King's Fund

AUGUST 2006

The Commissioning Framework

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Key points

- Commissioning functions of PCTs have been articulated in detail for the first time in the current reform programme. Commissioning is described as a highly complex, technical activity that will require a step change in how data is collected and analysed. However, it will also depend on the political and managerial clout of PCTs to act on this information effectively, especially when managing the activity levels of GPs and hospital providers. Commissioning itself is not new (it began in the 1990s), but the political and managerial focus needed to build those skills and techniques has been lacking until now.

- Managing demand (and keeping health care consumption within resource limits) has become a key focus of commissioning, which will require PCTs to exert effective downward pressure on GP referral patterns and upward pressure on hospital providers. The document provides a number of devices to help PCTs achieve this, such as contracts and demand management tools, in recognition that this has been a weakness in the past.

- Although the document refers to the importance of patient choice and Payment by Results (PbR) as key drivers of reform, the logic of the measures set out in the document appear to circumscribe some of their potential. Contracts will once again contain 'activity' limits; failure to adhere to them will allow PCTs to suspend or reduce tariff payments to providers and some of the demand management tools imply limits to patients' ability to choose where to be treated.

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Background

Although some of the key planks of the NHS reform programme, such as PbR and patient choice, began to take shape from 2003, it is only recently that the Department has begun to publish guidance, aimed at people working within the NHS, that attempts to communicate *why* the reforms are necessary and *how* they will mesh together. The first document, 'Health Reform in England: Update and next steps'[2] was published in December 2005. It promised further policy guidance, including the Operating Framework[3] which was published in February 2006. The Commissioning Framework followed in July 2006.

This latest update identifies three drivers of change within the NHS reform programme: patient-driven through choice, voice and competition; commissioner-driven through contracting, contestability and service redesign; and national-driven through standards, targets, agencies and regulatory approaches.

The Commissioning Framework provided is largely devoted to the commissioning function of PCTs (although more detail on commissioning 'well being' is expected later in the year – *see* below). More policy documents are promised in the near future for both patient-driven reform (choice) and national-driven reform (specifically regulation).

The Commissioning Framework

This Commissioning Framework is primarily about how PCTs should commission *hospital* services. Details of how preventative health care and jointly commissioned social care should operate will be published in December 2006.

This document identifies a number of commissioning goals for PCTs and sets out the mechanisms to achieve them, some of which are new.

'Securing comprehensive services'

PCTs will be given the freedom to use incentives to attract new providers, including offering minimum income 'guarantees' within the contracts, similar to those used to attract Independent Treatment Centres, supplementing the tariff to make the rewards higher for providers and making capital investment easier. This is very significant and will allow more local flexibility in procuring services; however, PCTs will face challenges in this, not least balancing the ability to offer incentives to new providers to establish themselves or enter the market with the need to offer a level playing field to competing potential providers.

There is a recognition that PbR might lead to existing providers pulling out of unprofitable, but necessary, areas of service delivery. The Framework suggests that stipulating a range of 'mandatory services' for providers to deliver might be a way round this, similar to those offered by Foundation Trusts as part of their terms of authorisation. Again, this will act as a brake on the market mechanisms introduced with PbR, a recognition that PCTs have a delicate balance to manage between planning and strong provider incentives.

To increase the uptake and improve the potential of practice-based commissioning, PCTs will be allowed to add bonuses, above and beyond the existing incentive payment to GPs. Importantly, these incentives are not linked to budget bottom line (earlier practice-based commissioning guidance suggests that PCTs can retain some of the 'savings' released by practices under certain circumstances) and can be treated as extra income by GPs. This seems sensible in that PCTs in deficit will have something to encourage engagement from local practices. PCTs will also be able to lend them money where start-up costs are proving a barrier to progress.

'Improving the quality, effectiveness and efficiency of services'

National regulation by the Healthcare Commission and other bodies is designed to guarantee the basic safety and quality of services on offer. However, the Commissioning Framework suggests that PCTs might be allowed to offer bonuses to high-performing local services in the future. The proposals would not take effect until after 2007/8. The Framework suggests that this would mean that PCTs could offer high-quality providers an incentive *in addition* to the national tariff payment specified under PbR. Although only a suggestion for further discussion at this stage, this might prove to be a particularly useful tool for PCTs to build in some more explicit local quality standards, particularly if they are faced with providers who are incentivised by PbR to deliver efficient but minimal quality services. Without such incentives on offer, there is a possibility that providers offering only basic services might triumph in the marketplace in some areas.

Faced with poor-quality *community* services, PCTs will be expected to tender for services that have fallen below an acceptable standard, although the mechanisms for this have not been spelled out. There are limited 'sanctions' currently available for PCTs to manage GPs or hospital providers. Under the current system, if providers pass the Healthcare Commission's standards and can offer services at tariff, then they have a right to offer services for patients to choose. It will be harder for PCTs to 'decommission' hospital services that can be chosen by patients and GPs under patient choice.

'Increase choice for patients and ensure greater responsiveness to people's needs'

Choice

This latest document has little to add in this area, except to specify that, over the longer term, choice and competition are most suitable to drive change in elective care, maternity care, primary, community and intermediate care and non-urgent mental health care, and that the remaining areas of urgent and emergency health care (including mental health) are more suitable for Commissioner-driven improvement. Much of the current document, however, specifies how commissioners should plan and control *elective* hospital care, so it is not clear what the respective balance between choice and commissioner-led care should be. There is no evidence presented about how effective the current policy of choice at the point of referral (introduced in January 2006) is proving to be. The popularity of patient choice is illustrated, once again, by evidence from pilot projects (now completed), which were also different from the current patient choice policy in a number of respects. There is still a lack of evidence at this stage about how patients behave when confronted with choice at the point of referral.

More detail on the future of choice is promised for the autumn of 2006. The document observes, meanwhile, that 'PCTs will always need to set some boundaries around choice' to keep services fair and within available resources, a more explicit recognition that there may be limits to choice.

Responsiveness

PCTs will be expected to produce an annual prospectus aimed at patients, the wider public and potential providers. The PCT prospectus is an ambitious idea: it goes beyond any document currently produced by PCTs, containing needs assessments and patient ratings of services, and explanations of future commissioning directions and current commissioning decisions. Full public disclosure of spending decisions would certainly increase public accountability. There are, for instance, huge variations in the spending patterns of PCTs that are currently not subject to any public or regulatory scrutiny. However, there are considerable costs implicit in the compiling and dissemination of the prospectus, especially if it is to be fully 'accessible to members of the public'.

Better community engagement is also considered to be a useful tool to improve services. A major reform of public involvement structures was announced in parallel with this document, which replaces Patient and Public Involvement (PPI) forums with new Local Involvement Networks. These are designed to have a less rigid involvement structure than PPI forums and be better positioned to

consult a much wider section of the public. However, their full effectiveness will depend on legislative change to section 11 of the Health and Social Care Act 2001, which is designed to strengthen the duty on the NHS to respond to the public, a duty that is not considered to be very effective at the moment.

New proposals to strengthen the public's voice are put forward, as a consultation, at the end of the document in the form of public petitions, to which the PCT will be obliged to respond. There is much detail to be added to this, including just how many signatures will be needed to trigger action and who will be allowed to initiate them.

'Achieving best value within the resources provided'

This document recognises that the acute hospital sector now faces powerful incentives under PbR to 'improve productivity' but that PCTs also have a statutory duty to achieve financial balance. Controlling and planning the level of admissions to acute hospitals has traditionally been a weak area of PCT activity (and in some cases has led to substantial deficits as money has flowed uncontrolled from PCTs to hospital trusts). The wider NHS reforms are designed to rectify this, partly through practice-based commissioning, partly through adjustments to the PbR tariff to make non-hospital based treatments more attractive, and partly through some of the techniques outlined in the Commissioning Framework.

In the longer run, PCTs will be expected to critically analyse their local data on referral rates, admission rates and other intervention rates, to see where they stand in relation to the national average and to start developing more evidence-based approaches to hospital-based treatment, which above all take into account the outcomes for patients. To assist PCTs to act on the insights from the data, the Commissioning Framework suggests using two techniques to control patient flows: referral management centres and 'prior approval'. Referral management centres are already being used in the NHS, and act as a bridge between referring GPs and hospital consultants. They aim to direct the patient to the 'most appropriate' place for treatment, but so far they have not been popular with doctors, some of whom have perceived them as interfering.[4] Prior approval is designed to ensure appropriate 'consultant to consultant' referrals by sending the patient back to the GP first.

As the Commissioning Framework acknowledges, Referral Management Centres have a number of pitfalls, including the risk of adding a layer of bureaucracy between the patient and the system. But they also potentially undermine the responsibility of GPs to refer appropriately in the first place, and add confusion (for patients especially) to the Choose and Book system, which was originally designed to reduce some of the delay and uncertainty in the whole process of securing outpatient appointments.

In the shorter run, the document recognises that more immediate solutions are needed and recommends the use of contracts, which specify pre-agreed volumes of activity. Although these are described as temporary for 2007/8, many of their features will remain in place for consultation in a new model national contract. These contracts will allow PCTs to take action if pre-agreed 'ranges' of activity are exceeded: PCTs are expected to establish whether the problem lies with over-referring GPs or hospitals exceeding their limits (through consultant to consultant referrals). If GPs are at fault, hospitals still have to be paid, but the PCT will be expected to 'manage' the referral rate down. If hospitals are at fault, the PCT is now allowed to reduce or even withhold payment if rates are exceeded. This vision is some distance from the rhetoric of consumer-driven services, where hospitals are given the freedom to expand where they prove to be popular with patients. It also suggests a very difficult balancing act for PCTs to maintain between enabling choice incentives to work and central planning for wider population needs. It also requires PCTs to have high quality, timely data from providers.

Contracts where multiple PCTs buy services from single providers will be held by one lead PCT to reduce bureaucracy.

The Commissioning Framework recognises that achieving some of the planning and demand management functions successfully will require a quantum leap for PCTs in both the volume and the accuracy of the data they receive and their ability to analyse it. It is here that a new role for the private sector is envisaged 'for many PCTs' that might buy in expertise from private companies. To facilitate this, the Department of Health is conducting a national procurement exercise to generate a shortlist of recommended companies. This, and other documents, makes it clear that PCTs cannot under any circumstances contract away their *accountability* for commissioning; however it is not clear whether or how far the private sector role will extend to making executive decisions about referral rates and demand management.

Conclusion

Overall, the Commissioning Framework has the potential to move the NHS in a positive direction, by encouraging a much more data-driven, rational approach to commissioning hospital services, rather than relying on a system that lets resources flow according to unchallenged historically based patterns. Intellectual investment in the techniques of commissioning is long overdue in the NHS. Perhaps more importantly, it also represents a political investment in the idea and role of commissioning, which has been lacking over the past two decades.

If it works correctly, good commissioning will allow spending to be more closely linked to health care outcomes. For the acute hospital sector it is still not entirely clear, however, what balance the government intends there to be between a consumer-driven system, based on choice and PbR, or a commissioner-led system, based on professionally driven planning and demand management systems. This latest guidance makes it clear that hospitals will *always* get paid if the referrals have come from GPs, opening up a new lobbying frontier between hospital consultant and GP.

On the other hand, it is hoped that the incentives built into practice-based commissioning will strengthen PCTs' and GPs' ability to devise their own more appropriate non-hospital based forms of care. However, it is still a matter of faith whether practice-based commissioning will kick in as an effective mechanism in the new system. Thus far, uptake has been patchy and if PCTs do too much overseeing of commissioning, then that might disempower practice-based commissioning. However, if commissioners rely too much on an immature form of practice-based commissioning to curtail demand, there is a risk that resources will be used inefficiently and that overspending will occur.

What this document also reveals is a growing awareness of the importance of the accountability and regulation of commissioning. The Commissioning Framework states that strategic health authorities will be responsible for managing and regulating much of the commissioning activity outlined above, but promises more detail later in 2006, including strategies to resolve disputes between trusts and how the performance of both providers and commissioners should be assessed. Clarification is also awaited on how private contracts are to be awarded and the market policed.

How commissioning is to be made fully accountable to the public remains unresolved. As the accompanying King's Fund briefing on PCT spending reveals, there are currently unexplained and substantial variations in what PCTs spend; yet at the moment there is no public scrutiny of this and PCTs do not publish this data. Increased use of the private sector in commissioning might not increase transparency in this area and there is a need for more clarity about who should be monitoring just how effectively PCTs are discharging their commissioning duties across the country, on behalf of patients and taxpayers.

[1]Department of Health (2006). Health Reform in England: Update and commissioning framework. London: The Stationery Office. Available online at:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137226&chk=D2YSig (accessed on 2 August 2006)

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[4]http://www.bma.org.uk/ap.nsf/Content/ARM2006bmanewscentres (accessed on 2 August 2006)