Commissioning: past, present and future

Introduction

The latest NHS reforms have taken shape in the form of 'commissioning'. The NHS Commissioning Board for England, established on 31 October 2011, has started its work in shadow form (Hawkes, 2011). It is planned that the Board will take on full commissioning responsibility in April 2013 providing the Health and Social Care Bill passes through parliament. The radical reforms proposed by this Bill and the NHS White Paper *Equity and excellence: Liberating the NHS* (Department of Health, 2010) could change the NHS landscape forever.

The drive for change is the need to help 'future-proof' the NHS. The rising cost and demand for NHS services are heightened by our ageing society, chronic illnesses and less healthy population. The government also feels that more accountability is needed within the NHS, while being more responsive to the patients it serves.

Commissioning will impact everyone. To a greater or lesser extent, all doctors will be affected by the changes, and hospital doctors would be naïve to think that commissioning is only relevant for GPs. The proposed changes represent one of the largest shake ups of the NHS since it was established.

This article highlights the history of commissioning and outlines 'clinical commissioning' and its relevance to day-to-day work. It also discusses the ingredients for effective commissioning and offers some case examples of commissioning projects so far. These cases should help give a flavour of where individual doctors could fit into the big picture of commissioning and how it may impact junior doctors in training. The positive and negatives of commissioning are also weighed up in this article, as well as the future of commissioning.

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History of commissioning

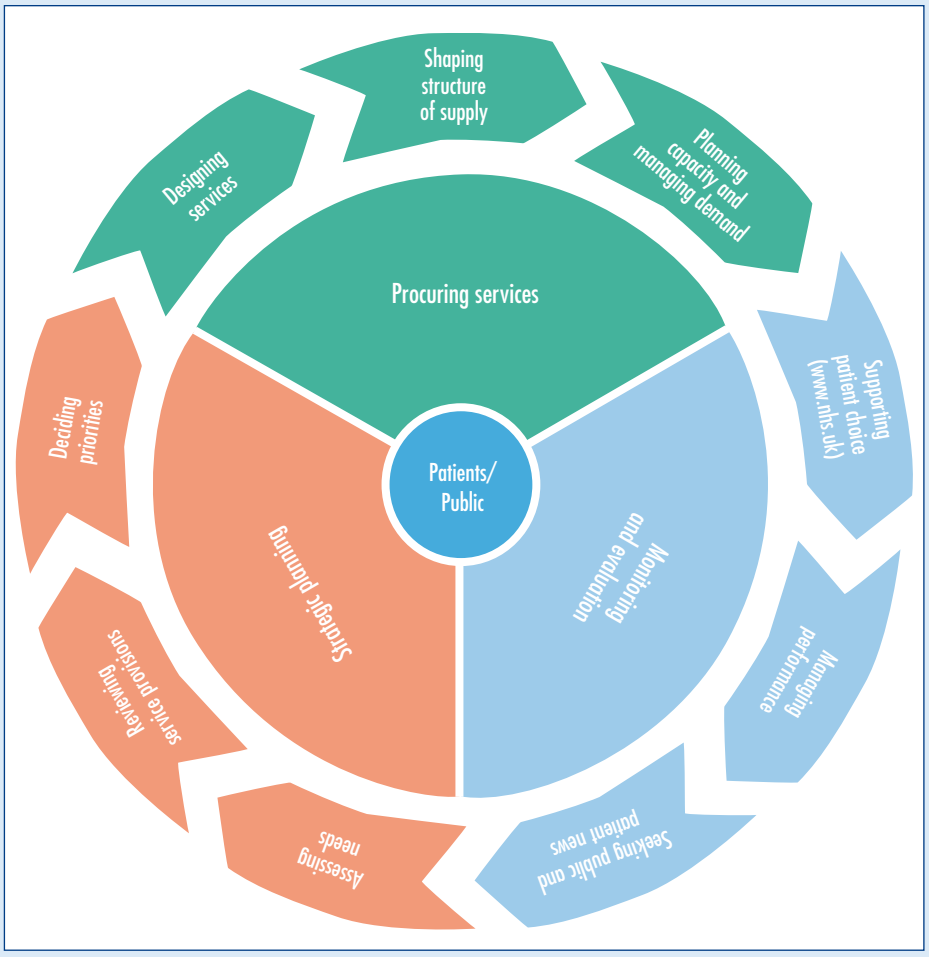
First and foremost, a commonly asked question is 'what is commissioning?' The Department of Health (2010) offers a concise definition:

'Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers'.

With the new government proposals and widespread media coverage, it may seem as if commissioning is new to the NHS. However, commissioning has been common practice since the Community Care Act 1990 which divided health-care providers and health-care purchasers. Since then, successive governments have modified the way in which commissioning is implemented, but the overarching principles have remained the same (*Figure 1*).

In 1991 fundholding was introduced, which represented the earliest form of commissioning. It mainly covered prescribing, outpatients costs and elective surgery (Rivett, 2012). Fundholding was optional. Fundholding GPs were given real budgets and a management fund to provide services, arrange contracts and monitor activity. They were supported by commissioners from the Family Health Service Authority. Any savings from the

Figure 1. Principles of commissioning (The Information Centre, 2011).



budget could be reinvested in patient services (The Kings Fund, 2010). Some practices grouped together to control much larger budgets, known as 'multifunds'.

In 1994 total purchasing pilots extended the role of fundholding to include potentially all services. They acted as a subcommittee to the health authority and used an indicative rather than real budget (The Kings Fund, 2010). Fundholding was not popular with all GPs. Some complained it had created a two-tier service which disadvantaged patients who were not registered with a fundholding GP (House of Commons, 2010). In 1997 fundholding was abolished by the Labour government but the concept of purchaser–provider split was retained. The Family Health Service Authority became primary care groups and then primary care trusts.

In 2004 GPs were encouraged to become more involved in commissioning via practice-based commissioning (The Kings Fund, 2010). This was also optional. Practices received an indicative budget which paid for the majority of patient services (Department of Health, 2004). Ultimately the primary care trusts were in control of the contracts with the hospitals and of the budget. Practices received incentives to assist the primary care trust in monitoring service activity, and all savings had to be reinvested in patient care (The Kings Fund, 2010). The aim was to increase patient choice of provider and encourage more local services (Department of Health, 2004).

Understanding commissioning

As a clinician you can view a patient's journey, map it out and then look at ways to improve it, as indicated in *Table 1*. The consultation skills you have learnt to date can be transferable, and subsequently built upon. Do remember that the emerging information technologies which are gaining momentum can be used to improve communication, efficiency and support but equally align these with realistic cost envelopes to ensure delivery of the health service you have in mind. The ultimate drive and underpinning ethos behind clinical commissioning should be to continually improve the clinical care delivered to individual patients.

Ingredients for effective commissioning

Commissioning aims to deliver the triad of high quality health care, improved patient satisfaction and adherence to a defined budget via cost effectiveness. This can only be achieved by effective commissioning to ensure a balanced health economy. Effective commissioning will bring new prospects and opportunities, but will also pose potential risks and challenges (*Table 2*).

GPs have been placed at the forefront of commissioning and patients at the heart of it. Clinically led commissioning will enable doctors to be at the forefront of service redesign and allow doctors to use the organizational, leadership, negotiation, prioritization and communication skills which they demonstrate every day – but now on a much larger scale. All of these skills, alongside those highlighted within the General Medical Council's (2009) *Good Medical Practice* guidelines, make doctors the ideal candidates to head these reforms.

Public and patient involvement is crucial to inform the commissioning consortia by establishing their needs, ideas and expectations. Their input must be actively sought, welcomed and incorporated into commissioning strategies. Each commissioning consortia will have a patient representative on their board, but additional patient opinions will need to be sought and local population views collated in order to glean representative input.

Good communication between everyone involved in the commissioning process is vital, and all stakeholders involved must demonstrate mutual respect. The organizational framework, form and function of clinical commissioning groups continues to both develop and evolve at the time of writing. In general terms the new commissioning architecture consists of NHS commissioning boards with different centres, sectors and local offices, plus invaluable input from health and wellbeing boards (NHS Commissioning Board, 2012). The key aims will be to ensure good lines of communication, governance and clear identification of roles and responsibilities between the various stakeholders involved to ensure the delivery of health-care services in an integrated seamless patient journey and good patient experience. Multidirectional communication is needed, and

Table 1. Understanding and applying commissioning

History	What has prompted you to look at a particular area, analyse the local population needs, ask questions to determine if things can be done differently
Examination	Review the data, are they up to date, do you look at one system or the 'whole' system
Investigation	Examine the evidence base and interpret the relevance to your local needs
Treatment plan	Is the pathway specific to a speciality or impacting on a whole system, i.e. the continuous patient journey
	Would you need further expert advice and who would you bring in to assist you
Shared decision making with the patient	Collaborative working with stakeholders, inclusive of patients
	Ensure you are all on the 'same page' and speak a similar language, to enable common goals and thereby realistic deliverables
Differential diagnosis and agreed treatment plan	Review of options and agreement on the plan that is being moved forward following initial evaluation weighing up the pros and cons
	Do other services need to be introduced and are the clinical pathways clearly integrated
Review	Governance, clinical audit, assessing progress, lessons learnt and continual improvement

Table 2. Benefits and risks associated with commissioning

Benefits	Doctors at the forefront of service redesign
	Greater patient involvement
	Accountability for finite resources
	Consideration for local population need
	Leadership and management roles for doctors
Risks	Lack of commissioning skills
	Erosion of public trust
	Risk of 'privatization'
	Risk of soured doctor–patient relationship
	Clinical training needs overlooked

proposals must be presented in a format which is understandable by all members of the consortia. For example, a patient representative must not be made to feel alienated or less involved in the process because of jargon used in proposals.

Accountability by the consortia is needed. They will be managing finite public resources and their decisions must be justifiable and accountable. Standardized outcome measures will need to be implemented to monitor and assess new services.

Some doctors will embrace this opportunity to demonstrate their management and leadership skills. However, many junior doctors are concerned that their clinical training opportunities and needs will be overlooked. In order for commissioning to be successful, investment in training will be needed for the doctors of tomorrow.

Commissioning case examples

Case 1: medicines management

The cost of medication is the second highest health-care spend after health-care staffing costs. Medicines management is defined by the National Prescribing Centre (2002) as 'a system of processes and behaviours that determines how medicines are used by patients and by healthcare services'.

Example exercise

Find out the costs for the preparations listed in *Table 3*: levothyroxine 50 µg and hypromellose eye drops. Which one would you prescribe and in what setting?

Further exercises

1. Have a look at the Medicines Management Formulary in your local area – is there one that is shared by both primary and secondary care?
2. Next time you are in your local pharmacy or supermarket, have a look at the variety of paracetamol or senna products. What would influence your choice of the preparation that you buy? To what degree are the products different in relation to the medicinal content? What influences your choice of medication when you prescribe for your patients – is there an agreed formulary that you use?

Useful further links

www.drugtariff.co.uk/
www.npc.nhs.uk/developing_systems/

Case 2: planned care referrals

A 56-year-old man has been referred by his GP after being seen by the optometrist and being referred for his left cataract. He was seen in clinic and subsequently discharged, being advised that at the present time his cataract was not advanced enough to require extraction and intraocular lens implantation.

What are the referral criteria for a cataract in your area?

How would you manage this clinical pathway, which health-care professionals would be involved and how would you manage the patient's expectations accordingly?

Further exercises

1. Do you know which conditions are regarded as having thresholds for procedures in your speciality in your area – list at least two. Google 'low priority procedures and thresholds UK'.
2. Do you know the price of a consultation for first and follow-up appointments in your speciality?
3. Have a look at five cases that you recently discharged from clinic following first attendance. Was a locally agreed clinical pathway in place for that condition, did the referral in question fulfil the referral criteria, could anything have been done differently? How would you change or influence a change in the pathway?

Improving quality outcomes is a key principle of clinical commissioning. A good starting point is to consider the variation of health-care outcomes between different areas. On a national level this is enabled by the use of tools such as Atlas of Variation (accessible via www.rightcare.nhs.uk). The variation of care delivery in a local area can be viewed on local websites (e.g. www.myhealth.london.nhs.uk) thereby informing a case for change.

Useful further links

www.northwestlondon.nhs.uk/shapingahealthierfuture/
http://pathways.nice.org.uk/
www.dh.gov.uk/health/2011/12/pbr-2012-package/

Case 3: unplanned care

A 21-year-old woman has unprotected sexual intercourse around 10pm on a Friday night. She awakes on Saturday morning and is aware that she needs emergency contraception. What should she do, who should she phone and where and when should she see someone? What would you advise?

A single telephone number, 111, is currently being introduced. Underpinning it is the need to ensure that up-to-date information is easily available on the local services open at the time of the patient's call and that an assessment is undertaken to best fulfil the patient needs. It is important to ensure that good communication and integration does occur in real time.

Useful further link

Royal College of General Practitioners Urgent and Emergency Care Commissioning Guide (www.rcgp.org.uk/pdf/Urgent_emergency_care_whole_system_approach.pdf)

Table 3. Medicines management example of different drug preparations and their cost

Drug name	Drug strength	Formulation	Quantity	Price (£)
Levothyroxine	50 µg	Tablets	28	1.78
Levothyroxine	50 µg/5 ml	Liquid	100 ml	42.75
Levothyroxine	50 µg	Lactose and sugar free	28	95.37
Hypromellose	0.3% eye drops		10 ml	1.35
Hypromellose	0.5% eye drops	Isopto plain	10 ml	0.81
Hypromellose	1.0%	Isopto alkaline	10 ml	0.94
Hypromellose	0.25%	Preservative free (special)	10 ml	14.40

Future of commissioning

As a busy junior doctor you may feel you are far removed from the world of clinical commissioning. However, it is as relevant

to you as it is to your senior colleagues, if not more so, as by being increasingly aware and being involved from the onset you can influence the delivery of future health-care services. Every time you undertake an activity, be it a prescription, requesting an investigation or suggesting a further referral, you will be influencing the patient journey. Remember that your interaction with the patient is one link in the clinical pathway and reviewing it as a part of a whole system and its implications will put you in a better position to stay informed of the key components of the individual's clinical care. Whichever field of medicine you choose to follow you will undoubtedly need to be aware of clinical commissioning. Even if you chose to have little direct involvement with it, your everyday activity will have a ripple effect on the local health-care economy. **BJHM**

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KEY POINTS

- Commissioning is relevant to all doctors and health-care professionals.
- Commissioning is not a new concept, but the new proposals could dramatically change the NHS landscape forever.
- Commissioning may help 'future-proof' the NHS.
- Think about your role within the wider NHS and on the patient journey.
- Consider your impact on resources and commissioning by analysing your investigation requests, prescribing decisions and referrals.