Liberating the NHS – commissioning for patients – consultation on proposals

This document is the response from Association of British Healthcare Industries (ABHI) to the consultation above.

ABHI has responded to the White Paper itself and aspects of our responses below are contained also in that higher level document.

ABHI is the industry association for the UK medical technology sector. Our purpose is to promote the rapid adoption of medical technologies to ensure optimum patient outcomes throughout the UK and key global markets.

Response to consultation questions

Questions [p13]

- In what practical ways can the NHS Commissioning Board most effectively engage GP Consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?
- How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?
- Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia

(This response does not address the commissioning of maternity services.)

Whilst the proposals for commissioning offer many opportunities, there are also threats and risks. ABHI’s comments are intended to focus on the opportunities, whilst taking into account also the threats and risks.

ABHI suggests that it will be vital to build on what is already working well as regards commissioning of specialised and/or low volume services and to mitigate against risks that this substantial change in the machinery of commissioning could upset existing service provision.

Risks:

- Significant increases in transaction costs as a result of an increase in the number of commissioning entities (consortia taking over from PCTs) and potentially in the number of intermediaries if existing regional/sub-national specialised commissioning groups do not continue ‘as is’.
- Fragmentation of services with the entry to the market of new providers that put at risk incumbent providers, if new commissioning arrangements lead to selection of ‘new’ rather than ‘familiar’ and thereby to a form of commercial ‘churn’ with unintended consequences.
New providers may be better placed to provide innovation but it will be vital to prevent ‘cherry picking’ that leaves incumbent services with only the more difficult cases. In the proposed new regime, ABHI is concerned that new entrants at superficially lower cost may offer increased vfm only in the short term, whilst destabilising income streams for established services in generally larger providers and threatening the maintenance of established expertise in specialisms. The new regime is unlikely to shelter such providers and some criteria may need to be established against which proposed service changes can be benchmarked, for sustainability. This need not preclude innovation in service design but does need to be assessed.

Possible approach to mitigate:

- Involvement of patient groups in assessment of such changes, whether under the first or the second questions, could help to obviate more extreme risk.
  - It may be that there is not at present a patient involvement model that fulfils this requirement and previous NHS service change consultation processes may also be deficient.
  - It therefore follows that some benchmarking needs to be developed both to enable patient voice and to satisfactorily ‘stress test’ changes against criteria that are foreseeable but not currently set out stringently.
- It is highly desirable that expert clinicians, including where necessary from incumbent providers, should be integral to the above outline assessment process [see also multi-professional involvement question, p33]. This approach appears to be consistent with the oversight arrangements set out in the White Paper and consultation documents.
- As a corollary of the above, it will be important to ensure that a suitable range of expertise is available to GP consortia to enable them to deal with specialised commissioning issues effectively. It might be helpful to create a set of criteria, possibly loosely linked to those previously developed as part of general commissioning improvement work.
- Measurement of GP consortium performance on these specialised/less common services should be picked up in the development of the outcomes framework which is to influence the commissioning framework.

On the question of whether any current regional specialised services could potentially be commissioned in the future by GP consortia, answers remain somewhat hypothetical as we cannot at present know the configuration of consortia, nor are regional/sub-national capabilities of the commissioning board known. NHS history to date suggests that size of consortium, expertise and the adequacy of existing arrangements (excellent already in some places) all influence the extent of risk. A number of services currently in place might fall between practice level commissioning ‘as is’ and national arrangements.

Questions [p20]

- How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?
• Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

ABHI’s comments are in respect of the five broad functions set out for the NHS Commissioning Board and this comment links particularly to providing national leadership on commissioning for quality improvement.

The framework proposed appears sound, at a high level. We propose that the functions outlined, to provide national leadership for quality improvement, need to be given some additional depth and to be connected in specific ways. Key points for ABHI would be:

- the board should ensure protection of the integrity of local services, especially emergency and complex work for which there is no established business model for private sector providers
- GP consortia will make investment decisions, as do existing NHS commissioners (reference paras 5.11ff). These investment decisions will be appraised retrospectively for performance against the NHS Outcomes Framework as summarised in this consultation document and the White Paper. However, there is at present a relatively poor NHS experience of appraising investment decisions, including ‘do nothing’/change nothing, as regards which pattern of resource use gets the best combination of results for patients.
  o ABHI suggests that prospective appraisal and subsequent checking against performance, mapped on to the NHS Outcome Framework, would be both possible and desirable in the context of heightened restrictions on finance. This activity would be for GP consortia to undertake as part of an appropriate assurance framework and for the NHS Commissioning Board to promote.
    ▪ Such activity would be regarded as routine in most private sector organisations deploying resources on any scale. The core activity would be a programme management/benefits realisation approach to ensure that investment decisions deliver what they are intended to deliver.
    ▪ A key feature of the above, inherently complementary, is the need to consider strategies for dis-investing in outdated treatments or in those which yield relatively poorer results than modern comparators, as defined say by NICE.
    ▪ There is a strong analogy with the kind of assurance framework set in place by Monitor for Foundation Trusts in terms of, for example, service-line accounting. This approach to stewardship of public funds is inherently tougher than the language of ‘guidance’ which has prevailed on the commissioning (and previously administrative) side of the NHS over decades, and is literally far more business-like.
  o The NHS Commissioning Board should be encouraged to develop links between the above activity and several activities explicitly mentioned in the consultation; and also to one that is not mentioned explicitly.
    ▪ The proposals for ‘setting commissioning guidelines on the basis of clinically approved quality standards developed with advice from NICE’ (para 3.27) should be linked closely to designing and operating the structure of tariff.

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One of the key issues in operating the tariff under Payment by Results to date has been linking new treatment guidelines and technologies to appropriate reimbursement.

- The Board’s activities in relation to both quality standards and tariff should be designed in such a way as to link to and promote an ‘investment appraisal’ approach as sketched above.
- All these activities should in turn be linked to consideration of the NHS duty to innovate. At present resting with Strategic Health Authorities, ABHI suggests that this duty needs a new home and to be linked in a coherent way to a rolling process of investment appraisal/induction of new treatments/reimbursement. This could be consistent with the proposal from the Arm’s Length Body Review to lodge some of the functions of the NHS Institute for Innovation & Improvement in the new NHS Commissioning Board.

Questions [p25]

- How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?
- Should there be a minimum and/or maximum population size for GP consortia?

ABHI notes that the interaction between these issues and our comments against the questions on p13.

- Participation in GP consortia on a non-geographical basis would require arrangements to ensure mitigation of risks to continuity of specialised services and of expertise in commissioning such services.
- If GP consortia are to cover very small populations there will need to be assurance that relatively lower capacity does not reduce access to suitable advice and expertise in commissioning specialised services.
- All patients should be entitled to access a full range of NHS services, including emergency, complex and specialist work and treatments for rare conditions. Typically, both within the NHS historically and by international comparisons, this is unlikely to be achieved in populations smaller than about 4 million. Smaller consortia should be able to demonstrate that they have made provision for collaborative commissioning arrangements in this regard.

Questions [p27:]

- What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?
- What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
• Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?  
  [p31:]  
• How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?  
• How can GP consortia best work alongside community partners ... to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

ABHI notes a strong unifying theme among these issues and suggests that:
- An investment approach as sketched out under q20 will be entirely relevant to the investment decisions question on p27 and to the first question on p28;
- That patients should be involved in assuring commissioning plans not only locally (questions on p31) but also nationally by being involved in an oversight process at Commissioning Board level. This would bring together consideration of investment, innovation, treatment quality guidelines and tariff so that it is not only possible to see the progress of innovation into the NHS but also to track it at local level, both involving patients.

As regards the second question on p28, ABHI suggests that a CQUIN-like approach could be developed for commissioning in ways that would emulate its existing application to provider measurement.

Question [p33]

• How can multi-professional involvement in commissioning most effectively be promoted and sustained?

ABHI’s comment on the questions on p13, in respect of specialised commissioning, is relevant here also, in terms of ensuring in particular that secondary care clinicians are involved in service planning and development.

In many areas of community care a lead role is played by Nurses or Allied Professions. Where this is the case, they should have an active role in the commissioning process through a multi disciplinary team approach.

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