nhsalliance

SPECIALISTS IN COMMISSIONING

Looking beyond current policy

Dr Minoo Irani
Specialists in Commissioning Network

The NHS Alliance Specialists in Commissioning Network would like to hear from those interested in getting involved in the discussion about the role of specialists in the current NHS reforms and their influence in clinically-led commissioning. For more information please email Dr Minoo Irani at minoo.irani@nhsalliance.org

Introduction

The Health and Social Care Bill proposes a different approach to commissioning a significant majority of NHS services. Clinical Commissioning is expected to empower NHS professionals to improve health services for the benefit of patients and communities. Most NHS services will be commissioned by clinical commissioning groups (CCGs) and GPs are ideally suited to lead on commissioning based on their understanding of the needs of their patients and local communities (1).

When the NHS White Paper, Equity and Excellence: Liberating the NHS (2) was published in July 2010, specialist doctors (Consultants & Specialty, Staff and Associate Specialist Grade doctors) understandably felt excluded from the mainstream NHS Reform agenda when there was no mention of their role in clinical commissioning. The important role played by specialists in providing leadership to the health service and their potential for making clinical commissioning a success was acknowledged in the NHS Future Forum Report (3).

The Government responded to the recommendations of the report by emphasising the role of the secondary care specialist doctor on the Clinical Commissioning Groups' (CCG) governing bodies and by supporting the proposal for clinical networks and clinical senates (4).

This brief discussion paper proposes a transformation of the traditional relationship between GPs and Specialists in the NHS, which has increasingly been limited by professional and policy constraints and requirements, rather than necessarily by an ethos of common purpose and benefit for patients and the public.

It emphasises the position of the Specialists in Commissioning Network on the current NHS reforms, that any policy which could risk creating artificial barriers between primary and secondary healthcare services or promote mistrust between GPs and Specialists, is likely to be far less effective than policy which allows true professional engagement for the common purpose of high quality patient care.

The current proposals for the role of the secondary care specialist doctor in CCG governance, clinical networks and senates goes some way in including specialists in clinical commissioning. Further guidance on this and implementation of this policy needs to be carefully balanced to allow GPs and Specialists to collaborate on a range of common purpose issues rather than feel pressurised to implement elements of policy which may appear unconvincing to either or both groups of doctors.

Commissioning and the role of the Specialist

While 'commissioning' has been defined in a number of ways (5) to emphasise that it is more than just purchasing, a fair description of a health service commissioner would be someone who is "*an advocate for patients and communities, who secures a range of needs- based, high quality and outcome focussed healthcare and health promotion services by committing finite resources"*.

It is acknowledged that GPs are probably the most appropriate clinicians to have a comprehensive view of population health needs and are well suited to assume the role of advocacy for their patients. This should not exclude a range of healthcare clinicians (including specialists) from making a positive contribution towards improving quality and outcome measures for specific areas of specialist healthcare services.

The increasing complexity of population and patient healthcare (and social care) needs, will make it necessary for CCGs to collaborate with each other and with local partners in developing commissioning plans to meet those needs.
The challenge remains to allow professionalism among doctors to lead the process for GPs and Specialists to share skills in order to make clinical commissioning successful, rather than depending heavily or exclusively upon policy levers.

Specialists can play a role in supporting clinical commissioning in a number of ways as defined in policy documents from the Department of Health:

- Membership of **governing bodies** of CCGs
- Clinical leadership input to **clinical senates**
- Supporting the development and functioning of **clinical networks**

The details about these roles for specialists in CCGs are awaited and the NHS Alliance Specialists Network has discussed current policy and also debated issues which require addressing beyond the confines of current policy. Recommendations are listed, which would allow policy makers to reflect upon the limitations of current policy and guidance in this area and encourage broader clinical engagement while developing this policy.

Specialists also have a unique opportunity to enable **integrated care** in the NHS by engaging in dual roles-- influencing commissioning and also designing and providing services which are seamless and patient led.

CCG Governing Bodies

Current Policy

Specialists will have responsibility towards enabling clinical commissioning through their role as members of the governing bodies of CCGs. Amendments to the Health and Social Care Bill (6) introduce a requirement that all CCGs have a governing body. The main function of the governing body is to ensure that the CCG has in place appropriate arrangements to make sure that it exercises its functions effectively, efficiently and economically and that it complies with generally accepted principles of good governance. Membership of the governing body must include at least two lay members, one registered nurse and one doctor with secondary care experience. It is proposed that these professional members should have no conflict of interest in relation to the CCG's responsibilities (and hence not employed by the local provider). The role of the specialist doctor would be to provide an independent perspective, informed by their experience and expertise.

Beyond Policy

Good governance arrangements will be necessary for CCGs to function as accountable bodies and it is expected that the NHS Commissioning Board will produce further guidance about minimum governance requirements.

The debate from GPs is whether the bureaucracy and costs involved in securing a specialist doctor for the CCG governing body would produce significant benefit for anyone. Some argue that ensuring the CCGs follow good governance principles of accountability, transparency and probity does not necessarily require a specialist doctor on the board, since anyone with the necessary training and skills about governance could effectively perform this function. Understandably, they are concerned about the possibility of specialists gaining dominance in the governance functions of the CCG, to the extent that CCGs perceive this a barrier to effective functioning.

There is little clarity about remuneration for specialist doctors on CCG governing bodies and this is likely to be complicated either way—if hospital trusts are to be remunerated for all of the time required by their specialist doctors for involvement with CCG governance, the costs for CCGs may be prohibitively high. On the other hand, if all members of CCG governing bodies (including GPs, nurses, specialist doctors and lay members) are remunerated at the same level, hospital trusts may not actively encourage their most senior, experienced and expensive specialists to apply for these positions, especially when those CCGs are expected to fall outside the limits of their influence.

Specialists have maintained silence on this policy proposal, possibly awaiting more specific advice before expressing an opinion. Early indications are that specialists remain unconvinced that their time would be best spent by involvement with CCG governance, unless a specific function is identified for them in this role. Also, the time commitment involved for practicing specialists to engage with CCGs well outside

their sphere of geography and clinical practice could be a barrier. Some specialists feel their knowledge and skills are better utilised by CCGs in discussions about commissioning for high quality local services, rather than trying to influence governance of CCGs outside their localities and clinical interactions.

There are some specialists however, who do support this policy of specialists on CCG boards, arguing that the only group of clinicians who could effectively challenge poorly evidenced decisions about commissioning for the range of specialist services, would be consultant level or other senior career grade level specialist doctors and that this scrutiny would be more robust if it came from a specialist doctor who had no service links with the CCG or its constituent practices.

Recommendations:

The NHS Alliance Specialists in commissioning group proposes the following policy details which would be required to enable the best use of specialists for CCG governance:

- Clarification of the purpose, role and responsibilities of the specialist doctor on CCG governing bodies
- Guidance about the specific skills set or additional training required by specialists to be able to perform this role
- Additional guidance about the requirement that the specialist should have no conflict of interest in relation to the CCG's responsibilities (and hence not employed by the local provider).
- Proposals for remuneration options for specialists who take on this role

Clinical Senates

Current policy

In order to enable the NHS Commissioning Board and CCGs to have strong relationships with a range of health professionals, clinical senates (7) have been proposed. These clinical senates are expected to be a way of bringing clinical leaders together across broad areas of the country to provide a vehicle for cross specialty collaboration, strategic advice and innovation to support commissioners. While it is expected that the number of clinical senates will be in the order of 15, the details about membership and specific roles of members are being consulted upon.

Clinical senates will not be statutory bodies or formal organisations and will not have a right of veto for plans or proposals of CCGs. The senates will simply enable doctors, nurses and other professionals to come together to give expert advice on how to make patient care fit together seamlessly in each area of the country. They will help CCGs to make sure that improvements in patient care are made in an integrated way that support more joined up care and better population health outcomes It has also been proposed that clinical senates should include public health specialists and adult and child social care experts in order to support better integration of services.

Beyond Policy

Concerns have been expressed by some GP leaders that specialist doctors on clinical senates could interfere with or create barriers to effective clinical commissioning. There is a perception, possibly created by the title of ‘senates’ that these bodies will take the decision making powers away from CCGs into the realm of committees of privileged individuals removed from the reality of frontline clinical practice.

Secondary care doctors providing highly specialist services at regional level (spanning several CCGs) remain concerned that CCGs may not understand the complexity or need for some of these specialist services to be provided at population levels beyond individual CCG boundaries, risking some services falling in- between the responsibilities of the National Commissioning Board and local CCGs. Specialists would prefer a process for reassuring themselves and patient groups that when CCGs commission these services, there is due attention paid to the issues of integration of service pathways and a track record of service providers aligned to quality and patient outcomes.

Recommendations

- The term ‘senates’ is abandoned in favour of a more inclusive term for these bodies, which are proposed to serve as a means of communication between the NHS Commissioning Board and the CCGs.
- The roles and responsibilities of specialists on these bodies should be specified
- Functions of these bodies should include a regional overview of highly specialist services and a requirement for measuring quality and patient outcomes for these services
- ‘Senates’ should be "jointly owned" by CCGs and the National Commissioning Board, to avoid perception that they are agents of the NCB.

Clinical Networks

Current Policy

Networks are defined as linked groups of health professionals and organisations from primary, secondary and tertiary care working in a coordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality, clinically effective services (8).

There are already national clinical networks: groups of experts, including patient and carer representatives, brought together around particular pathways or conditions (such as cancer care). The proposal by the government is to strengthen networks and enable them to cover many more areas of specialist care. Clinical networks will be given a stronger role in commissioning to support the NHS Commissioning Board and local CCGs.

Beyond Policy

The complexity of commissioning and providing specialist services in a resource limited system, while ensuring that quality of clinical care, accountability and regulation are integral elements of the service across the provider landscape, requires robust arrangements for different types of clinical networks.
Networks can be organised with several levels of detail and sophistication:

1. Clinical Association: this is an informal group that corresponds or meets to consider clinical topics, best practice or other areas of interest

2. Clinical Forum: this is a more formal group that meets regularly, focuses on clinical topics and formulates jointly agreed clinical protocols

3. Developmental Network: this is a clinical forum with broader focus other than purely clinical topics, with emphasis on service improvement

4. Managed Clinical Network: this network includes function of a Clinical Forum and has a formal management structure with defined governance arrangements and specific objectives.

Recommendations

- Guidance for commissioning of networks is required for CCGs and Specialists to be able to initiate early interactions and discussions about the most suitable networks based upon local healthcare needs and priorities
- If managed clinical networks are to be hosted and funded by the National Commissioning Board, GPs and Specialists should be involved (along with a range of other stakeholders) in the early stages of setting standards for commissioning for networks
- GPs and Specialists should be involved with setting standards for providers of networks of care for a range of services
- Robust governance arrangements are necessary for networks, to reduce the risk of monopolies and conflicts of interest and to ensure quality control.

Integrated Care

Current Policy

The Health and Social Care Bill has been amended to promote integration.
Integrated Care can take many different forms. In some circumstances, integration may focus on primary and secondary care, and in others it may involve health and social care. Ham and Curry (9) provide a sophisticated analysis of three levels of integration and propose lessons for the NHS based upon evidence from research.

Beyond Policy

A fully Integrated Healthcare System includes the commissioning and provision of a coordinated continuum of services (across primary, community and secondary healthcare) to a defined population with accountability for both the clinical & financial outcomes achieved and the health status of the population served.

The combination of commissioner and provider separation and payment by results has probably contributed to preventing a fully integrated healthcare system in the NHS.
The unique challenges of combining patient choice (where the patient is not the payer for healthcare), promoting competition among providers, public preference for locally based hospital care and ensuring social care involvement have also made it difficult to practically adopt any of the successful international models of integrated healthcare.

In July 2008, NHS Alliance published a position statement (10) in collaboration with medical specialty organisations and GP representatives, affirming that integrated healthcare systems within the NHS should:

- Have the primary aim of improving the health of the population
- Focus on quality and clinical outcomes
- Involve patients and clinicians early in the development process
- Explore evidence based treatment pathways before considering organisational or structural changes
- Foster an ethos of collaboration between primary, community and specialist clinicians so as to improve the patient experience of healthcare
- Include social care partners in planning and implementation of services that support patients with long term conditions, those who are elderly and vulnerable patients with mental health problems

Recommendations

- To reduce the risk of over-complicating the integration agenda, policy should focus upon reducing the barriers to integration rather than propose implementation of one or more models of integrated care
- Commissioners and providers should be encouraged to adopt the principles of a good integrated health and care system (as above) using policy levers
- Fully integrated healthcare systems should not be discouraged in localities where benefit from a closer commissioner-provider relationship has been demonstrated

Conclusion: From policy to practice

The potential contribution of specialist doctors to the NHS reforms and especially clinical commissioning appears to have been explored by policy makers somewhat as an afterthought. Proposals for specialist involvement in governance of CCGs, clinical senates and networks offer an opportunity for GPs and Specialists to collaborate, but also carry a risk of professional and service barriers between primary and secondary care if policy is not inclusive or based upon the perceptions and expectations of both groups of doctors.

The proposed NHS structure, involving commissioning of significant proportion of healthcare at primary care level and provision of specialist care within hospitals and Foundation Trusts, raises the potential for creating clinical and service barriers along the patient journey through primary- community-secondary care services. If policy around inclusion of specialists in CCGs is not sensitively delivered or appears as unnecessary interference by GPs, it is very unlikely then to contribute in any positive manner to making the NHS reforms successful.

GPs and Specialists are probably at their best with professional and clinical collaboration if their focus remains upon the common purpose of enabling high quality, patient centred care, albeit within the constraints of financial resources likely to be present for healthcare services over the next few years.

Integrated care, however defined, will not be possible without specialist doctor involvement or their collaboration with GP commissioners, primary care providers, local authority partners and clinical and management colleagues in secondary care. The principles for a good integrated healthcare system should be promoted and models of provision should be allowed to evolve at locality levels in collaboration with local authority partners. The role of policy should simply be to enable barriers against integrated care to be minimised and to facilitate collaboration between clinicians, managers and social care colleagues.

While further guidance is awaited, GPs and Specialist doctors need to ensure that every interaction between them is a small step towards establishing trust and positive professional relationship and to explore common ground for clinical expectations from each other. No amount of policy around CCGs, clinical senates or networks can be a substitute for this.

References

1. Clinically-led commissioning—the Health and Social Care Bill. Department of Health. https://www.wp.dh.gov.uk/healthandcare/files/2011/10/B1-Clinically-led-commissioning.pdf

2. Department of Health. Equity and Excellence: Liberating the NHS. July 2010

3. Department of Health. Clinical Advice and Leadership: A report from the NHS Future Forum. June 2011

4. Department of Health. Government Response to the NHS Future Forum Report. July 2011

5. House of Commons. Health Committee-- Fourth Report: Commissioning. Session 2009-10.

6. Department of Health. Government response to the NHS Future Forum report: briefing notes on amendments to the Health and Social Care Bill. 27 June 2011.

7. Department of Health. Developing clinical senates and networks. Gateway Reference Number: 16614. 15 September 2011.

8. The Introduction of Managed Clinical Networks within the NHS in Scotland. 1999. The Scottish Office Department of Health.

9. Ham C, Curry N. Integrated Care. The King's Fund. 2011.

10. Integrated Healthcare: from aspiration to implementation. 2008. NHS Alliance.