

Commissioning Health

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Secretary of State for
Health**

Guest Editorial

I am delighted to have been invited to contribute to the first issue of *Commissioning Health*.

The development of commissioning to ensure that the NHS provides the best health, the best healthcare and the best value for money for the public is a critical part of the evolution of the NHS. If this magazine can stimulate debate, develop new ideas and spread best practice, it will be making a highly valuable contribution.

Commissioning is the vanguard of efforts to maintain an NHS true to its founding values. It must continually demonstrate to the public that a tax-funded system is the most efficient and effective way to provide high-quality, accessible healthcare; and, it must make a decisive contribution to maintaining people's health and well-being to reduce the impact of an ageing population and modern lifestyles on healthcare costs.

I am confident that we can achieve both of these objectives if we do four things.

Firstly, commissioners must respond to the public's demand for a high-quality NHS that is personalised to their needs and treats them with respect and dignity. This will mean change. Some services need to move from acute hospitals to patients' homes or primary care. Other services need to be centralised in specialist units, but patients should come back to their local hospital as soon as it is appropriate. It is up to the commissioners to describe the standards that they expect and work with their providers to achieve this, without destroying what is good in their local hospital.

Secondly, the tough decisions that commissioners make must be based on sound clinical judgement. Practice-based commissioning (PBC) has not been created to make PCTs' lives more difficult. It reflects the fact that most of the money spent by the NHS is spent by doctors, not managers. PCTs must make PBC a genuine opportunity for primary care clinicians to develop better services for their patients - providing timely information, management support and freedom to innovate.

Thirdly, commissioners must take action to create choices for patients. Patient choice is at the heart of the NHS reforms because patients in the 21st century don't want a "one-size-fits-all" health service - and because competition drives improvement.

All around the NHS, we can see that where competition exists, the NHS is responding by delivering faster, better care at lower cost. But patients do not want a smorgasbord of options where it becomes their responsibility to create a logical clinical pathway. Commissioners must commission pathways that offer choices and create competition without inappropriate fragmentation or delay.

Finally, commissioners must remember their objective: health, not just healthcare. The energy and intellectual effort used when negotiating a contract with a hospital needs to be more than matched by that used to design programmes which will keep people well and away from the NHS.

And when you've done all that, take time to step back and feel proud of the fact that you are part of one of this country's greatest achievements and one of the finest examples of social partnership anywhere in the world.

Contents

Michael Sobanja	2	Jennifer Dixon	8
Barb Allen and		Nick Bosanquet	9
Elizabeth Wade	3	Philip Housden	10
Natalie-Jane		Bob Sang	11
Macdonald	4	Andy Cowper	11
David Stout	6	David Jenner	12

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Commissioning Services

Commissioning for outcomes: preventative management needed



Michael Sobanja is chief executive of the NHS Alliance

Commissioning is the process of deciding how we are going to commit our available resources; of actually committing them; and of working out whether they did any good; and feeding that evaluation back in to future decisions.

The risk with any reform in health-care is that we get tied up in process and don't pay enough – or sometimes any – attention to outcomes.

Take a district nurse's work: you can (though many don't) measure that nurse's professional activity in, for example, treating leg ulcers. So at the moment, if you measure just that process, you might come up with a figure for 'leg ulcers treated'.

That's not good enough. It tells us about activity (a bit, anyway), but surely a commissioner who's thinking even a little bit should want to know about 'leg ulcers treated successfully'?

The least we should do is commission successful activity. A more insightful commissioner might want 'improved mobility' for the person with a leg ulcer, to lower risk of a recurrence. And a really savvy commissioner would commission for 'independent living' for their at-risk population who might get a leg ulcer.

This kind of commissioning isn't about buying capacity – it's looking at buying 'finished treatments', 'ulcers healed within 12 weeks' or even 'improved mobility'.

It introduces the notion of quality, outcome and even equity.

So an effective commissioner needs to look at promoting independent living, as well as removing pain and suffering. Independent living means looking at a range of services and ties in to the local authority's work in areas like meals on wheels services and home safety.

Why should we commission for outcomes? A lesson from history: when I first came into the health service, we used to do child tonsillectomy at a huge rate of knots, something like 160 surgical removals per session – very efficient, and very brutal as they were removed with a garrotte. And there was high risk to patients.

Over time, we realised that routine tonsillectomy often does little good and may cause damage.

So the committal of resources (which is commissioning, though it wasn't called that then) was a waste of money and didn't improve health.

We should commission for outcomes because of the risk of wasting public resources and of putting patients at risk from interventions which do no good and may do harm.

The first rule in doctors' ethical code is, '*primum non nocere*' – first, do no harm. Perhaps we need an ethical code for commissioning?

But we can't commission for outcomes without knowledge of the health status of the population we serve. We need to start by understanding why we're commissioning individual services – what is the outcome we're trying to achieve? Is it

health improvement for all; equal access for equal need; or what?

Once we know that, we must think of alternative, credible and, if possible, evidence-based means to achieve that outcome, and about our relative priorities between competing demands.

All of this is more towards the art than the science end. It's also about making judgments. If clinicians and the public are not engaged early on in commissioning, then there's no suitable foundation for commissioning in the scientific – technical sense. The root of the problems with developing commissioning may be that we've been trying the technical without the philosophical – and without local people's values.

'The root of the problems with developing commissioning may be that we've been trying the technical without the philosophical – and without local people's values.'

Horizons and timescales for outcomes are important. If you're commissioning osteoporosis treatments, is patient care better served by measuring bone mineral density, or measuring avoided vertebral and hip fractures over 18 months?

For coronary heart disease, are you commissioning individual episodes of ill-health or management for those at significant risk over their lifetime?

For diabetes, are you commissioning for haemoglobin levels within a certain range, or the patient's overall quality of life and capacity to live normally with a disease for a long time?

Commissioners must lift their horizons and think of the future as well as the now – and really think about how to deliver independent living for older people: it's not just about sending in services.

The big picture is about preventative management – not firefighting. That's

why we need to focus on avoidance of hospital admissions – particularly unscheduled admissions – to promote health, not to avoid cost.

We have to do the technical aspects of commissioning as well as the philosophical ones. If a service adds little value, then we have to know how to change it to one that does. But focusing on the scientific and technical aspects around purchasing services will be building a house on sand without the philosophical bits.

Some in the NHS do worry about involving private sector or not-for-profit commissioners in the NHS. For me, it's simple – if we use taxpayers' money to commission resources, the ultimate decisions about resource should be in publicly appointed or elected hands.

So PCT boards should always be in place and accountable for commissioning, since it is public expenditure. In terms of technical advice and support, I couldn't care who does it as long as they are competent and accountable. You can outsource support, but never the top level of accountability. The philosophical bedrock has to remain in the public sector; even if the independent sector are chosen to inform or advise on commissioning. That's the backstop of public accountability.

And should that accountability be via external regulation or local participation? I think that is tied up with the future of healthcare regulation. Regulation is essentially about three things: market entry rules; price and quality; and market exit. Some of that can be efficiently done by third-party external regulators like the Healthcare Commission: it's essentially about the first part – market entry, as in giving providers a licence to operate in the market. Most of the other two aspects are in commissioning.

Let's beef up commissioning, and develop practice-based commissioning where it can be done well, but let's also invest in getting the bedrock right, making sure our reasons are sound, and rooted in local community judgements as well.

How will we start measuring success in commissioning?

Barb Allen and Elizabeth Wade from the Health Services Management Centre, University of Birmingham, look at how we will measure success

The new *Commissioning Framework for Health and Well-being* (DH 2007) demands a commissioning system that works more effectively across boundaries at national, area, neighbourhood and individual levels, with the latter likely to include more self-commissioning of care by service users.

But how will we know if we have been successful on each or any of these levels?

This depends on how we define success. This complex terrain involves many layers of regulation and accountability, and multiple actors from across the public sector, as well as the public themselves.

We suggest three specific, but far from simple, measures. First, success will mean more individuals receive the care they need in a time, place and manner that they find acceptable.

While politicians may hope otherwise, it is clear that in a cash-limited system, providing individualised care can never mean providing everyone with everything they might ever want.

It can and should, however, mean that users of publicly-funded services have their 'demands' listened to with respect, by professionals willing to be flexible and creative in their attempts to meet individual needs, as far as available resources allow.

The commissioner's role in this is to hold service providers to account for delivering the highest standards of user experience possible with the income they receive. Commissioners are also responsible, of course, for providing this income in the first place.

The issue of resource management cannot be ignored: commissioning must be organised such that accountable public bodies meet their statutory financial duties.

A second measure of success will be a balanced budget. Balancing quality

and cost to achieve these two objectives will require commissioners to be both creative and brave.

Pooled budgets, for example, present risks as well as opportunities – but where they promise outcomes far greater than the sum of those that individual organisations could achieve, then such opportunities must be seized.

This joint approach might be applied to the personal level (for example, through the allocation of individual budgets that can be used to purchase both health and social care), but may well have the greatest impact at a more strategic level.

So the third indicator of success will be the existence of meaningful plans to improve the well-being of local people – plans genuinely shared by all relevant commissioning bodies.

Delivering these three outcomes will be difficult. Public service commissioners are currently spread across organisations, and across functional areas within organisations. It is increasingly important for these individuals to develop their understanding of each others' targets, regulatory systems and budgetary constraints.

Perhaps most importantly, they must develop shared expectations and aspirations for individual service users, and their local communities.

This 'coming together' will involve formal training through seminars, workshops and educational programmes (such as the new Masters in Public Service Commissioning at the University of Birmingham's School of Public Policy), as well as increasing use of informal networks at a local level.

Assessing success in commissioning will require a shared understanding of what we mean by success, and a clear framework for shaping activity.

In this exciting period, all of us involved in the commissioning landscape bear some responsibility in this undertaking.

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Building confidence, earning trust and taking a



Dr Natalie-Jane Macdonald is director of commissioning for BUPA Commissioning Services

A belief that good commissioning is a key mechanism for improving the value of health care services for citizens, increasing productivity and maintaining equity of provision is reflected in the effort that has gone into establishing the new DH *Commissioning Framework for Health and Well-being* (2007).

The whole area must become a core capability for NHS commissioners over the next 2 to 3 years. The challenge is big, and there is no point in pretending that all the answers about commissioning are just waiting in the private sector: I certainly don't believe that.

Where organisations like BUPA may be able to help commissioners is in bringing in learning from our commissioning experience in the UK and

internationally in other health care systems.

This can offer PCTs, practices and consortia a different perspective.

Challenges for commissioning

The challenges for NHS commissioning are many. Commissioners in the NHS have to balance multiple priorities, and often it is not easy to reconcile all of them.

The fact that commissioning in its current guise is a relatively new entity means that it will call upon different skills and make calls itself on limited resources, before perhaps having proved itself.

The need to create quick wins to bring all local stakeholders on board – even the sceptical – and the need to disentangle complex sets of issues into rational plans that can be addressed in a systematic way over time are vital to success.

The long game and hard decisions

In our early commissioning projects with NHS colleagues, we've worked with a number of very good and motivated people who certainly have a strong drive for commissioning to be successful.

One of the challenges of commissioners in any health care system, and

particularly in what has traditionally been a provider-dominant NHS is to effect influence over providers and in order to make sustained improvements in service provision and overall value.

Fiscal incentives and contract structures are part of this, but it also requires a belief on the part of the commissioner that it can be done –

even in monopolistic local provider markets.

Yet this belief is not yet embedded among commissioners. Why is this?

Accessibility to a good fact base and information to guide decisions are key to enabling NHS commissioners, and we've supported some PCTs in getting to a point where they believe that real change can and will be delivered.

In PCTs with real challenges (which are often long-standing ones), defining the root causes is hard – there's a risk of just looking at the symptoms and thinking that deep-seated problems can be resolved in months.

This is unlikely to be the case, and it's important that the effectiveness of commissioning in making sustained improvements is judged over an appropriate time period.

Commissioning is not a quick fix, so observers who are looking for evidence need to think in terms of years and not months.

Managing change

Some commissioning decisions will inevitably involve change to existing service configuration, which is difficult, not only for patients, but also for staff.

If we keep on defining a provider as a specific entity, or physical asset, it's hard to avoid 'zero-sum' views about change – that there will be winners and losers (both patients and clinicians).

The use of competitive forces needs to be balanced with recognition that collaboration among commissioners and local providers will be essential to see through significant change.

We need to redefine hospital services in such a way that they are not merely regarded as the buildings where health interventions occur.

A similar redefinition needs to apply equally in primary care so that care is seen as a continuum. And we can't forget self-interest and conflicts of interest. The right incentives will be needed to encourage people already working in the service to change their ways of working.

The change has started, with the

'Health inequalities are rising relentlessly: we can't pretend that addressing this in future is going to be easy.'

Longer-term view: independent sector thinking

'The independent sector is tiny in relation to the giant of the NHS.'

'Acute medicine and surgery private spending is less than 5% of total UK spending on health.'

'better care closer to home' agenda, and we have to build on that.

Demand, equality and equity

We also need to think about the role of commissioning in satisfying the varying definitions of equity and equality. Health inequalities are rising relentlessly: we can't pretend that addressing this in future is going to be easy.

There will be hard choices in commissioning in the future, driven by raised public expectations and health care demand relative to limited supply of funds.

Increases in patient choice too, will over time, inevitably raise people's expectations of their health service.

The expectation that all this will be met by better commissioning and productivity improvements may be a bit heroic.

Economies of scale

There is still some risk that 152 PCTs will have 152 different approaches to commissioning: that would do interesting things to equity and equality, especially for patients living near a PCT boundary.

It would also be chaotic. The early wins with commissioning will be about aligning incentives well and providing better information to inform commis-

sioning decisions.

Every PCT will need to have these building blocks in place - but scale may also be important to create standardisation and economies of cost or knowledge. The emerging commissioning hubs in metropolitan areas are evidence of this.

Defining processes rigorously

Successful

commissioning in five years' time will be about the spread of good practice.

The NHS has always proven good at having pockets of best practice, and pilots abound - but industrialising and sustaining that good practice seems very hard.

Success will also be about avoiding having 100 different versions of commissioning business models.

Working with the private sector

For us at BUPA, we are aware that some people in the NHS remain uneasy with the independent sector.

As I've already mentioned, I don't believe that the private sector has all the answers about commissioning.

The independent sector is tiny in relation to the giant of the NHS. Acute medicine and surgery private spending is less than 5% of total UK spending on health.

The independent sector might provide support to NHS commis-

ers; it cannot supplant them.

BUPA does have a tradition of focusing on the customer or patient, providing individualised services - and the NHS reforms mean that a relentless focus on the customer or patient is equally relevant to the NHS.

And it is very clear that those offering commissioning services to NHS commissioners need to be judged on their results, not their promises.

Starting slowly and building

I don't think we'll see many end-to-end contracts in the early days of call-offs under the Commissioning Services Framework.

PCTs and their SHAs are likely to start out with a measured approach. It would be a brave PCT or SHA that took a core part of their business and outsourced it completely to any third party without being pretty sure that the third party in question will deliver.

PCTs will test and try out a private commissioning organisation on less risky and smaller-scale projects.

At the end of the day, the independent sector doesn't have a right to commissioning contracts: we have to earn them.

'It would be a brave PCT or SHA that outsourced a core part of their business to a third party without being pretty sure that the third party will deliver.'

A new agenda and radical change: new commiss



David Stout is the director of the NHS Confederation's PCT Network

When we consider the state of commissioning for health in 2007-8 and the direction of travel, it's worth first stepping back to define what we are talking about. In my experience, commissioning means quite different things to different people.

There are several definitions of the commissioning process that are used - some more complex than others - but I favour a relatively simple approach setting out four stages to commissioning at local level:

1. Strategic Needs Assessment;
2. Planning and modelling of responses to local priorities;
3. Procurement of services or other interventions;
4. Performance management and market management of delivery of services.

Commissioning, in my view, is not just one or two bits of this cycle: it is all of the parts. It should be driven by good use of information and underpinned by effective communication. Its aims are to improve both delivery of health services and health outcomes for patients and to reduce health inequalities.

So what's new?

Of course, commissioning was a stated goal for PCTs from their inception, and before them, for primary care groups and district health authorities.

Yet many commentators have

argued that commissioning is too weak and too low a priority.

I think it is important to acknowledge some of the successes of commissioning in the past - there is no doubt that health services have improved and that patient outcomes continue to improve. It seems reasonable to recognise the role of commissioners in these successes.

However, I think it is also fair to say that commissioning has developed more slowly than we would have liked it to have done.

But it is important to put this pace of change in context. Three years ago, there wasn't Payment by Results and PCTs did not hold the contracts with general practices; there was not a Quality and Outcomes Framework (QOF) for primary care or a framework for locally enhanced services.

Commissioning back then was a different beast to commissioning today - the tools of the trade have changed radically.

'There has been a significant increase in pace, a much broader set of responsibilities and higher expectations of commissioning now.'

There has been a significant increase in pace, a much broader set of responsibilities and higher expectations of commissioning now.

We also need to recognise that effective commissioning with all these new tools is difficult. The skills haven't necessarily been developed in the NHS yet. Nor do I think the skills are necessarily out there to buy 'off the peg' commercially - either nationally or internationally.

The world's healthcare systems are all struggling with more or less the set of challenges that we call commissioning in the NHS.

We need to think quickly how we will develop commissioning skills in all parts of the commissioning process within the NHS, as well as where it makes sense to buy in expertise to support commissioning.

Think local

A key aim for commissioning in the future is to move beyond commissioning of delivery of national targets to commissioning to meet local needs and priorities and to solve local problems. This change is very much a journey, where localism will emerge over time.

Shifting The Balance Of Power (Department of Health, 2001) suggested that by 2010, the 2001 ratio of 80% of national-set targets to 20% local-set should be the other way around.

Will it happen? The rhetoric in the Department of Health all points that way, which is encouraging - but PCTs need to grab the initiative to make it

happen and stop waiting for permission from above to focus on what they think is most important.

Links with local government are important in delivering a local focus. The emphasis on joint strategic needs assessment in the recent *'Commissioning Framework For Health And Well-being'* was welcome. Similarly, the emphasis on Local Area Agreements in the Local Government White Paper *'Strong And Prosperous Communities'*.

But the rhetoric of localism also needs to be underpinned in performance management and regulatory arrangements.

The new performance management system for the NHS and partners must recognise local targets and objectives to be at least as important as (if not more so than) national targets.

Commissioning tools to engage clinicians and the public

'The world's healthcare systems are all struggling with more or less the set of challenges that we call commissioning in the NHS.'

Engaging clinicians

Commissioning will never fully succeed unless we manage to engage local clinicians in the process.

So what gets in the way of clinician involvement with commissioning? Perhaps a perception among some front-line staff that the Department of Health is the customer of the NHS - not the patient. I don't think this is the Department's aim, but I think this message sometimes gets lost in translation to the front line.

The solution - and not an easy one - will be to shift the perception of commissioning so that it is seen as being about improving patient care, outcomes and reducing health inequalities. I think policy aims to do that, but making it look and feel different to clinicians is part a national challenge and part a local challenge.

Practice-based commissioning (PBC) is one of the tools to help engage clinicians in commissioning. However, you would be forgiven sometimes for thinking that PBC is an end in itself, with a series of complex guidelines setting how it should work, about which managers and GPs argue *ad nauseum*.

I think it is important to keep in mind that PBC is basically a device to encourage clinicians to engage in commissioning to improve the quality of commissioning and, ultimately, patient care.

The challenge for PCTs is to work out how to make this happen at local level. PCTs need to consider how they

incentivise their clinicians locally to get meaningfully and actively involved in commissioning to the extent that clinical care is improved and clinical behaviour changes for the better.

There will be some PBC techniques and practices

that apply regionally and even nationally, but every locality will have its unique clinical priorities and solutions.

Engaging patients and the public

The other major challenge for commissioners is engaging the general public. Successful commissioning implies change in how and where services are delivered. If this is to be successful, we need to change the public perception that it's about saving money or cutting services.

It is vital that PCTs and practice based commissioners engage patients and public in the commissioning process to make sure we get it right and to help to explain what we are doing and why.

We will have to get smarter in the means of engaging patients and the public as early as possible in what we are doing.

If the first the public hear of a service reconfiguration is the formal consultation, it is not surprising that they might be at best sceptical.

Are we succeeding?

I believe that most PCTs are doing some parts of the commissioning process well for some of their services. Yet few, if any, are delivering

effective commissioning across the board so far.

As I have said, this is not surprising, but it is important that we are able to demonstrate real progress over the next year or two.

So how will we know when commissioning is working, and what will success look like? I think we need both national and local metrics. By clearly understanding and setting out local health needs and priorities, we should be able to measure when progress is made.

But the NHS is a national service, and there has to be a national component as well. Ultimately, it's hard to get away from things like service quality measures (such as clinical outcomes, patient experience and access).

We'll also want to see population health outcomes continue to improve and health inequalities begin to decline. And we will want to see demonstrable improvements in value for money.

'PCTs need to grab the initiative to make it happen and stop waiting for permission from above to focus on what they think is most important.'

Will we be able to achieve this? I think we can, if PCTs are given the space to develop solutions at a local level and if they succeed in engaging clinicians and the public in doing this.

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Wanted – a body-building course to help boost NHS commissioning



Dr Jennifer Dixon is director of policy at the independent think-tank the Kings Fund

Let's be frank: NHS commissioning is extremely weak. In Charles Atlas terms, commissioning is the weakling getting sand kicked in its face by muscle-enhanced providers.

Yet this isn't just a feature in the NHS. The commissioning of health-care is not done really well anywhere across Europe.

So how could it be improved here? Training commissioners will help only at the margins - it is just not going to do what is needed.

Some possible solutions, like introducing competition between commissioners, would be genuinely

'We should look closely at integrating delivery systems: vertical (or virtual) integration between primary, secondary and community providers.'

radical, and would create problems like selection bias and competing on risks - but these problems might be worth the benefits and so worth considering.

However, before going that far, I think we should look closely at the idea of integrating delivery systems: vertical (or virtual) integration between primary and secondary and community providers.

These systems might just energise and engage doctors far more than they are at present. We could give them an annual sum per capita (risk adjusted) for each individual enrolled in the system, and ask them to manage this sum, allowing them to keep any surplus.

However, in order to work, these integrated systems would need to be subject to competitive challenge, otherwise they risk becoming self serving and not responsive enough to patients.

For some time, policymakers' minds have been unclear as to how to boost commissioning. An initial idea has been to involve the independent sector to help.

Yet the DH's new commissioning framework seems to be pulling back from using the independent sector fully in commissioning - originally, the DH was looking for end-to-end commissioning by them. They appear to have backed away from that, and the process looks like it's being

slowed. The independent sector probably don't know if they're coming or going.

GP practice-based commissioning is not delivering yet, because it is in the very early stages of implementation. Not enough GPs seem to be interested.

'GP practice-based commissioning is not delivering yet, because it is in the very early stages of implementation.'

To make it work, we need something radical – either to mandate GP responsibility for spending in secondary care (which would mean a new GP contract); or to make the financial incentives of commissioning far more attractive to GPs, which might be difficult, since many have seen large pay rises and are comfortably off.

Integrated primary and secondary care, as mentioned above, might help - but must be designed to avoid allowing hospitals to 'capture' GPs to 'feed the beast'.

GPs' clinical decisions already make them responsible for huge resources spent in hospitals. They must take more responsibility to make sure this money is spent more efficiently.

I am not suggesting another wholesale system reform foisted on the service, but to allow a few pilots to evolve from local decisions and be closely monitored.

Strategy: the vital first step to be taken towards better commissioning



Nick Bosanquet is Professor of Health Policy, Imperial College

Effective commissioning by a PCT must, before anything else, first start with community leadership.

The PCT has to develop a strategy for the local health economy which sets clear directions for change and a series of immediate steps for improving services and reaching targets.

The PCT is the only local organisation which can work in the interests of the whole health economy.

In developing this strategy, as was done in Cornwall PCT (2007) with Ann James as leader, the PCT can connect with local communities,

patient groups and front-line staff.

The key message is that progress and improvement in services is going to come about through getting more value from the existing funding.

Any limited growth in funding will be absorbed by the cost increases already in the system. There will also be a strong priority to make best use of experienced staff hours.

So the key themes are those of a DIY investment and change programme.

The PCT strategy is not a shopping list of projects, or an attempt to supervise or regulate services: it aims to empower staff locally to find solutions and to manage services more effectively. The PCT must empower people to bring about change and empower local managers and PBC groups to get results.

The PCT strategy must set out a clear vision for more local services, delivered closer to patients. It needs to show how the funds available can be used to develop this.

A clear, longer-term strategy will make it much easier to manage problems of deficits or inescapable cost increases.

The PCT strategy is needed to offset the powerful forces towards fragmented decision-making and towards hospital care.

The health service is 'Balkanized' into trusts and larger primary care centres, which are under strong compulsion to pursue their own interests. Payment By Results at present gives powerful incentives to treat more patients in

hospital.

Only the PCT can set a longer-term direction towards more community-based services.

The PCT can also set an example of how to build a strong relationship with local government and social care. The PCT can likewise give a lead on co-operation with private sector partners including pharmacies and opticians.

Commissioning is being seen in terms of very detailed development of services, as in recent guidance on audiology and services for children and young people.

All this has to be done: but it is equally vital to free up management time for leadership in the whole health economy.

The PCT can create a sense of opportunity about using the vast resources of the NHS - for Cornwall health and social services, at least £10 billion in real terms over the next decade - to deliver more responsive services which really drive though the investment required to build communication between patients and teams of healthcare professionals.

The PCT strategy must also set out clear steps which move in the longer-term direction.

In Cornwall, these included reinstating community physiotherapy at the Marie Therese Centre, improving self-help services for patients with COPD who work out at the Eden Centre, bidding for funds for community hospitals and achieving the 18-week target.

Professor Bosanquet was the independent Chair of the Health Review for the PCT in Cornwall.

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'PCT strategy is needed to offset the powerful forces towards fragmented decision-making and towards hospital care.'

Commissioners and providers must seek to avoid 'zero-sum' games



Philip Housden is MD of Housden & Co. Ltd, a specialist healthcare consultancy

The dynamic concurrent NHS reform agenda of Payment By Results, patient choice, practice-based commissioning, and provider plurality is a complex challenge for commissioners and providers alike.

I may be in a slightly unusual situation, in having both provider and purchaser experience from both the NHS and independent sectors. It gives me a different perspective.

So if all this were 'simply' a game, how would we play it?

We can predict how players play from Game Theory (von Neumann and Morgenstern 1944), and the two basic game types. The first are 'zero-sum' games, where rewards are fixed so that what is gained by one is therefore lost by the other – a showdown over a capped budget is close to this approach. By contrast, in 'non-zero-sum' games, the total amount gained is variable (or can be creatively extended to be so), and so both or all players may win or lose.

So, are commissioners playing the game so that both they and providers can win by co-operating in some way?

Playing to a strategy driven by local short-termism re-creates the classic 'Prisoner's Dilemma' from Game Theory. This is where the two players in the game can choose between two moves, either 'co-operate' or 'inform'. Each player gains when both co-

operate, but if only one co-operates, then the informant will gain more! If however both inform, then both lose but not as much as the 'cheated' co-operator whose co-operation is not returned.

The Prisoner's Dilemma shows that trust should deliver the best possible outcome for the players as a whole. But without trust, each individual will aim for his or her best personal outcome - which can lead to the worst possible outcome for all.

The Prisoner's Dilemma impacts on many NHS interactions. For example, understanding what is being commissioned / purchased and what is being provided is still as much an art as a science – as the Audit Commission says in its 2005 report '*Early Lessons From Payment By Results*': "inaccurate coding leads to inaccurate payments, which can impact negatively on the finances of providers or commissioners."

So, can we predict that in playing a short-term game there will be a sharp growth in the number of diagnostic codes assigned to each patient? The Audit Commission report '*Early lessons from payment by results*', predicted that based on the experience in Australia (where PbR was introduced a decade ago), as coding directly links to payments there will be a sharp growth in number of diagnostic codes assigned to each patient. This trend, noted the Audit Commission report, was already being seen among

'The Prisoner's Dilemma shows that trust should deliver the best possible outcome for the players as a whole.'

Foundation trusts which currently average 2.4 diagnoses. The report added that in Australia the average is about three and in the US the average is closer to six.

The Prisoner's Dilemma is that if providers gain income in this way in the short term, partner commissioners' ability to invest in other priority areas is limited - so providers should expect to be chased for expedient actions to deliver targets.

For commissioners and providers to obtain the best outcomes from the Dilemma requires a commercial long-term relationship. By founding this long-term relationship on three key principles: best value; transparency and regular review, we will enable both the Prisoners to be set free!

References

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'But without trust, each individual will aim for his or her best personal outcome – which can lead to the worst possible outcome for all.'

Patient perspectives on commissioning



Bob Sang is professor of patient and public involvement at South Bank University

What do patients think about commissioning? Are patients even aware what commissioning is?

I'd guess that the public are largely unaware what commissioning is and more importantly, of the current threat that the healthcare reform agenda splits between public accountability in the democratic sense and the denial of a real patient-centred approach through the possible adoption of quasi-consumerist, marketised commissioning systems.

As to patients, they commission every day - through the agency of their GPs; by self-care and self-referrals etc. Too little attention has been given to learning from this day-to-day experience which, in business terms, impacts on 85% of NHS spending on the 10% of the population with long-term conditions or disabilities.

There is a growing movement among such people, including an alliance with those promoting personal care budgets, person-centred planning and crucially, the Wanless Reports' 'fully engaged' scenario to create continually grounded and collaborative approach to commissioning.

So what is the way forward to involve patients in commissioning? Until now, public and patient involvement has focused on voice and

influence, and not role and capability. This has enabled policy pundits and other vested interests to come up with meaningless proxies for patient involvement (such as the use of surveys, population needs analysis etc.). In other words, the marketers and their public policy adherents have both got it wrong!

By enabling people to take on an active role, in personal and community health - building on successes like the Expert Patient Programme, In Control, and the independent living movement; and increasingly initiatives in acute care like the co-design of cancer services and acute mental health services - we have an opportunity to develop genuine ownership of local healthcare plans, while addressing the inevitably contentious business of deciding priorities from the bottom up. After all, this is meant to be a patient-led NHS. Isn't it?

The current local government bill on public involvement in health gives the opportunity for active engagement in health improvement, which explains the marketeers' desperate attempts to outsource end-to-end commissioning before it is too late. However, criticism of the proposed Local Involvement Networks (LINKs) is valid - see the robust interrogation of the minister responsible in the recent Health Select Committee report on PPI (April 2007 HC 278-1).

For commissioning to succeed in the longer run, it must achieve trustworthy patient and public engagement in two respects. Firstly, a much higher order of community governance, using the new Local Area Agreements, linked explicitly to practice-based commissioning. Secondly, through day-to-day active involvement of people with long-term conditions and disabilities in improving the effectiveness of treatment and care, enabling them to enhance their social and economic contributions to the wider health improvement, social inclusion and service improvement.

Editorial

Starting something

Far wiser and better informed people than I have helped us with this issue, offering their definitions of commissioning and their thoughts about its development and progress.

So instead of me yabbering on about what I think commissioning is and what it should be, I would instead like to thank all of our contributors to this: *Commissioning Health's* launch issue. Your help has been vital.

I would also like to thank our sponsors, without whose help and support *Commissioning Health* would not exist. BUPA Commissioning Services and NHS Alliance are already thinking ahead with regards to commissioning. The independent sector and the independent voice of primary care have been a joy to work with on this launch.

Anyway, you certainly don't need me to tell you why commissioning matters. You don't need me to tell you that it's not easy, either. Starting something - whether it is a new publication or a new way of working - is never easy.

Mottos and mission statements can be of questionable value. They can also become a rod for your own back - remember Google's motto 'don't be evil'; and their subsequent collusion with the Chinese government's censorship? But one of the best mottos ever has to be the one Lord Reith gave to the BBC - 'to educate, entertain and inform'.

Borrowing from Reith, we very much hope that *Commissioning Health* will live up to these aims.

We also look forward to your feedback and views - articles, even, for our next issue, due in the autumn. Let us know how you are doing with commissioning and what you are thinking. Please e-mail your feedback, comments, ideas, notes and queries to andycowper@hotmail.com

Andy Cowper is a freelance journalist and editor of *Commissioning Health* www.commissioninghealth.com

A front-line view on what commissioning can do



Dr David Jenner is a GP in Devon and practice-based commissioning lead for the NHS Alliance

Commissioning is about meeting health needs, in my view. Its process has four main elements. First and foremost is the process of health needs assessment. The second is planning health and social interventions to address the health needs found. Third is procuring and purchasing services to meet those health needs. Finally, ongoing review, audit and evaluation. The whole commissioning process aims to improve health and reduce health inequalities.

Yet for all these clear stages, we've found it very difficult so far to use commissioning to make changes in our GP practice. Why? Because until just recently, the PCT has not really wanted to involve us meaningfully. What we have actually done is peer-reviewed our referrals; looked to provide more services in our local community hospital; and tried to reduce unnecessary emergency admissions.

To be honest, we've not done much service redesign yet because we haven't had a decent health needs assessment. Public health has gone off the national agenda: it's all national targets on 18-week waiting and healthcare-acquired infections. So we've been trying to make interventions to become more cost-efficient, and deliver more local services. But I'm not going to pretend that I think that's true commissioning.

Commissioning needs to change in three main ways. Firstly, we need proper and meaningful health needs assessment. Secondly, we need reliable and accurate activity data, particularly for the acute sector: that's what we end up paying for!

Thirdly, being radical, we need the legislative process to align health and social services budgets and charging rules. We need this to get more joint health and social care commissioning, but that's proving very difficult when social services are obliged to means-test and charge whereas health services have to be free at point of delivery. The differences between health and social needs are just not that clear-cut.

I would like to see either legislation or a DH directive to provide care for the first week of any episode for free in health or social care, so budgets can be merged, with means-testing and charging kicking in after a week and with the means test and the health and social care assessment obliged to take place within the week.

To bring more people on board with commissioning (particularly more GP practices), we need better data, better presented and interpreted and tangible incentives for identifying and meeting local health needs and priorities. These don't all need to be cash – partly cash, sure; but partly in autonomy over the use of any freed-up resource; and partly in the reward of delivering better patient care. The potential for cash incentives are already there, but professionals are often motivated as much by ability to make a difference to local services as by cash.

Once the national 'must-do' agenda of 18 week waits is reached, local commissioning must be empowered and assessment of local organisation should be on their local responsiveness to health needs as much as implementing national political targets. Could local or regional government be the mechanism to achieve this?

Events

This brief list gathers forthcoming events with key strands, themes or indeed total focus on commissioning. It also includes deadlines for consultations to which you may want to respond.

**Department of Health
'Commissioning Framework for Health & Wellbeing'
Consultation ends 28 May
www.dh.gov.uk**

**Kings Fund
Bridging The Gap - improving access to primary care services
30 May
www.kingsfund.org.uk**

**HSJ Intelligent Commissioning Conference, Birmingham
13 June
www.hsconferences.co.uk**

**NHS Confederation
2007 Annual Conference
20, 21, 22 June
EXCEL, London
www.nhsconfed.org**

**Department of Health
'Payment by Results'
Consultation ends 22 June
www.dh.gov.uk**

**Care & Health National Commissioning Conference, Birmingham
16 & 17 July
www.careandhealth.com**

**NHS Alliance
2007 Annual Conference
22-23 November
Manchester ICC
www.nhsalliance.org**

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