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Development and policy

Title to come?

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I was invited to talk about some of the work that we have done with the Sainsbury Centre for Mental Health, and what we think some of the models of commissioning might be. I work at a policy level rather than a practical level, but I hope some of my thoughts may be useful in at least setting the context for what is happening in the NHS now.

The first point to make about commissioning is that it is underdeveloped. It was called project 26 in the 1989 NHS reforms and it has not really risen above 26 in terms of overall government priorities since then. The second problem is that commissioning is a portmanteau term, and I do not think people have a clear understanding of what it means. It includes needs-assessment, planning, procurement and contracting, monitoring and evaluating, and managing the market. Those are all quite different functions. They require different skills, and they work at different levels. It would be foolish to expect a practice to undertake procurement, and it would be quite difficult for a primary care trust (PCT) to manage the market for forensic services. So it is important to choose the level at which things are done.

What about the claim that providing healthcare has distracted PCTs from commissioning? It could be argued that PCTs have been better at commissioning than health authorities, and health authorities were not providers. One reason that health authorities failed is because they did not have the engagement of frontline clinical staff. They also failed because no one was clear about what success would look like. There may be a lesson we can learn from that.

Commissioning has been underdeveloped and there has been very little investment in it. Mental health commissioning has been even less developed. There are two possible reasons for this is. The first is that, like specialist tertiary services, mental health takes up a relatively small proportion of the total commissioning budget. The second problem, which is also similar in tertiary services, is that the expertise is in the provider to a greater extent than it is in primary care and normal secondary care. Mental healthcare is a relatively small area of our activity and we do not know much about it. This is not a great place to start when you are commissioning. What has tended to happen, therefore, is that it has been thought about in a similar way to secondary care.

The development of increasingly large mental health trusts (I am waiting for a mental health trust that reaches from coast to coast – it can only be a matter of time) has meant that the specialist providers have risked becoming increasingly separated from primary care. This is a big issue for practice-based commissioning, because some practices are being asked to commission a service where elements of services have been carved out from primary care, leaving behind the less seriously ill. So we may also have practice-based commissioners with similar problems to those of PCTs.

However, there are significant opportunities to link up with social care, housing and some other areas. (Those who are not fed up with us reorganising again, that is.) Mental health has often led the way in this. Local area agreements and public service boards will start to emerge to provide a way of capitalising on these opportunities – as long as the trusts do not get so large that they find it difficult to sustain those relationships.

There are also a large number of other challenges. One important example is working with a reduced inpatient bed stock, which throws up some big issues about safety and quality in inpatient care, and I think that really is going to come to the fore

as quality and safety rise up the policy agenda. There are big pressures on residential care and care management budgets. While the NHS has had extra money, our colleagues in social care have not been enjoying anything like the same levels of growth. And in 2008 the NHS will return to historic levels of growth – about 3% , if we are lucky.

We have got opportunities to use alternative provider medical services (APMS) and specialist provider medical services (SPMS) and plurality of provision in primary care, and perhaps to improve the extent to which they can take a bite out of secondary-care activity.

Agenda for change and new ways of working should allow us to develop new types of staff and new skills, and we need to do this urgently. The consultant contract and the modernisation of medical careers offer some opportunities. There is also a new contract for specialist-grade doctors. We really need to see all of these, and APMS, and all the new levers – payments by results, practice-based commissioning, and the ten high-impact changes etc – built into commissioning.

So what could we try to do? Well, we might try to commission for outcomes and wellbeing rather than just numbers of people or even episodes, which is what has happened in the past. Often, commissioning has become a method of global budget-setting. We could judge it against the extent to which it allows personalisation. Increasingly we cannot just talk about populations and global numbers. We need to know about the individuals.

If we were an insurance company, we would know about the individuals for whom we were buying care. We need to do the same and that means an important change in the way we think. We must start to use explicit quality and outcome standards. All the policy we have already provides quite a good basis for defining what some of that would mean. But it is a lot more complex than simply copying the relevant chunks out of the national service framework (NSF) and handing it to the providers. We also need to improve the expertise of our commissioners and create pooled funding to allow the space to develop innovative projects, not just with social care but with the Department for Work and Pensions and with housing and other agencies. We also need to make the funding more transparent and explicit. If you decide not to put money into mental health or Herceptin, for example, it has to be obvious and not a series of fudges concealed in 40 pages of densely typed spreadsheets with hundreds of footnotes in eight point Times Roman. If you have transparency, you have the opportunity to create better incentives.

How do we take this forward? Well, I want to mention briefly some of the models that Cliff Prior, chief executive of the mental health charity Rethink, and others have helped us to create in order to do this.

- **The standard model:** The standard model will be practice-based commissioning with some form of strategic commissioning, yet to be defined, which will really just develop what we have got now. Well, that is fine, except that, as I have said, individual practices have been somewhat isolated from the more severe end of mental health. Also, the problem of expertise remains. If this is all we do, we may end up with a great deal of variability because there will be groups of practices that do this really well, while elsewhere there will be problems. This is probably a reasonable model.
- **The specialist provider model:** Another model is the specialist provider. Here, and this happens already in a number of places – you 'capitate'. In other words, you give a sum of money to a secondary-care provider and ask it to buy care on behalf of a defined population of service users. This model is very attractive if you are the chief executive of a secondary-care provider. It is also a nice model because it increases your income and it increases your certainty, but, and this is the rub, it allows you to buy from yourself when you should buy from someone else. 'So, we've got a few spare psychiatry sessions – they're not very good, but it will be cheaper if they do our addiction work rather than me having to buy it from Turning Point. It covers my overheads.' There is a real problem here and to solve it we would have to invent a raft of regulations. We are also faced again with the problem that they have the expertise. I think this might work for highly specialist tertiary services, but I am dubious about it for anything else.
- **The health maintenance organisation (HMO) and the stakeholder models:** A third model is the HMO model. An HMO is an organisation that takes responsibility for providing care over a year of life for its population. In this case, it would be a specialist commissioner for mental health. I think Cliff saw this merging into the fourth model, which brings together all the stakeholders in a community to pool the funding and to make decisions on commissioning. Bringing in users and a range of other stakeholders – perhaps even including the providers – could overcome some of the problems of expertise. It could also provide a vehicle for informing the local area agreements with local authorities.

All these models are interesting and worth exploring and I think people will make a variety of them work differently. But we do need to enrich the expertise and knowledge base and participation in

commissioning decisions at strategic level. So while practices may well be making individual referral decisions, it will be within the context set by a much wider group of stakeholders and, in particular, one that brings together all of the money.

Let me enlarge on some of the tools and techniques. Traditionally, we have commissioned for populations, but now there is a problem with that. We must not stop doing it because it is very important to have a population view. But we actually know many of the people for whom we are commissioning. If they have a home, we know where they live. We can find them if we need to and we know a lot about them. However, we are not using that information enough in the commissioning decisions in the way that we do in provision. A new set of skills is required, which involves understanding the relatively small number of people who use large amounts of resources. These are people for whom we often do not get the services right or co-ordinate them particularly well. Commissioners need to move from thinking not just about populations but about individuals. However, if practices are going to start developing expertise in particular areas – not just in mental health but across the board – there is a particularly important problem. This is what you might call 'adverse selection'. It works like this. A practice develops a particular expertise in managing people with an expensive disorder such as psychosis. Its reward for this expertise is that lots of patients register with it because they want to use its high-quality services. The practice will be funded at the average cost for the postcode from which those patients come. But there is a problem with this. Its reward for doing the right thing clinically is to attract patients it cannot afford to treat. That is because of the way the budget is set. What the practice really wants is young men aged 16 to 44 who never bother to use its services, but for whom it gets the average funding. There is a real issue here, which is getting practice budgets that reflect the risk associated with potentially high-cost individuals. Otherwise, a practice can personalise patient care but it cannot then deliver any of it.

What about a pool budget? Don't we know how to do that? As I mentioned before, I think there are interesting opportunities here, particularly with increased interest in incapacity benefit and the importance of housing in discharging people from both elderly and acute care. Bringing those budgets together is a major issue.

Once a contract has been set up, how doe we define quality and outcomes? The international view of the quality and outcomes framework (QOF) in general practice is that it is probably the leading attempt at defining quality in a contract anywhere in the world, which is something we should be proud of. The question is, do we need a super QOF, a big quality and outcomes framework that starts to define what we mean elsewhere outside primary care?

That seems a logical step because then one could hold a practice to account not just for the delivery of its quality and outcomes framework as a primary-care provider, but as a commissioner as well. This involves negotiation. The NHS has an adversarial approach to negotiations, which is not good. It's win or lose stance tends to annoy suppliers. What you hear not just from the voluntary and independent sector, but from anyone who supplies the NHS is that it does not know what it wants. It approaches the discussion in an adversarial way, asking the supplier to guess what it wants. Then halfway through the process, it changes its mind, and it does not want to pay for quality. Not only that but it cannot give any long-term financial commitment, so independent and voluntary-sector providers feel put upon. I think this reflects a nervousness and lack of skills development in many of the people we ask to do this, and they resort to defensive tactics. We have a great deal to do in the area of skills development in order to put that right.

Now I want to mention briefly some issues of policy. First, separating commissioning and provision is obviously flavour of the month, but having people who do a bit of both results in some interesting creative tension. There is a danger that we will try to manage all that creative tension out of the system. This is what happens to most people in big bureaucracies.

The second interesting question issue is contestability. A group of people in Surrey have formed their own co-operative and are going to leave the NHS. This puts them in a very interesting position. Contestability means that they might be coming to get you. Competition means that they are already here. So they are probably going to get you sooner or later. By doing what they have, the people in Surrey have moved from being in a position where their services could be competed for, to one where they will have to be competed for. When their commissioner wants to buy something from them, they will have to put it in the official journal of the European Union and invite people from across Europe to bid for it. I wonder whether they have thought of that.

Looking at orthopaedics, you may not need much contestability to get many of the benefits. The mere fact that there is a threat to you as a provider may be sufficient incentive for you to improve your performance, response and efficiency, productivity and the way you treat your patients. Contestability involves substantial costs – not least differentiation that the user does not need. In the US, for example, they offer Jacuzzis. That may be very nice, but it does

not improve outcome and probably is not terribly good in terms of cross infection. It has costs in terms of transactions, billing, marketing and management. It can also mean you have spare capacity that you mostly do not need, but which has to be available so people can use it when they do need it. So there are some big trade-offs. In particular, there are threats to continuity and the possibility that services will be fragmented as people carve out different bits to create their own value. In out-of-hospital care, for example, to buy a hospital-at-home package you may have to talk to five different providers. People do not want to do that and it is probably not good for the patient. So that is a big issue.

Is payment by results (PBR) a good thing? For most mental health services, I would say not. I do not think it is an appropriate instrument in the form that it has been proposed until now, which is payment for each episode. It does not fit what we want to do. Here is an even bigger challenge then for both providers and commissioners, to find a method of paying for these services in a way that would help.

Should we argue for ring-fencing for mental health? This would be less of an issue if we could pool all the funding, because mental health services would then be big enough to compare favourably with acute services in the minds of commissioners. I do not think we can argue for ring-fencing because if we do, cancer networks, neonatal intensive care networks, in fact, everyone would barge into the queue ahead of us. Once ring-fencing is allowed, everyone can have it, and mental health would be in danger of being pushed out by people with sharper elbows and louder voices.

Mental health providers need to make some strategic choices. Should they specialise or should they go into primary care? I think the answer is obvious – there is only so much room for specialist providers, and they might be able to add real value to primary care.

Finally, let me say that it is time for some significant investment in mental health commissioning. It is well overdue. Some people are doing it really well and we can learn from them. But we urgently need to learn new skills and techniques – we are already a couple of years late.

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