



discussion paper

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Commissioning in a cold climate

Key points

- PCTs should plan for a real-terms reduction of at least 2.5% to 3% in the resources available to them from 2011.
- Different PCTs will need different strategies for coping with the financial and health effects of the economic downturn.
- More could be done to improve the productivity and efficiency of services in all healthcare sectors, but this will not be sufficient.
- The only real way to manage with fewer resources is to remove capacity and costs from the system.
- Effective clinical leadership and public engagement will be critical to achieving the scale of change that is required.
- While high-quality local leadership is vital, the scale and nature of the change required is likely to require regional support and national policy intervention.

The World-class commissioning (WCC) programme is designed to improve the capacity and capability of primary care trusts (PCTs) to deliver better care, better health and better value for the populations they serve. Since its launch in December 2007, there is no doubt that the programme has had an impact. The profile of PCTs as local leaders of the NHS has risen, and the growing confidence and focus of commissioners is reflected in their ambitious strategic plans.

However, since the WCC programme was conceived the country has moved into economic recession, changing the context significantly. Although the NHS financial settlement for the next two years remains relatively generous, the forecast for 2011 and beyond is very grim. PCTs must now assess whether the financial assumptions underpinning their five-year strategies and organisational development plans are still valid. Given the extent of the anticipated downturn in public spending, it seems inevitable that commissioners must reconsider the scale, pace and methods of change required to achieve their objectives.

In May 2009, the PCT Network held a policy seminar where members discussed the implications of the new financial climate, and considered how their own and other organisations need to respond. Drawing on the discussion at the seminar and with the PCT Network board, this *Discussion paper* outlines the challenges facing commissioners over the next few years and identifies actions that PCTs might take to prepare their health economies for what is to come. It highlights key messages on how national policy needs to change to enable PCTs to perform their role effectively, and to ensure the sustainability of the system.

'Forecasts suggest the NHS should plan for real-terms funding to fall by 2.5 to 3 per cent per year from 2011/12'

New challenges for PCTs

The Budget

While the full implications of the recession are still far from clear, the April 2009 Budget provided the first formal indication of how it will impact on public services over the next few years. PCT allocations for 2009/10–2010/11 were not changed, so for the remainder of the current Comprehensive Spending Review (CSR) period PCTs will receive their anticipated growth of 5.5 per cent per year.

However, the Budget also confirmed that 2011 and beyond will feel very different. Public spending will rise by just 0.7 per cent per year over the next CSR period, the lowest three-year growth since April 1997 to March 2000. According to the Institute of Fiscal Studies' analysis, in order to service debt interest and other pressures such as increased social security spending, this could require a reduction in real terms of around 2.3 per cent per year for other government departments.¹

The specific implications for the health service are not yet known,

but if the cuts were to be shared evenly across departments, and once inflationary pressures are taken into account, forecasts suggest the NHS should plan for real-terms funding to fall by 2.5 to 3 per cent per year from 2011/12. This is equivalent to a cut of £8–10 billion over the next CSR period and up to £15 billion over five years.

The Budget report outlines some of the ways in which the Department of Health (DH) is expected to achieve savings of this magnitude. These include:

- £500 million per year released through reductions in average length of stay in hospital
- £500 million per year released through
 - improved capability and planning capacity in commissioning processes
 - improved quality at lower costs through the new tariff pricing system, and extension of the tariff into community services and mental health
- £100 million per year delivered by further improving collaborative procurement through the new Commercial Operating Model, and by improving efficiency in back office functions.

The extent to which such actions can realistically be expected to deliver the savings required is discussed below.

Effects of recession on health

It is widely anticipated that the recession will also impact on NHS resources in another way, by creating greater need and demand for health services. The evidence on the health effects of recession is not entirely clear, as the impact on particular individuals and populations will depend on a range of factors. However, it is expected that the health of those parts of the population particularly hard hit in economic terms, for example through unemployment, is likely to suffer. In particular, an increase in cases of psychological distress, depression and substance misuse linked to unemployment and fear of unemployment may occur.

Demographic changes

In addition to the specific impact of the current economic recession, it is known that the changing demographic profile of the UK population will create increasing demand for health and social care services in the coming years. The UK population is projected to increase from an estimated 60.6 million in 2006 to 71.1 million in 2031. This is equivalent to an average annual growth rate of 0.69 per cent, or 17.3 per cent over the 25-year period. What is significant is that this larger population will also be older. By 2026 older people will account for 48 per cent of the growth in households. According to the 2005 General Household Survey, 60 per cent of over-65s suffer from one or more long-term condition,

¹ Tetlow, G. (2009) *Public spending*. Institute of Fiscal Studies – Presentation from post-Budget lunchtime briefing held on 23 April 2009. www.ifs.org.uk/budgets/budget2009/public_spending.pdf

compared to just 17 per cent of the under-40s. Taken together, these figures add up to a projected 50 per cent increase in the number of people requiring social care services between 2002 and 2026.

New policy

Alongside the tightening of finances for economic and demographic factors, a number of recent policy changes also have resource implications for PCTs. These include:

- the impact of changes to the NICE appraisal process for end-of-life medicines, which will increase costs to the NHS
- the new directions to PCTs on exceptional cases, which may lead to increases in numbers of individual funding requests
- the move to HRG4 for the 2009/10 tariff, which is creating net cost pressures for some commissioners
- the separation of PCTs' commissioning and provider functions and the restructuring of community health services, which are increasing management and transaction costs.

To make the task even more complex for commissioners, the forthcoming local and national elections will mean political support for difficult and contentious decisions is harder to come by. The possibility of a change in government also creates uncertainty and the risk of either inertia or 'knee-jerk' policy-making, both of which are damaging to

the type of medium- and long-term plans required to develop world-class commissioning and deliver its benefits.

How should commissioners respond?

None of these challenges would seem to undermine the premise of the World-class commissioning programme. If anything, the situation described above reinforces the need for the highest possible standard of commissioning. To ensure that tax-payers receive the best possible value for money from their investment in the NHS, that the needs of the most vulnerable are not set aside in the scramble for scarce resources, and that service quality, safety and investment in future health and well-being are not sacrificed for short-term savings, commissioning needs to be stronger than ever.

Thus, while there is no denying the scale of the task commissioners face, they also have an opportunity to demonstrate the value they add to the system. In particular, there is an opportunity to use the looming 'crisis' as a catalyst for considering radically different ways of meeting health and social care needs. The scale of the spending reductions about to hit the NHS may enable commissioners to have conversations with local people, politicians and providers about previously unthinkable solutions to local health and healthcare

'The possibility of a change in government also creates uncertainty and the risk of either inertia or knee-jerk policy-making'

challenges, and to demonstrate real leadership in difficult times.

The following sections summarise and build on the discussion of these issues at the seminar and with the PCT Network board. They outline the type of action commissioners will need to take in order to manage through leaner times, and the support and development they will require.

Throughout these discussions, members emphasised that as PCTs exist and operate in very different (financial, social and geographic) environments, their strategies for living within reduced means will also inevitably differ. However, there were some key messages that all agreed on.

The first was that although more could and should be done to improve the productivity and efficiency of NHS services, this will not be a sufficient response to the downturn from a commissioners' perspective. Ultimately, in order to cope with fewer resources it will be necessary to remove capacity (both in terms of staff and estate) and cost from the system.

The second was that the real risk to achieving this lies not in a lack of ideas and solutions, but in potential failure of implementation. Any strategy for reducing cost and capacity will

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depend on the actions of healthcare professionals and service users. Serious attention must therefore be given to engaging professionals in developing and articulating the case for change at a national, regional and local level, and to communicating this effectively to the public.

Increasing efficiency and productivity

The NHS has benefited from huge increases in resources in recent years and there is mounting pressure on the health service to demonstrate that this money has been well spent. Participants at our seminar acknowledged that more could be done to improve productivity and efficiency, and that they have a role in working with providers to ensure this is achieved. Examples of strategies that commissioners are pursuing include reviewing the 'better care, better value' indicators and ensuring the guidance associated with these is implemented systematically across their health economy, and capitalising on new technologies to increase the use of telemedicine and reduce requirements for both physical facilities and face-to-face contacts.

While greater efficiency potentially benefits all parties, the real objective of commissioners with shrinking

budgets is to ensure that efficiency and productivity gains accrue to them as cash. This requires that increased efficiency translates into lower prices and/or lower volumes of activity (fewer interventions, appointments or admissions). If by operating more efficiently providers simply achieve a higher return, create capacity to see more patients, or shift cost to another part of the system, it does nothing to help commissioners reduce their expenditure.

Acute services

In theory, the national tariff-setting system provides an opportunity to drive actual cost out of the acute hospital system, particularly if best-practice tariffs are introduced. In reality, however, the experience of many PCTs is that adjustments to the tariff (such as the introduction of HRG4) often have an inflationary effect on cost and/or activity. Participants at our seminar felt that the current payment by results system, which was designed to reward increased activity during a period of growth in NHS funding, is unlikely to ever be an effective mechanism for reducing the cost of whole-care pathways. As discussed below, they suggested that a fundamentally different approach to payment by results is required if it is to be used as a means to drive efficiency across the whole healthcare value chain. Members felt current work to introduce currencies and tariffs for specialist mental health services should be reassessed in this context.

Primary care and community services


Commissioners are also constrained in their ability to reduce their expenditure on primary and community health services. For example, the cost of core General Medical Services (GMS) contracts cannot be reduced locally, even if practices are able to work more efficiently and reduce their own costs. And although it is widely believed that there are significant efficiencies to be found in community services, most commissioners are currently seeking to increase rather than decrease capacity in this sector.

However, if there is scope to increase the productivity of primary and community services, there are potential savings elsewhere in the system. Indeed, many commissioning strategies are based on the premise that by utilising community services more efficiently, demand for more intensive and costly services can be reduced. This argument applies in the case of mental as well as physical health. As a result, community services increasingly provide the focus for productivity and efficiency reviews by commissioners. At our seminar, members discussed the fact that they do not necessarily have clear evidence on whether or how this logic translates into reality. However, there was a sense that we do not have time to wait for such evidence to emerge. As one participant put it: "If we do not even try, it definitely won't happen". Rather than piloting and trialling multiple small initiatives,

now is the time to experiment ‘at scale’ in the transformation of community services.

In the case of general practice, PCTs need to review the level of service they are receiving under the core contract, and whether the enhanced services they are paying for are providing sufficiently increased value. Members reported that there is still great variation in what practices consider to be core general medical services. Some PCTs have developed primary care performance frameworks and are using these to clarify their expectations and drive up quality. As in the case of community services, the group felt there is significant potential to increase the role of primary care without increasing costs, and that it would be helpful to explore this further at a national level.

PCTs need to:

- review and implement existing guidance on improving efficiency and productivity (for example, better care and better value indicators)
- ensure that provider efficiency releases cash to commissioners by agreeing (where this can be negotiated) lower prices, lower volumes of activity, and/or a shift in the activity profile from higher to lower cost interventions
- focus on maximising the productivity of primary and community service providers – this includes reviewing the productivity of GMS and PMS 

PCTs need to: continued

providers, and the added value of enhanced services

- experiment at scale with new community service models and the use of technology (for example, to enable telecare) and share the learning with each other rather than duplicating similar pilot projects across the country.

Policy-makers need to:

- introduce best-value tariffs for acute services as a matter of urgency
- provide a more explicit statement of the range and acceptable standards of service provided under the national primary care contracts.

‘In the case of general practice, PCTs need to review the level of service they are receiving under the core contract’

thresholds are adhered to. Many commissioners have incorporated prior approval schemes or consultant-to-consultant referral rate caps into their contracts locally, and there may be scope to develop and share these more widely.

However, participants also agreed it will be necessary to introduce tighter criteria and raise treatment thresholds in some cases. On first consideration this appears to be a particularly contentious option, as it suggests that the universal NHS offer is being reduced in some way. However, this assumes that every service the NHS currently provides adds value for every individual who receives it. Evidence from the recent pilot studies for the new Patient Reported Outcome Measures (PROMs) initiative suggests that this is almost certainly not the case. Data from this study suggests that large numbers of patients undergoing hernia, vein and cataract surgery not only report no improvement in their health following surgery, but do not actually report any problems before surgery in terms of mobility, self-care, undertaking usual activities, and experiencing pain/discomfort or anxiety/depression.²

Reducing demand and capacity

While increasing productivity in community services may create capacity to shift activity away from the more costly parts of the healthcare system, other actions will be required to ensure that the shift actually occurs, and that redundant capacity is then removed.

Review referral criteria and treatment thresholds

Although referral management and utilisation initiatives have had a very mixed press, participants at the seminar still believed that more could be done to ensure that existing referral criteria and agreed treatment

² Devlin, N.J., Parkin, D., and Browne, J. (2009) *Using the EQ-5D as a performance measurement tool in the NHS*. School of Social Science, City University of London

'PCTs are now establishing more efficient methods of collecting, validating and analysing provider activity data'

The authors do caution that this may indicate a problem with the measures rather than with patient selection and treatment. However, further investigation of the value of treating certain groups of patients does appear to have merit.

Where practice-based commissioning is working well and practices have accepted responsibility for devolved budgets, action to review and impose referral and treatment criteria would be led by GPs. Indeed, participants noted that under a regime of patient choice, 'any willing provider', and payment by results, PCTs themselves can now do relatively little to determine what gets referred where. However, it is still unclear whether practice-based commissioning offers sufficient incentives for practices to take on this responsibility, particularly if budgets need to be reduced. Ultimately, changes to referral and treatment thresholds require one or all of the following:

- a rapid and profound change in the extent of GP engagement in practice-based commissioning
- the ability of PCTs to limit patient choice or 'any willing provider' models (by removing certain providers from the list of choices)
- the ability of PCTs to refuse to pay for interventions that are known to have limited effectiveness, for

inefficient services, or for treatment of groups/individuals likely to receive limited benefit, or who could have been more appropriately treated elsewhere.

The latter requires a more rigorous and systematic approach to utilisation review and management, including improved coding and counting of activity. PCTs are now establishing more efficient methods of collecting, validating and analysing provider activity data, whether through sharing data management services across a number of PCTs or outsourcing the function to specialist agencies. However, while analysis of acute/tariff-based activity and outcomes data is becoming more sophisticated, in other sectors commissioners' access to reliable and meaningful information is still limited. This suggests that further and rapid investment in informatics and IT systems is required, albeit perhaps at a more distributed level than the current National Programme for IT (NPfIT).

Increasing patient involvement

The data from the PROMs pilot referred to above highlights the need to involve service users as partners in decisions about the responsible and effective utilisation of health service resources. The NHS's common preoccupation with reducing what commissioners and providers consider to be 'inappropriate' demand from patients (for example, use of emergency services rather than primary care) creates a tendency to assume that

overutilisation of services is driven by service users rather than providers. In fact, however, it may often be the case that individuals are offered and accept a particular service only because of a failure by health professionals to consider alternative ways of improving that individual's well-being. For example, as Paul Corrigan has recently highlighted,³ in the management of long-term conditions patients themselves hold the key to reducing demand for care and increasing the value of health service interventions, but this requires a change in the attitudes of healthcare professionals as much as in the expectations of the public.

Decommissioning services

Where services are funded under a tariff regime, a reduction in activity should automatically reduce expenditure by the commissioner, as long as measures are taken to ensure that activity is not replaced with new demand.

Where tariffs and currencies are not yet used, commissioners will need to decommission services more proactively, and renegotiate contracts with providers. Obvious candidates for decommissioning are those that have remained open even after new services have been established to meet the same demand in a different way or location. As an example, it was suggested that commissioners might examine community mental health

3 Corrigan, P. (2009) 'DIY doctors: patients can boost NHS's value'. *Health Service Journal*, 30 April.

services to establish whether assertive outreach, crisis resolution and early intervention teams have replaced elements of more traditional community mental health teams, or simply been added to them.

In reality, taking capacity out of NHS services is not straightforward, whether funding is through tariff or a block contract. Unless buildings can be closed providers retain overhead costs, and making staff redundant is costly, time-consuming and may be politically difficult. It is for this reason that if one source of activity and revenue is shut off to a provider, there is a tendency for the flow from other sources to increase, or for new sources to emerge. If a commissioner is successful in preventing this, the viability of the provider (which may well be supplying other services extremely valuable to the commissioner) may be threatened. Therefore, while services must be allowed to close, neither assuming that this will happen through provider choice, nor allowing it to happen through provider failure, is likely to be an effective strategy. Instead, PCTs will need to identify opportunities for planned decommissioning of infrastructure, and work with providers to agree how this will be achieved.

This type of change cannot necessarily be implemented quickly, and commissioners therefore need to think about the phasing of their savings plans. If significant cost cannot be withdrawn from the system until community services are

developed further and acute capacity taken off-line, PCTs may need to plan for 'steady state' expenditure for several years followed by a significant drop in a single year, rather than year-on-year savings. This highlights again a point that PCTs have frequently made in the past, that the requirements placed on them to break even on an annual basis can undermine medium- and long-term strategic planning.

PCTs need to:

- ensure all existing referral and treatment thresholds are adhered to by implementing referral and utilisation management initiatives (GP-led referral management, prior approval schemes, utilisation review, activity validation etc.)
- consider the option of raising referral and treatment thresholds or tightening eligibility criteria for certain interventions
- increase patient involvement in decision-making and care delivery, and support a fundamental shift towards self-management of long-term conditions
- ensure that where new services are introduced to manage demand in a different way, the existing services are actively and explicitly decommissioned
- identify opportunities to decommission infrastructure (buildings and staff) as part of an agreed strategy to cease or shift service provision.

Policy-makers need to:

- provide consistent national guidance on referral and treatment criteria, and enable commissioners to refuse payment for 'unauthorised' treatment
- allow commissioners to manage and phase financial commitments across more than one year.

Developing commissioning capacity and competence

The WCC programme had already set out a framework for strengthening commissioning, before the financial downturn made this even more important. Whatever specific issues the recession throws up for a particular health economy, it seems unlikely that they will require a completely different set of organisational competencies to those set out in the WCC framework. PCTs' existing plans to develop these competencies should therefore have been good preparation for implementing the type of measures outlined above. However, the seminar group did debate whether, given the increasing urgency of the commissioning task, the current approach to developing commissioning capability, which has involved very limited national coordination or direction, is sufficient, and whether the relative priority of particular competencies has changed.

In this discussion members emphasised the fact that the WCC

'Over the next few years, the leadership role of PCTs will involve agreeing new compacts with local people, partner agencies and providers'

competencies combine two different types of capabilities: those that depend on 'technical' knowledge and expertise (such as knowledge management, procurement, accountancy, predictive modelling, and contracting); and those that require 'relational' skills (for example, in communication, engagement, dialogue, and influencing). The point was also made that effective leadership of a commissioning organisation requires certain attributes that are not reflected in the competencies, including credibility, judgement and resilience. The clear message coming from members was that different approaches are required to develop these different competencies and characteristics.

There was general agreement that there is scope for greater collaboration between PCTs, and potentially a degree of national coordination, to enable commissioners to quickly develop the more technical competencies. It was felt that more could be done to, for example:

- gather and share intelligence on the burgeoning market for commissioning support and training services to ensure PCTs are achieving the greatest possible

value and economies of scale, and to allow a degree of quality assurance

- enable PCTs to share information about what works, and what interventions they have particularly benefited from
- encourage PCTs to work together more in deploying what are still relatively scarce skill sets, particularly in undertaking commercial activity.

The new Commercial Operating Model⁴ and proposed commercial support units (CSUs) were discussed in relation to this last point. While most PCTs are already working with others to develop commercial capability, there was acknowledgement that in some cases this might be accelerated or expanded in scope. Where a CSU model can provide a vehicle to strengthen existing joint arrangements, it could be valuable. However, if they are imposed in a way that cuts across or undermines existing infrastructure, there is a risk they could further fragment rather than consolidate commercial expertise. The key point here was that although more could be done collectively between PCTs in both the development and deployment of commercial skills, this does not mean a single model can be applied across every health economy.

⁴ *Necessity – not nicety: a new commercial operating model for the NHS and Department of Health.* Department of Health (2009)

However, there was some concern that too much emphasis is being placed on developing commercial skills, on the assumption that this is the highest priority for PCTs. Seminar participants noted that in the current climate the skills they feel they require most are those associated with priority-setting, decision-making, evaluation and stakeholder engagement. Furthermore, while aspects of these tasks do depend on 'technical' expertise in areas such as knowledge management and forecasting, the more political and contested aspects of these activities (those least amendable to technical solutions) are increasingly coming to the fore.

There was a very strong message from seminar participants that effective strategic commissioning of public services requires the development of deeply embedded relationships based on continuity, integrity and trust. Over the next few years, the leadership role of PCTs will involve agreeing new compacts with local people, partner agencies and providers. This responsibility cannot be shared with other bodies or outsourced to technical experts, but requires talented, committed individuals to gain credibility and exercise judgement over a sustained period of time.

One of the implications of this is that as well as developing the skills and competencies of functional specialists working within and across PCTs, serious attention must

be paid to creating the right support and incentives for PCT leaders. These will not be easy roles to fulfil, and consideration must be given to the factors that might motivate individuals of the necessary calibre.

Commissioners need to:

- share intelligence about inputs and outputs from commissioning support services
- work together more effectively to secure and deploy technical commissioning expertise and capacity
- focus on developing skills in priority-setting, decision-making, evaluation and stakeholder communications.

Policy-makers need to:

- recognise that effective commissioning requires the development of deeply embedded, sustained and trusting relationships with local partners, not just technical skills
- ensure there are sufficient incentives for individuals and teams of the right calibre to take on leadership roles in PCTs.

Realignment of policy and system management

While many of the strategies for reducing cost, demand and capacity can be implemented only through

strong commissioning, it is imperative that other key elements of system reform are aligned behind this. PCT commissioning does not operate in a vacuum. Indeed, one of the notable features of the discussion at our seminar was that most of the strategies that commissioners might implement locally require some kind of national policy change if they are to be effective. Commissioning has to interface effectively with and be supported by effective policy-making, standard-setting, regulation, system management and performance management by bodies including the DH, strategic health authorities (SHAs), Monitor, the Care Quality Commission (CQC), NICE and others. Even the most highly skilled commissioners and robust PCTs cannot manage the fall-out of the recession unless all these parties work together effectively. The rest of this paper outlines what needs to change if commissioners are to be successful.

Redesign of payment by results

To date the payment by results system has focused predominantly on funding acute services in a fair and transparent manner that reflects average current costs. It is increasingly clear that the use of the tariff needs to be refocused as a means to drive efficiency within provider organisations, with prices reflecting best practice and value for money rather than average cost.

However, the group also began to discuss a more fundamental re-conceptualisation of tariffs, to

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ensure they encourage efficiency along whole care pathways rather than cost-shifting and encouraging supplier-induced demand. This conversation was based on the argument that however hard efficiency is squeezed out through increasingly lower tariffs for individual episodes of care, a system based on payment for discrete units of activity will never create the right incentives for providers to help make care pathways (or the sum of multiple pathways) more efficient and less costly. This suggests that rather than unbundling tariffs and seeking to dissect, define and cost services to ever more specific degrees, we should be looking to re-bundle and extend tariffs so that they truly reward results (for individuals and for the system) rather than activity.

Review of standard contracts

Seminar participants also felt that the standard NHS contracts should be reviewed to identify other ways of encouraging providers to find cash-releasing efficiencies. This should include the standard primary care contracts as well as those for acute, mental health and community services. In particular, a more explicit statement of what is included in the core GMS contract is required, as well as a performance framework that

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enables PCTs to more clearly identify the value they derive from core and enhanced services.

System management

In the new economic environment, commissioners need to be fast-moving and pragmatic in their decision-making. Currently, however, the performance and system management regime does not always support this. Decision-making processes within PCTs, SHAs and the DH are often lengthy and highly risk-averse. With a stronger assurance system through WCC and an effective commissioner failure regime, there may be room to loosen day-to-day performance management of PCTs and to encourage more innovation and managed risk-taking.

It is also important that the various regulators and system managers, including SHAs, the CQC, Monitor and the Co-operation and Competition Panel, work together in a way that supports commissioning and commissioners. Commissioners recognise that scrutiny of value and quality is more important than ever, and that this applies to their own activity as well as that of providers. However, it is equally important to ensure that regulatory requirements do not divert management resources

and attention away from organisations' core business, and that conflicting expectations and priorities of different regulators do not inhibit creative problem-solving and decision-making. More work is required, therefore, to ensure the roles, responsibilities and requirements of all system managers are unambiguous, coordinated and appropriately orientated towards commissioning.

Collective action

As discussed throughout this paper, commissioners will have to make a number of difficult and risky decisions over the coming months, including those regarding reductions in capacity and services, and the raising of treatment thresholds.

While PCTs clearly need to manage these decisions and tensions at a local level through effective clinical, public and political engagement, it may be necessary for some of the most contentious and challenging issues to be agreed and implemented at a national or regional level. It does not seem to make sense, for example, for discussions regarding treatment thresholds and rules for reducing treatments of limited value to take place between each individual commissioner and provider.

The role of NICE should also be considered here. At present there is a view from many PCTs that NICE's decisions are increasingly at odds with other aspects of PCT decision-making, particularly in light of the change of threshold for

end-of-life drugs. This leads to inflationary pressures on PCTs and opportunity costs. Reducing NICE's responsibilities would be neither politically nor practically desirable, but a stronger duty on NICE to take account of available NHS funding might lessen the discrepancy between national and local funding decisions. There may also be opportunities to use NICE's knowledge and expertise in priority-setting to support national and regional decision-making around the decommissioning of services.

There is likewise a role for the DH and SHAs to support PCTs by helping to promote and articulate the case for reconfiguration and rationalisation.

Coordination/alignment of policy and approach with other sectors

The NHS is clearly not the only part of the public sector facing hard times. In fact, those working in other areas may increasingly come to envy the still-generous settlement for the health service this and next year. In this context, there is a growing risk that hard-won progress in partnership working could be threatened as the resources of partners become relatively stretched. To help avoid this, PCTs will need to invest heavily in preserving and improving relationships with local authorities – particularly colleagues in social care. All opportunities to reduce duplication between, and combine resources with, partner agencies should be explored. For example, PCTs should engage with

and seek to learn from the 'Total Place' pilots announced in the Budget, which will map flows of public spending in local areas and make links between services, to identify where public money can be spent more effectively.

Values-based leadership

The challenges currently facing the NHS call for responsible leadership from all organisations within the system, including providers of NHS services. Messages to providers from the DH, Monitor and SHAs, as well as from their commissioners, should reinforce their duty to cooperate. It is more important than ever to convey to providers a new model of success – in which a successful organisation is one that contributes optimally to the health of the local (or its constituent) population, rather than one that maximises activity and income. Clinical and non-clinical leaders in provider organisations should play a role in managing the expectations of staff and patients, and supporting necessary service change.

Clinical ownership

Clinicians in particular must be seen as central to any strategies that are developed to reduce the cost and improve the efficiency of health services. Approaches to clinical engagement must find ways of harnessing rather than undermining the skills, motivation, and professional standards of clinicians.

The recent DH publication on clinical commissioning and practice-based

commissioning is a useful start. However, a much broader strategy to engage professionals and their representatives in developing solutions will be required. Again, relationship-building at a PCT level will be important, but insufficient on its own.

Linked to their discussion of payment by results, our seminar participants began to consider whether exploration of new ideas, rather than refinement of existing policy, is required. For example, there is growing interest in the idea of clinically-led integrated care organisations with responsibility for the total budget for a registered population, or for particular care pathways. By creating incentives for primary care professionals and specialists to manage resources together, this model is seen by advocates as a means to align professionalism with the guardianship of limited resources. However, detail on exactly how such a model would operate is currently lacking, and none of the recently launched integrated care pilots appear to seriously explore this option.

Commissioners need to:

- invest heavily in preserving and improving relationships with local authorities and other partners, particularly colleagues in social care
- consider all opportunities to combine resources with partners and reduce duplication of functions across public authorities.

Policy-makers need to:

- fundamentally redesign the payment by results system so that it encourages efficiency across whole care pathways and care delivery systems
- review the standard contracts (including primary care contracts) to identify opportunities to encourage greater efficiency and reduce costs through national mandate
- ensure that regulation and system management activities are coordinated, proportionate and appropriately oriented to support commissioning objectives
- provide national guidance on and support for the most contentious decisions regarding treatment thresholds, service configuration and rationalisation
- consider placing a stronger duty on NICE to take account of the availability of NHS resources
- work closely with other central government departments to ensure policy is aligned and enables public bodies to work together effectively at a local level
- promote values-based leadership in the NHS, where all leaders recognise their role in managing limited resources responsibly and in the interests of improved population health
- engage clinical leaders at a national level, and explore options for a radically new approach to professional leadership of sustainable healthcare systems.

Conclusion and next steps

The recent economic downturn does not alter the need to strengthen PCT commissioning or change the thrust of the WCC programme. What it does do is raise the stakes for the delivery of this ambition and drive greater urgency for improvement. The anticipated financial settlement for 2011 and beyond means that PCTs and SHAs need to revisit their five-year strategic plans, NSR and workforce strategies. Although their long-term objectives and ambitions may not have changed, it seems inevitable that some of the plans for achieving them must.

This paper sets out a number of preliminary ideas for how commissioners need to respond, and how policy-makers and system managers can support them. They are intended to prompt discussion and debate, and do not represent our final views on this

issue. We will continue to work with PCT Network members to help them evaluate the impact of the recession, identify strategies for change, and influence the development of policy.

To provide feedback on this paper, share your ideas or contribute to the debate, contact Elizabeth Wade, Senior Policy Manager – Commissioning, at elizabeth.wade@nhsconfed.org

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs.

We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The PCT Network is one of these.

For further details about the work of the PCT Network, please visit www.nhsconfed.org/Networks/PrimaryCareTrust

Further copies can be obtained from:

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 THE NHS CONFEDERATION

The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0870 487 1555
Email enquiries@nhsconfed.org
www.nhsconfed.org

