

## Response to the Department of Health consultation on the Commissioning Framework for Health and Well-being

29 May 2007

**The King's Fund welcomes the opportunity to respond to the Department of Health's consultation on the commissioning framework for health and well-being. The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships and through funding. We are a major resource to people working in health and social care, offering leadership development programmes; conferences, seminars and workshops; publications; information and library services; and conference and meeting facilities.**

We welcome the Department of Health's focus on health and well-being as this is often secondary to service-related issues. However, we foresee difficulties once primary care trusts (PCTs) attempt to develop a business case for particular interventions as public health interventions are difficult to evaluate and payback in terms of health gain and saved costs is uncertain. Effective health promotion programmes are also multi-faceted and work at both national and local levels, so programmes may not be effective if viewed as isolated local-level interventions.

This framework is an element of the wider reform agenda that sees PCTs' role changing from that of provider to commissioner. Effective commissioning will be dependent on setting clear goals and making effective use of health and health care service data. Better use could be made of already existing data sets, but if the health service is to develop a more personalised approach to health care and health promotion then it has to develop: ways of segmenting patients according to their health needs, attitudes to risk, independence and autonomy; interventions tailored to different groups; and ways of monitoring the pathway of patients across health promotion interventions and primary and acute services. As commissioners, PCTs will also need to: develop ways of using health and service data sets to evaluate provider performance: develop a knowledge base about how local populations use health services: and finally assess whether provider services are efficient and effective.

*Q1. Are these measures sufficient for people to take control of decisions about their health?*

The Commissioning Framework uses two meanings of individual control over health: the first refers to individuals' capacity to take and act on informed decisions about their health; and the second, to citizens' ability to engage with and comment on the provision and quality of government services. These issues require different support and services and should not be merged.

The Commissioning Framework suggests that people should have greater choice over services and treatments, easily accessible services and access to information about their health care, self care and healthier lifestyles. Evidence suggests that education programmes are an important *complement* to multi-faceted health promotion programmes, but are not sufficient in themselves to promote healthy behaviour (Coulter and Ellins 2006). There is also considerable evidence that decision support programmes and advocacy support help people take control of health decisions, understand the consequences of their choices and feel more active in the decision-making process, and may reduce the use of health services and cost (O'Connor 2002; Coulter and Ellins 2006). Tailoring care may help individuals to personalise services, but in social care, decisions over who has access to direct payment schemes and how the menu of services is defined has been contentious.

The Commissioning Framework also suggests that individuals should be able to contribute to defining commissioning priorities, and should be able to comment on the quality of service. The framework is unclear about how PCTs should prioritise the needs of different segments of the community, particularly where resources are limited. There may also be a tension between more intelligent commissioning and what patients want, particularly when there is no clear evidence about the benefits of a particular demand. For example, many mental health patients support their local day care centre, but money for these centres is contracting as other more individualised models of care are prioritised (Department of Health 2006). There is considerable evidence about the barriers to involving the public arising from the lack of clarity about the aims of public consultation, resource and organisational constraints, professional or managerial resistance and concerns about representativeness (Coulter and Ellins 2006). Finally, while transparency on quality of services and comparison with other areas is useful, patients will be unable to act on this information without being able to access better services in a different area, and if this was possible, there may not be capacity to deal with increased demand or gate-keeping may prevent individuals accessing services in other areas.

*Q2. What special arrangements might be needed to ensure that the views are heard of those who don't routinely use local services?*

Market research and polling using well-established sampling techniques can be used to get views of all segments of a local community.

*Q3. Will this approach help commissioners undertake an assessment of an individuals' needs, group needs, Joint Strategic Needs Assessments?*

The Commissioning Framework suggests using the Care Programme Approach for patients with pre-existing care needs to assist them in directing their own care. In the mental health sector, this approach is generally regarded as an effective way of helping patients to receive the services they want. However, there are some significant failings in practice: for example, some patients are unaware they have a care plan, are not consulted about what it might cover, or simply do not receive the services specified, indicating possible shortcomings if the Care Programme Approach is extended to other specialties.

The Framework suggests using QOF to case-find individuals at risk of disease or unplanned admission to hospital. This has limitations as QOF does not incentivise systematic identification and management of high-risk patients. Of proven effectiveness are risk stratification tools such as the Combined Predictive Model, developed by the King's Fund and its partners, Health Dialog and New York University, which enables PCTs to identify which patients are likely to be at high risk of emergency admission in the future, and to design appropriate interventions to prevent this. There is also a need to understand the healthy patient population better and develop data on potential health risk, lifestyle and attitudes. The proposed Life Check is a start in this process – particularly if the information is used to develop a better understanding of potential health needs and to personalise interventions.

The suggestion to use personal triggers such as the death of a spouse to engage with older people may be difficult to implement unless medical records were to allow linking of personal details of different patients. This may not be possible under data confidentiality rules, and may be regarded by patients as invasive unless they themselves request help.

The Joint Strategic Needs Assessment is advocated as a tool to inform annual, medium- and long-term planning by identifying local priorities and a common planning platform for local authorities and PCTs. This is to be welcomed, particularly if real efforts are made to work with patient groups and voluntary organisations about their members' experience of existing services, and their views of what needs to change, combined with objective survey assessments.

*Q4. How can we shape the duty of the Joint Strategic Needs Assessment to have greatest impact on health and well-being?*

It may be helpful to define the duty of the Joint Strategic Needs Assessment in broad rather than specific terms to allow flexibility for local conditions. The definition of health should include physical and mental health, and the definition of well-being should include the social and environmental factors that affect people's ability to live independent and healthy lives. The Joint Strategic Needs Assessment should not just identify need, but should also specify what needs to change and a timeline for accomplishing this.

The duty of the Joint Strategic Needs Assessment should emphasise the need to prevent disease and maintain independence from an early stage of diagnosis, rather than on crisis management once a person is ill or in distress.

*Q5. Will this approach be suitable for children and young people?*

No comment. This is not an area in which we have specialist knowledge.

*Q6. Are the main information requirements for effective commissioning identified here? Are there any obstacles or gaps that need to be addressed?*

Considerable information is already available in databases and the challenge is how to integrate databases effectively so the information is meaningful and can be used effectively. The Combined Predictive Model, for example, already combines inpatient, outpatient, GP and A & E data as health data can be linked by using the NHS number.

Adding data from other sources is more difficult. 'Fuzzy matching' typically yields only a 60 per cent to 70 per cent match. A unique identifier (for example, the National Insurance number) for all health and social data would make data sharing much easier, and encryption could protect confidentiality. The DH's Patient Information Advisory Group (PIAG) offers clear guidance on how this can be done in an acceptable manner using pseudonymous data.

The absence of real-time information is also a hindrance to commissioning and managing contracts and ways of improving this should be considered.

One area that needs to be addressed is the accuracy of coding for ethnic groupings. Recent work by the King's Fund identified deficiencies in this, with implications for epidemiological analyses and service provision (Georghiou and Thorlby 2007).

It is unclear how health promotion and well-being services will be costed as current reference costs exclude separate health promotion and prevention from cost tariffs. In addition, the Framework suggests that such work may be commissioned from the voluntary sector, yet this is also excluded from cost referencing. The Charity Commission recently reported that voluntary sector organisations tend not to receive full-cost recovery for services commissioned by the statutory sector – a problem which will undermine the possibilities of creating a fair marketplace for contracted services (Department of Health 2007; Charity Commission 2007).

Another challenge is the difficulty of making a strong business case for a particular intervention when the certainty of impact is often unclear, the payback very long term, and successful interventions tend to be multi-faceted and operate at local and national levels, making it difficult to identify the exact components that have had the greatest impact. It may be difficult to encourage commissioners to invest in health promotion when the outcomes and payback are uncertain.

*Q7. Is the legal position on data sharing for commissioning clearly set out? Do we need to review the current rules?*

We would recommend a review of the current rules and consideration of developing unique identifiers for health and social data.

*Q8. Are there specific issues around sharing information on children and young people that should be addressed at a national level?*

No comment. This is not an area in which we have specialist knowledge.

*Q9. Would it be helpful for the DH to work with other government departments and national stakeholders to develop a common set of principles to help underpin local agreements?*

Yes, we believe a common set of principles would be helpful. Key issues to address include: firstly, the inclusion of a unique identifier; secondly, common standards for the acceptable use of pseudonymous data; and thirdly, establishment of a cross-government equivalent of the Patient Information Advisory Group (PIAG).

*Q10. Will the proposals support commissioners to assure a range of high-quality providers for all services?*

The proposal to commission services based on outcomes rather than episodes of care is to be welcomed, but with caution. Public health and health promotion activities may not lead to short term benefits, but may have long term positive effects, which would be difficult to commission for. Health behaviour is influenced by social norms, individual attitudes and the regulatory context and health promotion programmes are just one element of a complex range of initiatives needed to promote behaviour change. Finally, lifestyle change programmes may result in short-term change, but patients find this is difficult to maintain, so quitters frequently begin smoking again and dieters regain lost weight and this makes it difficult to define a useful outcome measure. It is suggested that commissioners define long term goals with staged milestones and develop a series of short term process measures and long term health outcomes to evaluate contracts and services.

Commissioners should rely on data about outcomes and episodes of care. The latter is more easily measurable and less controversial but could also allow commissioners to standardise care and assess providers adherence to care pathways and efficiency. Linking care and outcomes data could also allow PCTs to assess whether there is a relationship between particular care programmes and health outcomes, and begin to develop an evidence base for effective practice.

The proposal to involve current and potential providers in needs assessment may not lead to better service provision. It is inappropriate for commissioners to rely exclusively on existing and potential providers to define needs and appropriate services, as providers will have vested interests that may not necessarily represent the collective good of the local community. However, it is appropriate for commissioners to share the Joint Strategic Needs Assessment with actual and potential providers as a basis for their tendering for services. There needs to be a clear delineation of roles between commissioners and providers. If PCTs are to become commissioners, then their task is to identify needs, priorities and desired outcomes and the task of providers will be to translate this into a service subject to the outcome and quality standards required by the commissioner.

Commissioners should actively try to encourage new providers and diverse and innovative service provision. However, the recommendation that commissioners make the provision of new services more attractive to providers by paying a supplement to the tariff, reducing the capital investment, or pump priming loans should not be followed unless a proper market assessment has been undertaken that demonstrates evidence of supply problems and high entry costs. Potential entrants to a market should also seek traditional means of venture capital.

To ensure high-quality provision contracts, commissioners should include outcome and performance metrics, as well as penalties should the providing organisation not meet the specified quality of service. To help assess need commissioners should examine ways of using QOF, Life Check or patient registration to gather data about their local population, and develop new targets, for example, weight or fitness measurements of particular age cohorts.

*Q11. Should the DH develop one contract template for out-of-hospital services (except GMS and PMS) or one for each of the main service segments (for example, mental health, long-term conditions, etc)?*

A contract template is useful for commissioning a homogenous service that can be delivered in any setting. Interventions to promote health and well-being will be very varied, and will have different outcome measures. It is thus harder to see how a single contract could be used across mental health, long-term conditions and health promotion services.

*Q12. Are there sufficient levers and incentives for commissioners and employers to improve health and well-being?*

This chapter of the report demonstrates the benefits of keeping individuals in work, and helping people to return to work speedily, but it is not explicit about what kind of ‘levers and incentives’ can be used to promote this and relies heavily on the PCT ‘encouraging’ different groups to promote health. The onus is also on small- and medium-sized businesses to develop ways of improving health and well-being in their workplaces by pooling resources or partnering with larger businesses. PCTs can provide tools for self assessment and evaluation of workplace schemes.

The use of benchmarks in contracts with providers seems a practical way of ensuring NHS-associated providers support the health of their employees, however, the suggested metric of reduced sickness absence on its own is not necessarily indicative of a good occupational health service, as reduced sickness could be due to other factors; and if the intention is to promote the use of the workplace for wider health promotion, then other indicators, such as the availability of smoking cessation or reduced smoking prevalence, might also be relevant. It would also be helpful to expand occupational health services to include psychological therapy, as mental health problems constitute a significant part of the burden of ill-health in the general population.

*Q13. What practical, legal and financial issues need to be considered in enabling PCTs and practice-based commissioners to spend effectively on non-health interventions?*

Some European cities have used clauses in OJEC contracts to further their health and well-being duties while still offering transparent, non-discriminatory contract process. Further consideration should be given to how health and social considerations can be built into contracts as part of the quality specification, rather than as the basis for a premium.

If NHS funds are used to pay for community care services, it will raise several practical issues, namely, whom will be eligible for such services, how will demand be managed and what impact will it have on the way social services determines eligibility for social care.

*Q14. What further changes would make it easier for resources to follow individual service users?*

Linking resources to individual service users raises three concerns. Firstly, the Department of Health should consider whether payment-by-results tariffs can be extended to prevention and wellness services and how these services and outcomes

might be valued. Secondly, it might explore different models of linking resources and users. For example, it might be possible to develop individual health budgets for people with chronic illness, similar to direct payments in social care, which are regarded positively (although take-up is patchy). However, social and health care differ in significant ways: social care tends to be more predictable than health care; social services relies on means testing and individuals accept topping up services with their own money, while this is not generally accepted for health care services. The evidence on medical savings accounts in the US suggests that they reduce consumption of preventive services and lead to delays in accessing necessary services as service-users become more cost conscious and try to avoid expenditure (Fronstin and Collins 2006).

*Q15. What considerations do you see in increasing the use of single audit arrangements for pooled budgets?*

No comment. This is not an area in which we have specialist knowledge.

*Q16. How can we ensure that practice-based commissioning (PBC) and children's trust arrangements work effectively together to improve outcomes for children?*

No comment. This is not an area in which we have specialist knowledge.

*Q17. What further measures might be required to clarify accountabilities for commissioners?*

It is important that PCTs are held accountable for how they spend public money. They are currently subject to performance management by strategic health authorities (SHAs), but other ways of increasing their accountability are possible. For example, local government could be given powers to contract with a commissioning organisation on a three-yearly cycle. This would mean that commissioning organisations would be subject to contestability. If they have not demonstrated good value-for-money, their contract might not be renewed. Alternatively the Department of Health (via SHAs) could broker a stronger agreement with PCTs linking services and outcomes to resource allocation. Another possibility is for PCTs to develop more local accountability through links with local government, or through being given foundation status in the expectation that this will reflect the expectations of their local populations in a more democratic way. It might be possible to develop objective standards for commissioning, monitored by the regulator. However, this may not fit with the future role of the Healthcare Commission, which will focus on ensuring that all service providers (public and private) are safe. Finally, some have suggested that commissioners should be accountable to their members, and appointment should be through election. However there is no local experience of election of local service leaders.

*Q18. Should a local authority have some say in the capital investment plans of a PCT (and vice versa) to ensure they support more integrated service delivery, where appropriate?*

Theoretically local authorities already have a say in assessing PCT services through the Overview and Scrutiny Committees (OSCs), and LAA and LSPs encourage integrated aims for service delivery. It is unclear whether this is effective, and whether the OSCs need a clearer brief about their mandate and professional and technical support to assess the validity of PCT proposals.

The Joint Strategic Needs Agreement could consider capital planning as well as service needs to ensure a common planning framework for local authorities and PCTs.

*Q19. What metrics would best support a single health and social care outcomes framework?*

The King's Fund is developing its work on the Combined Predictive Model to develop a Person-Based Resource Allocation model that better predicts the costs of hospital and outpatient treatment. This tool may be useful for assessing need, services and costs and could potentially be used to performance manage a local health and social care economy.

*Q20. What do local commissioners need in terms of national support for developing commissioning capability?*

There is an urgent need to develop PCT and PBC capacity. SHAs, supported by national agencies such as the NHS Institute and the Improvement Foundation, need to build a cohort of skilled commissioning managers and clinicians. Support for leaders in the new, and still weak, PCT boards and PBC consortia is also vital to help set commissioning priorities and manage providers.

There is a need to develop a national set of outcome measures and standardised tools for assessment. PCTs will face similar problems and a common set of tools will allow commissioners to evaluate the performance of local programmes, and also compare performance of different programmes or providers. National, standardised metrics could offer the means to develop evidence-based knowledge about best practice.



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