‘Commission impossible? Is world class commissioning achievable in the NHS?’

Grand Committee Room, House of Commons, 16 July 2008

The ‘NHS Next Stage Review’ recently published by Lord Darzi has been billed as a ‘once in a generation’ opportunity to reinvigorate the health service.

Consonant with the review, Civitas is hosting a number of high-profile debates to explore the potential for consensus on some of the key themes. The aim is to bring together the grassroots of the medical profession, along with key stakeholders in the NHS, private sector and politics, in healthy, open and unassuming discussion, independent of government.

This is the fourth in the series, looking at the highly topical issue of world class commissioning. Engaging an audience of around one hundred interested delegates were **Mark Britnell** (p.2), **Dr Mike Dixon** (p.5), **Dr Tim Richardson** (p.8) and **Mike Farrar** (p.10), with commentary by **Professor David Fish** (p.14).

Comments (p.15) were also heard from: **Charles Fraser, Rob Finch, Dr Hamish Meldrum, Sophia Christie, Catherine McLoughlin CBE, Sarah Khan, Mr Jonathan Fielden, Mark Atkinson, Denise Chaffer, Dr Keith Brent, Dr Kath Checkland and Dr Paul Robinson.**

Introduction:
Professor Aidan Halligan

Commissioning is supposed to be the process that ensures appropriate healthcare services are secured for relevant populations. It’s the corner stone of the health reforms. Decision-making has increasingly been shifted from the centre to local Primary Care Trusts (PCTs), on the assumption that that this takes it closer to the patient. In real terms we’re also supposed to have moved from a supply-based organisation to a needs-based one.

But have we? Commissioning needs new skills and a new cultural approach than that which has gone before. That’s the big challenge; is it commission impossible, or is it actually achievable?

Mark Britnell
Director General of Commissioning and System Management, Department of Health

After taking this job, *Private Eye* responded by saying it was the equivalent of being given the Northern Ireland job as a Secretary of State. So I certainly recognise the enormity of the challenge!

I want to start with some background to the NHS. Henry VIII. In abolishing the monasteries he set a pattern of health care in this country which largely entrenched and fossilised its supply; the nature of general practice, the nature of the hospitals and the nature of the municipal hospitals. Subsequent reorganisations in 1948, 1974, and all the government reforms of the past 25 years, have primarily been aimed at gingering and spicing up the supply side, which has culminated in the foundation trust movement. In a sense the history of the NHS has been a history of provision.

When I was invited to do this job I spent some quiet moments reflecting in July and August of last year on what commissioning actually was. So I commissioned some work to look at the evidence base for commissioning! We looked at the US – a particular form of insurance-based commissioning in being selective and leaving 52 million people underinsured or with no insurance whatsoever – but also Australasia and Northern Europe. Put simply we found that it's simply not possible to transform health care to meet the needs of the 21st century without strong initiatives that focus on the demand side; no matter how good the regulator is.

My contention tonight is that, despite the seven or eight reorganisations of PCTs, PCOs, PCGs and Health Authorities since I came into the health service in 1989/90, commissioning has never been tried before. It's been contract management. I remember in the early 1990s, people actually spent hours, weeks, days of their lives, simply writing contracts that merely reflected services provided by hospitals.

Commissioning is very different. It starts with an absolute and profound assessment of need. That can be a local need, based on a GP-practice population, or a much larger area, but the first and defining feature for commissioning as opposed to contracting or purchasing is the assessment of need. Then we move to the design of service – competition or co-operation – and the need to hold organisations to account on their performance.

In spite of successive governments' best attempt to think about commissioning, they have simply redefined supply and fossilised relationships between purchasers and suppliers that can't meet the needs of the society we now live in. Indeed, the 2005 document, *Commissioning a Patient Led NHS,* could potentially have done more harm than good. It sought yet again to define commissioning as a process and a reorganisation, not a vision with content.

From our international study we concluded that this vision must above all be a focus on outcomes. World Class Commissioning must always focus on need and health outcomes – adding life to years

and years to life. The absolute purpose must be to transform the health status of the people that we work with and the communities in which they live.

Because we were afraid that if we left PCTs to their own devices there would be another reorganisation over the next three or four years, we then defined eleven or twelve competencies which granulated and demystified what commissioners should do and how they should go about it. I don't mind telling you that I hope in three or four years time we can drop these, but over the next three or four years they will be absolutely vital to make sure we don't simply slip back into a regional structure of very powerful SHAs, supine and subservient PCTs and cantankerous fundholding – though obviously that's got a place as well. Developing such competencies over the next three to four years will involve the best of public and private, the best of British, European, and American, all coming in to help commissioners make sure they are different to what they were before.

Next, the issue of governance. Many of us who have worked in the service for many years have been driven by annual targets – yes, they're important – annual income and expenditure balance – yes, it's important – but it's simply not sufficient anymore to face the needs of our society in the 21st century. Now, for the first time in 20 years, we're giving PCTs the permission to invest over a 3-5 year period; to put their money where their ambition is and specify to their public exactly how they will add life to years and years to life.

However, hard questions must be asked of such large organisations, many of whom are consuming over £750m of taxpayers' money, and it is quite refreshing that they are. Yes, they'll be held to account by SHAs, but more importantly they'll also be held to account by the people they serve. We will talk about five-year strategies, about proper professional operation plans, about talent plans – as we need to drive new talent into PCTs if they're not to revert to being grant giving authorities that simply defer to the mighty power of the big teaching hospitals – and whether the board has understood and gripped its business. PCTs should be given no room to squirm out of adding life to years and years to life.

I now want to come into this sterile debate about PbCers and PCTers. PBCers need very strong strategic commissioners and strong strategic commissioners need exceptional PBCers. Sometimes the arguments become theoretical and tautological, but for me it's as simple as that.

And that's why in summary, with the work that we've seen in Darzi – whether it's the creation of new social enterprises, whether its bringing the best from the private sector in the framework for external support and consultancy (FESC) for the commissioners, or whether its liberating the best in terms of Tim (Richardson) in Surrey or Mike (Dixon) in Devon to form new integrated care organisations with public and private sector support as they develop in the next phase – I think commissioning is here to stay. You need strong demand to control and shape supply in a more personal and responsive fashion. So, commission impossible? I say mission commission.

In discussion:

I genuinely believe we have only had contracting and purchasing previously. I used to run a big teaching hospital in Birmingham and I never really met any commissioners who came to me with arguments about their local population in a scientific or empirical fashion, with much more nuance

around social marketing. If they did, then they would have had a lot of power behind them in terms of changing services.

When you look at the ten clinical visions from Ara Darzi's report, you would need something like world class commissioning to implement them, because they transcend political and fiscal cycles, organisations and care pathways. If you're not going to return to old-fashioned regional planning – and I hope we don't – then you need active commissioning for clinical services, as well as public health.

The great thing about world class commissioning – and I've spent years writing columns criticising the DH for central initiatives – is that it has been co-produced by a number of people to capture their own ambitions. Responsibility for its success sits with all of us. For SHAs to be competent in developing systems, they have to develop the competence of PCTs and PbCers in commissioning. In retrospect more perhaps should have been done with primary care in the past, but we are where we are. In fact, the latest GP survey shows patients are still pretty happy with their access, but if you look at the variation in referrals, the exclusions in QOF and the way people access or don't access services, I believe we are in the foothills of really radical commissioning here.

It will also involve competition. My own view on competition is that you can't be a commissioner unless you can offer the threat or opportunity of competition. By 1 October we will create a cooperation and competition panel and will be working very hard to ensure that all providers have a fair and equitable chance of providing new or existing services.

Added to this I am also in favour, as is the DH, of piloting not just integrated care organisations, but individual budgets for patients to give them more control, which could really open up the potential for the voluntary sector and others.

The logical conclusion of successful integrated care pilots in particular will be the abolition of the contracts the BMA successfully negotiated! It will create some very interesting incentives and pressures for hospital-based consultants and GPs to organise themselves for the benefit of their patients on a risk and reward basis, particularly if there is the transfer of total capitation risk, which I am in favour of.

Pilots will be a sign of innovation, and I want to see all sorts of different bids coming forward.

When I was head of a foundation trust I was absolutely 'gagging' to create organisations funded by the foundation trust but managed by others. Actually I think this is a smarter way to do business as an FT; liberating cash, innovation and talent. And consultants do now have the power to go and create social enterprises as well, because pensions will follow you.

But we are talking about world class commissioning when it's less than a year old and we have to recognise that we need to invest in new skills. No-one was born as a natural commissioner; it's nurture not nature that will develop it and we have to keep the faith. The goal of our framework was to make sure the system is so good that it transcends political cycles and stops politicians fiddling.

One thing I would say though is fiscal challenges will make things very interesting, about how one prioritises investment and the balance between cooperation and competition. We are now working with HM Treasury on value for money and how commissioning will drive value into deliver systems over the next period. The extent to which commissioning can drive value for money will be one of the determinants that make or break it.

Dr Mike Dixon
Chair, NHS Alliance

Can the NHS do world class commissioning? My answer is absolutely, yes. And, without flattering too much, mostly because of the personalities, the drive and unremitting determination of people such as Mark (Britnell) and Mike (Farrar) who are speaking tonight.

I just read Mark's world class commissioning booklet prior to this debate hoping to pick lots of holes in it, but it's actually a very good document. World class commissioning is very important because if we don't have it at PCT level then everyone else, the patients and the others, will be entirely lost.

Of course, cynics might well say that this is just another performance framework. As we all know we've had star ratings of PCTs, fitness for purpose assessments and various initiatives before, but did these actually achieve anything? I don't think they did. The only way that world class commissioning will actually make an impact is if – in Ara Darzi's words – we can make it something that is clinically-led and locally-driven.

In my world as a GP and as a practice-based commissioner, the problem as I see currently it is that we live in a parallel universe. In the world that Mike (Farrar) and Mark (Britnell) live in, it's all talk of metrics, diagrams, arrows and the nice sunny highlands of commissioning. But where I live down in the marshy bog-land of real life in general practice – where only 50 per cent of the time do I make a diagnosis and only 25 per cent of the time if I've made a diagnosis is there an evidence-based treatment I can give them – it's very different. That's the reality of the situation.

This morning, for instance, I saw a patient who for ten minutes talked about such the issues he wanted to talk about and only as he was leaving the room did my computer flash up '26 per cent chance of a heart attack in the next five years'. We fiddled with the knobs and found out that he had a simple choice. To get down to a 16 per cent chance he either had to give up smoking or go onto statins. Yet he didn't want to go on statins and giving up smoking was a difficult option because his partner, who had a tendency to depression and psychosis, was on lots of tables and as a chain smoker would find it difficult to help him through that.

These are the real choices that make a difference to a person's life expectancy and that perhaps matter more in the health system than who does your hernia and where you have it done. Importantly, these choices depend on very human things like relationships, trust, integrity and things like how you can motivate people or perhaps even persuade them. These choices – rather than so

much of the things that commissioners bang on about like care plans and care pathways – ultimately matter.

Commissioning must take these things on board; and the only way it can do so is if it's led by front line practitioners meeting with patients and that, of course, is practice based commissioning. The whole ethos of PbC is that over 80 per cent of patients want to make treatment decisions with a frontline practitioner, ergo why not predicate the whole commissioning system on that patient-practitioner interaction all the way up. There are good reasons to do so, because first of all you might commission services that actually work and are appropriate. Secondly, having had a hand in formulating those services, patients might actually use them. But more than anything at last the NHS might be able to balance its books, because while I'm not linked into the system there's no way of risk managing it financially. I'm described as a runaway horse in surgery in terms of prescribing referrals and diagnostics.

So practice-based commissioning, I think, is absolutely essential. But the question is where does it belong in world class commissioning? Is practice based commissioning the servant of PCT commissioning or its master? Talk to the PCT people and you'll probably find they say practice-based commissioning is the master, but talking to the GPs and frontline officials you'll get the opposite answer. This is the very problem we have at the moment. Neither realise how important it is to interact; PbC is the filling in the sandwich, if we take this away you've just got bits of bread.

Where I differ with Mark is that I don't think you can have world class commissioning by PCTs without PbC. PbC is not just operational, it is also strategic. They are interlinked; both need to get involved in each others' strategy and operations. If you think of PCT commissioning as the clean kitchen, then PbC is the food that's made in there. Good commissioning that takes practice based commissioning on board fully is the equivalent of good organic – and British – cooking.

I want to end by saying what I think this is. If you go back a few years to locality commissioning groups and primary care groups, then there were two real means of changing the way services were run. One was peer pressure. By putting the two in the same group and banging their heads together most actually came out with really a rather good way of looking after patients. The other means was commissioning leverage, perhaps having a contract with a private hospital so you could send patients elsewhere if patients wanted to go. It always worked but you very rarely needed to use it; it was like a nuclear button.

Yet somehow we lost the leverage and peer pressure that was really changing services in the late 1990s. In the early 2000s, commissioning became a very bland managerial process that did very little. Now we're saying we really need to get that right again and do world class commissioning.

But we mustn't lose some of the history, some of the organic development in the previous era that was so powerful in changing services, for the danger is we go into a very arms-length relationship between commissioners and providers and we end up just tendering. This must be a last resort. It worries me a bit when I hear commissioning leads and PCTs saying they're not allowed to sit down with providers and see how they can improve their plans, because they've got to keep them at arm's length. Tenders will then just be received in envelopes; we need a much more hands on or organic way of commissioning.

Now to the British side. HP sauce is what we're threatening to leave out. H is the healing factor. We risk losing it if all commissioning is done in monetary terms. P is the people factor. I hear all the time that people are consumers, but people power and people energy should be used within the NHS. I recently saw a lady who said her back feels better and a fat man who said he'd lost a quarter of a stone. I said how did you do that? They said they'd been on walks with the walk-and-talk group set up by the patients.

In discussion:

The great thing about the Darzi strategy is the emphasis on people power; about the perception of your care being as important as the medical view of what your care was. It seems to me that if we have people dying at 41 in St. Mungo's (homeless accommodation), that is everyone's problem and practice-based commissioners should be involved.

The real problem of course is that we have never really assessed need before and, if we have, we haven't properly acted on it because we've left health off the list, leaving it to the director of public health to produce a large report that gets sat on a shelf somewhere and never actually filters down.

What I think is different here is the focus on primary care, in terms of commissioning and provision. We know that primary care has the biggest impact on health – see Barbara Starfield's work in the US and Brian Jarman's in London – but we've always been focused on secondary care. Getting your operation a bit earlier doesn't have a huge impact on overall mortality and health.

But the main problem I've had with my own PbC peers is to persuade them that health is their problem in the first place; we've got totally jammed into the idea that it's just about the consultation instead of the much more important issue of what goes on before it, after it and how we stop the consultation and secondary care referral being necessary in the first place. We need to focus on this. Purchasing and transforming health services must go upstream into health. Having bullied my director of public health as a practice-based commissioner I now know what the problems are and I can't hide. Public health should be everyone's responsibility. The problem is that we've handed it to public health consultants in the past and nothing's happened.

When commissioning leads to reconfiguration, the whole issue is about involving the public, making them feel as though they are commissioners and learning the opportunity cost of a hospital against other services that might have a greater impact.

In my area the number of consultants has trebled, whereas the number of GPs has gone up only very marginally, which is extraordinary when you think the chances of dying in hospital are more linked to the number of GPs outside than staff numbers within it. As foundation trusts focus more on marginal profitability, I think a number of consultant's jobs will be at risk. But the disease in our system is exemplified in a couple of responses; we have a very motivated consultant saying he thinks integrated care organisations are the right thing – and I do too – but that the system is such that he couldn't possibly risk doing that. And again from the mental health trust saying isn't this somehow going to threaten the organisation I'm a member of? We need to get out of that and look at what is the best system for providing care and take some risks (for which we may also need an exit procedure if things go a bit pear-shaped).

Dr Tim Richardson
Director, Epsomedical Ltd.

I come from a background of commissioning. For me, it was in the total purchasing era that we started to work on the basis that we wanted to use resources to improve care; and to do so we had to start by understanding where care was not as good as it could be – similar to the stated aims of world class commissioning.

As a result, when fundholding came along we decided to set up what became the first independent treatment centre in the country in Epsom and employed consultants from a wide range of specialities working with us in primary care. In effect, we started the process of integrated care way back in the 1990s, though this was threatened at the end of the fund holding era when we lost control of our budgets.

Fortunately, collaboration between the two main parties led to a change that introduced personal medical services (PMS) contracts which moved us from part two of the NHS Act to part one; as a general practice we could also provide secondary care. So we were able to consolidate what we had started to develop through fundholding and total purchasing into a provider arrangement. Our practices worked together with secondary care and community teams to formally deliver more services to patients within a single contract.

We managed to achieve this where a lot of our practice colleagues didn't because we moved before 1999 when the main mantra for PCTs seemed to become supporting district general hospitals (DGHs). Instead of actually planning care and changing care, moving investment from secondary to primary care, we have actually seen PCTs' efforts focused on the retention of the local DGH at the expense of reconfiguration.

This has fragmented care. When you have different organisations providing so many different elements of the same patient's care – through the GP and primary care contract, through consultant contracts, secondary and tertiary care contracts, independent sector contracts, community care service contracts and social services within their contracts – you can see how much potential there is for gaming and losing the patient.

So the bit of the change which I really welcome within the Darzi review is the potential to develop integrated care organisations. As GPs and as clinicians we want to be providing services to our patients and get away from the confusion that has arisen from potentially being both a provider and a commissioner (or purchaser). We want to be involved in commissioning in the sense of defining the right patient services and pathways, and in working with colleagues, but really we want to be providers of a service.

Under the Primary and Community Care Strategy is the opportunity to become the provider of patient services in collaboration with our health care colleagues in secondary, community and tertiary care, within a single contract – a single responsible provider contract which I think is going to

be called an integrated care contract – and develop an integrated care organisation. That allows us to work a lot more closely with our colleagues to define pathways that are most clinically and cost effective. If we take on an integrated care contract, we take on an element of risk in using that resource for the patient over the year, but by taking it on as a contract rather than as a budget – as it is in practice based commissioning – we have a degree of certainty in investment. We have the ability to invest, whether that is in facilities, training or teams and to move away from the current silo approach where patients fall down the drain.

It could, of course, work vertically down from foundation trusts if they take over local GPs, but it will have to involve general practice because it is going to be based on a registered list of patients. Most likely, the integration will based around general practices working with their secondary and other colleagues in a single contract to define patient services, monitored and managed from the commissioning point of view by either the PCT or the Strategic Health Authority.

Potentially there could be an element of competition if we had competing integrated care organisations providing comprehensive care for patients a bit like Kaiser Permanente. Patients would have a choice of signing on with different integrated care organisations competing on the basis of outcomes for the patient, to attract the patients, deliver the best care and give them the opportunities for better access to care closer to home. It's a lot of the buttons the government want to push.

In discussion:

It's funny that we keep saying the NHS is fantastic and then we get a whole series of reasons why it isn't. The reality is we have this new initiative because the NHS hasn't yet delivered or it's far to variable where it has. The concept of integrated care means the commissioning of primary, secondary and other care together, instead of doing each bit separately or asking primary care to commission secondary care and secondary care to commission tertiary care. What that will also do is put a greater emphasis on health and prevention because our biggest cost in the medium-term is the failure to manage to health care better or make people healthier. When you get a contract as an integrated care provider with a level of risk, you have to address this.

With respect to this model and our consultant colleagues, there clearly are difficulties where a trust puts the lockers on their staff but it must be up to the consultant to decide where their future lies. In 1991, our local DGH had 1 ½ consultant paediatricians and 2 or 3 SHOs, mostly GP registrars. It now has six consultants and about 15 or 16 middle grade staff, yet our commission rate is much the same and length of stay is probably lower, so we're now providing numbers of doctors to simply cover hours in acute care. In other words, we've got the workforce, but it's just tied up doing the wrong things – just 'being there'. In effect we've stripped our community services to keep bailing out the acute, with the result that we have to admit to acute care where many would be better managed in the community. For consultants, we're more likely to offer them control, partnership, discussion, connectivity around patient flows and possibly new contracts.

It could also work well for under-represented groups. As yet, for example, we haven't perhaps gone into the voluntary sector as much as we will do in an integrated care model, but we are aware of people who want to help and we've accepted what they've offered.

Part of the problem in getting underrepresented groups into the system is the system itself; with homeless people for example most will not be registered with a GP and you fall into a black hole. This is where PCTs must pick up the mantle in commissioning because these individuals will need more resources than the straight capitation payment to a GP. Our current contracting arrangements do not support the most vulnerable.

Of course, one of the things the DH would be concerned about with regard to integrated care contracts would be complete monopolies in a given area, whether that's a foundation trust seeking to bind all its referring practices together, or whether it's a PbC group covering several hundred thousand people. Together they will either deliver an excellent service or, if they don't, patients will have to travel a long way for an alternative. But we could potentially open the door to new independent providers coming in to offer a competitive and potentially better service.

The question for the DH, SHAs and PCTs is whether they want a complete unified model that everyone's incorporated into or whether they want to ensure an element of competition. There's a debate to be had here; probably we'll get some answers in the pilot schemes. However, I do believe that if you have to compete for your patients to provide better services that are joined together, but also deliver value for money, then that is a positive thing.

Mike Farrar
CEO, NHS North West

I want to start by being very positive about world class commissioning. There are two elements from the word go which are already world class: the fact it is ambitious enough to desire to be so, and the fact that a series of steps have been set out to describe what commissioning actually is.

However, I can see a number of risks in its ability to deliver the kind of impact that Mark (Britnell) hopes for it. Do we see world class commissioning as a means to an end, or an end in itself? The reason I think this is important is because if we take the end as world class health and world class health care, I believe you can probably have them without world class commissioning. In this case, we must start to think about the contribution of commissioning as a means to an end rather than simply about what world class commissioning is.

I'll use a rather cheap analogy. Let's think about commissioning a toilet. I could go through a fantastic priorities-setting exercise in my own home, agree the priority for the next set of spend is to have a new toilet, think about what specification of toilet will best meet the needs of all the various

users, and then what a world class u-bend might look like. But ultimately I only get a world class toilet if the skill of the plumber who installs it is up to scratch.

Let's not set world class commissioning up to fail. Let's think about what its value is in bringing us towards the desired outcomes, because if we can capture that I think we have a fighting chance of really being successful.

Nonetheless, there are two or three areas where world class commissioning might be conceived as an end in itself; where I think it not only adds value, but in my view creates value in its own right irrespective of whether or not it leads to improved health or improved healthcare.

The first is that world class commissioning for the first time starts to ask the right sort of questions in terms of how accountable you are for expenditure. How are we going to demonstrate that the £11.7 bn of expenditure I have in the North West is being used well; that there is actually some dialogue and debate with the public about how we're spending their money? Of course, we'll fail on this if we ask the wrong questions, but I think world class commissioning will in its own right help us to move there.

The second is legitimacy. I remember saying about a year ago that the biggest threat to world class commissioning may not be its incompetence but its illegitimacy. We have to connect back to the people we're serving and the people whose money were spending, because without that connection there is a huge risk we just won't be able to meet the challenges ahead – particularly of trying to engage a population that has an illness health bomb ticking away. We have to change the dialogue because more and more supply side solutions to that kind of issue are unlikely to be sufficient.

The third is what world class commissioning is doing in terms of bringing a clinical voice into play. But that creates a slight tension, in that PbC – in putting the clinical voice to the fore, which I think we have to – could actually drown out the public voice. I think it's a real challenge for us to empower our clinicians in a way that they recognise they too have to defend their legitimacy in terms of how they are deciding to spend money. The great news in this is that from where they sit they are the most trusted group of people to spend it; more trusted than Mark and I, and certainly more trusted than politicians. People actually believe clinicians will help in terms of spending their money well.

So, as an end in itself – on top of the means to better health – world class commissioning has three points where it can really add value to where we are now.

But how ambitious are we going to be? In defining it, Mark (Britnell) has shot for the stars, and I think that's right, but I can see elements where we are going to have real problems. I think there's a sense out there that world class commissioning will deliver better buying, but not necessarily intelligent commissioning. My worry here is that we will spend a lot of time and effort trying to recoil and challenge the way we buy secondary care. But will we realise that if we want to use commissioning to transform acute care the best thing we might do is to agree a strategy of supporting an acute trust over and above tariff to enable it to change its model of care, diversify the services it provides and move into a much more integrated model? Intelligent commissioning would take the latter course, whereas better buying might force the provider into a rather different place.

Here, I also want to think about the role of practice-based commissioning. Why do we have practice-based commissioning not consultant-based commissioning? The reason for PbC is to take a preventive primary care view of how we use resources; it's really important that PbC is able to commission *health* as well as health care.

However I remember at the NHS Alliance conference recently there was lot of push back from PbC-ers who said they didn't want to get into all that stuff, just make sure we get the best secondary care services. This is laudable but it's a level of ambition which belittles the ability and requirement on a modern health service. We might want to think of an analogy we've been drawing in the North West. The NHS at 60 is in the position of the main frame computer that's added great value to society. The next iteration in the IT industry was to create the lap top, or bringing the computing closer to home. But the real transformation in technology has been the internet; that's what's added the most value. So in commissioning the ambition is not just preoccupy ourselves with getting from mainframe to laptop – or how we build a polyclinic – but see our own version of the internet, changing people's relationship with their own health and how they use services.

The last point from me is this question about SHAs, the intermediate tier. Are SHAs going to be the new centralisers? Already we have this lamentable set of conversations of who's going to hold people back in the fight between strategic health authorities and PCTs, PCT and PbCers, and PbCers and the public. We have an enormous propensity to think about power in terms of a finite resource; that if power shifts from one place to another, someone else must lose it.

But the truth is SHAs need to realise that in empowering in PCTs to take forward world class commissioning, they themselves become more powerful in system management as a whole. So SHAs need to empower PCTs, PCTs need to empower PbCers and PbCers need to empower their patients if we are to realise the potential of world class commissioning. The role of SHAs is not one of sitting in a powerful position and man-managing, but of empowering the system to work. If we don't realise this, then the NHS will fail its job in the next ten years.

In discussion:

What I was trying to say with regard to means and ends is that we need to be clear about what our aims for world class commissioning are and the contribution it is to make. There are ambiguities around it and if we want it to be successful we need to set expectations so that we can define whether or not it has delivered. My general thesis is to say that I think world class commissioning has to be based on whether it delivers improved health and health care, but it's not the only responsible element here, because the skill of the provider has got to be a significant factor as well. So we need to isolate where the value-added element is and assess world class commissioning on this.

Commissioning can and should also really engage with the people who's money we are spending. We are prepared to pay through taxation for one of the fairest, most equitable and openly transparent health systems in the world, but the downside is that when we pay our money through taxes we disregard our responsibilities for our own health. We've got to engage people in this; the NHS isn't an answer to everything and we have to bear some responsibility. We can only do this by engagement in the use of resources.

But in this dialogue, I don't think we can sit here and say we should have more of it and then the moment the public say don't close the local hospital we turn around and say, well you're wrong. There is a risk that we are just searching for better and better ways of telling the public they can't have what they want, rather than saying we understand what it is you want and we will find ways to deliver that by being more creative about how we operate. For example, we can maintain more local services if we a. run more ICU; b. invest in robotic surgery – in the States 60 per cent of prosthetic surgery is done in this way, but 2 per cent here - ; and c. accept that economics should never drive the reconfiguration of services – it should be clinical, because we can always change the economic framework in which we operate.

There are a lot of people who believe that the answer to this and variability is regulation. But regulation was brought in to protect a minimum level of acceptable standards; what commissioning should do is move beyond that by creating a situation where excellence can thrive by getting the resources in the right place and by signalling intention and ambition. Commissioning primary care exemplifies this; the pattern of services in this country is wrong because the pattern of primary care is wrong (which leads to either under or over use of secondary care).

Public health has a profound impact too and we must work on this, but for people with known problems our inability to get to them and diagnose quickly means they are dying earlier than they should do, even accepting they have that problem.

I've been involved in and very interested in the development of Connecting Care, which is an initiative run by *Turning Point*. There's a very interesting dynamic here, where some very deprived communities in the North of England have been given budgets as a community for the services they need. I just wonder whether, for example for St. Mungo's, health budgets could be transferred to you as a carer to commission on behalf of the homeless. This could really tailor services to the needs of people who will have very specific health needs.

I also think there is real merit in integrated care pilots. There is a tension in the system in managing community services for people at the upper end of primary care and pushed towards using secondary care. The integrated care organisation is a really good opportunity to debate whether we want primary care to go up the pathway and expand services, or want our secondary care colleagues to come down the pathway and diversify supply. In different communities this will differ. In the mid 1990s there was a survey done on the impact of fundholding on services deemed to have shifted from secondary to primary care; 15 per cent of the time it was being provided by GPs, 30 per cent by primary care therapists and nurses, and 55 per cent of the time by secondary care staff coming out to primary care settings. In the North West – the most under-doctored region in the country – we desperately need to increase provision of primary care to get diagnosis and treatment done earlier, so the answers are likely to be bringing secondary providers out. But this can only be done by good quality commissioning.

Commentary:
Professor David Fish, Medical Director, UCLH NHS Foundation Trust

I want to start by saying this discussion has been very comforting for me, because I expected to be the white elephant in the room! Speaking from one of the big foundation trusts I very much want to see world class commissioning and I know my Chief Executive wants to see it; I checked that with him before I came out tonight! We want to see it because we want to get world class healthcare.

Mike (Dixon) said that we're only going to achieve this by more wide dialogue between providers and commissioners, rather than a big stand-off and I agree. What I want to see is better outcomes for patients and I have been using that as a litmus test for what I have been listening to this evening. Will I welcome the knock on the door from the commissioner? Or will I view it like an inspector calling?

Just like patient care, I suspect we know what world class commissioning is when we see it. Before coming here, I was reflecting where I have seen it in my time to use this as a yard stick. The best example was when a commissioner came to see me to talk me out of doing a specialist service at UCLH, where we were one of 22 national providers. They succeeded in talking me out of it because they succeeded in persuading me that if UCLH stopped providing it then a number of other providers would and we would see considerable rationalisation of service.

And why was it world class? Primarily because she presented a very good argument, she came with members of the public and carers who wanted to see smaller numbers of specialist centres and just like any other leader she had courage. In the white heat of dealing with consultants who may well lose the service they have built up over many years, a lot of courage is required.

I think the yard stick for world class commissioning won't necessarily be an excel spreadsheet but the leadership qualities of the commissioners who knock on the door and come through it.

Listening to this evening my overall view is that everyone seems to have a different perspective, which is dangerous because it risks divide and rule, which won't deliver anything. Mark (Britnell) presented the historic perspective, which shifted from seeing the big providers as the wicked witch of the west which need reining in, to how do we deal with them, to how do we develop the necessary skills and levers. I would certainly welcome the knock on the door from someone who has a skill set to convince us to change.

We then heard that primary care can do it best and then that there should be an integration of primary and secondary care with a better split between providers and purchasers. I personally would like to see commissioning well separate from provision – and I thought that that argument was well made irrespective of what model you want to see of integrated care – though I would also welcome better integration of primary and secondary care and I can see a good model outside the commissioning of services.

We then heard a focus from Mike (Farrar) on the voice of the shareholder or taxpayer on commissioning. This we must surely buy into; the voice of taxpayers has to be caught by commissioning, especially for the excluded groups who don't have access to the interest. Mark (Britnell) also talked much about innovation and how we should encourage it to transcend the usual pathways; the only way we will deliver on the Darzi review.

I end optimistically by saying I welcome the knock on the door from world class commissioners and I probably see it coming sooner than I thought. But a warning from the provider side, it's nice to have lots of different faces knocking on your door, but if it's not cohesive then it's not going to achieve anything.

Comments and Questions:

Charles Fraser, St. Mungo's: We run homeless hostels in ten PCT areas in London; 65 per cent of our hostel residents have four or more serious health problems and the average age of death is 41. In some hostels we have quite good access to health care, in others it's patchy, in others it's nearer non-existent.

I want to make a plea that the assessment of need properly includes the homeless; I do not know of a single time when we have been approached by a PCT to ask about the health needs of our residents. The problem is that the sort of people the government work with to transform health are not the people we work with.

Rob Finch: We've made pros and cons for world class commissioning, but is it just a political and financial end, rather than anything practical?

Dr Hamish Meldrum, BMA: Sometimes we get bogged down in terminology and in believing that there is one solution to fit all problems, which is not true. The best definition I've heard of commissioning is assessing the needs of the population, deciding how you're going to deliver to those service needs and then assessing how effective you've been in terms of outcomes. To use this general term is much more helpful because to many people it's about buying and selling, which can get you into all sorts of problems about the purchaser-provider split etc.

I'm very much in favour of the collaborative commissioning model, because the part of the commissioning cycle that decides how to deliver to need should involve clinicians, the public and managers. Now, in inner cities you may then end up with your competing HMO model, but you're not really going to get that in rural areas; patients are not really going to have much of a choice. So how do you then get the element of competition that Mark was talking about?

Sophia Christie, Birmingham East & North PCT: There's a very interesting debate to be had about whether the NHS we currently have has been shaped by providers. Has this led to the massive

variation in outcomes, in standards and huge inequalities in health? We clearly have a problem to be solved.

So what is it that is different about world class commissioning this time? It strikes me that it lies in the fact we are actually seeking to apply commissioning to primary care for the first time, rather than just primary care's actions on secondary care.

The other massive issue is PCTs' relationships with the public. Recent activities we've undertaken in patient engagement show those most disadvantaged and most at risk are those least likely to be presenting to their GP – and that's not because they're not registered, but because they don't want to go there. We need to get to grips with this.

Commissioning must absolutely be about starting from the local situation we face and then prioritising investment to really make a difference. This is about procurement, but just as much about relationship-management.

Catherine McLoughlin, CBE, Age Concern: If we are concerned about outcomes we have got to listen to what patients are actually saying. In the voluntary sector we are doing this. But what engagement have GPs in particular actually done in commissioning the voluntary sector to provide the integration they require? I think there's a huge potential within commissioning to really involve the voluntary sector to provide services in collaboration with other organisations.

Sarah Khan, Oxleas NHS Foundation Trust: Mental health has taken a slightly different model to other healthcare in that we already operate on an integrated provider model, with the voluntary sector, leisure and housing organisations. It also works vertically into primary care. What I can't see is where existing secondary care providers fit within this integrated care model we are talking about and what impact might it have on them?

Mr Jonathan Fielden, BMA: The concern from the consultants' side with PbC and commissioning is that to get commissioning right you have to have strong involvement of secondary care; without it your focus doesn't completely understand the more specialist needs of them. Tim's (Richardson) idea would help this, but in our competitive environment if I talked to GPs about providing an orthopaedic service my trust would say hang on, you're our employee. The only way I can apparently talk to GPs is to go through a court case to try to do it or leave my employer, my salary and my pension. This is a major obstacle to forming integrated care organisations.

Mark Atkinson, Camden PCT: There are a number of contractual issues that need to be sorted out to give PCTs sufficient leverage. The wave one IT contracts are an incredible nightmare to deal with and the DH has failed to produce any contractual framework for the any willing provider bids. Locally, we produced a variant APMS contract to deal with this, but it would be very helpful if something could be done centrally to help us rather than each PCT having to do it locally. We've been experimenting with a new musculoskeletal pathway over the past year with a number of trusts, of which one has performed significantly better than the others. The obvious procurement route in

terms of getting the best outcomes for patients would be to move to an any willing provider contract, but there is no national framework.

Denise Chaffer, Mayday University Hospital NHS Trust: In my previous job I was working in the South East where there were quite vigorous reconfiguration debates going on, but I also worked in Epsom when it was an integrated acute and community trust before total fundholding hit.

New pathways that will no doubt develop around world class commissioning will entail reconfiguration of services and destabilisation may come with it. My plea is that this happens in a planned way and not by default, particularly having regard to the co-dependency of emergency services. I would also say that having seen the demonstrations in the streets down on the south coast around reconfiguration, maximum public engagement is vitally important, because they certainly weren't convinced here even though the clinical case for change was and is overwhelming.

Dr Keith Brent, BMA: I despair of this competition and divide between GPs and consultants. The the greatest health changes are made not through primary or secondary care, but through public health. I suspect problems for example in the North West are probably more to do with poverty than failure to diagnose, and it seems to me that world class commissioning is more of a syllabus for public health than anything else. Perhaps it is public health officials that should be world class commissioners, not constantly reorganised, disorganised and demoralised.

Dr Kath Checkland, National Primary Care Research Centre: We've heard a lot about involving the public, but from our research we've found that nobody really knows what that means or how to do it! Who are the public? It's a very difficult question to answer. We can look at 'representatives', but who are they; who are the representative of; and who's opinions are they? It's a lovely idea trying to involve the patient, but nobody has really pinned down what it actually means.

Dr Paul Robinson, CHKS: We've talked a lot about the interface between primary and secondary care and the organisational bit, but it's the 'outside the box' that is likely to make the difference; 78 per cent of GP consultations for example involve a psychological element.

With thanks to Norman Lamb, MP, for hosting this debate.

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25 July 2008
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