3 Commissioning

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Commissioning is the term used in the National Health Service (NHS) to describe what, in other health systems, is usually known as 'strategic purchasing' or 'planning and funding'. It is concerned with decision-making about the health needs of a population, the services that might be provided to meet those needs, the allocation of resources to organisations or practitioners who can deliver such services, and the monitoring 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 (eg, Ovretveit 1995) 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 health providers.

Woodin explained the more proactive and strategic intent of NHS commissioning as follows.

> *Commissioning is a term used most in the UK context and tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or health care interventions should be provided, who should provide them and how they should be paid for, and may work closely with the provider in implementing changes. A purchaser buys what is on offer or reimburses the provider on the basis of usage.* (Woodin 2006, p 203)

How far NHS commissioning in England 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.

This chapter uses research evidence to set out the balance sheet in respect of the performance of NHS commissioning under New Labour. We examine the development and implementation of NHS commissioning policy over the period 1997–2010, exploring the reasons for different attempts to strengthen commissioning, and assessing the impact of these changes in relation to equity, effectiveness, efficiency and responsiveness.

We root our analysis within the spectrum of commissioning from the individual (personal budgets and patient choice) to the national (highly specialised commissioning). We focus on commissioning by primary care trusts (PCTs) and practice-based commissioners because these were the two main forms of commissioning during the Labour years with responsibility for the majority of NHS resources.

The chapter concludes with a discussion of the lessons to be learned from the experience of NHS commissioning from 1997 to 2010 and reflects on what this means for the next phase of NHS reforms.

The purchaser–provider split

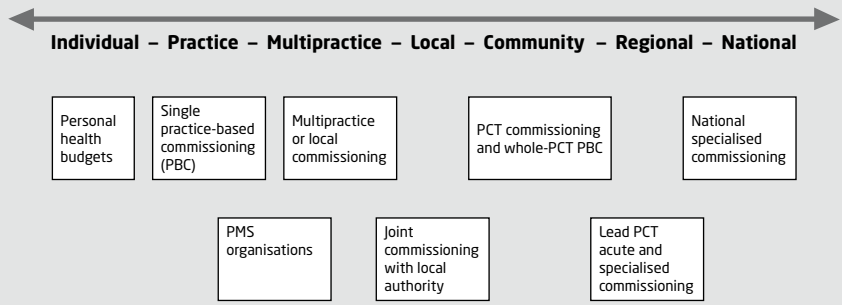
The separation of commissioning (or purchasing) from provision, often referred to in the NHS as the purchaser–provider split, dates back to the Conservative government's NHS reforms in the early 1990s. The theory behind this separation is that those who fund and purchase care (the commissioners) can concentrate on assessing needs, planning services, and ensuring that an appropriate mix of services is available for a specific population (Le Grand *et al* 1998). 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 (eg, the PCT) acting as an agent for the patient or member of the public.

Commissioning in the international context

Health care commissioning is something that is regarded as being very difficult to do. In a review of the international evidence on health care purchasing in 2000, Mays and Hand 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' (Mays and Hand 2000, pp 30–1).

Likewise, a major review of health care purchasing in Europe (Figueras *et al* 2005) found a significant diversity across European countries in how health funding and planning was organised, and noted that these varying approaches were the 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.

Figure 3 The continuum of commissioning at the end of the New Labour years



Source: Smith *et al* 2004 (adapted)

PCT, primary care trust; PMS, personal medical services

While some health care purchasing is best done at a local level (eg, primary care and chronic disease management), other elements will require a regional or even national approach (eg, very specialised hospital services and public health programmes such as flu prevention). There is no 'one size fits all' approach, but rather a need for 'levels of commissioning' (Smith *et al* 2004, p 22). A 'continuum of commissioning' (Smith *et al* 2004, p 5) has emerged within the NHS (*see* Figure 3 above).

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 and yet important. Commissioning does not exist in isolation – it operates alongside (and within) the complex array of policy mechanisms within a health system.

Implementation

There were two main approaches to commissioning in the NHS under New Labour:

- commissioning by PCTs
- practice-based commissioning.

We examine both in more detail below.

Commissioning by PCTs

PCTs, the 303 statutory bodies (reduced to 152 in 2006) with responsibility for improving the health of the local population by using public money to plan and purchase health services, began to form from 2000 onwards. They covered all of England by 2002, following implementation of *Shifting the Balance of Power Within the NHS – Securing Delivery* (Department of Health 2001b).

They were regarded as the 'NHS Local' (Wade *et al* 2006, p 6) and brought together the functions of their forerunner health authorities (ie, public health, resource allocation, planning, purchasing, service review, primary care contracting) with those of primary care groups (ie, primary care-led purchasing, local planning, clinical governance in primary care). PCTs also assumed responsibility for managing community and other health services previously in the remit of NHS community health service trusts. The PCT model was predicated 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 other services.

In 2008/9, the NHS operating framework (Department of Health 2007b) 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 separation was intended both to improve PCT provider services through more robust purchaser challenge, and to enhance commissioning by giving PCTs the opportunity to focus on their commissioning activities.

In late 2007, the Department of Health introduced world class commissioning (WCC), an initiative intended to bring about a step-change in the commissioning capacity and capability of PCTs. WCC set out a number of competencies that PCTs were expected to achieve (*see* Box 1 overleaf). PCTs' performance was measured against these competencies in order to track – and encourage – progress. PCTs completed the ratings process for two years (2008/9 and 2009/10). In each year, PCTs were scored for each competency. In 2009/10, an extra competency was added bringing the total to 11, and PCTs were also scored for three areas of governance (board, strategy and finance). In addition, a tougher assessment standard was used in the second year (NHS Confederation 2010).

Practice-based commissioning

The second approach to commissioning was practice-based commissioning (PBC) introduced in 2005 (Crisp 2005). Forerunners included GP fundholding, locality purchasing, and total purchasing in the 1990s (*see* Le Grand *et al* 1998 for a summary of the evidence on their performance), and GP commissioning and primary care groups in the early 2000s (*see* Dowling and Glendinning 2003; Smith and Goodwin 2006 for an overview).

PBC was set up as a voluntary scheme for GPs in which 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 their practices. Practice-based commissioners were, subject to the approval of the local PCT, able to keep financial savings in order to develop other local services and could pay themselves to provide such services, or buy them from other providers. This ability to 'make or buy' has been a feature of most forms of primary care-led commissioning in

Box 1 The 11 WCC competencies

The Department of Health document described the WCC competencies by means of a series of 11 headlines. These required commissioners to:

1. be recognised as the local leader of the NHS
2. work collaboratively with community partners to commission services that optimise health gains and reduce inequalities
3. seek and build meaningful engagement with the public and patients in a proactive manner in order to shape services and improve health
4. lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. manage knowledge and undertake robust and regular needs assessments to establish a full understanding of current and future health needs and requirements
6. prioritise investment according to the local needs, service requirements and values of the NHS
7. stimulate the market effectively so as to meet demand and secure the required clinical, health and well-being outcomes
8. promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. secure procurement skills that ensure robust and viable contracts
10. manage systems effectively and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. make sound financial investments to ensure sustainable development and value for money (2009/10 only).

Source: adapted from Department of Health 2007d

the NHS to date and has been regarded as offering the potential for GPs to scope new forms of better integrated services (Smith *et al* 2009; Lewis *et al* 2010; Smith *et al* 2010).

PBC took a range of forms (eg, individual practices, consortia of practices, social enterprise organisations), and research in 2009 (Wood and Curry, 2009) revealed that 30 per cent of practice-based commissioners were part of a cluster that had set itself up as a formal organisation. Evidence on the effectiveness of PBC is, however, equivocal, as we shall see in the next section of this chapter.

Impact

The 'weakness' of commissioning

Critique of commissioning under New Labour typically asserts that it was weak and failed to become a major driver of improvement in the NHS. An editorial in the *British Medical Journal* discussed whether PBC was the 'sick man of the reforms' (Lewis *et al* 2007, p 1168), successive Audit Commission reports have pointed to a disappointing lack of progress by both PCTs and PBC, and the House of Commons Health Committee inquiry into commissioning published in March 2010 concluded: '… 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 unevidenced variations in clinical practice' (House of Commons Health Committee 2010a, p 38).

The challenge of evaluating NHS commissioning

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 PCTs and PBC make it difficult to attribute change to commissioning as opposed to other functions, such as performance management, payment systems or regulation. In addition, it can be difficult to separate the contribution of the commissioner from that of the provider in any service improvement.

Furthermore, the development of commissioning in the English NHS has been characterised by regular structural change. During Labour's time in office, each set of commissioning arrangements (eg, primary care groups and health authorities, small PCTs, larger PCTs with PBC) lasted only a few years, which inhibited longitudinal evaluation. Many of the objectives of health 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.

The result is that there is relatively little robust research evidence about the performance of commissioning on which to draw. Evaluations of commissioning during the 1990s were found to be similarly problematic (*see* Le Grand *et al* 1998; Mays *et al* 2001; Smith and Goodwin 2006), although the localised or pilot nature of some of those reforms (such as GP fundholding and total purchasing) offered the possibility for some analysis comparing populations served by fundholders and those not.

The section below draws together the evidence there is on the impact of commissioning over the period 1997–2010.

Equity

A core role of NHS commissioners is to assess health needs and commission services to meet those needs. This involves ensuring equity of provision and access to services for the local population. Indeed, the NHS Plan stated that PCTs would 'identify and maintain registers of those at the greatest risk from serious illness – concentrating particularly on areas where ill health is most prevalent – so that people can be offered preventive treatment. In the process the NHS will help tackle health inequalities' (Department of Health 2000b, p 18).

PCT commissioning and equity

The publication of *Shifting the Balance of Power Within the NHS* (Department of Health 2001b) signalled the devolution of new responsibilities for health improvement to PCTs. PCTs were given responsibility for 'assessing the health needs of their local community and preparing plans for health improvement which recognise the diversity of local needs' (Department of Health 2001b, p 13).

In later policy documents, PCTs, especially in their role as commissioners, were described as 'the most powerful agent to reduce health inequalities' (Department of Health 2008a, p 65). In this role, PCTs were required to undertake 'health equity audits' to identify how fairly services or other resources were distributed compared with needs in a particular area in order to identify priorities (Department of Health 2003b, p 41). They were also required to produce health improvement plans that outlined and co-ordinated activity to improve health and reduce inequalities within a local population. These plans were driven by a number of national public service agreement (PSA) targets designed to reduce health inequalities (*see* Box 2 below).

Box 2 Key PSA inequalities targets

The government's aim to reduce health inequalities was supported by a national PSA target:

- by 2010, to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth

The PSA target was underpinned by two more detailed objectives:

- starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole
- starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

Source: Department of Health 2003b

In an attempt to focus effort on the most disadvantaged communities, a number of so-called spearhead PCTs were identified in 2004. Spearhead PCTs were the most deprived 20 per cent of areas in England with the poorest health indicators. A new funding formula was introduced that placed more emphasis on inequalities, and a National Support Team for Health Inequalities was established in 2007 to support local partners to reduce inequalities through evidence-based commissioning according to need rather than historic patterns (Department of Health 2008a).

A review of spearhead PCTs found that only 11 per cent were on track to meet the 2010 life expectancy target, although some other targets had been hit (eg, to reduce inequalities in cardiovascular and cancer mortality) (Pears 2009). This research concluded that spearhead PCTs had largely failed to narrow inequalities gaps, partly because commissioning arrangements encouraged a focus on annual operational targets and financial balance rather than on preventive public health. This is consistent with evidence from the 1990s that found that health authority commissioners appeared to focus on cost and activity levels rather than equity considerations, largely because of the financial imperative of contracting (Majeed *et al* 1994). In addition, the impact of the commissioning levers that were meant to be exclusively available to spearhead PCTs (ie, the additional intelligence provided by the National Support Team and Health Inequalities Intervention Tool), was lessened when these tools were made available nationally (Pears 2009).

A review of the performance of the NHS under New Labour reported that health inequalities had widened (Thorlby and Maybin 2010), and a review commissioned by the Labour government found that people living in the poorest neighbourhoods in England died, on average, seven years earlier than people in the richest (Marmot 2010). Although this review acknowledged that it was not simply access to health care that had led to such inequality and that wider determinants of health were important, it did suggest that commissioners should be doing better in procuring services 'that prevent or ameliorate the health damage caused by living… in disadvantaged circumstances' (Marmot 2010, p 154).

In 2009, a Department of Health review of health inequalities, found that despite an increase in overall life expectancy and a fall in infant mortality, health inequalities between different groups, areas and the whole population had persisted (Department of Health 2009c). Indeed, the recently published *NHS Atlas of Variation in Healthcare* (Right Care 2010) shows that there are significant differences across England in terms of treatments, expenditure and outcomes, suggesting that unwarranted variation exists with resulting implications for equity. The atlas states that those who 'commission healthcare have a responsibility to mitigate the effects of factors that influence poor access to, and provision of, healthcare' (Right Care 2010, p 13).

All this suggests that although there is evidence of improved health overall, PCTs largely failed to reduce health inequalities. Data from WCC supports this assessment. The average score for the relevant competency in 2009/10 – 'prioritising investment according to local needs' – did demonstrate an improvement on the

score for 2008/9, but remained the second lowest scoring competency at 1.81 out of 4 (NHS Confederation 2010).

PBC and equity

The Department of Health saw PBC as having a 'pivotal role' in tackling health inequalities through GPs working with other partners to meet the needs of individuals and groups with particular needs (Department of Health 2008a). Evidence on GP fundholding in the 1990s concluded that this form of purchasing had, to some extent, created a 'two-tier service', with patients of fundholding practices having faster access to services (Goodwin 1998). The Audit Commission likewise warned that, if not managed well, PBC might lead to 'widening inequalities of provision and access between areas, as well as fragmentation in service provision, where some commissioners are more successful than others' (Audit Commission 2006, p 7).

No studies have looked specifically at the impact of PBC on equity. A survey carried out in 2007 revealed that few PCTs reported widening access or narrowing inequality as goals for their practice-based commissioners (Coleman *et al* 2007). Research into the impact of PBC did not comment on equity specifically, but it did find variation in the level of engagement and capability of GPs (Curry *et al* 2008). This research also found some indication that the size of the commissioning cluster had an impact on its ability to bring about change, a finding that echoed the evaluation of total purchasing in the late 1990s (Mays *et al* 2001). Although far from conclusive, these findings suggest that PBC was variable in its impact and that this may have had implications for equity.

Effectiveness

One of the main aims of commissioning under New Labour was to shift care out of hospitals and into the community, as well as shaping the provision of services to meet the needs of the local population. Although, as with equity, research evidence on the effectiveness of PCT commissioning is limited, there is a consistent finding that NHS commissioning has had a limited impact in shifting services out of hospital, reducing avoidable use of hospitals and developing new forms of care (Audit Commission and Healthcare Commission 2008; Ham 2008; Lewis *et al* 2009). Smith *et al* (2004) and Gillam and Lewis (2009) concluded that there was little evidence that any form of commissioning had had a significant or strategic impact on hospital services.

PCT commissioning and effectiveness

PCTs have been much criticised for their alleged failure to bring about significant change to patterns of service delivery, particularly in the acute sector and in intermediate care. PCTs were found to be weak in the face of strong providers

with large and relatively long-term contracts. PCTs also had little direct control over referrals made by GPs, patients or consultants (Smith *et al* 2010). The relative lack of clinical expertise within PCTs was seen as a disadvantage in their ability to negotiate with secondary care providers (Curry *et al* 2008; Smith *et al* 2010), which arguably limited their capacity to respond to patient needs.

We have argued elsewhere (Smith *et al* 2010) that, although many of the criticisms are fair, the achievements of PCTs have often been ignored in the rush to categorise commissioning as weak, while not examining other aspects of the NHS reform programme that could be inhibiting PCTs from making progress. Achievements that PCTs have made include:

- working with providers to ensure significant reductions in waiting times for treatment
- the establishment of clinical governance structures and processes to assure quality and safety (National Audit Office 2007)
- the procurement of new providers such as GP-led primary care centres
- securing financial balance following a period of significant deficit (Audit Commission 2007).

Indeed, towards the end of the period, the Audit Commission described 'an overall picture of significant improvement over the three years assessed' (Audit Commission 2008a, p 4).

A survey of PCTs undertaken within the Health Reforms Evaluation Programme as part of a Department of Health-funded study of PCT commissioning revealed that a majority of the sample had commissioned changes to care in a number of disease areas (Sampson *et al* forthcoming). The most commonly anticipated outcomes of these changes to care were to be a reduction in emergency admissions and an improvement in disease-specific health outcomes. PCT commissioners in this study were mostly unable to quantify the level of intended impact, although there was some evidence of more sophisticated assessment of intended change in the final phase of the study.

WCC assessments in 2009/10 indicated an overall improvement in performance compared with 2008/9 (NHS Confederation 2010). The Department of Health did not officially publish WCC scores, although the *Health Service Journal* and the NHS Confederation published their own analysis. Improvements were particularly noted in the 'board' and 'strategy' elements of the governance ratings, while financial performance showed only marginal improvement. In terms of individual competencies, the highest scores were achieved for working with community partners, locally leading the NHS and managing knowledge. Improvements were recorded in each of the competencies, but the greatest improvements were observed for competencies that had achieved relatively low scores in both years.

The Care Quality Commission (CQC), the national regulator of quality in health and social care in the NHS in England, indicated in its annual health check of the NHS in 2008/9 that 70 per cent of PCTs fully met the core standards as commissioners of services, no PCTs were classed as not having met the standards, and 51 per cent of PCTs were 'full year compliant' for all core standards in their role as commissioners (Care Quality Commission 2009). No direct comparison with earlier years was possible as this was the first year PCTs had been required to make separate declarations to the CQC as commissioners and providers. Previously, PCTs had made one overall core standards declaration – in 2007/8, 21 per cent of PCTs were 'full year compliant' for all the core standards (Care Quality Commission 2009). These indicators suggest that steady progress was made by PCTs. However, such assessments tended to focus on the *process* of commissioning rather than its impact.

Despite some positive indicators of progress, most assessments of the performance of PCTs have been rather bleak. The House of Commons Health Committee (2010a) report on commissioning found that there were examples of good work being undertaken by PCTs, but concluded that many PCTs believed they were working more effectively than the evidence would suggest. For example, research into referral management found that half of PCTs studied believed they had been successful in curtailing demand, but quantitative analysis suggested that this was not the case (Imison and Naylor 2010). PCT commissioners have faced difficulties in shifting care from hospital to community settings. Analysis of admissions data in the NHS in England revealed an 11.8 per cent increase in emergency admissions between 2004/5 and 2008/9 (Blunt *et al* 2010). While not solely the responsibility of PCTs, this analysis does highlight the fact that PCTs have struggled to have an impact on emergency admissions.

The effectiveness of PCTs as commissioners has been limited by a number of factors that are explored in detail elsewhere (Smith *et al* 2010). One principal limitation has been the typically weak clinical leadership and engagement in PCTs in comparison with their provider counterparts. Capability and capacity limitations have also constrained PCTs, and regular reorganisations have led to a loss of commissioning expertise, which has then taken time to redevelop. PCTs have also suffered from a lack of autonomy when compared with providers (particularly foundation trusts), and information asymmetry has meant that providers are more powerful when it comes to the negotiation of contracts. This lack of access for PCTs to detailed information about provider services has made it difficult for PCTs to challenge provider billing and, in some cases, PCTs have lacked the skills to analyse this information (Smith *et al* 2010).

In response to the challenges facing them, commissioners increasingly turned to the independent sector for support with commissioning, and the use of such external support became the norm among PCTs (Naylor and Goodwin 2010). Research into whether the use of external support helped to develop more effective commissioning found that such support was not always used effectively, as a result

of which commissioners did not always achieve what they had hoped for. PCTs with the greatest development needs appeared to be in the weakest position to use and benefit from the services of external organisations (Naylor and Goodwin 2010). This speaks again to the capacity and capability issues in many PCTs, as outlined above.

PBC and effectiveness

There is a stronger evidence base for PBC, but studies were limited by the fact that this policy was slow to get started and did not function long enough to enable a full assessment of its impact. Research by the Audit Commission, The King's Fund and the National Primary Care Research and Development Centre provides a helpful insight into how PBC was implemented (Audit Commission 2007; Curry *et al* 2008; Coleman *et al* 2009). However, unlike evaluations of GP fundholding and total purchasing in the 1990s (eg, Coulter and Bradlow 1993; Dowling 1997; Mays *et al* 2001; Propper *et al* 2002; Wyke *et al* 2003), none of these studies attempted to quantify impact.

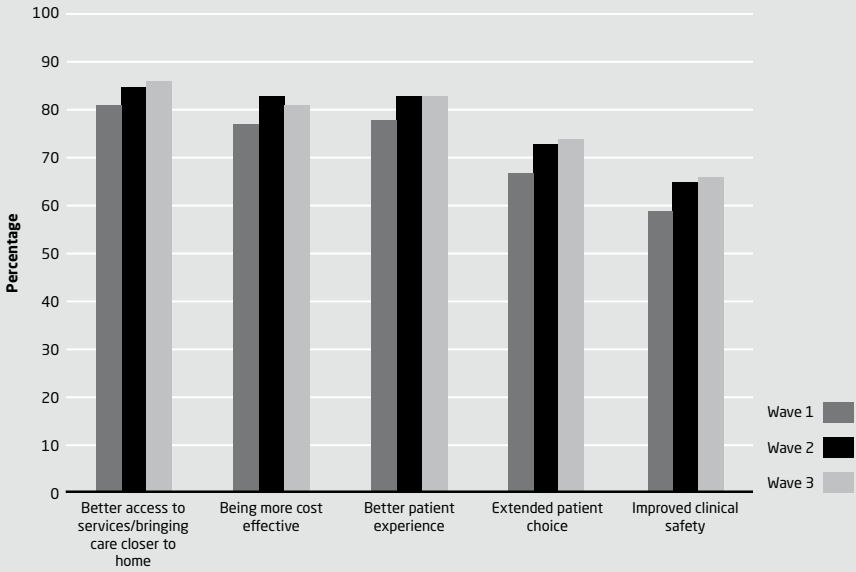
Early assessment of PBC by the Audit Commission (2007, p 3) found that 'the redesign of services and their transfer from secondary to primary care had yet to gather pace'. This presaged the findings of a later study by The King's Fund, which found that many practice-based commissioners were more interested in using their budgets for small-scale re-provision of services within their practices than more strategic commissioning of services from other providers (Curry *et al* 2008). This suggests that PBC, as with its predecessor forms in the 1990s, seemed to be effective in developing extended primary care (Mays *et al* 2001; Dowling and Glendinning 2003; Smith and Goodwin 2006), but was much less effective in bringing about large-scale strategic change. Many practice-based commissioners felt they lacked the requisite skills to be effective commissioners. Key capability gaps were felt to be around data analysis, financial management and negotiation (Wood and Curry 2009).

A Department of Health survey, carried out in three waves at three-month intervals (Department of Health 2010g) attempted to explore to what extent PBC had enabled GPs actively to improve the quality of care available to patients in terms of better access, cost-effectiveness, choice, patient experience and clinical safety. The results indicated that the majority of respondents felt they had had at least some impact on each measure, although a relatively small proportion (up to 17 per cent) felt they had had 'a great deal' of impact. A perceived improvement was demonstrated over the three waves of the survey (*see* Figure 4 overleaf).

Efficiency

The purchaser–provider split introduced into the NHS in the early 1990s was intended to drive cost-effectiveness and productivity (Department of Health 1989). The more efficient use of resources remained at the heart of the commissioning

Figure 4 PBC group and independent leads survey – answer to question 13*



Adapted from: Department of Health 2010g

*Question 13: To what extent, if at all, do you think your PBC actively has improved the quality of care available to patients in terms of: better access to services/bringing care closer to home; being more cost effective; better patient experience; extended patient choice; improved clinical safety. Values given represent the total of those who answered 'a great deal', 'a fair amount' or 'just a little', i.e. those who felt there had been 'at least a little' improvement

reforms under New Labour and was included as a key criterion in the WCC assessment process (Department of Health 2007d). PCTs had a clear duty to commission services from providers to meet the needs of their populations without exceeding their financial allocations. Likewise, one of the key intentions of PBC was to improve the use of resources by providing an incentive for GPs to avoid unnecessary admissions to secondary care, either through demand-management or by developing services in the community (Department of Health 2006b).

PCT commissioning and efficiency

As with effectiveness, finding evidence on the efficiency of PCT commissioning is problematic as few studies have attempted to attribute impact to commissioning and then quantify this impact. Any analysis of NHS commissioning typically points to the need for commissioners to tackle un-evidenced variations in clinical practice as a way of making efficiency savings and delivering more integrated care (eg, Blunt *et al* 2010; House of Commons Health Committee 2010a; Smith *et al* 2010).

The Department of Health's atlas of variations (Right Care 2010) suggested that commissioners were not yet addressing such issues in a systematic manner. The House of Commons Health Committee report (House of Commons Health Committee 2010a) pointed to a lack of power among PCTs to challenge 'clinical

norms' that might be inefficient. This apparent reluctance and/or inability of PCT commissioners to use data to challenge providers, and a reticence on the part of providers to be transparent about variations, emphasised the 'information asymmetry' that we noted earlier in this chapter as being a key challenge to all health purchasers.

It was expected that the biggest efficiency gains were likely to be made in increasing services provided out of hospital, both to prevent and substitute for hospital care. It is in this area that commissioning has most conspicuously failed to deliver (Audit Commission and Healthcare Commission 2008; Audit Commission 2009). One manifestation of this inability of PCTs to extract improved efficiency from the NHS is the failure of the majority to decommission services, or to assess their resource allocation priorities in a manner that entails root and branch (as opposed to marginal) analysis (Crump 2008; Robinson *et al* 2011). Robinson and colleagues suggest that PCTs' lack of autonomy limited their ability to make longer-term investment and redesign decisions, given that national short-term 'must dos' often conflicted with local priorities. This led these authors to conclude that PCTs only 'tinkered around the edges' of priority setting and rationing (Robinson *et al* 2011).

The financial regime in the NHS that has required PCTs to break even on an annual basis (*see* below for further discussion) has contributed to the difficulty faced by PCTs in making large-scale decommissioning decisions (NHS Confederation 2009). This annual financial cycle has also further exacerbated the power imbalance between PCTs and foundation trusts – the financial autonomy of the latter does not require them to break even on an annual basis and so allows them to make long-term investments and savings (Smith *et al* 2010).

In addition to a failure to yield savings, the efficiency of commissioning has aroused concern. The Audit Commission found that, in 2008/9, PCTs increased spending on community health services by 13.2 per cent but, instead of a corresponding decrease in spending on secondary care, acute provider trusts increased their income from PCTs by 6.6 per cent, suggesting that PCTs had made little progress in transferring care into the community or in dampening demand (Audit Commission 2009). In the same period, the number of inpatient and day cases increased by more than 4 per cent (more than in 2007/8), and outpatients by nearly 8 per cent (Audit Commission 2009). The Audit Commission has since reported that these trends continued into 2009/10, with inpatient and day-case activity rising, fuelled by less complex cases (Audit Commission 2009), and this is underlined by analysis of rising emergency admissions by the Nuffield Trust (Blunt *et al* 2010).

A survey of PCTs undertaken by the National Audit Office and commissioned by the House of Commons Health Committee in early January 2010 found weaknesses at PCT level in strategic planning, procuring services, and monitoring and evaluation. The National Audit Office found that commissioners had a poor understanding of costs and lacked evidence for the effectiveness of their commissioning activities. They also concluded that commissioners had a poor understanding of whether

they had achieved value for money (National Audit Office 2010). The WCC score for the 11th competency (make sound financial investments to ensure sustainable development and value for money), which was added in 2009/10, was the lowest of all competency scores for that year.

In contrast to this evidence, researchers who have compared productivity in the English NHS with that in the other three countries of the United Kingdom – two of which do not have a purchaser–provider split – reached a favourable conclusion in respect of the apparent efficiency of the NHS in England (Connolly *et al* 2010). This report found that 'England has the lowest per capita funding for the NHS and makes better use of its lower level of resourcing in terms of shorter waiting times and higher crude productivity of its staff' (Connolly *et al* 2010, p 104). As with much of this evidence, it is difficult to know the extent to which that achievement can be attributed to commissioning in England compared with other factors, such as top-down targets, but it is nevertheless a counterbalance to the generally critical assessment of NHS commissioning in England.

PBC and efficiency

PBC is widely seen to have failed to challenge existing models of care and release savings (House of Commons Health Committee 2010a; Smith et al 2010). Research by The King's Fund into PBC, based on four case studies, found that the 'extent to which PBC was successful in improving the use of resources has not yet been demonstrated conclusively', even in sites where financial management had been a focus (Curry *et al* 2008, p 25). Where claims were made about savings, individual accounts differed and no empirical evidence was provided. The report concluded that it was unclear whether PBC represented a cost-effective form of commissioning (Curry *et al* 2008).

The findings of the other in-depth study of PBC echoed those of Curry *et al*. Some savings had been made by commissioners but these seemed to be mostly random or attributable to other factors, such as hospital reorganisation (Coleman *et al* 2009). The authors concluded that PBC had had a limited impact on demand for hospital care, with some examples of reduced consultant–consultant referrals, but overall that it had not been successful in challenging secondary care, again underlining a key message from previous research into different forms of primary care-led commissioning.

Despite this, Coleman *et al* (2009) are more optimistic about PBC than are Curry and colleagues, suggesting that there was still a future role for PBC in effective commissioning, cost reduction and quality improvement. They agreed that active engagement of GPs was lacking, but argued that this was not necessarily desirable, suggesting instead that this role should be occupied by a legitimised and committed activist sub-group of GPs. They also identified spin-off benefits from PBC, reporting potential quality improvements in primary care. PBC provided GPs with a platform for peer review in their prescribing and referral behaviour, allowing them to

generate closer working relationships and ground-level intelligence to support PCT activity (the converse was true where GPs and manager relationships were strained, especially when efforts to innovate were prevented). These findings suggest that the PBC model had the potential to involve clinicians in commissioning and to raise standards in primary care. In practice, this requires the development of a shared process for priority setting and the establishment of a mechanism by which GPs could develop into commissioners for public health rather than simply developing small-scale projects at the margins of primary care.

Responsiveness

Commissioning by PCTs was intended to improve the responsiveness of services to the needs of patients, but a search of the literature failed to identify any studies on this subject. Department of Health guidance in April 2002 spelled this out thus: 'PCTs will want to use their local commissioning discretion to reshape how local health care services are delivered to reduce waiting times, increase responsiveness and improve clinical outcomes' (Department of Health 2002f, p 2).

Similarly for practice-based commissioners, guidance from the Department of Health exhorted them to: 'secure a wider range of services, more responsive to patient needs and from which patients can choose' (Department of Health 2004b, p 1).

PCT commissioning and responsiveness

PCTs had a duty to facilitate patient choice. The Healthcare Commission sought to create a 'choice' target against which to measure PCT performance, and to do this they combined data from the national NHS patient survey with data on the uptake of the Choose and Book system (the electronic hospital booking system through which GPs – or referral booking centres – can book secondary care appointments for their patients) in general practice. This indicated that PCTs made a slow start in enacting choice of elective care for patients. In 2007, 70 per cent of PCTs had failed to meet the target (with only 2 per cent deemed to have achieved it). The Healthcare Commission concluded: 'This is by far the worst level of performance for any of the existing national targets' (Healthcare Commission 2007b, p 49). Performance on this indicator showed some improvement the following year, with 39 per cent failing and 16 per cent achieving it (Healthcare Commission 2008d). This again points to some steady improvement by PCTs in relation to the processes of commissioning, and of attempts to embed a culture of choice within the local NHS.

Although PCTs were instrumental in establishing patient choice, this further limited PCTs' capacity to direct demand (Imison and Naylor 2010). Some PCTs established referral management centres, through which some or all GP referrals were channelled in an attempt to control this element of demand. There is, however, a question about whether their main focus being on assuring effective and efficient

referrals was at odds with patient choice. Research into referral management schemes found that many were primarily intended to support choice and implementation of Choose and Book. Although this was the intention, few (24 per cent of the research sample) believed their scheme had successfully supported patient choice (Imison and Naylor 2010). This paper also found that referral management centres could create extra steps in the referral process, which could be confusing for patients who were unsure about the purpose of the centres (Imison and Naylor 2010).

Patient and public involvement is a key dimension of responsiveness. Commissioners are acting on behalf of the population they represent, and, for that reason, patient and public involvement should be embedded within their commissioning activity. WCC (Department of Health 2007d) sought to embed patient and public involvement in commissioning by setting out engagement with the public and patients as one of the core competencies against which PCTs were to be assessed. In relation to this competency, PCTs were required to 'proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health' (competency 3). WCC scores showed an improvement on this measure across PCTs in England between 2008/9 and 2009/10: average scores were 1.66 in 2008/9 compared with 2.35 in 2009/10, an increase of 45 per cent (NHS Confederation 2010), suggesting some improvements in this element of responsiveness by PCTs. However, a survey of PCTs in 2007 suggested that, although patient and public involvement was well established in the everyday business of PCTs, they did not (at that time) feel ready to involve patients in commissioning (Chisholm *et al* 2007).

Although some of the specific indicators of choice and public involvement showed some progress, public accountability among PCTs remained relatively weak (Thorlby *et al* 2008). Upwards accountability to the Secretary of State via strategic health authorities was strong, but downwards accountability to the public was weak, particularly when compared with local authorities which, unlike PCTs, are accountable to the public via elected councillors. The public had very little leverage over the local health services provided or commissioned by PCTs (Thorlby *et al* 2008). The general public had very little understanding of how local health services were organised or held to account – a survey commissioned by the Local Government Association (LGA) found that half the public did not know what a PCT was and three-quarters could not name their local PCT (Local Government Association 2008). This paper by the LGA points out that no organisation can be held to account by the public if the public does not know it exists.

PBC and responsiveness

PBC was introduced in recognition of the fact that PCTs were failing to produce the expected improvements in the performance of secondary care providers (Commission for Health Improvement 2004c) and in the belief that GPs felt

disengaged from PCTs with little influence over commissioning decisions (NHS Alliance 2003).

One study that sought to measure the extent to which services had changed found it difficult to assess the contribution of PBC towards service improvement (Curry *et al* 2008). In some cases, initiatives had been rebadged as PBC-related when it was felt that these would have happened anyway. This study found that there were few examples of GPs undertaking systematic data analysis in order to identify need and clinical priorities, and the authors concluded that GPs tended to look at what they *could* do, rather than what was *most needed* for the delivery of better services to their populations (Curry *et al* 2008).

National guidance for practice-based commissioners stated that they were required to meet patient needs and to make plans available for public scrutiny, but there was no specific requirement for them to involve or engage patients in commissioning decisions. The guidance stated that PCTs needed to ensure that 'practices have engaged their patients in service redesign' (Department of Health 2006b). It might be expected that business cases would have had to include a commitment to patient engagement, but case study research found few examples of active patient involvement in PBC beyond consultations on specific redesign proposals. Where there was evidence, processes were not sufficiently developed to assess any impact (Curry *et al* 2008).

The third wave Department of Health PBC survey of GPs found that 86 per cent of respondents felt that PBC had enabled them to bring about better access to services to at least some extent (14 per cent of them 'a great deal'); 83 per cent felt they had improved patient experience (16 per cent of them 'a great deal'); and 74 per cent felt they had extended patient choice (10 per cent of them 'a great deal') (Department of Health 2010g) (*see* Figure 4, p 42).

Table 3, overleaf, summarises the key points presented in this chapter on the evidence of the impact of commissioning.

Discussion

It is important to note the limited nature of the research carried out into commissioning, and the difficulties associated with designing and carrying out longitudinal studies given New Labour's frequent reorganisation of NHS commissioning: the abolition of fundholding and establishment of primary care groups in 1999; the abolition of primary care groups and establishment of PCTs in 2002; and the merger and expansion of PCTs and the setting up of PBC in 2006. Indeed, some have suggested that the regular reorganisations themselves have limited the chances of commissioning achieving its goals (Dickinson *et al* 2006).

It is clear from our examination of the available evidence on PCT and PBC that the assessment by many commentators of commissioning as weak is, in many ways,

Table 3 Summary of the evidence on the impact of commissioning

Impact domain	PCT	PBC
EQUITY	■ PCTs failed to mitigate the impact of wider determinants of health. ■ Few PCTs focused strategic planning on reducing inequities. ■ PCTs achieved relatively low scores for equity-related competencies under WCC. ■ Spearhead PCTs failed to reduce health inequalities between areas and groups.	■ No strong evidence is available about impact on equity. ■ Evidence of variable capability among PBC clusters suggests variable impact on equity.
EFFECTIVENESS	■ PCTs failed to make significant shifts of care out of hospital and into the community, failed to reduce demand and failed to reduce consultant–consultant referrals. ■ External support for commissioning was not always used effectively. ■ Some positive examples of PCTs procuring new providers (eg, GP-led primary care centres) and establishing robust clinical governance processes. ■ WCC scores suggested PCTs made improvements in terms of performance over the two years measured (eg, in terms of governance). ■ PCTs played a role in working with providers to meet national waiting targets.	■ PBC resulted in some extended primary care and mainly focused on the re-provision of services outside hospital. ■ Few GPs actively engaged in, or led, large-scale strategic change.
EFFICIENCY	■ PCTs secured financial balance in 2006. ■ PCTs failed to challenge inefficient clinical norms. ■ PCTs largely failed to decommission services. Where decommissioning did happen, it did not result in a release of savings. ■ PCTs failed to increase provision of community-based services. ■ PCTs achieved low WCC scores for efficiency of spend and many had a poor understanding of whether they had achieved value for money. ■ England, with its commissioner/provider split made better use of resources compared with other UK countries.	■ There is little evidence as to whether PBC improved use of resources. ■ PBC seemingly had little impact on demand for hospital care. ■ Practice-based commissioners failed to redress the power imbalance between primary and secondary care or make significant changes to services.
RESPONSIVENESS	■ PCTs had weak accountability to the public. ■ PCTs were slow to offer choice, although their performance did improve. ■ PCTs struggled to involve patients in commissioning. ■ PCTs struggled to influence providers, partly because of their lack of clinical leadership. ■ There is a lack of clarity over the impact of referral management centres on choice and responsiveness.	■ Evidence suggests that GPs focused on re-providing services that they were able to do themselves rather than commissioning or providing services that their populations needed. ■ There is little evidence about patient and public involvement within PBC.

PCTs: primary care trusts; WCC: world class commissioning; GPs: general practitioners; PBC: practice-based commissioning

justified. Along with other reform mechanisms, commissioning would appear to have failed to reduce health inequalities in England, struggled to shift care away from hospitals towards community settings, been unable to reduce emergency admissions, and been unable to demonstrate significant efficiencies or changes to funding priorities. When weighed against the transaction costs of running a commissioning system, the verdict would seem to be weak or at best equivocal. Box 3, below, sums up the conclusions of two previous major reviews of evidence on commissioning.

Box 3 Conclusions of two previous major reviews of evidence on commissioning

But why did these [NHS internal market of the 1990s] organisational and cultural changes not result in more demonstrable impacts in the areas we have investigated? Although it is possible there were significant changes, and the studies we have surveyed simply did not pick them up, this seems unlikely to be the whole explanation … The explanation must, therefore, lie with the way in which the internal market was implemented. And here there is a ready economic answer: the incentives were too weak and the constraints were too strong. (Le Grand *et al* 1998, p 130)

There is little evidence to show that any primary care-led (or other) commissioning approach has made a significant impact on the way hospital care is delivered, except in relation to waiting times for treatment. This challenges health funders and planners to find more powerful and sophisticated ways of exerting required changes from health providers. (Smith *et al* 2004, p 3)

We must, however, take into account the interrelated nature of health reforms and the inherent difficulty in ascribing outcomes to specific policy interventions (Figueras *et al* 2005; Ham 2008). The weakness of commissioning in the English NHS may be a feature of factors such as:

- the Payment by Results (PbR) regime for funding hospital activity
- the power and constitution of foundation trusts in comparison with that of PCTs
- the lack of real budgets for practice-based commissioners
- the struggle to secure adequate specialist analytical support for commissioners (Smith *et al* 2010).

Evidence from assessments by the Audit Commission, Care Quality Commission, National Audit Office and Department of Health WCC Directorate suggests that PCTs were 'upping their game' by 2009/10, making some achievements, and

demonstrating enhanced capability as commissioners. It is frustrating, therefore, that a further 'redisorganisation' (Smith *et al* 2001) of the NHS is taking place, leading to the rapid dissolution of PCTs and PBC, and the snuffing out – for the fourth time since the creation of the purchaser–provider split in England – of the potential for the longitudinal study of commissioning achievements and outcomes.

Tentative evidence about PCT commissioning points to systematic and potentially important changes to patient care (Sampson *et al* forthcoming), and analysis of case studies of innovation in commissioning (Ham *et al* 2011) shows how some (albeit an apparently small minority) PCT and practice-based commissioners were able to reshape local services to better meet local needs.

The critical question left unanswered by this review is why so few commissioners appear to have been able to make the significant changes expected of them and whether the costs of running a commissioning system have been worth the rather limited results, as measured by research evidence.

There is a number of possible reasons for the underperformance of commissioning during this period, including the following.

- PCTs' lack of autonomy rendered them risk-averse and unable to challenge effectively more powerful providers that had greater financial freedoms.
- 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 (Smith *et al* 2010).
- The voluntary nature of GP engagement in PCT commissioning put PCTs at a disadvantage when negotiating with providers, where clinical leadership and engagement were strongly embedded. Although PBC went some way to strengthening clinical engagement, it failed to provide PCTs with sufficient clinical legitimacy to be able to challenge powerful providers in an effective manner.
- PCTs generally lacked sufficiently skilled and experienced commissioning staff, and this was compounded by regular reorganisations of commissioning bodies (Smith *et al* 2010). Many GPs felt they lacked the skills and time to undertake commissioning (Wood and Curry 2009), and the lack of real budgets meant that the incentives for GPs to engage in active PBC were weak (Smith *et al* 2010).
- Commissioners had limited access to detailed information about referrals and lacked the ability to perform complex analysis of the data that was available to them. This limited commissioners' capacity to challenge billing decisions and to take strategic decisions.
- The dominant hospital payment regime (PbR) rewarded providers on a per case basis, potentially acting as a powerful incentive to maximise activity.

Commissioners were apparently powerless to counteract this. The complexity of 'unbundling' the hospital tariff, along with the absence of a corresponding tariff for community services, further restricted the ability of commissioners to shift care from hospitals to community settings (Smith *et al* 2010).

The next phase of reform

Given the relative lack of impact that commissioning has had to date, and the problems associated with trying to make strategic purchasing effective, we conclude this chapter by making an assessment of the prospects for the next phase of reform of NHS commissioning.

Some of the fundamental problems associated with PCTs and PBC should be tackled by the next round of reforms. Under the new proposals (Department of Health 2010c), we should see GPs along with other professionals – in the form of clinical commissioning groups – taking full responsibility for both the clinical and financial outcomes of their referral and commissioning decisions. This is intended to bring about stronger clinical engagement in NHS commissioning, improved alignment of financial risks and incentives, and reduced levels of bureaucracy.

It remains uncertain whether the new arrangements will achieve their intended aims; and it is unclear whether the new commissioning bodies will offer more of a challenge to dominant providers than did their predecessors, and whether they will be more effective at shifting care out of hospitals, avoiding unscheduled care, and providing more efficient models of care for patients with long-term conditions. A key concern is whether clinical commissioning groups will be able to develop (or have the resources to buy) the management and analytical support they will require. The experience of the use by PCTs of external support for commissioning raises questions about whether GPs will similarly lack the skills to use such support effectively.

Although the proposed arrangements may overcome some of the issues that held back commissioning under PCT and PBC, it should be acknowledged that clinical commissioning groups will be operating in a very different system from that of their predecessors. Unlike their experience with PBC, GPs will be managing real budgets, competing for patients, and accounting to the public and patients for health care rationing decisions. In addition, GPs will be taking on these significant new 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.

Finally, will the government be patient enough to allow the reforms time to work? Successive reorganisations of NHS commissioning structures have impacted upon commissioners' ability to bring about real change. There is a risk that this trend will continue, preventing the new arrangements from bedding in and taking effect.