MAKING IT HAPPEN

Next steps in NHS reform

Report of an expert working group
April 2008

Chair: Alasdair Liddell
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The pace of change and reform in the NHS has been relentless as government and those who work in the NHS seek ways to improve the service. The King's Fund set up an expert working group to examine how effective the current incentives were in achieving this aim. The group focused on the role of PCTs as commissioners and on practice-based commissioning but discussed other issues, including patient choice. This paper includes specific proposals for government, the Department of Health, strategic health authorities and primary care trusts. These conclusions should feed into Lord Darzi's review and help to clarify the next steps for the NHS.

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Letter from chair of expert working group

23 April 2008

Niall Dickson
Chief Executive
King's Fund
11–13 Cavendish Square
London W1G 0AN

Dear Niall

Expert working group on NHS system reform and incentives

I am enclosing the report of the independent expert working group charged with reviewing the systems and incentives involved in the current NHS reforms, and producing recommendations to inform Lord Darzi's NHS Next Stage Review.

When the government came to power in 1997, the key levers ministers used to ensure improvement in the health system were central directives, targets and performance management. However, in the past few years there has been a growing acceptance that while these levers could be effective, they were limited, could produce damaging side-effects and might well be subject to a law of diminishing return.

A range of additional new levers was developed, focusing on incentives such as competition, choice, fostering a more diverse range of providers and more sophisticated regulation. This, combined with a commitment to free up the provider side from Whitehall control, resulted in a range of new policies and approaches, including NHS foundation trusts, Payment by Results, patient choice and the reform of regulation.

You invited me to chair a small expert working group, which was asked to look at how effectively the current incentives in the health system were working in terms of the NHS objective of achieving continuous improvement in services for patients and the public. Given the central role of commissioning within the reformed NHS, much of our report focuses on the role of PCTs as commissioners, and on practice-based commissioning. But we also looked at patient choice and primary care delivery. We have included some brief comments on Payment by Results and capital, although we are aware that more detailed work on these is being undertaken elsewhere.

The working group comprised the following people:

John Appleby, Chief Economist, King's Fund
Penny Dash, independent consultant and King's Fund Trustee
Anna Dixon, Acting Director of Policy, King's Fund
Mike Farrar*, Chief Executive, NHS North West
David Mobbs, Chief Executive, Nuffield Hospitals
Keith Palmer, Chairman, Barts and The London NHS Trust
Stephen Thornton*, Chief Executive, The Health Foundation

Nicholas Timmins, Public Policy Editor of the *Financial Times*, worked with us to shape and write the report; he was also an invaluable source of information and clarity in our deliberations. Rebecca Ashton from your own office worked with us diligently to ensure we kept pace and focus. Both of them served the group extraordinarily well. We also had invaluable support from the Fund's policy team, including especially Nick Goodwin, Candace Imison, Ruth Thorlby and Jo Maybin. I am also grateful to Jennifer Dixon, Director of the Nuffield Trust, for her input to our thinking.

We did not have time to carry out any in-depth analytical work but we met on two occasions as a working group to identify and discuss the

* Mike Farrar and Stephen Thornton contributed to our work but were unable to attend the meetings of the group.

issues, in what were often lively debates. We also conducted a one-day workshop that brought together a much wider group of people from the NHS and independent sectors. On behalf of the working group, I extend thanks to the workshop participants for their expertise and insights, which we drew upon in this report.

Members of the group all contributed to the report, and while inevitably some different views emerged in our discussions, all of them support the thrust of the analysis presented here – though as chairman I must take sole responsibility for the report in its final form and its recommendations. I should mention that, while all of us as members of the working group have an 'interest' in the NHS, as chairman I felt I should declare my interest as health adviser to Building Better Health Ltd, which is the private sector partner to three of the London NHS LIFT projects.

The pace of change and reform in the NHS is relentless, as ministers and those who work in the NHS search for new ways of improving the service to patients and the public. If I had to single out one message from our review, it would be the need for a clear statement of the direction of travel for the reformed NHS, to provide a consistent and coherent framework for the management of the system as a whole. We have suggested such a statement as a 'unifying narrative' in the introduction to our report, and we hope it may be adopted.

Yours sincerely

Alasdair Liddell
Senior Associate, the King's Fund

Summary

This paper is the report of an expert working group established by the King's Fund to examine the systems and incentives involved in the current National Health Service (NHS) reforms in England, and their state of play, as a contribution to Lord Darzi's NHS Next Stage Review.

The members of the group were as follows:

Alasdair Liddell, Senior Associate, King's Fund (Chair)
John Appleby, Chief Economist, King's Fund
Penny Dash, independent consultant and King's Fund Trustee
Anna Dixon, Acting Director of Policy, King's Fund
Mike Farrar*, Chief Executive, NHS North West
David Mobbs, Chief Executive, Nuffield Hospitals
Keith Palmer, Chair, Barts and The London NHS Trust
Stephen Thornton*, Chief Executive, The Health Foundation
Nick Timmins, Public Policy Editor, the *Financial Times* (Rapporteur)

In essence the group's view – supported by the output of a one-day seminar held with a wide mix of people working in and for the NHS – is that all of the various elements of the reforms are working somewhere, although not always as intended. None is working everywhere.

Most importantly, there is still no clear understanding of the 'rules of the game' out in the NHS, or the strategies needed for 'winning', in response to a set of incentives designed to deliver continuous improvements in services for patients and the public.

* Mike Farrar and Stephen Thornton contributed to our work but were unable to attend the meetings of the group.

It is early days and many of the reforms need to be given time to bed down. Nonetheless, without tearing the system apart again, some changes are needed, although most are a matter of evolution, not revolution.

A unifying narrative

This report is based on the assumption that the main goal of policy is to create a self-improving health care system – one that is much more decentralised and much more responsive, where day-to-day ministerial involvement in its operation becomes redundant and the need for centralised performance management is much reduced.

- Such a system needs standards, regulation, boundaries and rules, but the main driving force for improvements in health care quality and efficiency will come from commissioners' informed purchasing decisions. Patient choice can provide an additional incentive but should not be seen as the sole lever for improved quality.
- This goal and the means of achieving it need to be captured in a succinct 'unifying narrative', which could best be expressed in the following terms.
- Ministers and the Department of Health will still be responsible for setting standards, goals and priorities. But day-to-day operation, and precisely how those goals are achieved, becomes a matter for the service.
- The NHS will increasingly become a commissioning rather than a providing organisation. The provision of care will come from free-standing organisations, which, while regulated, will be responsible for their own success and failure, whether they are NHS foundation trusts, general practitioner (GP) practices, social enterprises or independent and voluntary providers.

Patients will be given significantly more choice over how and where they receive care, underpinned by easier availability of information about the quality of care in provider organisations.

Clinicians and managers, in a system that operates with more of the disciplines of a supplier market, will have greater freedom to innovate in the search for services that are responsive, cost effective and of continuously improving quality.

The forthcoming Next Stage Review Report provides an ideal opportunity to clarify the future direction of travel, and to address a number of changes required to achieve the objectives outlined above.

Recommendations

Our report includes 33 specific proposals, set out in each section under the heading 'What needs to be done?'. They are all important in their own terms. But we have summarised below 10 key recommendations, which we believe are central to achieving the reform objectives, and which we would like to see included in the Next Stage Review Report.

- First, and most importantly, ministers need to re-state clearly the future direction of travel for the reformed system, in terms of a 'unifying narrative' such as the one set out above. This is essential to dispel any lingering doubt about the government's commitment to the market-based reforms. Such a statement should be on the front page of the Next Stage Review Report.
- Clearer rules for dealing with provider failure and (at worst) exit are long overdue. The Department of Health, in consultation with Monitor and the Healthcare Commission, should draw up these rules so that they are in place before they are needed. This applies to both NHS trusts and foundation trusts.

- Strategic health authorities (SHAs), working with primary care trusts (PCTs), should develop a set of positive incentives for the performance of PCTs as commissioners. We suggest some examples in this report, but there is no need for a national blueprint. Different approaches can be tried in different places, with lessons disseminated.
- The Department of Health, working with the best academic and commercial support, should develop detailed quality indicators, which PCTs should routinely use in contracts, alongside patient-reported outcome measures.
- Public consultation should be based on commissioners' service strategies and specifications, and not on providers' plans for meeting those requirements. Ministers should commit to aligning the current statutory arrangements to reflect this.
- Ministers should set a clear timetable for the divestment of PCT provider functions to allow PCTs to focus on and fully develop their commissioning role. The Department of Health should work with SHAs to develop a range of organisational models and a detailed human resources plan to protect the interests of staff affected by this transition. PCTs should make external support available to existing provider units, which should take the lead in determining the most appropriate organisational model for local circumstances.
- PCTs should appoint independent clinical panels to advise on commissioning, rather than simply relying on practice-based commissioning to provide clinical input.
- Ministers should consider practice-based commissioning as just one element in a suite of commissioning tools that may be used locally. But, where GPs want to provide a wider range of services, practices (or practice consortia) should be commissioned as principal contractors – rather than as commissioners in their own right.

- The biggest changes to the status quo are needed in primary and community care, where the market should be opened up through greater use of contestability and contracting mechanisms, so that these services are eventually commissioned on the same basis as other services. This requires a phasing out of the minimum income guarantee and continued evolution of the Quality and Outcomes Framework.
- The Department of Health should continue to actively encourage and support the exercise of choice – not least through the development, use and publication of detailed quality metrics, including patient-reported outcome measures

System reform and incentives

Reform of the National Health Service (NHS) in England, as it nears its 60th anniversary, has reached a critical point, with much – though not all – of the architecture needed to run the 'new' NHS in place.

The objectives of the reforms are, we think, reasonably clear. The goal is to create a self-improving health care system – one that is much more decentralised and much more responsive, where day-to-day ministerial involvement becomes redundant and the need for centralised performance management is much reduced.

Such a system needs standards, regulation, boundaries and rules. But the main driving force for improvements in health care quality and efficiency will come from commissioners' informed purchasing decisions. Patient choice can provide an additional incentive but should not be seen as the sole lever for improved quality.

This goal and the means of achieving it need to be captured in a succinct 'unifying narrative', which could be expressed in the following terms.

- Ministers will still be responsible for setting standards, goals and priorities. But day-to-day operation, and precisely how those goals are achieved, becomes a matter for the service.
- The NHS will increasingly become a commissioning rather than a providing organisation. The provision of care will come from free-standing organisations that, while regulated, will be responsible for their own success and failure, whether they are NHS foundation trusts, general practitioner (GP) practices, social enterprises or independent and voluntary providers.
- Patients will be given significantly more choice over how and where they receive care.

- Clinicians and managers, in a system that operates with more of the disciplines of a supplier market, will have greater freedom to innovate in the search for services that are responsive, cost effective and of continuously improving quality.

But while the rhetoric is there, the reality lags behind. This is why the King's Fund asked this working group to look at the current state of play and how the incentives within the system are operating, with the aim of feeding conclusions into Lord Darzi's Next Stage Review Report (*see* www.ournhs.nhs.uk). Members of the working group all contributed to its findings and while different views emerged, they support the thrust of the analysis presented here. The report is the chairman's, though, and he is responsible for its recommendations.

The findings are based on the knowledge, insight and experience of the working group, buttressed by support and analysis from King's Fund policy staff and the output from a one-day workshop attended by a wide range of people working in and for the NHS.

It is important to state that it is still early days. Many of the incentives in the new system have been in place for only the shortest of time. It would be wrong to dig everything up by the roots to examine its progress before much of it has had the chance to flower.

Nonetheless, it is clear that while all of the incentives in the new system are working somewhere – although not always in the way intended – none of them is working everywhere.

It is also important to note that incentives are not purely financial, even though this paper, like much of the NHS reforms, tends to focus on this aspect. There are plenty of other incentives that act as both carrot and stick – many of them driven by information and transparency – that can confer power, status, professional recognition and satisfaction: the

knowledge (because the evidence is there and available) that a good job is being well done in comparison to one's peers.

Self-evident though it may be, incentives need to be closely aligned to objectives, and structured to minimise the risk of adverse effects. As the health system matures and develops, there is a constant need to keep incentives under review, to ensure that they are achieving the intended benefits.

We have looked at the system overall and some of its key components, examining the issues raised and setting out what needs to be done.

But perhaps our most important conclusion is that there is still no clear understanding of 'the rules of the game' out there in the NHS, and thus of the strategies that are needed to 'win', in response to a set of incentives designed to deliver continuous improvements in services for patients and the public.

The main reason for this is that 'success' has not been defined in a measurable way. That makes it difficult for people to work out for themselves what the key deliverables should be, with the result that they have to be directed. The unintended consequence is that activities become skewed to focus on those areas where there is some clarity and measurement. For example, because Payment by Results (PbR) is a clear measure and financial success a goal, there is a strong incentive to ramp up activity.

Even where people do understand the levers and incentives available, there is often reluctance – for a variety of reasons – to use them. The 'new' NHS is dealing with the legacy of years of heavy command, control and performance management from the centre. The story of the zoo, where the doors to the cages are thrown open but the animals stay inside, is a powerful analogy. Without a clear framework against which to deliver, the NHS ends up having to direct from the centre.

The system

Issues

Despite the work on world class commissioning, and the publication of the Department of Health's *Principles and Rules for Cooperation and Competition* (with its statement that services should be commissioned 'from the providers who are best placed to deliver') (Department of Health 2007), there remains ambiguity over the government's commitment to market-based reforms.

The rhetoric has become clearer in recent months. But doubts remain in both the public and independent sectors. The Department of Health's attempt to instruct foundation trusts on detailed control of infection arrangements cuts right across the principle of devolved provider management in a regulated market. And the recent history of wave 2 of the independent sector treatment centres (ISTCs) programme has left the independent sector feeling bruised. On the hospital side, some of the bigger independent providers now say they no longer see NHS work as core to their strategy. On the primary care side, there are plenty of organisations interested in providing high street and in-store NHS services, and building other, often private, services around them. But there are fewer organisations interested in directly employing clinicians to provide core primary care.

That in turn is hampering the development of strong commissioning, where primary care trusts (PCTs) need the availability of a wide range of providers if they are to use competition and contestability as a means of driving service improvement. For that to happen, there needs to be clear evidence that the desire for new players to enter the market is real. That does not mean that the NHS needs to offer guaranteed business to a particular provider – a private sector monopoly has no advantage over a public sector one. But the independent sector does need to believe that NHS commissioning in future will not simply involve parcelling out bits of service to existing NHS organisations.

What needs to be done?

- If the government is serious about its market-based strategy, ministers need to match actions to rhetoric and prioritise market development (not just market management; there is, after all, not much of a market to manage at present). The private and voluntary sectors remain unconvinced that they have a long-term future as substantial suppliers of NHS care, as opposed to merely being used in the short term as a means of temporarily stimulating better performance from the public sector, only for them to be discarded later. Without the certainty of a sustainable business, the private sector will be less innovative. The NHS market will be seen as a risky one to enter because the market itself may not have a long-term future. If this happens the private and voluntary sectors will invest less and charge more, or indeed not invest at all.
- There needs to be a much clearer strategy for dealing with provider failure and exit, most notably for NHS institutions, including foundation trusts. Often such failures will affect an individual service or services; but it may on occasion involve an entire institution. It is an important part of the 'new' NHS that the focus is on the patient, and that the unwritten obligation for commissioners to prop up failing institutions needs to end. The nature of a more market-based system is that failure will occur. Steps to deal with failure need to be in place before it happens.

Primary care trust commissioning

Issues

Successful commissioning is the key test for the new system. Failure to develop it has been the Achilles heel of successive NHS reforms since the internal market was initiated in the early 1990s. It is the test on which the new system will stand or fall.

PCTs are the key player in commissioning. They have, to be fair, been going through a difficult time. They have had to devote effort to

continuing as provider organisations while taking on new duties to engage more closely with local authorities. Some of this has come at the expense of sorting out the nature, quality, productivity and safety of the services they commission.

Many parts of the country have faced large-scale reorganisation, which is widely recognised to produce a dip in performance ahead of any improvement. They have been focusing on achieving not just financial balance but a surplus; on reducing hospital-acquired infections; and on hitting the 18-week target. That target, whether or not it is achieved, is unlikely to be sustained, or sustained amid continuous quality improvement, without significant changes to the way services are configured.

However, most PCTs seem reluctant to depart from existing service patterns or to change service providers, partly for the reasons just stated, and partly from a combination of risk aversion and a fear of destabilising existing services. They are under pressure from the public, mindful of deep local attachment to local hospitals even where their services could be provided more safely, and/or more conveniently, elsewhere.

The current rules on public consultation make it difficult and time consuming to deliver desirable change. Doing so can be a deeply bruising experience. And there is a strong perception that they will be blamed from above if things go wrong, while receiving neither recognition nor reward if things go right.

Payment by Results remains a misnomer. It is payment for activity, not for results. It is an incentive for providers to maximise activity, not quality. Its fixed price was indeed intended to take financial negotiation out of the equation, forcing competition on the grounds of quality. But PCTs are not generally performance managed on quality. Few of them are using good-quality indicators. And on their own they are not well

placed to develop such indicators. They lack both information and capacity, yet they are subject to centrally imposed controls on staff numbers. They can outsource work to support commissioning, but moves to build their own in-house capacity can be limited by controls on their workforce numbers.

Their main incentives are negative ones: performance management from above allied to the ultimate threat of removal of their chairs or chief executives. That only encourages a risk-averse approach. They need other, more positive incentives.

There is an assumption – certainly in ministerial rhetoric – that all commissioning will take place at the level of PCTs, which hold 70 per cent of the budget. But, as a Health Foundation report noted (Smith *et al* 2004), different population bases are needed for commissioning different services, ranging from practice or locality up to much larger populations for specialist services. It was suggested to the working group that, with some variation around the country, perhaps 15 per cent of secondary care needs to be commissioned at regional level and 40 per cent at a sector level (in other words, involving more than one and sometimes many PCTs).

Furthermore, PCTs' continued management responsibility for provider services remains a distraction from concentrating on commissioning. It inevitably takes up management time and focus. It reinforces the sense that PCTs are responsible for providers, not for the continuity and quality of care. And it discourages new providers from suggesting service innovations, fearing that, despite the competition rules, they will not face a level playing field.

On top of all this, practice-based commissioning (PBC) has to date proved a disappointment. It has in the main failed to provide effective clinical input into the population-based commissioning decisions that PCTs need to take.

In the long run, some believe that the answer is to extend patient choice to the point where patients can choose their commissioner. PCTs would then become the British equivalent of competing but publicly funded health maintenance organisations (HMOs). The incentives on them would cease to be largely negative. Successful ones would grow: unsuccessful ones would wither and die.

To introduce this now would, in our view, be a bridge too far. It would involve a shift from the current population-based funding formula to an individual-based formula. Current (as yet unpublished) research commissioned for other reasons by the Department of Health is providing a basis for doing that; but such a formula is not yet available.

Moreover it would put an even stronger onus on the role of public and patient choices in improving care. Making choices when you need health care is one thing; choosing your commissioner when you are healthy is another. There is little evidence from other sectors (such as banks, phone or broadband services) or around the world (for example, German Social Funds) that the public is quick to exercise choice.

In any case, the quality of commissioning is simply not yet good enough to provide an effective basis for competition. And one of the big lessons from the outsourcing in the 1980s and 1990s of a wide range of services, from emptying dustbins to information technology to back office functions, is that such changes produce the best results when the service being outsourced is already relatively robust – so that those commissioning the change understand the business they are buying.

Furthermore, introducing competing commissioners would create a massive structural upheaval that would go way beyond anything the government is currently attempting – and at a time when many of the structures and mechanisms needed to make such a system work have barely begun to bed down.

It does, however, need to be recognised that if commissioning is the key to making the reforms work, then issues about the accountability of commissioners do become more prominent. In the long term, providing patients with a choice of commissioner would be one answer to the accountability issue.

It is important not to get too carried away by a debate that tends to fascinate politicians and policy-makers far more than it does the public. Just as with street cleaning, the quality of schools, street lighting or policing, what people care about is a service that works, not – until things go badly wrong – who is accountable for it and how. The working group's view is that the government should resist the temptation to hand over responsibility to local government for deciding which services the NHS should provide – through either the automatic appointment of councillors to PCTs or, as some have advocated, direct elections to PCTs.

The reasons are manifold. Holding elections for members of PCTs would risk introducing party politics into the commissioning of NHS care. Appointing councillors to PCTs would forget the unhappy history of councillors' previous automatic entitlement to sit on health authorities. And the government has recently put in place a slew of policies to ensure that the health sector and local government work more closely together – across the health/social services divide and other areas. Examples of these policies include local government oversight and scrutiny committees, which have defied the sceptics by being in the main supporters of sensible change; and the as yet untested local area agreements that have recently placed a statutory duty on all parts of the health service to co-operate with local councils in agreeing goals for their areas. Both look like improvements to what went before. Both need to be allowed to bed in to see how well they work.

A more detailed analysis of local accountability of PCTs is given in a recent King's Fund discussion paper (Thorlby *et al* 2008); and Niall Dickson, Chief Executive of the King's Fund, is currently chairing a commission for the Local Government Association on accountability in health, which will also no doubt consider these matters in more detail.

What needs to be done?

- There need to be stronger incentives for PCT performance: for example, publication of performance against metrics that the PCT can influence, such as survival and quality of life after stroke. They should not, however, be measured on goals over which they have only limited influence: for example, the overall incidence of heart disease (though they could be held accountable for the use of statins or other evidence-based measures that can help reduce heart disease).

- By way of positive incentives, a number of performance-linked freedoms could be introduced. For example:
  - performance-linked flexibility to manage surpluses and deficits over longer time scales, of up to five years
  - performance-linked access to innovation funds for new service development (formula-based to avoid bureaucratic application processes)
  - performance-linked flexibility around existing staffing levels – do well and you can appoint more staff to do better. Indeed, it is difficult to see why there are central controls on staffing levels. PCTs should be held to account for how well they perform, not for how many people they employ. In any event there may be a good case for them spending more to develop the commissioning role to its full potential.

- In line with the current co-operation and competition rules, PCTs should actively develop their local health care market, not just manage what is there. That means looking for, appraising and encouraging new market entrants.

- Specialist services should be commissioned at the appropriate level – multi-PCT or higher. Once providers are designated as able to meet the required quality standards for specialist provision, other providers should not be paid. Such changes should be easier to achieve than in the past; current surpluses can help meet double running costs as improved services are introduced while existing ones are wound down.
- Quality indicators need to be developed. This is more a national than a PCT issue. They should be applied to providers and routinely used in contracts. And there is also a need to develop measures of a PCT's success in ensuring that services are co-ordinated across service and organisational boundaries.
- Key among the quality indicators should be faster and wider introduction of patient-reported outcome measures such as Euroqol EQ-5D (*see* www.euroqol.org), allied to procedure-specific measures of outcome. Such measures provide not only a tool to decide how and from whom services should be commissioned but also a powerful piece of information that will create peer pressure among clinicians for improvement.
- The current limited system of financial penalties for failure to achieve quality standards – for example, for missing hospital-acquired infection targets – should be developed further. This could extend to a refusal to pay for some adverse incidents or poor-quality outcomes. It could also include some 'extra' payment for reaching quality thresholds.
- Such systems require extremely careful design to avoid gaming or 'paying twice' for quality, and heavy penalties for non-performance risk disadvantaging subsequent patients. In practice, there may be little difference between a penalty for under-performance or a reward for achieving quality standards, provided both are held within the overall tariff. On balance, the working group favours a system of positive incentives: one option might be to hold an element of the tariff back at commissioner level, using that to reward quality performers.

- Performance management of strategic health authorities (SHAs) and PCTs is the chief executive's remit. But an independent assessment of the quality of commissioning by the Healthcare Commission and its successor is also important. That will not only provide a spur to improvement but also help address the accountability issue.
- The current legal requirement for providers to undertake extensive consultation on individual service changes should be abolished. Instead, public consultation should focus on PCTs' published commissioning strategies. The requirement for 'double' consultation may deter or dramatically extend the timescale of desirable change. Indeed, there is a risk that commissioner-instigated plans (consulted on or driven by patient choice) may be derailed by subsequent provider-based consultation.
- PCT provider functions must, over time, be removed. In other words, the thrust (though not the style) of the infamous 28 July 2005 letter from the then Chief Executive Sir Nigel Crisp was right (Department of Health 2005). PCTs cannot be impartial commissioners on behalf of their populations if part of their function is service provision. As a first step, their provider functions need to be genuinely run at arm's length and subject to the same commissioning rigour as any other service.
- Ministers should set a clear timetable – say three years – by which time most of the existing PCT provision will have been separated into new, managerially autonomous organisational forms. PCTs need more help – not direction – to achieve this, including a range of organisational models to accommodate the services and a detailed human resources plan to safeguard the interests of staff affected by the transition. These models might include community foundation trusts and social enterprises, although both have been slow to develop and neither might be entirely appropriate, especially if they sustain the historical aggregation of a set of services that are, in practice, quite different.

- Provider units themselves should be able to decide which organisational model(s) best suit local circumstances (just as NHS trusts and foundation trusts shaped their own organisational destiny), with specialist external support and a regulatory overview to ensure that NHS assets are safeguarded by a robust business plan.
- PCTs should appoint independent clinical panels to advise on and review the quality of commissioning decisions, rather than simply relying on practice-based commissioning to provide clinical input. Clinicians should be individually appointed, properly remunerated, and subject to performance assessment of their advisory role. Advisers on secondary services might best be drawn from out of area to avoid conflicts of interest. Any conflicts of interest that do result should be placed on the public record and managed by proper tendering of changed services.
- To improve local accountability, PCTs should develop membership schemes analogous to those of foundation trusts. These would provide a focus for informed public engagement around quality, safety and service development. But this should not in any way be seen as a substitute for public and patient engagement, which is absolutely essential for effective population-based commissioning, and is not always seen as the core function it should be for PCTs.
- Relationships with local government should continue to be developed through joint planning and needs assessment, not through automatic board appointments.

GPs and practice-based commissioning

Issues

PBC was intended to bring a greater clinical perspective into commissioning decisions; to facilitate the transfer of services from hospital to more local settings where this was appropriate; to give PCTs feedback on provider performance; and to encourage GPs to refer responsibly (or, put another way, to manage demand).

While it is early days, there is little or no evidence that PBC is making a substantive contribution to these objectives, or that it has achieved significant or widespread quality improvements (King's Fund 2007).

As might have been predicted given our understanding of the impact of fundholding and variants, most of the commissioning objectives put forward by practice-based commissioners have tended to focus on specific service elements that can be moved from hospital to primary care. There has been relatively little focus on the whole range of commissioned services, or how the elements being moved fit into them.

The contribution of a clinical perspective to wider commissioning strategies has been limited, and it is hard to see why feedback on provider performance depends on a commissioning (rather than a referring) responsibility. Perhaps more significantly, it is becoming clear that the transfer of services closer to home requires a more fundamental redesign of the patient pathway than could reasonably be achieved without the full involvement of all parties in the local health economy. Again, it is difficult to see how that could effectively be led by any but the very largest PBC consortia.

PCTs are statutorily required to engage with the public on service change, but there is currently no incentive or requirement for practice-based commissioners to do the same.

It might be argued that PBC should be given more time to achieve its objectives. While the intent was to stimulate systemic service redesign, the average GP in PBC seeks opportunities to develop practice-based services and innovations.

Moreover, there is a structural flaw to PBC in the fundamental conflict of interest between GPs as commissioners and as providers. This blurring of the purchaser/provider roles effectively limits contestability and potentially choice, but more importantly is compounded by the

potential for personal gain arising from individual commissioning decisions. Declarations of interest to patients are a necessary but insufficient safeguard.

Aside from this, PBC detracts from and confuses the PCT's primary role as the commissioner for the whole population. In our view, there are more effective ways of meeting the objectives of PBC – for example, through the appointment of clinical panels to advise on commissioning, a whole health economy approach to the redesign of patient pathways, and the development of detailed quality metrics to support choice and manage provider performance (including primary care delivery and referral practice).

Turning to the delivery of primary care services, the Quality and Outcomes Framework (QOF) has in many ways been a success. Even so, there is still a wide variation in the range and quality of care delivered by GPs. PCTs are applying QOF standards differently, and the process needs to be refined and developed. While GPs have reacted rapidly and forcefully to the financial incentives QOF provides, it covers only 20 per cent of GP income. There is no quality measure over much of the rest of GPs' activity.

Finally, there are still barriers to PCTs bringing in new providers where they are unhappy with existing GP services. In particular, the minimum practice income guarantee means that PCTs face large and unproductive double running costs. If they bring in a new service that successfully attracts large numbers of patients from existing GPs, they are, in some cases, still required to pay the existing provider a minimum income.

What needs to be done?

- It is clear that many practices have no real appetite for being involved in practice-based commissioning. Requiring all of them to undertake PBC is likely to be a waste of time, effort and

money. Instead, PBC should be regarded as one element in a suite of commissioning tools that may be used locally to enable service redesign, rather than as the key lever for change.

- Where GPs want to provide a wider range of services that involve other staff or organisations, practices (or practice consortia) should be commissioned as principal contractors – rather than as commissioners in their own right. This would still allow GPs to innovate, and they would be free either to provide additional services themselves or to contract services from others. But such arrangements would be part of the contract and thus transparent. That would avoid the conflict of interest inherent in hidden 'self-commissioning'. It should be the normal means of commissioning practice-based services. The creation of the competition panel offers an appeal mechanism when a PCT rejects a good business case unreasonably.
- PCTs should appoint their own independent panels of clinicians from the primary and secondary care sectors to advise on commissioning (see recommendation under PCT commissioning).
- Ultimately, primary and community care services should be commissioned on the same basis as other services.
- To enable that to happen, the minimum income guarantee should be phased out, along with seniority payments; greater use should be made of Alternative Provider Medical Services (APMS) contracts; and new or relocated services should be subject to tender.
- The QOF should be extended to a wider range of services and progressively made a larger part of GPs' remuneration. As some of its current standards become the norm, they should be absorbed into the core of the contract so that they cease to be subject to incentive payments.

Choice

Issues

The working group believes that choice, while good in its own right, has the potential to improve quality. But it needs time to achieve this. It is much more effective in some areas than others; indeed, for some services (such as emergency admissions) it will never have a routine role.

Patient choice is currently limited by a number of factors: the lack of information on quality, and particularly on outcomes; the difficulties patients have in interpreting outcome and quality data, even when it is available; the relatively small proportion of care over which choice can be exercised (at present limited to initial outpatient appointment, with perhaps the possibility thereafter to choose another provider for an operation); and the lack of feedback to providers about why patients may choose to go elsewhere.

In addition, patients' ability to exercise choice depends critically on the availability of at least some spare capacity, and mechanisms that allow providers to adjust (and sometimes exit from) service lines when patients choose to go elsewhere.

Choice can and indeed should extend to options for treatment, rather than just where treatment takes place.

What needs to be done?

- More information about outcomes and patient satisfaction needs to be made routinely available in as close to real time as possible (*see* also recommendations on quality indicators under commissioning, above).
- Providers need to solicit customer feedback and develop their market analysis skills so that they understand the reasons for the choices patients make.
- It should be made easier for patients to receive some services, or

elements of service, near their place of work rather than near their home. This might need some adjustment to the primary care fee structure, and could involve the extension of walk-in centres.

Payment by Results

Issues

One of the objectives of PbR was to remove price competition in order to focus competition on quality. But the immature nature of the market, with limited alternative providers, poor information for patients on quality, and the limited application of choice to date, means there is little evidence that such an approach is working.

In addition, the tariff is insufficiently granular to reflect important differences in case complexity or to allow accurate unbundling.

Where there is evidence that PbR is working is in the incentive it has provided for hospitals – initially foundation trusts but now some others – to undertake service-line reporting. It is early days, but this appears to offer a route to involve clinicians directly and constructively in managing the costs and design of service. There is evidence that, in some cases at least, PbR is producing services that are both better and cheaper (Monitor 2007).

What needs to be done?

- The current process of refining and developing the tariff in the light of experience needs to be continued. Office of Population Censuses and Surveys (OPCS) coding should replace Healthcare Resource Groups (HRGs) to give greater granularity, enabling case-mix to be more accurately matched to costs.
- There remains a debate over how far local flexibility in the tariff should be permitted. The case in favour is that some see a degree of flexibility as essential for the provision of chronic disease and

networked services. The case against is that it would reintroduce price competition, with all the downsides evident when it was used under the original 1990s internal market. Huge effort was too often devoted to bartering over tiny price changes at the margin rather than examining the nature and quality of the services being provided. At a minimum, the working group's view is that a fixed price should remain for elective, episodic care.

Capital

Issues

There has been a massive underspend on capital in recent years. Compared with 2005 plans, there has been a cumulative underspend of more than £6.4 billion over the period 2004/5 to 2006/7 – and there are problems with the capital element in the tariff.

At 6 per cent of the total, it is insufficient to enable significant capital investment on new buildings or equipment, especially where these improve quality without a corresponding increase in volume.

The NHS Local Improvement Finance Trust (LIFT) scheme suffers from onerous and long-winded development and approval systems, which can add to costs. Yet there remains a need to improve the quality of the built environment in both primary and community care.

What needs to be done?

- PCTs should be permitted to pay an income supplement above tariff for a limited period to offset extra capital charges (in other words, above the 6 per cent already included in tariff). But this should be limited to certain objectives. Its equivalent with the private sector was a willingness to pay above tariff for the first five years of wave 1 ISTCs to establish a service.
- Ultimately, for primary and community-based services, PCTs should

concentrate on commissioning services rather than buildings (and, if appropriate, specifying explicit environmental quality improvements), leaving it to the service provider to contract with a property/construction partner (which may or may not be the local joint venture company (LIFTCo)).

- This may not be possible in all cases until PCT provider functions have been established as effectively separate entities with the skills and resources to contract with property/construction partners.
- In the meantime an 'earned autonomy' approach should be applied to accredited PCTs and LIFTCos to streamline development and approval processes for LIFT projects.

Recommendations

Our report includes 33 specific proposals and they are all important in their own terms. But we have summarised ten key recommendations below, which we believe to be central to achieving the reform objectives, and which we would like to see included in the Next Stage Review Report.

- First, and most importantly, ministers need to re-state clearly the future direction of travel for the reformed system, in terms of a 'unifying narrative' such as the one set out in the first section of this report. This is essential to dispel any lingering doubt about the government's commitment to the market-based reforms. Such a statement should be on the front page of the Next Stage Review Report.
- Clearer rules for dealing with provider failure and (at worst) exit are long overdue. The Department of Health, in consultation with Monitor and the Healthcare Commission, should draw up these rules so that they are in place before they are needed. This applies to both NHS trusts and foundation trusts.
- Strategic health authorities (SHAs), working with primary care trusts (PCTs), should develop a set of positive incentives for the performance of PCTs as commissioners. We suggest some examples in this report, but there is no need for a national blueprint. Different approaches can be tried in different places, with lessons disseminated.
- The Department of Health, working with the best academic and commercial support, should develop quality indicators, which PCTs should routinely use in contracts, alongside patient-reported outcome measures.

- Public consultation should be based on commissioners' service strategies and specifications, and not on providers' plans for meeting those requirements. Ministers should commit to aligning the current statutory arrangements to reflect this.
- Ministers should set a clear timetable for the divestment of PCT provider functions to allow PCTs to focus on and fully develop their commissioning role. The Department of Health should work with SHAs to develop a range of organisational models and a detailed human resources plan to protect the interests of staff affected by this transition. PCTs should make external support available to existing provider units, which should take the lead in determining the most appropriate organisational model for local circumstances.
- PCTs should appoint independent clinical panels to advise on commissioning, rather than simply relying on practice-based commissioning to provide clinical input.
- Ministers should consider practice-based commissioning as just one element in a suite of commissioning tools that may be used locally. But, where GPs want to provide a wider range of services, practices (or practice consortia) should be commissioned as principal contractors – rather than as commissioners in their own right.
- The biggest changes to the status quo are needed in primary and community care, where the market should be opened up through greater use of contestability and contracting mechanisms, so that these services are eventually commissioned on the same basis as other services. This requires a phasing out of the minimum income guarantee and continued evolution of the Quality and Outcomes Framework.
- The Department of Health should continue to actively encourage and support the exercise of choice – not least through the development, use and publication of detailed quality metrics, including patient-reported outcome measures.

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