A New Commissioning

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Summary
Whatever emerges from the parliamentary passage of the Health and Social Care Bill and any subsequent political fallout, one thing seems clear-we need a fresh approach to commissioning. It is in its infancy compared to the literally hundreds of years history of provision, so an unequal task if we persist in a narrow and linear approach. We need to re-define and extend the concept of commissioning without adding to and in fact ideally lessening the tasks it currently ascribes itself.
The key roles for 'new' commissioners aggregate around four domains; being the 'people's organisation'; new relationships and partnerships within the wider public's health eco system; the healthcare system leader across organisations ensuring quality-safety, effectiveness and patient experience and equally to promote innovation, productivity and integration across all NHS funded providers; with a consequent fourth domain to have a new and in reality a completely new relationship with providers of care.

The key underpinning role for a statutory commissioner is to create and foster relationships that ensure sustainable partnerships whether formal or informal. The overarching relationship being with their public as citizens, and the overall defining culture being of sustainability. Commissioning of course takes place at many levels whether by clinicians in the act of referral to other services, by small organisations such as general medical practices, and right across to the non-statutory yet central role in commissioning of the future Health and Well Being Boards. The responsibility of the statutory commissioner whether in healthcare or local government is not to subsume that activity but to support, challenge where necessary, co-ordinate and be the strategic leader for the many levels of commissioning. Successful commissioners would major on sustainable transparently accountable relationships for which they are held to account. An accounting loop in the original proposal for 'World Class Commissioning' but sadly and inexplicably removed.[1]

Many commentators within and without the NHS identify an under achievement of NHS commissioning. The NHS in general and its commissioners in particular usually adopt a very hierarchical and often reductionist managerial approach. In a complex adaptive system such as the NHS, linear approaches to management are of limited value and effect especially when it pertains to commissioning. Effective commissioners need to exhibit a clarity of purpose in a multiplicity of relationships within a complex system. A future where commissioners strongly perceive themselves and the NHS performance system ensures commissioning organisations are the accountable 'people's organisation' for the NHS. An integral part of that responsibility is enjoying new relationships and partnerships within the wider public's health eco system. But NHS commissioners' primary task is to be the local healthcare system leader across organisations with a clear focus on holism, accountability, and outcomes.

General Medical Practitioner led clinical commissioning within the proposed Clinical Commissioning Groups is an opportunity for all clinicians with a particular emphasis on list based General Practices to shape the system and encourage a better focus on outcomes and value for their patients. This can be achieved chiefly by focusing more on commissioning for individual patients as the essential building block of a population responsibility and in which the sometimes inherent tensions between individual and population responsibility are faced. Commissioning for patients and the public, not majoring on contracting for quantities of activities or isolated processes. Commissioners as the system enabler encouraging an approach which avoids the current all too frequent scenario of a series of stand-alone services contracted separately. Starting from the point of view of patients for which good experiences of easy access to high quality co-ordinated care and incorporating interventions of which patient reported outcomes are seen as important. Hopefully a precursor to patient determined outcomes.

Commissioners need to enlist providers in their task - working collaboratively, describing outcomes and not prescribing of processes. Relationships and power dynamics will need to therefore radically change so the individual provider organisation not the commissioner is clearly and explicitly accountable for its care quality and population focus. Clinically led commissioning can facilitate clinician led provision so as to align their activity with budgetary responsibility. With the providers to be held responsible for enabling clearly identified clinicians to be transparently accountable for new clinical system thinking, development and implementation. For instance clinicians clarifying the distinction between care pathways for elective treatment and a time framed care plan for people with long term conditions, all as a key component of 'right care'. Clinical leaders are often 'invisible' to the public gaze yet it is they who 'spend' the money by their deployment of clinical resources.

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[1] Department of Health (2007).*World class commissioning.* DH

Provider leadership can be extended as for instance in the provision of urgent care where a single provider organisation can be commissioned to be the accountable principal provider of a network of providers. That principal holding other providers to account utilising where appropriate sub contracts. In primary care commissioners to support not subsume provider leadership in developing federated general practice and more holistically 'the Primary Care Home'.

The 'Primary Care Home' offers one model of integrated financially responsible provider organisations. Commissioners enabling, supporting and contracting for such transparently accountable organisations will call into question the scale, functions and indeed the size of commissioning itself. Whilst it inappropriate to prescribe local structures, herein lies an opportunity to radically re-shape NHS organisations to lessen unnecessary or duplicative administrative and managerial functions. Providers can and must take on many functions currently undertaken by commissioners within a transparently accountable system.

There is too much focus on a 'top down' prescription for the functions and an obsession with a centralist ordained population size of commissioning organisations. Their size in a complex system has to be ultimately defined by the capabilities within the whole local healthcare system including the providers of care. To manage financial risk does not need to entail forming a vast distant organisation but a formal arrangement with other commissioners or indeed at the PCT cluster level to have a locally centralised banking function. A function that acts as an insurer against unexpected large financial pressures and/or clinical risk.

In a devolved system there is a valid headquarters function that advises and challenges but not prescribes on structures and detailed function. That holds local systems to account for value and outcomes and not formulaic imposition of governance arrangements. That in essence displays two way relationships with the organisations it statutorily holds to account. Only through a management culture far removed from linearity but strongly accountable to their populations will the NHS be more effective, efficient and sustainable. 'Top down' gives a short term sense of certainty and safety but spawns dependency and an aversion to innovation. Indeed and disappointingly amongst many clinicians a passivity and indeed a victim culture.

Making hard decisions is a core commissioning task so commissioners need to ensure both a public transparency and the public's effective involvement and engagement-to be the 'people's organisation'. To obtain commissioning support clinical commissioning groups must view themselves as the customer and need to identify a choice of support maybe in conjunction with other groups. Providers of support apart from PCT clusters could include Local Authorities, acute and other NHS providers, public health and quality observatories and the third sector – private or voluntary. These organisations can also contribute significantly to the information needs of commissioners.

A lot to ask but a necessary ask for commissioners to exhibit a leadership of a complex adaptive fiercely local system. A test writ large for a clinician leadership and an opportunity to slightly paraphrase yet challenge the Dr Julian Tudor Hart aphorism 'clinicians often lay claim ground they do not wish to occupy'[2].

Discussion and a proposed model of commissioning

Commissioning much like the practice of medicine will be at its best when it conjoins art and science. Good management has always combined both those key attributes so why generally has it been so lacking in the practice of commissioning? What has created an NHS focus on commissioning being predominantly about setting contracts? A focus on input procurement and even within that narrow contractual approach there is a paucity of effective clinically oriented contract review. Much of the art lies in developing on-going multiple relationships with a particular reference to clinicians. Again much lacking in commissioning practice which seems overly preoccupied with contractual relationships. It is no wonder large swathes of clinicians from across the healthcare spectrum are disengaged from and disinterested in the commissioning process. The proposed reforms to the NHS is a response to the lack of engagement and involvement of the body clinical. It is after all clinicians and particularly doctors who 'spend' the money by their deployment of clinical resources. There are purists who rigidly state that commissioning and provision must be separate. If that is the case practising clinicians can never influence commissioning let alone lead it when the goal of successful healthcare management is to better align incentives. In particular to align clinical activity with budgetary responsibility, an aim that manifests across nations.

Whatever emerges from the parliamentary passage of the Health and Social Care Bill and any subsequent political fallout, one thing seems clear-we need a fresh approach to commissioning. The current estimated costs of commissioning stands at over £3.4b (evidence to House of Commons

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[2] Hart J. *A New Kind of Doctor. (1989)* Merlin Press.

Health Select Committee 2010). The return on that investment even in a world before a focus on QIPP (the DH policy for Quality, Innovation, Prevention and Productivity) is to say the least disappointing. Much of the improvements in NHS care whether in access to services or clinical improvements in cancer and cardiovascular care have been achieved by national targets or direction. The input locally has majored on delivering national priorities but has that predominately administrative function required such huge resources? What has been the extra achieved through locally based commissioning leadership whether managerial or clinical? There are as always the honourable exceptions but too few it seems to have made a local specific sustained and sustainable difference.

Commissioning is in its infancy compared to the literally hundreds of years history of provision, so an unequal task if we persist in a narrow and linear approach to it. We need to re-define and extend the concept of commissioning without adding to and in fact ideally lessening the tasks it currently ascribes itself. The current proposed NHS reforms aids that process by removing NHS commissioner's responsibility for provision of community services - a process begun by the previous administration. Further the prime leadership for improving the public's health is to be the remit of local government.

NHS Commissioner's prime responsibility in this new world is to focus on the provision of care. A very necessary focus as whether it is the scandal of Stafford Hospital in particular to the lack of prioritising those with long term conditions especially care of the frail elderly, ultimately it is the commissioner who is the *system* funder and leader[3].

The issue is how should NHS statutory commissioners effectively discharge their responsibility? A key initial task is to decide on an effective board membership. From initially refreshingly offering flexibility as long as the board details were in the public domain, the government after much standard traditional NHS pressure is now prescribing in more detail. There seems to be many confusing and conflicting thinking about the roles and responsibilities of boards. It must be clear that the responsibility of the board is chiefly about the governance of an organisation. This is quite a separate responsibility to the very important task of engaging local clinicians and others in service design and review. It seems that the two separate responsibilities have often been unhelpfully conflated and of more concern that board membership is seen as conferring some sort of high status on its members. It may be useful to separately raise the profile, status and distinctiveness of local clinical and professional input to commissioning to ascribe the group a title such as 'cabinet' or 'local senate'.

The current confusion and ambiguity will not help the necessary governance that the public need from their statutory organisations. It is also clear that the somewhat formulaic composition of NHS boards in the past has in many cases not identified major problems that have arisen in their organisations. Some prescription is now policy but as with positional executive leaders-clinical and managerial - it is important to choose individuals who possess technical skills AND the appropriate behavioural attributes. The latter can be ascertained systematically from the individual's behavioural history that should demonstrate the appropriate attributes and skills.

The key roles for commissioners aggregate around four domains; being the 'people's organisation'; new relationships within the wider public's health eco system; the healthcare system leader across organisations ensuring quality- safety, effectiveness and patient experience and equally to promote innovation, productivity and integration across all NHS funded providers. With a consequent fourth domain to have a new and essentially a completely new relationship with providers of care

The people's NHS organisation

First and foremost commissioners need to define themselves as the visible NHS organisation for their population. The people's NHS organisation in more popular parlance. That is what should be its defining role but as such is not what the public recognise whether evidenced in a previous Picker Institute review[4], or the much quoted survey where the public thought-refuse collection was in the top three of Primary Care Trust activities.

Statutory commissioners are the predominant funders of the local healthcare system and given that responsibility, the system leader across NHS funded organisations on behalf of and transparently accounting to their public. A leadership to enable better health and ensure better health care with a strongly enhanced focus on individual patients and the public's population needs rather than the needs of NHS providers.

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[3] *Dr David Colin Thomé* (2009). *Mid Staffordshire NHS Foundation Trust: A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation.* DH

[4] Chisolm A, Redding D, Cross P and Coulter A (2007). *A survey of primary care trusts.*

The NHS in general is relatively underdeveloped in devolving influence and more power to its public with the aim of the 2006 government white paper to address this issue being largely unrealised (Our Health, Our Care, Our Say: a new direction for community services. DH). Indeed its patients have become accustomed to the NHS in all its facets exhibiting a didactic approach, an approach that tends to create a dependency culture. To be of the people will initially necessarily entail both a community leadership and community facilitative approach as early stages of a journey; a journey to patient determined outcomes, and of methodologies to measure transparent accountability, and partnership with their public. If Foundation Trust providers have a membership even if nationally ordained, commissioners should be in the same territory. The focus being about creating a membership type culture and a 'feeling of' belonging to an organisation rather than a necessity of formal membership. Formal membership to be encouraged as an option if legally possible and within a wider approach to community development, engagement, involvement and ideally community organising. The 'people's organisation' to be of, for and accounting to their public and patients in ways that should be defined organically as part of a journey.

New relationships with the wider health eco system

The overarching priority for the wider health eco system is sustainable development. To reduce carbon emissions is hugely important but the guiding principles of sustainable development are much broader; living within environmental limits; ensuring a strong, healthy and just society; achieving a sustainable economy; promoting good governance; using sound science responsibly[5].

The reforms to the Public Health System give Local Authorities quite rightly the lead role locally for improving the health of their population. Rightly as their services and influence have far more impact on sustainability and the social determinants of health than the NHS. The evidence also strongly shows a multi-agency approach involving the public is essential for *inter alia* successful health promotion and disease prevention. The proposed Local Authority led Health and Well Being Boards need to ensure that the individual agencies are held to account for delivering their part of the local public health strategy. There are many facets of improving the public's heath that the NHS will lead for instance-vaccination and immunisation, cervical screening and improving the health of those who have a long term condition. Services in which population list based general medical practice providers have already achieved much. NHS Commissioners have a system wide role in enabling and ensuring all their providers deliver to both a defined population and individual patients. The responsibility for a population is essential to having an important role in improving the public's health whilst recognising that a population is made up of individuals and their needs. Population responsibility is often interpreted in a utilitarian collectivist manner rather than a way of enabling individuals within that population to fulfil their health potential. An important healthcare principle is that whether the patient is 'in front' or 'not in front' of the professional, the organisation has a responsibility to them. Where population and individual care clearly conflate and as a priority is in better support and care for those with long term conditions; conditions that have a major impact on health inequalities.

'Personal health services have a relatively greater impact on severity (including death) than on incidence. As inequities in severity of health problems (including disability, death, and co-morbidity) are even greater than are inequities in incidence of health problems, appropriate health services have a major role to play in reducing inequities in health'[6].

'Put succinctly, societies with a sharper distinction between material 'haves' and 'have nots' have, regardless of average wealth levels, higher rates of harm resulting from broadly defined metabolic syndrome related disorders than more equitable communities. This might be because of as yet not adequately understood physiological factors linking social and economic inequalities to psychological (di)stress and/or an experienced lack of social support. Such findings have global implications regarding the illness prevention and treatment provision. They support the view that in rich and poor countries alike the optimal management of metabolic syndrome related disorders is likely to demand political actions and social changes that go beyond those aimed at facilitating the more effective use of medicines and behavioural change programmes aimed just at individuals'[7].

The Institute for Public Policy Research report[8] explores British attitudes to public services. It argues that the better-off receive superior health and education services to the poor, and that although the

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[5] Council of the European Union (2005).*Guiding Principles for Sustainable Development* ***http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ec/85349.pdf****. Accessed 26/8/2011*

[6] Starfield B (2006) Journal of Health Politics, Policy and Law, Vol. 31, No. 1.

[7] Marmot,M., Friel, S., Bell, R., Houweling, T. and Taylor, S (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* Lancet, 372, 1661–1669

[8] Brooks R (2007)*Public Services at the Crossroads* .IPPR

choice agenda has helped improve services for those at the bottom further personalisation of services is needed. The report shows that the more affluent and better educated a person is the greater the health benefits they gain from the NHS. It reports that higher socio-economic groups access health care more frequently as elective, planned admissions, while lower socio-economic groups typically enter as emergencies. The report also shows that, across a disparate and wide range of conditions, lower socio-economic groups tend to present to clinicians at more advanced and severe stages of illness.'

And to support better long term conditions care; (the following quote from an article was written for an USA journal. Hence the use of the phrase chronic disease which rather than England's 'long term conditions' terminology is still the internationally used description);

'Various policies have been developed since the 1990s to address the needs of people with chronic diseases. These policies include a stronger focus on the prevention of illness, measures to strengthen primary care, and initiatives designed to support people with chronic diseases in managing their own conditions. The NHS Improvement Plan, published in 2004, was important in bringing together these and other initiatives and in signalling the government's commitment to giving explicit priority to chronic care as a policy in its own right. In identifying chronic care as a priority, the government was reflecting international recognition of the need to reorient health systems in response to the changing burden of disease, as well as specific weaknesses in the performance of the NHS in this area.

The chronic care policy promulgated in 2004[9] identified the need for action at three levels: self-management interventions for people able to manage their own conditions; disease management by primary care teams for people with conditions that could be controlled through regular contact with a family physician, nurse, or other team member; and case management for patients whose complex needs meant that they needed more intensive support than that available through self-management and disease management. The NHS and Social Care Long Term Conditions Model was developed to describe the various elements in government policy. The model drew explicitly on the Chronic Care Model developed by Ed Wagner and colleagues. The inclusion of social care in the model was intended to signify that people with chronic conditions required a range of support services that extended beyond the limits of the NHS'.

And in a more prescient quote than I hoped it to be;

'Looking back on the period since the NHS Improvement Plan was introduced, the national director for primary care judges that implementation of the chronic care policy has not been as rapid or as far-reaching as he would have hoped for, although four years may be too short a time in which to offer a considered judgment.'[10].

The healthcare system leader

The above is a convincing indeed compelling narrative and evidence base that *the* healthcare issue of this early part of the 21st century and on which we should have focused more intensely is on long term conditions. Yet despite as evidenced based a policy as could be achieved, the NHS and Social Care Long Term Conditions model having been instigated in 2004 remains incompletely implemented. A fact reinforced as its belated systematic implementation is one of the key work streams of the current Quality, Innovation, Productivity and Prevention (QIPP) programme; a past failure of commissioning, provision and indeed managerial and clinical leadership. The most salutary example is the often very poor care offered to the frail elderly whether it was specifically at Mid Staffs hospital or generally as identified by the Ombudsman[11].

In summary, nowhere is the coming together of individual and population needs more important than for serving those patients and individuals with long term conditions. And nowhere is there a more urgent need for system leadership. There are many imperatives if we are to deliver a quality, equitable and cost effective service. This applies to all services but the system of care of those with long term conditions in particular those who have co-morbidity of conditions and especially who are also frail and elderly should serve as a template, an exemplar and an accountability of NHS commissioners. The NHS and Social Care long term conditions model provides a useful and evidence based framework. Long term conditions is the health and health care issue of this early century and as such is a key priority for all four domains of commissioning. Delivery will depend on the NHS providing

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[9] Department of Health (2004). *Raising the profile of Long Term Conditions: A Compendium of Information. DH.*

[10] Ham C. *(2009)* Health Affairs 28,no. 1: 190–201; 10.1377/hlthaff.28.1.190.

[11] Parliamentary and Health Service Ombudsman (2011) *Care and Compassion. Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. ***http://www.ombudsman.org.uk/care-and-compassion/home*** accessed: 26/8/2011

optimal care but many facets of the strategy are also for the wider public health eco system and its system wide accountability. NHS commissioners as must all statutory bodies need to exhibit a leadership beyond their own remits and specific responsibilities – a leadership for sustainable development.

A New Relationship with Providers
If in discharging their NHS responsibility commissioners cannot ensure as their basic and unique role an excellent provision of care, what is their role? It is the providers who deliver the services and supply the professionals the public recognise and relate to. There is currently too rigid a split between commissioner and providers as only the actual setting of contracts needs to be separated within the commissioning cycle. Can commissioners look beyond a focus on solely contractual relationships to a role as system facilitators and leaders? A role and a responsibility to enable publically accountable and preferably population focused providers to define their quality and consequently lead and deliver on care all within a contractual framework that supports and incentivises quality care. Current contracts are often too detailed impositions coupled often with inadequate review processes with the frequent exclusion of clinical input as for instance in General Practice Out-of-Hours Services[12].

There is of course a corollary to commissioning. Where is the provider responsibility and leadership in ensuring good quality care that is cost effective and achieving maximum efficiency? Providers should be committing to delivering transparent quality outcomes and to be held to account for their performance. Commissioners could employ the use of incentives and sanctions to achieve this end but far more preferable in a mature service is for providers to set their own high ambitions in return for contract payment. And not for commissioners to be forced to take the responsibility to manage the consequences if an individual provider loses income. That as in any other walk of life is what provider management is paid to do. The focus of a new relationship is how the commissioners ensure a system of provision for their population, not to be preoccupied with the needs of an individual provider organisation. Many of us are wearied by the frequently tendentious claims of 'this will de-stabilise my organisation' when this is used as a pretext for inaction.

Good commissioners need good providers, and vice versa. The future optimal position must be about a transparent partnership between commissioner and provider. A need therefore for less detailed and far more clinically influenced enabling contracts. With the need for a more detailed contract or indeed searching for competitors reserved only for those providers who lack the necessary vision and leadership for a new partnership relationship with commissioners.

For provider organisations the optimal approach to making an impact on commissioners and play to clinician's strengths is of course to provide high quality, extended scope but necessarily accountable services. The extra dimension that will create more meaningful partnerships and to influence and complement commissioners is when the provider serves a defined population. Population responsibility has too long with the exception of general medical practice, been the preserve of commissioners. And a population responsibility should not preclude the opportunity to serve the public who do not live within that population. The strength of a population approach is to be a proactive service to those of the public who are 'not in front of you' as much as to those who have sought your services.

Commissioning for community based services
In the short term commissioners will have to focus on many aspects of service provision. The longer term priority if the NHS is to achieve significant whole system service re-design is to major on a step change in community based services. It will be *the* priority to ensure a high quality, cost effective, extended 'care closer to home' with ideally no unwarranted variation in care. Many commissioners currently complain that as the contracts of the independent contractors are held nationally it impedes or makes impossible their ability to manage those services; compounded in their eyes by the pejorative 'it's like herding cats' view of managing primary care. The riposte is that only unimaginative managers would wish to 'herd cats' but more seriously it reflects the too common NHS management culture that only through a contractual relationship can you manage clinicians. In fact forty per cent of current GP contracts are local without much evidence that those contracts are outcome oriented. Clinician led commissioning proffers the opportunity for a new relationship approach to the management of primary care and its clinicians so as to achieve the step change required even if the contracts are held nationally. A big but not impossible task and crucially may depend on choosing the right leaders of commissioning organisations - possessing an awareness of the various cultures of community based services, technical skills and a past history of enabling and change management skills.

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[12] Colin-Thomé D, Field S (2010). *Project to consider and assess current arrangements. DH.*

The providers of most first contact primary clinical care are general medical practitioners who nationally provide some 80% of all the NHS clinical contacts with patients, general dental practitioners, community pharmacists and community optometrists. These independent contractors have as a group the highest regard within the NHS of their patients, with for GP services in particular an extensive bibliography demonstrating their popularity and success[13 14 15]. And a more questioning report[16]. But the culture of these contractor services is different from and often ill understood by the mainstream NHS.

NHS care is also provided by community health services, social services, voluntary organisations and on occasions privately funded services but rarely have these community services enjoyed a centrality that their importance deserves. A deficit rectified to some extent by the potential of the 'Transforming Community Services' initiative of the NHS Next Stage Review Primary and Community Services Strategy (DH 2008). A quality improving potential that has become lessened by the current structural and contractual focus on community services with the title 'Transforming Community Services' being misapplied to describe this linear and reductionist approach to community health services.

All community based services need to contribute to and for many patients deliver the whole clinical or 'year of care' pathway from prevention, screening, early diagnosis through to co-ordination and review of care. With a clarity of which organisation and which professional is chiefly accountable to patient and commissioner alike. Incidentally the clarity of which clinician is accountable is also essential for good co-ordination of care throughout a hospital stay. Community dentists and Optometrists can be a source of health promotion and identifying systemic disease. Community pharmacists who are amongst the most popular of local professionals and whose services have a large 'footfall' of the public are very well placed to contribute to and indeed lead on many aspects of care. There are excellent national examples of the extended role of community pharmacy[17]. Community health services in conjunction with social services and GP practices to provide personalised support for people including children and young people with long term conditions and also for end of life care. The 'Gold Standard Framework' or the 'Liverpool Care Pathway for the dying patient pathway' provide excellent audit tools for end of life care. Long term care should be audited against the national generic long term conditions framework and any locally agreed standards.

But general medical practice provision with its local and popular focus, its major clinical activity, and its list based population responsibility will have for the foreseeable future the key provider role in system care. The successful delivery of the national pay for performance Quality and Outcomes Framework (QOF), the allocation of generic practice based budgets in the past as in GP Fund Holding and the future GP leadership role in NHS commissioning all depend on and are a consequence of a population responsibility. It is to be hoped that other community based professionals and their various organisations will embrace a population focus- a clear role for facilitative commissioners.

The role of the GP and the role of the practice despite being inextricably linked are essentially separate. A good GP to quote is Kenneth Robinson, the Minister of Health who introduced the ground breaking 1966 GP contract 'has a liking for people and a flair for diagnosis', Two attributes that must stand the test of time as community and clinical credibility enhances the potential to lead. An individual GP optimally has a continuing relationship with their patients and extended family often over many years. But it is the practice with its extended team and population responsibility that has the potential to be the major local resource for their registered patients. The key attributes of a GP service are:

- First point of contact care for many
- Continuous person and family focussed care
- Care for all common health needs
- Management of long term conditions
- Referral and coordination of specialist care

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13 Berwick D (2008). *A transatlantic review of the NHS at 60.* BMJ.337;p838

14 Wilson T, Roland M, Ham C. *The contribution of general practice and the general practitioner to NHS patients.*J R Soc Med 2006; 99:24–28.

15 Starfield B, Shi L, Macinko J. *(2009) Contribution of primary health care to health systems ... quality of care in England.* N Engl J Med. 361(4): 368–78

16 Kings Fund (2011).Improving the quality of care In general practice. King's Fund Inquiry and report. ***www.kingsfund.org.uk*** accessed: 26/8/2011

17 Department of Health (2006). *Implementing care closer to home - providing convenient quality care for patients. A national framework for Pharmacists with Special Interests. DH.*

- Care of the health of the population as well as the individual[18]

Apart from very specific specialised care, all aspects of the clinical pathway can be delivered through the practice working with fellow community based health and social care services and supported by hospital staff with a community role.

By adopting the community oriented primary care approach practices can also significantly contribute to and potentially lead locally the necessary multi agency approach to prevention and community awareness of early disease. The practice can play a major role in promoting all aspects of screening and could be incentivised and equally held to account in ensuring uptake. Early diagnosis is the key skill of the clinician "the ability to organise; the chaos of the first presentation ...'' as Paul Freeling late emeritus Professor of General Practice described. Early diagnosis awareness can be much aided by computer system support for instance 'flagging' smokers, heavy alcohol drinkers and those with a relevant family history to be a constant reminder to clinicians to respond promptly to relevant symptoms. There are incidentally systems well on the way to development that can identify for clinicians likely differential diagnoses from patients previous input of their symptoms. Primary care clinicians must have easy access to diagnostics with no stigma attached to negative investigations but regularly audited to identify unwarranted variation. Investigations that are part of locally agreed pathways. 'Map of Medicine' software can underpin the development of these pathways, a system that can lead to a future increase in direct access to more advanced diagnostics. The general practice to audit and ultimately hold all its individual clinicians to account

And for those patients who are currently on treatment for long term conditions or require end of life care to have access to practice based 'community matron' nurses to ensure co-ordination and responsive care. In my former practice community nurses employed by the practice resulted in better quality and audited care that produced significant reduction in hospital bed days and at the end of life more patients dying in the place they wished[19].

The individual practice may lack the capacity, capability and willingness to provide such an extended service but if they are part of a federation or locality of provider practices, that organisation can provide the strategic and operational management skills and staff needed[20]. Whether single or multiple practices, devolution of budgets to those practice models will encourage more innovation and ownership than the simple payment incentives that currently predominate. To lessen financial risk such budgets only appropriate to the population base covered similar to fund holding budgets of the past. Further the commissioner will remain the statutory accountable organisation. Budgetary devolution being about imaginative management that was so generally lacking in implementing the similar principles of Practice Based Commissioning. A real opportunity for clinical led commissioning to promote clinical innovation with budgetary responsibility

To bring many of these strands together, I am promulgating the concept of the 'Primary Care Home'[21]. Integrated population responsible community based care. Where the needs of the individual and of the community can be met, commissioned by statutory commissioners and served by a holistic budget that enables a 'make or buy' approach to care delivery. A home not only for general medical practitioners and their teams but for all primary care independent contractors and their staff (Pharmacists, Dentists, Optometrists) together with community health service and social care professionals. And potentially a home for many currently working in hospitals in particular those who have a responsibility for long term conditions care, for rehabilitation and re-ablement and for the surgeons who in particular specialise in 'office based' procedures.

The 'Primary Care Home' offers one model of integrated financially responsible provider organisations. Commissioners enabling, supporting and contracting for such transparently accountable organisations will call into question the scale, functions and indeed the size of commissioning itself. Whilst it inappropriate to prescribe local structures, herein lies an opportunity to radically re-shape NHS organisations to lessen unnecessary or duplicative administrative and managerial functions. There is too much focus on a 'top down' prescription for the population size of commissioning organisations. Their size in a complex system has to be ultimately defined by the capabilities within the whole local healthcare system including the providers of care. Providers can

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[18] Chambers N and Colin-Thomé D *(2008). Doctors Managing in Primary Care. International Focus*

[19] Lyon D, Miller J, Pine K. (2006). *The Castlefields Integrated Care Model: The Evidence Summarised*. Journal of Integrated Care. Volume 14, Number 1.

[20] *(2007) BMJ 335 : 585 doi: 10.1136/bmj.39342.589294.DB*

[21] Colin-Thomé, D *(2011). Personal communication awaiting publication*

and must take on many functions currently undertaken by commissioners within a transparently accountable system.

In a devolved system there is a valid headquarters function that advises and challenges but not prescribes on structures and detailed function. That holds local systems to account for value and outcomes and not formulaic imposition of governance arrangements. That in essence displays two way relationships with the organisations it statutorily holds to account. Only through a management culture far removed from linearity but strongly accountable to their populations will the NHS be more effective, efficient and sustainable.

Commissioning of 'Right Care'

A truism but also a significant programme within the Quality, Innovation, Prevention and Productivity (QIPP) national DH programme. Integrated care pathways are much in vogue and for elective procedures a pathway involving specialist intervention is often necessary. For long term conditions a different approach is necessary that could be wholly community based but there are some necessary characteristics of all pathways[22]. *'They ideally need to be prospectively costed, with a review of variance and include quality indicators and outcome indicators'*. The latter may solely be patient reported outcomes. '*To expand on these design principles there are important clinician focused provisos in delivering on pathways- they are not immutable documents setting out inviolable treatment regimens. The existence of a pathway does not obviate clinicians' responsibility to make clinical judgements and to tailor care according to their assessment of the clinical needs of individual patients. Thus clinical variation remains a 'to be expected' (in the sense of an often required) feature of clinical practice. The matter at issue is what a clinical team can learn from these variations and how they can systematize this learning. Accordingly, when the care process varies from that described in the pathway, the reasons for the variance are recorded and become the focus of structured clinical audit and education'*

Continuing on the theme of 'right care', the word rationing is often loosely and incorrectly applied. A useful definition of rationing is the delay or denial of appropriate and effective interventions. Many aspects of current care delivery and some clinical interventions are now out dated, inappropriate or ineffective for instance much of follow up out-patient care, large variation in GP referral patterns and in hospital lengths of stay. Such a description also applies to clinical interventions of low clinical value. Ceasing such interventions is not rationing but a providing of 'right care'. Protecting patients from deleterious inappropriateness and ineffectiveness is a public health issue albeit currently not well identified.

Providers need to have a clearly defined leadership responsibility for 'right care' by providing cost effective care and services but where they seem 'unwilling' a contractual intervention that may entail competition will be necessary.

Key messages about information needs of commissioners

The author of this paper is currently chairing for the organisation Dr Foster an advisory board to describe the necessary information requirements of commissioners. The report will be published in autumn 2011 but a summary of some of the key principles for a new approach to commissioning information are;

An important aspect of caring optimally for individuals with long term conditions is the use of predictive modelling and risk stratification. Predictive models identify individuals and groupings within a population who are expected to be high utilisers of health care resources, predominantly people with long-term conditions. However predictive modelling is just one of the strategic information needs to support evidence based commissioning and service delivery. Population risk profiling is defined as the process by which the health status of a population is measured for planning services, equitable budgeting, resource management and assessing outcomes. The Adjusted Clinical Groups (ACG) System is designed to meet all of these needs from one data set and one clinically-inspired analytics tool[23]. The ACG System is primary-care based[24]. As the methodology identifies at the individual patient level, it opens up further uses at patient, practice and healthcare system level - not least budget setting at a very local level and adjusted for demography.

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[22] Degeling, P, Close, H & Degeling, D. (2006). *Re-Thinking Long Term Conditions: A Report on the Development and Implementation of Co-Produced, Year-Based Integrated Care Pathways to Improve Service Provision to People with Long Term Conditions.* Centre for Clinical Management Development. Durham University

[23] .Starfield B et al. *Comorbidity and the Use of Primary Care and Specialist Care in the Elderly* ,Ann Fam Med. 2005 May; 3(3): 215–222

[24] Starfield B. *New paradigms for quality in primary care*. British Journal of General Practice, 2001, 51, 303-309

In setting contracts, encouraging the definition of a few key outcomes and putting greater responsibility on providers to demonstrate how they will assure themselves and how they will assure the commissioner. The latter in turn can assure their public.

Avoiding the 'tick box' approach to contract monitoring. An emphasis on the value of soft information as well as hard data. If the commissioner has become 'of the people' as previously described, it will have ample source of soft data from public, patients and clinicians alike.

The importance of looking at quality in the round by adopting the NHS Next Stage Review (DH 2008) definition of quality as the combination of clinical effectiveness, safety and patient experience. An important part of a quality focus is identifying unwarranted variation in care[25] in the achieving of 'right care'[26].

A post script

What can be done to shift the NHS culture to partnership, accountability and outcomes? The NHS Nest Stage Review (DH. 2008) led by Lord Darzi defined quality as incorporating three domains; Safety, Effectiveness and User Experience. These domains could/should be the contractual overarching framework between commissioner and provider. Using national standards and methodologies where they exist for each domain. And also for locally identified standards and methodologies to be incorporated in local contracts preferably proffered by the provider. In the latter case the commissioner role is to triangulate and benchmark the evidence and ambition behind the proffered indicators and to hold the provider rigidly to account. An example of a transparent accountable partnership. Patient reported outcomes to be paramount but ideally in all three domains patient determined outcomes.

Quality across all these domains were poor in Stafford Hospital within the whole Hospital Trust with a particular lack of user feedback . The views of the user were either ignored or not garnered hence my recommendations in the Mid Staffordshire Foundation Trust Review.

To obtain commissioning support clinical commissioning groups must view themselves as the customer and need to identify a choice of support maybe in conjunction with other groups. Providers of support apart from PCT clusters could include Local Authorities, acute and other NHS providers, public health and quality observatories and the third sector –private or voluntary. These organisations can also contribute significantly to the information needs of commissioners.

Conclusion

Transparency and accountability are key challenges – what information do commissioners need to make available to the public? And why do we not make all performance data of providers and commissioners publically available? Whose NHS is it? To whom should commissioners account to? And how should they ensure good provision of care? A good adage for the NHS is maybe worry less about making people accountable and more about how to help them feel responsible.

There is too much focus on a 'top down' prescription for the functions and an obsession with a centralist ordained population size of commissioning organisations. Their size in a complex system has to be ultimately defined by the capabilities within the whole local healthcare system including the providers of care. In a devolved system there is a valid headquarters function that advises and challenges but not prescribes on structures and detailed function. That holds local systems to account for value and outcomes and not formulaic imposition of governance arrangements. That in essence displays two way relationships with the organisations it statutorily holds to account. Only through a management culture far removed from linearity but strongly accountable to their populations will the NHS be more effective, efficient and sustainable. 'Top down' gives a short term sense of certainty and safety but spawns dependency, an aversion to innovation and even disappointingly amongst many clinicians a passivity and indeed a victim culture.

A lot to ask but a necessary ask for commissioners to exhibit a leadership of a complex adaptive fiercely local system. A test writ large for a clinician leadership and an opportunity to slightly

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[25] *Mulley AG. (2009). Inconvenient truths about supplier induced demand and unwarranted variation in medical practice.* BMJ; 339: b4073

[26].Department of Health 2010. *NHS Atlas of Variation in Healthcare.* DH

paraphrase yet challenge the Dr Julian Tudor Hart aphorism ‘clinicians often lay claim ground they do not wish to occupy’[27]. A test and opportunity for a new commissioning

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Post Script

Contracting

Currently contracting for care does not seem to be sufficiently effective as witnessed by the frequent evidence of provider failure of care. The most salutary example is the often very poor care offered to the frail elderly whether it was specifically at Mid Staffs hospital or generally as identified by the Ombudsman or more recently the Care Quality Commission. There are other examples eg recently identified problems in surgical care of children, the continuing provision of clinical interventions of low value and the failure to systematically implement the evidenced based DH Long Term Conditions strategy of 2007. Long Term Conditions being the healthcare issue of our current time.

There are numerous contracts set locally but for instance from the experience of a GP Out Of Hours review undertaken for the Department of Health, very poor contract monitoring (Colin-Thomé D, Field S (2010). Project to consider and assess current arrangements. DH). So we have a system which seems to be focused on the input part of procurement, inadequate contract review with no systematic clinical input and in general a focus on mainly contractual relationships. And rarely any user or carer involvement.

What can be done to shift the NHS culture to partnership, accountability and outcomes? The NHS Nest Stage Review (DH. 2008) led by Lord Darzi defined quality as incorporating three domains; Safety, Effectiveness and User Experience. These domains could/should be the contractual overarching framework between commissioner and provider. Using national standards and methodologies where they exist for each domain. And also for locally identified standards and methodologies to be incorporated in local contracts preferably proffered by the provider. In the latter case the commissioner role is to triangulate and benchmark the evidence and ambition behind the proffered indicators and to hold the provider rigidly to account. An example of a transparent accountable partnership. Patient reported outcomes to be paramount but ideally in all three domains patient determined outcomes.

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[27] Hart J (1989). *A New Kind of Doctor*. Merlin Press.