Mid Staffordshire Public Inquiry Seminar on the role of commissioning in securing safety and quality in health care - 3 November 2011

NHS commissioning – learning from the past, reflections on the future.

Dr Judith Smith¹ and Natasha Curry²

This paper is based on the chapter ‘Commissioning’ by Judith Smith and Natasha Curry in Understanding New Labour’s Market Reforms of the English NHS³ and also draws on an expert paper prepared by Chris Newdick and Judith Smith as evidence for the Mid Staffordshire Public Inquiry The Structure and Organisation of the NHS⁴

Key points

- International evidence points to the challenging nature of commissioning in any health system – having to make decisions about how to allocate scarce resources in a way that can meet the health needs of a population.

- The English NHS has held faith for 20 years with a system based on separation of commissioners and providers, believing in the potential of commissioners to challenge providers and use contracts to bring about improvements in local services.

- Commissioning is difficult to evaluate, for it has been subject to regular restructuring, and is inevitably bound up with other health reforms such as the approach to payment of hospitals, patient choice, and the organisation of hospital care.

- Evidence suggests that all commissioning approaches struggle to make a significant or strategic impact on hospital care, in particular in relation to developing new models of care to address the rise in chronic illness within an ageing population.

- The available evidence points to the potential of primary care-led commissioning in respect of improving and extending primary and intermediate care, controlling prescribing costs, and making hospital care more responsive to patients’ needs.

- Current NHS reforms place significant faith in the potential of clinical commissioning groups to become the main statutory local health purchasers. However, these groups are likely to struggle to deliver the economic and health service changes required by 2015, and they will need significant support, guidance and skilled management from the new NHS Commissioning Board.

- It will fall to the new NHS Commissioning Board and health regulators (Monitor and the Care Quality Commission) to ensure that there is robust performance management of health providers, support for emerging clinical commissioning groups, and assurance of the quality of services funded by the NHS.

¹ Head of Policy, the Nuffield Trust for research and policy studies in health services, London
² Senior Fellow in Health Policy, the Nuffield Trust
³ Mays N, Dixon A and Jones L [eds] (2011) Understanding New Labour’s market reforms of the English NHS. London, the King’s Fund
Introduction
This paper has been written to inform the Mid Staffordshire Public Inquiry seminar on the role of commissioning in securing safety and quality in health care. We make a brief examination of the origins of NHS commissioning and then consider how this compares with international experience of strategic purchasing of health services. We then explore the different iterations of health commissioning in the English NHS over the past 20 years. This is followed by an overall assessment, drawing on research and policy analysis, of the balance sheet in respect of the performance of NHS commissioning, with a particular focus on its ability to secure and assure safety and quality of health services.

The paper concludes with an assessment of the Coalition Government’s proposals for reform of NHS commissioning in England, using the lessons from the past two decades to draw out the main challenges facing the new NHS Commissioning Board, clinical commissioning groups, and the wider health system.

What is commissioning?
Commissioning is the term used in the National Health Service (NHS) to describe the process of aligning resources to the health needs of a population (within a defined budget), putting in place cost-effective services to meet those needs, and monitoring the quality of services to ensure that they fulfil the standards set out in contracts.

The term ‘commissioning’ is specific to the English NHS, and used only rarely elsewhere to denote health planning and purchasing (apart from in relation to the planning of major capital developments). There is, however, academic analysis that distinguishes commissioning from purchasing or contracting. Such analysis suggests that commissioning has a more strategic and proactive intent, seeking to influence and shape what is offered by providers. Woodin explained the more strategic intent of NHS commissioning as follows:

‘A commissioner decides which services or health care interventions should be provided, who should provide them and how they should be paid for, and work closely with the provider implementing changes. A purchaser buys what is on offer or reimburses the provider on the basis of usage.’ (p203)

How far NHS commissioning has been able to enact this more proactive role and provide a real, constructive challenge to those organisations that provide health care has been the subject of considerable debate.

The origins of commissioning in the English NHS
The separation of commissioning (or purchasing) from provision, often referred to in the NHS as the purchaser-provider split, dates back to the Conservative government’s NHS internal market reforms of the early 1990s. The theory behind this separation is that those who fund and purchase care (the commissioners) can concentrate on assessing needs, planning services, and ensuring that an appropriate mix of services is available for a specific population. This split is predicated on a belief that health providers (hospitals, doctors, general practices, etc.) have greater knowledge about health services than those who use them. A dedicated commissioning function is intended to help overcome this asymmetry of information with the commissioner (e.g. primary care trust, GP commissioner) acting as an

---

agent for the patient or member of the public, deciding how best to spend taxpayers’ money to meet the local population’s health needs.

Commissioning is therefore fundamentally about challenging the self-interest of health service providers, and the taken-for-granted ways of doing things.

**Commissioning in the international context**

What the English call ‘commissioning’ is usually described as ‘strategic purchasing’ in other health systems such as the Netherlands and Germany, or ‘planning and funding’ in those countries that have abandoned the purchaser-provider split of an internal market and seek a more integrated approach, as in New Zealand or Scotland. What is common is a desire to lever change in the provision of services, and to try and align funding with needs. The distinctive nature of ‘commissioning’ is the intent of separating funding and planning from the provision of services.

Health commissioning is something that is regarded as being very difficult to do. In a review of the international evidence on health purchasing in 2000, Mays and Hands\(^8\) summed it up thus:

> ‘Purchasing health services is inherently difficult in publicly financed health systems since purchasers are continually faced with the multiple and frequently conflicting explicit and implicit expectations of politicians, central government officials, managers, clinicians, patients and the public for the health system.’ (pp30-31)

Likewise, a major review of health care purchasing in Europe\(^9\) found that there was significant diversity across European countries in how they organise health funding and planning, and noted that these varying approaches were a result of a complex interplay of historical, cultural and economic factors within individual countries. For example, some countries rely on national social insurance funds to purchase health care, others place this function within local or regional government, and others (like the NHS) establish specific health commissioning bodies within the publicly funded health system.

One of the conclusions from Figueras et al’s work was that there is no ‘one size fits all’ solution to health commissioning, for whilst some health care purchasing is best done at a local level (e.g. primary care and chronic disease management) other elements will require a regional or even national approach (e.g. very specialised hospital services, public health programmes such as ‘flu prevention). This need for ‘levels of commissioning’ was underlined in a review of the evidence on commissioning in the UK\(^10\). A ‘continuum of commissioning’ has emerged within the NHS and is set out at figure 1.

The task of allocating limited resources to different services in a way that can maximise the health of a specific population, and assure appropriate levels of care and patient satisfaction, is challenging yet important. Commissioning does not exist in isolation – it operates alongside (and within) the complex array of policy mechanisms within a health system.

---


In a review of international evidence on health care commissioning, Chris Ham\(^\text{11}\) (p7) underlined the complexity of health purchasing, and the way in which it is inextricably bound up with wider health system functions and reforms:

‘commissioning is only one element in the programme of health reforms and its impact will be affected by how other elements are taken forward. [...] much will hinge on providers having autonomy over their own affairs and the ability to respond rapidly to changing market conditions. Similarly, the impact of commissioners will be influenced by the payment systems that are in place, the strengths of the incentives contained within these payment systems, the arrangements for market management and regulation [...], and the degree to which politicians are willing to ‘let go’ and allow commissioners to exercise their leverage, even if the consequences are unpopular with the public.’

![Diagram of the continuum of commissioning](image)

A further problem for commissioning is that it tends to lack profile and legitimacy in the eyes of the public. It falls to commissioners to lead the process of developing health service strategy for a local area, and to take and be accountable for (potentially difficult) decisions about resources and services. However, in comparison with well-known health institutions such as hospitals, commissioners are typically invisible to the general public, and reported as ‘NHS bureaucrats’ in the media. Current plans to place family doctors at the centre of health commissioning are, in part, intended to overcome this anonymity of commissioners.

The evolution of NHS commissioning

1990-1997 – NHS purchasers under the Conservative Government

When the NHS market was established by the Conservative Government’s ‘Working for Patients’ reforms in 1990, the main purchasers were (a) health authorities whose role was to focus mainly on this planning and purchasing role (i.e. they did not also manage the provision of services such as hospitals, as they had done until 1990) and (b) GP fundholders. GP fundholders were family doctors who elected to take on a budget for buying a limited range of health services (e.g. outpatient visits and some common operations) on behalf of the patients registered with their general practice.

About 50% of GPs became GP fundholders, over the seven years of operation of the scheme. In parallel, many GPs formed different organisations from which they sought to influence the way in which NHS services were planned and purchased. Such arrangements included: locality or GP commissioning groups (typically constituted as sub-committees of health authorities); GP multifunds (organisations formed from collectives of GP fundholders); and total purchasing projects (a national set of pilot schemes where groups of GP practices were allocated a total health purchasing budget for their local population. Total purchasing projects were subject to a national evaluation study which reported in 1999.12

1998-2002 – health authorities and primary care groups

When a Labour Government was elected in 1997, its main NHS White Paper The New NHS – modern, dependable13 had the following to say about the purchaser-provider split:

‘The Government will retain the separation between the planning of hospital care and its provision. This is the best way to put into practice the new emphasis on improving health and on meeting the healthcare needs of the whole community. [...]’

At this stage, the 100 health authorities continued to be the main planner, funder and purchaser of care for their population (the commissioner). GP fundholding was abolished, although the Labour Government ‘went with the grain’ of primary care-led purchasing (i.e. GP fundholding and similar approaches) and set up a national system of 481 ‘primary care groups’, collectives of GP practices and other community health service providers who had some delegated responsibility from their health authority for elements of health planning and purchasing. With effect from 1999, primary care groups were put in place in the NHS, as sub-committees of health authorities. In 2000, the first PCTs were established, as free-standing commissioner-provider organisations.

2002-2006 – Shifting the Balance of Power towards PCTs

Just as PCTs were being set up within the NHS it became apparent, in 2001, that what had originally been set out in 1997 as a ten-year timescale for establishing PCTs was to become a much more condensed three-year trajectory. The publication of ‘Shifting the Balance of Power – Securing Delivery’14 signalled that all PCGs were to become PCTs in 2002 and that in doing so, all were to be established as statutory commissioning organisations, taking on a

range of responsibilities over and above those described for PCTs back in the 1997 White Paper. Additional responsibilities for post-2002 PCTs included: public health; partnership working with local authorities; holding the contracts for general practitioners, dentists, optometrists and community pharmacists; and all commissioning of health services. In ‘Shifting the Balance of Power’, the role of PCTs as commissioners was described as follows:

‘PCTs will become the lead NHS organisation in assessing need, planning and securing all health services, and improving health. They will forge new partnerships with local communities and lead the NHS work with local government and other partners.’

The new PCTs were at once commissioners, providers (of community health and other services), public health bodies, and responsible for primary care contracts.

2006-2010 – fewer and larger PCTs, and practice-based commissioning

In 2005, three years after the move to create 303 PCTs as the local commissioning bodies, a letter from the chief executive of the NHS to PCTs in July 2005 signalled another major change to the structure and functions of NHS commissioning. Commissioning a Patient-Led NHS\textsuperscript{15} called for: PCTs to be aligned with local authority boundaries; to reduce their management costs by 15%, to move away from being providers of services and instead focus on their commissioning role. This reform led to a reduction in the number of PCTs with effect from October 2006 (they merged down from 303 to 152), and a further disruption to the demand (commissioner) side of the NHS, just three years after a previous centrally imposed major reorganisation.

Practice-based commissioning was announced in October 2004 in a document entitled Practice Based Commissioning: Engaging Practices in Commissioning\textsuperscript{16} and was set out as being a logical next step beyond the 1997 White Paper and 2000 NHS Plan reforms which sought to ‘devolve more power to the frontline’. The logic for practice-based commissioning was claimed in relation to: patient choice (practices would be able to commission services more responsive to patient needs and from which patients could choose); the NHS funding system that would enable ‘money to follow patients’ as GPs helped patients choose which services to use; and the need to support people with long-term conditions, whose care GPs typically co-ordinate.

Practice-based commissioning was set up as a scheme whereby a practice or (more commonly) a group of practices could ask their PCT to delegate an indicative (not real) budget to them, with which they would then plan and commission a defined set of services for the population of patients registered with local GP practices. Whilst practice-based commissioning was voluntary for GPs, PCTs were required to put in place the framework and structures within which practice-based commissioning could develop.

Commissioning at the end of New Labour

At the end of the New Labour era in May 2010, there were 152 PCTs in the NHS in England, each having responsibility for improving the health of the local population by using public money to plan and purchase health services. They were regarded as the ‘NHS Local’\textsuperscript{17} and brought together the functions of their forerunner health authorities with those of primary

\textsuperscript{15} Department of Health (2005) Commissioning a Patient-Led NHS. London, Department of Health


care groups. PCTs had also assumed responsibility for managing community and other health services previously in the remit of community health services trusts. The PCT model was based on a belief that strong local commissioners would be able to assume financial risk for a defined geographic population, providing community health services and buying others.

In 2008/9 the NHS operating framework\textsuperscript{18} required all PCTs to create an internal separation of their commissioner and provider functions and to agree service level agreements with their provider arm on the same basis as all other providers. This was intended to improve PCT provider services (mainly community health care) through more robust purchaser challenge, and to enhance commissioning by giving PCTs the opportunity to focus on their commissioning activities.

**Weighing up the evidence on NHS commissioning**

*The ‘weakness’ of commissioning*

Research and commentary on the performance of NHS commissioning since 1991 asserts that it has struggled to be effective.\textsuperscript{19,20,21,22} In particular, the shortcomings in management capacity and capability relative to that of acute hospital providers have been noted\textsuperscript{23}, along with imbalances in power between relatively weak commissioners and more powerful providers, and the concomitant lack of impact by commissioners when seeking to shape the hospital sector and reduce avoidable use of acute and emergency care\textsuperscript{10, 22}.

An editorial in the British Medical Journal discussed whether practice-based commissioning was the ‘sick man of the [New Labour NHS] reforms\textsuperscript{24} and successive Audit Commission reports have pointed to a disappointing lack of progress by PCTs and practice-based commissioners. Furthermore, the House of Commons Health Committee inquiry into commissioning published in 2010 concluded\textsuperscript{25}:

‘...weaknesses remain 20 years after the introduction of the purchaser-provider split. Commissioners continue to be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers, particularly unevideanced variations in clinical practice.’ (p38)

It is clear that the narrative surrounding NHS commissioning has been one of weakness and of a relative failure to perform. A caution is however needed here, for commissioning has been subject to more analysis than parallel developments in the organisation of NHS


\textsuperscript{23} Walshe K and others (2004) Primary care trusts – premature reorganisation, with mergers, may be harmful’. British Medical Journal 329: 871-2


provider services, perhaps because of the relatively unique nature of NHS commissioning arrangements in the UK and international health policy context.

The nature of the evidence
Assessing and quantifying the impact of commissioning is difficult, not least because it is just one of a set of interdependent reforms. The plethora of reforms implemented in parallel with GP fundholding and purchasing in the 1990s, and PCTs and practice-based commissioning in the 2000s, make it difficult to attribute change to commissioning as opposed to other functions such as performance management, payment systems, or regulation. Furthermore, it can be hard to separate the contribution of the commissioner from that of the provider in any service improvement.

A critical factor in relation to any assessment of commissioning is that this element of the English NHS has been characterised by regular and profound structural change. During Labour’s time in office (1997-2010) each set of commissioning arrangements lasted only a few years, and this inhibited longitudinal evaluation. Many of the objectives of commissioning are however measurable only over the long term, the result being that where research has been carried out, it has necessarily focused on the structures and process, rather than the impact, of commissioning.26

There is relatively little robust research evidence about the performance of commissioning on which to draw, both in relation to the New Labour years when commissioning was regularly restructured, or the Conservative period before that when there was little political appetite for evaluation, albeit that some researchers did examine developments such as GP fundholding and total purchasing.

Commissioning in the 1990s

A major review7 of the internal market reforms of the 1990s concluded that commissioning failed to ‘pack a punch’ when the transaction costs of running a commissioning system were weighed against the evidence on performance. It suggested that this was due to ‘a ready economic answer: the incentives were too weak and the constraints were too strong.’ (p130)

Research into primary care-led commissioning in the 1990s (e.g. GP fundholding, locality commissioning, total purchasing) revealed that some progress was made in curbing the rise in emergency admissions and prescription drug costs, and in reducing waiting times for hospital treatment27282930. There was also evidence that two-thirds of total purchasing projects were able to make a significant reduction in length of hospital stay compared with health authorities12. GP fundholders reduced elective admissions to hospital by an average of 3.3%31 and total purchasers by 13%12.

There were however also problems. GP fundholders had high transaction costs relative to larger population-based organisations such as health authorities, practices were too small to

take on significant budgetary risk, they were largely unable to tackle the entrenched interests of hospitals, and there were worrying conflicts of interest as GPs were able to re-route funds for NHS care into their primary care businesses. A review of the evidence on primary care-led commissioning carried out in 2004 (when policy makers were planning the introduction of practice-based commissioning) concluded the following:

**Figure 2: Review of the evidence on primary care-led commissioning – conclusions**

Where clinicians have clear influence over budgets, they can secure improvements in the responsiveness of health services and change the place of care.

Primary care-led commissioning makes its greatest impact in primary and intermediate care services and can bring about changes to prescribing practice in general practice.

There is little evidence to show that any commissioning approach has been able to make a significant or strategic impact on secondary care services.

Primary care-led commissioning increases transaction costs in commissioning.

Primary care-led commissioners struggle to involve patients and the public in their decision-making processes.

There is no ideal size of commissioning organisation – it depends on the nature of the service being funded and the size population for whom care is purchased.

Highly determined managers and clinicians can use their commissioning power to bring about new models of care, but they will struggle to shift resources to match this.

*Source: Smith et al, 2004*

**Impact of commissioning in the 2000s**

As described earlier, the two main commissioning mechanisms during the Labour years were PCT commissioning and practice-based commissioning (PBC). In assessing the effectiveness of commissioning during this period, it is important to take into account the inter-related nature of health reforms and the inherent difficulty in ascribing outcomes to specific policy interventions. The complexity of measuring the impact of commissioning during this decade has been further frustrated by regular reorganisations of the NHS in England which have made longitudinal studies of commissioning achievements and outcomes near impossible.

Where research has been carried out, evidence points to limited impact. Assessments of PCT performance found that the majority of PCTs were poor or mediocre in respect of the competencies established for world class commissioning. Although PCTs can claim some achievement (e.g. securing financial balance in 2006 and working with providers to reduce waiting times), they largely failed to make significant shifts of care out of hospital and into the

---

community and failed to reduce demand, decommission services or mitigate the impact of the wider determinants of health\textsuperscript{25}.

A key criticism of PCTs is that they had weak accountability to the public. Although PCT commissioning was intended, amongst other things, to improve the responsiveness of services to the needs of patients, the public actually had very little leverage over the local health service provided or commissioned by them\textsuperscript{35}. A survey of the general public revealed that half did not know what a PCT was and three-quarters could not name their local PCT\textsuperscript{36}. It is, therefore, unsurprising that many PCTs struggled to involve patients in commissioning\textsuperscript{37}. Another key function of PCTs was to facilitate patient choice. Although PCTs made a slow start in this area (in 2007, 70 per cent of PCTs had failed to meet the patient choice target\textsuperscript{38}), performance improved over subsequent years\textsuperscript{39}. However, as PCTs started to come under pressure to reduce referrals to secondary care, many introduced referral management centres which some felt was at odds with their duty to promote patient choice\textsuperscript{40}.

Despite this rather bleak picture of PCT performance, there is evidence that PCTs were making steady improvements in more recent years. Evidence from the Audit Commission, Care Quality Commission, National Audit Office and Department of Health World Class Commissioning Directorate suggested that PCTs were ‘upping their game’ by 2009/10, making some achievements and demonstrating enhanced capacity as commissioners. World Class commissioning scores also suggested that PCTs were making improvements in a number of domains\textsuperscript{34}. In addition, tentative evidence about PCT commissioning points to systematic and potentially important changes to patient care\textsuperscript{41} and analysis of case studies in innovative commissioning\textsuperscript{42} shows how some (albeit an apparently small minority of) PCTs and practice-based commissioners were able to reshape services to better meet local needs.

Practice-based commissioning was the other key commissioning mechanism during this period – introduced in 2005. Given the current policy focus on GPs as commissioners, it is important to examine this body of research evidence alongside that for PCTs.

Practice-based commissioning was slow to take root and has since been superseded by the Coalition government’s set of reforms so there has been little opportunity to establish a solid body of evidence around its impact. The evidence that does exist suggests there was variability in the capability and capacity of practice-based commissioners, indicating a mixed picture of achievement and impact across the country\textsuperscript{43,44}. Where change was attributed to

\textsuperscript{42} Ham C, Smith JA and Eastmure E (2011) Commissioning integrated care in a liberated NHS. London, the Nuffield Trust
PBC, the focus tended to be on the re-provision of services that commissioners were able to do themselves rather than on commissioning strategic change to meet the needs of their populations. This focus on provision was not without some benefits for patients; PBC resulted in some extended primary care and saw the shift of some diagnostic services from hospitals into GP surgeries. In the main, PBC failed to become a driver for large-scale strategic change and, like their PCT counterparts, practice-based commissioners failed to redress the imbalance of power between primary and secondary care and struggled to shift resources away from acute care. Practice based commissioners cited a lack of real incentives to get involved in strategic decision-making and many blamed a lack of time and skills to really embrace it.

Evidence about the impact of PBC on the responsiveness of care is extremely limited. Self-assessment reveals that GPs felt that PBC had enabled them to improve access and patient experience and to extend patient choice. However, case study research suggested that, in some cases, existing initiatives were rebadged as PBC-related. There is little evidence about patient and public involvement within PBC; whilst practice based commissioners were required to make plans available for public scrutiny, there was no specific requirement for them to involve or engage patients in commissioning decisions.

**Figure 3: Review of the evidence on PCT and practice-based commissioning – conclusions**

- PCTs and practice-based commissioners were largely unable to mitigate the impact of wider determinants of health.
- PCTs and practice-based commissioners failed to make significant shifts of care out of hospital, did not reduce demand and failed to decommission services to any significant extent.
- Commissioning during the 2000s did not redress the imbalance of power between primary and secondary care.
- Practice-based commissioning resulted in some extended primary care but few GPs engaged actively in large-scale strategic change.
- PCTs’ performance steadily improved over their latter years.
- A key weakness of PCTs was their lack of public accountability and visibility.
- Practice-based commissioners and PCTs struggled to involve patients in commissioning.

**Interpreting the evidence**

The critical question left unanswered by reviews of evidence on commissioning is why so few commissioners appear able to make the significant changes expected of them and whether the costs of running a commissioning system have been worth the limited results, as measured by research evidence. It should be noted that the Health Select Committee

---

Inquiry into commissioning in 2010\textsuperscript{47} was unequivocal in its view that commissioning had not indeed been worth this investment.

Possible reasons for the underperformance of commissioning in the NHS in England in the last decade include\textsuperscript{48}:

- PCTs’ lack of autonomy rendered them risk-averse and unable to challenge more powerful providers which had greater financial freedom. Foundation trusts are able to carry surpluses and deficits from year to year, facilitating long-term planning. PCTs, in contrast, had to break-even annually.

- The misalignment of financial risks and incentives meant that PCTs carried financial responsibility for referral decisions over which they had little control and this exacerbated their tendency to be risk-averse.\textsuperscript{19}

- The voluntary nature of GP engagement in PCT commissioning put PCTs at a disadvantage when negotiating with providers, where clinical engagement and leadership were strongly embedded\textsuperscript{49}. Practice-based commissioning went some way to strengthening clinical engagement in commissioning, but failed to provide PCTs with sufficient clinical legitimacy to be able to challenge powerful providers. It also failed to secure specialist input into commissioning.

- PCTs generally lacked sufficiently skilled and experienced commissioning staff, and this was compounded by regular reorganisations of commissioning bodies\textsuperscript{19}.

- Many GPs felt they lacked the skills and time to undertake commissioning\textsuperscript{50},

- The lack of real budgets meant that the incentives for GPs to engage in active practice-based commissioning were weak\textsuperscript{43}.

- Commissioners had limited access to detailed information about referrals and lacked the ability to perform complex analysis of the data that were available to them. This limited commissioners’ capacity to challenge billing by providers and to take strategic decisions.

- The dominant hospital payment regime (Payment by Results) rewarded providers on a per case basis, potentially acting as a powerful incentive to maximise activity. Commissioners appeared powerless to counteract this.

Some of these barriers to effective commissioning should be tackled in the next round of reforms but others will remain (see next section). Unless these barriers to effective commissioning are addressed, it is likely that new clinical commissioning groups may also find it hard to move beyond primary care developments to tackle the ‘big ticket’ items of long-term conditions, urgent care, and care for people nearing the end of their life. It will also be


\textsuperscript{49} Spurgeon P, Clark J and Ham C (2011) Medical leadership: from the dark side to centre stage. Milton Keynes, Radcliffe Publishing

\textsuperscript{50} Wood J and Curry N (2009) PBC – two years on: moving forward and making a difference. London, the King’s Fund
a challenge for them to engage specialist colleagues (clinicians and managers) in redesigning and changing services.

At the end of the Labour years, incremental policy change was looking unlikely to deliver results and it was looking inevitable that more decisive steps were needed to energise the general practice part of the commissioning continuum. It was not therefore surprising that the incoming Coalition Government chose to focus on reform of commissioning as part of its wider plans for the NHS.

Proposals for NHS commissioning in England from 2013

Clinical commissioning groups

The NHS White Paper *Equity and Excellence: Liberating the NHS* published by the Coalition Government in July 2010 had the reform of NHS commissioning as a core element. It proposed that all 150 primary care trusts in England (the current statutory local funders and commissioners of health care) be abolished in April 2012 and that new clinical commissioning consortia – later changed to clinical commissioning groups (CCGs) comprising of GPs and other health professionals - put in their place.

These new groups are to take full responsibility for both the clinical and financial outcomes of their referral and commissioning decisions, and become the local statutory commissioners of NHS care, being responsible for over 60% of NHS resource and the outcomes associated with its expenditure. The intention is that these CCGs will bring about stronger clinical engagement in NHS commissioning, being predicated on the idea that family doctors are well placed to act as agent of the patient and make sound decisions about the services that are funded and provided for a local population. It is also hoped that there will be improved alignment of financial risks and incentives, and reduced levels of bureaucracy, addressing two of the core criticisms often levelled at PCTs.

The proposals for CCGs have subsequently been modified during the parliamentary process (it should be noted that the Health and Social Care Bill is still making its way through parliament and as such the proposals are as yet to be enacted in legislation) and the plan is now for CCGs to assume commissioning rights from April 2013. There is to be a process of authorising CCGs as fit and ready for commissioning, led by a new NHS Commissioning Board.

NHS Commissioning Board

The second main change to NHS commissioning proposed by the 2010 white paper is the establishment of an NHS Commissioning Board as an independent body at arm's length from government. The NHSCB is to guide the development of the new commissioning system and then act as its headquarters. The NHSCB is to be based in Leeds, and its chief executive designate is Sir David Nicholson, current chief executive of the NHS.

Guidance on the development of the NHSCB sets out its role as follows:

> 'the Government proposes establishing an NHS Commissioning Board whose role will include supporting, developing and holding to account an effective and comprehensive system of clinical commissioning groups.' (p5)

---

51 Department of Health (2011) Developing clinical commissioning groups: towards authorisation. London, Department of Health

52 Department of Health (2011) Developing the NHS Commissioning Board. London, Department of Health
As well as ‘ensuring that the whole [commissioning] architecture is cohesive, coordinated and efficient’ (op cit, p6) the NHSCB will undertake a significant amount of direct commissioning, including specialised services (care for conditions such as rare cancers, transplant surgery, and burns) and primary care (contracting with GPs, community pharmacists, optometrists and dentists). In this way, the NHSCB will have a dual role as architect/guardian of the commissioning system, and as the commissioner of two major areas of health care.

The NHSCB will also host clinical networks that will advise on specific areas of care, such as cancer, or maternity services. Furthermore, clinical senates (new entities comprised of a range of clinical professionals) will be based with the NHSCB. These senates are intended to provide clinical advice and expertise to the new commissioning system and further detail on their role and functions is awaited.

**NHS outcomes framework**

The NHSCB will hold clinical commissioning groups to account for their performance in relation to a new NHS outcomes framework. This will cover five domains:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover following episodes of ill-health or after injury
- ensuring that people have a positive experience of care; and
- treating and caring for people in a safe environment and protecting them from avoidable harm.

A set of indicators will be developed for each of these domains, and the performance of NHSCB and CCG commissioning will be measured against these indicators. The NHSCB talks about its role in assuring consistency and avoiding centralisation, along with promoting the NHS Constitution and helping local commissioners implement agreed national standards (including those from the National Institute of Health and Clinical Excellence - NICE), and addressing health inequalities. This role in assuring national standards is summed up as follows:

> 'The Board can promote national consistency in the way that it conducts its direct activities and through its relationship with clinical commissioning groups. The way that clinical commissioning groups are supported, developed and held to account can be used to ensure that national standards are achieved and national accountabilities are discharged.' (op cit p9)

Of particular relevance to the Mid-Staffordshire Inquiry is the role of the NHSCB in 'leadership for a patient-centred system'. The Board describes itself as being a 'champion for patients and their interests.' (op cit, p9) How far it will be able to achieve this within the wider context of reforms to the NHS is explored later in this paper. It also spells out a core function as being 'to support quality improvement by promoting consistent national Quality Standards' and 'to promote innovative ways of demonstrating how care can be made more integrated for patients'.

**Commentary on the new commissioning arrangements**

GP commissioning is something of a minority sport internationally, with few countries having been as bold as the UK (or latterly England) in placing core strategic health purchasing responsibility into the hands of family (or indeed other) doctors. This minority sport has been variously played in the UK as: GP fundholding; GP commissioning; locality commissioning; total purchasing pilots; primary care groups and trusts; practice-based commissioning; and
now GP commissioning (in its latest version). It is however now moving centre-stage, as clinical commissioning groups become 'NHS local'.

Clinical commissioning groups have significant similarities with GP fundholding of the 1990s, and in particular with total purchasing projects, but their compulsory, territorial (i.e. relating to a geographical population more than to general practices) nature, together with holding wider and real budgets makes them different, as does the statutory nature of the organisations and their form.

Advantages
A number of advantages may accrue from the move to a clinically-led commissioning system:

- In comparison with their predecessor commissioning bodies, CCGs have the potential to use their combination of financial and clinical 'clout' to design and put in place new forms of care that meet the needs of local people. For example, they may redesign out-of-hours general practice, 24-hour home nursing care, urgent care assessment in local hospitals, and the role of the local ambulance services, as a way of reducing inappropriate admissions to hospital and enabling people to be cared for at home wherever possible.

- It is possible that GP commissioners will develop standing and influence with hospital consultants and managers in a way that was more difficult for the former PCTs, helping to address the power imbalance that bedevils commissioning. This will be enhanced by CCGs holding real and extensive budgets - the lack of real budgets was perceived as a significant impediment to progress by practice-based commissioners over the period 2005-2010.

- Furthermore, clinical commissioners, with their particular insight into local health needs and provision, will be well placed to shape new forms of care that is better integrated across organisations and sectors, and to influence their primary and community health colleagues to work within such reshaped services.

- There is potential for much greater local accountability and visibility of commissioning within the new system. Clinical commissioners will be fully accountable for the health outcomes of the local population, patient experience of services funded by the CCG, and financial performance of the CCG. This brings the accountability of commissioning into sharp relief, and the use of an NHS Outcomes Framework to underpin this is a significant (and not sufficiently discussed) development. Healthwatch, the local health and wellbeing board, and the NHSCB will have a clear framework against which to assess the performance of CCGs.

Risks
The policy of moving GP commissioning centre-stage is not however without its risks, and research evidence is useful in highlighting where such risks are likely to lie. The assessment of research evidence set out in this paper suggests the following challenges for clinical commissioners:

- CCGs may struggle with being statutory bodies, for research shows that primary care commissioning organisations have stronger clinical (and in particular medical) engagement where they are literally (or metaphorically) owned by local GPs, rather than by 'the state'.

• CCGs will need to develop robust methods of engaging with and involving a wider range of stakeholders in their commissioning, including: local people; Healthwatch; patients; GPs and practice staff; community health staff; hospital and other NHS providers; local councillors and the health and wellbeing board; clinical senates the regional/local arm of the NHS Commissioning Board; and the regulators Monitor and the Care Quality Commission.

• The governance arrangements being developed and extended for CCGs as reform proposals make their way through parliament are highly complex, with groups likely to work with and account to: the NHS Commissioning Board, local health and wellbeing boards, clinical networks; clinical senates; Healthwatch; Monitor; and the Care Quality Commission. These potentially competing and overlapping accountabilities may stunt the work of CCGs, or risk overwhelming them.

• It will be a real challenge for CCGs to make a significant or strategic impact on acute secondary care, and to lever changes to services that are underpinned by shifts in resource across health organisations. This will be particularly difficult at a time of constrained NHS and social care funding, when decisions about investment in one service are likely to necessitate disinvestments (and hence possible service closures) elsewhere.

• It will take time for new organisations to develop and gain expertise, and they will have limited resources with which to buy or develop management and analytical support for commissioning, as the NHS seeks to reduce management costs by some 40%.

• CCGs will need to work out how best to relate to the new NHS Commissioning Board, and ensure that they can negotiate an appropriate degree of local freedom to commission according to local needs, whilst ensuring that they meet NHSCB standards in terms of quality, consistency and expenditure.

• Related to the previous point, CCGs will have to work out what services they will commission independently, which they will commission in clusters of CCGs, and what they will 'block back' to the NHS Commissioning Board as being specialised. This will entail detailed work about financial and service risk, and will form part of the authorisation process of CCGs that is to be led by the NHS Commissioning Board.

• CCGs will need to work closely with the NHS Commissioning Board to determine how best to commission and influence local primary care services, given that these will be commissioned by the NHSCB yet will be crucial to the development of new forms of care within CCG areas. Careful thought needs to be given to this, for the oversight of primary care provider performance will be apparently split between CCGs and the NHSCB.

It remains uncertain whether the new arrangements will achieve their intended aims, and it is unclear whether CCGs will offer more of a challenge to dominant providers (especially hospitals) than did their predecessor primary care trusts, primary care groups, and health authorities. It is also uncertain whether CCGs will be more effective at shifting care out of hospitals, avoiding in appropriate unscheduled care, and providing more efficient models of care for people with long-term conditions.

The Nuffield Trust John Fry Fellow for 2010-2011, Professor Lawrence Casalino of Weill Cornell Medical College in the United States, studied the policy of clinical commissioning
during his fellowship in 2010, and published a monograph\textsuperscript{53} in which he made ten suggestions for the successful implementation of GP commissioning in the English NHS. These suggestions are set out in figure 4 below.

<table>
<thead>
<tr>
<th>Box 4: Ten suggestions from the United States for clinical commissioning in the NHS in England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GP commissioning consortia and NHS policy makers should seek to learn from US independent practice associations.</td>
</tr>
<tr>
<td>2. To succeed, clinical commissioning groups will have to invest heavily in leadership, management and infrastructure.</td>
</tr>
<tr>
<td>3. Provide training to GP leaders.</td>
</tr>
<tr>
<td>5. Incentives for CCGs to generate cost savings for the NHS should neither be excessively strong, nor excessively weak. CCGs should have the ability to use meaningful incentives for their member practices.</td>
</tr>
<tr>
<td>6. The consequences for poorly performing CCGs should be made clear in advance and should be consistently enforced.</td>
</tr>
<tr>
<td>7. To the extent possible, minimise the 'insurance risk' that CCGs bear.</td>
</tr>
<tr>
<td>8. Either 'real' or 'virtual' budgets can work, but details matter.</td>
</tr>
<tr>
<td>9. Encourage hospitals and specialist physicians to cooperate with CCGs and remove barriers to cooperation.</td>
</tr>
<tr>
<td>10. Assume that, even if the NHS creates perfect incentives, it is likely to take many years for most CCGs to become highly competent.</td>
</tr>
</tbody>
</table>

\textit{The Commissioning Board and the wider NHS}

For the NHS Commissioning Board, there is a profound challenge in terms of how far it will 'hold on or let go' in its relationship with CCGs. In other words, will it operate as a force for centralisation and national control, or be more of a supportive, enabling and yet accountable body which provides assurance to the overall NHS and its taxpayer funders? How the NHSCB crafts its operational arrangements, and how it works with different parts of the health and social care system, will be critical.

Indeed, commissioning reforms cannot take place in a vacuum. Changes to the Payment by Results system of funding hospitals, revisions to the incentives for different providers to work together across care pathways (including any changes to the GP contract), and the way in which policy on competition and choice is enacted, will all influence the scope and power of commissioners.

It will fall to the NHSCB to determine the fitness of CCGs to commission (as assessed through the authorisation process) and to carry out commissioning on behalf of those groups not deemed to be ready. This suggests that the NHSCB will need to be of a scope and

\textsuperscript{53} Casalino L (2011) GP commissioning in the NHS in England: ten suggestions from the United States. London, the Nuffield Trust
size to have a regional presence and local knowledge, something that adds to the challenge of ensuring an appropriate balance between 'holding on and letting go'.

The NHSCB will also have a role in ensuring that adequate managerial and technical support is available to local commissioners, and will need to adapt the role and functions of PCT clusters as they develop CCGs, 'let them go' and ensure they can access the expertise they need to carry out their functions.

The Board will also set budgets for CCGs, decide what degree of financial and service risk each group can handle, determine a framework within which funding priorities are made, hold groups to account against the NHS Outcomes Framework, and account to parliament for overall NHS performance. The Board will therefore be a significant public body, with high visibility.

It was not always clear as to whether PCTs and practice-based commissioners were accountable for the quality of services provided by those organisations funded through commissioning. However, the clarity provided by the new NHS Outcomes Framework is striking. CCGs will be held to account for the quality and outcomes of local health services. What is less clear is how CCGs will relate to the regulators (Monitor and the Care Quality Commission), public involvement bodies (Healthwatch), and joint commissioning arrangements (local health and wellbeing board) alongside their formal accountability to the NHSCB. A question that is yet to be fully answered in respect of the new commissioning arrangements is one of core significance to the Mid-Staffordshire Inquiry. Namely, how will an individual NHS provider (whether an NHS trust, an NHS foundation trust, a GP practice, an independent or voluntary sector provider) be held to account for the quality of care it delivers, and which body will be mandated to assess provider performance in the round, and take action where there are failings?

Conclusion
The proposed reforms of the English NHS may overcome some of the issues that held back commissioning under primary care trusts and practice-based commissioning. It should however be acknowledged that clinical commissioning groups will be operating in a potentially very different system from that of their predecessors. GPs will be managing real budgets, competing for patients, and accounting to the public and patients for health care rationing decisions. Furthermore, GPs will be taking on these responsibilities at a time of unprecedented financial constraint. The question remains whether they will be able to meet the tough financial challenges while also grappling with their new roles.

Perhaps the most profound question is whether the government will be patient enough to allow the reforms time to work. History is not encouraging here, for successive reorganisations of commissioning structures have impacted on commissioners' ability to bring about real change.

Too often over the past 20 years, commissioning appears to have been blamed for being the weak link in the NHS system, despite the international recognition of it being a difficult task to perform. The challenge for the next phase of NHS reform is for the NHS Commissioning Board, Monitor and the Care Quality Commission to work together with the leaders of clinical commissioning groups in crafting performance management arrangements that can both assure the quality of care for patients, and support commissioners in working with providers to take action where such care falls short.

Judith Smith and Natasha Curry

The Nuffield Trust, London
1 November 2011