THE **WELSH NHS** CONFEDERATION
CONFFEDERASIWN **GIG CYMRU**

Locality Commissioning

Evidence and ideas for the way ahead in Wales

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Introduction

Despite the frequent talk about the need to strengthen commissioning, nothing meaningful was done to bring it about. (Stevens, 2006)

It is a widely held view that health commissioning in the UK needs to be strengthened. In Wales, *'Designed for Life'* (Welsh Assembly Government 2005) has signalled the need for a thorough review to strengthen the planning and commissioning of health services.

The starting point for this Welsh NHS Confederation (WNHSC) study is our view that:

- Commissioning is vital in the 21st century NHS and must be strengthened
- A strong local dimension is one of the major assets in health policy in Wales and must be preserved

It follows from this that examining locality commissioning should be an important task for us as we consider how to develop a commissioning framework that is right for Wales

In this study, as in our other recent paper *'Commissioning - can we get it right'*, our aim is to open up the debate , not argue the case for a particular model or approach. We draw on literature on the subject of locality commissioning, and first-hand experiences from the front-line, and from England as well as Wales.

Whilst we acknowledge there has been some consideration in Wales of the role that commissioning at a locality level might play, we aim to explore more fully the potential role of primary care and localities in developing health services, particularly for those with long-term conditions. Our opening proposition would be that the care of people with long term conditions needs to emanate from the heart of the communities in which they live.

In England, the role that primary care can play in commissioning services for patients and local populations is reflected in the current policy of involving all GP practices in Practice Based Commissioning (PBC). Practices are seen as one of the main determinants of healthcare utilisation; and, through their role as co-ordinators, as a major influence on what care a patient receives and how a patient exercises choice.

It may be the case that there are doubts in Wales that PBC would fit our circumstances partly because of a lingering, rather negative, recollection of GP fundholding. The aims of the present study , therefore, are to:

- Look at the evidence of the advantages and disadvantages of GP fundholding;
- Look at the approach to PBC in England;
- Give a Confederation viewpoint on the way forward for commissioning in Wales.

The context

Our recent report – *Commissioning: can we get it right?* - explored in detail the relevant literature on commissioning including definitions, models and activities.

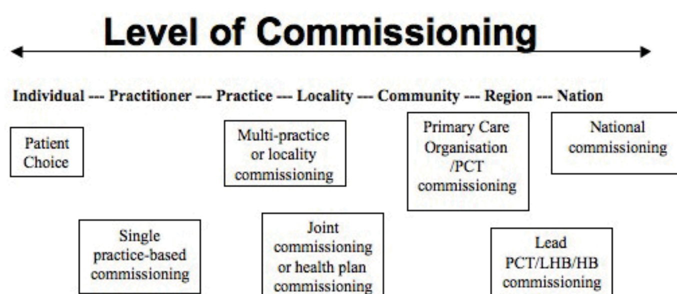
For the purpose of this paper, Smith et al (2004) (who were highly influential in informing the policy development of Practice Based Commissioning in England) give the following definition of 'primary care-led commissioning':

'Commissioning led by primary care clinicians, particularly GPs, using their accumulated knowledge of their patients' needs and of the performance of services, together with their experience as agents for their patients and control over resources, to direct health needs assessment, service specification and quality standard setting stages in the commissioning process in order to improve the quality and efficiency of health services used by their patients ... [this] need not include the contracting stage of the commissioning process as long as the decisions on needs and services are shaped directly by clinicians taking responsibility for the use of resources.'

Insights from international and developing UK experience, particularly in respect of long term care, has highlighted the need for the further development of commissioning skills, such as:

- stratification of patient and population risk
- advanced case management
- predictive modelling of high use patients
- advanced data analysis
- greater refinement in assessing service quality and outcomes

Smith et al. stress throughout their report that practice-led and locality commissioning are part of a spectrum of commissioning ranging from individual patients 'spot purchasing' at one end to the national commissioning of tertiary services at the other.



Smith et al (2004)

They go on to argue that it is for each local health economy to decide on the appropriate blend of approaches to commissioning in the light of its own circumstances. In the light of our research and discussions we would argue that running alongside Smith et al's model, governance arrangements are essential in creating the dynamics throughout the system that either promote or hinder service development and re-design, effectiveness and efficiency.

Since the change of UK Government in 1997, Wales, England, Northern Ireland and Scotland have all used a mixture of markets, hierarchies and networks as part of their governance arrangements for the NHS. The balance between them, however, has varied considerably, with England favouring market mechanisms, Scotland abandoning the internal market and favouring a mixture of hierarchical structures and professionally driven networks and Wales favouring collaboration, but retaining some aspects of the internal market, (principally the purchaser-provider split). Each country is now in the process of re-balancing – with England accelerating market plurality in terms of providers (and possibly commissioners) on the one hand, but considering networked arrangements in an attempt to align clinicians with services rather than hospital buildings on the other, (National Leadership Network, 2006); and Scotland signalling in the Kerr Report (2006) that it is considering whether market mechanisms in the form of tariffs might play a part in the relationship between Health Boards and hospitals. It is essential, in considering whether and in what form locality commissioning might play a part in Wales, that the governance arrangements in relation to the whole system are fully worked through.

In terms of the policy context in Wales, it is worth noting that the First Minister's views on these issues appear to be unequivocal:

"There are two basic models which both aim to extract extra value from spending on public services. The first is based on breaking up large scale organizations into smaller bodies with delegated budgets and a greater degree of freedom as providers. Enhanced efficiency and responsiveness levels emerge through the more competitive and entrepreneurial environment for managers.

Whereas competitive models appear at first sight to offer ... more choice, in practice it is the management team who are empowered ... There is a perfectly respectable case to be argued for this model but not for Wales.

The second model seeks to maximize efficiency through the scale economies of more effective co-operation and co-ordination between [public sector] agencies [and] the independent,

voluntary and private sectors. By using co-ordination rather than competition, users and producers of public services are ... on the same side ... the best outcomes are obtained when those who use and those who provide services work together in collaboration."
(Welsh Assembly Government 2004)

The recent report by the National Leadership Network (2006) on the future of local hospitals in England wrestles with the trade off between choice and contestability on the one hand and integration and collaboration on the other.

'Any sustainable future for local acute services will be about commissioned networks of hospitals working in tandem with community based services providing high quality, local care as part of a whole system – and not about individual hospitals struggling to survive in isolation. It will need to deliver high levels of co-operation and service integration in a way which promotes competition and choice rather than local monopoly.

... providers will be required both to compete with each other for activity in some services and to collaborate in others within commissioned and contestable networks and partnerships."

Arguably, in the Welsh context, values underpinning the development of health, well-being and social care prioritise collaboration, integration, and maintaining a geographical link between the commissioning of services and the communities served over choice and contestability. The English perspective on the Welsh system that came through from practices and PCTs was:

- the link between services and communities was important;
- the relationship between health and local government appeared to be better developed in Wales and would be welcomed in England;
- the focus on determinants of health was important – whilst, on the other hand, issues of access to services and service redesign had, prior to *Designed for Life*, been left to drift unacceptably. In tackling issues of access and service redesign, we should be careful not to throw the baby out with the bath water;
- the principle of having a nationally led, but locally focused National Public Health Service was seen as a plus;

It was not uncommon to hear sentiments along the lines of:

'Wales should hold its nerve'.

About the study

Gathering views

The two principal strands to gathering information were:,

- a review of the literature relating to fundholding and PBC;
- taking soundings in Wales and in England about the legacy of fundholding, PBC in practice and the issues for Wales.

It should be stressed that those with whom these discussions have been held were not a representative sample in a scientific sense, or, by any means, a comprehensive set of stakeholders. Our intention at this stage was merely to seek a range of views to contribute to an agenda for discussion with the NHS and its partners in Wales.

Soundings were taken from:

- Welsh GPs from former Locality Commissioning Groups and former GP fundholders
- English GPs (former fundholders, currently involved in PBC)
- LHBs, Trusts & PCTs
- Private sector
- Academics in Wales and England

Findings

The messages from the literature and from the soundings we have taken are discussed under the following main headings:

1 Fundholding - what worked and what didn't
2 Practice Based Commissioning
3 Confederation viewpoint

1 Fundholding - what worked and what didn't

GP fundholding was brought in as part of the then Conservative Government's introduction of an internal market into the NHS in 1991. Initially restricted to practices with a population of 11,000 or more, this limit was subsequently reduced to 5,000.

Fundholders received a cash limited allocation through which to purchase:

- community health services
- diagnostics
- out patient referrals
- elective surgery
- prescribing

The scheme was controversial, and received adverse commentary in Wales where there seems to have been a concentration on concerns about equity, divisiveness, 'cherry-picking' and transaction costs and perhaps not enough exploration of the scheme's capacity to engage clinicians and achieve a range of benefits albeit mostly, (but not exclusively) for fundholders' own practice populations.

It took some years after the demise of fundholding for research evidence to be accumulated about both the positive and negative impact of fundholding. It has been argued that the lack of evaluation from the outset of the scheme was a deliberate policy:

"The Conservative Government set its face against sponsoring its own evaluative studies, suspecting, (with some justification) that those who called for experimentation and evaluation ...intended to brake and perhaps even to derail the reforms"
(Le Grand, 1999)

As well as the lack of formal evaluation, Le Grand has pointed out that the methodological difficulties of studying the effects of fundholding are also substantial. More recently a health economist at the University of York (Mannion, 2005) identified that some evaluation proved possible after the scheme ended. He also highlighted that because the end of fundholding was signalled well in advance, it proved possible to undertake a 'difference in differences' study of practices during the last two years of fundholding, compared with their activity in the two years after the scheme finished (Dusheiko, Gravelle, & Jacobs, 2004). Whilst taking into account that the evidence is somewhat limited, the pros and cons of fundholding can be summarised as shown in boxes 1 & 2.

Pros of GP fundholding: box1

Service Provision
Range of secondary services provided at practice level; for example, physiotherapy, ophthalmology, counselling.

Waiting Times
Waiting times 8% shorter on average – particularly in evidence for services with longest waits; orthopaedics, ophthalmology and gynaecology.

Admissions
Reduction in elective admissions by 3.3%.

Choice
Theoretically, more choice of provider (there is not much evidence that this often happened in practice).

Prescription costs
Held down prescription costs (may have been largely a one-off saving related to moving formularies and generic prescribing).

Engagement
Engagement of clinical and managerial staff at practice levels because of being able to make change happen.

Fostered clinical to clinical discussion between primary and secondary care.

Savings
Savings reinvested to help improve patient care.

Cons of GP fundholding: box 2

Inequity
Longer waiting times and less choice for non-fundholders' patients – the 'two-tier' system. Fundholding practices received a higher than equitable share of resources in some areas.

Cherry-picking
There was a concern that fundholders might 'cherry-pick' patients to exclude those with complex needs. (This does not appear to have emerged as an issue in practice). Also 'cherry-picking' in the way that services were commissioned leading to fragmentation and possible de-stabilisation of Trusts.

Service redesign
Limited impact on service design.

Transaction Costs
Transaction costs were high. The Audit Commission (1996) estimated overall costs of £232 million compared with savings of £206 million. These figures are in themselves an underestimate as they only include audited savings against budget and do not take into account the cost to providers of dealing with multiple purchasers, nor the practices' costs in terms of the time they had to put in.

Use of Savings
Savings invested to improve patient care were seen as directly benefiting GPs when, for example, practice premises were extended or refurbished.

Patient satisfaction
Reduced patient satisfaction: financial aspects of the scheme tended to be perceived as distorting the patient/doctor relationship.

Adapted from Lewis (2004)

Unscheduled care was not part of fundholding and therefore the scheme had no impact on reducing unscheduled admissions. The development of Total Purchasing Pilots with comprehensive responsibility for commissioning did lead to a reduction in bed days, admissions and to a degree of demand management, although Lewis concludes that few Total Purchasing practices tackled patterns of specialist care.

Locality / GP commissioning pilots

Alongside fundholding, a number of locality/GP Commissioning projects developed. Some brought together GP practices who were philosophically opposed to fundholding. Others developed that brought both fundholding and non fundholding practices together. In marked contrast to fundholding, a pilot scheme involving 40 such commissioning groups had an evaluation process built in from the start. The intention was that the pilots would run for two years. However, one year into the project, the policy of developing Local Health Groups and Primary Care Groups meant that the pilots had a very limited shelf-life. Nevertheless, evaluation of Locality/Commissioning pilots suggested that they led to a number of benefits including:

- improved collaboration amongst practices;
- peer-review of prescribing budgets;
- shared corporate management arrangements; and
- establishment of service review mechanisms

(Smith et al.,2000)

The conclusions that could be drawn about the effectiveness of the formal locality commissioning pilots were, however, necessarily limited because of the short length of time in which they operated.

Overall, the literature reveals a tentatively positive picture in relation to locality commissioning and a fairly mixed picture of fundholding. It seems fair to conclude that fundholders did achieve a number of benefits for their patients, especially shorter waiting times, new services at practice level and reduced prescribing costs; but that these benefits were probably outweighed in the end because of the tendency to exacerbate inequity and because of the scheme's overall costs.

From the perspective of 2006, however, the recollections of people working in and around both fundholding and locality commissioning identified some very important issues for the future.

The view from the ground - reflections on GP fundholding and locality commissioning

From the perspective of practice level staff, whether former fundholders or locality commissioners, the overwhelming message that came through was the sense of loss of influence, and quite often a feeling of being excluded, once the schemes were abolished. It was not untypical for practices to describe themselves as having been 'enthusiastic' fundholders, or locality commissioners. It was felt that both schemes promoted higher quality services and had afforded the opportunity to develop a range of services within primary care settings, including:

- Physiotherapy
- Counselling
- Podiatry
- Outpatient sessions in ENT / Ophthalmology
- Sessions from private providers
- Some complementary therapies, such as oesteopathy
- Practice based social workers
- Elderly care assessment

The withdrawal of such services and the return to block contracts with NHS Trusts was consistently described as a backwards step:

'We went from having a practice based social worker to a phone number. We're told the quickest route to assessment is to send the patient into hospital!'

'We used to have a handle on what was happening with all of our patients needing a procedure ... we knew where they were in the system – not now."

'It took a little while before the Trust realised it did not have to negotiate anymore!'

As well as the general relationship with Trusts, the significant reduction in the scope for clinician-to-clinician dialogue between primary and secondary care was much regretted.

It was generally felt that *'having the rug pulled'* had left a high level of cynicism that had to be got over as PBC was introduced in England and would be an important factor in Wales if moves were made towards practice-led commissioning.

'If they want us to take on commissioning it will have to be paid for – nobody will be doing it for love anymore ...'

An interesting legacy from the lack of universal coverage of GP fundholding, was that in England, even before it was decided that PBC should cover all practices, former non-fundholders positively wanted to be involved – not to 'miss out' this time.

It seems that in Wales considerable reassurance would be required in developing primary care's role in commissioning so that practices would not find themselves putting a lot of time and effort into new initiatives which could be 'stopped on a whim'.

Those outside primary care tended to highlight the downside of fundholding, principally in terms of inequity, 'cherry-picking', transaction costs and the limited ability of small purchasers to influence large Trusts. There was also some doubt as to whether the non-fundholding locality commissioners had had the necessary 'teeth' to drive service reform. It was noteworthy, though, that Trusts themselves felt that a return to block contracts had been a backwards step and that to an extent the system had been left 'sloshing about'.

The picture that emerged from 2006 was not uniformly gloomy. There were examples of good partnership working between LHBs and primary care and of highly innovative practice; for example:

- developing 'year of care pathways' for people with long-term conditions;
- reducing hospital admissions through the establishment of referral management systems;
- partnership between primary care and secondary care clinicians leading to direct booking by GPs onto daycase and in-patient lists;
- salaried GPs and clinical sessions from GPs being directed towards the management of long-term conditions, notably:
  - COPD
  - CHD
  - Diabetes

However, there was clearly nostalgia on the part of GPs and practice level staff both in England and Wales for the scope to influence, innovate, and enter into a dialogue with secondary care colleagues that they associated with fundholding and locality commissioning - in other words, a sense of engagement. Taking full account of the reservations to do with the general feeling of being somewhat dispirited and cynical, and the need for any new approaches to be properly resourced, there was clearly an appetite for primary care clinicians to re-engage and to feel that they could genuinely influence service development in partnership with clinical colleagues in secondary care.

2 Practice based commissioning - perspectives

The need to re-engage primary care in commissioning was one of the main motives behind the introduction of practice-based commissioning (PBC) in England. Indeed this is reflected in the title of the relevant policy guidance 'Practice Based Commissioning – engaging practices in commissioning' (2004)

The benefits that the Department of Health sought to achieve by introducing PBC were:

- A greater variety of services from a greater number of providers in settings closer to home and more convenient to patients;
- More efficient use of services;
- Greater involvement of front line doctors and nurses in commissioning decisions;
- Payment by Results (PbR) meaning that funds will follow patients into primary care where practices are able to provide, or commission, services locally; and
- With the increasing importance of supporting people with long term conditions, practices will be able to direct funding into packages of care that best meet the needs of patients.

The key attributes of the scheme are:

- Practices are given an indicative budget, with the actual budget being held by the PCT. The PCT remains responsible for securing service level agreements with secondary care providers.
- On the basis of their indicative budget, a practice, or group of practices identify the appropriate level of services to be provided.
- Savings can only be reinvested in patient services. 'Reasonable' start up and management costs are also to be funded from savings.
- Practices can decide what range of services they wish to commission.
- Expenditure must be kept within an annual limit. Practices exceeding their budget over a three year period will forfeit their right to be part of the scheme.
- Indicative budgets will initially be based on historical spend, but over time will be calculated on a 'fair share' of the PCT allocation.
- Practices must offer patient choice for elective care.

A review of the literature has led Mannion (2005) to set out the evidence for the benefits and drawbacks of PBC that might be anticipated from the experience of previous schemes. (Box 3)

Key benefits and drawbacks of PBC

Practice level budgeting/commissioning has taken a variety of forms in the NHS including, standard GP fundholding (GPFH) Total Purchasing Pilots (TPPs) and locality/GP commissioning pilots (CPs). To aid interpretation of the published evidence a star rating system is used, ranging from three stars (high) to one star (low) to indicate Manion's assessment of the quality of evidence.

Benefits

- lower elective referral/admission rates (GPFH and TPPs) ***
- reduced emergency related occupied bed days (TPPs) *
- lower waiting times for non-emergency treatment (GPFH TPPs) **
- improved co-ordination of primary, intermediate and community support service (GPFH and TPPs) *
- improvement in financial risk management (TPPs) *
- better collaboration between GPs across practices (CPs)
- reductions in growth in prescribing costs (GPFH, TPPs and CPs) **
- engagement of clinicians in the commissioning process (All) **

Drawbacks and limitations

- reduced patient satisfaction (GPFH) ***
- increased management and transaction costs (GPFH, TPPs) *
- inequities of access (GPFH, TPPs) ***
- little impact on the way hospital care is organised and delivered (All) **

Mannion 2006

Feedback on PBC from Regional Workshops

During September and October 2005 five regional workshops on Practice Based Commissioning, involving around 850 participants, were commissioned by the NHS Alliance, Astra Zeneca and Medical Management Services and run by Durham University. (Marks & Hunter, 2005) Some of the key messages were:

Engagement

Payment by Results without primary care taking on PBC would suck resources into the acute sector, leaving primary care weakened and ripe for competitors to move into the English market. It was, therefore, urgent for practices to get involved.

Enthusiasm, or the lack of it

Some saw the potential for innovation, clinical mentoring, peer review of referrals and extricating resources from secondary care. Others were concerned that the development of the market would make PBC irrelevant over time. Contradictions were perceived between PbR and 'choose and book'. Whose choice would prevail, the patient's or the payer's?

Many felt they were being asked to take on extra work without additional reward.

There was concern about the potential for conflict between practices and PCTs because of PCTs' role in approving commissioning plans.

Collaboration or competition?

The overwhelming view was that PBC and PbR would lead to competition, not collaboration. It would be difficult to encourage collaboration between primary and secondary care with PBC and PbR 'pulling in completely different directions'.

This then is the theory of PBC, but what is it like in practice?

The realities of PBC

The transition from an entirely permissive scheme at its inception in 2004, to a decree that all practices in England would be part of the PBC scheme by the end of 2006, illustrates the Department of Health's underestimation of the degree to which primary care would need to be persuaded of the benefits of being involved. Amongst Welsh GPs simply raising the possibility of some form of practice-led commissioning led to comments like:

'We are going round and round in circles ...'

English practices too had been left feeling disempowered by the ending of fundholding and other forms of local commissioning. PBC was greeted initially with:

'anxiety, cynicism and disbelief.'

Despite these reservations, English practices have wanted to regain a more influential role and have, therefore, got involved. There seems to be the desire amongst primary care clinicians to be much more involved in decision-making around quality improvement, service re-design and the development of care pathways.

Practice-led commissioning, not Practice Based Commissioning

As practices have become involved, it is interesting to note that the focus in all PCT areas contacted was on practice-led, locality-based commissioning. Individual practices were not acting alone. One of the benefits of PBC was seen to be the bringing together of practices within a geographical area, whether they were former fundholders or not. Practices all described themselves as being involved in 'practice-led commissioning', not 'practice based commissioning'.

Practices had concentrated on re-engaging in dialogue with secondary care colleagues, establishing care pathways and negotiating quality improvements in terms of:

- reduced length of stay
- reduced admission rates
- provision of pre-operative assessment and diagnostics at practice level
- 'quick wins' to re-establish services, like physiotherapy, from the fundholding era and to develop services locally. Priorities included:
  - COPD

- o Community Services*
- o Diabetes
- o Renal failure
- o Mental health
- o Sexual health

* the imposition of Community Matrons to engage in care/case management was not particularly welcome at practice level. It was felt that the effectiveness of this type of intervention had not been demonstrated to their satisfaction. Strengthening already well-developed District Nursing services would have been preferred.

A PCT Chief Executive confirmed that the emphasis in practice-led commissioning was quite different from fundholding. Whereas fundholding had sometimes felt like it was all about the money, practice-led commissioning was about care pathways and quality.

Indicative budgets

A very cautious approach had been taken in relation to the financial aspects of the scheme. In one area, practices rejected indicative budgets, partly because they mistrusted their accuracy, but also because the PCT was struggling to balance the books and the practices could see only problems in potentially having to take on deficits to manage. As with the former locality commissioning schemes, they felt there were advantages in 'commissioning without the money'.

Treatment of savings

In theory, savings generated by practices would be reinvested by them into patient care. Incentives within the scheme typically allows for 50% of savings to go to the practices, with 50% returned to the PCT. The PCT has to resource practices' management costs and set up costs for PBC from its share of savings. Where indicative budgets had not been accepted by practices, moving resources from secondary care fell to the PCT.

In one area Payment by Results (PbR) had been starting to bite. There was dismay and disillusionment that the response to Trust deficits in that health economy, was for the Strategic Health Authority to direct that savings would be reinvested in stabilizing the health economy, and would not be available to practices.

Payment by Results

An important influence on the development of PBC, acknowledged in the Department of Health's Guidance, was the publication of 'A review of the effectiveness of primary care-led commissioning and its place in the NHS' (Smith et al., 2004). A crucial finding was that:

'there is little substantive evidence that any commissioning approach has made a significant or strategic impact on secondary care services.'

As far as the internal market is concerned Le Grand et al (1998) have also emphasised:

'there is no sign that other commissioners, such as health authorities found it any easier to extract resources from the hospital sector in line with their commissioning priorities than their primary care-led counterparts.'

Whilst acknowledging the need for co-operation and collaboration in developing care pathways and the advantages of long term relationships with providers, Smith et al's prescription for cracking this especially hard nut was to advocate the introduction of 'contestable collaboration' between commissioners and providers and a range of financial and non financial incentives, including Payment by Results, (PbR). PbR was seen as giving the opportunity for PBC to pull the full cost of services out of the acute sector, if primary care could prevent unscheduled admissions, or provide alternative services in primary/community settings.

Issues arising from our discussions on PbR were:

- some services are being provided more locally and resulting savings should in theory, but may not in practice, accrue to practices;
- there is a reluctance on the part of primary care to destabilise local Trusts;
- there is a reluctance to take on financial responsibility for commissioning from PCTs heading for deficits;
- PbR incentivises Trusts to increase activity and admissions, including unscheduled care. PbR and PBC are, therefore seen as pulling in opposite directions

Tariffs

A separate, but linked initiative with the development of PbR in the English system has been the development a national system of tariffs based on Trusts' average costs. The Welsh Assembly Government is considering the possible introduction of tariffs in Wales.

The theory in England is that, with tariffs being fixed at the national level, and applying to all providers, whether they are NHS, private, or 'third sector', allows commissioners and patients to select providers on the basis of access and quality rather than price.

Discussion on tariffs identified the following issues:

Gaming
Despite the development of a code of conduct/assurance regimes the amount of 'gaming' is significant, including;

- multiple 'spells' relating to one admission;
- charging 'extra' for services allegedly outside the tariff (eg for smears/swabs in addition to the tariff for a gynaecology referral)
- where there is co-morbidity charging for the most expensive condition, even if it is secondary to the admission
- 'creative' hospital coding/'code creep'.

Validation
PCTs are having to make enhanced service payments for practices to validate care against tariffs at a significant level of detail; for example checking where marginal rates apply, (as in cases where stays in hospital of less than 48 hours follow a visit to A&E, leading to 40% of the tariff price being payable) or whether 'extras' should be paid for. The question arises as to whether a system requiring clinical input to police it in this way is an effective use of resources?

Unbundling
'Unbundling' of tariffs is yet to be a reality so diagnostics/outpatient services cannot be disentangled financially from Trust services. This leads to a perverse incentive for services that could be provided in primary/community settings to continue to be provided in the acute sector.

Costs
The Independent Foundation Trusts' Regulator, Monitor, has expressed concern, (2006) that the costing information from which tariffs are constructed still requires significant development. Average costs attributed to some services have proved to be subject to significant variation from one year to the next. It is also unclear why adjacent hospitals in the same health economy have radically different costs. In other words, it is not clear that current tariffs actually reflect average cost.

Although pricing based on average cost is intended by policymakers to promote commissioning based on quality rather than price, in practical terms the policy favours lower cost providers rather than high quality providers operating from a higher cost base. To move towards paying for quality rather than low cost, Monitor suggests that tariffs could be related to 'best practice' in the future rather than average costs; but it is acknowledged that it is going to take years to refine the system.

Market Mechanisms

At a local level, the financial incentives within the English system were seen as creating a competitive environment that has a tendency to turn people into, what Le Grand (1999) has described as 'knaves'. There was a yearning towards a more collaborative regime and interest expressed in other models based on mutuality, co-operatives and HMOs.

The approach in England to PBC is inextricably linked to a range of policy initiatives that do not currently feature in Wales. The English have opted for the introduction of a highly complex set of policies simultaneously including:

- PBC
- PbR
- Tariffs
- Choose and book
- Plurality of provision including:
    - PMS Plus
    - Specialist Provider Medical Services
    - Alternative Provider Medical Services
    - Public Interest Companies
    - Mutuals
    - Co-operatives
    - Community Ownership Initiatives

As Marks and Hunter have pointed out:

'how these reforms will work in practice is largely unpredictable ... the changes taken together are significant in their scope and complexity and will leave no part of the NHS untouched.'

Since their report was published in October 2005, we have seen the difficulties in which parts of the NHS in England has found itself. Whilst proponents of market based approaches will argue that the current problems are a legacy from the 'pre-reform era', the impact of market based incentives leading to a lack of room for manoeuvre in handling deficits is certainly part of the equation. The shedding of jobs and capacity in an unplanned way in an attempt to retrieve deficit positions over a relatively short time scale is not reassuring from the public's point of view.

Michael Dixon's remarks, recently reported in the Health Service Journal, might also give us pause for thought:

'Where is the altruism and the fire? At least in the days of fundholding there was a passion ... the government has blundered down a blind alley of bribery, guidance and performance management ... now there is just apathy. What have we done to everyone ... ?'
(Dixon, 2006)

PBC and long-term conditions

The practices who contributed to this study, both in England and in Wales, did not tend to conceptualise long-term care, unscheduled care and elective care as separate issues. Clearly all are interrelated. Their interest centred on developing the care pathways, packages of care and access to elective care that would meet the needs of individual patients, into whichever of these categories they might theoretically fall. The issues they identified that would, nonetheless make a significant contribution to improving care for long-term conditions included:

- working with community, secondary care and social care colleagues to develop care pathways and care packages;
- provision of diagnostics and pre-operative assessment locally;
- provision of out-patient sessions locally;
- providing 'one stop' support for diabetes;
- demand management in relation to both unscheduled and elective care; for example, through peer review of referrals, (often by a GP with a Special Interest), or through referral management centres;
- negotiating quality improvements on access;
- developing community services;
- better access to information through which to identify high need/risk patients and keep track of their care;
- evaluation of the impact of introducing community matrons.

English practices and PCTs felt that the community services' ability as part of multi-disciplinary, multi-agency teams to:

- tailor their support to people with long-term needs;
- deliver care and support in community settings and at home;
- help prevent inappropriate admission; and
- provide the practical support behind decisions to move services and resources out of hospital settings through PbR

were key issues in designing and/or assessing the effectiveness, not only of the services themselves, but also commissioning process and the organisational framework with which such services are built managed and delivered.

Feedback in parts of Wales suggested that the perceived underinvestment in, focus on and responsiveness of community services was a real issue.

Reflections on PBC

In the course of discussion about PBC, the potential benefits to primary care of regaining influence and of having some means to move resources out of the secondary sector, were very much welcomed. Significant reservations were expressed, however, about the impact of market based incentives. There were aspirations to find ways of creating co-operative means through which to engage clinicians and move resources across the current boundary between primary and secondary care. Clinical engagement and clinical leadership were thought to be absolutely fundamental in achieving better integrated, higher quality services, especially if clinicians could be aligned with care pathways and services rather than hospitals. For patients generally and those with long-term needs in particular, the aspects of PBC that centred on localising care, creating pathways, demand management, improving quality and having, (at least some) mechanisms to influence service design were all seen as very positive.

Following up his observations around the need to strengthen commissioning, Simon Stevens, President of United Health Europe and former Health Policy Advisor to the UK Government has suggested three aspects that need further development:

Clarity
There needs to be absolute clarity about what is expected from the various levers in the system:

- commissioning
- tariffs
- regulation (Monitor and the Healthcare Commission)

Commissioners and contestability
Repeated structural reorganisation has not worked. Whilst the English system is not yet at the stage where commissioners could compete for patients, contestability could support change by allowing effective commissioners to bid to commission services where current commissioners are perceived to be weak. Successful commissioners would not necessarily be limited to operating in defined, or even adjacent, geographical areas.

PBC

PBC is a necessary, but not sufficient mechanism. GMS and QOF go part of the way to creating the right incentives, but need further development. Even where high levels of clinical engagement are achieved, practices are always going to vary in their capacity to commission, and an appropriate commissioning infrastructure needs to be developed to support them in terms of:

- data gathering and analysis
- insights around population needs
- transactions
- back office functions

3 Confederation viewpoint

The views reported in this study, from relevant literature and from discussions with key individuals. give a range of different perspectives on different forms of locality commissioning. They provide some lessons for us in Wales as we seek to find a way forward on commissioning. Drawing on the evidence from this study, and on the work reported in our previous paper - Commissioning: can we get it right? Our own viewpoint on these issues is as follows:

Commissioning

- Commissioning is vital in the 21st century NHS – it is right that it is at the centre of debate
- Getting it right is everyone's business, not just the LHBs'. LHBs have a particularly important role, however, and we must support them in developing commissioning capacity
- Any model or solution has to recognise that commissioning happens at different levels - it is a continuum across the whole health system
- Choices about appropriate commissioning approaches are contextual. Rigid blueprints, especially when it comes to engaging with primary care, should be avoided.
- Building better partnerships between health organisations is a prerequisite for any approach to commissioning to succeed - this means not just a culture of partnership but also concrete steps such as pooled budgets, outcomes and performance measures

Locality commissioning

- It is essential that primary care is fully engaged in the commissioning process
- Some form of locality commissioning (ie below LHB level) should be in place, as part of the continuum of commissioning that stretches across the health system
- There are different approaches to locality commissioning - such as the old model of fundholding and the English model of practice-based commissioning. Both of these models provide lessons for the future development of commisiioning in Wales
- We are not advocating a return to fundholding, or the adoption in Wales of practice-based commissioning. But it is important to look in a balanced way at the benefits and drawbacks of these and other approaches, as we try to find an approach to locality commissioning that is right for Wales.

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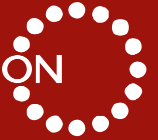

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