured PCTs were formally established on 1 October 2006 to create eight PCTs. The PCT Chief Executives across South East Coast have recognised the need for a high level of collaborative working to take forward shared priorities and have established the South East Coast PCT Alliance.
4. The region covers one of the healthiest and most affluent regions in the UK, with a population of approximately 4.2 million people, but there are pockets of deprivation and inequalities in health.
5. Approximately 100,000 people work for our NHS including 2,500 GPs in 700 surgeries and, as such, the NHS is a major local employer, employing approximately 2.4 people out of every 100 (or 3.9 out of every 100 men and women of working age).
6. There are 13 acute trusts, 4 mental health / community trusts, 1 ambulance trust and 1 strategic health authority.
7. The annual budget is approximately £6 billion.

**World Class Commissioning**
8. World Class Commissioning is welcomed and supported as a vehicle to develop organisational capability but not an end in its own right.
9. Any widespread systematic change such as the move to a commissioning-led NHS requires a wide reaching development programme. The requirement for such a programme should not be viewed as a failing but as a necessity to support a step change in management practice. Just as we expect clinicians to deliver evidence based clinical care, we also need to ensure that NHS management practices are clearly defined and based on established management good practice. World Class Commissioning helps deliver this objective.
10. Commissioning through use of commercial skills as highlighted by World Class Commissioning will need to deliver economies of scale. The development of Commercial Support Units has the potential to support this but needs to build on arrangements that PCTs have already put in place where they have recognised the need to work in collaboration (as detailed in the diagram below).

Developing World Class Commissioning Competencies

The PCTs and SHA in South East Coast have sponsored a range of development programmes to improve commissioning competencies, with a particular focus on transferring knowledge and developing skills found within the commercial sector. Programmes have covered areas such as developing market management techniques, refined approaches to the prioritisation process and long-term financial planning and learning how other sectors undertake knowledge management. These are all enabling activities that support commissioners to better respond to the challenge of meeting the needs of the population and it is suggested the World Class Commissioning should be seen in the same context.

Purchaser/Provider Split

11. The purchaser/provider split is a necessary requirement in a system with a finite budget. Prioritisation and demand management cannot most effectively be delivered by provider organisations due to the tensions in working with competing ethical frameworks (eg rights based vs. duty of care vs. utilitarian), with providers potentially dominated by a clinically focused duty of care and rights based approach. In comparison commissioners need to work to a framework that encompasses aspects of all these doctrines.

12. The role of PCTs in prioritising healthcare spending is a complex and reflects the role PCTs play in acting as advocates for the populations they serve, whilst operating within spending constraints, ensuring the most vulnerable members of our society are treated fairly.

South East Coast Health Policy Support Unit

The Health Policy Support Unit is a shared resource across the eight PCTs in the South East Coast region and is responsible for developing policy recommendations on what treatments and technologies (including drugs) will and will not be funded by PCTs. This is necessary to ensure an equitable approach across the region. PCTs are responsible for identifying the work plan of the unit (eg the areas where it is felt consistent policy is required). The unit is governed by a committee consisting of representatives of all PCTs and makes recommendations to PCTs through a clinically dominated Policy Recommendations Committee. The unit also supports PCTs in developing best practice.

Recent work undertaken by the unit includes developing a consistent policy across PCTs on dealing with individual patient funding requests and a review of procedures not normally funded. Recent policy recommendations include policies on assisted conception, co-careldopa intestinal gel (Duodopa R) for the treatment of advanced Parkinson’s disease and surgery to remove excess skin following profound weight loss.
13. The move to Foundation Trusts and independent sector providers will promote customer focused provider organisations but NHS values, including the NHS Constitution, will increasingly need to be supported through commissioners.

**NHS Eastern and Coastal Kent**

The recently established NHS Continuing Healthcare at Home Team ensures that appropriately assessed patients with complex health needs have the right health and social care services delivered at home. This care is available for appropriate patients over the age of 18 and comprises an individualised and regularly reviewed care plan.

Home Treatment Teams and Admiral Nurses have been commissioned in Ashford, Shepway and Swale to work with people with dementia; these additional teams will complement existing services in Canterbury, Thanet and Dover. Home Treatment Teams support dementia sufferers and their carers in their own homes to avoid unnecessary hospital or care home admissions. The role of Admiral Nurses is to provide psychological and practical support to the carers of people with dementia.

14. In general there has been more stability within NHS provider organisations than in NHS commissioning organisations. Whilst the importance of appropriate organisational form is recognised, continued reorganisation (both in terms of organisational reconfiguration and internal reorganisation) is disruptive and developmentally puts organisations back 12 to 24 months.

15. The further key role for PCTs is commissioning services and interventions focused on prevention, rather than on cure. This approach will be vital in managing the health demand of an aging population. The majority of providers, and the services they offer, are focused on delivering treatment interventions for patients with recognised clinical conditions, rather than proactive approaches to prevention. It is suggested that the development of prevention strategies, and commissioning services to deliver these, would not be well supported without the purchaser/provider split.

**NHS Brighton and Hove**

The Healthy Living Centre is a multi-agency team delivering a diverse portfolio of over 30 health related programmes, activities and initiatives in East Brighton.

It promotes health in an innovative and accessible way by providing one to one support, information, resources, signposting and encouragement to local residents, as well as establishing and supporting groups and activities. The service seeks to empower clients to be more aware and take ownership of their health so they can make lifestyle changes.

The Healthy Living Centre has developed strong and successful partnerships with more than 40 statutory and voluntary agencies including South Downs NHS Trust, Brighton & Hove City Primary Care Trust, Brighton & Hove City council. Services offered include; mental health support, substance misuse support and community cookery.

**Commissioning and “system reform”**

16. There needs to be active involvement and leadership from clinicians in the planning, development and monitoring of clinical services. Practice Based Commissioning provides one mechanism to achieve this and is a general framework that can be tailored locally. The key issue that needs to be tackled is the establishment of practice based budgets and there are arguments for and against this. It will be important to ensure appropriate attention is given to developing any required framework.

**NHS Surrey—UK’s First Integrated Care Pilot**

In January 2009, NHS Surrey and Integrated Health Partners (IHP) announced a local Integrated Care Organisation (ICO) pilot with six innovative practices covering 73,000 patients. The pilot aims to improve patient care by supporting different health and social care professionals to work more closely together. Launching ahead of the Department of Health ICO pilots, this project is broad in scope, covering patient engagement, chronic disease management, end of life care, medicines management, elective care, claims validation, urgent care and single point of access.

Patient and commissioning benefits already being achieved include; improved access to services; greater involvement of patients in decisions on their care; more support and education for patients and carers to better manage conditions.

17. With regard to contestability and the “quasi” market, whilst the market may not be fully formed it is felt that this is now only a matter of time and the independent sector will challenge commissioners, either through the Competition Panel or through the courts under European Competition Law. As independent providers have already entered the market it may not a question of “if” a true market will be established, but “when” will the full impact be realised.
18. This continued development of the market is necessary not only to enable patient choice, (eg by using competition and contestability to support new entrants to the provider market), but also to give PCTs commissioning leverage (ie to ensure there is the option to not only commission from traditional NHS providers, who historically have had a monopoly position). This leverage is needed to drive down cost and increase quality.

**NHS West Kent**

CareCall is an innovative service open to all GP practices supporting patients make more informed decisions and gain increased control of their health. Qualified registered nurses help patients get the most out of their appointments, and ensure they understand the information they receive and better follow treatment plans.

The PCT organised multi-agency dementia care forums including primary, secondary and social care and the voluntary sector, to help identify key areas that require improvement. A broader listening exercise is underway with a view to offering new services.

19. Commissioners will also need to ensure that there are viable providers of not just commercially desirable more “easily” delivered services, but also of less commercially attractive services (ie the focus for commissioner-led market management is not just about choice but also about ensuring all the recognised health needs of the local population can be met).

20. The significant challenge faced by PCTs during the economic downturn is well recognised. However, there also needs to be an appropriate national contracting framework in place. The current national payment framework (Payment by Results) needs to ensure it is flexible enough to deliver commissioning savings in an economic downturn (eg savings potentially accrue to the provider). At a local level the principle of using programme budget headings, which are being promoted across South East Coast, support pathway working rather than the traditional organisational focus, which does not best support patient focused commissioning (as the organisational priority can become the dominant priority).

**Specialist Commissioning**

21. Specialised commissioning was originally established to ensure low volume, high-cost, specialised services were given appropriate consideration due to concerns that the commissioning of these services would become fragmented, leading to services becoming destabilised. In addition, arrangements were meant to ensure that specialised commissioning knowledge was developed and maintained (ie knowledge that could not reasonably be expected to be found in individual PCTs). Generally, this requirement still exists although the development of larger PCT as a result of Commissioning a Patient-led NHS means a small number of PCTs are getting near covering populations as large as those that are meant to be supported through specialised commissioning arrangements.

22. Many of these services are delivered by influential teaching hospitals and increasingly these are becoming Foundation Trusts. A further nuance is how commissioners, through specialised commissioning arrangements, can ensure that these services are not inappropriately favoured during the funding prioritisation process (ie that the funding of services is commissioning led and not directed by influential providers).

23. It is important that specialised commissioning, including at a national level, is seen within the context of the overall clinical pathway, the entirety of which is under the responsibility of PCTs. In many areas (eg cardiac and renal care) the preventative and primary care work is essential in managing the specialised demand.

24. The system reform challenges for specialised services needs to continue to be recognised as being slightly different than for acute commissioning, as choice for patients with rare conditions needs to be balanced with small numbers of expert teams. Free choice in the sense of ‘any willing provider’ can only be appropriate if the quality of service can be assured.

25. Whilst there is a national definition set for the services and procedures that are to be commissioned through specialised commissioning arrangements, within South East Coast it has been identified, that due to local circumstance, there are other services that are best placed to be commissioned collaboratively through the local specialised commissioning team (eg ambulance services where South East Coast Ambulance NHS Trust is the single blue light provider across the region). This allows PCTs to set consistent strategic direction and performance management arrangements. This approach also enables ambulance commissioning to influence national policy development, which has previously been mostly provider led.
South East Coast Specialised Commissioning Group

The South East Coast ambulance commissioning strategy sets out the aims for a fast and responsive emergency ambulance service which enables patients to be effectively treated in the most appropriate place. The agreed objectives focus on developing the clinical workforce across South East Coast, with Paramedic Practitioners working with community based services to maintain people at home where possible, and Critical Care Paramedics to treat and safely transfer the more seriously injured people to the specialist care they need. The contracting framework defines the patient experience in terms of response times and recognises clinical outcome measures.

Specialised commissioning, working with the perinatal networks, identified the need for a twenty-four hour dedicated neonatal transport service to improve the care of babies across South East Coast. Extensive clinical leadership has enabled service specifications for a dedicated service to be agreed, mainly by reshaping the existing daytime teams. This meant that the case for funding was supported and the extended service is due to start within the next month. This was developed ahead of the principles launched through the national neonatal taskforce (to which we contributed) and is a good example of collaborative working with commissioners and clinicians.

COMMISSIONING FOR QUALITY AND SAFETY

26. The re-emphasis that has resulted from the Next Stage Review, High Quality Care for All on the need for quality is welcomed. This is viewed as an appropriate and important focus, which it will be important to maintain as the Government and NHS works to tackle the challenges of the economic position.

27. PCTs can support quality improvements through the contracts they place with providers and it is important that nationally defined contracts provide the flexibility for PCTs to specify their requirements.

NHS Eastern and Coastal Kent

Patient Safety and Care Quality must be at the heart of all NHS ECK’s commissioning pathways. To achieve this, the clinical directorate supports commissioners in:

— Incorporating baseline requirements into a pathway or into a service.
— Defining actions to mitigate risks specific to a service over and above the baseline requirements.
— Monitoring the performance of providers against the baseline and specific requirements.

A toolkit for commissioners has been produced which contains the baseline Patient Safety and Care Quality information all commissioners should include in key documentation throughout the commissioning pathway, and key considerations that should be considered during the development of pathways and / or services.

28. The primary responsibility for healthcare quality lies with the clinical staff providing the care and the board of the provider organisation. PCTs should not undermine this. However, there is an important role for commissioners in assuring themselves of the quality of the services they commission on behalf of the population they serve. High profile service failings have highlighted the need to be clear on the different roles of the constituent parts of the service (commissioners, regulators and SHAs). Locally PCTs are developing systems to assure themselves of the quality of the services they commission and there is recognition that assurances from a provider or regulator may not be adequate. This remains a key issue and one that might benefit from further national debate.

29. It is also important to recognise the significant system management and leadership role played by PCTs. Even prior to the nationally driven policies on patient choice and plurality of provision,211 the UK healthcare system operated as a fragmented model. Since the inception of the NHS care pathways have been delivered across primary, community and secondary care settings, and sometimes tertiary or specialised centres, resulting in the patient being transferred between these. This is also matched by a requirement to work closely with local authorities, as commissioners or providers of social care, to ensure seamless and comprehensive care. This is a complex service provider infrastructure with potential risks for patients as they transfer from one part of the system to another.

NHS West Kent

The PCT has developed and improved services which have benefitted the lives of people with ill health and long term conditions. The stroke services focus on prevention, treatment and rehabilitation, resulting in one of the most extensive rates of improvement in the sentinel audit between 2006 and 2008. We have five day a week TIA clinics, a 24-hour thrombolysis service, across four hospitals, increased numbers of specialist staff and a new stroke specific psychology team is being recruited.

30. PCTs play a vital role in ensuring robust services are in place to deliver care along the entire length of the patient pathway, including managing the system to ensure the patient journey across different health sectors is delivered without complications. The system leadership role extends beyond ensuring the

211 Care delivered from an increased range of providers in order to introduce competition and contestability and make patient choice possible.
appropriateness and robustness of cross-organisational care pathways to include providing an external push to coordinate the systematic rollout of evidence based practice and promote innovation. Whilst the latter has been identified as a key role for SHA, it is also a core component of commissioning and a key means of delivery clinical and cost effectiveness.

September 2009

Memorandum by the British Dental Association (COM 77)

1. EXECUTIVE SUMMARY

1.1 The challenges of oral health commissioning, and the difficulties many PCTs have faced since assuming full responsibility for dental commissioning in 2006, have been well documented by the Health Select Committee in its 2008 report into dental services, and more recently by the Steele Review. In recognition of these challenges, the British Dental Association has implemented an innovative programme of commissioning research and commissioned a wide-ranging review of dental commissioning from an independent working group.

1.2 If the World Class Commissioning (WCC) initiative is to fulfil its potential to drive the delivery of high-quality NHS services, there is a clear need to work towards a more sophisticated scoring and assessment framework which drills down to service level data, providing a more comprehensive analysis of a PCT’s strengths and weaknesses.

1.3 Driving forward service improvement means all stakeholders, including clinicians, patients, community partners and the public, need to be supported to interpret commissioner performance under the WCC framework and hold PCTs to account.

1.4 Progress toward the purchaser/provider split has not, to date, been smooth. Despite a clear requirement to consult, some PCTs do not appear to be seeking to engage staff sufficiently early in the process, leading to real concerns about both the future of essential services to vulnerable patients and the job security of those currently providing those services.

1.5 The need for PCTs to achieve centrally derived, inflexible targets inhibits their ability to commission creatively and innovatively to best meet the needs of their populations.

1.6 High-quality, properly interpreted, and well managed data is the backbone of high-quality commissioning. The NHS needs to invest in data management across the whole of the health service, and specifically within dentistry invest in the IT infrastructure required to effectively collect and extract data.

1.7 Many PCTs do not have the available resources to commission creatively within oral health, in particular lacking sufficient access to dental public health and practice adviser expertise. If PCTs are to achieve world class standards in commissioning there is a clear need to invest in dental public health and dental practice advisor capacity, as well as support commissioning networks and sharing of best practice.

1.8 Currently, one of the most significant challenges within dental commissioning is the lack of agreed, nationally benchmarked key quality indicators and clinical guidance available to commissioners when designing and procuring services.

2. INTRODUCTION AND BACKGROUND

2.1 The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its near 24,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

2.2 NHS dentistry has been an important service, greatly valued by patients since the inception of the NHS; yet, largely as a result of the national contractual and funding arrangements which bypassed the local NHS, it has not featured highly on the PCT agenda.

2.3 However, the Health and Social Care Act 2003 began the process of transferring responsibility for the planning and delivery of dental services to PCTs, with PCTs assuming full responsibility at the same time as the introduction of the current general dental services and personal dental services contracts in 2006.

2.4 Unfortunately, despite the timely warnings of the National Audit Office in 2004 that PCTs would need “to develop new expertise in dentistry” given that they had “little experience of high street dentistry” many PCTs were unprepared to take on their new role.212 In addition to which, the difficulties caused by the rushed introduction of a new and unpiloted contract—which did not give PCTs or practitioners sufficient time to learn about the new arrangements—coincided with a large scale reorganisation of PCTs themselves. Some of the worst affected PCTs have only recently returned to full staffing levels.

2.5 The Health Select Committee itself highlighted the unacceptable variation in the quality of dental commissioning in its 2008 report into NHS dental services stating that:

“Some PCTs do not:

Without adequate oral health data on the oral health of the population, PCTs are not able to make valid dental needs assessments. We recommend that PCTs take immediate steps to widen the scope of the data they collect on the oral health of their local population. We also recommend that PCTs:

- Establish consultative committees comprising a mixture of experience and expertise including; patients, professionals and PCT personnel; and
- Employ appropriately trained staff and make full use of dental public health specialists and consultants.

In addition, the Department must clarify how it intends to improve the performance management of PCTs which are failing to implement contract with sufficient flexibility. SHAs must place greater importance on their role in managing the performance of PCTs in respect to dentistry”. (Paragraph 211)

2.6 The Steele Review of NHS Dental Services echoed many of these findings in its report earlier this year, concluding that “The amount of work involved and the unique nature of dental commissioning was perhaps underestimated (by commissioners)”.

2.7 The findings of the report further corroborate the particular concerns of the Select Committee and the BDA that “three years on, many PCTs are still not using the (contractual) flexibilities introduced in 2006” as their concern about patient charge revenue income and meeting UDA targets resulted in “a natural caution”. In addition to which the Steele Review highlighted that “many of the commissioners involved were junior, which may have contributed to the difficulties”, a problem which, along with the rapid turnover of commissioning staff, is reflected in the experiences of many BDA members.

2.8 Nonetheless, despite the challenges and difficulties experienced to date, the BDA believes there are clear benefits in commissioning services locally to meet the oral health needs, and aspirations, of the local population. Indeed, robust commissioning based on clear local data, supported by experts, and undertaken with the full engagement of professionals, patients and the public has the potential to deliver excellent services and drive forward quality.

2.9 Consequently, the BDA believes that excellence in commissioning is vital, and is committed to developing the principles set out by the World Class Commissioning framework and the NHS Next Stage Review in the context of oral health services. In order to support this commitment, and move some way towards addressing the current deficiencies of oral health commissioning, the BDA has established its own programme of work, aimed at; filling the knowledge gap on the real state of NHS dental services commissioning; beginning the process of building an evidence base around commissioning initiatives; and developing practical guidance tools for commissioners and clinicians. To date this work has included:

- Surveying commissioners and local dental committees about commissioning practise, attitudes and future intentions.
- Undertaking in-depth case study interviews with dental commissioning leads about their commissioning initiatives.
- Establishing an independent local commissioning working group, with representation from commissioners, practitioners, public health and clinical specialists, patients, and local government, to develop practical guidance on becoming a world class commissioner of dental services.
- Holding a dental commissioning lead focus group on commissioning best practice.

2.10 We refer to a number of the findings of the research and working group as part of this evidence and would be pleased to provide the Committee with copies of both full reports.

3. “World-Class Commissioning”: What does this Initiative Tell Us About how Effective Commissioning by PCTs is?

3.1 The WCC competencies framework is a much welcomed initiative aimed at improving and recognising the skills of commissioners; however, the extent to which this initiative is a useful tool for monitoring and improving effective commissioning by PCTs currently has some limitations.

3.2 If local commissioning of services is to fulfil its potential to deliver truly world class services, tailored to the needs of individual communities, then it is important to hold PCTs to account and monitor their progress. However, currently the information produced is limited to an overview of the PCT’s overall performance. Unfortunately, commissioning is not just variable between PCTs but within PCTs as well. Commissioning of dental services in particular, because they have not been afforded high priority by many PCTs or SHAs and as a result of the problems of staff ‘churn’ we have highlighted, frequently may not be

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213 Health Select Committee inquiry into dental services, 2008, page 56.
215 ibid, page 32.
Recommendation 1: WCC should work towards more sophisticated service level monitoring and assessment of PCT competency within the WCC framework to enable greater scrutiny of their achievement in planning and delivering different services.

3.3 To date, as may be expected, the WCC agenda has been very focused on commissioners and PCTs. However, the final performance assessment of PCTs’ achievements against those competencies does have significant implications for practitioners, patients and community partners, and indeed all those engaged in holding the PCT to account for their performance. However, despite this there has so far been little effort to effectively engage a wider audience with the WCC agenda. Therefore, we believe there is also a need for guidance for patients, the public, clinicians and community stakeholders to understand and interpret the performance of their PCT and effectively hold it to account.

Recommendation 2: Work should be undertaken to develop and communicate guidance and information to wider commissioning stakeholders to ensure PCTs can be held to account for their performance and management.

4. The Rationale Behind Commissioning: Has the Purchaser/Provider Split been a Success and is it Needed?

4.1 In January 2009 the Department of Health published the Transforming Community Services report which required PCTs to consider further separating their purchaser and provider functions through fully divesting provider services, unless there is a clear reason for not doing so.

4.2 This has led to a great deal of uncertainty amongst those providing community services as the process of divestment unfolds. There are real concerns surrounding both job security and the possibility that the provision of salaried dental services to vulnerable members of society will be overlooked by commissioners and PCTs during the drive to divest.

4.3 PCTs have been issued with guidance reminding them of the requirement to consult with the recognised trade unions. This is paramount to the future success of any changes to service provision and ensures that staff and patients have an opportunity to discuss future objectives and their potential consequences at every stage. It is of concern that some PCTs do not appear to be engaging with their staff sides at an early enough stage in the process.

Recommendation 3: The lack of consultation and engagement of affected professionals, employees and patients needs to be swiftly remedied.

Recommendation 4: PCTs need to work together with clinicians, patients and stakeholder organisations to ensure that there are robust plans in place to protect the provision of essential services for hard-to-reach and special needs groups.

5. Commissioning for the Quality and Safety of Services

5.1 Defining the key elements of quality and what quality looks like for different services and in different circumstances—including designing services and monitoring appropriate indicators—is also one of the most challenging aspects of commissioning. In particular, translating outcomes and principles into practical actions and service delivery models which can be then monitored and their quality assessed. Consequently, quality needs to be at the centre of every stage of the commissioning process starting with determining model care outcomes and then ensuring that the service design and implementation process, systems monitors and review processes work to support those aims. Seeking to achieve this is, of course, at the core of the WCC competencies framework.

5.2 Nonetheless, despite some efforts by the Department of Health and Primary Care Contracting, there is still significant work which needs to be undertaken on producing practical guidance and support for commissioners on how to interpret the competencies framework into practical steps in the commissioning of different services. The WCC competencies framework is, of course, generic, and does not attempt to demonstrate what achievement of each competency would look like within each service. This is of particular concern within dental commissioning due to the high turnover of staff: the BDA survey of dental leads showed that those surveyed had held their positions for an average of 3.4 years with just over a quarter (27%) having been in post for less than a year. It takes time to build a body of expertise, and unless more support and practical information is provided to commissioners, PCTs may find themselves slipping back in the achievement of competency each time lead staff move on.

216 British Dental Association Local Commissioning Audit research report, 2009.
5.3 Recognising this deficit, the BDA established an independent working group, with representation from all stakeholders in the commissioning process, to develop that practical guidance based firmly on the WCC competencies framework within dentistry; which we believe serves as a model that could be replicated across a range of services to the benefit of commissioners, clinicians and patients.

Recommendation 5: Work should be undertaken to develop the practical supporting implementation guidance for the commissioning of different services to underpin the WCC competencies framework.

5.4 Despite the WCC initiative and the health service quality agenda, PCTs are still limited in their ability to commission effectively for quality or oral health improvement due to UDA-focused patient access targets. The need to achieve targets set by the centre inhibits the ability and incentive for commissioners to introduce greater innovation or meet their own local priorities. There is a clear need for PCTs to be given more room to innovate by the centre if commissioning is to achieve its potential. For example, the results of the BDA commissioner survey showed that over half of the dental leads surveyed (60%) felt that the standard GDS contracts and PDS agreements do not allow them to be as innovative as they would like in responding to local health needs. However, where PCTs had introduced variations into the contract with the aim of improving the quality of services, all consider the initiatives to have been successful in doing so.  

Recommendation 6: PCTs need to be allowed greater flexibility to commission to deliver high quality services to meet the needs of their population, not centrally derived targets.

5.5 A significant challenge faced within the commissioning of high-quality dental services is the lack of nationally benchmarked key quality indicators and evidence-based clinical guidance available to commissioners when designing and procuring services. Currently a number of PCTs have sought to design their own quality frameworks for dental services; however, this work has not been brought together or evaluated in a consistent way or shared effectively where best practice is identified—something which the BDA is seeking to address through conducting case study analysis. The Department of Health has now set up a number of Clinical Effectiveness and Outcomes Groups to look at identifying quality outcomes and key performance indicators within dentistry, a move acknowledged by the BDA.

Recommendation 7: Department of Health should invest in producing and maintaining up-to-date key quality indicators and clinical guidance researched and benchmarked at a national level.

5.6 Commissioning high-quality, safe services is underpinned by robust data. Data is essential in developing national guidelines and undertaking research, as well as for individual commissioners in developing and monitoring their oral health strategy. Indeed it is very unfortunate that the collection of much of the original clinical dental data set was dropped from the system in 2006. This resultant dearth of data within oral health needs to be addressed in order to strengthen commissioning. The single greatest barrier to effective data collection is currently the lack of IT infrastructure. There needs to be significant investment in the computerisation of dental practices and transfer of data between agencies to ensure that commissioners, practitioners, and national bodies are quickly and easily able to extract necessary data. In addition, data which is collected is not managed effectively. In particular data which is collected by PCTs as part of their monitoring arrangements is often not shared with PCT colleagues or clinicians themselves as part of an ongoing drive towards quality improvement.

Recommendation 8: The NHS needs to invest in data collection and management systems across the whole of the health service, specifically within dentistry investing in IT infrastructure and coordination of data collection systems.

5.7 Excellent commissioning requires proper resourcing. Currently there is a serious lack of resourcing within dental commissioning, particularly in terms of access to sufficient consultant in dental public health expertise. Although never published, the Dental Public Health Workforce in England status report (January 2005), commissioned by the Chief Dental Officer, identified this shortage. The BDA is also aware that during the 2006 PCT reorganisation, dental public health capacity was lost due to redundancies. The Department of Health have commissioned a review of dental public health capacity. The BDA is disappointed to note, however, that despite an original publication date of 2007 this valuable work has not yet been completed.

5.8 In addition to a lack of available dental public health expertise, the BDA research has also identified a lack of capacity for commissioners themselves. Of the commissioning leads surveyed, over a quarter (27%) felt that they did not have the resources to develop variations on the standard (dental) contract. Indeed nearly a fifth of PCTs surveyed (19%) did not have an oral health strategy in place. The lack of capacity for commissioners to conduct robust commissioning processes, planning and procuring services, to meet the needs of their population is a significant concern.  

5.9 The BDA also recently hosted a dental commissioning lead focus group; it is interesting to note that the participants also highlighted the lack of support for regional commissioning networks as a particular issue within dentistry as a result of needing to deal with cross-PCT boundary patient flows. 

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217 ibid.
218 ibid.
Recommendation 9: The Department of Health needs to make significant investment in commissioning resources, including:

- Investing in consultant in dental public health and dental practice adviser capacity.
- Support for developing commissioning networks and sharing of best practice.

5.10 Dentistry and dental professionals have, so far, been neglected in terms of clinical leadership as many local and national initiatives have not sought to include dentists. Robust clinical leadership is a vital component of the commissioning process, therefore it is essential to support its development.

Recommendation 10: PCTs, supported by SHAs and the Department of Health, need to develop the engagement, and contribution, of all clinicians and frontline staff in commissioning by extending and developing clinical leadership initiatives.

September 2009

Memorandum by the National Institute for Health and Clinical Excellence (NICE) (COM 78)

1. EXECUTIVE SUMMARY

This memorandum covers the following issues in the terms of reference of the Health Committee’s inquiry: commissioning for the quality and safety of services; and World Class Commissioning—what does the initiative tell us about how effective commissioning by PCTs is?

NICE guidance supports commissioners and enables them to improve both quality and productivity. It will be an important resource for commissioners as the NHS moves into a period of budgetary constraints.

We are reviewing in consultation with NHS professionals how we can improve our offer to PCTs and trusts. The findings of the review will mean that we will be better able to help commissioners and other professionals identify opportunities to save money now and invest to reduce costs in the future, and how to protect and promote the quality of their services.

We have invested heavily in recent years in a range of resources and a team of implementation consultants to support commissioning and other processes for putting our guidance into practice. The purpose is to help commissioners and others meet the planning and financial management challenge of changing treatments and re-designing care pathways in line with NICE guidance. We are currently discussing with commissioners how we can further develop our implementation support products.

Following the 2008 report of the Darzi review, ‘High quality care for all’, NICE is providing commissioners with new resources: NHS Evidence, the web-based portal providing commissioners with access to an increasingly comprehensive evidence base; and NHS quality standards, succinct statements with accompanying indicators that will enable commissioners to specify service requirements and monitor performance in meeting them.

NICE guidance supports world class commissioning by enabling commissioners to achieve, and demonstrate their capability against, eight of the 11 world class commissioning competencies.

2. ABOUT NICE

NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE produces guidance in three areas of health:

- public health—guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector
- health technologies—guidance on the use of new and existing medicines and devices as well as diagnostic and therapeutic procedures within the NHS
- clinical practice—guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

NICE guidance thus helps to improve the public’s health and makes access to healthcare more equitable across the country.

Since 2004, as part of its implementation strategy, NICE has invested heavily in resources to support implementation of guidance by commissioners and front-line health professionals.

Over the last year or so, NICE has taken on important additional functions as part of implementation of the measures to improve the quality and value for money of NHS services announced in the final report of the Darzi review, “High quality care for all” (Department of Health 2008). These functions are:

- NHS Evidence, a web-based service providing easy access to high quality clinical and non-clinical information from accredited sources about health and social care.
— NHS quality standards, a set of specific, concise statements derived from the best available evidence that act as markers of high quality, cost effective care across a pathway or a clinical area. We expect to publish the first set of quality standards early in 2010. Commissioners will be an important target audience.

— the Quality and Outcomes Framework (QOF) indicators programme, which develops clinical and health improvement indicators for the quality and outcomes framework for primary care services and recommends whether existing indicators should be discontinued.

3. Commissioning for the Quality and Safety of Services—NICE’s Contribution

3.1 Quality and productivity

NICE guidance is an essential resource for commissioners. By using guidance as a reference point commissioners can ensure that promotion of good health and prevention and treatment of ill health in the NHS are in line with the best available evidence of clinical and cost effectiveness. Improving quality will often improve patient safety, generally enhances patient experience, and can also result in cost savings.

The relationship between quality and productivity is a major theme of ‘High quality care for all’ and is particularly salient when there are budgetary constraints. NICE is committed to working with the NHS and the wider public health community to help equip it to deal with a period of significantly reduced funding. We’ve been making recommendations on the optimal use of resources for 10 years, but in recent months we have been reviewing our guidance and how we present and promote it to see if there are ways in which we can improve our offer to PCTs and trusts.

We have also been talking to NHS staff to find out what they want us to do. In a forthcoming workshop (on 25 September), “Shaping NICE’s agenda for a resource-constrained NHS”, we will bring together mainly senior PCT, SHA and NHS trust professionals. In November, we will be meeting with NHS medical directors to present the results of the review and will show participants how they can use our guidance and accompanying resources to identify opportunities to save money now, where to invest to reduce costs in the future, and how to protect and promote the quality of their services.

This review, and the activity arising from it, will advance the work we described in our comments in ‘NICE response to the Committee’s first report of session 2007–08’ on the Committee’s recommendation that NICE must give more emphasis to disinvestment.

3.2 Supporting commissioners—guidance-based resources

In previous reports the Committee has commented on weaknesses in PCT commissioning, mainly resulting from lack of the relevant experience and skills. We recognise that it is a planning and financial management challenge to build the changes to treatments and the re-design of care pathways recommended by NICE guidance into commissioning objectives. This is why we have invested heavily in recent years in a range of resources and a team of implementation consultants to support commissioning and other processes for putting our guidance into practice.

For particular guidance topics these resources include web-based commissioning guides. These guides support commissioning decisions on service reconfiguration and the commissioning of evidence-based care for patients, assist with financial modelling and costing by offering a commissioning tool to calculate and cost local service provision, help in the preparation of a business case, and provide a framework for investment decisions. During September 2009 we are holding two workshops to review the needs of commissioners and how we can further develop our implementation support products. Feedback indicates that there is a wealth of information on the ‘commissioning process’ but sometimes commissioners need topic specific information tailored to their needs.

Other resources accompany each item of guidance and are designed to enable commissioners to:

— include the implications of NICE guidance into their forward plans, make detailed projections of local costs and savings, and consider the impact on finances and on payment by results (PbR);

— make use of national support and other resources, tools and examples of good practice; and

— audit progress in implementing recommended changes to services, whether uptake of a specific drug or procedure or putting in place major programmes to tackle obesity or dementia.

NICE’s implementation consultants are a team of field-based consultants who help commissioners work with our tools or provide general advice on how NICE guidance can be used in the commissioning of evidence-based services for their population.
3.3 NHS Evidence

NHS Evidence is a new resource. It provides access to an increasingly comprehensive evidence base for health and social care commissioners including primary research literature, practical implementation tools, guidelines and policy documents.

3.4 NHS Quality standards

The purpose of quality standards, as set out in ‘High quality care for all’, is to clarify, and establish a single source for, quality standards in the NHS. The Department of Health has commissioned NICE to manage the process of developing quality standards. We will receive sequences of topics from the National Quality Board (NQB) and develop quality standards in these areas. We will work with other organisations and consult with individuals and stakeholder groups during field testing of the quality standards. We are piloting this process with the following topics and the first quality standards will appear early in 2010: stroke; dementia; neonatal care; venous thromboembolism (VTE).

Quality standards will cover the three dimensions of quality: ensuring patient care is safe; ensuring patient care is effective; and ensuring patient care considers the patient experience. They will have two key features:

- Qualitative statements: Descriptive statements of the key infrastructural and clinical requirements for high-quality care, as well as the desirable or expected outcomes.
- Quantitative measures: Quality measures that set the expected degree of achievement. These will be “quality indicators”.

These features make quality standards an important tool for commissioners. They enable them to specify service requirements and monitor performance in meeting them.

The precise status of quality standards remains to be determined. However, they will have a role to play within the Quality Accounts that PCTs will be publishing from April 2010 as part of the continuous process of quality improvement. For commissioners, they will be markers of high quality care. For patients and the public, they will be clear statements of what they can expect from services. The Care Quality Commission (CQC) should find them a useful marker of the quality of care offered to patients when it applies its registration and assessment processes.

4. World Class Commissioning and the Role of NICE

The Committee commented on world class commissioning in its report of January 2009 on the “NHS next stage review. Since then, the Department of Health has fleshed out the elements of the world class commissioning assurance scheme. NICE guidance and related resources and quality standards are important for commissioning for health and well-being generally and thus for world class commissioning in particular. They enable commissioners to achieve, and demonstrate their capability against, several commissioning competencies.

Commissioners should regard NICE guidance (and, in the future, NHS quality standards) as a reference point when assessing their performance against the criteria for the following world class commissioning competencies:

- Competency 4 (Collaborate with clinicians): NICE guidance helps PCTs in ensuring that they work with clinicians to “build on the current evidence base, maximise local care pathways and utilise resources effectively”.
- Competency 5 (Manage knowledge and assess needs): NICE commissioning guides and costing tools help PCTs assess the needs of their population by providing information and benchmark estimates of people affected by our guidance.
- Competency 6 (Prioritise investment): NICE guidance helps PCTs to “set strategic priorities and make investment decisions focused on the achievement of key clinical and other outcomes”, including “investment plans that address areas of greatest health inequality”.
- Competency 7 (Stimulate the market): NICE guidance and resources help PCTs to invest in such a way as to “secure the desired outcomes and quality”.
- Competency 8 (Promote improvement and innovation): NICE guidance helps PCTs to apply “innovation, knowledge and best practice” locally to “improve the quality and outcomes of commissioned services”.
- Competency 9 (Secure procurement skills): NICE guidance and resources help PCTs to ‘specify quality standards and outcomes’ as part of putting in place “excellent procurement and contracting processes”.

— Competency 10: (Manage the local health system): Having specified quality standards and outcome using NICE guidance, PCTs are better able to manage their “contracts with providers in order to ensure they deliver the highest possible quality of service and value for money”.

— Competency 11: (Make sound financial investments): NICE guidance takes into account both clinical effectiveness and cost effectiveness. Therefore, in implementing our guidance, commissioners can be reassured that they are making sound financial investments. We provide interactive costing templates in order to help organisations assess the investment required, and potential savings delivered.

September 2009

Memorandum by Monitor (COM 79)

The Health Committee has decided to undertake an inquiry into Commissioning, the terms of reference of which are as follows:

(a) “World Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?—No comments provided by Monitor.

(b) The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?—See comments below.

(c) “Commissioning and system reform”: how does commissioning fit with Practice –based Commissioning, “contestability” and the quasi market, and Payment by Results?—No comments provided by Monitor.

(d) Specialist commissioning—No comments provided by Monitor.

(e) Commissioning for the quality and safety of services.—See comments below.

Monitor would like to submit evidence in the areas (b) and (e) outlined above.

EXECUTIVE SUMMARY

Monitor is the Independent Regulator for NHS foundation trusts and is directly accountable to Parliament. Our mission is to provide a regulatory framework which ensures that NHS foundation trusts are well led and financially robust so that they are able to deliver excellent care and value for money.

NHS foundation trusts are a key component of the Government’s NHS reforms and a fundamental part of the purchaser/provider split. Monitor considers that the purchaser/provider split aims to ensure that the funding that is provided to the NHS through general taxation achieves the best possible value for money, and that the NHS allocates the resources that it receives efficiently to meet the expectations of the public.

In this document, Monitor submits evidence to demonstrate that the transparency and accountability associated with the purchaser/provider split has brought real benefits. We also outline some lessons we have learnt over the past five years as the regulator of NHS foundation trusts, and suggest these could be useful as part of the further development of commissioning in the NHS.

MONITOR’S DETAILED COMMENTS ON AREAS (b) AND (e)

NHS foundation trusts and Monitor

1. Monitor is the Independent Regulator for NHS foundation trusts and is directly accountable to Parliament. Our mission is to provide a regulatory framework which ensures that NHS foundation trusts are well led and financially robust so that they are able to deliver excellent care and value for money.

2. Since 2004 when Monitor was established 122 acute and mental health trusts have achieved foundation trust status. There remain 45% of acute and mental health providers which still need to achieve NHS foundation trust status.

3. NHS foundation trusts are a key component of the Government’s NHS reforms and a fundamental part of the purchaser/provider split. When an organisation achieves NHS foundation trust status it is no longer accountable to Strategic Health Authorities and the Department of Health (who have ongoing responsibilities for commissioners). Instead NHS foundation trusts are accountable to their local communities (through their members and governors), to their commissioners (through contracts), to Monitor and to Parliament.
Rationale for purchaser/provider split

4. Monitor considers that the purchaser/provider split aims to ensure that the funding that is provided to the NHS through general taxation achieves the best possible value for money, and that the NHS allocates the resources that it receives efficiently to meet the expectations of the public.

5. The purchaser/provider split is supported by the Payment by Results tariff system which aims to ensure that for the vast majority of acute services commissioning decisions are only based on the quality of service that providers are willing to offer. The Government has also worked with the regulators (Monitor and the Care Quality Commission) to develop improved metrics for quality which should further enhance the ability for commissioners to drive local improvements in quality based on the needs of the local population.

6. The alternative to a purchaser/provider split is a form of the arrangements that relies on a central body setting standards and allocating budgets to individual organisations. Monitor considers that a purchaser/provider split introduces a number of advantages over a central budget model.

7. First of all, the purchaser/provider split has made the performance of both organisations more transparent. It is now possible to identify when a provider is failing to deliver services efficiently. The increased level of transparency with both purchasers and providers enables a degree of accountability in the delivery of healthcare. This in turn allows Monitor to take action in the event that an organisation is failing to meet the expectations of its local community and/or commissioners.

8. With a purchaser/provider split, organisations have a focus on their purpose that is often lost in an organisation with multiple objectives. On the provider side, this has led to stronger governance, better financial management, a focus on quality and a drive to innovate. Within NHS foundation trusts we have seen the development of service line management, which enables clinicians and managers to understand the efficiency and quality of the different services within a hospital. World Class Commissioning has also seen important investment for the first time in the skills that are necessary to purchase healthcare services from different provider types with the objective of increasing the quality of care to patients.

9. A further important benefit of the purchaser/provider split is improved decision-making in relation to the allocation of NHS resources. For commissioned services, resources are allocated on the basis of commissioners’ views on the services that the local population demands. In some cases this has meant that services are moved from the acute setting into the community in response to local demands. Under the system of budget allocation, large organisations (often in the acute sector) spent considerable time and resource on attempting to influence budget allocation decisions. In some circumstances the outcome that could be observed was that large organisations that “shouted loudest” received higher levels of funding which may be contrary to the demands of the local population.

10. Finally, the purchaser/provider split has resulted in improved access to and use of information on local issues and priorities, in a way that could not be achieved by a central body. Although national guidelines such as recommendations issued by NICE on best practice care pathways continue to be adhered to, local purchasers and providers have access to detailed information about local issues and priorities, and can make decisions to meet these demands. NHS foundation trusts have 1.5 million local members and 3,800 local governors which work to influence the strategic decisions on the delivery of healthcare services in their local communities.

Evidence of provider performance

11. The next section focuses on NHS foundation trust performance. We have focused our comments on provider performance given our expertise and that autonomous providers have been in place for a number of years which enables an evidence base to be established and evaluated. There is, however, some evidence available around the benefits of commissioning particularly under the GP fundholding arrangements. In his book The Other Invisible Hand, Julian Le Grand sets out how GP fundholders were effective in bringing down waiting times, reducing hospital referrals and holding down prescription costs.

12. The transparency and accountability associated with the purchaser/provider split has brought real benefits to NHS foundation trusts. A study conducted by Monitor to understand its impact as a regulator (“Monitor’s impact study”) provides a number of examples. The study found that financial issues are identified early on in NHS foundation trusts, and as a consequence are resolved more rapidly than they are in other organisations. In interviews held as part of the same study, senior executives of NHS foundation trusts indicated that improved governance has resulted in issues being more likely to be identified quickly, and increased accountability places more pressure on boards to resolve any issues identified.

13. Similarly, Monitor’s impact study provided evidence that the increased focus resulting from the purchaser/provider split has led to, among other things, better performance on quality. Although consistent and reliable quality metrics are limited across the NHS, the study found that NHS foundation trusts outperformed NHS trusts on all the metrics that were examined, including waiting times and infection rates. This finding is supported by the results of the Annual Health Check conducted by the Care Quality Commission, which show that NHS foundation trusts consistently outperform NHS trusts on the Quality of Services measure.
14. The evidence uncovered as part of Monitor’s impact study in relation to access to and use of local information is also encouraging. The study encountered strong examples of NHS foundation trusts engaging with their governors and members to take strategic decisions, and also of governors and members holding their NHS foundation trust to account for poor performance.

**Next steps in commissioner performance**

15. The Government has taken a number of steps to ensure that the maximum possible benefits arise from the purchaser/provider split. Monitor believes that the introduction of World Class Commissioning has been a significant step as it has placed improving commissioning at the heart of the agenda for delivering the Government’s healthcare strategy. This new level of focus has already resulted in increased investment in leadership and skills for commissioners.

16. The World Class Commissioning programme fits well with the Government’s increasing focus on quality, and with the development of quality metrics. Monitor strongly believes that the transparency associated with the development of these metrics will be very valuable in helping commissioners make well-informed choices and the expectation is that overall quality will be improved as a consequence.

17. These developments are however recent, especially when compared with the developments on the provider side. This means that commissioning organisations are now playing catch-up and it will take some time before all the benefits associated with the recent reforms become apparent.

18. In this regard, it may be useful to consider the lessons which Monitor has learnt over the past five years as the regulator of NHS foundation trusts. It is difficult to isolate the aspects of the NHS foundation trust regime that have contributed to the higher levels of performance of NHS foundation trusts compared with NHS trusts, but Monitor believes the following four factors have been significant:

(a) Clarity about what constitutes good performance: Monitor does not performance-manage NHS foundation trusts, but it is very clear with NHS foundation trusts about what are acceptable levels of performance. Each year, Monitor publishes a Compliance Framework which NHS foundation trusts need to adhere to. In this document, Monitor sets clear minimum standards of performance in terms of governance and finance. Failure to comply with these standards results in regulatory action by Monitor, which could take a number of forms ranging from increased reporting requirements to changes in board membership.

(b) Local engagement: One of the most important features of NHS foundation trusts is their accountability to their local communities. NHS foundation trusts are required to develop and grow a representative membership to ensure that all members of the community are able to remain informed about their local hospital, and to influence their local hospital if they want to do so.

(c) Clear lines of accountability: In Monitor’s regulatory regime, the board of directors of an NHS foundation trust remains ultimately accountable for its performance. The board is accountable for the trust’s own success or failure to the local communities through members and governors, to commissioners through contracts, to Parliament and to Monitor as independent regulator.

(d) Clear incentives: Monitor believes that the “stick” incentive outlined above is not enough to incentivize good performance. Monitor’s regulatory regime provides ‘carrot’ incentives too: high-performing NHS foundation trusts are given more autonomy, and have more opportunities to invest in improved services for patients.

19. These lessons could be useful as part of the further development of commissioning in the NHS. Monitor believes that clarity about performance, local engagement, accountability and incentives are crucial tools in the realisation of benefits of the purchaser/provider split.

*September 2009*

**Memorandum by the Alzheimer’s Society (COM 80)**

Alzheimer’s Society is the leading care and research charity for people with Alzheimer’s disease and other forms of dementia, their families and carers. It is a national membership organisation and works through nearly 230 branches and support groups. The Society has expertise in providing information and education for people with dementia, carers and professionals. It provides a helpline and support for people with dementia and carers, runs quality day and home care, funds medical and scientific research and gives financial help to families in need. It campaigns for improved health and social services and greater public understanding of all aspects of dementia. We are pleased to be able to respond to the Health Committee’s inquiry into commissioning.

— Commissioners have a key role in improving the quality of life of people with dementia.

— Significant sums of money are being spent on poor services which deliver bad or limited outcomes for people with dementia. There is an opportunity through commissioning to deliver better care and outcomes within existing budgets, although over time more investment will need to be found.
1. Why Commissioners Need to Understand the Needs of People with Dementia in Their Local Community

1.1 Care and support for people with dementia has historically been a low priority at a local and national level. This has hampered the establishment of sufficient support services. The development of clear strategies for meeting the needs of people with dementia and their carers in local communities has occurred only recently in many areas following the publication of the National Dementia Strategy for England.

— There are 575,000 people with dementia in England and this will rise to over 700,000 by 2020.

— The cost of dementia is £15 billion a year in England which is more than the costs of cancer, heart disease and stroke combined. The King’s Fund in their report “Paying the price” estimates that the cost of dementia will rise from £15 billion a year now to £23 billion a year and that by 2026 dementia will consume three quarters of mental health costs.

— The National Audit Office (NAO) report “Improving services and support for people with dementia” (2007) highlighted that a whole systems approach at a local level supports effective commissioning and can lead to much more efficient use of resources. A case study in Lincolnshire looking at the reasons for unnecessary acute bed use identified much more efficient ways of using available resources. Because of the concern the NAO have about progress on dementia and the opportunity for far better use of resources they are to produce a second report, only two years after the first, at the request of the Public Accounts Committee.

1.2 In the past lack of evidence about the number of people with dementia by locality and how services can best optimise people’s quality of life has hindered long term planning for dementia care. Only about half of people with dementia ever receive a diagnosis, which risks a serious underestimation of need.

1.3 However, the evidence base is growing and measures such as the GP quality and outcomes framework dementia registers will provide commissioners with more information. It is vital that commissioners use the data available to them and also ensure that people with dementia and carers are partners in the development of commissioning plans. Involvement of service users will increase the likelihood that resources will be targeted to services that make the most difference to people’s lives.

1.4 People with dementia need a variety of mainstream and specialist services as dementia progresses and increasingly has an impact on every aspect of the person with dementia’s life. Mainstream services including hospitals, general practice and community services all need to be commissioned with a view to being able to provide an effective and efficient response to people with dementia. The National Dementia Strategy for England highlights the importance of, for example, memory services, dementia advisers, workforce development in dementia and location of leadership within different services on dementia.

1.5 The National Audit Office report “Improving services and support for people with dementia” (2007) highlighted that a whole systems approach at a local level supports effective commissioning and can lead to much more efficient use of resources. The case study of hospital use in Lincolnshire found that many people with dementia (68%) in acute beds did not require acute care, but there was a lack of available alternatives such as the NHS continuing care beds in care homes or rehabilitation services staffed by people trained in dementia care. Acute hospital wards are unsuitable places for people with dementia, not least because of the lack of training of staff in caring for people with dementia. These wards can also be disorientating and distressing to people with dementia and many people find their condition deteriorates in hospital, often to the point where they cannot return home.

1.6 Health and social care agencies in Lincolnshire used these findings to redirect funding from acute care into more appropriate alternatives. They have developed a revised commissioning plan for dementia services, based on the evidence about capacity requirements in acute, intermediate, care home and specialist mental health services. The NAO (2007) concluded that this “should provide better care for some 500 people with dementia a year and redirect a total of £6.5 million (a significant part of which will relate to dementia) to more appropriate services. This kind of exercise could be replicated relatively easily elsewhere. Furthermore, in view of the importance assigned by Community Mental Health Teams (CMHTs) nationally to greater availability of care home, respite and rehabilitation beds (Figure 22), it could identify significant opportunities for reconfiguration of services”.


221 National Audit Office (2007) Improving services and support for people with dementia. London: NAO.
2. **Why Commissioners Must Understand What Good Dementia Care Looks Like**

2.1 A key concern of Alzheimer’s Society has been whether commissioners have sufficient understanding of what good dementia care is. We believe this is essential if they are to commission appropriately. An important example of this was highlighted in the APPG inquiry into the dementia care skills of the social care workforce.

2.2 Many witnesses raised the problem of local authorities commissioning domiciliary care visits which were too short to enable care staff to carry out good person-centred care. Short visits may be appropriate for a person without dementia who requires help with heating up a meal, but not for a person with dementia. The person with dementia may not understand why a stranger is in their house or why they are helping them get dressed, for example. Care staff need to spend time with the person, helping them to understand why they are there and what support they are going to provide. It is a very different job to providing care to people without dementia and commissioners need to understand these differences and how to account for them in the way they commission.

2.3 Alzheimer’s Society recommends that commissioners are involved in multi-disciplinary training so that they understand what good dementia care is in order to commission appropriately. Training alongside social care and health staff can also help to encourage communication and shared understanding of the problems faced by the different sectors.

2.4 In addition the Society is concerned that sometimes commissioning decisions are made about services for older people or older people’s mental health services as a whole without enough specific attention being paid to how both mainstream and specialist services can be commissioned to support people with dementia. It is a very different service providing care to people with a cognitive impairment to people without one and commissioners need to understand these differences and how to account for them in the way they commission.

2.5 Alzheimer’s Society has produced a guide for commissioners that should increase their understanding of the needs of people with dementia, as well as the current and predicted future prevalence of the condition. It aims to help commissioners understand how to effectively commission services for people with dementia and their carers in line with the National Dementia Strategy for England. To access please go to www.alzheimers.org.uk/commissioning

3. **Using Commissioning as a Tool to Increase Quality**

3.1 The Society would also like to raise our concerns relating to a failure by commissioners to use commissioning to improve quality. In many cases the focus has been on driving down costs. We understand that there is a need to use resources efficiently, but this must not be at the expense of the quality of life of people using services. The focus should be on findings efficiencies which can enhance outcomes, as exemplified by the NAO Lincolnshire case study.

3.2 The Alzheimer’s Society report “Home from home” highlighted opportunities for improving standards of dementia care in care homes and the way that could use the power they have through commissioning to drive up the quality of care homes. This is a power not currently being exercised in many areas effectively as highlighted by CSCI’s “State of Social Care 2005–06” (2006), which focussed on commissioning. Commissioners should use incentive payments to reward providers who are providing good quality care to people with dementia. It is simply unacceptable for local authorities to continue to commission poor quality services.

3.3 We would like to draw the Committee’s attention to witness statements from the recent APPG on dementia inquiry into dementia care skills of social care staff, which criticise local authorities for failing to commission for quality. Many witnesses believed that in many areas cost is more of a concern than securing good outcomes for people with dementia:

“I was in Croydon the other day and we had 32 different providers for their domiciliary care and you cannot tell me that that is because they have chosen quality services. They have chosen services where actually at the end of the day—I am not going to say what the conversation was about—someone does not sleep happily about because they know that for some of those services the staff are not trained and not trained going into people’s houses or offering care. Some of it could be a very clear steer to commissioners about the quality of dementia care services that they commission”. (Parsons, 17 March, oral evidence)

“Worcester County Council who commission services from us and with whom we have a contract have acknowledged the training we have done and have actually asked us to mentor their staff. Are they willing to pay more for that service? I am sorry to bring it back to funding because that argument is well-versed but, no, they cannot. We are a not for profit organisation but we are not for loss either. We do invest in our staff and the quality is in our quality ratings from CSCI, 222 APPG on Dementia (2009) Prepared to care: challenging the dementia skills gap. London.


whatever people think about those. I have got nine three star homes. I believe in promoting quality and looking at it from the residents’ perspective, but it has not changed the finance that is available to us”. (Blackburn, 18 March, oral evidence)

3.4 However, there are also good examples of councils who look to ensure people with dementia receive good services by rewarding good providers. For example, Kirklees Adults and Communities Directorate have introduced a Quality Scheme for care homes: “Upon meeting dementia quality standards, homes are paid a premium payment per council funded placement”. They explained that many dementia homes are now working towards these standards”. (APPG on dementia, 2009, p 23)

3.5 The Society would be happy to give further evidence to the committee.

September 2009

Memorandum by the British Association for Sexual Health and HIV (BASHH) (COM 81)

WORLD CLASS COMMISSIONING

EXECUTIVE SUMMARY

The British Association for Sexual Health and HIV (BASHH) welcomes high quality commissioning. BASHH supports the principles and aspirations behind World Class Commissioning (WCC), particularly the need for meaningful clinical engagement, commissioner competencies and genuine collaborative working. However, the experience of BASHH members of commissioning to date has been variable and in many cases, very negative. BASHH expresses concern that some commissioners fail to understand, or fully take into account, the public health requirement to provide the full range of sexual health services on an “open access” basis.

Although cost and value for money must be a factor in service redesign, it should not be the principal driver. Reducing health inequalities, widening provision, extending choice, promoting service integration across defined care pathways within communities and ensuring consistent service quality that promotes good individual patient care without detriment to public health control, should be paramount.

Commissioners must be clear on what services are currently being provided, the needs of its local population, the intended outcomes and how they are to be measured. Only then can a proper option appraisal take place, which might subsequently require a tendering process.

WCC should require the development of genuine partnerships between commissioners and providers, which must not become an adversarial contest. Clinicians and commissioners have a joint responsibility to collaborate with other local providers and PCT representatives in order to help design and provide better services to meet future needs.

Commissioners must actively engage with clinicians in order to ensure that sound clinical governance processes are in place. Commissioners also need to work collaboratively with their commissioning colleagues from neighbouring localities, where the impact of their decisions may well be felt. Their plans should include a detailed impact assessment.

For commissioning to be truly world class, there needs to be genuine partnership working and meaningful (not just token) clinical engagement, greater involvement in sexual health networks and the development of care pathways with strong clinical governance processes, better planning and collaboration.

ABOUT THE BRITISH ASSOCIATION FOR SEXUAL HEALTH AND HIV (BASHH)

1. The British Association for Sexual Health and HIV (BASHH) was formed in 2003 through the merger of the Medical Society for the Study of Venereal Diseases (MSSVD) and the Association for Genitourinary Medicine (AGUM). BASHH’s membership of over 1,000 includes medical practitioners, health advisers, nurses, scientists and other healthcare workers.

2. Our objectives are to:

   — Promote, encourage and improve the study and practice of the art and science of diagnosing and treating all sexually transmitted diseases, including infections and HIV.

   — Advance public health so far as it is affected by sexually transmitted diseases and to promote and encourage the study of the public aspects of sexually transmitted diseases.

   — Advance the education of the public in all matters concerning the medical specialty of GUM, including the management of HIV infections and the broader aspects of sexual health.

   — Promote a high standard in the medical specialty of GUM.

3. We have a long and proud heritage of working hard to support and deliver key Government initiatives and policy developments in the GUM field, such as the 48-hour appointment target for sexual health clinics.

4. We welcome the opportunity to submit evidence to the Health Committee’s current inquiry into NHS Commissioning and have consulted widely with BASHH members across the UK to allow us to respond to the terms of reference, some of whose comments are included in the submission. We will address each of these in turn.

“WORLD-CLASS COMMISSIONING”: WHAT DOES THIS INITIATIVE TELL US ABOUT HOW EFFECTIVE COMMISSIONING BY PCTs IS?

5. BASHH welcomes the need for high quality commissioning of all services, including GUM services, and therefore supports the principles and aspirations behind World Class Commissioning (WCC). The introduction of this new initiative at a national level would imply that current commissioning arrangements by Primary Care Trusts (PCTs) do not necessarily uniformly reach desired standards of quality or consistency. We welcome an improvement.

“. . . If they used this [WCC] to commission a recent GUM service in xxxxxxxx then the whole commissioning process was a shambles, with no regard to quality, with in-experienced people commissioning the service, little involvement of GUM clinicians and an opaque process in decision making”.

6. Unfortunately, in practice, the experience of BASHH members of commissioning to date has been variable and in the case of service tendering processes, largely negative.

“It is hard to put in words just how poor the PCT tendering documents were. If I explained that they failed to correctly spell “nurse-led” and also the name of the prison for which the PCT has responsibility and that the document went downhill from then on, you should get the gist. It was vague, incoherent, opaque and very badly written. It was a poor document (and this view was widely shared)”.

7. For commissioning to be truly world class, there needs to be genuine partnership working and meaningful (not just token) clinical engagement, greater involvement in sexual health networks and the development of care pathways with strong clinical governance processes, better planning and collaboration and the avoidance of a narrow PCT financial focus to the exclusion of the broader considerations above. Many of these points were raised in the July 2008 review of the National Strategy for Sexual Health and HIV, commissioned by the Independent Advisory Group on Sexual Health and HIV and undertaken by The Medical Foundation for AIDS and Sexual Health (MedFASH). We would commend this review to the members of the Health Committee.

THE RATIONALE BEHIND COMMISSIONING: HAS THE PURCHASER/PROVIDER SPLIT BEEN A SUCCESS AND IS IT NEEDED?

8. The reported experience of senior clinicians on this issue is very mixed, although clinicians who have been unsuccessful in recent tendering exercises of sexual health services suggest that the purchaser/provider split does not exist in reality. In June 2008, following verbal expressions of concern, the views of GUM service leads in England were sought in respect of their experience of the tendering of sexual health services. The survey was conducted by the Clinical Governance Committee of BASHH, on behalf of the Independent Advisory Group on Sexual Health and HIV.

9. In the survey report, GUM service leads expressed concern that commissioners and PCT provider arms were effectively “joined at the hip”. Members also reported that information was not shared fairly between bidders within tendering exercises and that the outcomes of certain tendering exercises were pre-determined. Others reported unfair exclusion from the bidding process for specific services on grounds regarded as entirely spurious and designed to exclude. Some reported behaviour that was unethical and generally somewhat removed from public expectations of the ethos of the NHS.

“Yes [a split] was needed. There were clear divided loyalties when trying to both commission fairly and provide services. It has allowed commissioners to concentrate on this and service providers to do what they do best”.

10. Similar concerns have been expressed in respect of practice based commissioning (see paragraph 16 below), in respect of conflicts of interest. If there is to be a purchaser-provider split, it should be real. Whilst we welcome an element of contestability into the NHS, one needs to be mindful of unintended consequences, such as encouraging “sharp practice” by NHS organisations.

11. WCC requires clinicians to be actively and meaningfully engaged in the commissioning process. The need for clinical experts to guide commissioners on aspects of clinical quality and effectiveness is critical and we are pleased to note that this has been reflected in competency 4 of WCC.

12. Sadly, the experience of our members is that there is very little meaningful or good quality engagement between clinicians and sexual health service commissioners, although some good examples do exist. Moreover, the purchaser/provider split, insofar as it really exists, has resulted in commissioners becoming disengaged and remote from clinicians. We have seen many examples of commissioners who clearly have little or no knowledge of how services are currently run, let alone what the patient needs. As noted above, the focus on financial considerations means that some, but by no means all commissioners fail to engage
with their clinicians over the need to safeguard clinical standards, sustain excellent but vulnerable services, increase productivity and improve access and the patient experience. Where commissioners and clinicians work well together, very positive outcomes are possible.

“We have very good working relations with our commissioners—clinicians are involved in planning and strategy. A countywide group (prevention, training, clinical care and voluntary orgs) in relation to HIV, meet regularly—the commissioner attends. After presenting an audit of our HIV cohort, the commissioners agreed to fund a local HIV clinical psychology service which is now up and running”.

COMMISSIONING AND “SYSTEM REFORM”: How does Commissioning Fit with Practice-based Commissioning, “Contestability” and the Quasi-market, and payment by Results?

13. BASHH supports quality commissioning, which implies a framework of ensuring quality standards, clinical engagement and a fair basis for remuneration. In this respect, it is not clear how high quality commissioning can be maintained given the competing, and often conflicting, drivers from other aspects of the NHS reform agenda.

14. Together these reforms have resulted in unintended consequences, such as a reduction in collaborative working and a lack of true clinical engagement. Decision-making processes are not transparent, they are remote from the clinical coalface and commissioning appears to have become cost-driven, at the expense of quality. In addition, it is important to remember that sexual health services are required to be “open access” (ie where a GP referral is not needed). People must be able to present at the service that they feel is right for them. However, many of the reforms introduced in recent years do not lend themselves well to supporting the principle of “open access”.

“. . . My worst example happened in September 2009 when we were informed that our newly-advertised post for a consultant in family planning had been “pulled” by the commissioners. The reason?—“we only have funding for 2 years for this post’! They are unable to grasp what the financial cost is of unwanted pregnancy to the local health economy”.

Quasi-market

15. The introduction of a quasi-market and contestability in sexual health may have helped to drive innovation and modernise services, but it has also had an adverse impact on collaborative working as competition between provider organisations has become more explicit. Lack of cooperation between providers ultimately results in fragmentation of services and raises particular concerns for the control of sexually transmissible communicable disease.

“I am a bit skeptical about the competition process for tenders because I think quality of care suffers as costs inevitably become the deciding factor”.

Practice-Based Commissioning

16. Practice-Based Commissioning (PBC) is potentially very problematic for sexual health services, which are required to be “open access” and free to all users, irrespective of their usual place of residence or PCT locality.

17. There are concerns that PBC may lead to a fragmentation of GUM services in some areas, resulting in increased healthcare inequality detrimental to current infection control strategies for sexually-transmitted infections (STIs). Some GPs may not share the broader community perspective of the Director of Public Health. BASHH advocates a public health based approach to commissioning and provision.

18. More generally, it is unclear how PBC currently relates to PCT based commissioning and wider collaborative commissioning (for HIV services, for example).

Payment by Results

19. The introduction of Payment by Results (PbR) has enabled some sexual health services to receive sufficient funding to allow expansion in response to patient demand.

“PbR has allowed us to stop talking about money directly and concentrate on quality”.

20. The benefits have, however, been patchy. Specific issues include:

— Delays in de-hosting services resulting in a lack of income from patients from outside the local area.
This acts as a disincentive to the provision of open access sexual health services for patients.

— The variable transfer by Trusts of PbR income to sexual health services. The lack of investment by Trusts in these services, despite having received appropriate income, has limited provision of care in a number of places.

21. Once the value of the GUM tariff was known, our experience is that some PCTs sought ways to avoid paying it. In the opinion of many senior clinicians, avoidance of PbR costs (and not quality or service improvement) has been the key driver to tendering exercises.
22. The GUM PbR tariff is a considered reasonable price, based on a GUM case-mix. The case mix consists of simple (net profit) and complex (net loss) cases. Hiving off the simple cases to primary care or community-based services, leaving only the more complex cases in GUM (level 1-3) services, immediately makes the specialist service non-viable unless some package to support it is in place. It is important to note that GUM services are established as “open access” services providing all levels of care. Patients seeking care usually do not know what level of service they require, and so the fragmentation of provision often leads to a more complicated patient journey.

“A local example of concern is that our integrated sexual health service (which includes family planning and GUM) and which is funded on a block contract is developing towards Contraception and Sexual Health (CASH) clinics. However, this is increasingly threatening the GUM service, which is losing its core identity; it’s quality features are having to ‘dumb down’ in favour of CASH. A Specialty GUM doctor has already decided to leave, and two of the three GUM consultants are probably going to leave the service because of this. Also, CASH is not currently connected to a national system of funding, whereas GUM is, and this, or a large portion of it, may be lost locally”.

**Specialist Commissioning**

23. Whilst HIV services no longer fulfil the criteria for specialised commissioning as described in the National Specialised Services Definitions Set, it is still vital that HIV services are commissioned at a Strategic Health Authority (SHA) or regional level for several reasons.

24. Firstly, HIV patients frequently travel across PCT boundaries to seek appropriate care and the open access approach is particularly important. Secondly, given the very high cost and low volume nature of the HIV specialty, PCTs often lack the critical mass of patients to commission services at a purely local level. Thirdly, the nature and complexity of HIV diagnosis, management and treatment means that there remains a strong case to retain HIV commissioning expertise at a supra-PCT or regional SHA level.

**Commissioning for the Quality and Safety of Services**

25. With national policy drivers pushing for a plurality of providers (including private and third sector providers), it appears that quality and safety are not the key drivers for commissioning.

26. In some areas, commissioners have displayed an alarming ignorance of what they have been trying to commission. There is a need for commissioning to be both collaborative and competent.

“We have frequent dealings with commissioners. They communicate very poorly with us as providers despite our best efforts over several years. They tend to produce very poorly written documents, which they continually revise . . . Where they are embarrassed by their deficiencies, they are very quick (and skillful) at pinning all the blame on us as providers. This general lack of communication, and overall poor quality of basic administrative skills, are obviously very deleterious to developing a coherent sexual health strategy. Another reflection is that our relationships with them always have an air of antagonism—the feeling we as professionals get is that our expertise is not valued or appreciated, and that they always approach us from the point of view that we are solely defending a selfish vested interest (“you would say that wouldn’t you” seems to be their prevailing cynical view of us)”.

27. Senior BASHH members have reported concern regarding clinical governance arrangements. Their experience is that commissioning for quality and safety has been alarmingly absent in some tendering exercises. Many indicate that the driver to the exercise was not service or public health improvement but rather, that it was entirely financial.

“I am the only specialist with accreditation in GUM in xxxxxxxxx and I have been excluded from [the PCT’s] draft sexual health services plan (it was forwarded to me by a GP). The PCT has announced that it intends to try and withdraw over half the income we generate by PbR and move the service for sexual health to the community. It is not clear how they are proposing to make this work, but their draft plan is to pay GPs £60 for seeing a new patient, and allow them to undertake limited numbers of tests, when PBR tariff in secondary care is £139”.

“The local PCT commissioner for my patch says openly that every patient which can avoid having to attend the sexual health clinic is a cost saving. The PCT are therefore looking into getting other people to provide mini STI services out in the community to make cost savings . . . I’m actually quite “for” providing a local service for people—my area is quite rural—but it should be delivered by people who know what they are doing. We have even offered to start rural clinics and specialist clinics for high-risk groups, but have been told there is no funding. I think it’s poor that discussions go on without involving the people who are already doing the job. Amazing how there is funding for someone based at the PCT to start a new clinic, but not for a member of my clinical team who has more experience to provide the same clinic!”

28. Commissioning on a larger footprint than a single PCT patch might mitigate against these tendencies to some extent. Given that GUM services cater for patients who may travel from neighbouring PCT areas to an open access service, a collaborative approach between commissioners in neighbouring PCTs (for example, in a sexual health network footprint) may be a way forward.
“Sexually transmitted infections do not respect PCT or other boundaries and patients concerned about infection often wish to travel out of their area for reasons of confidentiality. It was very alarming that the commissioners in PCT(A) did not inform their PCT(B) neighbour of their commissioning intentions, particularly as their commissioning intentions made our service non-viable and we are the main provider for PCT(B).”

29. What is needed is clear guidance on how to tender for services, using a “level playing field”, agreed quality standards and appropriate audit mechanisms to ensure and measure compliance. National quality standards for sexual health services are being developed and would provide an objective framework for assessment of services.

“The commissioners made a terrible hash of this tendering exercise. The unintended damage to our service was almost fatal and we are still recovering (at one stage over half of the staff had left and I didn’t have a single trained nurse left). There were other vulnerable services that should have been protected in the tendering document, but were not and have now closed (eg the psychosexual therapy service). I have seen some fabulous commissioning in my time, but this wasn’t an example. We all need high quality commissioning and that implies high calibre commissioners who understand the unique and complex issues in sexual health”.

30. BASHH anticipates that, if WCC is followed, the standard of commissioning will improve. Real engagement between clinicians and commissioners is vital for WCC to become a reality.

“The collaborative commissioning of HIV services in London is an example of good quality commissioning which has sought to improve standards whilst at the same time drive costs down. London commissioners have time and time again demonstrated how serious they are about true clinician engagement”.

September 2009

Memorandum by the Health Foundation (COM 82)

1. Executive Summary

1.1 The Health Foundation’s evidence draws on the findings of research commissioned to build our understanding of the role of value for money and efficiency in achieving the best quality healthcare. It has clear implications for commissioners.

1.2 Professor Gwyn Bevan and his team at the London School of Economics (LSE) are testing, in the NHS, a way to prioritise investment in health services which combines technical value for money analysis, epidemiology and stakeholder engagement. The award-winning approach provides an audit trail, empowers senior managers to justify difficult decisions and engages the local community who feel a sense of ownership of the decisions taken. Following its successful development at NHS Isle of Wight it is now being trialled with NHS Sheffield.

1.3 The Health Foundation recommends that the Department of Health promotes socio-technical approaches to support decision making and that these are more widely adopted by primary care trusts (PCTs) to enable the engagement of stakeholders, ensuring decisions are transparent, based on data and take account of the greatest potential impact on the health of the population.

1.4 Professor Peter Smith and his team at the University of York are developing a sound technical approach to measuring the efficiency of PCTs in its bid to discover whether value for money has been secured from the significant extra investment in the NHS since 1997. As more extensive and longer time series of data become available, this sort of analysis will yield increasingly useful insights into PCT performance and efficiency.

1.5 The Foundation recommends that strategic health authorities (SHAs) closely scrutinise which services are being commissioned through the interpretation of more detailed data sets than the national programme budgeting data.

1.6 Finally, there is a need for strong leadership on commissioning by the Department of Health following the departure of Mark Britnell. The Health Foundation recommends that this is given priority by the Department.
3. “WORLD CLASS COMMISSIONING”: WHAT DOES THIS INITIATIVE TELL US ABOUT HOW EFFECTIVE COMMISSIONING BY PCTs IS?

3.1 The Health Foundation supports the principles of World Class Commissioning to secure better health and well-being for all, better care for all, and better value for all. A key recommendation from research commissioned by the Health Foundation in 2004 was that commissioners need to get “new and more advanced forms of support, in particular in developing a range of new skills and competences”, something which World Class Commissioning aims to provide (Smith, et al, 2004). As the commissioning assurance process becomes firmly embedded in the strategic planning cycle of PCTs, this framework should support PCTs to improve their commissioning to the benefit of the health of their local communities.

3.2 The Foundation believes that effective commissioning should efficiently purchase high quality services. In 2005 we commissioned a five year programme of research to explore whether value for money was being gained from the extra investment in the NHS and how commissioners might make the best investment decisions that ensure improved health and value for money.

3.3 These research programmes, summarised below, have investigated issues which relate to the following competencies from the world class commissioning framework:

   2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.
   3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health.
   6. Prioritise investment according to local needs, service requirements and the values of the NHS.
   11. Make sound financial investments to ensure sustainable development and value for money.

4. SUPPORTING EFFECTIVE SPENDING DECISIONS IN PCTs

4.1 Commissioners need to prioritise to make effective use of limited resources. We have a positive vision of how NHS commissioners can adapt to the times of reduced funding ahead and continue to make cost effective decisions about spending. In this vision, management is enabled to use information on performance and on value for money to take tough decisions about the tradeoffs facing the service using sound evidence in a transparent way that engages key stakeholders.

4.2 The Health Foundation has supported the development of an approach by Professor Gwyn Bevan and his team at the LSE, which enables commissioners to meet world class commissioning criteria: “Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health”, “Prioritise investment according to local needs, service requirements and the values of the NHS”. It incorporates engagement with stakeholders and technical value for money analysis, allowing commissioners to take account of different factors when deciding areas of healthcare to focus on and providing evidence for determining where resources can most effectively be invested. The team began their work by developing methods to provide information on the scale of likely costs and benefits for populations of health policies (Bevan et al, 2007).

4.3 This study required substantial original methodological research and the development of models of disease. The research identified serious limitations in using the conventional method of QALYs (quality adjusted life years) and DALYs (disability adjusted life years) to estimate the impacts of interventions in terms of reductions in the burden of disease. In addition the team factored in opportunity cost: commitment to one course of action necessarily means that other opportunities are forgone; and the transaction costs associated with any change. This study has been recognised by NICE who now endorse the LSE approach as the preferred method for comparative assessment of treatments.

4.4 The team also reflected that their methodological approach still neglected to consider all the additional criteria facing commissioners. Apart from population health, priority setting must take multiple criteria into consideration, such as reducing inequalities, feasibility, political acceptability and national priorities.

4.5 Professor Bevan’s team were keen to develop their approach to be of use to senior managers in the NHS. They joined up with NHS Isle of Wight to develop a process that technically assessed these multiple criteria, engaged local stakeholders and, finally, allowed for sound strategic decisions on spending.

4.6 NHS Isle of Wight sought to invest £2 million over two years. Before their work with the LSE, they had no discernible or transparent process for resource allocation. Decisions were made in various meetings and not shared throughout the organisation. Like all PCTs, it faces its own distinct local challenges in serving its population of 140,000.

4.7 The PCT had already set its strategic priorities, prior to the LSE involvement but wanted to ensure that the most cost effective spending decisions were taken to deliver the goals. It aimed to focus on increasing life expectancy in the most deprived areas and on five key clinical areas: cardiovascular disease, cancer, mental health, respiratory disease and children’s health.

4.8 The LSE developed a two-stage approach to value for money for the PCT. It used a combination of decision conferencing and multi-criteria decision analysis, or in other words, a socio-technical approach.
4.9 The first step was to hold day-long stakeholder workshops for each of the five clinical priority areas. These workshops were attended by commissioners, clinicians, patients, local authority and voluntary sector representatives, nurses and GPs, and supported by a member of the executive team. Overall about 100 people took part.

4.10 The aim of the workshops was for stakeholders themselves to declare where investment was most needed and how best to deploy it, so that they “owned” both problem and solution. Participants identified key issues in each priority area, reviewed progress and identified gaps in services. An initial long list of ideas had to be justified in terms of impact by anyone proposing a new intervention. Participants were asked to picture an “average” patient in order to understand the full pathway and who might benefit. Gradually, through systematic questioning and comparing of interventions it became evident which of the proposed interventions would bring most benefit. Usually workshop participants found it easy to reach consensus.

4.11 Between them, the workshops generated a total of 21 potential strategic initiatives to improve population health and quality of life while reducing health inequalities. These initiatives were reviewed in a one-day priority setting event with a similar mix of stakeholders and additional members from the PCT board and Professional Executive Committee. The event was organised as a decision conference and facilitated by two researchers from LSE.

4.12 In a transparent and systematic process, through discussion and challenge, participants built a model of the costs and value to the PCT of the 21 possible initiatives. Each was scored, and all the scores weighted to ensure they were comparable, using multi-criteria decision analysis. Three important aspects of scoring were:

- estimating numbers who would benefit from each proposed intervention by using demographic, epidemiological and hospital admissions data or expert judgement;
- visualising the “average” beneficiary of an intervention and agreeing a qualitative description of the expected benefit, derived from evidence of effectiveness or expert judgement; and
- identifying the option with the greatest individual health benefit and assigning it a benchmark score of 100, then assigning scores to the remaining interventions relative to 100.

4.13 All 21 interventions were ranked. A high ranking suggested that for each pound spent the intervention returned the greatest possible benefit. When the results surprised participants, they were explored extensively, with assessments of cost and benefit revised if necessary.

4.14 The decision-making process was thus transparent and it enabled the PCT to engage with ease with a wide range of people. The methodology demonstrates visually the nature of the choices to be made and the scale of an intervention's potential impact but the major benefit is the engagement in the process.

4.15 This approach supports the priority-setting and stakeholder engagement competences demanded by the World Class Commissioning assurance framework. The process provides an audit trail, it empowers senior managers to justify even the most difficult decisions and it engages the local community who feel a sense of ownership of the decisions taken.

4.16 The priority-setting initiative was recognised at the South Central Regional Health and Social Care Awards, where the joint team received the “Excellence in Commissioning” Award. The approach is now being trialled with NHS Sheffield on other prioritisation decisions, particularly the reallocation of resources within cancer, mental health and dentistry. The approach is also being used by the Department of Health in their development of the new mental health strategy, New Horizons.

5. Testing the Efficiency of English PCTs

5.1 Over the past four years, Professor Peter Smith and his team of economists at the University of York have tackled the question, in a number of ways, of whether value for money has been secured from the significant extra investment in the NHS since 1997, incrementally developing a sound technical approach to measuring the efficiency of PCTs in England.

5.2 Efficiency as defined by the York team is the equivalent of value for money—the ratio of valued outputs to the costs expended. The valued outputs for the health service can reasonably be assumed to be the health of the population. The latest study from the team at York tests efficiency in this most fundamental way, asking whether PCTs have purchased good health for their population, given the resources they have been allocated (Martin et al, 2009).

5.3 A technically efficient organisation is one that either: produces the maximum possible volume of outputs given its inputs or produces a specific level of output with the minimum volume of inputs. An allocatively efficient organisation is one that either: employs the appropriate mix of inputs, given their relative prices, to minimise the cost of producing the chosen level of output or produces the appropriate mix of outputs, given their relative prices, to maximise the value of the chosen level of output. An economically efficient organisation is both technically and allocatively efficient.

5.4 A straightforward assessment of inputs to outputs will not suffice when measuring PCT efficiency. The budgets allocated to PCTs vary considerably and PCTs operate in a variety of different local environments, facing different challenges when trying to improve population health. These variables must be factored into the final measurement.
5.5 A range of measured inputs and valued outputs were considered to identify the efficiency of each PCT relative to what seems to be best practice among the 152 PCTs. In doing so, efforts are made to adjust for the different environments in which the PCTs operate and to indicate how well each PCT is performing relative to its peers.

5.6 For each PCT data are available for various inputs and outputs, including healthcare expenditure, population size, the local need for healthcare, and the mortality rate. Spending data are taken from the Department of Health’s national programme budgeting project for the year 2006-07. Since 2003, data on expenditure on healthcare across 23 programmes of care have been prepared by each PCT. These programme budgeting data seek to allocate all items of NHS expenditure to disease categories. Outcomes are calculated by the National Centre for Health Outcomes Development.

5.7 Using these techniques and publicly available data, the researchers find PCT efficiency scores are as much as 96% (depending on the economic model used) but with little variation amongst PCTs. As such, the researchers suggest that potential efficiency gains are unlikely to be substantial. Likewise, the study also finds little evidence of “allocative inefficiency”, that is the misallocation of resources between different disease categories.

5.8 A second stage of analysis attempts to identify those factors that determine efficiency levels. The researchers analysed whether there were characteristics of PCTs that explain any variation in efficiency rankings. Unfortunately there are few useful measures of PCT structural characteristics but the team were able to test whether certain indicators of local circumstances were related to efficiency scores. They included the average age of GPs in the PCT, the proportion of female GPs, the proportion of GPs who secured their degree outside of the UK, deprivation in the PCT patch, recent merger or reorganisation of the PCT and whether the PCT’s 2006-07 budget was under or over its target funding allocations.

5.9 The study showed that measured efficiency is largely associated with just two factors: the extent to which funding exceeded the target budgetary allocation; and deprivation. PCTs with “excess” budgets are less efficient in securing health outcomes than their less generously funded counterparts. PCTs with higher levels of deprivation were also found to be less efficient. This may be a problem with the needs adjustment, or captures other challenges faced by the PCT, such as problems in recruiting high calibre staff or funding being directed at tackling health inequalities.

5.10 This study shows the sort of analysis that is possible when assessing the efficiency of commissioners. The researchers conclude that such assessment is essential in holding PCTs to account for their commissioning performance—securing good health for their population and value for money. They found only small amounts of inefficiency in terms of the economic analysis used and concluded that commissioners are spending efficiently. However, the small number of outlier PCTs found by the study does warrant further investigation. As more extensive and longer time series of data become available, this sort of analysis will yield increasingly useful insights into PCT performance and efficiency.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 PCTs will move into a period of difficult decisions around commissioning, when the economic downturn starts to affect healthcare spending. We recommend that the Department of Health promotes socio-technical approaches to support decision making and that these are more widely adopted by PCTs to enable the engagement of stakeholders, ensuring decisions are transparent, based on data and take account of the greatest potential impact on the health of the population.

6.2 Given the departure of Mark Britnell, the director who led the development of the World Class Commissioning concept, there is a need for strong leadership on commissioning by the Department of Health. The Health Foundation recommends that this is given priority by the Department.

6.3 The results to date of comparative research show that overall PCTs are commissioning efficiently. We recommend that SHAs closely scrutinise which services are being commissioned through the interpretation of more detailed data sets than the national programme budgeting data. The availability of more extensive data over longer time series will enable more detailed analysis of PCT performance and efficiency.

6.4 The Health Foundation is supporting further research into value for money in the English health system. This includes research into the cost effectiveness of different components of treatment and care, using national data as the basis of the study.

6.5 The Health Foundation will also be supporting the further development and dissemination of the decision conferencing and multi-criteria decision analysis approach. We will work across geographical areas through application across SHAs and through formal and informal commissioning networks.

7. REFERENCES


Memorandum by Tribal and the Chief Executive of Ashton Leigh and Wigan PCT (COM 83)

EXECUTIVE SUMMARY

1. Radical improvements in the efficiency and effectiveness of NHS Commissioning are being achieved through a genuine partnership between Ashton, Leigh and Wigan PCT and Tribal.

2. The *Transforming Commissioning—Saving Lives programme (TCSL)* was launched in September 2008 by NHS Ashton Leigh & Wigan (NHS ALW) and healthcare and commissioning experts, Tribal, in recognition of the fact that people who live in Ashton, Leigh and Wigan are more likely to die early from heart disease, stroke and cancer than the national average.

3. This innovative programme—one of the first in the NHS—aims to help the PCT and local Practice Based Commissioners to become World Class Commissioners of health services. More importantly the programme aims to improve the health and wellbeing of local people, increase life expectancy and support people to live healthier lives.

4. Following a recent review the Department of Health confirmed that NHS ALW is a very successful partnership. Significant tangible achievements have been made in the first year of this partnership on a range of fronts, including identified savings of over £3.5 million to be reinvested in rebalancing health expenditure and improving health outcomes. The performance at the end of year one of the contract means that NHS ALW is well on track to ensuring a positive return on its investment in Tribal’s services.

5. The scope of the TCSL programme is designed to address capacity and capability gaps based on the PCT’s and PBCs’ requirements in the following areas:
   - demand and utilisation management;
   - PBC and operating processes;
   - health information;
   - shaping the structure of supply;
   - information management; and
   - organisational development.

6. The programme acts as a catalyst for the redesign of health and social care services, shifting resources into the community and thereby providing a wider range of clinical services and greater investment in primary prevention and health improvement services.

7. The commercial nature of the partnership between NHS ALW and Tribal is based on partnership. This approach is absolutely essential to the success of the venture. Although this is hard to define contractually, the contract clearly sets out the intention of the partnership:

   “the full potential to achieve transformational change through World Class Commissioning will only be achieved if there is a real and trusting partnership between the Authority (PCT) and the Contractor (Tribal). A real partnership cannot be created via a procurement process or by a contract and can only develop over time through alignment of values, culture and ways of working”.

8. The model is one of insourcing not outsourcing. Tribal provide a powerful catalyst for change in the early phases through added capacity, capability, intellectual property and enthusiasm; with a gradual transfer of skills and responsibility to PCT staff so that the change is self sustaining at the end of the contract.

9. There is considerable scope for replicating the success of ALW across the NHS, and accelerating progress towards World Class commissioning competencies, provided that current barriers to the procurement of strategic partners are effectively addressed.

INTRODUCTION TO TRIBAL AND NHS ALW

10. Tribal has been working as a strategic partner for NHS ALW since September 2008 under the FESC contractual arrangements.

11. Tribal is a public limited company that provides consultancy, support and delivery services focused on improving the delivery of public services across health, education, local government, housing, social generation and central government. Tribal’s health commissioning team focuses on supporting and strengthening NHS commissioning by using best practice tools and experience from the UK and internationally so that resources can be effectively invested in improving the health of local people.
12. Tribal works in long term relationships with over 2,500 public service organisations and employs over 2,400 staff. With over 20 years experience to all parts of the healthcare sector, Tribal’s broad offering combines professional and technical expertise with an in-depth understanding of chosen markets. Clients include the Department of Health, PCTs and other health providers.

13. The three year TCSL programme sets out the objectives of the partnership between the PCT and Tribal, which are:

— to design and deliver a comprehensive programme which will mean that local people can access the right services, in the right place, at the right time;
— to support local people to play a greater role in managing their own health and to enable them to make informed choices about the treatments and support that they receive from the NHS;
— to work with health professionals to make it easier and simpler for people to access healthcare services;
— to improve financial management and generate savings which will be re-invested back into patient care; and
— to apply international standards and best practice that can benefit the residents of Ashton, Leigh and Wigan.

14. It is anticipated that this programme, alongside the other elements of the World Class Commissioning programme, will transform the way health and care services are commissioned in Wigan borough. It will deliver a more strategic and long-term approach to commissioning health and social care services, with a clear focus on delivering improved health outcomes and reducing health inequalities.

**Factual information**

15. The Framework for External Support for Commissioning (FESC) programme is part of a national NHS initiative to help PCTs invest in services which will make a positive difference to the health of their population and improve value for money. Under the scheme, NHS organisations can add to their capacity, skills and experience by bringing in independent organisations, such as Tribal.

16. NHS ALW entered into a three year strategic partnership with Tribal which commenced on 29 September 2008. NHS ALW is one of a small number of national pilots which follows a national framework, set up by the NHS, under the Framework for External Support for Commissioners (FESC).

17. The total value of the contract with Tribal is £4.8 million of which £2.3 million will be funded from “guaranteed” savings delivered by Tribal, which results in a net “worst case” cost to the PCT of £2.5 million. The contract states that the first £2.3 million of savings are to be paid to Tribal in full. Savings over and above the £2.3 million will be split on a basis of 75% to the PCT and 25% to Tribal. This sum is capped at £10 million, so that after this value is reached, the PCT retains 100% of the additional savings generated. Any recurrent savings beyond the first 12 months (after they have been realised) will be retained 100% by the PCT.

18. Since Tribal’s commencement on 29th September 2008, the PCT has reported significant progress and achievements through the partnership. Highlights of these achievements, extracted from a PCT Board paper, are described below:-

**Achievements of the joint TCSL programme—year one**

| General achievements | Working with the PCT commissioning team and primary care, Tribal has introduced new tools and techniques. NHS ALW is the first PCT in the UK to deploy the Johns Hopkins operational population risk profiling tool (ACGs).  
| |  
| | Working with Public Health, Tribal has completed world class health equity audits with Sheffield School of Health and Related Research for COPD, CVD and Diabetes.  
| |  
| | Tribal has worked alongside the PCT Executive Team to assess the scope for productivity improvement in the health system and used this to develop and initiate an action plan to target identified areas. The MCAP utilisation management tool, has been deployed to provide clinically-based assessments of weaknesses in the health system and identify why they occur.  
| |  
| | Tribal has helped the PCT clarify its overall strategy as a “solely commissioning” organisation. Together the parties developed a Strategy on a Page that provides clarity of corporate aims, objectives, health outcomes and priorities.  

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226 ACGs provide the ability to develop clinically-led commissioning strategies on the basis of locality, disease, and predicted resource consumption. This enables the PCT to visualise and model the impact of “personalised” budgets for health and social care.

227 MCAP uses the intensity of services delivered to the patient based on the patient’s severity of illness to accurately determine the best level of care for patient placement.
Tribal has worked with the PCTs contracting functions to re-define the relationship with the newly created Foundation Trust and enabled NHS ALW to achieve better value for money from its investments.

Performance management.

- Tribal led the development of a Health Intelligence Strategy and action plan setting out the information needs of a world class commissioner.
- The parties are working together in an integrated project team to introduce a contract management system and business intelligence suite to deliver performance management systems for the PCT and PBC partners.
- Tribal introduced and are operating automatic activity validation systems to underpin contract performance management with the PCT’s acute providers. The PCT have also used Tribal’s contracting expertise to significantly strengthen contract negotiation for 2009–10.
- Tribal created a tool for modelling changes in the health system (StratComm) to evaluate the impact of changes and model different scenarios. The PCT and Tribal have used this tool to support capacity planning and to understand the impact of the Secondary Services Review.

Practice Based Commissioning (PBC)

- Tribal has worked closely with the PCT and primary care to lead the development of Practice Based Commissioning and consolidate PBC consortia.
- Tribal has created a wider clinical network through PBC to allow greater clinical engagement.
- Tribal has supported PBC service improvement activities in areas such as diabetes, stroke, CHD, ENT, breathlessness and MSK.
- With Tribal, the PCT are now beginning to use the Johns Hopkins risk stratification tool to support a wide variety of primary care development activities.
- Tribal’s business case support team have supported the Finance Directorate with commercial and procurement skills to produce investment cases for PBC service improvement activities.

Shaping the structure of supply

- Tribal is working alongside the PCT and the wider health community to develop system-wide strategies for primary, community and secondary care providing a clear future direction for integrated service provision.
- Tribal has helped NHS ALW use concepts such as “transitional care” to develop a model that allows the PCT to test the expected levels of clinical intervention at different stages of the care pathway.

Demand and utilisation management

- Tribal is using the full range of tools described above to drive greater efficiency in the areas of emergency admissions, outpatients and medicines management (statins and PPIs).
- Tribal and the PCT are using tools such as MCAP to launch system wide clinical utilisation management to understand weaknesses in care pathways. MCAP reviews have been completed for elective and non-elective care in Wrightington Wigan and Leigh, and also for non-elective care in Bolton. A productivity programme for the short and medium term is now underway.

Savings

To the end of August 2009, the contract achieved:

- Identified savings to £0.35 million in statin and PPI228 medicines management by switching patients from high to low cost equivalents.
- Over £2.2 million savings through acute invoice validation, reductions in baseline contracts and the introduction of new contract conditions.
- Projected savings of £1.2 million in April 2010 through introduction of reduced tariffs.

Tribal is also confidently forecasting £1 million savings from acute invoice validation in 2009–10.

19. In the spirit of genuine partnership, Tribal has also supported the PCT, with initiatives beyond the scope of the contract. This has resulted in the PCT achieving additional value for money from the strategic partnership with Tribal. These areas are described below:

- supporting the PCT in calculating the impact of HRG 4;

228 PPIs are ulcer inhibiting drugs.
— contributing to the development of the PCT’s Cash Releasing Efficiency Programme (CRES) and Financial Recovery Plan (FRP);
— recommending and supporting the implementation of system changes and performance improvements to turnaround A&E performance at Wrightington Wigan and Leigh Foundation Trust;
— supporting the PCT Board and Executive Team on organisational development, organisational reform and the demonstration of World Class Commissioning competencies;
— investing additional resources to support the implementation of Sollis Contract Monitoring System;
— providing Director leadership of Practice Based Commissioning and investment of additional resources within Practice Based Commissioning, over and above that described in the contract; and
— production of a business case for Assertive Disease Management.

Conclusions and recommendations for action

20. Early results from this public-private sector NHS commissioning pilot are very encouraging. To achieve similar success stories across the wider NHS, we believe that the following key components of the proven ALW-Tribal model should be fostered by the Department of Health in its guidance to PCTs:

— a spirit of true partnership—not outsourcing, but in-sourcing. The ALW-Tribal model, where the ultimate goal is self sustaining World Class commissioning, is one which demonstrably fosters genuine partnership. No “us” or “them”, but “we”. A solution where the private partner is a change agent with the ultimate goal of leaving the PCT as a World Class Commissioner without having to rely on external support; and
— a win-win commercial model—based on sharing, goals, risks and rewards. The TCSL project has shown how it is possible to construct a commercial model based on aligned goals, where success means the same to all parties (ie the PCT, GPs, patients and Tribal.) It has also changed the relationship with service providers. Unlike conventional management consultancy, the service provider takes considerable delivery risk by relating its fee to success—delivering demonstrable value for money to the taxpayer.

21. To improve effectiveness and efficiency commissioners essentially have three strategic options—buy, build or partner. We believe that the first year of the Transforming Commissioning—Saving Lives programme (TCSL) in Wigan demonstrates the potential in the “partner” option to accelerate progress towards World Class status. The challenge therefore is to realise this across a wider landscape.

22. To address this challenge we believe that it will be necessary to build upon and improve the FESC contractual framework, and address the barriers that prevent some PCTs from using the “partner” option.

23. There is a fear of the complexities of the FESC contractual framework among some PCTs, which we feel may be a barrier to them accessing similar services to ALW, and achieving similar success. The solution to this requires progress on two fronts. Firstly, the process of securing a partner needs to be further streamlined and the procurement timeframe shortened; and secondly, the contractual framework itself should be simplified to take into account the inherent flexibility required by true partnership.

24. We would also suggest that to support the emerging model of public private partnership, as described in this paper, PCTs at the leading edge form a Commissioning Partnership Network to share best practice and provide mutual support.

25. Tribal stands ready to work with the Department of Health and PCTs to address these challenges.

September 2009

Memorandum by The King’s Fund (COM 84)

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

This paper is a formal response to the Health Select Committee’s call for evidence for their inquiry into Commissioning.
1. “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

Commissioning is regarded as the weakest link in the English NHS system and the World Class Commissioning (WCC) initiative represents the latest and most concerted attempt to define the task; to set out the competencies required; and to create the momentum to deliver high quality commissioning. There is broad agreement that commissioners have lacked the management and technical expertise, the capacity and the basic infrastructure to be successful.

As expected, the 2009 WCC assurance process confirmed that the quality of commissioning by PCTs was largely poor to mediocre. There was a sizeable gap between what is currently being delivered and the standards expected within the WCC brief. In particular, weaknesses were found in the commercial aspects of commissioning which represent new territory for NHS commissioners. These include:

- mapping and understanding the strengths and weaknesses in the local provider market;
- using the commissioner’s investment power to stimulate the market, such that providers develop in-line with local health needs and community aspirations;
- managing relationships with providers, engaging in constructive performance discussions with them to ensure continuous quality improvement; and
- building relationships with potential future providers.

That said, forthcoming research from The King’s Fund—to be published in Spring 2010—indicates that WCC has been largely welcomed inside and outside the NHS as an approach that will improve the quality and impact of commissioning. There is a common perception that the policy has helped by setting out a clear vision of what high quality commissioning is and what commissioners should be aspiring towards.


It is too early to judge whether WCC will be successful or cost-effective. A number of organisations are undertaking studies to establish the impact of WCC including the Treasury, National Audit Office, NHS Service and Delivery Organisation and the Policy Research Programme at the National Institute for Health Research.

2. What is the rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

The internal market that was introduced in 1991 was designed to introduce competition between strong, monopolistic health care providers. In the absence of consumers with the money, information and expertise to act as a countervailing force, there was a need for an informed, critical agent—the purchaser—who could act for the patient as well as ensuring that the public’s goals for the health sector were achieved.

Later “commissioning” replaced “purchasing” as the term used to describe this function. Commissioning was intended to be more sophisticated and strategic than purchasing, encompassing an assessment of the health needs of the population, the buying of services to meet those needs, alongside various interventions to promote health. More recently, PCTs have been shedding their role as a provider of community services—in effect becoming agencies whose primary function is to secure services from a range of providers for a specific geographical population.
Has the purchaser/provider split been a success?

There have been a large number of studies of the various models of commissioning that have been tried in the English NHS, such as fundholding, Total Purchasing Pilots, GP Commissioning Groups, and more recently Primary Care Groups and Trusts [1-14]. There have also been some international comparative studies [15-16]. The early research suggested that commissioning for health services was a fairly new, and correspondingly unsophisticated activity. More recently, renewed emphasis on how to make commissioning effective has led to a series of review studies [17-26]. Each supports the view that the commissioning function has yet to reach full maturity and that those responsible for it lack many of the necessary skills required. A recent survey of GPs and PCT managers, found that many felt deficient in the key skills of commissioning, which they identified as negotiation, finance and data analysis [27].

This lack of a skill base has been compounded by constant reorganisation. Skills and knowledge that were built up have been lost and fragmented as organisations have been forced to repeatedly reinvent themselves. Moreover it has proved difficult to recruit the brightest and best into the commissioning side of the NHS with senior positions in the acute sector attracting higher pay and status. Although relationships vary there is often an adversarial component to the commissioner/provider split and this has not helped PCTs to engage with secondary care clinicians.

Is the purchaser/provider split needed?

As yet there is no evidence to suggest that the commissioner /provider split in England has created a more or less efficient system than those, such as Scotland, that have opted not to follow this route. Whilst it could be argued that commissioning within a purchaser/provider model has the most potential to challenge monopolistic provision and deliver choice, contestability and service redesign, the evidence suggests that large providers have dominated the relationship, largely because of the information ‘asymmetry’ between buyer and seller.

There are other constraints. For elective care, the payment by results tariff, patient choice and the “any willing provider” requirement mean that PCTs have little control over what they pay or where patients are treated while quality standards are set nationally. The increasing concentration of some services in specialist centres effectively creates more local monopolies and large acute hospital trusts can be even more dominant in their local provider markets. Early research from a joint University of Birmingham and King’s Fund study on the collective impact of the NHS reforms suggests that it is these factors, more than commissioning, that have shaped and driven the way care is delivered. The ability of commissioning to be an effective lever for change has, therefore, yet to be proven.

3. How does World Class Commissioning fit with Practice-Based Commissioning; Contestability in the Quasi-Market; and Payment by Results?

As a set of principles, WCC does not conflict with PBC, PBR and contestability. However, when examined in detail and in the context of the system as a whole, it is apparent that there are areas where the various incentives and structures do not align. As a result commissioning remains weak. It is not that the policies themselves do not “fit” with WCC, but rather that the structures and mechanisms within which they are operating are working against the aspirations of WCC. The interplay of practice-based commissioning: contestability and payment by results with WCC is considered below.

Practice-Based Commissioning

On the whole, PBC has yet to make a significant impact on care pathways and service redesign and as such it does not appear to have strengthened commissioning as a whole. Competency 4 in WCC specifies that PCTs “lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation”. In theory this aligns with the policy intentions of PBC, in practice it has not yet happened. The reality is that PBC remains voluntary for GPs and has proved attractive to those who have been motivated to become involved principally by the desire to re-provide some services themselves.

Under PBC, a GP is able to decide when and where to refer a patient yet the financial risk remains at the PCT. Few sanctions (other than very severe contractual threats) are available to a PCT to make sure GPs comply with the PCT’s overarching strategy and priorities. Instead, PCTs rely on GPs being sufficiently engaged and involved in the agenda—yet this involvement remains voluntary. In contrast, secondary care trusts are established as highly structured organisations with a history of embedded clinical engagement, which puts them in a strong position at the contract negotiating table.

Research has revealed that PBC has largely brought about small-scale projects involving the re-provision of elements of services outside hospital rather than large-scale strategic redesign [28]. This is largely because the incentives embedded within PBC reward GPs for short-term gains and do not encourage longer-term investment. Thus far, PBC has not demonstrated that it can advance commissioning, especially of secondary care, and it is therefore not clear that PBC provides value for money.
Contextability

WCC specifies a clear requirement for PCTs to “effectively stimulate the market”, so it could be argued that the promotion of contestability—to create a competitive environment through tendering—fits well with the policy. However, it is clear from the results of the WCC assurance process that market stimulation is the least well advanced of all competencies. WCC states that PCTs should be recognised “as the local leader of the NHS” (competency 1). However, the power imbalance means that in most cases, it is the acute trusts that hold the negotiating power. Foundation trusts have significant freedoms that give them even more clout—for example by being able to retain their savings and build up reserves and by devising their own investment strategies. Thus, while WCC aims to increase contestability between providers, large hospitals have been given increasing powers which in some cases is likely to make them stronger monopolies. The commissioning side meanwhile has not been given the means to counter those powers.

PBR

PBR has encouraged acute trusts to pull in patients and in some circumstances has created adversarial relationships between commissioners and providers. PCTs have few of the freedoms afforded to foundation trusts—they are restricted by stringent governance and regulatory structures and must break even on an annual basis. As noted above, the power differential is exacerbated by a mismatch in the quality of information accessible to trusts and commissioners. Work undertaken in the acute setting is coded and costed very carefully to ensure that costs are covered, but there is a significant delay before commissioners receive that information. The lack of specialist knowledge at PCT level means that commissioners find it very difficult to challenge coding. The complexity of the pricing structure of PBR has combined with these incentives to restrict the ability of commissioners to act on strategies that seek to redesign services and/or shift care out of hospitals.

Although WCC provides an overarching strategy that appears to integrate contestability, choice, PBR and practice-based commissioning the reality is that these different incentives and structures do not amount to a coherent whole. In practice commissioning suffers because these key elements of the system are not aligned.

4. WHAT HAS BEEN THE CONTRIBUTION OF SPECIALIST COMMISSIONING?

The Carter Committee recently recommended a number of changes designed to ensure that specialist commissioning arrangements were available in all parts of the country because local commissioners are unlikely to have the expertise to purchase these services effectively. The current arrangements apply only to a narrow range of services where the case for national or regional levels of commissioning is clear cut. However, there are a large number of other services where effective commissioning also requires high levels of clinical expertise and where the most effective scale of service provision is larger than most PCTs. Most PCT commissioners have acknowledged this and agreed local arrangements by which one PCT takes the lead on behalf of another—for example, in commissioning services for the local cancer network, or the provision of stroke services.

5. WHAT IS THE SCOPE FOR COMMISSIONING FOR QUALITY AND SAFETY?

The competencies required by the WCC programme clearly set out commissioners’ roles in quality and safety, and in recent years there has been a number of new mechanisms to support this—such as best practice tariffs and the Commissioning for Quality and Innovation scheme (CQUIN). The former will be used to set prices at a level which reflects best practice in delivery and quality. Initially this will cover five service pathways—cataracts, colecystectomy, fragility hip fracture, renal dialysis and stroke. The latter makes a small proportion of providers’ income dependent on locally agreed quality and innovation goals. In 2009–10 this proportion has been set at 0.5% and it is expected to increase over time. It is hoped that this will address the criticism that PBR is payment for activity rather results but will require commissioners to make effective use of these levers.

Other initiatives, such as the Indicators for Quality Improvement project led by the NHS Information Centre, is developing, assuring and promoting sets of quality metrics, which commissioners are encouraged to use to inform their contracting. Patient Reported Outcome Measures (PROMs) are a further important new source of quality information for commissioners.

Overall, there has been a definite and welcome shift towards the development and use of payment mechanisms and data on care quality, through which commissioners can seek to reward quality and maintain safety. However, access to and use of information critical to effective commissioning for quality and safety by PCTs is lacking, particularly in primary and community care.

Conclusion

World Class Commissioning is a policy that seeks to bring a ‘step change’ in the capacity and capability of PCTs to act as effective commissioners. However, the enduring weakness of commissioning is unlikely to be addressed by WCC alone. It is not just a matter of aligning incentives; it is also about reconciling the structural complexities of the current commissioning arrangements.
WCC is aimed at PCTs, but commissioning can only be understood by recognising that there are other players operating in different ways at different levels. PCT-led commissioning has not had the impact that was anticipated but that should not lead to the conclusion that the purchaser/provider split is a failure or that structural reform—such as PCT mergers—will address the problem.

Recognising and affording different powers to the various “layers”—a form of “matrix commissioning”—could go some way towards creating a more rational model. PCTs should retain a statutory responsibility to commission care for a defined population but they might then delegate responsibility to a range of different organisations with expertise in commissioning care for their part of the system. These might include a better supported model of PBC, Integrated Care Organisations, joint commissioning with other PCTs and/or local authorities; or supra-PCT commissioning agencies such as those required for specialist care. The role of the PCT would be to broker the most appropriate mix of commissioning arrangements to meet the needs of its population. Such matrix commissioning arrangements are becoming more common as PCTs seek new partnerships—an evolution that might eventually improve the effectiveness of the commissioning function.

References


September 2009

Memorandum by the Specialist Orthopaedic Alliance (COM 85)

1. BACKGROUND

This submission of evidence from the Specialist Orthopaedic Alliance229 (SOA) is offered in response to the Health Select Committee’s call for evidence on commissioning. Given the nature of our member organisations, which include all the country’s remaining orthopaedic hospitals, it focuses solely on specialised commissioning.

Our members play a vital role within the NHS in respect of patient care, training and research. For many patients, including a cohort who travel long distances, our services are often a last hope. All our members are vital to ensuring that there are sufficient numbers of highly trained specialist orthopaedic surgeons, and allied health professionals, available in the future to meet the needs of our ageing population. Also our members are vital innovators, and over the years have set the agenda, both nationally and internationally for the development of new procedures, treatments and joint replacement prostheses.

These hospitals, with their extensive experience of high volumes of complex procedures, can provide the type of multidisciplinary teams and leading-edge treatment that are vital for patients with a range of very rare conditions or serious complications. For example, joint replacements that have become infected following surgery and require a revision operation should, in our view, only be treated by specialist providers for these cases; specialist surgical, nursing, microbiological and histological support is required—often not available at non-specialist sites. Allowing non-specialists to seek to treat these cases may make further surgery even more complex and it less likely that sepsis can be eradicated.

2. EXECUTIVE SUMMARY

In 2006 the Carter Review of commissioning arrangements for specialised services found that the problems identified in earlier reports, such as those by the Clinical Services Advisory Group and the Audit Commission had still not been fully addressed, for example commissioning and financial arrangements were still unsatisfactory. While the Review looked at all specialised services, its findings are particularly true for specialist orthopaedic providers, many of whom have found it difficult to fund, and make long term plans for, their high complexity/high cost services.

2.1 Providing value to the NHS?

Despite working in a challenging environment, specialist orthopaedic hospitals provide excellent value for the NHS, and if used more, and in the correct way, could provide further value still.

Avoiding the need for revision and correction surgery, and potentially long term dependence on social care, reduces costs and allows patients to experience a better quality of life—we are strongly of the view that many initially more expensive treatments save thousands of pounds over the longer term. Examples include properly managed rheumatism (both adult and paediatric), swiftly and effectively treated bone infection, and the appropriate treatment of the many rare and difficult to diagnose bone and soft tissue cancers.

See Appendix 1 for a description of the Specialist Orthopaedic Alliance’s remit and membership.
For example, out of the approximately 56,000 surgical procedures that the five main specialist orthopaedic hospitals provide each year, the average infection rate for primary hip replacements and primary knee replacements is 0.2%—and the majority of these will be complex cases—against a national infection rate of between 1% and 4%. In fact the specialist orthopaedic hospitals’ track record on infection control is exemplary with only two cases of MRSA bacteraemia in the five main hospitals over the last three years.

If you consider that the mortality rate for MRSA bacteraemia is often in the region of 75%—and that in addition to this enormous human cost there is a huge financial cost—moving more work to these hospitals could save both lives and a great deal of money.

2.2 Meeting and managing demand

Specialist orthopaedic hospitals are playing a key role in helping train the orthopaedic surgeons of the future that will be required as our population continues to become more elderly—with, for example, a 32% increase in the over 65s between 2005 and 2011 and a 64% increase in the over 85s. This translates to an anticipated volume of around 51,000 hip and 54,000 knee replacements annually by 2010. Indeed, this trend is clearly already underway with an increase in the number of revision hip arthroplasties of 20% and of 60% for knee revisions since 2004.

In our view, specialist orthopaedic providers need to expand to meet the growing demand and to ensure that the challenge of infection control, always an increased risk with highly invasive surgery, is met. Our view is confirmed in Lord Darzi’s report recommendation that 20% of surgery should be focused in specialist units, which makes sense in terms of economics, outcomes and patient satisfaction. With a current average of 14% of all hospital admissions being orthopaedic, this would mean an expansion of capacity at specialist orthopaedic providers, for both highly complex and more routine operations. Overall, money would be saved and outcomes improved.

2.3 The need for specialised commissioning

The changes recommended by the Carter Review for the organisation of commissioning of specialist services have not been fully implemented. Few Strategic Health Authorities have universally adopted the Carter Review proposals and primary care level commissioners often do not have the necessary expertise needed, leading to poorly organised higher level commissioning in many parts of the country.

Also, our members’ experience is that commissioners are often less interested by low volume procedures or treatments and can neglect them. This leads to a fractured national service for many highly complex conditions—for example the provision of paediatric scoliosis surgery in the UK is in complete disarray.

In addition, there is a need to recognise the importance of the symbiosis between the providers of straight forward elective services and the specialists. There is enormous potential to share expertise using satellite or hub and spoke models—and also, potentially, telemedicine services. All this, however, requires significant, and strategically managed, specialised commissioning across regions. For example, the recent National Audit Office Review of services for people with rheumatoid arthritis concluded that “there is a lack of integration between primary care” and also “a lack of impetus or incentive for changing the way services are configured, with little shared knowledge and understanding about the extent of the disease, or an evidence base as to the most effective way of providing services to reflect different local needs”.

An example of where good strategic commissioning can transform this type of problem can be seen in the Nuffield Orthopaedic Centre NHS Trust’s paediatric rheumatology service, OxPARC. This is the Regional Paediatric Rheumatology Unit for South Central England and is provided by a multidisciplinary team that provides access to cutting edge treatment and one stop clinic access to physiotherapy, occupational therapy, pain management, psychology and ophthalmology. The service has over 500 registered patients, and provides one stop clinics in Oxford as well as outreach support clinics at District General Hospitals across the region. It also provides support by phone to GPs and nurses managing patients in the community. This approach helps patients spend their time at home and at school instead of at repeated hospital appointments and would not be possible without strategic commissioning.

3. VOLUME/OUTCOME

“Specialised services” are treatments for relatively rare conditions which, if they are to be provided safely and effectively, need a minimum number of patients under the care of each centre providing the particular service. Inevitably, they are not provided in every hospital and tend to be found only in much larger hospitals and in specialist units and hospitals. Only through ensuring this critical mass of patients is it possible to:

- achieve the best outcomes and maintain clinical competence;
- maintain the training of specialist staff;
- improve cost-effectiveness; and
- make the best use of scarce skills and equipment.

In the sense we are discussing here, the term “specialised” means that the service needs to be commissioned for a population of at least one million, and many of the rarer conditions need much larger populations than this. Generally, PCT populations are often around a third of a million and so, for these services, PCTs should
not, in our opinion, seek to commission these services individually. Our clinicians are of the view that specialist orthopaedic care should, in most cases, be commissioned through the regional specialised commissioning groups at a regional (population of between one and five million people) or supra-regional (population of between five and 50 million people) level.

For very rare conditions, where total national case load in England is numbered in the hundreds, there are a group of services which are commissioned nationally by the National Commissioning Group (NCG). These services tend to be very expensive and will be provided in perhaps only one or two centres in the country. Although this creates some issues regarding access it does at least provide a guarantee of provision and of quality.

Furthermore, there is a case, in our view, to consider a national strategy for a number of higher-volume but also high-complexity conditions—for example the current arrangement for all forms of spinal surgery is extremely unsatisfactory and patients’ treatment is constantly compromised as a result.

4. Access

Lord Darzi’s report Next Steps set a new agenda for the NHS centred on quality of care. The SOA believes that ensuring the availability of high quality, strategically planned and appropriately funded specialist services to patients in all parts of the country is a key part of that vision.

The underlying aim of the arrangements for commissioning specialised services should be to ensure fair access to specialised services right across the country—the SOA is very concerned that these objectives are not being achieved due to the disparate quality of national provision and the ability of PCT commissioners to spend time understanding issues around low volume / high complexity procedures and treatments leading to a fractured national service for many highly complex conditions.

5. Defining what is Specialised

In 2008 the SOA reviewed how much of our members’ clinical activity came under the remit of either a national or a regional Specialised Commissioning Group (SCG). The results of this review demonstrated that in most cases less than 15% of our activity is commissioned by an SCG, while many of us believe that up to 80% of our work would more appropriately be classified as specialist and therefore commissioned by an SCG.

Moreover, an in depth understanding of complex cases and patients is needed to ensure that they are treated by appropriate providers. This is vital to securing better outcomes—and also to helping avoid the high cost (in both money and poor patient outcomes) of misdiagnosis, ineffective treatment or unsuccessful surgery.

In September this year we were invited to comment on the latest draft of the specialised orthopaedic services national definition set. This draft is in many ways an improvement on a draft produced in September 2008; however there are still some notable omissions—for example the following conditions and procedures are excluded although they include both clearly specialised as well as standard treatment:

— infection and/or inflammation due to joint/bone replacement;
— chronic osteomyelitis (an infection of the bone) of pelvis and long bones;
— bone grafts;
— osteotomy (cutting and realignment of bone) and internal fixation (pins, plates, rods, screws etc to secure fractured bones);
— excision of bone; and
— Autologous Chondrocyte Implantation (a biopsy of healthy knee cartilage is cultured in the laboratory to produce millions of new cells that are then re-injected to stimulate the production of new cartilage to replace previously damaged and worn tissue)—while this is included in the text definition, only one of the possible relevant codes (OPCS), and in fact the one least likely to be used, is included in the code list, thereby ensuring that this procedure is effectively excluded.

We are also concerned that the list is unreasonably weighted towards upper limb micro surgery.

It is vital that the final version of this document should detail the ways in which it links to the recommendations of the Carter Review of Specialised Services Commissioning arrangements in 2006. Particularly the recommendation that “SCGs should formally designate specific providers to provide specific specialised services. Designation should be based on a nationally agreed set of patient-centred clinical service quality and financial criteria and be re-assessed every five years”.

6. The Proposed Solution?

The Carter Review set out a clear direction which highlighted the importance of specialised services coming under the remit of national or regional groups for commissioning arrangements. This direction of travel has been reaffirmed in the recently published operating framework for the NHS. As an alliance, we want to promote the use of specialist commissioning groups at a regional level, rather than individual PCTs commissioning our specialised activity, on the basis that this will help to direct referrals to trusts undertaking
high volumes of specialised treatment, thereby securing the best possible outcomes for patients. Once again, this is in accordance with national policy as highlighted in the musculoskeletal services framework published by the Department of Health.

The SOA’s view is that for truly specialised cases, patients’ wellbeing and safety must be the first priority. For example there are cases where patients with complex medical conditions would have a dramatically improved prognosis if transferred to a specialist provider—ensuring fewer complications or revisions or more quickly resolved wound or bone infections.

The Specialised Commissioning agenda proposed by the Carter Review should be pushed through to improve the quality of care received by vulnerable groups of patients. This would require the next edition of the National Commissioning Groups Definitions Set for Specialised Orthopaedics (No.34) to be made wholly mandatory on either a national or regional level, from a nationally vetted group of specialised providers.

The current process of involving clinicians, and the Royal Colleges, in creating robust definitions of what should be specially commissioned and then not obliging commissioners to adopt these does patients a disservice. We are not proposing the wholesale removal of specialist treatment from district general hospitals—but rather the removal of a very small number of ‘super specialist’ procedures in order to improve patient outcomes.

September 2009

APPENDIX 1

BACKGROUND TO SPECIALIST ORTHOPAEDIC ALLIANCE

The Specialist Orthopaedic Alliance has been formed by a group of specialist centres dedicated to providing orthopaedic services ranging from the straightforward to the highly specialised, to patients across the UK.

These centres, based at trusts around the country, are at the leading edge of best practice in medicine and conduct world-renowned training and research. They not only provide services to patients, they are responsible for training many of the UK’s orthopaedic surgeons and other specialist staff including, for example, physiotherapists. They provide essential clinical training, leadership and research.

Their reputation means they take referrals from across the UK and also receive private referrals from across the world.

Specialist orthopaedic centres have developed a high degree of competence and clinical effectiveness for routine orthopaedic treatments and highly specialised complex procedures. The nature of the specialist centres bring together some key components that enable development of procedures which other hospitals are unable to undertake.

These trusts provide specialist services not routinely provided elsewhere, including:

— Specialist paediatric rheumatology services.
— The treatment of primary malignant bone tumours and chronic bone infections for which the only other option would be amputation.
— Complex disorders such as spinal deformity and developmental dysplasia of the hip.
— Each of the centres undertakes more than 1,000 hip and knee procedures every year and specialise in joint replacement.

2009 Membership
Robert Jones and Agnes Hunt NHS Trust, Oswestry;
Royal Orthopaedic Hospital NHS Foundation Trust, Birmingham;
Royal National Orthopaedic Hospital NHS Trust, Stanmore;
Nuffield Orthopaedic Centre NHS Trust, Oxford;
Wrightington, Wigan and Leigh NHS Foundation Trust;
Ashford St Peters NHS Trust;
South West London Elective Orthopaedic Centre;
Memorandum by the Nuffield Trust (COM 86)

1. INTRODUCTION

1.1 The Nuffield Trust has a mission to promote improvements in the quality of healthcare and health policy, with the aim of improving patient care and public health. Thus we regard health commissioning as a critical function within a health system, given its fundamental role in assessing needs, allocating resources, specifying and procuring services to meet health needs, and monitoring service performance.

1.2 We have been engaged in research and policy analysis of NHS commissioning for over 15 years, primarily when based at the King’s Fund (Jennifer Dixon) and the University of Birmingham (Judith Smith). In this submission of evidence, we highlight what we consider to have been our main contributions to research and policy analysis of NHS commissioning since 2002 (the date of establishment of PCTs across the whole of the English NHS), drawing out the key lessons for policy and practice.

1.3 The Nuffield Trust is currently working with the King’s Fund to develop a new monograph that examines the evidence on NHS commissioning, and sets out a way forward for making commissioning more effective in the future. Whilst we are not in a position to set out the conclusions of this monograph in advance of publication (due in November 2009), we include in this evidence a brief summary of what we consider to be the main challenges currently facing NHS commissioning, and the areas in which we think policy reform is needed in order to strengthen commissioning to be fit for the uncertain financial future ahead.

2. LESSONS FROM RESEARCH

2.1 Review of the evidence on primary care-led commissioning (2004)

In a major review of the evidence on primary care-led commissioning across the four countries of the UK (Smith et al., 2004; Smith et al., 2005), we reached the following conclusions about commissioning in the NHS:

— 2.1.1 There is little substantive independent research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services. Evaluation may have been done within the NHS which is not easily accessible.

— 2.1.2 Primary care-led commissioning, where clinicians have a clear influence over budgets, can however secure improved responsiveness in areas such as access, information and waiting times.

— 2.1.3 Given an opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change long-standing working practices and enable service innovation.

— 2.1.4 There is no “ideal model” of commissioning and primary care-led commissioning may be effective as part of a wider continuum of commissioning approaches, particularly for community-based and chronic disease management services.

— 2.1.5 There is a need for more systematic assessment of models of health commissioning, including the examination of their ability to achieve specific service and patient quality objectives which can be monitored in a rigorous manner.

— 2.1.6 Commissioning organisations need a degree of stability that has not, to date, been afforded to them, especially in comparison with the experience of acute providers.

— 2.1.7 Commissioners need new and more advanced forms of support, including in the areas of data analysis, risk prediction, and more refined assessment of service quality and outcomes.

— 2.1.8 Clinical engagement and the appropriate use of incentives are crucial to effective primary care-led commissioning and service development at all points along the “commissioning continuum”.

2.2 Review of evidence on effective commissioning (2006)

In 2006, two members of the research team from the 2004 review (Judith Smith and Richard Lewis) worked with Tony Harrison to carry out a further examination of how best to develop effective commissioning in the NHS, updating the earlier review of published evidence, and carrying out interviews with key national stakeholders. In the papers resulting from this analysis (Smith et al., 2006; Lewis et al., 2009), the authors concluded that there were four key elements required for successful commissioning in what they asserted was a more “external” NHS market than that developed in the 1990s:

— 2.2.1 The identification of need and demand (ie analysis of both needs and demands of the local population).
— 2.2.2 The shaping of markets (ensuring the existence of a proper ‘menu’ of local services from which people can choose).
— 2.2.3 Holding the market to account (ensuring that the basics of commissioning are in place as a prerequisite to “bolder” commissioning).
— 2.2.4 Holding commissioners to account (putting in place new and more radical approaches to enabling greater public involvement in and legitimacy of commissioning decisions).

2.3 This analysis concluded by asserting:

“To date, the purchasing function in the English NHS has proved weak in its influence over suppliers of care. [...] If purchasers are to demonstrate that the decision to separate their role from provision is justified, they will have to learn new skills and apply them effectively. If they fail, then it will be hard to resist the conclusion that they will have to be content with being the financiers of a health care market driven by the interaction of providers and patients exercising choice of where they are treated and by whom”. (Lewis et al., 2009, p 50).

2.4 Current Nuffield policy analysis of NHS commissioning performance

In 2009, our analysis of the current continuum of commissioning arrangements leads us to note the following as being distinctive features:
— 2.4.1 The continuing “twin-track” of population-based (PCT) and patient/primary care-focused (PBC) approaches, reflecting the original design of reforms in 1991.
— 2.4.2 The persistence of a plurality of models of commissioning, across a continuum that encompasses national purchasing of specialised services, regional, supra-PCT, PCT, practice-based, and individual patient approaches.
— 2.4.3 The enduring conclusion that “one size does fit all” and that model of purchasing needs to fit scale and scope of service under consideration
— 2.4.4 The relative lack of diversity within the practice-based approaches to commissioning in 2009, in comparison with previous needs.
— 2.4.5 The relative lack of autonomy of these practice-based approaches (from the PCT) in comparison with previous approaches.
— 2.4.6 The apparent reliance by PBC approaches on PCTs for their management support.
— 2.4.7 The lack of delegated “real” budgets to most of the practice-based models of commissioning.
— 2.4.8 The apparent absence of significant “hybrid” approaches that seek to transcend the PCT/PBC divide, namely models that seek to draw real population-based purchasing responsibility together with groups of primary care (and perhaps other clinicians).

3. HOW TO STRENGTHEN NHS COMMISSIONING

3.1: Reflecting back on the conclusions of our 2004 analysis of the evidence on commissioning, we would wish to make the following points in respect of the current situation in 2009:
— 3.1.1 It would seem to us that commissioners continue to struggle to make a significant or strategic impact on secondary care services.
— 3.1.2 Primary care-led commissioning (through PBC) is not realising its potential, and is less influential than in its previous incarnations in the 1990s and early 2000s.
— 3.1.3 Highly determined managers and clinicians still manage to bring about innovation in service delivery, both through commissioning and also through taking on responsibility for extended service provision.
— 3.1.4 There continues to be a continuum of commissioning approaches for different services and population bases, and this is appropriate to a system such as the NHS.
— 3.1.5 Whilst there is now a more systematic approach to developing and assessing NHS commissioning through the World Class Commissioning initiative, this does not appear to have enabled local commissioning communities to carry out the robust local assessment of commissioning models that we anticipated in our 2004 analysis—WCC appears overly formulaic and not sufficiently focused on organisational development and innovation.
— 3.1.6 Commissioning organisations were reorganised and merged again in 2006 (from 300 to 152 PCTs), practice-based commissioning was introduced in 2005, so the instability and change we cited as an inhibitor to progress persists.
— 3.1.7 Research into PCT commissioning suggests that at least PCTs are indeed becoming more sophisticated in their use of routine data as a basis for commissioning—predictive risk techniques
are now used, as is programme budgeting, and other analytical approaches. What is now needed is support for PCTs to use these in a more extensive manner, as part of an overall effort to "move to another gear".

— 3.1.8 Clinical engagement in commissioning is even more of a challenge than it was in 2004, especially as PBC appears to be relatively ineffective, and to have failed to excite frontline practitioners.

3.2 Based on this analysis, it is not surprising that PCTs have been much maligned for their lack of effective commissioning and failure to bring about significant change to patterns of service delivery, particularly in the acute sector and intermediate care. We believe that these accusations have sometimes been too harsh and that the achievements of PCTs, such as ensuring significant reductions in waiting times for treatment, introducing new forms of access to primary care, and investing in new primary care premises have been under-represented.

3.3 However, as the economic downturn feeds through to the NHS and as the challenges posed by long term conditions escalate, it is critical that PCTs and PBCs are in a position to make bold and radical decisions. Based on our current work analysing the performance and promise of NHS commissioning, PCTs are not well-placed to tackle forthcoming financial and health challenges. Their relative invisibility amongst the public feeds a lack of understanding over their form and function which compromises the degree of public support they can expect for their decisions.

3.4 PBC, far from enhancing and strengthening commissioning, is characterised by lukewarm support amongst GPs, inadequate incentives, lack of management capacity, and unclear responsibilities in relation to those of PCTs. Where there has been PBC-driven innovation, it has tended to be focused on small-scale provision within primary care and not larger-scale strategic commissioning that reshapes secondary care or enables more integrated forms of service delivery.

3.5 We feel that there are key changes to the policy environment that are required if commissioning is to stand a chance of becoming effective in the way that was originally intended. These changes are summarised in the box below.

— 3.5.1 Assuring legitimacy for commissioners, in the eyes of the public, health professionals, and provider organisations.

— 3.5.2 Developing contracting mechanisms that have sufficient flexibility to enable commissioners to bring about timely and radical service change.

— 3.5.3 Reforming the payment by results system to enable commissioners to "unbundle" service tariffs and invest resource in new forms of care that transcend traditional primary and secondary care boundaries.

— 3.5.4 Finding ways of incentivising and motivating GPs "beyond practice-based commissioning", with an opportunity to hold hard capitated budgets (which are risk-adjusted to allow more resources to flow to people with greater health needs) and assume full responsibility for commissioning and providing care for their population. Incentives could include sharing savings.

— 3.5.5 Extending the concept of PBC to enable integrated care organisations or multispeciality clinical groups to take responsibility for funding and providing a wide range of care for their registered population.

— 3.5.6 Exploring how the health system might set funding priorities and direction for PCTs and PBC organisations in a way that enables proper governance and accountability for morer influential local purchasing bodies.

— 3.5.7 Determining the appropriate range of functions and size of a PCT, taking account of the potential role and scope of any organisational arrangements that emerge "beyond PBC."

— 3.5.8 Creating a compelling narrative for the public and the NHS about the importance of effective commissioning that can enable high quality and transformed services able to meet the health and financial challenges ahead.

— 3.5.9 Considering the merits of introducing competition between commissioners (for state contracts and for patients) to provide external challenge to help improve performance in addition to central direction and regulation currently in place.

4. References


**Memorandum by NHS Richmond (COM 87)**

Some of the key areas of commissioning responsibility for NHS Richmond include being the local lead for the NHS, working with community partners and engaging with a range of stakeholders including the public and patients, collaborating with local clinicians to understand and assess local health needs and plan service provision to meet these needs which is then executed via our contracting and procuring processes and managed within the resources allocated to the PCT.

The following example is an illustration of the role and responsibility of the PCT in ensuring that the local population within the London Borough of Richmond upon Thames have access to appropriate and a range of mental health services to meet their needs whilst also working with partners to both develop, performance monitor and ensure high standards of quality of these services.

The PCT is currently working jointly with the Local Authority to develop joint five year commissioning plans for both Adults of working age and Older adults with mental health difficulties. This work has been embarked on as a result of the need to refresh our local demographics and prevalence data together with emerging new policy and guidance in terms of future direction of service provision. This process is being managed as follows:

— Gathering and mapping of local demographics and prevalence data and the joint strategic needs assessment is being refreshed.

— Review of current service provision and use of services to gauge local demand and appropriateness of current services.

— Understanding of costs of services and impact of future financial climate to ensure effective use of public money.

— Engagement with public and patients is being pursued through a range of forums giving them the opportunity to influence the plans. Some of these include focus groups, workshops, health events eg World Mental Health day (10/10), Older peoples day (06/10) whilst also keeping the engagement interactive via the website and other local bulletins.

— Working with and getting support from our community partners in providing advice and suggestions as well as supporting us facilitate the engagement meetings, allowing for local ownership of the project.

— Seeking local clinical intelligence by engaging with our primary care and secondary care clinicians and professionals across health, social care and the voluntary sector.

— The key outcome of the project will be the development of five year joint commissioning plans for service provision for Adults of working age and Older People with mental health difficulties. These will include identification of priorities that need to be taken forward to deliver the plans which will entail contracting and procurement processes to be undertaken by the commissioning team at the PCT.

— The plans will be kept flexible to enable adjustments to be made within the five years in view of ongoing policy and other changes as may be required.

— The PCT and the Local Authority will be accountable to the local community partners, public and patients on the delivery of the plans and communication mechanisms developed in this process will be maintained to ensure ongoing engagement.

*September 2009*
Memorandum by the East of England Specialised Commissioning Group (COM 88)

EXECUTIVE SUMMARY:
This paper sets out a brief introduction to the EoE SCG, lists the benefits of the collaborative model for specialised commissioning, and lists a number of areas of work undertaken by the EoE SCG for patient benefit.

1. Introduction
1.1 The East of England Specialised Commissioning Group (EoE SCG) was established on 1 April 2007. It was formed from a merger of the local specialised commissioning groups for Essex, Norfolk, Suffolk, Cambridge, Hertfordshire and Bedfordshire.

1.2 The Specialised Commissioning Team commissions services on behalf of the population in the East of England, acting under formal mandate from the 14 PCTs within the Region. Specialised services are commissioned from most of the hospitals within the East of England region as well as more widely across the country.

1.3 The EoE SCG is currently responsible for a commissioning budget of £680 million.

2. Benefits of a collaborative model for Specialised Commissioning
2.1 The benefits of a collaborative model for specialised commissioning have largely been realised in the East of England. These include:

2.1.1 development of specialised service expertise by commissioners;
2.1.2 ability to appropriately plan and procure services over a multi-PCT geographical area;
2.1.3 opportunity to manage financial risk across a large baseline for volatile services;
2.1.4 administrative economies of scale. The EoE SCG salaries and wages budget is equivalent to 0.5% of the service commissioning budget; and
2.1.5 a structure to represent the interests of patients who otherwise might not be prioritised because of their relative paucity of numbers and higher-than-average unit treatment costs.

3. Some examples of work carried out for patient benefit by the EoE SCG
Please note that this is presented as a table, and will be published (subject to SCG Board approval) as part of the 2008/9 Annual Report in October.

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Position 2007–08</th>
<th>Position 2008–09 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neo-natal service</td>
<td>No 24/7 service across the EOE</td>
<td>24/7 service now provided across the EOE</td>
</tr>
<tr>
<td>transport service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fertility Treatment</td>
<td>No EoE policy, service specification</td>
<td>Policy, specification and criteria agreed and consistent across EOE</td>
</tr>
<tr>
<td></td>
<td>or access criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No choice of provider offered to</td>
<td>Couples offered choice from five providers</td>
</tr>
<tr>
<td></td>
<td>couples</td>
<td></td>
</tr>
<tr>
<td>Morbid Obesity Surgery</td>
<td>Surgery undertaken on <em>ad hoc</em> basis</td>
<td>Preferred providers agreed through South of England review</td>
</tr>
<tr>
<td></td>
<td>No agreed quality standards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No common policy</td>
<td>Services evaluated against quality standards</td>
</tr>
<tr>
<td></td>
<td>Limited access</td>
<td>East of England policy agreed and implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services available to all patients meeting criteria</td>
</tr>
<tr>
<td>Name of Service</td>
<td>Position 2007–08</td>
<td>Position 2008–09 and beyond</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Spinal Injury Services</td>
<td>No common commissioning arrangements or financial risk sharing</td>
<td>EoE Spinal Consortium established. High financial costs risk shared across PCTS</td>
</tr>
<tr>
<td></td>
<td>National Spinal injury Board established to develop and implement national standards</td>
<td></td>
</tr>
<tr>
<td>Neuro-rehabilitation Services</td>
<td>No common access criteria</td>
<td>Outreach service extended to include Essex.</td>
</tr>
<tr>
<td></td>
<td>Delayed discharges from either ITU, neurosurgical or orthopaedic beds</td>
<td>Patients assessed at early stage Timely referrals made to appropriate setting</td>
</tr>
<tr>
<td>Renal</td>
<td>Strategy developed to increase capacity</td>
<td>Locations for additional capacity identified for consultation and procurement with services on stream for 2010 and 2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategy to increase availability of home haemodialysis</td>
</tr>
<tr>
<td>PPCI</td>
<td>PPCI not commissioned in EoE</td>
<td>All patients in EoE have access to PPCI for STEMI heart attacks at specialised centres with the region. Services rigorously audited to ensure optimum outcome.</td>
</tr>
</tbody>
</table>

*September 2009*

**Memorandum by the National Patient Safety Agency (COM 89)**

**EXECUTIVE SUMMARY**

1. We know that healthcare can be safer. Action is needed both nationally and locally to make patient safety the top priority at every level of the NHS. Strong and visible leadership around patient safety and understanding the importance of reporting and timely implementation of preventative measures are essential to making sure commissioning drives patient safety improvement.

2. Commissioners must ensure that care they commission is safe on behalf of patients and the public. They must be able to understand and assess the services they commission to assure themselves that they are as safe as possible.

3. Commissioners can and should be influencing provider behaviour around patient safety through existing contracting mechanisms. They should understand how they can use contracting to ensure services meet key standards for quality and safety and how they can drive improvement.

4. Commissioners should be able to define what they need to know to assure themselves that providers are meeting quality and safety expectations. They should aware of outcome indicators, process indicators and other quality and safety indicators that are available nationally and locally.

5. Commissioners must be responsible for communicating information about the quality and safety of care they commission to patients and the public.
6. The National Patient Safety Agency (NPSA) was established in 2001 to lead and support the NHS to improve patient safety; in particular through managing a national patient safety incident reporting system. Lessons from incident reports are used to provide patient safety recommendations, advice and feedback to the NHS in England and Wales, and wider organisational support and tools have been developed.

7. Many aspects of NPSA work provide support for commissioners, helping them to understand and scrutinise aspects of patient safety in their providers. These include training for Non-Executive Directors, the development of Fact Sheets for Boards, work around serious untoward incident reporting, the Never Events policy, and indicators that demonstrate the use by providers of nationally available tools and advice.

INTRODUCTION

8. Over more than 60 years, the NHS has evolved to meet the growing needs of its patients. Advances in technology, the development of new services and increased complexity of treatments bring both opportunity and risk.

9. The Department of Health published a report on patient safety, An organisation with a memory in 2000,230 recommending the establishment of a national agency, the National Patient Safety Agency, to take on the leadership in England and Wales. Over the past decade understanding of patient safety has grown in the NHS and it is now seen as a core focus for many health systems worldwide.

10. The NPSA currently includes the National Reporting and Learning Service, the National Clinical Assessment Service, the National Research Ethics Service and an oversight role for the three Confidential Enquiries. Details are shown in Annex One.

11. Work on patient safety at the NPSA focuses on the following:
   — better detection and understanding of risks to patients when serious harm or death is reported;
   — advice for the NHS on risks and hazards, and practical strategies for addressing these at a local level;
   — working with senior clinicians to develop and implement safer practices within specific clinical areas and care settings;
   — working towards guidance that is “implementation ready”; and
   — closer working with regulators and commissioners to embed patient safety in national standards, assessment of services, and assurances around safety in providers.

12. The NPSA submitted more detailed evidence on its role and way of working to the Health Select Committee’s Inquiry into Patient Safety carried out in 2008–09.231

13. This submission from the NPSA addresses primarily point 5 of the terms of reference of the Inquiry: “Commissioning for the quality and safety of services”, and is written from the point of view of a national organisation that supports patient safety in England and Wales.

14. The NPSA believes that commissioners have an important role in creating better understanding and information for patients and the public about the quality and safety of providers. This will strengthen patient choice and drive better care. In this submission we outline aspects of national work that support commissioners in their role as advocates of safe care for their patients.

MAIN POINTS

Driving patient safety improvement through commissioning

15. The NPSA regards commissioning for quality and safety is an important way of driving safer care on behalf of patients. As commissioning organisations mature, there is a real opportunity now to consolidate the learning about patient safety and strengthen commissioners’ understanding of how commissioning can build further patient safety improvement.

16. Commissioners have a responsibility for understanding how existing contractual mechanisms can be used to improve patient safety in their providers, acting on behalf of the patients they contract for. This submission focuses on these existing mechanisms, and on current work that is being undertaken and is being planned in this area by the NPSA and others to help support the NHS.

17. The NPSA provides support and policies that aim to strengthen mechanisms that can improve commissioner and provider understanding of patient safety, and that can be drawn upon by commissioners to improve patient safety.

Ensuring that care that is commissioned is safe

18. The NPSA works with the Appointments Commission to provide training and information on the importance of patient safety at Board level; in particular for Non-Executive Directors. The NPSA inputs into all Non-Executive Director induction events (approximately every six weeks around the country) run by the Appointments Commission, with a session on patient safety. This is an opportunity to raise safety concepts for Non-Executive Directors in all healthcare organisations, and to talk through the responsibilities of Boards in commissioning organisations in assuring themselves that their providers are as safe as possible.

19. Working with the Appointments Commission and the NHS Confederation, the NPSA has developed a Fact Sheet *Questions are the answer!*233 to help Boards ask themselves whether they understand patient safety and what they need to know about the safety of their organisation. The current version is directed at provider organisations, and highlights seven questions every board member should consider and suggests what “good” should look like in relation to patient safety in their organisation. The NPSA is currently developing a similar question-based Fact Sheet for Boards of commissioning organisations, again working with the Appointments Commission and the NHS Confederation. This will be launched later this year to help Boards of commissioning Primary Care Trusts (PCTs) assure themselves that care they commission is safe.

20. Commissioners should already regularly meet with providers and discuss aspects of patient safety, including serious untoward incidents, as part of existing contractual processes. This includes the occurrence of patient safety incidents, investigations carried out by providers, and any actions put into place. Through these discussions, the commissioning Primary Care Trust (PCT) should be assuring itself that the provider is taking safety seriously.

Influencing provider behaviour around patient safety

21. The contractual process with providers can also be used to influence provider behaviour within the discussion and reporting process.

22. The NPSA has defined what commissioners of NHS care should have set up around the occurrence of serious incidents in their providers in a national framework for reporting and learning from serious incidents requiring investigation.233

23. The framework for reporting and learning from serious incidents clarifies the roles of NHS organisations. They all have a responsibility to ensure that when a serious incident does happen, systemic measures are in place for safeguarding people, property, resources and reputation, for understanding why the event occurred, and to ensure that steps are taken to reduce the chance of a similar incident happening again. Commissioners are expected to demonstrate that arrangements are in place around the governance of serious incident management, reporting, investigation and action planning, learning and follow up and media management as necessary.

24. To further strengthen the commissioning role in management of serious untoward incidents, the NPSA has developed a policy around the management of certain incidents, termed Never Events, putting them into the public domain.234

25. The suggestion that a policy on Never Events should be introduced in the NHS in England from April 2009 came from Lord Darzi’s report *High Quality Care for All*.235 Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers.

26. A focus on Never Events, as potentially extremely serious incidents, is intended to raise PCT commissioners’ and providers’ awareness of patient safety, and reporting and response processes for serious incidents. It aims to promote and support discussions between commissioners and providers, and help commissioners understand how providers learn from serious incidents.

27. The NPSA has developed a core list of eight “Never Events” for use by commissioners in 2009–10, and PCTs can add their own to this list for local use after discussion with providers.

28. All core and locally-defined Never Events must fit set criteria: the Never Event may or does result in severe harm or death to patients, there is evidence that the Never Event has occurred in the past, there is existing national guidance and/or national safety recommendations on how the Never Event can be prevented, the Never Event is preventable if the latter are implemented, and occurrence of the Never Event can be identified and measured on an ongoing basis.

29. From April 2009, when a Never Event occurs, providers will be expected to use existing mechanisms to report the incident locally and nationally, and discuss learning and preventative action with the commissioning PCT.

30. Responsibility for reporting publicly on Never Events in providers has been placed in the hands of PCTs as commissioners. This should give additional publicity to their occurrence and also ensure sharing of the investigations carried out, the lessons learned and preventative measures that have taken place.

31. The first year of the Never Events policy will test the process. It will investigate how the concept can be used locally as a lever to drive the numbers of these incidents to zero, how it is being used in commissioner/provider discussions, and more generally how it might contribute to better understanding of patient safety in providers by commissioners. Subsequent years may include financial elements that commissioners may wish to use; for example linking to incentives schemes. Commissioners are also likely to want to use additional locally-defined Never Events to drive better care in selected areas, or with particular providers or in certain care settings.

Defining what commissioners need to know

32. The NPSA is increasingly putting patient safety data on NHS organisations in the public domain, from our own Reporting and Learning System and other sources. One example is the publication of the Organisation Feedback Reports published by the NPSA twice a year, giving information around indicators in relation to reporting patient safety incidents in every NHS provider organisation in England and Wales. Individual providers receive data from us comparing them with other similar organisations. Timeliness of reporting patient safety incidents, consistency of reporting and number of reports give important information about an organisation and its safety culture. The NPSA works with other organisations, for example Dr Foster and research groups, to pull other comparative data together and put into the public domain.

33. Commissioners should be looking and discussing reports on patient safety indicators from various sources with their providers and assuring themselves of what the numbers mean for safety.

34. Individual providers will also increasingly be encouraged to put further safety data and newly developed indicators into regular publicly available reports such as Quality Accounts. There may also be locally held data that commissioners should ask to see. These will be another source of information that commissioners need to be able to understand and discuss with their providers.

35. Commissioners may also wish to scrutinise how providers are making use of other safety tools and advice available nationally. The NPSA has developed patient safety tools for use in providers; for example for them to assess their safety culture, to help train staff in good investigation after incidents take place, and how to support patients and staff involved when errors take place. The NPSA regularly puts out rapid response reports and other alerts around changes in clinical practice that would prevent patient safety incidents. Providers should be monitoring their own implementation of this advice. The NPSA supports high level leadership for patient safety and participation in national campaigns on patient safety, working with other organisations. All of these aspects of patient safety should be part of a package of measures that commissioners can examine in their providers for assurance that they are taking patient safety seriously.

Communicating information about the quality and safety of care commissioned

36. Commissioners have a responsibility for putting the information they receive and ask for on quality and safety into the public domain in a transparent, simple and accessible form. The Non-Executive Director engagement work, the Fact Sheet development, the framework on serious untoward incidents, the Never Events policy and nationally available tools and advice discussed above all support this.

37. Commissioners have an important role in creating better understanding and information for patients and the public about the quality and safety of providers. This will strengthen patient choice and drive better care.

Summary

38. The NPSA asks the committee to consider the following recommendations. In summary, all organisations that commission NHS care should:

- drive patient safety improvement through commissioning,
- ensure that care that is commissioned is safe,
- influence provider behaviour around patient safety,
- define what they need to know, and
- communicate information about the quality and safety of care they commission to patients and the public.

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39. The following ways of working would help to ensure commissioning for the quality and safety of services meets the needs of the NHS, patients and the public.

40. All organisations that commission NHS care need to:
- demonstrate that patient safety in their providers is their top priority,
- ensure that their Boards, senior managers and senior clinicians understand how to assure themselves that providers are as safe as possible
- regularly meet provider organisations, discuss and receive reports and investigations on patient safety incidents and other aspects of implementation of safety advice,
- support and discuss mechanisms in providers to improve patient safety,
- provide information for patients and the public about how they are ensuring that providers are as safe as possible, and
- ensure that skills are in place to achieve the above on behalf of patients they commission for.

41. All organisations that provide NHS care need to:
- work transparently with commissioners,
- demonstrate to them that patient safety is their top priority,
- ensure that their Boards, senior managers and senior clinicians support open and transparent discussions around patient safety with commissioning organisations,
- provide information on the mechanisms they use to improve patient safety
- regularly provide and discuss robust reports and investigations for learning from patient safety incidents and other aspects of implementation of safety advice, and
- ensure that skills are in place to achieve the above on behalf of patients they treat.

September 2009

Annex One

National Patient Safety Agency Directions

(1)(a) to co-ordinate systems wide patient safety functions by promoting a culture of reporting and learning from adverse events;
(b) to devise, implement and monitor a reporting system based on relevant national standards issued by the Department of Health regarding adverse events and near misses to promote a culture of reporting and learning;
(c) to collect and appraise information on reported adverse events and near misses and other material useful for any purpose connected with the promotion of patient safety;
(d) to provide advice and guidance useful in the maintenance and promotion of patient safety, clinical assessment, English NHS Research Ethics Committees and the patient environment and to monitor the effectiveness of such advice and guidance;
(e) to promote research which the Agency considers will contribute to improvements in patient safety, clinical assessment and the patient environment and to facilitate research which the Agency considers will contribute to improvements in English NHS Research Ethics Committees;
(f) to report to and advise Ministers on matters affecting patient safety, clinical assessment, English NHS Research Ethics Committees and the patient environment;
(g) to publish information relating to the exercise of its functions;
(h) to support NHS bodies who are concerned about the performance of an individual practitioner;
(i) to issue good practice and other guidance for the handling by NHS bodies of cases of poor performance on the part of practitioners in relation to—
(ii) the NHS services which such practitioners provide, or
(i) the NHS services which they assist in providing;
(j) to determine who may refer practitioners to the Agency or other bodies acting on its behalf for the purposes of assessment and to determine the criteria for the making of such referrals and for their acceptance by the Agency;
(k) to provide advice, support and agree action plans in relation to practitioners referred to the Agency;
(l) to determine criteria, methods and procedures for the carrying out of assessments and related activities and for the drawing up of action plans;
(m) to carry out assessments and related activities or to arrange for other persons to carry out any of those functions on its behalf;
(n) to monitor the diversity of practitioners referred to the Agency;
(o) in liaison with the Medical Royal Colleges and Faculties, specialist societies, those with general practice interests and any other interested parties whom the Agency may decide to consult, to establish and maintain lists of professional and lay persons who are authorised to carry out assessments in whole or in part (“authorised assessors”);
(p) in relation to assessments carried out by the Agency, to appoint one or more authorised assessors (whether as employees or contractors of the Agency) to carry out the assessments;
(q) to arrange, or approve, training for authorised assessors or for those who wish to become authorised assessors;
(r) to review the carrying out of assessments and related activities by the Agency and other persons on its behalf in order to ensure consistency in the way in which assessments are carried out and in the contents of reports, recommendations and action plans, and to ensure compliance with legal obligations;
(s) to work in partnership with and to liaise with the General Medical Council, the General Dental Council and the Healthcare Commission in developing policies to ensure that overlap between the respective activities of these bodies and of the Agency is kept to a minimum and that effective channels of communication exist at both national and local levels;
(t) to consider possible improvements in relation to the assessment by an NHS body of the clinical performance of practitioners in connection with the provision of NHS services;
(u) to respond to requirements of the Secretary of State for Health including—
(i) establishing and operating effective alert systems and associated databases;
(ii) assisting in resolving suspensions and exclusions by NHS bodies of practitioners,
(iii) providing advice to NHS bodies who are considering the suspension or exclusion of a practitioner,
(iv) developing and administering the national suspensions and exclusions monitoring and reporting project, and
(v) providing advice to NHS bodies in respect of the application of conduct and capability procedures;
(v) to identify, in such areas of health care as may be notified by the Secretary of State, patterns of practice or service provision in the health service that appear to them to be causally related to unexpected or serious adverse outcomes and thereafter to make recommendations for good practice arising there from, including responsibility for ensuring the separate and effective management of the four National Confidential Enquiries;
(w) to work and liaise with the Department of Health in the development of delivery and educational programmes in relation to the operational components of improving hospital food and related nutrition;
(x) to work and liaise with the Department of Health in the development of delivery and educational programmes in relation to the operational components of improving hospital cleaning;
(y) to support the Department of Health in relation to design safety in healthcare facilities through—
(i) contributing to the Department of Health’s development and production of relevant design guidance and standards,
(ii) undertaking specific projects relating to design safety which will contribute to the Department of Health’s design policy development and strategy, and
(iii) providing a communication strategy for disseminating design safety information to the NHS including working with partners identified by the Department of Health who are associated with design safety issues; and
(z) to provide advice and assistance to English NHS Research Ethics Committees.

(2) In addition to the functions in paragraph (1) the Agency may—
(a) consider, and where appropriate, endorse guidance issued by other bodies concerning patient safety, clinical assessment and, with the approval of the Department of Health, the patient environment;
(b) with the approval of the Secretary of State, set local or national goals for improvements in patient safety, clinical assessment, the systems supporting research ethics committees and the patient environment;
(c) in relation to an assessment which it carries out under paragraph (1)(m), refer the practitioner the subject of the assessment to another body for particular tests or procedures notwithstanding that the individual who is to carry out the tests is not an authorised assessor; and
(d) in relation to an assessment which is to be carried out by another person on its behalf pursuant to arrangements made under paragraph (1)(m), include provision in those arrangements to the effect that that other person may make such a referral.

(3) In exercising the functions in paragraphs (1) and (2) the Agency shall have regard to the following factors—

(a) any guidance from the Secretary of State on the resources likely to be available to the NHS and any other relevant guidance from the Secretary of State; and

(b) the effective use of available resources.

(4) The Agency must obtain the consent of the Secretary of State to the issue of any good practice and other guidance and to the determination of any criteria, methods or procedures developed by the Agency.

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Memorandum by Together We Must (COM 90)

1. Together We Must has been established in the last few days to promote the following ideas.
   
   1. Participatory service redesign is an alternative to public service cuts. Those who work in the services and those who receive the services must be empowered and inspired to reshape them so as to provide better services at lower cost—this cannot be delivered by accountants, bureaucratic managers and top down methods.
   
   2. Keynesian monetary creation at local level can bring idle resources into use to meet social need. This can fund the eradication of poverty, the development of communities, environmental improvement and local green infrastructure developments
   
   3. The burden of taxation is not reduced if it simply shifts costs to the people to be borne in a less efficient and more expensive way.
   
   4. Indicators of health and well being are a better measure of the performance of a society than economic indicators.
   
   5. The three Es of equity, empowerment and the environment are key to human health and well being and therefore to economic success.
   
   6. The debate about taxation of the most productive members of society must move on from the “low tax for incentives/high tax for fairness” debate which wrongly assumes the most productive members and natural leaders of our society to be greedy, selfish and venal. The concept must be of stewardship involving their skills, energies and idealism in creating a greener and fairer society.

2. As we have only existed for a few days this evidence is inevitably brief.

3. The first of our six key ideas is directly relevant to your enquiry.

4. Commissioning is identifying the needs that a defined population has for health care and translating that into the services the population receives.

5. Commissioning, so defined, is essential to any health care system planned to meet need.

6. The creation of a market nexus between commissioners and providers is not an essential part of commissioning.

7. We believe that considerable progress towards providing better services at lower cost can be made in most public services by methodologies which involve service users and staff fully in that process. This has been achieved elsewhere but not in the UK and we believe that the reason it has not been achieved in the UK and we believe that it has not been achieved here because of the top down style of government and managers which turns citizens into demanding consumers without any financial responsibility for their demands which they view as entirely separate from their equally vociferous demand for lower taxes, and which turns staff (even senior professional staff) into alienated and demoralised observers.

8. In the NHS we believe that considerable savings can be made by service redesign and by reducing unnecessary demand.

9. This requires close collaboration between GPs and consultants, the full involvement of the public, and managers working together across the interface. It cannot be achieved by a market.

10. We are grateful to the BMA for the following example of why this will not work.

11. In district A the cost of providing the services which the population receive is some 3% above the funding currently available to the PCT. The hospital has a surplus which Monitor regards as dangerously small in comparison to its turnover. The reason this situation has arisen is that the hospital has failed to achieve the 3% Treasury efficiency savings and the PCT has underestimated the growth in demand for services. The hospital is under pressure and has difficulty meeting waiting list targets.
12. To bring this system into balance requires reduced costs of care. It would be possible to do this by the PCT taking harsher rationing decisions, the PCT funding community services to ease the pressure on the hospital by facilitating earlier discharge, clinicians cooperating to avoid some unnecessary use of services, and lean health care being used to reduce costs. By these approaches the system should save considerably more than 3% and fund growth.

13. However if the hospital increases the activity it carries out it can earn more money and avoid harsh decisions about costs. It has set up information systems to code activity more effectively and business models aimed at persuading GPs to refer more patients more people to come to A&E. This will worsen pressures on the hospital and the financial state of the health economy but nonetheless it is a rational decision for the hospital as it can treat more patients at marginal cost (lower than the tariff as its overheads are already met).

14. The PCT can route patients into an intermediate care system to monitor referrals and save money and incentivises its GPs to reduce referrals. It spends money on these systems.

15. The activities of the two organisations are both rational in market terms but do nothing to solve the problems of the system. The PCT cannot provide community services to ease the pressure on the hospital by facilitating discharge because it will cost money and will not save on tariffs unless precisely (and clinically inappropriately) focussed on break points when length of stay triggers extra payment. The hospital cannot turn away referrals because it will lose income. The hospital has a theoretical solution to its problems but only by making its pressures worse and earning entitlement to money that doesn’t exist (a classic toxic asset). The PCT has a theoretical solution to its problem but only by destabilising its hospital. If they realise this and work together to solve their shared problem in an intelligent way they will breach competition principles.

16. It is also important to have regard to Pigou’s Theorem which is better understood in the transport field but nonetheless is relevant to hospital care. This states that markets alone will not achieve allocative efficiency where there are high entry costs and a downwardly sloping cost curve because if the price is set so as to recover the entry costs then at the point where the market clears there will be unused capacity. However if that capacity is sold at marginal cost it will undermine the willingness of those who would have paid the full price to do so, thus threatening the return on investment.

17. There are a number of ways to deal with Pigou’s problem from subsidy of infrastructure (such as the commissioner-owned infrastructure adopted in Transforming Community Services) to two part pricing structures (such as the cheap but otherwise unattractive tickets developed by railways and airlines).

18. What is entirely unworkable is to set a tariff based on average cost and then promote unrestricted use of the capacity at that price. This will simply result in an unaffordable system. Exactly what has happened. Exactly what would have been predicted by anybody who understood markets instead of simply having a blind faith in them.

19. Our other five key ideas are also relevant to the NHS but not perhaps to your current enquiry although we look forward to opportunities to present them to you on other issues.

September 2009

Memorandum by the Specialised Healthcare Alliance (COM 91)

1. The Specialised Healthcare Alliance (SHCA) is a coalition of 44 patient organisations supported by ten corporate members, which campaigns on behalf of people with rare and complex medical conditions for whom key services cannot be sensibly planned, procured and delivered at a local level. It is chaired by Baroness Pitkeathley.

EXECUTIVE SUMMARY

2. The principles of world class specialised commissioning pre-date the World Class Commissioning programme and are laid down in the Carter Report of 2006.

3. The genesis of the Carter review was the recognition that Primary Care Trusts (PCTs) were not collaborating effectively in the specialised arena to the potential detriment of people in need of specialised care.

4. The need for collaboration hinges on optimising the development and use of clinical resources for relatively smaller patient populations for whom the NHS is also uniquely well placed to share financial risk.

5. Carter therefore proposed, and the Government accepted, that responsibility for such services should be clarified and rest with the National Commissioning Group for the rarest of the rare and ten regional Specialised Commissioning Group for all other services in a revised National Definition Set.

6. To ensure proper provision and equity of access, Carter laid down that services should be funded through budgets pooled between the constituent PCTs in each SCG on the basis of weighted capitation. Furthermore, to ensure standards of safety and quality, providers should be designated according to agreed service specifications and a full understanding of costs along the patient pathway.
7. Significant progress has been made since Carter, with ten SCGs now in existence and revision of the National Definition Set at an advanced stage. The extent of genuinely collaborative commissioning is, however, highly variable and, in many parts of the country, limited. In particular, despite encouragement in the two DH Operating Frameworks following publication, financial risk-sharing is rare while designation of providers and, more importantly, the knowledge required to underpin it, has scarcely got underway.

8. The reasons for this limited progress more than three years after Carter’s adoption by the Government are manifold, including the scale of tasks such as designation and the availability of limited resources. Crucially, however, Carter depends on the willingness of PCTs to share sovereignty and resources in a way which is counter to their instincts and the rhetoric of localism. This reluctance to implement world class specialised commissioning may well grow as PCTs look to protect local services in the downturn, to the detriment of clinically and cost effective specialised care.

9. The unacceptable consequences of these shortcomings for patients have been highlighted in a number of recent All Party Group reports covering muscular dystrophy, Parkinson’s disease and spinal injury.

10. Although the principles of Carter remain sound, the SHCA is doubtful whether PCTs will ever give them sufficient support across the country. At the same time, top-slicing, as employed to fund the work of the National Commissioning Group, is a source of constant and unnecessary resentment. Far better, in the Alliance’s view, to build on the foundations which have now been laid by changing funding flows so that money is routed directly to the NCG and SCGs, with the latter sitting in their respective SHAs rather than a lead PCT.

11. Localism is an important principle but the very existence of the NHS confirms its limitations. Local people need specialised services but they cannot be effectively funded and provided at a local level. Dogma about maximising the proportion of funds flowing to PCTs is misplaced. The appropriate commissioning tier should receive its funds direct and be held to account for their use.

**Pre-Carter**

12. Prior to the Carter Review and Report, nationally commissioned services were managed and funded within the Department of Health through the National Specialised Commissioning Advisory Group (NSCAG), mainly comprising a range of eminent clinicians and reporting to Ministers. All other specialised services, legally defined as involving planning populations in excess of one million, sat in the NHS but with collaborative commissioning taking place on a purely voluntary basis. In particular, associated guidance from the DH recommended that services with planning populations of one to two million should be managed by 25 Local Specialised Commissioning Groups broadly aligned with the then 28 SHAs, while services with planning populations of three to six million should be managed by eight Regional Specialised Commissioning Groups. This left huge scope for confusion, not least for planning populations of more than six million but falling short of nationally commissioned status.

13. Research published by the SHCA in the spring of 2004 suggested that collaboration between PCTs was for the most part patchy and that large swathes of the Specialised Services National Definition Set had not been addressed. Associated weaknesses included a lack of risk sharing, poor availability of patient data, very limited patient involvement and a general absence of transparency. In the context of increased localism, the SHCA was concerned that money intended for specialised services would be diverted to more pressing priorities at PCT level, with hard evidence being adduced by members such as BLISS and the Terrence Higgins Trust. More broadly, a typical comment from the NHS was that specialised commissioning always tended to be an afterthought in health policy.

**Carter**

14. Against that background, the SHCA warmly welcomed the decision of Lord Warner, then Minister of State for Health, to invite Sir David Carter to undertake an independent review of specialised commissioning and was pleased to sit on the review group.

15. The Carter review superseded an Audit Commission study of specialised commissioning. The Audit Commission nevertheless fed in the results of a survey it had conducted which found that there was considerable geographic variation in approach to specialised commissioning, a need for greater engagement in the commissioning process and a lack of management tools for commissioners. Furthermore:

- the influence of patients and SHAs on commissioning was seen to be unimportant;
- under staffing and skills problems appeared widespread; and
- about half of growth funds were reported as being diverted in-year by individual PCTs to other services.

16. The Carter Report concluded that much more robust and consistent ways of working were required with key recommendations including:

(a) a National Specialised Services Commissioning Group (NSSCG) to coordinate specialised services commissioning across all regional groups (see below) and to provide a framework within which binding commissioning decisions requiring pan-regional agreement can be made;
(b) national commissioning to be conducted where appropriate by a sub-group of the NSSCG, the National Commissioning Group using transparent and published criteria in providing advice to Ministers on designation;

(c) responsibility for determining the arrangements for all other specialised commissioning to be vested in ten Specialised Commissioning Groups aligned with the new Strategic Health Authority boundaries and acting on behalf of all PCTs in the SHA area;

(d) budgets for SCGs pooled from PCT allocations to promote robust, long-term commissioning arrangements and manage financial risk;

(e) periodic designation of specific service providers to ensure quality and safety with strong patient and public input;

(f) SCGs to work closely with their clinical networks to ensure that commissioning and investment plans support the delivery of integrated care;

(g) the DH to initiate an immediate review of the Specialised Services National Definitions Set with a view to more balanced and consistent coverage with clear criteria for inclusion;

(h) SCGs and the NCG to contribute annually to an NSSCG website giving details of their commissioning arrangements including contact details for the lead commissioner for each specialised service;

(i) SHAs to ensure strong performance management of specialised services commissioning, ensuring that PCTs have appropriate arrangements in place for collaborative commissioning and that SCGs are working effectively.

(j) performance assessment of PCT commissioning by the Healthcare Commission to include the commissioning of specialised services;

(k) a higher profile for specialised services and their commissioning arrangements within and outside the NHS with commissioning given greater prominence in career options for managers and clinicians.

17. The SHCA warmly welcomed the report, which was rapidly adopted in all its essentials by the Government. The focus of attention then moved onto implementation.

POST CARTER

18. The starting point for implementation of Carter was establishment of the SCGs, recognising that the culture of collaborative commissioning was relatively well developed in some regions eg West Midlands and in others hardly at all eg South West. In particular, the report recognised the importance of binding decision-making and delegated authority with a view to SCGs and the National Specialised Commissioning Group being able to take decisions without constant referral back to constituent PCTs.

19. The report also set out a number of timelines for key elements of specialised commissioning. These included immediate revision of the National Definition Set; initial pooled budgets for a specified minimum list of 25 services by April 2007, expanding to all services in the NDS by April 2008; full quantification and costing of disaggregated service costs by April 2008; and designation of all specialist providers by 2010.

20. The timetable for implementation was probably always over-optimistic but nevertheless the rate of progress has been disappointing. After a slow start, revision of the National Definition Set is now advanced with completion projected for next year. Carter had, however, envisaged the NDS encompassing nationally agreed service standards and clinical outcome measures, whereas in practice it has been largely limited to a clinical codings exercise. Delivery of service standards and the like shifted to the designation programme; a legitimate decision undermined by the glacial rate of progress.

21. More fundamentally, while many SCGs have apparently large budgets, in some cases approaching £1 billion, very few of these are genuinely pooled in the sense that risk is shared across the region regardless of the incidence of a disease in a particular PCT.

22. The three main approaches to budget calculation are actual by PCT, three-year weighted average, again by PCT but helping to even out some of the peaks and troughs, and weighted capitation, where the cost of a service is shared according to the number of people in a PCT.

23. The incidence of rare and complex conditions requiring specialised services is arbitrary but can generate very substantial costs in a particular PCT. At the very least, this means that major treatment decisions are likely to be referred back to individual PCTs, undermining the role of the SCG in a way which is completely at odds with the principles of Carter. More importantly, it can put pressure on optimum care, for example if a large potential bill arises towards the year-end there may be a temptation to delay treatment.

24. As one commissioner put it, in theory there would be financial sense in re-housing families with some rare conditions in neighbouring PCTs. It is perverse that this situation should arise when the taxpayer funded nature of the NHS initially shares risk across the entire population.
SCG Survey

25. As part of its preparations for the Committee’s inquiry, the Alliance undertook a small survey of SCGs. A full set of 10 replies has been received but it has not been possible to analyse these fully before the deadline for submissions. The following observations may, however, be of interest to the Committee:

- none of the SCGs commissions all of the services in the National Definition Set. The maximum number of service categories reported to be fully commissioned by any SCG is 28 out of 36 and the minimum is six. There is scope for confusion between individual services and NDS categories which may cover several services eg in the field of cancer, neurosciences or mental health. It is common for services to be planned but not procured or planned or procured by some PCTs within the SCG only;
- mapping and costing of services is often dependent on their coverage by Payment by Results, which is limited, and otherwise based on historical costs;
- the nature of PCT and SHA representation at SCG meetings is highly variable with PCT Chief Executives attending in significant numbers in some regions but scarcely at all in others. Similarly SHA representation ranges from Director-level to not at all; and
- the very welcome achievements cited in the responses tend to concentrate on issues such as IVF, neonatal intensive care, renal services and mental health.

26. We separately ask SCGs to let us know each year who is the designated lead commissioner for each service category within the National Definition Set. Carter recommended that such information should be included on SCG websites as an aid to greater accountability and transparency but few do so. It is notable that there seems to be considerable turnover in the individuals specified; that they often cover large swathes of services; or that no one is nominated, even on occasion for services which the SCG reports as being collaboratively commissioned.

Patient Perspective

27. SCGs deserve congratulation for bringing about significant improvements in some services. This is perhaps best described in an article by Nicholas Hunt (Health Service Journal 8th January 2009), Director of Service Development at Royal Brompton and Harefield Trust, which highlights the transformation in knowledge and expertise since responsibility for commissioning cystic fibrosis services transferred from PCTs to SCGs. This is seen as having brought about savings to the health economy as well as better standards of care, crucially combining delivery in tertiary and local settings. The Cystic Fibrosis Trust is thought to share much of this view.

28. Less positively, a recent All Party Parliamentary Group on Muscular Dystrophy concerning Access to Specialist Neuromuscular Care observes a dearth of engagement by specialised commissioners with poor diagnosis, a large gap in mean life expectancy for those with Duchenne from 19 years in the South West to 30 years in the North East and closure of specialised wheelchair services at Stanmore without adequate replacement, despite their specialised status.

29. The All Party Group for Parkinson’s Disease has also published a report recently into Access to Health and Social Care. In particular, the report notes difficulties in obtaining funding from PCTs for deep brain stimulation. This was originally commissioned at national level and is one of the few services which all SCGs claim to commission, underlining questions about the robustness of funding arrangements, which should preclude the need for exceptional funding decisions by PCTs.

Assessment

30. In general, the principles of specialised commissioning laid down in the Carter Report hold good. Significant progress has been made in a number of areas but the rate of progress is slow and the wider NHS’s commitment in some doubt.

31. When Carter was published, the hope was that the clamour for services to be commissioned nationally, with discrete budgets top-sliced from PCTs, would die down and that there would be more two-way traffic, with services moving in and out of nationally commissioned status. Thus far, these hopes have been disappointed with the number of nationally commissioned services rising from 33 in 2005/06 to over 50 today. The problems reported with deep brain stimulation since it was devolved to SCGs provide some explanation.

32. The structural problems at the heart of SCG commissioning are perhaps best exemplified by the attitude of regulators and its status within the DH’s current World Class Commissioning programme. As a consequence of the purchaser provider split, the Healthcare Commission extended its sphere of interest to commissioning. The Alliance, however, had extreme difficulty in persuading the Commission to take an interest in specialised commissioning because legal responsibility lay with PCTs, even though they vested that responsibility in SCGs in relation to specialised services. The first indications are that the Care Quality Commission will similarly struggle to square the circle, leaving specialised commissioning in a form of regulatory limbo.
33. This phenomenon is also exemplified by the World Class Commissioning programme. The SHCA pressed vigorously for WCC to apply to specialised services with a separate assurance scheme recognising the different arrangements involved. The DH eventually produced documentation for World Class Specialised Commissioning but this only partially reflected those differences and, crucially, was excluded from the mandatory assessment applied to PCTs. In consequence, SCGs are free to adopt WCSC as they see fit or not at all, again leaving 10 per cent of NHS activity in limbo.

34. Structural and financial issues come together in the reluctance of PCTs to share risk on the basis of weighted capitation. Although risk sharing has been separately encouraged by the Audit Commission, the propensity to do so is probably in inverse proportion to the need. The effectiveness of the approach is therefore dependent on having a sufficiently large pool of risks to ensure that what an individual PCT loses on the swings it will gain on the roundabouts. The incremental approach to implementation of the National Definition Set means that PCTs are likely to look at individual risks and prefer to hold on to what they consider to be their money.

35. In these two interrelated respects, the Carter arrangements have shown themselves to be vitally flawed, putting SCGs in an invidious position, which is likely to worsen as financial pressures grow in the NHS.

CONCLUSION

36. The NHS now has the right tiers of commissioning to deliver high quality services to patients depending on the nature of their condition at practice, local, regional or national levels. In the case of specialised services, however, there are flaws which need to be addressed:

**National Commissioning Group**

37. NCG services are ultimately determined by Ministers but funded through top-slicing of PCT budgets. Ministerial involvement makes sense given the strategic nature of such decisions but top-slicing causes considerable and avoidable friction. It would be better for money to be channelled directly to the NCG with performance management conducted by the Department.

**Specialised Commissioning Groups**

38. SCGs sit in a financial and regulatory limbo with SHAs given the task of performance management but responsibility formally residing with PCTs, while pooled budgets exist in largely nominal terms from a risk-sharing perspective. SCGs have considerably more potential to deliver clinically and cost effective specialised services than has yet been realised. Consideration should therefore be given to channelling funds direct to SCGs and re-locating them at SHA level.

September 2009

Memorandum by UnitedHealth UK (COM 92)

INTRODUCTION

1.1 UnitedHealth UK welcomes this opportunity to submit evidence to the Health Select Committee’s inquiry into commissioning within The National Health Service (NHS). The purpose of this note is to comment on the role that effective commissioning should play in ensuring high quality outcomes for patients and efficiencies within the NHS; the role of the private sector in supporting Primary Care Trusts (PCTs) and Practice Based Commissioners enhance their commissioning capabilities; and evidence that demonstrates that UnitedHealth UK is already working in partnership with the NHS to deliver results.

THE ROLE OF EFFECTIVE COMMISSIONING

2.1 For 60 years, the NHS has provided comprehensive access to primary and acute care services to all long-term residents of the United Kingdom (UK). Free at the point of care and financed through a progressive tax code, the NHS is one of the oldest examples of an attempt to reduce individual inequity of access to a desired good-health.

2.2 However, as with many other health systems throughout the world, it faces significant financial pressure caused by changing demographics, technological advances, and increasing individual patient expectations.

2.3 While the NHS budget grew on average at 7% per year in the last century, a recent report published by the King’s Fund predicts that the NHS would have to increase productivity by 3.4 to 7.4% in order to fill potential funding gaps as a result of the worsening fiscal climate—equaling gains of £3.6-7.8 billion per year.237 The increasing burden of chronic disease, the tendency for people with chronic illness to have multiple co-morbidities, and the rapidly aging societies of the industrialised world compound the fiscal

challenges facing the NHS. For example, in the UK there are more than 15.4 million people living with long-term conditions. This number is expected to increase 23% over the next 25 years. Further, evidence from a number of PCTs shows that a small percentage of patients (from 5 to 10%) drive more than 40% of NHS costs.

2.4 Improved commissioning, managing clinical-care pathways, and using care-management strategies are among the best options for organising and financing an NHS that can meet today’s health care challenges. In the Next Stage Review, Lord Darzi established a 10-year vision for an NHS that is fair, personalised, effective, and safe. World Class Commissioning (WCC) is an essential component in establishing policies that spread this vision across all PCTs and communities.

2.5 Automated technologies that enable use of patient, provider, and population data regarding quality and cost means that commissioners can make decisions based on real-time evidence. Providing commissioners with support from expert organisations—both public and private—is a key strategy to making evidence-based commissioning a reality.

2.6 With a wide and ambitious range of high-level policy objectives, public-private partnerships that improve NHS commissioning provide a powerful lever to build consistency among objectives and initiatives; to create innovative solutions within the NHS itself; and to translate policy into meaningful health improvement for patients.

2.7 The range of Department of Health (DoH) goals and initiatives combined with the current financial outlook necessitate strong organisational capabilities that produce meaningful productivity and quality improvements. Specifically, initiatives advanced by public-private partnerships include: WCC; Practice Based Commissioning; Integrated Care; Expanded Consumer Choice and Provider Competition; Quality, Innovation, Productivity and Prevention (QIPP); The Quality and Outcomes Framework (QOF); and Public Reporting of Quality Data.

2.8 Through risk-sharing arrangements and other mechanisms, UnitedHealth helps PCTs to implement the strategies that we recommend. While these are still in early stages of development, initial evidence suggests that more time and increased project-scale can produce outcomes consistent with the WCC agenda, and all WCC competencies.

2.9 Through collaboration with private companies and building on the work already underway in the NHS to commission health services, the NHS has a unique opportunity to harness the capabilities and experiences of the private sector to help it deliver improved outcomes for patients.

2.10 As such, we believe that external contractors that implement practical solutions should be viewed as an integral part of reform and used to their full capacity to: improve use of data; redesign clinical care pathways; drive evidence-based policymaking and adherence to clinical standards; transfer knowledge and performance management techniques; and empower patients to make informed choices.

ABOUT UNITEDHEALTH UK

1.1 UnitedHealth UK is the UK company which forms part of UnitedHealth Group—a leading international health and well-being company that commissions care and provides health management services to over 70 million individuals.

1.2 UnitedHealth UK has been working in partnership with the NHS since 2002, drawing on our global expertise and experience to deliver commissioning and health management solutions with all parts of the NHS, including DoH, Strategic Health Authorities (SHAs), Specialised Commissioning Groups (SCGs), PCTs, and Practice Based Commissioners (PBCs). UnitedHealth UK also holds five Alternative Provider Medical Services (APMS) contracts for GP and primary care services.

1.3 We believe that world class commissioners proactively orchestrate health systems to ensure continuous improvement in health outcomes for their local population. To do this, they need to be underpinned by information technology and tools to drive evidence based practice and to measure, improve, and report health outcomes and patient and public engagement.

1.4 Our work with the NHS includes the provision of the tools, people, and processes to support four key areas:

— Population Health Needs Assessment - understanding the specific needs of a local population, the healthcare community, providers, and individual patient needs
— Clinical Services Redesign—reconfiguring the health care delivery system to support the highest quality and most efficient individual clinical needs
— Contracting and Performance Management—defining and negotiating contracts, managing relationships with acute and community providers underpinned by robust and evidence based data
— Population Health Management—improving the effectiveness of care delivery for individual patients through proactive interventions and empowering patients through the provision of information and decision support programmes

1.5 There are a number of key principles which underpin the work we do with the NHS to support best practice commissioning that can deliver real value:
— A culture of using data to drive decision making (and the skills and tools to identify sources of data, to clean, and to improve this data) and the skills and competencies to systematically use data as part of operating within a PCT/Practice Based Commissioning Group.

— Use of evidence based practice to underpin commissioning decisions. Despite high quality tools available to PCTs (eg National Institute for Health and Clinical Excellence (NICE) Commissioning Guidelines and Map of Medicine), these are not systematically used within the NHS to support commissioning.

— Technology infrastructure and enablement that supports PCTs/PBCs to bring together disparate sources of information (eg SUS data, GP data, census information) and layers intelligence upon it (eg Evidence Based Medicine rules or population based risk stratification tools) to enhance decision making.

— A culture of delivery and execution: identifying outcomes, performance managing implementation, bringing robust and rigorous programme management, and driving rapid change.

3.6 UnitedHealth UK is an approved supplier under the DoH Framework for Securing External Support for Commissioners (FESC). To date we have worked with up to 60 PCTs. Some of our key FESC work includes partnerships with the following PCTs: Northamptonshire PCT, Northeast Lincolnshire PCT, Berkshire West PCT, and the South Central Specialised Commissioning Group. For some of these contracts we have taken risk, meaning we do not get paid our fees unless we drive savings for the PCTs.

CASE STUDIES

4.1 The following case studies provide examples of partnership working already underway to enhance NHS commissioning.

Case Study: Northamptonshire Primary Care Trust

Background

UnitedHealth holds a three-year contract with NHS Northamptonshire (NHSN) under FESC. The contract has four major work streams in the initial year, including: (1) health needs assessment; (2) performance management; (3) patient experience; and (4) communications and social marketing. UnitedHealth staff are partnering with NHSN staff on each of the work streams, drawing on support from UnitedHealth Group solutions and data analytic capabilities from the US.

Core Objectives and Outcomes: What is being Done?

June 2009 marked the end of the first year of the contract. Whilst it would be early to expect substantial quantitative results, there have been achievements that provide insight into the potential impact of the FESC partnership arrangement.

Health Needs Assessment

— UnitedHealth is undertaking an in-depth assessment to determine the health needs, disease burden, health access inequalities and outcome inequalities of the population. The assessment has started to specify investments necessary to improve health outcomes. Specifically, health needs assessments and equity audits were carried out in five NHSN priority areas: health failure, stroke, COPD, diabetes, and maternity. The team has deployed actuarial modelling techniques not traditionally been used in this sphere in the NHS.

— The team are working together to redesign a care pathway for patients with Cardio Obstructive Pulmonary Disease (COPD). Using international best practice, the pathway is based upon analytical data and will include an accelerated consultation process, which will become a model for other clinical services redesign.

— UnitedHealth prepared a Programme Budgeting Marginal Analysis report, which builds a systematic approach to identify areas for the PCT to drive efficiency and improve health outcomes.

Performance Management

— UnitedHealth has implemented sophisticated acute invoice validation (AIV) tools to increase programme efficiency. AIV confirms that payments are consistent, not only with the services provided, but with care according to evidence-based standards. AIV and clinical audits have already contributed to £144,000 of savings within the first few months. Manual audits of coding and clinical practice already completed or scheduled are expected to produce £1.07 million between July and December 2009.

— The team has developed a savings work plan that has identified savings of £6.9 million—with an additional £15.9 million projected savings through initiatives under development.
A monthly validation tool (MVT) that can be used as an early warning system to identify data quality and coding issues for the Trusts was developed and implemented and is projected to return £1.3 million in savings each year.

Data system enhancements were implemented, allowing an automated transition from quarterly to monthly health care utilisation data. This change has not only enabled more timely use of data for intervention, but has assisted the PCT in meeting the national reporting target.

Communications and Social Marketing

UnitedHealth developed the thrive worksite wellness programme; a targeted, data-driven employee wellness strategy designed to improve and maintain employee health. Phase 1 of thrive was launched in May 2009 and specifically targeted at NHS Northamptonshire employees.

Phase 1 of thrive was launched in May 2009 and specifically targeted at NHS Northamptonshire employees. Staff were invited to undergo an individual health needs assessment and respond to a cultural health audit. Based on employee feedback, Phase 2 of the programme will provide each participant with a “Personalised Wellness Programme”, enabling staff to track their own health statistics over a period of time. The Wellness Programme will include weight and hypertension management, as well as opportunities to participate in physical activity and wellbeing programmes.

Nearly 75% of staff participated in the thrive health needs assessment and approximately half completed the cultural health audit. The programme aims to sign up 100 employees to the personalised wellness programme by September 2009. The success of thrive will be measured on a regular basis by using different comparisons against the baseline data compiled at programme commencement.

UnitedHealth will work with the organisation to target a broader range of stakeholders within the local health economy and NHS Northamptonshire priority groups.

Case Study: Northeast Lincolnshire Care Trust Plus (CTP) and Community Engagement

Background

North East Lincolnshire Care Trust Plus (NEL CTP) commissioned United Health UK to support the development of a community engagement model. The CTP is comprised of 177,000 residents served by 33 General Practitioner (GP) practices. The initiative uses a community-membership model to involve stakeholders, including patients, in decision-making and learn about the preferences of the population of North East Lincolnshire. The stakeholder engagement initiatives established make a special effort to include “hard-to-reach” and vulnerable groups.

Core Objectives and Outcomes: What is being done?

To implement the model, UnitedHealth supported the CTP in the election of 18 public representatives to the emerging ‘Commissioning Group Boards’. The representatives are elected from a community membership group of 2,200. Seven of the elected representatives sit on Commissioning Group Boards where they will have a majority vote in the commissioning decisions of the CTP. Any member of the community is eligible to join the larger community-membership group.

UnitedHealth have worked alongside Membership Engagement Services (MES) to implement this Model within NEL CTP.

To roll-out the community engagement strategy, UnitedHealth staff:

- Developed a Community Engagement and Accountability Framework;
- Recruited Community Engagement Workers;
- Developed draft volunteering and reimbursement policies; and
- Launched a mass community membership outreach plan, including mailing letters to all households and hosting ‘roadshows.’

Next Steps

Next steps include setting up a NEL CTP community engagement resource bank; developing a comprehensive Communications Plan; agreeing on performance metrics; and developing a process for gathering continual evidence on the effectiveness of community engagement initiatives and how these initiatives can feed into the commissioning of the most appropriate health care.
Case Study: South Central Specialised Commissioning Group

Background

UHUK works with South Central Specialised Commissioning Group (SCSCG) under a FESC contract to improve commissioning for specialised and acute-care services with 17 London hospitals. Representing 3.9 million patients in the geographical areas of Buckinghamshire, Hampshire, Berkshire, Isle of Wight, and Oxfordshire, SCSCG commissions care for the population and meets regularly with providers and stakeholders to strategically address and measure quality improvement.

Historically, PCTs determined their contract budgets largely based upon prior experience, rather than through an analysis of population health risks and appropriate case-related hospital payments. Currently and in line with WCC, UHUK is working with SCSCG and London hospitals to move toward a system that pays for and measures quality and efficiency.

Core Objectives and Outcomes: What is being done?

— Programme Management. UHUK staff manage contract negotiation and other aspects for provider relationships with the London hospitals.
— Reporting. UHUK works with hospitals to improve monthly submission of consistent and high quality cost and utilisation data. UHUK is also developing a provider handbook comparing prices and bundles of services at the Health Resource Group (HRG) level. Monthly reporting has been achieved and based on the data, performance reports have been developed for each individual PCT and individual action plans have been created for each provider.
— Knowledge Transfer. UHUK staff, who physically work within the SCSCG offices, share business practice and arrange staff training sessions on a range of commissioning-related issues.

Currently, UHUK is actively pursuing quality and price data that will be used to compile standard cost and outcomes data and specify components of episode-based payment across hospitals. This capability will enable UHUK together with the SCSCG to advance a strategic quality improvement plan for the patients in the partner PCTs.

Conclusions

5.1 To achieve the goals of improved quality and access while meeting important productivity and efficiency targets, successful commissioning with tested external organisations should be continued and expanded.

5.2 The current fiscal climate and quality improvement agenda suggest an increasingly important role for good health care commissioning. Public-private partnerships can provide an essential component of improved commissioning, providing strategic needs assessments, improving data capabilities and usage, redesigning care pathways and measurement, and improving provider contracting and performance management.

5.3 The fundamental success of WCC depends upon a number of key themes, including:
— Creating a culture of using data to drive decision making (with skills and tools to identify sources for, to clean, and to improve data) and the skills and competencies to systematically use data as part of PCT and Practice Based Commissioner operations.
— Using evidence based practice to underpin commissioning decisions.
— Bringing technology infrastructure and enablement that supports PCTs and Practice Based Commissioning Groups to bring together disparate sources of information and layers intelligence upon it to enhance decision making.
— Creating a culture of delivery and execution.
— Bringing willingness to take risk and to be paid on the basis of results.

5.4 A new Cabinet Office review of DoH activity praised improvements made, but suggested that it also improve the coherence of its vision. Areas for improvement cited in the review included to the need to: “select direction; build capability; focus on outcomes; base choices on evidence; develop clear roles, responsibilities and delivery models; and ignite pace, passion and drive.”

5.5 Based upon the evidence provided, these “areas of needed improvement” overlap with the value that private sector support can bring to enhance commissioning in the NHS. Therefore, focusing private-sector involvement on these core functions—building an evidence base and using that evidence to redesign and integrate care pathways and programme management/will provide the greatest gain from a public-private sector strategy, pulling the themes of reform together within an action plan.

5.6 Allowing private companies more autonomy with commensurate increases liability for savings and quality improvements will bring increased value within limited budgets. FESC is unique in setting out a framework that allows for true partnership, for private companies to share risk and not simply to take fee for service payments for traditional consulting. There is significantly more value for the NHS in adopting this model for its relationship with private partners going forwards.

5.7 PCTs are not always able to build critical mass to be world class commissioners and to invest in the enablement infrastructure required to support this on an individual basis. Private companies can strengthen commissioning by providing enablement across multiple PCTs. This infrastructure needs to include enhanced informatics and other automated technologies that enable improved data collection and analytics; improved actuarial capabilities; population management techniques and robust evidence base. If this can be coupled with rigorous programme management, then the partnership between private organisations and the NHS will ensure that commissioning becomes truly world class.

September 2009

Memorandum by Alec Fraher (COM 93)

The views contained in this response are my own and do not represent the views of any other organisation or person.

WORLD-CLASS COMMISSIONING

1. I have responded to the Health Committee from an experiential perspective having been involved with a number of Local authorities and Primary Care Trusts for several years and have participated in the emergence of commissioning as a subject area in its own right. I am the author and architect of a number of approaches considered at the time of writing them as exemplars of best practice in mental health, learning disabilities, older people and substance misuse. I am a qualified social worker, although not currently registered, and Cipfa certificated Performance Manager with 28 years experience covering both adult and children’s services. Since 2002 I have been employed within local partnerships, have worked at a sub-regional and regional level and reviewed the commissioning and contracting arrangements, in service specific area’s, for 12 Local Authorities/PCT’s and worked directly for seven Local authorities, five PCTs, three regional and regional level and reviewed the commissioning and contracting arrangements, in service specific area’s, for 12 Local Authorities/PCT’s and worked directly for seven Local authorities, five PCTs, three National Charities and three locally (estate or city level) owned enterprise covering a multitude of programmers from Quality protects, Safeguarding Children, Youth Offending, Supporting People, Valuing People, Tackling Drugs, Every Child Matters, Neighbourhood Renewal, Service Transformation, Personalisation and World Class Commissioning. I have personally handled the accreditation and assessment of 200 providers from the public, voluntary and commercial sectors. And undertaken a regional review of s135 LGA 1972 arrangements.

2. In writing this response I have reflected on the work of Deming, Shewart, Brandenburger and Nalebuff, Peter Kraljic, Donald Shon, Marrianna Jennings, Prof Micheal Clarke, Art Kleiner, Rudolph Klein, Eugene Litvak, Don Berwick, Peter Senge, Prof Roger James, Prof John Seddon, Dr John Craven, Dan T Jones and Jim Womack. I do this having been mentored, formerly and informally, by Dr Phil Barden, Geoff Beacon, Geoff Elliott, Lavinia Weismann and Dr Lilly Evans.

3. Why? Well, as far as I can see it’s because those cited show up to some extent or another as the thought leaders or distributors in current public and social policy. And, the first observation I make and that I’d ask the Health committee to note is that the language and concepts used by those mentioned are not the language and concepts used when being trained in health and social care. This is not to say there is no connectivity there clearly is. It is to say that greater care is need when handling the re-use of these ideas and approaches as embedded aspects of the commissioning agenda.

4. Added to this jigsaw are the principles of how we now engage in commissioning activity as the rule sets are governed as much by case law and qualified by OFT, the Competition and Cooperation Panel and the EC. As they are also determined by the clinical wisdom of front line operational staff. That the OFT, the EC and Competition and Cooperation Panel have entered everyday conversation within the professions is a direct reflection on the importance attached efficiency, competition and competitiveness, the methods espoused beit LEAN, Kaizen, Theory of Constraints or Hard Systems Thinking are not intended to be the language and concepts used in every day practice but increasingly this has become so.

5. It is now, in my view, a question of whether the Health Committee consider it appropriate that this is so, and if so, in what combination are these idea’s/practices to be filtered down, by what means and approach and what is the impact on the wider health and social care sector, especially from a workforce development and retention perspective.

6. The language and concepts used are like any new technology and may bring about some efficiency and innovation but can in equal measure be disruptive and can have net result of producing ineffectiveness.

7. So, in addressing the matters the Health Committee raise my observation is that the concepts of purchasing, provider and commissioning are poorly aligned to the actual physical needs for service improvements, and this is largely because the wider strategic objectives for health improvement have been
established solely within a narrowly conceived physical context ie at the level of a PCT locality or LA boundary with little or no attention being paid to the wider socio-legal-economic context ie the universal service obligation (USO). The principle of solidarity and the bearing these obligations has on third party contracted provision. My own observations suggest little or no mitigation against a breach of the USO, the development of two and three tier health care and at worst the potential for economic crime may arise from the uncheked transfer of property rights from State Owned Enterprise (SOE) to the Third and Commercial Sector.

8. At present, as illustrated by the McKinsey Report and the FT rebuttal of Government control, an over reliance solely on the analysis of efficiency gains, (which it has to said, at the level of an organisation is useful) without firstly setting out the wider environmental and conceptual dimensions will inevitably mean that solid internal service improvements that boost performance at the level of an organisation but may not stand up to the impact of the many socio-economic externalities driven by the increased harmonisation within Europe, increased cross border mobility, and the emergence of a new health provider, namely the GP with specialist interests, may have an uplifting numerical impact in specialised areas traditionally provided by Acute NHS Trusts but also may work against the satisfaction of the universal service obligation to local residents as market opportunities diffuse or dilute a local focus as business development extends beyond that first commissioned.

9. A EU level perspective may help with these deliberations and I would ask the Health Committee to examine how the requirements of Article 152 (the promotion of health) of the Treaty of Rome are being satisfied and assess what work has been carried out to judge the viability of compliance with Article 95 (harmonisation) at the level of a local, sub-region and region, and the impact this has on the satisfaction of obligations arising from Article 152, and also on LA wellbeing powers and the relative economic purchasing power of PCT’s set against the new economic bargaining strengths of FT’s and GP based social enterprise and other newer primary care based commercial and NHS PCT provider interests.

10. In short, the economic presence and the interactions of the new institutions of health and welfare is poorly understood. And, critically commissioning strategy and commissioning practice are divorced from one another—commercialisation is and will continue to have an increasingly fragmenting effect on both. My concern is that the social protection of vulnerable adults and children may not be realised in this environment and that the interaction between public procurement law, EC law, contract law and social welfare law is so poorly constructed that service users or their carers may find it extremely difficult to exercise their rights of re-dress otherwise afforded by SEO’s, interfering with Human Rights responsibilities owed to service recipients by the State.

11. I would say that the concept of commissioning and impartially the WCC competency framework advances the concept of purchaser in words only, traditional approaches to purchasing remain. My observations suggest that the pattern of behaviour evident in 1990’s when introduced by the Griffith Reforms is not dissimilar to that of today. Purchasers (commissioners) are concerned with the effective and efficient purchasing of (volume) items/services against standard conditions of contract and agreed budgets. The wider concepts/competencies of World Class Commissioning facilitating the introduction of a common language and setting out promises that purchasers (commissioners) behave in a particular way but doing little to alter that which purchasers (commissioners) already believe they are going to buy. It is worth noting that the role assigned to procurement within WCC usually limits it to a functional and transactional role of handling the technical and administrative aspects of the process and fails to utilise the full and comprehensive approach advocated in the National Procurement Strategy. More than this, such a narrow view of this one area severely limits the scope of making use of the full range of procurement procedures and options available within EC Law. And this does little to challenge the often idealised standardisation of specifications and contracts.

12. In this scenario procurement is reduced to a functional and administrative role, WCC plays little attention to this area other than to say it is required and must be lawful.

13. In this sense purchasing and commissioning are one and the same, although in strict use, the terms should be markedly different. Indeed some would say that Purchasers are NOT involved in the procurement cycle and do not get involved in the technical and commercial evaluation of bids or design options. In health and social care the commissioner is often the purchaser and actually drives the procurement process. And this is often done without cognisance of the distinct and separate nature of a procurement cycle from both the stated commissioning cycle and purchasing cycle. And most crucially the knowledge of a particular service life cycle. In a study of work force retention in social care it was said that 2/3rds of new entrants left within 1yr of joining the independent sector.

14. Commissioning in its current form combines or subsumes the procurement and purchasing functions leaving commissioners ie purchasers open to a challenge of process violation and contestability. The waste inherent in these arrangements is staggering, not least because the move toward shared services and regional procurement hubs as an efficiency and streaming measure is premised on a false causal assumption and design fault.

15. Popular Myths. There are several myths and mis-conceptions around. One, purchasing/commissioning has primacy over procurement. From a financial, legal and democratic perspective they do not. Secondly, the assumption that procurement is an unnecessary bureaucratic process that is and can be
divorced from purchasing and post procedure award contracting will and does leave public authorities open to challenges of process abuse; Thirdly, that a transactional review of provider performance against a functional specification is the same as understanding a provider position in new and changing market conditions. It is not. And lastly, that EU Part B exceptions are best suited to all health and social work procure procedures. They are not and limit the scope an authority has to actually determine (i) whether or not competition will yield the outcomes sought and (ii) if so, which of the many procurement procedures will offer a sustainable long term benefit to service recipients. Part B limits the use of procedures to open and restricted, which work well in stable, easily specified and standardised arrangements. I am yet to see this work.

16. Additional myths. Often it is thought that Prince and Prince2 are suited to monitoring contract deliverables, they are not. They are reporting and programme governance arrangements that require a detailed assessment, and feasibility study to determine whether or not a particular service or outcome is attainable and if so how. Commissioning in health and social care is said to deal with a programme or scheme life cycle from inception/feasibility through to commission. All too often this agenda is driven by purchaser personalization and short circuits any examination of service system integration both operationally and procedurally when aligning the commissioning requirements with procurement. And lastly, a reliance on closed system data analysis as the means to performance manage individual providers is systemically flawed as personality driven decisions hold sway and substitute objective feedback loops.

17. In conclusion, its my view that we have some way to go before the visionary framework of WCC reaches fruition, understanding how the USO is satisfied while developing new health markets requires (i) that a relevant market exists and (ii) that the attributes of the market are made transparent and assessed against non personality driven processes. The only way that I can see this happening is if a procurement life cycle has primacy over both purchasing and commissioning. By procurement life cycle I am referring to the term as understood by INCOSE, the international standard for scheme development.

September 2009

Memorandum by the Royal College of General Practitioners (COM 94)

1. The College welcomes the opportunity to contribute to the Health Committee’s inquiry into Commissioning.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the “voice” of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 37,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. Clinicians wish to see the NHS using resources wisely and achieving the best outcomes for all patients. In addition, models of service provision will have to adapt to changing need. For example, people are living longer, meaning that the provision of care for patients, especially those with co-morbidities, will become increasingly complex. A strategic, long-term and community focused approach to commissioning services is required involving commissioners, healthcare and other professionals and patients working closely together to achieve improved health outcomes.

4. Practice-based commissioning (PBC) is about involving GP practices and other health and primary care professionals in the commissioning of services. GP practices are at the frontline of delivering patient care and can use their significant knowledge of the local population to identify patient needs, including those of specific individuals or groups. The College is actively involved in PBC programmes and aims to improve the quality of patient care by sourcing clinical expertise to support SHAs, PCOs and individual practice in PBC projects in partnership with experts in healthcare, leadership and organisational development.

5. The RCGP Patient Pathway Toolkit was launched in May 2006. This has been designed to assist PBC groups in developing and re-designing safe, well-considered, quality assured patient pathways within primary care.

6. PBC has the potential for public health benefit. However, the commissioning process must be improved. Commissioners require education and training to equip them with the skills required to deliver appropriate services to patients. Support is needed for GPs and others involved in commissioning; patients must be involved in setting priorities; and improved communication and IT systems are required. There needs to be a concerted effort by the NHS and commissioners to bring more diagnostics and better services to the community, including Out of Hours (OOH) care. Whilst good OOH care exists in some areas, the College has significant concerns about the quality and safety of patient care and the variability of services and training.

7. Primary Care Federations, which involve general practices and community primary care teams coming together in an association to share responsibility for developing and delivering services for their local community, would be in a strong position to play a major role as practice-based commissioners, providing that leadership and governance models could manage conflicts of interest and ensure probity, particularly in instances where Federations both commission and provide services.

8. PBC at local level is still in its infancy. This is partly because GPs have been slow to pursue PBC, but also because PCTs have been reluctant to delegate commissioning responsibilities to a community level.

RESPONSES TO SPECIFIC TOPICS AND QUESTIONS RAISED BY THE INQUIRY

“World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

9. One of the aims of the World-Class Commissioning (WCC) initiative was to focus PCT strategy on identifying the priority areas for investment and then working together with patients, clinicians, and its social service and local government partners to deliver more cost effective and equitable services for patients. However, it is arguable that PCTs have not fulfilled their commissioning role to date, largely because population need has not figured extensively enough in commissioning decisions. In order to be effective, commissioning must be evidence-based and led by the local epidemiology of common conditions and their impact upon the health of populations.

10. We are encouraged that WCC is putting pressure on PCTs to engage with GPs, particularly PBC groups. However, not enough services have been moved to the community and there has been too little investment in generalist person-centred services (as opposed to specialist disease-focused services).

11. Greater leadership and accountability is required at PCT level. Furthermore, the evidence that PCTs provide to demonstrate that they are adhering to WCC standards must be scrutinised by SHAs. Otherwise, we risk WCC becoming a paper-based exercise.

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

12. A purchaser/provider split should, in theory, create a system where users’ and carers’ needs are put first and competition between providers increases standards of patient care. It has allowed a certain degree of flexibility to involve non-NHS providers appropriately where there is need and spare capacity, and has led to more considered and sensitive commissioning in complex areas such as mental health. The purchaser/provider split has, as one commentator suggests, educated the provider organisations that their role is to deliver services that are needed rather than those which they have historically delivered. Many professionals would see the purchaser/provider split as necessary unless conflicts of interests can be accommodated in an integrated care organisation.

13. Other commentators have, however, suggested that the purchaser/provider split makes joint planning between purchaser and provider less likely and hinders the flow of information and sharing of expertise which is necessary to plan effective services. One commentator provided the following example of a situation where the “purchaser” is no longer engaged with clinical problems:

   The Director of Public Health used to be a member of the Senior medical committee, was frequently in the hospital talking with consultants, often the DPH was involved with sensitive staffing issues and his/her contribution was welcomed. This has been largely lost and there can be an additional problem where the DPH is no longer medically qualified and is less likely to be seen as an equal partner and colleague.

14. One perception is that the purchaser/provider split has resulted in competition rather than collaboration between primary and secondary care. This increasing gap between the two care sectors is bad for patients as they experience radical discontinuity as they move between sectors. System-wide approaches, encompassing primary, secondary and social care, are necessary to achieve improvements and one way to overcome this fragmentation would be the establishment of networks involving purchasers and a range of providers to share expertise and knowledge.

15. Organisational changes which result from the purchaser/provider split can be disruptive and result in the loss of staff experience and “organisational wisdom”. It is difficult to maintain strong links between healthcare providers and local authority services—particularly in Education, Social Services, Environmental Health and Housing—when there is persistent change, job instability and threat to personal security for key staff.

16. Some commentators have expressed concern that the split has resulted in the “financial bottom line” becoming the over-riding priority of NHS trusts. It is suggested that this narrows both motivation and aspiration, makes patient-centred care less of a priority and prioritises demand over need. One commentator perceived the system to assume that patients are able and want to exercise choice. However, there is an argument that most patients are not interested in choice but instead feel an affinity to their local health facilities and simply expect these to be of a high standard.

240 Primary Care Federations—Putting patients first (RCGP, 2008) http://www.rcgp.org.uk/PDF/Primary%20Care%20Federations%20document.pdf
17. Others have questioned the cost/benefit for patients and tax-payers, highlighting the opportunity costs for such a system and its potential to set up perverse incentives (eg expensive alternative provision to try and divert people from A & E and out-patients).

18. One or two commentators felt strongly that the purchaser/provider split has not been a success because of poor quality data, poor quality commissioning and ineffective monitoring of contracts—which have been, until quite recently, overly focused on “activity” and “cost” rather than “quality”.

Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

19. Contestability and the quasi market

The quasi market, is arguably, a very powerful mechanism to achieve change, but one which can come with a cost. Contestability and the quasi-market rely upon purchasers knowing what outcomes are required from a service and being able to identify what resources are available. Tendering out services should, in theory, deliver more cost effective services, but because of the difficulty in defining outcomes, and with the need for profit/savings to be achieved, unforeseen circumstances can result.

20. The quasi market introduces competition to run services, particularly for services where significant government spending occurs. Unless GPs and practices are fully equipped to engage in the tendering process, other providers are likely to step in. These new competitors may not be able to provide complex care to the same standard of existing providers, and patient care is likely to suffer as a result. Many GPs are concerned that professional, patient-focussed organisations such as GP practices, will be replaced with managerial, profit-motivated companies.

Practice-based commissioning (PBC)

21. The role of the GP is to focus on the total needs of its registered population. Therefore, the theory of allowing GPs to use their allocated resources in an individual way to ensure that their patients have what they need is commendable. However, a practice working in isolation may struggle in the following respects: firstly, it may not be possible to capture epidemiological data at the practice level; secondly, due to the population size resources are likely to be too small to manage risk adequately; lastly, the administration costs for a practice commissioning in isolation are likely to be too high. The situation could be improved if practices worked together in Primary Care Federations around a more sustainable population of c70,000, for example. These Federations would have “real” as opposed to “indicative” budgets to work with and would be able to commission services effectively. However, this would require, firstly, GPs to actively engage in the commissioning process and, secondly, PCTs to support commissioning at this level.

Payment by results (PBR)

22. The purpose of PBR—to reward efficiency, support patient choice and to encourage waiting time reductions—is commendable. In some circumstances, however, PBR can focus on activity rather than outcome. One or two commentators have suggested that PBR focuses too much on things that are easy to quantify and fails to take account of the importance of quality of care eg the care of the dying.

23. It has also been suggested that the PBR agenda has been over influenced by specialists, resulting in the diversion of funding to hospitals at the expense of primary care.

24. Many GPs would be unhappy with the idea of the GP practice as a money making entity. It has been argued that the drive for profits could potentially skew practice work and impinge on the doctor/patient relationship.

Specialist commissioning

25. Specialist Commissioning is required for those services applicable to less than 1% of the population and yet costing the NHS 8-9% of its budget. These expensive services utilise “cutting edge” technology and in many cases their evidence base is still being developed. The Specialist Commissioner needs to develop models of care which take account of the numbers of patients who use such services, the likely benefits that these services will confer, the impact of technology and some projection of costs over a ten year period to enable such services to have a reasonable horizon for development. Thus a service to treat Cystic Fibrosis, a service for Paediatric Cardiac Surgery or a Treatment-Renal replacement therapy service can be developed, compared with the performance over time and then remodelled as new data and new technology alters predictions. For these reasons, specialist commissioning should be based on large populations on a regional or national scale. The service providers are scattered, often through historical accident rather than clinical need (eg liver transplant facilities in England and Wales.) Such services need to be funded nationally and developed nationally.

26. However, such an approach can lead to loss of ownership by PCTs if they have no input into the process and their own identified priorities are subsumed. For example, the East of England SHA specialist commissioning group for IVF provision has imposed its decisions on all PCTs in that region. The dictat to provide all eligible couples with up to three fresh IVF cycles has diverted scarce resources from local PCT priorities and has allowed no account of local circumstances.
27. Some specialist commissioning contracts have suffered from poor quality data and a lack of robust monitoring. In some cases, there has been very little clinician or patient involvement and “activity” and “cost” rather than “quality” have been the focus of monitoring arrangements. Commissioning monitoring has been more lax where PCT provider units have provided these services.

Commissioning for the quality and safety of services

28. Agreed, national standards of quality and safety, developed with the involvement of clinicians and patients, should be integral to the commissioning process and built into contracts. Commissioning should drive up standards of quality and safety and contracts should be used to gather useful data. However, at present the skills of writing quality markers and quality schemes are scarce. Most schemes have an unenforced audit but it is usually so comprehensive as to be of little use or too process-based leading to difficulty in measurement. Specialist care should follow primary care’s example with limited numbers of population based quality markers of important proxy outcomes—the method of the Quality and Outcomes Framework (QOF). This would start to show when parts of the population are missing out and help reduce the deprivation divide as well.

29. However, cost is likely to be the main driver for PCTs, especially in the current financial climate. There is a need to define quality better in PCT tenders. This should be measurable and costed.

30. I gratefully acknowledge the significant contribution of Dr Peter Davies, Dr Peter Sims, Dr Iona Heath, Dr Pauline Brimblecombe, Dr Steve Holmes on behalf of IMPRESS, Dr Agnelo Fernandes and Dr Andrew Spooner towards the above comments. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.

September 2009

Memorandum by the Care Quality Commission (COM 95)

EXECUTIVE SUMMARY

“Making sure people get better care” is CQC’s central mission and is at the heart of our statutory work to review and assess the performance of Primary Care Trusts (PCTs) and councils as commissioners and publish the results.

We are in a unique position to assess, from a position of independence, the success with which large sums of public money are applied by health and adult social care commissioners to deliver services to people, which meet their care and support needs and improve their lives.

For us, commissioning is the overall activity of shaping services to deliver better outcomes for people and includes the processes that support this such as needs assessment, purchasing and contract monitoring.

The focus of our work to hold commissioners to account is shaped by our draft strategic priorities which include championing joined up care, eliminating poor quality care and promoting high quality care. To this end we are committed increasingly to assessing how PCTs and councils are working together to improve outcomes.

Alongside our major task of introducing a common registration system for all health and adult social care providers over the next few years, we see strengthening our challenge to commissioners as the most effective lever we have to improve the quality and safety of services.

Our biggest priority for health commissioning is the joining up of care and support, within the NHS and beyond.

We believe that the decisions of commissioners have never been as critical to the care people receive as now when public sector resources come under greater pressure.

1. What is the role of the Care Quality Commission (CQC) in relation to health commissioning?

1.1 CQC, the independent regulator of health, adult social care and mental health services was created on 1 April 2009.

1.2 CQC has legislative duties241 that include reviewing the performance of councils and PCTs as commissioners, assessing their performance against indicators and standards agreed by the Secretary of State. We must then publish our results.

1.3 Our governing legislation also gives us a function “for the general purpose of encouraging the efficient and effective use of resources in the provision of health and social care services”.

1.4 CQC inherits approaches to the assessment of commissioners from its predecessor bodies—the Healthcare Commission and CSCI, which differ markedly in their maturity.

— The assessment of adult social care commissioning by councils has been in place for over a decade, reflecting implementation of a policy to separate purchasing and provider functions linked to the Community Care reforms of the mid 1990's.

— The assessment of health commissioning by PCTs has become a separately scored element in the Annual Health Check for the first time this year (the results from the 2008–09 assessment will be published in October 2009).

— Also due for publication in mid December 2009 are the first Comprehensive Area Assessment reports which describe quality of life for people where they live and how effectively service commissioners are collaborating to achieve this. CQC is part of this work and is contributing evidence from its inherited assessment processes.

1.5 Our task as the new integrated regulator for health, mental health and adult social care is to use the tools available to us to bridge the gaps and join up our various assessments. Our submission gives more information about what we know about the state of health commissioning and how we are proposing to develop a joint approach with adult social care commissioning.

1.6 We start with our draft five year strategic plan—to be consulted on from September 2009—which identifies five objectives, all of which have important resonance for how we move forward on our assessment of commissioners:

(i) ensure care is centred on people’s needs;
(ii) championing joined-up care;
(iii) acting swiftly to help eliminate poor quality care;
(iv) ensuring and promoting high quality care; and
(v) regulating effectively in partnership.

2. What do we mean by “commissioning”?  

2.1 The term “commissioning” has a variety of uses across health and adult social care. Our interpretation was shared and agreed as part of the consultation process on how we should conduct the 2009–10 reviews the results from which were published in June 2009:

2.2.1 “Commissioning by PCTs and councils assesses the needs and wishes of local people in order to make sure that they receive timely and good quality services that:

— meet their needs;
— Promote their independence;
— provide choice;
— are cost effective; and
— support the whole community by supporting health and well being.

2.2.2 Our understanding is that both PCTs and councils in their commissioning capacity will ensure that:

— the assessment of current and projected future needs is reflected in the way they commission;
— people who use services have good information so that they can make better informed choices about the care they receive;
— people can make decisions about their care, regardless of whether they are entitled to financial support from the state;
— assessments are carried out and opportunities given to people to control their care;
— a range of services is available that are of high quality, improve outcomes for people using them and represent value for money;
— they work in partnership with people who use services, their carers and families, and other stakeholders; and
— they monitor and review commissioning decisions and services in relation to improving health and wellbeing outcomes and, where appropriate, make changes”.

2.3 Our view on commissioning therefore seeks to track the high level use of resources and its impact on groups of individuals defined by where they live (local population), by situation (care need) and by diversity (dimensions of equality such as gender, race, sexual orientation and age).

242 http://www.cqc.org.uk/getinvolved/consultations/pastconsultations.cfm#2
3. What do we know about the effectiveness of health commissioning currently?

3.1 Our evidence on health commissioning through the Annual Health Check process is limited as this has only been a focus, for the first time, in the current year. However, other reviews and studies undertaken by CQC and predecessor commissions, as part of our regulatory toolkit, have shed light on this area.

3.2 The terms of reference for this Select Committee touch on a range of interwoven issues. From our review and study evidence we have drawn out six key themes relevant to the effectiveness of health commissioning:

1. Use of information
   In our work we have commonly identified significant concerns about the availability and use of relevant and reliable data to inform accurate assessments of service need—for example in our most recent review of statin prescribing, stop smoking services and cardiovascular disease

2. Involvement of service users
   Whilst our work has captured some excellent practice—for example in commissioning healthcare in prisons—the lack of involvement of users as a part of the commissioning process remains an area of concern

3. The assessment and performance monitoring of providers
   Our reviews have highlighted how performance data could be better utilised by commissioners to drive continuous improvement—for example in the context of maternity services and prisons

4. Commissioning across areas and specialisms
   Greater difficulty for effective commissioning appears to be evident where the need being addressed or the services being commissioned range across geographic areas or do not fit neatly within traditional specialist boundaries. This suggests that significant gains might be made by focusing on care pathways and better integration of services

5. Commissioning to reduce inequalities in health
   We have identified both excellence and limitations with the current commissioning practice to reduce inequalities and offered recommendations to support better practice

6. Commissioning an appropriate balance between acute and preventative services
   Our reviews suggest that commissioning practice does not use (or have access to) sufficient information from which commissioners can assess the most effective balance between acute and preventative services.

4. What are we doing to hold commissioners to account for the quality and safety of services, going forward?

4.1 Our legislative duties allow us to focus on two levels of performance—that which meets a minimum level of quality and that which has higher aspirations for the quality of care that people get.

4.2 Whilst this concept may be easier to apply to our assessment of providers, it can also apply to our reviews of commissioners, where we can identify where performance is adequate in meeting outcomes for people and where it exceeds this basic level of assurance.

4.3 We know that joining up health and adult social care is of critical importance to people. We have evidence to show that when services are not joined up there is a negative impact on people’s outcomes and the quality of their lives.

4.4 As CQC is the regulator for both sectors, we have a unique opportunity to focus on the extent to which health and adult social care commissioners are responsible for good or poor service coordination across both sectors as well as within each sector. We can explore how they are finding ways of working together to commission services across the whole of people’s pathways, and how they are promoting joined up care.

4.5 This issue rises in importance in looking ahead to an era where public finances are likely to be severely constrained. This is because of the well established interconnectivity between adult social care and health investments and service configurations—as illustrated in the government focus over the last ten years on avoiding delayed discharges from hospital by better joint commissioning.

4.6 Work by the Department of Health demonstrates that there continues to be significant variation in the commissioning approaches taken by different councils in how much of different kinds of care are purchased—for example whether people are more likely to be offered care and support at home as opposed to being placed in a care home. We also know from the work of our predecessor, CSCI244 that there is widely variable access to adult social care between councils.

4.7 There are likely to be similar variations in investment in different kinds of healthcare interventions which will also impact on how well people’s outcomes are being supported in ways that they would prefer—for example in relation to continuing health care or end of life care.

244 Cutting the cake fairly, CSCI review of eligibility criteria for social care, October 2008.
4.8 In developing our approach to assessing how well health and adult social care commissioners are working effectively, we have identified three distinct elements of commissioning performance:

1. The aggregate quality of the services that are being purchased (Are the services that a PCT or council is paying for on behalf of their population of high quality?)

2. The balance and pattern of services being commissioned (Are the services being commissioned, even if they are of high quality, the right ones in terms of people’s needs, aspirations and preferences? And is there a good range and quality of services for people accessing their own services as self funders or recipients of individual budgets?)

3. The competency and capacity of each PCT and council to deliver and sustain good outcomes (Are there good systems, procedures and policies in place which provide assurance that performance will stay high or improve?)

4.9 The world of performance assessment, monitoring and management of health and adult social care agencies is a crowded one.

4.10 CQC is clear that, for commissioners, it can add most value by focusing on the first two of the above lines of enquiry. Within these we can highlight the joined up care issues around quality, balance and pattern of services.

4.11 For assessments of PCT competency and capacity we are happy to rely on the assessments of others where we believe they are robust, for example World class commissioning and Audit Commission judgements.

4.12 We have the following step by step plans for bringing about changes in outcomes for people through our assessment of commissioners’ performance:

<table>
<thead>
<tr>
<th>Performance Year (Date of publication)</th>
<th>Assessing PCTs as health commissioners</th>
<th>Assessing Councils as adult social care commissioners</th>
<th>Assessing the impact of health and adult social care commissioning on people’s outcomes in areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008–09 (Autumn 2009)</td>
<td>Inherited approach from Healthcare Commission. First time that a score will be given to PCTs as commissioners under the Annual Health Check system</td>
<td>Inherited approach from CSCI. First time that star ratings have been replaced with scores based on outcomes only—evidence on capacity pooled with other inspectors to give scored organisational assessment over all the council’s functions</td>
<td>CQC evidence form inherited approaches—separately for health and adult social care issues—is being pooled with other inspectorate evidence to produce first reports on quality of life in areas to be published under the Comprehensive Area Assessment system, coordinated by the Audit Commission</td>
</tr>
<tr>
<td>2009–10 (Autumn 2010)</td>
<td>Revised free standing approach to assessing PCTs as commissioners with three scored components relating to targets/outcomes, financial management and World Class Commissioning</td>
<td>A repeat of the approach taken for 2008–09</td>
<td>Similar to the 2008–09 approach but with possibility of a single health and adult social care commentary fed into CAA by CQC based on all our relevant evidence about health and adult care outcomes in an area.</td>
</tr>
</tbody>
</table>

4.13 We will be consulting on our plans for commissioner and other assessments for the 2010–11 performance year and beyond at the end of 2009.

4.14 CQC has a wide range of regulatory tools at its disposal and it is our intention to exploit our ability to use information collected for one regulatory purpose for another. We also intend in line with Better Regulation principles to make use of information that others have collected.

4.15 Explicitly, for our commissioning assessments, we expect to make use of:

- the “ratings” we give to the health and adult social care providers that we register and review—in aggregated form linked to which services commissioners are responsible for;
- the various “fieldwork inspections” that we conduct of services and care pathways, under our powers to conduct special reviews;
- the “surveys” we carry out of patients and people who use services as part of different regulatory or other methods;
— the assessment of PCT commissioning competencies developed by the Department of Health (World Class Commissioning);
— the assessment of PCT financial management provided by the Audit Commission; and
— surveys that are robust and carried out by others eg Skills for Care data collections.

4.16 Most importantly, in line with our statutory duty to actively involve people who use services in all aspects of our work, we are committed to;
— auditing all the ways that we have inherited from our predecessor commissions to gather the views of people who use services across all our regulatory functions; and
— developing strategies for making best use of evidence that is collected or available to Local Involvement Networks (LINKs), particularly as they now have a brief to comment on both health and adult social care issues in their area.

5. Conclusion

5.1 The Care Quality Commission has a challenging task to bring together different approaches to the assessment of health and adult social care commissioning outcomes.

5.2 Whilst our evidence on adult social care commissioning practice and effectiveness is relatively strong we have a lower starting point in relation to health commissioning. Our submission has drawn out our evidence taken from a series of reviews and studies rather than from the main vehicle of assessment—the Annual Health Check.

5.3 The organisations we are assessing are very different in terms of their accountabilities and governance and predecessor commissions have taken very different approaches to how commissioners are held to account.

5.4 At the same time CQC is committed as a single regulator of health and adult social care services—to shed light on how people’s outcomes are improving and to encourage improvement by promotion of good practice whilst taking decisive action against poor performers. Getting to a well designed and established process for calling commissioners to account is underway.

September 2009

Memorandum by Sue Ryder Care (COM 96)

1. About Sue Ryder Care

Sue Ryder Care is a leading third sector provider of specialist palliative care and long term-neurological care in the UK. It operates hospices, neurological care centres, homecare and community based care services.

Its vision—‘Care that liberates lives’—means that the charity cares for all of a persons’ needs, be they physical, emotional, psychological or spiritual, and is dedicated to helping people get the best from their lives, while living with chronic and life-limiting conditions and illnesses.

Sue Ryder Care’s specialist palliative care services are based around consultant led inpatient units and comprise day hospice facilities, specialist community nurses, social work and bereavement services, which integrate with the NHS and other organisations, including oncology units, GPs and social services. In 2007, its six hospices provided 1,800 episodes of in-patient care and 5,500 attendances at our day care hospice services.

Its neurological care services provide specialised long term care and support for people with conditions including Multiple Sclerosis, Stroke, Parkinson’s Disease, Motor Neurone Disease, Huntington’s Disease, Brain Injury and Dementia, with most centres recognised as preferred providers of respite care by the MS Society. Admission is based on referral by NHS or Social Services and individual assessment by the charity. Its eight neurological centres provide care for over 400 people, with a further 3,750 people receiving care through neurological day services.

Sue Ryder Care homecare provides social support for people with a range of care needs in the community. The majority of the people the service cares for, often in partnership with other agencies, are adults with a high level of need, recognised following assessment by a social worker. Sue Ryder Care provides 12,000 hours of homecare every week through these services.

Sue Ryder Care services are funded through a combination of statutory funding, personal funding and voluntary donations. In order to provide these services, which provided over four million hours of care last year, the charity relies on generous donations from the public and statutory funding from the government via local authorities and primary care trusts for commissioned services.
2. EXECUTIVE SUMMARY

Sue Ryder Care has examined the following part of the Committee’s terms of reference:

“World Class Commissioning”: What does this initiative tell us about how effective commissioning by PCTs is?

Sue Ryder Care recognises that while the World Class Commissioning Programme has improved commissioning in some areas by changing some working practices, concerns remain that positive steps are not widespread nationally, and that problems remain with the standard of commissioning and the high turnover of those in the profession.

3. SUCCESSES OF THE WORLD CLASS COMMISSIONING PROGRAMME

Sue Ryder Care constantly works to engage its Commissioners across the country. We work to improve understanding and create opportunities for improved working relationships.

3.1 World Class Commissioning has made an impact on the behaviour of Commissioners, and in some parts of the country we are witnessing PCTs grasping more coherent processes and procedures for selected services. In some areas, new community health packages are emerging which compliment the social care support Sue Ryder Care provides.

3.2 Some PCTs are also working together and commissioning in clusters. Commissioners have made progress with developing the structures that will shape and stimulate the new competitive and diverse market place, in terms of framework agreements to bid for tenders, preferred providers and NHS contracts based on three rather than one year arrangements. Tender specifications are becoming more detailed with increased asks in terms of outcomes, quality measures and reporting. They are now more reflective of the personalisation agenda.

4. AREAS OF WORLD CLASS COMMISSIONING THAT REQUIRE IMPROVEMENT

Sue Ryder Care does have concerns about progress in some areas though; the positive steps are infrequently country-wide and there are a number of factors threatening our charity’s ability to build meaningful relationships with Commissioners.

4.1 The onset of the personalisation agenda has as yet unexplored implications for Commissioners; if Personal Budgets are introduced as widely as the government’s recent green paper on social care suggests, the implications for the future of Commissioners are great.

4.2 There is also a high turnover of Commissioners which does not allow us to build strong and lasting relationships as we would like to. In some areas, the skills of existing Commissioners are not as high as they should be. Evidence from Sue Ryder Care’s Development Team suggests that ‘they are clear on the concept—innovation and value—but beyond that they don’t know what they want.’ There needs to be more critical dialogue between the Commissioners and the service providers to ensure the process can run more smoothly.

4.3 As an organisation providing specialist palliative care, we are faced with challenges in the way we are funded. Our contracts are often split—while those that we receive from Local Authorities tend to be three plus two year contracts, those from PCTs are still largely on an annual tariff or annual grants basis. With the introduction of community contracts, we anticipate that the relationships will be longer in the future; but as yet a move towards this is not widespread. Continuity of care is essential to avoid service user disruption and to promote the development of quality innovative services. Joint commissioning for health and social care needs to be stepped up. Moving from one funding stream to another for those nearing the end of their lives adds an additional and unnecessary layer of bureaucracy with some missing out on the services they need.

4.4 As part of the World Class Commissioning programme, there is an expectation that Commissioners have a greater knowledge of the needs of their local communities and that they respond to these. Sue Ryder Care’s 2007 report *Filling the Void* highlighted that “local commissioning bodies are inconsistent in their use of data. When challenged they were unable to provide reliable, valid and current information about their communities on which to base their decisions about the provision of care for neurological conditions.”245 While the situation may have improved since 2007, we remain concerned about progress in some areas.

5. THE FUTURE

It will be interesting to see whether competition between the World Class Commissioning and personalisation agendas conflict with one another as both continue to embed. Organisations such as ourselves will need to negotiate our position to ensure that we drive up standards to exceed expectations in the new marketplace.

245 Sue Ryder Care *Filling the Void* (2007).
It remains to be seen whether World Class Commissioning will bring the step change in the quality of Commissioning it initially promised, or whether interest will wane.

September 2009

Memorandum by the Royal College of Psychiatrists (COM 97)

Introduction

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

This consultation was prepared by Dr Martin Elphick- Specialist Adviser on Information based funding, quality and outcomes.

The following groups also contributed to the response:

— Academic faculty;
— Child and Adolescent faculty;
— General and Community faculty;
— Northern and Yorkshire division;
— Old Age faculty;
— Rehabilitation and Social faculty; and
— South West division.

This consultation was approved by: Dr Ola Junaid-Associate Registrar.

The Royal College of Psychiatrists welcomes the opportunity to provide evidence on commissioning, which has become a concern to everyone involved in mental healthcare. The College has consulted members through its structure of specialist faculties and regional divisions. There was widespread agreement across the sub-specialties and in each area of the country. Please note that verbatim comments by members are included.

Executive Summary

1.1 The Royal College of Psychiatrists is concerned that the rationale behind commissioning is based upon assumptions that do not apply well to mental health services, and that this is having negative effects.

We are also concerned that the preconceptions and practices of individual commissioners may be leading to a poorer quality service to the population.

1.2 We therefore welcome the Inquiry and any examination of modifications or alternatives that may arise from it.

1.3 Plans to improve the collection and use of information, the training of commissioners, published local mental health strategies, and a better linkage of direct quality measures to funding decisions are also supported.

Terms of Reference

“World-Class commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

2.1 Most Mental Health professionals believe that the commissioning of mental health services by PCTs is unsatisfactory. Three concerns are of particular relevance to commissioning for mental healthcare:

2.1.1 Individual commissioners often lack a broad enough knowledge of mental health services. They may have responsibility only as part of a portfolio, or in a temporary role. They may have no direct contact with provider services.

2.1.2 Scarcity of information. Local populations vary considerably in their mental health needs, and commissioning should respond to that. But there is a lack of good quality local information on population needs, including unmet need, which is important because those who are in most need may be less able to seek help. Poor use of evidence by commissioners may be the reason why the fivefold variation per person in NHS budget for mental health services does not seem to follow known patterns of prevalence or need but appears to be almost random.

2.1.3 Mental health service configuration. The problems of mental health service users extend into many domains—including the immediate symptoms of mental illness, social, occupational, educational, housing, environmental, forensic, and others. Accordingly, the NHS component of care overlaps with that provided by other agencies, creating uncertain boundaries of responsibility. The same applies to prevention,
promotion, and recovery, for the causes of problems and the factors that impede recovery are often multifactorial. Effective commissioning should involve a much wider set of active partnerships than is currently the case, addressing each stage of promotion, prevention, treatment, and recovery for each type of problem with the appropriate agencies.

“I would . . . stress the need for truly collaborative commissioning that can drive a whole system approach to mental health service development and provision, that engages NHS, independent and voluntary (3rd sector) provision. This is especially obvious in rehabilitation services where all clients have complex needs and require high levels of support from a wide range of mental health and social care providers to maximise their functioning and autonomy and achieve successful community living.”

2.2 The relative lack of priority given by commissioners to mental health services is illustrated by the proportion of mental health parameters against which commissioners are assessed in the World Class Commissioning programme (only 4 out of 57). Mental health problems account for 25-30% of total morbidity, and 12-15% of NHS spending; they are the commonest health-related cause of disability and unemployment.

“It is as though they are saying ‘This is the biggest public health problem we have, but it is chronic and complex, so we will give it very little attention.’”

“We are beset by commissioners who often don’t care about what is going on as they are “passing through” to their next job and by higher dictates . . . so have multiple services with competing or antagonist treatment policies that come and go!”

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

3.1 The success of the purchaser/provider split should be judged by its end effect upon the whole population of people with mental health problems, or at risk, rather than the achievement of business or policy objectives. The effects of the split can be considered in terms of the quantity and quality of services:

3.2 Quantity: The internal market began while there was increasing investment in health services generally, and mental health had a share of this good fortune. But historically mental health services have always tended to receive a higher percentage of the total health budget in a good financial climate. So it is difficult to abstract the consequences of the purchaser/provider split from the pervasive economic effects.

3.2.1 In terms of the proportion of the health budget allocated to mental health services, the argument seems to have been widely accepted, for instance by the Audit Commission (in The Right Result? 2008) that we have been relatively disadvantaged by the internal market. Lacking both the data and the tariff mechanism for remuneration provided by Payment by Results for the acute sector, it has been hard to compete for a share of fixed local budgets. Mental health providers resort to scaring commissioners that things will go publicly wrong, rather than presenting an argument for evidence-based, world class services (which would be achievable).

3.2.2 The split has introduced extra costs:

“In my area in 1999 there were five NHS organisations, four Acute Trusts and a guiding organisation, the Health Authority. By 2001 there were eight NHS organisations, four PCTs and four Acute Trusts, so management costs had increased by 37.5% as each organisation had its own Chief Executive and Board. As some of the Health Authority’s funding went to the Strategic Heath Authority it was probably more than 37.5%. This produced no improvement in patient care. Perhaps what it did do was provide a blame sump . . . if the new money had been put directly into patient care just think of the improvements there could have been. The reinforcement of the Purchaser/Provider split . . . has ensured we have two management organisations where previously we had one.”

3.3 Quality: There is little evidence on the effects of the purchaser/provider split either on the population or on mental health services. With no quality measures collected over a long enough span of time, it is hard to disentangle the effects from other factors.

3.3.1 Most of the current central indicators used in purchasing measure local compliance with policy objectives, such as setting up crisis and home treatment teams, or the stated use of clinical guidelines. These “process” measures are not necessarily a guarantee of improved quality even within the service—one team’s development may be at the expense of another; guidelines may be followed inappropriately. There is so far very poor linkage of commissioning decisions to direct quality indicators such as clinical or patient–related outcomes measures, and almost none to population measures. Commissioners are therefore systematically blind to the effects of their decisions.

3.3.2 Perverse financial incentives on providers resulting from competition to cut costs could easily drive down quality covertly or unintentionally in such an environment—for instance, by raising the threshold of acceptance for patients to services, leaving people untreated in the gaps between services. Who would know they were there?
3.3.3 Psychiatrists are also concerned about narrow business objectives leading to the fragmentation and destabilisation of Trusts: shifting contracts from one provider to another may seem like good business, but good mental healthcare is seamless.

“. . . it is my impression that (the split) has distanced clinicians from the commissioners as they are driven to become more independent and towards blind tendering . . . It is also leading to more paranoid and fearful organisations which all fear predation from their neighbours and others. This is leading to less inter organisation co-operation and defensive management of trusts which is as wasteful as defensive medicine.”

“Politiced govt initiatives . . . lead to too many changes of management which takes the emphasis away from how we can provide the best services. There is too much reorganisation diverting managers away from what they should be doing.”

“The internal market reinforces a culture of business management at the expense of front line services. There tends to be lack of provision for services based upon long-term outcomes that can lead to sustained clinical improvement [and thus be cost-effective in the long term].”

3.3.4 The lack of confidence in commissioner’s decisions may also be a reflection of a lack of consensus on political or cultural values against which quality must ultimately be judged.

“. . . the rhetoric seems to be against sustained care which is critical for those with the most severe and enduring mental illness.”

“When explaining the benefits of liaison psychiatry services for older people to the acute care commissioner last year she said ‘Why haven’t we heard about this before?’—we have provided a service since 1999! Of course, nothing came of it despite the benefits. Some of the reasons for age discrimination in mental health are a consequence of the decisions, interpretations and ignorance of local commissioners. There are serious concerns and perverse effects in the way they interpret national policy or even know about it. Mental health commissioner’s agenda is about nothing but younger adults. If the primary goal of commissioning is to meet the needs of local people then it is failing where older people are concerned . . . Increasing numbers of older people is not matched by increasing investment or resource.”

3.10 In summary, the split is not currently advantageous to our service, and we do not believe it represents value for money. Whilst there are examples of good commissioning, they seem to have been a simple consequence of competent senior managers working towards a common aim, which could be achieved by other means.

“There are some examples of areas (localities) where excellent commissioning has facilitated improvements in service provision in terms of both quality, service user experience, and financial efficiencies through the creative partnerships they can foster between different providers.”

“Purchaser provider divides, potentially, creates transparency on the use of public money and a means to change the way care is delivered, but, in its present state of ignorant, compartmentalised parochialism is a rather blunt instrument. I do know areas where the purchaser provider relationship works in partnership quite well and so it can be successful and improve local situations. I’m not averse to it in principle at all but in practice it has to get a whole lot more sophisticated.”

Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, ”contestability” and the quasi-market, and Payment by Results?

4.1 Practice-based Commissioning: There is little evaluation yet of Practice-Based Commissioning, beyond surveys of implementation rates and GP’s opinions on the benefits. Very few have commissioned more than two or three “new services” and the proportion that are mental health services is unknown. The incentive is the retention by GPs of 70% of cost savings made, with no incentive for quality improvement.

4.2 A contestable market (according to Price Waterhouse Cooper) “is one in which competitive pricing exists, where there is actual and effective competition, or there is potential competition due to the existence of low barriers to entry to the market. Contestability can be achieved within the public sector alone or via the introduction of competition from the private and third sectors”. There is no “actual and effective competition” for most types of mental health service in most areas of the country. Generally, each area has its own mental health trust which provides a range of general and specialist services. Patients move between teams, but within the same organisation, as their needs change. Many other countries look to this integrated service as a model of good practice. It is not an advantage for existing trusts to expand further—economies of scale are rarely realised and optimal sizes have probably already been achieved. Commercial barriers to entry into this market for new providers are high. Recruitment and planning permission are serious obstacles. The service components that are “contestable” (small, specialist services like psychological therapies or high-cost forensic services) can be cherry-picked from mainstream organisations, but leave behind the NHS elements that are less cost effective and higher risk. It is not helpful for vulnerable service users to be sent from one team to another as soon as they get used to a friendly face.
4.2.1 The market approach promises competition but cannot deliver it, and we are not sure anyway that competition improves cost effectiveness in this sector. We risk reverting to a pre-NHS situation in which better quality independent services were for patients with less disability and more resources, while those with serious problems made do with state provision.

4.3 The Payment by Results programme has not been implemented yet in mental health services, although a variant of PBR is planned by the end of 2010.

4.3.1 PBR in acute services provides the mechanism for setting a national tariff for “costing currencies”—groups of procedures or conditions that are similar clinically and in cost. The model works best for well-circumscribed procedures. According to the last Audit Commission report there is not much evidence that the mechanism has materially altered the amount of care provided or its quality, but an early benefit has been an improvement in the use and availability of information.

4.3.2 PBR in mental health has had a different set of problems to deal with. There is no costing currency available for which a tariff can be set—neither an established classification of interventions, nor groupings of diagnoses that correlate well with costs. Furthermore, the information infrastructure and culture has been inhibited by a chronic lack of IT resources.

“Commissioning is piecemeal; there is no capacity to view whole systems hence for most of older people’s problems and mental health it’s a bit of a nonsense as it stands. It’s ok for commissioning an operation which is rather like buying a can of beans at the supermarket.”

4.3.3 Mental health services were excluded from PBR implementation for many years because they were “too difficult”. But the way forward has been to develop a set of “Care Clusters” as a mental health costing currency. This is a standard system for grouping people with similar mental health problems which, in contrast to diagnosis, members of all of the mental health professions can use. Although variation in costs may still prevent the establishment of a national tariff on the “Acute PBR” model, data on clusters will enable better analyses of local need, and quality and outcomes measures, to be undertaken; from team and personal audits up to national reporting level.

4.3.4 Therefore the benefits of PBR, in furthering the ability of mental health teams to measure their own performance, are independent of the purchaser/provider split, even though the programme has been driven so far by the need for a costing currency.

4.4 Personalised budgets are used in some areas of mental health and social care, enabling service users or carers to choose services that they prefer. Whilst that is a welcome step for some types of care, service users often cannot make good judgments without the factual knowledge and support of a professional so personalised budgets are not a universal solution. There can be a conflict between “needs” and “wants”.

“I fear these might be disadvantageous as money is drawn to the more competent and away from the most ill whose competencies and motivation restrict their ability to manipulate this system to their advantage.”

Specialist Commissioning

5.1 We understand that a new set of specialist service definitions is about to be implemented. We have no comment to make on the present mechanism.

5.2 The commissioning of Child and Adolescent MH services is different to adult services because of the involvement of local authority children’s services including education and youth justice as well as social services.

Commissioning for the Quality and Safety of Services

6.1 “Funding mechanisms and contracts for mental health services should be inseparably linked with measures of quality and outcome as well as levels of activity and need” (Royal College of Psychiatrists, Statement of Principles on Funding and Quality Measures, 2008–09, Appended).

6.2 The Advancing Quality project in the North West has begun to develop a quality contracting mechanism which could work alongside the mental health PBR programme. We do not see the value of such developments as necessarily dependent upon the present contracting model. The identification of a set of simple, valid quality indicators will be of value in any evidence-based governance mechanism.

Recommendations

7.1 The purchaser/provider split could be abandoned without a negative impact upon mental health services, but an expected cost saving.

7.2 If the split continues the recruitment and training of commissioners must be improved, and the College and universities are happy to assist.

7.3 If the split is modified, the planned implementation of care clusters and direct quality measures should continue, but under the authority of local health or quality boards.

7.4 A needs-based multi-agency local mental health strategy should be published in every locality.
7.5 There are several initiatives within, the Department of Health and the Department of Children, Schools and Families in relation to commissioning and it is important that they are “joined up”.

7.6 The collection and use of quality indicators must be rationalised, in place of the variety of measures independently devised and operated by a number of governmental silos.

7.7 More research is needed on the estimation of population needs, and unmet needs.

7.8 The information gap is remediable—through improved skills, collaboration with professional bodies and universities, and better resourcing of informatics.

September 2009

Memorandum by Neurological Commissioning Support (COM 98)

EXECUTIVE SUMMARY

Approximately 10 million people in the UK have a long term neurological condition (LTnC). These individuals account for 20% of acute hospital admissions and are the third most common reason for people seeing their GP. Over 350,000 people in the UK need help with the activities of daily living because of a neurological condition and a further 850,000 people provide care for this group.

Neurological conditions have not been a priority for health and social care services and there are widespread inequities in the way services that are currently commissioned.

This situation has been one of the key contributors as to why the Multiple Sclerosis Society, the Parkinson’s Disease Society and the Motor Neurone Disease Association have developed Neurological Commissioning Support; to try and raise standards of commissioning.

Our experience shows that with informed commissioning, services would better meet the needs of people with neurological conditions and ensure that resources are spent more effectively.

RECOMMENDATIONS

— Consultations with service users should not be tokenistic and involve both service users and the general public through a wide range of methods like focus groups, local media and social networking sites (to attract younger members of society).

— There should be individual disease registers for people with neurological conditions to provide commissioners and planners with data on the populations of people with neurological conditions. These may already exist in Primary Care/General Practice but if not this is an opportunity to ensure these are developed at gatekeeper level. The MS Society is currently developing a national register of people with MS. There is also a need to properly integrate the data capture methods into the NHS records systems and to work closely with the patient support groups in the design and execution of these registers.

— Services should be jointly commissioned across health and social care, should respond to the holistic needs of people living with the condition, and should do so in a way that is both timely and appropriate.

— There should be a review of specialised commissioning arrangements to ensure there is consistency in commissioning decision to avoid inequalities in access to services such as deep brain stimulation surgery for Parkinson’s.

— Governments in England, Wales, Scotland and Northern Ireland should work to produce guidance on outcomes in commissioning neurology services. This approach should be aligned to deliver value for money, a focus on proactive management and ensure quality delivery. Currently there is only a commissioning approach explicit in England.

— We suggest commissioning for neurological conditions could be undertaken using a Year of Care paradigm as identified in section 4.49.

Neurological Commissioning Support (NCS) is pleased to be able to respond to the Health Select Committee Inquiry into Commissioning. NCS has been formed by a coalition of three of the largest neurological charities in the UK: the Multiple Sclerosis Society (MSS), the Parkinson’s Disease Society (PDS) and the Motor Neurone Disease Association (MNDA).

1. BACKGROUND

1.1 Neurological Commissioning Support

Each of these charities has links with the majority (around 85%) of PCTs across England and liaises with their commissioners regarding services on a regular basis. For example, the Parkinson’s Disease Society and the MS Society have, for many years, offered up to two years pump priming funding for specialist nurse posts and it is usually in this context that they have been involved in service redesign negotiations with commissioners. PDS, MSS and MNDA also have representation on many PCT commissioning groups.
through its regional staff and members. Additionally, all three organisations support a comprehensive branch structure and have contact with thousands of people affected by neurological conditions, which provides a unique perspective on the experiences these people have of their local health and social care services.

1.11 Recognising the importance of influencing the commissioning process, these three charities have formed Neurological Commissioning Support (NCS) to work alongside commissioners in order to improve the way that neurological services are commissioned. This is done through a service user focus on the key elements of commissioning and, in particular, the planning component.

In this context NCS focuses on:

— understanding the current approaches for service delivery;
— working with the local Joint Strategic Needs Analysis to identify trends whilst simultaneously analysing activity and current expenditure;
— engaging with people affected by long-term neurological conditions in a range of different ways to better understand the patient perspective in terms of expectation of service delivery;
— developing strategy, redesigning services and creating the outline business case for changed working practice where relevant;
— an emphasis on partnership working, across health and social care; through primary, secondary and tertiary care; and between the statutory and third sector partners; and
— supporting the development of more effective service networks in order to deliver service improvements which in turn will lead to improved use of resources locally and streamlines working practice.

1.12 The service thus combines the credibility, authority, knowledge and expertise of three reputable and well-established national charities with the unique experiences of a strong and widely spread service user base. This strong service user engagement is perhaps the most attractive element of NCS, adding a unique blend of knowledge and experience into core processes of commissioning. Recognising the needs and constraints of health and social care commissioners, NCS seeks to work alongside its commissioning partners in order to enable, influence and improve the experiences of people affected by long-term neurological conditions.

1.2 How many people are neurological services being commissioned for?

Approximately 10 million people in the UK have a long term neurological condition (LTnC). These individuals account for 20% of acute hospital admissions and are the third most common reason for people seeing their GP. Over 350,000 people in the UK need help with the activities of daily living because of a neurological condition and a further 850,000 people provide care for this group.

1.21 Improving the care of people with long term neurological conditions is a key government priority in England and Wales. The National Service Framework (NSF) for Long Term Conditions (DH 2005) which sets out a clear vision for neurological services will be at its mid-point for implementation next year. Now is a critical time for commissioners to get commissioning right for those patients relying on neurological services.

1.22 All people with neurological conditions will share common characteristics, despite the different trajectories of their condition. All will face major adjustments that need to be made for daily living; adjustments which may need to be made rapidly and sometimes unexpectedly as the conditions progress.

1.3 NCS: Our place in World Class Commissioning

We believe that by forming this coalition we are signalling our support for the drive towards World Class Commissioning and indicating our willingness to be an active partner in securing the most appropriate services for the people we represent.

1.31 The key features of Neurological Commissioning Support are:

— the ability to actively engage people affected by long-term neurological conditions in the commissioning process;
— the opportunity to effectively involve patient organisations in the commissioning of services;
— the ability to maintain a cross-neurological focus;
— the ability to utilise and develop partners’ skills and knowledge base; and
— the facility to ensure the dissemination of best practice.

1.32 Within the broad toolkit of NCS is a Quality Neurology audit and evaluation tool, which allows a health care providers and commissioners to receive a comprehensive evaluation of how an organisation fulfils all of the quality requirements specified in the NSF The tool assesses the strengths and weaknesses of each area in question, making recommendations for improvement. Outcomes are tested against the views of service users and carers to ensure that any recommendations made are a true reflection of need. As well
as providing a benchmark to allow comparisons between different Hospital Trusts and PCTs, the tool also creates a means for recording the progress trusts are making annually to implement the NSF and the clinical guidelines published by the National Institute for Health and Clinical Excellence (NICE) for example the Clinical Guideline for MS and Parkinson’s disease.

In response to the specific questions for this enquiry

2. **World-Class Commissioning: What does this Initiative tell us about how Effective Commissioning by PCTs is?**

2.1 **World Class Commissioning: Background**

The World Class Commissioning (WCC) framework vision is to improve commissioning so that people live healthier longer lives; to reduce health inequalities and the use of NHS resources and to develop evidence-based care with increased patient choice, maximising the use of NHS resources.

2.1.1 Historically, decisions affecting service commissioning in neurology have been taken at levels far removed from clinical reality, whilst new health care services have been commissioned with little thought given to existing services or to how they have worked. There has been little measurement of quality or regard for patient satisfaction with services in the past.

2.1.2 Central to the process of commissioning is the allocation of funding to optimise management costs and reduce the risk of overspending. In the future, in order to gauge the effectiveness of commissioning, performance must be monitored by using reliable contract activity information set against agreed pathways of care.

2.2 **A critique: PCT commissioning versus WCC**

World Class Commissioning Competencies should, in theory, raise the standards for commissioning in the future; however central to effective neurology commissioning is engagement with the public and with service users, patients and carers. Specifically WWC competency 3 stipulates “engagement with public and patients” but in our experience with PCT’s this is frequently a “token” engagement with one “patient” being part of commissioning decisions, rather than a wide-ranging, qualitative consultation.

2.2.1 NCS is undertaking widespread consultation as part of its commissioning support to Primary Care Trusts in a variety of different ways; including through focus groups, via internet discussion boards and social networking sites, telephone interviews, questionnaires, newsletters, home visits, and emails. NCS is also engaging with the public via local media, including newspapers and radio stations. Awareness of neurological conditions among commissioners, as well as among health and social care professionals in general, is often, we feel, disproportionately low.

2.2.2 Widespread consultation should therefore ensure a greater awareness and understanding of the issues that people with neurological conditions, and the communities in which they are living, are facing. We believe that this awareness will result in more effective commissioning decisions.

2.3 **Observations on commissioning from WCC implementation to date**

Owing to our contact with commissioners, we have noted a number of trends since the introduction of World Class Commissioning.

2.3.1 There has been a significant improvement in commissioner’s levels of engagement with service users and a more genuine attempt to involve them in commissioning decisions. We feel however, that as PCT service user involvement is still in its infancy and not completely consolidated into in all commissioning practice; if there is pressure on spending in the future, progress may regress when difficult decisions need to be made. We would also like to highlight that a number of PCTs (although a minority) are very inaccessible to patient groups, and individuals find it immensely difficult to engage with their commissioners or even—in some cases—to establish who the lead commissioner might be.

2.3.2 An added challenge and frustration for patient involvement in commissioning is the regular turn over of commissioning staff and the resulting loss of organisation knowledge and the history of commission decisions. PDS, for example, have details of many different occasions where long-standing relationships with local people with Parkinson’s have been left broken and lacking in trust when a key commissioner leaves the organisation.

Of greater concern is when PCT contractual commitments to pick up the funding of Specialist Nurse posts that have been pump primed by the PDS are “forgotten”. We recommend that PCTs develop a better system for their knowledge management of commissioning decisions from year to year.

2.3.3 NCS have also observed an improvement in the competency of commissioning in many PCTs since the introduction of WCC. Some are truly exploring the whole patient pathway in order to redesign services. However, neurological conditions are complex and many PCT commissioners do not have sufficient knowledge or expertise of these to plan services in a way that fully meets all WCC competencies.
NCS’s experience of commissioners in general is that they need guidance and support in the form of accessible knowledge of the condition, advice of best practice, business case development, how to engage service users and quality measures. NCS can provide much of this guidance; however, take up of this support is not universal and not always welcomed by commissioners.

To support this statement PDS and the APPG Inquiry into Parkinson’s Disease Services recommend that the Government works with stakeholders to produce guidance for commissioning and planning Parkinson’s service, including data on cost-effectiveness and how these services can help achieve better outcomes for patients.

2.34 One of the biggest hindrances regarding effective commissioning of services is the lack of joined up working across health and social care. Given the length of time that people will be living with long term neurological conditions, and the fact that much of the care required will be social care as opposed to health care, there needs to be greater involvement with Local Authority commissioners, equitable partnerships across health and social care, and a joint approach to the planning of services. We would also like to suggest that if organisations which support commissioning, such as NCS, are not utilised then PCTs should employ wider and more imaginative methods of patient engagement than questionnaires or lay representative on a committee; methods such as the use of focus group, social media and community engagement activities.

3. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

3.1 A balance needs to be achieved between an independent and strategic commissioning process and the involvement of providers who have first hand knowledge of where innovation and service improvement may be needed. In our experience, the most effective and creative commission occurs when the providers are engaged in decisions about developing services and where all stakeholders can work together to look for improvement.

Examples of best practice here include NHS Bath and North East Somerset who undertook work on end of life care with NCS during 2008, consulting with a large number of service users and carers, and continuing to listen to them after outcomes had been achieved to continue to assess the effectiveness of implemented changes.

3.2 We have observed that when commissioning becomes overly weighted with details of pricing and costs, or where tendering processes created a secretive and competitive atmosphere, this can move the focus away from the service user and the quality of care they need. Providers and commissioners should have a shared goal of developing the bests and most cost effective services for people with neurological conditions. Finances should be viewed in terms of a whole health economy, not a “yours” and “ours” approach. NHS Gloucestershire and Gloucestershire County Council are an excellent example of this.

4. Commissioning and “System Reform”: How does Commissioning fit with Practice-based Commissioning, “Contestability” and the Quasi-Market, and Payment by Results?

4.1 System Reform

For long-term, neurological, degenerative conditions commissioning needs to be effectively joined up between health and social care services, yet there is a body of evidence (for example APPG Inquiry into Parkinson’s disease) that illustrates poor integration between health and social care commissioning.

4.11 One of the key reasons expressed was that benefits and incentives are often different between the two sectors. For example, social care investments such as home adaptation may disproportionally benefit the health sector financially by enabling people to move out of hospital faster—therefore the incentive to establish such schemes often lies with health, who are not the provider.

4.12 The same Inquiry evidence also highlighted the perverse incentive that Payment by Results is creating in the management of people with long-term conditions such as Parkinson’s. The introduction of PbR has resulted in a loss of the flexibility in care that is demanded from the individual nature of Parkinson’s, MS and MND and it is also acting as a disincentive for community based multi-disciplinary services because the tariff for these interventions is not high enough.

4.13 The introduction of the 18 week target has had a huge impact on reducing waiting times but in order to meet this target a number of hospitals have adopted ‘new to review’ ratios, setting out a stipulated number of new patients that they must see for every existing patient they are seeing for a review appointment. This is affecting people with neurological conditions who often need regular review appointments, which are being cancelled. Additionally, in order to achieve this target, consultants are being pushed to discharge people in order that they then are referred back as a new patient for their review appointment.

4.14 Many submissions to the PD APPG Inquiry also pointed to a lack of integration between different aspects of services for people with long term neurological conditions. For example, commissioning for mental health services, for acute services and specialised commissioning does not appear to be joined up in many cases.
4.2 **Tariffs**

If a service does not have a tariff then patients are disadvantaged, as the regulations regarding these are unclear. This needs immediate recognition including, for example, in areas such as deep brain stimulation.

4.3 **Gaming**

A reward system is likely to create perverse incentives and business opportunities that may not be aligned with the best interests of the patient. PbR has resulted in some gaming, such as amongst patients with neurological conditions and co-morbidities. The rule that only one procedure cost can be charged per admission has led to patients being discharged and the re-admitted as a new patient purely to earn extra income. For someone with a long term neurological condition this can cause significant upheaval to daily routines.

4.4 **Practice based commissioning**

We have some real concerns with commissioning services for neurological conditions. For example, the numbers of people living with neurological conditions may be low in comparison to other diseases like diabetes. Thus knowledge and expertise to understand the commissioning priorities for Parkinson’s services will be much less than they are for diabetes.

4.41 Similar problems arise for respiratory management in MND. One of the most severe and distressing symptoms of MND is respiratory insufficiency. Weakness in breathing means that the person with MND cannot expel carbon dioxide from the lungs properly, particularly when asleep. This results in: severely disturbed sleep (as the body’s response is to wake the person and force them to breathe deeply); daytime headaches; extreme exhaustion; reduced appetite; and sometimes hallucinations—this can be one of the greatest threats to the person’s quality of life.

Most people with MND experience respiratory insufficiency during the course of their disease and it may be present from diagnosis. Respiratory failure is responsible for the majority of deaths of people with MND. Since respiratory insufficiency compromises the quality of life and length of survival of people with MND, clinical management is necessary. Non-invasive ventilation (NIV) has been proven to have a significant effect on quality of life and length of survival in MND. Clinical research published in 2006 showed that NIV increased median survival in MND by seven months in a randomised controlled trial. In a complementary prospective study, NIV increased survival in MND by almost 11 months. By contrast, the only drug licensed to treat MND—riluzole—on average extends life by 3 months.

Respiratory insufficiency can arise at any time during the course of MND, so regular respiratory monitoring is vital: a baseline assessment of the person’s respiratory function should be carried out at diagnosis, and further assessment done at three month intervals.

4.42 At present, not everyone with MND has their respiratory function monitored on a regular basis. There is a wide variation in the availability of respiratory support for people with MND, with perhaps as few as 5% of people with MND having access to NIV. The MND Association has carried out detailed mapping of the respiratory services available to people with MND throughout England, Wales and Northern Ireland. In England we have identified 44 areas where respiratory support for people with MND is of serious concern. The human cost in terms of life extension and quality of life of denying access to this vital service for so many people with MND is enormous.

4.43 The National Institute for Health and Clinical Evidence (NICE) is currently producing guidance on NIV for MND. This guidance is expected to be published in 2010, and must be implemented to ensure easy and consistent access to respiratory assessment, and to NIV when appropriate. This is illustrative of the problems that can arise from uninformed commissioning.

4.44 NCS’s experience of engaging with GP commissioning has not been particularly positive—unless there is an individual with a personal interest, neurological conditions are low on the list of priorities.

4.45 Added to this is the fact that most neurological conditions are not currently part of the Quality and Outcome Framework (QOF) process and therefore not a perceived priority for GPs. We would therefore recommend that neurological conditions are commissioned at PCT and specialised commissioning levels and not devolved to PBC.

4.46 NCS is also concerned that a move to more PBC will lead to greater inequalities in access to services and there is a need to increase incentives for PBC groups to work together and collaborate on commissioning more effectively.

4.47 PBC is an opportunity for service users and clinicians to help shape future neurology healthcare but in our experience this opinion is not reflected in the opinions of all primary care clinicians. There is a need for clinical leadership and delivery of improvements in patient care in the community to enthuse and involve all primary care clinicians. NCS is looking at neurology training programmes for GPs to ensure that they are given the skills to manage these conditions more effectively.

PBC is not solely GP commissioning and must involve secondary care clinicians in the planning process as well as service users. There has been a tendency for people with neurological problems to be treated in secondary care and this has had the effect of de-skilling some GP’s.
Providing more care in the community for people with neurological conditions is essential as in the future the cost of secondary care provision may become unaffordable. It is therefore essential that the PBC consortia are of suitable size to estimate population needs. A national disease register specific to each neurological condition would be useful. The MS Society is in the process of developing such a database for people with multiple sclerosis.

4.48 Most of the healthcare budget in the past has been spent within hospitals with new services paid for out of growth money, but there was little discussion about existing services, evaluation of quality or patient satisfaction. Payment by Results was instituted as a national system of tariffs for all elective and emergency episodes of care and hospitals reimbursed for the activity they undertake.

The danger for commissioning with PbR is that the system could become unaffordable as hospitals would get paid for any work undertaken regardless of whether it was a priority for the whole community. There is concern that commissioning decisions may address common conditions like diabetes and give little regard for neurological conditions that are lesser in number overall—for example multiple sclerosis, Parkinson’s disease and motor neurone disease. Spec commissioning for care provision like MNDA’s care centres may be lost within this system due to being seen as lacking priority. The centres currently span the country but do not provide equity of access for all people with MND, and this equitable access is essential if we are to provide local support to patients.

More regard should be given to the costs of managing these conditions as more appropriate commissioning can ensure resources are spent more wisely. For example, if someone with Parkinson’s disease is cared for in the community the cost of care is £4,000 per annum. If that person needs hospital or long term care the costs rise dramatically to £19,000 per annum. This can pose a significant unrecognised cost to each health economy if commissioning for these conditions is not prioritised.

4.49 There are alternatives to PbR. For example, MNDA has developed the Year of Care (YOC) tool for Health and Adult Social Care commissioners and practitioners. The pathway maps out all the possible needs that a person with MND might have over the course of a year, and gives a costed outline of the services required to meet each need.

It can be used to improve the planning and delivery of services for people with motor neurone disease. It also plays an important role in helping to implement the National Service Framework for Long Term (Neurological) Conditions. Using the MND YOC pathway will help commissioners demonstrate the competencies required for World Class Commissioning and achieve a more effective use of resources to meet the needs of people living with MND in their areas.

MNDA have organised a joint learning exercise and a light touch evaluation in four pilot areas around England (Leeds City, Teesside, Derbyshire and Wolverhampton) to support PCTs and Local Authorities who want to improve commissioning and secure the benefits of implementing the Year of Care. Participating areas receive consultancy support from Association regional personnel and they will also benefit from the shared experiences of other authorities who are engaged in the same objective.

The project is piloting the use of Year of Care commissioning tool with commissioners to explore and evaluate how its use can support commissioners to improve commissioning, delivering better outcomes for people with MND.

NCS have recently negotiated funding for year of Care development work to be undertaken for both multiple sclerosis and Parkinson’s disease which is commencing currently and will be completed by March 2010, thus offering this same benefit to commissioning across a wider demographic and ensuring that commissioning can deliver better outcomes for people with long-term neurological conditions.

4.5 Specialist commissioning

4.51 As a result of the recommendations made by the Carter review of specialised commissioning arrangements in 2006,246 Specialised Commissioning Groups (SCGs) were established in the 10 regions of England. One of the rationales for establishing SCGs was to harmonise the commissioning of specialised services and ensure there was equality of access.

4.52 Some of these SCGs are well integrated with their constituent PCTs in order to commission in a planned way. Others are not so well developed. Reform of Specialised commissioning arrangements is therefore not being implemented consistently across the country leading to inequalities in access. This can be illustrated by using the example of Deep Brain Stimulation (DBS) surgery for the management of Parkinson’s.

4.53 The clinical and cost effectiveness of the DBS for Parkinson’s was assessed by NICE in 2003 in an Interventional Procedure and as part of the Clinical Guidelines in 2006. In both documents NICE recommended the use of DBS for certain categories of Parkinson’s patients. DBS is also listed in the Specialised Services National Definition set247 which identified services that should be commissioned at a SCG level and all the SCG in England have identified DBS within their commissioning plans. However,

against this clear guidance, a significant number of people with Parkinson’s have had funding declined by their PCT, even after appeals through exceptional funding panels. This is despite the patient being clinically eligible and against the recommendation of the neurologist and neurosurgeon. Notable areas where there are problems are Bristol and Gloucester and Hillingdon PCTs.

4.54 We feel there are not sufficient drivers for PCT and SCG commissioners to work together to deliver a uniform specialised services. There is also no national strategy for evaluating the variability in access. We therefore recommend that specialised commissioning arrangements should be subject to independent review, such as by the Audit Commission.

5. Commissioning for the quality and safety of services

5.1 Additional comments we would like to make in respect of commissioning

NCS has the following observations to make for this enquiry from its experience of working with commissioners over the last two years:

5.11 Problems are caused primarily because of a lack of investment in non-acute services. For example, following diagnosis individuals could spend up to 30 years living with a disease like MS or Parkinson’s disease. During this time they will require information on how to live with the effects of the disease to minimise disability and maintain independence and self care.

5.12 Many individuals find it difficult to access information about how to access services, obtain equipment to aid daily living, and such. Better commissioning of information services would be beneficial. Resources such as Expert Patient Programmes and NHS Choices are not promoted widely enough to patients.

5.13 In relapse situations for people with multiple sclerosis, as an example, short term relapse services could provide benefits to patients and prevent them from making unnecessary demands on NHS health and social care. Timely responses could ensure individuals are supported at the time of greatest need. However, unless a commissioner has specialist knowledge of what a relapse service can do, they are unlikely to commission this.

5.14 Access to equipment that can promote independence is not being commissioned appropriately. There needs to be greater understanding of how equipment can ensure patients are able to manage at home: the equipment must not only be appropriate for the individual’s needs (not all people with a particular condition will have the same needs), but also be available rapidly.

5.15 Access targets are in place in many Strategic Health Authorities (SHAs) for the provision of equipment. For example the SHA in the South west has an ambition regarding wheelchair provision that 90% of admitted patients and 95% of non-admitted patients to be treated within 8 weeks by 31 March 2011. Whilst the SHA may be working towards a target it feels is acceptable, this wait will still not be acceptable to some of service users. A person with MND, for example, who may need use of a wheelchair within several days, or for their wheelchair to be modified once or even several times as their condition progresses.

In the same way, someone with MS may relapse and need a wheelchair instantly, but for those with Relapsing-Remitting MS, this may on occasion, be needed for a short period of time only, and they may have gone into remission and no longer need the wheelchair by the time the equipment is finally provided.

The MND Association has negotiated equipment pools with some commissioners to ensure people are provided with a wheelchair at the time it is required, and we feel that this practice should be recommended for use more widely.

5.16 There is an urgent need to clarify the current position in relation to funding for equipment but also to ensure there is robust assessment of funding need that relates to a good understanding of the population requiring equipment as well as efficient referral, assessment and procurement services. There are also issues about good models of practice that can be considered.

Access to equipment that can promote independence is not being commissioned appropriately. There needs to be greater understanding of how equipment can ensure patients are able to manage at home.

6. Key examples from mapping exercises which have been found to be applicable across many areas.

6.1 There are a lack of rehabilitation services and a lack of resources for patients’ activities in self management, including use of the internet.

6.2 Vocational rehabilitation services are limited, and there are very few examples of services for younger disabled people who are not at work or who need rehabilitation to resume work.

6.3 Specialist nursing resources are still inequitable for people with MS or Parkinson’s despite the fact that the value of these nurses has been demonstrated.

6.4 There is limited capacity for local respite care services for people at the more advanced stages of their disease, especially people who are younger than pensionable age.
6.5 There is a clear lack of information on services which are available, meaning that those services which are commissioned are not necessarily being utilised to their fullest, or reaching the patients they are intended to support.

6.6 For services to respond to the needs of people with neurological conditions, they need to be commissioned and planned across organisational boundaries. Whilst there is good evidence to show the benefits of commissioning many elements of services it would appear this is not being presented effectively to commissioners and planners.

For example specialist nurses can help to manage people with neurological conditions more effectively, they can build capacity for consultant clinics and keep patients out of hospital delivering care closer to home. The benefits of these and specialist neurology therapists should be recognised.

September 2009

Memorandum from the British Society of Gastroenterology (COM 99)

1. Introduction

1.1 This memorandum is the response by the British Society of Gastroenterology (BSG) to the Health Select Committee Inquiry on Commissioning. Representatives from the BSG would welcome the opportunity to give oral evidence to the Committee.

1.2 The BSG exists to maintain and promote high standards of patient care in gastroenterology and hepatology and to enhance the capacity of its members to discover, disseminate and apply new knowledge to the benefit of patients with digestive and liver disorders. Founded in 1937, the BSG has over three thousand members drawn from the ranks of physicians, surgeons, pathologists, radiologists, scientists, nurses, dietitians, and others interested in the field.

2. Executive Summary

2.1 The BSG welcomes initiatives to improve the commissioning process and is keen, as a body representing the clinical and research community in gastroenterology and hepatology, to contribute to a system which improves the delivery of services to patients. Patient feedback and satisfaction are paramount in the NHS and the BSG is pioneering approaches to ensure the patient is the heart of its activities in research and service improvement.

2.2 The BSG believes that excellent commissioning will only be achieved when expertise from the specialist clinical community is a systematic part of the commissioning process.

2.3 The BSG believes more must be done to improve the interactions between primary and secondary care so that quality standards are followed and patients are managed more effectively. Payment by Results and Practice Based Commissioning are opportunities to shape a closer working relationship if approached correctly.

2.4 Case studies in inflammatory bowel disease and endoscopy show how the BSG’s members have worked in partnership with colleagues to ensure patients receive high quality and improving services.

3. World Class Commissioning

3.1 The BSG welcomes the Department of Health’s World Class Commissioning initiative as a means to improve the delivery of services to patients in a local setting. However, while the rationale behind the initiative is well founded it is apparent that more must be done to improve the quality of interactions between commissioners, clinicians and patients so that implementation is improved on the ground. As the Society that represents providers and recipients of gastrointestinal and liver services, the BSG would welcome a fleet-footed system that tests the validity of its advice and then enables local interaction with commissioners to achieve rapid nimble adoption of best practice and abandonment of older practices, which otherwise often persist for very many years. The BSG, like other professional organizations produces recommendations for the provision of care. A well defined pathway should be established for the recommendations of where this pathway best lies will be strongly influenced by the extent of the powers and autonomy of devolved purchasers. The need to deal with potentially hundreds of commissioners is a major obstacle to communication, and inhibits adoption of world class services and the abandonment of futile and outdated ones, with much potential for postcode lotteries.

3.2 In order to secure the most value for patients and the NHS in terms of outcomes it is essential that clinicians in both primary and secondary care play a more significant role in the commissioning process. By improving the interactions which take place between primary care and secondary care, and by involving active patient groups, greater value and outcomes can be achieved. Outcomes and experiences for patients must be paramount. Via a number of interactions with patient groups and patient feedback organisations, the BSG has placed patients and patient panels at the heart of service provision and improvement, as well as offering patients access to its scientific and professional activities.
3.3 The BSG, as a professional medical society, is keen for its members to play a greater role in the world class commissioning process and stands ready to work closer with colleagues in primary care and PCT commissioners.

3.4 Commissioners must make every effort to engage more closely with specialist professional medical societies and patient groups throughout this process since clinicians and patients are best placed to provide advice and feedback during the process. By consulting with local networks, commissioners will be better placed to ensure they are pursuing the needs of the local populations. Clinicians are willing and able to collaborate with commissioners but all too often this is not the case.

3.5 Information and research are vital tools in the process. The BSG is collaborating closely with Connecting for Health to develop practical information systems, initially focused on the ultra simple but practical task of identifying all patients in each SHA with inflammatory bowel disease by October 2010 so that services can be developed and targeted at all patients who need them. The intention then is to develop this database to more complex details and to other disease processes. In addition, many BSG members are actively involved in clinical research and in the development of registries for specific diseases. These are resources that should be exploited and developed in partnership for the benefit of local services. Better information can only be of benefit in prioritising investment decisions at a local level.

3.6 The BSG is keen for the world class commissioning process to do more to promote improvement and innovation in the NHS. BSG runs interactive fora with its members and is open to discussing its findings with the Department of Health as a form of clinical focus group to provide helpful information to the Department of Health and thence to purchasers. Within gastroenterology it is clear that many of the most innovative technologies are slow to flow through to local hospitals so that they can benefit all patients. There are clear examples within the area of endoscopy technology which mean that many patients do not benefit from the latest technologies available. While some of these blockages to the adoption of technology lie elsewhere in the appraisal and approval processes it is important that commissioners are aware of their availability and the benefit they can bring in the early diagnosis and treatment of various gastrointestinal diseases, especially cancers.

4. THE PURCHASER-PROVIDER SPLIT

As an organisation that represents doctors, nurses and allied health professionals in both primary and secondary care, BSG believes that the most important issue is the identification of key evidence and the drawing of rational conclusions from this. In addition, there is a disconnect between national and regional policies. Ambiguities should be dispelled. If policy is made centrally the statutory regional obligation should be made clear. Where there is latitude for local decision making it is important to make sure this is not just a postcode lottery.

5. COMMISSIONING AND “SYSTEM REFORM”

5.1 Practice-based commissioning offers the potential for GPs to work with their secondary care colleagues and with panels of patients to improve local systems of care and develop services. It holds a lot of promise in bringing clinicians together to shape services, to peg clinical pathways to quality standards and to manage patient care more effectively across the interface between primary and secondary care. The problem with the idea is that it seems to remain just that, an idea. From the secondary care perspective, progress is slow and confusing.

5.2 Hospital doctors are confused about the progress of practice based commissioning—whether PCTs are retaining control of some aspects and how much GP commissioners will have. Despite a lack of clarity about organisational and financial arrangements it is clear that the direction of travel is for groups of clinicians to lead the commissioning process, and that is a good thing.

5.3 It is a fundamental problem that GPs and consultants do not speak to or meet each other on a regular or routine basis. It is a problem that PBC should aim to resolve. A recent case study of developing a service for a long-term condition reached a surprisingly simple conclusion—it is vital to make clear to the professionals providing care who the commissioners are. GPs taking forward PBC should let local providers know and involve their secondary care colleagues.

5.4 There are concerns in secondary care about the implications of current financial incentives on clinical quality and a need for some reassurance from commissioners that new services will be commissioned and audited within a framework that is commensurate with national standards.

5.5 The BSG’s Clinical Standards and Services Committee is made up of local representatives and can help commissioning consortia to define pathways and monitor quality. Locally, commissioning groups should involve hospital specialists in reviewing, planning and auditing new services. There needs to be a dialogue between primary and secondary care on the management of specific conditions.

5.6 Inflammatory Bowel Disease is a condition that cannot be completely managed in primary care, but where care might be delivered in new ways (refer to section 8 below). Better managing chronic conditions will require a review of how patients are managed across the primary and secondary care interface. To
achieve this, gastroenterologists are keen to work with commissioners in new ways and to talk to them about running clinics in different settings or offering new community services. The BSG is actively pursuing these issues with CfH.

5.7 For a real partnership to develop between the sectors, greater financial flexibility is needed. The blocks of money paid through Payment by Results create a financial imperative and incentive to move care out of hospitals and into community settings, something that is feared will be a wholesale shift. The financial incentives risk setting primary and secondary care against one another rather than ensuring a more efficient and effective partnership. Arguably payment is not by results but by activity and the efficacy and ingenuity of coding which varies from one area to another. Arguably there is a logical fallacy about commissioning by practice based individuals who are also providers of services. The BSG believes that a more collaborative model in the assessment of patient needs and two way flows between primary and secondary care could be developed.

5.8 If tariff payments could be unbundled, for example, this would enable the different payments to be unbundled and for different parts of the care process to be delivered in different settings. An unbundled payment might also allow innovative use of consultant time, including the ability to pay for telephone advice and discussion with specialists. The BSG believes that far greater innovations beyond this can be achieved via technology.

5.9 One of the impetuses for reform is need to make healthcare more efficient, yet too often these efforts have been focused on individual entities, requiring an institution to make 2-3% efficiency savings, for example. Too little attention has been paid to increasing efficiencies by improving the connections across the whole pathway of care, examining interconnections within the system of care. The BSG strongly supports this view and as the organisation representing gastroenterology in secondary care would like to engage in such discussions.

5.10 Practice-based commissioning could spawn the kind of collaboration between primary and secondary care that will help to define good outcomes in patients with functional GI disease, including GI disease in the elderly, and the best way to manage their care. It is vital that these metrics are also meaningful to patients. Practice-based commissioning provides an opportunity to more centrally involve patients in commissioning, as a sounding board and a pool of experience. For many patients, GI conditions are long-term and many take part in local groups, providing a really important resource for commissioners.

5.11 Practice-based commissioning has the potential to really transform local services and create a partnership between clinicians and patients, in developing services, but it will only be successful if it genuinely engages hospital specialists and patient experience.

6. SPECIALIST COMMISSIONING

6.1 The BSG believes there should be top slice regional funding for specialist commissioning (both rare diseases and specialised treatments). This should include a 15% component for research procedures (eg stem cell transplantation) as this is the key to improving the application of rare treatments or the treatments of rare diseases.

7. COMMISSIONING FOR THE QUALITY AND SAFETY OF SERVICES

7.1 BSG strongly believes that direct patient feedback should play a major role in assessments of the quality and safety of services.

8. CASE STUDY—SERVICE STANDARDS FOR INFLAMMATORY BOWEL DISEASE (IBD)

8.1 The aim of the IBD Standards is to ensure that IBD patients receive consistent, high-quality care and that IBD Services throughout the UK are knowledge-based, engaged in local and national networking, based on modern IT and that they meet specific minimum standards. IBD is estimated to affect about 240,000 people in the UK, approximately 400 patients per 100,000 population. In 2006 a UK-wide Audit of IBD Services and Care, revealed unacceptable variation in services and aspects of clinical care.

8.2 A Working Group (the IBD Standards Group) of the key professional organisations including the BSG and the National Association for Colitis and Crohn’s Disease (NACC), the IBD patient organisation, was formed to recommend national standards for IBD care.

249 Association of Coloproctology of Great Britain and Ireland, British Dietetic Association (Gastroenterology Specialist Group), British Society of Gastroenterology, British Society of Paediatric Gastroenterology, Hepatology and Nutrition, National Association for Colitis and Crohn’s Disease, Primary Care Society for Gastroenterology, Royal College of Nursing (Crohn’s and Colitis Special Interest Group).
250 The standards are also supported by the following professional and patient organizations: the Royal College of Pathologists, British Association for Parenteral and Enteral Nutrition, British Society of Gastrointestinal and Abdominal Radiology, Royal College of General Practitioners, UK Clinical Pharmacy Association (Gastroenterology Interest Group), UK Digestive Federation, CICRA—Crohn’s in Childhood Research Association, and the IA—The ileostomy and internal pouch support group.
8.3 The IBD Standards document is designed to inform NHS managers and commissioners as part of a UK-wide strategy to improve services for people who have IBD. The need for these standards were highlighted by the Joint Advisory Group undertaking a comprehensive National Audit of adult IBD Services and Care in 2006, to which 75% of hospitals in the UK voluntarily submitted data. Consequent audit rounds have taken place (and will do so going forward) to ensure the evidence base continues to be developed.

8.4 It is hoped that the implementation of these standards locally by commissioners will ensure that IBD Services meet key requirements of the strategies set out by the Department of Health for England (High Quality Care for All—NHS Next Stage Review Report and NHS Next Stage Review—Our vision for primary and community care), NHS Scotland (Better Health, Better Care Action Plan), the Welsh Assembly Government (Designed for Life: creating world class health and social care for Wales) and the Developing Better Services Initiative in Northern Ireland.

8.5 By working collaboratively, professional and patient organisations have succeeded in providing a set of Standards which commissioners can use to meet the local needs of IBD patients in a way which aligns to service organisation and priorities in their locality. The IBD Standards are flexible and inexpensive way for commissioners to ensure that the needs of IBD patients are met. In addition, they are an example of how clinicians and patients can contribute effectively to the commissioning process.

9. CASE STUDY—ENDOSCOPY GLOBAL RATING SCALE

9.1 Endoscopy is the direct visual examination of any part of the interior of the body by means of an optical viewing instrument. Endoscopes are steerable, flexible, cylindrical instruments usually containing multiple channels and equipped with fibre optics for illuminating and viewing. An endoscope may be introduced into the body through a natural orifice—the nose, mouth, urethra or anus, or through a small surgical incision made for the purpose. Examples are a gastroscope, which is used to obtain a view of the stomach, or a colonoscope, used to obtain a view of the colon.

9.2 More than 20 different types of endoscopy are performed in the NHS and these are key diagnostics in over 26 clinical specialties, so faster throughput in this area is essential if the 18 week pathway is to be delivered.

9.3 The Endoscopy Global Rating Scale (GRS) is the Quality Assurance standard used within endoscopy units, and, together with its unique knowledge management system, is the main tool for accelerating uptake of service improvement. The GRS assesses two domains of patient care: Clinical Quality and Quality of Patient Experience.

9.4 The Joint Advisory Group (JAG) is the service accreditation status that can be obtained by endoscopy units. The JAG quality assures both the training and service aspects of endoscopy. Achieving JAG accreditation in the next 12 months is the greatest immediate challenge for most endoscopy services. At present 95 endoscopy units have been JAG accredited. Feedback from JAG accreditation and less formal visits indicates continued improvements in the patient experience. For several items of the GRS more than 85% of services have achieved the minimum standard (level B or better) for an excellent patient experience.

9.5 In addition, the National Endoscopy Project has overseen unprecedented reductions in waiting times and substantial improvements in the quality of care. The expected average waits have reduced considerably over the last two years. In April 2006 the expected average waits were around 10 weeks for gastroscopy, cystoscopy or flexi sigmoidoscopy and more than 15 weeks for a colonoscopy. November 2007 data showed the average waiting time for a colonoscopy was 5.5 weeks and cystoscopy 3.8 weeks. By April 2009, very few patients will be waiting more than six weeks for their procedure. The recent GRS returns show continued improvements. The 18 weeks referral to treatment target (RTT) and Bowel Cancer Screening Programme (BCSP) have raised the profile of the service considerably. Endoscopy teams have been working exceptionally hard to reduce waits and endoscopy is no longer considered to be a key constraint on achieving the 18 week target. The reduction in waits enables the service to focus on making further improvements in quality and training.

9.6 The GRS, JAG accreditation and the National Endoscopy Project has been shown to be an effective measure for improving the quality of service provision and patient experience. It is equally a valuable tool in the commissioning of services by PCTs. Clinician led improvement programmes have ensured that valuable resources and data are available to help decisions with the commissioning of endoscopy services in the NHS.

September 2009

Memorandum by the Primary Care Trust Network (COM 100)

EXECUTIVE SUMMARY

The Primary Care Trust Network (PCTN) welcomes the Health Select Committee’s inquiry into commissioning, and this opportunity to provide evidence. We would be pleased to provide further detail regarding any of the issues highlighted in our submission, and to provide oral evidence to the Committee.

PCTN believes the functions carried out by commissioners in the NHS in England are necessary in a tax-funded/cash-limited healthcare system that seeks to balance individual and population health needs, to reduce health inequalities, and to offer personalised but co-ordinated health and social care services.
It is important that these commissioning responsibilities are separated from responsibility for service provision in some way and at some level. This ensures that there is an agent in the system representing the interests of tax-payers/citizens and patients, rather than service providers and professionals.

In England, due to the size, structure and complexity of the healthcare system and the variation in healthcare needs across the country, and particularly in the context of wider health system reform over the last decade, most commissioning responsibilities have to be devolved to a local level.

In the past, commissioners have been held back from fulfilling their full potential. Repeated restructuring has been disruptive and costly, and has meant that commissioners have not had a chance to develop the capacity, capability and organisational maturity required for effective strategic commissioning. However, there is good evidence that commissioning has improved significantly in the NHS in England in recent years, and there are numerous examples of commissioners having a positive impact on the range, quality and accessibility of NHS services, and of leading service improvement that would not have come about in the absence of external scrutiny, challenge and support.

Whilst good progress has been made, we recognise there is still work to be done to improve commissioning. If commissioners are afforded sufficient organisational and policy stability, we are confident that they will continue to improve both their own capabilities and, more importantly, health outcomes for their populations. Commissioning will be even more important in the coming years as the financial position in the NHS becomes more challenging.

1. **Introduction**

1.1 The NHS Confederation is the independent membership body for the full range of organisations that make up today’s NHS across the UK. The PCT Network provides a distinct voice for Primary Care Trusts within the Confederation.

1.2 The PCT Network represents primary care organisations only in England. The points made in this submission therefore specifically relate to English health policy.

2. **The Rationale behind Commissioning: Do we need a Purchaser-Provider split in the NHS?**

2.1 Within the NHS, the term “commissioning” refers to the ongoing process of planning, securing, coordinating, funding, and monitoring all of the health improvement and health care services provided in a defined geographical area, or for a specific group of individuals.

2.2 Commissioners are not just health care purchasers or payers, but have a much more proactive role to play in leading and managing local health systems. They are responsible for assessing health care needs, identifying health improvement priorities, and making decisions about how NHS resources should be invested at a locality, town, or county level in order to address those priorities and to drive up quality and value for money.

2.3 Commissioners also seek to influence the wider determinants of health by working closely with and informing the activities of other statutory and non-statutory bodies that have an impact on health and wellbeing.

2.4 We believe that the separation of these commissioning functions from responsibility for service provision is necessary at some level and in some form within a healthcare system like the NHS which has finite resources, and with those resources seeks to secure high quality comprehensive health care services to individuals, while also delivering value for money and reducing health inequalities and improving the health of the population as a whole.

2.5 In such a system, difficult decisions about funding and service configuration have to be made. The “right” decisions will not always be in the interests of existing service providers (for example, a decision to reduce or close a service because the resource it requires could produce greater health benefit if invested elsewhere, or to use competition to change a service provider because the incumbent is inefficient or of poor quality) which is why they have to be taken by an independent party: a commissioner.

2.6 An independent entity is also required to hold service providers to account on behalf of patients, and to intervene when organisations are not offering sufficiently high quality, outcomes or value for money.

2.7 The way in which the separation of commissioning and provider functions is achieved, the level of the healthcare system at which it occurs, and the specific ways in which commissioners work will vary in different organisational and policy contexts. In England, due to the size, structure and complexity of the healthcare system and the variation in healthcare needs across the country, most commissioning responsibilities have to be devolved to a local level.

2.8 In England, Primary Care Trusts hold the statutory responsibility for commissioning most health services. However, PCTs form only one part of the total commissioning infrastructure, which operates on a continuum; from supporting individuals to make decisions about what health services they use, through to national commissioning of highly specialised services.
2.9 It is appropriate that commissioning takes place at many different levels in this way, because different commissioning tasks require different approaches. While some are best carried out on a large scale, others require very detailed local knowledge and relationships. PCTs are increasingly collaborating to ensure they achieve critical mass and economies of scale.

2.10 The two fundamental roles of health service commissioners are to act as custodians of NHS resources on behalf of tax-payers, and as advocates, representatives and agents of health service users. Balancing these roles is complex and challenging, and involves making difficult, sometimes unpopular, decisions. There is no doubt, however, that an actor somewhere within the healthcare system has to perform them, and that they have to be carried out with a degree of separation and independence from those responsible for directly providing patient care. We believe that in the context of the English health system these roles are best performed locally, and that the ‘purchaser-provider split’ is, therefore, necessary.

3. The Development of Commissioning in the English NHS

3.1 To be effective commissioning bodies require individuals, systems and infrastructure of the highest standard. Such standards can only be achieved when organisations are given time to develop a skilled and motivated workforce, and to establish effective relationships with providers and partner agencies.

3.2 Although the purchaser provider split was first introduced in the early 1990s, since that time there have been numerous changes to the structure, size and remit of commissioning organisations in England. Repeated organisational restructuring has been disruptive and costly, resulting in a fragmented workforce and a loss of expertise, motivation and organisational memory. At the time, this restructuring seriously undermined the status and effectiveness of commissioning in the NHS.

3.3 Compounding this, the introduction of a distinct commissioning role to the NHS was not initially accompanied by the type of changes to health system “rules” and procedures that are necessary if commissioning is to work. With inadequate information systems, unsophisticated payment regimes, and a largely uncontestable market, commissioners were severely constrained in their ability to assess the quality and value of the services they were purchasing, or to make changes to service provision where these were found lacking.

3.4 When the purchaser-provider split was first introduced, therefore, commissioners were given neither the right tools to do the job, nor a sustained opportunity to develop the capacity, capability and organisational maturity required for effective strategic commissioning.

3.5 However, in recent years the focus of national health policy has begun to shift. Far more emphasis is now being placed on strengthening the demand-side of the NHS by providing commissioners with the tools they need to be effective.

3.6 For example, the introduction of payment by results (PbR) has created an environment in which movement of patients between acute hospital providers is now technically possible without creating unmanageable cost pressures for commissioners.

3.7 At the same time, opening up the quasi/internal market to any provider (including those in the independent sector) willing and able to meet NHS standards is beginning to inject some real competition into the system. Policies encouraging commissioners to market test services are prompting existing providers to examine and improve their current practice, performance and productivity and, in some cases, leading to the introduction of new services.

3.8 The adoption of standard contractual terms and conditions to be used when commissioning NHS services should also, over time, support a shift in the focus of contract negotiations away from financial and legal issues, toward service quality and outcomes.

3.9 Other aspects of system reform, such as the introduction of the national quality framework are also helpful to commissioners in making information about service quality, patient experience and outcomes more transparent, accessible and consistent.

3.10 As a result of these policy changes, commissioners do now have a more realistic chance of exercising their role as patient advocate effectively.

3.11 There are however elements of current policy that require review and refinement to ensure that they continue to support the objectives of commissioners. For example, while initially helpful in imposing discipline on the recording and reporting of activity data and in facilitating patient choice, there have been some negative effects for commissioners resulting from PbR. In particular the way that it creates incentives for providers to generate, rather than help manage, demand for secondary care is becoming increasingly problematic. This needs to be addressed as the mechanism evolves, with tariffs constructed in a way that rewards efficiency and coordination across whole pathways, and not simply increased activity in one part of the system.

3.12 There are many other examples of ways in which policy-making, standard-setting, regulation, system management and performance management could be refined so as to better support commissioning objectives. On balance, however, the recent direction of travel in system reform has been generally positive for commissioners.
3.13 Perhaps the most obvious example of this is this launch of the World Class Commissioning (WCC) Programme. Published in December 2007, the World Class Commissioning framework sets out a vision for excellence in commissioning leading to better health, better care and better value for patients and the public. It includes a set of 11 competencies, the governance standards which PCTs must demonstrate as world class commissioners and a process for ensuring these competencies and standards are being developed. As such, the WCC programme marks the beginning of the first serious national improvement programme for PCTs as commissioners.

3.14 2008–09 was the baseline year for the programme. Every PCT undertook a self-assessment and was reviewed by a panel of experts to establish their commissioning competency, governance arrangements and capacity to improve.

3.15 On each of the 11 competencies, PCTs were scored on a scale of 1–4, with level 4 representing a 90% compliance with core standards. PCTs were expected to, and most did, score at “entry-level” (ie levels 1–2 out of 4) on most of the competencies in the first year. However, they are now expected to progress rapidly over the next few years.

3.16 WCC has been described as the commissioning equivalent to the Foundation Trust development programme for providers. In our view, however, the World Class Commissioning Programme is much more stretching and ambitious. PCTs are being required to demonstrate not just good standards of governance and financial control but excellence in all aspects of their business. Furthermore, while providers have worked toward Foundation Trust status in successive waves, all PCTs are being judged against world class standards at the same time.

3.17 However, comparison with the FT process does provide some useful context and perspective. Had every trust in the country been assessed against the criteria for achieving Foundation Trust status in 2004 when the policy was first introduced, it is clear that the vast majority would not have met the required standards. This did not mean, however, that the majority of trusts were considered to be failing at the time. It simply indicated that higher standards were being demanded of organisations and that, as in any sector or industry, the consistent adoption of new standards would take some time.

3.18 In the same way, the fact that in the first year of assessment PCTs have generally scored at the lower end of the scale for their commissioning competency does not indicate that commissioning has “failed”. It simply demonstrates, as PCTs recognise, that there is significant scope for improvement.

3.19 The impact of the WCC programme will not be fully evident for another two to three years, when it will become possible to assess PCTs’ progress against the health improvement objectives set out in their commissioning strategies. However, the year one assurance process has demonstrated that PCTs are ambitious and enthusiastic organisations focused on improving health outcomes and reducing health inequalities.

3.20 It has also indicated that some PCTs are already close to the best in the world in certain areas of commissioning practice. For example, several were already achieving level 3 assessments in relation to their local leadership of the NHS, work with community partners, and collaboration with clinicians.

3.21 The areas where PCTs generally scored least well are those which are relatively new to the NHS, in particular market making and securing procurement expertise, and so lower levels of knowledge, experience and capacity would be expected.

3.22 We believe these early indicators are highly encouraging, suggesting that PCTs are building foundations of strong leadership, effective partnerships and good governance, which are the first right steps toward becoming world class.

3.23 This view is supported by evidence from other sources that, following a period of stabilisation after their reorganisation in late 2006, PCT performance is now improving significantly.

3.24 For example, the number of PCTs reporting an operating deficit fell from 42 in 2006–07 to just one in 2008–09, while the 2008–09 self assessments against the Care Quality Commission core standards indicate that PCTs, as both commissioners and providers, now outperform acute trusts for the first time. Measured by 90% compliance with core standards, PCTs are now the best performing sector of the NHS.

3.25 Having established and demonstrated strong internal governance, PCTs are now increasing their strength and influence even further by establishing shared commissioning arrangements with other PCTs and with local authorities. This includes formal collaborative arrangements such as those required for regional specialised commissioning. However, there are numerous other examples of PCTs working together to share their resources and expertise in areas such as needs assessment, market management and procurement, to aggregate functions such as data collection and contract monitoring, and to standardise policies and processes for priority-setting and decision-making.

3.26 There is clearly much more work to be done before world class standards of commissioning are uniform across the NHS. However, we believe that PCTs, working closely with each other, with practice based commissioners and with local authorities, currently have an unprecedented opportunity to demonstrate the full potential of commissioning as a driver of health improvement, high quality care and
better value for money for the whole NHS. If they are afforded sufficient organisational and policy stability, there is every reason to believe that PCTs will continue to improve both their own capabilities and, more importantly, health outcomes for their populations.

4. Commissioning for the Quality and Safety of Services

4.1 The primary responsibility for healthcare quality lies with the clinical staff providing the care and the board of the provider organisation responsible for delivering it. However in acting as the agents of local service users, commissioners also have responsibility for promoting and specifying quality improvement, for assuring themselves that the services they commission for their population are of appropriate quality, and for intervening in cases of concern.

4.2 Commissioners promote quality improvement by specifying high quality, evidence-based services, and including incentives for the delivery of good patient outcomes and experience in contracts and service agreements.

4.3 Commissioners also encourage quality improvement by raising local people’s expectations of NHS care, empowering them to choose services on the basis of quality and outcomes and to constructively challenge inadequate service when encountered. This requires commissioners to engage in dialogue with local people to develop a shared understanding of what high quality services look like, and to report back to the public information about the quality of services which are commissioned on their behalf.

4.4 Commissioners also have arrangements in place to assure themselves of the safety and standards of existing provision. This involves synthesising and interpreting both hard data, such as mortality and clinical outcomes measures, patient reported outcome measures (PROMS), reports on serious untoward incidents, patient and staff survey responses etc. and soft data such as informal feedback from staff, patients and the public about the quality of local services. This type of analysis is backed up with first-hand scrutiny of services by commissioners for example through visits to provider organisations, allowing observation and on-site dialogue with patients, carers and clinical staff.

4.5 Where commissioners are not assured about the quality of any of the services they commission, for any reason, they have a right and a responsibility to intervene. Commissioners are increasingly exercising their powers in this regards, through interventions ranging from a relatively informal discussion with the provider to raise and resolve a minor concern, through to giving notice to an organisation and re-commissioning services from new providers where problems are serious and persistent.

4.6 Promoting quality improvement and assuring appropriate standards are being met is a core responsibility for commissioners as agents of patients and the public. This is a resource intensive role but, as the recent reports on events at Mid Staffordshire NHS Foundation Trust starkly highlighted, one that commissioners need to strengthen and develop.

4.7 At the same time there needs to be more work done nationally to explore the respective roles of commissioners, regulators, and Strategic Health Authorities (in their system management capacity). There is a significant risk of overlap or gaps in the current system due to ambiguity of respective roles which could lead to either unreasonable burden on providers or inappropriate inaction when problems are occurring, or both.

5. Commissioning Achievements

5.1 Most commissioning achievements are locally based and are difficult to summarise at national level. Every PCT will be able to give examples of local improvements in the range, quality and accessibility of NHS services, and of leading service improvement that would not have come about in the absence of external scrutiny, challenge and support.

5.2 However one of the roles of commissioners is to oversee the local implementation of national strategies and requirements. In doing this, commissioners have made a significant contribution to the improvements in access, quality and outcomes that have been seen across the NHS in recent years. For example:

— By July 2009, only 344 patients for whom English commissioners are responsible were waiting over 13 weeks for one of 15 key diagnostics tests. This is a fall of 3,744 (91.6%) from July 2008.

— The 2008–09 NHS Operating Framework set a commitment for PCTs to procure 152 GP-led health centres (one in each PCT) and 112 new GP practices in the 50 PCT areas with the greatest need. By July 2009 50 new health centres had been opened, and 90 percent are expected to be operational by the end of the year.

— Following national agreement to reward GP practices that extend their opening hours, PCTs have worked with practices to implement the changes, so that by July 2009 77.1 percent of GP practices were providing extended opening hours at evenings, early in the morning and at weekends.
6. **PRACTICE-BASED COMMISSIONING**

6.1 Practice based commissioning (PbC) is an integral part of commissioning. PCTs see clinical leadership as fundamental to strong, effective commissioning. Practising healthcare professionals hold much of the knowledge and expertise required to assess health needs, design effective and efficient healthcare services and assess the quality and outcomes of the care delivered by their peers. Consequently a PCT could not be considered a “world class” commissioner if clinical expertise and experience does not drive its commissioning strategy, alongside public and patient engagement. This expertise should be drawn from a range of sources including primary care and public health professionals as well as specialist secondary and tertiary care clinicians.

6.2 One aspect of PbC is the allocation of budgets to primary care teams, which places a specific responsibility on such teams to take a proactive role in managing the resources available to provide healthcare for their patients. Again, PCTs see this as a positive and logical development of commissioning because it aligns the ability to commit healthcare resources (by prescribing treatments or making referrals) with responsibility for managing them.

6.3 However, PbC is not just about budget holding, but is a vehicle for ensuring there is clinical input to all aspects of local planning and decision-making.

6.4 Significant progress is being made across the country in both devolving appropriate commissioning responsibilities to practices and in engaging healthcare professionals in all aspects of strategic commissioning. Further development along these lines will be welcomed by PCTs.

6.5 However, there will always be a role for a coordinating body operating at a level above practice-based commissioning, retaining a focus on whole population health and the need to reduce health inequalities, managing the performance of practice-based commissioners, and coordinating relationships with strategic partners such as local authorities.

7. **FUTURE CHALLENGES**

7.1 The economic downturn will have significant financial implications for the NHS. The need to improve productivity and reduce costs, while at the same time maintaining or improving quality, poses a huge challenge for the NHS. This makes strong commissioning more important than ever.

7.2 Commissioners are best placed to lead on driving productivity and quality in the NHS as providers on their own are unlikely to take decisions that might threaten their own organisations, or take a whole population perspective when rationalisation is necessary.

7.3 Our discussion paper, *Commissioning in a cold climate*, sets out the implications of this for commissioners, and identifies some of the proactive ways commissioners can respond to this challenge. 

*September 2009*

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**Memorandum by the of the NHS Confederation Provider Networks (COM 101)**

1. **THE NHS CONFEDERATION AND ITS NETWORKS**

1.1 The NHS Confederation is the independent membership body for the full range of organisations that make up today’s NHS across the UK.

1.2 The Ambulance Service Network (ASN), Foundation Trust Network (FTN), Mental Health Network (MHN) and NHS Partners Network (NHSPN) are constituents of the NHS Confederation and between them represent the views of NHS providers:

- the ASN is the representative body for NHS ambulance services in England, Wales and Northern Ireland;
- the FTN represents aspirant and authorised NHS foundation trusts across the acute, community, mental health and ambulance service sectors;
- the MHN provides a distinct and independent voice for mental health and learning disability providers; and
- NHSPN members are independent (commercial and not-for-profit) healthcare providers involved in all aspects of NHS care at primary, secondary or acute level, including diagnostic and specialist treatment centres.

1.3 This response puts the views of providers operating within England on the English system.

1.4 We should be pleased to provide further detail on any of the points raised.

251 [http://www.nhsconfed.org/Publications/Documents/Commissioning_in_a_cold_climate_FINAL.pdf](http://www.nhsconfed.org/Publications/Documents/Commissioning_in_a_cold_climate_FINAL.pdf)
2. **EXECUTIVE SUMMARY**

2.1 This submission by the provider networks of the NHS Confederation highlights that:

- There is a need for a strong commissioning function;
- World class commissioning is a suitable framework to deliver this;
- System stability is a significant means of ensuring increased competency and delivery of value to patients—through retention of contracting and development of Payment by Results mechanisms and a better appreciation of provider risk;
- Marketisation should be completed expeditiously, including full separation of provider and commissioner functions;
- There are a range of mechanisms available that enable commissioners and providers to work together to promote quality and safety—CQUIN being one, the development of quality accounts, use of Patient Reported Outcome Measures (PROMS) and benchmarking being others.
- Stakeholder engagement is a powerful tool in underpinning effective commissioning, ensuring the primacy of patient and public interest in the system.

3. **GENERAL POINTS**

3.1 The best commissioning is a mutual activity between a purchaser and its providers; the purchaser has a vision of the end product or outcomes that are required, but providers understand how these can be delivered, because of their specialist knowledge. A more joined up approach between commissioners and the full plurality of suppliers operating in local health economies would better support innovation in service design and delivery and is to be encouraged.

3.2 PCTs need to make better use of data to inform their commissioning strategies, predicting, planning and commissioning realistic levels of activity and managing that delivery through the contracting process.

4. **“WORLD-CLASS COMMISSIONING”: WHAT DOES THIS INITIATIVE TELL US ABOUT HOW EFFECTIVE COMMISSIONING BY PCTS IS?**

4.1 The recent outcomes of the PCT assessment against the world class commissioning (WCC) competencies show that:

(a) there is a long way to go;
(b) competency across PCTs is variable;
(c) no one commissioning body is yet world class against the set criteria.

**Supporting the market**

4.2 We fully support the need for a robust effective commissioning function. All NHS organisations need commissioning to work well. The WCC initiative is appropriate, but progress needs to be made quickly in light of the coming economic restrictions; further, in this context, it is vital for the pace of market reforms to be stepped up in order to deliver the necessary productivity gains required of the service.

4.3 The WCC competencies that scored most poorly were those relating to market stimulation and procurement skills—vital elements to fully utilising the pluralistic market to its fullest. Proficiency in these areas will need to be nurtured and developed alongside the other competencies in order for commissioners to be world class in all aspects.

4.4 Market management remains a particular challenge for PCTs who appear to see the use of limited tendering as their main tool for developing/managing the market. There are a number of issues which are not easily resolved by PCTs (for example, NHS pensions) which make it very difficult to achieve a level playing field.

**Subsidiarity**

4.5 Commissioning needs to be carried out at the most effective level and there is an argument for rationalising the function—can 152 organisations all be world class commissioners of all types of health service? To achieve a step change in capability we need to consider how PCTs work collectively, and how they achieve the greatest impact by sharing skills and capabilities across organisations.

4.6 There exist local examples of where commissioners have pooled their capability to effectively commission services, through cross-locality confederations (particularly in London), and for ambulance services at pan-SHA level where there is a PCT lead commissioner arrangement. Lead commissioners for ambulance services are developing a good understanding of what ambulance services do and relationships with providers are maturing.

4.7 However, where a lead commissioner arrangement is put in place, of whatever service, it is important that PCTs in the area do not disengage and rely excessively on that lead commissioner, otherwise sections of the population risk being under-served. It is also important that lead commissioners work with other services’ commissioners, wherever they reside in the infrastructure, to develop effective patient pathways.
4.8 Further co-operation between NHS commissioners and other agencies, such as local government, would also assist the development of truly integrated health and social care services and, by shifting the focus to preventive and re-ablement services, would help ensure more people get treated in the right part of the system.

4.9 Some specialised services are commissioned nationally, and some services remain centrally funded, such as the new Hazard Area Response Teams which ambulance services are developing. However, it is not clear how these will be sustained in the longer term once responsibility for funding them is devolved to PCTs; more certainty is needed so that AS Trusts can plan effectively.

4.10 Notwithstanding local decisions on pooling capability, we would caution against a further restructuring at the current time. However, it would be a costly diversion from the immediate productivity demands required and the growth of competency in commissioning which is nurtured by stability.

Sustainability of the healthcare system

4.11 WCC provides a potential framework by which commissioners’ understanding of the supply chain and system risk can be assured. We are not convinced this is given due priority in the current arrangements.

4.12 As marketisation of the NHS continues, commissioning needs to support the sustainability of the market. In a true market, companies have flexibility over which assets they wish to acquire in order to provide their chosen services. The NHS context is different: the assets are publicly-held, often inflexible and politically charged; and incumbent providers have the universal service obligation—ie providing those services that are deemed necessary but which are unattractive to new entrants.

4.13 Commissioners need to recognise the risks to the system of a quick win on costs made by contracting with a new provider, which might threaten the viability of a larger range of statutory services in the longer term: transition to increased provider plurality requires strategic consideration, particularly regarding the stewardship and optimal use of existing public assets.

4.14 Commissioners also need to find a way to achieve the advantages that long term supply chain relationships bring, such as certainty and continuity of care, while also incorporating sufficient levels of challenge to those relationships to drive continuous improvement, added value and innovation.

World class commissioning of long term services

4.15 Long term conditions are an area which presents PCTs with particular challenges. Whilst PCT commissioning appears to have developed in the areas of physical conditions (elective surgery, relatively straight forward medical conditions) the same progress has not been made uniformly in areas such as mental health and older peoples’ services. This is clearly a workforce issue, often those individuals responsible for commissioning mental health are relatively junior, which considering the scale of expenditure seems inappropriate.

5. The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

5.1 It is too soon to judge the success of the purchaser/provider split as it has not been fully implemented nor has it had a chance to mature and begin to show the expected improvements and benefits that were the original goal of the policy. The split is critical to the success of the market reforms and yet thus far, the split has not gone far enough, quickly enough.

5.2 Many PCTs have yet to fully divest their provider arm and competition issues are bound to arise when provider arms are kept in house behind Chinese walls or contracts are let without a full tender process. We support full divestment using a range of models to increase plurality and maximise patient benefit—for example, community foundation trusts, social enterprises, mergers and acquisitions activity etc.

5.3 In a competitive, pluralistic market the benefits of competition and innovation will only be realised when the elements of the market (fair playing field, low barriers to entry and an open market etc) are allowed the time and space to work effectively. As we enter a period where innovation and alternative approaches to care provision are vital, there needs to be increased willingness to relax the many overly tight constraints on provider organisations and to commission against desired outcomes and not on the basis of historic processes.

Separating needs assessment from resourcing decisions

5.4 There is a strong argument for further separation of the functions identifying local need and making decisions on how best to spend the finite NHS resource to meet this need. It is too early to judge whether the current model of PCT commissioning is the most effective approach. In regard to mental health it is important for any health commissioning function to be highly integrated with the social care commissioning function—to date PCT/ local authority commissioning integration is very variable.
6. Commissioning and “System Reform”: how does Commissioning fit with Practice-based Commissioning, “Contestability” and the Quasi-Market, and Payment by Results?

6.1 Commissioning must play a central role in system reform, using the WCC programme in its entirety to bring powerful changes and improvements to the NHS. The potential of the tools of system reform has not yet been realised as there has not been enough time to judge effectiveness, nor to fully implement them.

6.2 It should be noted that there remain commissioning “gaps” where providers still bear the risk of coping with extra demand, particularly in emergency and urgent care services, without any contractual agreement for PCT commissioners to pay for this.

Payment by results (PbR)

6.3 The continuing absence of a tariff/PbR for mental health is a real concern—we understand any arrangement will not be in place until 2013–14. This leaves mental health services disproportionately vulnerable in the current economic climate (being commissioned via block contracts), at a time when demand for these services is likely to increase.

6.4 In respect of ambulance services, the shift from block contracts to a cost and volume arrangement has led to much more meaningful and useful information being available to support commissioning.

6.5 The importance of PbR across the healthcare system cannot be overstated. It promotes transparency, stability and makes available to commissioners and providers the market information needed for an efficient effective system (ie clarity of service definition, through the HRG system, and cost) that delivers value and quality for patients. It explicitly supports competition on the basis of quality.

6.6 While the immediate economic constraints might make alternative payment systems appear attractive, the benefits, both delivered and possible through PbR are significant. For example, in the NHS Foundation Trust sector, PbR has supported the investment of £339 million in improved patient services in 2008–09 alone, with £353 million anticipated in 2009–10. PbR has enabled independent sector providers to enter the market competitively and further drive service improvement in areas where they provide services alongside incumbent providers. It is a system that maintains a national health service, avoiding the disruption of local pricing which would be inefficient and chaotic.

Practice based commissioning (PBC)

6.7 It is not clear how PBC and PCT commissioning fit together. PBC could provide innovative approaches to meeting local need which may not necessarily be conventional health services but at present it often appears to be more of the same.

6.8 Furthermore, smaller PBC consortia could experience difficulties in delivering the scale of change required in the current financial climate.

Contestability and the quasi-market

6.9 We comment on the special characteristics of the NHS market in paragraph 4.12 above.

6.10 Co-operation and competition principles are important tools by which the NHS market can be managed to deliver better results for patients and the public and these should be used to promote a better understanding of dynamics and benefits within the system. These principles are not mutually exclusive—in many industries the more formal mechanisms for co-operation between legally distinct and competing organisations result in better practical co-operation than informal arrangements within large systems, where co-operation is assumed but poorly structured and often not incentivised.

6.11 Wherever possible, tendering processes should be streamlined; they are too time-consuming for both PCTs and providers. To improve efficiency, transaction costs should be reduced.

7. Specialist commissioning

7.1 Specialised commissioning is one area where relative stability has seen lower turnover of key staff and commissioners over the past three years. This has led to an ability for longer-term planning and negotiation relationships to be built, and thus maturity and understanding to develop in commissioning relationships.

7.2 Also “slash and burn” tactics do not appear to figure in specialised commissioners negotiations with providers. This enables some element of surety when planning and developing services which are often there to serve seriously ill patients.

7.3 Opportunities for improvement in the specialised commissioning field centre on central systemic issues, such as a lack of tariff and currency (for example, due to variations in morbidity, provision and care packages).
8. **Commissioning for the Quality and Safety of Services**

8.1 The priority attached to quality and safety has been variable.

8.2 The ‘commissioning for quality’ agenda requires a more developed patient pathway approach. For example, it is not sufficient merely to judge ambulance services getting to the patient quickly as good performance. There is need for a systemic approach to evaluating success, focused on the patient perspective.

8.3 Whilst Commissioning for Quality and Innovation (CQUIN) is a move in the right direction PCTs need to focus more clearly on quality and safety—a quality improvement plan should be at the centre of the commissioners’ approach as the evidence suggests good quality services also deliver value for money; however, it needs to be remembered that commissioning is not the only driver for quality in the system and needs to work alongside other drivers.

*Quality accounts*

8.4 Quality Accounts are a significant driver introduced in 2010 that will help the boards of provider organisations to own and deliver on quality, performance and service improvement is quality accounts. These will include quality improvement plans. NHS Foundation Trusts and NHS Trusts in the East of England produced a set of pilot quality reports for the year 2008–09, which set out a quality narrative and the baseline data from which to map and report on improvement in subsequent years.

8.5 Quality accounts are a means of holding providers to account for services delivered and for NHS Foundation Trusts, they are a means of ensuring that members and governors have input and a real say over the strategic direction of their local health services.

8.6 PCTs can learn from the example of foundation trusts’ stakeholder engagement, as a means of identifying the quality priorities that are important to the patients and public in the local health economy.

8.7 Of course, PCTs are stakeholders too, and have an important role in shaping local services, but real quality is achieved through meaningful ownership of the quality journey—ie achieving a consensus in determining a small number of indicators that reflect local concerns, where improvements can be visibly demonstrated in a sustainable way.

*Lessons from Mid-Staffordshire NHS Foundation Trust*

8.8 In light of the example of Mid-Staffordshire NHS Foundation Trust, it is increasingly clear that quality should be at the centre of services. There are a number of means of assuring this, including:

- PCTs should invest in the supply chain and better understand the relationships that deliver quality across the whole patient pathway;
- The quality profiles being developed by the Care Quality Commission (CQC) can usefully inform PCTs’ activities;
- Quality accounts will put quality at least on a par with financial reporting requirements;
- Using the standard contracts for acute, mental health, ambulance and community services effectively;
- CQUIN.

*CQUIN*

8.9 Extending CQUIN has potential to promote quality and innovation.

8.10 In 2008–9, CQUIN comprised 0.5% of current contract values and while it may be appropriate to extend the percentage given over to this income stream in due course we would recommend a cautious approach given that existing schemes have not yet been fully developed yet alone evaluated.

9. **Conclusion**

9.1 While the outcomes of the recent competency assessment show that commissioning can be improved, it is on the right trajectory; we would recommend system stability and locally determined rationalisation together with an advancement of the market as the right way forward. This should be accompanied by an increased awareness of system risk.
9.2 Quality should be embedded in system development through appropriate means of stakeholder engagement, such as that offered by the quality account process. PCTs can assure themselves of quality by having regard to these provider accounts, complemented by the range of information and controls available to them, such as standard contracts, CQC quality profiling and CQUIN.

September 2009.

Memorandum by the Royal College of Speech and Language Therapists (COM 102)

The Royal College of Speech and Language Therapists is the professional body for speech and language therapists and support workers. We also promote the views of people of all ages with communication disability. We promote excellence in practice and influence health, education and social care policies. Speech and language therapists play a major role in working directly with children and adults, as well as supporting other professionals in working with speech, language and communication needs.

Summary

— Speech language and communication needs services for children in England underwent an official independent review in 2007–08 chaired by John Bercow MP. Both the Bercow Report and the Government’s response recognised ongoing issues in the area of commissioning, and the government is committed to tackling these problems through commissioning pathfinders in eighteen local authorities.

— In order to meet the holistic needs of children, it is crucial that commissioners in health, education and social care are enabled to work together to deliver seamless, integrated services. Too often, this is not the case.

— There is still a lack of integration and an unwillingness to cooperate, to pool resources or to share funding in the joint commissioning of services across health, education and social care.

— The Bercow Review found that, “in planning, commissioning and delivering universal, targeted and specialist provision, it is critical that health services and children’s services, including schools, work together in support of children and young people with speech language and communication needs.

— No single agency can deliver any one of the five Every Child Matters outcomes for children and young people by working in isolation. Separate silos produce misunderstandings, cause divisions and can be bewildering or infuriating to parents for whose children services are delayed or denied as a result.”

— The evidence presented to the review found that over half the responses said health and education only worked together “sometimes” and around a third “rarely” worked together.

We have surveyed our network of Speech and language Therapy managers of services for children and adults with speech, language and communication needs. They have identified the current following problems with commissioning, and we have collated their responses below.

“World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

Children’s speech and language therapy is generally jointly commissioned. That certainly is the case here in Kingston. BUT a framework for Commissioners from the PCT and LA sitting down together to consider the priorities across the patch and who is buying what still does not exist. This could be contributed to by a number of factors…the LA see themselves as Commissioners and Providers and do not understand the “Health” commissioning process—the targets for Education and Health are different—Local GP’s as Commissioners does not “fit” neatly with Children’s and Young Peoples Plan Agenda & the Children’s Centre Agenda.

WCC—league tables published do not give much information as Broad brush. In terms of effective commissioning it is in its infancy in our locality and the latest drive to tender out services highlights the inequality of the process as there has been nothing like the input to the bidding part of the process for instance I have been closely involved in two bids for services and the time taken to respond to WCC tenders has been long and onerous—we have had teams of people working on bids then having to present bids when there is no funding for this and Commissioners do not expect to fund providers to put together bids.

Commissioning is causing confusion for other agencies eg education as the local authority is both commissioner and provider and can’t see why we need 2 different aspects. Children’s services are not jointly commissioned at the moment and an easier process would be helpful.

We don’t feel it is a success and see the main outcome as a whole range of new business managers needed at the provider level which doesn’t seem to be an effective use of resources.

GPs place in commissioning is confusing.

Transparency in the commissioning process is not occurring.
Focus on quality of services is not apparent.

Commissioners appear very busy gathering evidence, setting up reviews etc, but no increase in establishment has ensued. Work is lost and therefore time is wasted when commissioners leave or are moved to other projects. For example, I have been pursuing SLT’s portion of the cochlear implant bundle since 2003 as the surgery is carried out outside the city and have been over the same ground several times.

The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

The split is needed . . . Our Provider Services will be externalized as a new organization of the Social Enterprise type on Oct 1st of this year . . . in line with Government policy & therefore to have clear purchasing/commissioning arrangements is essential to the sustainability of our services and all other “Provider Services”. The Services that are to be externalized are all those that ‘sat’ previously in the Primary Care Trust.

ie Adults in the community, Children & Family Services & Adult Learning Disability Services.

The Purchaser/provider split has resulted in better ownership of strands such as Core Standards BUT when the Provider organisation is small there is a huge time burden on all staff and reduces time available for clinical provision. Need to look at economies of scale etc in organisational form. Has built rigour into the system and being business ready has resulted in all knowing their business better. Regarding users I would observe that locally waiting times have come down, users are more involved and will be included in future plans more effectively. The split has made us all stand back and reflect on what we are doing, quantifying it more accurately and making improvements in efficiency.

In my view it has been a negative force in the NHS. The commissioners are not in a position to be close to patients and understand their needs. Most are surprised by the complexity of the SLT role and are not aware of the range of pathways that involve us so a lot of work is carried out explaining our work and preparing papers, bids and tenders to an ever-changing army of commissioners.

Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

I think I have answered this bullet above BUT Payment by Results applies only to the Acute Hospital Sector (I think). Contestability is really hard with S and LT because services have generally evolved to meet local need and therefore benchmarking against other similar services is almost impossible and is often comparing “apples and pears” But Key performance indicators could & should be the same...matched against the evidence base. This also addresses the quality and safety commissioning bullet point number 5 below.

PBC/PBR etc PBC has been a mixed picture. Where practices are working together well as at one side of our patch the commissioning is more effective although we have had some developments with GPswSI that have not been clinically robust.

In terms of responding to Commissioning from Practice Groups it increases the time needed to interface and again provider services have no funding to increase their capacity for this so again will drain clinical resources if not careful. PBR has been mixed as we do not yet have a community tariff so many of our service still on block Contracts which means more difficult to plan as no extra income for increases in referrals/activity etc and we still have to meet same waiting times as services which are paid for increases in activity.

Contestability –My observation is that Commissioners often use this for services that they can easily tender out in order to tick the Contestability box. As tendering out services is a lengthy process and there are few providers in our area it doesn’t always look like an attractive option. I think they should concentrate on driving up the quality of existing services wherever possible as abetter investment of resources. A couple of local examples where private single handed providers have been used as “spot purchasing” and we know these providers would not meet usual Health standards.

Competition between different services initially Foundation Trusts vs. the rest, now the tendering for services involving private and 3rd sector sets service against service; reduces cooperation; and information sharing which has a detrimental effect on patient care.

Specialist commissioning

Specialist commissioning should be about local priorities across an area— in other words where there is an identified need and an agreed local priority.

See above re cochlear implants. The same problem has occurred for other aspects of therapy where the specialist centre is not our city eg cleft palate. The specialist commissioners do not always understand the need to commission the AHP parts of the pathway.
**Commissioning for the quality and safety of services**

Commissioning for quality and safety –where we have responded to formal tenders there has been an enormous number of quality/safety questions and assurances so confident that these will be built in. Less so around the more ad hoc procurement referred to above and not sure who oversees that process. TCS quality Indicators should help when they are finalised and look forward to those. However observe that often indicators are based around waits and volume of activity rather than outcomes which we would prefer ie what difference does the input make to user.

NHS is over-managed at commissioner level who put demands on provider services to provide them with reams of info that is not acted on with the result that providers also have to have top heavy managers and admin. The commissioners have little reference to patients and clinics on the ground.

*September 2009*

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**Memorandum by the Chartered Society of Physiotherapy (COM 103)**

**INTRODUCTION**

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the 48,000 chartered physiotherapists, physiotherapy assistants and students in the UK. Our members work in the NHS, private practice, the independent sector (charities, private businesses and local government) and universities. We are pleased to be invited to submit evidence to the Health Committee Inquiry into Commissioning.

**EXECUTIVE SUMMARY**

- CSP fully supports the aim of World Class Commissioning to succeed in “adding years to life and life to years”.
- CSP welcomes the significant improvements already achieved through WCC, notably the reductions in waiting times for hospital in-patient services and reductions in death rates from cancer, cardio-vascular disease or stroke.
- CSP strongly supports service redesign and innovation aimed at improving patient care, but also believes that mainstream NHS services are best delivered by NHS-employed staff.
- However, CSP has significant concerns that the intention that the commissioning process should improve quality and encourage innovation (and be underpinned by co-operation and collaboration) may be being compromised in some cases where the main driver for some local commissioners appears to be primarily the achievement of financial savings.

**MAIN EVIDENCE**

1. Physiotherapists assess, treat and rehabilitate people with physical problems caused by accident, aging, mental illness, disease, injury or disability. Physiotherapists are involved in the improvement of the health of the public at every stage from prevention, to diagnosis and treatment and through the development of sustainable programmes to help individuals maintain and improve their general good health.

2. The CSP recognises, that while the informed view of professional bodies, trade unions and other stakeholders are very valuable, it is the experience of service users that must be central to determining whether or not World Class Commissioning (WCC) is effective in improving service provision. We expect that the Government’s recent emphasis on improving the quality of services and patient experience will help to change substantially the focus of NHS commissioning, provided it is followed.

3. The CSP strongly believes that health promotion and well-being are crucial to improving health outcomes in the future. Tackling health inequalities and preventing of ill-health is a major challenge. CSP is particularly concerned about the growing numbers of adults and children who are overweight or obese, and the worrying numbers who take insufficient exercise. CSP is a partner in the Change4Life programme and is running a long-term initiative called “Move for Health” which aims to promote the benefits of regular physical activity in maintaining health and well-being in adults and children. There would seem to be only limited evidence so far of WCC having any significant impact on health promotion and well-being. Instead, the focus of commissioning still remains the provision or improvement of acute and community-based health treatment services.

4. Lord Darzi, in his Next Stage Review Interim Report acknowledged that over the past decade, despite significant investment and improvements in care, ‘The gap in life expectancy between the most deprived and least deprived areas has widened, despite improvements in life expectancy in the most deprived areas. Someone’s social status or where they live should not affect when they die’. By placing greater emphasis on assessing local needs, and prioritising investments to deliver long term health outcomes, WCC 253 Commissioning Assurance Handbook. Department of Health 2008. London.

should be pivotal in reducing health inequalities; supporting the shift from treatment and diagnosis to prevention and the promotion of well-being. The CSP is concerned that because the NHS is being instructed to prioritise the achievement of major financial savings, WCC will not be able to end inequalities in health outcomes.

5. WCC and the commissioning process have already achieved a number of significant improvements. These include significant reductions in waiting times for hospital in-patient service, together with the substantial improvements in the reductions in death rates from cancer, cardio-vascular disease or stroke. Commissioning has also resulted in the rapid expansion of healthcare staff providing front-line patient care services.

6. Nevertheless, the CSP has evidence of the narrow focus of WCC. This includes the fact that until recently, physiotherapy and other AHP out-patient services were disregarded in calculating waiting times and in decisions about needed investment to improve patient experience. Similarly, our experience of the commissioning of physiotherapy patient self-referral systems into Musculoskeletal (MSK) services was poor until the Government announced its backing for a national policy in September 2008.

SPECIALIST COMMISSIONING

7. The experience of several user organisations has recently demonstrated evidence of problems with commissioning specialist services. These include cardiac rehabilitation, neuromuscular conditions and community stroke services.

8. A recent report from the British Heart Foundation demonstrated that there had been little progress in the commissioning of adequate cardiac rehabilitation services. This is despite the fact that cardio-vascular disease is a major health problem and that the clinical evidence shows that those with access to cardiac rehabilitation are likely to have a 25% better survival rate than those who do not.

9. Recent work by a number of user organisations for neuromuscular conditions (such as muscular dystrophy or multiple sclerosis) has shown that the responsibility for the commissioning and development of specialist neuromuscular services (including physiotherapy) appears confused, with different levels within the NHS apparently having a role, and with varying degrees of knowledge. This has resulted in a lack of accountability to patients and families, potentially causing avoidable suffering and distress. The CSP would commend the recent All Party Parliamentary Group for Muscular Dystrophy report “Access to specialist neuromuscular care: The Walton Report” to the Committee for details of the success and failings of the current specialist commissioning arrangements.

10. Another problem is the ongoing attempts to develop and “unbundle” the tariff for services. The creation of responsive tariffs for non-medical services, in particular those delivered by multi-disciplinary, multi-agency teams (such as those provided by AHPs) is undoubtedly a challenge. However, if we are to ensure that health and well-being services reflect the care pathway approach, are “seamless” and delivered in the appropriate setting, that challenge must be met. A similar challenge faces the development of quality metrics for those same services.

COMPETITION AND TENDERING FOR NHS SERVICES

11. The CSP has issued policy and advice to its members in dealing with changes in NHS services arising from the Government position on “Transforming Community Services”.

12. Our policy states that “The CSP strongly supports service re-design and innovation aimed at improving patient care, but also believes that mainstream NHS services are best delivered by NHS-employed staff”. CSP believes it is essential that decision-making is supported by the following:

- There must be demonstrable evidence that any alternative providers will deliver better quality patient care than NHS services.
- The consultation must include genuine alternative choices between alternative providers and NHS services. When no choice is being offered except to leave NHS Trusts the CSP will oppose the proposals in principle.
- There must be fully informed and proper consultation with CSP members and their CSP representatives concerned, including the opportunities to discuss the evidence base for patient care and sufficient time to consider the proposals in detail.
- The starting position should be that mainstream NHS services are best delivered by NHS-employed staff.

13. Where CSP members conclude that a different model of service delivery is genuinely in the best interest of the users of services and of the staff employed in them, the CSP will support members in their choice.

254 The National Audit of Cardiac Rehabilitation 2009: British Heart Foundation
CLARIFICATION FROM THE SECRETARY OF STATE

14. On 15th September 2009, the Secretary of State, Andy Burnham, in a major speech to the King’s Fund, issued a significant clarification of the Government’s position on competition and the external tendering of NHS services.

15. He stated that NHS organisations are the “preferred provider” of state-funded health care. He reiterated that it is the job of the commissioner to test whether services provide best value and real quality. He went on to state that where a provider is not delivering quality—then the Government will set out a clearer process that will provide an opportunity for existing providers to improve before opening up to new potential providers. He further explained that this is “fair to all as it means everyone knows where they stand and services stand or fall on the quality they provide”.

16. He also told the Financial Times that where a new or redesignated service was needed, NHS organisations “should be given an opportunity to meet this new requirement.” He told the FT “it seems to me to be fair and right that the existing staff get the opportunity to respond to new requirements” first rather than automatically facing the “destabilising” process of a tender.

17. This clarification of policy is very helpful in dealing with a number of problems that the CSP has recently experienced with the compulsory tendering of physiotherapy services or fragmented sections of those services.

CSP CONCERNS

18. CSP has a number of serious concerns, as follows:

Despite the assurances of Ministers that “quality and innovation will be the two most powerful weapons” to counter the imminent financial restrictions, the apparently simplistic behaviour by some commissioners that is being exhibited now (which was also seen during the NHS financial crisis in 2006), does not bode well for the long term health of the population and in our view would appear to be at odds with the aspirations of Lord Darzi’s NHS Next stage review and also the aim of WCC.

19. In many NHS provider trusts, managers are being told they must bid for any and all services that are put out to tender by local commissioners, regardless of whether they believe they are in a strong position to win the tender or not. Any one tendering process for a single service is involving the physiotherapy managers in up to six NHS trusts submitting full tenders for the service in competition with each other and any alternative non-NHS providers. The tendering process is time and resource intensive.

20. This process is damaging the helpful collaboration between health professionals across NHS trusts, pitting NHS manager against NHS manager and rendering organisations unwilling to share information, innovation and expertise about their services because they are told this is “commercially sensitive” information.

21. Where tenders for NHS services are awarded to private providers and staff are transferred to the private sector, skilled professionals that the NHS has trained at undergraduate and post-graduate level with tax-payers money are transferred into private companies who then gain that expertise which is lost to the NHS.

22. Staff who are transferred via TUPE to non-NHS providers are initially moved on NHS terms and conditions. However, this does not apply to the NHS pension scheme (unless it is a social enterprise), nor does the protection apply to new staff employed. This could result in two-tier employment terms and conditions developing in non-NHS providers.

23. The messages from the DH that co-operation and collaboration should underpin the commissioning process are not being applied by all commissioners. The CSP has evidence that commissioners are awarding contracts on the basis of price rather than with a view to any long term improvement in the population or on the basis of quality. Recently, the Royal Free Hospital had its out-patient MSK physiotherapy service put out to compulsory tender by Camden PCT. Whilst it is difficult to gather detailed information, because of the confidential nature of some commercial information, we have evidence that appears to show that the Royal Free Hospital physiotherapy service came out with top marks for its very well regarded and high quality patient service. This suggests that the tender was lost by the hospital physiotherapy team because of a substantially lower price, not an improvement in quality. There are also a number of aspects of the commissioning process that prevent a “level playing field” approach; for example this NHS provider was required to make available staff costs, for the purposes of TUPE, to an alternative provider bidder—given that in most cases 70% of physiotherapy service costs overall are staff costs, this undoubtedly gave the alternative provider bidder information that enabled a commercial advantage.

24. The CSP has serious concerns about the inadequacy of consultation and in some cases the arbitrary approach of some primary care trusts. Current experience is that consultation ranges from excellent to extremely poor. For example West Essex PCT is holding information evenings for staff, inviting union representatives to contribute, and have made it clear to staff that, in line with DH guidance, they will not

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256 Financial Times “Shift on policy on private sector services” by Nicholas Timmins, Public Policy Editor 17 September 2009
257 Rt Hon Mike O’Brien MP, Minister of State for Health, Westminster Health Forum Event 9th September 2009 (in answer to a question).
seek to establish social enterprise company status for their provider arm unless they know through a ballot that they have the support of staff. By contrast, staff at Bedford PCT have voted by 875 to 4 in favour of remaining directly employed by the NHS. Yet they have been told by their employer that this will make no difference to the PCT's intention to turn the provider arm into a social enterprise organisation.

25. The CSP is a member of the Social Partnership Forum (SPF), an England-wide partnership body of health unions, the Department of Health, and representatives of NHS Employers. The staff side of the SPF has also expressed significant concerns about the future of workforce, planning, training and development; and has real doubts about the ability of a fragmented system to be able to undertake long-term workforce planning. There is concern that there is little incentive for the alternative provider sector to undertake training and development, with the consequence that the NHS is, in essence, subsidising the alternative provider sector. Furthermore, in the face of competition and also where NHS providers have lost elements of service contracts, the willingness and ability of NHS providers to offer clinical placements will be compromised. The sustainability of high quality services for users will only be achieved where the education and service commissioners work together and the SHAs enforce a “level playing field” approach by requiring both the alternative providers and NHS providers to contribute.

CONCLUSION

26. The timing of this Health Committee inquiry is very significant. The Committee has the opportunity through its enquiry to try to ensure that WCC spreads good practice in improving the quality, delivery and experience of NHS patient care services. It also has the opportunity to emphasise the important role of commissioning in focussing on the prevention of ill-health and the future well-being of the population.

27. The CSP also hopes that the Committee’s Report will help to redress some of the serious problems which are beginning to emerge in an NHS which is being told that it has to produce productivity and efficiency savings of up to £20 billion over the next four years. The CSP is willing to provide oral evidence for the Committee.

28. The DH Commissioning Framework for Health and Wellbeing set out to secure a:
— shift towards services that are personal and maintain independence and dignity
— strategic reorientation towards promoting health and wellbeing, investing now to reduce future ill-health costs
— stronger focus on commissioning the services and interventions that will achieve better health, across health services and local government, with everyone working together to promote inclusion and tackle health inequalities.

29. These remain admirable aspirations. It is too early to say whether WCC will achieve these. The indications are mixed.

September 2009

Memorandum by the Joint Epilepsy Council (JEC) (COM 104)

EXECUTIVE SUMMARY

— Paragraphs 1-3 lay out some basic facts about epilepsy including avoidable deaths.
— Paragraphs 4-10 asserts basic commissioning failures and lists official sources recognising the deficiencies in the service to people with epilepsy.
— Paragraphs 11-12 refers to the failure to implement the NICE clinical guidelines of 2004.
— Paragraphs 16-20 discusses the World Class Commissioning programme, the stress between its aims of saving money and improving services and its potential to assist people with epilepsy.
— Paragraphs 21-22 refers to the stress between local commissioning and Government intervention.
— Paragraphs 23-27 discusses the problems of specialist commissioning for low volume, high needs groups, local commissioning practices and their effects.
— Paragraphs 28-32 details the problem of the ordinary residence rules including reference to a local authority refusing to assess people wishing to move out of specialist residential accommodation.
— Paragraph 33 summarises in conclusion “...the commissioning failures affecting people with epilepsy have not improved under PBC. New programmes such as WCC may prove to assist in the medium to long-term but do not directly address the failures. The consequences are both a waste of money and avoidable events including many deaths experienced by service users. The strong emphasis on local commissioning has made it harder to address the deficiencies.”
— The Appendix contains the letter from Health Minister Ann Keen MP to Strategic Health Authorities of July 2009 referred to in the submission.
1. The Joint Epilepsy Council (JEC) is the umbrella body for 26 epilepsy organisations operating in the UK and Ireland. The JEC also provide the secretariat to the APPG on Epilepsy (APPGE).

2. Epilepsy is a common serious neurological condition characterised by recurrent, unprovoked epileptic seizures, controlled for many, but not cured, with anti-epileptic drugs. Surgery works in some cases but is rarely available. Epilepsy affects almost half a million people in the UK, that is one in every 131 or 705 in an average constituency.

3. 990 people in England die every year of epilepsy-related causes. About 365 of those deaths are young adults and children. Of the total number of deaths about 400 per year are avoidable. A shameful 59% of childhood deaths are considered avoidable.

4. There has been a deep and widespread failure to commission services for people with epilepsy, identified over a number of years and most recently in January 2009. None of the following documents have led to a substantial improvement in the service.

5. The Chief Medical Officer’s Report of 2001 called for a genuine commitment to put right serious and long-standing weaknesses in the standard of care for people with epilepsy.

6. The National Sentinel Audit of Epilepsy-related deaths of 2002 showed that 39% of adult deaths and 59% of childhood deaths were potentially or probably avoidable.


8. The National Institute for Health and Clinical Excellence (NICE) published its clinical guideline on the epilepsies in 2004. Commissioners have not put in place the service structure that would allow clinicians to follow the NICE guideline. This was authoritatively confirmed in a survey of Trusts in January 2009, which more later. The contents of this survey have been accepted by Government.

9. The National Service Framework on Long-term (Neurological) Conditions of March 2005 whilst not dealing directly with the key challenges did in theory offer to deliver some improvements. In 2007, the APPGE warned that “progress towards success must be monitored or risk catastrophic failure”. A requirement that all Trusts and the NHS needed to demonstrate progress at the end of the planning period in 2008 was not met. Finally, after persistent pressure, a mid-term review of the NSF was announced in Summer 2009.

10. In 2006, the White Paper “Our Health, Our Care, Our Say” offered more support for people with long-term conditions including integrated personal health and social care plans. Little or no benefits have been seen by people with epilepsy.

11. The key initiative that would directly address the failures in the service to people with epilepsy is the NICE clinical guideline on the epilepsies however the evidence is that the services have simply not been commissioned. Much anecdotal evidence of this failure was available before 2009. In January 2009, incontrovertible proof was supplied in the form of a survey of Primary Care and Acute Trusts entitled “Epilepsy in England: time for change” published by Epilepsy Action and subsequently endorsed by the relevant Minister, Ann Keen MP, in her letter to Strategic Health Authorities (SHAs) of July 2009 (see Appendix for copy letter).

12. The headline figure in the survey was that more than 90% of the responding Trusts failed to meet the two-week guideline for first appointment with specialist, in some cases by a very wide margin. It is worth noting the reasons why NICE considered this first appointment to be a matter of urgency. A specialist is required to diagnose epilepsy and no treatment is offered before diagnosis. The consequence is that many people suffer serious injury and even death before being offered treatment.

13. The clear and obvious service and commissioning failures need to be addressed directly. The old commissioning system failed people with epilepsy. Practice Based Commissioning has not helped and the new programme of “World Class Commissioning” does not directly address the deficiencies.

14. The Department of Health recognised the inadequacy of commissioning in its 2007 publication “Commissioning framework for health and well-being” and used those suffering from long-term conditions (such as epilepsy) as an example: “Too often, services are commissioned on a ‘one size fits all’ basis, insufficiently flexible to meet people’s needs and preferences. And the impact of local ‘voice’ is variable, with local people frequently involved only after a strategy or plan has been published, rather than being integral to its development. Poorly designed services as the consequence of a lack of engagement can mean that services are ultimately used inappropriately, or not at all, and can result in a poor experience for those using them. For example, at the moment, around half the people with long-term conditions are not aware of support or treatment options. They do not have a clear plan that lays out what they can do for themselves to manage their condition better.” This is strong language in an environment where criticism is more often hidden behind a rhetoric of aspirational plans for improvement.

15. In the same document, the Department reported on a survey of commissioners views of blocks to good practice. The responses were summarised on p15. “Capability to commission well, particularly in terms of commissioning skills, is under-developed. This is partly historical, partly a function of being spread out over different organisations that do not always share skills and knowledge, and partly because competing immediate
16. The answer to the Committee’s first term of reference—“World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?—is largely supplied in the above quotes. The Department (and commissioners themselves) clearly identified failure and has introduced the new programme in an attempt to secure improvement.

17. It is the stated intention of Gary Belfield, Director of Commissioning at the Department of Health, that “the aim of world class commissioning, and therefore the ultimate test of its success, will be an improvement in health outcomes…” (Interview, May 2009). Service users paying the price for poor service delivery now will ask how long will it take before we know whether or not WCC has been successful.

18. In addition, WCC has been identified by the Treasury as a key mechanism for PCTs to deliver required efficiency savings and Mr. Belfield goes on to advise trusts how to maximise value for money opportunities through WCC. Whilst this does not necessarily contradict the intention to improve health outcomes, it does make its achievement more challenging.

19. The APPGE Report of July 2007 entitled “Wasted Money, Wasted Lives” (WMWL), again endorsed by Minister Ann Keen MP in her letter to SHAs of July 2009, drew upon figures from NICE and other sources to clarify that £189 million was wasted each year in delivering the poor service to people with epilepsy. Service failures and delays lead to further calls upon NHS resources. It is also estimated that about 60,000 people with epilepsy claiming Disability Living Allowance could be returned to employment. We remain concerned that these are not the sort of efficiency savings the Treasury, and hence the commissioners, will be looking to achieve.

20. Can the World Class Commissioning (WCC) Programme correct the failures in commissioning? Well, possibly, in time, however it does not directly address the specific commissioning failures rather it seeks to improve the general standard of commissioning. While people with epilepsy wait and hope to eventually receive an acceptable service, 400 avoidable deaths and many avoidable events every year will continue to occur.

21. The overarching concept of devolving power to a local level has not produced the intended result of services better suited to the needs of local service users in general and specifically not for people with epilepsy. Government has recognised this implicitly by the number of interventions for specific conditions that have a sufficiently powerful political champion or a sufficiently high media profile including autism, diabetes, coronary heart disease, AIDS, childhood cancer etc. We in no way wish to diminish the importance of these conditions but do note, for instance, that the number of epilepsy-related deaths owing to service failures exceed those for AIDS-related deaths and cot deaths combined.

22. Whilst some will argue that the way forward is to reduce the level of Government intervention in local decision-making, service users such as people with epilepsy look to Government for support when local decision-making has failed to deliver. Ultimately, democratic responsibility for the NHS must lie with Government and the power to intervene must be retained.

23. There are particular problems in the specialist commissioning for the low volume high needs group of people with epilepsy who require residential accommodation.

24. It is not reasonable to expect local commissioning and purchase of the specialist residential and nursing care services which some patients with complex epilepsy need and it is unlikely that such services will exist locally.

25. The solution offered under PBC is for PCTs to group together to commission these services. In the main, this is not happening. The “solution” adopted by many PCTs is to place the service-user into cheaper but inappropriate non-specialist residential care. It is an issue faced by many charities supporting specific disability groups where needs are high but numbers are relatively small. There is anecdotal evidence of avoidable deterioration in peoples’ conditions where this “solution” has been adopted.

26. Additionally, and increasingly in the current economic climate, the pressure on budgets has led to commissioners regularly offering fees which fail to meet the cost of providing the care that is needed and, on occasions, threatening to remove a patient correctly placed in a specialist setting to an inappropriate, less specialist care setting. There are instances where this threat has been carried out.

27. The APPGE in WMWL in 2007 recommended that Government develop a National Plan for specialist residential care. It is clear that the route suggested by PBC of PCTs commissioning these services in groups has not been adopted in the main and that individual service users are paying the price for this. These service users cannot wait to find out if WCC will eventually resolve their problems. The damage is being caused now.

28. There is another issue faced by those in a residential care setting and this relates to the “ordinary residence” rules. When a patient has, through the care provided in specialist residential accommodation, become more able to live independently, the rules of ordinary residence create bureaucratic difficulties when people wish to leave residential care. Such patients may have been in residential accommodation some time and often wish to move to supported housing in that area.
29. The consequence of the ordinary residence rules is that the duty to fund their needs now falls on the receiving local authority, rather than the one who placed the patient in the residential accommodation. This can create an unfair burden on local authorities where these rare specialist centres are located and, for the patient, commonly leads to extensive delays and uncertainty.

30. This has led to the current situation where one local authority is refusing to assess people that wish to move out of residential care into community settings because of the new funding responsibility that would be transferred to them. As the Chief Executive of the residential provider puts it “…this is illegal, they know it is illegal and they are challenging us to pursue a judicial review.”

31. There are only negative consequences flowing from these problems. Whilst the move to much cheaper supported housing is blocked and delayed, the overall costs to the State are increased. Equally, for the patients used as pawns in this way, their right to live independently and self-manage their condition asserted by Government policy as laid out in 2006 in the White Paper “Our Health, Our Care, Our Say” and elsewhere is denied.

32. The APPGE in WMWL in 2007 recommended that Government bridge the gap between policy and practice by developing guidance to local authorities to ensure resources follow the individual when moving from residential care into supported housing. This would avoid both negative consequences described in the previous paragraph at a stroke. No such guidance has been developed.

33. In summary, the commissioning failures affecting people with epilepsy have not improved under PBC. New programmes such as WCC may prove to assist in the medium to long-term but do not directly address the failures. The consequences are both a waste of money and avoidable events including many deaths experienced by service users. The strong emphasis on local commissioning has made it harder to address the deficiencies.

September 2009

APPENDIX

Letter of July 2009 from Health Minister Ann Keen MP to Strategic Health Authorities

SHA LONG-TERM CONDITIONS LEADS

Dear

I would like to draw to your attention the report *Epilepsy in England: Time for Change*, which was published by Epilepsy Action earlier this year.

*Epilepsy in England: time for change*, which is available on Epilepsy Action’s website at www.epilepsy.org.uk/timeforchange, reports on the results of a survey of acute trusts and Primary Care Trusts (PCTs) in England as well as a survey of people with epilepsy. The results of these surveys revealed wide variations in the provision of epilepsy services, as well as variations in the collection of information and the quality of care provided.

Particular problems indentified in the report included:

— access to specialists in epilepsy
— waiting times for a first appointment
— access to diagnostic tests
— the lack of care plans and transition services.

These problems principally stem from low levels of implementation of the National Institute for Health and Clinical Excellence (NICE) clinical guideline on the diagnosis and care of children and adults with epilepsy.

Epilepsy in England: time for change follows an earlier report, *Wasted Money Wasted Lives*, published by the All-Party Parliamentary Group on Epilepsy in 2007. This report raised similar issues in terms of variable implementation of the National Service Framework (NSF) for Long-term Conditions and NICE guidance and highlighted the social, economic and personal cost of not implementing this guidance.

I know that many PCTs are working towards full implementation of the NICE clinical guideline, as well the NSF for long-term conditions, and I would like to reinforce the importance of the NICE guidance and NSF in delivering high quality, accessible services to this client group. Investing in the services envisaged in both the NSF and NICE guidance will help people live more independently, improve their quality of life and be a more cost effective way of providing services.

The Epilepsy Action report’s recommendations are directed at NHS organisations as well as the Department of Health. I hope that, with your partners, you give appropriate attention to the messages contained in the report to ensure better outcomes for service users and their carers.
Thank you in anticipation of your support for this important area of work.

With best wishes,

Ann Keen
Parliamentary-Under Secretary of State for Health

July 2009

Memorandum by the Consortium of External Commissioning Contractors (COM 105)

EXECUTIVE SUMMARY

This evidence is submitted jointly by companies that provide external support to National Health Service (NHS) commissioners (Aetna UK, BUPA Health Dialog, Humana-Europe, Tribal Group, UnitedHealth UK). It is intended to give an outline for the role of private-sector organizations in achieving better commissioning and better health outcomes for populations served by the NHS.

1.1 The development of skills and competencies of commissioners in the National Health Service (NHS) is an essential strategy for achieving the Department of Health (DoH)’s key objectives of delivering better health and well-being for all, better care for all, and better value for all. The current financial climate highlights the need for strong organisational capabilities within PCTs to produce meaningful productivity and quality improvements in health and care for the populations they serve.

1.2 Public-private partnerships that bring private-sector innovation and expertise to complex public-sector commissioning dilemmas can be an effective way to improve quality, access, choice, productivity, efficiency, and savings for the NHS.

1.3 These partnerships also provide a powerful lever to build consistency among initiatives; to spread innovative solutions within the NHS itself; and to translate policy into meaningful health improvement for the population served by the NHS.

1.4 The companies submitting this evidence are involved in a unique form of contracting with the NHS. Rather than outsourcing particular functions for a fee, many of the contracts awarded to these companies provide the NHS with the opportunity to share risk with the external organisations. This “risk-transfer” provides a model for the NHS to increase the value gained through purchase of external contract time/moving beyond conventional consultancy per diem contracts and creating a deeper partnership between public and private-sectors.

1.5 Specific DoH initiatives that do or could benefit from private-sector engagement include: Quality, Innovation, Productivity and Prevention (QIPP); World Class Commissioning (WCC); Practice Based Commissioning (PBC); Integrated Care; Expanded Consumer Choice and Provider Competition; The Quality and Outcomes Framework (QOF); and Public Reporting of Quality Data.

1.6 These activities are essential elements for a patient-centered NHS that is responsive to the needs of the public.

BRIEF INTRODUCTION

2.1 Each of the companies submitting this evidence is currently engaged in commissioning-support throughout the NHS.

2.2 The capabilities that these companies bring to NHS commissioning allow sophisticated analysis of data; risk-stratification of patient populations; targeted intervention and care-planning; care-management and lifestyle-coaching; redesign of clinical pathways; improved transparency of quality and cost information; and increased patient-choice and provider competition.

2.3 To help commissioners to engage appropriately with the private-sector, the comprehensive Framework for External Support for Commissioners (FESC) was established by DoH. Potential private-sector partners and public officials put tremendous planning and effort into FESC and it is a useful option for NHS commissioners to obtain support.

2.4 Despite the fact that it is still relatively early days (the first contract was let in July 2008), the case studies below demonstrate the success of partnerships both in improving the health and quality of care for patients and in achieving genuine efficiencies.

2.5 This group of companies has engaged in commissioning-support both within and outside of FESC, and have provided significant support to NHS managers and clinicians in their drive to be world class commissioners.

2.6 A recent King’s Fund report argues that in order to fill potential funding gaps as a result of the current fiscal climate, the NHS would have to increase productivity by 3.4 to 7.4 percent/equaling gains of £3.6-7.8 billion per year.258 Faced with demographic factors that are likely to increase costs, improved commissioning and better care management strategies are the best options for achieving these gains.

2.7 Most major private-sector commissioning projects are in early stages with many just completing their first contract year. As such, impact data are still forthcoming. However, some initial case studies, highlighted below, demonstrate a range of improvements including patient health, quality of care, and cost savings.

**CASE STUDIES**

**NHS ASHTON LEIGH AND WIGAN**

NHS Ashton Leigh and Wigan (NHS ALW) entered into a 3 year strategic partnership with Tribal Group (Tribal)—one of a small number of national pilots under FESC. This programme is helping to catalyse the redesign of health and social care services so that local people can access the right services, in the right place, at the right time.

One of the five partnership objectives is “to improve financial management and generate savings which will be re-invested back into patient care”. Significant tangible achievements have been made in the first year of this partnership on a range of fronts, including identified savings of over £3.5 million in 2008–09 to be reinvested in rebalancing health expenditure and improving health outcomes. To the end of August 2009, the contract has achieved:

- Over £2.2 million savings through acute invoice validation (AIV), reductions in baseline contracts and the introduction of new contract conditions
- £0.35 million identified savings (recurring) in statin and Proton Pump Inhibitor (PPI) medicines management by switching patients from high to low-cost equivalents (PPIs are ulcer inhibiting drugs)
- £1.2 million projected savings in April 2010 through the introduction of reduced tariffs
- Tribal is also confidently forecasting £1 million savings from AIV in 2009–10.

The total value of the contract is £4.8 million, of which £2.3 million will be funded from “guaranteed” savings delivered by Tribal which results in a net “worst case” cost to the PCT of £2.5 million. The contract states that the first £2.3 million of savings are to be paid to Tribal in full. Savings over and above the £2.3 million will be split on a basis of 75 percent to the PCT and 25 percent to Tribal. This sum is capped at £10 million, so that after this value is reached, the PCT retains 100 percent of the additional savings generated. Any recurrent savings beyond the first 12 months (after they have been realised) will be retained 100 percent by the PCT.

One of the 5 partnership objectives between NHS ALW and Tribal is “to apply international standards and best practice that can benefit the residents of Ashton, Leigh and Wigan”. Working with the NHS ALW commissioning team and primary care, Tribal has introduced new international best practice tools and techniques, including the following:

- NHS ALW is the first PCT in the UK to deploy the Johns Hopkins operational population risk profiling tool (ACGs) widely regarded as the leading edge population and risk profiling tool in the world.
- The MCAP (MCAP) utilisation management tool, has been deployed to provide clinically-based assessments of weaknesses in the health system and identify why they occur; reviews have been completed for elective and non-elective care and a productivity programme for the short and medium term is now underway.
- Working with Public Health, Tribal have completed world class health equity audits with Sheffield School of Health and Related Research for COPD, CVD and Diabetes.

Early findings have demonstrated that 40 percent of unscheduled inpatients are in the wrong care setting. Introduction of pro-active discharge planning on two pilot wards reduced length of stay by two days.

Risk stratification found that a cohort of four percent of the population who consume 40 percent of the healthcare resources. A hospital at home service has been set up managing 100 patients most of whom would otherwise be managed within the hospital setting. This group is now being targeted for evidence-based disease and case management models following the international best practice. A re-ablement service has also been created for the frail elderly and this is showing over 95 percent patient satisfaction and reduction in social care costs. This is being linked to high-risk management programmes through the developing community matron services.

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259 ACGs provide the ability to develop clinically-led commissioning strategies on the basis of locality, disease, and predicted resource consumption. This enables the PCT to visualise and model the impact of “personalised” budgets for health and social care.

260 MCAP uses the intensity of services delivered to the patient based on the patient’s severity of illness to accurately determine the best level of care for patient placement.
NHS WEST KENT

NHS West Kent entered into a partnership with BUPA Health Dialog (BUPA) to deliver a collaborative care programme in across the PCT implementing predictive risk modelling at both PCT and General Practitioner (GP) level as part of a system to support the PCT and its GPs to identify and prioritise which services are most appropriate for their populations.

BUPA’s analytics target patients including those with chronic conditions who have gaps in recommended care; people who are at risk of hospital or accident and emergency admission; those facing selected surgeries; and people who have high future predicted health needs. By overlaying socio-demographic insights with complete hospital and GP data a fuller picture of patients’ health needs and past interventions is generated as well as view on how most effectively to communicate to them. The West Care Call programme uses BUPA’s NHS trained nurses to deliver intensive non-directional whole-person health coaching which is designed to influence the behaviours of the targeted patients.

This supports the PCT to deliver a long term condition care management programme, reduce high cost avoidable hospital admissions, and commission more relevant services in the community as well as improve the patients care support and improve health outcomes. There is added benefit of better identifying hard to reach patients who may not have attended GP surgeries supporting the further PCT aim of reducing health inequalities and empowering patients more generally to manage their own care more effectively.

Since its start in February the programmes has so far enrolled 233,000 people with only 4.5 percent of the whole population opting out. The programme is being managed within tight return of investment criteria to ensure value for money for the PCT.

NHS NORTHAMPTONSHIRE

UnitedHealth holds a three-year contract with NHS Northamptonshire (NHSN) under FESC. The contract has four major work streams in the initial year, including: 1) health needs assessment; 2) performance management; 3) patient experience; and 4) communications and social marketing. UnitedHealth staff are partnering with NHSN staff on each of the work streams, drawing on support from UnitedHealth Group solutions and data analytic capabilities from the US.

June 2009 marked the end of the first year of the contract. Whilst it would be early to expect substantial quantitative results, there have been achievements that provide insight into the potential impact of the FESC partnership arrangement.

Health Needs Assessment

— UnitedHealth is undertaking an in-depth assessment to determine the health needs, disease burden health access inequalities and outcome inequalities of the population. The assessment has started to specify investments necessary to improve health outcomes. Specifically, health needs assessments and equity audits were carried out in five NHSN priority areas: health failure, stroke, COPD, diabetes, and maternity. The team has deployed actuarial modelling techniques not traditionally been used in this sphere in the NHS.

— The team are working together to redesign a care pathway for patients with Cardio Obstructive Pulmonary Disease (COPD). Using international best practice, the pathway is based upon analytical data and will include an accelerated consultation process, which will become a model for other clinical services redesign.

— UnitedHealth prepared a Programme Budgeting Marginal Analysis report, which builds a systematic approach to identify areas for the PCT to drive efficiency and improve health outcomes.

Performance Management

— UnitedHealth has implemented sophisticated AIV tools to increase programme efficiency. AIV confirms that payments are consistent, not only with the services provided, but with care according to evidence-based standards. AIV and clinical audits have already contributed to £144,000 of savings within the first few months. Manual audits of coding and clinical practice already completed or scheduled are expected to produce £1.07m between July and December 2009.

— The team has developed a savings work plan that has identified savings of £6.9 million—with an additional £15.9 million projected savings through initiatives under development.

— A monthly validation tool (MVT) that can be use as an early warning system to identify data quality and coding issues for the Trusts was developed and implemented—and is projected to return £1.3 million in savings each year.

— Data system enhancements were implemented, allowing an automated transition from quarterly to monthly health care utilisation data. This change has not only enabled more timely use of data for intervention, but has assisted the PCT in meeting the national reporting target.
Communications and Social Marketing

— UnitedHealth developed the *thrive* worksite wellness programme; a targeted, data-driven employee wellness strategy designed to improve and maintain employee health. Phase 1 of *thrive* was launched in May 2009 and specifically targeted at NHS Northamptonshire employees. Staff were invited to undergo an individual health needs assessment and respond to a cultural health audit. Based on employee feedback, the next phase of the programme will provide each participant with a “Personalised Wellness Programme”, enabling staff to track their own health statistics over a period of time. The Wellness Programme includes weight and hypertension management, as well as opportunities to participate in physical activity and wellbeing programmes.

— Nearly 75 percent of staff participated in the *thrive* health needs assessment and approximately half completed the cultural health audit. The programme aims to sign up 100 employees to the personalised wellness programme by September 2009. The success of *thrive* will be measured on a regular basis by using different comparisons against the baseline data compiled at programme commencement.

— UnitedHealth will work with the organisation to target a broader range of stakeholders within the local health economy and NHS Northamptonshire priority groups.

NHS Stoke

In a city with the highest rates of obesity in the West Midlands and a growing incidence of preventable disease, NHS Stoke on Trent needed a community wellness programme that would inspire people to lead more active lifestyles. Humana-Europe created a pedometer-based programme that encourages people to take charge of their health by walking more.

After a successful pilot of 227 “at risk” NHS patients (Body Mass Index/BMI over 25), the programme has been extended to a further 1800 people across the city. The programme is free to join and includes a web-enabled pedometer. These are easy to set up and, when connected to a computer, automatically upload the step data to the programme website. By logging onto their personal home page, participants can see how well they are doing, set daily, weekly, and monthly goals and access helpful information. People without access to computers can use ones provided at local community facilities, such as libraries.

Participants needing extra help are contacted by health coaches specially trained in motivational interviewing techniques. They stay in regular telephone contact to offer advice and encouragement. The health coaches enable participants to understand their own motivations for and barriers to living a healthier lifestyle, and thus help them stay focused and enthusiastic. This close relationship can be hugely motivating for people.

Some of the findings:

— 71 percent of participants reduced their BMI by an average of two points, which equates to an average weight loss of 12.4 pounds per person

— There was a 251 percent increase in reported hours of exercise among participants

— 49 percent of participants increased their daily servings of vegetables

— Some participants are taking less medication

— Participants’ families also benefit through healthier diets and more exercise

“I went to the doctors yesterday and he has taken me off the steroids as I’m so much better… Everyone has been commenting on how well I look. I feel the best I have in years!”

Female participant

Following the success of the community programme, NHS Stoke in partnership with Stoke City Council have commissioned a health and wellness programme for their staff running over two years. In total 7,000 places have been provided which aims to enroll 50 percent of the 14,000 employees within the two organizations. The programme was launched in April 2009 and already over 1800 people have enrolled and 45 percent of these are exceeding 7,000 steps a day as at 31st July 2009. In April only 20 percent of participants were achieving this level of activity. This is an example of the NHS taking the lead with employee wellness and working constructively in partnership with a private company.

Recommendations for Action

3.1 To achieve the goals of improved quality and access while meeting important productivity and efficiency targets, successful commissioning supported by demonstrated private-sector capacity should be continued, supported, and expanded.
3.2 Good commissioning with private-sector organisations has already contributed to quality and efficiency gains in the NHS, but could be making a much greater impact. This impact would be increased by allowing private partners to take more responsibility in exchange for greater financial risk.

September 2009

Memorandum by NHS Birmingham East and North (COM 106)

1.0 EXECUTIVE SUMMARY

1.1 Since April 2000 Primary Care Trusts have been responsible for the commissioning of healthcare services for a defined population. In 2006 PCT’s were reconfigured from 303 to 152 PCT’s most of which are now co-terminus with Local Authorities.

1.2 In the West Midlands seventeen PCT’s cover the population of 5.2 million. NHS Birmingham East and North covers a population of 440,000 and has a commissioning budget of £693 million per annum but also hosts specialised services for the West Midlands Region which equates to a total commissioning budget of £1.4 billion.

1.3 NHS Birmingham East and North is responsible for the wise investment of this resource on behalf taxpayers whilst also ensuring the provision of high quality safe services which demonstrate value for money. Since 2002 Eastern Birmingham Primary Care Trust and latterly NHS Birmingham East and North has and continues to have a clear core purpose which is to “reduce health inequalities and increase health and well-being” and has four key goals:

— To be so responsive to the population we serve that no one waits for the quality care they need
— That the health and well being of the population will have improved so much that people will enjoy 10 more years of healthy life
— That people regard us as the first choice organisation to work with and for
— Our communities will be the most involved, informed and empowered in the country

1.4 This core purpose and key goals are fundamental to organisational success and they have underpinned the organisation’s approach to commissioning services over the last six years. There are a number of examples of effective commissioning which NHS Birmingham East and North has delivered over the last three years to demonstrate how commissioning can assist in reducing health inequalities and increasing health well-being across a largely deprived population.

2.0 IS COMMISSIONING IMPORTANT IN HEALTHCARE?

2.1 The National Health Service since its inception has been dominated by discussions about provision of services particular hospital based provision. The development of commissioning as a function was until 2000 underdeveloped.

2.2 The development of the Purchaser/Provider split in the 1990s was the first attempt to differentiate commissioning from provision. Has it been successful and is it needed? During the 1990s there was much work to set up the transactions around how the purchaser/provider split worked however this may have been at the expense of strategy. Commissioning starts with effective planning. The problem with the early versions of commissioning was that many saw it as a contracting transaction rather than as we see commissioning today as encompassing a range of different activities that need to have been undertaken to ensure development and implementation of new services. The 1990s promoted a culture of them and us. Since 2000 commissioners and providers have grappled with the polarity between collaboration on the one hand and competition on the other. In a world where all organisations wish to be the best they can be, then you have to do both.

2.3 Commissioning is a process by which you achieve service change for the benefit of patients, public and taxpayers. It is attempt to demonstrate that you can improve current services, redesign services where required and introduce new services by focusing an organisation on improving health outcomes for its population rather than, has been the traditional approach to commissioning which was previously about buying levels of activity. Commissioning has moved us some way from this by promoting the importance of commissioning services to prevent things from happening rather than continuing to commission more and more treatment which as Wanless pointed was simply unaffordable.

2.4 Commissioning in 2009 is different there is substantially more focus on prevention rather than just treatment, there is increased focus on different levels of commissioning which runs from national specialised commissioning, to regional commissioning, through joint commissioning, PCT Commissioning and Practice based Commissioning to in the future patient level commissioning through personal health budgets. All these levels of commissioning are at different stages of development and it is fair to say that Practice based Commissioning is underdeveloped. It has been difficult for policy makers to describe what we want from Practice based Commissioners. Do we want there clinical expertise and skill in developing new pathways of care or do we want them to manage budgets? At the moment the focus nationally is on managing budgets, world class commissioners will develop the Practice based Commissioner to focus on
clinical pathways, service redesign and using the skills which undoubtedly General Practitioners have. This way of focusing on commissioning will drive the quality and safety of services and will enable all commissioners to demonstrate their increased value and worth to taxpayers.

2.5 Over the last nine years we have seen increasing importance and focus given to commissioning without really attempting to describe what an effective healthcare system looks like when commissioners and providers are working to the optimum. World Class Commissioning is the first attempt to describe what an optimum performing health system would look like and therefore describes in some detail the expectations on PCT’s as Commissioners in delivering a different type of health service which is built on the premise of prevention as well as treatment. The introduction of the World Class Commissioning programme has undoubtedly focused the mind of organisations tasked with commissioning health services about what commissioning really is, how commissioning should be undertaken (the commissioning tasks) and what it looks like for patients and the public when commissioning has been successful.

2.6 World Class Commissioning has challenged health systems to describe in some detail the outcomes to be achieved for the populations served as well as being able to demonstrate that those outcomes are being delivered through effective commissioning.

2.7 World Class Commissioning was important when launched it is even more important now because of the economic situation being faced by the public sector. Commissioners will be required to describe how they are going to use commissioning to deliver high quality services, increasingly productive services but at a reduced cost. This will not be achieved without organisations who understand what it is to be a World Class Commissioner.

August 2009

Memorandum by Professor Chris Ham (COM 107)

EXECUTIVE SUMMARY

1. In this paper, I draw on research into health care commissioning internationally and in the UK to highlight the formidable obstacles confronting the NHS in England in implementing world class commissioning. Experience in other countries demonstrates the difficulties facing those charged with commissioning health care. Likewise, both previous and current experience in the NHS underlines the imbalance of power between commissioners and providers. Notwithstanding the emphasis placed on world class commissioning, and the resources put in place to support its development, it remains doubtful whether commissioners can negotiate on equal terms with providers, at least within the timescale demanded by impending financial constraints. The alternative is to encourage the development of integrated systems rather than those based on a commissioner/provider divide.

INTERNATIONAL EXPERIENCE

2. In a review commissioned by the NHS West Midlands, I analysed the evidence on experience in other countries of health care commissioning (Ham, 2008a) recognising that the word “commissioning” is an English invention and overseas experience is not an exact parallel. The review focused on the published literature from Europe, New Zealand and the United States. It concluded that in no system is commissioning done consistently well. To be sure, there are examples of innovation and “good practice” in all systems, but equally there are examples of the limits to effective commissioning and the barriers that have inhibited commissioners in discharging their functions. This has been shown in a recent study of value based purchasing (VBP) in a number of US states. This study described the initiatives being taken under three headings, and the findings are important because VBP is broadly analogous to world class commissioning.

3. First, purchasers in the states studied joined together to standardize performance measures and data requirements, generally based on national measures and best practices such as the HEDIS measures. Second, they gave priority to public reporting of performance data in order to increase transparency in the health care market. Third, value-based purchasers were using incentives to change the behaviours of consumers, employers, and providers in ways that promote better quality care and value. Examples included tiered premiums or co-payments to encourage consumers to choose higher value performers, and pay for performance programmes to reward health plans or physician practices for quality improvement.

4. In describing these three strategies, the study noted that it was too early to measure in a quantifiable way their impact. At an anecdotal level, there was evidence of positive impact, such as health plans and providers using information on comparative performance to improve the quality of care they offered. At the same time, a number of challenges were noted, including getting consumers to use such information. In summary, the authors noted:

“... a considerable amount of time must be available for VBP initiatives to gain significant participation and reach the critical mass needed to make an impact on their local market. The case study sites highlighted in this report have a good head start, but replication in other regions that have
different histories and cultures may be more challenging. The value-driven health care movement will be further slowed by attempts to address the technical and other formidable challenges described in this report” (Silow-Carroll and Alteras, 2007)

5. Why is health care commissioning so difficult? The answer can be found in the complex nature of health care and the need for commissioners to have a high level of technical and managerial skills. Because health services tend to be complex, are difficult to define in clear contractual terms, exhibit marked information asymmetries between buyer and seller, involve the exercise of professional discretion, require lengthy training to deliver, frequently rest on long term relationships between patients and professionals and, for some services, are subject to major problems of local monopoly, there are major obstacles to the efficient operation of systems in which the roles of commissioners and providers are separated (Mays and Hand, 2000).

6. In the language of transaction costs economics, health care involves “intractable transactions” (Williamson, 1996). In these circumstances, economists raise serious questions as to whether it is better for services to be procured through contracts negotiated between commissioners and providers, as opposed to being provided directly by integrated systems that hold the budget for health care and take responsibility for service delivery. The levels of performance achieved by integrated systems in the United States—such as Kaiser Permanente and the Veterans’ Health Administration—reinforce these questions by demonstrating empirically the value of “making” care in house instead of “buying” it from a range of suppliers.

7. As the head of Kaiser Permanente has observed, the quality of health care commissioning in the United States, the country that arguably has far more experience of seeking to develop this function than any other, is light years away from that achieved in other sectors of the economy (Halvorsson, 2007). This is a timely and salutary reminder of the challenges that face the NHS in developing world class commissioning.

**UK EXPERIENCE**

8. The UK has experience of health care commissioning dating back to the Conservatives’ internal market reforms in the 1990s. Various studies and evaluations were carried out into the impact of these reforms, and they showed that purchasing (as it was known at the time) was widely perceived to be the “weak link” in the internal market. My own work emphasised the need for the functions which made up purchasing to be performed at different levels, a theme that was taken up in a summary of much of the evidence on primary care-led commissioning in a review funded by The Health Foundation (Smith et al, 2004).

9. This review found:
   - primary care-led commissioning (where clinicians have a clear influence over budgets) can secure improved responsiveness such as shorter waiting times for treatment and more information on patients’ progress
   - primary care-led commissioning made its greatest impact in primary and intermediate care, for example in developing a wider range of practice-based services
   - given a sustained opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change longstanding practices in the local health system
   - primary care commissioners can effect change in prescribing practice, with financial incentives playing a key role
   - primary care-led commissioning increases transaction costs within commissioning
   - there is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services (emphasis added)

10. The need to make available adequate resources to support health care commissioning is a recurring theme in the literature. This point has been emphasised by Donald Light in comparing the NHS with the United States. Light argues that commissioning organisations need to be large and strong and commissioning teams need to be smart, well trained and technically supported. He notes:

   “The best American commissioning groups have concluded that health care is far more complicated to purchase than anything else—mainframe computers, aircraft, telecommunications systems—you name it. Their salary and bonus packages are designed to attract the best and the brightest. They require excellent data system analysts and programmers, clinical epidemiologists, clinical managers, organisational experts, financial specialists and legal advisers” (Light, 1998, p. 67).

11. Weiner and colleagues have reported that managed care organisations in the US have levels of administrative support 30 times higher per capita than primary care organisations in England (based on 1999 data). Similarly, Mays and Hand, in their analysis of New Zealand experience, note that “purchasers need to be large enough to recruit high calibre staff with the expertise to take on specialist providers” (2000, p. 14). These observations are reinforced by evidence from UK experience of commissioning indicating that total purchasing pilots with higher levels of management cost achieved the best outcomes (Mays, et al, 2001).

12. The difficulty in acting on this evidence is that recent reforms to the NHS, such as the reduction in the number of PCTs in 2006, were designed to reduce management costs. Also current debates about how the NHS should find the savings needed to deal with the prospect of much tighter financial settlements emphasise the scope for cutting “bureaucracy” and protecting front line clinical services. Bureaucracy in this
context refers in part to the skills and competences needed to undertake world class commissioning. Not only this, but also with the Conservatives promising to save £1.5 bn in management costs at the same time as devolving responsibility for commissioning to “GP budget holders” (exactly the type of primary care-led commissioning that is likely to increase transaction costs, according to The Health Foundation’s analysis of the evidence), there are some challenging circles to be squared.

13. These issues take on greater force at a time when world class commissioning remains a work in progress and practice based commissioning (PBC) has failed to engage more than a minority of enthusiastic GPs and primary care teams. I have argued consistently that PBC was unlikely to be attractive to many practices because of the imbalance between the rewards available and the effort and workload involved. At a time when most practices perceive there to be greater benefit from maximising the gains available through the new GMS contract introduced in 2004, and when some PCTs have been reluctant to devolve budgets and support PBC through the timely provision of information and management support, it is not surprising that PBC has failed to deliver. Although on paper the Department of Health’s surveys show high levels of involvement in PBC, this is not the same as the genuine engagement required for it to really make a difference (En passant, it is worth noting that PBC is a misnomer in that it is really a veneer of commissioning overlaid on a strong foundation of primary care provision ie it is a basis for developing integration of commissioning and provision—see para. 22 below).

14. More progress is being made in supporting PCTs to improve their performance as commissioners, but my assessment is that the programme that has been put in place by DH with the involvement of management consultants will take a number of years to make a real impact—always assuming politicians have the patience to allow the programme to run its course. The reasons for the slow development of commissioning include the inherent difficulty of commissioning health care, referred to earlier, the limited resources available to commissioners, the lack of staff with the skills needed to commission health care to a high standard, and the greater attractions for many of the top managers and clinical leaders of working for provider organisations like Foundation Trusts (in itself linked to the higher salaries and rewards available in these organisations). For these reasons, it remains doubtful whether world class commissioning can be implemented in the timescale demanded by impeding NHS financial constraints.

15. To support PCTs and PBCs, the Department of Health has put in place the FESC programme under which the expertise of approved private sector organisations can be accessed by the NHS. Little information is available on the extent to which FESC has been used and its impact. However, it is relevant to note that the views expressed by the director of commissioning in BUPA:

“The private sector has no ‘magic bullet’ to deliver effective commissioning over night, nor is it an alternative to the role of NHS commissioners who must ultimately make choices on behalf of patients and citizens...capable private sector companies can supplement the capabilities of NHS commissioners as they seek to exert their influence in an increasingly commercially savvy health system” (Macdonald, 2006).

COMMISSIONING AND THE PACKAGE OF HEALTH REFORMS

16. In carrying out its inquiry, the Health Committee will wish to make an assessment of the current state of health care commissioning alongside other elements in the package of NHS reform in England. My reading of the evidence is that different elements of the package, including supply side reforms, demand side reforms, transactional reforms and regulatory reforms, interact in complex and unpredictable ways. The success or otherwise of commissioners needs to be assessed in this context with appropriate attention being paid to the way in which the NHS Foundation Trust programme, incentive systems such as payment by results, and the work of the regulators either enable or inhibit the emergence of world class commissioning.

17. To be specific, the freedoms available to NHS Foundation Trusts, the regulatory regime under which they operate with the requirement to generate financial surpluses for future investment, and the system of payment by results which creates incentives to increase hospital activity, present formidable obstacles to PCTs and PBCs in achieving financial balance and bringing about the shift in care closer to home that has been at the heart of recent policies and priorities. Even more challenging is the expectation that commissioners will give priority to health improvement by working in partnership with local authorities and voluntary sector organisations when this objective is seen to have lower priority than other aims such as improving patients’ access to care and reducing health care associated infections. The reform programme as a whole, and not simply the commissioning element, needs to be reviewed to ensure it is fit for purpose.

AN ALTERNATIVE

18. The alternative to the present direction of reform would be to recognise the challenges in making a commissioner/provider system work effectively and to actively explore the alternative route of integrated systems mentioned earlier. In work for the Nuffield Trust, I have suggested that the arguments for integrated systems are both theoretical and empirical (Ham, 2007). The theoretical arguments derive from the insights of transaction costs economics (see para. 6) into the circumstances in which it is appropriate to rely on “buying” products and services through contracts with independent suppliers as opposed to “making” these products and services in house. The complex and diverse nature of health care means that integrated systems that both hold the budget and provide services are likely to be better placed to achieve high levels of
performance than systems based on a commissioner/provider split and the use of contracts. One of the considerations here is the high cost of running a commissioner/provider system, including the need to write and monitor contracts.

19. Integrated systems have led the way in improving care for people with chronic diseases. One of the most notable examples is the Veterans Health Administration (VA) which has been described as “the country’s best health care system” (Longman, 2005). Research has shown the improvements in quality of care achieved within the VA over time and the superior performance of the VA compared with Medicare fee-for-service (Jha et al., 2003). Another example is Kaiser Permanente which has been highlighted by the New York Times as achieving consistently excellent ratings in the assessments undertaken by the NCQA, and as being a possible model for the future of American health care (Lohr, 2004). Group Health Cooperative in Seattle is a close cousin of Kaiser’s and similarly achieves high levels of performance for the population it serves. The record of integrated systems as high performing systems has been acknowledged by Porter and Teisberg (2006) in their critique of health care in the US.

20. A common feature in these integrated systems is the role of doctors in leading work on service and quality improvement. This is important because it addresses the challenges of information asymmetry and professional discretion that are fundamental obstacles to the efficient operation of systems based on a commissioner/provider split. Medical leaders in integrated systems work closely with experienced managers and are supported by the provision of real time information about performance (often derived from the electronic patient care record that is used to good effect in these systems). There is also a strong alignment of incentives that facilitates the provision of cost effective care. In effect, integrated systems turn doctors from pouchers to gamekeepers and incentivise them to keep the game alive and in healthy condition.

21. One point to emphasise is that integrated systems in the US function in a competitive market and it has been argued that competition provides an important spur to these systems to achieve high levels of performance. I have suggested that in the NHS the emphasis should be on clinical and service integration, rather than organisational integration, and that consideration should be given to how patients might choose between competing integrated systems (Ham, 2008b). This needs to be done in a way that avoids another major reorganisation by building on those elements of the current health reform programme which will lend themselves to developing in this direction.

22. For reasons noted above, PBC is one of these elements and could be used as a platform to establish a form of multispecialty commissioning and provision, if the right incentives could be put in place to make this attractive to GPs and specialists. Social care could be included in these arrangements where there is local interest in so doing. Over time it is possible to envisage how patients could choose between multispecialty commissioning and provider groups, formed by like minded clinicians rather than those working in geographically contiguous areas. This would need to be underpinned by person based resource allocation with risk adjustment, and regulation to ensure mandatory acceptance of enrolees and a standard benefits package. It would also require oversight by a body like a PCT but this body would act more as a system manager than commissioner. The point I would emphasise in conclusion is that there should be a progressive migration towards clinically integrated systems building on the most promising aspects of current reforms and drawing on the evidence that shows the benefits of integration and the challenges of making a commissioner/provider system function effectively.

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**Memorandum by NHS Institute for Innovation and Improvement (COM 108)**

**EXECUTIVE SUMMARY**

1. Commissioning strategies should demonstrate how they will commission providers of services based on their responsiveness to the patient and population needs; increasingly they should also demonstrate the quality and value of the services they provide. As commissioning skills are being developed and attention is being given to the quality of information to support commissioning decisions, the process should become increasingly effective at driving improvements in healthcare and patients’ experience of the service.

2. The work of the NHS Institute has highlighted the importance of developing capacity and capability of commissioners in order to help them play their full part in making the system effective.

**INTRODUCTION**

3. The NHS Institute for Improvement and Innovation welcomes the opportunity to respond to this timely and important inquiry by the House of Commons Health Select Committee.

4. Since its inception in 2005, the NHS Institute for Innovation and Improvement has worked to develop and disseminate new ways of working, technology and world class leadership, operating as a catalyst to fast track the best ideas to improve patient care.

5. Funded by Strategic Health Authorities and the Department of Health, the NHS Institute strives to improve the patient’s experience and deliver a better quality of healthcare using innovation. It supports NHS organisations in analysing their current practices against best practice and implementing changes to achieve better results. The NHS Institute works with frontline staff and managers to develop tools for providing improved healthcare quality, productivity and safety, generating solutions by the service, for the service.

6. Although our work originated in programmes developed for the acute sector, the NHS Institute has also developed a number of products and services for the primary care sector, in recognition of the importance of quality and innovation in community services, GP practices and other non-acute settings. We feel it is just as important that the virtuous circle which sees continuous improvements in quality lead to greater efficiency and enhanced patient safety is implemented in GP surgeries and community services as in acute hospital wards.

7. In addition, the NHS Institute has developed products and services to meet the needs of commissioners in recognition of their importance as the controllers of the financial flows in the health system and as decision makers with regard to the quality and settings of health care and in relation to their role in preventing health needs arising. Our products in this area are intended to accelerate the achievement of world class commissioning.

8. As an NHS organisation, commenting on policy development and choices is beyond our remit to; however, we are keen to make observations about successful implementation and delivery of Commissioning within the current policy framework.

“World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

9. WCC recognises the needs of PCTs and PBCs for training and good information to support commissioning as a means of shaping health services to meet the needs of local populations and to act as a catalyst to drive up the quality of healthcare in England.

10. The NHS Institute for Innovation and Improvement has worked with the Department of Health, Commissioners and information analysts to develop tools which will support Commissioners to make informed commissioning decisions for example the Prioritising Commissioning Opportunities (PCO) product and the Opportunity Locator Product. The latter benchmarks where healthcare is delivered for PCT populations and demonstrates where more care can be commissioned closer to home.

11. NHS Northamptonshire used PCO to support a transparent prioritisation process which was applied to provide a “ranking” of potential investment initiatives which could be appreciated by all interested parties, which supported the rationale behind the level of investment provided and during which financial year of the five-year plan. Project Delivery for Commissioners, Commissioning Patient Pathways and Commissioning to make a Bigger Difference are also products developed to help commissioners meet their responsibilities.
12. The NHS Institute is also in the process of delivering Commissioner Development Programmes in each SHA to assist Commissioners in using these tools and raising their awareness of best practice patient care pathways. Our High Volume HRG patient care pathways analyses the clinical pathways of trusts achieving excellence in these areas over a nine month period and captures learning points for other NHS organisations to implement. One example of this focuses on how patients with diabetes admitted to hospital for other conditions can receive safer and more effective care through our “Think Glucose” approach. Commissioners need to be aware of and support the improvement programmes undertaken by their providers.

*The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?*

The NHS Institute’s main focus has been to help develop the skills and capability of commissioners by providing tools, workshops and learning opportunities. Our experience is that there is a substantial need to help Commissioners move up the levels of the World Class Commissioning Competency framework and that this is critical to the success of this, or any similar framework.

*Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?*

13. Practice Based Commissioning (PBC) should form the building blocks on which the PCT Commissioning Strategy is based. This should draw together information from the Joint Strategic Needs Assessment for their population, together with local clinical information and information regarding National and International best practice.

14. Their PBC Commissioning Strategy should then come together with other PBC Commissioning Strategies for the PCT to create the framework on which the PCT Commissioning Strategy is based. The PCT will wish to add the areas which fall outside the remit of PBC which could include; Personal Medical Services (PMS), Personal Dental Services (PDS), Mental Health, some specialist commissioning etc.

15. The PBC and PCT Commissioning strategies should demonstrate how they will commission providers of services based on their responsiveness to the patient and population needs and increasingly on how they can demonstrate the quality and value of the services they provide. Whilst there is still limited competition within the healthcare market there are examples of where opening healthcare services to the market has resulted in changes of practice of existing providers which previously had been resisted.

16. NHS Somerset has shared their experience of dealing with the challenge of deciding when to go to market and when not to; in some service areas they made a conscious decision to use competition as a lever for change and service improvement. But, in other cases, they worked through a strategic partnership with our providers which proved a better approach.

17. Payment by Results is the funding mechanism created to support the purchaser/provider split. It has been effective in raising awareness of costs of procedures and in monitoring volumes and costs of healthcare activity and informal feedback suggests that this had some unintended consequences in financial flows when the tariff is changed, which has resulted in cost pressures in different parts of the system. There has also been some difficulty in splitting the tariff in a way which would support the policy of moving care closer to home.

*Specialist commissioning*

18. Whilst the NHS Institute has not been asked to support Specialist commissioning, we are currently in discussion with Specialist commissioners to explore where our general commissioner support products could support the specialist commissioning agenda also. There is no reason why the NHS Institute’s prioritisation and project management tools should not be equally relevant to speciality commissioning.

*Commissioning for the quality and safety of services.*

19. Commissioners face a challenging agenda: they must secure high quality services which are safe for patients whilst achieving best value for the resources they have to spend. Commissioning to specifically improve quality and safety requires additional skills in agreeing metrics by which to monitor improvements and generating drivers for change.

20. The NHS Institute is currently working with the Department of Health and exploring how we can develop Commissioners competencies in relation to Commissioning for Quality, QIPP and Prevention and Control of Infection.

21. The NHS Institute is also working with individual PCTs as part of our Turning Data into Information for Improvement programme to help them develop more effective patient experience metrics and use these to drive up improvements in quality and safety. Commissioners are now using Commissioning for Quality and Innovation (CQUIN) schemes to drive up the quality, safety and patient experience. The NHS Institute’s website supports PCTs by enabling them to share their CQUIN schemes and to learn from each others’ schemes.
22. The NHS Institute has developed a range of programmes in safety for providers and many of the lessons learned can be used to inform the commissioning process

*October 2009*

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**Memorandum by Professor Gwyn Bevan**

**EXECUTIVE SUMMARY**

1. This note aims to give evidence relevant to the first three terms of reference of the Health Committee’s inquiry into Commissioning:
   
   (a) The rationale behind commissioning: has the purchaser/provider split been a success and is it needed?

   (b) “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?

   (c) Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?

**THE RATIONALE BEHIND COMMISSIONING AND THE PURCHASER/PROVIDER SPLIT**

The rationale behind commissioning may be seen as developing the fundamental role of health care insurers to challenge provider dominance: to ensure that patients are treated safely and appropriately across the care pathway; put pressure on providers to improve quality and reduce cost; and make hard choices that optimise outcomes for populations within available budgets. This requires good systems to set priorities prospectively and assess performance retrospectively, but is undermined if government nullifies challenges to provider dominance and threats to the stability of poorly-performing providers.

The NHS has been trying to do commissioning effectively since 1974, and within a purchaser/provider split since 1991, which it was hoped would enable District Health Authorities (DHAs) to be free of running services and focus on meeting the needs of their populations. But none of the four models of the purchaser/provider tried since 1991 has worked well. The evidence from the US suggests that patient choice is unlikely to be an effective means of improving quality of hospital care.

**“WORLD-CLASS COMMISSIONING” AND EFFECTIVE COMMISSIONING BY PCTS**

Most of the aspirations of “Word-Class Commissioning” ought to have applied to the NHS since 1974, but few of these have been achieved systematically throughout the NHS in England or other countries where commissioning has been tried. This is in part because of effective commissioning requires technical expertise, managerial capability and good information; but also because of the political difficulties caused by effective commissioning (eg, long-term gains for populations at short-term costs to providers of acute care).

The Health Foundation’s memorandum of evidence to the Health Committee recommended that the Department of Health promotes socio-technical approaches to provide a basis for most of the aspirations of “World-Class Commissioning”, and cited the example of the approach developed through its five-year programme of collaborative research between LSE and Primary Care Trusts (PCTs). This approach enables local stakeholders to use evidence, which is displayed visually, so that they can understand and agree a priority ordering. Last year LSE worked with a PCT that runs its acute provider to set priorities for deployment of its “growth money”, and this year is working with a PCT that purchases acute care to examine options for re-allocating resources.

There is now strong evidence from the US and the UK that we can improve provider performance by designing systems of public reporting to damage the reputations of organisations shown to be performing poorly. A particularly promising example for the NHS has been developed in Tuscany in which performance is published, reported to regular meetings with Chief Executives of the Districts and regional staff, and presented in a striking visual way that is easy to understand.

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261 Gwyn Bevan is Professor of Management Science and Director of the MSc in Public Management and Governance in the Department of Management at the London School of Economics and Political Science where he is an associate of two research centres: LSE Health and the Centre for Analysis of Risk and Regulation. For the past five years he has organised seminars of the European Health Policy Group where a community of scholars present and discuss papers on reforms to European systems of health care. His current research includes: comparisons of performance of health care and schools across the UK; developing methods for reducing NHS expenditure for least harm; methods of equitable funding of insured populations; and implications of introducing purchaser competition into the English NHS. He is a member of the Department of Health’s two advisory groups on formulas used to allocate resources to Primary Care Trusts. His report for the Secretary of State for Health on the developments of these formulas was published in 2008. He is also a member of the working committee responsible for identifying targets and metrics for the Sir Michael Marmot’s current review of health inequalities. From 2001–03 he was Director of the Office for Information on Health Care Performance at the Commission for Health Improvement (CHI) where he had lead responsibility (for the NHS in England) for: developing “star ratings”; national surveys of staff and patients; developing national clinical audits; and analyses for CHI’s clinical governance reviews, investigations, and national studies. He has worked for the National Coal Board, HM Treasury, and an economic consultancy; and, as an academic, at Warwick Business School, and the Medical Schools of St Thomas’s Hospital and Bristol University.
Commissioning ought to challenge “supplier induced demand” indicated by geographical variations in rates of medical and surgical services. A common implication of these analyses is that “less is more”: ie areas with low rates of interventions often enjoy better health. Effective commissioning in England would be strengthened by systems that report evidence of geographical variations in rates of treatment.

**Commissioning and “System Reform”**

The prospects for the NHS of no growth in real income will require GPs to manage demand to keep provider payments within PCTs’ budgets, which is difficult to reconcile with an emphasis on patient choice and paying providers fixed tariffs. A more promising organisational form is that of creating organisations that integrate primary and secondary care (as in the famous Kaiser Permanente Health Maintenance Organisation). There are, however, risks from creating such integrated organisations within the NHS as monopolies. These risks could be remedied by effective regulation by systems that generate pressure to improve performance (as in Tuscany). The Nuffield Trust will be publishing a Report that explores another more radical option of introducing both purchaser and provider competition in to the NHS in England. This is based on reforms in the Netherlands, where the Ministry of Health can now aspire to steering a complex system and the Minister can reasonably reply to questions in Parliament on day-to-day problems that other bodies are responsible for their resolution. It may be that only by insulating governments from pressure from providers in this way can we hope to create the atmosphere in which effective commissioning can flourish.

**The Rationale Behind Commissioning and the Purchaser/Provider Split**

2. The rationale behind commissioning may be seen as a natural development of the role of insurer, which is fundamental for health care, because this can be costly and is uncertain. Evidence from the US shows that if insurers passively pay bills for providers’ demands, this results in escalation of costs and troubling variations in rates of treatment across populations and in quality and cost of providers (Wennberg et al, 2002 and 2004). Evidence from the US also shows patients did not use information on quality to switch from poor to good hospitals (Marshall and 2004). Evidence from the US also shows patients did not use information on quality to switch from poor to good hospitals (Marshall et al, 2000; Fung et al, 2008; Shekelle et al, 2008) and hence patient choice is unlikely to be an effective way of improving quality of care in England. Effective commissioning ought to: ensure that patients are treated safely and appropriately across the care pathway; put pressure on providers to improve quality and reduce cost; and make hard choices that optimise outcomes for populations within available budgets (Mays and Hand, 2000). This requires good systems to set priorities prospectively and assess performance retrospectively as illustrated by Figure 1. Effective commissioning challenges provider dominance, may threaten the stability of poorly-performing providers and is undermined if government nullifies such challenges and threats.

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**Figure 1: Setting future priorities and retrospective performance assessment**

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This point was made by Paul Shekelle in presenting the findings from the latest systematic review of evidence of the impacts of publication of information on quality of care (Shekelle et al, 2008) at a Health Foundation seminar in January 2008.

Mays and Hand (2000) identified the objectives of commissioning by purchasers as: “to improve technical efficiency by allowing purchasers to select the best value provider accessible to their populations; to allow those charged with determining the future pattern of health services in relation to the needs of the population to concentrate on this task unhindered by their previous responsibilities for managing health care institutions; to act as a counterweight to decades of professional dominance of service specification, and to challenge traditional patterns of resource allocation and sectional interests; to improve allocative efficiency by permitting purchasers to negotiate a new balance of services with providers; to encourage providers to respond more accurately and effectively to the needs of individual patients in order to retain contracts from purchasers; to facilitate clear lines of public accountability for the performance of the purchaser and provider roles in the health system; to clarify providers’ costs and the amount spent in each service area by comparing the services and costs of each provider; to make priority decisions more explicit”.

Mays and Hand (2000) identified fundamental difficulties in effective commissioning from “the multiple and frequently conflicting explicit and implicit expectations of politicians, central government officials, managers, clinicians, patients and the public for the health system”.

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3. The idea of commissioning in the NHS goes back to the 1974 reorganisation, which created for the first time in England organisations responsible for Hospital and Community Health Services for defined populations.265 The 1982 reorganisation created District Health Authorities (DHAs) that were responsible for meeting needs of populations and managing providers. One of rationales of the purchaser/provider split, introduced in 1991, was that this would free DHAs from managing providers to focus on purchasing to maximise their population’s health gain without regard to providers’ interests (Enthoven, 2000, p 33). The NHS has been trying to do commissioning effectively within and without a purchaser/provider split for over 30 years. Our collaborative research with PCTs in developing effective commissioning has also been within and without a purchaser/provider split.266

4. Since 1991, the NHS in England has been subjected to four different models of the purchaser/provider split reflecting dramatic shifts in policy emphases, which entailed periodic root and branch reorganisations. Table 1 summarises their key distinguishing features (and footnotes give details of the accompanying organisational changes):

(a) 1991–97: An internal market267 (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989).

(b) 1997–2001: The “third way”268 (Secretary of State for Health, 1997).

(c) 2001–05: “Naming and shaming”269 (Secretary of State for Health, 2000a).

(d) From 2005: Patient choice and provider diversity270 (Secretary of State for Health, 2002).

5. The internal market encountered serious structural problems (which are outlined in Table 2). Successive Labour Governments sought alternatives to provider competition between 1997 and 2002, by the “third way” and “naming and shaming”,271 but deemed neither to have offered a good system of governance. The fourth model of patient choice and provider diversity was designed to remedy flaws of the three previous models and has been evaluated by the Audit Commission and the Healthcare Commission (2008). They found problems with, and little hard evidence of benefits from, the innovations of Foundation Trusts (FTs), patient choice, and Independent Sector Treatment Centres (ISTCs); and a lack of effective commissioning by Primary Care Trusts (PCTs) and Practice-Based Commissioning (PBC).

6. Tuohy (1999), in her penetrating account of the travails of the internal market, identified three kinds of fundamental problems (Table 2 identifies these and other difficulties):

(a) Because Ministers are accountable for ensuring good access to local services they constrained commissioning to avoid threats to the stability of providers.

(b) Because the real decisions on care are made collegially between GPs and consultants, DHAs experienced difficulties in shaping services through contracting with providers.

(c) DHAs lacked the necessary information on comparative price and quality for effective contracting.

7. Other countries have abandoned provider competition within a purchaser/provider split and gone back to an integrated model (similar to NHS prior to 1991): Scotland (Woods, 2001), New Zealand (Ashton et al, 2005) and Wales (Welsh Assembly Government, 2008).272 The final section of this note considers alternatives to the purchaser/provider split.

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265 These were Regional Health Authorities and Area Health Authorities, which could create a number of Districts, which were responsible for both meeting needs of populations and running providers (as were single-District Area Health Authorities). Prior to that reorganisation, the NHS was rightly described as a “National Hospitals Service” (with organisations focused on hospitals without regard to meeting needs of populations). The new health authorities and Districts were responsible for planning services (which we might now describe as commissioning): previously “planning” in the NHS was about new hospitals.

266 We have worked with Lambeth and NHS Sheffield PCTs, that are separated from their acute providers, and Isle of Wight PCT, that exceptionally runs its acute provider.

267 During this time, the 192 District Health Authorities (DHAs) were reorganised into purchasers and the scheme of GP fundholding was introduced; the 192 DHAs were merged with the 90 Family Health Service Authorities to become 90 Health Authorities; the 14 regional health authorities that existed in 1991 were replaced by eight regional offices.

268 As a “third way” to two failed alternatives (Secretary of State for Health 1997: 10): the “divisive internal market system of the 1990s” and the “old centralised command and control policies of the 1970s”. During this time, GP fundholding was abolished, and within the 90 Health Authorities (HAs) about 480 Primary Care Groups (PCGs) were created, the eight regional offices were abolished and replaced in 2001 by four new regional directorates of health and social care.

269 During this time, the 90 Health Authorities were replaced by 28 Strategic Health Authorities (SHAs), and the 480 Primary Care Groups by 303 Primary Care Trusts (PCTs). Also in preparation for the policies of patient choice and provider diversity, a start was made in developing Independent Sector Treatment Centres (ISTCs) Foundation Trusts (FTs), and Practice-Based Commissioning (PBC).

270 Although, of the four models, the only one for which we have good evidence of its effectiveness is of “naming and shaming” by “star rating” (Bevan and Hood, 2006; Bevan and Hamblin, 2009; Bevan, 2009).

271 There are variations within Sweden counties (Harrison and Calltorp, 2000) and Italian Regions (France, personal communication; see also Carbone et al, 2008).
### Table 1

**FOUR MODELS OF THE PURCHASER/PROVIDER SPLIT AND THEIR KEY FEATURES**

<table>
<thead>
<tr>
<th>Model</th>
<th>Purchasers</th>
<th>Providers</th>
<th>Choice by Intended driver of change</th>
<th>Price information and regulation</th>
<th>Quality information and regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal market (1991–97)</td>
<td>192 District Health Authorities (DHAs) &amp; varieties of GP fundholders (GPFHs).</td>
<td>NHS Trusts &amp; private providers.</td>
<td>DHAs &amp; varieties of GPFHs (but not patients).</td>
<td>Provider competition.</td>
<td>Limited information, no regulation of provider prices, but regulation of DHA costs.</td>
</tr>
<tr>
<td>Patient choice, provider diversity (from 2003)</td>
<td>151 PCTs &amp; Practice-Based Commissioning (PBC).</td>
<td>NHS Trusts, NHS FTs &amp; ISTCs.</td>
<td>Patients, PCTs &amp; PBC.</td>
<td>Provider competition, regulation of price &amp; quality.</td>
<td>Prices determined centrally by “Payment by Results” (PbR).</td>
</tr>
</tbody>
</table>

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### Table 2

**EFFECTIVE PROVIDER COMPETITION: REQUIREMENTS AND PROGRESS**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Progress 1991–97</th>
<th>Progress 2006–08&lt;sup&gt;274&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From hierarchy to market</td>
<td>Ministerial accountability limited autonomy of DHAs &amp; NHS Trusts (Tuohy, 1999; Enthoven, 2000).</td>
<td>Limited systemic impacts from the creation of FTs &amp; ISTCs as providers independent of government. NICE regulates what new therapies PCTs ought to provide.</td>
</tr>
<tr>
<td>2. Choice of provider for elective care&lt;sup&gt;275&lt;/sup&gt;</td>
<td>Enhanced through scope to use private providers; but limited in rural areas. Problematic (Tuohy, 1999; Enthoven, 1999).</td>
<td>Enhanced through scope to use private providers and ISTCs; but limited in rural areas. Problematic (Ham, 2007) with additional difficulties created by mode of regulation of FTs by Monitor (Bevan, 2008a).</td>
</tr>
<tr>
<td>3. Threats to stability of providers</td>
<td>Contracts between DHAs and providers did not pay average costs per case (Raftery et al. 1996; Croxson 1999).</td>
<td>Incentives for a provider to treat more patients where its costs are below the PbR tariff.</td>
</tr>
<tr>
<td>4. Provider incentives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<sup>273</sup> For a clear exposition of phased introduction of the elements of this package of system reform see Audit Commission and Healthcare Commission (2008, p 12).<sup>274</sup> Evidence for most these points comes from Audit Commission and Healthcare Commission (2008).<sup>275</sup> Patient choice is less relevant for emergency care, disease prevention, and chronic diseases (Ham, 2008a).
5. Purchaser incentives
None from purchaser competition. Regulation by the “Purchaser Efficiency Index” that aimed to reduce costs per episode of DHAs (Bevan and Robinson, 2005).

6. Effective autonomous purchasing
Collegial decision-making by doctors limits effective purchasing by DHAs (Tuohy, 1999). Only a few GP-led purchasers were effective (Audit Commission, 1996; Mays et al. 2001; Wyke et al. 2003).

7. Managing provider payments within a budget
Contracts constrained payments for increased volume.

8. Information on prices
Inadequate because of a lack of comparative reliable information on hospital prices (Enthoven, 1999).

9. Information on quality
Inadequate with a lack of publicly-available information (Enthoven, 1999).

**“WORLD-CLASS COMMISSIONING” AND EFFECTIVE COMMISSIONING BY PCTS**

8. This section is primarily concerned with the eight aspirations of “World-Class Commissioning” (described as “competencies” by the Department of Health, 2009) that encapsulates what we would have wanted successive NHS bodies to achieve since 1974 (see Box 1). (The other three only apply within a purchaser/provider split and provider competition.) Few have been achieved systematically throughout the NHS in England, or other countries (Ham, 2008b). This is in part because effective commissioning requires technical expertise, managerial capability and good information; but effective commissioning creates political difficulties (e.g., long-term gains for populations at short-term costs to providers of acute care).

**Box 1: Eight aspirations of “World-Class” Commissioning**

- **“World-Class” Commissioners**
  - are recognised as the local leader of the NHS;
  - work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities;
  - proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health;
  - lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation;
  - manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements;
  - prioritise investment according to local needs, service requirements and the values of the NHS;
  - promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration;
  - make sound financial investments to ensure sustainable development and value for money.

9. The Health Foundation’s memorandum of evidence to the Health Committee (Health Foundation, 2009a) recommended that the Department of Health promotes socio-technical approaches to provide a basis for the aspirations of Box 1, and cited the example of the approach developed through its five-year...
programme of collaborative research between LSE and Primary Care Trusts (PCTs). This approach combines a technical process of evaluating options against multiple criteria (Multi-Criteria Decision Analysis) with a social process that enables local stakeholders to use evidence in such a way that they can understand and agree a priority ordering (Decision Conferencing) (Phillips and Bana e Costa, 2007). Box 2 outlines the five stages of this process.

10. In our work with PCTs, we have found it invaluable to be able to display evidence visually:

(a) For population health gain by rectangles: with health gain on the vertical axis and numbers who benefit on the horizontal axis. This is illustrated by Figure 1 which shows that achieving the government’s priority of treating all patients on specialist stroke units (compared with 50% in such units and 50% in general wards as in 2006) would reduce current Burden of Disease caused by strokes in England by 6% only (Airoldi et al., 2008).

(b) For VfM by triangles (see Figure 2): with the health benefit score (across multiple criteria including population health gain—see Box 2) as the vertical line, cost as the horizontal line, and VfM as the slope.

(c) Ranking options in order of VfM triangles against a budget (as illustrated by Figure 3 in which options A, B & C can be afforded but option D cannot).

Box 2: Five stages of a socio-technical approach to priority setting

1. Identify options for prevention and treatment across the care pathway.
2. Estimate, for each option, its population health gain from:
   (a) the numbers who are likely to benefit;
   (b) the typical individual who is likely to benefit;
   (c) health gains for that typical individual (in Quality-Adjusted Life Years—QALYs).
3. Estimate, for each option, its health benefit score across multiple criteria which are decided by stakeholders (and may vary depending on the options being evaluated). In our work with PCTs so far, these criteria have been used:
   (a) health gain;
   (b) reduction in inequality; and
   (c) probability of successful implementation.
4. Estimate, for each option, its Value for Money (VfM) from its health benefit score and cost.
5. Rank policy options in terms of VfM to set priorities against the budget.

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277 This is described in Health Foundation (2009b). Our research team includes Mara Airoldi, Nikos Argyris, Gwyn Bevan, Alec Morton (Department of Management, London School of Economics and Political Science); Monica Oliveira (Instituto Superior Técnico, Technical University of Lisbon); Jennifer Smith (Isle of Wight PCT); Hiten Dodhia (King College London and Lambeth PCT); Karen Phillips (King’s College London and Southwark PCT); Jennifer Field (National Institute for Health and Clinical Excellence). We have worked with Isle of Wight PCT to prioritise investment of £2 million in 2008 (this award-winning work was described by the Health Foundation (2008)); Lambeth PCT to prioritise options for staying healthy. We are currently working with NHS Sheffield to examine the allocation of resources within: eating disorders (as a start on mental health), cancers and dentistry. We have also worked with the Ontario Ministry of Health and Long Term Care on prioritising primary care.

278 Decision conferencing has been widely applied successfully to eg, disposal of nuclear waste, and setting priorities and prioritising R&D by pharmaceutical companies. The estimates used in Decision Conferencing ought to be generated by requisite models: ie models that provide information that is good enough for the purpose of setting priorities. In estimating benefits for populations, our approach uses evidence from the literature on estimates of average benefit (based on QALYs) and numbers who benefit. The problem faced by PCTs is that such evidence is not available for all options that need to be considered. The strength of Decision Conferencing is that it enables hard evidence from the literature to be supplemented by subjective estimates based on expert judgement, which can be anchored with reference to the hard evidence; and these subjective estimates (especially when contested by stakeholders) are subjected to sensitivity analysis. Experience shows that typically priority ordering is robust to such analyses. Where this is not so, this process highlights where effort is most needed to provide the data necessary for stakeholders to be confident about their decisions.

279 This adds new information to that provided by standard approaches to setting priorities from estimates of the Burden of Disease of populations (which gives no information on how interventions reduce this) and Incremental Cost-Effectiveness Ratios (which gives no information on the scale of the impact).
Figure 1: Rectangles of annual burden of disease from stroke and health gain from treating all patients on specialist stroke units

![Graph showing average QALY person and numbers lost to stroke](image)

* over lifetime discounting @ 3.5%

Figure 2: Value for Money Triangle

![Value for money triangle](image)

Population health benefit score

Costs
11. Our collaborative work with PCTs on realising the aspirations of “Word-Class Commissioning” was pioneered with Isle of Wight PCT last year to set priorities for deployment of its “growth money”. We have been developing this approach with NHS Sheffield this year to examine options for re-allocating resources to finance new developments. (For example in Figure 3, a PCT funding options A, B and D may decide to cut spending on D to be able to finance a new option C.) We recognise that for the NHS to be able to do this, it needs also to develop good ways of reporting past performance to drive improvement (as illustrated by Figure 1).

12. There is now strong evidence, from the US and the UK, that we can drive improvements in provider performance by designing systems of public reporting that damage the reputations of organisations shown to be performing poorly (Chassin, 2002; Hibbard et al 2003 and 2005; Bevan and Hood, 2006; Oliver, 2007; Hibbard, 2008; Bevan and Hamblin, 2009).280 A particularly promising example for the NHS of another socio-technical process has been developed in Italy in collaboration between the region of Tuscany and the Sant’Anna School of Advanced Studies in Pisa (2008).281 Performance is published and reported to regular meetings with Chief Executives of the Districts in Tuscany and regional staff. In this way, those who are performing poorly can see who is performing well and find out how they can improve. This information is presented in a striking visual way that is easy to understand. (Figure 4 illustrates this for the District of Empoli: indicators in the innermost circle are of very good performance and in the outermost circle of alarmingly poor performance.)

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280 Hibbard et al (2003 and 2005) have argued that this needs to be designed as: a ranking system, be published and widely disseminated, be easily understood by the public (so that they can see which providers are performing well and poorly), and be followed up by future reports (that show whether performance has improved or not).

281 This collaboration with the Laboratory Management and Health (MeS) provides: management training for Chief Executives in the Tuscan Health System; research to support change and innovation; and assessment of performance (see http://www.meslab.sssup.it/sito/). The health service in Tuscany is modelled on the NHS but without a purchaser/provider split.
13. Commissioning ought to challenge “supplier induced demand” indicated by geographical variations in rates of medical and surgical services (Wennberg et al., 1982). Persistent and troubling evidence of these variations are documented in the US by the Dartmouth Atlas (http://www.dartmouthatlas.org/); more recently of variations in care delivered by during the last six months of life (Wennberg et al., 2004). The few studies of England have also documented troubling variations (McPherson et al., 1996; Bevan et al., 2004). A common implication of these analyses is that “less is more”; ie areas with low rates of interventions often enjoy better health. Hence a vital element for effective commissioning in England is evidence on how rates of treatment vary across populations (as eg, produced by the Dartmouth Atlas).

Commissioning and “System Reform”

14. The prospects for the NHS of no growth in real income will require GPs to manage demand to keep provider payments within PCTs’ budgets. Although models for reforming the NHS in the UK on the idea of markets in the 1980s were designed to do this; this is difficult to reconcile with the current emphases on patient choice and paying providers fixed tariffs for hospital services. Enthoven’s idea of an “internal market” (Enthoven, 1985) was based on two ideas: giving DHAs freedom to contract out services to better providers; and transforming DHAs into organisations that integrated primary and secondary care (as in the famous Kaiser Permanente Health Maintenance Organisation), which evidence suggests to be a better organisational form than any of the four models of the purchaser/provider split (Light and Dixon, 2004; 2003).
Ham 2008a). There are, however, risks from creating such integrated organisations within the NHS as monopolies. These risks could be remedied by effective regulation by systems that generate pressure to improve performance (as in Tuscany). Another more radical option would be to introduce the system favoured by Enthoven (1985), which allows people to choose between purchasers, which contract selectively with competing providers.

15. Over the same period as governments in England have tried various models of the purchaser/provider split, governments in the Netherlands have gradually implemented a clear conceptual model of purchaser competition, in a process of learning by doing. This has, over time, has won support from all involved (government, private insurers, hospitals, clinicians, population and patients). The Nuffield Trust will be publishing a Report that explores introducing this option into the NHS in England as a “thought experiment” and aims to identify the conditions necessary for its successful introduction (Bevan and van de Ven, 2009). In the Netherlands, the multiplicity of activities involved in insuring, providing and regulating health care are now dispersed between various different agencies, each of which has a clear goal. So the Ministry can aspire to focusing on steering this complex system and the Dutch Minister of Health can answer questions in Parliament that other bodies are responsible for the resolution of the day-to-day problems. It may be that only by insulating governments from pressure from providers in this way that can we hope to create the atmosphere in which effective commissioning can flourish.

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