

# Consultation response

## **The King's Fund Response to the Commons Health Select Committee Call for Evidence on Commissioning**

The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

This paper is a formal response to the Health Select Committee's call for evidence for their inquiry into Commissioning.

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

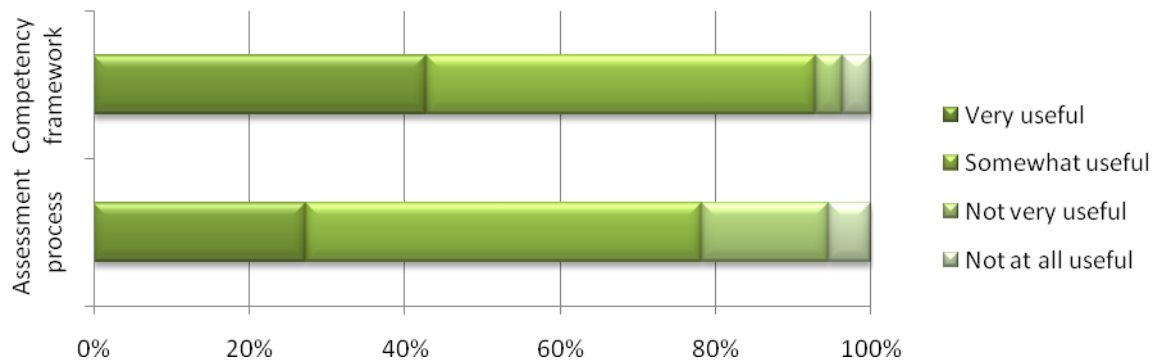
Commissioning is regarded as the weakest link in the English NHS system and the World Class Commissioning (WCC) initiative represents the latest and most concerted attempt to define the task; to set out the competencies required; and to create the momentum to deliver high quality commissioning. There is broad agreement that commissioners have lacked the management and technical expertise, the capacity and the basic infrastructure to be successful...

As expected, the 2009 WCC assurance process confirmed that the quality of commissioning by PCTs was largely poor to mediocre. There was a sizeable gap between what is currently being delivered and the standards expected within the WCC brief. In particular, weaknesses were found in the commercial aspects of commissioning which represent new territory for NHS commissioners. These include:

- Mapping and understanding the strengths and weaknesses in the local provider market
- Using the commissioner's investment power to stimulate the market, such that providers develop in-line with local health needs and community aspirations
- Managing relationships with providers, engaging in constructive performance discussions with them to ensure continuous quality improvement; and
- Building relationships with potential future providers

That said, forthcoming research from The King's Fund - to be published in Spring 2010 - indicates that WCC has been largely welcomed inside and outside the NHS as an approach that will improve the quality and impact of commissioning. There is a common perception that the policy has helped by setting out a clear vision of what high quality commissioning is and what commissioners should be aspiring towards.

### Results from PCT survey - How useful is World Class Commissioning as a tool for improving the quality of commissioning?



Source: Kings Fund forthcoming report on external support for commissioning. Survey of all PCTs in England, conducted January 2009. Number of respondents: 98.

It is too early to judge whether WCC will be successful or cost-effective. A number of organisations are undertaking studies to establish the impact of WCC including the Treasury, National Audit Office, NHS Service and Delivery Organisation and the Policy Research Programme at the National Institute for Health Research.

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

The internal market that was introduced in 1991 was designed to introduce competition between strong, monopolistic health care providers. In the absence of consumers with the money, information and expertise to act as a countervailing force, there was a need for an informed, critical agent - the purchaser - who could act for the patient as well as ensuring that the public's goals for the health sector were achieved.

Later 'commissioning' replaced 'purchasing' as the term used to describe this function. Commissioning was intended to be more sophisticated and strategic than purchasing, encompassing an assessment of the health needs of the population, the buying of services to meet those needs, alongside various interventions to promote health. More recently, PCTs have been shedding their role as a provider of community services - in effect becoming agencies whose primary function is to secure services from a range of providers for a specific geographical population.

#### *Has the purchaser/provider split been a success?*

There have been a large number of studies of the various models of commissioning that have been tried in the English NHS. such as fundholding, Total Purchasing Pilots, GP Commissioning Groups, and more recently Primary Care Groups and Trusts [1-14]. There have also been some international comparative studies [15-16]. The early research suggested that commissioning for health services was a fairly new, and correspondingly unsophisticated activity. More recently, renewed emphasis on how to make commissioning effective has led to a series of review studies [17-26]. Each supports the view that the commissioning function has yet to reach full maturity and that those responsible for it lack many of the necessary skills required. A recent survey of GPs and PCT managers, found that many felt deficient in the key skills of commissioning, which they identified as negotiation, finance and data analysis [27].

This lack of a skill base has been compounded by constant reorganisation. Skills and knowledge that were built up have been lost and fragmented as organisations have been forced to repeatedly reinvent themselves. Moreover it has proved difficult to recruit the brightest and best into the commissioning side of the NHS with senior positions in the acute sector attracting higher pay and status. Although relationships vary there is often an adversarial component to the commissioner/provider split and this has not helped PCTs to engage with secondary care clinicians.

#### *Is the purchaser/provider split needed?*

As yet there is no evidence to suggest that the commissioner /provider split in England has created a more or less efficient system than those, such as Scotland, that have opted not to follow this route. Whilst it could be argued that commissioning within a purchaser/provider model has the most potential to challenge monopolistic provision and deliver choice, contestability and service redesign, the evidence suggests that large providers have dominated the relationship, largely because of the information 'asymmetry' between buyer and seller.

There are other constraints. For elective care, the payment by results tariff, patient choice and the 'any willing provider' requirement mean that PCTs have little control over what they pay or where patients are treated while quality standards are set nationally. The increasing concentration of some services in specialist centres effectively creates more local monopolies and large acute hospital trusts can be even more dominant in their local provider markets. Early research from a joint University of Birmingham and King's Fund study on the collective impact of the NHS reforms suggests that it is these factors, more than commissioning, that have shaped and driven the way care is delivered. The ability of commissioning to be an effective lever for change has, therefore, yet to be proven.

### **3. How does world class commissioning fit with practice-based commissioning; contestability in the quasi-market; and payment by results?**

As a set of principles, WCC does not conflict with PBC, PBR and contestability. However, when examined in detail and in the context of the system as a whole, it is apparent that there are areas where the various incentives and structures do not align. As a result commissioning remains weak. It is not that the policies themselves do not 'fit' with WCC, but rather that the structures and mechanisms within which they are operating are working against the aspirations of WCC. The interplay of **practice-based commissioning; contestability and payment by results** with WCC is considered below.

#### *Practice-Based Commissioning*

On the whole, PBC has yet to make a significant impact on care pathways and service redesign and as such it does not appear to have strengthened commissioning as a whole. Competency 4 in WCC specifies that PCTs "lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation". In theory this aligns with the policy intentions of PBC, in practice it has not yet happened. The reality is that PBC remains voluntary for GPs and has proved attractive to those who have been motivated to become involved principally by the desire to re-provide some services themselves

Under PBC, a GP is able to decide when and where to refer a patient yet the financial risk remains at the PCT. Few sanctions (other than very severe contractual threats) are available to a PCT to make sure GPs comply with the PCT's overarching strategy and priorities. Instead, PCTs rely on GPs being sufficiently engaged and involved in the agenda - yet this involvement remains voluntary. In contrast, secondary care trusts are established as highly structured organisations with a history of embedded clinical engagement, which puts them in a strong position at the contract negotiating table. Research has revealed that PBC has largely brought about small-scale projects involving the re-provision of elements of services outside hospital rather than large-scale strategic redesign [28]. This is largely because the incentives embedded within PBC reward GPs for short-term gains and do not encourage longer-term investment. Thus far, PBC has not demonstrated that it can advance commissioning, especially of secondary care, and it is therefore not clear that PBC provides value for money.

#### *Contestability*

WCC specifies a clear requirement for PCTs to "effectively stimulate the market", so it could be argued that the promotion of contestability - to create a competitive environment through tendering - fits well with the policy. However, it is clear from the results of the WCC assurance process that market stimulation is the least well advanced of all competencies. WCC states that PCTs should be recognised "as the local leader of the NHS" (competency 1). However, the power imbalance means that in most cases, it is

the acute trusts that hold the negotiating power. Foundation trusts have significant freedoms that give them even more clout - for example by being able to retain their savings and build up reserves and by devising their own investment strategies. Thus, while WCC aims to increase contestability between providers, large hospitals have been given increasing powers which in some cases is likely to make them stronger monopolies. The commissioning side meanwhile has not been given the means to counter those powers.

#### *PBR*

PBR has encouraged acute trusts to pull in patients and in some circumstances has created adversarial relationships between commissioners and providers. PCTs have few of the freedoms afforded to foundation trusts - they are restricted by stringent governance and regulatory structures and must break even on an annual basis. As noted above, the power differential is exacerbated by a mismatch in the quality of information accessible to trusts and commissioners. Work undertaken in the acute setting is coded and costed very carefully to ensure that costs are covered, but there is a significant delay before commissioners receive that information. The lack of specialist knowledge at PCT level means that commissioners find it very difficult to challenge coding. The complexity of the pricing structure of PbR has combined with these incentives to restrict the ability of commissioners to act on strategies that seek to redesign services and/or shift care out of hospitals.

Although WCC provides an overarching strategy that appears to integrate contestability, choice, PBR and practice-based commissioning the reality is that these different incentives and structures do not amount to a coherent whole. In practice commissioning suffers because these key elements of the system are not aligned.

#### **4. What has been the contribution of specialist commissioning?**

The Carter Committee recently recommended a number of changes designed to ensure that specialist commissioning arrangements were available in all parts of the country because local commissioners are unlikely to have the expertise to purchase these services effectively. The current arrangements apply only to a narrow range of services where the case for national or regional levels of commissioning is clear cut. However, there are a large number of other services where effective commissioning also requires high levels of clinical expertise and where the most effective scale of service provision is larger than most PCTs. Most PCT commissioners have acknowledged this and agreed local arrangements by which one PCT takes the lead on behalf of another - for example, in commissioning services for the local cancer network, or the provision of stroke services.

#### **5. What is the scope for commissioning for quality and safety?**

The competencies required by the WCC programme clearly set out commissioners' roles in quality and safety, and in recent years there has been a number of new mechanisms to support this - such as best practice tariffs and the Commissioning for Quality and Innovation scheme (CQUIN). The former will be used to set prices at a level which reflects best practice in delivery and quality. Initially this will cover five service pathways - cataracts, colecystectomy, fragility hip fracture, renal dialysis and stroke. The latter makes a small proportion of providers' income dependent on locally agreed quality and innovation goals. In 2009-10 this proportion has been set at 0.5% and it is expected to increase over time. It is hoped that this will address the criticism that PbR is payment for activity rather results but will require commissioners to make effective use of these levers.

Other initiatives, such as the Indicators for Quality Improvement project led by the NHS Information Centre, is developing, assuring and promoting sets of quality metrics, which commissioners are encouraged to use to inform their contracting. Patient Reported Outcome Measures (PROMs) are a further important new source of quality information for commissioners.

Overall, there has been a definite and welcome shift towards the development and use of payment mechanisms and data on care quality, through which commissioners can seek to reward quality and maintain safety. However, access to and use of information critical to effective commissioning for quality and safety by PCTs is lacking, particularly in primary and community care.

## CONCLUSION

World Class Commissioning is a policy that seeks to bring a 'step change' in the capacity and capability of PCTs to act as effective commissioners. However, the enduring weakness of commissioning is unlikely to be addressed by WCC alone. It is not just a matter of aligning incentives; it is also about reconciling the structural complexities of the current commissioning arrangements.

WCC is aimed at PCTs, but commissioning can only be understood by recognising that there are other players operating in different ways at different levels. PCT-led commissioning has not had the impact that was anticipated but that should *not* lead to the conclusion that the purchaser/provider split is a failure or that structural reform - such as PCT mergers - will address the problem.

Recognising and affording different powers to the various 'layers' - a form of 'matrix commissioning' - could go some way towards creating a more rational model. PCTs should retain a statutory responsibility to commission care for a defined population but they might then delegate responsibility to a range of different organisations with expertise in commissioning care for their part of the system. These might include a better supported model of PBC, Integrated Care Organisations, joint commissioning with other PCTs and /or local authorities; or supra-PCT commissioning agencies such as those required for specialist care. The role of the PCT would be to broker the most appropriate mix of commissioning arrangements to meet the needs of its population. Such matrix commissioning arrangements are becoming more common as PCTs seek new partnerships - an evolution that might eventually improve the effectiveness of the commissioning function.

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