



House of Commons  
Health Committee

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# Commissioning

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*Oral and written evidence*

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## **The Health Committee**

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

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## Taken before the Health Committee on Thursday 22 October 2009

Members present

Mr Kevin Barron, in the Chair

Charlotte Atkins  
Mr Peter Bone  
Sandra Gidley

Dr Doug Naysmith  
Dr Howard Stoate  
Dr Richard Taylor

*Witnesses:* **Professor Gwyn Bevan**, London School of Economics, and **Dr Hamish Meldrum**, British Medical Association, gave evidence.

**Q1 Chairman:** Good morning, gentlemen. We are just a few minutes early, but we thought, given that we are ready, that we could start the session. Could I ask you, first of all, if you would give us your name and the current position that you hold for the record, please?

**Dr Meldrum:** I am Hamish Meldrum; I am still a practising GP and, last time checked, still Chairman of the Council of the BMA.

**Professor Bevan:** I am Gwyn Bevan, Professor of Management Science at the London School of Economics.

**Q2 Chairman:** Thank you. Welcome to what is our first evidence session on our commissioning inquiry. I have got a big ask for you here, because I would like both of you to tell me what you understand by the word “commissioning” in one sentence. I do not know who would like to attempt to try it.

**Dr Meldrum:** I will try. To me commissioning is assessing the health needs of the population, discussing with all interested parties how you are going to deliver these needs and then assessing how well you have succeeded in that task.

**Professor Bevan:** I would say it is about ensuring appropriate high quality care across the patient pathway; ensuring providers improve quality and reduce cost; and making hard choices for the population to achieve the best health benefits within a limited budget.

**Q3 Chairman:** What is the role of commissioners in contracting for healthcare services in the English NHS in 2009?

**Dr Meldrum:** First of all, you have got to define what commissioners are and, as I gave in my definition, I do not believe they are just people who purchase packages of healthcare. Going back to my definition, I think all those who are involved in the delivery of care and in the receipt of care, so that mean the patients as well, should be involved in particularly the local decisions that are going to be made about the quality and standard of the way of providing that healthcare; so I think there is a key role for commissioners in any healthcare system. I am sure we will get on to discuss some of the particular situations that apply in the English healthcare system at the moment compared with, say, Scotland or other countries.

**Professor Bevan:** There is a difficulty here between the principles we would like to see achieved by commissioning and the practice of commissioning, and actually the evidence is that, in practice, commissioning is not done very well. We have been trying to do it in England, I would argue, since 1974 without a purchaser-provider split, with a purchaser-provider split and the evidence from other countries is that it is not done very well there either. I think behind your question is this paradox as to why is it, when you look at what the Department of Health has called the common instances of “world-class commissioning” that I say are the aspirations we would like to have achieved, many of them we would agree to, but they are so hard to realise in practice. I think that is the paradox.

**Q4 Chairman:** Would you like to tell us what you think personally the three main effective areas in commissioning are as we stand at the moment? What are the main characteristics of effective commissioning?

**Dr Meldrum:** Obviously, I think you have to get best value for money from limited resources but also to try to achieve the highest quality healthcare. I would agree with Gwyn that I do not think in many places it is or has been terribly well done. My feeling is that one of the reasons for that is that we have not managed to get all the parties who should be involved in these decisions around the table, and we have tended to do it in a rather fragmented and sometimes almost confrontational way rather than in a collaborative way, which, I believe, is the only way that you are likely to reach the best decisions and get the best value and end up with proper joined-up care rather than fragmented care.

**Professor Bevan:** Again, it seems to me it goes back to this paradox. If you describe it as effective commissioning, we describe an ideal that we would like to see and then what we see on the ground is a long way removed from that. That is my short answer to that question.

**Q5 Chairman:** When you talk about collaboration versus confrontation, do we know what the arguments are, it is just that we cannot agree them, or is there a dispute between these two organisations about what we mean by effective commissioning?

**Dr Meldrum:** As you know, we have never been a fan of the purchaser-provider split, for a variety of reasons. First of all, I do not think you can ever have a pure split and coming from primary care general practice immediately there we are both mixed purchasers and providers, to use that term. Secondly, I think it does tend to put you almost in opposition, the commissioner and the provider of the service, which is not always helpful. I think actually where commissioning has been well done they have almost ignored that split and they have worked together despite that and reached common decision-making. I still think that the basic environment of competition between providers and, in that sense, having these discussions between a variety of providers and the commissioner has not been particularly helpful if you are going to get effective healthcare and you are not going to get either duplication or, at times, gaps in the system.

**Professor Bevan:** I think there are two related but different questions. One is the structural organisation of healthcare which Hamish has referred to. It seems to me you have to have a question. We have been trying to make the purchaser-provider split work since 1991 with various different models. None of them has looked very effective and countries that have tried it, like Wales, Scotland and New Zealand, have abandoned it and gone back to an integrated service. The other model that I am attracted by interest in is in the Netherlands, where you have purchasing competition, but that would allow integration of primary and secondary care across the care pathway—so the structural questions—and then there is a question as to how would you get the collaboration that Hamish has referred to. The work we have been doing at LSE with PCTs is a socio-technical process where we get stakeholders, GPs, hospital doctors, patient representatives and managers to look together at the hard choices the PCT have to make, and in that collaborative process it is possible to make the decisions we would like to see come out of commissioning.

**Q6 Charlotte Atkins:** From what you have both been saying, I get the impression that you think commissioning has not been successful. Would that be your view?

**Dr Meldrum:** At best it has been very patchy. I think there are one or two areas where it has been successful, and I think Gwyn has espoused some of the reasons for that, but overall, generally (and this is not just over the last few years but going back 20 years) I do not think it has been. There have been various attempts with fund-holding, with non fund-holding, commissioning, and such like, and in some areas for some small parts of the system they may have worked, but as an overall system of how to get the best value in healthcare for populations, I do not think they have been terribly successful.

**Q7 Charlotte Atkins:** Is there an evidence base which demonstrates that? As we say, we have been trying since 1991 with the purchaser-provider to get the right spec to get this issue right. One would assume

there would be some evidence, one way or the other, about whether commissioning does get both best value and best service to the patient.

**Dr Meldrum:** I think Gwyn will want to come in on this. There is such a huge range of evidence that you can always find some evidence that will back up the argument on one side or the other, but, as he mentioned, countries like Scotland, Wales and New Zealand, having tried it, have gone back because they find it wanting. Thirdly, I think if you are wanting to engage with healthcare professionals and the public, then certainly our evidence is that the majority of healthcare professionals do not like working in this purchaser-provider split situation and would prefer a more joined up, collaborative system of working, and I think that is quite a key element if you are wanting to make something work. I would add into that too that I think, particularly as you have to make hard choices when money gets tight and you have limited resources, if you do not involve the public fully in those choices as well, then you are going to fail, because you will get increasingly unrealistic demands on your healthcare system that will be increasingly difficult to deliver.

**Q8 Charlotte Atkins:** So is your position to leave it to the doctors and they will decide?

**Dr Meldrum:** No, it is not to leave it to them. That is why I emphasised “the public” as well. I think clinicians are key (and I do not just mean doctors) as part of the process, but certainly do not just leave it to the doctor. That is not what we are arguing.

**Q9 Charlotte Atkins:** The BMA in the past has not been too keen on competition: health centres, that sort of thing, to compete with the GP. Is your concern about commissioning that it does actually open up competition for the GP or for doctors?

**Dr Meldrum:** I do not think commissioning of itself opens up competition. In some ways, I suppose, we are arguing about what sort of competition. I and most of the people I represent believe that doctors and other clinicians want to know how good a job they are doing, and in that sense will want to compete, as professionals, with other professionals to make sure they are doing as well, if not better than, their colleagues down the road. That is different, though, to having a system where you have both a split between purchaser-provider and you have competing providers bidding to provide services, and you have got all the bureaucracy. You have got to add into that system transaction costs, putting in budgetary bids and all that sort of thing too, which seems to add to the cost but also, I think, does not help. There is not much evidence that it has really improved quality. The idea of the split and Simon Stevens' view of creative discomfort was that you would drive up quality and drive down the costs. I do not think there is a lot of evidence that that has happened.

**Professor Bevan:** In terms of evidence, you would like to have a controlled experiment, and people did actually advocate that when Kenneth Clarke introduced the internal market in 1991 and the Government set its face again that. Another kind of

evidence comes from the way in which successive governments have tried to get to it work: in 1974, for the first time, organisations were created that had responsibility for what we describe as commissioning. Before that you just had a hospital run, essentially, NHS and the idea of the purchaser-provider split in 1991 was that the then district health authorities that were responsible for both running hospitals and planning services for the population would be freed of this dominance of providers, the concerns of purchaser-provider interest, free to properly undertake needs assessment of the population and shape services for that. Then the evidence is the internal market that ran from 1991 to 1997 was not very successful. Hence, the Labour Government decided get rid of the idea of competition but maintain the purchaser-provider split, and the rhetoric was all about collaboration in place of competition, and that was called the third way. It was felt that was not working terribly well, so they then introduced star ratings, which I was involved with when I worked for the Commission for Health Improvement, which did do dramatic things in terms of reducing waiting times. Although there are critics, I think it was beneficial to the NHS. Then they thought that was too top-down, and so we have gone back to competition again. Then, last year, the Audit Commission and Healthcare Commission did an evaluation of the whole package of system reforms and found them disappointing and pointed out that that commissioning remained weak. This is the thing that is so frustrating. After having tried to do this for about 34 years, the auditors go in and look at it and still find it weak on the ground.

**Q10 Charlotte Atkins:** Is that because we are expecting too much of our commissioners? We do not put enough resources into commissioning, whether in terms of building up skills or in terms of giving PCTs the resources to do it. What is the problem?

**Professor Bevan:** I think there is this real difficulty at the heart of the whole process. It follows on from your earlier questions to Hamish. Basically, the idea of commissioning is the world will be a different place, from if they were not there and we just funded providers for what they do; but the politics of the whole process is that challenging providers is deeply unpopular, and so it is very hard to get strong political support for making unpopular decisions that challenge providers. There is another difficulty, which is that typically we do not have the data. Doing these assessments is incredibly difficult to do. We do not have the data we need to do that. PCTs typically lack the skilled staff and expertise to do this properly. You have evidence of successful examples of commissioning that tends to be done in collaboration with outsiders. I think the other problem is what size should they be? Recently we had 200 district health authorities. They are felt to be too small. You create 90 health authorities and then 480 primary care groups within health authorities. You then think primary care groups are too small, so you create 350 large PCTs and abolish health

authorities. You then think 350 PCTs are too small, and so it goes on. There is this continued tension as to, on the one hand, what we would like to have, which is the sort of romantic view I use to have of GP fund holding, of GPs in touch with their population knowing what they need and shaping services according to that, for which you want a small cottage industry, as in GP fund holding; but then the skills and expertise you need for needs assessment across the population needs a much bigger organisation.

**Q11 Charlotte Atkins:** Is it because the balance of power is wrong that the commissioners, if they are the PCT, are less powerful than perhaps the acute hospital, particularly if they have to stick to the normal contract anyway, and that there is this problem that the commissioner really has not got the power to control what the hospital does?

**Dr Meldrum:** I think that part of the problem (and I think it is part of the problem inherent in the system) is that, unless you have an almost equal balance of power between commissioners, or purchasers in this case, if you are using the purchaser split model, on the one hand and providers on the other, then it is not going to work terribly well, but the likelihood of ever achieving that balance and maintaining that balance so that actually either commissioners do not become too powerful or providers do not become too powerful is very remote. I think that is part of the problem. I certainly agree with Gwyn that what also has not helped has been continual organisational change and that actually people who at the same time have been trying to deliver commissioning have been wondering whether they are going to be in a job next week, or which organisation they are going to be in, or who is actually responsible for doing this. So I still think the basic philosophy behind the policy is wrong, but there have been huge issues about the practical implementation that have made it even worse.

**Professor Bevan:** I think you have put your finger on a fundamental difficulty in the process, which is that in a sense we would like effective commissioning but we would like it in a painless way that does not upset the providers. It does seem to me, if you think about the big London teaching hospitals and the esteem and respect in which their chief executives are rightly held, the idea that their local primary care trust will somehow shape what they do I just find very hard to believe.

**Charlotte Atkins:** Sometimes it is better to ensure (if you are not talking in London terms, because I think London is a different picture), where you have a local acute hospital, it should be delivering better services for the population more geared to the needs of that population rather than what they fancy doing.

**Q12 Chairman:** Professor Bevan, we did look at the latest reorganisation of primary care trusts a number of years ago now, and that was based on trying to align health and social care in terms of the statutory body local authorities. Do you think that was a right and proper way of changing the size of PCTs at that time? Did you have a look at this?

**Professor Bevan:** I remember when I worked for the Commission of Health Improvement, it was about mental healthcare, and this problem came up, exactly that—the mental health provider saying, “We cover a number of different local authorities”—but you also had a problem that, because of the scale of the psychiatric services, some of them carried a number of local authorities anyway, so it is always hard to pitch it right. I think the sort of problem at the heart of it is your heart sinking at yet another NHS reorganisation. That is the overall reaction to that.

**Q13 Dr Naysmith:** Both of you have just said in your replies to this little bunch of questions that you did not think competition was essential to this process, but surely it must be. If a commissioner does not have the ability to take a service away, even from a big London teaching hospital, then it has not got any levers to do anything. I am not saying it is necessarily the cheapest, but even if you are looking at quality, you have to have some lever, and that means an alternative if you are going to say, “We do not like the way you are doing this service. We are going to ask somebody else to do it.”

**Professor Bevan:** Absolutely. I absolutely agree with that. I think there are these two different models you could have of that. One is, as I say, the Dutch model, where the commissioners become quite large insurers covering the population, so they would have the expertise you would need to do this job, and people can choose which insurers they use, and there is movement of about 3% a year between different insurers. So they are kept on their toes to make sure they are trying to do things to improve provision in terms of quality and reducing cost, and that is one model of doing that.

**Q14 Dr Naysmith:** That involves competition.

**Professor Bevan:** That involves competition. The other model that I am attracted by would be, as within an integrated NHS, which has developed in a region in Italy, in Tuscany, where they have linked up with an elite academic centre at Pisa and they regularly report performance of their integrated local health units at meetings with chief executives and they publish this performance. I think someone referred to peer group pressure but, basically, no-one wants to be bottom of any ranking system when it is displayed in that way, and you have people in the same room who are doing well and who are doing badly and those who are doing badly can find out from those who are doing well how to improve; but the thing is that to do that within the NHS would involve, it seems to me, going back to creating something like regional health authorities and real regional presence, and the reason why Wales and Scotland find this easy to do is because their government is, in effect, a regional presence.

**Dr Meldrum:** I do not think you need necessarily competition of the type that people often think of to achieve the right results. As I said earlier, I think clinicians want to know how well they are doing and they use these data to help them improve. I may have given you this example before, but I look at what

happened to diabetic services in my area 20 years ago when an enlightened consultant came in and when 95% of diabetic care was taking place in the hospital. He wanted move it out to the community, so he got all the players—GPs, the hospital, patients—together to decide what would be good services, and over time the right training was done and there was a service shift. I am not sure, under the present model of commissioning, whether that would happen: because his trust would have said, “Hang on, you cannot go out there and actually flog off, essentially, part of our services and our income. We do not want you to do that.” In that sense, I think the market works against actually achieving good joined-up care. If you then add into that equation too the fact that some people’s idea of competition, looking at, say, transforming community services, is to have lots of independent providers of, say, dietetics, district nursing, of diabetes specialist nursing, then you have an even more fragmented service.

**Q15 Dr Naysmith:** I do not disagree with that at all, Hamish, I am just suggesting that if you have got the present system of commissioning, I do not see how you can make it work without having alternative providers, which means competition. You can organise it all totally differently, but that is not really having PCTs, is it?

**Dr Meldrum:** Yes, but the competition model goes only so far. We have never really addressed what we do with so-called failure in the NHS. It is almost impossible for you to close down a hospital or close down a unit that is not doing well. There are a whole lot of political and other things that intervene when you try to do that. So I think you have to primarily look at how you are going to work together to improve services. Again, it has always seemed to me rather perverse that if somewhere is not performing very well, you say, “Okay, next year we will give you less money and that will make you perform better.” You have actually got to analyse why they are not performing well, and it may actually be because they have not got sufficient investment. So it is a very crude tool, it seems to me, to try and achieve improvement.

**Mr Bone:** I notice the bells are not working. They have not rung. So there will not be any audible notices of things to say you have to watch the monitor.

**Chairman:** Thank you, Peter. It is a bit worrying because I was told it was connected to the fire alarm system as well, so just watch me!

**Q16 Dr Taylor:** So far I have got a pretty bleak opinion of commissioning, and one of the questions in our terms of reference was: has the purchaser-provider split been a success and is it needed? I want to try and dig out: have there been any advantage of commissioning? Can you pick out any advantages of commissioning?

**Dr Meldrum:** Richard, I agree that I have certainly been a bit bleak about the present system, but I do not equate commissioning with the purchaser-provider split. It has become almost a shorthand thing for purchasing. Actually the definition I gave

you right at the beginning, I believe, is much greater than that. Any healthcare system will have to commission, but that does not mean you have to have a purchaser-provider split to do that. If commissioning is deciding how you are going to provide healthcare services, whatever system you have got you have to do that. We had commissioning, although we did not call it that, before 1991 and the purchaser-provider split, in the sense that we did sit down and decide where we needed services, what sort of level of services we wanted, whether hospital A was going to provide them or hospital B was going to provide them. We did it through block contracting mainly, but it was still a form of commissioning. Actually what I am saying is that I do not believe the present system, or the system that has been running over the last 20 years, has been particularly successful. Yes, there have been pockets of success, but I think they have been in spite of the system that people have been asked to work within rather than because of it.

**Q17 Dr Taylor:** I would agree that commissioning has always existed, so really the question is different. Is it since the purchaser-provider split that things have not worked?

**Dr Meldrum:** I certainly do not feel they have worked any better, and in many areas I think they have been worse. I think also it has been costly, both in money and human resource terms, because there is quite a lot of work that needs to be done to make the sort of purchaser-provider split we have had try to work and, as we said earlier, unless you have got some balance between purchasers and providers too, that is another added problem. So when you add in transaction costs, when you add in all the reorganisations and various other things, I do not think we have made best use of the growth in NHS money that we have seen over the last few years.

**Professor Bevan:** There are two different ways in which you might put this. This is hardly giving evidence, but before 1991 there was a problem with district health authorities running services and planning for their population. It certainly felt that running services took over this broader commissioning role. I was involved with the first wave of GP fund holders, and although the evidence is that only a few of them had a significant impact, it did feel like a breath of fresh air in the NHS, where GPs would talk to hospital doctors about how they had changed services. I suppose it is just things that stick in the mind. In one hospital you could not get to see the physiotherapist unless you had seen the orthopaedic surgeon, and there was a three-year waiting list to see the orthopaedic surgeon, and then the GP fund holder, said, "This is not acceptable", and you were allowed direct access to physiotherapy. The trouble is that this little story hardly justifies the purchaser-provider split. If you think about it in terms of what commissioning ought to do is to challenge providers to do things differently, I would say that the policy that has the biggest impact in terms of hard evidence was the star rating process, but that had very little to do with the purchaser-provider split, it had more to do with targets and a

process of publishing performance, and that is the sort of thing I see them having developed in Tuscany on a regional basis for things that matter locally there.

**Q18 Dr Taylor:** In Tuscany they are really integrating?

**Professor Bevan:** Yes.

**Q19 Dr Taylor:** Is that something we should be going back to?

**Professor Bevan:** I agree with Hamish. I find it hard to believe the division between secondary, primary and community care is a good way of organising things. The evidence from the United States is that the high performing providers of care, like Kaiser Permanente and Geisinger, indicates that that is the model that they do to integrate care across a care pathway.

**Q20 Dr Taylor:** As it is likely that we are rather stuck with the present system, what are the main weaknesses that we should be tackling?

**Dr Meldrum:** I hope we are not stuck with the present system because, as we have been saying, we have had it for 20 years and, despite all the changes we have tried to do, it has not really worked. I would not want to say that we should tinker yet again with the present system and try and do something else with the present system to make it work because I think there is a fundamental flaw in the present system.

**Q21 Dr Taylor:** So you are saying we should get rid of it altogether.

**Dr Meldrum:** Yes.

**Q22 Dr Taylor:** As they have done in Scotland?

**Dr Meldrum:** Yes.

**Professor Bevan:** I think there are these two models. There is a difficulty. If we move towards a wholly integrated system in which you have got the health authority, in a sense, contracting with GPs and hospitals as an integrated body, and if that was not done terribly well—and you had an inquiry into Mid Staffordshire just before the recess with really troubling things coming out of that about how things can go wrong with an organisation. In the United States, it is actually hard to believe, but they did a randomised controlled trial, allocating people with different insurance packages, with free care, paying user charges and integrated care, and they showed integrated care was the most cost-effective system; but then that led to the growth of health maintenance organisations and concerns over them under serving their local population. So I think that if you were to get rid of the purchaser-provider split, you are still going to have to have some challenge to those organisations and, as I say, you can either do it, it seems to me, as in the Dutch system, where people can move between different integrated organisations or you have an effective system of regulatory challenge to what is going on.

**Dr Meldrum:** Can I add to that. I was not suggesting, when I said the very short “get rid of it”, that we would go back to some so-called idyllic period in the sixties and seventies. I think you absolutely do need challenge within the system and, as I keep saying, I think that requires really good data about outcomes, including patient reported outcomes, which will challenge providers of care, not using it in the purchaser-provider sense, to ensure that they are doing as well if not better than their colleagues. To some extent we have seen in GP practice and in the quality and outcomes frameworks that actually colleagues want to know that they are doing as well if not better than their colleagues down the road, and I am sure if we can move towards better quality data and outcomes that is what will raise standards, that is what will provide the sort of grit in the oyster, the competition in the system, and if there are poor standards, that is what will make people look at the reasons for that and try to remedy that.

**Q23 Dr Taylor:** So with better data and better skills in commissioning, could it work?

**Dr Meldrum:** I still do not believe it will work with the present purchaser-provider split system.

**Q24 Mr Bone:** It is all doom and gloom here at the moment, but in the past a lot of things that are now being done in GP surgeries were done in hospital.

**Dr Meldrum:** Yes.

**Q25 Mr Bone:** Surely that is as a result of PCT pressure to change things. Would that necessarily have happened if we had a different system? Has there not been some success?

**Dr Meldrum:** I have been a GP, I am afraid to say now, for over 30 years, before purchaser-provider split really got going in that sense. There are shifts of care. I did work for three years as a hospital doctor, and certainly there were shifts of care taking place and taking place long before you did that, because actually clinicians and the public decided that was a better way to provide care. The idea that if you get rid of the purchaser-provider split you will get stagnation I do not think is true, because I think people will always be looking at new and innovative ways and cost-effective ways of providing care. I actually think these discussions will be easier to have in that non-confrontational, “You only want to talk about this because you want to take our money away”, sort of environment, and actually you will get better decisions because of it. So I do not hold with the idea that, in order to create change, you need the purchaser-provider split.

**Professor Bevan:** There was a very interesting study in the British Medical Journal a few years ago that compared Kaiser Permanente health maintenance organisation with the NHS, and they looked at the nature of service supplied, and what was striking was in the US health maintenance organisation there were far fewer hospital admissions than there were in the NHS, and that is an integrated organisation without a purchaser-provider split.

**Q26 Dr Stoate:** I start with my usual declaration that I am a practising GP, a Member of the British Medical Association and a Fellow of the Royal College of GPs. Hamish, you have made some very interesting observations that you believe that the purchaser-provider split actually has not helped at all, and yet we do obviously have to have some form of commissioning to ensure that somebody decides what the needs of the population are, how they are best provided and which institution or unit is the best place to provide them. So there is no argument that we need commissioning, although the purchaser-provider split does seem not to have helped very much. What I want to do is to move on to the latest initiative to try and improve commissioning, which is this “world class commissioning”. Do you think that has made any discernable difference at all to the situation?

**Dr Meldrum:** I am conscious of who is sitting behind me, so I had better be careful what I say.

**Sandra Gidley:** We would like the honest answer.

**Q27 Dr Stoate:** On the record, the honest answer.

**Dr Meldrum:** I do not think it has made a huge amount of difference, to be perfectly honest. I think it is an attempt to try to make a system that is obviously not working well work a bit better, and it may have helped if you can have better expertise, if you can decide on various other things that will help to maybe improve it, but I come back to my fundamental view, that I think the system is flawed. So whatever you do, or whatever you call it, I do not think you are really going to succeed, and there is certainly not much evidence—to be fair, we have only had “world class commissioning” for about a year or so—that there has suddenly been a great upsurge in uptake in commissioning either amongst GPs or by PCTs, or whatever. So, with all due respect to Mark, nice try, but I do not think it has really helped, and that is because I do not believe the underlying system is the right one.

**Q28 Dr Stoate:** I accept that—that is a perfectly clear argument—but if we have to have commissioning, how would you like commissioning to look?

**Dr Meldrum:** I go back to my collaborative model. Depending on which services you are discussing, you get the important key players in the provision of that service and the management of that service and the receivers of that service, and that includes the patients too, and you look at how it is being provided now, in what way might it be provided better, what are the challenges there, look at how other people are doing it, look at your results compared with other people and sit down in that collaborative atmosphere to work out whether or not you need to change and, if so, how you need to change.

**Q29 Dr Stoate:** Gwyn, have you got the same view or a different view on that?

**Professor Bevan:** I am conscious of Mark Britnell sitting just behind us.

**Q30 Dr Stoate:** Do not worry about him; it is for us to worry about him.

**Professor Bevan:** I hope he will talk to me afterwards. I think it is very helpful in laying out the aspirations of what we would like to see commissioners do, and it has articulated those extremely clearly. The difficulty, of course, is for PCTs to achieve those aspirations. We have talked about the many challenges that there are in doing that. It is about skills and expertise, and the research that we have been doing, funded by the Health Foundation, we think, is one approach that helps people do that. There is hope in this, but there is a long way to go to realise those aspirations.

**Q31 Dr Stoate:** You do not think yet that “world-class commissioning” has made any difference either to patient care or to taxpayer value for money?

**Professor Bevan:** It is not because Mark is sitting behind me, but I do not think I am in a good position to answer that question, because we have worked with just a few PCTs.

**Q32 Dr Stoate:** I want to come on to CQUIN (Commissioning for Quality and Innovation Payment Framework). We all know that Payment by Results, effectively (and we have looked at this before) is hospitals putting up a sign in the car park saying, “Coach parties welcome”. The more activity they do, the more money they get. Clearly, that is a flawed system, and CQUIN is designed to try and counteract that by at least measuring quality of outcomes rather than just activity. Hamish, do you think that has made a difference?

**Dr Meldrum:** I think it is potentially a move in the right direction, because, as I said earlier, although we would probably advocate a system that would be nearer to block contracting, you would have to build in variation for that for both quantity and quality; but I do not think you can just purely use a crude financial lever to achieve that. As I said, I think when you find variable quality, that should make you ask more questions rather than just say, “Okay, it is not so good. We are going to pay you less”, or, if it is better, “We will pay you more.” Certainly, in terms of the idea that you want to try and monitor quality and get better data about quality, I am very much in favour of that, but I think, again, it is tagged on to this rather flawed system of Payment by Results, which, as you say, can have perverse incentives in it, and even though you built in quality to that, you may not necessarily be paying for the right quality in a particular service.

**Q33 Dr Stoate:** Do you think that Payment by Results has undermined the commissioning process?

**Dr Meldrum:** The short answer is, yes. The problem I have with Payment by Results is that you either have a very crude system where you have a relatively small number of resource groupings, in which case it is easy for certain providers to cherry-pick the easy cases, leaving the more complex ones to the NHS who have got intensive care facilities and such like, and get paid the same. So you either do that, or else you go down a much more complicated route where

you have many, many more disease groups and payment groups, but, of course, the more you go down, the more sophisticated you make that, the more bureaucratic it becomes and the more you get more onto the American system where almost for every aspirin you have to put a tick in the balance sheet. So I think there is a real *Catch 22* situation that actually, if you want to make it fairer, you have got to make it more bureaucratic. The more bureaucratic it is, the more costly it is to administer and to run and you will end up with administration costs of getting on to 30%, as they have in the American healthcare system.

**Q34 Dr Stoate:** Do you have anything else to add to that, Gwyn?

**Professor Bevan:** I think there are a number of things. There is the problem about just paying providers because they do activity. CQUIN is an attempt to remedy that in some way. Over the years I have been very impressed with the work that Jack Wennberg and colleagues have been doing at Dartmouth looking at variations in medical practice, and they have found extraordinary variations. They have done interesting work recently looking at care in the last two years of life in academic medical centres in the United States studying two-fold variations, and the spend in the last two years of life comes to about 30% of healthcare costs, and this is very significant. The cheapest provider is the Mayo Clinic, which has a reputation for very high quality care with lower use of intensive care and more patients dying at home. The general message from nearly all the Dartmouth work is that less is more. So you do not want to have a system that simply rewards activity. The whole point about these integrated care organisations is that is exactly what they are trying to avoid. CQUIN (and I am thinking aloud now really) feels like having got a system that actually is not working that well, can we modify it to make it work better and, you might think, is that really the system we want to have in the first place? There obviously is a conflict here between paying primary care trusts as a fair share of the NHS budget for their population and paying providers for the volume of services that they supply. There is no guarantee, of course, that these two will equate, and as we are entering very hard times in the NHS, it is difficult to see how these tensions will be resolved. If you look at the evidence on pay for performance, which is very fashionable in the United States, there is very weak evidence of it having been an effective innovation.

**Dr Stoate:** That is very interesting. Thank you.

**Q35 Sandra Gidley:** I want to hone down onto practice-based commissioning. We have heard generally about the advantages and disadvantages of commissioning, so it would be helpful if you can both say what you think are the three main advantages and disadvantages of practice-based commissioning. Hamish, do you want to go first?

**Dr Meldrum:** I have to preface it by saying that it is still something within the system that I think is fundamentally flawed. I personally, although I am a GP, do not really like the term “practice-based commissioning”, not because I do not think GPs should be very integrated and involved, but actually I think to place it in either a practice or in secondary care is wrong because of the fact that I believe more in collaborative commissioning and, therefore, I do not think putting all the power in the hands of GPs is the right way.

**Q36 Sandra Gidley:** So you do not support Conservative Party policy then.

**Dr Meldrum:** I do not say whose party’s policies I support. I promote the BMA’s policies and it is for other people to judge which party’s policies they are more closely aligned with. You are trying to catch me out on that one, Sandra. We have talked about fund holding and, although it had some limited success in certain areas about trying to change services, a lot of the things that Gwyn was talking about, we sat down and talked with consultants locally long before we had fund holding. I think it was maybe a lever in those cases where there were poor relationships to try to bring people to the table, but it seems to me a rather crude way of doing it, that actually you cannot get colleagues round a table to talk about the service unless you threaten to take their money away. We should be a bit more grown up and better than that. I think also, if you are talking about single practices, the unit is too small. So you are then talking about groups of practices, and if you are talking about groups of practices, as I said earlier, where groups of practices have got together and worked collaboratively with their providers and with their PCTs, I think that is where you have seen the greatest successes, but that is why I still think the term “practice-based commissioning” is a wee bit of a misnomer.

**Q37 Sandra Gidley:** The groups have been imposed; they have not been natural collaborations.

**Dr Meldrum:** Well some have, and, again, I think where it is imposed, it is less likely to work. If you get natural collaboration between groups in an area who share a provider or common providers, then it is more likely to work. It often works more in the smaller, more rural areas where you may only have one or two providers. I think it is much more difficult in the big cities like London where you may have a dozen providers on your door step, but even then there is much more reason or argument to me to have real joined-up thinking about how you are going to provide care. I know we do not want to get into how we are going to rationalise London’s healthcare again, but I do not think practice-based commissioning will achieve it.

**Q38 Sandra Gidley:** Were there any advantages? I did not pick any out in what you were saying.

**Dr Meldrum:** The advantages are that you must involve GPs in the decision—they do know a lot about their patient populations—but there is always a dilemma for GPs. Are they advocates for the

individual patient that is in front of them or are they really deciding healthcare for populations? That always puts them in difficulty, because on the one hand they want to do what they believe is their absolute best for the individual patient, but that could conflict with the greater need of wider population, and I think it does produce tensions. They are not insurmountable, but, again, that is why I would not purely base it in general practice and I would have this wider model.

**Professor Bevan:** I have to say, I am not aware of the evaluations of practice-based commissioning; I have not been involved in it. Years ago when there was enthusiasm for GP fund holding, I was part of a massive research team that did an evaluation of its extension, which was called Total Purchasing, which did create networks of GPs, and the idea was that since GP fund holding was felt to be so successful, they could extend out of the narrow range which were restricted for the whole range of hospital and community health services. That proved to be a very disappointing development, and part of the problem, in a way, what we found, going back to the nub of the point that Hamish just made, is that in terms of getting GPs to manage referrals against budgets, that worked well when they were in single practices, but when you extended it to a broad network it became much more difficult to do. So you are still back into this difficulty, which is the tension between the attraction of the GP in touch with his or her patients and in touch with a consultant, having that input, together with the scale you need for the support and resource allocation for it to work. It is very hard (and I am a member of advisory groups on resource allocation) if you want a fair allocation of a budget, to give that to a practice of 10,000 population. You just cannot do it very well, so you have real difficulties.

**Q39 Sandra Gidley:** Some of my local GPs were heavily involved with the Total Purchasing pilots and actually won awards, so they were very enthusiastic about practice-based commissioning, but felt very let down by the reality and the limited input they actually had into the process. Were they unusual in wanting to be involved? I am aware of other practices who have no interest at all in becoming more closely involved with commissioning. What is the more normal picture?

**Dr Meldrum:** There is a very wide spectrum. I think there are, at one end, the enthusiasts and, at the other, there are the ones who really want nothing to do with it and who say, “Just let me get on and see my patient.” I think there is a big group in the middle who, depending on the system and what they are being asked to do, would be quite keen to get involved. I think all of us feel that, whilst we want to look after individual patients, there are these wider healthcare issues that we have to discuss and we have to get some rationality into. Therefore, I think if the system they were asked to work in was perceived to be fair and effective and adequately resourced, then more would get involved.

**Q40 Sandra Gidley:** How many of your members would miss practice-based commissioning if it was abolished?

**Dr Meldrum:** As I said, you would not abolish it and leave nothing, because I think you still have to have GP involvement in commissioning. I think a lot would depend on exactly what the nature of that involvement was; what you were replacing it with. If you said, We are going to get rid of it and have nothing”, then that would not be very welcome.

**Q41 Chairman:** Commissioning is about improving the patient’s lot. You have just given a description there that some of your members do engage in commissioning work within groups and things like that, and some of them remain GPs in small practices that do not want to get involved other than seeing their patients. Is that because of the contractual situation that GPs have with the National Health Service, or not?

**Dr Meldrum:** If you want to go back to 1948, and here I can have a chance to lay to rest the idea that the BMA opposed the NHS, we did not. We did oppose doctors being employed within the NHS, which is why you ended up with GPs as so-called independent contractors, so they would not have this conflict, in one sense, being advocates for their patients and, in the other sense, being state employees, which they felt was a conflict. I think that there is always a tension, and there are some doctors who believe that if they are really behaving in the best interests of the patient in front of them, that is the only person. I personally think that is a minority and I think these days that is not an acceptable position. We work in a healthcare system, which is a system of social solidarity, and if you do not consider the wider interests of the population and take that very narrow view where it may make you feel easy in your bed at night, on the one hand, that you have done the best for that individual patient, if you are looking to do the best for the wide population, it is not sustainable, but I do not think it is the contract particularly that does that, Kevin, I think it is more the mindset of doctors, and when they see these very difficult problems that involve very difficult decisions as to how you are going to, in effect, ration or make best use of limited resources, they almost find it too difficult and they resort to the safer place of saying, “I am not having anything to do with it, I am just going to think purely of the best interests of the individual patient in front of me at the time.”

**Q42 Chairman:** You are pretty clear in that respect, that maybe a single-handed practice is something that should not be around.

**Dr Meldrum:** No, I do not think that is anything to do with single-handed practice. I think it can occur in a big practice as well. I am talking about the relationship between the doctor and the individual patient; nothing to do with the size of practice. What you are talking about is the tension between that individual relationship and the wider population decision. Do not get me to say that single-handed practice is bad and should be abolished.

**Q43 Chairman:** No, no. I have experience of single-handed practices with another hat on. I have a lot of sympathy for them in terms of how they are treated in the system. I have to say that. I am more interested in this suggestion of yours that wider collaboration between groups of GPs and their immediate partners in terms of healthcare is better for the patient. Is it better for the population as well?

**Dr Meldrum:** It is better for the overall population, but it will create tensions for what you are doing for the individual patient. To take an example, if it is decided that actually you are only going to refer people for hip replacement when they have got to a certain degree of disability, or whatever, because you have to ration resources, it might well be that a doctor with individual patients might want to refer them much sooner than that, at an earlier stage, because they feel that for that individual patient it would be better, but in terms of the good of the wider population, then they might have to fit in with what are the normal referral criteria.

**Q44 Chairman:** Do you think that professional regulation is going to get practices, multiple partnerships, or whatever, looking at the wider needs of the population and their involvement with the immediate health service in terms of revalidation, and things like that? If not now, do you think in the future that is how you may get the small co-operative work taking place in communities?

**Dr Meldrum:** I do not think revalidation of itself will improve co-operation. What I do hope it will do, though, is provide people with better information about how they are doing relative to others and to ask questions, if they do not appear to be doing as well as others, as to why not and how you generally raise the standards and get rid of unacceptable variations, but I do not necessarily think that of itself it will necessarily make the commissioning process or make collaboration work better.

**Q45 Dr Naysmith:** Given that neither of you seems to be very enthusiastic about the current system of commissioning in England, there would seem to be three options. We could either spend more money on it to do it more thoroughly, or we could do it more cheaply and simply, or we could abolish it, as has been done elsewhere, as has been pointed out by you already this morning in Wales, Northern Ireland, Scotland and New Zealand. What do you think about these three options?

**Professor Bevan:** I do not think either of us was saying you should abolish commissioning.

**Q46 Dr Naysmith:** No. Let us say the current system of commissioning, even if we call it world-class commissioning or not.

**Professor Bevan:** Academics like to enumerate. (You used to be an academic yourself actually.)

**Q47 Dr Naysmith:** I did once upon a time, yes. I get very confused in these sessions as well!

**Dr Meldrum:** Surely once an academic always an academic!

**Professor Bevan:** There is commissioning and there is the purchaser-provider split, and there is commissioning in practice and there is commissioning in what we would like to see in principle. I suppose the feeling I have (and Hamish is saying the same) is that, having tried the purchaser-provider split for 18 years in various forms, with not much evidence of it working, it does make you wonder whether this is a good way and whether it is an unsatisfactory halfway house between an integrated organisation within an NHS in a regulatory regional system.

**Q48 Dr Naysmith:** It is always difficult for academics, as you pointed out, to come to a conclusion firmly.

**Professor Bevan:** It is so nice of you to compliment me in this way, if I may say so.

**Q49 Dr Naysmith:** Are we going to abolish it, are we going to continue with it and improve it or are we going to try and find a compromising manoeuvre that is much simpler and easier to understand, or none of these three, which is the other option, of course?

**Professor Bevan:** The evidence from elsewhere is that there are enormous advantages from integration between primary and community care, and things that get in the way of that are a hindrance to that; but that will enable us better to improve care across the care pathway. The other issues we have are that we have to challenge the providers of care to improve quality and reduce cost; and these hard choices that Hamish was talking about, about the population good and the appropriate clinician's view of the patient in front of them. I think if you were to move towards an integrated organisation, which I think would be the better way of improving care across the care pathway, how could you then make sure that we have commissioning effectively representing the patient's view? As I was saying, there are these two different models. One would be as in the Italian scenario, which was actually modelled on our National Health Service, a proper regional structure with power and authority to regulate and examine performance of these integrated organisations, or the other much more radical model would be as in the Netherlands, where you have purchasers in competition and people can move between different insurers, but that may not be the question.

**Q50 Dr Naysmith:** That is fine. One of the things that strikes me about the places that we have kept talking about where they have abolished it—Wales, Northern Ireland, Scotland and New Zealand—is that they are actually all relatively small countries. We quite often in this committee visit Scotland and we get lots of interesting initiatives from up there, but it is quite clear when we do go there that, whatever bit of the National Health Service you are talking about, if you get all the experts from Aberdeen, Glasgow, Edinburgh and Dundee in one room, you can have a discussion that involves almost everybody in Scotland who is involved in any particular area of the National Health Service and

thrash out something that everybody agrees upon. That is much more difficult than in big countries. How would you apply that?

**Professor Bevan:** Italy is a big country.

**Q51 Dr Naysmith:** You keep talking about Tuscany, and we are just discussing whether we should have a trip to Tuscany to find out what is going on there!

**Professor Bevan:** Yes, I suppose in the winter it would not be a bad thing to do. The Italian Health Service is modelled on the English National Health Service with a regional structure the way we used to have but because of the structure of Italy (it has regional governments), the regions continue to exist. So, unlike ours (they get abolished every four years), they have been in existence now for 20 years and they exist and there are regional elections. My wife is a clinician, and I remember her talking about the regional meetings that they used to have when there would be a community of clinicians who would meet together and you would know each other and then you keep on re-organising and changing the boundaries. I think the sort of thing you are hinting at is that that model, if we were not to have competition in it, an integrated system, would entail a strong regional structure. So within England you would create regions of the same sort of size as Scotland.

**Q52 Dr Naysmith:** We would be going back to regional health authorities.

**Professor Bevan:** We would, yes.

**Q53 Dr Naysmith:** And that is not getting us very far. Do you have any views on this?

**Dr Meldrum:** I do take the point that the countries you have mentioned tend to be smaller. One of the problems we have seen with the NHS is that it was too big, too monolithic. I personally still think it could have been made to work better and that fragmentation is not necessary. There will always have to be a degree of regional delivery or organisation in terms of how you are going to deliver, but within that you have to maintain the ethos of a national health service. You have to get around some of the problems. People have said to me, "It's only with choice and payment by results and budgets that as a GP you can start to refer people to particular areas outside your area," but when I started out as a GP I could refer anybody to any part of the country without anybody saying anything.

**Q54 Dr Naysmith:** It did not happen very often, though, did it?

**Dr Meldrum:** It did a bit. But then huge restrictions were put upon you and you could only refer where you had a contract. We are starting gradually to get back to a system which prevailed 20/25 years ago. I still want to see the concept of an NHS, but I agree that, in organisational terms, in order to get the collaborative approach we have been talking about you will need to have areas of a manageable size where that sort of activity takes place.

**Q55 Dr Naysmith:** You are clearly in favour of abolishing the present system.

**Dr Meldrum:** Yes.

**Q56 Dr Naysmith:** You have both mentioned the voice of the clinician being important in organising commissioning and in doing the job properly no matter what system you have, but one of the things that particularly Dr Meldrum has emphasised is the population importance, that really we are talking about public health. Are public health experts involved enough in the process? If not, why not, and what can we do about it?

**Dr Meldrum:** Public health experts, yes, need to be involved. We have been mainly talking about commissioning for an illness service, which is 99% of what the NHS does. If you are looking at wider public health or at health of the public issues, then you are looking much wider than just the healthcare system.

**Q57 Dr Naysmith:** It is commissioned still in the same sort of way, is it not? Other initiatives come in from the top every now and again, but there is a public health component to whatever is seen to be necessary.

**Dr Meldrum:** Yes. Obviously if you are looking at areas like smoking and alcohol, yes, you want to make sure that all these services are aligned. Public health needs to be involved in that.

**Q58 Dr Naysmith:** Is it involved enough, is really the question at the moment.

**Dr Meldrum:** No. Partly because there are not enough public health people. There has been a huge reduction in the number of public health doctors and they are stretched pretty far and wide. I do not think there is enough input there, but unless, as I say, we involve all the other areas, like social care, education and such like, we are not really going to address the wider health issues. You can divert resources from the illness service but there is a long lag time before you get buy-in or improvement by putting them into public health. Of course there are some arguments which say that putting more money into public health is great: people live longer and healthier lives, but the overall health costs will probably go up because people living longer develop the chronic diseases, the cancers, which are expensive. That is not to say you do not do it. Of course we want the public to live healthier and longer, but on a purely economic argument I am not sure that it will necessarily make the system cheaper.

**Q59 Dr Naysmith:** If you are suggesting there are not enough of them, what would they do if there were more of them?

**Dr Meldrum:** They would be more involved in these wider public health issues for their populations. As I have said earlier, one of the problems, particularly, with involving GPs and other clinicians is that they still think of individual patients, and you do need that wider population base perspective which public health would help to offer.

**Q60 Dr Naysmith:** Do you have any views on this, Professor?

**Professor Bevan:** The work we have been doing is essentially trying to introduce a population perspective into the choices PCTs have to make. Working with PCTs, we have found that we have this social process where the stakeholders are involved, which includes GPs, hospital doctors, patients, the public and managers and so on. You are able to show to them the impact the different options are having on the health of the population and what it costs, and they make choices. For example, we are doing work in the Isle of Wight on prevention and treatment of stroke. Stroke causes a massive burden of disease in England: there are about half a million Quality Adjusted Life Years every year from premature mortality and disability. The Department of Health's two main priorities are to ensure that patients are treated in specialist stroke units—and the last Royal College of Physicians stroke audit showed that only 50% spent most of that on stroke units—and thrombolysis—which you have to have within the first three hours of a stroke to break the clot. Of these acute interventions, putting people in a stroke unit would reduce the burden of the disease by about 6%, and thrombolysis by about 1.4%, so the huge burden of disease that we are all troubled by will not be tackled by these acute interventions. To treat thrombolysis on the Isle of Wight would mean 24/7 helicopter cover to get patients to the mainland, and we worked out that eight patients a year would benefit from this. The question is: If there are only limited changes you can make in a given year to a system like the Health Service, is this the change you really want to make for population health? If you have a stroke, of course you would quite like to have thrombolysis, but in terms of population health is that a helpful thing to do? We found that by displaying information in a way that people can visualise and understand, you do get stakeholders to agree on what the hard choices ought to be, but it is a radically different way from the methods that are conventionally used to help people set priorities.

**Q61 Dr Naysmith:** We are moving into a time when there is probably going to be restriction on public spending. What effect do you think that will have on the current commissioning set up?

**Professor Bevan:** I agree with the point Dr Meldrum made earlier, that it is going to be even more important that we find ways of getting the public involved to make these hard sorts of choices. The process we have been working on enables the public to do that. If you can have a proper debate that involves the public, then you are in a much better position, it seems to me, for the primary care trusts to present these difficult choices to the public and to the media.

**Q62 Dr Taylor:** Is one of the problems with the current system of commissioning that too many cooks are involved? We have PCTs, GP commissioners, NICE, Tsars, clinical networks, patient choice.

**Professor Bevan:** There are two different things. One is the drivers of change. As you say, there are PCTs, PBC and patient choice, so in effect we have three different sets of purchasers. The whole idea about paying providers on cases through patient choice is not consistent with PCTs having a budget that they have to manage a population for. That is a tension. As regards the other issues, about people being involved and NICE and so on, we talked earlier about the need to get people involved across the care pathway to improve quality of care, and NICE provides useful evidence for that. It is not in that sense that there are too many cooks, because they are cooking different recipes, there are different meals—I am sorry, I must not get carried away with the analogy. We would say that you need to have a good process to which you can harness these different viewpoints and take the view for what is best for the population. That is the most important development.

**Q63 Dr Taylor:** Is it not a huge argument for integration? Should not all these people be integrated together?

**Professor Bevan:** Neither of us has expressed enthusiasm for the purchaser/provider split, but we have been working with PCTs at the moment and you can get the different stakeholders here, including local authorities, to look at the choices and provide their views. In the end, of course, it is the PCT which has to make the decision.

**Dr Meldrum:** We do not need physical or organisational integration to get practical integration. I do not think it means that primary care needs to take over secondary care or vice versa and they have to be all in one, but they have to be working together. I am not sure if it is a case of too many cooks, but certainly the fact that there are so many types, in various places, of people getting involved shows that there is not one model that seems to work very well. It is not so much about the numbers of people involved; it is how effectively they are working together and whether the system helps them achieve that.

**Q64 Dr Taylor:** Going back to integration, you have rather implied that if that happened we would have to have regional health authorities back. If you look at the whole programme of reforms of the NHS over the last 20 to 30 years, it has been a continual cycle of going back to what had been discarded before, so it would not be anything new to go back to RHAs and an integrated service.

**Professor Bevan:** It is the old hymn about history repeating itself. I certainly would not say and I do not think Dr Meldrum would be saying that we should go back to as it was in 1974, because then we had this division between primary care, and hospital and community health services, and you would want to create a different form of organisation. The first time I got involved in the Health Service was doing research for the Royal Commission in 1978, when it was a heavily bureaucratic, hierarchical structure, and people found planning a rather strange concept which they seemed to liken to Stalinist five year plans

really. We are talking much more about integrated organisations. I am thinking about this as a regional body, which would be challenging that organisation in terms of its comparisons of provider performance, what the needs of its population are and all sorts of sets of additional information, and saying, “Look, these are things we think you should develop.” I have this idea that, as part of that, you would have annual meetings at which the local organisation would report to the public what they have achieved as had been set over last year: where they have done well, where they have not done well, how they are going to do. I have a different vision than going back to the past.

**Q65 Dr Naysmith:** You would go back to the late 1980s.

**Dr Meldrum:** In general practice I have seen FPCs, FHSAs, and then we went to DHAs, PCGs, PCTs. It is just a list of acronyms. I do not particularly want to see another massive organisational change. If we change the underlying system, I would like to see it evolving. You can change the way people behave and operate and the processes without necessarily having to have major organisational change. That may evolve, but I would want to see it ideally being done and evolving, and not going back but going to something better. If you want to ask me where in all that process I thought things worked pretty well, when we had DHAs—we had about 100 of them—maybe some of them were too small but at least you did have quite good integration of primary and secondary care at that time. But they were not allowed to last very long before they were changed again.

**Q66 Mr Bone:** I would like to go back to something Dr Meldrum said on commissioning for the population. Your argument is that with public health improving it costs more because people then get chronic diseases. The biggest move forward has been the banning of smoking in public places. Should we not reverse that and encourage people to smoke because they are voluntarily laying down their lives for the rest of the population, reducing a huge amount of duty for the Government for the rest of the population? Would that not be the logic of your argument?

**Dr Meldrum:** I did say that on purely economic terms we should not expect it in the long run to be cheaper, but of course the fundamental idea is that we are trying to get people to live longer, healthier lives. I am a passionate supporter of the smoking measures, but I was trying to make the point—which even goes back to the days of Beveridge and Bevan and the idea that with the National Health Service costs would go down—that there is no evidence in history or in any healthcare system, I am afraid, that the longer people live and such like the costs will go down. They tend to increase. But of course we must be trying to ensure that people live as long and as healthy lives as possible.

**Q67 Mr Bone:** Professor Bevan, I was attracted to your radical approach using the Dutch model. I do not think we have ever seen in the NHS competition with purchasers.

**Professor Bevan:** That is right.

**Q68 Mr Bone:** But I am not sure how you can translate the Dutch model into a state-run health service. Would there be advantages to have competition between purchasers and how could we do that?

**Professor Bevan:** In the 1980s we were thinking about GP fundholding and the idea which I and Kenneth Clarke had then—he was on a beach in Spain when he had the idea, so he says—was that patients would choose their GP and the GP would then choose hospital care. Right at the start there was the idea that you would have choice, being the purchaser. Alain Endhoven's ideas were very influential. He saw it as an integrated organisation, in which district health authorities would employ general practitioners and they could contract out if they were unhappy with local services. He thought that the better thing would be purchaser competition. How you do it, I agree, is going to be quite tricky. The Nuffield Trust will be publishing a report which explains how we might do that. In the Netherlands they started off from a system of having multiple insurers, so it was very easy to introduce competition there. You could envisage people being able to choose between neighbouring PCTs, but that is going to be a marginal thing. The other idea would be to allow private insurers to come in and organise services. Two things were very important in the Netherlands to get it to work. One is that they essentially have universal coverage through multiple insurers and people are free to choose different insurers and they are subsidising that choice. The same individual will pay the same premium to different insurers and then there is a complex risk adjustment formula, because the costs of health care are very skewed, so the most expensive 5% of the population account for 60% of healthcare costs. It is very important, given the choices people have made by these different insurers, that you adjust the risk profile of those insurers for the mix of risk that they have. They have also introduced things to ensure and protect competition to regulate quality. There is

a complex set of regulatory arrangements you would have to have in place if you were to move down a radical reform of purchaser competition. When I talked to Professor van de Van from Erasmus who is working with me on this report, he described that in the Netherlands the government feels they can get out of having to deal with day-to-day problems of healthcare. There was a recent issue in the Netherlands where a hospital was threatened with closure. Under the system, they should have been able to leave that to these different organisations to resolve, but the government intervened because they felt, as Dr Meldrum says, that ministers cannot stand by and let hospitals close. Afterwards, however, there was a lot of criticism of the government acting in that way and it was pointed out that various providers had decided they were already going to try to move in to fulfil the gap in the market left by that hospital. There is a feeling now that if that issue were to recur, the government would probably stand back and let the get on with it.

**Q69 Mr Bone:** Absolutely that can happen in Holland. I do not have a hospital in my constituency, we have two outside, but there is no way a private company could build a hospital in my constituency and then there be competition between purchasers as to whether they use that one or others. I do not see how you can do that in our system. I know we are talking about the purchasers, but you also have to be able to move between different providers, do you not?

**Professor Bevan:** They do have selective contracting. At the back of this is the idea that in well-designed markets organisations will choose forms that minimise both costs of transaction and costs of production. It looks as if the most effective way of doing that is through an integrated organisation. We both have this thinking—although it has to be said, in all honesty, it has not happened yet—that if you were to create a proper regulated market, organisational forms would then evolve to provide the best form of health care. The way we describe this is as a thought experiment for the NHS. As you say, we are a very long way and it would be a very radical step from where we are now.

**Chairman:** I would like to thank you both very much indeed for coming along and helping us with our inquiry.

*Witnesses:* **Mr Gary Belfield**, Director General of Commissioning and System Management, **Dr David Colin-Thomé**, National Clinical Director for Primary Care, **Mr Mark Britnell**, Former Director General of Commissioning and System Management, Department of Health, and **Mr David Stout**, Primary Care Trust (PCT) Network, NHS Confederation, gave evidence.

**Q70 Chairman:** Good morning, gentlemen. Welcome to our first evidence session on our inquiry into commissioning. For the record, would you give us your name and the current position you hold.

**Mr Britnell:** I am Mark Britnell. I am a partner and head of health for Europe for KPMG, latterly the Department of Health where I was Director General.

**Dr Colin-Thomé:** I am David Colin-Thomé. I am the National Director for Primary Care, Medical Adviser to the Commissioning Directorate, former GP and fundholder.

**Mr Belfield:** Good morning I am Gary Belfield. I am the acting Director General of Commissioning and System Management and before that I was Director of Commissioning in the Department.

**Mr Stout:** I am David Stout. I am the Director of the Primary Care Trust Network, NHS Confederation. We are an independent voice for PCTs representing 95% of PCTs across the country. Prior to that, for six years I was the PCT chief executive in Newham in East London.

**Q71 Chairman:** Once again, thank you and welcome. What gains to the NHS have there been over the last 20 years of the purchaser/provider split?

**Mr Belfield:** I am happy to start on that, Chairman, having listened to the debate with the BMA. We have needed to have a purchaser/provider split. I do not think that we have put the support and the effort and development into the purchaser side that perhaps we should have done and we have put more into the provider side. When you have a system as complicated as the NHS, with £100 billion spend this year, you need to have a system of a tension between the purchaser and the provider. If you look at before we had the purchaser/provider split, we had a provider-dominated system, a hospital-dominated system from 1948 onwards, does not really focus—because it is not what they are set up to do—on long-term conditions, health inequalities and long-term health gain in the system. They look at the treat and the cure side. For me, it is really important that we do have this tension between purchasers and providers. The benefits we have had are going to be realised only recently. Listening again to the debate, it feels to me as if we have not really had commissioning until the last two or three years. We have had movement of money before that. I was in the NHS myself in the 1990s when purchaser/provider split first came in, and all we did as a hospital was argue about the money. We did not really talk about quality or improving care at the time. It is wrong to think there has been an improvement over the whole 20 years. I do not think there has, personally. It is only in the last two or three years that we have realised we need to help commissioners to become much stronger, to help them develop and to help them have an equal footing with providers so that we can have some tension in the system to improve care for the local population. The final point I would make is that we need to have

somebody who is an advocate of the patient and the local population and also an advocate for the taxpayer. That is the key role of the purchaser, in terms of ensuring that we get a high quality of care for all but also good value for money.

**Q72 Chairman:** Do you have anything to add?

**Dr Colin-Thomé:** As you have heard, there has been little evidence to suggest that there has been a major change. I suppose the best evidence of change has been that because of targets there has been the biggest movement. But I suppose the real issue is that health services are extremely difficult to manage. That is an international issue. The previous model was arguably even more inefficient but it was focused too much on the clinical providers, and especially secondary care, which covers a tiny percentage of health care. We are searching for a better management approach. My feel on what we have got, even though the evidence is not currently strong, would be to have a separation and organisations looking at the healthcare needs rather than provider domination. I think that providers are not naturally the most objective people to be suggesting how health care should develop. They are a key part, but I think there should be much more objectivity about their effectiveness.

**Q73 Dr Stoate:** Surely there is still a huge disparity in power. The fact of the matter is that the foundation trust hospitals, using payment by results, dominated the power structure in the NHS. PCTs have almost no freedom of movement whatsoever. In my local area when the hospitals ran into difficulty, the PCT came banging on the GPs doors to say that we have to save money. That is no equality of power and control in the system. That is total domination by very, very powerful secondary sector organisations.

**Dr Colin-Thomé:** The point I am making is that basically you have a dominant position of hospitals and maybe we have made it worse. There are two things there. One is that we need better commissioners and internationally they are in a weaker position. One of the MPs was saying before, Ms Atkins I think, that it is a provider-dominated world and there is nobody making any interjection on behalf of the population or asking if there is any comparative data. The only thing about payment by results that seems odd is that we always assume that therefore it will only go to the hospital—and I think your coach party analogy was quite nice. On the other hand, payment by results also helps the commissioner if we can develop them enough—which is the whole point of trying to develop them. If you do not refer for outpatients or shorten lengths of stay, then you do not need to give that money to the hospital and you can use it for something else. The PBR has only been a tool, but because of the disproportionate power—the whole point of trying to make commissioning better and at the moment it is underdeveloped and we have had big hospitals for

100-odd years—is to equalise that and to have a more rational view of how we use resources. Yes, not much success in 20 years, but the potential is necessary because of our obsession with bio-clinical care, much of which is now ineffective and inappropriate.

**Mr Stout:** I have to say I would not be quite so gloomy about where we have succeeded. I agree with the analysis in terms of the relative power imbalance and so on. I have spoken to several of your local PCTs before coming here, and if you look at the action they have been taking over the last two or three years in terms of improving health, in terms of redesigning services, in terms of making changes in care pathways that both improve health and achieve better value for money, then every one of you, in talking as you do to your local PCT, knows that there are improvements being made. To take, as an example, the work on obesity in Rotherham. It is fantastic work. In South-East London, where I think you practice, there is work going on about redesigning a pretty challenged healthcare system using an evidence base, using proper analysis, using the tools of commissioning to drive clinical change. There are lots and lots of examples of really good progress being made.

**Q74 Chairman:** Commissioning has been seen as a bit of a weak link in the National Health Service for quite a while now, has it not? Why is that?

**Mr Stout:** If I can kick-off on that from a PCT point of view, it is right to say that has historically been the case. Why? First, the tools of commissioning did not really exist until three or four or five years ago, so we did not have a contractual system, we did not have payment by results. PCTs/commissioners did not hold contracts with GPs or with dentists. All those things are new. They have all happened in the last four or five years. What has changed in the last couple of years is a more serious policy focus on commissioning. The Prime Minister's Delivery Unit did a review in 2007 on commissioning and basically concluded that there was not a clear story of what commissioning was. There was not a proper programme of support there. We are starting to combine policy levers that are designed for commissioning and a programme that supports the development of skills and capacity within commissioners to use those tools. That is why it has been weak but also why it is now strengthening.

**Dr Colin-Thomé:** Internationally we are obsessed by the provider side, especially hospitals. This is not peculiar to the United Kingdom. Whichever country you go to, that tends to be the policy or managerial focus. This is a chance to begin to shape different health care provision by giving more skills and talents and other things to our commissioners. It has been an uneven contest in the past and we need to improve on that.

**Mr Belfield:** It is also right to remember that we keep changing what we call the commissioner or the purchaser function. We have had something like five or six changes since the 1990s, so every time we get somebody in post, then two or three years later they are moving on, as described in the last session. There

is something about letting us have some continuity and some stability here to help commissioners work. Also, picking up on David Stout's point, we have never really set out nationally, until very recently, the compelling vision about what commissioning was meant to achieve. We have never really set out what we think are the real tools of development to help support PCTs. We have never really set out what we think you need to be competent at to be a great commissioner. We have done that in the last two or three years. As David said, it is early days. We are beginning to see some real improvement across PCTs. The levelling up will take some time because the organisations are quite young and some of the FTs have been around for a long time. If you call me back to this Committee in two or three years, we will be talking about a much more even balance in the system.

**Q75 Dr Taylor:** My question was going to be: Is the continuous reform of commissioning evidence of continuing failure?—which is the message I got from the last session—but you have said very clearly that in the last two or three years the changes have begun to lead to improvement. Can you clarify that a bit? In what way? What changes have come in the last two or three years that have radically changed the whole system so that we can now look forward to commissioning being a success?

**Mr Belfield:** The big differences have been, in the last two years particularly, that PCTs have begun to analyse deeply and understand the long-term health needs of their population. That has not really been done before. They are looking forward more than they have done before. We are seeing more examples of collaboration and partnership in the last two years, where the local providers (the voluntary sector, PCT and local authority) are working together on single projects. Again, we are seeing much more of that. And we are seeing professionalisation of commissioning. An example of that—and this goes against the BMA argument about collaboration—is that in Manchester and Cheshire ten PCTs are working with ten hospitals and the ambulance service to redesign stroke services across the complete care pathway for nearly three million people. That is down to the PCT saying, “We need to work together. We have looked at the needs, the health needs of particularly stroke patients in Manchester, and we want to make a difference.” We have examples of that on a large scale, and on a smaller scale, if you go to somewhere like West Sussex, the PCT are working with the police and with the local authority there on a very small scheme about looking at helping women who are suffering domestic violence. We have examples at both ends of the spectrum of PCTs beginning to understand the needs of their population and designing services in partnership with others.

**Mr Stout:** It would be characterised by effective use of evidence; effective use of data; effective engagement with clinicians of all sorts in both primary and secondary care (doctors and nurses and so on on the patch); and a dialogue with the public. Those are the four things you need. You asked the

previous witnesses what the criteria for effective commissioning would be and I would say those pretty much define it.

**Q76 Dr Taylor:** Are they getting better data? We felt from the previous witnesses that the data was still pretty poor.

**Mr Stout:** It is certainly better than it was. What are the things that hold commissioning back? It is the fact that we still do not have data that is live; it is still often out of date; there are still coding issues in terms of how well activity is coded and so on. But is it better than it was five years ago? Absolutely. Undoubtedly. Why is that? It is because we are using it. Data will always be bad until you use it for a purpose. If you use it for a purpose, that incentivises everyone who provides the data to get it right.

**Q77 Dr Taylor:** Has the reduction in numbers of PCTs helped?

**Mr Stout:** Yes, to some extent I would say it has, but I would also caution against this obsession which your previous witnesses touched on of constantly reorganising. There is no optimum size for a PCT because commissioning operates at multiple levels. You can play around with structure as much as you like, but the downside of that is that it then destabilises. It has the effect Gary talked about of not giving you a very continuous leadership or a continuous focus in a particular area.

**Q78 Dr Taylor:** You do not see further upheavals.

**Mr Stout:** That is up to politicians ultimately. I would certainly hope not. We would certainly advocate leave the structures where they are and focus on making them work, rather than focus on every two or three years and then throw the structure up in the air again.

**Q79 Chairman:** Could I prod this a bit further. You say about the last few years and you talk about what Rotherham PCT is doing on obesity, but they are doing it on other things as well. I know very well about the disease burdens in communities that I have lived in all my life and represented here for many years in. We do not need people to tell us about that, but we have only just started looking at it in the last few years. Is that because of commissioning or wanting to commission, or is that because of the amount of resources that have been made available at local level? Which one is it?

**Dr Colin-Thomé:** I would have said from my experience that it was because of our focus on commissioning for broader needs and to look beyond the bio-clinical. There is that old saying from Rohmer that a bed built is a bed fillt, but if you just provide more bio-clinical acute care, you tend to use it more and more without necessarily challenging its effectiveness. We have to make a balance as to what those priorities are. I would not take the Gwyn Bevan point about strokes: I think you do need to both those things for strokes. But there is a whole lot of other things that are currently being done by clinical providers, whether in primary or secondary care, where its effectiveness and usefulness can be

heavily challenged. In fact there is a better web page now, taking Dr Taylor's point of view, on productivity and all such things, readily accessible to all of us, so that we can begin to compare different services. I think it is because of the focus on commissioning—it is beginning to shape where we are. Of course health care is important, but also we have to look at some of the broader issues, like obesity, which maybe we had not focused on in the past or had looked at only on a bio-clinical model. I think it is shaping a difference.

**Mr Belfield:** In answer to your question, I think it is both things. The resources have certainly helped and it has certainly helped as well that we have taken away many of the access issues in secondary care. That means that the PCTs have been able to focus on other things. That is certainly part of the answer. The other issue as well is that as a society we are moving away from hospital-based provision into more community-based care. It is more about dealing with long-term conditions. Society is moving that way anyway, but commissioning has certainly helped push it faster.

**Mr Stout:** The role of commissioning in that is both paying for and planning health service delivery, but also paying for and planning for health promotion and wider activities. It is that combination. The fact that there is one body at local level responsible for both those tasks has led to the focus in all the different areas on the right things that matter to the populations in your area, rather than simply the theory that you can do this once at national level with regulation and that will give you the right answer. I simply do not believe that, which is why we are strong advocates for maintaining the separation of commissioning from provision of responsibilities.

**Q80 Chairman:** Does this mean that if things get tight in terms of NHS resources commissioning of lifestyle issues will remain?

**Dr Colin-Thomé:** I am hoping so. I think that is the balance you have to make.

**Q81 Chairman:** You are hoping so?

**Dr Colin-Thomé:** Yes.

**Q82 Chairman:** I am looking for this change.

**Dr Colin-Thomé:** That is the potential. That is what the World Class Commissioning assurance bit is about, to look at health as well as health care. My premise would be that a lot of what we currently spend on health care is not always the most effective way of spending our money. That is significant, if you look at the NHS Institute figures about the different use of resources and if you look at some of the clinical interventions which now are not as effective as maybe we thought they were, if you add that up there is a significant amount of money in our current resource which we could begin to release for both better health care on things we are not doing but also on some of the broader health issues as well, such as obesity.

**Q83 Sandra Gidley:** Mark Britnell, originally this was your project, as it were. We have heard from Gary Belfield about how he has perceived the system has changed, but, more specifically, what would you say were the three main changes that you introduced into the system? What was your evidence base for those?

**Mr Britnell:** It is quite important to go back to the 2005–06 reorganisation, which is when we first met each other back in South Central. All the commissioning of patient-led NHS was produced from the Department of Health, which reduced the number of PCTs, and then quickly after that, in 2007, as I was invited to join the Department by David Nicholson, the Prime Minister’s Delivery Unit produced a report which basically—to try to summarise a 20- or 30-page document—said that the reorganisation itself had been for its own sake and that it lacked some vision, ambition, definition of competence and definition of health gain as well. If one were being playful, one might say that the last eight or nine reorganisations that we have had since I joined the NHS in 1989 have concentrated on giving providers more freedom. I used to be a foundation trust chief executive but did not really concentrate on purchasing. The great reforms of the 90—I think project 26, as it was called—referred to purchasing. My analysis, as I came into the post back in the summer of 2007, was that if people did not know what was expected of commissioners, it was almost impossible to professionalise them as a class of managers or clinicians. In a sense, therefore, I wanted to create something which had the discipline and rigour of the foundation assessment exercise and the stretch that gave people the ambition to raise their sights. We looked at different systems from around the world and, recognising that the English NHS is the English NHS, we tried to pick bits and bobs, as it were, from different systems: insurance-based systems, integrated systems, trying basically to reach a consensus with a number practitioners—which we did in the summer of 2007—with managers and clinicians, local government and private sector/public sector. Basically, we defined these 11 competencies—which I do not think anybody really disagreed with. It might strike you as slightly odd—it did me coming into the department—that no-one had defined what good commissioning was in 20 or 30 years. As one of the speakers, the academic, said before, the star rating systems—which I know very well from my experience in a foundation trust—define some optimal levels of a narrow range of performance in a hospital but not for a PCT. We looked for evidence across insurance-based or integrated systems, we reached a consensus with firms and clinicians and managers about the competencies, and then we tried to let the commissioners have five-year plans. In my 20 years’ experience of the NHS we have never asked commissioners—probably because they got reorganised more quickly than five years—to put their money where their own ambition is. The “Adding life to years and the years to life” slogan was trying to maximise investment in a local

population and do it much more professionally. That was and I think still is the theory and, increasingly, it is the practice behind what we try to do.

**Q84 Sandra Gidley:** Coming back to “we picked some bits and bobs,” which sounds a bit random, what evidence was available for the bits and bobs that you picked? We have been picking up so far that there is not much evidence around for what the UK is doing. What evidence is available from other countries to back up what you were doing, to make sure you were doing the right thing?

**Mr Britnell:** I will start the answer and then hand over to Gary, who did a lot of the work. We commissioned research looking at different commissioning and insurance models from around the world and then distilled what we thought the key competencies were. Without rehearsing the 11 competencies, one is the effective use of knowledge and information. Of course different systems around the world, be it in the States or Europe, do use, in my opinion, information in a smarter way—something which we have not historically done in the NHS. We looked for competencies and criteria from the desk-based research and we spoke to people to try to get these 11 competencies, and they basically form the definition of what good commissioning could be like. I do not know whether Gary wants to add to that or not.

**Mr Belfield:** We looked at more than just the health sectors across the world, I think it is important to say. For example, when we looked at some of the research coming out of Birmingham and other places that looked across Europe, one of the weaknesses of health systems across Europe was that they did not really do detailed health needs assessments, which meant they could not plan their services longer term. We looked at that and we thought that would be a key competency. Then we looked at the industry where internationally they are the best at looking ahead, the pharmaceutical industry. It takes, as I understand it, 16 years for a drug from concept to licence in the UK, and as a business they are now looking forward 25 years all the time to stay in business. We looked at how they did that, to think about building that into our competencies. We looked at places like Google and how they use information, to think about how that would be built into our competencies. We also looked at the retail industry.

**Q85 Sandra Gidley:** I am sorry, I am not quite sure of the relevance of Google. Did you just Google “commissioning”.

**Mr Belfield:** I apologise. As part of a series of workshops in the middle of 2007 we interacted with a number of different people—beyond health, is what I am saying. We sat down with the NHS but also with representatives from Google and from Marks and Spencer to ask them about how they ran their businesses and which aspects or principles were transferable into the UK or the English NHS. We tried to look beyond health systems. We started there, but we wanted to look beyond health systems. When we got our 11 competencies, we wanted to say,

“This looks like the best in the world,” which is where the World Class Commissioning point came from.

**Q86 Sandra Gidley:** I am sorry, I think you were going on and I disrupted your flow.

**Mr Belfield:** Health needs assessments were something we looked at from the point of view research. We looked at research, in terms of the insurance-based markets in Germany, France and the States, to look at what we could learn from them. The key for me was always not to bring a system from somewhere else into England but more about bringing principles. For example, in the US we looked at the Kaiser Permanente system and why that had worked in California in terms of integration but why it had not worked in Carolina. We then tried to bring the principles back. For a four- or five-month period, from when Mark joined in July through to about November, we probably had interactions with dozens of organisations and from that we distilled what we now call World Class Commissioning. I cannot, hand on heart, point now to one single piece of evidence that then affected that piece because we were bringing things into the melting pot over a period of months.

**Mr Stout:** It is worth emphasising the amount of work with primary care trusts and primary practice-based commissioners in developing this. It was not just an academic exercise, a theoretical exercise.

**Q87 Sandra Gidley:** But they were not very good at it, so why were they involved if you were starting from first principles?

**Mr Stout:** I do not think that is right: they were very good at elements of it and always have been. The point was that we were not doing it systematically across the piece in an effective way, and so testing the theory with the practitioners is the same as we do in any other type of research.

**Mr Britnell:** We have just been through, as you can recollect, a fairly bloody battle reorganising 303 PCTs into 152. It struck me as being rather strange that you would not then involve the 152 people who had been appointed as chief executives, because we were trying to help them create their future as much as improve the health of the population. They were not all involved in the design but a good 50 or so must have been.

**Mr Belfield:** I was absolutely determined that we would do this Department of Health policy differently, so we went out to the NHS with a series of ideas about how we could improve commissioning, and then we wanted to work with them so that we were producing together. Because we did it together, we probably managed out many of the mistakes, many of the unintended consequences. We also have better buy-in from the NHS as a whole because we involved them from the very, very start. David Nicholson now uses World Class Commissioning as an example of how the department needs to develop policy in future of the NHS.

**Q88 Sandra Gidley:** That is good. We talked about the evidence base earlier and you mentioned some general themes that seem to have improved, but is there any hard evidence that World Class Commissioning has improved efficiency?

**Mr Belfield:** Is that any hard research-based evidence?

**Q89 Sandra Gidley:** Yes.

**Mr Belfield:** No, not university-based evidence, but we are only in year one for World Class Commissioning and we intend to do some desk-based research at the end of year two. We do now have anecdotal evidence and evidence from a variety of surveys that were done within the NHS that it is beginning to make a difference. I go into a PCT maybe once a week, and the first thing I ask is “What have you done differently?” I am hearing examples—quite small ones, quite large ones—where people are making a difference. We surveyed the whole of the NHS between Christmas and February last year, an online survey asking people, “How is commissioning beginning to make a difference now that we have this format?” and an overwhelming majority of people came back from PCTs, SHAs and local authorities that are involved to say that they could see this was beginning to make a difference. But I do not have hard evidence yet. It is too soon.

**Mr Stout:** In terms of some objective evidence, hard evidence if you like, the Care Quality Commission, and the Healthcare Commission before them for the last five years, have published ratings of core standards—so performance against the core standards for health. When that started, PCTs were the worst performing sector in the NHS. PCTs in the year just published, 2008–09, were the best performing sector in the NHS. That is an evidence base of an improvement in performance.

**Q90 Sandra Gidley:** Or it could mean the others had got worse!

**Mr Stout:** No. In compliance with core standards, PCTs are better than any previous performing part of the NHS. It is not that the others have got worse; it is that PCTs are now, historically, the best performing ever part of the NHS.

**Q91 Dr Stoate:** I would like to ask Mr Belfield a question. Considering that we are talking about £100 billion of public money every years, it sounds alarmingly patchy and, frankly, alarmingly amateurish. The assurance process published earlier this year showed weaknesses, some quite significant weaknesses in some areas, particularly the ability to stimulate the market and procurement skills. What is being done to address this? How can you distinguish between weak and less weak PCTs?

**Mr Belfield:** We have put in place the most rigorous process of assessment for PCTs that we have seen across the NHS. It is comparable with the monitoring of FTs, but it goes beyond that because it looks at development as well. We have put a system in place and the result from year one, a developmental year, are exactly where I expected

them to be. Because we have never really asked PCTs in the past to manage markets and such like, why would they, from a standing start, all be able to do that? We knew which scores would be relatively weak in those areas. Equally we knew that people would score well on partnership, because traditionally the NHS has done well on that. That was my starting point. The more important point for the future is what we are doing to develop that. We have had a development programme that we have run with the SHAs and with the NHS Institute for Improvement, looking at helping every single PCT in the country to improve their performance, so I would expect to see, for example, competency scores to rise this year. We are doing things on the technical side, about how to do procurement well. We are doing things on how to manage markets, which is as much about collaboration as it is about competition. We are helping people to showcase where they are doing really well on public engagement, for example, and public engagement is beginning to move forward very quickly. Where PCTs are doing that well—and I am sure David has examples of that—we are using those PCTs to help showcase, to show others how quickly you can move forward. Absolutely this is a longer-term project. It is £100 billion, as you say. We need to put a lot of effort into development and we are certainly doing that nationally but also very locally as well. Quite encouragingly, 35 PCTs, recognising that they need to do things to develop, are working together for their own development, so there are a lot of things happening at a very local level as well.

**Q92 Dr Stoate:** I find it even more alarming that you talk about a standing start as if we have only just invented this. The purchaser/provider spilt has been around since 1991 or whatever, 28 years ago, and you talk as if we have just decided we ought to look at quality of commissioning 27-odd years later. That is the most alarming thing. Why have we not been doing this for the last 20-odd years?

**Mr Belfield:** I am talking about this in relation to the way that we have defined commissioning, which I think is the first time we have ever really defined commissioning.

**Q93 Dr Stoate:** After 20-odd years we have just decided to define commissioning, and then we will have a standing start and see if we might be able to improve it—and we are still spending £100 billion a year in, to be honest with you, a fairly random fashion.

**Mr Belfield:** I am just thinking whether I can answer for 27 years of policy.

**Mr Stout:** I am not from the Department of Health, I am sure I can say something. As a national health system we did not invest appropriately in commissioning. We did not give it sufficient clarity, we did not give it sufficient support, we did not give it sufficient status, and we suffered as a result. We are now catching up a little late in the process—but we are catching up.

**Q94 Dr Stoate:** I would like to quote from a paper from the Office of Health Economics 1998: “The best American Commissioning groups have concluded that health care is far more complicated to purchase than anything else.” That was ten years ago and yet we are still grappling with the basics.

**Dr Colin-Thomé:** I do not know if it is basics. It is because it is down to complexity. This is not unique to Great Britain. Most of the countries that we know of have focused very much on the provider side. If you look at some of the American insurers, the aim seems to have been to shovel money to the acute providers rather than making more discerning judgments. I am not defending this—of course we should have done stuff earlier, but the fact is that most healthcare systems have focused predominantly on that. In one sense we should get some credit in this country for making an attempt to professionalise commissioning. Other countries have palpably failed to do that and have spent a lot more GDP on often just more inefficient health care rather than making a huge difference to health gain.

**Dr Stoate:** Thank you. I am a bit more reassured.

**Q95 Dr Naysmith:** How can we be sure that PCTs are up to the job and that they have the expertise and the resources necessary to do what they need to do? Before Dr Colin-Thomé starts telling me all about the good things that South Gloucestershire and Bristol PCTs are doing, I am very well aware of that. Quite a bit of evidence has been submitted in previous hearings that a lot of people think the PCTs do not have the resources and they do not have the expertise to commission lots of things.

**Mr Stout:** The assurance points in the World Class Commissioning system were designed just for that purpose; in other words, it is a public, systematic, rigorous assessment of how effective commissioning is. We have never had that before. We have never had a means of giving the assurance you are asking for. We now have a system that does that and it shows, as we have already said, that there is some way to go before we can claim, hand on heart, that we are world class or anywhere near it. It definitely shows there are development needs of PCTs. Beyond the “I want to do a good job because I want to do a good job” incentive, it also creates some incentive, by being held to account in a public way, for organisations to take their responsibilities seriously and to do something about it where they have deficiencies in capacity or capabilities. You can see PCTs individually and collectively starting to work on those areas where they do not have those skills. That is either through bringing in external partners to work with them or working together. For example, on Howard’s question about market-making and procurement, most PCTs are now starting to say, “Let’s not do that 152 times over; let’s set up specialist units working to us who will ensure that our procurement skills are up to scratch and that we do not dissipate resource by doing it 152 times over.” You can be assured by the system of assurance and the public nature of that and by seeing what PCTs are doing in terms of action to address the deficiencies that system has thrown up.

**Q96 Dr Naysmith:** When this Committee was doing the inquiry into the commissioning of dental services quite recently, we discovered that there was huge variation between PCTs in their ability to commission dental services. In some places—and Bristol was one—they were really good onto the job of commissioning dental services. We found that in other PCTs they asked the office boy or girl to do it and they did not have the skills to do the job properly. How can we ensure that does not happen?

**Mr Stout:** You will have variation and we do have variation. You are quite right: there is variation in performance of commissioners that is exposed in this process I have described. There is also variation about where commissioners put their efforts and some of that variation is entirely legitimate and reasonable. If in analysing your local patch you find that your fundamental health problem is the inadequacy of your stroke services, then, given limited management capacity, you should focus your efforts in that rather than dentistry if that is less of a problem. The areas that do have particular problems of NHS dentistry characteristically are the ones who have put particular management effort into doing something about it. The areas that have had historically poor access to NHS dentistry, by and large—and I cannot say for certain that they all have—are the ones which will have invested time and effort into procuring new services, developing, be they new GDP practices or mobile services, whatever is the right answer in their local patch. You will see variation, just inevitably, because we start from different starting points, and almost systematically, because people will be focusing on the specific priorities where you are going to get most impact for your investment of time and management of the commissioning effort.

**Q97 Dr Naysmith:** What roles do Commissioning for Quality and Innovation (CQUIN) and Never Events have? Also, is there any role for punishing providers for not doing or—even worse—making people ill when they are supposed to be making people better?

**Mr Stout:** They are two examples of commissioning interventions around quality. The CQUIN one being incentivising through cash—either more for doing better or less for doing worse—incentivising providers to respond; the Never Events being having a systematic approach to publishing data on things that should never happen.

**Q98 Dr Naysmith:** Is it used? Is this a way of having consequences now?

**Mr Stout:** As a policy it came out in the Next Stage Review, so it is relatively recent, but, yes, it is starting to be used as one measure of quality in the commissioning process. Those are two examples rather than the whole way that a commissioner can intervene in relation to quality. Every PCT lead commissioner for a hospital, for example, will be having monthly clinical quality review meetings now with much better data on what good looks like, so much better metrics for performance, and starting to use those to drive the dialogue about their

performance at the hospital rather than simply counting widgets. Earlier the PBR critique was that it was simply about numbers of people; now we are looking in much more fine detail at the quality of commissioning.

**Q99 Dr Naysmith:** Traditionally that is what happened.

**Mr Stout:** It is caricaturing it a little, but, yes, there was an element of the concept of commissioning being a remuneration system rather than a commissioning system. That is what we are moving away from. This not simply about how you get money from the Treasury to providers of service; this is about treating that money as a health investment rather than just a spend mechanism. That is the sort of change we are talking about.

**Q100 Dr Naysmith:** Does anyone have anything to add?

**Dr Colin-Thomé:** One of the international issues is what Al Mulley at Harvard calls “unwarranted variation” and that is true in providers as well as commissioners. A bit like the GP QOF system, World Class Commissioning is about a continuous quality improvement programme, so it is trying to systemise that and iron out as much of the unwarranted variation as you can. In which case, there will be a good process to begin to shape that but the issue that David mentions is hugely important, that we need to make certain that the variation in capability is tackled, but if you want to have a certain amount of devolution, individual PCTs have to have the incentives to make decisions which are appropriate to their population. Those are two separate issues, but in terms of capability, we are trying to make certain that we can get a more standard set of PCT people.

**Mr Belfield:** We would absolutely agree with the point that PCTs are starting from different places and so capability, like in any large organisation, is variable. We have recognised that as part of having a development programme to support individuals as well as the PCT, but the places that did not do so well in the first year of World Class Commissioning are already having intervention with their SHAs, helping support that PCT to improve. We know that time is of the essence and we need to move on, so we are doing something now rather than waiting for the future. On the point you make about CQUIN, that is definitely where this trend is going. We are going to give more tools and more support for PCTs to be able to commission for quality. That is absolutely the direction of travel.

**Dr Colin-Thomé:** Also, it will help to get more clinicians excited about this, because otherwise it seems a hugely bureaucratic thing. It is very hard to be a good commissioner without having responsive, good quality providers, and this is one way of getting clinicians involved in setting some of the standards. If you do set your own standards, again there is an international evidence base that peer group review is a powerful way of learning and improvement.

**Q101 Dr Naysmith:** The other thing that happens quite a lot now to do with competency is that PCTs collaborate. A PCT will take the lead in a particular area where they have the competence. Presumably you would think that was a good thing.

**Mr Belfield:** Absolutely. That is happening organically. Particularly where people have low expertise in something or it is technical, they are working together. We are finding that all over the place. There are 14 PCTs in the West Midlands working together on data, for example, to take Dr Stoate's point earlier. We are seeing that happening across the country and it is a good thing.

**Dr Colin-Thomé:** Sometimes you are commissioning for individuals, and that is what clinicians are often doing, and yet you can be commissioning for quite rare things, like forensic psychiatry. One of the fits for practice-based commissioning is that you can do some of that local clinical stuff and be an adjunct to PCTs and then for other functions PCTs need to merge their functions.

**Q102 Dr Naysmith:** We are going to deal with specialised commissioning a little bit later.

**Dr Colin-Thomé:** I am saying that we should not be frozen by the structure; it is about the attributes of these organisations. We have to tackle local stuff as well as having the big stuff, which is part of what our process is certainly going to improve.

**Q103 Mr Bone:** World Class Commissioning. Have the spin doctors taken leave of their senses? We have heard from the previous evidence and from what you have been saying that it is trying to make a little bit of an improvement. Should it not be, "Err, we are trying to get it a little bit better"? The idea that we are moving from now to world Class Commissioning seems to be ludicrous. Discuss.

**Mr Belfield:** Everyone is looking at me. We are one of the largest organisations in the world, we have 60 million people in England looking for our care, and we need to have high ambition. I do not apologise for calling it World Class Commissioning. We are not at anywhere near world class. I completely accept that we are nowhere near world class at the moment, but we need to aim high. If we aim low, then we will hit low. We need to aim really high and have great ambition for our local population, for the health of the local population, and say we can do things differently. I do not apologise for calling it World Class Commissioning.

**Q104 Mr Bone:** That is fine. It is an aspiration.

**Mr Belfield:** It is aspirational.

**Q105 Mr Bone:** Given where we are at the moment and given the limited resources, what can we realistically expect from commissioners at the moment?

**Mr Belfield:** With the impending financial change that is coming, I think we need commissioning more than ever. Otherwise, we will end up reverting back to type. We will revert back to a big provider system. In times of financial tightness—and remember it is still £100 billion, so it is a lot of money—we need to

make sure that we are looking on prevention agenda, we need to make sure that we are delaying illness for people. That is why commissioning for long-term health is even more important than ever. That is why we are pushing harder this year for year two of World Class Commissioning, to help PCTs to get ready for what will be a tighter fiscal regime 2011 onwards. It is even more important than ever, I think.

**Dr Colin-Thomé:** We could also lead the way in this country on beginning to challenge ineffectiveness. There is a huge international evidence base that there is much duplication and inappropriate ways of organising health care. Hopefully we can drive that out, so that it does not damage services or quality. Sometimes it is called rationing—which is nonsense. You ration by not giving people the stuff that has a good evidence base. But if you look at the way we structure a lot of our health care, and if you look at the NHS Institute webpage and all the others and the amount of money we are spending on things which we should be shedding. We need commissioners to be able to lead the way on that, to try to get providers to shape up on those issues.

**Q106 Mr Bone:** We have heard some media reports this week about PCTs banning together to lobby NICE, to restrict cancer drugs. Is that an appropriate way of commissioners spending their money?

**Dr Colin-Thomé:** If there is a strong evidence base for clinical intervention, it is very hard to say no. The issue is that what happens is we focus on cancer drugs and can we afford more expensive drugs, or on this stroke issue, say, on whether you need both high-tech care for people who have had a stroke and also prevention. My argument is that there are lots of other things we do—and I will come to some of the bees in my bonnet. The construction of out-patient care in this country, which amounts to 45 million patients a year, probably has the flimsiest evidence base of anything that we do, and yet we spend millions of pounds on that when, in fact, a lot of the time they are not necessary contacts or are duplicating what is happening in general practice. If you began to drive out some of the unnecessary high volume/low cost care and began to challenge that, you would release significant amounts of money. The NHS Institute talks about comparisons in performance between hospitals, that if the bottom hospitals, as it were, were to achieve the levels of lengths of stay and all the things that the top hospitals do, we could save over £2 billion within our resource. There is a lot of money available from high volume/low cost things. That is what commissioners might need to do, because providers have obviously not been up to beginning to challenge that.

**Mr Stout:** The media report you refer to is, I have to say, slightly misleading. PCTs are there working together—as I think we have all argued they should—to use evidence effectively to make sure that decision making is as consistent as we can make it, and to work with NICE to make sure that when NICE is appraising new technologies that is done with specialist input from commissioners as well as

specialist input from the pharmaceutical industry, patient groups, clinicians and so on. It is not a lobbying intervention; it is a using skills intervention.

**Q107 Mr Bone:** This Commissioning Support Appraisals Service is a PCT initiative, not set up in the Department of Health.

**Mr Stout:** Yes, it is PCTs working together collaboratively to get the most effective collective input to the NICE process that they can. As I say, I think that is something we should welcome rather than criticise.

**Q108 Mr Bone:** Some of the personnel that are advising you from a company called Bazian also work for NICE. Is there not a conflict of interest in that? Most people I speak to would expect your money to be spent on commissioning services, not really in the lobbying field, I would have thought.

**Mr Stout:** As I say, I do not know the detail about the company but this is not work on lobbying; this is work on expert input to the process of appraisal.

**Q109 Mr Bone:** Is that not lobbying?

**Mr Stout:** No, I do not think so—not what lobbying suggests to me, anyway.

**Dr Colin-Thomé:** NICE does produce commissioning guidelines on many issues. I have been involved with some of that, and I suppose I could say that was a conflict of interest with the Department of Health, but they need information from people who have been involved in the service. NICE use other people from the service to begin to help not just on the clinical appraisal of drugs and technology but also on the clinician guidance. On the NHS evidence they are going to be producing, they have used many of us. Conflicts of interests are sometimes raised that stop all advance. If there is a conflict of interest, sometimes you have to make certain it is transparent rather than stopping some of those tensions inherent. Otherwise, you get a bureaucratic nightmare and you do not get the best innovation.

**Q110 Charlotte Atkins:** We are going to be hitting a tightened period of public expenditure. How is that going to impact on commissioning? Some witnesses have suggested that we should get rid of commissioning to be done in other places. Others have said that we should spend more money on it. Others are saying we should make it cheaper and simpler. What is your approach? Clearly all of you have said that commissioning has a role. In a situation where there is going to be tightened expenditure, in those straitened times what will the role of commissioning be? Will it still have an important role within the NHS?

**Mr Stout:** Gary has already said, and I agree, that in straitened times the role of commissioners becomes even more important than it ever was. In terms of who is responsible for driving up quality and driving up value for money in the healthcare system, it is the commissioning function. The arguments you have heard from previous speakers were about how you

do it rather than whether you do it. I did not hear anyone saying, “You shouldn’t be doing that function.” In terms of the question about investment and how we use the commissioning capacity that we have, everything we have already discussed suggests that we need to continue to strengthen the way we do commissioning. I do not think, necessarily, that means extra investment. It means using the skills and capacity we have to maximum effect and making sure we develop those skills as far as we can. The pressure is that it is probably only a year or 18 months away before the real financial burden on the NHS starts to be felt in a very significant way. We have this period of time to do the kinds of development that Gary was talking about earlier and we have to get that right to make sure when times get really tough we have those skills in place to deliver commissioning efficiently and effectively.

**Q111 Charlotte Atkins:** Will that ensure that the primary care focus of present policy will continue rather than going back to the old system, where acute hospitals completely dominated and ruled the roost?

**Mr Stout:** Absolutely.

**Mr Belfield:** I would completely agree with that. I am not advocating that we spend more on commissioners necessarily. There are some things that commissioners can do together to reduce their back-office costs—personnel and payroll and such like that—so there are savings that can be made.

**Q112 Charlotte Atkins:** Do you want to go into that a bit more?

**Mr Belfield:** Instead of having, say, 152 PCTs all having their own back-office function, like payroll, HR departments, et cetera, we are finding already that people are beginning to collaborate. One might do it on behalf of ten others, which makes a lot of sense in terms of the public purse. I think we will see more of that coming through. I know we will see a debate in the next weeks and months about how you can have improved quality and also improved productivity, and some of the things we have already talked about to date, particularly David’s point about reducing some of this unwarranted variation between practice, is where we need to help PCTs/commissioners to really step up, in a sense, and challenge the providers to change their practice. We will see commissioning being strengthened from that point of view—not necessarily with more money, but strengthened. It is also really important that we remember that we have, all things being equal, another 5.5% growth next year, so there is an opportunity, if we think through now what we need to change in the future, that we can invest money now, which means we will save money down the line. We will see elements of that this year, particularly in 2010–11 coming through.

**Q113 Charlotte Atkins:** Can I ask you to give me an assurance that you are not talking about more mergers of PCTs, you are just talking about sharing some back-office costs.

**Mr Belfield:** Absolutely. I am sorry if I have given you the wrong impression.

**Q114 Charlotte Atkins:** No, I just wanted to get that on the record.

**Mr Belfield:** One of the messages I wanted to leave the Committee with today is: Please, please no more national reorganisation. It does not really help the situation at all. But we can have collaboration. The 14 PCTs in the West Midlands are collaborating together to share their data, only doing it once rather than 14 times. Those sorts of things make sense, but it still does not take away the statutory responsibilities of the individual PCTs. There is certainly no policy at all from this current Department of Health to have any mergers. That has been made clear by the last two or three secretaries of state.

**Q115 Charlotte Atkins:** Do you think that the bigger the PCT, the more unlikely they are to be able to reflect the real needs of their local communities? I fought very hard to keep a local PCT and I am not intending to see it merged.

**Mr Belfield:** Absolutely. I agree with you completely.

**Dr Colin-Thomé:** I was involved when I was at London Region in looking at PCGs and how they were going to develop. I think we get stuck on size and structure rather than the attributes. I used to say that if you are big you have to demonstrate localness and if you are small you have to demonstrate collectiveness. It is the attributes we need to be judging on. That is what some of the competencies are about. They are principles rather than a set model. That is what I find so attractive. If you have a huge PCT, they have to demonstrate some locality and leadership for connecting with primary care and local communities. We have already described that if you look at some of the rarer things, they need to begin to say that there is a lead commissioner with all the skills. It is in those ways we will improve, without having to have a lot of cash going to them but more effective ways of working, depending on what level of commissioning you are looking at and what population you are looking at.

**Mr Britnell:** Since the introduction of the competencies, I genuinely believe that for the first time in the history of the NHS it has given PCTs nowhere to hide. It is a very explicit way of judging their competence against the 11 criteria. We are finding—and Gary has just spoken to you fairly eloquently—that it is producing larger scale where that scale does not detract from patient care. In some of the analytics in knowledge and information management, you can still have localism but have a big powerful engine that sits behind a number of PCTs. As you well know in the West Midlands, in your particular patch, that knowledge centre could be based literally anywhere in the West Midlands or somewhere else, as long as the information is then applied to the populations concerned. The assessment is making people move on much more quickly. In a sense, that is more profound and organic and better than having a top-down solution. When the previous speaker said the evidence base

was limited, it really is the first time in 60 years that we have tried to assess commissioning and we are only second year into it. It is a bit early to say, but I think all the movement is in the right direction.

**Q116 Charlotte Atkins:** We have acute hospitals which would very much like to have commissioning from one big commissioner. It makes their lives easier just to have one commissioner, a big area, with their commissioner being the person or the organisation that they just deal with, rather than having to deal with different PCTs that may have different needs: a more rural community, an older community, a more deprived community. They would much rather deal with just one organisation. That means that what they deliver suits them rather than suits the local community.

**Mr Britnell:** The issue that Mr Bone raised as well, about the next five years or so in the fiscal efficiencies that need to be made. There is a big debate that needs to be had—and perhaps you are at the foothills of it today in the first meeting about commissioning—about whether the systems are simple funding systems for hospitals to provide care or they are active commissioning systems. One is completely different from the other about how you make investment over a long period of time. With World Class Commissioning the department has tried to give PCTs the ability and permission to have five-year plans. Of course it is sometimes difficult to predict exactly how much funds will be going on after the next comprehensive spending review, but you can model it and make different scenarios. It seems to me that whichever system you have, you need an intelligent commissioner to wrestle with these issues. None of these issues is pain free. The idea of having fully integrated systems does not obviate the need for a very stringent and crisp and challenging discussion and debate over how resources are used. That is why you need local commissioning, because it needs to be closest to the population served.

**Mr Stout:** On that flexibility that we are talking about, again in your local patch, looking at the redesign of services, North Staffordshire and Stoke PCT are working together on that because it makes sense to. In other services which will be much closer to home, it makes more sense for the local PCT to be drilling much closer to the community through practice-based commissioners and so on. It is both and. It does not have to be either or, it really does not.

**Q117 Sandra Gidley:** Mr Britnell, you provided us with a PowerPoint presentation from your time when you worked at the department, and it looks as though the PCTs have only been scored against ten competencies. Why were they not scored against the missing one, which seems to be “make sound financial investments”? Because that seems to be quite an important one to me.

**Mr Belfield:** Do you mind if I answer that? It was deliberate

**Q118 Sandra Gidley:** I assumed so.

**Mr Belfield:** We measured finance very stringently through the governance system. We had ten competencies which we measured separately and then we measured governance looking at strategy, finance and how the borders are operated. We had a very stringent look at the finances through that route, alongside the Audit Commission who supported us on that. For this year, even though we thought it worked pretty well, we have considered the changing financial regime and we have changed competency 11 slightly to be about how effective care is commissioned, and therefore we have made it a separate competency that will be measured separately this year.

**Q119 Sandra Gidley:** So finance has gone now.

**Mr Belfield:** No, it is part of competency 11.

**Q120 Sandra Gidley:** Are we talking about clinically effective or financially effective? Because there is a difference.

**Mr Belfield:** There is. In our competencies we look at both, but competency 11 is about how financially effective the commissioning plans are. I can give you more details on that after.

**Q121 Sandra Gidley:** You can still balance your books but not make sound financial investments.

**Mr Belfield:** Yes.

**Dr Colin-Thomé:** That has been a problem in the past,

**Q122 Dr Naysmith:** Mr Britnell, do you think that any country does commissioning well? The World Class Commissioning we are talking about now, does that exist anywhere in the world?

**Mr Britnell:** The answer is no. However, in reference to the earlier questions asked and answered, we have tried to take the best out of different systems and so we did spend a lot of time looking at North America, and that includes Canada as well, and looking at the developed nations in Europe and also Australasia. I would say there is no perfect system. There are some interesting systems that people want to know more about, such as Singapore or Hong Kong, but they have no relevant context to the English NHS. There are things that you can pick out of different systems, and that is what we have tried to do with the competencies. It is worth saying, by the way, in relation to one of the issues that Mr Bone raised about the spin of World Class Commissioning, that the Commonwealth Fund in 2006–07 did rank health nations and on a mixture of indicators considered that the English/UK system was probably the most developed. Of course that has been open to some comment and debate, but it is worth bearing in mind that we have some excellent preconditions for commissioning because of the nature of social insurance that is the NHS. In a sense, many of us formulating the policy—and Gary might want to say something—felt that the odds were stacked with this lot against us because of the way the funding has developed in this country.

**Q123 Dr Naysmith:** Why did you involve Kaiser Permanente when you were doing your panels for WCC? Did it turn out that they were value for money, bringing them from, for example, California?

**Mr Belfield:** When we were forming panels, we wanted to have a really rigorous test, as I said earlier, so the panels that we created would spend a whole day assessing the PCT, they would be chaired by the SHA, would have a clinician on board from the local area—a doctor or a nurse, so broader than just doctors. We would have a local authority person (often a director of adult social services on the Panel—not always but often) and then we would have a PCT chief executive of the patch. We thought that was quite a partner with the SHA. We thought that would be a pretty rigorous test. Given that we were looking to aspire to being the best across the world, we thought it might be helpful for the first two years to have another organisation in to really push and test. Because we were quite taken with some of the work that Kaiser Permanente are doing in California about integrated systems and they know our systems quite well, we thought we would bring them into the assessment for the first two years. The reflection back from the panels was quite mixed. Where the panels in terms of Kaiser Permanent were really good, the directors, then it was a very good experience, very developmental, very challenging. Some other PCTs did not find it as helpful, but that is partly because we got the wrong people. This year we have learned from that and we are bringing a smaller number of people from Kaiser Permanente, the better ones, who will test the system. The better PCT panels certainly found it was helpful to have Kaiser in the room.

**Q124 Dr Naysmith:** Previously this Committee has had discussions with Kaiser Permanente and visited them in the States. One of the things they do is to limit your choice of doctor—you see the company doctor, to put it rather crudely. That is not part of our system, is it, because GPs now can refer to any specialist in the country they want? Do you think about involving this principle or not?

**Mr Belfield:** When we were bringing Kaiser Permanent directors and senior clinicians along, it was for their personal expertise rather than for the organisation they stand for. We were not making any statement that this is where we think the NHS is going at all. It is only for the first two years. We will not be using them after this year.

**Q125 Dr Naysmith:** We have Mr Britnell's view that commissioning is not done very well anywhere in the world and there is no world class commissioning anywhere in the world that you can go and look at.

**Dr Colin-Thomé:** Professor Bevan was suggesting maybe the Netherlands.

**Q126 Dr Naysmith:** Yes, so that is worth looking at, is it?

**Dr Colin-Thomé:** Maybe not—because, like I say, it is too radical a shift, is it not? Mr Britnell and Mr Belfield have said that it is almost like looking at the

design principles of what makes a good commissioner that we would go for, rather than to try to bring a model from abroad and dump it here. The structural difference would be so radical as to be a nightmare to try to absorb, but some of the principles of how they do it are what we would like to learn from rather than imposing a model. I was brought up to believe that the right model is that there is not a model. It is about what are the basic principles and how can that help a management in the context of whatever health system you are in.

**Q127 Dr Naysmith:** The other thing which flows from this line of questioning is that we heard earlier that in New Zealand and Wales and Scotland and Northern Ireland they have decided to go the other way. Having been exposed to commissioning type systems, separation of provider, they have gone back and decided to do something else. Have they made a mistake?

**Dr Colin-Thomé:** They may have done. I suppose the proof of the pudding is how good are their health systems going to be in terms of their quality and use of resources? There is quite an issue that they might go back to a much more provider-dominated approach. They may or may not. The real issue for all of us internationally is that health services are hellishly difficult things to manage. The jury is out. I do not think going back means it is going to be better. That was the assumption certainly of Hamish Meldrum, but it is a reflection of the fact that these are very difficult issues. I would argue that the design principles we have tried to bring in to keep that slight separation from the providers has a lot to offer, but rather than saying it is right or wrong we will have to wait and see about evaluation. I know we have caught up virtually with European averages, but we do a lot of work. Productivity could be better, but compared with other healthcare systems we do use our resources much better than many. That is what the Commonwealth Fund Assessment was about.

**Mr Stout:** It is fair to say that Scotland and Wales are still doing commissioning.

**Q128 Dr Naysmith:** You cannot get away from commissioning. You have to commission services somehow.

**Mr Stout:** Yes, you must be commissioning because someone is planning, someone is remunerating service providers and so on. The point you made earlier about the scale of the country does make a difference. The question is how separate have they made their commissioning function from their provider function. It must be separate to some extent. I cannot see how it cannot be. Whilst I am no expert on their healthcare systems, (1) I do not think it is quite as different as your question implies, and (2) David is right that this is, if you like, a great natural experiment. We will be able to see in five years time how the two different types of systems evolve.

**Q129 Charlotte Atkins:** What are the benefits of bringing in external support for World Class Commissioning? Is it cost effective? Given the

comments about commissioning in other countries not being particularly brilliant either, what are the benefits and what are the costs? Is it value for money?

**Mr Belfield:** If PCTs are intelligent commissioners, then they can use outside bodies really helpfully. That is my starting point. If we are trying to move commissioning forward in the way that we have all talked about today, then it is important, where there are weaknesses, if they can bring people in for short-term or even medium-term to help them improve their skills and experience, then that is okay. We have encouraged that, but only where they have their gaps. For example, in management of data, where PCTs in some areas have been quite weak they have found it beneficial to bring in organisations to help them improve their data. That then flows on very quickly to improving their commissioning decisions, which improves the health of the population. I can see the benefit of that. Answering your question about whether it is value for money and how much is being spent, I do not know that. I do not collect that at a national level. Anecdotally, it feels to me that PCTs are getting better at using organisations to bring them in. It is moving on quite quickly. PCTs are now looking to help each other as well, so there has been quite a shift in the last 18 months. I cannot answer your question properly, I am afraid.

**Q130 Charlotte Atkins:** Is it the decision just of a PCT, or are they pushed into it by the Department of Health or by the strategic health authorities—as they were, for instance, with the ISTC contracts, where they were told basically they had to buy into them? How voluntary is this? Is the decision making made by the PCT or are they told by the SHAs or by the Department of Health that they have to appoint people?

**Mr Stout:** It is the PCT's job to decide how it spends its resource, and that includes decisions about how to spend its resource on commissioning and whether to bring in external support or not, so it is absolutely the PCT's decision.

**Q131 Charlotte Atkins:** In the past we have seen, with the ISTC contracts, for instance, that basically they had to.

**Mr Stout:** That was not a PCT decision. That was explicitly a national procurement process. That is very different.

**Q132 Charlotte Atkins:** But the level of their involvement was a PCT decision.

**Mr Stout:** Where there might be pressure would be if in your World Class Commissioning assurance assessment and your SHA's view of your competency more widely your PCT appears not to be doing very well, and you say, "Well, I am not going to do anything about that. I am happy." Then I think there would be pressure to say, "That's not good enough." I think that is entirely legitimate. That is not pressure necessarily to bring in external support; that is pressure to improve. External support is only valuable where it is adding skills and capacity that you do not have internally. In those

circumstances, a PCT board absolutely rationally will say, "The quickest and most effective way of getting better at our job is to bring in skills from outside that we do not have." That is the PCT's board decision and they should be held to account on that like any of their other decision-making processes.

**Q133 Charlotte Atkins:** Is there any analysis of the use of these consultants to make sure that they are getting value for money? Clearly, if they are spending a lot of money on consultants there has to be some sort of scrutiny of how effective the choice of the PCT is in bringing these people in. To take United Health, a US insurance company, they probably do not have a huge amount of experience of providing free universal health services because they do not have those in the States, so what relevance do those particular companies have in PCTs? Are they given a short list of companies that they could look to buy expertise from? Is there a list of approved contractors, as it were, from the NHS, or do they make their own arrangements either at regional or local level?

**Mr Belfield:** The Department of Health is not mandating any PCT to use private contractors at all. That is not part of what we are doing. To help PCTs who want to bring in expertise from parts other than the NHS, we have created a framework of companies that we have approved and assessed, to say to PCTs that these have been kite marked, in a sense, to say that they could help you with some of your commissioning decisions. United are in there as part of their data management, because they are very good at data management, for example. We do not tell PCTs they have to use them; we say, "You could use this framework." Equally, if PCTs want to go out to the market to tender locally, they can do that. In terms of your question about how much is being spent and value for money, et cetera, we do not collect any of that data nationally apart from this framework I have mentioned. I am very happy to write separately to the Committee to explain how that framework has been used in terms of where it has been used and the costs incurred.

**Q134 Charlotte Atkins:** Those that have the sort of Department of Health kite mark, do their charges also have a kite mark? Given that we have already been talking about the balance of power between PCTs and secondary care, if you are talking about a big company that they are buying in to with great expertise, what sort of kite mark do they have in terms of their tariff of charges?

**Mr Belfield:** It works very similar to the other national commercial frameworks we have. The tariff is set, so it is part of the process of approving a company on to the framework. We do not only approve them whether they are fit for purpose, but we also approve their prices, and therefore, transparently, PCTs can see the price in terms of per day or per week or whatever as standard practice.

**Q135 Charlotte Atkins:** They also go to other providers who do not have the kite mark. Is that the case?

**Mr Belfield:** That is right. If they think that there is something very specific to them that is not served by this framework—because this framework is not comprehensive—then they can go to other people. It is completely a local decision.

**Q136 Charlotte Atkins:** In terms of transparency, does the PCT separately identify the amount of money that they spend on consultants of this nature in their annual accounts?

**Mr Belfield:** I am sorry, I do not know the answer to that.

**Mr Stout:** I do not think there is any statutory obligation, but I would expect a board to be transparent in its working. I would expect that kind of information to be transparent about how they are spending healthcare resources in every sense.

**Q137 Charlotte Atkins:** If someone were to put in a freedom of information request, for instance, they would have to reveal that, would they?

**Mr Stout:** As far as I know. I am not an expert on FOI, but as far as I know, yes, unless it is commercially confident you are obliged to publish.

**Q138 Charlotte Atkins:** Again going back to the ISTC issue, we have had problems in the past where we could not get information about the nature of contract with independent secondary treatment centres because that was commercially sensitive. I am trying to find out whether PCTs buying services from outside consultants, whether they are kite marked or not. Would the services they buy be itemised in some way or another so the public could see them? If you do not have the answer, maybe someone could come back to us and give us the answer, and also the answer, if it is not identified in their annual accounts and a freedom of information request was put in, whether that would indeed also be revealed to whoever might ask for it by the FOI.

**Mr Belfield:** We will come back to you on that one.

**Charlotte Atkins:** Thank you.

**Q139 Mr Bone:** My PCT, Northamptonshire, is very keen on external consultants and they are spending millions of pounds on them. They think it is the way forward. But theirs is performance-related. They are not paying the consultant by the hour; but related to the success. They think other PCTs should be doing the same. One extraordinary answer is that the Department of Health does not know how much money PCTs are paying to external consultants. There are only 152 of them. Would you not like to write to them and ask them? I think that should be in the public domain. We are talking about millions of pounds of public money paid to private contractors. Why on earth does the Department of Health not know about this?

**Mr Belfield:** First of all, I agree with you about the way they are working in Northampton. Increasingly PCTs are looking to have a risk-share arrangement. That is what I think you are describing for

Northampton, and certainly we would encourage that. That is certainly happening. In terms of the collection of data, I think it is quite difficult really, in the sense that whenever we do try to collect data then PCTs and the NHS complain that the Department of Health is quite bureaucratic in collecting data. We are trying to get a system where PCTs are the local leaders of the NHS in running their system and they need to be transparent and accountable to the local population. I am not sure necessarily it is always the answer for the Department of Health to collect data. There is something about transparency locally, with PCTs taking some responsibility of this, rather than the department.

**Mr Bone:** No, I am not thinking of that. I know what happens. I can find out from my PCT what my figure is, but I want to know what is happening nationally. I want to know where it is happening in different regions. Every time I send a freedom of information request to my local hospital, they send me back reams of pages telling me why they will not answer it. Come on, it does not work. Transparency. If the Tories get in power, you are going to have publish anything you spend over £25 grand, so you had better get used to providing this information.

**Chairman:** I think this is something we can pick up in our PEQ annual exercise. We will have a look at it.

**Q140 Sandra Gidley:** I must admit I have become slightly confused with all this talk of different types of commissioning. I listened to where we have got with the practice-based commissioning, but we have heard a lot talked about PCT commissioning. What is the difference between the two?

**Mr Belfield:** The PCT is the statutory body that holds the money. When I talk about commissioners, I talk about the PCT, because they are the body which is given the money to then spend it on behalf of the taxpayer locally. PBC fits within that though.

**Q141 Sandra Gidley:** Can you explain how it fits within it, because it is not at all clear to me.

**Mr Belfield:** For commissioning to work, it has to have much more clinical engagement, so practice-based commissioning fits within PCT commissioning the following way. The PCT looks at its needs assessment for the local population. It does that with its partners, including local GPs and clinicians. They then choose their top ten health outcomes that they want to achieve: reductions in cancer rates, improving heart disease, et cetera. The idea is that the practice-based commissioners and GPs have had a say into that.

**Q142 Sandra Gidley:** They have only had a say into the top ten.

**Mr Belfield:** We did not want people to have 500 objectives; we wanted them to focus on ten so that they could really start to make a difference to the people's lives for those ten things. Practice-based commissioners or GPs if they are not practice-based commissioners all can have a say with the PCT. Then the PCT says "This is where we want to get to, say in five years time, for the reduction in cancer rates, the reduction in obesity, the reduction in smoking rates"

or whatever they have chosen, and the practice-based commissioners can have a contribution by providing some services to try and move the services forward or, equally, by being part of the challenge to the local secondary care organisations to say about how they want care pathways to change. Practice-based commissioning—or clinical commissioning is probably a better phrase for it—fits very much within what we are describing as PCT commissioning.

**Q143 Sandra Gidley:** Are the ten priorities decided at PCT level?

**Mr Belfield:** They are decided at PCT level, yes, within the local population.

**Q144 Sandra Gidley:** My PCT is Hampshire—very diverse. If you have this group of surgeries in an area that is not interested in that ten but wants to do something completely different, they cannot, are you saying?

**Mr Belfield:** Not at all. You are talking about practice-based commissioner, are you, in that example you have just given?

**Q145 Sandra Gidley:** Yes.

**Mr Belfield:** We would like everyone locally to all work towards the ten, so reducing obesity, smoking, et cetera, but if you have local ideas that can make a difference to your patients and you want to move, say, a phlebotomy service from being in hospital to your practice, then you are completely free to do that within practice-based commissioning. It does not run counter.

**Q146 Sandra Gidley:** They do not have to run it past the PCT.

**Mr Belfield:** It depends on what the processes are at the local level. Some places, depending on the value, might need a business case to approve that, but other places would let things go. I do not know Hampshire that well.

**Q147 Sandra Gidley:** How often does a PCT say no?

**Mr Belfield:** I could not tell you that information.

**Mr Stout:** It would vary depending on what you are talking about and what they say. The process by which PCTs are making their strategic decisions should be fundamentally clinically driven. That is basic to being a commissioner. You cannot commission without clinical leadership being part of that. Many PCTs are building their clinical leadership teams out of the leads for each individual practice-based commissioning group. Hampshire is doing something along those lines, if I remember rightly, from what I know of Hampshire. For the overall strategy for Hampshire, that would have been led by the clinical leads of the practice-based commissioning groups. That is for the overall strategy for Hampshire. Within Hampshire and within individual local areas, clearly there are other more localised initiatives going on. In some cases that will need a business case to be signed off by the PCT. How often will they be signed off? That would entirely depend on how good the business case is,

obviously. The smart PCTs which have this well developed, work really effectively upstream of the business case being received, so they work together on what a good business case would look like, debate whether it is a runner at all in the first instance. The more you have done that upstream work, the more likely you are to say yes to a completed business case once it comes through. But you only need a business case in instances where, in effect, practices are increasing their income base because they are providing new services, and there needs to be some due diligence over that decision. In other words, PBC groups cannot just sign cheques for themselves.

**Q148 Sandra Gidley:** There is an awful lot of stuff that falls outside those ten.

**Mr Stout:** Ten is just the high level objectives of the organisation. That is not the only ten things going on in the PCT. We should not over-emphasise them.

**Q149 Sandra Gidley:** It is a bit of a mish-mash really, is it not, trying to get a handle on it?

**Mr Stout:** It is like any big organisation. There will be big strategic objectives and there will be local initiatives happening.

**Q150 Sandra Gidley:** I meant that it is very hard for us to get a view on what is happening around the country because it is completely different anywhere.

**Mr Stout:** Yes.

**Q151 Sandra Gidley:** Those who are into localism might support that but it is very difficult to find out where it is working well and where it is not.

**Dr Colin-Thomé:** We are doing a major bit of work in the Department of Health about getting evidence-based measurement, metrics, both on clinical care and on the processes, and that is quite a big push from both the medical directorate and others. As Gwyn Bevan said, when the Conservatives introduced fundholding, in one sense it was meant to be slightly competitive, even though the size was different between the DHA and the fundholders. We thought there was a lot of money spent on some good stuff in fundholding, but it also costs a lot from a bureaucratic point of view. Practice-based commissioning is an adjunct and also covers some of the idea that commissioning is not all at one level. The only thing about British general practice is that we have a population, and not many general practices in the world have that. Some do, some do not. What we are trying to encourage is that you can give a budget to a practice—they will not have to have skills to run everything and the PCT and them will have to have a relationship—but there are some things which, like in the old fundholding model, you can make a big impact on in changing because you have a clinical knowledge of the processes. We need clinicians to help the PCTs with their commissioning, and we need secondary care colleagues as well as primary care, but because you have a registered population and you could release money yourselves—because you could say, “I do not like how we are wasting money this way” and that is sometimes us in primary care—you could then have

also local objectives. If these practices, single or multiple, are good enough, they will get more and more freedoms, including an element of hard budget to make some of those decisions. It might make it more complex, but this is a complex way of running a health service, and to have it just stuck at the PCT does not capture some of the localism in clinical energy. There is a double dimension: clinicians need to help in commissioning but there is also an element that around a local population clinicians and not just GPs could begin to have a local focus as well to tap into energy. Otherwise it becomes too distant. Of course this is difficult, but we do not want linear management in the Health Service. We want people who are helping to transform the Health Service and we have to play into different skills. That is some of the test of what commissioners are going to be.

**Mr Stout:** If it helps, it is analogous to a hospital having clinical directorates and then teams within the clinical directorate with decision making happening at different levels of the organisation. It is a very similar model but in a more complex environment.

**Q152 Dr Taylor:** I am really quite puzzled because you have all said that commissioning is working better in the last two or three years. Practice-based commissioning seems to be a part of what has been happening in the last two or three years and yet we have the King's Fund saying, “In its current form, PBC is clearly not operating effectively” and, unless David has been completely misquoted—

**Dr Colin-Thomé:** It has taken a long time to come to this!

**Q153 Dr Taylor:** —he is saying, “I think it is a corpse, not for resuscitation.”

**Dr Colin-Thomé:** You are all far more expert communicators than me, and using rhetorical questions maybe is not the best thing if the press are there. I said, “Are we trying to reinvigorate a corpse?” and that it was a challenge. I then went on, which the press did report, to say that there are many examples of good practice. Maybe I should have had better judgment. I have now been told that the best way never to make a mistake in a speech is to be really boring. Maybe that is a lesson learned. The issue is that it is hugely patchy. That is what I was addressing.

**Q154 Dr Taylor:** Is that what the King's Fund is getting at too?

**Dr Colin-Thomé:** Yes. In fact the King's Fund used practice-based commissioners as part of their assessment, yet in some places it is hardly functioning—and that could be the PCTs' fault, it could be the practices'—but in other places they are doing some fantastic things. It was a challenge by me, which it was probably inappropriate to say, but it is like all the rest of life, in that there is a huge variation in its uptake and yet it is a great vehicle to get clinicians involved, to be challenging some of the clinical stuff I was talking about—the use of money and so on. Some PCTs are doing it brilliantly with

their practices and others are not. That is what we are trying to make certain, that there is push to try to get less variation and more ambition in this.

**Q155 Dr Taylor:** To be fair, the King's Fund do go on to say, "However, to abandon the idea of PBC entirely would most likely be regarded as a significant breach of trust among GPs." It would certainly not encourage GPs.

**Dr Colin-Thomé:** You asked, "Should not all GPs be doing it?" and I suppose in an ideal world yes, but most of us were trained to be good doctors. I led on the Primary and Community Care Strategy, the Darzi Review, the Next Stage Review, and we had a deliberate event and the patients were saying, "Don't get involved in all this stuff. I just want you to be a good doctor for me." That is something we cannot lose. If GPs are great doctors but are not keen on looking at this whole organisational stuff, why stop them? But there are a few of us who also think we need to do more than that. If we can do that and bring our colleagues along and help them, that is great, but to say all GPs have to get involved in this organisation when their real job is to be seeing patients seems to get in the way of good patient care. How do we use the skills of some of us to move on the concept that practices should have both an individual patient look as well as a population accountability? This is a new world and there is huge variation in PCT/GP relationships, and that is what we are working on.

**Q156 Dr Taylor:** Is practice-based commissioning one of the ways of getting integration?

**Dr Colin-Thomé:** Yes.

**Q157 Dr Taylor:** That the other people were talking about.

**Dr Colin-Thomé:** Yes.

**Q158 Dr Taylor:** We are told here that practice-based commissioners work closely with PCTs and secondary care clinicians.

**Dr Colin-Thomé:** Yes. I would like to be more ambitious.

**Q159 Dr Taylor:** How widespread is that?

**Dr Colin-Thomé:** We went further in our Primary and Community Care Strategy and asked for pilots of integrated care to push the pace on. The reason we asked for pilots was not because of our obsession with pilots. Even though Gwyn Bevan says that integrated care is the way forward, remember the more you get integration, the potential downside is that there could be a collusion of providers and the patients get less choice and responsiveness. In the pilots we were looking to test out the mindset of more ambitious models of integration, but practice-based commissioning with a budget, and even if GPs think it is their play thing, if they have responsibility for budgets it will make them certainly realise that we need the help of our pharmacists, our social care workers—because the best outcome for patients with long-term conditions is that you need social care input to lessen the need for hospital. It is almost

like a training process, with incentives to create some more ambition locally amongst clinicians to be broader. The population is important in that respect.

**Mr Stout:** I talk to PCTs a lot and one of the things I ask about is how practice-based commissioning is working locally. Almost every PCT will say, "We have really embedded clinical leadership into our commissioning process very effectively." When you then go on to say, "And how about the indicative budget incentive to individual practice, as in individual practitioners?" that is often a lot less embedded and a lot less powerful, and that is a lot more patchy. It kind of depends what we mean by practice-based commissioning, to be honest. If you mean effective, meaningful clinical leadership in the commissioning process, I would say that we are doing pretty well. If you mean to what extent is every single practice directly and effectively thinking about their own population in expenditure terms, quite a lot less well or quite a lot more patchily. We have to come back to what we are trying to achieve.

**Dr Colin-Thomé:** We were trying to achieve both, I suppose. To get the first stage is great progress, but we need to be more ambitious.

**Q160 Dr Taylor:** Thank you very much for putting us straight. We all know we have to be careful what we say to the tabloids, but we now have to be careful what we say to the HSJ as well.

**Dr Colin-Thomé:** I think the problem is maybe my inappropriateness of language.

**Chairman:** We have all had our comments taken out of context one way or another.

**Q161 Dr Naysmith:** Practice-based commissioning used to mean you got a little bag of money for a budget that you in practice could spend on what you liked, and it has clearly evolved quite a lot from there on what you have been saying this morning. The other idea that Professor Bevan was throwing about and which we have discussed a bit was this idea of purchaser/commissioner competition, competition between purchasers. Do you think that is the next frontier for choice and contestability?

**Mr Stout:** Not unless we are going to radically redesign the healthcare system we have. The Netherlands example that he quotes is competing insurance-based systems. We do not have anything remotely like that. Could you have that sort of system? Yes, I guess you could, but it would mean yet another fundamental reorganisation, and we have argued quite strongly that the last thing we need is a fundamental reorganisation. Theoretically there is choice, in that you have a choice of GP. As a patient, you choose your GP; your GP is making commissioning decisions every time they make clinical judgments about you. In that sense there is a degree of choice. But to move to a competing system of commissioners—as in, that you can choose which PCT or equivalent you are a member of—while theoretically possible would be an incredibly major overhaul of the healthcare system as we know it. To be honest, from what I know of the evidence of the Netherlands it is not particularly clear how effective that element of their system has been. It is relatively

new. The evidence, from what I have read anyway, is not particularly strong in terms of its effectiveness. There are other strengths of the Netherlands system, but I am not sure that is one of them.

**Mr Belfield:** I agree. Hidden in the middle of Gwyn Bevan's report is the point that they spent a bit of time making sure that their commissioners improved their capability first before they went to that system, and, as Mark said earlier, we are in the foothills really of getting our commissioners into good shape to do well for their population, so we are nowhere near that debate at the moment. I would like to do what we are now doing well first, please.

**Dr Colin-Thomé:** I think Gwyn Bevan said there was 20 years of preparation for some of his thinking. These things take time. I think we could use what we have here better as a way forward. The Netherlands are different from us anyway in some of the way they set up their social insurance schemes. Let us use what we have and do better. This is what our process is about.

**Q162 Chairman:** We are about to publish the written evidence to this inquiry in the next week or two. It is quite substantial. Much of the evidence that we had submitted to us is critical of the commissioners' specialised services, arguing that the commissioning is not joined-up enough and that Sir David Carter's Review in 2006–07 has not been implemented. What can be done to improve this situation, if indeed that evidence is right?

**Mr Belfield:** I am mindful of that. I have heard that a lot. There are two things we have done. First of all, we have worked with the ten specialist commissioning groups which fell out of the Carter Review and to work with them to understand how we can help them become better commissioners. We have not—which is where some of the criticism has been—embedded the specialist commissioning groups into our assessment process, which I think is one of the things that they would like us to do. For this year we have put out a framework that is a voluntary framework where specialist commissioning groups can assess themselves in a sense, and we have said that after this year of a voluntary process we will consider with all ten specialist commissioning groups of next year about whether we then integrate it completely into our assurance process for the PCTs. One thing I would like to say though is that every PCT has the responsibility somewhere in their portfolio for commissioning specialist services. They do not discharge that responsibility; they involve the specialist care commissioning groups to do it on their behalf, but they still have to take responsibility and accountability at a local level. Our process does look at that, but it is a fair criticism from the group—and I am pretty sure I know who sent this to you—and we will consider this year how we can do it on a voluntary basis and then we will consider for next year whether we need to embed it into our systems or not. It is a fair criticism.

**Chairman:** Okay. Thank you all very much indeed for coming along and helping us with this inquiry.

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## Thursday 14 January 2010

Members present

Mr Kevin Barron, in the Chair

Charlotte Atkins  
Mr Peter Bone  
Sandra Gidley  
Dr Doug Naysmith

Mr Lee Scott  
Dr Howard Stoate  
Mr Robert Syms  
Dr Richard Taylor

*Witnesses:* **Professor Andrew Street**, Professor of Health Economics, University of York, and **Dr Peter Brambleby**, Director of Public Health, NHS North Yorkshire and York Primary Care Trust, gave evidence.

**Q163 Chairman:** I welcome the witnesses to the second evidence session of our inquiry into commissioning. For the sake of the record perhaps you would give your names and the positions you currently hold.

**Dr Brambleby:** I am Peter Brambleby, the director of public health in North Yorkshire and York Primary Care Trust. In six weeks' time I shall take on a new position as director of public health in Croydon.

**Professor Street:** I am Professor Andrew Street. I work at the Centre for Health Economics at the University of York.

**Q164 Chairman:** Professor Street, can you explain briefly what payment by results is and how it works?

**Professor Street:** Payment by results essentially is a financial system whereby hospitals are paid according to the activity they do, so if they provide more treatment they are paid additional money for each and every patient they treat. The specification of activity compared with previous financial arrangements is more precise. Previously, the contracts would have been specified at specialty level, say a patient in trauma & orthopaedics, and now it is more precisely defined, for example a patient who is treated for a hip replacement.

**Q165 Chairman:** What was the intention of introducing payment by results?

**Professor Street:** The Department of Health set out a number of intentions, one of which was to ensure that hospitals were rewarded for providing more activity, so they had incentives to treat more patients rather than pile them onto the waiting lists once their annual contractual budgets ran out. There was a clear rationale for the hospitals to have incentives to treat more patients. I believe that is the primary objective.

**Q166 Chairman:** Are there any international comparators? Where else is it used in the world and what results are achieved?

**Professor Street:** England is a very late arrival on the scene with this type of payment arrangement. Many other countries have introduced this form of payments system. It operates in many other European countries and in the United States, Australia and so on. Many of them have adopted this payment arrangement because in the funding of hospitals it is superior to other contractual

arrangements, although there is a lot of fine detail that needs to be worked out in terms of how it is implemented and refined over time.

**Q167 Chairman:** What about the effect on providers?

**Professor Street:** Providers under payment by results have clearer incentives to do more activity and treat more patients because they are paid for each and every one they treat. Therefore, they have a clear incentive to treat more patients provided they believe that the extra income they receive exceeds the costs of that treatment. Many hospitals believe that they can treat additional patients at essentially a profit.

**Q168 Chairman:** Would you describe it as just a payment for activity as opposed to a payment for results?

**Professor Street:** It is an activity-based financial system as currently specified. Essentially, that is what payment by results is doing. The more patients you treat the more money you receive. It would not be too problematic to make the payment conditional on other things. You could make payment conditional on the quality of care provided by a hospital or set other rewards alongside this payments system, but currently in its crudest form it is payment by activity. That does not prevent its expansion into other areas.

**Q169 Chairman:** How does this impact on trusts with PFIs? There was an article in the *Health Service Journal* in January 2007 which argued that trusts with PFIs had significantly higher costs than other trusts, but we are led to believe that potentially the payment is the same.

**Professor Street:** It is very difficult to establish how the costs associated with PFIs are dealt with in different organisations and whether trusts that have entered into PFI schemes are at a financial disadvantage to others. That is probably an area that needs further investigation, but I am not in a position to give a definitive answer to that.

**Q170 Dr Stoate:** Do you have any idea why it was called payments by results in the first place?

**Professor Street:** Probably because it sounds quite a nice catchphrase. Essentially, it is an activity-based funding system.

**Q171 Dr Stoate:** What does that have to do with results?

**Professor Street:** The result is defined purely in terms of the amount of activity undertaken, so if what you want to achieve is more activity and that is the primary result that is fine. But if you believe that the results you want from the health system are broader than more patients being treated, for instance results that encompass the quality of care they receive, you may want to expand your definition of results and set the payments that hospitals receive according to that broader definition.

**Q172 Dr Stoate:** Currently, the only real result is an increase in the bank balance of the hospital?  
**Professor Street:** It is an increase in the amount of activity they undertake. Undeniably, more patients have been treated over the past few years for a variety of reasons, not solely because of payment by results which has not had a great deal of coverage as yet. A number of other changes have happened, but undoubtedly over the past few years more patients have been treated by the NHS than previously.

**Q173 Dr Stoate:** What has been the effect on PCTs? Are they stronger or weaker because of this system?

**Professor Street:** PCTs have always been in a weak bargaining position relative to hospitals for a variety of reasons. Payment by results probably strengthens their arm in some respects but puts them in a difficult position in others. They have been freed from doing things that they had to do in the past, notably to negotiate on the basis of price, but now it is much more difficult for them to control the volumes of activity for which they are financially liable. That has become even more difficult under the patient choice arrangements.

**Q174 Dr Stoate:** What incentives are there under the PbR scheme for the providers to improve quality particularly on things like patient safety?

**Professor Street:** At the moment they are not embodied in the PbR arrangements. The incentives for them to improve quality come from other types of mechanisms, for instance the inspections and penalties they face. It is fine to have one type of arrangement that encourages some sort of behaviour but you do not want to use just a single instrument to achieve a whole array of behaviours across the health sector.

**Q175 Dr Stoate:** Is it going too far to say that payment by results is really a question of “piling them high, selling them cheap”?

**Professor Street:** I am not sure that is the best description of the arrangement and it is not something to which I would necessarily subscribe. The essential description at present is that it is purely and simply a payment for the amount of activity you undertake.

**Q176 Dr Stoate:** The NHS Confederation is pretty impressed by PbR and has some positive things to say about it, particularly its view about the independent sector providers being brought into the market. Do you share those views?

**Professor Street:** I am not sure I share their views about how successful the arrangements have been for introducing into the market the independent sector treatment centres. At the moment there are questions about how they are paid which need to be resolved and the nature of the contracts that have been written with them. The findings of the Select Committee on Health that looked into independent sector treatment centres a couple of years ago still hold.

**Q177 Dr Stoate:** Is there a simple way in which PCTs could be given more leverage?

**Professor Street:** I believe there are two options available to PCTs. At the moment it is very difficult for them to control the volumes of activity for which they are financially liable because they do not negotiate volume controls with each individual provider. Even if they did so it would be difficult for them to do it in the context of patient choice where patients are moving around the system. Therefore, if they are unable to control volumes and vary the price they have to pay they are at financial risk of blowing their budget allocations. One option would be to give them a bit more flexibility over the prices they pay. Instead of paying the fixed price they might pay a maximum price, for example, but whether or not that would be successful is open to question. Given the relative bargaining powers it is probable that there would not be much deviation from the maximum price anyway. I am not sure that that option is one that would give PCTs the requisite balance of power in that negotiation. The other option is to release them from having to negotiate with the secondary care sector at all and to focus instead on improving services in the primary community care sectors. The experience of other countries is important in this respect. Although every other country has adopted a financial system for this arrangement not one of them has thought that what is needed to make it work is the introduction of a set of commissioning organisations. Other countries have this activity-based funding system but not commissioning bodies to implement or oversee it on a day-to-day basis. The role of commissioning bodies under this financial system is not essential. They are in the English system and have had a role to play in it because they pre-existed this type of financial arrangement, but it may not be the best role for them to undertake. It could be that that role is undertaken by a central organisation that sets prices and controls volumes and instead primary care trusts focus on what they really ought to focus upon and influence, namely the more neglected areas of primary and community care where there is probably a good need for concerted action and attention. That is quite a radical option but it deserves exploration going forward.

**Q178 Mr Scott:** Professor Street, how can we have a healthcare market with fixed prices?

**Professor Street:** Most markets rely on prices to signal a number of things: whether consumers are willing to pay for the goods or whether providers are willing to provide goods on the market. They change when there are new entrants or goods offered to the market. They provide important signals and adjust when things change. When a new provider wants to provide new goods or increase market share one of the strategies it will adopt is to change its price; it will lower its price and gain market share. But in a market situation it does not rely solely on price; it may change its prices and also the quality of the goods it offers. If one is constrained to a fixed set of prices and wants to gain market share one must compete not on the basis of price but quality. If you want a market under fixed prices one needs clear incentives for providers to gain market share. Why would hospitals want to undertake more activity? What incentive do they have to do more work? PbR gives them that that incentive. One needs clear information on quality so that consumers can make informed choices about that dimension when they do not face prices. One can have a healthcare market provided there are clear incentives for providers to compete and good quality information on which consumers or patients or their advocates can make informed choices about which are the best providers around.

**Q179 Mr Scott:** Is there a danger that PbR can become unaffordable for PCTs?

**Professor Street:** There is a danger of that if the activity for which it must pay from the secondary care sector exceeds its budget. The problem is that at the moment it is not able to impose volume controls so if hospitals engage in greater activity ever more of the budget will be sucked into the secondary care sector. There are two strategies they have to resist that: one is that they can invest in substitute services out of the hospital sector in the hope that patients will be diverted to use those services and do not turn up at the hospital in the first place. That might take a while to happen because that investment takes a while. The second strategy is to encourage GPs to change their referral behaviour and keep patients out of hospital, but again their ability to influence GP behaviour is limited. Therefore, their power to restrict patients getting to hospital is not as it might be. That being so, there is a danger that they will spend more than they have available to them. There need to be stronger mechanisms in place to ensure that PCTs have the levers and instruments available to them to give them budgetary control.

**Q180 Dr Naysmith:** Professor Street, can you explain to the Committee the two-part tariff and tell us whether in your opinion it has advantages and disadvantages?

**Professor Street:** The two-part tariff is really analogous to buying two to get the third at half-price. It is a bit like the old cost and volume

contracts. Essentially, you pay a fixed price up to a certain volume of activity and beyond that you are still paid but at a lower rate than previously.

**Q181 Dr Naysmith:** It was introduced for a year and in the current year it has stopped and will be reintroduced in 2010, the forthcoming NHS year. Why was it stopped and why is it starting again?

**Professor Street:** This type of arrangement has not been introduced for everything. The form in which that two-part tariff can be specified can be quite open-ended. The cut-off point at which the lower payment rate kicks in can vary. You can also choose whether it is a higher or lower payment rate. The specification of the two-part tariff can be quite wide according to what you want to achieve. What one wants to achieve might vary from one year to the next, or what one PCT might wish to achieve might vary from one to another. One cannot necessarily specify in advance all the things one wants to achieve. What one then wants is the flexibility to adjust the payment arrangements according to what pressures one faces at any given period. That crucial point is that PCTs, the Department of Health or the system as a whole has flexibility in its financial arrangements to adjust as circumstances change.

**Q182 Dr Naysmith:** Do you know why this happened? Were there problems with it that have now been sorted out and it will be reintroduced?

**Professor Street:** I do not know the details of the change of that specification from one year to the next.

**Q183 Dr Naysmith:** There has been some criticism of transaction costs associated with PbR. Do you think they are excessive or are they outweighed by the benefits to the patient and taxpayer?

**Professor Street:** There are always transaction costs associated with any contractual arrangement that you wish to introduce and they are different as between one and the other. The question is: are those costs worth bearing? Are the benefits of those contractual arrangements outweighed by their costs? The factors that drive transaction costs under payment by results are the problems faced by PCTs in volume control. I think that is problematic and needs to be resolved. Because payments are specified much more precisely than was the case under previous contractual arrangements PbR needs more information to ensure that the contractual specification is accurate, so hospitals have to collect more detailed information to ensure it is more accurate and PCTs must validate that. That can be quite useful. I believe that the more information and greater specification available the better able we are to make informed decisions about what is going on. Generally, I believe that the balance of transaction costs to benefits should be neutral.

**Q184 Dr Naysmith:** There has been considerable criticism of the data which you have said it is important to collect. The Audit Commission has been quite critical and a few of the bodies which have submitted evidence to this inquiry have said that the

data are not very good, to put it mildly. What do you believe are the weaknesses of the data and what should be done to improve what we collect?

**Professor Street:** In other countries, particularly the United States where this type of financial arrangement was introduced in the early 1980s, there have been big problems of gaming, in some cases providers falsifying information about the patients they treat and basically claiming to have provided treatment that has not been provided, or recording complications in patient cases that are not present. The reason they do it is that it increases the probability of receiving additional income.

**Q185 Dr Naysmith:** Do you think that happens in our system?

**Professor Street:** The evidence in England has not supported systematic gaming. There is evidence that coding is not as it might be and it has been inaccurate. There is evidence that in some cases there has been over-coding and in other cases under-coding, so there is no systematic pattern of gaming as yet. The problem is that at the moment the information systems can be improved. We can collate more information about patients than has been coded in the past which is to be welcomed, but generally the data collected on patients in England are pretty good compared with what is available in other countries. We are building on a pretty strong foundation that has been laid basically since the 1980s and payment by results introduces incentives to improve that information base which I believe is to be welcomed. At the moment I do not think systematic mis-coding of information is a problem but we need to be alive to the possibility that it might be in future and the role of audit in ensuring gaming does not take place and accurate coding occurs across the system as a whole as the payment system rolls out will be critical.

**Q186 Dr Naysmith:** But is the audit system up to the job of doing that?

**Professor Street:** I do not see why it should not be. Essentially, one can just introduce a random audit of records and use that on a regular basis to ensure one understands coding behaviour and that best practice is rolled out across the NHS on an ongoing basis.

**Q187 Dr Taylor:** Professor Street, first I appreciate your evidence which is short, relevant and readable. I want to come back to the need for local commissioners on which we have already touched. You implied that they were used just because they were there. Can you sell your radical option to us? To me, it has some great attractions and if we adopted it it would be a radical recommendation, so could you go through it and sell it to us?

**Professor Street:** I think it needs much more careful consideration than I have given it up to now and I have been able to present in the note. One of the areas of the health service that has had less attention paid to it than it might merit is the primary and community care sector. From our limited knowledge there is probably quite wide variation in provision and performance and primary care trusts are in a

good position to provide scrutiny to ensure that GPs in an area work together in a collaborative fashion to improve the health of their local communities. I do not believe they have been able to undertake that role as successfully as they might because much of their attention has been diverted into focusing on the secondary care sector where they have limited power to influence change anyway.

**Q188 Dr Taylor:** Therefore, you would take away their commissioning role to allow them to concentrate on their providing role?

**Professor Street:** On their providing and organising role in the primary and community care sector which seems to have been neglected up to now.

**Q189 Dr Taylor:** Who would do the commissioning and how?

**Professor Street:** The commissioning role would be done as it is undertaken in other countries. What one needs under a payment by results system is an organisation that will set prices and have flexibility over price-setting. At the moment the Department of Health does that but the price-setting arrangements up to now are quite limited. We set prices on the basis of average cost and there is limited flexibility to vary price when there are volume changes. We do not use the two-part tariff to any great extent at the moment. Other countries do that much more because all the price-setting arrangements are undertaken at central level. Volume agreements are then reached with providers according to what they undertake. To do that is quite straightforward. Every other country does it quite successfully, but it is difficult to do it in a system where there is decentralised purchasing which causes a lot of the headaches.

**Q190 Dr Taylor:** If commissioning was centralised would there be a better way to control hospital activity and affect referral behaviour? How would it work?

**Professor Street:** It would not necessarily control referral behaviour because that would have to remain the remit of the primary care trust, but the central price-setting authority could control activity by agreeing activity targets with each individual hospital and say that once it has met a certain level of activity it will still pay it for doing more but at a lower rate. Instead of the very strong incentives that hospitals currently have to increase activity they would have an incentive which up to a certain point would be quite strong but moderated beyond that.

**Q191 Dr Taylor:** Would this in any way lessen the purchaser-provider split between primary and secondary care?

**Professor Street:** Yes. It would mean essentially that primary care trusts would not act as purchasers of secondary care in the way they have up to now. Their attention would then be focused on purchasing other things and organising services in the primary and community care sector. These matters require careful thought and clear delineation of responsibility and budgetary arrangement, but it is

time that consideration was given to that type of arrangement. At the moment it strikes me that the system is neither one thing nor the other.

**Q192 Dr Taylor:** Who would be putting that extra thought into it?

**Professor Street:** It is something that the Department of Health may want to consider because it will require a fundamental revision of the way the system is organised.

**Q193 Dr Taylor:** Should we try to get more evidence on it before we make our report or should we just raise it as a possibility?

**Professor Street:** I do not think I am at liberty to advise you on what the timing should be.

**Q194 Dr Taylor:** If we get rid of PbR altogether is there an alternative?

**Professor Street:** There is. At the moment payment by results has not been rolled out across the whole system. I think we need to refine the incentive structure and use it as it ought to be. Basically, what we need for the NHS are clear incentives for each organisation and the ability to moderate those incentives as the system changes and payment by results is a very useful tool for that purpose. We probably need to use that tool appropriately and build on the system, but on the whole there are clear advantages from this type of financial arrangement. We have seen some of them but have not yielded the maximum benefits because the system is not fully in place.

**Q195 Dr Taylor:** Can we really use it to improve quality?

**Professor Street:** If we have clear information about quality and monitor it on a systematic basis there is no reason why organisations cannot be rewarded either within a payment by results system for enhancing quality or through a system that sits alongside payment by results, but what we need is good evidence on the quality of care patients receive.

**Q196 Dr Stoate:** There is good evidence that now primary care trusts put pressure on GPs not to refer to hospitals but to use community-based clinics, alternative providers, nurse specialists and so on. There is work going on but I entirely agree that it is not a systematic arrangement; it is more a matter of local PCTs making local decisions. It is right to put on record that there is work in that direction but a lot needs to be done.

**Professor Street:** I do not wish to deny that that has happened and PCTs have worked extremely hard to influence referral behaviour by GPs or invest in substitute services. That needs to be acknowledged.

**Q197 Dr Stoate:** Dr Brambleby, I turn to the whole problem of coding and the ability of PCTs. The King's Fund has argued that PCTs simply do not have enough detailed knowledge at that level to challenge hospitals on their coding. What do you think about that view?

**Dr Brambleby:** That is probably fair. We are catching up as fast as we can, but there is an imbalance in the detailed knowledge of what has actually happened in a particular clinical episode or pathway of care and as a result under the present dispensation commissioners are at a disadvantage.

**Q198 Dr Stoate:** Speaking of my own experience as a GP it was not uncommon for me to get my coding sent back by the hospital three or six months late for a diagnostic group, for example UTI, and find out that the cost was well over £20,000 with absolutely no detail of how one got to £20,000 without passing go but certainly collecting plenty of money.

**Dr Brambleby:** I agree. There is a simple fix for that. I think it would go a long way to improving the situation if it was a simple requirement on the provider to give an indicative cost of the episode at the time of the discharge summary so that the GP, who is better placed than the PCT to check, can say, "Hang on! That patient was a man and he could not have had a hysterectomy!", or, "Three thousand pounds for that? That's not normal." He can make an instant check, and so it would improve data coding. It would also instantly remind the referrer of the opportunity cost. Or he could say, "Was it £350 for that diagnostic test? I wonder if I need to do that every three months or whether I could do it every six months?" That is a simple way to improve the system. We are told it cannot be done. I do not believe that it cannot be done.

**Q199 Dr Stoate:** One problem that happens in hospitals is that when something goes wrong, for example somebody contracts MRSA or falls off a trolley and breaks his or her hip, it simply goes onto the cost. In some systems about which we have heard if something else happens in the hospital that is the hospital's fault. The Americans code those as never events and they are simply not paid by the insurance companies. In this country if somebody goes in with a urinary tract infection contracts MRSA and then falls off a trolley and ends up in hospital for five months—I have had patients who have experienced it—the bill is astronomical and out of all proportion to the original condition for which he or she went in. Nevertheless, the PCT has to pick up the bill. Is that right?

**Dr Brambleby:** There is a very clear imbalance of risk, is there not? That does not seem right and it does not build in an incentive to improve it. I think that with minimum adjustment to the current system those sorts of anomalies could be ruled out.

**Q200 Dr Stoate:** Can you explain up-coding to us and how much of a problem it is in your experience?

**Dr Brambleby:** To give a simple illustration, a different tariff is paid for someone who has an operation to replace a faulty hip and an individual who has it done with complications. The difference in price can be in the order of £1,000. If you were a clinical coder in a hospital with an incentive to protect your income, possibly for very laudable purposes, you would scrutinise very carefully to see whether there was any mention of diabetes, in which

case you could add it as a second diagnostic field. The price will then go up. But the reality may be that the additional cost of that episode from the patient's diabetes is not commensurate with the amount of money the trust has just attracted. That is up-coding. If it was deliberately exploited to the maximum allowed by the rules that would be gaming, but if there was a deliberate attempt to add codes that did not exist that would be fraud.

**Q201 Dr Stoate:** Do you have much evidence that gaming is going on?

**Dr Brambleby:** The longitudinal trends we observe would suggest that trusts use the maximum flexibility available to them to attract the greatest possible cost for each episode, so if that is gaming perhaps. Prices were set on the basis of the typical experience of a typical patient and that is why different bands and healthcare-related groups were put in place. However, once the price has been set there is an incentive to move the goal posts and to reclassify people for the maximum income.

**Q202 Dr Stoate:** Do you have much evidence of cost shifting where a hospital sends someone back to the GP with a long list of things which effectively that GP pays for subsequently? I have seen examples of it.

**Dr Brambleby:** We do not see as much of it now as we did in the old days. There is now a developing sense of common purpose. At the end of the day there is one NHS budget and not much point in cost shifting, but there is competition and so if anything there is reluctance to move people around the system because then you lose your tariff-paying customers.

**Q203 Dr Stoate:** Can you explain what tariff granularity is?

**Dr Brambleby:** I believe it means the degree of specification within the tariff. If you had a tariff for an orthopaedic episode it would have very low granularity. If you could break your orthopaedic episodes into hips, knees, carpal tunnels and so forth that would increase the granularity; you would have smaller grains. I think that is what it means, but it is an ugly term.

**Q204 Charlotte Atkins:** What impact has payment by results had on the quality of care for patients?

**Dr Brambleby:** It is definitely mixed. There is an upside and very definite downside. On the upside one of the rationales, such as there are, behind payment by results is to encourage different providers to compete on the basis of quality because the price is fixed. It harks back to the question about fixed prices put by Mr Scott. In that regard it has been a stimulus to improve quality. On the downside it has not encouraged us to look at, or indeed commission, whole pathways or patterns of care and that can have a negative impact. To illustrate that, in my patch we had evidence recently from a general practitioner who said he wished a patient could have ended his days in his own home but because of the disinvestment in the community nursing set-up that community support was not available. Therefore,

the person died in a place not of his or her choice, and at greater expense. That is an example of an anomaly in the system that adversely impacts on the patient's quality of care.

**Q205 Charlotte Atkins:** In a hospital context there is no incentive for the hospital to discharge the patient as quickly as possible. The patient may be lying on the bed waiting for a doctor or consultant to come along to do whatever has to be done. Very often there does not appear to be very much urgency in terms of co-ordinating all the tests and consultations that a patient needs once in hospital. Payment by results does not really help us achieve a more co-ordinated and focused pathway of care.

**Dr Brambleby:** Yes and no. That takes us into a technical area of trim points. For example, a patient may be an emergency admission for a chronic obstructive pulmonary disease that has flared up. Whether the patient stays for three days or 17 days we pay the same tariff. In that case there will be a very strong incentive on the hospital for the stay to be a shorter space of time because it is not getting any added income, but it becomes difficult at the trim points. The gap between two and three days is very substantial; it is more than £1,000. Therefore, there is a disincentive to keep the patient for a shorter time because one loses money potentially. At the other end, once the 15 or 17 days are up thereafter it is a daily rate, so there are mixed incentives for either keeping or discharging the patient. To amplify that just a little, imagine a system where chronic obstructive pulmonary disease patients stay on average a week but the trust wants to get it down nearer to four or five days and quite sensibly improve efficiency. If it does that simply by referring the patient to a community provider who will pick up the rest of the patient's recuperation and a new tariff and cost begins one can end up adding more cost to the system. That takes us from trim points to "bundling" and "unbundling" tariffs. Those of us who work at the sharp end of commissioning would like to see much more commissioning of patterns and pathways rather than simply episodes of care.

**Q206 Charlotte Atkins:** Can you identify any benefits from payment by results?

**Dr Brambleby:** There have been some. I am not by any means alone as a clinician working in the NHS to be deeply ambivalent about payment by results. We feel that it was a sincere and partially successful attempt to address the wrong question. What we see as the mission, which is hidden or imbedded in "commissioning", is to improve the health of the population, not just secure healthcare for the population and not necessarily make the hospitals the pivot or the main gravitational attraction for that care. It is the overall health of the patient for which we want to commission. To that end payment by results has been a distraction and distortion and is tangibly counter-productive in some cases.

**Q207 Sandra Gidley:** You suggested that payment by results is “too blunt” a tool for many clinical pathways and that “purchasers have to pay the tariff whether the patient is better or worse, alive or dead.” What system would you have instead?

**Dr Brambleby:** To set some reference or normative costs for a typical admission would be very helpful. Had payment by results stopped at a guide price or a starter for negotiating—maybe a maximum price—it would have taken us some way. Where it fell down was that, first, it was far too late; we needed it right at the beginning of the internal market and long before we started to talk to external providers. I should like to come back to the point about the rationale for payment by results. A lot of it was to bring the external independent sector into the market on a level playing field. The major flaw in it was that it did not apply right across the health system; it did not even apply right across the hospital system. In the early years it was set just for planned operations and procedures in the hospital context, not the rest. Therefore, for it to be successful and achieve what we hoped it would and reach its considerable potential tariffs should have been set right across the board for mental health episodes and community episodes. A quick check should have been made that if we multiplied the current volume of activity by the tariffs set for that activity did it come close to the money available so it did not break the system? Did we have the IT in place to monitor all of this? It should have been piloted in one or two areas to check that it worked and then launched. That would have made a lot of sense. It could then have achieved its full potential. If I give an analogy which I think is helpful, it is a bit like changing from driving on the left to driving on the right. If you are to do it you do not simply say it should be introduced for buses and lorries for the first six months to see how it goes. I do not believe that is a ridiculous analogy because that is what it has felt like. It has not been gaming per se. I do not believe there has been a lot of deliberate manipulation of the system for ulterior or narrow ends but the system has led to people bumping into one another.

**Q208 Sandra Gidley:** You wanted to come back to external providers.

**Dr Brambleby:** I think I managed to slip it in. Having said that, it was explained to us that one of the principal rationales for introducing payment by results and to fix the tariff and make it non-negotiable was to give new entrants into the healthcare field the security of income for, say, a three-year period which would justify their investment in capital and staff to enter the market in the hope that contestability and competition would drive up quality. In the end it had an adverse impact to a degree; it got in the way of quality, flexibility and choice.

**Q209 Dr Naysmith:** When you answer Charlotte Atkins’ question earlier I got the impression that your ambivalence about the PbR system was more to do with the fact that you hoped we would move

into the community and more into public health and this system really was not doing that. Is that a fair summary of what you said?

**Dr Brambleby:** It is a very fair summary. They key word in your question is “hoped”. We had hopes and expectations.

**Q210 Dr Naysmith:** It is the government’s stated aim to shift more care out of hospitals and into the community and yet it seems PbR is having exactly the opposite effect. Is that how you see it?

**Dr Brambleby:** It is a question of degree, but generally that is how I see it. There are some unnecessary impediments to the development of community services and the community setting has suffered hitherto and is now in a weaker position; it starts from a poorer base than it might have done, say, five, seven, 10 or 12 years ago.

**Q211 Dr Naysmith:** How do you believe PbR sits with other recent reforms such as practice-based commissioning and foundation trust hospitals?

**Dr Brambleby:** Those are two very different questions. I am a fan of practice-based commissioning. It would add another clinical voice to the discussion which should be about “co-missioning”. It takes us back to the “mission2. I do not suggest for a moment that the clinical voice should be the dominant one. There should be a partnership between the patient voice, the policymaker who holds the purse strings and the clinician. But what it does is address, to a degree, the secondary/primary imbalance. GPs are ideally placed to assess the need of their practice population, to do something about it by prescribing, referring or whatever, to assess the quality in real time because they see their patients afterwards, and, as an addition to that mix, to have some knowledge and control over the budget. I do not go as far as to say they have to own the budget but they certainly have to see it, recognise it and own the opportunity cost, to use the jargon. As to foundation trusts, I think that if a local hospital has a good connection with its local population—it is often a major feature of local population, and there are friends of local hospitals up and down the country—that can only be a good thing. If the freedoms that they enjoy are used responsibly and there is a sense of common purpose about meeting local health needs within the available budget, fine.

**Q212 Dr Naysmith:** Do you believe that PbR facilitates the standards of commissioning that world-class commissioning now calls for, or is it an obstacle?

**Dr Brambleby:** Perhaps I should declare an interest in that I was invited by Mark Britnell and Gary Belfield to have some input into defining the World-Class Commissioning values and competencies.

**Q213 Dr Naysmith:** That makes you more of an expert, so we are glad to hear it.

**Dr Brambleby:** I do not know about “expert”. But it started very well with defining some of the values in World-Class Commissioning. As I have seen from the evidence of Mr Britnell to your Committee, it

was about adding life to people's years as well as years to people's lives. That takes us into education, housing, leisure opportunities, having a job and being all you can be. It is an awful lot more than simply the delivery of caring services when you are ill. Therefore, the values were good. Commissioning competencies made a helpful attempt to define, belatedly, the syllabus. If you wanted to be a commissioner and learn your craft here were the competencies which as an individual or organisation you needed to cover to be good at what you did. I believe that has been sidetracked into an understanding of commissioning as the procurement of secondary healthcare services. It has lost its way slightly in overemphasis on the transactional side of commissioning and has not sufficiently emphasised the partnership approach and a much wider health improvement agenda rather than a healthcare delivery agenda.

**Q214 Charlotte Atkins:** Senior officials of the Department of Health have told us that commissioning did not really start to work until two years ago. Is that a fair assessment?

**Dr Brambleby:** Yes; it had not begun to realise anything like its true potential until two years ago.

**Q215 Charlotte Atkins:** Why do you think that was?

**Dr Brambleby:** That is a key question. I think it would be interesting to ask people to define what they mean by "commissioning" because many see it as the procurement of secondary healthcare. They use it synonymously with purchasing and payment but it is different. It was explained to me by one of my trainers when I came into this area. Think of the difference between commissioning a painting and purchasing it. There is a totally different relationship between the artist and the person who holds the funds. As someone who has committed his career to the commissioning function I have been waiting eagerly for it to start for the past 19 years.

**Q216 Charlotte Atkins:** Is that because people are just not skilled enough in commissioning the right things, or do you think the levers are not right?

**Dr Brambleby:** The skills are abundant. The NHS is blessed with innovative people with good ideas and commissioning could fly. What has happened is that we have not managed between ourselves either to construct a system that really liberates that creativity and local accountability, shaping local pathways to local needs within a finite budget—we could go a long way but the system sometimes gets in our way—or have sufficient ambition to go for the available levers. It is a very rich question and a very mixed answer. It has left us with very mixed patterns across the country.

**Q217 Charlotte Atkins:** Presumably, it varies around the country; it is not uniquely good or bad. In different parts of the country different commissioners do a better or worse job?

**Dr Brambleby:** Exactly so. If I may venture an opinion to illustrate how asking new questions leads to new answers, there is an approach to commissioning practised in other countries round the world, some parts of Canada being a good example. It is called "programme budgeting" which is sometimes linked to "marginal analysis". Here the proposition is a very simple one. Instead of a PCT asking how much is spent on this or that hospital, prescribing general practice and community services, the question is how much is spent on mental health, cancer and maternity services, etc, across the board. That should not be a difficult question but at the moment people struggle to answer it. On the principle that it is better to light a candle than curse the darkness there are some enthusiasts, of whom I claim to be one, who say we should see if we can construct that debate. It is timely to raise it because today on the Department of Health's website the 2008–09 returns from every PCT in the country have just been posted. Every PCT in the country has declared where it estimates it has spent its resources in that year on mental health, maternity and so on, that is, the 20 chapters of the international classification of diseases. If we could correlate the programme objectives and the providers' objectives we would be an awfully long way down the road of being able to account for where the money was going and do more good with it. For example, I should not look at Scarborough Hospital simply as a £100 million-plus trust near the coast; I should think of it as 6% of our cancer programme, 20% of our maternity programme and so on. Every year we should have a discussion at the PCT about what we want to do for mental health and maternity and therefore what we want our various hospitals to contribute, or our GPs and community services to contribute. "Is everybody happy with that? Do patients agree with that?" If so, we let the contracts and then on a monthly or annual basis we ask: "How are mental health and maternity are getting on? Is it costing what we thought? What will we do if it is going adrift? Is it delivering the outcomes we hoped for?" There is a better way.

**Q218 Charlotte Atkins:** Do you believe World-Class Commissioning has improved patient care?

**Dr Brambleby:** To a degree, yes, but it is nowhere near its full potential. Is it sufficiently complete and finished as an exercise? No.

**Q219 Charlotte Atkins:** What needs to happen to take it to completion?

**Dr Brambleby:** I believe there needs to be a re-attunement and re-engagement in what the mission for commissioning is, to get everybody on the same page. "Are we a national health service or a national healthcare procurement business?" "What is the dominant theme and therefore what is the model?" If we are a health improvement business it takes us into the realms of practice-based commissioning and much closer partnership working with local authorities which can have a very significant impact

on how well and how long people live. Take for example educational attainment. It takes one to a different model from the one being pursued fairly aggressively with an entire competency based on whether the market is being stimulated. It is a very market-oriented approach, whereas one could develop some of the earlier competencies such as: "Are you showing leadership? Are you engaging with your local community? Are you truly accountable and delivering what local people need?"

**Q220 Mr Scott:** How important is the voice of the clinician or public health expert in commissioning healthcare? Do you believe there are too few public health experts on the ground at the moment?

**Dr Brambleby:** It is very important. What we have in healthcare which makes it very different from other markets and other traditional economic models is the whole concept of need. It is not simply supply and demand or a patient saying, for example, that he needs to check his diabetes 16 times a day with a test kit. You need a clinician, who may be a doctor or nurse, to be the patient's advocate and agent and say that the evidence suggests that for his condition maybe testing twice a day is sufficient. You need an agent to interpret the symptoms, signs and pattern of care, so you require the clinician voice. The appropriate involvement of clinicians in defining need and the pattern of services is important. With that, clinicians must also embrace the necessity to own, understand and be accountable for opportunity cost. It is no good insisting on the very best for the patient in front of you, never mind everybody else who may have to go without. We have to start to address that. We also need the patient voice. I say that not just in a tokenistic sense. I have seen it work and make a difference and have learnt from it. I give two very quick examples. When I was director of public health for Norwich it was the user group for mental health services that made me look much harder at alternatives to pills and hospital admission for the management of a lot of mental health patients. They asked about the arts and exercise. We took note and made it happen. The consequence was that in two years we were able to cut the antidepressant prescribing bill by 30% and took £2 million out of acute mental health care in the secondary care provider. We instituted an NHS Counter Fraud and Security Management Services review of a local private mental health provider which we felt had possibly gone beyond gaming. That led to police and court activity. The case subsequently collapsed in court, but some directors lost their jobs. It took us to an interesting place. The other example was an attempt to do a needs assessment of Bengali women in Norwich. We rapidly learnt that we were applying too narrow a model. They said, "What would we do? We keep house and cook." It suddenly occurred to us that that was incredibly useful and said, "We need people who can keep house and cook. Would you like to show your neighbours how to do this?" It taught us that it was about assessing and harnessing the

abilities of communities and giving them opportunities to raise their own game, not to treat them as passive recipients of our benevolence in a way we determined for them.

**Q221 Chairman:** We hear a lot of rhetoric about commissioning and the expectations of what PCTs can achieve. What evidence is there of strong commissioning?

**Dr Brambleby:** If you take the definition that commissioning is about "co-missioning" there is tangible evidence of co-operation to deliver a joint vision. You could test that. I believe that would be the strongest test of commissioning. To do that would require a combination of not just measurement and data but narrative. There is no way round it. You have to visit it, see it, touch it and believe it. If your definition is whether it can be shown that more episodes of care are being delivered by local providers for the same or reduced cost, again there will be evidence of that, but I earnestly steer you away from seeing that as a marker of success of commissioning because it is so much more than just the procurement of episodes of care in a productive mindset where more cases are going through a hospital. Look at the outcomes. "Are more people getting better?" Take it at different levels. First: "If a patient has had a heart attack did he have a good experience of care and get better?" So that would be one measure of commissioning. Second, you could collectivise that and look at heart attacks in general: "In general how does the local health system deal with mortality rates in circulation disorders? Are they better or worse than the national average?" Third, you could visit York, Scarborough, Harrogate or other parts of my patch and ask whether this is a heart-healthy city or community. "Is it the sort of place where healthy options are easy options for the population?" I suggest that all three levels of outcomes would be tangible markers and ought to be scrutinised as evidence to answer your question about whether commissioning is working, and is it working better under World-Class Commissioning.

**Q222 Chairman:** You heard Professor Street say earlier that he believed PCTs should cease to commission services from the acute sector. Do you agree with that, and do you have any additional comment to make?

**Dr Brambleby:** It is an interesting suggestion. I do not agree. We are where we are and have a commissioning function and it could and should serve a useful purpose. It is important that someone is tasked with the job of ensuring that the deployment of resources for a local community genuinely reflects the needs of that community and that no vested interest group, be it clinician, patient or particular provider or technology manufacturer, dominates and has an unfair advantage. What we are striving to do is achieve equity of marginal net need, to use a technical term, which means that the next person coming into the local health system is

the next most needy person—that there is nobody in the health system being treated who has less need than someone outside it whose need is greater.

**Q223 Dr Taylor:** Following on from that, earlier you mentioned the importance of engaging with your community. How do you do that?

**Dr Brambleby:** In many and various ways. There is a distinction between engaging with patients and engaging with the public. Beginning with patients, we should engage with them a lot more. You say, “How was it for you? You have been through our system. What do you think of the GP and the hospital?”

**Q224 Dr Taylor:** It is really engagement with the public?

**Dr Brambleby:** It is engagement with the wider public. You can engage with them directly by leaflet drops and the annual report of the Director of Public Health or the PCT with a “reply to” strip incorporated. You can have a regular slot in the local newspaper and publicity and radio campaigns, the use of libraries and so forth, but there is also something called “rapid participatory appraisal” for which there is a good evidence base. You get a few “key informants”—that is the buzzword—for example the local health visitor, the bobby, the headmaster and a couple of businessmen, and put them in a room and ask them what the community needs.

**Q225 Dr Taylor:** So, local involvement networks do not figure in that?

**Dr Brambleby:** I have not finished! I would include local involvement networks and health scrutiny committees. But the point is to make sure you triangulate this against several different sources because it is too easy for one particular group with the best of intentions to over-emphasise its experience. That in itself can skew priorities. One also needs an advocacy role. Who is speaking for the people who do not come to the meetings, who are not registered with a GP or are a transient population, or do not speak the language, or have learning disabilities? One needs an informed advocate for that. I believe that is a public health role. One of the earlier questions, which I did not completely answer, was whether we had enough public health practitioners. If one takes the definition of public health as being the science and art of promoting population health and preventing disease and helping people live longer, then all GPs, their staff and all other clinicians are public health practitioners. It is not restricted to the health service—anyone with an interest in improving the health of a population rather than an individual in front of him or her is a public health practitioner. Anyone who focuses on the outcome and quality of life rather than simply a narrow measurement of whether the disease has gone away is a public health practitioner.

**Q226 Dr Stoate:** I am very interested in your definition of commissioning and how we can separate it from purchasing. As far as I can see there is really no role for PCTs to do much purchasing because under payment for results, Choose and Book or NHS Patient Choice there is very little you can do to pull the levers. Professor Street made the point very clearly: if you cannot control the price and the volume there is not much for you to do. Why can we not just expand on his model in a way and do much more commissioning which, as you rightly say, is really the procurement of good health rather than simply the purchase of services over which we have very little control?

**Dr Brambleby:** The point is about linking it back to making it happen. It is no good simply defining the needs of a population. I often feel that we should not do needs assessments but needs “addressment”. How are we to address unmet need in this population with the resources available given the people, the time, the commitment and money? You need a commissioner who can allow the money to follow the agreed pattern of care.

**Q227 Dr Stoate:** Most of the money is swallowed up under payments by results. For example, in my area whenever I talk to the PCT about developing community services there is a sharp intake of breath and they say that unless they can strip money away from the hospital and generate this money from the hospital there is no money to develop community services, so it is a chicken and egg. How do you get to the point where you can develop the very services you need to reduce reliance on the hospital? The hospital sector effectively has a big sign up in the car park saying coach parties are welcome.

**Dr Brambleby:** Easy! We come back to the programme budget approach. You say “Here is my PCT and I have £1.2 billion. Last year we spent approximately £60 million on, say, cancers”. The resource assumption going forward is that there is not a lot of new money around, so it will be about £60 million again next year. You then convene a cancer advisory group. You put service users, primary and secondary care clinicians and managers in a room and ask how the budget is to be divvied up to better effect next year. It is as simple as that. The way money will flow into the hospital sector for that part will be by payment by results, but we say to the GPs, the referrers, that they should sign up to the newly agreed pattern of activity. “If we all agree that the objectives of the cancer programme include prevention, and includes end-of-life care, let us protect some resource for that. Does everyone agree to abide by the rules we set?” If so, you go for that. The money can follow the patient according to payment by results but they will have to self-police it and be encouraged to work to the agreed pattern of activity that has been set up, not just let the vagaries of demand, chance and referral determine priorities for them. It is about stepping up to the mark and using the levers we already have but having a more collaborative discussion and, critically, being allowed time to have that discussion and being encouraged to scrutinise things during that

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discussion and not be constantly diverted by over-elaborate emphasis on the transactional side. World-Class Commissioning itself says that this should not be a transactional but transformational activity. There are plenty of people out there on the periphery

who are up for that and skilled for it; they just need the permission and the environment in which to deliver it.

**Chairman:** Thank you very much for coming along and giving evidence this morning.

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Witnesses: **Professor Rod Griffiths**, Chair, National Specialised Commissioning Group, **Mr John Murray**, Director, Specialised Healthcare Alliance, **Ms Deborah Evans**, Chief Executive, NHS Bristol and Chair of South West Specialised Commissioning Group, and **Ms Teresa Moss**, Director, National Specialised Commissioning Team, gave evidence.

**Q228 Chairman:** Welcome to the second evidence session in our inquiry into commissioning. For the record, perhaps you would give us your names and current positions.

**Ms Moss:** I am Teresa Moss, director of Nationalised Specialised Commissioning.

**Ms Evans:** I am Deborah Evans and I chair the South West Specialised Commissioning Group and I am chief executive of NHS Bristol.

**Mr Murray:** I am John Murray, director of the Specialised Healthcare Alliance.

**Professor Griffiths:** I am Rod Griffiths, chair of the National Specialised Commissioning Group.

**Q229 Chairman:** Ms Moss, can you explain the structure of commissioning for specialised services and the rationale behind it?

**Ms Moss:** Thank you for giving me this opportunity. I will give a brief overview of specialised commissioning. It is important to begin by stressing that the NHS is here for everyone, not just those with conditions we can diagnose and treat rapidly. The NHS is there even for patients with very rare conditions which sometimes require expensive and specialist treatment. We refer to very rare treatments and therapies as specialised services. They are commissioned either regionally by specialised commissioning groups, of which there are 10 in England based in the 10 strategic health authorities or nationally by the National Specialised Commissioning Group. The distinction between those two tiers is really based on the rarity of the disease. For national commissioning one really expects only 400 or 500 patients with those conditions needing that treatment a year. We are talking of a wide range of specialised services. To give examples, at national level we commission heart and lung transplants and liver transplants; at regional level we commission bone marrow transplants, children's heart surgery and brain surgery. They really are very specialised services. By commissioning these services centrally either on a regional or national basis we can achieve very important benefits on behalf of patients. The first of those is equity. If this was left to every PCT they would have different arrangements. By doing it on a collaborative basis across a region we can ensure more equitable access to these services no matter where patients live. The second good reason for doing it is that we can start to establish common standards that patients can expect across the country which means better outcomes. There is another issue

about what we call risk sharing or cost sharing. The 152 primary care trusts around the country can share the costs of these treatments so that no single PCT is overwhelmed by the cost if they have a cluster of patients perhaps with a rare inherited genetic disorder or a number of expensive treatments they need to resource for their patients in a single year. That is another important reason. Most importantly, by co-ordinating this commissioning we can set up specialist centres and concentrate the services for these rare conditions in specialist services. Clinicians become very knowledgeable about those services and patients get a much higher quality service. That is really important for patients with a rare condition who have been from pillar to post trying to find somebody who understands their condition.

**Q230 Chairman:** The Carter Review of specialised commissioning took place in 2006. We have had evidence submitted to us that some of the reforms recommended by that inquiry have not been fully introduced. Do you have a view about that?

**Ms Moss:** We have made a lot of progress so far and there is still work to do on that. Sir David Carter said we needed to review the processes that he recommended about now. Where have we got to? He proposed that we set up the arrangement that I have described in part. All of the regional specialised commissioning groups in each SHA are fully in place and are stronger than they have been in the past. We have the national commissioning group in place and the National Specialised Commissioning Group oversees national commissioning and also supports those specialised commissioning groups to make pan-SCG decisions. The groups are there and we need to keep developing the expertise we have been building in those committees and get the further benefits of those structures. He recommended that we completely revise the specialised services national definitions set that describes rare conditions and services in much greater detail. We have completed that revision in the past few days. It was an enormous task with enormous consultation around it. There were contributions from a huge number of patient and clinical groups. I believe that will be a valuable tool as we go into the next phase of specialised commissioning. He also asked that we focus on service mapping and costing to identify costs and quality indicators so we could do effective benchmarking across the country for specialised services. All of the SCGs have agreed a top 10 list of

priority areas and each leads on one of those to identify those costs and quality indicators they can take forward and benchmark. That project is well under way but it will need to be resourced if we are to pick up the pace of it. From my perspective it is important we do that so the specialised commissioning groups have that information available to them; otherwise, we rely on patient groups to give feedback on variations across the country and the services we are commissioning and that cannot be right. There are lots of examples of where we have made progress since.

**Q231 Chairman:** Who is responsible for pushing through the reforms of the Carter Review?

**Ms Moss:** It is done at different levels. For national commissioning I lead that particular team and NHS London does that on behalf of the other SHAs. For the 10 SCGs PCT chief executives are given the responsibility to chair those local services. Sir David Carter laid strong emphasis on SHAs providing a championship role to oversee the strength of SHAs in specialised commissioning in their areas. It is important to make sure that all the PCTs are fully engaged around the specialised commissioning agenda.

**Q232 Dr Stoate:** Ms Evans, who holds the purse strings?

**Ms Evans:** The arrangement is that PCTs and their regional specialised commissioning groups make an agreement about what will be commissioned by the specialised commissioning group regionally. That amount of money is drawn from the PCT baseline, so they agree on a sum of money and their list of services and those are the things that the specialised commissioning group commissions on behalf of PCTs.

**Q233 Dr Stoate:** Are the SCGs free to make any spending decisions on their own or do they have to listen to the PCTs?

**Ms Evans:** It has a very strong and clear government arrangement which is that the specialised commissioning group is formally set up as a sub-committee of every primary care trust in a region. In my region there are 14 primary care trusts. Each chief executive is a voting member of the specialised commissioning group and collectively takes those decisions. Those decisions are reported back to every primary care trust board.

**Q234 Dr Stoate:** Is it fair to say that the national commissioning group has no influence in this at all; it has to be done locally?

**Ms Evans:** The PCT level of governance is very clear. We have to make sure that when we are formally taking decisions about service change they are rooted at the appropriate level. A lot of the decision-making is formally to do with the primary care trust, but I do not think it is right to say that the NSCG does not have a role. Each of the chairs of the specialised commissioning group—I am chair for the south west—is a voting member of the National Specialised Commissioning Group. We sit

collectively in that group and take decisions about the priorities for work that is to be done and so on. The national specialised group is also the place where NCG agenda and budgets are discussed. Ms Moss may want to talk a little more about the role of NSCG in that respect.

**Q235 Dr Stoate:** Surely, the NSCG does not have any financial power. My understanding is that the rules insist that it is all done locally. Does that not lead to the risk of a postcode lottery among the different groups, or is all of that being ironed out?

**Ms Evans:** My colleague was right to put equity as one of the key things we are trying to achieve. We try to do that in a number of ways. For example, when we look at designation of services we consider the whole pathway and concentrate on the specialised element of the pathway. We go through a process of setting service standards which we expect to be met. Those are set jointly with clinical, managerial and patient involvement. We get a set of standards and then a process by which we designate centres. What each SCG also has to do—we are able to draw it together by looking across the country—is look at some of the difficult issues about access. To use an example close to home, in the south west when we were first established in 2006 we looked in a basic way across our region and asked whether we had deficits in terms of specialised services. One that leapt out was services for neuromuscular diseases where in outline we appeared to be doing poorly in terms of outcomes. That suggested we did not have good enough access and since then we have had a programme to develop and invest in those services which is partly under way now. We are at an early stage with some of these services in being able to understand access and compare how well we are doing across the country. That is work that increasingly we need to strengthen. My colleague has already mentioned the service mapping and costing groups which mean that each SCG will take a lead. For example, one will look at both the costing and quality issues in renal services; one will look at neurosurgery; another will look at HIV, and so on.

**Q236 Dr Stoate:** But what if you looked at your neuromuscular services and found them wanting but decided you did not care much about them? What would happen then? Obviously, I am caricaturing it. Let us say you decided that you were pretty poor at it but it was not a priority.

**Ms Evans:** One of the reasons why the role of specialised commissioning groups is very hard is that it is our responsibility to make those decisions and be accountable for them.

**Q237 Dr Stoate:** To whom are you accountable if there is no national standard?

**Ms Evans:** All of us have to work with the evidence we have and strengthen it as we go along; we have to look at what we know about health needs. We have already heard a lot about assessing health needs this morning.

**Q238 Dr Stoate:** You are telling us about the process that you undergo, but if you decided that it simply was not an issue because it was not a priority for you and you would not do it what would happen?

**Ms Evans:** Clearly, we have made those decisions and are accountable to our primary care trust board, so each board carries that responsibility and would have to account for it. It is also right to acknowledge that strategic health authorities have a responsibility to performance manage specialised commissioning groups. Their role is to make sure we are doing our job properly. Obviously, they have decided to ask the chief executive of NHS London to be responsible for having a specialist in specialised commissioning and chairing the national group. Therefore, we have performance management at that level and accountability at the PCT board level.

**Q239 Chairman:** On average specialised commissioning groups have about 15 PCTs sitting on them. What happens if you do not reach agreement? How do you get a consensus?

**Ms Evans:** We have very long meetings if we do not get agreement. We have a clear national establishment agreement which sets out how decisions will be taken. We have a quorum. In our case there is a requirement that 10 of the chief executives out of the 14 will be present at any one time, so it is a demanding quorum. We have a formal route by which we take decisions by majority if we have to. We prefer not to do it that way and wherever we can we will sit down and hammer out the debate until we have agreement round the table.

**Q240 Chairman:** Ms Moss, does that happen with other specialised commissioning groups? Is it the norm?

**Ms Moss:** Inevitably, there are specialised commissioning groups that are stronger, visionary and strategic in their thinking and others that perhaps are not as strong in those ways. That is why regional oversight is really important. As we go into tighter financial circumstances it is inevitable that different PCTs have different financial difficulties within that cluster. I think the art is to make sure that each of those SCGs does not move at the pace of the slowest.

**Q241 Chairman:** Are you convinced that if there is a gap between them it does not happen in such a way that there is a lesser service?

**Ms Moss:** It is about getting better information and benchmarking. Dr Brambleby talked of the importance of information being available to commissioners. The information available to PCTs around the majority of their services is much stronger than it is about specialised services. Perhaps I may suggest that in your report you make that recommendation to help us get better information, and the support and infrastructure for that is really important. You will also know that through the World-Class Commissioning process we have developed a toolkit for an assurance process around collaborative decision-making between the PCTs. I believe that will become more and more important.

With formalised processes each of the SCGs can see how well it is doing relative to other areas of the country. Tools and mechanisms are being developed. There is a developmental process this year and probably it will need to be formalised over the years to come.

**Q242 Chairman:** Ms Evans, you have been involved in the burns review in the south west. Can you explain to us what this involved and why it has taken so long?

**Ms Evans:** I would be happy to do that. Designating burn services is an interesting example to consider. It was the first of its kind that the NHS tried to do. I believe its antecedents were in 2004, so you are right that it has taken a long time and we hope we are coming towards the end of the process. It is complex because we looked at different severity of burns. The area that has been most difficult is to address the very complex and most severe burns which are very small in number. For the south west, south central and South Wales there might be 30 to 40 adult patients a year, so they are small numbers of very complex cases. We expected to designate a centre which would serve a number of regions, so it would be supra-regional and go beyond one region. In our case we had the south west, Wales and south central all working together, which in itself is complex. The purpose of designation is to ensure that we can achieve the highest quality, concentration of workforce, expertise and so on. That was highly contested by clinicians. In these designation processes often they are contested by somebody; it might be by clinicians, hospital trusts that do not want to lose a service; it might be contested by service users sometimes, although there is a lot of evidence that they are prepared to go far to get what they see as the best quality. In all of that it was important to have a cast iron process. When our specialised commissioning group was formed in 2006 we reviewed where we had got to and decided whether or not we were ready to go out to public consultation. We came to the view that it just was not strong enough and we wanted to redo various part of the work. One was to get to the bottom of understanding clinical outcomes, which I do not believe has ever been done before with very complex burns. We wanted to redo all the work about travel and access and have much better patient involvement. We did not feel that our service user involvement had been robust enough. Therefore, we took the time to redo all of that. We paused for a general election and NHS reorganisation on the way. I am pleased to say that we have now reached the point where we are working through the very complex arrangements we need to make to establish whether public consultation is necessary. I should like to outline those to you because they will make your mind boggle. We have eight or nine overview and scrutiny committees in south central. They came together and said they would form one committee to consider whether or not it wanted public consultation, and they did so. Wales does not have overview and scrutiny committees; it still has community health councils. Therefore, Wales used

that mechanism to decide whether or not it wanted public consultation. The 15 overview and scrutiny committees in the south west decided not to form a joint committee and asked whether we could work round them individually. We have done the Isles of Scilly, Cornwall, Bournemouth, Poole, Dorset, Devon and Bristol and have a number more to work through before we can come to a view about whether or not public consultation is necessary. That is why it has taken a long time, but I am confident we now have a set of proposals formed in the right way and are cast iron and if we do need public consultation, even if we have to pause for another general election, we will come out with the right answer in the end. What I have described is a designation process in which we were learning that took a lot longer than any of us would have wanted. It is also the most complex type you can get. While we have been doing burns over the past 18 months we have done two other designations, sarcoma and bariatric surgery, in the south west from start to finish. Not all of them have to take this long but each is a process that requires a high degree of resource and skill.

**Q243 Chairman:** Is there a level of disinvestment in that as you suggest hospitals do not want to lose the provision of a service? Is that level of disinvestment higher in this particular instance?

**Ms Evans:** It is significant but it is not at a level which will damage the surrounding services, for example plastic surgery or critical care services, but one of the complexities is that we need to understand these services in their context and the impact they can have on other hospital services. That is one reason why local authorities become very anxious.

**Q244 Dr Naysmith:** Mr Murray, what are your views on some of the things we have been talking about? Do you believe that specialised commissioning groups are free to make spending decisions on their own; if so, do they exercise that ability? What about the slowness of decisions in some cases?

**Mr Murray:** First, I emphasise that the Specialised Healthcare Alliance is strongly supportive of the Carter reforms. We agree with Ms Moss that the structures are in place. Where we might disagree is in relation to the extent of underlying reform. We believe that a huge amount of progress remains to be made. We question whether the current approach is capable of delivering that progress. To revert to the underlying principles which are mentioned in the submissions to the Committee of both the Department of Health and the National Specialised Commissioning Group, above all the intention here is to deliver equity of access and to share risk. I would argue that the Department of Health has a strong overarching responsibility to ensure that the Carter reforms are effectively delivered in their entirety. In the operating frameworks immediately following publication of the Carter Review it sought to do so. Most recently in the document for 2008–09 it urged SCGs to cover progressively more of the national definitions set. The definition set in its entirety would pool budgets by 2009–10. If we look at what has actually happened, there are notable

examples of progress. Indeed, from a standing start the south west has made significant progress, but we suggest that in no case is there an SCG that is anywhere near commissioning the whole of the national definitions set. For example, as far as we can see from its response the south east coast commissions six of the chapters in their entirety, but it is complicated by the fact that sometimes there are a number of services within a definition. With rarer cancers there are about half a dozen services encompassed within it. South central is commissioning 19 out of 73 services covered within the definition set. There are some disparities here. The northwest covers 22 out of 81. That gives an indication that there is still a long way to go.

**Q245 Dr Taylor:** Just when I thought we had all the acronyms sorted out we had further mind-boggling from Ms Evans. I want to ask about strategic health authorities to make sure I have their role clear. Although the regional SCGs are coterminous with the strategic health authorities the latter do not have much to do with it. You said they had a championship role. What does that mean? How do they do that? You said that SCGs are made up of chief executives of the local PCTs. Who else is there?

**Ms Evans:** The health authority has a director who sits on the specialised commissioning group. The role of the health authority is to performance manage the specialised commissioning group. I recognise that it will vary across the country, but perhaps I can give you a flavour of the level of our health authority's involvement.

**Q246 Dr Taylor:** Do all your PCT chief executives come to the meetings or do they have deputies?

**Ms Evans:** They can send deputies if they need to. There are 14 of us and the quorum is 10. We always have 10 present; sometimes all of us attend. Last week we did it by telephone because all 14 were snowed in at home. We have a high level of chief executive attendance. The health authority is very involved because it scrutinises our communications and our patient and public involvement work. It also scrutinises the reviews we carry out, so for the designation of bariatric surgery, burns or any of those things it will be involved in reviewing all of that. It has a slot on the directors of finance and performance at every monthly meeting which discusses specialised commissioning issues. We then directly brief the chief executive of the health authority as necessary. Our health authority is thoroughly involved in the work of the specialised commissioning group.

**Q247 Dr Taylor:** You have also said that you send certain disease groups to other SCGs. Is that not just going back to the supra-SCGs that one had before Carter?

**Ms Evans:** We keep to ourselves within the SCG the responsibility for commissioning the services, but we have 10 directors of specialised services who work together to use their resources in the best way. For instance, one region will say it will develop the quality standards of neurosurgery for designation

for the whole country and we can have a look to see if they are all right. Otherwise, we would be reinventing things 10 times over. One region will do a lot of work on behalf of the others. For example, what standards do we need for the renal pathway? One will take the lead in developing that and it will then be consulted on more widely.

**Q248 Dr Taylor:** Each SCG has a director?  
*Ms Evans:* Yes.

**Q249 Dr Taylor:** Do those directors meet regularly?  
*Ms Evans:* Yes. One very important message is that we need to regard specialised commissioning as something that is still strongly developing in its competencies and ability. In order to get better we need to keep developing the skills of our people, information systems and so on. Building up our ability to be successful is really important if we are to deliver the Carter Review and I am sure that the Specialised Healthcare Alliance would support that view.

**Q250 Dr Taylor:** Did Mr Murray imply that there were some disease groups that were not covered by all the SCGs?  
*Ms Evans:* I think that is true.

**Q251 Dr Taylor:** They ought to be covered but they are not in some areas?  
*Mr Murray:* Furthermore, there are areas that are ostensibly covered. I take deep brain stimulation as an example where in practice because the budgets are not pooled the decisions go back to PCTs and patients encounter delay—sometimes more than that—in getting treatment.

**Q252 Dr Naysmith:** Mr Murray, we have returned to where we were a few minutes ago and started to explain why it is that so many specialised commissioning groups have not yet begun to commission all the services in the national definitions set. You suggested that it was partly to do with the pooled budgets.  
*Mr Murray:* Yes. A stronger part of the rationale is to share risk. The evidence suggests that PCTs within the SCGs are reluctant to do so and the engagement of PCTs is highly variable. I believe that the south west is the most developed in that regard. There is another SCG which has over 20 PCTs in membership and the only chief executive representative is the PCT chief executive who chairs it. Similarly, there is an SCG where there is no SHA representation, so it is hugely variable. We asked SCGs in the past few weeks to let us know the proportion of their budgets which were pooled bearing in mind that this was a primary objective of Carter. In a couple of cases it was between 1% and 2%. In most cases it was in single figures and the very best performance adduced was around 20%. All the SCGs for the most part have to work with resources attributable to individual PCTs and it is therefore understandable that the latter feel they retain ownership of the money and where particular

treatment decisions are concerned they may well ask the SCG to refer back to them. That was certainly not intended under the Carter reforms.

**Q253 Dr Naysmith:** How far does the need for a critical mass mean that one or two PCTs can potentially frustrate the commissioning plans of several others? Does that ever happen? Perhaps you would also pick up some of the points made by Mr Murray.

*Ms Evans:* I pick up a number of points. One is about the definition set and which specialised commissioning services are picked up and which are not. One of the issues we think about in the south west is that because the definition set was originally on the basis that anything that needed to serve a population of over one million must be designated as specialised there are lots of things that have come under the definition set we now regard as matters that PCTs can and would expect to commission within their normal pathways. An example would be a lot of local cardiology and cardiac surgery. In our case we have decided that that will stay with the PCTs and the SCG will handle the more complex end of that, so new cardiology interventions will be done by the SCGs. Similarly, there is a whole issue about child and adolescent mental health where what we have decided is that it is only the very complex end that will be done by the specialised commissioning group. The rest of it has so many links with local education, children's services and families that we think it is better commissioned by PCTs. There is not an absolute rule here. We would expect some things to move into designated specialised services. Over time new things will come in and others will move out and go back to PCTs.

*Ms Moss:* I support what my colleague has said. My interpretation of the Carter Report—Mr Murray and I have had conversations about this—is that he set SCGs up to oversee the commissioning arrangements of all the specialised services on the list. That is a really important role. Now that we have redefined them it is important to set up the notion of SCG guardianship of those services or, if appropriate, national services. We have that conversation and have finished defining and refining that list so it can happen now. The guardianship of those services is definitely in Carter. I do not think it means one has to commission or procure all of those services for the reasons Ms Evans said. Some PCTs have a population of one million and they can perfectly well lead the commissioning of those services, but I believe that the SCGs have a role in the way Ms Evans indicated. Are the commissioning arm arrangements appropriate for this service or is it a mess and do we need to focus on it? I believe the term “guardianship” is important.

**Q254 Dr Naysmith:** Is not a logical extension of it that you should move to a system whereby the money goes to the specialised commissioning group directly and leaves out the PCTs? Obviously, you have get the definition bit right and not have other bits that really should not be there, but if that was the case that is what should happen?

**Ms Moss:** If you are trying to be responsive to the different sizes of PCTs in your area and the like it is difficult to identify a particular sum of money that you are to pull out for these services. I think we would spend the next 15 years trying to work out exactly what the right budget would be to take out for these services, a lot of which do not have tariffs so there are different costs in different places even within the same SCG. That would be quite a tough process.

**Ms Evans:** I do not believe it is in the interests of patients to take all the money to do with specialised commissioning away from PCTs and put it with another body, whether or not that specialised commissioning group is a part of the health authority. We have heard this morning that the challenge but also the strength of PCTs is that they look after a whole population and look across a whole pathway. I do not think it makes sense to take the very specialised end of, say, renal services and give it to another body and then say that all the other aspects of renal services, like looking after people in primary care, early detection of disease and end-of-life care, should be put elsewhere. We should not leave part of it with PCTs and take the rest of it and put it somewhere else. That is not in the best interests of patients. The best interests of patients are for us to make the dynamic between PCT commissioning and SCG commissioning work. Rather than give up on it we should make it work better and that is in the interests of patients. Turning to Dr Naysmith's question, do we find in effect that two or three PCTs veto something which will be good for everybody? We have not found that yet. We have some big debates about whether to invest in things. Neuromuscular services is a good example where, looking across the whole pathway, some PCTs do not feel that their local general hospital neurology services are very strong, so they ask whether it is right to invest all this in the very specialist end. We resolved that in a positive light by looking at the evidence and health needs and having that discussion. We have not found that to be a problem yet.

**Q255 Dr Naysmith:** You said you had a quorum of 10. Does that mean you can have a majority vote with 10 people present and outvote somebody who is not present?

**Ms Evans:** I know that politicians like voting arrangements. In our national establishment agreement there are very clear voting arrangements, but we try not to resort to that because the next time you sit round the table it creates bad feelings if you have outvoted your colleague from Devon.

**Mr Murray:** It is ironic that the reference to services which can be commissioned at PCT level encompasses renal services. When the national definitions set was recently revised the question whether renal services should be in or out was the subject of heated debate. There was a substantial body of opinion among PCTs that they should be taken out because the number of patients in receipt of those services has grown, but supported by the renal tsar the decision taken ultimately was that they

should remain in. As I understand it, the renal tsar felt that the services would be more effectively integrated right along the patient pathway if they continued to retain specialised status. It is interesting to note that if it were seen as a service that was primarily the responsibility of PCTs it is also one of those 10 services which have been taken on by the SCGs for the purposes of designation. By comparison, a lot of the more specialised stuff easily gets overlooked. I think the evidence from the Children's Trust Tadworth is particularly compelling in that respect. It clearly feels that these services are not engaging PCTs because the latter do not see the number of children involved as significant in their terms and so they are not priorities, and the costs involved can be extremely high. The budgets and risk are not shared and therefore young people are suffering according to the Children's Trust Tadworth. You might say that to go from PCT to SCG level would be the right thing to do, but reading between the lines there seems to be a certain lack of confidence because the proposal they make is that they should go from the current situation where these services are apparently in the gift of the PCTs to national commissioning. There must be something wrong with a system if one goes from one extreme to the other. I think that a healthy regional commissioning system would be exactly one where services move between different tiers depending on the needs at the time. I do not believe that we have that healthy system at the moment.

**Professor Griffiths:** I was a member of the Carter Committee. The crucial point to which we must keep returning is that the intention was that these services should be just as good everywhere in the country. Whilst I agree it is very complicated—I endorse all the discussions that have been described—what the NSCG has not spent much time on is trying to challenge itself to assure everybody that it has made the effort to try to find out if services in place *x* are as good as in place *y*. I do not mind if the money is moved around in different ways but we have not yet done that bit of what Carter intended and we need to do so. Now that the definitions set is in place maybe that is a greater possibility, but I believe that is the real challenge.

**Q256 Sandra Gidley:** I have a question to Ms Evans and Mr Murray. What is your opinion on how World-Class Commissioning fits with specialised commissioning?

**Ms Evans:** As a PCT chief executive, the World-Class Commissioning programme which has run through its first year has been a really useful development tool and helped us focus on key health outcomes that we want to achieve and the range of competencies we need. It has been a very useful spur to our development. I should like to see the same discipline, appraisal and, importantly, development programme applied to specialised commissioning. Ms Moss and I have talked about how much we need further development. Professor Griffiths has just made the point that different specialised commissioning groups need to compare themselves one to the other; they must benchmark themselves.

We need to know what the best is and work out how we can move more quickly towards it. I believe that the World-Class Commissioning programme can be a good vehicle for doing that but not the only one.

**Mr Murray:** We were very keen for World-Class Commissioning to apply to specialised services and we were pleased when eventually it emerged from the bowels of the department but we were disappointed when we discovered that it would not be part of the overall assurance process. I am indebted to Gary Belfield's reply to your question at the end of the previous session in which he rather said it all in exemplifying the difficult position where specialised commissioning sits. He said: "One thing I would like to say though is that every PCT has the responsibility within their portfolio for commissioning specialist services. They do not discharge that responsibility; they involve a specialised care commissioning group to do it on their behalf, but they still have to take responsibility and accountability at a local level." That perhaps explains why there is presently a difficulty in addressing specialised commissioning in the context of something like World-Class Commissioning in the wider regulatory sense where the Care Quality Commission and its predecessor bodies have also struggled to reconcile the fact that their focus of attention is on primary care trusts, or potentially strategic health authorities, and the SCGs sit in a kind of limbo in between. I think that is a weakness to be addressed one way or the other.

**Q257 Sandra Gidley:** You mentioned that World-Class Specialised Commissioning had been introduced but it seemed to be half-hearted. Can you explain that?

**Mr Murray:** My understanding, to which Ms Moss may wish to add more detail, is that after a pilot in the north west last year the materials were developed further with all SCGs but they were allowed to assure the process rather as they saw fit. Some have employed independent auditors to help them to do so; some have decided to do something by way of internal assessment; and some are probably not doing very much at all. It is a very mixed bag.

**Q258 Sandra Gidley:** Do you think World-Class Commissioning should be mandatory?

**Mr Murray:** For specialised services, absolutely so. How can you leave 10% of NHS activity outside and have a worthwhile scheme?

**Q259 Dr Taylor:** Ms Evans, some of the groups that have submitted evidence to us argue for a more integrated approach to commissioning for rarer conditions which they think could save the NHS money and improve care. For example, CLIC Sargent says: "Specialist commissioning must better connect with the whole range of community services including health, social care, information and education in order to provide a holistic community-based service that sick children and young people need." Should PCTs be doing something about that, or are you trying to do it in any case?

**Ms Evans:** I think we are. I read that submission to the Committee. I am aware that a number of other submissions to you say the same thing and I agree with it. It illustrates my point that we need the PCT and specialised commissioning perspectives to work side by side. To go back to my neuromuscular example for a moment, there are some elements of service for children with neuromuscular diseases which are highly specialised. We know we need to address that. But there are also some very important elements of those services that are not specialised; they are to do with children's equipment, like wheelchairs and so on. That is firmly in PCT territory. In my PCT we have done a lot of work on sorting out those services which frankly have been very poor. We have spent the past 18 months improving children's equipment services and getting them into a much better position. That is the dynamic we need between the PCT and specialised levels so we get the whole pathway right for these families who are dealing with very difficult, enduring and long-term conditions.

**Q260 Dr Taylor:** Is it right that one of our recommendations should be that the presence of PCT executives in these groups is absolutely vital?

**Ms Evans:** I think so.

**Q261 Dr Taylor:** Mr Murray, in your evidence you have picked out some SCGs where there are very few PCT chief executives.

**Mr Murray:** At the extreme it is one out of 24. Most of them are somewhere in the middle ground. For some the previous structures are reflected in current chief executive attendance, so there may be some subsidiary collaborative arrangements. Let us say there are 15 PCTs represented in the SCG but there will be five chief executives who go along to represent in each case two of their colleagues. It is that kind of approach.

**Q262 Dr Taylor:** I believe the Carter Review called for commissioners to seek the views of patients, carers and the public.

**Ms Evans:** Yes.

**Q263 Dr Taylor:** How do you do it?

**Ms Evans:** We do it in lots of ways. We have built into our process for service review and development some approaches which include having stakeholder days that include clinicians, service users and the local authority overview and scrutiny representatives. We often get them to work together so the clinicians directly hear the views of patients as do the local authorities. We have service user representatives and interest group representatives on some of our steering groups to implement services, of which neuromuscular is another example. As to the burns review, when we designate services we have visits to the centres which include representatives of LINKs; they include service user representatives and they can also include representatives from the relevant interest groups. We have a lot of standard mechanisms by which in all our routine work we

incorporate the service user view and the great expertise of the sorts of organisations that are represented by the Specialised Healthcare Alliance.

**Q264 Dr Taylor:** Do you find that overview and scrutiny committee members and LINKs members are helpful and interested in these very specific and rare conditions?

**Ms Evans:** I think they are interested. Local authority representatives quite understandably are always interested in the impact of a service proposal on their local area. They start with the local area as one would expect, but they have made a good effort to understand what happens when you have to serve a very wide geographical area where you have small numbers of patient and the different challenges involved in that.

**Q265 Dr Stoate:** Listening to this session one matter that comes through without question is the horrendous complexity of it all. I am genuinely more confused by the level of complexity than I was when we started the session. There are so many different tiers and so much bureaucracy. We have heard from people like the Specialised Healthcare Alliance. Some of the SCGs commission only six out of a possible 36 services. The possibilities for postcode lotteries and confusion are endless. When patients move from one part of the country to another I despair at how they can access what services they might need. Rare Disease UK argues that with payment by results, practice-based commissioning, foundation trust commissioning and regional and national commissioning the system is altogether more complex than it was before. The top prize goes to the witnesses who can come up with a way of simplifying the system in a few words. Who wants to pick up the challenge?

**Mr Murray:** I am surprised to hear you say that. The system is not as complicated as it was prior to Carter. If you go back to the arrangements prior to Carter not only were they very complicated but there was even more of a laissez faire approach and enormous scope for services to fall between the paving stones at many different levels. The levels of commissioning that we have are probably right. The problems relate to the way in which services are picked up by those levels and there is simply not sufficient consistency across the country in the way those services are funded. Ultimately, I think experience shows that unless you have responsibility for services along with the funds to procure them you will not be in a position to do a good job.

**Q266 Dr Stoate:** If PCTs can withhold or keep back the funding it makes it practically impossible for an individual SCG, let alone across the country. It is a dog's breakfast.

**Mr Murray:** That is why in our submission we propose that the funding issue should be revisited. I do not pretend that this is an easy issue because obviously one does not want to enter into a fixed funding arrangement when one does not understand the costs properly. For example, the Spinal Injuries Association has drawn our attention to the fact that

no one knows how many patients there are with such injuries across the country, let alone in different regions of it. Carter proposed that as a priority costs should be properly mapped in relation to the different parts of the national definitions set. It has scarcely got under way.

**Q267 Dr Stoate:** We have had the purchaser/provider split now for 20 years and you are telling me that it has scarcely got under way. In inquiry after inquiry we hear about the purchaser/provider split; we have had the internal market. It has been going for 20 years. Guess what? Most of it has not started yet. What will it take to get anything moving?

**Mr Murray:** I tell you one thing that might get it moving, although it will appal Ms Evans. Let us suppose that the money went to the specialised commissioning groups and that it was, as it is presently, top-sliced from the primary care trusts but only on the basis of proper costing analysis by the SCGs. That would concentrate minds very rapidly in terms of introducing a far more robust approach. I also think that in a situation of greater economic stringency there is a huge amount to recommend the greater use of commissioning at regional level. Notably, a couple of the specialised commissioning groups observe that their management costs are in one case .4% and in another case .5%. That seems to me to be a strikingly low figure. I might say that it is not necessarily adequate to do the job properly which may be one of the reasons things are not progressing as fast as they should, but it suggests there is tremendous potential to do a good job and do it efficiently in relation to these services at that level.

**Q268 Dr Stoate:** We always hear there is a lot of potential. Professor Griffiths, there is a lot of potential to do better but no one has actually achieved it. What can we do to simplify this?

**Professor Griffiths:** The crucial point is that the system should be patient rather than system-facing. I accept that the country is a complicated case and what you do in Birmingham is likely to be different from what you do in Cornwall or whatever just because of life. Why does not the system deal with it rather than make the patient have to grapple with it? If we gave SCGs the responsibility for facing the patient with all the regional services and somebody had a problem because he or she moved to another region and wanted to know what to do the patient could phone them and they would sort it out. You might well have an arrangement whereby some PCT commissioned this or that in your particular patch, but that is not to bother the patient. At the moment it is a system-facing arrangement and it is left to the patient somehow to grapple with it. That can be tricky and you need determination above and beyond the call of duty sometimes to be able to do it, but it is being paid for by the patient.

**Q269 Dr Stoate:** All I ask for is a system I can understand. I have been a GP for a long time. Frankly, I am really now more confused than I was a while ago. I thought I knew this stuff but now I find

I do not. I just want a system I can understand and I hope I can help my patients understand and I do not see it happening.

**Professor Griffiths:** In that case we ought not to reorganise every five years. Yes, we started in 1990 but we have messed it about. Any time anybody got any good at it we kicked the horse from under them, but somehow or other you must change the way performance management thinks to make the system face towards the patient.

**Mr Murray:** Having policy is one thing; implementing it is another. The Carter policy is absolutely right in establishing SCGs as a one-stop shop for people who need information about services which they or their families require, whether those services are commissioned, as they probably would be for the most part, in a fully implemented system by the SCG or for whatever reasons commissioned by the PCT, but that is not happening because it has not been properly implemented. It requires consistency of purpose which sadly is sometimes lacking in the NHS.

**Q270 Dr Stoate:** We heard from Ms Evans earlier. We even have to decide whether to go to public consultation which will take two or three years. By that time I will probably have forgotten the question. It is completely insane. There must be a simpler way of doing it. There is silence.

**Ms Moss:** If we could simplify the public consultation systems that would be enormously helpful. They are truly very complex and we need to do something about that. This is a complex arena and I am not sure we will ever make it very simple. Dr Brambleby talked about programme budgeting. For that you have to get all the people in the room, focus on the patient pathway and plan their care along that pathway: the key interventions and the right places to prioritise. You need to get these different systems into the room to do that planning, decide your priorities and then leave them to commission appropriately to high standards the part of the care pathway for which they are responsible.

**Dr Stoate:** I know the theory; it is just that I do not see it happening.

**Q271 Dr Naysmith:** Mr Murray, what do you think about public consultation? Is it too onerous or could it be done in a much simpler way?

**Mr Murray:** You are not talking about patient engagement but public engagement?

**Q272 Dr Naysmith:** We heard about how long it was taking.

**Mr Murray:** It is hugely complex and sometimes it militates against very necessary change.

**Q273 Sandra Gidley:** Our earlier session was mainly about payment by results. How does that work in the area of specialised commissioning?

**Ms Evans:** In specialised services as in PCT commissioning we have a mix. Some of it is under payment by results and some of it is not. Most of it is not under payment by results. In particular, there are whole sectors like mental health where payment by

results is said to be coming but we do not have it yet. Probably for the south west 20% to 30% of our whole portfolio is payments by results. Next year our portfolio will be £520 million, so we will have moved to one of the SCGs who is commissioning a huge amount of the potential portfolio, but only 20% to 30% is payments by results. Examples of the parts that fall under that are cardiac and bariatric surgery and paediatric intensive care, but renal and neonatal intensive care does not. Therefore, the large and some of the more commonly used parts of specialised services are not subject to payment by results. That means one has local pricing. The price for something might be different in Plymouth from what it is in Bristol. That means PCTs and specialised commissioners have to work together because if when wearing my Bristol PCT hat I am commissioning ordinary general hospital services for Bristol from the main teaching hospital and specialised services are being commissioned from the same hospital and there are parts which are not payment by results, if we are not careful we shall pay for things twice. That is another complexity in specialised commissioning. Increasingly, we need to be able to make cost comparisons and know what we are getting for what we are paying and its quality, so it is difficult.

**Q274 Sandra Gidley:** Perhaps I am being a bit slow here. Why are some areas of specialised commissioning part payment by results and others not? How was that decision arrived at?

**Ms Evans:** Because the payment by results national financial regime has been rolled out over a number of years. It started with things that were relatively easy which would be common hospital procedures that are approximately the same up and down the country where one can set a normative tariff. Obviously, specialised commissioning is much more complex and quirky than that. By and large, specialised commissioning has not been able to be boxed up and put into payment by results. We are working on some areas. For instance, I have a responsibility for spinal injuries commissioning in the south of England. Currently, we are leading some national work on standard commissioning. We are working very hard to get to the point where we have standard pricing for spinal services across the whole country. We are one of the areas of specialised commissioning that has been working hard on that. We have had good support from the Department of Health, but each service must be worked through individually.

**Professor Griffiths:** For a lot of the national services there is not the level of detail in the standard data systems to be able to recognise them. You might be commissioning a particular procedure or just the delivery of a particular drug and that is not coded in a way that you can pick it up nationally to work out a cost for it, so in a sense you are stuck; you have to do a local deal with the person who does that process. Maybe we will get it one day but we have not got it so far.

**Ms Moss:** I fear that we are coming again to the term “granularity”. What it means is that sometimes we need bespoke databases to be able to capture this information from the services we commission regionally and at national level. We need stronger support to be able to put those in place and have co-ordination if we are to progress in the way we need to do.

**Mr Murray:** It is crucially important if payment by results is extended to specialised services that it captures the costs involved in delivering high-quality care effectively. That is always a concern for us. If it cannot do so we prefer payment by results not to be applied to specialised services. Equally, we have always been acutely aware of the fact that because it is difficult to control expenditure under payment by results everything outside potentially could come under a squeeze and that includes those specialised services. We see the process of designation as potentially a very important tool in identifying the providers who deliver requisite quality services in these areas and consequently giving an opportunity to capture the costs involved. That is another reason why we are very concerned, notwithstanding the more recent evidence of progress, about the very slow rate of progress in terms of designation. Service specification and standards of care were according to Carter meant to feature within the revision of the national definitions set. That was taken out of the national definitions set and put into designation. It is therefore very concerning that designation has progressed so slowly. That slow rate of progress, which is due partly to lack of resource, has potential knock-on effects in relation to things like payment by results.

**Q275 Chairman:** We received a submission from the Cystic Fibrosis Trust. Getting a tariff for somebody who suffers from cystic fibrosis is no mean task, is it? It affects so many different parts of the body. These are not simple things that can be dealt with rather quickly; they are complex areas.

**Mr Murray:** The Cystic Fibrosis Trust is strongly committed to the development of the tariff on a banded basis.

**Q276 Chairman:** It is still no easy task, committed or not.

**Mr Murray:** It is not.

**Q277 Dr Naysmith:** That is a relatively common condition.

**Professor Griffiths:** As relatively rare conditions go it is one of the more frequent ones.

**Q278 Dr Naysmith:** Ms Evans, how effective is the present system in sharing risks and costs? Some patients require expensive treatment but in relatively small numbers. Does it achieve equity in terms of sharing costs, or not?

**Ms Evans:** I was interested to listen to the concerns of the Specialised Healthcare Alliance which clearly see the fact that SCGs tend not to do risk sharing as a negative factor or perhaps prevents patients from getting treatment. I do not see it in that way. We

might be at a turning point and as more financial pressure comes upon the system PCTs as they sit round the specialised commissioning group table may find risk sharing more appealing than they have in the past. There are two or three reasons they have not felt the need to do it so much since the Carter Review in 2006, some of them simple. One is that in the 2006 reorganisation many PCTs were put together to create bigger ones. The bigger ones felt that they had more critical mass to withstand financial risk and did not necessarily feel the need to risk share. In addition, at that point the health service took the view that there was a need for health authorities to hold contingency funds on behalf of PCTs and for PCTs themselves also to hold bigger reserves than they had previously. The question then is: how many reserves and contingencies do you need? Those were the probable reasons why the risk sharing and pooling arrangements were not immediately taken up; they were not felt to be quite so pressing, but we may see signs of that beginning to come back as the NHS financial settlement is less generous than the very generous amounts it has had in the past two or three years. The other point I pick up is about PCTs taking a decision to withdraw certain treatments from the SCG portfolio and take decisions in their exceptional funding panels. In my experience that tends to happen where the evidence base is not absolutely clear and that is why the PCTs say they will look at it on a one-by-one basis and consider the evidence and be held accountable for it. I cannot give a view for the whole country; it may be there are different positions in different parts of the country.

**Q279 Dr Naysmith:** But you suggest that risk sharing is not taking place all that much?

**Ms Evans:** It probably is not. Ms Moss may have a bigger national picture than I do; mine is not substantial.

**Ms Moss:** Different PCTs and SCGs come up with different views. There is an element about: how do you retain the engagement of a PCT in treating their patients with diabetes well? That may move on renal failure and the need for a specialist service. You need to keep all PCTs engaged in that good proactive treatment of diabetes. That is one area where it is said we need PCTs to take responsibility for their specialist treatments. There is a different area where people may have groupings of inherited disorders in their PCT. Frankly, the allocation formulas do not take account of that. I believe that cost and risk-sharing arrangements are appropriate for PCTs that happen to face those problems. There are different tensions in play and again there is complexity.

**Mr Murray:** It is not the policy of the Specialised Healthcare Alliance; it is the policy of the Department of Health which is set out clearly in its submissions that risk sharing of this kind is a primary function of specialised commissioning. On the basis of the numbers that I quoted earlier with SCGs pooling as little as 1% of their funds by weighted capitation it is self-evidently not happening. Why is it not happening? It arises possibly because they look at an individual service

and with that specialised service, which may be a high-cost one, they do not have many or any patients within their patch and so have no incentive to risk share. Maybe their neighbours do but that is a neighbouring PCT, not them. It is only when you look at a broad spectrum of services where what you gain on swings you lose on roundabouts and vice versa that the incentive for sharing grows. I think this is part of the problem with the pick-and-mix approach to the national definitions set that we have at present. I find it deeply worrying that in Dr Howell's submission he calls into question the very purpose of the national definitions set and says he really does not believe it will have much relevance to the West Midlands in future. That is a pretty worrying attitude when so much time and effort has been invested in the revision of the national definitions set.

**Q280 Dr Naysmith:** Do you believe patients are suffering because of it?

**Mr Murray:** I refer to the Tadworth example, the Spinal Injuries Association and the question of deep brain stimulation. I am aware of other anecdotal examples. There is clear evidence that in some cases there is a problem.

**Q281 Dr Naysmith:** Ms Evans, you referred to the developing financial climate. Do you think it may have a deleterious effect on the services for rare conditions? We really do not know what will happen to the National Health Service apart from the fact it will be protected.

**Ms Evans:** We know that we will not continue to have the very generous levels of funding. We have always known that because the intention was to achieve a standard equivalent to European levels. We know that it is at least plateauing. There will be tremendous pressure on the NHS to look at ways to make patient pathways more effective. There is a good deal of scope for us to do that and that probably applies as much to specialised services as to PCT commissioning as a whole. There are a number of ways in which we run and deliver healthcare at the moment that need more work, of which outpatient services is a good example. People have talked about length of stay. Reference has been made to trim points and long lengths of stay and whether they are good for people or we can organise care more effectively. There will be tremendous pressure on the system and a lot of that will be good and will stimulate innovation and change. It is our responsibility as specialised commissioning groups and PCTs to look hard at issues of equity and ensure that the people who have the specialised conditions are not being unfairly penalised because of all the difficulties we have talked about today: they are less able to be counted, managed and all the rest of it.

**Q282 Dr Taylor:** I turn to Ms Moss and Professor Griffiths and deal with the very rare diseases. For my information, do the definitions roughly fit with orphan and ultra-orphan drugs?

**Professor Griffiths:** Yes. We work on fewer than 400 cases. I could take you through some of the arithmetic which suggests that that is about the right number. It could be even less but certainly not more than that.

**Q283 Dr Taylor:** When you say it includes heart and lung transplantation is that just the combined transplantations or both?

**Professor Griffiths:** Both together or whatever.

**Q284 Dr Taylor:** What are the real challenges for commissioning healthcare for this group of people?

**Professor Griffiths:** Essentially, there are two or three issues. One is that some things are very expensive. That comes down to the cost of developing new drugs. If it costs £1 billion to develop a new drug the UK's population is probably 5% or less of the total world population that might be able to afford it. The patent life is probably five to 10 years. You can divide it up and work out how much money the company must recover to pay back that £1 billion. Then you divide by the number of patients. Once you get past 400 patients you are down to a figure under £20,000, so that is in the same ballpark as everybody else. But up in the very rare region the thing is bound to cost more than NICE would normally say was cost effective. You must either say to those patients to forget it and they might as well go hang or you need a special mechanism to deal with things that are that rare. In a sense that is what the NCG does. The second thing is about expertise. Almost anybody can stand up and say he can treat some condition that nobody has ever heard of, but you need a way to make sure that is believable. We have some quite skilled medical advisers, plus we have the royal colleges and various other stakeholders on the committee. When we say that we will designate that person the idea is that everybody else can believe that person really does know what to do. By designating it in effect you create managerial pressure that only those hospitals will do it because the rest will not be paid. You have clinical and managerial pressures lined up in the same direction to say that is where you go for this condition. That means you can publicise it and you hope to get the referrals so patients get to it quickly. Those two things work reasonably well together. The last issue one is left with is gaming. Will the trust load overheads into that one and not the other, charge for something twice or whatever? Although people criticise the current arrangements I think that having the NSCG able to crawl all over what the SCG does allows us to say that, yes, they drive just as hard a bargain at that level as we do at local level and that at least gives everybody confidence. If we go back to when NSCG was inside the Department of Health—I chaired it then—there was a definite feeling in the health service that somehow those really rare things got a free ride and loads of money were chucked at them. I do not believe it was true but because nobody could scrutinise and challenge it that was what they thought. We have gone some way to being able to break that. There is a risk in the new proposals that that notion will re-emerge unless we believe that the

people on the new committee are able to challenge and drive just as hard a bargain on behalf of everybody else. I will not be chairman by then; I shall be out of it, but it has to be as good as it is now.

**Q285 Dr Taylor:** We have NSCT as well as NSCG.

**Professor Griffiths:** The “T” stands for “Team”.

**Ms Moss:** It is the team of clinicians and managers who commission the 50-plus services at national level.

**Ms Evans:** It is Ms Moss’s team.

**Q286 Dr Taylor:** I have gathered that. They do the work for the NSCG?

**Ms Moss:** We do; we are the legs on the ground going round visiting the services and working with the hospitals to set them up and monitor those services and driving a bargain.

**Q287 Dr Taylor:** We are told that you have the presence of the larger royal colleges. Are they pretty good at turning up at these meetings?

**Ms Evans:** They are.

**Professor Griffiths:** The surgeons and physicians usually have a job and so they send deputies; the other three normally send their presidents. They are very good. In the past I was president of a faculty in an academy and I have a bit of leverage in persuading them to come. If we really want them to be there for particular things I write to them individually or ring them and most of them turn up.

**Q288 Dr Naysmith:** How are therapies assessed for clinical and cost-effectiveness? What role does NICE play in this?

**Professor Griffiths:** NICE does not. There are some things that we have asked NICE to look at but it just puts it back to us, saying that it is too rare for it to bother with it. We collaborate and things are discussed, but it is not easy. Obviously, where you have something that is very rare it is difficult to organise a controlled trial because the numbers are too small. It must be international and so forth. You have to look at a range of evidence. I believe that is where the colleges are very useful. It means that you can put it in front of the colleges. Sometimes they will pass it through into their committee structure. You get the best opinion you can. We would press for trials wherever possible. In some cases we have funded services in order that a trial can be conducted. Referring to ECMO which was in the news during the height of the ‘flu scare, we funded the service for a while in order that a trial could be completed because we did not feel confident in saying that it definitely worked until we had a trial. We try to get the best evidence we can. Take the service in the south west where a chap glues an acrylic lens onto a piece of tooth and then transplants it into the eye. He has done only about 10. It will take a while before you get a trial going, but the fact is that patients who were blind can now see in 90% of cases, so you believe it. You do the best you can.

**Q289 Dr Naysmith:** Does cost-effectiveness come into it at all?

**Professor Griffiths:** Some but not all of these things will be expensive. If you average the whole lot they would probably come in under the threshold, but some things are very expensive. I think you can do some modelling to estimate where drug companies are really over-charging, and some are. The trouble is that the way the drug costs are done in this country is through the PPRS which caps profit rather than price, so sometimes we do not challenge one or two companies that I think are overdoing it. You could put in place that sort of mechanism. There would be a case for working with the rest of the EU perhaps to try to get tighter prices on some of these things, but the total amount you gain from it will not be a hill of beans compared with the total NHS drug budget. Some people may say that it will save only £30 million or £40 million, so why bother? If money gets really tight I imagine that that issue would re-emerge.

**Q290 Dr Naysmith:** How is the final decision on whether to buy or not buy a very expensive orphan drug taken?

**Professor Griffiths:** At the moment we thrash it out in the NCG and come to a conclusion on whether or not it is a good idea. We then propose that to the NSCG—the folk like Ms Evans—and they argue about it and gets their finance directors to crawl all over it. Some of it is chucked out and we end up with a bunch of things which people say look like a good idea. Those are then commissioned.

**Q291 Dr Naysmith:** How long can that take?

**Professor Griffiths:** We have an annual cycle and we get them done in the year.

**Ms Moss:** It has worked very well for the new proposals around services that have come up. We have worked very well with the finance and public health directors and SCGs to agree whether it should be commissioned nationally or should remain regionally commissioned. Usually they are not co-ordinated at all. In quite a number of cases this year we knew that the NHS was wasting more money treating patients badly than getting a proper service set up where they could be diagnosed, assessed, given the right treatment and sorted. That is very often the storyline behind our services. Infrequently new technologies will emerge which have usually gone to PCT exception committees and different views have been taken. They are the ones that involve high-cost services. Those are much more difficult areas. We have had more difficulty with the system in coming to a consistent view on patients, and that applies also to ministers.

**Q292 Dr Naysmith:** When a new and sometimes very expensive therapy is being developed for a rare condition how is the patient and the community best served in the interim? Professor Griffiths, you probably have an example that is apposite: Eculizumab.

**Professor Griffiths:** It depends a little on how the thing has developed. There are two standard patterns. One is where a particular clinician or a team over a period of time, perhaps because they have done research on it, has developed a new service. They gradually get to the point where their trust says that they keep bringing in these terribly expensive patients and they cannot get the money back, or it looks like they are about to retire and perhaps they should recruit somebody else with that skillset. They then say that if they can get it nationally commissioned they can stabilise the position. There is an argument as to whether it does or does not require it and whether or not they are doing something clever and that goes through all the process. Those are reasonably straightforward because they develop over quite a period of time. The other example is something like Eculizumab where somebody invents a new drug and discovers almost out of the blue that it works on some condition he has not expected. Eculizumab was thought originally to be good for asthma and it turns out to be terrific for an extremely rare condition of which very few have heard. Surprisingly, they did a trial and our people were in touch with the clinicians who conducted it. Everybody thought it would cost about £30,000 a year, which is expensive but not exorbitant. At the end of the trial they said that it would be £300,000 per patient per year and the patient would need to take it for quite a while, possibly for ever. Some may get better but because it has never existed before we do not know. Suddenly you have problem because that looks like it is off the clock. We spent a long time discussing that. It was then discussed by the NSCG. Between the end of the trial and our making a decision individual patients were thrown at individual PCTs or SCGs and there was debate within the individual regions, so there was a period of uncertainty. Some regions said no, some yes and so forth. Eventually we arrived at a common position and it went up to the minister. The minister decided to pay for it but we thought it was a bit on the dear side. We hoped that perhaps a different bargain would be struck. However, the decision was made. It took about six months to chunter through that process. That was the extreme end of things; it was a lot more than anybody expected. On modelling grounds one could argue that they are charging more than is reasonable. I have sent my arithmetic to your clerk. There are grounds for challenging it, but you have to make a decision as to whether or not you say to these patients that you are sorry but you will not pay for this in the UK. I think you can insist on the numbers in terms of treatment being as close as possible to one in one; in other words, it works every time you use it. If something works only one out of five times or gives only a small gain we would probably say it is not worth it at those prices. But the issue is: how do you defend that decision? That is where the difficult process is at the moment. That was discussed when Carter came along. We need to make sure that those processes are robust, can withstand challenge and so forth. I have said in my paper that I am not completely happy with some of the things in the new

consultation proposed, but we have to be able to say that occasionally there are very small numbers of patients where to pay over the odds is justified, but we need a mechanism to be able to argue about price and properly assess effectiveness. We have most of it in place but there are a few bits left to deal with.

**Q293 Dr Taylor:** Moving on to consultation, the title is Strengthening National Commissioning. Ms Moss, can you tell us how it is going to do it before we get Professor Griffiths' objections to it?

**Ms Moss:** It is a Department of Health consultation as a team decision with the NHS but we have worked with the department on it. National commissioning is pretty strong and as a country we have some very specialist services that do a fantastic job. The nature of the NHS means that we can focus on getting these services into very few places in the country, get that expertise to flourish and control the entry of new services and not let them go everywhere and increase cost everywhere. It is a good story. The bit on which we have had a problem is where new technologies come in that may be pretty expensive and there is a need for consistent decisions for patients, not a postcode lottery for them. There are difficult and complex decisions to be made. Carter set up a set of arrangements; he also said we needed to review them. With the benefit of hindsight if you were trying to get a consistent set of decisions you would not set up a group comprising largely clinicians, then put the proposals to a group almost entirely composed of chief executives of PCTs and then put the proposals to SHAs and hope to get something clear and concise out of it. Essentially, the proposals are to bring the different stakeholders into a room together and thrash out those proposals, taking into account all of the different issues that we need to take into account: the costs, the clinical effectiveness, the benefits that that gives to patients who often have very painful and awful conditions, societal benefits and a whole range of other issues. One looks at those in the round rather than different aspects in different rooms and then makes recommendations and puts them to ministers on behalf of patients. That is our aim and that is the proposal within the consultation. The oversight of NSCG about whether you get good value for money in the way you commission is there and I will carry on accounting to them; we assure them that we will do that. But it is really about the new services that will come into national commissioning, in particular new technologies. Let us have a good, effective way to get a quick decision on whether or not we fund these as a country. It will always be difficult and painful, but at the moment we do not even have a robust system. If we felt we needed to say no we probably do not have a sufficient robust system to withstand scrutiny.

**Q294 Dr Taylor:** To say no to the drug for PNH would have been incredibly difficult. The aims sound pretty good. What are the criticisms?

**Professor Griffiths:** I do not have objections; they are slight anxieties if you like. First, I am not convinced that you need to change the system, but this is partly because I have sat through so many reorganisations

I have lost count. I think the knee-jerk reaction every time a problem comes up that we should redesign the committees is total rubbish. It has not made any difference each time we have done it. Why not just say to these two committees that they have to come up with a clear answer and it must be judicial review-proof? They all understand rules, so they should do it properly. My second point may be modified by the way the circular eventually comes out and is implemented. I do not believe it is sensible to have the minister appoint everybody rather than having them as representatives as they are at the moment. I think all the stakeholders should be there. I agree with Ms Moss that it is quite useful if you have everybody in the same room. I am glad that I shall not be chairing the meetings. Get all of them there but ensure that their stakeholders know why they are there and believe that these people will not go native when they turn up at the NSCG meeting and take the soft option by saying yes to something they should not agree to. By all means let the minister appoint the chair but have the committee clearly representative of the stakeholders who need to be there with a process that guarantees that when they turn up they know to whom they are accountable. I think that will give it a lot more power and will maintain the basis of trust between national commissioning and the other levels which we have spent the past two years trying to create. Having chaired NSCG and been part of the public health community since I was president of a faculty I know what people thought about in NSCG. We have done a lot of work to try to put that right and build that kind of trust. There is a risk that it would be thrown away by these processes. I already sense some of that distrust turning up in opinions that I tap outside. It is not insoluble; you can get it right by the implementation even if you go ahead with this, but you need to get that right.

**Ms Moss:** We are out to consultation at the moment and we hope everybody writes in to say they think it is a very good idea that the presidents of the royal colleges continue to be part of that committee and that the PCTs that chair the SCGs are part of that committee. Some of the most expert PCT chief executives in the country chair the SCG committees. I believe that would be perfectly appropriate and that we have an appointments panel to get the lay representatives and the like. One hopes that will come out of the consultation.

**Q295 Dr Taylor:** So, the presidents of the royal colleges and the best chief executives should remain there?

**Ms Moss:** I think that will be one of the results of consultation.

**Professor Griffiths:** We need lay members to be appointed; we also need patients. They are not the same. Clearly, patients have a vested interest in having the service. Somebody else has to represent the opportunity cost. If you decide to pay for some of these expensive treatments you are taking money away from other services. They may be happy enough with you because we all feel that nobody should be left out, but we need all those balances. I

am sure it is better to have a clear process of appointment that does not just disappear somewhere inside Whitehall.

**Mr Murray:** Ultimately, there is a political dimension to that which is why ministerial involvement remains important. What kind of society do we want? Do we want to help these people in dire need at the extreme or do we want to follow a rigorous purely bureaucratic approach? We feel very strongly that there should be an involvement for that reason. We welcome the proposals. We have not yet finalised our thinking but we believe that greater robustness in the arrangements will be no bad thing.

**Q296 Sandra Gidley:** Ms Evans, senior officials from the department told us that commissioning had not really started to work until two years ago. Do you agree with that statement?

**Ms Evans:** I read that evidence with interest. Whilst I do not think it is fair to say that commissioning did not start until two or three years ago today we have talked a lot about ways in which the health service has been developing, for example payment by results, programme budgeting approaches, developing sophisticated approaches to health needs analysis, developing and understanding social marketing and how to target particular groups within the population with health messages. A lot of these disciplines and approaches have been developing over time. Over the past, say, three years we have seen a real acceleration of what commissioning can achieve because we have PCTs with capability, skills and an appetite for innovation. We have seen PCTs that are increasingly close to their local authorities and communities, so they get a really rich source of partnership and ways to bring about change. It is that combination of things that has allowed us to see a lot of improvements. In some of the evidence the Committee has received I was encouraged to see PCTs giving you very clear examples of their achievements for their populations. It has really taken off as a result of being able to use lots of different tools and approaches.

**Q297 Sandra Gidley:** Has commissioning started to work properly now or do you still have quite a way to go?

**Ms Evans:** It is still work in progress. The first year of World-Class Commissioning results has showed a real spread against those competency and outcome measures. The important thing is about distance travelled. As long as the next time round we can show we are travelling a good distance and improving on what we can achieve for communities, populations and people then we are delivering what we need to deliver. As we go into the next period, which we know will be subject to considerable financial pressure, there will be management cost restraints. It will be all about PCTs working together to make their money go further in producing capability and levers for change.

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14 January 2010 Professor Rod Griffiths, Mr John Murray, Ms Deborah Evans and Ms Teresa Moss

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**Q298 Dr Naysmith:** Wearing your PCT chief executive hat—it is nothing to do with specialised commissioning—obviously from what you have said already you believe that World-Class Commissioning is a good thing. Is there any real evidence that it has improved patient care? Can you give any examples of its impact on the work of NHS Bristol?

**Ms Evans:** The issue as to whether it has improved patient care is a big one. In NHS Bristol our governance committee reviews what we are doing on health improvement; it reviews what we are doing on commissioning health services, and it looks at how our organisation is working. In that committee we look at all the national standards and service frameworks, so we look at the national service framework for mental health which sets out all the quality standards in mental health and looks at how we are doing. We look at the stroke care pathway to see how we are doing against that. Dementia services are in the news today. We look at the recent review conducted by our health authority to see whether we are making improvements. I believe we can demonstrate that we are making improvements in health service delivery and the parts in the pathway that go back to prevention, early intervention and preventing people becoming ill in the first place. For World-Class Commissioning we chose 10 outcomes of which eight were oriented towards the health improvement end. As to alcohol misuse, in our PCT and in the core cities we are campaigning for a minimum unit price because we believe that will have a big impact. We were delighted with this Committee's work on it. Therefore, we are concerned with alcohol, smoking, teenage pregnancy and all the things you would expect in a

city. It is difficult to measure progress on that. We believe we are making progress on those matters. We also believe we are making broad progress on the commissioning of health services.

**Q299 Dr Naysmith:** Has it helped with the commissioning of mental health services in Bristol? You and I both know that there have been a few problems there in the past.

**Ms Evans:** I can say a number of things about that. We have an annual assessment against a whole range of indicators about how we are doing on mental health services. I am pleased to say that we have improved our performance. We have a green rating for 20 indicators whereas a year ago we had only seven. There has been a broad improvement. This is an interesting example of the use of the different tools available to us. The PCT recently went out to tender; it invited people to bid to provide a city-wide primary mental health service. This is the first time we have had a city-wide primary mental health service. It is part of a government initiative about improving access to psychological therapy. The organisation that won that competitive process was a respected national voluntary organisation called Turning Point. This is an example of being quite strategic about where you want to open up the market to bring in new blood and run a different model of service from that we have run in the health service before to be very responsive to local communities, particularly those with different needs. It is a good example of the use of a whole range of commissioning skills in order to make an improvement for people.

**Chairman:** I thank all four witnesses very much for coming along to help us with our inquiry.

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## Thursday 28 January 2010

Members present

Charlotte Atkins

Mr Peter Bone  
Sandra Gidley  
Dr Doug Naysmith

Mr Lee Scott  
Dr Howard Stoate  
Dr Richard Taylor

In the absence of the Chairman, Dr Naysmith was called to the Chair

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*Witnesses:* **Mr John Parkes**, Chief Executive NHS Northamptonshire, and **Ms Julie Garbutt**, Chief Executive, NHS Norfolk, gave evidence.

**Dr Naysmith:** Good morning and welcome to the House of Commons Health Select Committee. I am obviously not Kevin Barron. Kevin is unfortunately unable to be with us this morning. He has got another engagement.

**Mr Bone:** On a point of order, Dr Naysmith, I would just to let you know for the record that I know Mr Parkes. He is my Chief Executive and we have crossed swords on a number of occasions.

**Q300 Dr Naysmith:** Just for the record could I ask you to say who you are and who you represent this morning?

**Mr Parkes:** Good morning. I am John Parkes and I am Chief Executive of NHS Northamptonshire.

**Ms Garbutt:** Good morning. I am Julie Garbutt. I am Chief Executive of NHS Norfolk.

**Q301 Dr Naysmith:** What do you understand by commissioning? The rub is that it has to be in one sentence, please.

**Mr Parkes:** For me it is using the resource that I have been allocated to best effect and to meet the needs of the population whilst reducing inequalities.

**Ms Garbutt:** I would agree with that. I think it is about assessing need and then looking at how I meet that need within the budget that is available to me.

**Q302 Dr Naysmith:** What is the role of commissioners in this? What do commissioners have to do to fulfil this function?

**Mr Parkes:** Within Northamptonshire what we have been trying to do is better understand not just that need at a total population level, ie, for the 700,000 people, but to then understand the needs of individuals and then what risks or lifestyle choices are those individuals making and how can we then support them into a position where they will live longer and have better lives as a consequence.

**Q303 Dr Naysmith:** Do you agree with that?

**Ms Garbutt:** I think for me commissioning is about ensuring that we have health improvement and good services available for local people. I think the role of the PCT is to act as a system co-ordinator to bring all of the organisations together within Norfolk in my case and ensure that we work together as providers and commissioners to deliver that health improvement and those better services.

**Q304 Dr Naysmith:** Is the phrase “the role of commissioners” the same as “the role of PCTs” or is there more in a PCT than just commissioning?

**Ms Garbutt:** From my perspective clearly commissioning is a large part of what a PCT does, but I think a PCT also does have that system leadership role in which it is co-ordinating and bringing together partners. I think it also has a public health role in terms of health improvement and reducing health inequalities.

**Q305 Dr Naysmith:** Does it not have to commission public health services as well as acute services?

**Ms Garbutt:** In some respects we directly provide public health services, and increasingly we are commissioning them from others.

**Q306 Dr Naysmith:** John, do you want to add anything to that?

**Mr Parkes:** All I was going to say was, because I used to be a chief exec in hospitals, that I think when you are a chief exec at a hospital you are running an organisation, but as a chief exec of a commissioning organisation you are running a system.

**Q307 Dr Naysmith:** The Health Service has been trying to commission and do commissioning for almost 20 years since the purchaser/provider split began around 1991, yet even the Department of Health admits, and it has done in evidence to us, that it has been done poorly and claims it has only really been given the status it deserves in the last couple of years. Why has the commissioning role been so weak for so long?

**Mr Parkes:** For my particular primary care trust, when we were created just over three years ago I do not think at that time we had the skills necessary to be a really good, effective commissioner, and we have gone down a deliberate path to try and either buy in those skills or develop those skills. I can look back over the last three years and see that we used to, in effect, spend money and now we are much more investing money and looking for that return on investment but still working in partnership with clinical colleagues.

**Q308 Dr Naysmith:** It is interesting that you talk about skills in PCTs. What skills do PCTs lack?

**Mr Parkes:** Certainly three years ago I would not have had the ability to do effective social marketing, so how I influence the public to make different

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lifestyle choices. I probably would not have had information or information systems that allowed me to look explicitly at where people live and try and then understand what individual risks they were facing as an individual. We use actuaries now to look at what has happened in order to project forward trends so that we can begin to think through in a much more measured way what is going to be not just the need today but the need tomorrow and how can we plan to meet those needs. Those skills may have been there in part previously but they certainly were not as developed as I would be able to show you today.

**Q309 Dr Naysmith:** What skills do you lack now that you would like to have?

**Mr Parkes:** Perhaps not a skill. I would really like to have access to the data that, for example, is held within primary care and I would like to have access to that data to put it alongside the hospital data and social care data because we have got the ability now, if we had all of that data together, to then share it back to, for example, GPs, "Here is somebody with more than one long-term condition. Here is the particular risk for that individual. Here is how that risk can be managed", or, "Here is somebody for whom a prescription has been prescribed, never been filled, not being taken at the right frequency". We could use that information in a joined-up way.

**Q310 Dr Naysmith:** That is not happening at the moment; is that what you are saying?

**Mr Parkes:** Certainly access to the primary care data is done very much on a voluntary basis and I think my colleagues in primary care are worried about things such as patient confidentiality. I really do not want to break patient confidentiality but I want to be able to bring that data together to support really good quality care and support clinicians at the front line.

**Q311 Dr Naysmith:** Julie, do you have anything to add?

**Ms Garbutt:** I would very much endorse what John has said. Reflecting on where you started with your question about we have been doing it since 1991 and why has it not worked, my reflection would be that I was working in the NHS at that point and I was working in a district health authority on what was then the purchasing and planning side, and I think there is a lot of resonance with that idea: it was purchasing. I think there was the wrong focus in the beginning and it was very much about trying to have contracts and trying to be very focused on what do you buy. What we did not have at the time, though, were any of the levers, any of the tools that we now have, and whilst I think there are many things wrong with Payment by Results, the idea of having a tariff did allow us as commissioners to start looking at moving services away from areas where they were not working to areas where we could get a better quality of care. I can remember when I was director of contracting taking an awfully long time to move some ophthalmology work from one hospital to another because I was arguing about marginal costs

and the fact that I needed more than marginal costs to fund that shift. With tariff it is perfectly possible to define a service, allocate the sum of money and then test the providers who are out there to get the best possible service for local people. I think we now have a lot of different tools and techniques that allow us to be true commissioners and we spend far more time analysing need to really understand our population, not just at that whole population level but in particular pockets, and to tailor services very specifically to the needs of patients. We did not have a sophisticated approach in the nineties because we did not have the tools to enable us to be that way.

**Dr Naysmith:** We will move on to investigate some more of these things in more detail now.

**Q312 Mr Scott:** Could you tell me what people the PCT employ in their main roles and what they do?

**Ms Garbutt:** NHS Norfolk employs 400 staff or thereabouts across a range of functions. They fall into the public health function. We have strategists and commissioners. We have finance staff, obviously, to manage the resources as they flow out to providers and within our own organisation. We have clinical leadership roles, we have a medical directorate and we have a chief nurse directorate. We commission across all of the various care groups so we have people who lead on commissioning for children's services, sexual health services, planned and unplanned care, and then we have support staff who do contracting, who do relationship management with our providers. All of the staff are commissioners or they are supporting commissioning in some way.

**Q313 Mr Scott:** John, is that the same for you?

**Mr Parkes:** Very similar. We have 3,000 staff but the majority of those, something like 2,700, are what we would refer to as our provider arm, providing services such as district nursing and health visiting. The policy at the moment is shifting away from a mixed commissioning provider model. If you went to being a pure commissioner, the number would drop more to 300 and my internal structure would be very similar to Julie's.

**Q314 Mr Scott:** And in the same way they are doing the commissioning?

**Mr Parkes:** Yes, absolutely. We are probably fixated on public health, spotting the health need, then making sure that we are securing absolute best practice in the way that that need is being met. Can I give an example?

**Q315 Mr Scott:** Yes, please do.

**Mr Parkes:** We looked, for example, at what we were doing with diabetes and compared our spend and population need with other PCTs and saw that our spend was high. We then looked at the evidence for where are the most effective interventions on a care pathway for a diabetic patient and put a process in place where we worked closely with our primary care and secondary care clinicians and as a result of that we have come up with absolute knowledge around,

“Here are the things that will make a real difference”. We have improved the quality but it has saved us £1.5 million.

**Q316 Mr Scott:** With no loss of front-line services?

**Mr Parkes:** With absolutely no loss of front-line services. Predominantly the saving came as a result of changes to clinical practice where some expensive analogue insulins were being routinely prescribed and once we made that information available to clinicians and said that there were other ways of doing things they were open to saying, “Let us look at this together”, and we did look at it and we involved patients and patient groups as well. This was not us being an aggressive commissioner; this was us being quite a supportive change initiator and that has resulted in the PCT saving money but also in us reinvesting some of that money into diabetes so that the clinicians can see that there is an absolute benefit in participating in that process. I like that example because it allowed us to save money without in any way compromising clinical care.

**Q317 Mr Scott:** Is there part of the PCT’s work that you spend a lot of time doing and you would rather not, and if you had a free hand what would you do more of?

**Ms Garbutt:** I think I would build on the comment that John made about the provider side of PCTs. I gave you the information about the commissioning wing in terms of number of staff. We have somewhere in the region of 3,000 staff who are employed delivering services in the community. It is such an important aspect of our push forward in terms of integrated services, more personalised services, but it is very difficult to focus on being a commissioner and a provider at the same time, and, of course, we have been on a journey, as all PCTs have, to look at divesting ourselves of that responsibility. Personally I am very keen that we make swift progress on that so that we can get on with commissioning, but particularly so that we can get on with being commissioners of a new style of community service which is part of an integrated service which is designed to help us move care out of our hospitals and into our local communities. I would like to do far less of that because I think other people are much better placed to do it. I want to be commissioning that service, not delivering it.

**Ms Garbutt:** I agree with the provider comment. Certainly within my PCT and across, for example, the East Midlands we still have some administrative functions, some pay and ration type functions, for paying or remunerating GPs and that type of thing, and I think as we move forward more of us will be saying, in terms of some of these back office functions, do we need to be doing them 152 times across the country or what is the scope for bringing some of those functions together, and I would be very keen to progress that because again it is a way of making the system more efficient without in any way compromising clinical care. The other area I think we have got to move into is to be more explicit around setting standards and setting standards around the particular pathways and the

interventions on a pathway that we have agreed with clinicians that we know will absolutely make a difference, managing some of that clinical variation rather than just allowing it to happen, understanding it, agreeing what the right pathway is, and then having a discipline that says that where you have got variation is that innovation or is it just variation, and having a mechanism that makes sure we are using resource to best effect to benefit patients. I do not do enough of that at the moment.

**Q318 Dr Naysmith:** Just before we leave that and go on to Howard, Julie, you were talking about divesting yourself of provider functions. Is there still a bit of pressure from the top to do that because it was quite controversial at the time of the reorganisation?

**Ms Garbutt:** It is still policy, I believe, to see a separation of commissioning and provision. However, in the latest guidance we have we are being asked as PCTs to firm up our plans by the end of March in terms of what we are going to do with our provider services. There is a range of options there, one of which is to keep them. However, I think the view is that there would have to be a very good, clear and strong rationale for why it made sense for a primary care trust, whose essential role is to be a commissioner and a public health agent, to want to provide services. In Norfolk we have what I would call quite an underdeveloped market in as much as we have a very large single teaching foundation trust, we have a smaller district general hospital, one mental health trust and then a plethora of independent contractors, primary care contractors and voluntary sector organisations. It can be quite difficult in a market like that, which is fairly enclosed, to have conversations that allow you to have some contestability in order to allow you to drive up quality. For us there is a big incentive to move our provider arm into a community foundation trust model. That is not necessarily one of the most favoured models nationally but, as a very large provider arm, we believe that by setting our provider services as a community foundation trust they will be able to help us create what we call a care brokerage model. We are very focused on the patient as an individual, the need to have more personalised care for individuals that is crafted to meet their needs. More and more people in Norfolk are elderly. They have multiple conditions, long-term conditions. They need very specific packages that reflect their needs. To do that we need to have an organisation or organisations in our system that we can contract with to say, “We would like you to provide 25,000 packages of care for the diabetic sufferers in Norfolk next year”, and for them to have the ability to put together those individual packages of care for those patients, and that is what we would term as care brokerage. I need that organisation to have that ability to drive those services that are personalised and enable us to have ways of putting services that are currently in hospitals into a community setting, so it is a very important thing for us.

**Charlotte Atkins:** Do we really want another reorganisation? It was only a few years ago we had the mergers of PCTs and we were told by doctors and hospitals, "Please: no more reorganisations", and now you are saying that you really welcome floating off the provider arm. We were told that you really do not want another reorganisation and I would have thought PCTs generally do not want yet another reorganisation, and in such a tight timeframe, by the end of March.

**Dr Naysmith:** Just before you answer that Richard has a quick question and then we must move on.

**Q319 Dr Taylor:** So you probably would not agree with a witness at a previous session who said that PCTs, he thought, should concentrate on providing and divest the commissioning role, exactly the opposite way round that you are saying?

**Ms Garbutt:** I think if you were to concentrate on providing and divest commissioning you would no longer be a primary care trust; you would be something else. I think we are probably agreeing but from a different perspective. I think there has to be a focus on being a commissioner, and I do agree with you that I do not want to see massive reorganisation of PCTs. I think that would be so unhelpful with the challenges we are facing with the economic climate and needing to drive World Class Commissioning, but I do need a different future for my provider arm. That element of it I think is advantageous to the Norfolk system in terms of moving us forward to deliver our strategy, and we have to do something with our provider services; they cannot stay as they are.

**Q320 Dr Stoate:** It all sounds rather wonderful, what you were saying just now. I am just rather concerned that it might sound too wonderful. We have got a report that was done for us by the National Audit Office, which was a telephone survey of PCTs, which said that in fact it is so good that 95% of commissioners thought that commissioning was going well and 82% believed it was going very well, which, of course, is absolutely splendid, and the Operating Framework of the NHS has called for "bold, capable commissioners", again, excellent stuff, and you have told us that you have developed these skills over the last few years and to really go with it. How come therefore that The King's Fund found that 80% of practice-based commissioners in particular found that they lacked some or all of the necessary skills? There does seem to be a bit of a difference here, that you all think it is going to be wonderful, and yet 80% of practice-based commissioners, so say The King's Fund, lack the skills they need to do the job.

**Mr Parkes:** I absolutely believe that we are on a journey and different parts of the country may be at a different stage on the journey, but even with where I believe we have made progress we absolutely are not at the end point. There are some things that we need to be doing differently and some things that we need to be doing better, so I can certainly empathise with commissioners saying, "We believe we have made progress", but others saying—

**Q321 Dr Stoate:** They did not say that. They said that 95% believe it is going well or very well. That is in some ways an alarming figure, if 95% of them believe it is that good and yet The King's Fund finds that 80% probably lack the right skills. Surely there is something going wrong.

**Mr Parkes:** Practice-based commissioning is again in a slightly different position because we have got a PBC consortium that covers 98% of the population in Northamptonshire and we find that by us working with them they work with GPs, they get the views from primary care, they are able to look at changing things, so when we said, "The population are saying to us, 'We would like greater choice in terms of where we die, in terms of end of life'", it was the practice-based commissioning consortium that worked with their practice nurses and they came up with a model to improve the choice for the people of Northamptonshire, and they absolutely feel that they have got to a good position and, as NHS Northamptonshire, I am grateful to them for their help. They have engaged with individual practices to win hearts and minds around delivering the necessary change.

**Q322 Dr Stoate:** It all sounds wonderful. It is just that I am concerned whether it is really on the ground as wonderful as that, given that The King's Fund has picked up such disparity between the figures that they found from commissioners and the figures that the National Audit Office found by a telephone survey.

**Ms Garbutt:** I am inclined to say I believe both things are true. That might sound a bit strange but the reason I think that is that there is a level of what I would call strategic commissioning which I think is what PCTs are doing now, which is quite large-scale commissioning. I suppose an example of that from my area would be the transformation of the stroke care pathway that we led as a strategic commission and changed significantly the quality of services that were available to local people. Practice-based commissioning I would call a local operational type of commissioning, and certainly in Norfolk we have struggled. It has been more of a struggle to get that moving forward as we would like and as our practice-based commissioners would like. We have made some real progress over the last year and we have been working with external consultants to really help with the organisational development, so I can see that if somebody specifically asked NHS Norfolk about that, we would cite some really exciting and positive things at NHS Norfolk level but we would also recognise that our practice-based commissioners would say, "Actually, we still have quite a long way to go". I think it is real that both those things could be true at the same time. I think what is really exciting about the last few years is the ability we have had as PCTs to start acquiring skills, capacity capability to do commissioning as we have always wanted to do it so that it has real impact on the services that people will experience, and I think that is why there has been such a degree of positivity in that feedback, because it feels tangible; it is almost within our grasp to be these World Class

commissioners if we did not have massive reorganisation. I do think there has to be some stability to allow us to get on with that journey.

**Q323 Mr Bone:** In a nationalised, state-run health service employing 1.4 million people is the truth of the matter not that bureaucrats grow and grow and empires are built up? Are PCTs commissioners not exactly that, just a lot of ever-increasing, overpaid pen-pushers, and is not Government recognising this by demanding a 15% cut next year in commissioners, going up to 30% over four years? If we have a different government after 6 May, will it not be even tougher because the incoming government will want even more cuts in commissioners? How is this going to affect commissioning? Can you just cut 15%, or 30%? What will that equate to—11,400 commissioners are made redundant over the next few years? What effect is that going to have on commissioning, or is the initial analysis right?

**Mr Parkes:** I think that, because of the economic situation we are having, dealing with my overhead cost could never be exempt from somebody saying, “You need to reduce it”. I have no philosophical problem with reducing mine by 30% over a four-year period. That is not to say that we are 30% inefficient at the moment, but there will be scope for us to be doing more things once in the East Midlands rather than nine times because there are nine PCTs. We can get efficiency through that way. I think some of our IT and IT systems will give us added benefit and insight into areas where we can again use technology to become more efficient as well. The one thing I have done and would want to carry on doing is that we use external management consultants or we employ an external company on a permanent basis, so, rather than me always having my people doing something, I have found that the opportunity to buy those services in rather than to always grow them internally—and I have tried growing them internally—will probably lead me to a position where I may well reduce more than 30% but would want to carry on using external companies to help me be even more efficient as a commissioner.

**Ms Garbutt:** I would absolutely endorse what John said. I think it would be unreasonable to expect that somehow commissioning resources or management costs could be exempt from needing to be trimmed back quite considerably when you consider the economic climate that we are in. I think that does present PCTs with something of a challenge. Again, I would agree that the sorts of areas that John has outlined are the areas that we will be looking at. It is important that where we have developed skills, capacity and capability, we do not lose that, but there are lots of different ways that we can share to enable that skill and capacity to be available for more PCTs. My concern is that with a level of 30%, particularly if that is seen to be taken out quickly, and John referred to four years but certainly within my SHA area there is talk of trying to drag considerable amounts of that out in years one and two, there is a danger that you destabilise the capacity and capability to the extent that commissioners cannot do what they need to do, and

commissioning is going to be the way that we go through the next three or four years and work with a vastly reduced resource and still deliver quality, productivity and good services for patients. I think there is going to be a real delicate balancing act to make sure that we do deliver efficiencies in our management resources because we must, but also to make sure that we keep that skill base and that capacity and capability. I think John is right: some of that is how you buy that in rather than investing in full-time resources in your own organisation.

**Q324 Mr Bone:** Julie, you just mentioned SHAs. Would one of the easiest cuts to make not be just to scrap SHAs? I do not know what they do. They do not seem to add anything. Do you think it would be a good idea to get rid of them?

**Ms Garbutt:** I believe there is always going to be a need for some sort of intermediate tier between the primary care trusts and those out in the field and the Department of Health and Government. I do not think it will be possible to have that sort of direct relationship with 150 or even a smaller number of primary care trusts. However, whether we have the right number of organisations in the intermediate tier I think is a good question. It is not one I can answer but certainly I would be making a strong case, and within our SHA area we have to say, “How much can the SHA slim back by and can they deliver more than a 30% reduction?”, because we are moving into a phase where we all have our five-year strategic plans and they are fitted to the economic climate. We need to deliver those strategic plans; we need to deliver different services that are better value for money, so we need to protect the resources of the front-line.

**Q325 Mr Bone:** I just want to ask Mr Parkes something on that. Mr Parkes, yes or no: do you think we should get rid of this useless SHA?

**Mr Parkes:** No, but I will tell you why. I think one of the key roles will be to make sure that good practice in Northamptonshire or wherever is rolled out across the country.

**Q326 Mr Bone:** I will now focus on the other side of it. Is not all this nonsense about cutting back just populist MPs looking for votes in the next general election, and is not the reality of the thing that if we want to improve productivity, which has not been improving, we have got to have first-class commissioning? How are you going to get World Class commissioning if you are having your resources cut by 30%? Your model of outsourcing was quite interesting.

**Mr Parkes:** I think we have got to get to a position where you do not have 152 PCTs across the country looking at numerous different pathways. We have got to get to a position of “Here is the expert, evidence-based, good practice pathway for condition X” that we then interpret locally. If we can then use that type of methodology to avoid

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inappropriate admissions or inappropriate use of resource and translate those pathways with clinicians locally, I think you will see a marked improvement in the way that money is being spent and in outcomes as well.

**Q327 Sandra Gidley:** We have heard evidence that there is an imbalance of power between providers and commissioners, and the Government have been banging on for years about moving resources and services out of secondary care into primary care. It does not really seem to have made huge amounts of change. I just wondered what your relationship was with the acute trusts in your regions, because presumably they want to protect what they do.

**Ms Garbutt:** One of the benefits we had in Norfolk from the last reorganisation, bringing five PCTs into one—and I am no particular advocate of big or small; I think both have their place according to local circumstances—was that instead of five PCTs all trying to have a relationship with the local large provider, the NHS trust, now foundation trust, we were able to have a single point of contracting commissioning with that provider. What we have done over the last two or three years is significantly enhanced our ability to be very businesslike and professional in the way that we deal with that provider. They have seen the impact of that and they have recognised it quite publicly. What we have also done is brought them into the work we did to design our five-year strategy, so although they might not necessarily like the concept of moving work out of hospitals because that is their income base, is it not, they have been able to see what the rationale was for that in terms of meeting the specific needs of people in Norfolk, and what we have been able to say to them is, “Just because work is coming out of a hospital and being done in a community setting does not mean you could not be the provider of that service but you would be delivering it differently”. I think the balance is starting to shift and I think that is about having real, good quality relationship management and contracting skills but also really working the system management to ensure that they are part of that system and feel part of it, because sometimes providers can be a little bit distant.

**Q328 Sandra Gidley:** We hear a lot about GPs being involved but some of the feedback I have heard in different places is that clinicians in hospitals are not involved; it is all with the management. Are we missing a link of the chain there by not including clinicians in hospitals? You used to work on the other side, John.

**Mr Parkes:** I think to be a credible commissioner you have got to be engaging with both primary care clinicians and secondary care clinicians. If I just sat in my headquarters and thought up ideas and did not involve primary care and secondary care clinicians, they would not be credible, so in that diabetes example we put in some challenge, brought in some experts from elsewhere but really did involve both primary care and secondary care clinicians in it.

**Q329 Dr Naysmith:** How did you involve them?

**Mr Parkes:** By showing them the evidence, showing them where their practice varied from an internationally agreed best practice pathway, not in an adversarial way but there was one particular clinician whose drug costs were, in terms of money, over £1 million more expensive than colleagues’. He did not know that.

**Q330 Dr Naysmith:** You let him and everybody else know that and that changed his behaviour?

**Mr Parkes:** We made that information available to that person and talked through whether there was a real benefit from the way that money was being spent rather than doing something differently, so it was done very much together. The other point I want to make is that whilst I am employed by NHS Northamptonshire I work for and will always work for the NHS, and I think that is quite an important mindset.

**Q331 Sandra Gidley:** But are you unique in that because some people do get quite territorial about their little patch? You are a senior manager but you have to deal with lots of people.

**Mr Parkes:** Others will occasionally fall into the trap of working for particular organisations, but I think part of my leadership role would be to get all of my managers and others to understand that we work for the NHS.

**Q332 Sandra Gidley:** So it is fair to say that the best way of changing behaviour of providers is having a very good evidence base?

**Mr Parkes:** Yes.

**Q333 Sandra Gidley:** Is that lacking in some areas? Are there areas that you find it difficult to drive change in because the evidence base is not there because there are huge amounts of data in a hospital, less so in the community?

**Ms Garbutt:** I think that is a fair comment—there are areas where the evidence will be more ambivalent and therefore there is real scope for clinicians to have different perspectives, but even then if you bring all your clinicians together, they will work their way through and generally come to a consensus about what makes the best sense for your local area.

**Q334 Sandra Gidley:** But will they come to the same consensus as the PCT?

**Ms Garbutt:** That would be with PCT clinicians as well. In NHS Norfolk we have very well embedded clinical leadership and clinical engagement. All of our programme commissioning boards are led by members of our clinical executive—GPs, nurses, pharmacists, whatever—but what we have also been doing is bringing PBC leads into that and increasingly forming networks with the clinicians in our hospitals. I mentioned earlier the stroke care path work we did. That was co-led by my clinical executive committee lead, who is a particular expert in long-term conditions, and one of the lead stroke clinicians in the local hospital, so they brought the project together themselves and sponsored it

through the changes, and that meant that we had buy-in from clinicians both in primary care and in secondary care.

**Q335 Sandra Gidley:** In the diabetes and stroke examples that is all about commissioning new services, but there is increasing evidence that there are quite a lot of clinicians out there doing things because they have always done them for years; there is no real evidence base. Have you got any examples of any services that you have decommissioned because they were not a good use of money?

**Mr Parkes:** There are areas where clinical practice has moved on. For example, I really would not be expecting to be seeing large numbers of tonsillectomies being undertaken.

**Q336 Sandra Gidley:** That is a bit of an old chestnut.

**Mr Parkes:** No, no, or if you took C-section rates, we would be through the national—

**Q337 Sandra Gidley:** They are going up and up.

**Mr Parkes:** Yes, but that is why I think through the Payment for Quality indicators that there will be a CQUIN reward payment linked to those numbers being brought down. I think, rather than perhaps decommissioning things, we try and use new tools like, for example, CQUIN as a means of changing behaviours and getting to a better position.

**Q338 Sandra Gidley:** Apart from your tonsillectomies, are there any other services that have changed behaviour rather than decommission?

**Ms Garbutt:** I will perhaps give you an example which is a specialist commissioning example from within the East of England where the 13 PCTs collaborate. Until quite recently I chaired the specialist commissioning group in the East of England. We were, I think, probably the first group of PCTs to totally re-commission and decommission IVF services and we went through a complete tendering process which meant that some providers of IVF services that were not getting the sorts of quality results that we wanted were no longer providing that service to patients in the East of England and other providers that were offering good quality services were given the contract, so we have done some decommissioning. Because we have been in an era of growth of resources there has also been more of an inclination to look at what new things you would like to buy rather than really looking at, "Perhaps we should not be doing that". As the focus gets very tight on absolutely being certain that you are deploying all your resources to best effect, there will need to be more decommissioning and a much more rigorous appraisal of the information that allows you to say, "Actually, that is not really very good value for money", or, "The quality outcomes are not really what we expect there so we need to stop buying that and buy something different".

**Mr Parkes:** We certainly have put services out to tender when we have looked at cost and quality, and there have been examples where we may have been having services provided out of county, such as wet macular degeneration, and there was a desire from

the public to have the service in-county, so we have decommissioned the out-of-county service and established an in-county facility. One of the pieces of evidence that I gave to the inquiry around children's mental health was that we did not have a good in-county service; we were spending a lot of money on individual packages of care out of county, and by decommissioning those and bringing patients back into county we have been able to come up with a better experience for the patients and for their families and we can demonstrate that we have avoided some hospital admissions as well. There are things like that which we are doing quite deliberately.

**Q339 Sandra Gidley:** But do you predict more decommissioning as a result of financial pressures?

**Ms Garbutt:** I think there will have to be. We want to spend the money in the right places.

**Q340 Dr Taylor:** One of the initial criticisms of the purchaser/provider split was that it drove a wedge between commissioners and providers and really what you have both said, and I think it is in the Northants evidence, is that you have adopted a collaborative approach, working in partnership with providers, so really you have overcome that split in the sense that purchasers and providers do not talk.

**Mr Parkes:** Absolutely. If I have a £1 billion budget, which I do, and if at the end of the year I have not allocated that in a way that has services that are sustainable, that are of a better quality, and if I am then sitting on a big surplus and my hospitals are in deficit, to me that would not be a place I would be aiming to be. Where I want to work with them is, "How have you been spending the money and how can we spend it in a better, more effective way?", and manage the change in a way that allows them to alter their size, capacity, staff numbers, et cetera, in a way that does not suddenly result in a stop-start mentality.

**Q341 Dr Taylor:** One of the criticisms we have had is that PCTs do not really have much control over hospital admission rates and things like that. We have been told that research in 2004 showed that primary care-led commissioning and GP fund-holding did result in lower rates of hospital admissions, lower prescribing costs and innovations in primary and intermediate care. Would practice-based commissioning, if really we gave that more support, not achieve those goals and would that not give you control over hospital admission rates and things like that?

**Mr Parkes:** If I can use a Northamptonshire example, we have just allocated £4 million on an invest-to-save scheme specifically for primary care, to say to them, "Whatever the scheme is—community geriatricians, community diabetologists, whatever idea you want to come up with—here is a £4 million fund that, as commissioners, we have made available for you to use and all I want is a better return on investment than the £4 million that I am putting up front". We are quite deliberately making funding available to primary care, to our PBC consortium, to develop those services out of

hospital so that they can be transforming the services and giving the public what they want, which is a greater range of services close to their home. Rather than just say, "You are not managing demand", we are saying, "Here is a fund. You come up with the ideas around if patients were being supported differently how could they be supported to stay at home rather than being admitted to a hospital or into a nursing home".

**Q342 Dr Taylor:** How are you actually managing that, because one of the constant criticisms we get is that it is impossible for the NHS to move money between silos, to move the monies from acute care into prevention, which obviously would be an economy in the long run? How do you happen to have £4 million that you can do that with?

**Mr Parkes:** The way that I am doing that is that this will be the last year that I receive, in effect, an uplift in my allocation, so I have got a 6% uplift in my allocation and, rather than just spreading that out in a random way, we are using that as an innovation fund.

**Q343 Dr Taylor:** To make economies in the future?

**Mr Parkes:** To absolutely make economies in future, so if primary care or secondary care want to come along and, say, do more home technology to support people having long-term conditions monitored in the home rather than being brought into hospital, we will use that whole 6% or the majority of the 6% as a means of an innovation fund to support both primary care and secondary care to be more efficient. Otherwise I have missed that opportunity before we go into a more difficult economic situation.

**Q344 Dr Taylor:** Are you unique in this foresight?

**Ms Garbutt:** If I could add to that, I think we are doing something very similar. My board yesterday approved two business cases from practice-based commissions, both valued at £1 million each, to substantially change the way that they are managing referral patterns and service development in the community, and I think that is exactly the right thing to be doing. Going forward, we are looking at bringing whole budgets devolved to practice-based commissioners into place next year. The reason we want to do that is that we have to make a connection, I think, between what is spent on primary care delivery and what is spent in hospitals and in the community into one place, because it is the GP, when they are seeing the patient in front of them, who makes the resource allocation decisions by deciding to refer them to the hospital, to write a prescription or to treat a patient with one of their services locally. They are committing those resources. In terms of our practice-based commissioning groups, we have four large consortia. They are very keen to be able to use that total budget to say, "If we are going to pay ourselves more in primary care, we are going to do more in primary care and build more services here because we know that will give us more options to stop patients going to the hospital, which means we will not be paying them so much", and at the same time the hospitals are very keen to support this

because we are reaching a point where the infrastructure of the hospitals is at breaking point. It cannot keep taking the increases in numbers of patients and we do not want to be investing in very expensive hospital infrastructure, so absolutely it is the right way to be going to be putting the money with the people who are making the referral decisions.

**Q345 Dr Taylor:** From your contacts with other chief executives do you think virtually everybody is doing the same sort of thing in this one year when there is that bit of spare money?

**Mr Parkes:** Yes.

**Ms Garbutt:** Yes.

**Q346 Charlotte Atkins:** Before I go on to another question I just want to follow up on that. You may be reducing hospital admissions but are you reducing the length of period that patients spend in hospital? One of the problems is, and I know there are tariffs and everything else, that ultimately it is still the PCT that picks up the bill for a patient who is in the hospital. For instance, if you have a situation where a patient gets one or, dare we say it, two infections, it is the PCT ultimately that is picking up the bill rather than the hospital. They basically have an open cheque book which the PCT has to pay for. How do you deal with that?

**Mr Parkes:** I think we have already started doing this, but we have got to move to a position where we do not pay for those pre-admission days and we do not pay for those excess bed days unless there is a reason for them.

**Q347 Charlotte Atkins:** An acceptable reason for them?

**Mr Parkes:** Absolutely, an acceptable reason for them.

**Q348 Charlotte Atkins:** If there is an infection, it is down to the hospital?

**Ms Garbutt:** Yes, absolutely.

**Mr Parkes:** Yes.

**Q349 Mr Bone:** On this business of not paying for things, what is your view on emergency re-admissions because they are climbing in percentage terms? The hospital sends somebody home saying they are well and you pay for that and then you are lumbered with it again. In America they would not pay for the hospital re-admission. What is your view on that?

**Mr Parkes:** Certainly for me there is a need to change from a system that would require me to agree not paying the invoice that the trust has submitted. I would need to agree with them that their invoice could be adjusted. I would prefer to have an ability to say, "That was inappropriate. I am just not paying for it", rather than having to agree not to pay for it. If I had that freedom but also agreed what the right practice was, then we would be in a slightly different position from the one we are in today. Nationally, again, one of the CQUIN payments will be linked to patients who are re-admitted within 28 days, so,

again, trying to get the right either incentive or disincentive into the system I think is fairly fundamental.

**Q350 Charlotte Atkins:** When you are talking about those additional days you are paying nothing or you are paying a reduction on what you would normally pay?

**Mr Parkes:** Yes.

**Q351 Charlotte Atkins:** Which is it? You pay nothing or you pay 30% of the normal cost?

**Mr Parkes:** In terms of my position, and my position may be unique, on those excess bed days we pay nothing.

**Q352 Charlotte Atkins:** And what about Julie?

**Ms Garbutt:** It is much the same, but that has to be negotiated upfront, and there have to be clear parameters because there will be occasions when it is perfectly appropriate that patients have stayed longer or that patients have been re-admitted.

**Q353 Charlotte Atkins:** Absolutely. To move now on to the new Operating Framework 2010–11, it calls for PCTs, in the jargon, to “commission transformed and integrated pathways to optimise health gains and reduce health inequalities”. It says that that will require stronger joint commissioning and collaborative working. What do you understand by that and what evidence is there that you are doing it—collaboration, the joint commissioning? How much of that is going on?

**Mr Parkes:** I will give you a couple of examples with an integrated care pilot site, and I think the future destination for my provider arm will be for them to be working in a more integrated way with both primary care and social care to try and minimise the hand-offs between those different sectors. What we have done already is that, for example, we have got pooled mental health budgets, we have got joint commissioning between the social service and the health service on major areas like mental health, and we would see the integrated care pilot or partnership as a means of looking at how you better integrate the care that needs to be given on a particular pathway. We touched earlier on the organisational form debate. I am really keen that we progress the transformational form debate rather than the organisational form debate.

**Q354 Charlotte Atkins:** Some PCTs, I think, would say that floating off the provider arm would make it more difficult to collaborate with social care providers.

**Ms Garbutt:** I think we are looking to do two sets of integration as PCTs. One is the integration of provision and, like John, our integrated care pilots, of which there are six covering 250,000 people, are combining in integrated teams those healthcare professionals, social care professionals and primary care professionals, so we are testing out how we bring the provision of service together anyway.

There is a lot of support for that, and indeed for children’s services as well; it is not just for adults. What we are doing more of now, though, is to say how do we integrate commissioning as well so that we do not simply say, “Social care will commission that bit and we will commission this”, but, “Could we do it together? Could we have one single team of people or one person leading on that?”. We have a joint director of integrated provision already in place. We are looking to have a joint director of strategy and commissioning with our county council and across mental health, learning disabilities, et cetera.

**Q355 Charlotte Atkins:** So those will be paid for—?

**Ms Garbutt:** They will be shared between the two organisations, which is another way of managing the 30% management cost reduction, to say how many ways can we work jointly with other organisations, whether it is other PCTs, local authorities, or indeed both, to combine the resource in that way, get a saving but also get that real co-ordination, because, let us face it, the patient does not differentiate between whether they need a social care service or a healthcare service. They just want the services to be available to them when they need them, so we need to take those boundaries out. Certainly, my PCT is very close to doing that and I think most are starting to look at that.

**Q356 Charlotte Atkins:** Your integrated care pilots are working well, are they, across both your regions?

**Mr Parkes:** We are certainly very pleased with the progress that has been made and we have developed things like proactive care where we are trying to make sure that we are giving the right individual package of care to somebody and avoid them being admitted into hospital, and that whole better integration between primary care, social care and hospital care I think has got to be one of the remedies that we take forward and take forward seriously.

**Q357 Charlotte Atkins:** Does public health get its feet into this integrated model or is public health left on the sidelines?

**Ms Garbutt:** No. Our public health practitioners are part of the models to help put the needs assessment in place and give them locally based needs assessments. The IC pilots are still quite new but one of ours in mid-Norfolk has been working for a little longer and they have had attached social care staff within the practices for a while. They have recently done an evaluation that was led by the University of East Anglia and because they have been able to co-ordinate their efforts and provide local services they have been able to reduce their admissions to hospital by 18%.

**Q358 Charlotte Atkins:** 18%?

**Ms Garbutt:** 18%. I think that is a really good indication that working together in this way does mean you can provide better services—

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**Q359 Charlotte Atkins:** 18% over what period?

**Ms Garbutt:** Over a year.

**Q360 Mr Scott:** Briefly, could you explain to us what clinical networks run in your region, what is their function and, as they cost a great deal of money, is it money well spent?

**Ms Garbutt:** There is quite a large range of clinical networks in our region. They cover things like cardiac network, cancer network, neonatal intensive care network, and they go on. There is an emergency care network. I think networks are a good idea in as much as they bring clinical leaders together, experts, to look at how services should develop and change, but they are not commissioning entities. Commissioning is done by PCTs. My perception is that probably over the last few years clinical networks have lost their way a little bit. I think as PCTs have grown their clinical engagement locally and as SHAs have built clinical engagement into their work, clinical networks to some extent have got a bit lost in that. It still seems to me that intuitively they must have value if they are bringing clinicians together, but I think it probably is time for that to be reviewed because they do carry a management overhead cost because they have to be serviced.

**Q361 Mr Scott:** Is that currently money well spent or not?

**Ms Garbutt:** It varies by network, would be my sense of it. Some of the networks are more effective than others.

**Q362 Mr Scott:** John?

**Mr Parkes:** I led a review of the networks in the East Midlands probably two years ago and we did not reduce the number of networks but we had a slightly different model where we were absolutely clear, "This network is there for providers. It is to support the movement of intensive care patients", or whatever. "This network is here to support commissioners and to inform the commissioning decision". What we have tried to do as a result of that is get the right product at a reduced cost. We absolutely think they still add value but they are subject in effect to an annual review.

**Q363 Dr Naysmith:** Where does the money come from if it does not come from PCTs?

**Ms Garbutt:** It does come from PCTs.

**Mr Parkes:** Yes. It is in effect top-sliced.

**Q364 Sandra Gidley:** I want to move on to a bit more about practice-based commissioning and how you work with GPs. Could you give a very brief overview of how you involve those clinicians?

**Mr Parkes:** We have got Nene Commissioning, the largest PBC consortium in the country.

**Q365 Sandra Gidley:** What, sorry?

**Mr Parkes:** Nene.

**Q366 Sandra Gidley:** Nene Commissioning—what is that?

**Mr Parkes:** It is the name of our practice-based commissioning consortium. It covers 98% of the population, so just under 700,000 people, and has within it six localities. It is very similar to the previous PCG areas.

**Q367 Sandra Gidley:** Are these GPs you are talking about?

**Mr Parkes:** Absolutely. It is GP-led, chaired by a GP. It has a chief executive and we use Nene Commissioning as the main route for us to be working effectively with GPs and to be influencing what is happening. What they will now be doing is using those localities to, in effect, have a federated model between GP practices so that if you cannot have a specialist nurse in one GP practice then by federating that specialist nurse becomes available to a locality and it supports more work being done out of hospital.

**Q368 Sandra Gidley:** It sounds like the sort of thing the Royal College of GPs was advocating. Did you follow up on that or were you doing that before?

**Mr Parkes:** In the original model we had two main consortia and they merged a year ago. It is a model that continues to evolve but one that we are very supportive of.

**Q369 Sandra Gidley:** Will they come up with an idea or a proposal? How long does it take to work it through, process it and adopt it?

**Mr Parkes:** When, for example, we asked them to look at the end-of-life provision it would have probably taken my team four times as long as it took their team.

**Q370 Sandra Gidley:** What are we actually talking about? Years, months?

**Mr Parkes:** No, it was done in three months, because they had won the hearts and minds and engaged with the clinicians at the front end, so therefore it was a proposal that was not meeting any opposition. I think the reality is as well that PBC is there and it is seen to be supportive of GP, primary care, changing practice, whereas I am seen more as the agent of government, so there is probably more openness to some of the ideas coming through the PBC board than would be always from me as a commissioner.

**Q371 Sandra Gidley:** Julie, is it the same in Norfolk?

**Ms Garbutt:** I think we are just a little bit further behind than John is. We have four practice-based commissioning consortia in Norfolk. Over the last year we have worked much more closely with them. We have a director and a number of business cases that work with each of the PBC groups to help them with their development. They are coming round to the realisation that they need to build their infrastructure and their capability in much the same way as John has described in terms of having resources, chief executives, people who can turn the good ideas that the clinicians have into the reality of business cases and service changes. Having said that, in terms of business cases, we have worked with them to improve the quality of the business cases

they can produce. That means they go through the system that much faster. The two business cases I referred to earlier that were around referral and demand management were sizeable, challenging business cases because they were looking at seeking £1 million worth each of funding. Because they worked so closely with us on developing them we were able to process them and get them agreed within a month and they will implement within the next three months. For something as big as that I think that is a fairly quick turnaround.

**Q372 Sandra Gidley:** So that is starting to work a lot more quickly?

**Ms Garbutt:** Yes.

**Q373 Sandra Gidley:** How do you go about improving the management of primary care networks and GPs? Would GP fund-holding be a way forward again? We always go round in circles in the Health Service anyway, so it is probably about time for it.

**Ms Garbutt:** I think the good thing about fund-holding was that it did allow the decision-making about who went where and got what in terms of services to be tied into the sums of money that were used, and I think fund-holders were very good at looking at how they could spend that money better, so I am a supporter of giving real budgets to practice-based commissioning groups providing that they have got the infrastructure and the ability to manage the money well.

**Q374 Sandra Gidley:** At what level would you do that? That would be at the group level, it would not be at the individual GP surgery level?

**Ms Garbutt:** No, I think they would carry too much risk in terms of the volatility of their budgets if they tried to do it at individual practice level.

**Mr Parkes:** My concern with going back to a GP fund-holding model is that, whilst I think there were elements that were effective, I do not think it was ever able to deal with, "Here is an area that is well resourced versus here is an area of real inequality and deprivation and how do you move the money between the two?". Peter Bone wants to talk to me about one of his constituents who has a particular need that will cost £250,000. As a £1 billion organisation, I can consider whether that treatment is warranted. I think that would be very difficult for an individual GP to say yes or no to.

**Q375 Dr Stoaite:** How did you develop your local CQUINs?

**Mr Parkes:** We have six that are in effect coming down through the SHA and we have two that have been specified nationally, and then we are agreeing probably another four locally.

**Q376 Dr Stoaite:** You have not developed the majority of them yourselves? You have taken national or strategic models, essentially? Is that the same for you, Julie?

**Ms Garbutt:** We have the two national but we are developing the rest locally with oversight from the SHA to spread good practice across.

**Q377 Dr Stoaite:** How will you ensure that they are evidence based if you are developing them locally?

**Ms Garbutt:** Because we are working with our providers and looking at evidence-based and looking at where there are particular areas where we think that by giving the stimulus of CQUIN we can drive through quality change.

**Q378 Dr Stoaite:** You believe that you have the capacity to exploit CQUIN properly to make it work?

**Ms Garbutt:** I think it is still very early days. I suspect we may need to deploy capacity more to that area in order to get the best benefit out of it.

**Q379 Dr Stoaite:** Is it the same for you, John, or do you feel as though you have got the capacity to deal with CQUIN?

**Mr Parkes:** I have. I just think that there is 1.5% in CQUIN and an expectation of 3.5% efficiency. We just need to be careful that we are not destabilising our providers but getting the right focus on improving quality.

**Q380 Dr Stoaite:** Does either of you expect it to make much of a difference?

**Mr Parkes:** Personally I think that for it to make a significant difference we would probably need to have a greater figure than the 1.5% and it would probably need to be there as a reward rather than part of a base payment.

**Ms Garbutt:** I agree with that.

**Q381 Charlotte Atkins:** John, you mentioned that the Operating Framework sets CQUIN at 1.5% but they are talking about the possibility of it rising to 10% in 2011–12. Are you comfortable with that and also have you ever fined one of your providers for poor performance, such as infection?

**Mr Parkes:** Yes, we absolutely have fined and we do it quite deliberately in order to try and get that balance between rewards and penalties as a means of influencing behaviour. I would be interested in the move towards 10% but I am worried that if that is part of the base funding it could have a destabilising effect, so I think perhaps the clever thing—

**Q382 Charlotte Atkins:** Can you explain that a bit more? Why would it be destabilising?

**Mr Parkes:** If I went back into running a hospital, if I potentially lost 10% of my income because I had failed CQUINs without there being a proper period of notice for recovery, it would have the ability to destabilise me financially, so I think the 10% would have to have periods of notice and periods of improvement before the 10% was either earned or removed.

**Q383 Charlotte Atkins:** In terms of fining for performance, can you give an example of that, and did it improve performance in future?

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**Mr Parkes:** We have certainly fined providers in the past for failing to achieve things like A&E targets, and, depending upon their financial position, it has either had an impact or not. It is probably more the threat of it that is the real value.

**Q384 Charlotte Atkins:** Julie?

**Ms Garbutt:** We have not fined, although the threat of that fine is there. I think for the reason that John said, unless you are talking about really sizeable chunks of money it is not going to have the desired effect. We need to incentivise more but I think there has to be the ultimate sanction if, after periods of recovery and notice, you are not getting improvements.

**Q385 Charlotte Atkins:** From April 2009 the Patient Related Outcome Measures were introduced into the NHS in four areas: hips, knees, hernias and varicose veins. Where that shows poor performance will you alter your commissioning? You have already mentioned this, John, that you have altered your commissioning in some ways.

**Mr Parkes:** Yes, and one of the things that we want to do is use that information to help patients make choices around where they want to go for their elective surgery.

**Q386 Charlotte Atkins:** But the evidence shows that patients are more likely to decide where they go on the basis of what the car parking is like rather than the quality.

**Mr Parkes:** I absolutely agree.

**Q387 Charlotte Atkins:** They look to their GP, do they not, to advise them which hospital to go to because they do not usually feel competent or aware enough to be able to choose?

**Mr Parkes:** If I need my hip doing, there is a model that says, "An expert orthopaedic nurse will call you tomorrow. We will talk through the treatment options, agree with you success, be it reduced pain or increased mobility, and we will share with you who the local providers are, the local surgeons, and what the feedback is in terms of outcome and patient satisfaction", and experience from other economies shows that the public like that because it is a half-hour conversation rather than a five- or ten-minute one, and it also in some instances results in people saying, "No, I do not want that operation because of the potential risk or lack of benefit to me", and we are wanting to get to a position where we pilot that in Northamptonshire.

**Ms Garbutt:** I think it is very early days still with PROMs, but I think making that sort of information available to patients does empower them to make different choices, and particularly the one about choosing not to proceed with having treatment is very important. Although, obviously, clinicians do go to great lengths to explain the pros and cons of any particular treatment that they are suggesting, I think knowing how other people have got on and

what their experience has been and whether it is a total success or not is very useful in terms of empowering the patient to make their own choices.

**Q388 Charlotte Atkins:** Including deciding not to be treated?

**Ms Garbutt:** Yes.

**Q389 Charlotte Atkins:** Do you think that fines have a problem in terms of maybe destabilising your local health economy, or is it just about shifting financial pressures from yourselves to providers? How do you see fines?

**Mr Parkes:** I think I have a role in terms of managing risk, and risk to the patient is at the forefront of my mind so I would want fines to be used to mitigate that risk, but at a secondary level I do not want to completely destabilise my providers, I want to have a professional relationship with them. My health economy would know that if we are having high cost, poor services, they will be put out to the market and market tested to see whether there are other people out there able to provide better quality at reduced cost.

**Q390 Dr Taylor:** World Class Commissioning in one minute. What difference has it made to the work you do? You have given us a list of things: the SWAN Partnership, Child and Adolescent Mental Health from Northants and Telehealth stroke services and things like that, so why could you not do those in any case? What has World Class Commissioning done to allow you to do that?

**Mr Parkes:** I think it has allowed me to move from a spending regime to an investment regime because it has set out almost a set of exam questions that represent good practice that I know I should be aiming to achieve, so that whole testing of what are now 11 competencies and being clear around what excellent is in those 11 competencies has allowed me to develop the form and functioning within my commissioning organisation.

**Q391 Dr Taylor:** It has really just been a way of focusing your efforts on the right way to go?

**Mr Parkes:** It has given me a whole set of questions that I have had to answer in terms of making myself a World Class commissioner, absolutely not there but I can see the journey and I can see where I need to get to.

**Q392 Dr Taylor:** You did, I think, rather better than Norfolk on the scores. Julie, why did you not do quite so well on the scores? How were the scores worked out?

**Ms Garbutt:** I would probably start off by saying I think it depends on where you start from. A number of the PCTs that did particularly well and boast very good scores were ones that had not been reorganised, so they were able to hit the ground running, they did not have the instability of having to reorganise, reappoint people, et cetera. We had a

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very complex and difficult reorganisation. The five previous PCTs did not particularly want to merge. They had not done much in the way of transition planning and, as they did come together, the ledgers proved that there was a 50 million deficit. I could say, therefore, no wonder, but I am also very conscious that John is sitting next to me and he had much the same start and he performed much better, so I do not think that can be a legitimate response. When I reflected on it I was saying two things. The first is that we did not have the capacity and capability in place that we needed, and the second is that is we did not have a strong strategic plan, and both those things feature very heavily in terms of whether you can demonstrate you are delivering competencies, and the strategic plan determines whether you are agreeing on your governance, your finance and your strategy. What I can say is, since we have had that experience, we have now got a first-class five-year strategic plan which has been benchmarked and agreed by our strategic health authorities as one of the best it has seen. We have a very comprehensive organisational development plan. We were supported both by external consultancy to make sure we were challenged and we have made great inroads to implementing those. I do intend and expect that we will do much better in the round that we are now in, but we were where we were and we needed to move fast. The good thing about world-class commissioning is it gives us very clear standards and very clear benchmarks and there is nowhere to hide.

**Q393 Dr Taylor:** Did it make you focus more on competency, engaging the public and partners?

**Ms Garbutt:** No, we were stronger in engaging public and partners and in system leadership. Our weaknesses were in the technical competencies, the market making, the utilisation of information, contract management, all areas in which we have significantly boosted our competences in terms of capability and capacity.

**Q394 Dr Taylor:** How much did either of you use the external organisations? We are told in the Framework for procuring External Support for Commissioners there are 14 private sector companies that you can call on for support.

**Ms Garbutt:** Yes.

**Q395 Dr Taylor:** Did you use those? How much did you spend on those?

**Ms Garbutt:** We used external support from the FESC agencies to develop our commissioning processes through our commissioning boards, we

used them to support us in developing the strategic plan, we used them to support us in developing our organisational delivery plan. We also used a number of interim agency appointees to boost senior leadership in the PCT whilst we embedded those practices in the PCT and we made substantive appointments. The investment was quite substantial and would run into millions.

**Q396 Dr Taylor:** Do you think that investment is going to pay off?

**Ms Garbutt:** Yes, I do.

**Mr Parkes:** We have the largest FESC contract in the country and regularly use external management consultants. I have no issue with that as long as whatever I am spending I can actually demonstrate that by so doing they have added real value. So far we have had no problem with a number of our external consultancies but, as with any external company, they do need to be managed and I am sure at some point we will part company with some but will play in others.

**Q397 Dr Taylor:** This would be one of the large proportions of money spent across the NHS on management consultants?

**Mr Parkes:** Yes.

**Dr Taylor:** Thank you.

**Q398 Dr Naysmith:** A final question. What would you like to see the Government do to help you to improve? That question could be framed another way. Do you want to be left alone or do you want further reform?

**Mr Parkes:** I certainly do not feel the need for further reform, and I think there is good evidence that says we tend to reform things on a three-year cycle when most things take six years before they reach their optimal level. I do not want to be reformed, but I do think that there are things that you could do, for example giving me access to the primary care data that would allow me to become a more effective commissioner but would allow clinicians to be more effective practitioners.

**Ms Garbutt:** Give us time to bed in. Please, no more re-organisations. Continue to support the shift in terms of the balance of power, so more of the changes around the tariff to enable us to move money around the system, and a slimmed down intermediate tier, please. We need to maximise the devolution of the money and the responsibilities to the frontline.

**Dr Naysmith:** Thank you both very much indeed. You have given us a lot of useful information that will help us to write our report. Thank you.

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*Witnesses:* **Dr Pauline Brimblecombe**, GP, **Ms Maureen Donnelly**, Chair, and **Dr Paul Zollinger-Read**, Chief Executive, NHS Cambridgeshire, and **Mr Stephen Graves**, Director of Corporate Development, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust, gave evidence.

**Q399 Dr Naysmith:** Good morning everybody. Welcome to the Health Select Committee. You have all, I think, been sitting in on the first session, so you pretty well know the score. What I want is fairly sharp answers, if you can, and not too much repetition and we will get through quite a long agenda. Could you, first of all, introduce yourselves for the record and say who you are representing?

**Ms Donnelly:** I am Maureen Donnelly; I am the Chair of NHS Cambridgeshire. I have been the Chair for just over three years.

**Dr Zollinger-Read:** Paul Zollinger-Read; I am the Chief Executive of NHS Cambridgeshire; I have been doing that now for nearly two weeks.

**Dr Brimblecombe:** I am Pauline Brimblecombe; I am a Cambridge GP and I am Chair of our local Practice Based Commissioning Consortium.

**Mr Graves:** Stephen Graves; I am Director of Corporate Development at Cambridge University Hospital, locally known as Addenbrooke's.

**Q400 Dr Naysmith:** We have invited you all here this morning to explore how a local health economy works. Can I start off by asking you how you see your organisations working in the relationships with each other?

**Dr Zollinger-Read:** NHS Cambridgeshire is clearly a commissioning organisation. The role of commissioning is to work with public health colleagues to understand the need of the local population and then, with patients and clinicians, to implement actions that deliver for that need, ensuring that we drive up quality. Clearly, partners within that are local authorities, primary care and our acute colleagues and ensuring that we commission correctly depends on collaboration between all those organisations.

**Dr Brimblecombe:** Just to explain what our Practice Based Commissioning Consortium is, it was formed very early on when PBC first came in. It is called CATCH (Cambridge Association to Commission Health) and it presently consists of 31 practices and the city itself and actually Hertfordshire and Bedford as well. Basically the consortium built itself around Addenbrooke's, because Addenbrooke's is really our only acute trust provider. Patients in Cambridge actually do not want choice, because they have a very good acute hospital on their doorstep. We built the consortium to improve collaboration between GPs and we thought we would be powerful enough to perhaps influence our acute provider, who, being a foundation trust, we regarded as being very powerful and perhaps influencing our spend rather more than we wished. Actually what we have achieved over the last four years more than anything is engagement of the clinicians. I think, if I am going to emphasise anything, the health reforms have come in and everybody at the top understands them, but the clinicians take a while to get on board and it has taken us four years for the GPs to really become engaged. They now understand particularly the health economics locally, and, as you probably

know, NHS Cambridgeshire has its problems—it still has a historical deficit to pay off. As far as practice based commissioning savings go we have very few, but we do have the GPs engaged now—they at least understand the problem—and they are accepting that it is part of their role, and the fourth principle of medicine of distributive justice, which I think clinicians have great difficulty in understanding, they are just about coming on board with.

**Q401 Dr Naysmith:** We will explore that more later on. Stephen, how do you see your relationships with your commissioners?

**Mr Graves:** I think they are absolutely fundamental. I think from the data you will see that we have a very large income stream from our local commissioners, but we have an income stream in terms of acute care which is about the same size from other commissioners and specialist services. As a large player locally, we understand fully that we have a fundamental role in terms of the health (in every sense of that word) of the local system, very different, I think, to a number of years ago. I think we fully understand that we have to live within the means of the local system and play our role in managing that system so the funds available to us can be used to best effect, and that, as Pauline has said, is now something that is fully understood by the lead clinicians as well as the management team.

**Q402 Dr Naysmith:** Pauline and Paul, you both have commissioning functions. Could you, please, describe what commissioning you each do? You do not do exactly the same sort of commissioning, do you?

**Dr Zollinger-Read:** The Primary Care Trust is responsible for the overall commissioning. That will only work if PBC and Primary Care Trust work together. In my view, PBC and Primary Care Trust need to agree what is the commissioning agenda for the year coming. What is it we are jointly going to do and how are we going to do that? Within that you will have elements that the PBC groups are particularly interested and want to push forward on, and then there will be other areas that they are not particularly interested in and want the PCT to lead on. Pauline, do you want to come in?

**Dr Brimblecombe:** A lot of the things we have done, we have put our strategy in with the PCT's strategy. Developing a community geriatrician role was something that PBC savings actually were used for to try and help a central frame of what we want to do, which is to improve the care of our elderly populations.

**Q403 Dr Naysmith:** Are there any services, Pauline, that you are better at commissioning than the commissioners in the PCT would be?

**Dr Brimblecombe:** Are there better ones?

**Q404 Dr Naysmith:** Are there any services that you think it is better for you to commission?

**Dr Brimblecombe:** On a day-to-day basis, because we know what our patients actually need—and I think there is a problem there with what they want what they need—looking at the pathways is something that we think that we can actually help develop much more effectively. Our plan in the future is actually to look at the pathway rather than just a service or provider. If you ask me what my role as a commissioner is, I commission every time I sign a prescription and every time I send a referral off. The problem is at the moment that our referrals are actually a blank cheque, and that is something that we really want to change.

**Dr Zollinger-Read:** The main plank of our strategy is really now engaging with PBC across the patch to enable PBC to fully commission. I have met with all the different clusters and there is a strong appetite for taking forward real budgets in clusters of varying size with support from the PCT. I believe that if you devolve that, first of all, you get clinical leadership, which is crucial for any commissioning, secondly, you are more likely to get the joining up of primary and secondary care working together on pathways and, thirdly, you will get local patient involvement as well; so I think that devolution is definitely the way that we are moving in NHS Cambridgeshire.

**Q405 Dr Naysmith:** Is everyone clear about their different roles in the health of your local communities?

**Ms Donnelly:** Yes.

**Q406 Dr Naysmith:** Maureen, are you happy with that?

**Ms Donnelly:** Yes, I am.

**Q407 Dr Naysmith:** Pauline, you know exactly what you are meant to be doing and you do not feel confused?

**Dr Brimblecombe:** I think there is going to be confusion because of the statutory role of the PCT with the budget at the moment. I think that has still got to be ironed out, whether we are going to be handed real money or whether it is still going to be just notional budgets. I think, probably, a lot of my colleagues are going to say, “Hang on, do we really want the responsibility to break even at the end of the year?” I know that a lot of my GP colleagues are very anxious about that, because if they cannot manage the budget at the moment, do they want to take on that whole risk? It is very easy for GPs at the moment to be able to hand off the risk to the PCT, and I think that is one of the challenges.

**Q408 Dr Naysmith:** We will explore some of that in more detail later on. Stephen, are you quite happy that everyone in your health community understands what they should be doing?

**Mr Graves:** I think, as has been said (and the word “journey” has been used a lot), if you take this particular example, we are moving from something that has been more led by the PCT to something that is being more led by local groups of GPs. If I had some of my doctor colleagues here, I am sure they

would say, “I want greater clarity”, but we are betwixt one and the other. The reality, I think, is that there need to be services where the core principles are the same across the whole area but that the way it is delivered will be more locally focused. Like many of the people coming in, Cambridge is a small city of 120,000 people, there is a ring of villages around the outside which are roughly another 100,000 odd people and then you move to the north in Cambridgeshire into some much more remote areas of the fens, and so the principle has to be the same, but the way that it is delivered in detail will be different. For people in Cambridge, maybe their local physical provider is the hospital for some services, whereas in the middle of the fens 20 miles away it may be a community hospital that that clinician in secondary and primary care needs to go to in order to provide it, but the principle of how it works needs to be the same.

**Q409 Dr Naysmith:** What you cannot say at the moment is anyone calls the shots. As to who calls the shots, actually, in different circumstances different organisations will call the shots.

**Mr Graves:** No, I think that the joint work between PCT and primary groups, GP groups, is starting to play out, and these are complex worlds, so I think we understand that we have all got to work between everybody as opposed to one person calling the shots in that way.

**Ms Donnelly:** May I add a comment to that? The way we are trying to think about it is we look, with the clinicians, at the service pathways, we then try to stop ourselves thinking about the walls of the current organisations and think: how do we get the most expert help and the most appropriate help for that patient to that person in a way that suits them? Whether it is within a hospital, outside a hospital, whether it is an expert consultant or a local clinician, can we get them to work in different ways that suits the clinical pathway?

**Q410 Dr Stoate:** Pauline, you put it very well when you said your aim is to achieve distributive justice, and I entirely agree with you there, but in your evidence, which is also very well put together, you say that the bulk of health expenditure is spent in the acute sector, yet delivers care only to the top 10% of the health pyramid and care in the community is mainly theoretical. What would you do to address that obvious imbalance?

**Dr Brimblecombe:** Somehow we have got to shift the care. It is the resource we need, and that is the conundrum we all have. We know what we want to do but we have not got the resource to be able to put the investment in community care. All the health reforms over the last three or four years have been directed towards acute care, so the focus has been totally on the acute sector, which has delivered very good outcome with the 18-week targets but, of course, it has consumed a lot of the resource. Now we are suddenly saying, “Whoops, we had better look at long-term conditions because if we manage those much better and patients with long-term

conditions better, we would then have some savings.” The problem is we have spent the savings first and now we need to try and recoup it to invest in things that we know actually down the line will benefit everybody.

**Q411 Dr Stoate:** The Audit Commission recently said that PCTs have made little or no inroads in 2008–09 for transferring care from hospitals into the community or in dampening demand either in investment or activity. What would you do as a GP commissioner to try and address that? You have already said what the problem is, but what would you do to try and put it right?

**Dr Brimblecombe:** I think we would specifically start looking at employing, particularly if you look at long-term conditions, our own specialist nurses, liaising much more specifically with an individual consultant to come and support us. We would try and change the way we deliver care. Choose and Book has driven, again, a carthorse through the individual relationship between the GP and the clinician in secondary care which has developed over a period of years so that you learn to trust each other, and that is really what has been lost. We want to get back the trust so that consultants can come and support us to look after our patients actually right there in the surgery. We need their expertise, but we need their support rather than actually taking over the problem.

**Q412 Dr Stoate:** You mentioned that your 37 practices were very slow to come on board. Why was that? Do you think they are being sufficiently incentivised? Are they interested in coming on board? Would they rather someone else did? What is the reason why it has taken four years for you effectively to engage with your 30-odd practices?

**Dr Brimblecombe:** Because, as you know, GPs are very busy people. They go to work, they see the patients in front of them and that is their main focus. That is what we have all been trained to do, to actually do the best for that patient in front of you and to block out everything else. I know in other countries they would feel that it was iniquitous for a clinician to actually be thinking about distributive justice and the use of resources in a different way.

**Q413 Dr Naysmith:** We are empowered to do that all the time, are we not, and in practice as well.

**Dr Brimblecombe:** Yes, but you can understand that now, but with most GPs it takes a while before you come on board and see that you have got a wider remit than the person in front of you. The strength of general practice is that individual relationship and individual care, but you do have to put it into context, and GPs have been slow in coming on board because we have not had to have budgets to look after. Before we did not know how much we spent. We would prescribe a drug and had no idea how much it cost. Now we do—it flashes up on our computers in front of us—we know exactly what it

is costing us, and that has, therefore, changed our behaviour. You cannot change behaviour unless you know what you are doing.

**Q414 Dr Stoate:** Is there a future then for GP commissioning or do you think David Colin-Thome may have got it right when he said, “I think the corpse is not for resuscitation”?

**Dr Brimblecombe:** I think that was slightly misquoted. It was rhetorical, I think, is what he says. It is like everything else, we are on a journey, and it was just totally unrealistic to expect that clinicians were going to understand what the big vision was when they had not actually been involved in developing it. Once they become involved, once they understand the problem, they come up with the solution. That is the real skill of clinicians because that is what we do in every day life: patients come with a problem and we help them to solve it.

**Q415 Dr Stoate:** Stephen, is the truth of the matter really that the acute hospitals are simply too powerful in relation to GP commissioners and, therefore, it is an unequal struggle?

**Mr Graves:** It is quite an interesting position listening to the debate. I guess, over the last few years we have seen Payment by Results as a huge opportunity for people referring and in the past, I think, as earlier colleagues said, people argued about what the level of marginal cost was for extra activity, whereas if you get the whole value of an extra patient coming in you, equally, save the whole value of a patient not coming in. Ironically and interestingly, for some time, I think, most secondary care providers have actually worried about the threat of all that money stopping coming in and yet the overheads were always going to remain. The interesting position, certainly from our position (and I do not think we are on our own), is that we day in, day out, say to colleagues in primary care and in the PCT we need to find ways of reducing the extra activity. Pauline has described from a GPs’ point of view how they know what the cost is. We started three years ago to understand what our costs were. We can now, in effect, produce a patient bill, so we know what per patient it costs very easily by HRG, and we start to understand that the extra over-activity that we have been seeing—putting on Saturday morning clinics, putting on Saturday operating lists, working later into the evening—if you look at the pure finances of it, loses money per patient.

**Q416 Dr Stoate:** I understand all that. We have looked into this in the past. I am not so worried about your income stream. We know what those are. I am more worried about the power relationship between you and the GPs, which seems to me hopelessly imbalanced. As Pauline has pointed out, 90% of the work is done in general practice in terms of patient numbers and yet virtually all the money actually goes to the acute trusts.

**Mr Graves:** We would say we want to reduce the number of referrals coming in, and I appreciate there will be some consultants that do not think that is a great idea. Many of our consultants actually, quite the opposite, say, “We want fewer patients coming in around diabetes, we want fewer patients coming to us around COPD because we have experienced different ways of delivering those services.”

**Q417 Dr Stoate:** But they are still putting you back in control; it all comes from you. What I am trying to get at is you are saying, “I do not want all these patients”, you are saying, “I do not want all these diabetics with complications coming in.” I am more concerned about the power structure. The relationship seems to be, “We are the acute trust, we do not want all these patients because we think they should be managed elsewhere.” I am much more concerned in the equality of the relationship between you. There does not seem to be any.

**Mr Graves:** If you take diabetes, one of our lead diabetologists has gone out to the fenland area and sat down with groups of GPs and started the debate, and what one finds about this is that people need to get to know each other and trust each other on both sides, if there are two sides of this clinical debate, and to start to say, “We do not believe it is right for these patients to come here; you do not believe it is right for them to come here. These are the skills that you may or may not have, these are the resources, in terms of specialist nurses, these are the clinical parameters that we think trigger somebody needing to come into hospital or ringing us as secondary care clinicians”, and that is actually really starting to have some debate.

**Q418 Dr Stoate:** That is helpful. I want to ask Paul the same question. Do you think that basically the hospitals are too powerful, or do you think it is about right?

**Dr Zollinger-Read:** I think we have got more levers now to manage that. I do not see it as a power issue. I think PBC has not been as successful and now we need to look at what we can do to make that work. Sitting on the other side of the fence, I also work as a GP and the frustration is that we in PCTs have not been quick at putting through business cases. I think that is a very fair comment; so we have frustrated PBC. If we can speed that up and liberate PBC, you then start to get changes. The other significant issue, and you mentioned the National Audit thing which I have not seen, but we have put in place lots of these Tier Twos, GPs with special interests, community clinics, and what we have not been good at is managing the demand, and so we have got an alternative over there but what we have not done is stopped that pathway over there. We have got the patients going over here, but they are still pouring into the hospital. We have got to crack that issue, and that is a primary care issue which I would put back to the clusters: “We can give you the tools but you have now got to start to manage that properly.”

**Q419 Dr Stoate:** Are you powerful enough to do it?  
**Dr Zollinger-Read:** Yes.

**Q420 Sandra Gidley:** A question to the PCT, but you have only been there two weeks.

**Ms Donnelly:** That is why I am here.

**Q421 Sandra Gidley:** Okay; that is helpful. Why have you been so passive in your commissioning? It seems that the PCT has just waited for central direction such as CQUIN before you have really thought about properly exercising purchasing power.

**Ms Donnelly:** In the case of Cambridgeshire that is not true, and I am sure Stephen will confirm this. Just a tiny bit of history, if you will bear with me. When I came on board the PCT had an historic debt of 52 million, half of which was in-year, so the first objective was to stop that money haemorrhaging and then to pay off the debt. We agreed with the SHA that we would have a repayment period over five years, so we have still got a couple of more years to go repaying that debt, but each year we have generated sufficient surplus to pay off, roughly, ten million each year. It was also quite obvious to me and the other members of the board that with 22% of our income going to Addenbrooke’s we needed to control that contract very rapidly, and what we did was we gave them notice of the old contract. We did this. It was robust but professional and friendly in the way that I expect to work in areas outside the NHS. We asked the department to send us down some people to help us with the contract and we renegotiated a new contract with Addenbrooke’s, which we ran for a year, which became the paradigm for the new acute contract the following year. I think in Cambridgeshire we have taken some initiatives. I am not saying there is not a lot more that we can do, but not all the levers are there; there are a number of things that could change those levers. The key levers that work against Primary Care Trust is the open-ended nature of Payment by Results—there is no capping of it—and if I look elsewhere in the developed world where they use HRGs or a form of payment like that, there is always some form of capping, whether it is marginal or whatever, and the way in which the rate is calculated is almost never done on the average across the country. There is room for a much more professional and sophisticated way of calculating those activities.

**Q422 Sandra Gidley:** A general question to everybody really. I do not know who wants to pick it up first. I wonder if you can tell us what the impact of Payments by Results has been and, lastly, CQUIN. Maureen, you just mentioned that it is a bit of an open-ended cheque. I have heard from some areas that those cheques are not necessarily being honoured by PCTs who have no money, which obviously causes problems for acute trusts.

**Ms Donnelly:** Cambridgeshire has one of the lowest capitation rates in the country—I think we are the tenth lowest—and we still have our debt to pay off, we have still got two more years to go in paying off

that debt, so we have always been, throughout that period, one of the most financially challenged in the country. We have never not paid any of our acute hospitals what is in the contract. We would never do that. That is not a professional way to engage. What we do is when we realise there are problems we work very hard with our clinicians, both primary care and secondary, and, indeed, the management at the acute trusts, to say, "It is not in anybody's interests for this to go out of synch. How do we manage it?", and we get through it, in general, because we all understand that. That is partly what Pauline said.

**Q423 Sandra Gidley:** How is it being managed: because when the financial pressure is on you cannot afford these open ended cheques?

**Ms Donnelly:** We manage it in a combination of ways. With all of our main providers the staff have set up monthly performance review meetings where they go in at different levels: they monitor the quality of the service, the outturn, the activity and the finances right through the day, and they check what is going on within that provider group; so constant checking, constant talking.

**Q424 Sandra Gidley:** That is not controlling the GPs who are prescribing or referring. You do not have much sway over them. Surely they are just pushing people through the system.

**Ms Donnelly:** There is a couple of things we do, and there is still the open-ended cheque. One of the things we have looked at is putting GPs in at the front end of the hospital so that, even though people physically go into the hospital, they are hitting primary care first. By the way, we do not want to stop people doing what comes naturally to them. Within Cambridgeshire we have got some transient people, both academics who come for two to three years, within the fenland people who come from Eastern Europe, for example, to work in the fens. They are used to a very different Health Service where they do not necessarily have primary care; they expect, if there is something wrong, to go to a hospital. It is hard to retrain people. It is easier to try and provide the service in a way that matches that and get primary care in in different ways. The other thing we do (and Paul will add to this) is work very closely with GP practices on monitoring GP referral, on monitoring prescription, making sure they all have the efficacy so they can see what is happening practice by practice. It is peer pressure in the end.

**Dr Zollinger-Read:** I think the medicines management is a shining success. What I have picked up from all the practices is that our medicines management team are very proactive in putting the information out and managing the variability and driving, effectively, effective commissioning.

**Q425 Sandra Gidley:** What about Payment by Results? Do either of you want to pick up on what impact that has had on what you do, if it has?

**Dr Brimblecombe:** We have got to demand manage—that is the problem—and the problem is being put back into the GPs' domain, because, as I

said, every time I write a referral letter, that carries a blank cheque and often we do not know where it is going to end up, and the only way you can do something about that blank cheque is to actually design a pathway so that you can fix how much you are going spend. That is for the future, and I think that is something that you have talked about with previous witnesses, but at the moment it is a difficult one because we have got patients who are being told, "You can have everything you want", you have got headline news that we have terrible cancer outcomes because GPs refer too late and yet, on the other hand, we are being told, "Actually you are referring too much. Stop referring", and I think the GP in the middle at the moment is saying, "I do not know what to do."

**Q426 Sandra Gidley:** Who is telling you to stop referring: the PCT?

**Dr Brimblecombe:** Yes, from our practice-based commissioning budgets, if we are overspent and our acute budget is overspent. We have incredibly good data from our PCT, we know exactly where our patients are going and what is happening to them. I know when my out-patient first appointments are overspent or my follow-ups are overspent—that is flashing up at you, it is in the red, I can compare myself with all the other practices in the PCT—and it is, "Do something about it", but sometimes I do not know what to do about it because I am only doing the best for the patient in front of me.

**Q427 Sandra Gidley:** Has that had any perverse effects on your patients yet?

**Dr Brimblecombe:** No, it has not yet, but when we have got a deficit situation and we have got a future NHS where we have got to make 15% cuts, why have Payment by Results for referring the patients' care? There must be other ways of managing that problem, and I think that is what we are trying to look at locally and why, in handing over a bit more responsibility to GPs, they will come up with these solutions, but, as I said, they are only going to come up with the solutions once they have understood that there is a problem.

**Q428 Sandra Gidley:** Mr Gray, this is good news for the hospital because it seems you are having a lot more activity and still being paid for it, but has there been any other impact of Payment by Results?

**Mr Graves:** I think perhaps I would go back; and I do mean this really seriously. We are probably the largest single entity consumer of money, as has been described. We know, based on the statistics you can get from the various information sources, that referral rates per funded head of population on a weighted capitation basis are, in general terms, above the money that the PCT has been given for that population, and I think it is true to say that historically, in general terms, secondary care, we have been fairly recessive in terms of working with local GPs to work out other ways of doing things, either to reduce the referral rates or to reduce the follow-up rates, and because our future is absolutely

entwined with the GPs and the PCTs from both a care point of view and a financial point of view, our doctors now understand, I think, fully well that they have to play a different role in working with primary care to see how we can get better use of that money.

**Q429 Sandra Gidley:** Is that really working? Doctor Brimblecombe's submission said that hospital doctors really were not off the starting blocks yet?

**Mr Graves:** No, I agree. That is why I absolutely said that if I sat here certainly two years ago, I think the conversation would have been, in general terms, GPs and other colleagues send us the activity and we do the work, it is an understood model, that is how it stood up, that is how it was set up, that is our role. As we sit here today and we project forward, clearly that is not going to be an acceptable way forward or a doable way forward.

**Q430 Sandra Gidley:** So, effectively, it comes back to more collaboration to try and improve the pathways.

**Mr Graves:** Yes, I think it is collaboration but actually action: because collaboration could be slightly soft. If I look at what is happening with diabetes and starting to happen with COPD, we are actually starting to see patients wanting to do these things together and, in effect, you are starting to say, "We do not need to grow the number of doctors in the way that we historically have, we need to grow the number of other professionals and we need to educate patients in terms of taking on more responsibility in managing their care, and between us we have an integrated care pilot, we also have a health foundation funded co-creating health pilot as well.

**Q431 Sandra Gidley:** That sounds a nightmare. What does that mean in practice?

**Mr Graves:** If I can take the latter one, it is saying that this is not just about managing the same bit of care in a different place—in other words saying we will follow up care in a primary care environment—it is starting to say, "I need to train hospital doctors, I need to train GPs and I need to train and educate patients to have a different conversation." My terminology is that we as the public and patients are far too often passive in our healthcare rather than dominating or trying to lead the agenda. It is easy to say that, but actually we have now got quite a lot of experience of the training programmes needed for each of those groups to actually enable a very different conversation so that when a patient comes in to see a secondary care clinician or a primary care clinician they more likely have an agenda that they walk in with—"What do I need to do to improve my health? What exercise do I need? What other things do I need to do?"—rather than just listening to what the Health Service is going to do to them. I can pick out hundreds and hundreds of examples, but I can pick out some individual examples, and evidence shows elsewhere that this, again, is a five to ten-year

training and change programme because colleagues and us as the public have been trained for many years in doing it in one particular way.

**Q432 Charlotte Atkins:** Maureen, do you feel that the PCT has strong enough clinical expertise to challenge the hospital?

**Ms Donnelly:** Yes. Obviously, our newly recruited chief executive is a GP, but we also have a medical director, we have a director of public health, all clinicians, and the chair of our PEC is a full-time director on the PCT board, and they work with other primary care clinicians, Pauline and her colleagues, to develop the pathways and to work with the hospital consultants to develop the pathways. That then goes to the people who negotiate the contracts and the targets and manage those.

**Q433 Charlotte Atkins:** Some of the evidence we have had suggests that commissioners do not have enough public legitimacy. Would you agree with that? At least that is the public perception. Do you think you are playing catch-up at the moment?

**Ms Donnelly:** If I was asked to say what the great British public thought about Primary Care Trusts, most of them do not know what they are, but, leaving that aside, I do think that in Cambridgeshire (and obviously I will not go into the democratic deficit discussions) we do have a fair degree of public legitimacy for a variety of reasons. One of them is that we have a very good close working relationship with all of the councils—the county council and the five district councils—we work very closely in that partnership. We also manage and commission adult social care on behalf of the county council—we have got section 75 agreements for that—and all those adult social care staff have been TUPE'd across to us, so they work as part of our provider arm, and there is a regular a meeting to monitor that with councillors and our board, regular engagement on that level.

**Q434 Charlotte Atkins:** I am not quite sure whether engagement with councillors necessarily gives you much public legitimacy, because councils themselves can be somewhat detached from their own constituents. It is only if they are engaged. I think you are right that PCTs are not known about by the public and very often when public health initiatives are launched I have found in my own PCT that it is quite difficult to get the PCT to engage in an effective way. If they put on a meeting and try to engage people, no-one will turn up and it will be their fault, not the PCT's fault. Likewise, if you have a health initiative and people have not turned up, that is their fault, it is not the PCT's fault. I think sometimes PCTs just do not look at themselves and say, "Hold on, if we are not getting a response here, why are we not doing more? Why are we not doing things differently?"

**Ms Donnelly:** I agree with what you are saying. It is very difficult to set up a meeting and get people to come to it. We have set up several public consultations over the past few years on

reorganising community hospitals and reorganising services on our out-of-hours contract most recently. We have got very good liaison with the LINKs teams and the patient groups within Cambridgeshire. In fact our Director of Communications is sitting behind me and she will kick me if I do not say this. We have put quite a bit of effort into not just holding meetings around the country ourselves, we have done a lot of that, but also very deliberately going out to offer ourselves to attend other people's meetings, and we have found that often that is a much more effective way of doing it. For example, if there is a local community or a local parish meeting, we will try and make sure that they know that we are there to come and talk to them about a particular issue.

**Q435 Charlotte Atkins:** What about your involvement with LINKs?

**Ms Donnelly:** Obviously there is a member of LINKs on our board. There are representatives of LINKs on the panel that was looking at our out-of-hours tender and the contract negotiations on that, so they were feeding through to that throughout the public consultation. In fact we had a board meeting yesterday where the LINKs representative who sits on our board commended us on it and said they really appreciated the way we had taken on board their comments throughout that process. I am not saying it is perfect; you have to work very hard to do this.

**Dr Zollinger-Read:** I think it is difficult to engage the public. In a previous role one of the most difficult groups to engage were young people. We went out of our way to work with all the secondary schools and had an adolescent forum, and that was a really powerful mechanism for helping us to change or improve our Chlamydia screening. I think there are things you can do, but this is one of the most difficult challenges we in PCTs face.

**Dr Brimblecombe:** The other thing is that actually when you are well patients do not actually want to be engaging with doctors, they are getting on with their life, and, therefore, often people only want to get engaged when they have got a real issue, and that sometimes makes it difficult to put that issue in the wider context.

**Charlotte Atkins:** PCTs are more than doctors. PCTs are also about promoting public health; it is not just about doctors. In fact, it is about other clinicians and it is also about engaging in a wider health agenda. I think patients probably do not want to engage with doctors when they are well, but I think there is a whole range of other things that PCTs should be doing. I do not see PCTs as just being about doctors.

**Q436 Dr Taylor:** I am just going to ask one question on that as well. In your organisation structure chart I am sure there is a misprint. On page six you have a heading "Communications Patient Engagement and PALS", whereas in the jobs you are describing, quite appropriately, you are calling the person Director of

Communications Public Engagement and PALS. Surely at the top the title should be Public Engagement and PALS.

**Ms Donnelly:** Yes.

**Q437 Dr Naysmith:** Thank you. You were with us, I think, for the first session, so you will have heard our two chief executives reasonably confident that they were going to manage this 30% cut. Again, in your organisation structure chart, something the Department of Health officials last week could not tell us at all for the country as a whole, you have actually given us a detailed split of the number of people you employ in finance and contracting and they add up to about 105 in the head counts. How are you going to cope with this cut?

**Dr Zollinger-Read:** If we look at our management costs, overall across the east of England we are in the lower banding of management costs compared to other PCTs.

**Q438 Dr Taylor:** Can you just define "management costs" for us?

**Dr Zollinger-Read:** That is a question in itself. How do we define them? There are various NHS definitions. The one we were using is above, I cannot remember, £22,000.

**Ms Donnelly:** Twenty-nine, I think.

**Dr Zollinger-Read:** There is a figure.

**Q439 Dr Taylor:** So it is on a salary split?

**Dr Zollinger-Read:** Yes. However, in the east of England we agreed that what we would look at is running costs, and so we are currently doing a piece of work to define what exactly running costs are because it is artificial to have that divide. My point is that NHS Cambridgeshire is pretty efficient, and so we have agreed to do this on a weighted capitation across the east of England. The challenge facing us, therefore, is not as great. However, we have already done quite a lot of work with the local authority, Cambridgeshire County Council, and on Tuesday we had a meeting of the local strategic partnership with all the boroughs and districts as well, and we have come up with five or six projects which essentially look at how can we radically transform the way the public sector works together to take out further costs. Some of that is around pure efficiency, back office stuff; others are around what does that actually translate into in someone's home, be it health or social care input. We have certainly done a lot of work there.

**Q440 Dr Taylor:** Do your management costs include all these accounts assistants, for example, who are obviously way below the £29,000?

**Dr Zollinger-Read:** They will not include that at the moment, no.

**Q441 Dr Taylor:** So how are you going to cope with a cut of 30%?

**Dr Zollinger-Read:** As I said, the cut may not necessarily be 30% for us because we are looking at it on a weighted capitation basis across the east of England.

**Q442 Dr Taylor:** So, because you are pretty efficient already, you will not have to cut that amount?

**Dr Zollinger-Read:** That is the understanding, yes.

**Q443 Jim Dowd:** I apologise, first of all, to our witnesses. I had various other conflicting engagements with constituents and local schools coming in that I had to see this morning. I am going to ask some questions, but if you have already answered them I can only apologise, so refer me to the transcript which I will read later. This is just about what general impression you have of world-class commissioning. Is it a step in the right direction and when will be a reasonable time to decide whether it has been successful or not?

**Dr Zollinger-Read:** I think it is a really helpful framework, because for the first time it has given us a set of competences that we should achieve to become world-class and it has enabled us to see where we are in that, what our needs are and start to put those in place. As the previous speakers, we were weak on certain areas such as prioritisation, stimulating the market and procurement, and we have done a fair amount of work in the past year looking at those areas. I think it is helpful, it gives you that framework and it helps you to put those skills and competences in place.

**Dr Brimblecombe:** Can I add, as a practice based commissioner, that actually we have locally for our consortium held an away-day a year ago to look at world-class commissioning and competences to see where PBC fitted in with it and took at least five of the areas which we felt that we should be contributing to as well.

**Q444 Jim Dowd:** Is there anything else to add?

**Ms Donnelly:** It is work-in-progress. They are helpful guidelines to make sure we are doing the things we should be doing.

**Q445 Jim Dowd:** Most things are in progress. To the question, “When would be an adequate time to decide upon its success or otherwise”, would that be another year?

**Ms Donnelly:** It will be longer than another year.

**Q446 Jim Dowd:** Five years?

**Ms Donnelly:** Hopefully it will be less than five years, but it is within those boundaries. We are hoping within two to three years.

**Dr Zollinger-Read:** Demonstrating improvements in the competences is one thing, but that is not particularly helpful to the public, is it? What we have got to demonstrate is improvement in outcomes, in services—that is the final common part of world-class commissioning—and we need to demonstrate that going forward year on year.

**Q447 Jim Dowd:** The difficulty with using the public as a yardstick is there is only one outcome they are interested in, and that is what happens to them. You can quote all the other numbers you like over time; if they have had a bad experience that will be their understanding of how the Health Service works. Equally, if they have had, as I have had recently, a very good experience, that is something as well. You mentioned, Dr Zollinger-Read, the weaknesses that were pointed out to you in your review last year before I could raise them, and I think you said you had looked at issues arising from that. Could you put a bit more detail on that?

**Dr Zollinger-Read:** Clearly we had a world-class commissioning assessment. Out of that was clear detail of what our strengths and weaknesses were. We formulated an organisational development plan, came up with work streams, implemented those work streams and managed them over the year so that the procurement function had been strengthened. We have a very able public health team who have looked at models of how we prioritise our expenditure, which is clearly essential, and so we are following that organisational development plan. We are coming up to another assessment in March some time and would hope to demonstrate a rise in those competences.

**Q448 Jim Dowd:** You would say that the weaknesses that were identified were valid, would you?

**Dr Zollinger-Read:** Yes, I think so. It has set a very high bar and where we were was at a point in time, as Julie said earlier, when PCTs came together and we were re-organised. It took quite a while to settle down, to focus where we were going, and so that was a point in time. We now have stability, we are now moving forward and our plea is, please, support us to move forward rather than re-organising.

**Q449 Jim Dowd:** There is a proclivity—I put no higher than that—not just in the Health Service but in the public sector generally, that if it receives bad news it tends to dispute the veracity of that rather than getting on and dealing with the shortcomings identified.

**Ms Donnelly:** Are you referring to the league table, or not?

**Q450 Jim Dowd:** It could be all kinds of things. People tend to like league tables when they are at the top of them.

**Ms Donnelly:** I know.

**Q451 Jim Dowd:** They tend to dislike them if they are at the other end.

**Ms Donnelly:** I know, and I sometimes call on the *Lake Wobegon* for that factor, for those who like Garrison Keillor. All the children of *Lake Wobegon* were above average intelligence. Somebody has to be at the bottom. We accepted the competency score. In the competency score our average was 18, which is above the median point between the 23, I think it was

at the highest, and the 11 in terms of the competency score. We were less happy with the way the HSJ interpreted that, but you just get on with it.

**Q452 Jim Dowd:** That is showbiz, yes. Has it improved commissioning or even made it worse over the past two years in your estimation?

**Dr Zollinger-Read:** No, I think it has definitely improved. First of all, we have formulated a clear strategy from that, areas that we wish to focus on and clear plans to deliver that. Pauline.

**Dr Brimblecombe:** Yes, I think it has really focused, again, clinicians on to the areas that are important to us. Our priorities are community based services, are care of the elderly, better long-term conditions, rather than perhaps some of the must-dos coming down from the Department of Health or from the SHA. We have a different focus, and it has meant that we can actually get our priorities in. It has also concentrated on other things engaging with the wider community, particularly GPs. I accept we tend to only see the person in front of us and the world-class competences has made us look outside, look at social care, look at the third sector as people who have got a good contribution to make.

**Q453 Jim Dowd:** I know this is a generalisation, but would you say it has improved? What has it done more effectively: improved value for money or improved services to patients?

**Dr Zollinger-Read:** I think we have achieved both. I think we have got significant evidence that we have improved services for patients and, yes, value for money. Let us take an example: the management of heart attacks. Now, through the commissioning process, if you have a certain sort of heart attack you are taken into a specialist centre and you have a balloon put in and it unblocks it and people live now who would not have lived before. That is a better outcome for the patient, it is more cost-effective for the country and that has come through a rigorous commissioning process.

**Jim Dowd:** I think it is undeniably a better outcome for the patient. Thank you very much indeed.

**Q454 Sandra Gidley:** A question about how we can better engage GPs. Obviously, they see most of the patients first. I got a sense from Dr Brimblecombe that they perhaps were not consulted or that better use could be made of their knowledge and expertise. What plans have you got to improve that in the future?

**Dr Zollinger-Read:** As I said earlier, we are having what is called the “big conversation”. We are going out and talking to all the GPs across the patch, and this, essentially, is about enabling them to form clusters. The clusters are up to them to form.

**Q455 Sandra Gidley:** You do not have those in Cambridgeshire yet.

**Dr Zollinger-Read:** We have PBC groups, but we are now talking about all the groups getting together in local clusters. It is a much more in-depth process and the crucial bit is that they will have a real budget

which will be weighted according to the need of their area and we will free-up the process so that they can assess local need, decide what they need to do and do that much more quickly than they can in the current process. I have only been to three of these meetings and there is a real buzz. You clearly have a spectrum and you have got some real leading edge GPs who are saying, “I want to put my house on the market and buy an x-ray machine and I am going to be a real risk-taker”, and you have got some who say, “Over my dead body”, but the weight of the curve is definitely, “This something we want to pick up with because we believe the NHS is facing difficult times. We are the local clinicians and we can make this more cost-effective”, and so at the moment there is a definite move in that direction. Pauline, I do not know if you want to say anything from your point of view.

**Q456 Sandra Gidley:** I do not know if you are aware of a Kings Fund survey of GPs and practice managers in 2007. They cited PCTs as a real barrier to practice based commissioning and cited high levels of bureaucracy and lack of PCT support. Has that changed or is that better now?

**Dr Brimblecombe:** Yes, the information we are getting is better now. The engagement, the understanding is getting there, the trust is building up, because, again, for PCTs who carry the can, Paul loses his job if he does not get financial balance; if my PBC a budget goes over, I have got my day job still. The understanding together is that it is our problem—rather than it is the PCTs problem, it is our problem—and that is the real change, because I think GPs now are worried that all the must-dos are taking away from the things that they would like to do. We were talking about Payment by Results and, as Maureen says, that bill has to be paid. We also have all the must-dos that come down from the Department of Health, we have the must-dos that come from the SHA and then there is this little pot of money with all the things that we would love to do, which is usually improving the care for our demented patients, or our more vulnerable patients, or our learning disability patients, or people who have less of a voice, who do not actually make the headlines but who actually, from a GP’s perspective, are the people we really want to put more resource into.

**Q457 Sandra Gidley:** You mentioned earlier that you are having to do things in a little bit of a different way to the way you were trained.

**Dr Brimblecombe:** Yes.

**Q458 Sandra Gidley:** There was almost a retraining need. Are you getting that help and support from anywhere?

**Dr Brimblecombe:** No, I think that is what we are doing ourselves.

**Q459 Sandra Gidley:** But there will be some who are not as engaged in that.

**Dr Brimblecombe:** I have to say, I think that is where central government should be. Where are the GP leaders at the top, where are they in the Department of Health, where are they in the SHAs actually saying, “This is where healthcare should go”? I have sat on a NICE committee. There was me with ten consultant gynaecologists. The last time I was in a Health Committee here was on dermatology. There was me as the lone GP amongst a sea of dermatologists. Therefore you always get pathways developed from the top rather than from the bottom, which is why sometimes, I think, some of the pathway development does not sit easily with how GPs feel we should be managing patients. We need more general practice right in at every committee. I sit on the SHA, the acute care pathway for the Darzi review for the east of England. This is one of the problems. Trying to get GPs to engage, of course, is a different matter, and a lot of it is because of our independent contractual status because there is nobody to pay for the GP to be out there. There are lots of issues why it does not work, but I think that again is changing because I think GPs are suddenly realising if their voice is not there they cannot keep bleating about, “Why is it not right?” I think things are changing. GPs do want to be engaged. Now is the time to really grab those who want to stand up and be counted because that will help with dissemination. I know the Royal College has got on board and the NHS Alliance and Michael Dixon. People like that are all saying the same things, “Please get GPs at the top, because then it will filter down.”

**Q460 Dr Naysmith:** Carrying on in this area a bit, would it be fair to say, Pauline, that quite often practice based commissioners do not have the levers and skills to manage providers and clinicians properly?

**Dr Brimblecombe:** I think that is perfectly true. We are clinicians, we have ideas, we are great at coming up with the ideas, but we do need the management skills to help us to actually implement them. We need in our clusters to have public health. You have to have public health there to ensure that you are focusing on the needs rather than on the wants or the demands.

**Q461 Dr Naysmith:** What would you say the three primary skills were that are needed to ensure that practice based commissioning works efficiently?

**Dr Brimblecombe:** We need good information—if we do not have information, we cannot do it—and I think we need a good manager to direct us. As I said, clinicians are great at ideas, they are really good at developing ideas, but they do need those ideas containing, help with prioritisation and help with actually implementing things.

**Q462 Dr Naysmith:** Have you tried to invest in these skills? Have you got them on board or are you trying to get them?

**Dr Brimblecombe:** In our cluster at the moment within CATCH we have a dedicated PBC manager, we have a team with informatics and finance that we have direct access to, and I particularly have direct access to because I can go into the PCT and I can see these people immediately. The problem is that still needs to be filtered out a bit more to the actual individual practices, because, of course, they still get their data and are not sure what to do with it. More support needs to be done on an individual practice basis, which, again, is part of my role as a PBC lead in trying to help and support the practices to come up to the level of understanding that I am at.

**Q463 Dr Naysmith:** What do you think the optimum size is for a practice based group?

**Dr Brimblecombe:** I think it depends. As we all know, it depends on what you are commissioning for a start, but I think it also depends on your circumstances. As I say, CATCH has about a quarter of a million patients and I think that is too big because we have disparate and different needs. The city practices have a different set of problems and needs than the rural practices, so we are looking at somewhere between 50–100,000. Again, if you are in a market town, there may be three or four practices who perhaps only will have 40–50,000, but that makes sense. The reason for being in a cluster is because you have got a shared agenda, you have got a shared vision, you have got a shared population that you can look at specifically; so it will vary.

**Q464 Dr Naysmith:** Is there any evidence for the optimum size? Have people written about this?

**Dr Brimblecombe:** I have written to all the different health economists I know in the country, including Martin Roland, who now is in Cambridge, and at the moment there is not very much evidence. It does depend on what you are commissioning. On an individual basis, from my practice I could commission for a lot of things like out-patient care, manage my own drug budgets, and you could risk-share because you could take off patients who are very expensive, which is what we do at the moment, but it is more for the system change that you need to be able to share resources within practices, because otherwise the transactional costs like the fund holding is so enormous. That was the problem with fund holding. To have a manager earning 60–70,000 for each practice was crazy; it was too expensive.

**Q465 Dr Taylor:** Integrated care. Your pilot looks to me to be one of the most difficult of all—end of life care. You have got to cut across GPs, nurses, pharmacists, social care, ambulances, schools, hospitals and hospices. How are you getting on? How are you doing it? Who is in charge of that?

**Dr Brimblecombe:** It is being led by the three providers we have. This was something that GPs were very keen on because we have the acute trust, we have our community trust and we now have Assura Cambridge LLP, which is the GP provider side of things, the patient voice, and they are taking the lead and collaborating very closely with Stephen

and his management and with the community services and with the hospice and with the PCT. We are not going to solve end of life. A lot of it is actually taking quite a small project which is basically making sure that everybody is sharing information on that patient so there is no duplication and the patient voice is at the forefront and that everybody knows what that patient's requests have been. It is all about communication.

**Q466 Dr Taylor:** How are you involving social services? Is that going well?

**Mr Graves:** Yes. Social services are formally brought in through the provider side of the PCT who have contact with social services directly which are run from the social care budgets locally, so they are directly integrated into it through that particular route.

**Q467 Dr Taylor:** So even though you are crossing different budgets and different management structures you are managing to do that somehow.

**Mr Graves:** I will be very clear; it is not easy. As the colleagues said earlier, some of the challenges in this is where is the information held? Can you access that information? People are in an end of life pathway from different areas, but, if you took one group from a nursing home, one of the issues that has come up is who has the information about that group of patients? Which GPs are actually formally "having a relationship" with that group of patients? I think all of us will have relatives or former relatives who have been in that environment, and the nursing home may or may not be in the geography of where the patient has historically been cared for. If I take my dad, he popped in and out of respite care into different places, one may be in the core catchment area of our GP practice and one may just be outside depending on availability of space. Unlike the past where it has probably been managers like me talking to other managers, it is actually GPs sitting there going, "How do I adapt my information system for Mr Blah Blah and Mrs Blah Blah, and how can I share that with the nursing home and what direct conversation can I have?", because it is likely to be the GP who is the person, if we can get it to work, who will be called to actually do something. Once a patient is put into an ambulance and arrives in an A&E department of a hospital, actually the best place for them to die at that point in time, sadly, maybe inside the hospital, having had all of that. The issue is: "Why did they get in the ambulance in the first place?", and that does require people in nursing homes to have the skills to deal with it and GPs to be available or other local clinicians to actually keep people in that environment.

**Q468 Dr Taylor:** You are able to look wider than just at cancer deaths: you can include motor neurone disease and things like that?

**Mr Graves:** Yes, we are looking at every group of deaths. In Addenbrooke's there are some 1,500 deaths per year and our goal is to focus on the notable groups and where we can have an effect.

**Q469 Dr Taylor:** Is there yet any evidence that integrated care is saving money or improving care?

**Dr Brimblecombe:** No, it is too early to say.

**Q470 Dr Taylor:** When does this pilot finish?

**Dr Brimblecombe:** It is three years, is it not?

**Mr Graves:** It is.

**Q471 Dr Taylor:** It is three years, and it has only just recently started.

**Mr Graves:** It started about a year ago, but I guess it is fair to say it has taken a year for us to all get our brains round the issue.

**Q472 Dr Taylor:** From your point of view, can you see that it is likely to be improving care?

**Dr Brimblecombe:** I am sure it will in the future, but it is also the spin-offs, it is the actual getting three different organisations working together and talking together, because from that, hopefully, it will be a model that we can then roll out to other areas of care, because that is the problem. It is working together and trusting each other, and you can only learn trust through actually doing things together.

**Q473 Dr Naysmith:** There is quite a lot of improved data nowadays about performance in hospital care, but there is still quite a paucity of data about primary and community care. I am sure you would all agree with that, would you not?

**Dr Brimblecombe:** Yes.

**Q474 Dr Naysmith:** Which aspects of performance data would you prioritise to improve commissioning, understanding and to facilitate better care for the patients? Where are the data gaps? Maureen, do you want to have a go, or Paul?

**Dr Zollinger-Read:** I think one of the major areas that we need to improve on is community services. We have contracts with community services, but what is it exactly we are purchasing? How are we going to measure that? If we look at the history of commissioning, I think we have come a long way with acute commissioning and the information on acute commissioning is quite sophisticated, but certainly on community care it is fairly embryonic. In terms of primary care, we have a reasonable amount of data, in terms of prescribing, that is well advanced and referrals, so we do have information to manage primary care, and so my focus through this year will be to develop community services data.

**Ms Donnelly:** I would add to that, because I think it is not just about managing community services data, it is how that fits into the whole picture of our spend and the quality of services we provide and relates to some of the questions that were asked earlier. I am very conscious that somewhere between 36–40% of our total budget is spent on the over-65s and we commission on behalf of the county council for the adult social care a significant proportion which is in the care of the elderly, and it relates to the discussion recently on the end of life care. We really want to get that working as efficiently as possible and as effectively as possible, first, so that the elderly are

looked after properly, do have a very good experience, people who are coming to the end of their life are properly looked after, that you do not just have a fall, the ambulance comes and takes you to hospital, you are there for two weeks, you come out again and you have gone downhill several steps. If you can get the information correctly together and commission that together correctly, it is my very strong belief that not only will we be delivering a much better service to the people of Cambridgeshire, but it will also be cheaper in the end. Just reducing inefficiencies in that in itself would ensure that.

**Q475 Dr Naysmith:** What couple of sources of data would help you, Pauline, to improve the way your organisation does its job?

**Dr Brimblecombe:** As I said, we actually get quite a lot of good information which allows us to compare. I think from the community side of things though (and this again, I think, is where some of our secondary care colleagues could help) it is actually setting the bar even higher, because most of the practices, particularly within the city and south Cambridgeshire, get very good QOF outcomes, they all get over a thousand points, but that does not indicate we could not do a lot better. We were talking about diabetes earlier and having outcomes actually set in collaboration with our consultants to enable us to actually push the bar a little bit higher would help and, I think, if we were given a more commissioning role in long-term conditions, we would then actually work with our community staff, because, again, our specialist diabetic nurses take great pride in the care they give their patients and, particularly being in Cambridge, we actually like a bit of competition; we like to be marked. We all think we are at the top and we do not like it when we are at the bottom, but we actually do like to improve. At the moment the data is still a little bit about the number of referrals. The score card, or whatever, that the PCTs are marking GP practices on, I think it is five or six areas, is just being developed and I suspect that will be a little bit gross at first, but unless you get something you cannot improve on it. If we get something, then we can say, "Actually, that is not quite right." We get a lot of feedback on patient information, on what they think about us, because of the patient questionnaires that go out, so I think we do actually have a lot of information in general practice that we just need to share.

**Q476 Dr Naysmith:** It has just struck me that all morning we have not mentioned the commissioning of mental health services at all. Do you have a separate Mental Health Trust in Cambridgeshire?

**Ms Donnelly:** Yes, we do.

**Q477 Dr Naysmith:** For whom the PCT will be involved in commissioning services?

**Ms Donnelly:** Yes, we commission the services from there.

**Q478 Dr Naysmith:** Is there anything special about commissioning for mental health?

**Ms Donnelly:** They were one of the pioneers of IAPT, the early intervention. We have got a very good Mental Health Trust.

**Q479 Dr Naysmith:** You have got enough information to enable you to improve?

**Ms Donnelly:** I would never say we have got enough and it is good enough, we can always improve, but we know that the outcomes are very good and we know that the value for money is very good from our Mental Health Trust, so on those two basic measures we have got sufficient.

**Q480 Charlotte Atkins:** You have an adolescent group, do you not, and, of course, very often mental health is not picked up very early. Do you get much information from your adolescent committee about issues around mental health, because I think youngsters in particular are quite concerned about that issue?

**Dr Zollinger-Read:** I think that is the most challenging area. Pauline can speak to what it is like on the ground, but in all the areas I have been the child adolescent mental health services are the most challenging area and have required the most significant investment. Do we get as much information as we would like? Probably not, but that is part of the evolving commissioning development, as I would see it.

**Dr Brimblecombe:** We have a very good relationship between the Mental Health Trust and GPs. One of the clinicians, the GPs, on the executive board works very closely with the Mental Health Trust. It is one of the areas which we think we have actually got good relationships with. They listen very carefully to what GPs say because so much care has already moved out into the community that we have a symbiotic relationship. Certainly, as far as the adolescence, again, our GP is waving the flag for that and certainly she has developed psychological services for that age group.

**Q481 Dr Taylor:** As a committee we asked the National Audit Office to do a telephone survey with directors of commissioning within PCTs just for their views, and they tell us that they did 114 telephone interviews from a sample of the 152 PCTs and had a response rate of 75%. The results really, I think, probably amazed most of us because they have not been fully analysed yet, but the general perceptions of commissioning are very positive with 95% of commissioners stating that commissioning is going well. Of these 82% believe it is going very well. That rather contrasted with what we have been told by the Department of Health, who felt that it was not as good as all that.

**Dr Brimblecombe:** I think it has changed too. I think before they just phoned up random GPs who had never heard of commissioning in their life. I think they changed and started to target people who were involved with commissioning.

**Q482 Dr Taylor:** So these were directors of commissioning?

**Dr Zollinger-Read:** Yes, they will be people in PCTs who are clearly under the belief that things are going swimmingly well. I think that the reality, as I said earlier, is that world-class commissioning has been extremely useful. It has provided a framework, it is enabling us to develop and there are always challenges; there are huge and significant challenges. We have had emergency pressure challenges. In Cambridgeshire the main challenge for us is managing the elective over performance, so routine referrals, but are we in a better place than we were a year ago? Definitely, and the journey has helped us to get there. I think if you were to ask PBC groups do they think it is going well, you would not come out with 95%, but if you asked them are they optimistic that PCTs and PBCs are now getting together and cutting through some of the bureaucracy we put in place, I think the answer is, yes.

**Q483 Dr Taylor:** Again, the survey showed that up to a quarter of PCT commissioners do not know what they spend on practice based commissioning. How can you not know what proportion of your commissioning is being done by PBC? You probably do know the proportion, do you?

**Dr Brimblecombe:** We do not actually commissioning anything directly, i.e. we do not hold the contracts with anybody. We are actually at the moment much more of an advisory service, so, no, we do not commission anything.

**Dr Zollinger-Read:** I think that is a difficult question that we might have got variable answers for. In another place we had a clear plan and they were taking care of this so you could quantify it. In other areas there is more input and advice, which is difficult to quantify. I suspect that is why there are some strange answers in that.

**Q484 Charlotte Atkins:** What would you like to see in terms of helping improve your commissioning? What would help you improve commissioning for your local population?

**Ms Donnelly:** Stability.

**Q485 Charlotte Atkins:** You mean no change.

**Ms Donnelly:** Stability is probably a better way of describing it; there is always room for some change. Every time there is a big reorganisation it destabilises everything and knocks things back. No organisational structure is ever perfect, but it is better to try and do the best with what you have got.

**Q486 Charlotte Atkins:** Floating off your provider arm: how would you see that? Is that going to be destabilising?

**Ms Donnelly:** That has been running as a separate organisation for the best part of two years. We very deliberately set it up with its own nominal P&L account. We really wanted to try to get to grips with the blancmange in the provider arm so that they began to look at business units and the value for money of each different business unit line, and they have gone a long way towards that, but they have been working on that for two years. Whether it

crosses the boundary or not into either a trust status or, eventually, an FT status will not make that much difference to the way we interact with them at the moment. We treat them at the moment as a wholly owned subsidiary.

**Q487 Charlotte Atkins:** Anybody else?

**Dr Zollinger-Read:** Yes, being a GP and being a manager, I know very clearly which the most challenging is. We need to invest in NHS management because it is a really tricky thing to do. It is managing really complicated relationships. A lot of what we do is through influencing others, so, first of all, we need to nurture our management and, secondly, we need to get more clinicians into management. When I was at medical school they did not tell you anything about management, and I am not sure they tell you very much now. Other countries are starting to integrate management into medical school, and I think that is a really good place to go. We have really got to crack this GP consultant business. If I look at the vision for my clusters, I would like to see a model where GPs and consultants are the same unit and they are not actually having a contract with my friend next door but they are working as one unit, that they will go to a hospital as a place of work and have a contract with them. Then you are commissioning a whole care pathway rather than a bit in primary care and a bit in secondary care. Finally, incentives. PBR has been useful and it is evolving and we need to involve it further. We need to think through carefully what are the other incentives that we need for primary care to manage how we commission primary care, because those are much woollier at the moment.

**Q488 Charlotte Atkins:** Would either of you like to comment, Pauline or Stephen?

**Dr Brimblecombe:** Personally, one of the problems we have is actually we would like more money.

**Dr Naysmith:** Everybody says that.

**Q489 Charlotte Atkins:** Why does that not surprise me?

**Dr Brimblecombe:** I know. The reason I say that is our patients are allocated a certain amount of money with which we have to deliver the total part of their care, and I do not think patients actually realise that a patient in south Cambridgeshire is worth a different amount than a patient in east Cambridge, fenland or in the city, Birmingham or somewhere like that. Of course, that was done for very good reasons, possibly not so good reasons actually, in that it was felt that by differential funding of medicine you could equalise health inequality. Some of it will help, but most health inequality, as we learnt earlier in the week, is to do with things completely outside of our control, and because healthcare has historically been done on demand rather than on need, actually at the moment, particularly at our south Cambridgeshire practices, we are having to be able to say to patients, "I am sorry, you have really good healthcare, you have very good outcomes but it is costing us too much money." Therefore, somehow we have got to be able to either take it away from them, be more efficient, which,

obviously, I am sure you would like us to be, or is the formula right? I put that up as one because it is going to be a real challenge for us locally to engage the GPs, because when they are already 4–5% over budget, and I have already shared this with our local MP, who is the shadow Minister of Health, how are we going to engage GPs when they are already facing a two and a half million deficit in their GP budgets?

**Q490 Charlotte Atkins:** So you are suggesting we should give more money to GPs so that you can meet the demands of your demanding patients rather than the needs of those where health inequality is the greatest?

**Dr Brimblecombe:** I would like that, unless you can help me engage with my public to understand that actually they have got to take a role in the total health, the distributive justice that I have talked about earlier.

**Q491 Charlotte Atkins:** Is that not what GPs are supposed to be so good at doing: engaging with their patients and public?

**Dr Brimblecombe:** They are on an individual basis. As we have said before, for an individual patient what they want is what they want and putting it into context is difficult.

**Q492 Charlotte Atkins:** That is what we have got to do; we have got to do difficult things, have we not?

**Dr Brimblecombe:** Yes.

**Dr Zollinger-Read:** I think one of the benefits of this cluster model is that what works with GPs is peer to peer pressure and what does not work so well is a PCT with a big stick. We have the information, and what we would expect within the cluster then is for GPs to sit down, look at their relative information and start to question each other. This is the sort of Holy Grail when you start to question each other about clinical decisions because you are an outlier, but that is where I believe we need to tread.

**Dr Brimblecombe:** Also with the politicians, I do think you have a role to stop fuelling demand the whole time and saying you can have whatever you want, because you can within a resource allocation, and to engage the public, as I have said before.

**Q493 Jim Dowd:** Let me clarify this, because just to say you want more money is pretty naive.

**Dr Brimblecombe:** I was being slightly facetious in that.

**Q494 Jim Dowd:** That is what I wanted to clarify—not whether you are being facetious or not, that is a matter for you, but whether you were actually saying you wanted a higher proportion within the current allocations or you just wanted more beyond that?

**Dr Brimblecombe:** I suppose I am challenging: is the allocation right? That is one thing, but for a GP to want to take on that budget they have got to be sure that it is a fair budget. What we are trying to say is we

are going to go to fair shares, and what that means within Cambridgeshire is we have got from certain areas in Cambridge to hand over to GPs in a different part, so we have got to take from the rich and give to the poor, if you like.

**Dr Zollinger-Read:** I think there is more to it than that, because there is so much more we need to do. One of our issues is orthopaedic growth, and that cannot bear any resemblance to a change in population because it has happened too quickly. If we also look at prescribing, we are relatively good but we are still giving shed loads of drugs out that if we stuck to rigorous guidance we would not do; so there are still more efficiencies we could get. Finally, there is the quality agenda. We have looked at MRSA and C.diff and clearly the improvement in those has substantial cost savings. There are many other quality areas we can start to look at which will drive out cost.

**Q495 Dr Naysmith:** Before I wind this session up, I cannot forbear from mentioning, Pauline, that some us on this committee have known for quite a long time—about 30 years—that medical intervention was not the most important things in terms of getting rid of inequalities, particularly those of us who have read the Black Report.

**Dr Brimblecombe:** That is why GPs would like to take on more commissioning, because, I have to say, that is not what comes from the Department of Health, it goes into acute care. We know that one of the greatest things that has happened is banning smoking in public places, which actually did come out from clinician pressure but eventually was taken on board by the politicians. Again, I know some people want to keep politicians out of medicine. Actually I think I would like to bring politicians into my cluster as well.

**Q496 Dr Naysmith:** Be careful what you wish for!

**Ms Donnelly:** Pauline always very passionately defends her patients and her population and we admire and respect her for that. It is very clearly one of the reasons why we engage so closely with our districts, and having a good health outcome is something that goes way beyond the Health Service. At the meeting that Paul referred to that we had yesterday with the local strategic partnership, we had the Chief Constable talking about domestic violence and how that interlinked with care of children, we had the Head of Fire Service saying when his people go in to talk about fire safety why do not they talk about not smoking. That is the sort of thing we really want to develop and work on.

**Q497 Dr Naysmith:** But that is not the base for it, surely.

**Ms Donnelly:** No

**Dr Naysmith:** Can I thank all four of you very much for contributing to our evidence this morning. We are not quite sure when our report is going to appear, but we will try and get it out before the election, which none of us knows when is going to happen. Thank you very much indeed.

## Thursday 4 February 2010

Members present

Mr Kevin Barron, in the Chair

Charlotte Atkins  
Mr Peter Bone  
Sandra Gidley  
Dr Doug Naysmith

Mr Lee Scott  
Dr Howard Stoate  
Dr Richard Taylor

*Witnesses:* **Professor Chris Ham**, Professor of Health Policy and Management, University of Birmingham, and **Dr Jennifer Dixon**, Director, The Nuffield Trust, gave evidence.

**Q498 Chairman:** Good morning and welcome to our fourth evidence session on our inquiry into commissioning. I wonder if, for the record, I could ask you for your name and the current position that you hold?

**Dr Dixon:** Jennifer Dixon, Director of the Nuffield Trust.

**Professor Ham:** Chris Ham, Professor of Health Policy and Management at the University of Birmingham.

**Q499 Chairman:** Again, welcome. A nice simple question for both of you to start this session. Why has commissioning been so weak for so long?

**Dr Dixon:** The fundamental reasons are that healthcare is very complex. It is probably one of the most complicated areas of contracting and commissioning that there is in the country compared to other sectors, so that is very important. The second thing is that the producers have much more information than the commissioners have and in what they are doing they have huge amounts of discretion and cannot easily be challenged. There is not much information about clinical care to help commissioning; there has been a lot of organisational turbulence amongst commissioners over time. They have not been able to settle and develop talents and a lot of managerial talent resides in hospitals and not in PCTs. Those are some of the main reasons why commissioning is weak, but the fundamental thing is that commissioning is complex and all the knowledge and power resides on the provider side and the providers do not necessarily have the same views or objectives as commissioners.

**Professor Ham:** I would agree with that and add a couple of other points. One is that in the Health Reform programme as a whole a lot of the early emphasis was placed on the development of new kinds of providers like the Foundation Trusts and the ISTC; only latterly has the same focus been put on the commissioners, both PCTs and Practice Based Commissioners through the World-Class Commissioning programme, and I am sure we will discuss that in more detail, so there was that late start in recognising that a lot needed to be done alongside the development of providers. The second thing is that the most managers and clinicians who work in the NHS have essentially come from a provider background, and the thing that we call commissioning does not come naturally and the people and the skills that we need to get anywhere

near what is called world-class commissioning are simply lacking in many places. There is also a lot of turnover in Primary Care Trusts of the people who have those commissioning responsibilities compared with much more stability on the provider side. I remember talking to a very experienced manager in a large Acute Trust in London two or three years ago who had been in that post for about ten years, was very experienced and able, and her reflection was that the commissioners that she negotiated with chopped and changed about every 12, 18 months, were generally quite junior people making their career very bright but were not in post long enough to be able to take on commissioning effectively. There is a number of reasons.

**Q500 Chairman:** If it is, in a sense, a weakness in PCTs, can we not do without them like they are doing in Wales and Scotland?

**Dr Dixon:** Somebody has to be the agent for the patients. There are very powerful forces within providers which mean that they do not necessarily align their objectives with what the taxpayer or populations might want for their health, so there has to be some agent, and therefore having direct feeds of money directly to the providers, without any kind of agent group like a commissioner, would be a problem.

**Professor Ham:** I think you have to ask what PCTs do and who would do their functions if we did not have them; so there is a responsibility for population health. Focusing on prevention, tackling health inequalities is a really important function: somebody needs to do that within the system. There has traditionally been the responsibility of running the PCT provider services in the community: somebody has to take on that responsibility. I think your question is about the third principal function, which is the commissioning role of PCTs, and then there is a more important first order question that lies behind that: do you want to organise your NHS on the basis of a commissioner-provider split or do you want to argue for an alternative sort of arrangement? If it is an alternative, then you do not need PCTs or other bodies to do commissioning.

**Q501 Chairman:** You have obviously looked at this issue, not just in the UK, but worldwide as well, and we will have some specific questions on that, but why did Wales and New Zealand abolish the purchaser-provider?

**Professor Ham:** I think for political reasons fundamentally. In New Zealand they had had their version of the old internal market with a purchaser-provider split because the Government at that time, going back to the nineties, as it was, wanted to introduce more choice and competition. Therefore, there was logic in trying to separate out the roles to stimulate a market to drive improvements in performance. A change of government, different priorities, did not believe that markets had a big role to play in healthcare; they therefore reverted to their integrated structures based on the health boards, like Wales now has and also Scotland. I guess (and Jennifer can speak to this better than I can), if you look at the performance of Wales and Scotland compared with England, the recent very comprehensive analysis done by the Nuffield Trust seems to suggest that England has made further faster progress in improving performance on things like access and waiting times than the more integrated systems in Wales and Scotland. It is, of course, much more complicated than that because there is never one thing, like integration or purchaser-provider, that helps explain variations in performance, but it gives us pause for thought.

**Q502 Mr Bone:** Should we not be worried about this weakness in the PCTs? What is it, £80 billion a year of taxpayers' money goes through things that are weak, and it has been suggested already that they do not have the highest calibre of staff. Mind you, I find it strange when chief executives are paid £200,000 a year. It is not lack of money that does not attract them, but if they are that rich should we not be very worried about that?

**Dr Dixon:** Yes, I think we should be worried. It is interesting that the attempts to try to boost skills of Primary Care Trusts, as Chris has said, have only really latterly started with World Class Commissioning. They have only recently been set out, and that was in 2007 in World Class Commissioning, but there are attempts now made to boost the skills in a number of ways and also to tighten up on performance management through analysis of a range of indicators. For example, there are commercial support skills through the Commercial Skills Units at regional level now to help PCTs tackle one of their most inherent weaknesses, which is management of the market, as fleshed out by World Class Commissioning, and through the *Performance Framework* in the NHS there is much greater and more forensic focus on a mixture of outcomes as well as competences and governance; so there is quite a lot more scrutiny, I would say, now on PCTs. It is still pretty weak but we are creeping towards something that is a lot better, but even if we really boost up PCTs, there is still this fundamental power imbalance with the fact that the people who generate most of the costs in healthcare are clinicians.

**Q503 Mr Bone:** I think we may be coming on to that in a later question. At the moment do we not have the PCTs really as price and quality takers rather

than price and quality makers? In other words, they very much take whatever price and quality the hospitals give them, do they not?

**Professor Ham:** I think, on the price side, it is constrained by the national tariff. One of the things that is very different from this version of competition in the NHS compared with the internal market is that there is no price negotiation, essentially, for those services within the tariff because the Government decided that, if you take that out of the equation, then it ought to be possible for the PCTs to focus much more on the second part of your question, the quality and the outcomes of care that are delivered. That has been, quite frankly, slow to develop. I do not think any of us would say hand on heart that PCTs have done a great job in being the active, intelligent commissioners leading the debate about quality and outcomes, putting lots of stuff in their service specifications and standards. That is very much work in progress.

**Q504 Mr Bone:** We have the Strategic Health Authorities sitting in these regions which are supposed to lick the PCTs into shape, but have they not just failed miserably? Would we not be better off just getting rid of the SHAs?

**Dr Dixon:** Like World Class Commissioning, it has become much more obvious now how SHAs should hold PCTs to account. There has been a lot of vagueness in the system, I would say, but now there is a much more obvious set of indicators that SHAs should hold PCTs to account on. Traditionally, they probably also have been quite weak, but now their roles are far more specified and the indicators on which they should be holding PCTs to account are more obvious. I think we may see more activity there.

**Q505 Mr Bone:** Are you not just being nice to them? Are they not terribly bureaucratic and are they not just jobs for the boys? If you talk about the standards in PCTs being bad, are not the standards in SHAs almost as bad?

**Professor Ham:** What I would say on that is that, again, you have to unpack what it is that SHAs are supposed to do within the system. One of their functions is to be the local arm of the Department of Health within the NHS. If the Department continues to push targets and performance management and lots of other stuff out in the system, you cannot do that from round the corner in Richmond House, you need to have a local presence, and that is what SHAs are partly there to do. Whether they need to be as big as they are with the range of staff they currently have, that is a really good debate to have, particularly given that in many parts of the country now—London is a great example of this—PCTs are being required to collaborate across sectors, sub-regions if you will, and it looks like there is a very crowded space between what those PCTs collaborating together across bigger areas are doing and what SHAs are doing. As that evolves I think your question is very pertinent.

**Q506 Chairman:** How much smaller do you think SHAs could be then?

**Professor Ham:** There are two parts to that. One is how many SHAs do we need? Is ten the right number? As a sometime historian of the NHS, then it has swung back and forward over the years. We started with 14 in 1948 and at some point it got down to four regional offices and we are now back to ten SHAs. There is no science about this; it is what fits the spirit of the times. I think there could be fewer than ten. I think the core question is what are their essential functions that cannot be done better lower down the organisation, whether on the provider side or on what eventually emerges on the commissioner side. I think you can legitimately argue the SHAs we have today are, by definition, transitional bodies. They have a job to move trusts to become foundation trusts, to take forward some of the World Class Commissioning stuff. When that process is more complete than it is today, I do not think anybody would argue you need SHAs with their current management costs and staffing.

**Q507 Dr Stoate:** We have been part of the internal market now for the best part of 20 years, and yet all the power (and I really mean all the power) is in the hands of the providers. Is that not a bit odd?

**Dr Dixon:** For various reasons we have described why PCTs have been inherently weak, but it is not so much that they are weak just here, commissioning is weak in other places in the world, largely for the reasons that we have pointed out, because all the power, the information, resides on the provider side.

**Q508 Dr Stoate:** I know it does, but why is that?

**Dr Dixon:** The focus has not been on commissioning. Why has that not been? Probably because some of the pressing problems in the Health Service have been particularly due to issues that providers can tackle directly, such as waiting times, and there has been so much focus on that that the focus on the commissioning side has been fairly weak; but now that we have Foundation Trusts that are becoming more independent, then we reside, or at least the NHS now resides far more on commissioning to lever up change through the contracting and commissioning system.

**Q509 Dr Stoate:** But if you have got Foundation Trusts which are now even more powerful, you are up against bodies which are inherently even less balanced, because PCTs, I think, would find it very difficult indeed to stand up against a well-run Foundation Trust.

**Dr Dixon:** Absolutely, and so that is why, if you want to try and improve commissioning, you cannot do it in isolation from other things in the system, in particular to re-orient incentives in the provider system so that everyone is pulling in the same direction, and they are not at the moment.

**Q510 Dr Stoate:** Why has it taken 20 years to get to this point, and this is not very far, let us face it?

**Professor Ham:** Because policy-making does not progress, if I may say, in a neat, linear, logical learning process.

**Q511 Dr Stoate:** If you look at the so-called internal markets of the world, let us take, for example, the food industry: if you speak to somebody like Tesco, who are rather good at that, they will say that they are entirely driven by their purchasers and that if purchasers did not like what they did, they would not do very well. If you look, for example, at the car industry, we have seen the problems that Toyota are having this week: if people stop buying Toyotas, they are in serious trouble. On the other hand, if people seem to stop wanting to use Foundation Trusts, Foundation Trusts simply get richer. I do not understand how it is that the market fails to work in the Health Service when it quite clearly does work in other sectors.

**Dr Dixon:** Again, there is not a market. Punters do not choose hospitals.

**Q512 Dr Stoate:** Even under Choose and Book we are still not choosing?

**Dr Dixon:** Not really. Also the movements under choice are actually fairly small and they are not providing the bite that is necessary to make providers sit up and listen.

**Q513 Dr Stoate:** What would happen if Primary Care Trusts had the power to refuse to pay hospitals that screwed up?

**Dr Dixon:** They are now having that power.

**Professor Ham:** I do not think it will make a huge difference. It is a fair point to make, the comparison with other sectors where procurement and purchasing is much further developed and much more effective, and the examples you have given demonstrate that, but, back to the very first point that Jennifer made, healthcare is different. Healthcare is much more complex. You cannot define the product, because there are so many different products. If you think about what comes out of an acute hospital, it is not widgets or car components, there is a whole variety of things that patients require that trained healthcare professionals do.

**Q514 Dr Stoate:** You can break them down, though. We have managed to break down what hospitals do into activities which are reproducible across different hospitals. We can say, for example, a hip replacement, generally speaking, takes these particular activities and an ultrasound scan takes this particular activity. We can break it down. Why is it we are so bad at commissioning services which are cost-effective and do work?

**Professor Ham:** Could I suggest the reason. When the internal market was first promulgated, people said exactly the point you made: "What can we learn from other sectors in healthcare to help our purchasers at that time do really well?" I spent a day in Marks & Spencer back in 1990 at their headquarters, then in Baker Street, to understand what did they do in terms of their skills, their people,

to be able to do effective contracting with a whole range of different suppliers. I learnt two things from that. First of all, they had one centralised procurement organisation, purchasing organisation, in Baker Street. They did not regionalise it, they did not have each store doing its own purchasing: they had a critical mass of people in one place. The second thing I learnt was that the people who were doing the buying for Marks & Spencer had a history, a career, an expertise in the things that they were responsible for buying. They had worked in food, industry, the clothing sector; they brought that deep knowledge and they were adding value to the suppliers of Marks & Spencer because they themselves were experts. Look at who we have in PCTs. Do we have expert GPs and clinicians across a range of specialties who have got the same depth of knowledge? No, we do not. That is why we have the difficulties we do.

**Q515 Dr Stoate:** One final point: I want to go back to this idea of PCTs leveraging more power by refusing to pay for poor quality, refusing to pay for “never events”, refusing to pay when hospitals miss their C.diff targets, refusing to pay when someone has waited more than two weeks for a cancer appointment. Why can they not arrest that power and simply say to hospitals, “If you do not deliver, you do not get paid”?

**Dr Dixon:** I think the answer is they are beginning to do this under this new payment system called CQUIN which has been brought in, whereby there is a certain amount of money that can be withdrawn from the contract or not given to providers, and in the future it is meant to be going up to 10%—it is now about 1.5%. There are seven “never events” at the moment that PCTs simply do not have to pay, so there is some help with the payment system. There is also other help. There are standard contracts, there are standard evidence-based pathways, from NICE and NHS evidence, that commissioners now have that they did not have, say, two years ago, but still the issue is two things. One is that there is a high amount of discretion in healthcare; physicians do not necessarily follow the path. Because healthcare is so complex, there is a huge amount of discretion that is still possible, and probably should be. The second thing is that there is still a lack of information for commissioners to be able to get a handle on some of these discretionary practices. For example, though we have quite a lot of information on patients flowing through the system, the information we have on quality of care is still fairly low. We are only just beginning to experiment with outcome measures. Although we are getting much better at standardising things, precisely for the reasons you are suggesting, to define pathways the information is not so good, as there are huge amounts of physician discretion still.

**Q516 Dr Stoate:** Is that acceptable, or do you think we should be looking to consult the contracts if they do not do what they are supposed to do, if they do not complete their contract?

**Dr Dixon:** The nature of medicine is that there will always be discretion, but this discretion should be justifiable in more ways than it is at the moment. For example, we should be much better in the Health Service at documenting variations and asking severe questions such as why are there such variations, and we have not been as clever at that as, for example, they have been in the States.

**Q517 Dr Stoate:** You do not advocate my Stalinist approach then of forcing them into line to deliver or not get paid?

**Dr Dixon:** I think everyone agrees that there should be some significant external challenge on providers: the question is what is the best mix of levers to use, and command and control is but one.

**Q518 Mr Scott:** Professor Ham, you were just talking about clinical leadership and the weakness of it in PCTs. We have also heard evidence about lack of management skills. From my colleague we heard that it is nothing to do with how much is being paid, because that is obviously, seemingly, more than adequate, but why is there such a lack of talent and skills and is it undermining the PCTs’ effectiveness?

**Professor Ham:** Could we go back to the issue about pay. I think the figure of £200,000 for chief executives was mentioned. Yes, in Foundation Trusts, not in PCTs. You might argue that is one of the reasons why we are still struggling, because the rewards and the status on offer if you are on a Foundation Trust are much greater than in a PCT, which is why many of the most experienced managers tend to work on the foundation trust side. We are still struggling to recruit the same experience and talent into Primary Care Trusts, not just at the chief executive level but further down among senior and middle manager posts too. The issue you raise about clinical leadership, I think, is so important in all of this. Jennifer mentioned the professional discretion available, whether it is GPs or hospital consultants, the difficulty for people who do not come from clinical backgrounds in challenging that. It seems to me that as we go forward and learn about the difficulties we have had in developing a really effective commissioning function, we still remain as the weak link in the reforms. What we need to consider is how we can do much better, in both primary care and secondary care, in supporting and developing doctors and nurses, AHPs to take on a much bigger responsibility for managing budgets, improving services, focusing on quality, which may take us beyond the purchaser-provider split as it has been introduced in the current reform programme.

**Q519 Mr Scott:** Dr Dixon, is there anything you would like to add?

**Dr Dixon:** No, I do not think so.

**Q520 Dr Taylor:** World Class Commissioning: what was the rationale behind it? How sound was the argument in favour of it?

**Dr Dixon:** We have both mentioned that for a long time commissioning has not really been focused on by the centre as a driver to produce increased

performance and quality, and World Class Commissioning was an attempt to do that latterly. I think its main aims were to define what kinds of skills and competences should be available in Primary Care Trusts, what sort of outcomes, what sort of governance should be there and then assess them. That is effectively the start—we have begun the process—and we are going through the second round of this now.

**Q521 Dr Taylor:** Chris, you argue that there are formidable obstacles, and I think you say the programme that has been put in place by the DoH 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. We heard just last week from two Primary Care Trusts who admitted that the investment into management consultants for this would run into millions and really the large proportion of the NHS money was spent on management consultants. Is it worth it? The examples we had last week, I could not understand why they could not have been done in any case without World Class Commissioning.

**Professor Ham:** There are two points here. One is nobody would argue that you need to provide the same support to commissioners to help them do their job better, as has been provided to providers through things like the Foundation Trust Development programme. The second issue is: is the World Class Commissioning programme as set up the best way of doing that? I agree, it has been a very expensive investment for the Department of Health and the NHS with the involvement of a number of consultancies and other others who have been charged with that big ambitious challenge of developing world-class commissioning. I am not aware of any evaluations that have been done. To answer your specific question: have the benefits been sufficient to justify those costs? It is difficult to say at this stage in the process, because it is entering year two and, by definition, it is going to be a long-term process, but the key point for me is I think the NHS recession has arrived too soon to give us confidence and hope that World Class Commissioning can rise to the challenge in the timescales we are talking about. To give a particular example, the fact that in the *Operating Framework* in December there was a change in the tariff for emergency admissions. Effectively what that does is shift risk within the system from commissioners to providers, and my reading of that is because commissioners are not yet generally in a position to manage demand for hospital care and, therefore, frankly, they are going to be bankrupt unless you pay less for increasing emergency admissions. That in itself sends out a big signal about the confidence in the Department of Health in the ability of commissioners to develop in tighter financial times.

**Q522 Dr Taylor:** Both the trusts last week felt that the investment was going to pay off. Do we have sufficiently sophisticated systems to evaluate whether it really is value for money?

**Professor Ham:** One of the risks with World Class Commissioning is you have got these competences, very technical, within the *World Class Commissioning Assurance Framework*. There is a time-consuming process that every PCT has to go through to show where it stands against those competences, and at the end there is a rating system based on a pretty thorough examination but largely a paper base with some face-to-face discussion. Whether that delivers—we talked earlier about better outcomes of care and better value for money for patients and the taxpayer—is not really inherent in the assurance process, so I would have some concerns about whether we are asking the right questions to give us that confidence.

**Q523 Dr Taylor:** Are not the competences—we have got a list of them here—just marvellous words? Is engagement with public and patients happening? Is collaboration with clinicians happening? Are these competences beginning to be met?

**Professor Ham:** If you look at the outcome of the *World Class Commissioning Assurance Framework*, I think it says a very small number of PCTs are doing pretty well against those. The vast majority are somewhere in the middle or struggling. Exactly so.

**Dr Taylor:** We have got this marvellous Technicolor table, reprinted absolutely beautifully, and there is just a handful that have got green lights on strategy, finance and the board: all the rest have got an awful lot of oranges and reds.

**Q524 Mr Bone:** Something you said, Professor Ham, about changes in payments for emergency admissions, which happened recently, I think. Does that tie in with why my hospital has now said you can only go to A&E for life and death admissions? “If your ten year old son is badly bleeding, please do not bring him along because he is probably not going to die.” Would that tie into the logic you were talking about?

**Professor Ham:** Possibly, I do not know your local circumstances. Effectively, what it says to trusts like yours is they are only going to get paid 30% for emergency admissions, from April this year, above the level achieved in 2008–09, and so finance directors around the country are rapidly remodelling their assumptions on the basis of a considerable drop in income from that particular source.

**Q525 Dr Stoaite:** We are talking about World Class Commissioning and whether in fact it is achieving what it set out to achieve, and Richard has laid out very well what the challenges are, but are they not making it more difficult with things like Foundation Trusts, Payment by Results, and regulators? Surely that gets in the way, does it not, of World Class Commissioning?

**Dr Dixon:** Does regulation get in the way of World Class Commissioning?

**Q526 Dr Stoaite:** Yes.

**Dr Dixon:** Not necessarily. I think the tension there is what organisation exerts pressure on commissioners to up their performance and to what extent should it

be the centre and to what extent should it be a regulator like CQC, and I think this is currently still being fathomed out. It is still under construction, let us put it that way.

**Q527 Dr Stoate:** Are we making things more difficult for ourselves by trying to bring in World Class Commissioning at pretty much the same time as introducing Payment by Results and Foundation Trusts?

**Dr Dixon:** Payment by Results and Foundation Trusts have been around for some time now and World Class Commissioning has only latterly be introduced; so I do not necessarily think that is a problem. I think at the moment the greatest thrust on commissioners to try and up their quality is coming from the centre, and it is not really coming from CQC that is obviously very concerned with getting basic registration right for providers. I think that is where we will need to see some more activity, and that is where we are going to see the major thrust to try to lever PCTs up into better performance.

**Professor Ham:** Could I offer a comment on that. I think the difficulty we have at the moment—and it is not just about commissioning, it is about the whole Health Reform programme—is there are three sets of drivers that have been put in the system. There is the Stalinism that you were advocating earlier on—targets, performance, management, drive the system hard from the centre—we also have increasing regulation through CQC and Monitor and God knows who else out there, a plethora of regulators trying to improve performance, and, thirdly, we have got the market-based reforms, World Class Commissioning, Foundations Trusts, Payment by Results. The logic was that over time we might migrate with less emphasis on Stalinism, a bit more emphasis on regulation and competition and choice would drive the system. Actually what has happened is they are co-existing with each other.

**Q528 Dr Stoate:** You think it is going in the right direction; you think it is working?

**Professor Ham:** No, I am not saying that at all. I think there are contradictory and conflicting elements in the Health Reform programme.

**Q529 Dr Stoate:** That is exactly my point. Are we just setting up conflicting systems which ultimately are doomed to fail?

**Professor Ham:** All systems will have a mixture of these different elements, but I think the UK, and England in particular, now stands out as a world leading example of a system which has laid one on top of the other on top of the other, and it is not at all clear going forward which of those is expected to deliver this further improvement in the language getting from good to great: will it be market driven World Class Commissioning, will it be regulator driven or will we revert to Stalinism?

**Q530 Dr Stoate:** My worry is that we may just have wrapped up huge bureaucratic complexities without actually managing to get much out at the end of our black box. Is that a view you share?

**Dr Dixon:** I would want to be a bit kinder than you are. Every health system in the developed world is a complex system and everybody is developing and evolving and trying to understand the best mix of levers there are available. The good thing that has happened, I suppose, is that there has been quite a lot of experiment in last ten years or so, absolutely too much probably, but I do think that we show signs of learning, but we do not know how best to titrate competitive forces with regulation and Stalinism, as Chris said, but we are kind of groping our way towards something that seems much more reasonable. The difficulty in this country, perhaps more than many other countries, is the political system; that because the NHS is so tied with politics there can be chops and changes which may not allow systems to embed and evolve in a more natural way; so I would be kinder. We are trying, we are developing and let us give it some time, but I suppose I would call for not too much rapid change over time, and that is not just me saying that either.

**Q531 Dr Taylor:** I have had a chance to look at this table in slightly more detail and there are 26 trusts that have got three green lights and 20 out of those are in the north of England. Is there any significance in that? Is that because, by and large, there is more money flowing in that direction? Is there a reason for that?

**Dr Dixon:** Historically the north has generally been better managed.

**Q532 Dr Taylor:** Better managed.

**Dr Dixon:** Yes, and on a range of indicators has historically, over a long period, better performance. No-one really understands why. Maybe it is the distance from Westminster!

**Q533 Dr Taylor:** So that just mirrors the traditional effect that you are rather better off in the north than the south.

**Dr Dixon:** It could also be stability of staffing, it could also be the resource allocation flows, as you say, but certainly, at least for the last ten or more years, it has been the case there is a kind of north/south divide in that respect.

**Chairman:** In my particular case, my local PCT is the eleventh green light but still does not get the allocation that the Government say it should have, so it is not just about resources.

**Q534 Sandra Gidley:** Moving on to primary-led commissioning and building on the comments made earlier by Howard Stoate, I think that everybody acknowledges that Practice Based Commissioning has been very slow to take off, and you alluded to some of the reasons earlier. I was not sure we had covered them all. Is the problem we are expecting something too soon, possibly not enough incentives in the system—I think training has been alluded to—conflicting initiatives. Are any of these the sort of dominant factor or is there something there I have missed?

**Professor Ham:** The point I would make is that Practice Based Commissioning is a bit of a misnomer. If you think about what Practice Based Commissioning is, there is a thin veneer of commissioning overlaid on a strong system of primary care provision. Practice based commissioners both deliver their primary care services and they are offered the opportunity of playing a part in the commissioning of secondary care and other services; so embryonically we have in Practice Based Commissioning the basis for a more integrated approach, if by integration you mean bringing commissioning together with provision. There are issues there around potential conflicts of interest and practices lining their own pockets, as some people might say, by using commissioning resources to build up services in primary care. I think they are manageable, but just to put that down. There are two thoughts I have. One is that Primary Care Trusts have sometimes been less enthusiastic about Practice Based Commissioning, either from GPs or, indeed, the Department of Health. I can think of a number of examples where they have been really slow to encourage GPs to devolve budgets, to provide information and management support, creating a lot of frustration in the primary care community. I think that is improving, but that has been really important. More significant perhaps, are the incentives really strong enough for GPs and their colleagues to put their hands up and say, "We want to play a bigger part in all of this"? Incentives are about improving care to patients by saving money on, let us say, hospital services to reinvest in the community, and many GPs will be motivated by that, but there is nothing more personal in terms of extra income or additional profits for the practice and at a time when the new contract for GPs that came in in 2003, 2004 clearly offered a lot more direct personal incentive to GPs, if you are faced as a small business person, as GPs are, with a choice between, "Do I put my effort into the contract maximising the QOF scores, profit and income, as opposed to taking part in Practice Based Commissioning, negotiating with these big powerful acute trusts?", it is a no brainer to me: you put in in the former, not the latter.

**Dr Dixon:** I would agree with all that and add that this business about not having a hard budget is very important. They have notional budgets, where it is not often clear whether they can make savings, and they may have a different view from the PCT, and so, unlike fundholding, where there was a hard budget and they could make savings and they could take money from the savings to put into their primary care practice, that simply has not taken place. Part of the reason why they have not had a hard budget is because they may be too small to take on the financial risk of a budget. They might actually be bankrupted through random variation through no fault of their own, because up until this year we have not had a very good way of setting budgets for practice based commissioners. We now have that, which is much better, and that could allow the budgets to harden and, therefore, the incentives to increase.

**Q535 Sandra Gidley:** There are obviously pros and cons in any system. Are you actually advocating bringing back GP fundholding with some sort of safety blanket, or should we stick with PBC? Obviously you are fairly anti further reorganisation in this area.

**Dr Dixon:** I think most people who looked at the evidence on GP fundholding found not only were they very much more active than apparently now in terms of commissioning, and so on, for the incentives that I mentioned, in part, but also they were too small really; they could not really handle much of a budget, only for elective care. Transaction costs were very high, they were too small to create any major change with the hospitals, which is precisely what we want now. We want them to take on these large hospital groups and pull stuff out of hospital where that is appropriate, and they were far too small to do that, and so, for all those reasons, I really would not advocate going back to GP fundholding or anything like it, but a principle of having physicians, or clinicians, say, to manage hard budgets at a bigger scale to inject some cost consciousness into their behaviour.

**Q536 Sandra Gidley:** I am a bit confused. How do you do that at a bigger scale? Obviously, surgeries vary in size. You have got small single-handed practices and huge multi-GP practices, and they are too small. I do not see how you can have doctors responsible for managing those budgets when there is a part of the system they have no direct link with, it seems to me. I cannot quite see how it works in practice.

**Dr Dixon:** If you wanted to do budget holding at scale, you would not have practices holding a budget, you would have conglomerates of practices. Some practice based commissioning groups have formed these conglomerates as it is, but even they are probably too small to make the local provider sit up and listen. I think they have to be much bigger, covering at least a 100,000 population, possibly even more. We will probably get on to this later, but what Chris and I in separate ways have been advocating is to create new systems whereby it is the docs in hospital and clinicians in hospital coming into the same organisational space as the docs outside (perhaps in general practice) to hold a budget.

**Q537 Sandra Gidley:** Are we talking care pathways now, effectively?

**Dr Dixon:** Yes.

**Q538 Dr Stoate:** You mentioned a 100,000 population. That is suspiciously like a PCT, and yet that has not worked either?

**Dr Dixon:** PCTs are about 300,000.

**Q539 Dr Stoate:** They started off at 100,000 and they got bigger by merging.

**Dr Dixon:** The difference between the PCTs and these super conglomerates, if you like, is that the clinicians would be responsible for divvying up the

funds, they would be responsible for managing a capitated, risk-adjusted budget and bearing the financial risk in a way they simply do not do now.

**Q540 Dr Stoaite:** What is the difference between the PCT simply getting some better quality physicians in to do the job? Why are we reinventing the wheel?

**Dr Dixon:** Because in PCTs, it is largely because of the incentives. The physicians at the moment are advisory to PCTs, they do not really have the incentives to manage the demand in the way that they would if they were managing their own organisation.

**Q541 Sandra Gidley:** Professor Ham, do you have anything to add to that, or do you agree?

**Professor Ham:** I agree. The key is how do we get hospital-based specialists working much more closely alongside networks of practices, taking more responsibility both for the delivery of service along the care pathway and, where they wish to, taking on the responsibility for a budget for the population they serve.

**Q542 Sandra Gidley:** You mentioned incentives earlier, and it is quite easy to see from QOF how GPs have reacted to that very positively, but is there a risk, two risks probably, that increased incentives to develop Practice Based Commissioning will just line GPs' pockets more, with little benefit to patients. If you are talking about these integrated care pathways, how do you incentivise the secondary care physicians, who are paid through a completely different funding stream?

**Professor Ham:** On the second point, you would have to give them the proper protection and security and continuity around their current NHS contracts. I do not think that is going to be insurmountable if you move in this direction.

**Q543 Sandra Gidley:** So you get back to this same old, same old: you cannot destabilise the secondary healthcare system. It seems to me that if we are talking about really providing change, we have to think about that.

**Professor Ham:** We are going to have to fundamentally destabilise the secondary care system. Let me leave no misunderstanding about my views on that score, because with the tight financial circumstances ahead of us, and even without that, the need for a very different model of care with the increasing prevalence of chronic conditions and the need to shift services, as we have talked about many times before, closer to home, out of hospital, then we cannot be patient and slow in allowing acute hospitals to take their time to move in this direction. What I was talking about specifically was giving specialists the comfort and the security that if they do realign with practices in the community, in the model that we have begun to discuss, they will not be disadvantaged personally in that position.

**Q544 Sandra Gidley:** So consultants get a security blanket; GPs get more money. What do patients get? Should this not be linked to patient outcomes in some way?

**Professor Ham:** It should be, absolutely. The whole purpose of this is we can have endless discussions until the cows come home about the intricacies of the organisation and management of the NHS, but fundamentally they are simply a means towards an end and the end is about better quality outcomes, improved access, more responsive services. That is why I say you need to put these debates within the framework of what kind of healthcare system do we need to move towards from where we are at the moment, and I think there is a lot of consensus on this: more emphasis on prevention, stronger more consistent standards of primary care primary care working much more hand-in-hand with secondary care with specialists aligned in this sort of way. That is a big radical change, but we need to make much faster progress in that direction if the NHS is going to be sustainable in future.

**Dr Dixon:** This could sound as if it is another big change, another Big Bang, to put clinicians in the same space as primary care clinicians, but actually we see the system moving towards this anyway, for example, through the commissioning of pathways, through getting better patient level information across pathways, extending service line reporting, which is out of Foundation Trusts into the community. It could start with a disease pathway and then grow into something which is bigger without having a Big Bang all at the same time, and this is beginning to happen.

**Professor Ham:** But there are obstacles. Going back to one of the earlier points, if you are a specialist or a manager in a Foundation Trust you have got your targets which have been set by Monitor, which include generating financial surpluses, the model of care closer to home, and taking your specialists out will probably have an impact of reducing the income you are getting because patients will be going elsewhere rather than coming in, so we have set up a system where there are contradictions and tensions getting in the way of us doing the right thing.

**Q545 Dr Naysmith:** Chris, you have looked fairly extensively at healthcare systems in different parts of the world. Would you say that commissioning is done well anywhere, either public or private?

**Professor Ham:** No.

**Q546 Dr Naysmith:** Would you draw attention to any particular examples?

**Professor Ham:** If you ask is there a system elsewhere in the world like the NHS where commissioning is done consistently well, the evidence on that is clear: there is no such system. If we ever get to having world-class commissioning in the NHS, we will be a world-class first.

**Q547 Dr Naysmith:** What do you think, if anything, we can learn from looking at some of those other places? Could I give you an example. I know you have been a fan of Kaiser Permanente in the past,

although the first rush of enthusiasm for Kaiser seems to be evaporating a bit, but when this Committee visited the States and looked at Kaiser, one of the things that was quite clear was that there is a lack of choice in some areas—if you go to the company specialist on this, you do not have much choice—and we seem to be going the other way in this country, so what would you say are good examples?

**Professor Ham:** I would say that the United States is the land of choice and competition. If you want to learn about how markets work, that is where you go, warts and all.

**Q548 Dr Naysmith:** It is quite restrictive in Kaiser.

**Professor Ham:** The way choice works is you choose to belong to Kaiser in the first place. If Kaiser is not delivering a fast, responsive service for you and your family, then you could vote with your feet go and to an alternative which is not Kaiser, but once you are in you are restricted in exactly the way you have described. The key lesson for me is that independent commentators who have offered their assessments of what works well in a very fragmented system in the States, which generally does not work well for the whole population, have tended to highlight the Veterans Health Administration, Kaiser Permanente, Health Partners—in other words, the integrated systems that bring together commissioning and provision—as generally performing better than the more fragmented arrangements on the issues we were talking about just now: the quality of chronic disease management, their preventative outcomes, the efficiency with which they use their resources. My contacts with the Veterans Health Administration and with Kaiser Permanente have led me to think quite radically whether we are going down the right route in pursuing this clear separation between commissioning and provision when in the States it is these integrated systems that combine and muddle up the two that seem to do better.

**Q549 Dr Naysmith:** Is there anywhere else you would pick out—New Zealand for instance?

**Professor Ham:** Commissioning is a distinctly English word. If you are talking about commissioning in other systems, people give you a blank look because it does not mean very much, but if you look at New Zealand, if you look at some of the Scandinavian countries which had their own versions of the internal market, the lessons there are very consistent with the lessons from the English experience, that commissioning is very difficult to do well; it is often seen as the weak link within their systems. If you look at Continental European countries like the Netherlands and Germany, which have always had an insurer-provider split, the lesson from them is historically the insurers have been passive payers, they have reimbursed doctors and hospitals rather than being the active, intelligent commissioners that we are aspiring to within the NHS. It has begun to change a little bit in some

countries like the Netherlands recently, but we cannot take a great deal of comfort from looking overseas.

**Q550 Dr Naysmith:** One of the things that has already been emphasised is that the skilled commissioners and good data really have to be there and you have to get them before you can do the job properly, and you have emphasised the high levels of technical and managerial skills that are needed for commissioning health and suggest it is uniquely different, although there are one or two other people who publish who do not think it is all that different. Where are we going to get these skills from? Do we just have to pay people better? In the published material it says you get the best and the brightest you can possibly get hold of and pay them a lot of money to do a really good job. How are we going to do that in our system?

**Professor Ham:** My answer to this (and Jennifer may have a different view) is that I think we can get some of those skills from smart private sector companies who have begun to come into the NHS through the FESC process. I do not know of any evaluative evidence about how successful that has been, but that is one potential source. Secondly, it is about PCTs collaborating with each other to share some of these scarce skills, which is beginning to happen in many places now in the West Midlands, London and elsewhere too. Making a virtue of that, I think, is really important, but the third point is back to the issue of clinical leadership. We need to have much more clinical input to commissioning. In PCTs we need to make sure that they are not just driven by people who have got smart management or technical skills, but they are people who understand the business that they are commissioning.

**Q551 Dr Naysmith:** Jennifer, do you want to come in and say anything?

**Dr Dixon:** I agree with all of that, and when you look at places like the Kaiser Permanente health plan, which mutually exclusively contracts with the Permanente medical group of doctors, you find it is stuffed full of very talented docs like Ben Chu, and you see the same with Health Partners—George Isham is their Medical Director—these are top-class people. Sure, pay must be some of it, but it is also something to do with the status of the insurance side, because that is what it is effectively, is it not, in those countries? I am sure we could get there. The other thing to bring into the equation is that PCTs at the moment are quite small, and while we do not want a Big Bang change there, if they were to morph into something which was more at an SHA level, then we could have more economies of scale or talent and attract them more to those entities instead.

**Q552 Dr Naysmith:** Finally, we are moving into an era where money is not going to be as widely available perhaps as it has been, and certainly that is going to affect pay levels. It is going to make it even more difficult to get the kinds of skills and people we want. What can we do about that?

**Professor Ham:** It is more challenging still, is it not, because there is a commitment both from the current Government, and opposition parties have been talking the same language, of reducing management costs, taking money out of “bureaucracy” and putting it into front-line services, with about 30% mentioned as a figure, a large sum of money (about £1.5 billion), so we are expecting to progress and develop world-class commissioning while taking 30% of management costs out and making it perhaps more difficult to fill some of the skills gaps we have in the system. I have not quite squared that circle in my mind.

**Dr Dixon:** The only way, and it is not a way of squaring it, is to centralise commissioning, which is almost running against policy, to run it more closely from the centre and have the raw talent concentrated up there, which you might want to do when times are tough.

**Professor Ham:** Maybe to add to that, if there is going to be a further development of either Practice Based Commissioning or GP budget holding, we know a lot of the evidence suggests that as you devolve commissioning to a more local level you increase the transaction costs in the system. Lots of little purchasers negotiating lots of contracts with big providers is going to be a more expensive thing to do. You have to ask the question: will the benefit that comes out be greater than the cost of developing in that way?

**Dr Naysmith:** I think we are going to have to reinvent District Health Authorities. That is a joke.

**Q553 Dr Taylor:** We have come really to, in my mind, the absolutely crucial question. Chris, you have asked: is it right to continue the purchaser-provider split system? What should we on the Committee be recommending, that we keep the purchaser-provider split and somehow make it work, or we chuck it out and go for integration? Chris, you have pointed out the Marks & Sparks model, one central organisation to do procuring. Jennifer, you have pointed out the disadvantage: somebody has to act for patients. Chris, will you start off: why should we be looking at integration?

**Professor Ham:** There may be a third way. I do not think we have to just stick with the purchaser-provider split. Nor, indeed, do we just need to check it all out and go in a very different direction. The last thing the NHS needs is another Big Bang reform on 1 April, or whenever. I think we are all agreed on that. The issue I have been puzzling about for a couple of years is how might you migrate from where we are with the Health Reform programme towards the model that Jennifer and I have both been writing about and advocating today: closer integration of commissioning and provision based on GPs and specialists working closely together. That, I think, is the hard intellectual policy work that needs to be done, both now and in the future. I do not think that means continuing with the purchaser-provider split. I have concerns, which you may not want to talk about today, around the current moves to separate out PCT provider services from PCT commissioners. I do not think you should continue

down that path, nor, indeed, should we throw everything up in the air and come down in some different shape or form, but if you look at what is happening out there in the NHS, there are a few examples where frontline clinical staff, GPs, in particular, through Practice Based Commissioning in maybe 10% of areas where it is beginning to work, are reaching out to work both with social care colleagues and with hospital-based specialists around these care pathways. I had a meeting earlier this morning before coming here with a colleague who is doing precisely that around diabetes across a whole county in the north-west of England and making some progress but finding it very hard, given the system we have set up which puts all these road blocks in the way of achieving the integration we need to achieve. I think I would build on those promising bits of the current reform programme and try and nudge us in that direction.

**Q554 Dr Taylor:** We did hear last week one of the PCTs we were talking to was going down this route and was involving hospital doctors much more.

**Professor Ham:** Absolutely.

**Q555 Dr Taylor:** In that way, Jennifer, one would retain somebody responsible for the patients' and the citizens' views?

**Dr Dixon:** Yes. I think there is still room for the purchaser-provider split actually, but what I see is the provider system should become much more integrated and take a risk-adjusted budget for which they are at risk: they are handed an annual budget, primary care migrates towards the hospitals, possibly along disease pathways, contracting in the first instance and then, as that grows, that could grow to more of an effective, integrated provider delivery system which still leaves somebody to commission that even if the provider system is taking on all the risk, and then I see that the PCT commissioners would ultimately conglomerate up to something like an SHA level. You would have a purchaser-provider split, but the provider would be integrated and the purchaser would be, in a sense, covering a larger ground, able to command more resources, skills and all the rest of it, and the kinds of skills that we really want to encourage general practitioners to develop under Practice Based Commissioning would be absolutely used but within this provider delivery system instead. They would be managing their own resources in pathways with hospital specialists in the same organisational space whether it is a merged or a virtual space.

**Q556 Dr Taylor:** Is not that rather just words, in that you are getting rid of the split because you are getting purchasers and providers talking? Doug raised the old District Health Authorities. We have both got memories long enough to remember that on a District Health Authority you had consultants and GPs who were talking together. This is what we have got to aim for, is it not?

**Dr Dixon:** But the incentives in this new system would be utterly different. They would be much more Kaiser-style than the incentives that were

pretty lacking in the old system, I would say. That is the critical difference. There would be much more clinical leadership encouraged to manage resources.

**Professor Ham:** Could I add a small point on this. Those of us who have been arguing for a more integrated model of care have been voices in the wilderness for most of the last five or six years. In the last 12 months policy has begun to shift. There are the ICO pilots, there is strong emphasis on the five-year plan that came out before Christmas and in the *Operating Framework*, suggesting integration is part of the way forward. David Nicholson has emphasised the efficiencies we need to pull out of the system are often in the interfaces between PCTs and Acute Trusts or between health and social care, so I think the argument is now being won. The hard practical question is: how do we get there?

**Q557 Dr Taylor:** A quote from your evidence, Chris, “Integrated systems turn doctors from poachers to game keepers and incentivise them to keep the game alive and in a healthy condition.”

**Professor Ham:** Yes, I could not have put it better myself!

**Q558 Dr Taylor:** One last point. The model in the USA, Managed Care in the Nineties, apparently, we are told, failed to control expenditure, inflation or improve quality. Why?

**Professor Ham:** Because Managed Care in the Nineties was about managing costs, not about managing quality.

**Q559 Charlotte Atkins:** Could I pick up on the point you made about your concern about the hiving off the provider arm of the PCT. Is that because you fear that will undermine integrated healthcare?

**Professor Ham:** It is partly that, it is partly because it is, I think, now being done incredibly quickly and provider arms are having to make up their minds: do they go to an Acute Trust, do they go to a Mental Health Trust, do they go somewhere else, other than the only option on the table is to stay with your PCT. Those of us old enough to remember the District Health Authorities and the integrated systems know that one of the concerns then was, putting it very crudely, asset stripping of community services where they were very closely aligned with acute hospitals. That might not happen again, but there is a clear risk there, so we just need to be a bit more thoughtful about what is the model of care we are moving to and will this drive towards integration of PCT provider arms, whatever form that takes, help or hinder getting to the right place?

**Q560 Charlotte Atkins:** You think it will hinder it.

**Professor Ham:** I think there is a risk of that.

**Dr Dixon:** There is a way of integrating care that integrates out from hospitals into community services, but that risks the monster of the hospitals becoming even more monstrous, if you like. Most of the models talked about in the US, for example, are rooted in primary care, they are rooted in a

population basis, so that the incentives in the system are to keep people healthy and out of hospital, not to gobble up more resources and capture the market.

**Q561 Dr Naysmith:** What do we know about the integrated care pilots that are being run in various places? Are they a positive first step towards developing integrated care and are they being properly evaluated?

**Professor Ham:** You are involved in the evaluation, are you not, Jenny?

**Dr Dixon:** There are about 18 or 19 of them. They are all very different. Some of them are horizontally integrated, some of them are vertically integrated, some of them are small, some of them are larger. I would say that they are an initial start—they look a little bit tentative—we will see if there is a second wave that is going to happen, and they are being evaluated.

**Q562 Dr Naysmith:** So they are likely to bring us some hard evidence.

**Dr Dixon:** There will be some hard evidence. We are evaluating the impact on service use and costs, in fact, but outside of those pilots, as Chris mentioned, there are some other big areas in the country which are attempting quite radical things: Trafford, Cumbria, Hampshire, for example, Redbridge and Waltham Forest, mostly because there is a burning platform there of a hospital that they cannot support any longer. Although there are these pilots that are being evaluated, outside of the pilots there are also some incredibly interesting experiments going on.

**Q563 Dr Naysmith:** Is there anything more you want to say? I know we have mentioned your proposals for local clinical partnerships. Have we discussed them enough?

**Dr Dixon:** There is a lot I could say about those, but, in view of the time, I think really the essence of those partnerships are effectively what we have discussed earlier. It is about putting clinicians in the same space with one another and giving them responsibility for a budget in a way that has not happened before.

**Q564 Dr Naysmith:** The very last question is a slightly controversial one: how might the creation of a NHS Board improve commissioning? This is a quote from the Conservative Party Manifesto for the next election. “To make sure that the NHS is funded on the basis of clinical need, not political expediency, we will create an independent NHS Board to allocate resources to different parts of the country.” If you could answer that without political bias, I would be grateful, Chris.

**Professor Ham:** My personal view is I do not think that change in itself will make either a positive or a negative difference. I think the key things that matter are all the issues we have been talking about

as to what happens locally within the NHS and the willingness of GPs to talk to specialists, and vice versa, for PCTs to give much greater encouragement and support to these innovative models that have emerged. Another example, to add to what Jennifer said, is Torbay, which has demonstrated some really good results through its integration of health and social care, reducing use of hospital beds, delivering care close to home. It is one of the national ICO pilots but it has been working on these issues for several years to achieve that result. My focus would not be about changes in the superstructure at the Whitehall/Westminster level, it would be getting it right on the ground.

**Dr Dixon:** I agree. Scrolling back to what we said earlier, if you have these integrated delivery systems developing and then the purchaser function or the commissioning function becoming much larger, then you could see how it could report to a headquarters that might be an independent board, and the supposed benefits of this is that they would be at arm's length from the political process which flip-flops and has a different policy a week, but the key question there is, could it be independent? The spectre of Derek Lewis hovers in the room, I think, at that point.

**Chairman:** Could I thank both of you very much indeed for coming and assisting us with this inquiry.

*Witnesses:* **Rt Hon Mike O'Brien MP**, Minister of State for Health, **Mr Gary Belfield**, Director-General of Commissioning and System Management, and **Dr David Colin-Thomé**, National Clinical Director for Primary Care, Department of Health, gave evidence.

**Q565 Chairman:** Good morning, gentlemen. Thank you for coming along to help us with what is our fourth evidence session on our inquiry into commissioning. For the record, would you give your name and the current position you hold, please.

**Mr O'Brien:** Mike O'Brien, Minister of State at the Department of Health, responsible for health services.

**Mr Belfield:** Gary Belfield, Acting Director-General of Commissioning and System Management in the Department.

**Dr Colin-Thomé:** Dr Colin Thomé, National Clinical Director for Primary Care.

**Q566 Chairman:** Minister, in the first evidence session for this inquiry, one of your officials stated that "we are in the foothills really of getting our commissioners in good shape to do well for their population" and yet a survey that was done on our behalf by the NAO found that 95% of commissioners thought that commissioning was going well. Is this because commissioners are hopelessly complacent and unaware of their failings or were your officials being overcritical?

**Mr O'Brien:** Or maybe it is because they are just doing very well in the foothills. The situation is that we have started this programme of World Class Commissioning, it is going to be very demanding, and I think most of them feel that they are doing well in so far as we have gone so far, but we would be the first to say that World Class Commissioning is there in order to deal with a weakness in the system; that is, that commissioning was not done as well and as competently as the public needed it to be done. It has been improving steadily over the last decade, but since the NHS plan ten years ago we have had a big job to do. In a sense, it was not until about 2005 that we really recognised that there was this purchaser/provider split, and it does not work by itself. Local problems with the NHS are not self-correcting, you have to have intervention, you have to have a programme to create the change. We have carried out, as you know, a lot of reforms in the NHS. We have not

only the increased demand there on managers for skill and competence because of commissioning but also because we have a new agenda around personalisation of health care so that people can identify much more what they want, a greater agenda around choice, a requirement to link up much more with local authorities. All of these are competencies which even the best of the commissioners needed to improve. World Class Commissioning is not just about increasing the competence in commissioning of the ones that were mediocre and were not so good, it is also about increasing the competence of those who are very good and appear to be among the best. They too have to increase their ability. We all need to raise our game. Weaknesses are there and we need to ensure that we have a programme to improve the skills of the managers who have to carry out commissioning.

**Q567 Chairman:** We have just heard in our earlier session about the lack of people who understand what providers do. Have you thought of seconding people from the acute sector into PCTs so that they are able to advise and give advice about what works at the other side of the fence?

**Mr O'Brien:** We will see, increasingly, some element of movement between PCTs and providers, but that has not happened much in the past. If you were a high-skill manager in the past, you would want to go and run a hospital and run a mental health centre or something like that. Some of the people who were involved in running PCTs and health authorities tended to be more management orientated than having an in-depth knowledge of clinical requirements and of what was needed clinically, and, therefore, there is a need to get a greater degree of cross-fertilisation. We are seeing some movement between the two, but we still need to go further with that.

**Q568 Chairman:** Do you know the ratio between the salary of a chief executive of a foundation trust and a PCT?

**Mr O'Brien:** Given that the salaries of foundation trusts, Chairman, vary quite substantially, I do not know the exact figure but I would imagine it is probably about double—but I am guessing.

**Mr Belfield:** The average is somewhere between 20% and 30% different.

**Q569 Chairman:** That is quite a large chunk. Do you expect that people are going to drift to taking their skills into a PCT if there is that type of difference?

**Mr O'Brien:** It is not necessarily the chief executives you want moving across; it is the people who will do the detailed commissioning, and so you are talking about that middle rank of management in hospitals and other health provider units, rather than necessarily the chief executives. I would have thought that once you get to that height in running a hospital you are probably going to want to move to larger and larger hospitals.

**Q570 Chairman:** I know it is argued that things are getting better now as far as the commissioning of PCTs is concerned, but how worried are you as a taxpayer and a politician that 80% of what is now a £100 billion a year budget for the National Health Service is spent by PCTs which for quite a long, long, long time have been quite weak, which some people would argue are still quite weak now, although we have tried to address that in the last year or two?

**Mr O'Brien:** You always need to ensure that the quality of the management is improving, particularly when you are making new demands on them. The only reason that you would want to worry is if the quality of that management skill was not improving. You are not going to find it easily elsewhere. Given that we need to improve commissioning, and we have to improve it across the board and across the country at a local level, that is a big job. Providing we get the priorities right, that is patient safety and the quality of care for patients, the second priority, in a sense, is value for money for that. That is what commissioning needs to do, to ensure that we get both quality and value for money. By and large we are getting the first. In terms of the second, we need to work a lot harder at that. As I say, providing we are improving the skills I would not get too worried about it, because, frankly, there is not an alternative. We need to get this right and we need to ensure that we have managers who are competent to do it. If they are not there, we have to train them, because those skills do not come easily.

**Chairman:** Okay. We will move on.

**Q571 Mr Bone:** I apologise, gentlemen, that I have to leave shortly after my questioning. Following that last issue through logically, that you have to have the right people and the right skill sets, is it then strange that at the top of this tree, when £80 billion is spent on PCTs, we have an excellent solicitor in the Minister before us? He is not an accountant or anything. Is that strange, if we are talking about looking after £80 billion, that he should be a solicitor rather than an accountant or something like that?

**Mr O'Brien:** I am definitely not sitting here as a lawyer; I am sitting here as a minister who has held eight or nine ministerial positions over a decade or more and, therefore, I am probably as well skilled in managing a department and dealing with policy issues. The key role of a minister, of course, is not to be responsible every time, to use Nye Bevan's phrase, "bedpan is dropped in Tredegar." I am not there for my skill at running a hospital; I am there in order to identify as a politician what the policy of the NHS ought to be in order to respond to the needs of my constituents and yours—and I think I am fairly well briefed on that.

**Q572 Mr Bone:** You did touch in your opening remarks on commissioning, but what do you understand as commissioning, very briefly?

**Mr O'Brien:** Without commissioning who would really control the Health Service? Would it be the provider interest? That is always the risk: that the provider interest would dominate. Commissioning represents the patients and the taxpayer. Commissioning is about assessing the needs of a local area; it is about ensuring you get a greater degree of openness into the process; it is about ensuring that there is a requirement for clinical input into what is happening and how the NHS is run. It also does the important thing of switching the focus of the running of the NHS, particularly for managers and those with the money, the PCTs, from administration to policy. It is very tempting, if you are running an organisation, merely to manage it and to keep it in some sort of steady state and to deal with the problems. If you are commissioning and you are in that commissioner role, then you have to look at the policy, what have we got to be delivering here? How do we best deliver it? Therefore the focus is on long-term health gains.

**Q573 Mr Bone:** Never ask a minister to be short in his answers.

**Mr O'Brien:** Such as prevention of healthcare issues and health protection and long-term issues.

**Q574 Mr Bone:** Thank you, Minister. The reality—and we have had evidence of this—is that commissioning is failing. It is not making any significant difference to secondary care whatsoever. Would you not agree that your reform over the last 13 years of commissioning has been rather like moving the deckchairs around on the Titanic, and that it is making no overall difference? The ship, in the case of the Titanic, is slowly sinking, but in our model the PCT is slowly sinking. Is that not the reality of the situation?

**Mr O'Brien:** First of all, the NHS has not been slowly sinking since 1997.

**Q575 Mr Bone:** Commissioning. Sorry, commissioning.

**Mr O'Brien:** We are now in a position where the NHS, as a result of commissioning, is making a number of changes that will improve the quality of health care. At the risk of giving you a longer answer—the objective of select committees is elucidation rather

than sound bites—let me just say that if you were in Somerset, where commissioning has had a particular success in terms of getting people with COPD treated in the community rather than this business of yo-yoing in and out of hospital, that is a result of successful commissioning. If you were in Manchester, ten PCTs have got together to develop through their various hospitals a new stroke service, which is a major change in the way in which stroke is dealt with in Manchester. It is a health improvement. It is the result of commissioning. It is a result of the way in which changes are taking place in the Health Service that have arisen out of the purchaser/provider split and the development of proper commissioning. I would not necessarily ascribe it all to the success of World Class Commissioning, because that has only had four years, but I would say that those sorts of initiatives have shown that commissioning works and that it makes real change. We also need to ensure that we get other PCTs up to the standard where the quality of their commissioning is as innovative as that.

**Q576 Mr Bone:** We are not on the way down; we are on the way down, you think.

**Mr O'Brien:** I think the NHS has gone from being poor to good and we now need to get it to great—so we are on the way up, yes.

**Q577 Dr Stoate:** Minister, you have given us some good examples of where commissioning has worked, and I accept that there have been some examples. However, witness after witness and evidence after evidence really has left us with one feeling in this inquiry, and that is that the providers are dominant and the purchasers are weak. Is that a criticism you would share?

**Mr O'Brien:** The whole objective here of commissioning is to try to deal with this issue where the providers' interest has become very dominant. 1.4 million people work in the NHS. The doctors, as you will know, Howard, are a very powerful lobby. The nurses are now well organised. Even the pharmacists—seeing Sandra Gidley there—are well organised. It is important that we have some counterbalance to that, and therefore the purchaser interest, the PCT, is there to represent the taxpayer and the patient and to try also to represent the long-term interests of health care, to try to ensure that we get the policy going in the right direction. You are right to say there is this real problem with the way in which the providers could be increasingly dominant. But that is not just a problem here; it is a problem in other countries across the world where providers can set the agenda. That is why improving the quality of the purchasers through World Class Commissioning is the objective of the exercise.

**Q578 Dr Stoate:** We have been hearing from witnesses before that PCTs do not have the skills; they do not have the top quality managers. The best managers are all in the secondary sector. They are in the acute sector, they are working for foundation trusts—possibly for financial reasons, possibly for other reasons—but, nevertheless, the situation is

that PCTs are very weak on commissioning and providers remain dominant. That has constantly come back to us throughout this inquiry. Are perverse incentives being built in? Foundation trusts. Payment by results. The choice agenda, which seems to us to run counter to the philosophy of moving care back into the community.

**Mr O'Brien:** We are trying, in a sense, to address the very problem you are identifying, both by having this purchaser/provider split and by trying to improve the quality of the purchasers. The whole objective of the World Class Commissioning exercise is to address the issue you are identifying. Are there perverse incentives? There are various incentives in the system. You cannot put all the burden of improving the quality of the NHS on to the commissioning process. It is one very important part of that policy—certainly an important part. One of the things we want to do, as you know, is to see if we can get more care taking place in the community and out of hospitals. There are issues around PbR, where this is the third kerchink, kerchink, as somebody goes into hospital, and there is a temptation to yo-yo patients with long-term care conditions in and out of hospital. Those sorts of issues are matters that we do have to look at. PbR, for example, has had beneficial effects in relation to getting down waiting lists—enormously beneficial effects. Just because you have some perversity in some of the outcomes does not mean that you, in a sense, throw the baby out with the bathwater. You try to identify how you can use the system to better deliver what you want overall.

**Q579 Dr Stoate:** I entirely agree with that; it is just that we have heard, again from primary care trusts, that PbR can so distort their budgets, because they have no control whatsoever over it. It makes it very difficult for them to develop other programmes because a huge chunk of their budget is effectively totally out of their control. That severely hampers their ability to be more imaginative in the commissioning of providing alternatives.

**Mr O'Brien:** There are several points there. Not all providers are well managed, so there is a lot of improvement that needs to be made there, and some PCTs are pretty good at commissioning. It is not uniform across-the-board. In terms of PbR, yes, it means that some of the PCTs do not have full control over their budget, because, in a sense, the demand will dictate and money will go to hospitals if they are carrying out operations. That results in the PCTs having to predict the level of demand that will come from PbR, but over time they will become better able to gauge that and be better able to ensure that we get finances effectively managed even with PbR. The benefits of PbR, for example, although I appreciate there are issues with it, are that it improves choice, so that patients can choose where they want to go, and it supports greater efficiency because hospitals get a certain amount of money for a procedure and if they can do it more efficiently then the result of that could be that they make a saving which they are able to spend elsewhere in the hospital system. With PbR—and perhaps we will come back to this later—we need to look at how we better use it to improve the

quality of the way in which care is provided, and PCTs will need to be involved in that as part of the Darzi agenda.

**Q580 Dr Stoa:** How can we develop PbR? At the moment it is payment for activity rather than by results. The results currently are not that closely allied to the payments hospitals get. Are you prepared to give primary care trusts the power to refuse to pay where quality has been compromised or, for example, where waiting times or targets have been missed? Are you prepared to give power to primary care trusts?

**Mr O'Brien:** To some extent we have already done it. In relation to not hitting the 18-week target, for example, as from 1 April primary care trusts will be able to say to hospitals that are not delivering on the 18-week target, and indeed the two-week target in relation to cancer—a very important target—then the PCT can decide not to pay them, so that power will be there. I think you have to be a little bit cautious. There is always this myth that if you create a general market in health, somehow everything will respond to the price mechanism. There are other mechanisms that can be much more effective. Getting rid of managers who are incompetent is much more effective. Getting those who are not delivering professionally through the disciplinary system can be an effective way of dealing with issues, holding managers to account publicly for failure to deliver and making sure the public are aware of what the issues are through openness in the way in which things are done. All of those are sometimes more effective ways of getting better delivery than the crude payment method. The straight answer to your question is: yes, we are prepared to do that, but do not regard that as some sort of panacea, because it is fairly crude as a mechanism and there are often better mechanisms to get better results for managers.

**Q581 Charlotte Atkins:** Following on from the question about PCTs refusing to pay for provider services, what about a situation where, for instance, a patient is in a hospital for several more weeks because of a hospital acquired infection or because of some event that occurred in hospital? There almost appears to be a perverse incentive for the hospital to keep the patient in the hospital, because the PCT has to pay over the odds for that patient staying in the hospital. PCTs at the moment do not seem to be saying to hospitals, “We are not going to pay for events in a hospital which should not have happened.”

**Mr O'Brien:** We have indicated in the recent document that we have put out that we propose not to have payments for never events (events that should never have happened). We need to make sure too that, when these events happen, there is a full audit of why they have happened and that we make sure from a clinical point of view—because there may be a clinical issue there—that the problem is addressed within the organisation. Is there an incentive on the hospital to keep them there? Hospitals, in due course, will not be being paid for never events anyway. We need to be a little bit

careful. As I have said already, the way in which you pay people is crude. It can send messages, but you are not penalising individuals, you are penalising an organisation, so do not assume that it will automatically by itself change the organisation, because the individuals running it have to make a decision to change it. The best it does is send a signal to managers that some sort of behaviour is unacceptable.

**Q582 Charlotte Atkins:** It is the issue of the imbalance between providers and commissioners that I am trying to get at here. The PCTs do not seem to have very much power in terms of what happens with their budget when a hospital over-provides—or whatever term you want to use. In my own patch there was quite a battle between the PCT and the hospital because they had over-provided to millions of pounds and there just does not seem to be a huge amount of leverage from the point of view of the PCT over the hospital. They seem to still be all powerful, and PCTs seem to be in a weak position in terms of trying to hold hospitals to account for what they are doing.

**Mr O'Brien:** Hospitals should certainly be held to account. The objective here is not to better administer the Health Service; the objective here is that patients get the highest quality of service that we are able to reasonably deliver. The patients' interests should be the key here. It may well be that if managers have not properly predicted the amount of money that a hospital needs to be paid to deal with patients, that more money just has to be paid and the PCT has to do that. I would not want to move to a rigid system—and we had it really before we developed commissioning—where the health authority would say to the hospital, “This is as much money as you get and you now have to manage your budgets.” We have to recognise that there will need to be some flexibility in this. But you are quite right to say that we need to increase the power of the purchaser so that the purchaser is better able to represent the taxpayer and the patient, and better able to manage the way in which NHS funding is spent, and better able to counterbalance the provider interest in this equation. All of that is around improving the quality of commissioning—and that is why World Class Commissioning as a process is so important—and, also, as we develop it, it being clear that if there are some providers who are not providing well enough, they will be changed and they may lose contracts. That is quite difficult, particularly if you are dealing with a big hospital in a locality, but so that you can change the management, you can change the running of it, you can change the chairman if they are not able to manage their budget properly, if they are not able to run the organisation effectively.

**Q583 Charlotte Atkins:** We are trying to refocus health care towards the community and closer to the patient. If the hospital is taking more than its fair share of the PCT budget, then that goes up in smoke, does it not? You cannot spend the money twice. If a PCT has a particular budget and a much bigger

proportion of that is taken by the hospital than was intended for whatever reason, then you are not getting what we want to achieve, which is better primary care, care closer to the patient, fewer hospital admissions, shorter hospital stays. We are getting the opposite.

**Mr O'Brien:** I certainly agree with your description of where we want to move the Health Service. We need, however, to make sure that through World Class Commissioning the quality of the decisions and the power available to PCTs is improved, that they are better able to negotiate arrangements and deal with the providers. This is about making a change in the way in which the Health Service operates. In a sense, you are identifying the nature of the very problem that World Class Commissioning is there to try to help address. It is the case that the providers have had too much power and we need to try to find ways in which we can utilise alternative sources of power. If you look at what World Class Commissioning is about, it is about the PCT being better engaged with the local community to identify their needs, it is about being better engaged with clinicians to identify what the best health care is, it is about being able to guide the NHS through national policy decisions. It is all of those things. The PCTs should be being trained through World Class Commissioning to hold the providers to account much more effectively. Through the development not only of World Class Commissioning but also the various ways in which we are seeing PBC develop, we are seeing the development of different kinds of relationships with local authorities and others in the healthcare system. The lack of control of PCT budgets, because of, particularly, PbR, I do accept is an issue—but that has the benefit of getting down waiting lists, so let us not say it is a problem of itself. It has a lot of advantages. We will increasingly see the PCT having a much stronger role, but it is not there yet and I am not pretending it is. The objective of the exercise here is to do precisely what you want, to address the problem of weakness.

**Q584 Charlotte Atkins:** Do you not think that the hiving off of the provider arm will make the providers even more of a monolith.

**Mr O'Brien:** The provider arm from the PCT?

**Q585 Charlotte Atkins:** Yes, particularly if you get the providers moving into an arrangement with the acute trust. This will do the opposite of what you want, which is to make the system more efficient. Particularly as providers, which are presently under the wing of the PCT, now have to move, as I understand it, quickly into an arrangement other than the PCT.

**Mr O'Brien:** The move away from the provider arm being held by the PCT helps bring clarity to the role of the PCT. Provider capture, if you like, is very easy. If you are running an organisation and you are responsible directly for the detail of it, it is very tempting to focus on the administration of it. We have been clear that we want the PCTs to focus on the overall nature of the Health Service in their area, ensuring that they deliver a better quality of care,

and that means that they are policy-orientated more than administration-orientated. Where the provider arm then goes is, I think, your concern. In my area for example, some of the GP surgeries are owned by the PCT. What would be the effect of that? We have to look at where those services are best placed, it may not be with a hospital, it may be with a different type of provider and different type of organisation. We are looking at various organisations and we are asking PCTs—

**Q586 Charlotte Atkins:** By the end of March.

**Mr O'Brien:**—by the next couple of months to come up with their views about how they are going to deliver the change and how they are going to best be able to ensure that the quality of the service that is provided, at the moment often directly by the PCT through its provider arm, continues to be provided to at least the same quality or better but by another way, so that there is greater clarity in terms of the role of the PCT and its responsibility. We make sure that we are not in a situation where there is provider capture. I do not know if Gary would like to say anything more about that.

**Mr Belfield:** In relation to the comment you made at the very beginning about the speed of this, we asked SHAs and PCTs in January last year to start considering this. I do not know whether some of the witnesses have talked about the deadline we have given for this March, but we did give notice last January, so it has been a whole 15-month period to think through exactly how their provider arm should be separated. We know that in some parts of the country people are keen to go into a social enterprise type model. We know that there are some areas where provider arms will be linked together to form a much stronger, more powerful provider arm for community services. There are areas where we know they are linking with mental health, as well, so it is not all about acute. Your point is absolutely right: we have to be really careful that we do not have community services sucked into the acute sector, as has happened in the past, so we are putting in some very strong tests through the Department of Health and through the SHAs to make sure that the outcome we have here is the most appropriate one. We are putting in some strong tests.

**Dr Colin-Thomé:** The other thing is the type of model of contract you have, because you still have the money as a PCT and it is important that they protect the community services as they should under the contract. In the past, when they were merged together, the community services often lost out—and some of us older ones will remember that—but with a contract you protect them, and I think that is what we have done. With the Transforming Community Services programme that I am involved with, we have given some clear indicators of what a good body of services should be and therefore the PCT is committed to contract for those.

**Q587 Charlotte Atkins:** Will CQUIN give PCTs any further leverage?

**Mr O'Brien:** Yes, it will give them some. As you know, we are increasing the amount around CQUIN in 2010-11 to 1.55% up from 0.5%. CQUIN is going to be increasingly important, particularly to encourage stretch and innovation. It will give a greater degree of negotiating power to PCTs. Again I would not want to exaggerate it. The Indicators for Quality Improvement (IQIs), which are benchmark improvements, will give some higher degree of control to PCTs, because they will be able to benchmark where the providers are and then what improvements there have been in service and quality. That gives them an ability to measure and say, "We are now going to pay you for what we have measured as an improvement." The combination of CQUIN and IQI will help. Also, of course, in terms of improving the quality of care overall—and it is a separate matter but I think you have to see it as a package—that is the way the CQC is going to have to register all the various providers and they are going to have to come up to certain standards. That will be able to be monitored and then they are going to have to publish their quality accounts. All these things fit together as a package.

**Q588 Dr Taylor:** We have already touched on World Class Commissioning. What are the skills that you see as essential to the development? Are these the known competencies? It says in the first session that these competencies sound rather like very good high-flown words. Are they based on any sort of evidence to choose these competencies?

**Mr O'Brien:** The PCTs are going to be buying health care and they need to be good at it. The question is: what is important? Partnership is clearly important. Assessing the local needs of patients is clearly important. The competencies are the key areas on which objectively anyone would say you need to have PCTs able to lead and have a clear sense of focus. They need to work with partners. They need to work with patients and with clinicians and manage the data/the information they get; prioritise investment decisions; promote innovation; be good at buying things; and be good at procurement, managing the local NHS, promoting efficiency and stimulating markets. These are all the various competencies that any good commissioner of health care really needs to have. They have to be outward facing. They must look at what is happening in the health economy and decide how they can best get the best quality of care for patients from that. In a sense, the skills that are required through World Class Commissioning are, by and large, obvious: the 11 pretty obvious skills.

**Q589 Dr Taylor:** Why ever did we need to spend these millions of pounds on management consultants, which we heard about from the two trusts we had last week, to make something that is pretty obvious happen?

**Mr O'Brien:** It is pretty obvious that it should happen, but, frankly, it does not always happen. It is obvious that PCTs should be good at this stuff, but making them good at this stuff is much more difficult. I am concerned about the expenditure on

management consultants by PCTs. Frankly, some of it is senior managers covering their backs. They get in, they have to make a difficult decision, and rather than make it, as they are paid to do, some of them are getting in some management consultants to look at it, paying these management consultants a lot of money, in order to protect the chief executive's back. That should not be happening. It should not be happening anywhere in the Health Service. People are paid money in order to make sometimes difficult decisions and they should make them without the back-up of some management consultant looking at it all. That is why when the Select Committee recommended that we were much more open and public about the responses and of course the system responded by saying, "No, no, no, we can't do this," the view we took was that we needed now to collect this data because we were not collecting it before. It was all part of decentralisation, you see. Decentralisation sounds very good, but in practice it means that you give power down to people who sometimes use it well, and sometimes do not—and then you do not have the ability to do much about it. Openness and transparency about the amount of money spent on consultancies I think is important, and that is why from April 2009, last year, we will be publishing all the money that the PCTs and SHAs have spent on management consultancies. They will have to be very open about that, why they have done it and justify it, but if we are to avoid having loads of consultancies, we have to recognise that sometimes there will be managers who quite rightly are saying, "I've got a decision to make, I don't think I am entirely competent in that specialist area in terms of making a decision, I need some help." Whether they should go to a management consultancy or whether the Department of Health should have available—as it is now trying to do—the Board Development programme, for example, to improve the quality of the board, and, also, through the FESC system, the level of external support with commissioning that we are providing, and, also, of course, through PBC, we have a number of areas where management advice and help can now be provided to managers. Sometimes they will need to use consultants, but I think they need to justify it far more than they have done in the past, but that is why I think the Select Committee was quite right about that.

**Q590 Dr Taylor:** David, in the first evidence session, you hit the nail on the head. You said, "We need better commissioners." If you do not have the right commissioners, rather than go to the FESC, the external support for commissioners, how should we be developing the right sort of managers with the better skills? What are we doing about that? How are we doing that?

**Mr O'Brien:** You have to know who has the right skills, so you have to make an assessment of which PCTs are being run well and which are not. Last year SHAs were told to focus very hard on the quality of management in the PCTs and identify where there were some weaknesses. The measure that we had was that any PCT marked "fair" or below, for four years running in terms of their quality of commissioning,

really needed to have some serious action taken. Because, frankly, if after four years they had not gone to better than “fair” they probably were not going to get to better than “fair” and that was not good enough, and, therefore, we needed to improve the quality of that management. How do you do it? Obviously, courses. David Nicholson has been working very hard on improving the quality of management courses available to managers in the Health Service, to improve not just their commissioning but their overall skills in PR, personal resources, and in terms of the way in which they provide leadership. There really is a need to look at providing the help to managers who want to improve themselves but, also, if you want to improve quality in the NHS you have to be able to identify where quality is and where it is not—identify it, measure it, and then do something about it if it is not happening.

**Q591 Dr Taylor:** We seem to have got a pretty clear measure of what is happening from this marvellous Technicolor table in the Health Service journal dated virtually a year ago: 5 March 2009. It gives 27 primary care trusts that have green lights for all the competencies. One thing we discovered in the last session was that 20 out of these were all in the north of the country, which seems rather odd. From what you have said, looking at the quality of management could we say that, if these figures were continued, you would be thinking of sacking loads of managers from the PCTs who are right at the bottom end of this table, scoring 11 and 12 on the total competency score, as opposed to the good ones that are up in the twenties?

**Mr O'Brien:** I wish life were so simple that you just sacked the people who did not hit the mark. What you really need to do is to ask why they are not hitting the mark. It may be that some of them are running organisations where there is an excellent chief executive and excellent clinical director or whatever and there is some problem with the way in which the system works locally that they are not able to get a grip on. There may be some managers who require improvement in terms of their skills and there may be some managers who require to be removed. It just is not that simple. But we do say in the operating framework for 2010-11 that by 2011 all PCTs should have improved their skills, so that they are rated in commissioning terms at three+ in seven of the 11 competencies. We have the 11 competencies and in seven of them they have to be better than three (four being the limit), otherwise we are going to be looking to the SHA to intervene. Intervention does not necessarily mean walk in and say, “You’re sacked.” It means go in and say, “What’s the problem here? Let’s get it sorted out. It may well be that you have to go, but it may well be that we need to put in some personnel support; it may well be that we need to put in some temporary management support; it may well be that we need to get your computer system right, your personnel system right” or whatever it is we need to do.

**Q592 Dr Taylor:** This is a real way of assessing how commissioning is working. You said by 2011.

**Mr O'Brien:** By 2011. That is in the operating framework, we have already said that. It is in the framework.

**Dr Taylor:** Thank you.

**Q593 Dr Naysmith:** Minister, the Health Service Journal recently reported that PCTs and SHAs were going to be asked to cut their costs by 15% in the forthcoming year and 30% over the next four years. If that is an accurate report and you are proposing to cut the PCT management budget by 30%, is this an indication that you think they have been squandering resources.

**Mr O'Brien:** No, I do not think they have been squandering resources. It is an indication that we need to recognise that budgets need to be very well spent. The NHS has had a decade of massive investment, as you know, virtually tripling—and it depends on how you want to look at it—the budget since 1997. But we also know that that level of increased spending will not continue. We said we would bring it up to the European average and, by and large, we are, in terms of health, up to the European average. We are getting 5.5% this year and 5.5% increase next year, and then we lock that in for the further two years. That is the settlement. That does mean that we can look for savings. It does mean that we are looking for £15-£20 billion of savings within the NHS. Let me be clear about what we are looking for, because that is not a cut. When people say “savings” it is usually a way of describing cuts. Yes, we want those savings made, but that money gets ploughed back into the Health Service. We know there is going to be increasing demand, particularly from an ageing population, and therefore we need to plough it back in. How do we deal with that? We have identified that back-office functions need to be improved substantially; that we need to ensure that PCTs are sharing services and working much more closely together. They can save costs like that. They need to focus on the quality and management improvements. There are ways of saving money in terms of management. We know good PCTs do it. As I think I have said to this Select Committee before, the NHS is good at innovation but it is innovating in one place and it does not spread it. In administration and management, we need to ensure that the best run, most efficient PCTs are replicated across the Health Service.

**Q594 Dr Naysmith:** Whether you call it savings or cuts or money being redistributed—

**Mr O'Brien:** It gets redistributed.

**Q595 Dr Naysmith:** —it is being taken away from PCT management budgets.

**Mr O'Brien:** Yes.

**Q596 Dr Naysmith:** How do you expect skills and performance to improve when you are reducing the money available?

**Mr O'Brien:** Because we know that good PCTs are able to be run much more efficiently than less good PCTs. Therefore, through improving the overall quality and efficiency of the running of PCTs and, indeed, the providers of management throughout the NHS, we are able to do that. I would also say, "Look, we have some choices to make here." We have been very clear as a government that we will not cut frontline services and that we will focus money there, and therefore we have to look at the back-office functions and we have to find savings there, so the pressure is on.

**Q597 Dr Naysmith:** You could argue for commissioners that the frontline services are making sure that what happens is what you have just said you want to happen. In a sense, they are frontline services. If we do not get the frontline services organised, we might as well not have the frontline services.

**Mr O'Brien:** Yes, but some of them run better than others. For example, I think we can make some savings in SHAs. I have been talking to officials about how we move some of the roles that SHAs currently have down into PCTs, so that the funding moves with it, and that we also take some of the cost out of the SHAs. I think the SHAs have to justify their existence much more than they have in the past. They are an important part of the Health Service. I do not think we can just get rid of them, but we have to make sure that they are run efficiently, and that we do not have people sitting at desks, not working as hard as they should.

**Q598 Dr Naysmith:** How are you going to set the priorities in these things? Are you going to set them in the centre? How are they going to be set?

**Mr O'Brien:** We are saying to managers that they have to identify how they are going to make savings of 30% between now and 2014 in their budgets. That should be in management, that should be in back-office function, that should be in administration. It is partly because we want to ensure that frontline services are maintained, but, also, because in the past there has been a temptation for managers to say, "We'll make the savings and the big savings will be down in the frontline, and we will cut that service and we will cut that," but managers stay in their jobs. The first thing we want managers to look at, chief executives to look at, is: "My management services: can I make a cut there?" That is not going to damage the quality of commissioning, that is not going to damage the quality of care delivered in the local area.

**Q599 Dr Naysmith:** We had some evidence in the previous session that in straitened financial times really top-class commissioning is even more important.

**Mr O'Brien:** It is.

**Q600 Dr Naysmith:** Than it is when there is plenty of money about.

**Mr O'Brien:** Which it is.

**Q601 Dr Naysmith:** You have to get it right and make sure that the right cuts are made.

**Mr O'Brien:** Yes, you do. You have to get it right. You are absolutely spot on to say that at a time when there are tougher financial circumstances, the quality of commissioning is crucial. That is why the old fashioned, Thatcherite, 1980s, across-the-board, slash-and-burn cuts are unacceptable. We have been reading in some of the medical magazines that this hospital or that PCT are talking about x% cuts in budgets. That sort of thing is old management speak. It is the sort of thing that if we find they are doing it, we will name and shame them. We need quality managers who make serious decisions and not just across-the-board cuts, who say that they will be able to find this by collaborating with other PCTs in terms of provision of various services, management facilities, who say they will cut some of their consultants' budgets or they will cut some of the administrative procedures that they have carried out as far as the back-office is concerned, that they will use clinicians to help guide them in terms of the decisions that they make. There are a number of areas where we expect managers to find those savings so that they can redirect the funding into the frontline.

**Q602 Sandra Gidley:** What improvements do you expect to see in the second year of World Class Commissioning? How will that league table to which Dr Taylor referred earlier improve?

**Mr O'Brien:** In a sense, I have already referred to the key area where we need to see improvement, and that is in the quality of management. We want to see the quality of boards' decision-making improved, the quality of the skills that they are able to display and will be measured on. It is not just the operating framework, which is going to measure the quality of what is being done, but also the PCTs will be subject to the commissioning Performance Framework which is due in April, which will measure the quality too of decision-making and direction of the local health service by the PCTs. We also want to see the SHAs provide more development and support to PCTs that need it, so in the second year of World Class Commissioning we are going to be taking it a step further. The first phase, year one, was getting a baseline of how good commissioning was being done. It was box-ticking, in a sense, and that is where we needed to be because we needed to establish that baseline. In year two we then had to move on to the skills and competencies that we need to ensure that each group of managers have to improve and that they are getting the opportunity to improve them. In year three we have to ensure that those improvements are put in place and we are measuring the improvement in the quality of commissioning. We are now into the situation where we have given them the chance to improve, we are measuring the quality of what they are delivering, and we now want to be able to say to them, "Look, you have improved this much." Some of them will not have improved enough. "This is the support you are going to get" or

“You’re just incapable of improving, we now have to take some serious action in terms of you.” We are now into that much more decisive phase. It is a process of baseline identification, putting in place the services to improve it, ensuring the improvement is taking place, measuring the improvement, and then, where it is not improving, dealing with it and reinforcing the improvement that is taking place. It is a year-upon-year process.

**Q603 Sandra Gidley:** I can accept that the first year was benchmarking, but I am not quite clear whether there are any targets for improvement, how the average patient will realise things are better.

**Mr O'Brien:** Once you have benchmarked, you can then see whether there is an improvement in the quality of what you have done.

**Q604 Sandra Gidley:** You are talking about seeing whether there has been an improvement. I am trying to get out of you how much of an improvement you hope to see. Can you quantify that in any way?

**Mr O'Brien:** It will vary depending on the PCT. Each of the SHAs, for the very reason that I described earlier, will have to intervene if there is a failure to hit the three + rating (four being the highest) in seven of the 11 competencies. There is a measurement: “This is the minimum you need to be at, otherwise we are going to intervene—not to necessarily sack you, but we are going to intervene.” In terms of the answer, I suppose it is that that is the measure, that three + in seven of the 11 competencies.

**Q605 Sandra Gidley:** You said if they do not achieve that, the SHA will intervene. SHAs have always struck me as particularly powerless and useless organisations. What do SHAs then do, slap them over the wrist? You cannot sack anybody, it seems. I am not quite sure how we are going to drive things forward.

**Mr O'Brien:** Certainly in my region, the SHA has intervened and people have gone. Whether those were the right decisions or not, I am not convinced they always were. In fact, I am pretty sure that in some cases they were not. The idea of seeing the SHA as some sort of toothless tiger is wrong. They do get rid of people. They do not always do it to allow publicity but people are moved on and I have seen it happen.

**Q606 Sandra Gidley:** So we sack the chief executive and then there is an interim period where there is not anybody in charge and we get somebody new in and we still have the same rubbish commissioners.

**Mr O'Brien:** The idea of bringing new managers in—you would not do it otherwise, would you?—is to improve the quality of performance. New managers come in to do that, and if they do not do it, then you have to get someone who will. You seem to be saying, “Let’s all despair about it.” Of course we cannot do that: we have a Health Service to run and if somebody is not up to it, then they will be moved on.

**Q607 Sandra Gidley:** You mentioned box-ticking and explained why the first year had to be a tick-box exercise, and there has been some criticism levelled at that, but there seems to be a lack of evidence that health outcomes are genuinely being improved. When will we know if World Class Commissioning has delivered improved health outcomes?

**Mr O'Brien:** Because they will be delivering on their outcomes, because they will be able to show that they have set out a strategy, that this is what they want to do in the local area and that they have delivered it. They have to measure themselves and they have to be objectively measurable. The SHA will be able to say, “At the start of this year, you as a PCT said that’s what you wanted to achieve, let’s have a look at whether you have done it. You have in this area; you have not in that area”—why have you failed and how have you achieved.

**Q608 Sandra Gidley:** But some health outcomes are longer term than a year to measure.

**Mr O'Brien:** It will be. If you have a longer-term project over a five-year or ten-year period (say, for example, to shift patients more into the community in terms of their care) then you can say, “Each year we will seek to achieve this.” You will break that down and say what each year is supposed to deliver. You will not say, “You have to deliver a ten-year project in a year.” You will say, “You have to deliver one-tenth of a ten-year project in a year and you have to identify what it is that you are going to have as your objective for that year as a PCT,” and the SHA will be able to measure that and ensure that it is delivered. It is about ensuring they deliver their outcomes.

**Q609 Sandra Gidley:** We have had practice-based commissioning for a while. The aim with a lot of the reforms has been to move services from secondary to primary care, but PCTs seem to have been unable to stimulate the market to achieve this. Why is that?

**Mr O'Brien:** In terms of practice-based commissioning?

**Q610 Sandra Gidley:** PCTs seem to have limited ability to stimulate the market to change things, to get best value for money.

**Mr O'Brien:** I am not convinced that that is the case. I can give you a couple of examples, which are fairly obvious, in a sense. PCTs have created 120 GP-led health centres. They have commissioned them.

**Q611 Sandra Gidley:** Only because they were told to by government.

**Mr O'Brien:** But they have done it.

**Q612 Sandra Gidley:** They were told to do it. That is not exactly stimulating the market. An individual PCT does not seem to have much muscle to flex.

**Mr O'Brien:** They have been told by government to create 120 GP-led health centres. They have to find the providers for that. In my local area, they have done it. I am sure in yours they have done it. That is one example.

**Q613 Sandra Gidley:** That is not local decision making. What do we have that is not a top-down initiative, evidence that PCTs can stimulate their local markets? It is not happening.

**Mr O'Brien:** I have already provided you with a couple of examples, and I can give you some more. I described the changes they had created in Somerset by commissioning. PCTs have led the process in Somerset to deliver COPD care in the community much more effectively. They have seen a 15% drop in hospital admissions in Somerset. That is an entirely new delivery of community care, stimulating the market. In Manchester the ten PCTs have provided new stroke care services. Another example would be at Bexley, where the cardiology service has been developed through PBC. PBC was the innovator of that at the request of the primary care trust. The primary care trust funded the innovation that has taken place, by delivering care for people with cardiology issues much more in their homes, rather than having them coming into hospital—a saving of £4 million, by the way, in the local budget—which is a combination of the PCT being prepared to innovate and, also, the way in which PBC has operated. Likewise, we have seen the co-ordination of GP visits in Halton and St Helen's PCT. There they have decided to get the GPs to work together much more effectively to carry out visits to homes during the day. As a result, because GPs are being commissioned to co-operate, they have managed to get 27 more patient visits per day out of the GPs and also seen a 30% drop in hospital admissions. That saved £1 million in the first six months in the budget and had a 90% patient satisfaction rate. All of that has been as a result of the ability of PCTs to innovate. There are a number of examples out there. It is happening.

**Q614 Dr Naysmith:** People currently complain that there are structural complexities inherent in the current commissioning arrangements. Do you think World Class Commissioning is going to solve this and make it more straightforward and easier?

**Mr O'Brien:** It is part of the process but it is not going to do it all. We were talking earlier about what is top-down and what is not, and there need to be some policy changes. If we want more people to be cared for in their homes rather than in hospitals, to stop the yo-yoing of the long-term care patients—which is something I feel very strongly about, as you can probably tell: I have mentioned it twice so far—then we do need to look at the way in which finances operate within the NHS. We do need to make sure that we have got the funding right on that. World Class Commissioning can carry some of the weight of change but it cannot carry all of it. There are structural complexities in the operation of the NHS and commissioning, managing data and so on, and we need to ensure that we get a greater degree of joint commissioning by PCTs and that we get the development of joint budgets too. Particularly important—something I announced the other day—was getting PCTs to work much more closely with local authorities on integrated care projects.

**Q615 Dr Naysmith:** We have also heard quite a lot of evidence that is critical of the amount of information and the quality of the data that commissioners have available to them. Do you have plans to improve the data to enable them to make better decisions?

**Mr O'Brien:** Part of the World Class Commissioning exercise is precisely that, to see if we can improve the quality of data handling. It is not just getting the data. There was an idea that if you get the data, somehow it would be used properly. There is a two-fold problem: you have to (a) get the data and (b) ensure the managers know how to use that data.

**Q616 Dr Naysmith:** I was about to say: you have to have people who know how to use data.

**Mr O'Brien:** Exactly.

**Q617 Dr Naysmith:** And have experience of the areas they are getting the data about.

**Mr O'Brien:** That is about improvements in skill and competence. Also, through the World Class Commissioning exercise, we are identifying the key areas of data that managers will need to have in order to commission effectively. We are also getting them to identify for themselves what locally they really need to be able to measure the outcomes of care for patients where they have commissioned, so they need to go to the providers and say, "In order to measure what you are providing for me, I need to have this data and you have to provide it." That would be a local decision. There is a national view about what needs to be provided and then there is a much more local one.

**Q618 Dr Naysmith:** Will patient recorded outcomes be part of this process? That is something that we do not know about.

**Mr O'Brien:** Gary is saying yes to me.

**Mr Belfield:** From a national level, through the information centre, we provided every single PCT with baseline data to help them do commissioning, so we have helped from a national perspective. Locally now we are finding more and more PCTs working together to pool their information: to do the information once, which obviously saves money. Last night I was with six PCTs in the West Midlands who are working together on risk stratification, for example, to look at where the patients who may end up in hospital are, so they are getting to people earlier through their GPs. We are seeing something from the top and action from the bottom as well. It is not perfect, though, I agree with you completely.

**Q619 Dr Naysmith:** There is some way to go.

**Mr Belfield:** Yes, but we are taking action.

**Dr Colin-Thomé:** I would say two things. We already had Public Health Observatories and since the Darzi Review we have set up Quality Observatories, which are a source of information and data analysis that PCTs can tap into. I think we have set up quite a bit. Of course we can always do better.

**Q620 Chairman:** I have a question about our old friend the decommissioning of services. There was publication of a survey in October 2008 which said

that in the year 2000 the majority of PCTs did not decommission any services whatsoever. This has been in several of our inquiries since I have been on the Health Committee. Why is this? Does NICE help or hinder the prospect of decommissioning services that probably do not have the value that they once had?

**Mr O'Brien:** Decommissioning is difficult, particularly if it is decommissioning a substantial service. Decommissioning in a local hospital is an enormous decision, and we certainly have not seen that. Decommissioning a smaller service or a part of a provision is a bit easier, but it is always going to be difficult. We have been clear that the NHS is a provider, that we want people operating in the NHS who are delivering services to have opportunities to improve the quality of it, but if they do not, you do have to decommission, you do have to say, "Look, this service is no longer able to be provided adequately to you," and that is a tough decision. Does NICE help? Yes, it does, because it sets standards, it provides a benchmark for services. NICE has also provided some guidance on how to disinvest, and what procedures to go through. One of the key areas where World Class Commissioning can provide assistance to managers is by showing them what the process is of disinvesting in and decommissioning a particular service.

**Q621 Chairman:** Do you agree that NICE guidance is inflationary and that it should be discretionary for PCTs rather than compulsory?

**Mr O'Brien:** It can be inflationary, I suppose, if it is the case that they are implementing the NICE guidance without being prepared to decommission anything. The PCT has to ensure that it is delivering the best quality of care, and if NICE is saying to it, "This is the best quality of care" then the PCT really needs to think very hard if it is going to exercise some sort of discretion not to deliver the best quality of care. It would have to have a hell of a good reason for not doing it. I think my instinct is to say that PCTs should be delivering what NICE wants, because NICE are there and they can identify, particularly in terms of the drugs available, what should be available across the country. We already have enough problems with discretion leading to what people call a postcode lottery. We need to have a level of standards, we need to have it available generally across the country, and managers need to think very carefully if they are even considering not delivering it.

**Q622 Sandra Gidley:** We have had practice-based commissioning for some years now. Why has it taken so long to do anything? What have been the barriers?

**Mr O'Brien:** Practice-based commissioning is working well in some areas and not so well in others. We know that where practice-based commissioning operates, 80% of GPs say they feel it goes well; 77% say that they do feel they are being listened to. Not all doctors want to get involved in practice-based commissioning. It is voluntary. Some doctors feel they do not have the time, energy or the commitment.

**Q623 Sandra Gidley:** Would it help to incentivise doctors?

**Mr O'Brien:** They are being offered the opportunity to get involved.

**Q624 Sandra Gidley:** I am talking money.

**Mr O'Brien:** I know you are. Doctors, by and large, do get reasonably well paid, particularly if they are a partner in a practice, and I am not sure I am in the game of paying them a lot more money at the moment. Doctors do a good job, and we have asked a lot more of them. And I can understand why they are a bit ticked off that sometimes we seem to be pulling money back as well as asking them to do more, but if you are a partner in a large scale practice in a big conurbation, you will be on a very good whack, and even if you are a partner in a reasonably small one, you could be earning £100,000. Okay, salaried doctors are in a different area—they can be on £50,000 to £60,000, which is far less. I do think that incentivising is not the way forward. In terms of the PBCs, we do need to look to encourage the development of more GP engagement. Let me just say, because it is something on which I know you want to hold a hearing shortly, that a greater degree of GP involvement in out-of-hour services through PBCs, or through the LMCs, indeed, would be beneficial to the system.

**Q625 Sandra Gidley:** We heard earlier that conflicting government initiatives had been a significant barrier. Would you agree with those comments from our earlier witnesses?

**Mr O'Brien:** I do not know quite why the person you were speaking to earlier would say that.

**Q626 Sandra Gidley:** There have been so many different initiatives.

**Mr O'Brien:** I would have thought it would be the opposite. The opposite would be: if you want to find out what is going on in the Health Service, get involved in practice-based commissioning because you will find out far more about what needs to be delivered. I would have thought it should be the opposite. I am not sure of the reasoning for that being said.

**Dr Colin-Thomé:** It is a skill for us locally to use all these initiatives for the betterment of our patients. I think many of us have not found that as big a problem as is claimed.

**Q627 Sandra Gidley:** Those theorising about it have a different view from those trying to deliver it.

**Dr Colin-Thomé:** You talked about payment by results. It is also budgets for commissioners, as I think I said before, because if you do disinvest you keep the money for something else. It is not as if it always has to go to the hospital. Practice-based commissioning can involve clinical engagement to help PCTs with their decision-making and take clinicians nearer to the money that we indirectly spend. It is in part about a mindset this, rather than thinking everything new is a problem.

**Mr O'Brien:** It is working very well in some areas, so let us not pretend it is not. It is working very well, it is just that in some areas it has been much slower to take off. I have never met a GP who does not have very strong opinions about the Health Service. Having attended one or two social functions where I cannot get away from GPs who want to tell me all about what they think about the local health service, it is sad that some of them have not become as involved as the opportunity is there for them to do.

**Q628 Sandra Gidley:** You talk about GP involvement. Is the answer to bring back GP fundholding?

**Mr O'Brien:** No. We need to be really careful about that. Some GPs want to hold a fund and will be quite capable of doing it. Some GPs simply want to be GPs. They do not want to be managers of funds; they want to deal with patients rather than being managers. That is not why they came in. If we were to force hard money/budgets on to practices, particularly smaller practices, I think they would go out of business. I know that is Conservative policy. Let me take the opportunity to say that I think it will destroy a large number of practices across this country and it is very counterproductive. Our view is that if people want to get involved in holding a budget and they want to get involved in the way in which the local health service is managed, that is one thing, that is voluntary, but forcing people in the way they are proposing is just wrong.

**Q629 Sandra Gidley:** Finally, the next stage review acknowledged that practice-based commissioning had not lived up to its potential. The King's Fund rather controversially produced a report: *Practice-Based Commissioning: Reinvigorate, Replace or Abandon*. Even one of your advisors—I think you knew this would come eventually—mentioned practice-based commissioning in terms of “a corpse not for resuscitation.” Should we not just abandon it?

**Mr O'Brien:** No, because where it works it does very well. Indeed, we need to continue to breathe life into it, and in due course we may find that it is up and dancing quite happily and providing us all with a better quality of delivery. GPs need to decide the extent to which they want to be involved. I do not want to force people to be involved; I want to encourage them to be involved. We do know that where they are involved, where they do volunteer to participate, they make an enormous contribution. I say to all those GPs who I have had moaning at me for various different things: the best way of doing something about the quality of your local health service is to get involved in PBC.

**Sandra Gidley:** Thank you.

**Q630 Dr Naysmith:** David must have had a bad week, perhaps.

**Mr O'Brien:** Let David say something.

**Q631 Chairman:** David, you have told us before, but put it into context.

**Dr Colin-Thomé:** It was an attempt, I suppose, to shock—which was ill-judged.

**Q632 Chairman:** Are you saying that it has been taken out of context?

**Dr Colin-Thomé:** I did go on to say that it was working in plenty of places, rather than it being all a disaster. But where it was not, I think it did need a big kick up its backside, really.

**Mr O'Brien:** If I went around saying that in areas it was not working and GPs needed a kick up the backside, I would have every GP magazine saying, “Minister says all GPs need a kick up the backside.” Anyway, I did not say it. David can.

**Q633 Dr Taylor:** A brief focus on specialised commissioning. Why is it so slow and cumbersome? Do you have plans to make it more efficient?

**Mr O'Brien:** Yes, it has been very slow. I am not sure “cumbersome” is the word I would use, but it has certainly been slow. There are substantial complexities in the way in which it operates. We have had varying degrees of capability in each of the Specialist Commissioning Groups that have been set up to coincide with each SHA area, and some of them are better than others. We also have seen, where you have a good SCG, that some of them have been distracted and asked to look at other wider issues, like the Ambulance Service—so there has been some element of distraction there. But we are moving towards PCTs pooling their budgets at SHA level. We have implemented the setting up of the National Specialist Commissioning Group and, also, the National Specialist Commissioning Team, which supports the local SCGs. We are moving to develop this. It has just proved more complex, more difficult, than we anticipated. Some of the rather optimistic views that were in Sir David Carter's report about how quickly this could be done were just a bit too optimistic. This is a very complex exercise. We are dealing with a wide variety of very difficult and varied decisions about what sort of services and drugs are to be brought in.

**Q634 Dr Taylor:** One of the great disappointments. The Specialised Healthcare Alliance did a survey. When they gave us their written submission, they had not really analysed the results fully, but they said, “The maximum number of service categories reported to be fully commissioned by any SCG is 28 out of 36 and the minimum is six.” When they came before us a fortnight or so ago, they gave much worse figures than those for the proportion of things in the definition set that are actually being commissioned. What can be done about that?

**Mr O'Brien:** I do not think it is a lack of will, I do not think it is a lack of clarity about the policy: I think it is the complexity of what we are asking people to deliver and the multiplicity of demands that we are making upon them in terms of analysis that has caused the sort of figures that you have identified. I

am not sure there is an easy way through this and I am not sure there is really an alternative. Some have said, "Look, just centralise it all in national government making big decisions." We do that to some extent for particular conditions, for about 50 services for the National Commissioning Group, but I think we are much better trying to work through what Sir David Carter advised and seeing if we can make it work. I think the key problem is complexity, multiplicity of demands, variety of different conditions, and the nature of the sorts of things that need to be commissioned. That is causing a slowness in terms of developing this. I think we need to persevere with it. If, say, in a year or two it is clear that we are not getting the attraction that we really need on this, we are going to have to look at it again, but I am not sure that there is an easier approach to this. It is a very difficult issue.

**Q635 Dr Taylor:** But you are still looking at the Carter Review and trying to put it into practice.

**Mr O'Brien:** We are still trying to get it to deliver, yes.

**Q636 Dr Naysmith:** We have heard evidence that integrated care through integrated care pathways is the solution to many of the problems with commissioning in its present form. Why are you not just pushing ahead with integration rather than fiddling with PCTs and their performance?

**Mr O'Brien:** PCTs are part of the process of getting integrated care pathways to work, so we need them. Making sure they do this well is important. I have just announced that the 16 pilots will be continued, and we are now asking all PCTs and local authorities to get involved in integrated care pathway models. In a sense, this should be happening anyway. We should be getting PCTs and local authorities to work together. I know from experience in my area that at various different stages the county council and the local PCT have seriously wanted to get involved in working together. Sometimes they have not had the will to get involved at exactly the same time, which is a problem, but there has in the past been the will to do it. Because of the fact that you are in your own silo and you have your own budgets, getting people to work together is really, really difficult. These pilots have shown that if you identify an area like substance misuse for young people or dealing with a particular long-term condition, you can get the local authority and the PCT to work together, you can deliver a pilot, and then hopefully you can begin to replicate it elsewhere because you know how to do it.

**Q637 Dr Naysmith:** These pilots are going to be properly evaluated and assessed.

**Mr O'Brien:** Yes.

**Q638 Dr Naysmith:** Because we have criticised the Government in the past for running out pilots before they have really assessed the evidence. We can be sure that that will not happen.

**Mr O'Brien:** One or two issues have arisen, but most of the pilots have shown that, where you do get this level of co-operation, you really get a much better service for people. It is sort of obvious that you would, is it not? It is obvious that it should all be being done, but these things are difficult to manage and breaking people out of silos is really not easy.

**Q639 Dr Naysmith:** Here is a silo that we might just put to you: primary and secondary care have been separated since the 1911 National Insurance Act, why have you not facilitated integration by, for instance, letting hospitals take over primary care or vice versa?

**Mr O'Brien:** My hospital runs the GP-led health centre in my area. It has not been open very long—I opened it about nine months ago.

**Q640 Dr Naysmith:** Is it not going to be the best way to get integrated care pathways?

**Mr O'Brien:** Yes. We want to see a greater degree of integration between primary and secondary care, and particularly in terms of the management of long-term care conditions. That is set out in the new document which we put out recently, the *Good to Great* document which sets out how we want to improve long-term care conditions and ensure that we get services joined up much more effectively. We want to ensure that if we identify areas where closer collaboration is possible and closer integration is possible, that that is able to happen by the organisations working much more closely together than they have in the past. Essentially you are saying to me that this is a barrier. I agree and I think we need to break it down.

**Q641 Dr Naysmith:** We have heard several ideas about how to improve the situation that we have been discussing this morning: competition between commissioners; a National Health Service Board being set up; local clinical partnerships. Do you think that any of these are worth consideration, in trying to solve some of the weaknesses in the system that we have been discussing?

**Mr O'Brien:** Certainly local clinical partnerships are crucial. We are seeing, increasingly, ways of keeping services in small district hospitals by better clinical links. Again these are not always easy to set up. The idea is good—indeed, when it is done the outcome is usually very good—but it is not without its traumas in setting these things up. Yes, I think there are a lot of good ideas out there about how we improve the quality of the NHS. As I have said earlier, innovation is what the NHS is quite good at; spreading innovation is what it has been bad at in the past. We need to have a greater degree of identification of what works, what works well, and then spread it across the NHS much more quickly. If we are to deliver on the budgets, innovation and focusing on quality are going to be the key to making sure that we hit budget targets much more effectively.

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4 February 2010 Rt Hon Mike O'Brien MP, Mr Gary Belfield and Dr David Colin-Thomé

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**Q642 Dr Naysmith:** Do you want to say anything about the NHS Board?

**Mr O'Brien:** The NHS Board is an idea of creating a super-quango. It will mean that ministers will walk into the place across the road, the House of Commons, they will be told that there is a serious problem and they need to do something about it, and they will not have the capability of doing anything about it because they have given the power to some quango called the NHS Board,

which will be full of people who are paid large amounts of money and probably make all sorts of decisions which are not democratically accountable. In terms of: "Would it be a good idea?" it is no.

**Chairman:** Could I thank you very much indeed. I think, Minister, you may be coming back to this Committee before we pull stumps up for the General Election. Up until then, thank you all very much indeed for coming along this morning.

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# Written evidence

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## Supplementary memorandum by the Department of Health (COM 01A)

The Committee heard evidence from Gary Belfield, Acting Director General of Commissioning and System Management at the Department, as part of their inquiry into Commissioning on 22 October 2009. During this evidence session, Mr Belfield committed to provide further details on three particular aspects of his evidence. With apologies for the delay in sending this to you, please now find attached:

*Annex A*—which provides more detail about Competency 11 of world class commissioning and what this competency is intended to capture;

*Annex B*—which provides an overview of how the Framework for procuring External support for Commissioners (FESC) has been used, where and an indication of the costs involved; and

*Annex C*—a short note about the availability of information on the costs of external consultancy bought in by PCTs.

12 February 2010

## Annex A

### WORLD CLASS COMMISSIONING—COMPETENCY 11

The world class commissioning (WCC) competencies describe the commissioning processes and capabilities that, when developed to a high level, will deliver improvements in health outcomes over time. Achievement of the competencies is not an end in itself, but a part of the process that drives towards transforming people's health and well-being at a local level.

For year two of WCC assurance, in addition to taking into account feedback from year one, all competencies have been revised to increase clarity, and ensure relevance to the current context and what is required of PCTs to deliver in these challenging times.

Competency 11, focusing on efficiency and effectiveness, is now being assessed as part of the core competencies. Competency 6 has been revised in the light of this and also requires PCTs to prioritise investment under different financial scenarios.

#### COMPETENCY 11

A core purpose of commissioners is to make sustainable trade off decisions and sound investments to deliver the highest level of health outcome for a given level of spend along each care pathway. Robust analysis of spend and its impact on health outcomes enables PCTs to make well informed investment decisions. By identifying and unlocking efficiency and productivity improvements across all commissioned activity, PCTs will deliver both better health outcomes and greater value for money.

The sub competencies for competency 11 are:

- (a) Measuring and understanding efficiency and effectiveness of spend;
- (b) Identifying opportunities to maximise efficiency and effectiveness of spend;
- (c) Delivering sustainable efficiency and effectiveness of spend.

#### COMPETENCY 6

By having a clear understanding of the needs of different sections of the local population, PCTs with their partners, will set strategic priorities and make investment and disinvestment decisions, focused on the achievement of key clinical and other outcomes. This will include investment and disinvestment plans to achieve health gains and address areas of greatest health inequality. Three financial scenarios are considered and their impact reflected in the investment and disinvestment decisions proposed.

The sub competencies for competency 6 are:

- (a) Predictive modelling skills and insights to understand impact of changing needs on demand;
- (b) Prioritisation of investment and disinvestment to improve population's health;
- (c) Incorporation of priorities into strategic investment plan to reflect different financial scenarios.

## Annex B

## FRAMEWORK FOR PROCURING EXTERNAL SUPPORT FOR COMMISSIONERS (FESC) SIGNED CONTRACTS, JANUARY 2010

<i>Commissioning Authority</i>	<i>Project description</i>	<i>Cost (net of guaranteed savings)</i>
NHS Hillingdon	<ul style="list-style-type: none"> <li>— <i>Acute Invoice Validation</i>—review of Acute planned and Unplanned Commissioned Activity</li> <li>— <i>Care Pathway re-design</i>—including MSK, renal and diabetes</li> </ul>	£1.3 million
NHS Northamptonshire	<ul style="list-style-type: none"> <li>— <i>Health Needs Assessment</i>—to understand disease segment requirements and re-design of care pathways for better health outcomes.</li> <li>— <i>Acute Invoice Validation</i>—to ensure accuracy in paying for what is used by PCT in secondary care</li> <li>— <i>Patient Experience</i>—to develop a strategy for determining the measurement and reporting of patients and carers experience of healthcare that includes clear proposals and delivery plan</li> <li>— <i>Communications &amp; Social Marketing</i>—to improve the capacity and capability within the communications and public engagement tea million</li> </ul>	£1.8 million
North East Lincolnshire Care Trust Plus	<ul style="list-style-type: none"> <li>— <i>PBC Operating Processes</i>—to ensure delivery of all PBC local and national targets</li> <li>— <i>Shaping the Structure of Supply</i>—to align demand for services and to shape the structure of supply</li> </ul>	£2.5 million
NHS Ashton, Leigh & Wigan	<ul style="list-style-type: none"> <li>— <i>Health Needs Assessment</i>—to improve health needs assessment to drive the commissioning process</li> <li>— <i>PBC Operating Processes</i>—to strengthen the PCT's capability to support PBC</li> <li>— <i>Managing Demand &amp; Service Redesign</i>—to proactively manage demand via PBC</li> <li>— <i>Shaping the Structure of Supply</i>—to shape the structure of the primary/community and secondary healthcare market</li> <li>— <i>Acute Invoice Validation</i></li> </ul>	£2.5 million
NHS West Kent	<ul style="list-style-type: none"> <li>— <i>Demand Management</i>—proof of concept pilot telephone outreach service (CareCall) for patients with long term conditions</li> </ul>	£4.1 million
NHS Hampshire (South Central Strategic Commissioning Group)	<ul style="list-style-type: none"> <li>— <i>Specialist Commissioning Project : Contracting &amp; Procurement for Secondary and Tertiary Care Services</i> (including <i>PhR Transactions</i>)—to negotiate contracts that will promote better value for money</li> <li>— <i>Budget &amp; Activity Management</i>—to establish robust processes to validate and reconcile activity data</li> <li>— <i>Performance Management</i>—to comprehensively performance manage awarded contracts</li> </ul>	£3.0 million
NHS Barnsley	<ul style="list-style-type: none"> <li>— <i>Patient &amp; Public Engagement</i>—to create and improve opportunities to access information to support self care and self determined care and through social marketing to prevent early deaths and minimise long term illnesses</li> </ul>	£1.3 million

<i>Commissioning Authority</i>	<i>Project description</i>	<i>Cost (net of guaranteed savings)</i>
NHS East of England	— <i>Acute Invoice Validation</i> —an SHA-wide collaborative programme incorporating all 14 PCTs and the SCG. Implementing a word class acute invoice validation service built on a central data warehouse and improved data flows between providers and commissioners — When implemented from January 2010, the service will be enhanced to focus on clinical as well as data validation	£5.0 million
NHS Kirklees	— <i>Health Needs Assessment</i> —Risk identification and stratification model; introduction of international best practice and innovation; and knowledge transfer	£0.7 million
NHS North Yorkshire & York Westminster PCT	— <i>Acute Invoice Validation and Care Pathway Re-design</i> —this includes skills and competency transfer — <i>Health Needs Assessment</i> —comprehensive review of health needs and issues for Westminster residents	£1.3 million £1.4 million
South Central PCT Alliance (contracting authority is Oxfordshire PCT)	— Review of service provision—development of programme of work to address health inequality/prevention in areas such as smoking, alcohol and obesity — The FESC element of the Commissioning Enablement Service (CES) will bring about a step change in commissioning capability by: — Identifying the biggest opportunities for improvement in quality, outcomes and productivity in the local health economies — Designing services to deliver better outcomes and improve use of services — Managing the performance of health providers in a more intelligent way by identifying and addressing unwarranted variation in practice	£23.0 million
Total Net Cost:		£47.9 million.

AVAILABILITY OF INFORMATION ON THE COSTS OF EXTERNAL CONSULTANCY  
BOUGHT IN BY PCTS.

At present, the Department of Health collects data on its own use of management consultants, but it does not collate and report detailed information on the use of consultants by NHS organisations.

The Department has committed to collating and reporting the overall expenditure by NHS organisations on management consultancy each year with effect from the financial return for 2009–10, which will be published in summer 2010.

Paragraph 3.53 of “The Operating Framework: for the NHS in England 2010–11”,<sup>1</sup> published in December 2009, states that: “.....all organisations must ensure they code their costs accurately and consistently on ESR to enable fair and effective comparisons. All organisations must report in their audited accounts details of their management costs, management consultancy costs and expenditure on temporary and agency staff to enable comprehensive benchmarking and cost control”.

**Further memorandum by the Specialised Healthcare Alliance (COM 91A)**  
SCG GROUP SURVEY—FEBRUARY 2010

INTRODUCTION

This report summarises replies received from regional Strategic Health Authorities (SHAs) and Specialised Commissioning Groups (SCGs) in response to a short questionnaire distributed in August 2009 with a view to informing the Health Select Committee’s inquiry into commissioning. A further question on the way in which SCGs pool budgets was sent out at the end of November. Although the information contained in the report is interesting and serves to highlight various strengths and weaknesses, its value for comparative purposes is limited by the different nature of many of the replies. Specialised commissioners have also pointed out that the policy environment is constantly changing with initiatives such as Quality Innovation Productivity and Prevention (QIPP) throwing up new challenges.

*SCG abbreviations*

EM—East Midlands  
EoE—East of England  
NE—North East  
NW—North West  
SC—South Central  
SEC—South East Coast  
SW—South West  
WM—West Midlands  
YH—Yorkshire and Humber

SGC FUNCTIONS

Q1 *How many services from the National Definitions Set has your SCG fully commissioned in 2008 and in 2009?*

Summary of findings:

**Carter Recommendation 3: Specialised Commissioning Groups**

*“Each SHA area should have a SCG responsible for the commissioning arrangements for all specialised services as defined by the Specialised Services National Definitions Set”*

**DH Operating Framework 2007–08**

*Key milestone: “SCGs to collectively commission a minimum of 10 specialised services; by 2008–09 SCGs to collectively commission most specialised services for their populations.*

Responses to this question confused commissioning of particular services with full commissioning of the 35 service definitions within the National Definition Set, each of which might comprise several services. The results are therefore difficult to interpret but show that, despite significant progress, SCGs generally remain well short of the objectives laid down in the Carter report and subsequent DH Operating Framework.

To provide additional information and for purposes of comparison, we have included in italics for each SCG a summary of their responses to a survey conducted in April 2008 by the NSCG.

<sup>1</sup> [http://www.dh.gov.uk/dr\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh\\_110159.pdf](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf)

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EoE	<p>EoE SCG presented costs associated with 34 of the 35 national definition set and estimates that it commissions at least 90% of related spend across the region. <i>From the April 2008 exercise EoE had planned to fully commission 10 services and partially commission 23 of the 35 nationally defined services.</i></p>
EM	<p>The EMSCG commissions 27 of the 35 national definition set. Discussions are taking place as to how this will be extended from 2010–11 onwards. <i>In their April 2008 response they had planned to fully commission 17 and partially commission 13 of the nationally defined services.</i></p>
London	<p>The SCG plans, procures and performance manages 23 services but does not clarify where services sit within the NDS. <i>In their April 2008 response they had planned to fully commission 9 and partially commission 10 of the 35 nationally defined services.</i></p>
NE	<p>The North East SCG fully commissioned ten specialised services, and partially commissioned (where the service is not procured by NESCG) eight specialised services. <i>This is close to their response from April 2008 where they had planned to fully commission 11 and partially commission 10 nationally defined services.</i></p>
NW	<p>The North West SCG fully commissioned 17 and partially commissioned 41 of the (86) individual services associated with the 35 categories in the National Definition Set. It plans to fully commission 22 and partially commission 44 out of 81 in 2009–10. <i>This is a similar position to that reported in April 2008, when they had planned to fully commission one and partially commission 24 nationally defined services, bearing in mind that some service categories comprise several components eg there are 8 services within the Children's definition of which NW fully commissioned 7.</i></p>
SC	<p>The South Central SCG fully commissioned 19 and partially commissioned 18 of the (86) individual services associated with the NDS for 2009–10. <i>In April 2008, they had planned to fully commission eight services and partially commission 13 in 2008–09.</i></p>
SEC	<p>14 individual services are fully commissioned across eight PCTs, three services are fully commissioned across most SEC PCTs, and nine services are partially commissioned. Six out of 35 national definitions are fully commissioned and 11 are partially commissioned. By 2010–11 15 national definitions are expected to be fully commissioned. <i>In April 2008 they suggested that 14 services would be fully commissioned by the SCG and 20 services partially commissioned in 2008–09.</i></p>
WM	<p>WM SCG reported 28 specialised services fully commissioned across all PCTs/8 fully commissioned for some localities only in 2008. 28 fully commissioned across all PCTs/8 fully commissioned for some localities only in 2009. <i>In April 2008, WM planned to fully commission 10 service definitions and partially commission 7.</i></p>
SW	<p>2008–09—Burns, Neonatal, Paediatric Intensive Care, Medium Secure and Personality Disorder, Spinal cord injury, Blood and Marrow Transplantation, Stereotactic Radiosurgery, PET CT, Renal transplantation, Deep Brain Stimulation, Pulmonary Hypertension, Cleft Lip and Palate, HIV-AIDs. Total £147 million. 2009–10—All specialised services apart from Child and Adolescent Mental Health, some rare cancers that are difficult to count, equipment for complex physical disability, cardiology eg revascularisation and ICDs and cardiac surgery. Total £450 million  <i>In April 2008, SW was involved in planning for all specialised services but only planning to fully commission 6 national definitions and partially commission another six out of 35.</i></p>
YH	<p>Y&amp;H SCG (Yorkshire and the Humber) Specialised Commissioning Group agreed a three year phased transfer of responsibilities for commissioning specialised services from PCTs (Primary Care Trusts) to SCG. Year 1 was in 2008–09 when the first tranche of services transferred concentrating on those provided by Y&amp;H NHS Providers. We estimate total expenditure on specialised services to be £600 million and in 2009–10 we are commissioning £550 million. <i>In April 2008, YH had planned to fully commission eight nationally defined services and partially commission 14.</i></p>

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Q2. *How many services commissioned in 2009 have been fully mapped and costed?*

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Summary of findings:	<p><b>Carter Recommendation 11: Service Mapping to Facilitate Costing</b>  <i>“By the beginning of the financial year 2008–09 SCGs should have defined (or re-defined), quantified and costed all specialised services included in the Specialised Services National Definitions Set”</i></p> <p>Most SCGs suggested that mapping was taking places, although some or all of their services could not show associated costings.  PbR tariff, local prices and historical costs were mentioned as means of costing.  In some SCGs, particular services were prioritised for mapping and costing in 2009–10, but several planned on fully mapping and costing all services going forward.</p>
EoE	All the services contracted for by the EoE SCG and priced by either PBR or local prices
EM	East Midlands attached a budget template but it was difficult to decipher how services were mapped and costed.
London	PbR tariff is used where available, there is an annual review of costs for HIV, remainder based on historical costs/funding
NE	Ten
NW	A project is being undertaken which will map out more services in 2009–10.
SC	Sixteen, including DBS/stereotactic radiosurgery & neurosurgery as three separate services
SEC	Twenty
WM	The key piece of work in 2009 has focused around amendment to the commissioning algorithm from specialty based to HRG based (for inpatient PBR activity) in 2009 which will ensure all of these services are mapped and costed
SW	2008–09 None of these services were formally designated in 2008–09 but processes were in place to support burns designation which is still in progress 2009–10 All new commissioning has been supported by a full stock take of activity and costs to establish commissioning baselines. Bariatric surgery has been designated during 2009–10 Commissioning is supported by full stock take of all activity and costs from providers in order to set commissioning baselines.
YH	<i>YH attached a document outlining what services were mapped or planned to be mapped. 21 specialised services were mapped in 2008 and 25 more are planned to be mapped for 2009–10. YH did not attach costs associated with services.</i>

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## SCG MEETINGS

Q3. *How many PCT Chief Executives attended at each of the last two meeting?*

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Summary of findings:	<p><b>Carter Recommendation 3: Specialised Commissioning Groups</b>  <i>“PCT membership of SCGs should be predominantly at PCT chief executive level (nominated deputies should be at director level or equivalent)”</i></p> <p>The involvement of chief executives in SCGs is highly variable with Establishment Agreements allowing for lesser representation than envisaged by Carter in many cases. The danger is that the commitment of PCTs will be compromised.</p>
EoE	19/3/09 Meeting was attended by eight PCT Chief Executives, six Director Delegates 26/6/09 Meeting was attended by 10 PCT Chief Executives, three Director Delegates, one absentee
EM	We have two PCT Chief Executives on the Board, although each PCT Board has had a detailed discussion as to who their delegated representative should be. The EM SCG is an agenda item on all East Midlands Management Board meetings (chaired by Dr. Barbara Hakin—CE of the SHA). All East Midlands PCTs and the executive team from the SHA are present at these meetings
London	PCT Chief Executive membership of SCG Board is the Chair, Caroline Taylor and one PCT Chief Executive from each of the five sectors. The June and July meetings were attended by five Chief Executives
NE	Four of the six Chief Executives attended both the March and June 2009 meetings of the NESCG. Chief Executives can send deputies, and the NESCG is quorate when three PCO representatives are in attendance

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NW	One—Leigh Griffin as Chair, but PCT Chief Executives (who are members) have nominated representatives as defined within the terms of the Establishment Agreement
SC	April—2 of the Chief Executives unable to attend sent delegated representatives August—2 of the Chief Executives unable to attend sent delegated representatives—the Chief Executives unable to attend were not the same each time.
SEC	Two out of seven
WM	WMSCG has five PCT CEO representing the 17 PCTs on its' Board as agreed through the establishment agreement. June 2009—four out of five [due to annual leave deputy in attendance]. March 2009—three out of five [apologies due to urgent meeting]
SW	CEO representation at SCG : June 2009—six Chief Executives out of 14—of the remaining PCTs, three were represented at Director level and three at Associate Director level; 12 PCTs were represented in all. March 2009—10 Chief Executives out of 14—of the remaining PCTs, three were represented at Director level and one at Associate Director level
YH	Number of Chief Executives attending SCG meetings is variable. Last two meetings, June—3 and July—6. Not all PCTs have nominated PCT Chief Executive Officers as the representatives; for some it is Directors of Commissioning

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Q4. *Who represented the SHA and at what level?*

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Summary of findings:	<p><b>Carter Recommendation 3: Specialised Commissioning Groups</b> In respect of membership: “There should also be senior SHA input (at least at Director level).”</p> <p><b>Carter Recommendation 29: Performance Management</b> “SHAs should be represented on SCGs and provide support and guidance, ensuring consistent behaviour across PCTs.” Seven of the 10 SCGs gave a named representative from the SHA who attended SCG meetings (all at Director or in one case Associate Director level) NHS London is not a member of the London SCG. SHA representation in the North East and North West has been minimal but is expected to improve.</p>
EoE	On both occasions the SHA was represented by Dr. Paul Watson, Director of Commissioning and Deputy Chief Executive
EM	Avril Johns—Director of System Reform has the SHA lead for specialised services. Dawn Atkinson, her deputy, sits on the SCG Board
London	SHA is not a member of SCG
NE	The SHA receives copies of agendas, papers and an invite to attend meetings. Specialised commissioning is part of the job description of one of the strategic heads at the SHA. However due to staff secondment and maternity leave the SHA has not recently been represented at meetings. This will be rectified when new people are in post
NW	There has been no regular representation from the SHA for 2008–09. In 2009–10, an Assistant Director of Finance has attended
SC	SHA representation was the Director of Finance & Performance for both meetings
SEC	SHA is represented by Dave Morgan, Director of Commissioning & System Development (Interim)
WM	Eamonn Kelly, Director of Commissioning NHS West Midlands
SW	The Strategic Health Authority is normally represented by Mr Bill Shields Director of Finance and Performance but he did not attend the last two meetings
YH	The SHA (Strategic Health Authority) representative is Helen Dowdy who is the Associate Director of Strategy

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## SGC FINANCE

Q5. *What increase in expenditure, if any, would you expect the SCG to be asking for next year for services in the National Definitions Set (excluding those which are nationally commissioned)?*

Summary of findings:	Survey responses ranged from “no automatic presumption” to “Too early to say” to exact percentage increases of between 2 and 6%. Overall funding increases are also affected by the movement of services into (or out of) the SCG, making comparisons problematic.
EoE	There is no automatic presumption of an increase in funding
EM	The SCG management team are currently evaluating the full SCG spend of around £600 million. It will be following this that any detail regarding business cases for next year will be considered. The SCG commissions all chemotherapy for the East Midlands and clearly this combined with the commissioning of NICE TAGs and drugs excluded from tariff results in substantial increases in funding year on year
London	Too early to say
NE	Apart from pre-commitments, the only increase in expenditure anticipated in 2010–11 will be planned increases in activity where the contract is subject to either a local tariff or PbR
NW	It is too early in the financial year to indicate the level of expenditure being sought next year. There will be some variance due to the transfer of responsibilities to SCG from PCTs where all services within a Definition Set are not yet commissioned by SCG or due to the transfer out of services no longer part of the National Definition Set. Work to clarify this for 2010–11 is being developed.
SC	2%
SEC	Excluding tertiary contracts, (which hold a mixture of specialised and non specialised services), and the ambulance contract that the SCG currently manages on behalf of PCTs, the SCG currently manages resources of £120 million, specifically attributable to Specialised Services National Definition Set (SSNDS) The Carter Report suggested expenditure on this area of service delivery should be around 10% of hospital acute care expenditure. PCTs spend approximately 50–55% of their total resource in this area. Therefore the SSEC SCG should be aiming to manage approximately £354 million across NHS SEC, ie £6.46 billion (Total NHS SEC x 55% x 10% = £3,354 million) Over the past two financial years the SCG managed budget for specialised services has increased by £13.4 million: £3 million in 07-08 to 08-09 and £10.4 million 08-09 to 09-10. The SCG would look to continue to refine service mapping, based upon the SSNDS revisions, and to create pooling budgetary arrangements for these services and move forwards towards full carter compliance (ie £354 million). Whilst the current gap is £234 million* we would not expect to increase by this much over a single year. The bulk of the gap will sit within general contractual arrangements and should be reasonably identifiable and transferable and this will need to be facilitated over a planned period. *Note this sum is contained partially in tertiary contracts that the SCG holds in its portfolio, it is planned to devolve these to PCTs by October 2009, with the SCG continuing to be the lead SEC commissioner with single specialty providers, eg Great Ormond Street and the Royal Brompton only. Incrementally we would probably look to increase by a similar amount as 08-09 to 09-10 to reflect the transfer of specialised service budgets to the SCG and the priorities identified in the SCG Operating Plan/Strategic Commissioning Plan. We should be able to quantify this in more detail over the coming contracting round.
WM	SHA planning assumption is 4%
SW	Expected growth in 2010–11—It is difficult to be specific at this point. For 2009–10 activity was funded at outturn for service already within the portfolio together with a development programme for priority services. In 2010–11 it is expected that the SCG will have agreed a medium term plan which will involve specific actions to control cost pressures in existing services together with robust prioritisation in relation to service improvements which are likely to be funded from service redesign and other commissioning processes that will improve the quality and cost effectiveness of our commissioning
YH	The SCG developed a five year financial and commissioning plan starting in 2008–09 which is currently being refreshed. The expectation is that the current spend of £550 million will increase to £600 million however this will be finalised during the contracting round for 2010–11 in early 2010

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 Q6. *What efficiency savings have been identified by the SCG for those services?*


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Summary of findings:	Although approaches vary, SCGs appear to be seeking efficiency savings in much the same way as the wider NHS.
EoE	The EoE SCG will be undertaking financial projections in line with guidance from the Department of Health
EM	The PCTs and the SHAs have not set a target efficiency saving but the SCG management team have identified a saving target of 5%. It is their view that efficiency and productivity targets are just as much an issue for specialised services as for other services
London	Too early to say
NE	None as yet. Still awaiting the outcome of national discussions
NW	The SCG requires services to make efficiency savings in line with national expectations such as those set out linked to inflationary uplifts and those required in PBR. In addition, the SCG continues to seek best value through the way it commissions services and to ensure value for money for existing services and for new services, eg through tendering for services and systems management arrangements.
SC	2%
SEC	Efficiency savings are implicit in the tariff uplift of 3.0% for 2009–10. Efficiency gains are arising from pooled budgets by reviewing currencies and prices, and standardising exclusions to contracts, eg within spinal injuries consortium. Standardisation through agreed policies and eligibility criteria, eg Pulmonary Hypertension drugs and Morbid Obesity Surgery. Where the SCG is a part of wider commissioning consortia, where purchasing power can lead to greater efficiencies, eg procurement of blood products for haemophilia patients
WM	In 2009–10 procurement framework for secure services and CAHMS Tier 4 identified £ 2.9 million savings in the first year 5 point programme established relating to efficiency programme presented to June SCG 2009 for next year. It includes: <ul style="list-style-type: none"> <li>— Housekeeping—review of all expenditure within healthcare contracts, network costs etc</li> <li>— Backroom functions—support for databases to obtain VFM</li> <li>— Procurement—options for procurement of services including third party providers of healthcare products and drugs commissioned.</li> <li>— Service redesign and innovation—home delivery of drugs/products eg home chemotherapy, factor products .Review of discharge/LOS of complex cases for paediatrics, neuro-rehabilitation</li> <li>— Policy-engagement in national payments by results on issues such as which services should go into national tariff next and the level of medical devices and drugs now excluded from national tariff</li> </ul>
SW	Efficiency savings—in 2008–09 savings of £2 million were achieved through re-commissioning mental health and learning disability placements in order to secure better quality, better value for money services
YH	The expectation is that the spend on SCG services will have the same efficiency savings target applied as other services ie likely to be around 3.5%. In addition efficiency savings will be looked at across new/changes in services. However, as is the nature of specialised services, for a number of specialised services the SCG has little or no influence on the pathway or the actual spend eg Forensic services where the spend, particularly on high secure, is determined largely by the courts or Specialised Burn Care as the incidence of serious burns is unpredictable and is urgent. This will make it more difficult to achieve efficiency savings

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## SGC PERFORMANCE MANAGEMENT

Q7. Please provide a copy of a performance report to illustrate how the SHA performance manages the SCG

Summary of findings:	<p><b>Carter Recommendation 29: Performance Management</b></p> <p>“SHAs should ensure strong performance management of specialised services commissioning, ensuring that... SCGs are working effectively”</p> <p>Responses suggest that SHA performance management is in many cases weak. A situation which should perhaps be viewed in conjunction with the current decision to omit SCGs from mandatory assessment under World Class Specialised Commissioning.</p>
EoE	<p>The SHA holds regular (quarterly) accountability meetings with EoE SCG Director and Chair. The Accountability Meeting is based on the delivery of the EoE SCG Work Programme that is agreed at the beginning of each year. Prior to the meeting an agenda is agreed and the EoE SCG produces an exception report against the work programme. The content of the meeting will include discussion of exceptions within the work programme, key pieces of service commissioning work, development of the EoE SCG team and World Class Commissioning, contract negotiations (at the x of the year and contract and financial management)</p>
EM	None received
London	NHS London’s performance management approach to the SCG is currently in development
NE	<p>There is no regular performance report since the management of the SCG has been delegated to the North of Tyne Commissioning Cluster on behalf of the wider SHA. The receipt of papers and minutes of the meetings allows the SHA to keep track. The SCG chair reports by exception to the NHS management board north east which meets monthly and comprises PCT chief executives and the SHA chief executive and executive directors. On the whole SCG arrangements function very well and it has not been necessary to institute onerous performance management arrangements. If the situation changed it would be easy to escalate to a more rigorous process</p>
NW	Nil return
SC	<i>SC attached documents outlining their reporting mechanism to the SHA and other documents outlining demand management and potential savings</i>
SEC	The SCG has a detailed performance framework with the SHA assessing the position in relation to engagement, structure, joint working, strategy, delivery, effectiveness, implementation, financial management and monitoring
WM	<i>WM attached a reporting framework outlining the dimensions and criteria of the particular area of work; whether they had achieved their goal; what evidence existed of that achievement and what plans were in place to reach full achievement.</i>
SW	<p>There is not a single mechanism for performance management the following arrangements are in place:</p> <ul style="list-style-type: none"> <li>— Director and Director of Finance both meet monthly with the SHA Director of Finance</li> <li>— Director of Finance is a member of SHA Director of Finance forums</li> <li>— Director is a member of Directors of Strategic Development Group</li> <li>— Informal monthly performance review meeting in place</li> <li>— Formal performance management meeting now starting to reflect change in portfolio</li> <li>— Procurement and Performance Management Group meets monthly with PCTs formally reviewing the position (report enclosed)</li> <li>— Regular reports of performance to main SCG based on the reports at Procurement and Performance Management Group</li> </ul>
YH	<p>Aspects of performance management include:</p> <ul style="list-style-type: none"> <li>— A senior member of staff at the SHA will attend the formal meetings of the SCG Board—to help make connections between key pieces of work and to ensure relevant SHA staff are briefed as necessary. Chris Welsh, Rosamond Roughton or Helen Dowdy will fulfil this role.</li> <li>— Helen Dowdy will meet regularly with Cathy Edwards and Amanda Forrest to ensure regional programmes of work are understood and effectively coordinated across the SHA, SCG and PCT Collaborative.</li> <li>— The SHA will review the SCG’s annual work plan and ensure connections are</li> </ul>

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- made within the SHA
  - SCG will report into the Strategic Commissioning Board on approaches to and the conduct of, key areas of region wide work. There will be a requirement for the SCG to notify the SCB of this type of work.
  - The SHA's SCAP will apply to any reconfiguration implications arising from the SCG work programme.
  - SCG will ensure attendance at Y&H Directors of Performance meetings
  - The SHA will agree with the SCG an annual accountability agreement and in year performance monitoring arrangements
  - The SHA will hold annual (and mid-year if appropriate) reviews with the SCG in accordance with existing arrangements
  - The SHA and NHS Barnsley will agree an annual Service Level Agreement for the provision of Contract Management and Clinical Guardian services to NHS Yorkshire and the Humber in relation to the E16 Renal Service North Independent Sector contract.
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## SCG ACHIEVEMENTS

Q8. *Please provide specific examples of how your SCG has improved services for patients*

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Summary of findings:	All SCGs reported improvement in services for patients. Examples relating to smaller patient populations were largely absent.
EoE	<ul style="list-style-type: none"> <li>— IVF Policy—standardisation of policy across EoE in line with NICE guidance—three cycles</li> <li>— Morbid Obesity—standardisation of policy across EoE and the development of a pilot to improve access to surgery</li> <li>— Neonatal Intensive Care—commissioning of a 24/7 retrieval service</li> <li>— Neonatal Intensive Care—approval and implementation of Essex neonatal intensive care service configuration and network arrangements</li> <li>— Renal—approval of strategy to provide an additional 20% capacity for haemodialysis across EoE Mental Health—review of medium secure capacity and improvement in standards</li> </ul>
EM	<p>Improving services for patients:</p> <p>Equity of Access</p> <ul style="list-style-type: none"> <li>— Children's Cancer Services—Development of an Integrated Centre of Excellence jointly led by Nottingham University Hospitals and University Hospitals of Leicester. The new improved service will ensure that patients receive the right care in the right place according to their needs. Improved partnership working with local DGH's will ensure that patients receive equitable care, regardless of where they live</li> <li>— Individual Funding Policy—On behalf of NHS East Midlands, EMSCG's Clinical Priorities Advisory Group introduced a Individual Funding and Top Up Policy which ensure that all requests for individual funding in the East Midlands are considered using a standardised process, ensuring consistency of approach and equity of access</li> <li>— Trans-cranial Doppler—The EMSCG Secured investment to improve access to the TCT screening service for children in 2009–10 which will improve access across the region. A clinical haemoglobinopathy network has been established to inform development of regional services</li> </ul> <p>Clinical Excellence</p> <ul style="list-style-type: none"> <li>— Trans Aortic Valve Insertion (TAVI)—EMSCG played a central role in developing a national commissioning strategy for TAVI with expert clinicians, NICE and the Department of Health. The strategy included a commitment to undertake a national clinical research programme into the long term benefits of TAVI, through the TAVI collaborative research group, and to explore its cost-effectiveness alongside open heart surgery. New investment funded 70 patients for TAVI in the East Midlands in 2009–10.</li> <li>— ABOI Transplantation—A new technique for allowing a kidney to be transplanted into an ABO (blood group) incompatible donor has been commissioned by EMSCG. Additional investment secured in 2009–10 will enable nine eligible patients across the region to receive a kidney transplant using this innovative new technique. This will support the transplant programmes already in place across the region.</li> </ul>

### Designating Services Around the Patient

- Neonatal Intensive Care—EMSCG has undertaken an extensive designation process for Neonatal Intensive Care for the East Midlands which will conclude in November 2009. Our approach has been to ensure that we put in a responsive, flexible NIC system to address the needs of mothers and babies across the region. Clinical thresholds have been developed for all units which will allow maximum flexibility across the whole system. This will enable units to support each other at peak times thus maximising our precious resources and ensure that as many as possible mothers and babies are cared for as close to home as possible and limit the number of babies going out of our regional networks.
- Paediatric HIV Services—EMSCG are reviewing the provision of HIV services against the national designation standards. We are working with our clinical teams across the region to implement an effective hub and spoke model of care to ensure that patients receive the expert levels of care they require throughout their care pathway.

### Other achievements:

- Clinical Priorities Advisory Group (CPAG)—In 2007 EMSCG established its Clinical Priorities Advisory Group (CPAG). The key objectives of CPAG are to oversee policy development and to make recommendations regarding investment and disinvestment in specialised treatments. Decisions about investment/disinvestment are made using the defined CPAG principles ensuring that access to new therapies is reviewed in a systematic process that ensures equity of access, reduced clinical variation and increased value for money. In 2008–09 CPAG developed four key treatment policies, including; “In Vitro Fertilisation (IVF)/ Intracytoplasmic Sperm Injection (ICSI)”, ensuring that access to treatments is both equitable and timely. CPAG works closely with clinical networks, ie EM Cancer Network in order to develop funding priority criteria for cancer treatments including; Non small cell lung cancer, colorectal cancer and renal cell cancer
- Development of Clinical Networks—EMSCG hosts two of the key clinical networks in the East Midlands. New appointments to network managers for both the Burns and Renal networks have been made and are accountable through the EMSCG management structure. Both networks have clinical leads in place, who together with the network managers have developed collaborative working between our clinical teams in order to create environments where we can continuously drive service improvements for renal and burns patients across the East Midlands.
- Quality Framework—Developing and delivering high quality specialised services across the health economy, is a high priority for EMSCG. In 2009 we introduced our quality framework which describes our approach to quality and how we are working with our providers and PCT’s to develop systems and process to measure quality in our specialised services. Working collaboratively, we have established a wide range of national and local quality indicators including, clinical effectiveness, patient safety and experience measures. Collection of this information is helping us to benchmark service providers and to support them to improve services and increase patient satisfaction
- Engaging Patients and the Public—In June 2008 EMSCG, in collaboration with the Tribal Group, created strategies for Patient and Public Engagement and Communication. These are in the process of implementation and are being embedded in the work programme. EMSCG is committed to ensuring that high quality patient and public involvement and effective internal and external communication is evident throughout the commissioning cycle. As an example we have undertaken extensive involvement and engagement with our children’s cancer families throughout the development of our new improved integrated cancer service. We have worked at a 1—1 level with parents and children in order to understand what is important to them and as far as possible to ensure that the service meets their expectations and aspirations. We are currently working on specific pieces of service improvement work as a direct result of parent/patient involvement
- In addition, Expert Patient Panels have been established as part of the development of perinatal mental health services and are proving to be an excellent way of engaging directly with service users in the development of services

- London
- Haemophilia Services—Total numbers have increased year on year. Over the five year period 2004–05 to 2008–09 numbers of patients on active treatment have increased from 994 to 1352 an increase of 36%. There is a clear downward trend in the average cost per patient from 2006–07 as a result of savings achieved through the national contract and other local initiatives such as the Clinical Advisory Group.
- Data Quality: Contracts require provider trusts to provide accurate and complete data to commissioners and the national hemophilia database within agreed timescales. Communicating the benefit of good monitoring data and how commissioners use this information is regarded as the better method of improving data returns. The consortium agreed a range of service quality measures including an annual review for all patients, ensuring patients on home treatment return completed treatment sheets and referral of all high cost treatments for pre- authorisation through the Clinical Advisory Group
  - Service Quality: There Outcomes and patient satisfaction measures have been developed in consultation with clinicians and patients and trusts are expected to develop monitoring systems during this year. Additionally the London SCG has secured national support for use of consistent outcome measures so we will be able to benchmark outcomes of care nationally. The Treatment Policy Sub Group developed a rolling programme of clinical audits the first of which started in January 2009 on compliance with agreed clinical practice on care for children with hemophilia. Trusts are required to provide an annual self assessment on achievement of quality measures
  - Commissioning Quality: During 2008–09, the consortium continued the strategic review of services and developed a new model of care with north and south London networks for adult and paediatric care. We believe the new model is sustainable, will improve patient outcomes and ensure accessibility to out of hours care for all. Cost per case has reduced over the last two years, with a significant decrease over the past year due to both an increase in the numbers of patients and the lower cost of clotting factor. The consortium continues to deliver savings through the national contract estimated at £7 million a year. Additionally, robust management of clinical guidelines and high cost patients has contributed to the overall downward trend.
  - Priorities: During 2009–10 we will be engaging with patients on the proposed model of care and Trusts will be asked for expressions of interest with a view to awarding new contracts the following year. We will also be working with London Ambulance Service to develop a protocol for patients with haemophilia who have suffered trauma to ensure people receive the right treatment at the right centre. At a national level we will be developing model documentation for designation of haemophilia services across the country to ensure services are providing consistent quality of care and standards of treatment.
- HIV Services—Numbers of patients known to the HIV service have been increasing year on year as shown in Figure 3. Despite this the average cost per case has reduced since 2005–06 in response to the introduction of a local tariff and maximum prices from 2006–07
- Service Quality: The HIV Audit and Outcomes Group, with the support of the London Health Protection Agency developed outcome measures for service quality
  - Commissioning Quality: Introduction of a local tariff and ceiling prices in 2006–07 has stabilised the average cost per patient, despite the rising proportion of patients on ARV drug therapy (78% in 2008–09) and the increasing number of patients on high cost ARV drugs who are resistant to standard ARV combinations.
  - Priorities: The 2009–10 Quality Improvement Programmes will build on the outcomes measurements (monitored by the London Health Protection Agency through SOPHID data) and require development in Patient Engagement activities from the 2008–09 baseline. The consortium will review the current outcome measures to ensure that 2010–11 CQUINs are used to drive continuous improvement in care. We will also progress the HIV service review in the context of Healthcare for London and likely service designation in 2010–11.

Specialised Neuro-Rehabilitation Services—In 2008–09, care for 690 patients was commissioned by the consortium at a cost of £16.141 million against a budget of £15.594 million. The over-performance was within the agreed additional PCT funding to manage the 18 week transfer into specialised neuro-rehabilitation.

- Data Quality: The patient level full minimum data set, which is submitted each time a patient is discharged, transferred elsewhere for further rehabilitation or when a patient dies, incorporates a range of complexity and outcome scales/ measures that are designed to help understand the effectiveness of the resources used, dispensed treatment programmes and pathways. Activity data is submitted monthly. During 2008–09, eight of nine centres consistently submitted the required information to the agreed timescale. The 2008–09 contract included penalty clauses, which were not invoked as the consortium has worked proactively with providers to optimise data submission and performance.
  - Commissioning Quality: There has been an appreciable reduction in the average cost per patient during 2008–09 by comparison with the previous year, due to reduced average length of stay across the nine centres to 13 weeks (as opposed to stays of up to 52 weeks—and sometimes up to 32 months—before the consortium’s establishment) and minimisation of delayed discharges through a rigorous management protocol that includes a trim point at day 14, following which funding responsibility transfers to the PCT if the patient has not been discharged. Additionally the leverage of a single commissioner has resulted in preferential contractual bed day unit prices lower than the rate charged to PCTs purchasing on a cost per case basis; lower inflation uplifts compared to those applied to spot placements by individual PCTs; funding of surplus activity at marginal rate rather than full cost (an advantage over cost per case, spot purchasing by PCTs); a better average daily price of £366 compared to the 2007–08 national reference cost of £389 and compared to prices in the range of £514–£750 charged by two similar units
  - Service Quality: We closely monitor the key actions needed to ensure that most rehabilitation programmes are completed within the timescales set by the multi-disciplinary teams to achieve prompt patient discharge. The 2008–09 average access response was eight weeks. Specialised neuro-rehabilitation at the nine centres is delivered to the benchmarks set out in the service specification as well as the performance and quality measures set out in individual contracts, which include access response times, complaints and PPE. The consortium also continually strives to benchmark performance against the quality requirements in the National Service Framework for Long Term Neurological Conditions
- NE
- NE SCG agreed to fund the treatment of the first eye of patients with age related macular degeneration, six months ahead of the publication of the revised NICE guidance
  - Home renal dialysis—implementation of regional policy and local tariff which is beginning to show an increase in home dialysis
  - Outreach services, including Washington renal satellite, primary care based neurology clinics and clinical immunology outreach service at Teeside
  - Reconfiguration of communication aids service which both improved the delivery of the service but also re-invested £130,000 back into the service to increase the availability of communication aids equipment

NW

In a number of areas, the Team has developed and implemented detailed service specifications setting out standards expected which are then monitored. Commissioning of services also aims to commission the most appropriate service to meet needs, as close to home as possible and within the context of a clear care pathway. Particular examples of work by the Team include:

#### Secure and Specialised Services:

- Three new dialysis units opened as part of the independent sector treatment programme to expand access to haemodialysis across Cheshire and Merseyside;
- New five-year Strategic Frameworks for Kidney Care were published for each of the three North West zones;
- Major procurement exercise led to the announcement of new contracts for bariatric services in Cumbria and Lancashire and Greater Manchester, again providing access to surgery closer to home;
- Launch of new primary angioplasty service in Liverpool—clinically proven as the most effective treatment for heart attacks;
- Establishment of North West Tertiary Children’s Strategy Group—placing children and their families at the centre of the commissioning agenda;

- Development of a low secure service specification, setting out the expected standards for such services;
- Procurement of an additional 56 secure beds;
- Agreement of a contract for 24 tertiary inpatient beds for patients with eating disorders.

## Public Health:

- Development of a statement on exceptionality for PCTs to help them consider individual funding requests;
- Contributing to the development of service specifications (ACHD, bariatric surgery);
- Carried out work on a prioritised list of pre-NICE cancer drugs for the North West to address the recommendation in the North West Cancer Plan regarding equity of access to treatments.

## Corporate:

- Development of the World Class Commissioning evidence base, which informed the NWSCG's participation in the DH pilot;
- Raised public awareness of specialised services via the media;
- Produced, in conjunction with patients, regular newsletters for those on dialysis;
- Engaged with PCT Non-Executive Directors across the North West to ensure they understand the particular issues associated with specialised services

SC

- Public engagement process as part of revising the criteria for access to IVF across South Central
- The work of Forensic Mental Health caseworkers to place and follow up patients in secure facilities
- Engaging with FESC partner (Framework for procuring external support for commissioners). This contract was signed in February (2009). The contractor, UnitedHealthUK, have developed plans to use nursing expertise to triage referrals so that patients are sent to the most appropriate and suitable facility, so that the best outcomes are obtained

SEC

- PET CT—Commissioned services to meet 800 pmp, as set out in DH framework
- IVF—full review undertaken, including demand and capacity review. New policy developed to ensure equity across SEC. Agreement to fully commission from 2010–11 SEC-wide with pooled budgets. Tendering exercise about to commence to standardise provision, quality and value for money
- Burns—Supported the development of a clinical network, across London and South East, which has given a comprehensive review of use of national money to ensure improved quality, by meeting national standards
- Cystic Fibrosis—Full needs assessments for adult services undertaken. Detailed service specifications being developed to be incorporated into 2010–11 contracts, improving quality
- Renal—Significant increases in renal dialysis capacity in place, with demand and capacity plan to identify areas under provision. Plans being developed to address these capacity gaps, in collaboration with the local PCTs. EOP tendering exercise carried out by renal providers in collaboration with the lead commissioner and efficiencies delivered as a result
- Mental Health—Review of medium secure units with regard to security audits, marked improvement on follow up audit

WM

- Implementation of primary PCI for patients in Black Country—HSJ Highly Commended Award 2008 [WCC Category].
- Procurement framework for secure mental health and CAMHS Tier 4. Implemented in 2009 ensuring consistent quality standards, specification for services across 80% of independent sector units in England—HSJ finalist in WCC Category 2009.
- Neonatal Surgery specification developed for dedicated service in West Midlands.
- Annual Report for 2008–09 details a comprehensive range of other deliverables for patients

SW

The following relate to 2008–09:

- Neuromuscular Services—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 £2 million investment in new services and the establishment of a Clinical Network to support further improvements to patient care

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- Mental health—the South West Specialised Commissioning Group reviewed all individual, specialised, 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
  - Patient and Public Engagement—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. 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

Other areas of significant development related to our governance structures and increasing the capacity of the team

YH

The key achievements in 2008–09 include increasing the range of commissioned services to £550 million with effect from 1 April 2009, development of the service designation process, producing a range of commissioning policies, developing prioritisation and decision making processes to support the introduction of new treatments, developing a patient and public engagement strategy and implementing the SCG website.

Over the last year the Specialised Commissioning Team has been working closely with clinicians on the implementation of a new integrated Paediatric Critical Care Transport service. The combined service will replace the existing ad hoc children’s services and the existing services for neonates which has limited hours of service and geographical coverage. The service will operate 24 hours a day, seven days a week and have a team of dedicated staff. There will be approximately 2,000 transfers a year. The new service will commence on a phased basis between November and April 2010.

During 2008–09 there has been a focus on improving morbid obesity surgery services. Working through the designation process we are now assured that all the current providers meet all the core standards. There has also been a full analysis of the morbid obesity surgery market which identified that there is a need to increase availability and choice of providers. A formal tendering exercise has enabled two additional service providers to offer this care.

Other services which have received interim designation, in the last year, include: principal treatment centres for HIV (adults); principal treatment centres for children and young people with cancer; pancreatic services; stereotactic radiosurgery; and cochlear implants. Implementation of a new region wide clinical network for renal services, with dedicated clinical leadership time will enable rapid sharing of good practice across the region and facilitate the delivery of the renal services strategy.

One of the key priorities for the SCG is a review of vascular services. This feeds into the regions strategy for improving health and wellbeing. During 2008–09 the SCG carried out the diagnostic phase of the review to understand current patient flows and service standards. This information will inform the designation of specialist vascular centres in 2009–10.

The “Involvement for Improvement” Project has attracted a lot of interest both regionally and nationally. The project has focussed on involving service users and staff, in low secure mental health services, in directly influencing the service model and service standards.

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## SCG CHALLENGES

Q9. *What are the three major challenges your SCG faces in the next 12 months?*

Summary of findings:	World Class Commissioning was the biggest common denominator, though its application to SCGs is currently optional. The financial climate also understandably bulks large.
EoE	<ol style="list-style-type: none"> <li>1. Development of an overarching strategy for the next five years, incorporating improved commissioning efficiency and service innovation</li> <li>2. Major renal consultation and procurement</li> <li>3. Improved and enhanced management capability for the team, incorporating further improvement towards World Class Commissioning Capability</li> </ol>
EM	<ol style="list-style-type: none"> <li>1. Putting robust processes in place to ensure that routine benchmarking of a range of specialised services are core to commissioning activity</li> <li>2. Ensuring that SCG staff remain part of mainstream commissioning development and as such that the SCG is subject to the same scrutiny as part of world class commissioning as PCTs</li> <li>3. Using the dynamics brought about by the economic downturn to engage clinicians in discussions around efficiency and productivity ensuring that clinical quality and improved outcomes are core to the commissioning agenda</li> </ol>
London	<ol style="list-style-type: none"> <li>1. The financial climate</li> <li>2. Consolidation of the SCG as a single team</li> <li>3. Delivering world class commissioning</li> </ol>
NE	<ol style="list-style-type: none"> <li>1. Designation of specialised services</li> <li>2. Implementation of world class commissioning</li> <li>3. Activity and financial pressures</li> </ol>
NW	<ol style="list-style-type: none"> <li>1. Financial outlook</li> <li>2. Understanding the PCT local plans and their effect on pathways into and out of specialised services</li> <li>3. Influencing PCT measures to manage demand</li> </ol>
SC	<ol style="list-style-type: none"> <li>1. Strategic planning for the next 3 years to cope with the economic downturn and the reduction in NHS funding</li> <li>2. Changing the mindset from expecting the traditional levels of growth in the specialised services world</li> <li>3. Consolidating and growing the Specialised Commissioning brand across the country as other models of collaborative commissioning emerge</li> </ol>
SEC	<ol style="list-style-type: none"> <li>1. Developing a prioritisation framework to support SCG world class commissioning and ensuring that areas with the greatest need/demonstrable inequalities in access to provision are given focus</li> <li>2. Demonstrating value for money for PCT stakeholders in terms of services commissioned and demonstrating added value of a centralised SCG team supporting the collaborative commissioning of rare and specialised services on behalf of constituent PCTs</li> <li>3. Increasing the SCG portfolio and pooled budgets to reflect the revised National Specialised Services Definition Set and to ensure sufficient resources across the SCG to support designation, in line with PCT procurement rules and competition and contestability guidance</li> </ol>
WM	<ol style="list-style-type: none"> <li>1. Financial challenge—economic climate. Need to ensure delivering high quality, innovation whilst reducing costs.</li> <li>2. Management of introduction of new technology/drugs [need to prioritise/engage public on decision making].</li> <li>3. Development of specialised tertiary paediatric strategy to maintain sustainable high quality, safe services [including key workforce issues to maintain viability]</li> </ol>
SW	<ol style="list-style-type: none"> <li>1. Team capacity to drive commissioning programmes, maintain financial balance and achieve World Class Commissioning</li> <li>2. Financial sustainability—challenging period ahead with plenty of potential for the future but time scales for delivery very short</li> </ol> <ol style="list-style-type: none"> <li>1. Driving up productivity and efficiency in all services</li> <li>2. World Class Commissioning assurance</li> <li>3. Supporting service development/change in a financially challenging environment—in particular responding to NICE guidance</li> </ol>

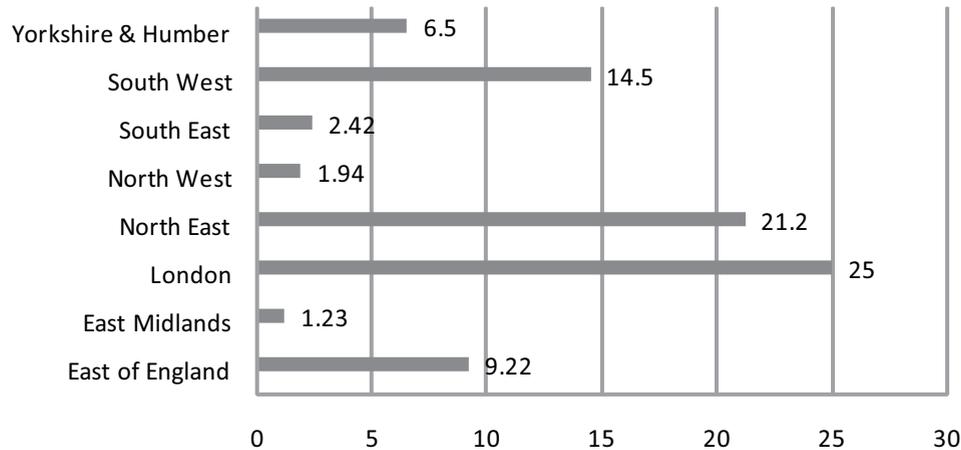
## SCG RISK SHARING

Q10. What percentage of the services you commission are funded by a budget pooled on the basis of:

- A. Weighted Capitation
- B. 3 Year Rolling Average
- C. Actual Cost per PCT

Summary Graph Representation:

### Percentage of Weighted Capitation



Summary of findings:

#### Carter Recommendation 10: SCG Pooled Budget

“To develop robust, long-term commissioning arrangements and manage financial risk, each SCG should have a budget pooled from PCT allocations to cover both the cost of specialised services that it commissions on behalf of PCTs and its management costs.”

#### Operating Framework 2008–09

“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.

This additional question was put to SCGs in November 2009 and has elicited seven replies to date. These demonstrate little progress towards weighted capitation since the Alliance’s previous survey at the end of 2007.

- EoE      A. 63 million (9.22%)  
Of our £683 million budget, £63 million is risk shared, the balance is managed on actual cost and usage by each PCT, but is fully managed by the SCG
- EM      A. 7.2 million (1.23%)  
B. 61.18 million (10.48%)  
C. 515.2 million (88.28%)
- London      A. 25%  
B. 40%  
C. 4%  
In addition, London pools some 26% by other means such as last year’s cost, historic block cost and recharging to PCT with 2% unknown. Total spend in 2009–10 is £756 million, of which £246 million is HIV, which has recently been removed from the National Definition Set.
- NE      A. 32.4 million (21.2%)  
B. 98.3 million (64.3%)—five year average  
C. 11.1 million (7.3%)
- NW      A. 18.6 million (1.94%)  
B. 381.3 million (39.55%)  
C. 550.8 million (57.14%)

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SC	None received
SEC	A. 3.9 million (2.42%) B. 97.2 million (59.7%) C. 61.7 million (37.9%)
WM	None received
SW	A. 65 million (14.4%)—relates exclusively to mental health and learning disability B. 31 million (6.9%)—ditto C. 354 million (78.7%)
YH	A. 6.5% B. 11.97% C. 79.36%

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## Memorandum by the National Osteoporosis Society (COM 111)

### COMMISSIONING

#### EXECUTIVE SUMMARY

1. Osteoporosis causes fragile bones and can lead to painful and disabling fractures. Bone protecting treatments, recommended by NICE and available on the NHS, have been shown to reduce a person's chances of fracture by up to 50%. Fracture Liaison Services (FLSs) ensure that those at risk are identified and offered treatment. However, only a third of local areas in England offer access to an FLS, leaving many patients without NICE recommended treatments. This is putting them at risk of unnecessary fractures and without access to follow-up services which may be necessary to reduce their risk of falls.

2. At present, the commissioning process is not working effectively enough for patients with or at risk of fractures. Guidance on commissioning comprehensive falls and fracture services has been produced by the Department of Health (DH) for PCTs and local authorities as part of the *Prevention Package for Older People*. The guidance must now be implemented. PCTs and local authorities should also review their falls and fracture services, to stimulate best practice. This process could be led by Strategic Health Authorities (SHAs).

#### OSTEOPOROSIS AND FRAGILITY FRACTURES

3. Osteoporosis causes fragile bones, which can lead to painful and disabling fractures. It is a long-term condition which affects 2.3 million people in England<sup>2,3,4</sup>. In the UK, one in two women and one in five men will fracture at some point after the age of 50, mainly because of poor bone health. 300,000 fragility fractures (fractures which result from a fall from standing height or less) occur every year in the UK.

4. Hip fractures which result from osteoporosis are extremely serious: 10% of patients die within one month of their injury; 30% die within a year. 78,000 hip fractures occur annually in the UK. £2 billion is spent every year treating and caring for UK hip fractures<sup>5,6,7,8</sup>.

5. Yet fractures which result from osteoporosis are not inevitable. Bone protecting treatments, recommended by NICE and available on the NHS, have been shown to reduce a person's chances of fracture by up to 50%.

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<sup>2</sup> Calculated using mid-2007 population data<sup>2</sup> and osteoporosis incidence from<sup>3</sup>

<sup>3</sup> National Statistics Online, 2007. Available for download from: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106>. Accessed on 19 January 2009.

<sup>4</sup> Kanis JA, Johnell O, Oden A, Jonsson B, De Laet C, and Dawson A, 2000. Risk of hip fracture according to the World Health Organization criteria for osteopenia and osteoporosis. *Bone* 2000; 27, pp. 585–590.

<sup>5</sup> Figures in<sup>5</sup> updated using mid-2007 population data<sup>6</sup> and the Hospital and Community Health Services (HCHS) pay and price inflation 06–07<sup>7</sup>.

<sup>6</sup> Torgerson D, Iglesias C and Reid DM, 2001. The economics of fracture prevention. In—*The Effective Management of Osteoporosis*. Edited by DH Barlow, RM Francis and A Miles, pp. 111–121.

<sup>7</sup> National Statistics Online, 2007. Available for download from: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106>. Accessed on 19 January 2009.

<sup>8</sup> NHS Finance Manual, 2009. Available for download from: <http://www.info.doh.gov.uk/doh/finman.nsf/Newsletters>. Accessed on 19 January 2009.

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**FRACTURE LIAISON SERVICES (FLS)**

6. The occurrence of a fragility fracture is often the first sign that an individual has osteoporosis and is at a higher risk of sustaining a future fracture. It is a fact that half of all hip fracture patients have suffered previous fragility fractures<sup>9,10,11,12</sup>.

7. It is, therefore, vital that every person who suffers a fragility fracture in any part of their skeleton is identified. This should be following presentation at a hospital or through their GP. Each fragility fracture patient should also be offered a future fracture risk assessment. Where appropriate, this should lead to advice and treatment to ensure that their future risk of falling and fracturing is reduced.

8. These important steps are recognised in a number of national policy documents in place for England, which advocate osteoporosis and falls assessment for older people who suffer fragility fractures:

- National Service Framework for Older People, Section 6: Falls. March 2001.
- NICE Clinical Guideline 21, November 2004.
- NICE Technology Appraisal 161, October 2008.
- Directed Enhanced Service (DES) on osteoporosis and fragility fracture prevention, 2008–10.

9. Despite this, a number of recent studies show that, worryingly, the majority of patients with fragility fractures are simply slipping through the net. Most are not receiving the assessment and treatment they need to prevent a further (or “secondary”) fracture, as recommended by NICE.<sup>13,14</sup>

10. As such, the most readily identifiable patients at high risk of future hip fracture are being consistently missed by the NHS. This is leaving those who are most vulnerable to hip fracture without the treatment they need.

11. The way to ensure that every fragility fracture patient receives the assessment and treatment they need is through the implementation of FLSs throughout England, linked to every hospital that receives fracture patients.

12. FLSs are usually provided by a dedicated nurse specialist, working under the guidance of a specialist in bone health. The nurse specialist is responsible for establishing systems of care to ensure that every fracture patient over 50 years (excluding high trauma and road traffic accident victims, whose fractures are unlikely to have been caused by osteoporosis) is identified, recorded and offered a “one-stop-shop” fracture risk assessment.

13. The FLS bridges the existing care gap between different areas of health and social care and provides seamless and efficient patient care. It also ensures that the patient does not have to manage all the different parts of the NHS themselves—the presence of an FLS means that the NHS does this on behalf of the patient.

14. Different areas of health and social care and FLSs are extremely effective in identifying those individuals with fragility fracture who may otherwise have slipped through the net. They have been found to assess over 95% of fragility fracture patients presenting at hospital, compared to just 25% at hospitals with other service configurations.<sup>15</sup>

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<sup>9</sup> Gallagher JC, Melton LJ, Riggs BL, Bergstrath E, 1980. Epidemiology of fractures of the proximal femur in Rochester, Minnesota. *Clin Orthop Relat Res*;150: pp.163–171.

<sup>10</sup> Lyles KW, Colon-Emeric CS, Pieper C et al, 2006. The Horizon Recurrent Clinical Fracture after Recent Hip Fracture Trial (RFT) Study Cohort Description. Abstracts of the 28th Annual Meeting of the American Society for Bone and Mineral Research. 2006, ASBMR 28th Annual Meeting in Philadelphia, Pennsylvania, USA. Abstract SA405. Available for download from: <http://www.abstractsonline.com/viewer/?mkey=%7BFC197A55%2DD8DD%2D4F3D%2D9994%2D290B64584CCB%7D>. Accessed on 14 October 2008.

<sup>11</sup> Edwards BJ, Bunta AD, Simonelli C, Bolander M, Fitzpatrick LA, 2007. Prior fractures are common in patients with subsequent hip fractures. *Clin Orthop Relat Res*;461: pp. 226–230.

<sup>12</sup> McLellan AR, Reid DM, Forbes K, Reid R, Campbell C et al., 2004. Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland (CEPS 99/03). NHS Quality Improvement Scotland. Available for download from: [http://www.nhshealthquality.org/nhsqis/qis\\_display\\_findings.jsp?pContentID=2755&p\\_applic=CCC&pElementID=0&pMenuId=0&p\\_service=Content.show&](http://www.nhshealthquality.org/nhsqis/qis_display_findings.jsp?pContentID=2755&p_applic=CCC&pElementID=0&pMenuId=0&p_service=Content.show&). Accessed on 14 October 2008.

<sup>13</sup> The Clinical Effectiveness and Evaluation Unit, Royal College of Physicians, London, 2007. National Clinical Audit of Falls and Bone Health in Older People. Available for download from: <http://www.rcplondon.ac.uk/clinicalstandards/ceeu/Documents/fbhpnationalreport.pdf>. Accessed on: 14 October 2008.

<sup>14</sup> Hippisley-Cox J, Bayly J, Potter J, Fenty J and Parker C on behalf of QRESEARCH and The Information Centre for Health and Social Care, 2007. Evaluation of standards of care for osteoporosis and falls in primary care. Available for download from: [http://www.qresearch.org/Public\\_Documents/Evaluation%20of%20standards%20of%20care%20for%20osteoporosis%20and%20falls%20in%20primary%20care.pdf](http://www.qresearch.org/Public_Documents/Evaluation%20of%20standards%20of%20care%20for%20osteoporosis%20and%20falls%20in%20primary%20care.pdf). Accessed on 14 October 2008.

<sup>15</sup> McLellan AR, Reid DM, Forbes K, Reid R, Campbell C et al., 2004. Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland (CEPS 99/03). NHS Quality Improvement Scotland. Available for download from: [http://www.nhshealthquality.org/nhsqis/qis\\_display\\_findings.jsp?pContentID=2755&p\\_applic=CCC&pElementID=0&pMenuId=0&p\\_service=Content.show&](http://www.nhshealthquality.org/nhsqis/qis_display_findings.jsp?pContentID=2755&p_applic=CCC&pElementID=0&pMenuId=0&p_service=Content.show&). Accessed on 14 October 2008.

15. There are some excellent examples of FLSs operating in the NHS in England. The Ipswich FLS team have published on practical aspects of setting up and running their service with a view to support like-minded colleagues wanting to establish an FLS in their own areas.<sup>16</sup> Other exemplary services include the Newcastle Fracture Clinic Service and the falls and fracture service in Greenwich, London.

16. Despite this compelling evidence, the proportion of hospitals in England with access to an FLS is shockingly low. An organisational audit of falls and fracture services by The Royal College of Physicians and the Healthcare Quality Improvement Partnership (HQIP)<sup>17</sup> published in 2009, found that:

- just 24% of NHS and Health and Social Care Trusts in England, Wales and Northern Ireland employ a Fracture Liaison Nurse
- 31% of Trusts have the assessment and management of fracture patients co-ordinated by a Fracture Liaison Nurse
- just 23% of Trusts have a written local commissioning strategy for bone health.

These results highlight a significant health inequality in terms of the future fracture risk that those patients who have and have not had their care co-ordinated by an FLS are exposed to.

17. *High Quality Care for All: NHS Next Stage Review* states that variations in the quality of care provided across England must be tackled if the visions of all 10 of the NHS regions are to be realised.

#### COMMISSIONING FRACTURE SERVICES

18. The majority of patients do not have access to services which would ensure that they receive NICE recommended treatments for fracture prevention. This shows that, for the majority of those at risk of fractures, the commissioning process is not operating correctly across England.

19. Commissioning strategies are vital to the provision of comprehensive services. All parties involved in a local falls and fracture service must be jointly involved in drafting a strategy. As an example, these should include:

- commissioners;
- health professionals (working in both primary and secondary care);
- managers at acute NHS trusts;
- intermediate care;
- local authority social care services;
- the local ambulance trust; and
- patient representatives (through a local National Osteoporosis Society support group).

20. Reviewing current service provision is an important part of the commissioning cycle. PCTs and local authorities should audit their falls and fracture care against that provided by comparator services within their SHA region. This approach has been piloted by DH the local SHA with the NHS South West region.<sup>18</sup> It should now be applied across England.

#### THE PREVENTION PACKAGE FOR OLDER PEOPLE

21. In July 2009, DH published the *Prevention Package for Older People*. This provides guidance for PCTs and local authorities on commissioning comprehensive falls and fracture services. The Package includes:

- a template care pathway;
- assistance on conducting a Joint Strategic Needs Assessment (JSNA);
- guidance on exercise training to prevent falls;
- a financial impact assessment, providing projections of:
  - the financial costs and savings associated with a comprehensive falls and fracture service for a PCT and local authority(s); this shows that such a service will be cost-neutral for local areas to provide over a five-year period; and
  - the fractures prevented by a comprehensive FLS for a population-size typically served by a PCT.

<sup>16</sup> Clunie G and Stephenson S, 2008. Implementing and running a Fracture Liaison Service: An integrated clinical service providing a comprehensive bone health assessment at the point of fracture management. *J Ortho Nursing* 2008;12: pp. 156–162.

<sup>17</sup> Royal College of Physicians and the Healthcare Quality Improvement Partnership, 2009. National Audit of the Organisation of Services for Falls and Bone Health of Older People: Public Report: March 2009: England, Wales and Northern Ireland. Available for download from: <http://www.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/Falls/Documents/National-Fallsand-Bone-Health-Public-Audit-Report-March-2009.pdf>. Accessed on 25 March 2009.

<sup>18</sup> South West Regional Taskforce, 2009. South West falls, bone health and fractures review. Available for download from: <http://www.southwestfallsandfractures.org.uk>. Accessed on 23 November 2009.

22. The guidance is based upon peer-reviewed evidence and provides local areas with the tools they need to provide patients with access to NICE-recommended treatments and care. It is consistent with DH's World Class Commissioning initiative. Though its implementation, PCTs can also deliver evidence-based, patient-centred services, helping them to meet the demands set out in the NHS Constitution and *High Quality Care for All: NHS Next Stage Review*.

23. The Charity was represented on the expert task group which advised the DH on the content of the *Prevention Package*. We are working with the Department to encourage its implementation; this includes taking part in a regional meetings held in each SHA region in 2009, led by the National Clinical Directors for Older People and Trauma Care.

#### *About us*

24. The National Osteoporosis Society is the only charity dedicated to improving the diagnosis, prevention and treatment of osteoporosis across the UK. The organisation was established in 1986 and is a well respected charity with approximately 25,000 members.

*November 2009*

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## **Memorandum by Keep Our NHS Public (KONP) (COM 112)**

### COMMISSIONING

#### WHO WE ARE

Keep Our NHS Public (KONP) was launched on 24 September 2005 by the National Health Service Consultants Association (NHSCA), The National Health Service Support Federation (NHSSF) and Health Emergency (HE). These groups felt that a campaign concentrating on drawing attention to the marketization and privatization of the National Health Service was needed. We are a non-party political organisation.

#### OUR AIMS ARE:

- To inform the public and the media what is happening as a result of the Government's "reform" programme.
- To build a broadly based non-party political campaign to prevent further fragmentation and privatisation of the NHS.
- To keep our NHS Public. This means funded from taxation, free at the point of use, and provided as a public service by people employed in the NHS and accountable to the public and Parliament.
- To call for a public debate about the future of the NHS and to halt the further use of the private sector until such a debate has taken place.

We are a campaigning body working in the public interest and are not a charity.

#### MEMBERSHIP

Over 5,000 people have signed the launch statement on our website and over 1000 have joined. Thirty-three KONP groups have been established (28 still active in 2009) and have been active locally in fighting hospital cuts and closures. Seventy-two other groups, many of them pensioners groups or those fighting cuts locally, and ninety unions or union branches have affiliated.

#### INFORMATION ABOUT US AND OUR POLICIES

The KONP website [www.keepournhspublic.com](http://www.keepournhspublic.com) has policy documents and analyses of the government initiatives and a round-up of national news stories about the NHS. It is a valuable resource for campaigners and academics. People can join on line and their names are added to the supporters list if they wish. In 2007 we started a bi-monthly e-newsletter to keep members of KONP and NHSSF updated.

We believe that the founding principles of the NHS, "medical care free at the point of need, available to all and funded from general taxation" are still relevant today. In addition we think that this service is best delivered by the NHS, not outsourced to private companies and corporations whose primary duty is to make a profit for their shareholders. The essence of the NHS since its inception has been a culture of co-operation between its branches: hospital, community and public health. There is no evidence that introducing competition is necessary or helpful in improving the service.

There is evidence that when the public are presented with a *fait accompli* (as recently in Camden or in 2007 in Derbyshire), then the majority are against using corporate providers.

## EXECUTIVE SUMMARY

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

1.1 Nothing.

1.2 Whilst there is a wealth of documents and high aspirations there are virtually no hard data. The few examples of change that have occurred which are given in the Department of Health’s submission to this committee might well have happened without this initiative. Some process measures have been monitored but we have found no systematic data about the outcomes of commissioning.

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

2.1 We do not believe the purchaser/provider split has been a success, nor that it is needed in a state-funded, co-operative NHS.

2.2 The only specialty where services were improved in the 1990s, after the introduction of the purchaser/provider split, was in the provision of termination of pregnancy. Legal abortion is a discrete area where doctors may exercise their statutory right of conscientious objection. This led to unacceptable variation in provision. There was already a well established charitable sector.

2.3 None of the 27 Keep Our NHS Public groups reported any improvements in services as a result of commissioning.

2.4 What the split does facilitate is the introduction of private health care companies into a market. Evidence from the USA suggests this will drive up costs and may lead to reduced 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 Firstly we must correct the use of “quasi-market” in this section. There is no doubt that since the creation of the Commercial Directorate in 2003 the DH has been engaged in creating a real market. The private sector are in no doubt about this nor is the head of the Foundation Trusts Network. The establishment of the Co-operation and Competition Panel consolidates the fact of this market.

3.2 Contestability is thought to improve services and efficiency by competition or the threat of it but there is little evidence to support this idea.

3.3 It is not clear exactly what is meant by practice based commissioning. If it means that GP practices are commissioning care for their patients we do not think this is a good idea. GPs are not trained for this task, have a heavy and increasing workload and there is a possibility for conflicts of interest to occur. If however it means working with PCTs to advise about improving services this seems eminently sensible. It does not need World Class Commissioning to do this.

3.4 Payment by Results is a misnomer—it is Payment by Treatment (or completed consultant episodes) not by outcomes. It facilitates the market by making treatments into commodities which is necessary if there is to be competition in a market. It incurs great transactional costs and the Audit Commission warned that it can cause financial instability in the NHS. It is necessary in a market but not in a planned, co-operative tax funded NHS.

4. *Specialist commissioning*

Planning of specialist services needs to be done at SHA level with considerable input from senior clinicians as even at PCT level the numbers involved will be small.

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

5.1 Providing a good safe service is a professional responsibility and should not require a huge bureaucracy to commission this.

5.2 There is already the Care Quality Commission overseeing services and monitoring by PCTs of adverse events, which are often a reflection of system failures as reported by the independent organization Dr Foster this week. The President of the Royal College of Surgeons is quoted as saying “Too many hospitals are too concerned with meeting NHS-imposed financial targets at the expense of clinical standards.” (29.11.09 The Observer).

5.3 The failure by the Department of Health to monitor the standards of the Independent Sector Treatment Centres has led to some preventable deaths (Panorama 2009) with a private company spokeswoman defending the lack of blood in a surgical unit—something that would not be accepted in the NHS. A government minister stated that the lack of monitoring was “to reduce bureaucracy”. This is not the way to ensure there is a culture dedicated to safety.

5.4 We do not see the need for this initiative which will spawn more bureaucracy at considerable cost.

## 0. Background to the topic.

0.1 For the first 40 years of the NHS medical care was provided by hospitals and GPs without specific commissioning of services. Regional Health Authorities were responsible for planning and allocated funds to Area and then District Health Authorities (DHAs), who using block contracts with hospitals ensured that the necessary services were provided.

0.2 The major problem for the NHS was the persistent underfunding which led to the UK having fewer doctors per head of population than almost all the other OECD countries. This in turn meant that there were long waiting lists for surgery and outpatient appointments and short consultation times with GPs

0.3 However negotiation between the District Health Authorities (DHAs), created in 1974, and hospital clinicians and managers meant that services were provided for the local population. As the DHA had representation from the local council as well as professional staff there was greater democracy than in the current system where PCT board members are appointed not elected.

0.4 Despite a completely new managerial structure, consensus management, being imposed on the NHS in 1974, this system worked satisfactorily and with minimal administrative costs for the NHS of about 5% (Webster 1998). Certain fields were not as well served as they should have been, eg mental illness and care of the elderly (and with all too typical spin these were labeled priority services but it made little difference to the share of the budget that they received). Major innovations in care were primarily pioneered by doctors usually facilitated by forward looking administrators.

0.5 The advent of general management in 1984 increased the administrative costs as more managerial staff were employed with no discernable difference in the scope or quality of the services provided. In 1988 a pilot study of resource management was started which involved clinicians in attempts to improve services in a cost effective way. This promising initiative was swept away by the reforms introduced by Kenneth Clark in 1990 which included an internal market, the purchaser provider split and GP fundholding. This increased the administrative costs to 12% (Dobson 2006)

0.6 Although the idea that GP fundholders would be able to address the power imbalance that was seen as a problem in services provided by hospitals, with a few exceptions, little changed. Some fundholders behaved unethically, the system was expensive to administer and the predicted benefits for patients did not materialise. No formal evaluation was done (Smith and Wilton 1998). In 1997 fundholding was abolished as had been promised in the Labour Party election manifesto.

### ANSWERING THE COMMITTEE'S QUESTIONS:

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

1.1 The “World Class Commissioning” (WCC) programme began in December 2007. The evidence given by the DH to the committee in its first session confirmed our fears that the phrase “World-Class Commissioning” has no substance to it but is an idea which is being implemented without piloting—see the quotation below (our emphasis).

*“The World Class Commissioning programme is designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way anywhere in the world. World class commissioning is about delivering better health and well-being for the population, improving health outcomes and reducing health inequalities”* (Transforming Community Services 2009a).

1.2 What the DH is doing under this umbrella is further indoctrinating PCT board members and executives into adopting a market model of the NHS despite there being no evidence that this is the best way to organize health care and much evidence to show that it is the worst possible model as exemplified by the US system which has administrative costs estimated at 30% and 47 million uninsured and more still underinsured..

1.3 The 11 competencies that the DH decided were necessary (DH 2008), include “stimulating the market” and “making sound financial investments” which we believe have no place in a tax funded co-operative and collaborative system which is what provides the fairest health care. One competence which is self-evidently useful is that of the service specification but we could see no mention of this in the many documents on the DH website which are full of worthy phrases and ambitions but extremely vague about actual practice.

1.4 What the WCC programme tells us about what PCTs are actually doing about commissioning, is negligible. They tell us for example, how many PCT board members have answered an evaluation survey of the assurance system pilot in February 2009. But the following statement of September 2009 suggests that they are so immersed in their aspirational project that they have lost touch with reality. World class commissioning (WCC) is transforming the way these services are commissioned, *leading to improved health outcomes and reduction in health inequalities, adding life to years and years to life.*” (World Class Commissioning: an introduction 2009b) (our emphasis)

It is possible that in ten years time these ambitions will be realized but such outcomes cannot possibly occur after such a short time.

1.5 So our answer to this question is : “Nothing”.

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

2.1 We do not believe that the purchaser/provider split has been a success and we do not consider that it is needed. As stated earlier hospitals and community services functioned effectively before this split was introduced and the block contract model for hospital services was a way of dividing resources between the competing demands of specialties and patients which had low administrative costs—and is still used effectively in many countries, such as Canada, which has performance indices at least as good as Britain’s.

2.2 The only specialty where services were improved in the 1990s was in the provision of termination of pregnancy. Legal abortion is a discrete area where doctors may exercise their statutory right of conscientious objection which led to unacceptable variation of provision. There was already a well established charitable sector. The proportion of abortions done or paid for by the NHS rose steadily from 50% in 1990 to 91% in 2008.

2.3 Not one of the 27 Keep Our NHS Public groups in England, which are spread across the country, reported any change in services which could be attributed to the introduction of the purchaser provider split or commissioning.

2.4 What the purchaser/provider split does is to facilitate the entry of private and corporate providers into the NHS which as a result will drive up the costs of health care and may well drive down the total amount of care available.

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

3.1 First we must correct the use of “quasi-market” in this section. There is no doubt that the DH have been engaged in creating a real market since the creation of the latter in 2005. The private sector is in no doubt about this as evidenced by their submissions to the Health Select Committee’s enquiry into the implementation of Lord Darzi’s Next Steps review (HoC Health Committee 2009). Sue Slipman, Chair of the Foundation Trust Network, in a fringe meeting in Sept 2009 at the Labour Party Conference stated that Foundation Trusts operated in a market and therefore could not have “ordinary” people on the boards but must have those with commercial experience.

3.2 Gary Belfield in his evidence to you referred to the market. The creation of the Alternative Provider of Medical Services (APMS) contract in 2003, the Framework for External Support for Commissioning in 2008 (DH 2009c) where 13 organisations, mainly US health corporations advise PCTs on commissioning, of the Co-operation and Competition panel in 2009 and the insistence of the DH that the GP led health centres imposed on PCTs by the DH in 2009 must use APMS, are all parts of this strategy.

3.3 Contestability and Payment by Results (PbR) are also untried ideas which in theory will improve services and reduce costs.

3.4 As the Audit Commission noted “*Payment by results creates an unprecedented level of financial risk for both PCTs and trusts, and greater potential for financial instability across the NHS as a whole*” (Audit Commission 2005).

3.5 There is no good evidence that forcing the NHS to compete with private companies will improve services and the transactional costs are high. The Conservative party released figures this year stating that administrative costs had risen by £6.9 billion for PCTs and £4.5 billion for hospital trusts in the last five years (Durham 2009) If these are correct that is over 10% of the NHS annual expenditure. A small in-depth study from The Centre for Health Economics in York showed that the extra expenditure on implementing PbR for PCTs ranged from £90–£190,000 and for hospitals from £100–£180,000, with little benefit (CHE 2006).

3.6 The fact that the Secretary of State for Health has recently stated that the NHS should be the preferred provider does not stop the enormous waste from competitive tendering and it remains to be seen whether his statement will reverse the market driven structures that have been destroying the ethos of the NHS silently and by stealth. As an example, a GP practice in Hackney recently spent £40,000 tendering (successfully) for a GP led Health Centre and the PCT apparently spent £3.5 million on this exercise (Hackney KONP 2009).

3.7 PbR is an expensive innovation, which could be dispensed with and replaced by block contracts. The transactional costs are high and there is no evidence that they cut the overall cost of care in the NHS. Involving staff in ways to reduce expenditure without detriment to patient care would be much more likely to do this.

3.8 “Contestability” in a market with a plurality of providers is another threat to the NHS. Fragmentation of services and the loss of co-operation with the introduction of a competitive model is wasteful and inefficient. There is no evidence that competition improves the way that health care is delivered but there is evidence that it increases costs and inequitable provision (European Health Care management Association quoted by Lister 2005).

3.9 Well trained and motivated professional staff, managers, doctors, nurses and others who work in the NHS strive to deliver good care. What was missing in the early days of the NHS was meaningful feedback about services from patients. In today's climate this feedback will be accepted and needs to be built into the system. It will be acted on by professionals who derive their job satisfaction by doing their work well.

#### 4. *Practice-based commissioning.*

4.1 The experience with GP fund holding did not suggest that this was a sensible way to proceed. We see a potential conflict of interest in practice based commissioning.

4.2 The size of a GP practice is too small to plan services and the skills needed are those acquired in Public Health training not the GP Vocational training scheme with its emphasis on the individual doctor patient relationship.

4.3 The British model of General Practice has been admired globally and is thought to have contributed to the relatively low cost of the NHS because of the GPs' gate-keeper function.

4.4 There is also a potential for a conflict of interest between the needs of the individual patient and the services commissioned for the practice population. The trust between patient and GP which is the cornerstone of good general practice will be eroded if the patient thinks that her/his treatment is being affected by the fact that the budget allocation by the GPs for her/his condition is insufficient. Also the skills required for effective commissioning take time to learn and GPs already have an enormous and growing workload with services being devolved from secondary care into the community.

4.5 "Commissioning is the process of assessing local health needs, identifying the services required to meet those needs and then buying those services from a wide range of healthcare providers, which can include hospitals, dentists, opticians, pharmacies and voluntary organizations" (PBC a guide for GPs 2009d). It is interesting that the private sector is not mentioned in this list, yet PCTs have been tasked to source 15% of services from for-profit providers—an example of disingenuousness, to say the least: if this is the government's policy, why is it not acknowledged?.

4.6 Reading though the documents on the DH website one is struck by the absence of any hard data. Surveys every three months of a 25% random sample of the almost 9000 practices with a 65% response rate showed that about two thirds of practices supported pbc, had been given an indicative budget and had provided new services in the practice as a result of this initiative (PBC survey 2009e). Is this commissioning?

4.7 It appears from the examples given that hospital based services are now being provided in GP surgeries which may well be a good thing for patients, but does this collaboration between GPs and PCTs require the WCC programme to make it happen?

4.8 In October this year Dr Colin-Thomé was quoted as saying that the policy of PBC had failed and was "a corpse not for resuscitation" and although he said he was quoted out of context to your committee, he was not alone in this view. Steve Furness head of the Social Market Foundation said it was time to stop ploughing money into expanding GP commissioning. He said to the HSJ that at least £100 million had been spent on trying to reinvigorate practice based commissioning through entitlements and that it was time to "turn off this tap". (Gainsbury and Ford 2009).

4.9 If practice based commissioning means that GPs assist PCTs in designing services, then it seems a good idea, but if it means taking on the task of commissioning services for their practice population the criticisms above apply.

#### 5. *Specialist commissioning*

5.1 If this refers to rare conditions then planning of specialist services needs to be done at SHA level with considerable input from senior clinicians as even at PCT level the numbers involved will be small.

#### 6. *Commissioning for the quality and safety of services.*

6.1 We can foresee another wave of civil servants and private sector consultants or advisors being employed to push the quality agenda whereas the evidence from pre-commissioning days is that professional staff will always do their utmost to provide a good service.

6.2 As regards to safety, putting systems in place to guard against error is a professional responsibility and where this falls down it is usually because of a lack of sufficient staff or inadequate training for the post. Improving staffing levels and maintaining a culture of openness about mistakes and what can be learnt from them will do more than attempting to "commission" safety (DH 2002, DH 2006, DH 2007).

6.3 The Care Quality Commission already oversees services and PCTs monitor adverse events, which are often a reflection of system failures as recently reported Dr Foster. The President of the Royal College of Surgeons is quoted as saying "Too many hospitals are too concerned with meeting NHS-imposed financial targets at the expense of clinical standards." (29.11.09 The Observer). This was also the case in Stafford where the drive to achieve Foundation status led to clinical staff being cut and standards falling.

6.4 The failure by the Department of Health to monitor the standards of the Independent Sector Treatment Centres has led to some preventable deaths (Panorama 2009) with a private company spokeswoman defending the lack of blood in a surgical unit—something that would not be accepted in the NHS. A government minister stated that the lack of monitoring was “to reduce bureaucracy”. This is not the way to ensure there is a culture dedicated to safety.

6.5 The Health Select Committee recommended that the Department of Health should proceed with caution in introducing financial incentives to improve quality. “Schemes such as *Advancing Quality and PROMs* which link the measurement of clinical process and patient outcomes must be piloted and evaluated rigorously before they are adopted by the wider NHS.” (HoC 2008)

6.6 We do not see the need for this initiative which will spawn more bureaucracy at considerable cost.

#### CONCLUSION

Reading through the documents on the DH website about commissioning reminds us of the story about the Emperor and his new clothes, and remember that (to paraphrase Raymond Tallis) “when the emperor is restocking his wardrobe, he usually shops in the USA” (Tallis, 1988). We hope that the Health Select Committee will speak up like the little boy who asked why the Emperor had no clothes.

I have started to read the written submissions to the committee which arrived at the end of last week, and whilst there are one or two managers who consider that WCC has been successful the majority of the submissions I have read point out the deficiencies in commissioning in general or for particular conditions. Some examples of good commissioning do not seem to be as a result of WCC but of individual PCTs working with clinicians to improve services.

#### REFERENCES

- Audit Commission (2005) *Payment by Results: Update*. Audit Commission London
- BBC Panorama (2009) *Dying to be treated*. TV programme shown 30.9.09
- Centre for Health Economics (2006) *The administrative costs of Payment by Results*. Health Policy Matters. [www.york.ac.uk/healthsciences/pubs/hmpdf12](http://www.york.ac.uk/healthsciences/pubs/hmpdf12) accessed 28.11.09
- Department of Health (2002) *Building a safer NHS: An organization with a memory*. Department of Health, London.
- Department of Health (2006) *Good doctors: Safer Patients*  
Department of Health, London.
- Department of Health (2007) *The regulation of the non-medical health care professionals* Department of Health, London
- Department of Health (2008) *The role of the Primary Care Trust Board in world class commissioning*. Department of Health, London.
- Department of Health (2009a) *Transforming Community Services and world class commissioning: resource pack for commissioners of community services*. Department of Health, London
- Department of Health (2009b) *World Class Commissioning: an introduction*. Department of Health, London
- Department of Health (2009c) *External support for Commissioners (FESC): procedures for PCTs*  
Department of Health. London
- Department of Health (2009d) *Practice based commissioning* Department of Health. London
- Department of Health (2009e) *Practice based commissioning: GP Practice Survey Wave 1–8 results*  
Department of Health. London
- Dobson F (2006) Cost of administration given in a speech to the KONP AGM in January.
- Durham N (2009) *Spending on NHS administration doubles*.  
Health Care Republic
- Gainsbury S and Ford S (2009) *Tory Plans could give GPs interest bonanza*. Health Service Journal
- Hackney Keep Our NHS Public 1.12.09 Personal communication
- House of Commons Health Committee (2008) *NHS Next Steps Review. First report of Session 2008–09*. Volume 1, TSO Norwich
- House of Commons Health Committee (2009) *NHS Next Steps Review. First report of Session 2008–09*. Volume 2, TSO Norwich
- Assura page 122 para 9.1 The Company Chemists Association page 125 para 4.1

Lister J (2005) *Health Policy Reform: Driving the wrong way?*  
Middlesex University Press, London.

Smith RD and Wilton P (1998) *General practice Fundholding: Progress to date*. Br J Gen Pract 48:1253–7

Tallis R, (1988) *Not Saussure: A Critique of Post-Saussurean Literary Theory*, Macmillan Press, 2nd ed. 1995.

Webster C (1998) *The National Health Service: a political history* OUP Oxford

January 2010

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### Memorandum by Professor Andrew Street (COM 113)

#### COMMISSIONING

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

#### EXECUTIVE SUMMARY

Primary Care Trusts should be given the means to negotiate on an equal basis with hospitals or simply released from having to deal with hospitals, leaving them free to concentrate on improving care in the primary and community care sectors.

#### BRIEF INTRODUCTION

Professor Andrew Street is director of the Health Policy team at the Centre for Health Economics, University of York. He has published extensively on productivity measurement, organisational efficiency, and Payment by Results. He serves as a board or committee member for the NHS Workforce Review Team, Connecting for Health, Payment by Results, and the NIHR Health Services Research programme.

#### FACTUAL INFORMATION

1. It is difficult for Primary Care Trusts (PCTs) to control the volume of hospital activity, a task made more complicated under Payment by Results (PbR).
2. In the past, block contracts ensured tight expenditure control but limited the amount of activity hospitals provided. Once the volume of services specified in the contract had been reached patients were added to the waiting list because hospitals had no financial incentive to treat them.
3. Cost & volume contracts provided more flexibility, allowing PCTs to pay for additional activity at a lower price once a pre-specified volume had been reached.
4. Under PbR these constraints on activity have been removed and prices (“tariffs”) are fixed nationally. Hospitals have strong incentives to increase activity because they are paid a fixed national tariff for each patient treated.
5. While some extra activity is to be welcomed, it has to be appropriate and affordable. Under PbR it is more difficult for PCTs to live within their budgets because they can no longer negotiate prices nor can they impose volume controls.
6. Instead, PCTs have two main strategies to manage demand for and expenditure on hospital services.
7. First, they can substitute hospital care for services provided in primary or community care settings. PbR gives them the financial means to do this, and this is a key advantage of these arrangements. Nevertheless there are limits as to what services can be substituted from one setting to another.
8. Second, they can set Practice based commissioning (PBC) budgets to encourage GPs to reduce their referrals to hospital. However, it would be inadvisable to rely heavily on PBC to restrain referrals. The benefits of fundholding, the predecessor to PBC, were modest. The savings resulting from reductions in admissions were cancelled out by the management allowance that practices received to manage fundholding. Moreover, the incentives for GPs to manage their PBC budgets are not as strong as they were under fundholding.

#### RECOMMENDATIONS FOR ACTION

9. Either PCTs should be given the means to negotiate on an equal basis with hospitals or—more radically—they should be released from having to deal with hospitals altogether.
10. PCTs would have more negotiating power if they had discretion over what PbR tariff to pay.
11. If the national tariff was a maximum price, this would allow PCTs to negotiate lower prices with hospitals. But there is unlikely to be much variation from the maximum, given the relative weaker bargaining power that PCTs have relative to hospitals.

12. An alternative is to re-introduce a form of cost & volume contracting. Hospitals are paid the national tariff up to a “planned” level of activity, after which the “marginal” price for additional activity is lower than the national tariff.

13. Both the national tariff and the marginal price could be set by the Department of Health, leaving PCTs and hospitals to agree the planned level of activity.

14. This will moderate—but not eliminate—the incentive for hospitals to perform more activity and expose PCTs to less financial risk than at present.

15. The disadvantage is that, particularly when patients have the choice of many hospitals, it is difficult for PCTs to predict activity levels for each hospital.

16. The more radical option would involve the Department of Health funding hospitals directly instead of having payments pass through PCTs. This is typical of PbR-type arrangements that operate in other countries, where “local commissioning” does not feature.

17. The arrangement combines the best feature of block contracting—certainty of expenditure—with the incentive properties of PbR since an individual hospital will receive more money if it treats more patients.

18. Again hospitals might be paid the national tariff up to a planned level, with a marginal price applying thereafter. Crucially, though, the planned level need not be negotiated between hospitals and PCTs but can be specified for the hospital as a whole.

19. The transfer of responsibility would allow the Department of Health to sharpen the incentives of PbR, using the tariff more effectively to control volume, and it would better facilitate free patient choice of hospital.

20. Freed from having to deal with hospitals directly, PCTs could then concentrate on improving care in the primary and community care sectors.

21. The arrangement requires a change to resource allocation, with PCTs receiving funds to pay for primary and community care only, with payments for hospital care made directly to hospitals by the Department of Health.

22. PCTs that are successful at keeping patients out of hospital would receive a proportionately greater budget for primary and community care. This proportion would increase over time if strategies to reduce referrals and to substitute hospital care for primary or community services prove successful.

23. Which of these options is to be preferred in the English context has not been established and it is recommended that they are subject to careful consideration.

*December 2009*

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### **Memorandum by the NHS Alliance (COM 114)**

#### **COMMISSIONING**

##### **EXECUTIVE SUMMARY**

Effective World Class Commissioning implies a strong partnership between clinicians and managers, which empowers both parties to work to their strengths to exert maximum power and leverage to deliver the best possible health outcomes for the population. However, so far, many such partnerships are not robust enough and, in some cases, even non-existent.

Indeed, it is our view that WCC and Practice-Based Commissioning should be complementary. PCTs will only be successful as world class commissioners if they are effectively delivering on PBC or clinical commissioning.

We believe that the concept of a purchase/provider split at some level is useful and that commissioning has the potential to provide a better more cost-effective care, especially in a cold financial climate. Hitherto, it has been handicapped by too frequent organisational change, too many other influences that have undermined the ability of the commissioner to be the prime mover in improving local services and health initiatives and specifying local priorities and incentives/disincentives that do not encourage system management.

In terms of assessment, a more robust 360-degree assessment is needed, which would give equal weight to the view of other parties such as PBC consortia, clinicians and local authorities.

It is also worth noting that there is a danger, through the WCC assurance process, that PCTs get fixated on demonstrating they have the competencies to be world class commissioners without testing out whether this is reflected on improved service quality, productivity and outcomes linked to local population needs.

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

1. The emphasis of World Class Commissioning is on a methodical and comprehensive process which has lent PCT commissioning a level of robustness that did not previously exist. As it is based on a comprehensive needs assessment (Joint Strategic Needs Assessment), it is led not only by the PCT but also jointly owned by the local authority's Adults and Children's Lead Directors. Therefore, it has brought a discipline of partnership working and joint commissioning which was previously lacking in many PCTs and Health Economies.

2. There are, however, problems that can be addressed:

- 2.1 The fundamental role of the commissioner is to define a service specification, which describes the services required to meet the needs of the population in terms of the quantity and quality of services to be offered as well as the impact on health outcomes. Through this process it will exert higher levels of quality, safety and value than would otherwise be the case if the commissioner did not exist and ensure that these specifications have been met. This fundamental process of exerting leverage over a provider, while maintaining a relationship may be lost within the other priorities of WCC, unless PCTs take WCC responsibilities and competence seriously. For example, one of the WCC competencies is about "effective market management by working in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes". Therefore, the PCT will have to exert leverage over providers. Critically, PCTs need to develop their relationship with their providers and see their role as an investor of funds which deliver improved quality and outcomes through commissioning, rather than just a "funder". This implies a different set of behaviours for commissioners and will be an essential part of WCC.
- 2.2 Because there are a lot of process measures, a PCT might follow the "due process" but still miss the point. There is a danger, through the WCC assurance process, that PCTs get fixated on demonstrating they have the competencies to be world class commissioners without testing out whether this is reflected on improved service quality, productivity and outcomes linked to local population needs. For instance, the imperative to create a competitive provider market may lead to unnecessary tendering of services and less integrated provision, when things were already satisfactory and simply needed commissioning pressure to improve the performance of the current provider. Also, being largely process measures, it might be possible to produce good strategies with appropriate clinical and public involvement but which failed to deliver the required services and outcomes.
- 2.3 One weakness of the WCC process is that, although theoretically it implies an objective assessment, PCT's Strategic Health Authority may project its own subjective views in terms of priorities and interpretation. Although the assurance process takes into account other views, including those of practice-based commissioners, this is limited and does not carry as much weight as other views, in particular the SHA, which is at the same time the assessor and assurer. The NHS Alliance has long argued for a more robust 360 degrees assessment, which would give equal weight to the view of other parties such as PBC consortia, clinicians and local authorities.
- 2.4 The NHS Alliance believes that the fundamental problem with commissioning is that it has, in recent years, excluded frontline clinicians in any meaningful and fundamental way, which is fundamental to any successful commissioning. Engagement, although one of the WCC competencies, can be relatively tame, whereas successful WCC/PBC would require a PCT to hand a significant leadership role to local clinicians in terms of wholesale service redesign. In our view, effective WCC implies a strong partnership between clinicians and managers, which empowers both parties to work to their strengths to exert maximum power and leverage to deliver WCC.
- 2.5 Within the current format of WCC it is possible for a PCT to score highly on all competencies even if it has handed its practice-based commissioners a relatively restricted role. This is partly a result of the way competencies are assessed. The crucial point is not to focus on competencies per se, but assess how PCTs can demonstrate the application of such competencies throughout the whole commissioning process and cycle.

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

3. The fundamental concept is sound. Research on fund-holding, total purchasing and locality commissioning suggested that commissioning that was co-lead by clinicians and managers could exert the necessary leverage on providers. The exclusion of clinicians from effective commissioning over the past few years has made PCT commissioning sometimes a process of the provider handing the bill and the PCT paying for it.

4. The incredibly time-consuming filling in of pro-formas has distracted commissioners from actually delivering the redesign that is necessary. There has been too much focus on the contractual part of commissioning in the belief that this would ensure that the needs of the population would be met, which of course didn't happen. Firstly because the contractual/transactional elements of the commissioning process

were too weak, too tortuous and too focused on money and activity, which meant that the focus shifted from health outcomes to the contract itself. Success was seen as having a signed contract in place, rather than the detail of what was included in such a contract to improve outcomes. Secondly, contracting and transactional activities were not the articulation of a given commissioning strategy to meet the population's needs; rather, they became focused on often the wrong things, such as targets which, although important, should not be the only objective.

5. When this happens, the PCT commissioner becomes hamstrung by national targets, national contracts, NICE/CQS and Payment by Results, to name a few factors. Organisational change within primary care has disabled commissioning and also allowed providers (especially in the Acute Sector) to dominate.

6. National policies, such as PbR, which were put in place to shift care away from hospital into primary care, had the opposite effect, placing an even greater focus on the transactional/contracting elements of WCC seeking to operate a counterbalance.

7. Foundation Trusts and Foundation Trust networks have a powerful powerbase at SHA/Department of Health level. All of this has disabled the primary care commissioner. But the concept of a purchase/provider split at some level is necessary, especially if the NHS wishes to introduce a variety of providers, including the third sector, social enterprise and the private sector.

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

8. World Class Commissioning and Practice-Based Commissioning are entirely compatible, indeed complementary. It is our view that PCTs will only be successful as world class commissioners if they are effectively delivering on PBC or clinical commissioning.

9. Unfortunately, the introduction of World Class Commissioning initially appeared to see PBC as an afterthought or as a second tier of commissioning. The recognition that WCC cannot be effective without frontline clinical engagement (hence NHS Alliance's refrain—no PBC, no WCC) has now been recognised. Nevertheless, few practice-based commissioners are fully emancipated and allowed/enabled to look at whole service redesign. In many cases there appears to be a power struggle between practice-based commissioner and PCT, which is partly a result of PBC having been, historically, insufficiently a focus of recognised success for PCTs.

10. The latest NHS Alliance/Nuffield Trust report *Beyond Practice-Based Commissioning: the local clinical partnership*, published in November 2009, suggests that practice-based commissioning might develop into local clinical partnerships (LCPs), bringing together a number of local practices, with secondary care clinicians whom might have an extended role in providing local services which the LCP cannot provide itself.

11. For the LCP model to work, local clinicians must have the ability to take "make or buy" decisions for their population. Therefore, they must have a commissioning focus, whereby they are able to decide on services they can provide as well as those that are not appropriate or relevant for them to provide, but which they need to have commissioned by the PCT from others on their behalf.

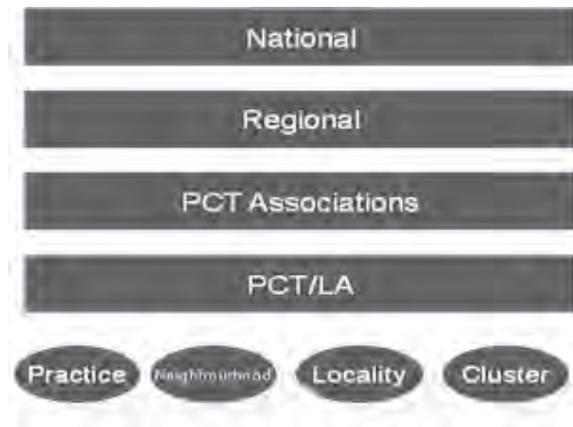
12. Commissioning and contestability go hand in hand. The principle should be that a commissioner tries to exert leverage on the provider. If the latter is unable or unwilling to meet the specifications of the commissioner, then the commissioner should go elsewhere, including tendering the service where this is perceived to be the appropriate procurement route. Where services are of sufficient quality already, however, contestability and change of provider for its own sake would seem inappropriate.

13. Too often, the procurement itself seems to be driving the commissioner, rather than the other way around. Procurement is merely a technical process that takes a high level commissioning strategy and commissioners (PCTs and their PBCs) need to determine the procurement principles that they will use to ensure that the commissioning strategy and specification is delivered.

14. The NHS Alliance has suggested in its report *Sustaining the Vision*, published in October 2009, that the current format of Payment by Results is not satisfactory at a time of economic downturn. In particular, we suggested that PbR should be a maximum and that PCTs should be allowed to block contract with acute providers so as to be able to predict spend and keep within budget. PbR—in fact by "activity" rather than "results"—was appropriate at a time when increasing capacity was the priority. Originally, the tariff was set at average cost, which effectively, inflated the system and the move to "best value" tariff was desirable. Nevertheless, it does provide a barrier to productive working between secondary care and primary care providers with mutual incentives that encourage greater cost-effectiveness and better integration of services.

## SPECIALIST COMMISSIONING

15. Commissioning takes place at many levels in the NHS, as can be shown below:



16. Specialist Commissioning is normally used to describe the activity that takes place above PCTs, either nationally or at a regional level based on SHA geographical areas. Nationally the NHS commissions over 50 specialised services at an annual cost of around £480 million. About 10,000 patients a year benefit from these services.

17. Specialised services are high cost, low volume interventions and treatments. 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.

18. In 2005 the Department of Health announced a review into commissioning arrangements for specialised services. The Review Group, headed by Scotland's former Chief Medical Officer, Professor Sir David Carter, investigated how the NHS commissioned specialised services. The Report of the Review into Commissioning Arrangements for Specialised Services (the Carter Review) and its recommendations for improvement were published in May 2006.

19. The primary purpose of the Carter Review was to propose improvements to commissioning arrangements for specialised services in England. The review recommended changes to structure, organisation and powers that would ensure the commissioning process is robust and fair, is understood by all, engages patients and offers optimal value for money.

20. The NHS Alliance supports the principles behind the Carter review and was pleased to take part in the formulation of the report. The NHS Alliance would wish to draw attention to the need to ensure that specialised service commissioning is accountable to PCTs and reflects local needs. This means that the commissioning of specialised services must be undertaken on behalf of PCTs and the governance arrangements reflect this. In many areas this works satisfactorily, but needs constant reinforcement.

21. More problematic is the link between practice-based commissioning and specialist service commissioning. Patients do not exist in a vacuum and every patient who benefits from specialised services is also a patient of their local GP and other services. It is therefore critical that there is a full awareness and connection between local commissioning and specialised groups. This is the case in only a few places, eg Hampshire, and these arrangements need to be duplicated across the country.

## COMMISSIONING FOR THE QUALITY AND SAFETY OF SERVICES

22. Commissioning should be exactly for that—quality and safety as well as cost-effectiveness. Its reality, however, is that patients and local people may not be best placed to judge the clinical safety and quality of services, though they are best placed to judge patient experience.

23. Primary care clinicians and PCT managers may also be unaware of areas where their local acute services are underperforming compared to others. Consequently, commissioners need proper information on areas such as HSMR (hospital standardised mortality ratios), so that they are in a position to form an opinion on the quality and safety of services and the direction of change required.

24. A recent report by Dr Foster Intelligence has shown relatively weaknesses in commissioning informatics, which need to be remedied if commissioning is to become more effective. Unfortunately, the lack of such information has not been a unique issue for commissioners as other organisations, such as CQC, have suffered from the same lack of good reliable data.

25. The NHS Alliance believes that if commissioners are able to get the necessary quality and safety data and involve both local clinicians and patients in analysing it, then this provides an important “propter hoc” means of improving the quality and safety of the health service leaving the role of “post hoc” regulator (eg CQC) to take a policing role, where standards are unsatisfactory.

26. It is also worth noting that organisational development plans are underutilized as an assessment method because the value of workforce development is not fully understood. OD is an immature skill in many PCTs, which are unsure as how they will be able to afford clinician/staff development.

27. The Transforming Community Services is not seen as an integral part of WCC. SHAs have asked for separate plans and incorporation of plans for TCC into new strategic plans. This is incredibly time consuming when PCTs and their provider arms need to be concentrating on service redesign delivery. There was a prescription for organization form, albeit with choices, but that is unaffordable. It seems that policy and economic analysis are at odds. For instance, there is a policy that all nurses will be degree trained, which would mean a huge cost to the service without an appropriate benefit analysis.

*December 2009*

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**Memorandum by Dr Daphne Austin (COM 115)**

**COMMISSIONING SUPPORT APPRAISAL SERVICE (CSAS)**

**SCOPE OF BRIEFING**

The Commissioning Support Appraisals Service (CSAS) was commissioned from Solutions for Public Health (SPH) in Oxford by NHS Birmingham East and North, on behalf of the 153 English Primary Care Trusts. It was established to facilitate PCT engagement with NICE during the development of Technology Appraisal Guidance (TAG). The newly established CSAS has stimulated a great deal of press interest, but much of it has been based on either poor information or misinformation. This briefing is intended to provide a full background about why CSAS has been established and the functions that it will deliver.

**BACKGROUND**

The National Institute for Health and Clinical Excellence (NICE) has a number of work programmes. One of these, the Centre for Health Technology Evaluation generates Technology Appraisal Guidance (TAG), which reviews the cost effectiveness of new drugs and other health care technologies. If approved for introduction, NHS organisations are required by statute to make funding available for implementation. Primary Care Trusts are the NHS bodies which receive a cash-limited annual allocation to deliver health improvement and ensure access to cradle to grave health care for all of their registered population.

The process for the development of each TAG is unique in that for each appraisal there is a specific list of designated consultees which are separate from the more general consultation process. Consultees are selected by NICE and invited by the organisation to engage in the appraisal process.

Consultees have special status in that:

- They are given additional opportunities, and at an earlier stage, to comment on the guidance. This includes having opportunities to give evidence directly to the appraisal committee.
- They have a right of Appeal.

The list of named consultees routinely includes professional bodies, patient groups, manufacturers and NHS PCTs. They number up to about 30 organisations. In addition to the NHS commissioners, of which in each case there will be two PCTs (picked at random) who are invited to contribute on behalf of colleagues, one or two Specialised Commissioning Groups might also be invited for relevant technology appraisals.

There are three problems with PCT engagement in the NICE process:

1. The first is that PCTs are not engaging at all. Of the first 176 TAGs published by NICE, NICE reported that none received any input from PCTs at either the scoping stage (where the research question is defined) or the evidence review stage. Seven of the named PCT consultees did appeal against NICE guidance but without having contributed views or evidence to the guidance whilst it was still being developed and considered. Such appeals have proven to be expensive, unpopular (due to perceived delay) and may have been avoided had the PCT consultee played its part more actively during the early development of the TAG. There are a number of reasons why engagement has been poor. These include: communication (PCTs were unaware that they had been selected to be a consultee or in some instances NICE had contacted PCTs that no longer existed), training (PCTs were unaware of why they should be a consultee and how to participate), capability (individual PCTs may be asked to contribute to a complex and technical appraisal of a relatively esoteric subject) and competing local commitments.
2. The second was that participating formally in a NICE appraisal requires a major resource commitment, usually from one individual in the PCT. The most likely contributor would be a senior public health specialist with commissioning experience. Many PCTs have only one individual in this role and this contribution is often part time at that. Furthermore, this individual may need to access other expertise such as clinical, economic and legal advice. Based on my experience I calculated that the resource cost to a PCT to participating in a straightforward consultation was approximately £2000–4000 and could go as high as £15,000 for more complex consultations and appeals.

3. Finally a number of public health practitioner who had considerable other contact with NICE were aware that NICE were finding it difficult to engage commissioners.

#### PCT ENGAGEMENT IN TECHNOLOGY APPRAISAL GUIDANCE

There are three reasons why PCT engagement in the development of NICE Technology Appraisal Guidance may be considered important:

1. **Budget.** PCTs are the legal guardians of the budget and tasked with the duty to oversee healthcare provision for their whole local populations. When another body, which has no budgetary responsibility commits the resources of the PCT—it has a legitimate interest in the decision of that body. Indeed I would go as far as to say it is a major stakeholder in the work of NICE. Not to engage in the consultation process, when invited to do so could be seen as a neglect of its function. Worse, given that only two PCTs are offered this opportunity at a time and that there is no current mechanism for PCTs to work on each other's behalf—failure of both PCTs to engage means NICE guidance is developed without evidence or information from PCTs which may be relevant and important.
2. **Other patient groups.** There are important ethical arguments for ensuring PCTs participate in their role as consultee. Less than 5% of committee members actually represent the population view. Out of the nominated consultees only the PCTs represent the whole population perspective, as opposed to the specialist interest of a particular patient group or disease. When making choices in a resource constrained system, it is vital that any decision maker or decision making body understands the full consequence of the decisions they take. Although the committees of NICE can never truly appreciate opportunity costs it is important, nevertheless, that they are made aware of competing patient groups and these other patients groups are represented when NICE makes its decisions. If the NHS budget holder is not present then other patients have no voice and the only views that will be heard are those with a special interest in that subject—the patient groups, clinicians with a special interest and industry. NICE has expressed a desire to better understand the opportunity costs of their decision and only PCTs can provide this information.
3. **Implementation.** There are practical reasons why PCT should provide input at all stages of the process. They have expertise and experience which others cannot provide—particularly around policy making with a view to implementation. NICE committees do sometimes deliver decisions which the NHS has found difficult to either interpret or implement. It is therefore important to have access to have PCT input before the final policy is written. Even if the overall decision is the same the technology appraisal may be a better document for PCT input. Similarly, in for example developing the scope of an appraisal, the technology appraisal teams can benefit by obtaining a strategic and population perspective in terms of areas to focus on.

There are therefore important reasons why PCTs should take up their invitation by NICE to participate in the appraisal process.

#### *Why the Commissioning Support Appraisal Service model?*

Any potential solution to improving engagement with NICE and providing NICE with information that they have been requesting from PCTs for many years needed to overcome a number of problems:

1. Many PCTs have insufficient capacity to release staff with appropriate skills, knowledge and expertise to take part.
2. PCTs are likely to be invited to participate only once every two or more years. There is a substantial learning curve with demanding timescales in understanding the NICE TAG process and how to contribute. The solution needs to support PCT consultees to fulfil the information requirements by NICE in a timely and effective way.
3. PCT consultee selection is currently a random process. It is therefore possible that the most appropriate PCT is not selected and therefore cannot contribute as a consultee. The service model needs to be able to access information from PCTs who have an interest in the healthcare intervention. Since the establishment of CSAS and the PCT Steering group, dialogue with NICE has indicated that they are interested in working together with PCTs/CSAS to consider alternative ways of selecting PCT consultees—with the aim of achieving high quality PCT engagement.
4. Prior to the establishment of CSAS, if the two PCT consultees were unable to participate there was no fallback position This resulted in guidance being developed without PCT evidence eg alternative treatments, the place of the intervention in the care pathway, the realistic likely cost impact and the opportunity cost for the rest of the population (many of whom have health needs which will never be considered by TAG).

It was therefore proposed that the best way to proceed would be for PCTs to collaborate through the commissioning of a central service to provide administrative and technical support and training as required. The support needed will vary from consultee to consultee and in each case this will be agreed between the two participating PCTs and the Unit. The Unit will also provide single point assessments for PCTs to aid

them in their decision making in the period before NICE makes its decision. This avoids individual PCTs making assessments on treatments in this pre-NICE period which is more efficient and is likely to lead to more consistent decision making.

The proposal was put before the Primary Care Network of the NHS Confederation to develop a central service. The proposal was accepted in principle and Sophia Christie and myself were tasked with developing more detailed proposals and costs and consulting with all PCTs on the proposal and securing support from all PCTs. This was done and as a consequence Birmingham East and North PCT was delegated the task of commissioning the service.

The proposal was also discussed with NICE in the very early stages. In March 2008, Andrew Dillon wrote to me following a meeting I had with him and Dr Gillian Leng:

*Thank you for giving us time to talk about how NICE can better work with PCTs. I look forward to hearing how the NHS Confederation initiative to resource a co-ordinating centre proceeds.*

The draft service specification for the unit was shared with Peter Littlejohns in advance of the tendering process.

The Health Select Committee was also made aware of these proposals from both the oral evidence made by Professor Rawlings to the Health Select Committee in one of its Inquiries into NICE and these was reiterated in NICE's formal response to the Health Committee in *National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report of Session 2007–08*:

*20. A number of steps were proposed by witnesses to alleviate the situation. To improve coordination between NICE and PCTs, we support the wider use of implementation consultants, who would provide information both from NICE to the PCTs and from the PCTs to NICE. (Paragraph 242)*

*We welcome the Committee's support for our six implementation consultants who work across England. Although they have only been operating for 18 months they have shown that they can provide a valuable service to PCTs and local government. We have recently submitted a proposal to the Welsh Assembly Government for the appointment of a comparable post in Wales and we would like to do the same in Northern Ireland. We are also working with the NHS Confederation on a scheme to improve the engagement which NHS organisations have with NICE as it develops its guidance.*

The initiative was discussed again in early 2009 at a workshop held by NICE which in part looked at the relationship between PCTs and NICE. Dr Doug Naysmith, MP, was at that meeting.

NICE have formally welcomed the establishment of CSAS. At their recent annual conference in December, Dr Carole Longson, Director, Centre for Health Technology Evaluation, invited Claire Cheong-Leen, Director, CSAS to talk about service as part of the conference programme citing CSAS as an "important development". Additionally, there is frequent communication between NICE and CSAS to facilitate PCT engagement and contribution to the development of TAG.

The Unit is an exemplar of collaborative commissioning to enable PCTs to participate in an important process in the most efficient and effective way. Such collaborative working is even more important given the current economic climate and likely staffing reductions within PCTs. PCTs are therefore disappointed that this initiative has been portrayed as a lobbying organisation and not about securing best quality evidence and information to support best health outcomes to inform the development of NICE TAGs or about improving PCT engagement and communications between two key decision makers.

In terms of the procurement details, the lead commissioner for the service is NHS Birmingham East and North. This PCT undertook a European tendering process via OJEU (as legally required) in January 2009 on behalf of all English PCTs. In May 2009, Solutions for Public Health were selected as the preferred provider. Based in Oxford, SPH is part of Milton Keynes PCT and has over 12 years experience in providing central public health support and expertise to PCTs in a number of areas. NHS BEN has contracted SPH to provide the CSAS for an initial period of three years. The cost of the service to each PCT is £2,000 per annum.

*Dr Daphne Austin*  
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West Midlands Specialised Commissioning Team

*January 2010*

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## Further memorandum by Dr Daphne Austin (COM 115A)

### WORLD CLASS COMMISSIONING

Following on from the 2nd session of the Inquiry I would like to respond to some of the comments relating to Specialised Commissioning.

#### THE NATURE OF SPECIALISED SERVICES

It is erroneous to see specialised services commissioning as commissioning for rare disorders. Whilst this might be the case for national commissioning it is not true at regional and sub-regional level. Many of the services Specialised Commissioning Teams commissioning are specialist services for common disorders or conditions.

- Neonatal intensive care and special care baby units are an integral part of maternity services. Most babies are not very small babies but need stabilisation or care for only a short period of time.
- Cardiothoracic surgery is comprised of surgery for people with coronary heart disease or valve disease.
- Radiotherapy is used overwhelmingly for patients with breast, prostate and lung cancer.
- Renal dialysis for end stage renal disease and again is an integral part of general renal services.

It is for this reason that the Department of Health proposals for two levels of specialised commissioning below the national level were supported. These proposals predated Carter by about five years. This meant that PCTs collaborated in clusters sharing a tertiary centre for common disorders—maternity and neonatal services, cancer services, cardiac services and so on. These often also coincided with network boundaries and planning was across the entire patient pathway for that common disorder. Local collaborative teams would still co-operate with each other at regional level. So it was possible to optimise capacity across the region for CABGs for example and also agree which area would get access to regional capital funds to establish the next satellite renal unit. For burns services however there generally is only one adult and one children's centre serving one or more regions and for these services commissioning was undertaken at regional level.

#### RISK SHARING

Each SCG will have its risk sharing schemes but in the West Midlands two different types have operated over the years.

*Capitation*—services are funded on a weight capitation scheme. These are only really appropriate where PCTs might be exposed to extreme risk—as in the case of the use of haemophilia blood replacement products either because a local patient develops inhibitors or a severe haemophiliac who has multiple trauma injuries. Here the risks are extreme and unpredictable. Serious burns would also be appropriate. Serious burns have become a rare event and it is likely that when they do occur a number of people will be affected at the same time. However—the whole region has to maintain the capacity which some years might not be used to maximum effect. It would therefore be appropriate to fund on a capitation basis.

*Three year rolling averages*—as indicated above—most regional services are specialised services for relatively common conditions. For these we generally use three year rolling averages. Risk is managed in year and across a three year period across the region which protects individual PCTs from peaks. In the long term however the PCT will pay for trends in usage.

At the Committee evidence session much was talked about top slicing in order to fund all specialised services on a capitation basis. I think few commissioners and public health practitioners would support this. I will discuss equity shortly but the top slicing which seems so attractive needs further examination.

The most important objection to funding on a weighted capitation basis is that PCTs currently do not receive their weighted and targeted funding. This fact seems to be constantly ignored whenever postcode variation is talked about. PCTs that form one of the local collaborations in the West Midlands is about £100 million short of its target funding. If the PCT which gets the least funding (Barnsley) were to be funded to the same level as the best funded (Richmond and Twickenham) it would receive a further £50 million.

If funding for specialised services were to be top-sliced on the basis of weighted capitation or even as a percentage of their funding—clearly the impact on the budget and therefore the opportunity cost would not be evenly distributed.

Secondly because many specialised services are services for common disorders—it is more logical for access and funding to reflect the burden of disease in each individual PCT. Coronary heart disease for example is distributed differently according to the age structure of the population and deprivation. A young population will not have as much CHD but more will be needed for primary prevention, children services and maternity services for example.

## VOTING

I would agree with Deborah Evans that PCTs aim to come to agreement through consensus rather than through the vote. But voting rules exist and below are the rules for the West Midlands. Our voting system is designed to serve both local and regional collaborative commissioning (tiers 1 and 2 as indicated in my presentation on 14 January)).

*Summary of West Midlands SCG and LCCB voting rules*

SCG: Majority voting 5:2

Pan Birmingham LCCB:	2 votes (can't be split)
Shropshire & Staffordshire LCCB:	2 votes (can't be split)
Black Country LCCB:	1 vote
Coventry & Warwickshire LCCB:	1 vote
Herefordshire & Worcestershire LCCB:	1 vote

*Shropshire & Staffordshire LCCB: Majority voting where meeting is quorate (minimum any four PCTs)*

South Staffordshire PCT:	2 votes (can't be split)
North Staffordshire PCT:	1 vote
Stoke PCT:	1 vote
Telford & Wrekin PCT:	1 vote
Shropshire County PCT:	1 vote

Black Country LCCB: Majority voting (2:1)

Pan Birmingham LCCB: Majority voting (3:2)

Coventry & Warwickshire LCCB: Both PCTs to agree

Herefordshire and Worcestershire LCCB: Both PCTs to agree

## REASONS FOR COLLABORATIVE COMMISSIONING FOR SPECIALISED SERVICES

I am somewhat surprised that equity is given as the main reason for commissioning at the regional level.

Firstly on what grounds can one support addressing equity of access and quality for certain groups of patients wholesale above others? Variation in access and quality in services for common disorders and in mainstream disorders is as great as it is in specialised services. Why should access to specialised cardiac interventions which may reduce admission rates and extend life for some people than say providing basic dementia services or tier 2 and 3 level mental health services for children? And why is it inherently more important for specialised services to be funded in order to provide the highest possible quality of service than any other? Many ethicists and PCTs would challenge this view. In an ideal World we would want to provide all needed services to the highest quality to everyone. However in a resource constrained health service the key question is which is the most important equity or inequality to address? Sometimes this might be health care for a rare disorder, a specialised services and sometime not. However, top-slicing prevents this sort of debate. Furthermore a system will be created in which any inequity either in access or quality in these services always getting priority when it comes to funding. A bias in favour of particular types of services or particular types of conditions should, in my view, be resisted.

Secondly, it is also important to consider the nature of the services commissioned. Many are highly technical. To give preferential treatment in all circumstances is to give preferential to the nature of the treatment and not the patient group or the health need per se.

Thirdly, if there is a view that rare disorders should take priority then are more coherent policy for rare disorders is required. In reality it is access to highly technical services which is the main focus of concern. Most services for the 10,000 rare genetic disorders and other rarer conditions or patient subgroups are commissioned by both the national and regional level are relatively small. Most problems are in co-ordination of care, and rehabilitation and support for long term chronic conditions—but many of these problems are common to services for other conditions.

Given the number of rare disorders and conditions alternative solutions need to be developed to help facilitate developing specialist interests amongst clinicians and enable clinicians and patients to access maybe clinical teams with a specialist interest.

Collaborative commissioning has an important role to play but one has to be very clear of the benefits and the purposes of collaborative arrangements for any specific services.

## CONSULTATION FOR REGIONAL SERVICES

I think most SCTs would welcome consultation being simplified. In our own region we have undertaken a needs assessment and designation for neonatal services but it has been difficult implementing aspects of because there is local resistance. Everyone supports designation when they win but are not supportive when they see their local service being downgraded. It has taken years to secure a location for a third medium secure service for personality disorders and sexual offenders in the West Midlands.

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 INDIVIDUAL FUNDING REQUESTS

Specialised commissioning teams are not statutory bodies. The responsibility for funding decisions sits legally with the PCTs. If there is a challenge on an individual funding request it is the PCT which will be taken to court and not the SCT or the SCG.

Most SCTs therefore have an arrangement whereby the delegated authority for funding decisions around individual patients is limited. However this does not mean that the PCT makes decisions in isolation. If our SCT forwards an IFR to the PCT—it does so with an analysis of the case and a recommendation to either to fund, not fund or indicating that the decision is a close call. When a capitation risk sharing applies then it is more essential that all PCT operate a common policy.

January 2010

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**Memorandum by Dr Pauline Brimblecombe (COM 116)**

COMMISSIONING

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

The vision of World Class Commissioning is for the available resources to be used as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare. Prior to the WCC initiative PCTs delivered services on a historical basis rather than a public health needs assessment. Delivering on demand rather than need has produced wide variations and contributed to some of the health inequalities. The fact that PCTs have not fulfilled their commissioning role to date is unsurprising given the emphasis of the health reforms on the provision side and on “patient choice”. Despite the emphasis of WCC on priority setting, commissioning decisions are still very much determined by government targets and other “must-dos” such as NICE decisions and SHA dictat.

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

The purchaser/provider split has educated the provider organizations that their role is to deliver services that are needed rather than on what they have historically delivered. This has been and continues to be a difficult message for acute trusts to assimilate. The bulk of health expenditure is spent in the acute sector and yet delivers care to only the top 10% of the health pyramid. Despite the wish to move funding from the acute sector into the community, the power of acute trusts and emphasis from government, (despite its rhetoric) on acute services, care in the community is mainly theoretical.

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

The logic of PBC is sound. The role of the GP is not only to deliver personalised care but also to focus on the total needs of its registered population. PBC falls down in that the population and therefore resources are too small to manage risk adequately and the administration costs duplicated. This could be improved if practices worked in localities or federations around a more sustainable population c70,000.

Contestability and the quasi-market rely upon knowing what outcomes you want and being able to identify the available resources. The tendering process should deliver more cost effective services but it is time consuming and only suitable for large contracts. PBC needs a speedier more flexible approach to implementing change.

PBR was helpful initially to focus providers on their activity. However now it stands in the way of real service transformation. PBR focuses on activity not outcomes and does not incentivise innovation. It makes collaboration between providers difficult and basically encourages the status quo.

*Specialist commissioning*:

To look at specific areas of specialist care with a large population makes sense. However it can also lead to loss of ownership by the PCTs if they have no input into the process and if 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. The dictat to provide all eligible couples with up to three fresh IVF cycles diverts scarce resources from local PCT priorities and with no ring fencing of the budget allows no account of local circumstances

*Commissioning for the quality and safety of services.*

This should be the number 1 priority but in reality is often superseded by affordability and the choice agenda. By more involvement of clinicians and patients in decision-making this could be changed. This is political, as most GPs and probably patients would rather sacrifice choice for an affordable quality and safe service.

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Personal view of why PBC has so far failed to deliver its potential

- *Failure of clinicians to understand what commissioning means*—and why should they as their training is in delivering the best care for the person in front of them? With the greater acceptance of the need for “distributive justice” this is improving—and as clinicians begin to understand the problem they come up with the solutions. GPs are nearly there; acute clinicians haven’t even reached the starting blocks.
- *Disempowerment of the GP*—by government, SHA, PCTs, acute care consultants. Good management is about improving performance through support and education— it is not about taking over. In any other profession a consultant advises and hands back the problem—they do not take over the problem.
- *The blank cheque phenomenon*—when a GP makes a referral they have no idea what the final cost of this transaction will be. Financial control is lost as soon as the patient enters secondary care.
- *Lack of performance review*—without feedback on which to reflect—behaviour change cannot occur. Comparative data stimulates professional pride to improve—league tables work.
- *Medicalisation of health*—the public have been medicalised into patients. There is a need to take back responsibility for their own health, learn to rationalise risk, and work in partnership with health professionals.
- *Managing expectation*—too much political fuelling of public expectation and emphasis of rights over responsibilities. Public say they value the NHS yet there is much wastage of resource especially medications and missed appointments.
- *Death*—there needs to be a recognition that death is a natural inevitable outcome of life. Managing a good death is as important as prolonging a poor quality life.

January 2010

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**Memorandum by Cambridgeshire Primary Care Trust (COM 117)**

**COMMISSIONING**

**EXECUTIVE SUMMARY**

Cambridgeshire Primary Care Trust is pleased to have the opportunity to contribute to the Health Select Committee’s inquiry into commissioning.

Cambridgeshire Primary Care Trust is responsible for improving the health of the population of Cambridgeshire by assessing health needs and by commissioning services from providers in response to those needs. The population of Cambridgeshire is changing and is expected to grow significantly in size and in age over the next ten years. Despite having areas of relative affluence, there are significant pockets and areas of deprivation in the County which need to be addressed.

Looking ahead, it is clear that the impact of the economic downturn will have a significant impact on future public sector funding. Having undertaken a strategic assessment together with key stakeholders, our view is that this is an opportune time to think more radically and innovatively about how commissioning could be conducted, whilst benefitting from the practical experience of Practice based Commissioning Consortia.

Cambridgeshire has a good history of support for NHS Reform and this is evident from the work of our service providers and our commissioning teams, past and present. The Purchaser/Provider split has proved to be a useful means of defining clearly our respective roles and responsibilities and has led to a steady path of evolution both separately in our respective roles and together by working in partnership.

Key elements of this are the introduction of a new commissioning model in 2010–11, supporting the aspiration of the PCTs provider arm to become a NHS Trust and taking forward the quality and safety agendas.

**1. INTRODUCTION AND CONTEXT**

1.1 Cambridgeshire Primary Care Trust (CPCT) was established on 1 October 2006 and is responsible for improving the health of the population of Cambridgeshire by assessing health needs and by commissioning services from providers in response to those needs.

1.2 Just over 600,000 patients are registered with GPs within the CPCT boundary. By 2021, it is estimated that there will be a further 90,000 people living in Cambridgeshire, mainly in South Cambridgeshire and Cambridge City, where a number of significant new housing developments are planned, including the new town of Northstowe.

1.3 The number of people aged over 65 is anticipated to increase by 60% between 2006 and 2021 in Cambridgeshire with the greatest proportional increase expected in South Cambridgeshire.

1.4 Life expectancy in Cambridgeshire has been increasing across all groups identified and has been consistently higher than the East of England average level from 2001 to 2007. However, life expectancy of the most deprived fifth has always been below the East of England average over this period and there is a 4 per cent relative difference between the most and the least deprived areas in Cambridgeshire.

1.5 Across all districts, Cambridgeshire has a lower deprivation score than the England average. The most deprived areas in Cambridgeshire are concentrated in the north east of the County. Deprivation varies greatly across the county, with Fenland, north-east Cambridge and parts of North Huntingdon having the highest levels of relative deprivation. The same pattern exists for children living in poverty.

1.6 Income deprivation for older people is more widely dispersed. Mapping of adverse lifestyle behaviours and health outcomes across Cambridgeshire follows the pattern of deprivation.

1.7 The annual budget is over £800 million. Nearly 90% of this is used to commission services from acute hospital and out of hospital care providers. The remainder is spent on mental health services (8%) and PCT support services (3%).

1.8 There are several Practice Based Commissioning (PBC) Consortia within Cambridgeshire with whom CPCT works closely covering Cambridge and South Cambridgeshire, Huntingdonshire and East Cambridgeshire and Fenland. Currently PBC budgets are indicative.

1.9 CPCT is lead commissioner for the following:

- (a) Cambridge University Hospitals NHS Foundation Trust.
- (b) Hinchingsbrooke Health Care NHS Trust.
- (c) Cambridgeshire and Peterborough NHS Foundation Trust (mental health services).

1.10 Community services are provided by Cambridgeshire Community Services, the PCTs provider arm which works on an arms length basis but has aspirations to become a Foundation Trust in its own right.

## 2. WORLD CLASS COMMISSIONING

2.1 CPCT welcomes the introduction of World Class Commissioning (WCC). The WCC programme is only in its second year of development but we believe that it has several advantages:

- (a) It sets out a staged development path to assist commissioning organisations to achieve world class commissioning status;
- (b) it places emphasis on the importance of robust strategic planning supported by a range of underpinning plans;
- (c) the range of competencies requires commissioning organisations to consider carefully their approach to balancing and managing external relationships as well as the developmental changes to their organisations; and
- (d) it aims to ensure consistency of standards across all commissioning organisations whilst enabling PCTs to develop at their own pace.

2.2 However, we believe that WCC is at too early a stage of development for it to provide a clear and reliable indication of the effectiveness of a PCT's commissioning approach. The WCC assurance process itself is changing and evolving. During this year, we have seen greater specificity of assessment criteria this year but appreciate that these, too, will continue to evolve as experience nationally and locally improves.

2.3 The process of preparing for WCC assurance has been helpful in several respects. Firstly, the discipline of following through from strategic vision to explicit clinical outcomes has encouraged greater clarity of thinking and a need for a logical and structured approach to strategic formulation.

2.4 Secondly, by incorporating the requirement to demonstrate good clinical and partner organisational engagement, partnership working has been enhanced. For example, in June last year, we held a stakeholder conference entitled "the Storm Scenario" comprising 80 leaders from a wide range of organisations to explore the likely impacts of the economic downturn. The results of this conference and the ensuing summit meeting were used to determine at least one of our major strategic change programmes set out in the five year plan. One of the by-products of this work is greater mutual recognition of our respective strategic challenges and a willingness to explore more and innovative ways of working together in future.

2.5 Finally, the need to closely align service and financial planning and to demonstrate this explicitly during the WCC assurance process has yielded several important benefits which, in time, will manifest as clear indications of the effectiveness of commissioning. These include:

- (a) better clarity of commissioning intention, supported by relevant performance metrics;
- (b) close working between directorates to ensure that commissioning intentions are sufficiently thought through and aligned with the strategic priorities set by the Board; and
- (c) assessment of the market development opportunities and the appropriate use of the procurement pipeline for service procurements.

### 3. PURCHASER/PROVIDER SPLIT

3.1 The Purchaser/Provider split has been in place for many years. It was introduced initially during the Internal Market in the 1990's and has continued since then. The distinction between the roles and responsibilities of those who purchase (commission) services and those who provide them has been an essential part of the development path for system reform.

3.2 We believe that the initial separation of purchaser and provider roles resulted over time in an approach which was dominated by transactional management. In its early stage of development, there was a lot of focus on devising and developing the transactional mechanisms for such a split to work. For example, this included the development of a range of contract types, development of information systems to sustain invoicing for services delivered and the initial development of the strategic and operational planning infrastructure required to support the development of a health care market.

3.3 Since then, the approach has become more sophisticated for several reasons:

- (a) the establishment and development of Foundation Trusts which has led to the creation of sophisticated provider operational management and service performance management systems;
- (b) the emergence of Intelligent Commissioning and the Intelligent Board concepts resulting in a better understanding of the role of purchasers (commissioners) and a push to translate more overtly the health needs of the population into coherent and achievable strategies for investment and/or service transformation;
- (c) recognition and better understanding of the opportunities which can be afforded by developing the health and social care market;
- (d) continuing development by the Department of Health of model contracts which ensure that respective roles and responsibilities of purchasers and providers are clearly set out within a legally binding setting; and
- (e) the introduction of World Class Commissioning and the continuation of Foundation Trust development programmes foster such a separation and provide a pathway for future development.

3.4 The continuation of the purchaser/provider split is needed if we are to avoid confusion of roles and if we are to maximise the opportunities for developing the health and social care market with the aim of achieving the best value for public money.

### 4. COMMISSIONING AND SYSTEM REFORM

4.1 Cambridgeshire has been and remains committed to taking forward System Reform. Examples of this include:

- (a) the early piloting and rapid development of Payment by Results at Cambridge University Hospitals NHS Foundation Trust;
- (b) the development of a more rational and intelligent commissioning approach shortly after inception of the PCT;
- (c) exploring with the Department of Health Commercial Team the feasibility of introducing the Framework for procuring External Support for Commissioners (FESC) in Cambridgeshire; and
- (d) in the diabetes integrated care pathway (which represents £19 million annual spend in acute with 38% related to diabetes direct admissions) a pilot in East Cambs and Fenland has been successful. Early indications show that there is potential to roll out across the county and reduce diabetes related admissions and out patient referrals.

4.2 CPCT has also wished to support actively the development of Practice based Commissioning (PBC) and we now have several thriving PBC Consortia in place.

4.3 In the light of the economic downturn and its estimated impact on future public sector funding, we believe that there are opportunities to be more radical and innovative in approach, particularly with respect to PBC. During formulation of our latest strategy, it became clear that the current commissioning model would be insufficiently robust to ensure that health and social care commissioning in Cambridgeshire could be confidently developed.

4.4 Our approach to commissioning in the past has been based on a centralised model with PBC Consortia providing complementary commissioning input within their localities using indicative budgets. Whilst this was an essential part of the development path to achieve more localised commissioning of services (and therefore more pertinent to the needs of patients), our view is that this centralised approach has not been as successful as it could have been.

4.5 Our Practice Basing Commissioning journey has taken some time, but we now have significant and improving clinical engagement. We have a great deal of interest in GPs forming into “clusters” to manage their own budgets. We believe this model will be more responsive to patient needs and less bureaucratic. Examples of where we have made progress include:

- (a) in the south of the County, working with the complexity of secondary and specialist services provided by Cambridge University Hospitals NHS Trust;
- (b) in Huntingdonshire, ensuring that there is a sustainable health system in place for the future; and
- (c) in East Cambridgeshire and Fenland, improving community hospital service provision and accessibility to services in what is largely a rural part of the County.

4.6 Having held wide-ranging discussions with primary leaders and opinion shapers, we have concluded that our current commissioning model is too removed from clinicians on the ground, in particular GPs, who make decisions every day about the treatment individuals receive. The result is a separation of clinical and financial responsibility. The people who probably know most about their patients’ needs are unable to be intimately involved in designing and commissioning the disposition of services to meet those needs.

4.7 If we are to achieve a commissioning model whereby local clinicians are able to respond directly and intelligently to health needs of people within a locality whilst maintaining a county-wide oversight at PCT level, the current commissioning model for Cambridgeshire will require a more innovative approach.

4.8 Therefore, we intend to introduce a new commissioning model which has at its heart Clusters of GP practices who accept responsibility for commissioning health services for their patients. They would be rewarded in proportion to the success they achieve against the agreed performance framework and would accept a share of the risk of failure. Cluster size could vary but a population of between 50,000 to 100,000 appears to be a reasonable proposition. Although the detailed prospectus is still being prepared, we are clear that we would need to agree real commissioning budgets with each Cluster and devolve as much authority to them as possible. Clusters would operate within a governance framework agreed with the Primary Care Trust, clearly setting out the roles and responsibilities of each party. Our aspiration is that the first wave of Clusters will be operational during the financial year 2010–11. Subject to satisfactory formal evaluation, we will invite future waves to participate. Participation in this system is voluntary. Any new system that allows and encourages GPs to commission in a more innovative way, on a larger scale, must also ensure rigour in governance and outcomes monitoring. They will also need support and the infrastructure to be able to hold their providers to account and to performance manage contracts they hold.

4.9 Whilst the introduction of a more radical commissioning model is an important part of our strategy to take forward NHS Reforms, we also have a responsibility to ensure that the health care “market” in Cambridgeshire has a viable and thriving community services provider. This is an important element in our strategy to ensure that there is a secure foundation of community service provision to support the safe shift of clinically appropriate care from an acute hospital setting to a clinical setting based at or near the patient’s home.

4.10 Cambridgeshire Community Services (CCS) operates as an “arms length” trading organisation but is legally part of the PCT. CCS provides a range of community based services including district nursing, therapies and a wide range of services for older people through managing the pooled budget for social care.

4.11 CCS has sought approval from the Secretary of State for Health to become an NHS Trust from 1 April 2010. The PCT Board welcomes this and sees it as a natural outcome of CCS’ current organisational development path.

## 5. SPECIALIST COMMISSIONING

5.1 Specialised services tend to be high cost and low volume services and are either very expensive to provide or they comprise services for rare conditions, for example, rare cancers, renal dialysis, complex surgical care and specialised care for children. These services are not provided by every hospital but require the expertise of highly trained and experienced clinicians, often using complex medical technology. Such services tend to be provided in specialist centres supported by satellite hospital units.

5.2 In the East of England, specialised commissioning is undertaken by the East of England Specialised Commissioning Group (EoESCG) which was established in April 2007 through an amalgamation of several smaller groups. The PCT is a full member of the EoESCG Board and make an active contribution to its constituent working groups.

5.3 While CPCT believes that this is a useful model for commissioning these sorts of services, it does not believe that it works as well as it could do at the moment. There needs to be better engagement with PCTs in this process, and closer monitoring at a local level of the impact of the services and the outcomes for patients. We also need a systematic approach for PCTs to hold the Specialised Commissioning Group to account when things don’t work well.

## 6. COMMISSIONING FOR QUALITY AND SAFETY OF SERVICES

6.1 The quality and safety of the services we commission is of paramount importance and, for that reason, the PCT Board re-structured the board meetings agenda to ensure that quality and governance issues are the first to be discussed at every meeting.

6.2 CPCT welcomes the introduction nationally of Quality Accounts and the Commissioning for Quality and Innovation (CQUIN) payment framework arising from *High Quality Care for All*, led by Lord Darzi. During the past year, the PCT has drawn up a CQUIN schedule for inclusion in our acute provider contracts and, although the content of the CQUIN schedule is continually evolving, our view is that provides a helpful focus during the contract negotiation stage and at subsequent performance management meetings.

6.3 In addition, we have organised a regular provider performance review day with each of our main providers and use this time to focus on key clinical quality, safety and contract performance issues.

6.4 The work of developing CQUIN frameworks will, in time, be complemented more overtly by the publication of Quality Accounts by Trusts and we believe that this will further enhance the value of the commissioner/provider discussion to the benefit of our patients.

January 2010

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### Memorandum by The National Audit Office (COM 119)

#### TELEPHONE SURVEY OF PRIMARY CARE TRUST COMMISSIONERS

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##### *Summary*

##### Part 1: Background, methodology and previous NAO findings on commissioning

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Previous NAO findings on commissioning

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The current state of commissioning

The main challenges faced by PCT commissioners

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Practice-based commissioning

World Class Commissioning

##### SUMMARY

1. Commissioning in the NHS is the process of deciding what health and care services are needed, acquiring them and ensuring that they meet requirements. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

2. The Department of Health's vision for healthcare commissioning is framed by "World Class Commissioning" which aims to deliver a more strategic and long-term approach to commissioning services, with a focus on delivering improved health outcomes. This vision is underpinned by a set of 11 organisational competencies which requires primary care trusts (PCTs) to demonstrate their ability to: locally lead the NHS; work with local partners; engage with public and patients; collaborate with clinicians; manage knowledge and assess needs; prioritise investment; stimulate the market; promote improvement and innovation; secure procurement skills; manage the local health system and make sound financial investments. The World Class Commissioning programme incorporates a yearly assessment of all PCTs performance against these 11 key commissioning competencies.

3. Practice-based commissioning is seen by the Department of Health as a key driver to achieving world-class commissioning. It involves increasing the participation of GPs and local clinicians in commissioning health and wellbeing services, as well as specialist services.

4. In November 2009, the House of Commons Health Select Committee requested the support of the National Audit Office (NAO) to help it obtain the views of PCT commissioners for its inquiry into healthcare commissioning. This memorandum has been prepared in response.

5. This memorandum is based on the results of a telephone survey with PCT commissioners undertaken for the National Audit Office by Ipsos MORI between 5 and 15 January 2010. A total of 114 telephone interviews were conducted, which represented a response rate of 75%. A subsequent focus group was held with PCT commissioners and senior NHS staff with a strategic view of commissioning to explore the results of the telephone survey in more detail. This has also fed into the memorandum.

#### MAIN FINDINGS

6. The survey found that PCT commissioners were generally very positive about the state of commissioning in its entirety across the PCT, with 95% stating that commissioning was going very well or fairly well. When commissioners were asked specifically in which key service areas commissioning was going well, the percentage of respondents varied from 50% for specialised commissioning to 77% for primary care services.

7. Our focus group participants thought that these results were a fair reflection of the current state of commissioning, but commented that the results needed to be set in context. Commissioning has improved from where it was a year or two ago, but there is clear evidence of the need for further improvement. The World Class Commissioning assurance process results for 2009 showed that PCTs received an average score of 1.65 across all competencies out of a possible score of four. Competencies that received lower than average scores were market development, procurement skills and prioritising investment.

8. The survey results can also be set in context by the results of recent National Audit Office value for money reports on a range of health services. These reports have highlighted weaknesses, at PCT level, in all three stages of the commissioning cycle: strategic planning; procuring services; and monitoring and evaluation.

9. Strategic planning issues identified in our reports were a lack of knowledge of local needs, insufficient use being made of available data in planning activity, poor understanding of costs related to addressing issues and a lack of clinical evidence to commission services effectively. Procurement issues we identified were fragmented procurement activities not realising scales of economy, poor understanding of costs of activity and limited benchmarks to guide PCT spending. Monitoring and evaluation issues we identified were poor understanding of whether services provided achieve value for money, the impact of activity not being assessed adequately, a lack of influence over providers and a lack of reliable methods in place to measure predicted benefits.

#### *Key challenges facing PCT commissioners*

10. The survey highlighted a wide range of key challenges facing PCT commissioners. The most frequently mentioned challenges (percentage of commissioners mentioning the challenge as one of their top three challenges) were:

- financial pressures and constraints (58%)—40% of commissioners mentioned this as their first major challenge;
- commissioning acute services (21%);
- clinical engagement to support change (15%);
- improving commissioning skills within the PCT (14%);
- greater commissioning capacity within the PCT (14%); and
- ability to decide how to prioritise services (10%).

11. Focus group participants supported these as the key challenges facing commissioners and commented that many of the challenges were inter-linked. For example, the focus group participants noted that tackling the top challenge, financial pressures and constraints, will require action in the area where the majority of the commissioning budget is spent, which is acute services (the second most frequently cited challenge), which will require engagement with clinicians (the third most frequently cited challenge). Another inter-related theme identified by the focus group was knowledge management and prioritisation—the availability and quality of information and how it is used to drive service improvements. The focus group also noted that these issues also relate to skills and capacity.

#### *Key actions identified to address the challenges*

12. PCT commissioners identified a number of key actions which would enable them to address the challenges they face. The most frequently mentioned actions by commissioners were:

- stronger commissioning skills and capacity (28%);
- clearer central messages about prioritisation (22%);
- encouraging PCTs to work together where appropriate (13%);
- clearer political leadership about challenges facing PCT (12%);
- more and better performance information about patient experiences and outcomes (11%); and
- greater leverage for PCTs over providers (11%).

13. For those commissioners that identified financial pressures and constraints as a key challenge, the most frequently cited actions to address this challenge were using the financial crisis to promote change (18%), clearer messages about prioritisation (16%), and encouraging PCTs to merge where appropriate to local conditions (15%).

14. The focus group supported the actions identified by the survey respondents and in particular drew out two issues: the opportunity to use the current and future financial situation to promote change and the fact that there needs to be an understanding that contractual levers are not enough to tackle the issues facing commissioners. Focus group participants noted that it will require strong leadership from PCTs to drive through changes along with effective engagement with both clinicians and the public to realise the changes necessary.

#### *Practice-based commissioning and World Class Commissioning*

15. PCTs commissioner's views on practice-based commissioning were also positive with 77% of commissioners tending to agree or strongly agree that their PCT is well placed for practice-based commissioning to take on a more prominent commissioning role. However, there was wide variation in the reported proportion of a PCT's commissioning budget that is directly determined by practice-based commissioning, from none up to the largest category, 76–100%. Our focus group suggested that this wide variation reflected the fact that PCTs are at different stages of development in their practice-based commissioning function—some are very developed, whilst others are only just beginning to develop this function.

16. PCT commissioners' general perception of World Class Commissioning was that it had had a positive impact on local commissioning, with 84% tending to agree or strongly agreeing that World Class Commissioning has made their PCT more effective at commissioning and 61% tending to agree or strongly agreeing that World Class Commissioning has delivered measurable benefits to patients.

17. When PCT commissioners were asked how they had changed as a result of World Class Commissioning, a number of positive themes emerged:

- a greater focus on outcomes;
- increased collaboration;
- more emphasis on commissioning skills;
- meeting patients needs; and
- improved systems and processes and re-organisation where necessary.

18. Although the majority of comments on what had changed as a result of World Class Commissioning were positive, there were a number of more mixed responses highlighting a number of concerns with World Class Commissioning. Examples included views that World Class Commissioning is just a tick box exercise and that the World Class Commissioning assurance process takes time to complete when there are other things staff could be getting on with. Some concerns were also expressed as to whether the World Class Commissioning programme had the right balance between being an assurance programme and a development programme.

## PART : BACKGROUND, METHODOLOGY AND PREVIOUS NAO FINDINGS ON COMMISSIONING

### *Background*

1.1 Commissioning in the NHS is the process of deciding what health and care services are needed, acquiring them and ensuring that they meet requirements. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.

1.2 The Department of Health's vision for healthcare commissioning is framed by "World Class Commissioning" which aims to deliver a more strategic and long-term approach to commissioning services, with a focus on delivering improved health outcomes. This vision is underpinned by a set of 11 organisational competencies which requires primary care trusts (PCTs) to demonstrate their ability to: locally lead the NHS; work with local partners; engage with public and patients; collaborate with clinicians; manage knowledge and assess needs; prioritise investment; stimulate the market; promote improvement and innovation; secure procurement skills; manage the local health system and make sound financial investments. The World Class Commissioning programme incorporates a yearly assessment of all PCTs performance against these 11 key commissioning competencies.

1.3 Practice-based commissioning is seen by the Department of Health as a key driver to achieving world-class commissioning. It involves increasing the participation of GPs and local clinicians in commissioning health and wellbeing services, as well as specialist services.

1.4 In November 2009, the House of Commons Health Select Committee requested the support of the National Audit Office (NAO) to help it obtain the views of PCT commissioners for its inquiry into healthcare commissioning. This memorandum has been prepared in response.

### Methodology

1.5 To seek the views of PCT commissioners, in the timescale that was needed, we undertook a telephone survey of PCT commissioners. To inform the development of the survey questionnaire, we held a focus group with four senior PCT staff with a strategic view of commissioning. We also received written feedback on potential survey questions from two PCT commissioners. The survey was undertaken on our behalf by Ipsos MORI.

1.6 The telephone interview for the survey sought PCT commissioners' views on the following:

- how well commissioning was going in its entirety and particular commissioning areas where it was going well;
- the three main challenges faced by PCT commissioners when commissioning services and the particular areas of commissioning in which these challenges are faced;
- the actions that would be most helpful in overcoming these challenges;
- whether practice-based commissioning was well placed in their PCT to take on a more prominent role in commissioning local health services and what proportion of their total commissioning budget was spent on practice-based commissioning;
- whether World Class Commissioning has made PCTs more effective at commissioning local health services and has delivered measurable benefits to patients;
- what has changed as a result of World Class Commissioning; and
- whether there were any commissioning challenges that are specific to local circumstances not covered in the previous questions.

1.7 For each PCT, we identified two senior commissioners, including the Director of Commissioning or an equivalent role. Only one commissioner from each PCT was interviewed by Ipsos MORI. Over the period, 5 to 15 January 2010, 114 telephone interviews were conducted, which represented a response rate of 75%.

1.8 Once the telephone survey was completed, we held another focus group with four PCT commissioners and other senior NHS staff with a strategic view of commissioning to explore the results of the survey in more detail.

### Previous NAO findings on commissioning

1.9 The NAO has not undertaken a value for money study focused solely on healthcare commissioning. Nevertheless, healthcare commissioning has featured in many of our value for money reports on health services. These reports have highlighted weaknesses, at PCT level, in all three stages of the commissioning cycle: strategic planning (Figure 1); procuring services (Figure 2); and monitoring and evaluation (Figure 3).

**Figure 1**

#### NAO FINDINGS ON COMMISSIONING—STRATEGIC PLANNING

<i>Issue identified</i>	<i>Report area</i>
Insufficient use was made of available data in planning activity	Mental Health <sup>19</sup> Autism <sup>20</sup>
PCTs lacked adequate knowledge of local needs	Services to reduce alcohol harm <sup>21</sup> End of life care <sup>22</sup> Autism Dementia <sup>23</sup> Rheumatoid arthritis <sup>24</sup>
Poor understanding of costs related to addressing issue	End of life care National Chlamydia Screening Programme <sup>25</sup>
Insufficient use of cost benefit analysis	Services to reduce alcohol harm End of life care
PCTs lack clinical evidence to commission services effectively	Rheumatoid arthritis

Source: National Audit Office reports

<sup>19</sup> *Helping people through mental health crisis: the role of crisis resolution and home treatment centres*, Report by the Comptroller and Auditor General, HC 5 Session 2007–08.

<sup>20</sup> *Supporting people with autism through adulthood*, Report by the Comptroller and Auditor General, HC 556 Session 2008–09.

<sup>21</sup> *Reducing alcohol harm: health services in England for alcohol misuse*, Report by the Comptroller and Auditor General, HC 1049 Session 2007–08.

<sup>22</sup> *End of life care*, Report by the Comptroller and Auditor General, HC1043 Session 2007–08.

<sup>23</sup> *Improving services and support for people with dementia*, Report by the Comptroller and Auditor General, HC 604 Session 2006–07.

<sup>24</sup> *Services for people with rheumatoid arthritis*, Report by the Comptroller and Auditor General, HC 823 Session 2008–09.

<sup>25</sup> *Young people's sexual health: the National Chlamydia Screening Programme*, Report by the Comptroller and Auditor General, HC 963 Session 2008–09.

**Figure 2**

NAO FINDINGS ON COMMISSIONING—PROCUREMENT

<i>Issue identified</i>	<i>Report area</i>
Fragmented procurement activities not realising scales of economy	National Chlamydia Screening Programme
Poor understanding of costs of activity	Services to reduce alcohol harm End of life care
Limited benchmarks to guide PCT spending	National Chlamydia Screening Programme National Chlamydia Screening Programme

Source: National Audit Office reports

**Figure 3**

NAO FINDINGS ON COMMISSIONING—MONITORING AND EVALUATION

<i>Issue identified</i>	<i>Report area</i>
Poor understanding of whether services provided achieve value for money	Services to reduce alcohol dependence End of life care
Impact of activity not assessed adequately	National Chlamydia Screening Programme
Lack of influence over providers	National Chlamydia Screening Programme
No reliable method in place to measure predicted benefits	National Chlamydia Screening Programme

Source: National Audit Office reports

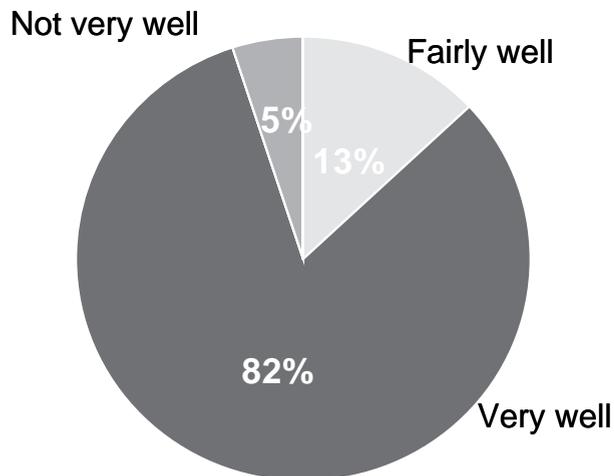
PART : RESULTS OF THE TELEPHONE SURVEY

*The current state of commissioning*

2.1 Primary Care Trust (PCT) commissioners were asked to comment on how well commissioning, in its entirety across the PCT, is going at the moment (Figure 4). Almost all of the commissioners (95%) stated that commissioning is going very well or fairly well. No respondents perceived commissioning across the PCT to be going not at all well.

**Figure 4**

HOW WELL IS COMMISSIONING GOING IN ITS ENTIRETY ACROSS THE PCT?

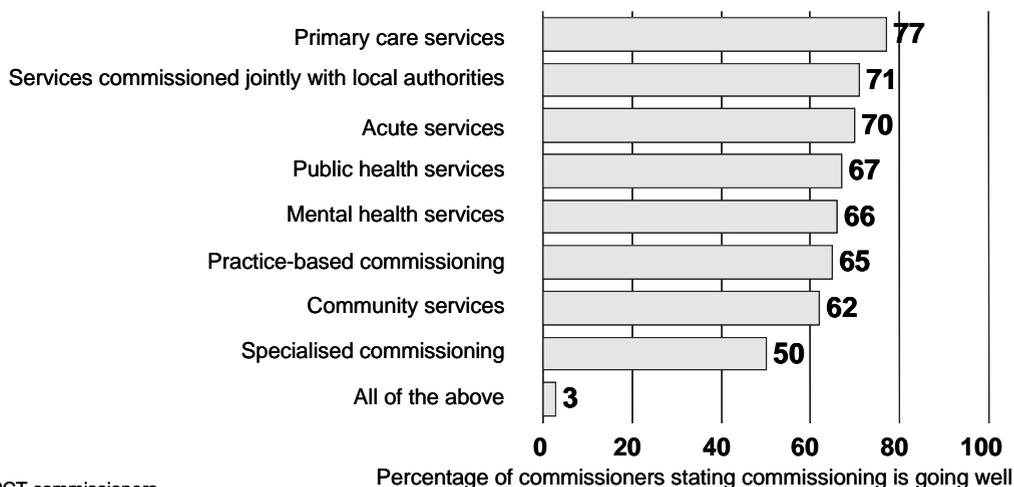


Base: 114 PCT commissioners

Source: National Audit Office analysis of telephone survey with PCT commissioners

2.2 PCT commissioners were asked to comment on which areas of commissioning are going well (Figure 5). More than six in ten commissioners thought it was going well in each area of commissioning apart from specialised commissioning, where 50% thought it was going well. Only three per cent of commissioners thought that it was going well in all areas.

**Figure 5**  
AREAS OF COMMISSIONING THAT ARE GOING WELL



Source: National Audit Office analysis of telephone survey with PCT commissioners

*The main challenges faced by PCT commissioners*

2.3 PCT commissioners were asked to identify the three main challenges they faced when commissioning services in their PCT. Figure 6 displays the challenges most frequently mentioned by commissioners. When listing their major challenges, 40% of commissioners cited financial pressures and constraints as their first major challenge. Commissioners mentioned a wide range of challenges—individual challenges cited by less than 5% of respondents made up almost one-third (33%) of the total responses. Some of the other challenges cited are highlighted in Figure 7.

**Figure 6**  
THE MAIN CHALLENGES FACING PCT COMMISSIONERS



Source: National Audit Office analysis of telephone survey with PCT commissioners

**Figure 7**  
OTHER KEY CHALLENGES FACED BY COMMISSIONERS

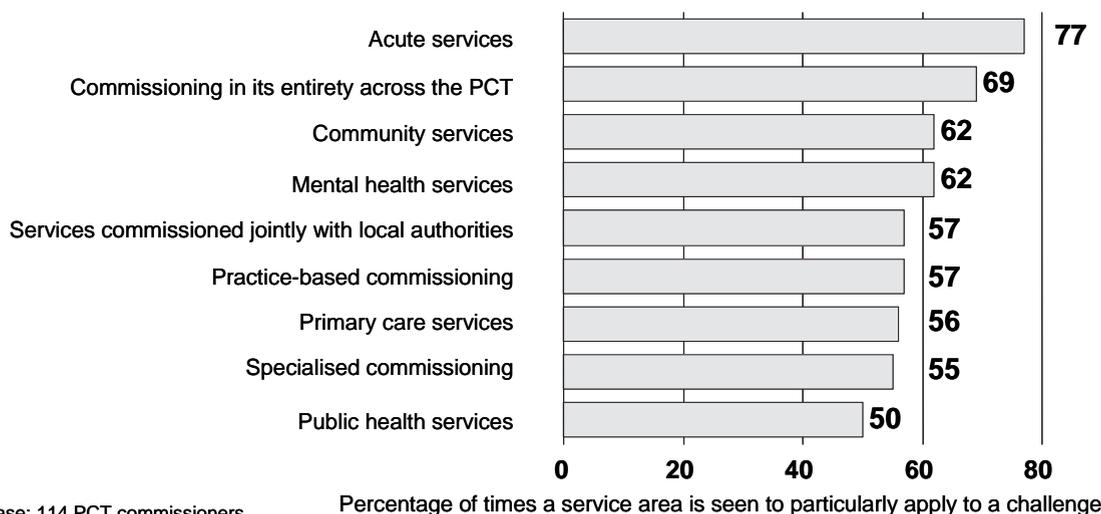


Source: National Audit Office analysis of telephone survey with PCT commissioners

2.4 Our focus group, established to explore the results of the survey, supported these as the key challenges facing commissioners and commented that many of the challenges were inter-linked. For example, the focus group participants noted that tackling the top challenge, financial pressures and constraints, will require action in the area where the majority of the commissioning budget is spent, which is acute services (the second most frequently cited challenge), which will require engagement with clinicians (the third most frequently cited challenge). Another inter-related theme identified by the focus group was knowledge management and prioritisation—the availability and quality of information and how it is used to drive service improvements. The focus group also noted that these issues also relate to skills and capacity.

2.5 For each of the key challenges identified, commissioners were asked to identify which commissioning areas the challenge particularly applied to (Figure 8). Over three-quarters (77%) of the challenges mentioned apply to acute services and 69% apply to commissioning in its entirety.

**Figure 8**  
THE COMMISSIONING AREAS WHERE THE KEY CHALLENGES ARE FACED



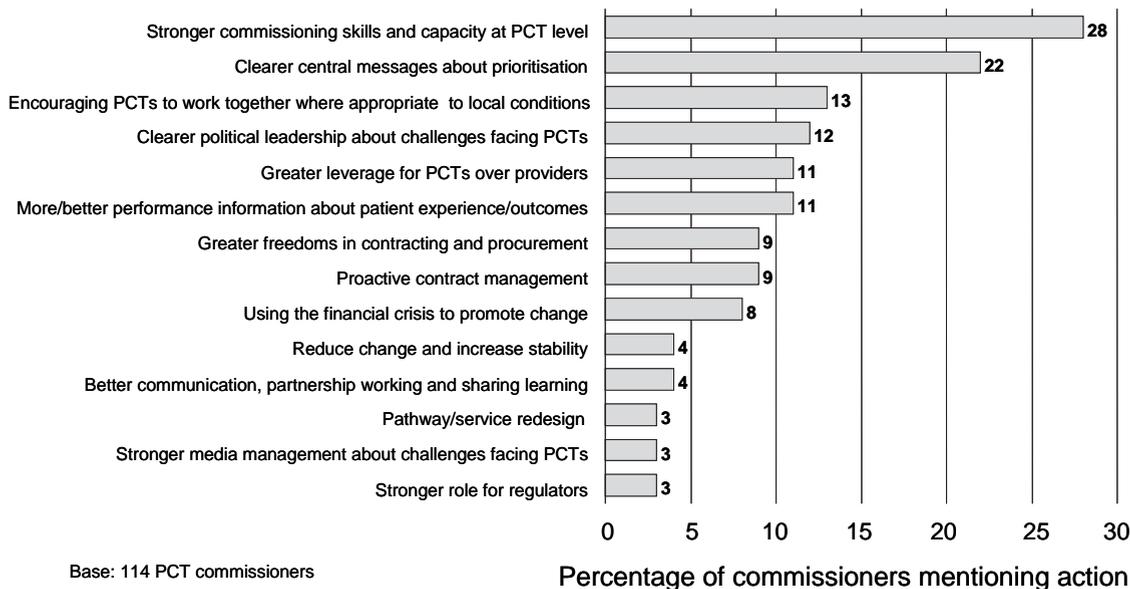
Source: National Audit Office analysis of telephone survey with PCT commissioners

2.6 PCT commissioners were asked to comment on whether there were any commissioning challenges that are specific to their local circumstances that were not covered in the previous questions. Although individual commissioners identified a number of challenges that were specific to their local circumstances, most of these had already been cited by other commissioners under the three key challenges. Local challenges not mentioned as one of the three key challenges were local population changes, such as an ageing population or an increasing ethnic minority population, and the PCT not being coterminous with their local authority.

*Key actions to overcome the challenges identified*

2.7 PCT commissioners were asked to identify what actions would be most helpful to them to overcome each of the three challenges identified earlier. Figure 9 displays the most frequently cited actions. Other actions mentioned, not presented in Figure 9, accounted for 18% of all the actions cited. Figure 10 displays some of these other actions.

**Figure 9**  
**KEY ACTIONS TO ADDRESS THE CHALLENGES FACED BY PCT COMMISSIONERS**



Source: National Audit Office analysis of telephone survey with PCT commissioners

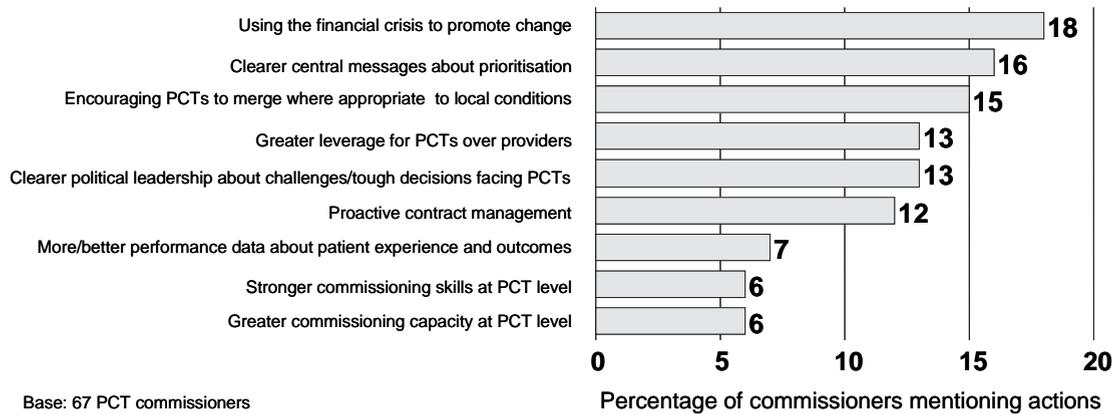
**Figure 10**  
**OTHER ACTIONS IDENTIFIED BY COMMISSIONERS TO ADDRESS THE CHALLENGES THEY FACE**



Source: National Audit Office analysis of telephone survey with PCT commissioners

2.8 Figure 11 displays the most frequently mentioned actions to address the most common challenge—financial pressures and constraints.

**Figure 11**  
**KEY ACTIONS TO ADDRESS THE MOST COMMON KEY CHALLENGE—FINANCIAL PRESSURES AND CONSTRAINTS**

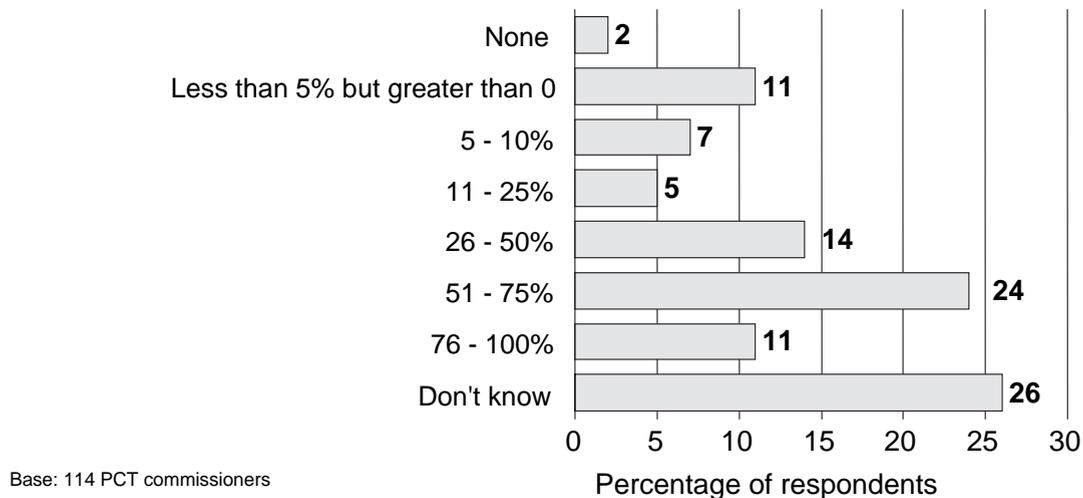


Source: National Audit Office analysis of telephone survey with PCT commissioners

*Practice-based commissioning*

2.9 PCT commissioners were asked to identify approximately what proportion of their PCT’s total commissioning budget is directly determined by practice-based commissioning (Figure 12). There is a wide variation in the proportion that commissioner reported. Our subsequent focus group to discuss the survey finding suggested that this wide variation reflected the fact that PCTs are at different stages of development with their practice-based commissioning function.

**Figure 12**  
**PROPORTION OF PCT’S COMMISSIONING BUDGET SPENT ON PRACTICE-BASED COMMISSIONING**

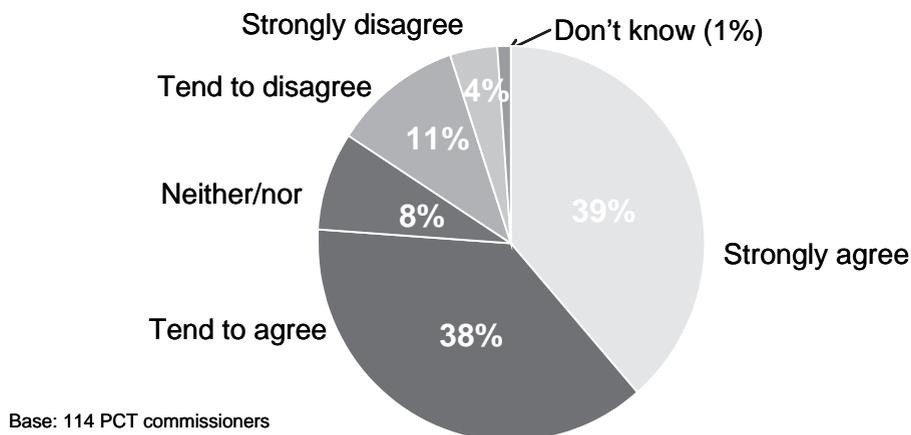


Source: National Audit Office analysis of telephone survey with PCT commissioners

2.10 PCT commissioners were asked to comment on the extent to which they agreed or disagreed with the statement “My PCT is well placed for practice-based commissioning to take on a more prominent role in commissioning local health services” (Figure 13). Over three-quarters of commissioners (77%) tended to agree or strongly agreed with the previous statement, with 15% tending to disagree or strongly disagreeing.

**Figure 13**

“MY PCT IS WELL PLACED FOR PRACTICE-BASED COMMISSIONING TO TAKE ON A MORE PROMINENT ROLE IN COMMISSIONING LOCAL HEALTH SERVICES”



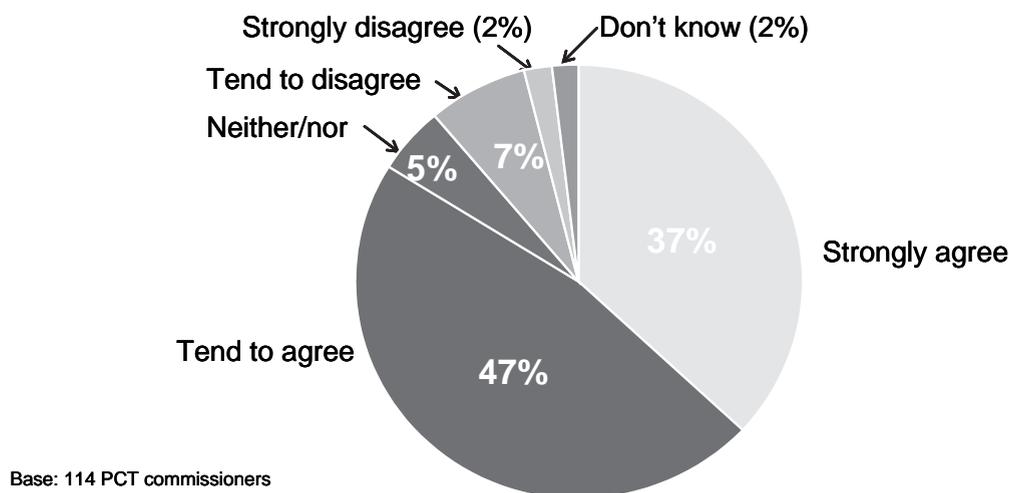
Source: National Audit Office analysis of telephone survey with PCT commissioners

#### World Class Commissioning

2.11 PCT commissioners were asked to comment on the extent to which they agreed or disagreed that World Class Commissioning has made their PCT more effective at commissioning local health services (Figure 14) and whether World Class Commissioning had delivered measurable benefits to patients in their PCT (Figure 15). More than four in five (84%) commissioners strongly agreed or tended to agree that it has made their PCT more effective at commissioning health services, of which more than one in three (37%) strongly agreed. Less than one in ten disagreed (9%), whilst 7% either don't know or neither agreed nor disagreed. The majority of commissioners also agreed that World Class Commissioning has delivered measurable benefits to patients (61%). However, 18% disagreed and 22% either don't know or say they neither agreed nor disagreed. This indicates that two in five commissioners are yet to see measurable benefits from World Class Commissioning for patients.

**Figure 14**

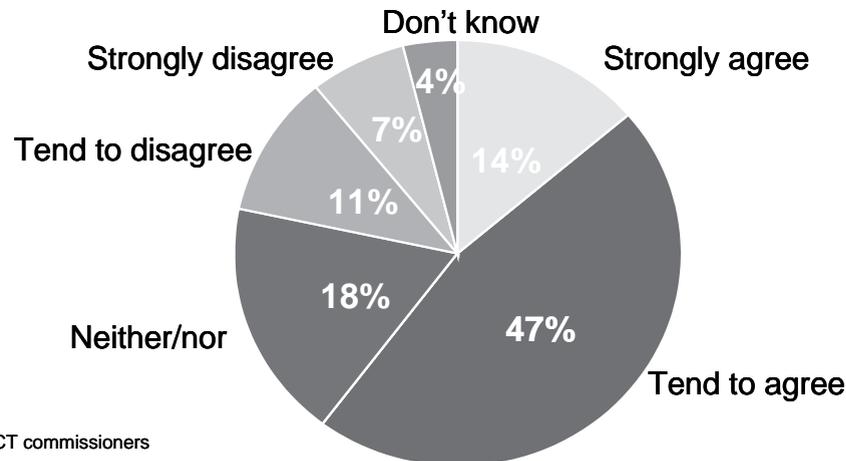
“WORLD CLASS COMMISSIONING HAS MADE YOUR PCT MORE EFFECTIVE AT COMMISSIONING LOCAL HEALTH SERVICES”



Source: National Audit Office analysis of telephone survey with PCT commissioners

Figure 15

“WORLD CLASS COMMISSIONING HAS DELIVERED MEASURABLE BENEFITS TO PATIENTS IN YOUR PCT”



Source: National Audit Office analysis of telephone survey with PCT commissioners

2.12 PCT commissioners were also asked to comment on whether they had changed what they do as a result of World Class Commissioning. Commissioners generally responded that the policy has had a positive impact. Key positive themes emerging from their comments (see Figure 16) were:

- a greater focus on outcomes;
- increased collaboration;
- more emphasis on commissioning skills;
- meeting patients needs; and
- improved systems and processes, and re-organisation where necessary.

Figure 16

POSITIVE COMMENTS FROM COMMISSIONERS ON HOW THEY HAVE CHANGED WHAT THEY DO AS A RESULT OF WORLD CLASS COMMISSIONING

#### A greater focus on outcomes

- “WCC helped us at a strategic level to become more focused on what we have to achieve and to decide what we as an organisation will focus overall our efforts and funds on.”
- “We’ve become more much more focussed. We are commissioning against the competencies so it gives us much more clarity and leverage and given us more status and authority with our providers.”
- “It focuses us more on outcomes rather than just on number crunching.”
- “There’s been more of a focus on outcomes and of stakeholder engagement and an increasing ability to manage providers.”

#### Increased collaboration

- “I think we have become more aware of the wider implications of our actions and the need to involve and collaborate on a wider stage.”
- “We have extended our partnership work with the whole health and social care community and we have focused more closely on developing PBCs and supporting them so that they can form their own consortium.”

#### More emphasis on commissioning skills

- “There is more emphasis on needs assessment and more emphasis on the skills required in order to deliver WCC.”
- “We’ve got more focus on ensuring the appropriate commissioning skills within the staff and also increased focus on outcomes.”
- “We’ve got better procurement processes in place and better contracting in place.”

### Meeting patients needs

- *“There’s a lot more awareness of following a process that focuses on and identifies patient need and enhancing and changing services as a result.”*
- *“We are looking objectively at where we can make changes and work more closely with patients and meeting their needs.”*
- *“WCC changed the way we engage with our community and particularly the public. We are much more active in public engagement and WCC has really embedded clinical engagement as part of the normal business of the PCT.”*

### Improved systems and processes and re-organisation where necessary

- *“We’ve become much more structured and use competencies to understand good practice.”*
- *“We have made some changes to some of our systems and to some of our processes and made a lot of progress in engaging with the public in a more systematic way.”*
- *“We have improved the systems and processes that underpin commissioning.”*
- *“I think there is a more rigorous and systematic deployment of commissioning techniques across the whole commissioning agenda.”*
- *“We much more focused on market management and the procurement of clinical services as an area.”*
- *“Far more strategic and structured in the way we approach our services around assessing needs and priorities.”*

Source: National Audit Office analysis of telephone survey with PCT commissioners

2.13 Although the majority of comments were positive, there were a number of more mixed responses highlighting a number of concerns with World Class Commissioning (Figure 17). Examples include views that World Class Commissioning is just a tick box exercise and that the World Class Commissioning assurance process takes time to complete when there are other things staff could be getting on with.

**Figure 17**

### NEGATIVE COMMENTS FROM COMMISSIONERS ON HOW THEY HAVE CHANGED WHAT THEY DO AS A RESULT OF WORLD CLASS COMMISSIONING

- *“The negatives have been very much around this assurance process. We’ve just finished the assurance process submission and it’s taken a number of people over three or four months, when there are other things they could be getting on with.”*
- *“There is a danger with all the pressure put on us with WCC that it can slow the process down and time is of the essence at the moment given current financial situation.”*
- *“My take is WCC is regarded as an assurance process first and foremost and may have changed ways individuals operate but in itself it hasn’t had the radical effect it might have done in commissioning process.”*
- *“Working on a day to day level as we do I can say that it has had little effect on my day to day work.”*
- *“Highlighting the gaps in the system its often short-termist and that causes problems as we don’t know how real it is. ie we don’t know if we are doing this [WCC] just because we have to or because its better.”*
- *“We’ve looked at the competencies and the actions we’ve taken to address these competencies and where there are gaps whether that translates to benefits to patients the jury is out.”*
- *“I think WCC isn’t inherent in everything we do. It’s not within us it is a process which is added afterwards, so at the end of the year we are trying to find proof of how we have done it. In fact it should be the other way round so we should be including it in everything we do... we have only been doing it for a couple of years so it is too early to have it as part of our culture just yet—a lot of our processes have changed recently but that is more through audit than WCC.”*
- *“[WCC] has felt like a tick box exercise to show you have that competency. I would question the value of the competencies and sub competencies as some of the sub competencies are not good value for money and increase costs.”*

Source: National Audit Office analysis of telephone survey with PCT commissioners

February 2010

## Memorandum by MEND (COM 120)

### COMMISSIONING

#### EXECUTIVE SUMMARY

MEND has provided evidence based primarily on our direct experience of child weight management commissioning by PCTs and DH. We believe that these observations have resonance in other areas. We would also like to emphasise that this evidence is not intended to be an exercise in blame. PCT management and staff have had much organisational, cultural and process change foisted upon them in an uncoordinated, inconsistent and unclear manner. They have received insufficient instruction, guidance, training and support in many fundamental areas. The consequences of implementing several changes of such significance across the complex PCT landscape have not been well thought through. Thus there are questions over both the desirability of several recent changes and how to remedy their poor implementation. This evidence is submitted in the hope that it can shed some light on areas that currently face challenges—as well as identify some potential recommendations for improvement.

Current commissioning arrangements in the field of child weight management are inefficient, ineffective and characterised by limited accountability. The result is that theoretically allocated public expenditure is having limited impact against intended targets. In 2008–09 the unringfenced Healthy Weight, Healthy Lives budget for PCTs was £65.9 million, with a stated policy focus on child weight management. However, we estimate that only a maximum of £6–10 million worth of child weight management services were commissioned in that period, clearly illustrating a failure of commissioning and offering lessons for improvement.

Some relatively simple steps can begin to address some of the issues and make some rapid improvements in commissioning. Reversing some of the structural changes should be considered—balancing this against the capacity and morale for yet another organisational change. Finally, we believe that there is the opportunity to trial new light-touch methods of commissioning at low risk in the field of child weight management—with significant implications across many areas of chronic disease management if successful. It appears possible to cut the Gordian knot of PCT commissioning whilst improving value for money and service provision and avoiding yet another fundamental restructuring.

#### INTRODUCTION

Evidence is submitted to inform the Committee's Inquiry on the following points:

1. World Class Commissioning—what does this initiative tell us about how effective commissioning by PCTs is?
2. Has the purchaser/provider split been a success and is it needed?
3. Commissioning for the quality and safety of services.

No comment is made on commissioning; commissioning and “system reform”, or specialist commissioning.

#### CONTEXT

MEND is a social enterprise which grew from research at the Institute of Child Health, University College London and Great Ormond Street Hospital NHS Trust to provide clinically-effective, scalable, responses to childhood obesity.

MEND's family-based behaviour-change programmes are delivered from leisure centres, schools, football clubs and other community venues. Services are delivered in partnership with local organisations from over 300 locations across the UK as well as in the United States of America, Australia, New Zealand and Denmark. Currently, MEND is the world's largest provider of community-based child weight management services.

The public health services provided by MEND are commissioned by Primary Care Trusts and Local Authorities. They are also sponsored by charitable and corporate donors.

The following evidence is informed by our experience of providing child weight management services since 2004. If required, specific examples can be provided to substantiate all the following evidence.

#### EVIDENCE

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

1.1 In our experience within the child weight management commissioning field, World Class Commissioning offers very little to demonstrate the effectiveness of PCT commissioning. Elements of the World Class Commissioning competencies are frequently cited in conversation and service specifications. However, our impression is that they are used as buzzwords rather than being a means of driving improvements in commissioning and service provision.

1.2 Some of the 11 World Class Commissioning competencies are encouraging ineffective and inefficient commissioning practices. Consequently, performing well against the competencies does not necessarily provide an indication of efficient commissioning. For example:

- 1.2.1 *Competency 6—“prioritise investment of all spend”*: in its current form, this competency does not sufficiently hold PCTs to account for the timing or quality of their prioritisation. In the last year there have been several examples of PCTs running full and costly tendering processes which have then been annulled (at various stages but often at the end of the process) due to financial constraints or reprioritisation. Whilst prioritisation is occurring, its timing is sometimes detrimental to commissioning effectiveness and is costing the PCTs and providers excessive amounts of time, money and goodwill. This is particularly problematic for small and medium sized providers who have a valuable role to play in providing services to the NHS.
- 1.2.2 *Competency 7—“stimulate the market”*: formal tendering is commonly used as a response to this competency even when the value/scale of the service does not warrant this approach. This means that some PCTs (and any bidders) spend disproportionate amounts of staff time and other costs on tendering for services that could have been (and used to be) commissioned more efficiently through other means. Full tender processes over several months have been followed for contracts worth less than £50,000. This competency is also intended to encourage dialogue and engagement with providers yet it is still common for PCTs to launch formal tender processes without offering any opportunity for discussion that could aid development of the service specification. In the child weight management field this is exacerbated by a DH Framework Contract that does not allow for any provider dialogue during the tender process. Since the advent of World Class Commissioning and the DH Framework Contract we believe that the market for child weight management services has shrunk. This is a complex issue. If the process is too complex or burdensome then busy commissioners without appropriate resources, support or training will not prioritise the area.
- 1.2.3 *Competency 9—“secure procurement skills”*: as procurement resource remains in short supply, some PCTs are sourcing this support from staff working in other NHS or public sector organisations (eg acute Trust, local council). Whilst this approach may satisfy some of the competency requirements, it does not necessarily improve commissioning efficiency or performance. In many cases, these procurement staff do not understand PCT commissioning requirements and do not have the right knowledge to properly advise their PCT clients. Examples include the provision of bidder response templates that do not allow for like comparison of bidders, service specifications that illustrate a lack of understanding of appropriate solutions and the withholding of the likely budget range for a new service. The lack of budgetary information is one reason why tender processes are annulled following bid submission. PCTs have been unrealistic about the cost of meeting their service specifications and provider offers are above their budget so they abandon the whole process. This puts the quality of services at risk and increases both the costs of commissioning and the risk of annulling the process. This is despite the costs of such services being in the public domain through the Cross Government Obesity Unit (“CGOU”) Framework Contract. A minority of PCTs disclose their budget and this impacts positively on the duration of the tender process and the likelihood of a contract award.

### 1.3 Recommendations:

- 1.3.1 Provide guidance to PCTs on minimum contract size/value required for the tendering route to be viable and cost-effective.
- 1.3.2 Provide guidance to PCTs and/or mandate increased joint commissioning between PCTs to ensure that tenders are of sufficient size to be viable for both PCTs and providers.
- 1.3.3 Issue further guidance on disclosing the budget that a PCT has available for a particular service in a formal tender situation in order to minimise the risk that PCTs receive offers that are completely unaffordable and beyond the scope for negotiation.
- 1.3.4 Provide guidance on the benefits of and how to engage effectively with providers prior to and during a tender process (for example, through greater use of the “Invitation to Participate in Dialogue” phase).
- 1.3.5 If deemed necessary as a stop-gap identify ways that PCTs can commission such services without resorting to the full tender process.

## 2. *Has the purchaser/provider split been a success and is it needed?*

2.1 In our view the purchaser/provider split has not been a success, particularly at smaller PCTs. We believe that not only is it not required but in many cases the split is detrimental to value for money, efficient procurement and rapid implementation. In our area of expertise the split is rarely needed. If the split is to become efficient a significant organisational change and training programme is required at PCT level—nationally.

## 2.2 The provider/purchaser split appears to be both theoretically flawed and poorly executed:

2.2.1 Theoretical flaws: The primary rationale appears to be based on the principle of “creating a market” and competition with all the supposed benefits that follow from such constructs eg transparency of information, efficient commissioning, competition, reduced prices and product/service innovation. The secondary justification was the observation that some PCTs were abusing their combined role to either exclude third party providers or to provide a poor level of service at an above market cost. The first is a theoretical construct that has been shown to be invalid (to a disastrous degree) even in financial markets. It is also optimistic at best to assume that a structural change, with little associated cultural change or training programme, personnel change or central support will facilitate a market and competition. In fact, when replicated in principle (but with different forms) 150 times around the country with no such clear guidance and control the result is an expensive mess with no standardisation and very low levels of transparency of information. The most widespread training seems to have been around the principles and process of World Class Commissioning, resulting in an at-best translucent market with imperfect information flows further constrained by cumbersome bureaucratic processes for even small contracts. We believe that despite the provision of significantly more funds the value of commissioned child weight management services has shrunk since 2007–08. Finally, a whole new management and overhead structure is required to lead and support new provider organisations. We do not dispute the second observation—namely that some PCTs may have abused their combined position,—but neither do we agree that the chosen solution is either justified or optimal.

2.2.2 Poor execution: Whatever the conclusion about the theoretical need for such a split it has clearly been poorly managed and supported. PCT procurement has long had a poor reputation. To take the competence which is largely held in low regard internally and externally and make a fundamental structural adjustment to ensure that it is THE key function of PCTs going forward is a strange management decision. Hard pressed PCT staff have not been given appropriate central guidance or training with the result that there are a large number of different models with varying levels of competence across functions.

## 2.3 The split has not been implemented consistently—geographically or by function.

2.4 Smaller PCTs in particular have struggled to manage the split effectively due to small numbers of staff in relevant teams. Consequences include poor commissioning practices, significant delays due to double commissioning (in the case of child weight management services this means first buying the training and programme resources and then separately buying a delivery team), increased costs (as the process is more bureaucratic so informal networks cannot be leveraged as effectively as previously) and poor value for money (VFM).

2.5 To ensure the continued existence of the provider arm—or parts that are spun off—the commissioning body will often have to pay more for service delivery—especially in the early stages. As a result VFM is impacted.

2.6 PCT commissioners have passed commercially sensitive information from potential suppliers to PCT provider arms.

2.7 As PCT provider arms often inform the design of service specification for tenders, they have an unfair advantage over non-PCT providers. Service specifications are sometimes designed so that they can only be implemented by local providers.

2.8 If all PCTs were to commission child weight management services on average once every two years and current commissioning practices continue we estimate that the commissioning costs ALONE would amount to £2–6 million per annum.

## 2.9 Recommendations:

2.9.1 Training: There is an urgent need for training in the basics, such as how to commission a service not a product, how to assess value for money, basic MS Excel skills.

2.9.2 Consider the establishment of central procurement hubs/centres of excellence which focus on specific conditions/service areas, such as child weight management, and so can understand the complexities of services, the need for localisation and also optimise value for money through bulk procurement. This mitigates the need for replicating the same capabilities, with very variable abilities, 150+ times at each PCT. Commissioning should improve, localisation should improve and costs should reduce.

2.9.3 Strongly consider reversing the provider/purchaser split, with the associated disruption this would cause, and provide clear guidelines, training and central support for commissioning and a rigorous and transparent audit/complaint handling “watchdog” with sufficient powers to make changes and reverse poor decisions.

2.9.4 Provide clear (binding?) guidance for newly formed PCT provider arms—for example to prevent them developing new interventions if it would be more cost and clinically effective to train their staff in the delivery of a proven programme

### 3. *Commissioning for the quality and safety of services*

3.1 Guidance for commissioners produced by the CGOU and the National Obesity Observatory (“NOO”) that should support quality and safety standards has often not informed service procurement. Primary outcomes of tenders, and even the basis of payment on results, have included those that are contra-indicated by NOO, NICE and experts in the field—and are actually potentially harmful eg weight loss for children

3.2 The pressure on PCT provider arms to become self-sufficient as legal entities encourages unnecessary in-house service development (precisely the poor VFM behaviour that justified the spilt) which does not necessarily take account quality and safety and published standards such as the National Obesity Observatory Standard Evaluation Framework for Weight Management Interventions.

3.3 At considerable expense, the CGOU established a Framework Contract and associated Panel of Approved Suppliers so that PCTs could commission child weight management services efficiently at scale without the need to conduct a full OJEU process on each occasion. Although a good concept, execution of this Framework even at DH level with all associated experience and resources was fundamentally flawed:

- 3.3.1 “Value for money” was the first stated objective. However, the health outcomes of each provider’s service offerings were only requested after an in-principle decision on the panel had been made. At no point was financial information collected in a comparable format. Thus we do not believe it was possible to assess value for money.
- 3.3.2 Another stated intent was to accelerate the PCT commissioning process, ideally allowing a call-off contract with local variations to be agreed within 4–6 weeks. A combination of the poor quality of the Framework, poor local understanding of the documents and process and the purchaser/provider split has led to an elapsed period at least 6 months from start of tender process to contract signature.
- 3.3.3 Commercial Department representatives on the CGOU assessment panel showed a poor understanding of both the subject and how to commission a service—as opposed to a product.
- 3.3.4 CGOU’s legal counsel had a poor grasp of requirements, resulting in an inappropriate and inflexible contract causing suppliers aggravation and reflecting neither the stated needs of PCT commissioners, NOO guidance nor academic evidence.
- 3.3.5 Since the Framework’s inception in April 2009, uptake has been low (six PCTs, one of which annulled the tender process after appointing a preferred bidder due to financial constraints). Some PCTs chose to procure services outside this Framework.

3.4 Services which are not clinically validated and which offer neither proven health outcomes nor value for money, are still being procured by PCTs in favour of alternatives which are evidence-based. This is partly due to the purchaser/provider split which puts pressure on the newly formed provider arms to become self-sustaining enterprises. In the child weight management field, many Providers are launching pilot programmes (which can run for an indefinite period) which receive very little scrutiny on safety and quality and do not comply with published standards.

3.5 Despite clear evidence that poorly designed child weight management services can cause children and young people to develop eating disorders and other psycho-social problems, this has received limited, if any, attention within the commissioning process. This relates to the need for ongoing monitoring and evaluation or to any evidence that particular services have demonstrated a good safety record. Such negative consequences not only impact on service users but also the value for money of the proposed service since additional treatment costs are incurred in a percentage of cases but not costed into the tender.

#### 3.8 Recommendations:

- 3.8.1 In response MEND and partners have developed an alternative model to procure child weight management services. This approach supports improved quality and safety standards as it encourages efficient commissioning, value for money, accountability and payment by results, as well as delivering measured health outcomes in line with NICE and NOO recommendations. It also allows for commissioning on an “industrial scale” as recommended by Lord Darzi. We would be happy to discuss this in more detail if this is of interest to the Committee. We believe that this approach has widespread application outside of child weight management.

MEND thanks the Committee for the opportunity to respond to the Inquiry and would be happy to contribute further detail if required.

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**Memorandum by John Ford Esq (COM 121)**

COMMISSIONING

I am writing to you in your capacity as a member of the Select Committee looking into health care commissioning. Unfortunately I was unaware of the Select Committee's topic for enquiry until recently and I appreciate that the deadline for written submissions has long passed.<sup>26</sup>

However, as it is a topic about which I feel strongly I thought I would write to you in case it was of any use to you in your contribution to the work of the Committee. I hope that you do not mind me writing as I am obviously not a constituent of yours. It is fortuitous that you are the nearest Member geographically but also one with direct experience of the NHS.

Until 15 months ago I was an Executive Director in a PCT and have held Board level posts in various PCTs with both commissioning and providing roles.

I have witnessed the rise of commissioning since I joined the NHS in the early 1990s. It has been a "covert" development from the inception of the original commissioner—provider split and the advent of Health Authorities. In the mid '90s there was a national limit on bureaucracy (£ per head of population) that was monitored but since then the growth has been unchecked.

A PCT with over half a million population might have over 300 staff (including public health). On a very rough estimate of an average salary of (say) £35,000 plus on costs this gives a cost of £10 million. Multiplying up for the UK then one is looking at the order of £1 billion. No doubt you will have been given figures.

Is there any evidence that all this investment in bureaucracy is worth it?

My thoughts are:

Most advances in the standards of service delivery have arisen from central commissioners, not PCTs or their predecessors. This started back in the 90's when National Service Frameworks were introduced because Health Authorities were failing to raise standards in mental health and CHD etc.

This reliance on central rather than local commissioning has continued through the last decade with the introduction of waiting time targets, NICE Guidance and Standards for Better Health. Local commissioners were unable to innovate and implement local standards on any comparable scale.

Local commissioners spend significant amounts of time deliberating on individual patient access to treatments that are not normally funded—eg: specialist Cancer drugs etc—creating bureaucracy and a post code lottery. Again this would be better dealt with through national policy—it is a national health service!

Local commissioning has not protected local services. Political pressure and community activists have protected services (as you well know!).

The balance of clinical expertise lies largely with acute trusts and that is where the power lies. This is demonstrated by the lack of any major shift to primary and community care despite it being national policy and unprecedented growth.

Numerous commissioner training events have endorsed the principle to review the use of 100% of the budget; not just the growth element. In reality the developments that have been achieved have used annual growth—not too difficult given the unprecedented growth in recent times.

PCTs are essentially "middle men". When an Ambulance Trust, for example, misses its Category A target, the Department of Health leans on the SHA Chief Exec who leans on the PCT Chief Exec who leans on the Ambulance Trust Chief Exec who has to sort the problem out!

World Class Commissioning has been introduced because it was realised that local commissioning was achieving very little. Because the problem of achieving value for money and strategic shifts in the NHS still exists does not mean that you have to try harder at a failed method!

Progress, where it has been made, has often been made with the addition of expensive consultancies. Even the Dept of Health FESC procurement programme (a list of preferred consultancies for PCTs for world class commissioning) designed to improve value for money includes national and international consultancies who are likely to be relatively high cost compared with NHS rates of pay.

Commissioners have ignored the substantial contract sums with primary care. PMS contracts came in over 10 years ago and I suspect that very few commissioners have actively managed those contracts since their inception to obtain better value and enhance the range of services

Primary care based commissioning has had various incarnations—initially Fundholding which produced significant changes in services in the community but at a high cost of supporting bureaucracy. Total fundholding, locality commissioning and PCGs all followed in their wake. Even Dr David Colin-Thomé was reported recently as referring to PBC as a corpse, before he had to clarify his response!

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<sup>26</sup> Sent to Dr Richard Taylor MP, a member of the committee, in the first instance.

My own observations are that practice based commissioning can work but only if there are clear gains (not necessarily profits) for GPs and minimal bureaucracy. How many times have we heard the cry: “Meetings, meetings, meetings”! My best example of successful PBC was a group of GPs determined to save their local community hospital and developed a plan to shift care from the acute sector and save the local health resource.

Salaries for PCT Chief Execs are now in the £ 100,000–£150,000 band. No doubt they would justify this by their budget responsibilities but in reality it is far simpler to manage commissioning budgets rather than provider budgets; it is the provider Trusts that have to deal with complexities

Despite various exhortations to manage salary increases this has had little effect on limiting expenditure middle and senior posts. Successive reorganisations and changes in priorities have led to frequent changes in roles with associated upgrades well in excess of inflation. Inspection of the adverts at the back of the Health Service Journal illustrates the point!

So what would I suggest:

- Rather than having huge local bureaucracies purporting to create local standards and unique service improvements, a sub regional contracting office is what is needed.
- Hence, abolition of PCTs in their current form (but I recognise the large redundancy costs that this would produce).
- Supplemented by centrally produced service profiles and specifications (which we already have to a large extent).
- Specialist services are already commissioned by specialist regional consortia—retain these.

I did look at the invitees to the recent hearings and noted that a number are serving senior employees of the NHS or the DoH. On the basis that turkeys do not vote for Christmas I thought I would offer you a minority view. My frustration arises from many years seeing clinical developments held back but commissioning bureaucracy continuing to develop.

*John Ford*

*February 2010*

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### **Memorandum by the Patients Association (COM 110)**

#### COMMISSIONING

##### *Executive Summary*

1.1 The Patients Association believes the Committee would gain useful insight into the ability of Primary Care Trusts to successfully commission services by reviewing the commissioning of out of hours care services. It would highlight concerns about the ability of Primary Care Trusts to commission safe and effective services for their local populations.

1.2 The Care Quality Commission publication *Care Quality Commission's Update on enquiry into Take Care Now and out-of-hours services* (2009) indicates this is a significant problem nationally.

1.3 Results from the national GP patient survey highlight the very wide variation in patient satisfaction with the service and FOI based research conducted by the Patients Association highlights further variation in cost and monitoring. This is also supported by research conducted by the Primary Care Foundation.

1.4 Commissioning of out of hours care is a useful indicator because PCTs were largely expected to commission the service from the same starting point, without being able to rely on simply referring to historical providers, as is done very frequently in the commissioning of secondary care services.

##### *Out of hours care*

1.5 There have been national concerns raised about ensuring PCTs commission safe out of hours care for a number of years (The Panel Report for the Serious Untoward Incident investigation into the death of Penny Campbell 2007) and recently highlighted by the death of David Gray in 2008.

1.6 We would refer the Committee to the *Care Quality Commission's Update on enquiry into Take Care Now and out-of-hours services* (2009) for consideration of further concerns around safe commissioning of OHC in general.

1.7 Much of the interest around the cases of poor out of hours care has surrounded the issue of eligibility of particular doctors to work in the service.

1.8 Whilst this is a valid and important concern we also feel that basic safety assurances should have been sought by PCTs as part of their duty to commission safe, high quality OHC on behalf of the local population.

1.9 The value of this issue is that it is a good example of a requirement of all PCTs to individually commission a service that needs to meet a variety of health needs in a variety of circumstances, without the ability to revert to historical providers (as is usually the case with secondary care) as a starting point.

1.10 Please see Appendix 1 for a summary of the result of research conducted by the Patients Association which highlights the wide variation in patient satisfaction found by the GP patient survey (Ev 169) and in spending (Ev 170) according to answers provided by PCTs to an FOI request.

1.11 As Appendix 1 highlights, the data provided by the FOIs has some *caveats* but its conclusions (in highlighting wide variations in spend) are also supported by research conducted by the Primary Care Foundation (ibid).

1.12 Of particular concern are answers given by a number of PCTs to questions relating to complaints and serious untoward incidents (Ev 172).

1.13 This variation in the quality of services would suggest a variation in the ability of PCTs to commission effectively. This is concerning and suggests much more research is required into the ability of PCTs to commission effectively if we are to be confident that they will be able to fulfil their role on behalf of local populations.

1.14 The ability of some or many PCTs to commission safely brings little comfort to patients that have a local PCT that is ineffective.

March 2010

## APPENDIX 1

### Patients Association Out of Hours—Postcode Lottery in Patient Care, Interim Findings Factsheet

#### 1. INTRODUCTION

The Patients Association carried out a series of freedom of information act requests to PCTs around the issue of out of hours care and also analysed the results of the quarters 1 and 2 of the National GP Patient Survey 2009–10.

FOI results from 90 Trusts reveal that the average spend per head of the registered patient population was £9.00 but there was significant variation with the lowest spending less than £1.50 and the highest over £20.00.

Director of the Patients Association Katherine Murphy said:

“These figures aren’t an exact science. There will be some PCTs that didn’t do a very good job of negotiating their contracts or calculating what the service really costs them. Some PCTs will have large rural populations which can be more expensive. But common sense would tell you that this degree of variation is worrying—it is hard to understand how one PCT might be spending 16 times more on out of hours care than another. Similar variations were also found in research conducted by the Primary Care Foundation. It is vital that the Department of Health press on with reform in this area so we can have a much better idea of what service is being provided for what money. Participation in benchmarking must be mandatory and the results published as soon as possible. Then we’ll be more able to say what value for money is and when PCTs are scrimping on such a vital service. Local scrutiny is only effective if you know how well your local services are performing.”

Analysis of the results of the GP National Patient survey and revealed that in over a fifth of Trusts (33) one in six patients rate out of hours care as either poor or very poor. This represents an increase from the 2008–09 results (30) though comparisons are limited due to different survey methodologies. On average 13% of respondents rated the out of hours GP service as either poor or very poor, with figures ranging from as low as 7% to as high as 21%.

PA Director Katherine Murphy said:

“Once again, there is huge variation with more than double the number of patients rating the service as poor or very poor at the bottom of the table compared to the top. This is completely unacceptable. The postcode lottery of care has to stop.”

The Patients Association also asked Primary Care Trusts to tell us how many complaints their providers had received and how many Serious Untoward Incidents (SUIs) there had been related to out of hours care. five Trusts were unable to tell us how many complaints there had been and three were unable to tell us how many SUIs there had been.

“This is appalling. If you are paying for a service for patients surely the most important thing you should be doing is monitoring when people aren’t happy with the service. Every Trust should have this information readily available” she added.

#### 2. QUARTERS 1 AND 2 OF THE NATIONAL GP PATIENT SURVEY 2009–10

The National GP Patient Survey is commissioned by the Department of Health and conducted by IPSOS MORI and asks patients a range of questions about General Practice care including a number on out of hours care.

The Patients Association accessed the results of the survey specifically on out of hours care via the House of Commons Deposited papers library reference numbers DEP2010-0390 and DEP2010-0389 which can be accessed online through the following link: <http://deposits.parliament.uk/>

The full results of the survey can be accessed via the Department of Health GP Patient Survey website: <http://results.gp-patient.co.uk/report/main.aspx>

The Patients Association combined the percentage response rate for question 36 of the survey which is as follows:

*Rating of the care received from the out-of-hours GP service (Q36)*

Very good

Good

Neither good nor poor

Poor

Very Poor

Nationally 13% of patients that took part in the survey rated the out of hours GP service as either poor or very poor. The tables (below) highlight the lowest and highest percentage scores of Primary Care Trusts for this question where respondents selected poor or very poor.

**Figure 1.1**

**RECOMBINED RESULTS FOR PATIENTS RATING OUT OF HOURS GP SERVICE AS POOR OR VERY POOR**

<i>Primary Care Trust</i>	<i>Percentage rating out of hours care as poor or very poor (18% and above)</i>
Richmond and Twickenham PCT	21%
Hartlepool PCT	20%
Ealing PCT	20%
Hounslow PCT	19%
Tower Hamlets PCT	19%
Harrow PCT	19%
Herefordshire PCT	18%
Darlington PCT	18%
Wandsworth PCT	18%
Newham PCT	18%
West Essex PCT	18%
Surrey PCT	18%
Barnet PCT	18%
Lewisham PCT	18%

<i>Primary Care Trust</i>	<i>Percentage rating out of hours care as poor or very poor (8% and above)</i>
Halton and St Helens PCT	8%
Central Lancashire PCT	8%
Cumbria Teaching PCT	8%
Plymouth Teaching PCT	8%
Bath and North East Somerset PCT	8%
Warrington PCT	8%
Oxfordshire PCT	8%
Medway PCT	8%
Stockport PCT	8%
Doncaster PCT	8%
Torbay Care Trust	7%
North East Lincolnshire Care Trust Plus	7%
Wirral PCT	7%
Western Cheshire PCT	7%
Knowsley PCT	7%

(Source: IPSOS MORI National GP Patient Survey Q's 1 and 2 2009–10).

**3. FREEDOM OF INFORMATION ACT RESEARCH**

On 15 January 2010 the Patients Association sent the following freedom of information act requests to all Primary Care Trusts in England.

**Figure 1.2**

**FREEDOM OF INFORMATION ACT REQUEST QUESTIONS SENT TO ALL PRIMARY CARE TRUSTS IN ENGLAND ON 15 JANUARY 2010**

1. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 how many complaints were received by the PCT about the primary care out of hours service?
2. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 how many complaints (about the primary care out of hours service) were received by organisations contracted by the PCT to provide the primary care out of hours service?
3. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 how many serious untoward incidents were there that were classified as relating to the primary care out of hours service?
4. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 how much was spent by the PCT on the primary care out of hours service (if a multi year contract was used what was the average annual value of that contract for its duration)?
5. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 what percentage of calls to the out of hours service were classified as urgent?
6. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 in what percentage of calls to the out of hours service classified as urgent was the patient assessed within 20 minutes of the call being received?
7. In the financial years 2005–06, 2006–07, 2007–08, 2008–09 what was the population size of the PCT?

The Patients Association received a very wide range of responses to our requests. Unfortunately a small number of Trusts did not respond in any way or stated that they could not supply us with the information because to do so would be too costly. An even greater number sent us responses past the legal requirement to respond within 20 days.

To provide some interim results the Patients Association collated the responses of all those Trusts that had provided spending figures in 2008–09 which totalled 90 organisations.

As the request for population figures received a low response rate we instead used the population figures provided by the NHS Information Centre to provide a basis for calculating a spend per person in the Primary Care Trust regions. These figures can be downloaded from the following website: <http://www.ic.nhs.uk/statistics-and-data-collections/population-and-geography/gp-registeredpopulations>

Please note that these figures do not give any weighting to density of population or the nature of the PCT (eg rural, urban). They also do not account for variations in population figures compared to the registered population. As such their use as absolute indicators of spend is limited, however the large variation in spend has also been highlighted by other research done by the Primary Care Foundation which found ranges of spend from less than £5.00 per head and more than £15 per head: <http://www.primarycarefoundation.co.uk/page1/page31/page21/files/EXAMPLE%20Report%20Round%202.pdf>

**Figure 1.3**

**10 HIGHEST AND LOWEST SPENDS ON OUT OF HOURS CARE PER HEAD OF REGISTERED PATIENT POPULATION 2008–09 (BASED ON ANSWERS RECEIVED FROM 90 PRIMARY CARE TRUSTS BY THE PATIENTS ASSOCIATION IN RESPONSE TO FREEDOM OF INFORMATION ACT REQUESTS AND NHS INFORMATION CENTRE REGISTERED POPULATION FIGURES)**

**10 LOWEST SPENDS**

<i>PCT</i>	<i>2008 Registered population</i>	<i>Spending on Out of Hours care 2008–09</i>	<i>Ratio of spending</i>
Hillingdon PCT	240,291	£339,778	£1.41
Heart Of Birmingham Teaching PCT	282,157	£587,021	£2.08
Sheffield PCT	534,251	£1,772,000	£3.32
Westminster PCT	234,500	£1,057,343	£4.51
South West Essex PCT	397,364	£2,094,563	£5.27
Hammersmith and Fulham PCT	169,996	£920,567	£5.42
Gloucestershire PCT	579,098	£3,413,874	£5.90
Islington PCT	187,274	£1,129,000	£6.03
Havering PCT	237,211	£1,457,314	£6.14
Redbridge PCT	239,977	£1,501,000	£6.25

## 10 HIGHEST SPENDS

<i>PCT</i>	<i>2008 Registered population</i>	<i>Spending on Out of Hours care 2008–09</i>	<i>Ratio of spending</i>
Leicester City PCT	308,698	£3,783,000	£12.25
North Yorkshire and York PCT	767,343	£9,475,365	£12.35
Herefordshire PCT	174,778	£2,260,000	£12.93
Sefton PCT	270,638	£3,590,000	£13.26
Wiltshire PCT	434,921	£5,800,000	£13.34
Shropshire County PCT	285,157	£4,040,132	£14.17
County Durham PCT	509,490	£7,398,871	£14.52
Medway PCT	265,207	£4,089,000	£15.42
Nottingham City PCT	305,234	£5,354,452	£17.54
Portsmouth City Teaching PCT	199,522	£4,610,259	£23.11

Average spend £9.00 per registered population.

**Figure 1.3.1**

FULL LIST OF SPENDING PER HEAD OF REGISTERED PATIENT POPULATION 2008–09  
(BASED ON ANSWERS RECEIVED FROM 90 PRIMARY CARE TRUSTS BY THE PATIENTS ASSOCIATION IN RESPONSE TO FREEDOM OF INFORMATION ACT REQUESTS AND NHS INFORMATION CENTRE REGISTERED POPULATION FIGURES)

<i>Primary Care Trust</i>	<i>2008 Registered patient population</i>	<i>Spending on Out of Hours care 2008–09</i>	<i>Ratio</i>
Ashton, Leigh and Wigan PCT	301,595	£1,898,395	£6.29
Barnsley PCT	231,551	£1,905,000	£8.23
Bassetlaw PCT	106,594	£882,000	£8.27
Bath and North East Somerset PCT	186,018	£2,070,000	£11.13
Bedford PCT	411,716	£3,966,985	£9.64
Berkshire East PCT	384,224	£3,172,000	£8.26
Berkshire West PCT	455,101	£4,320,609	£9.49
Blackburn With Darwen PCT	151,187	£1,153,752	£7.63
Bolton PCT	262,529	£2,444,450	£9.31
Bournemouth and Poole Teaching PCT	321,235	£3,044,000	£9.48
Bradford and Airedale Teaching PCT	497,635	£3,860,372	£7.76
Brighton and Hove City PCT	259,100	£3,013,812	£11.63
Bristol PCT	428,123	£4,760,000	£11.12
Bromley PCT	303,504	£1,981,000	£6.53
Buckinghamshire PCT	496,622	£3,977,686	£8.01
Bury PCT	182,115	£1,374,400	£7.55
Calderdale PCT	200,421	£1,267,585	£6.32
Cambridgeshire PCT	577,074	£6,386,000	£11.07
Central and Eastern Cheshire PCT	455,787	£4,444,559	£9.75
Central Lancashire PCT	438,711	£3,182,632	£7.25
City and Hackney Teaching PCT	220,479	£1,530,341	£6.94
County Durham PCT	509,490	£7,398,871	£14.52
Coventry Teaching PCT	322,770	£2,024,490	£6.27
Darlington PCT	98,203	£1,074,534	£10.94
Derby City PCT	271,023	£2,857,000	£10.54
Derbyshire County PCT	692,696	£7,078,000	£10.22
Devon PCT	732,201	£7,887,948	£10.77
Doncaster PCT	293,143	£2,381,000	£8.12
East and North Hertfordshire PCT	549,793	£4,006,449	£7.29
East Riding of Yorkshire PCT	304,296	£3,509,000	£11.53
East Sussex Downs and Weald PCT	326,731	£3,528,317	£10.80
Eastern and Coastal Kent PCT	715,898	£7,380,053	£10.31
Gloucestershire PCT	579,098	£3,413,874	£5.90
Hammersmith and Fulham PCT	169,996	£920,567	£5.42
Hampshire PCT	1,235,910	£10,661,000	£8.63
Hastings and Rother PCT	171,398	£2,018,308	£11.78
Havering PCT	237,211	£1,457,314	£6.14
Heart Of Birmingham Teaching PCT	282,157	£587,021	£2.08
Herefordshire PCT	174,778	£2,260,000	£12.93
Heywood, Middleton and Rochdale PCT	203,963	£1,400,000	£6.86
Hillingdon PCT	240,291	£339,778	£1.41

<i>Primary Care Trust</i>	<i>2008 Registered patient population</i>	<i>Spending on Out of Hours care 2008–09</i>	<i>Ratio</i>
Islington PCT	187,274	£1,129,000	£6.03
Knowsley PCT	150,286	£977,268	£6.50
Leeds PCT	767,081	£6,100,000	£7.95
Leicester City PCT	308,698	£3,783,000	£12.25
Manchester PCT	485,511	£4,321,859	£8.90
Medway PCT	265,207	£4,089,000	£15.42
Milton Keynes PCT	232,448	£1,990,059	£8.56
Newcastle PCT	260,861	£2,102,092	£8.06
Norfolk PCT	723,638	£5,359,594	£7.41
North Lancashire Teaching PCT	326,314	£3,311,000	£10.15
North Lincolnshire PCT	158,260	£1,247,728	£7.88
North Staffordshire PCT	204,102	£1,400,835	£6.86
North Tyneside PCT	204,085	£1,730,600	£8.48
North Yorkshire and York PCT	767,343	£9,475,365	£12.35
Northamptonshire Teaching PCT	660,508	£6,040,000	£9.14
Nottingham City PCT	305,234	£5,354,452	£17.54
Nottinghamshire County Teaching PCT	305,234	£2,677,226	£8.77
Oldham PCT	222,362	£1,700,000	£7.65
Oxfordshire PCT	612,823	£6,924,000	£11.30
Plymouth Teaching PCT	250,298	£2,541,036	£10.15
Portsmouth City Teaching PCT	199,522	£4,610,259	£23.11
Redbridge PCT	239,977	£1,501,000	£6.25
Salford PCT	222,861	£1,720,000	£7.72
Sefton PCT	270,638	£3,590,000	£13.26
Sheffield PCT	534,251	£1,772,000	£3.32
Shropshire County PCT	285,157	£4,040,132	£14.17
Somerset PCT	513,109	£5,268,026	£10.27
South Gloucestershire PCT	242,175	£2,089,000	£8.63
South Staffordshire PCT	583,057	£4,826,000	£8.28
South West Essex PCT	397,364	£2,094,563	£5.27
Southampton City PCT	245,611	£2,051,000	£8.35
Stockport PCT	281,488	£2,129,000	£7.56
Stoke On Trent PCT	258,117	£1,917,084	£7.43
Suffolk PCT	587,971	£6,050,400	£10.29
Surrey PCT	1,072,389	£7,279,865	£6.79
Tameside and Glossop PCT	225,259	£1,770,751	£7.86
Telford and Wrekin PCT	160,909	£1,689,000	£10.50
Trafford PCT	210,705	£1,461,000	£6.93
Wakefield District PCT	333,186	£3,106,000	£9.32
Walsall Teaching PCT	249,755	£2,228,000	£8.92
Wandsworth PCT	280,145	£2,116,082	£7.55
Warrington PCT	192,777	£2,091,000	£10.85
West Hertfordshire PCT	536,390	£4,088,859	£7.62
West Sussex PCT	773,856	£6,527,745	£8.44
Western Cheshire PCT	245,689	£2,188,000	£8.91
Westminster PCT	234,500	£1,057,343	£4.51
Wiltshire PCT	434,921	£5,800,000	£13.34
Wirral PCT	309,822	£3,266,000	£10.54
Worcestershire PCT	545,377	£4,874,000	£8.94

LIST OF PRIMARY CARE TRUSTS THAT WERE UNABLE TO PROVIDE US WITH DATA ON THE NUMBER OF COMPLAINTS THEIR PROVIDER ORGANISATIONS HAD RECEIVED (PLEASE NOTE THIS DOES NOT INCLUDE TRUSTS THAT HAVE NOT RESPONDED TO THIS QUESTION)

*North Somerset PCT*—Response received: The PCT, does not collate details of the complaints received by our Out of Hours Provider. Details of these should be obtainable directly from Harmoni. Their contact details can be obtained at [www.harmoni.co.uk/site/Harmoni/home](http://www.harmoni.co.uk/site/Harmoni/home)

*Somerset PCT*—Response received: NHS Somerset commissions the “out of hours” service from the South Western Ambulance Trust (<http://www.was.co.uk/>). As such, I would advise you to contact them for the requested information as NHS Somerset does not hold information regarding the number of complaints they have received with regard to the provision of the “out of hours” service.

*Barking and Dagenham PCT*—Response received: NHS Barking and Dagenham can now respond to your Freedom of Information request. We can only provide the answer to question 1. Questions 2, 3, 4, 5, 6, and 7 should be forwarded to the Partnerships of East London Co-operative as they provide our Out of Hours service and we are not informed of complaints which are sent directly to them.

*Manchester PCT*—Response received: Trafford PCT, does not hold this information. It can be obtained by writing to: Mastercall Headquarters, 226-228 Wellington Road, South, Stockport, SK2 6NW

*Bradford and Airedale Teaching PCT*—Response received: We do not have figures for the number of complaints received and dealt with directly by the provider.

LIST OF PRIMARY CARE TRUSTS THAT WERE UNABLE TO PROVIDE US WITH DATA ON THE NUMBER OF SERIOUS UNTOWARD INCIDENTS THERE HAD BEEN RELATING TO OUT OF HOURS CARE (PLEASE NOTE THIS DOES NOT INCLUDE TRUSTS THAT HAVE NOT RESPONDED TO THIS QUESTION)

*Medway PCT*—Response received: Answer = No information held.

*Barking and Dagenham PCT*—Response received: NHS Barking and Dagenham can now respond to your Freedom of Information request. We can only provide the answer to question 1. Questions 2,3,4,5,6 and 7 should be forwarded to the Partnerships of East London Co-operative as they provide our Out of Hours service and we are not informed of complaints which are sent directly to them.

*Bradford and Airedale Teaching PCT*—Response received: We are also not the data controllers so would not be able to provide this information. We do not hold this information in view that we do not performance manage the Out of Hours Service Serious Untoward Incidents nor have we done previously.

#### ABOUT THE PATIENTS ASSOCIATION

[www.patients-association.com](http://www.patients-association.com)

The Patients Association is an independent charity that highlights the concerns and needs of patients. We work with Government and a broad range of individuals and organisations to develop better, and more responsive, health services.

The Patients Association advocates for greater and more equitable access to high-quality, accurate and independent information for patients. Our aim is to reduce health inequalities by helping patients to be better informed and by campaigning for patients to have the right to be involved in decision-making.

The Patients Association is well placed as an organisation to stand strongly and enable a dialogue between all stakeholders involved in a patient's care. We work with the people that affect care directly—from the NHS itself to the companies that produce the medical devices it uses, as well as the pharmaceutical industry, the medical insurance companies and private healthcare providers—we believe in coordinating healthcare properly and taking responsibility.

The Patients Association is in a unique position, always challenging, always independent and always there for patients.

The Patients Association Helpline—0845 608 44 55—is there to help. This is a local rate number and if a phone provider charges, we are happy to return calls. The Helpline both informs patients and gathers their views. We are of course available online, providing advice, the latest health news, signposting to further information and general advice.

We also have a range of booklets and guides for patients. Especially popular titles include *Pain Management: A Guide for Patients*, *How to Obtain Access to your Medical Records*, *How to Make a Complaint*, *You and Your Dentist* and *How to make a Living Will*.

We have also produced a number of research reports including *Patients Not Numbers*, *People not Statistics*, *Your Experience Counts: Patient Experience Survey*, *All About Health Survey Report* and *Infection Control: How much do you know and want to know?*

March 2010

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#### Memorandum by NCT (COM 118)

COMMISSIONING, INCLUDING A PROPOSED MODEL TO REMOVE THE PERVERSE INCENTIVES IMPOSED BY PAYMENT BY RESULTS IN MATERNITY SERVICES

##### 1. Executive summary

1.1 Payment by Results has a negative effect on maternity services. Under the current system, more is paid to a Trust where more interventions are performed. This contradicts other government policy that aims to reduce the medicalisation of birth and increase normality, such as the National Service Framework for Children, Young People and Maternity Services.<sup>27</sup>

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<sup>27</sup> Department of Health. *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health; Department for Education and Skills; 2004.

1.2 By paying the tariff in this way, there is a perverse incentive towards interventions, and commissioners will see that any moves to reduce these will result in a loss to the Trust.

1.3 This system only acts to exacerbate the rising rates of caesarean section that so much work, such as the NHS Institute for Innovation and Improvement's "Self-improvement toolkit" on reducing caesarean section rates,<sup>28</sup> is aiming to curtail.

1.4 Instrumental births are associated with longer stays in hospital, which will lead to increased use of resources.<sup>29</sup>

1.5 Interventions in births are associated with increased "downstream" costs, the need for which will be reduced as normal birth rates are allowed to rise.<sup>30</sup>

1.6 The NCT recommends a system whereby one price is set for a birth. This will reward a service for making fewer interventions, and will allow commissioners to take decisions that will achieve movement towards higher normal birth rates, in keeping with government policy.

## 2. About the NCT

2.1 The NCT is the foremost charity working for parents in the UK. We support thousands of people each year through pregnancy, birth and early parenthood.

2.2 We have a membership of 104,000, and operate a branch structure to allow the UK office a comprehensive view of services for parents from both a national and local perspective.

2.3 The NCT believes that maternity and early parenting services should be designed around parents' needs.

2.4 The NCT believes that the normal physiological processes of birth and breastfeeding can make a major contribution to the health and well-being of women and babies but are threatened by pressures of modern society and need protection and promotion.

## 3. Factual information relating to the Inquiry

3.1 Payment by Results is a system intended to recompense services within the NHS for the delivery of care. It was introduced in 2003, in order to "pay NHS Trusts and other providers fairly and transparently for services delivered, while managing demand and risk."<sup>31</sup> Since this time, it has been growing increasingly complex in order to accommodate the various services available via the NHS.

3.2 In terms of maternity, there are nine levels of payment, depending on the complexity of the procedure.<sup>32</sup> These are as follows:

<i>Description</i>	<i>Tariff</i>
Normal delivery 19 years and over with complications	£1,881
Normal delivery 19 years and over without complications	£1,174
Normal delivery 18 years and under with complications	£1,921
Normal delivery 18 years and under without complications	£1,177
Assisted delivery with complications	£2,288
Assisted delivery without complications	£1,728
Caesarean section 19 years and over	£2,579
Caesarean section 18 years and under	£2,654
Caesarean section with complications	£3,626

3.3 This table highlights the misnomer of Payment by Results, as results are not accounted for. Payment is made by activity.

3.4 It is universally accepted that outcomes are better for women and for babies when interventions in labour are kept to the minimum necessary.<sup>33, 34</sup> For this reason, the Department of Health prioritises working towards normal births—those with no interventions—for women with low risk pregnancies.<sup>35</sup>

<sup>28</sup> NHS Institute for Innovation and Improvement. Pathways to success: a self improvement toolkit—focus on normal birth and reducing Caesarean section rates. 2009.

<sup>29</sup> Royal College of Obstetricians and Gynaecologists: Clinical Effectiveness Support Unit. The Care of Women Requesting Induced Abortion. Evidence-based guideline No 7. London: RCOG; 2000.

<sup>30</sup> National Institute for Health and Clinical Excellence: National Collaborating Centre for Women's and Children's Health. *Intrapartum care: care of healthy women and their babies during childbirth*. Clinical Guideline, 2007.

<sup>31</sup> Department of Health, *Reforming NHS Financial Flows: Introducing payment by results*, London, Department of Health, 2002.

<sup>32</sup> Department of Health, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Maternity Services and Payment by Results—A Simple Guide—Updated 2009/10 Version, London, Department of Health, 2009.

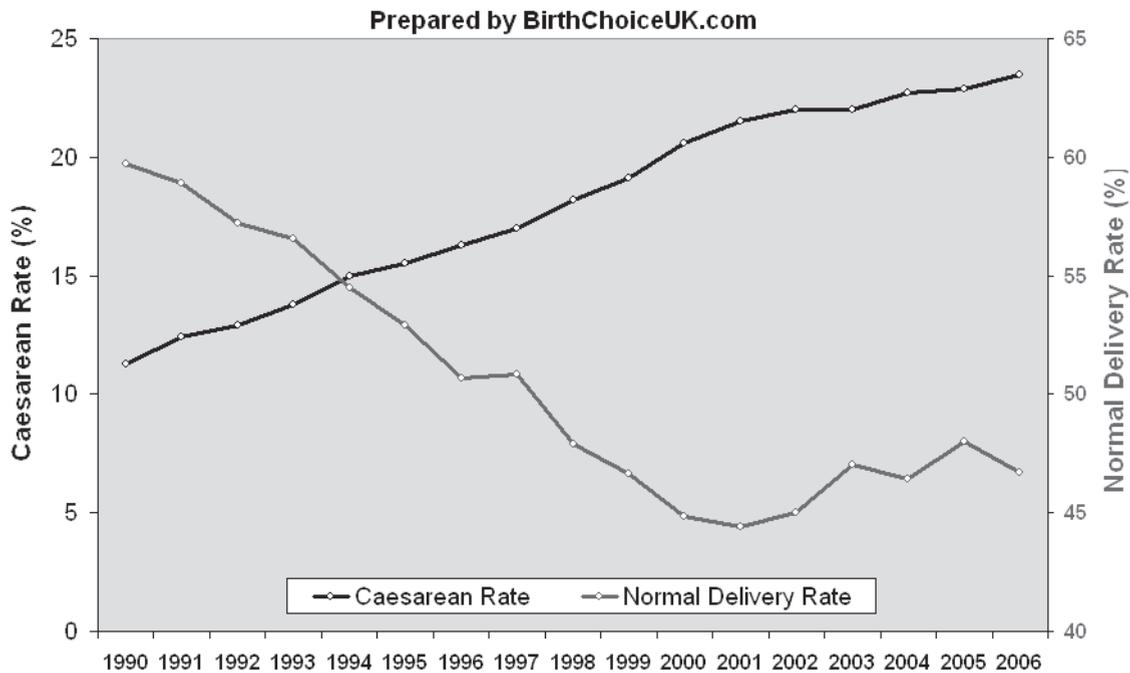
<sup>33</sup> Chamberlain G, Wraight A, Crowley P editors. *Home births: the report of the 1994 confidential enquiry by the National Birthday Trust Fund*. Carnforth, Lancashire: Parthenon Publishing; 1997.

<sup>34</sup> Hodnett ED, Downe S, Edwards N, and Walsh D. *Home-like versus conventional institutional settings for birth*. Cochrane Database of Systematic Reviews 2005, Issue 1. Art No: CD000012. DOI: 10.1002/14651858.CD000012.pub2.

<sup>35</sup> Department of Health. *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health; Department for Education and Skills; 2004.

3.5 For the past three decades, the normal birth rate has been falling, while the caesarean section rate has risen. This medicalisation is the reverse of the intention of the Department of Health in the National Service Framework for Children, Young People and Maternity Services.

## Changes in Caesarean and Normal Delivery Rates in England



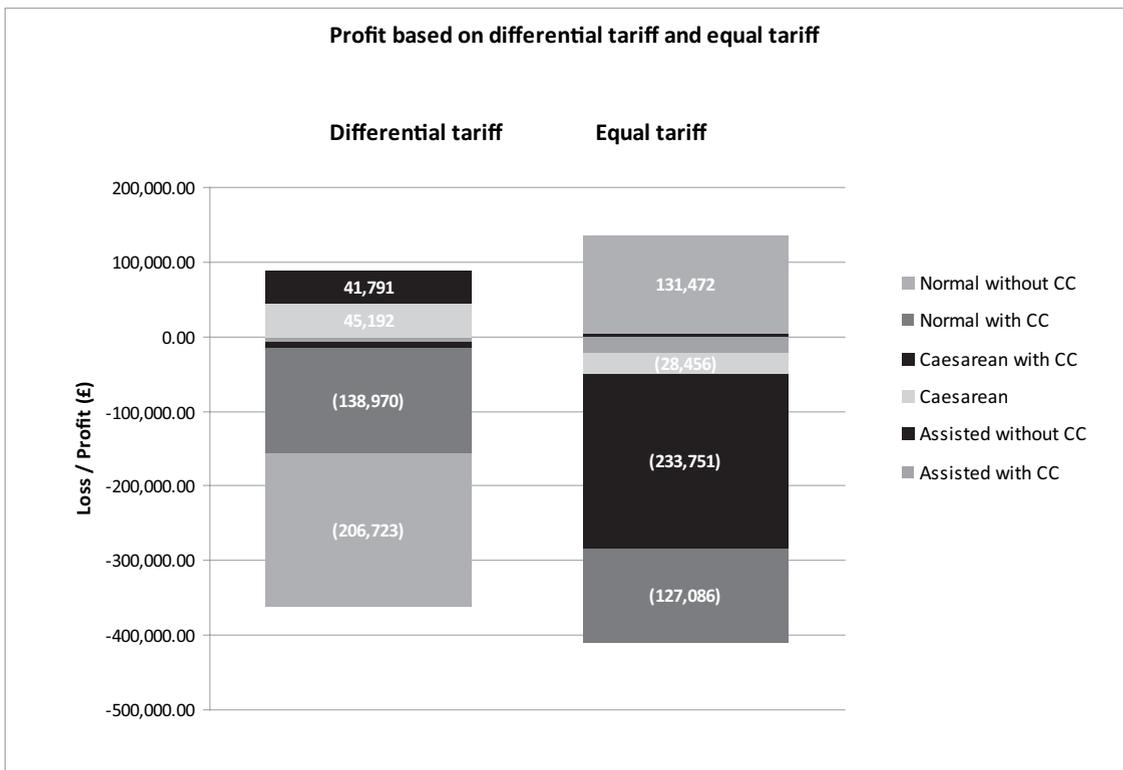
### 4. Recommendations

4.1 The left hand side of the chart below—using real figures from a Trust—demonstrates the disincentive for normal births, with interventions achieving a profit and normality a loss. With figures like this, it will be clear to any commissioner that initiatives intended to fulfil government commitments to increase normal births will achieve a loss for the service.

4.2 The NCT proposes a system that pays an equal amount for each birth, so rewarding by results, rather than by activity. This equal tariff will remove the disincentive for normal births by making normality profitable. Therefore, commissioners will be enabled to take steps that will encourage normal births without adversely effecting the financial viability of the service.

4.3 The right hand side of the chart shows how an equal tariff incentivises normal births. As the trust adjusts its profile to achieve more normal births, it will achieve more “profit”.

4.4 A significant advantage to this model is that the trust benefits further as its normal birth rate increases. As this happens, women and their families will also benefit. Additionally, there will be no extra cost to the health service, as the total tariff will equal its current level. This is more desirable than a model that would aim to add to the tariff for normal deliveries, which would be more costly to the health service, and would retain the price incentive for interventions.



February 2010

#### Letter to Howard Stoa MP from the NHS Confederation (COM 101A)

I was interested to read the transcript from the Health Select Committee's recent evidence session on commissioning held on 4 January where you said, "The NHS Confederation is actually pretty impressed by PbR, they have some very positive things to say about it, particularly for example their view about the independent sector providers and bringing them into the market."

Whilst we do feel that payment by results has an important role to play, we would not go quite so far as to say we are "pretty impressed" with it overall and I wanted to make sure we had been sufficiently clear to the Committee about our view of the significant benefits and real concerns with this policy.

We believe that the general principle that providers should be paid for the results they achieve is right. For elective surgery fee-for-service arrangements, like the current tariff, are in use in many countries and a nationally set price has the advantage of removing the transaction costs of negotiation. These mechanisms can also encourage efficiency and innovation where there are effective controls in place to avoid provider-led changes in clinical thresholds for treatment.

Tariff systems can work in emergency care and for long term conditions but unless they are used carefully they have the risk of providing incentives that are not really aligned with what patients or the wider health system needs. In particular, it has the potential to create incentives for providers to generate, rather than help manage, demand for secondary care. There are alternative approaches to payment for results mechanisms that do not rely on a fee-for-service payment which reward efficiency and coordination across whole pathways which would be preferable to the current arrangements.

As our written evidence to the Committee has also suggested, we are keen for PbR to be rolled out to other service areas—not least mental health and ambulance services—but in these cases it will be important that the payment system supports the objectives of policy in this area: a system designed for elective surgery can not just be translated into these areas.

We would be happy to discuss in further detail our views on PbR if that would be helpful, and we look forward to seeing the Committee's eventual conclusions on PbR and wider commissioning issues.

8 February 2010