

Where next for commissioning in the English NHS?

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ABOUT THE NUFFIELD TRUST

The Nuffield Trust is a charitable trust carrying out research and policy analysis on health services. Its focus is on reform of health services to increase the efficiency, effectiveness, equality and responsiveness of care.

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FOREWORD

The NHS faces an unprecedented period of economic constraint. Even the most optimistic of funding scenarios suggests that the NHS in England will have to achieve a step change in productivity. It is unlikely that increased technical efficiency will be enough to bridge the gap between demand for care and the funding available. The key will be to ensure allocative efficiency across the whole range of NHS spending and deliver value for money by doing less of some things and more of others. This will require commissioners to focus not just on new growth money, as has often occurred in the past, but to assess and prioritise the total budget available and to focus not on institutions but on the outcomes achieved across the whole pathway of care.

It is now nearly two decades since the introduction of a separation between purchasers and providers in the NHS, yet capacity to deliver on the ambition of commissioning is still lacking. It is often suggested that if only commissioning were to be 'strong' or 'world class', more progress would be made in areas such as moving care out of hospital into the community, or gaining greater productivity from health care providers. Initiatives such as the World Class Commissioning and

Practice-based Commissioning have been put in place to attempt to improve the quality of commissioning across the NHS.

Ensuring value for money is more critical than ever. It is important that the NHS is clear how commissioning will help deliver this, particularly where it may have previously failed to do so. This report, published jointly by The Nuffield Trust and The King's Fund, examines the development of NHS commissioning and sets out practical suggestions for how it might be strengthened to secure more effective and efficient care.

This report, together with a companion volume *Where Next for Integrated Care Organisations in the English NHS?* builds on previous work by researchers at both organisations. We hope that the combined efforts of our organisations will contribute to the debate about how the NHS should evolve to meet the pressing challenges that our health system faces.

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EXECUTIVE SUMMARY

Commissioning in the English NHS is subject to apparently endless debate and frequent criticism. The discourse would have us believe that if only commissioning were to be ‘strong’, ‘world class’ or ‘effective’, long-awaited changes could occur such as more care in community settings, reconfigured hospital services, and a more productive and cost-efficient health system.

In this report, we focus on what needs to be done to strengthen commissioning in the NHS, through an analysis of the problems with current commissioning arrangements. We begin by examining what is meant by ‘commissioning’ in the English NHS.

What do we mean by commissioning?

‘Commissioning’ in the NHS is where an organisation, and/or a group of clinicians, acts on behalf of a population to decide which health services to buy, using tax funds allocated by the Department of Health according to a formula based on health needs. It entails decision-making about needs assessment, resource allocation, service purchasing, monitoring and review.

What are the current arrangements for commissioning in the NHS?

Commissioning of local health services takes place through two main routes: first, via primary

care trusts (PCTs) who are responsible for using public money for commissioning a range of health services, primary, community, secondary and tertiary care. In carrying out their commissioning role, PCTs work with partners such as local authorities (to plan and purchase services such as mental healthcare), other PCTs (in networks or consortia for specialised services) and primary care clinicians.

It is the commissioning of care with primary care clinicians (mainly GPs) that forms the second main route for commissioning in the NHS – practice-based commissioning. This is a form of primary care-led purchasing where PCTs allocate to practices a notional (not real) budget that can be used for commissioning community- and hospital-based services to meet the needs of the practices’ enrolled population. Practices typically group together in consortia for their commissioning work and some are established as companies or social enterprises.

This all adds up to a complex set of commissioning arrangements in any one local area, with commissioning happening at a regional or national level for specialised services, through the PCT and local authority for the majority of care, and via various practice-based commissioning consortia for community-focused care. In this report we show this as a local commissioning continuum or matrix.

What are the problems with current commissioning arrangements?

We examine the problems with current commissioning arrangements from two perspectives: problems related directly to PCTs and practice-based commissioning policy; and those related to the wider features of the NHS.

Problems related directly to PCTs and practice-based commissioning policy

- PCTs have little control over the volume of referrals made by GPs and hospital doctors, and this is further compounded by patients having a free choice of provider. Referral management centres are one way in which PCTs can gain better information and some influence over referrals.
- PCTs currently combine both provider and commissioner functions, and observers disagree about whether this is a benefit or not. Current policy is forcing a separation of functions between PCTs and provider agencies.
- NHS commissioning bodies (PCTs and their predecessor bodies) have experienced numerous imposed reorganisations that have impeded their progress.
- PCTs have limited autonomy compared with NHS trusts and foundation trusts, which arguably makes them more risk-averse.
- Clinical leadership and engagement in PCTs is typically weaker than in provider counterparts. Practice-based commissioning has gone some way towards addressing this, but remains patchy in its progress across the NHS.
- PCTs are poorly understood by the general public, and accountability to their local population is relatively weak.
- Capability and capacity for commissioning are key concerns for PCT and practice-based

commissioning. The ‘World Class Commissioning’ (WCC) initiative is a national effort to develop skills and capacity, and there is some evidence of progress.

- Analysis of data and information is an area of particular concern in respect of commissioning capacity.
- The incentives for GPs to engage in active practice-based commissioning are weak.
- Hospital doctors are not involved enough in providing specialist advice to practice-based commissioners.
- The lack of real budgets for practice-based commissioners reduces the impact that they can have in relation to extending service provision and commissioning new forms of care.

Problems related to the wider features of the NHS

- Incentives for commissioners to improve quality and reduce costs of provision are not sufficiently strong, although regulation of commissioning is being developed further and this, together with a tight financial context, is likely to sharpen such incentives.
- PCTs are weaker organisations than provider trusts and foundation trusts. There are a number of reasons for this, both historical and related to current system reform mechanisms.
- The current NHS payment regime hampers the ability of commissioners to undertake more effective and challenging strategic purchasing, especially in relation to trying to shift care out of hospitals.

The verdict on commissioning to date

Commissioners have helped to implement numerous national plans, service strategies and

access/performance targets. Practice-based commissioning has prompted the growth of extended primary care services, and other areas of commissioning, such as specialised services, which work well. It is, however, questionable as to how far such achievements are directly a result of commissioners, rather than national direction and performance management. More disappointing is that there is still much to be done to bring about desired shifts of care out of hospitals and into community settings.

What is needed is a significant prompt towards care being orientated towards the needs of patients to stay well, much greater encouragement for clinicians to take responsibility for managing resources, and a huge advance by commissioners in the exploitation of patient-level information on costs, quality and service use.

What needs to be done?

Addressing problems related to PCTs and practice-based commissioning policy

- *Incentivise GPs beyond practice-based commissioning*: this could be achieved by granting real, risk-adjusted and capitated budgets to groups of GPs, in return for them assuming responsibility for financial risk and the health outcomes of the local population.
- *Recognise that clinical commissioning groups need to be larger*: to attract skilled management capacity, handle financial risk, and have ‘clout’ in the local healthcare system.
- *Practice-based commissioning needs ultimately to include hospital clinicians*: thus becoming a form of multi-specialty group or integrated care organisation. How this might work was explored in a Nuffield Trust/NHS Alliance report (Smith and others, 2009) and is examined further in the second report in this series (Lewis and others, 2010).

- *Allow PCTs to become fewer and larger*: with their role increasingly becoming that of the designer and manager of the local commissioning continuum, and the allocator of budgets to clinical commissioning organisations, specialised commissioning networks and so forth.
- *Strengthen the accountability of commissioners*: including having elected health boards/PCTs, extending foundation trust status to commissioning organisations, and offering people a direct choice of commissioner.
- *Allow commissioners more financial flexibility*: such as being able to retain surpluses and invest across different years, and hence increase bargaining power with providers.

Addressing problems related to the wider features of the NHS

- *Reform elements of the payment by results regime*: in particular, in relation to more ‘unbundling’ of the tariff and extending it to cover more community and other services.
- *Assume risk-adjusted capitated budgets are the future*: these will be the currency if integrated provider–commissioner organisations develop. It may then be that the financial currency locally within the integrated care organisation is not a nationally set service tariff, but locally agreed prices.
- *Accept that there is no one optimal model of commissioning*, but a continuum. The challenge for PCTs is how best to design and operate that continuum at a local level, while nurturing stonger devolved extended clinical commissioning organisations.
- *Explain to the public more of what commissioning is*. There is a need to create a clear and compelling narrative about the role and importance of

commissioning, both for the public and for staff in the NHS. This is critical if we are to move beyond the current (arguably unfair) narrative of commissioning as inevitably and seemingly irrevocably weak.

Going forward

We suggest that the health system is now at a fork in the road. On the one hand, the NHS could continue with minor changes to develop commissioning largely using the existing arrangements. But this would lose time. On the other, there is an option of pushing forward with a more radical model of clinician-led

healthcare provision and commissioning (see Lewis and others, 2010), as part of an overall strengthened continuum of commissioning arrangements designed and held to account by fewer and larger PCTs.

This more radical option does not need to be another large-scale policy pushed onto the service. Instead there are promising signs that parts of the NHS in England are evolving towards these arrangements and need practical and moral support to do so, especially in the face of a biting financial challenge. The right leadership now could set the NHS onto the road to this next stage of development.

1. INTRODUCTION

Commissioning appears at first glance to be something of an obsession in the English NHS, a function within the health system that is subject to endless debate and frequent criticism. The discourse suggests that if only commissioning were to be ‘strong’, ‘world class’ or ‘effective’, much needed changes could be brought about – such as moving care into community settings, reconfiguring acute hospital services, leveraging more productivity from healthcare providers, and bringing about better coordinated, or integrated, care.

But according to a wealth of research and commentary since the role of purchasing in the NHS was separated from the role of providing in 1991, population-based PCT commissioning of NHS care has throughout this time struggled to be effective (Light, 1998; Ham, 2008; Lewis and others, 2009). In particular, the shortcomings in management relative to that of acute providers has been noted (Walshe and others, 2004), and the lack of impact in shaping the hospital sector and reducing avoidable use of hospitals (Smith and others, 2004; Lewis and others, 2009).

The initial assessment of PCTs under the ‘world class commissioning’ initiative has done little to dispel this impression of relative weakness, revealing as it did that a majority of PCTs were poor or mediocre in respect of the competencies established for world class commissioning, albeit that some PCTs did receive ‘good’ ratings on certain dimensions. Assessments by the Audit Commission and the Healthcare Commission/Care Quality Commission (Audit

Commission and Healthcare Commission, 2008) over a longer period have shown steady improvement by PCTs as organisations on a number of indices, for example, financial management, demand management and efficiency (in part through ‘payment by results’ funding). Yet these improvements have fallen short of significant influence on the services provided by hospitals, or indeed on primary care.

Since 1991, there have also been policies to allow general practitioners (GPs) to commission through fundholding and its variants, total fundholding and multi-funds (Smith and others, 2004). Here, there is more research and evidence of impact, for example in curbing the rise of emergency admissions and prescription drug costs, and in reducing waiting times (Baines and others, 1997; Dowling, 1997; Croxson and others, 2001; Propper and others, 2002). But there were also problems. GP fundholders had high transaction costs relative to larger population-based entities 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 (Audit Commission, 1996; Goodwin, 1998; Le Grand and others, 1998), and there were worrying conflicts of interest as GPs were able to re-route funds for NHS hospital care into their primary care businesses.

Despite this, after scrapping fundholding in 1997, a watered-down version – practice-based commissioning – was introduced in 2005. For a mixture of reasons it has not incentivised GPs or

brought about significant changes to local health services (Audit Commission, 2007; Curry and others, 2008).

The immediate financial challenge in the public sector, the upcoming general election, plus longer-standing issues such as the rising demand for care, are forcing a rethink of policy on NHS commissioning. Now more than ever there is a need to extract more value out of the healthcare pound by reorienting the healthcare system towards improving wellness and supporting people outside hospital, as well as improving the quality of care in hospitals (NHS Confederation, 2009a).

Current thinking on supporting frail older people, as evidenced in the recent social care Green Paper (Department of Health, 2009a), is also encouraging more joint commissioning of healthcare and social care through pooled budgets, or local authorities allowing PCTs to commission adult social care – all to support wellness, independent living and avoidable future cost by taxpayers. The evidence on impact so far is mixed, possibly because these arrangements are variably implemented, outcome measures are not always specified, monitoring is often inadequate, and government guidance to different sectors can appear to be conflicting (Audit Commission, 2009a).

But it is in boosting ambulatory healthcare (care provided on an outpatient basis) to prevent, and substitute for, hospital care that the biggest efficiency gains are likely to be made, and where commissioning has most conspicuously failed to deliver (Audit Commission, 2009b). This is the area upon which this report focuses.

With a general election imminent, all political parties are now re-examining policies on commissioning, in particular practice-based commissioning. For Labour, PCT commissioning has not yet delivered, in a significant way, hoped

for objectives, and the impact of commissioning using pooled funding of health and social care is as yet tentative. Plans are afoot to offer more support to PCTs to develop the skills needed for effective commissioning, for example, in procurement and contracting.

For the Conservatives, strengthening practice-based commissioning through the allocation of real budgets to GPs is a key policy, yet how to do this while learning the lessons from the past and within a tight economic context is not made clear. The Liberal Democrats favour ‘democratising’ commissioning by advocating elected boards for PCTs – how exactly this will improve the quality and value for money of healthcare for patients and taxpayers is unclear.

Yet the enormous external challenges to be faced by the NHS in the short to medium term and some new opportunities (for example, from more intelligent use of digital and information technology) point to the need for urgent and independent discussion of where we are now and how we got here, and some options to strengthen commissioning for the future. As more providers achieve foundation status and the role of regulators will be far more concerned with commissioning, how might commissioning evolve? This report discusses this question by focusing on the past, present and possible future of commissioning in the English NHS.

The authors start by identifying what commissioning is, before moving on to examine the current arrangements for commissioning in place within the NHS. This is followed by an analysis of the problems with current commissioning arrangements, and the offering of an overall verdict on its performance to date. The report ends by suggesting what might be done to boost NHS commissioning in a significant way.

2. WHAT IS MEANT BY 'COMMISSIONING'?

'Commissioning' in the NHS is where an organisation, and/or a group of clinicians, acts on behalf of a population to decide which health services to buy – using tax funds allocated by the Department of Health – according to a formula based on health needs.

In the international context, this role in funding and determining services is more usually known as 'purchasing' – a term used in England between 1990 and 1996 in the early days of the NHS internal market. In order to distinguish the difference between purchasing and commissioning, as commonly understood in the NHS, Woodin's (2006: p203) definition is helpful:

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 healthcare 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.

This interpretation of commissioning draws on the work of Ovretveit (1995) who distinguished commissioning from purchasing by describing a broad set of linked activities including needs assessment, priority setting, procurement through contracts, monitoring of service delivery and review/evaluation.

In this report, commissioning is interpreted in much the same way, seeing it as an activity carried out by an organisation (or collective of professionals) on behalf of a geographic or enrolled population, and entailing decision-making about needs assessment, resource allocation, service purchasing, monitoring and review.

3. WHAT ARE THE CURRENT ARRANGEMENTS FOR COMMISSIONING IN THE NHS?

Primary care trusts

Commissioning of NHS-funded healthcare in England currently takes place through two main routes.

The first is via primary care trusts (PCTs), the 152 statutory bodies with responsibility for improving the health of the local population by using public money to commission a range of health services. PCTs are responsible for the majority of NHS resources and for making decisions about spending priorities, taking account of local needs and national policy direction. They evolved from a merger of the primary care groups (PCGs) that were put in place by the Labour Government in 1999 (collectives of GPs, nurses, managers, social workers and lay people) and health authorities that were the main local NHS purchasing bodies until 2002.

The political move in 1997 to develop PCGs across England, replacing the 'mosaic' of fundholding and commissioning groups previously in place (Smith and others, 1997), meant that all GPs and their primary care teams became members of primary care commissioning organisations (in other words PCGs). Membership by practices of PCGs was compulsory, in comparison with the voluntary nature of GP fundholding and its variants such as total purchasing. PCGs evolved into PCTs, which crucially are not primary care organisations as understood in the 1990s in the UK (and in other countries currently) since they are statutory NHS bodies that assume a whole variety of functions previously performed by health

authorities (public health, partnership working with local government, purchasing of secondary and tertiary care, for example) and not 'owned' by local clinicians (Smith and Walshe, 2004; Smith and Mays, 2007).

The PCT model assumes that PCTs can become strong local commissioners, drawing together:

- public health expertise in needs assessment
- integrated funding for hospital, community and primary care services
- management responsibility for most community health (and sometimes mental health and some acute) services.

The PCT was created to assume financial risk for a defined geographic population, providing the community health services it had inherited, and buying in the rest within annual resource limits based on a nationally set capitation formula. The potential for PCTs as commissioners was underlined in *Shifting the Balance of Power: The next steps* (Department of Health, 2002: p8):

[PCTs will be taking] the lead in developing and redesigning systems in primary and secondary care as well as tackling public health issues locally [...] In addition [...], they will have 75 per cent of the total NHS budget allocated to them for decision making.

The PCT also has responsibility for the commissioning of primary care services, holding and managing the contracts for general practice, general dental services, local pharmaceutical services and optometry.

Practice-based commissioning

The second route for NHS commissioning is through practice-based commissioning. Practice-based commissioning is a form of primary care-led purchasing where PCTs allocate to practices a notional (not real) budget which can be used to commission community- and hospital-based services to meet the needs of the practices' registered population. Practice-based commissioners are – subject to the approval of the PCT – able to keep financial savings in order to develop other local services (that is, a not-for-profit arrangement), and they can pay themselves to provide such services (on a for-profit basis, although such services may be subject to a national tariff or price) or purchase them from other providers. Thus practice-based commissioning is not purely concerned with commissioning, it is also (some would say more so) associated with the extension of provision of primary care services by local practices. This was also a common feature of GP fundholding and total purchasing (Mays and others, 2001), where GPs took full advantage of these opportunities, for example, through forming limited companies through which to trade their provider services.

Practice-based commissioning takes a range of forms, depending on the local context and history, particularly in how practices work together and the relationship that they have with the PCT (Curry and others, 2008). These forms include:

- individual practices
- consortia of practices in a locality
- groups including all practices in a PCT
- organisations based on personal medical services (PMS) provider groups
- social enterprise organisations established to manage and coordinate practice-based commissioning.

In recent research undertaken by The King's Fund and the NHS Alliance (Wood and Curry, 2009), 30 per cent of respondents in a survey of practice-based commissioners reported that their practice-based commissioning cluster had set itself up as a formal organisation. Organisational forms being used in such cases include: company limited by guarantee; community interest company; social enterprise; and public limited company. One example of the latter was where almost all the practices in one PCT had joined the practice-based commissioning group that was run by two appointed medical directors. These part-time GPs received a separate salary and had protected time and resources to run the company.

PCTs group together for the purpose of commissioning specialised services, in order to spread financial risk for the costs of high-cost patients over a larger population and to optimise transaction costs. These specialised commissioning groups may operate at supra-PCT level, strategic health authority (SHA) level or at national level for services for people with very rare conditions.

What this all adds up to is a complex set of commissioning arrangements that can be considered as either a matrix or, as in work carried out in 2004 (Smith and others, 2004), a continuum of commissioning arrangements, running from the level of the individual (in other words, the holding of a personal budget with which to purchase care for one's health needs) through to that of a nation (see Figure 1 on p.37 for an updated version of the 2004 commissioning continuum). A fuller assessment of the current complexity of commissioning (and commissioning/providing) arrangements is made in Table 1, opposite, drawing on similar analysis carried out by Mays and Dixon (1996) of the 1990s internal market purchasing arrangements.

Table 1: Profiles of current commissioning models in the NHS, 2009

(adapted from Mays and Dixon, 1996)

	National (specialised) commissioning group	Supra-regional specialised commissioning groups	Regional specialised commissioning groups	Joint commissioning with local authority	Primary care trust	Whole PCT practice-based commissioning	Locality PBC consortium	PMS provider organisation	Single practice PBC	Personal health budget
Population size	50,000,000 ¹	5,000,000–50,000,000	3,000,000–7,000,000	As for PCT where boundaries are coterminous	Average 320,000 ²	Average 320,000	Average 100,000 ³	Average 5,500	Average 5,500 ⁴	1
Geography or practice-based	Country-wide	Geographical: four regional groups (north, Midlands, south-east and south-west)	Geographical (ten groups coterminous with SHAs)	Geographical boundaries	Geographical boundaries	All practices in a PCT area	Usually geographic, though sometimes practice-based	Practice-based	Practice-based	Individual
Degree of budgetary control for purchasing	Real budgets contributed by PCTs	Real budgets contributed by PCTs	Real pooled budgets and financial risk-sharing schemes	Several models of joint funding: pooling of funds, grants and delegation of functions. Also non-statutory options, eg, budget alignment ⁵	Own capitation-based budget for acute, community and primary care services	Indicative budget for a specific range of services	Indicative budget for a specific range of services	Own budget for core and extended primary care services, plus indicative PBC budget	Indicative budget for a specific range of services	Indicative budget. Possibly real budget from Sept 2010
Range of services commissioned	Very rare treatments such as heart transplants	Rare treatments including severe burns	Relatively rare treatments such as children and young people's cancers and haemophilia. Also CAMHS ⁶	Any health-related local authority service	All hospital and community health services and primary care	Varies, usually some community and secondary care services for long-term conditions (LTCs)	Varies, usually some community and secondary care services for LTCs	Varies, usually some or most community services, and other LTC services	Varies, usually some community and secondary care services for LTCs	Not yet up and running. Will be very limited to LTC services

Table 1: Profiles of current commissioning models in the NHS, 2009 *continued*

(adapted from Mays and Dixon, 1996)

	National (specialised) commissioning group	Supra-regional specialised commissioning groups	Regional specialised commissioning groups	Joint commissioning with local authority	Primary care trust	Whole PCT practice-based commissioning	Locality PBC consortium	PMS provider organisation	Single practice PBC	Personal health budget
Provider role	None	None	None	Can provide any health-related local authority service. Can also delegate functions	All community health services and sometimes services for mental health and people with learning difficulties	Core and extended primary care within and across practices	Core and extended primary care within and across practices	Core and extended primary care, including LTC services into secondary care	Core primary care and perhaps some extra services within practice	None
Management structure	London SHA hosts the NSCG ⁷ on behalf of all SHAs with representation from each regional SCG. NCSG has responsibility for oversight of specialised commissioning. ⁹	Groups of SCGs ⁸ work together in partnership. Each SCG is represented	Organised at SHA level. Dedicated multi-disciplinary team of officers carry out activity on behalf of PCTs	Some joint appointments of PCT and local authority but more often two separate organisations with bureaucratic hierarchy working in partnership	Bureaucratic hierarchy with public health, GP and other professional advice on commissioning	May have its own CEO and management support funded by PCT, or may come from PCT	Typically a manager within the PCT and access to other PCT support functions	Own management support funded through PMS and practices	Reliant on PCT management support for PBC	Individual manages budget and services with help from GP
Degree of autonomy from PCT/ influence over PCT	Extensive autonomy from PCT	Extensive autonomy	Each PCT is represented but group is fairly autonomous	N/A	N/A	Varies depending on local arrangements, but typically modest	Modest or weak	Extensive autonomy apart from via PMS contract and PBC agreement	Weak, as lack scale for extensive commissioning	Weak. decision-making powers currently limited but with potential to increase

1. www.specialisedcommissioning.nhs.uk/ for population estimates.
2. www.specialisedcommissioning.nhs.uk/3_who_does_ss_commissioning.htm PCT population range from around 200,000 (for example, Camden) to 600,000 (South Staffordshire, for example).
3. Based on the mean from survey data (Wood and Curry, 2009).
4. www.york.ac.uk/inst/che/pdf/rp3.pdf: average practice size in England is 5,500.
5. www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/ClarifyingJointFinancing4Dec08REP.pdf
6. Child and adolescent mental health services.
7. National specialised commissioning group.
8. Specialised commissioning group.
9. Decision-making for national commissioning ultimately lies with Ministers.

Table 1 characterises the current forms of commissioning in the NHS and how they differ along key variables – from specialised commissioning entities made up of multiple PCTs to various forms of practice-based commissioning – and includes some of the primary care provider organisations that also play a commissioning role, such as PMS groupings.

At least six main observations can be made from Table 1, assessing the current situation in relation to how this compares with models of commissioning that have been used in the NHS since 1991.

First, there is the interlocking continuum of commissioning arrangements that was mentioned earlier and is explored in more depth later in the report. As argued elsewhere (Smith and others, 2004), different services are amenable to different forms of commissioning. For example, primary care-led approaches are likely to be more effective for community-based chronic disease management and primary care services, given that patients with chronic disease receive much of their care in out-of-hospital settings, and GPs and other primary care professionals are well placed to specify how such care could be further improved.

Second, a minority of models are more ‘purely’ concerned with commissioning (such as specialised commissioning arrangements), while other models combine commissioning and provider functions. This dilemma of whether commissioners should be at once purchasers and providers has been present in NHS policy for almost 20 years. For example, Mays and Dixon (1996) noted the paradox of policy: on the one hand aiming for contestability between providers; and on the other eroding the supposed split between purchasing and providing through giving GPs increasing influence over purchasing of hospital and community health services.

Third, there is a relative lack of budgetary control and overall autonomy experienced by the practice-based commissioning models, except where they are based on a PMS-type provider organisation or consist of a large consortium with its own chief executive and management support. This is mirrored in the rather constrained range of services that many of the practice-based commissioning models appear to purchase. PCTs still retain much of the commissioning responsibility and all the financial risk. Existing primary care provider consortia (such as PMS arrangements) offer the most potential for autonomous commissioning of local services by GPs and their teams.

Fourth, is the persisting ‘twin-track’ of commissioning approaches for the majority of services in the NHS, with the ‘meso’ PCT- and population-based ones in many ways taking up where health authorities left off, and ‘micro’ practice-based commissioning and its variants following in the footsteps of fundholding and its alternatives (albeit more diluted). To this could be added an emerging third track of commissioning approaches: person-level commissioning via personal budgets. Furthermore, since 1991 (and for some services even earlier) there have been national and regional arrangements for commissioning specialised services, usually those that are high cost and low volume. Regional specialised services agencies existed prior to the implementation of the NHS market in 1991 and represent a relatively consistent (or persistent) part of the continuum of commissioning models.

The essential duality of population-based and patient-focused commissioning in the NHS has long been noted, as has the possibility that the sum of multiple micro purchasing decisions might not always add up to a pattern of service provision appropriate to the needs of the population concerned (Ham, 1996; Mays and Dixon, 1996). This is very relevant now that free choice of provider has also been introduced for

patients, further complicating the commissioning task. It raises a critical question about who designs, monitors and takes overall responsibility for the matrix of commissioning approaches in a local area, a topic that is looked at again later in this report.

Fifth, is the relative lack of diversity within the practice-based approaches to commissioning in 2010 compared to the 1990s, in particular the relative lack of autonomy of the practice-based approaches (from the PCT) and the fact that they do not hold real budgets. Since 1991 there have been few significant 'hybrid' approaches that have drawn hospital clinicians together with primary care doctors into commissioning organisations: the majority of practice-based commissioning takes place in locality consortia (Curry and others, 2008) with small numbers of 'innovators' developing approaches that extend beyond primary care into secondary or social care.

Finally, the approaches are all in effect accountable vertically to higher authorities within the NHS and Department of Health, with no examples of other accountability such as direct patient choice of commissioner (apart from the theoretical choice of practice-based commissioner by selecting a GP practice), or accountability to local people through more democratic/elected or patient involvement routes.

In summary, the most striking message from this analysis is the complexity of commissioning arrangements, the different levels at which commissioning takes place, and the overlap in many 'commissioning' organisations between provider and commissioner functions. This report focuses on commissioning currently undertaken at the level of PCTs and practice-based consortia, in order to understand the problems commissioners face and to provide some suggestions as to how these might be addressed.

4. WHAT ARE THE PROBLEMS WITH CURRENT COMMISSIONING ARRANGEMENTS?

Problems related directly to PCTs and practice-based commissioning policy

1. Weak control over volume of referrals

Expenditure by PCTs is largely driven by clinical choices made by GPs and hospital doctors, which the PCT cannot easily influence. Furthermore, patients now have free choice of provider, which means in theory, at least, that even if PCTs were able to influence clinical decisions in local general practices and hospitals, patients may choose care in other hospitals. This weakens considerably the control the PCTs have over their budgets, for although the tariff fixes the price of an episode of care, they struggle to exert an influence over how much activity is referred.

Some PCTs have set up management centres through which all GP referrals to secondary care must pass, offering PCTs a degree of control over GPs' referrals together with better information about them. The aim of these centres is to reduce inappropriate referrals and introduce a level of quality control, the assumption being that there are inherent inefficiencies within the system that can be removed (Davies and Elwyn, 2006). Evidence as to the impact of these centres is yet to emerge: their introduction has not been without controversy, with concerns being raised that they could lead to a loss of communication between generalists and specialists and have an impact on continuity of care (Davies and Elwyn, 2006), reduce patient choice, and lead to potentially dangerous, and costly, delays in treatment (Lapsley, 2007).

There has been a lot of effort by PCTs to try to reduce avoidable emergency admissions, for example, through identifying high-risk patients using risk stratification tools such as patients at risk of re-hospitalisation (Billings and others, 2006) and case management by community matrons, or a host of other interventions such as telehealth, telecare and virtual wards (Lewis, 2006). Again, the impact of these is only just emerging.

It is important to note that GPs only control a proportion of hospital activity (elective referrals and some emergency care) and PCTs have to pay for episodes of care that result from consultant-to-consultant referrals, and from other emergency activity. As is discussed further in this report, the incentives embedded in practice-based commissioning are not sufficiently strong for GPs to counteract the financial incentives for hospitals to increase activity.

2. Commissioner and provider functions mixed

PCTs also deliver community health services, although this is intended to cease in the near future, as the policy of Transforming Community Services (Department of Health, 2009d) is implemented, and community services are transferred into new organisational forms separate from PCT commissioners. Observers disagree as to whether having a provider function is necessarily a handicap or distraction for a commissioning organisation, and it is yet to be seen whether all PCTs actually stop providing services directly.

Indeed, one of the possible futures for commissioning set out in recent work by the Nuffield Trust and NHS Alliance (Smith and others, 2009) involves GP groups taking ‘make or buy’ decisions relating to health services for their enrolled populations and is deliberately based on GPs as providers. However, the key issue is whether an integrated commissioner–provider has responsibility for the delivery of the most appropriate services and can influence which services are provided directly and which are purchased from others.

3. *Organisational turbulence in PCTs relative to provider organisations*

PCTs and their forerunners have experienced numerous imposed reorganisations that have prevented them from making and demonstrating consistent progress over time (Smith and others, 2001; Dickinson and others, 2006). NHS acute trusts and foundation trusts have, overall, been less subject to periodic reorganisation over the past two decades. Indeed, the current Transforming Community Services policy represents the latest in a line of reorganisations faced by PCTs, as work is carried out to find new organisational and governance form for community health services.

4. *Autonomy limited*

PCTs are constrained in how they operate, being subject to direct performance management by SHAs and the Department of Health, having to keep within a specified budget annually, possessing no potential to retain savings and invest resources for future use, and having lower access to capital for investment. These features make PCTs more risk-averse organisations in comparison with provider trusts and foundation trusts, and restrict their capacity to implement bold and possibly unpopular commissioning strategies. Indeed, even where a PCT would like to make changes to its commissioning strategies, or decommission services, the need to break even

on an annual basis and to give six months’ notice to any change to a contract, limits its ability to make swift changes (NHS Confederation, 2009b).

5. *Relatively weak clinical leadership and engagement*

Clinical leadership and engagement in PCTs is typically weaker than in their provider counterparts. NHS trusts have a long history of clinical engagement in budget-holding, service planning and general management, dating back at least to the resource management initiative of the 1980s. The core feature of resource management and clinical budget-holding persists within many trusts which operate with a ‘clinical directorate’ model with (usually) a doctor in the clinical director role for a specific service, supported by a general manager and a senior nurse or other professional. Clinical directors often form part of the main management team of a hospital or other provider, ensuring clinician involvement in strategic leadership of the organisation.

In PCTs, or practice-based commissioning groups, there is no direct equivalent of a clinical directorate system for the commissioning activity of organisations. Clinical engagement and leadership rest significantly upon GPs’ involvement in professional executive committees, which may be more advisory in nature rather than playing a central role in driving change (NHS Alliance, 2006).

Furthermore, GPs are contractors to PCTs (and hence volunteers in respect of providing clinical advice to PCT commissioning), and not core employees in the way that consultants are within NHS and foundation trusts. Practice-based commissioning has gone some way to increasing clinical involvement in PCT business but such engagement remains purely voluntary and, as such, relies upon the personal enthusiasm of GPs, resulting in very variable levels of engagement across the country. Thus PCTs face a significant challenge in respect of clinical legitimacy.

6. *Public legitimacy of commissioners*

A fundamental issue that has some bearing on the capacity of PCTs as commissioners – at least in terms of their role in seeking to interpret and enact local health priorities and needs – relates to the perceived or actual public legitimacy of the organisations (Thorlby and others, 2008).

Accountability to the local population is arguably weak (Glasby and others, forthcoming), other than for decisions about significant change in services for which there is a statutory duty to consult. In a Local Government Association report (Local Government Association, 2008, p3¹), ‘more than half the respondents did not know what a PCT was or did. Almost three-quarters of those questioned could not name their local PCT, and fewer than one in ten had been involved in a patient group or any other forum concerned with local NHS services.’

The local population has no choice of PCT, and unpopular PCT boards cannot be voted out by local democratic processes. Instead, the lines of accountability run upwards to the SHA and, ultimately, to the chief executive of the NHS. On the other hand, NHS foundation trusts were established as public benefit corporations and have a membership drawn from the local community, although the number and involvement of members is variable.

Arrangements for public involvement include local involvement networks, which are independent networks of individuals and community groups who work to improve local health and social services. How far they are able to have a significant influence on the scope, quality and direction of local services is as yet unclear.

PCT commissioners are also held to account by the health overview and scrutiny committee

(OSC) of the relevant local authority, a body comprised of elected local councillors that has a responsibility for scrutinising how local health services are provided and developed. OSCs can invite senior staff to provide information and explanations about how local health needs are being addressed, with the intention of enabling open local debate about specific services, or care for people with a certain condition.

A further area where PCT legitimacy is sometimes subject to challenge – and is likely to be to a greater extent as the financial downturn impacts on health funding – is in how priorities for health funding are set, both in respect of investment and disinvestment. Recent commentary (Crump, 2008) suggests that PCTs have yet to focus much time and attention on decommissioning services, and new research (Robinson and others, forthcoming) will report on how far PCTs have arrangements in place for making such decisions, and what they do in order to account to or involve the public in such decision-making.

7. *Capability and capacity for commissioning*

‘World Class Commissioning’ (Department of Health, 2007a) represents an attempt to articulate the skills a commissioner might require and how these should be developed. There is, however, a lack of specific training for commissioning – the first courses have only recently started at the University of Teeside² and the University of Birmingham. This is in stark contrast to the well-established NHS management scheme that has specific streams for general, human resource, finance, information and communications’ management, but no dedicated cohort for commissioning.

Unsurprisingly, research studies have pointed to a critical skills gap among commissioners, both at

1. www.lga.gov.uk/lga/aio/721828

2. www.healthcarerepublic.com/education/index.cfm?fuseaction=HCR.Education.Courses.Article&nEventID=3238

PCT and practice-based commissioning levels. A recent survey found that 80 per cent of practice-based commissioners felt they lacked some or all the necessary skills (Wood and Curry, 2009). The 'necessary skills' that they identified included, among others: negotiation, financial aptitude, data analysis and management. Similarly, PCTs themselves acknowledge that they struggle to fill commissioning posts with experienced individuals (Curry and others, 2008). Given that commissioning is a relatively new role within the NHS, perhaps this is not surprising. A further issue is that skills for commissioning take a long time to develop, as does an in-depth understanding of a local health community and its needs. As noted earlier, commissioning organisations in the NHS have been reorganised approximately every two to three years since the early 1990s, meaning that key commissioners – and their skills – are lost to organisations and the system has to redevelop such capacity and capability.

World class commissioning represents a statement of intent towards which commissioning bodies should be working: the intention of the statement being to drive 'unprecedented improvement in patient outcomes' and ensure that 'the NHS remains one of the most progressive and high-performing health systems in the world' (Department of Health, 2007a: p1). In so doing, the Department of Health hopes that world class commissioning will shift the focus away from more passive contracting towards proactive commissioning focused on prevention and wellbeing. Underpinning the vision is a set of 11 competencies, each of which is supported by a series of skills. The skills range from the very specific (for example, database management) through the very general (for example, relationship building), to the highly skilled (accountancy and

priority setting, for example), highlighting the variety of skills that commissioning requires (Department of Health, 2007b).

In order to judge PCTs' progress against competencies, an assurance framework has been developed by the Department of Health. The first round of assurance reports was completed in February 2009. The Department of Health set expectations deliberately low, suggesting that most PCTs would only score around 1 or 2 in the four-point scoring system. Actual scores exceeded these expectations with level 3 being awarded 37 times. At first glance, these results might suggest that commissioning is in a better state than first anticipated. The Department of Health, on launching the second assurance process, noted:

The results from last year's assurance process shows PCTs are making real improvements in the way they commission services but there remains much to be done in the coming year.

(Department of Health website,¹ 16 September 2009)

The NHS Confederation concurred, claiming that:

... there is no doubt that [world class commissioning] has had an impact. The profile of PCTs as local leaders of the NHS has risen, and the growing confidence and focus of commissioners is reflected in their ambitious strategic plans.

(NHS Confederation, 2009b)

The Audit Commission has also identified some encouraging indicators of progress. The latest Annual Local Evaluation report of PCTs pointed to an 'overall picture ... of significant improvement over the three years assessed' (Audit Commission, 2008). One example highlighted was of Ashton, Leigh and Wigan, a PCT that had sought to achieve successful commissioning by establishing a single commissioning agency in

1. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105117

partnership with the local council. A further example of good progress highlighted by the Audit Commission was that of the five-year commissioning plan developed by Heywood, Middleton and Rochdale PCT, underpinned by a financial modelling tool that was intended to inform strategy and planning (Audit Commission website, good practice examples¹).

However, the usefulness of the world class commissioning assurance-scoring framework has been called into question. The four-point scoring system has been criticised as too limited (Lynas, King's Fund website²), allowing PCTs at very different stages in their development to achieve very similar scores. The handbook for the second assurance process states that the revised assessment framework is more targeted with a focus on quality and productivity, but the four-level scoring system has been retained (Department of Health, 2009e). Concern has also been expressed that the type of criteria used might not be easy to score precisely (Woodin and Wade, 2007).

The CQC's Annual Health Check (2008/09) indicated that 70 per cent of PCTs fully met the core standards as commissioners of services. A further 28 per cent 'almost met' the standards, 1 per cent 'partly met' them and no PCTs were classed as not having met the standards. No comparison with earlier years was possible as this was the first year PCTs had been required to make separate declarations as commissioners and providers. Previously, PCTs had made one overall core standards declaration – in 2007/08, 5 per cent scored 'not met' and in 2006/07, it was 11 per cent. In addition, in 2008/09, 51 per cent of PCTs were full year compliant for all core

standards as commissioners. In the joint declaration in 2007/08, only 21 per cent were full year compliant (Care Quality Commission, NHS performance ratings 2008/09³). This suggests that progress is being made in respect of commissioning performance. It will be interesting to see what the second round of world class commissioning assessment reveals in this respect.

Although capability is clearly a critical factor in delivering the world class commissioning agenda, the weakness in commissioning also stems from limitations in capacity. The Audit Commission and Healthcare Commission pointed to 'under-developed commissioning capacity' as a key limitation in the reform programme (Audit Commission and Healthcare Commission, 2008). Commissioners have expressed concern about the burden of collecting and compiling information and evidence for the assurance process (Department of Health, 2008a) and, although the Department of Health has promised to align the three assessments required by world class commissioning, the Care Quality Commission (CQC) health check and the Audit Commission's assessments, some critics still question whether the effort entailed in data collection will be outweighed by the benefits of improved commissioning (Ham, 2008).

Practice-based commissioners frequently cite a lack of time as the prime reason for their limited involvement in commissioning activities, something that has been highlighted in numerous studies of primary care-led commissioning (Mays and others, 2001; Regen and others, 2001; Dowling and Glendinning, 2003; Smith and Goodwin, 2006). Most see practice-based commissioning as something they dabble in after

1. www.audit-commission.gov.uk/health/goodpractice/pages/default.aspx

2. www.kingsfund.org.uk/what_we_do/articles/world_class.html

3. www.cqc.org.uk/_db/_documents/0809_NHS_ratings_overview_document_161009_200910164847.pdf

hours when they have some spare time – few GPs have managed to ring-fence significant time to engage in practice-based commissioning and few appear to feel that there is much incentive to do so (Curry and others, 2008; Coleman and others, 2009).

Attempts have been made centrally to strengthen commissioning through establishing the Framework for External Support for Commissioning (FESC) in 2007 and, in late 2008, the Practice-based Commissioning Development Framework. Both frameworks are intended to provide PCTs and practice-based commissioners with support to achieve the aspirations of world class commissioning. Both frameworks allow for a range of support to be purchased – from joint work between the PCT/practice-based commissioners and the private provider to complete outsourcing of elements of commissioning. Little is known about the uptake of the practice-based commissioning development framework yet (having only been introduced in December 2008) but research into uptake of FESC suggests that only ten contracts, albeit of large monetary values, have been signed (Naylor and Goodwin, forthcoming).

8. Data and information

As mentioned above, data analysis has been identified as one of the key skills required by practices and PCTs to undertake effective commissioning but one that many of them feel they lack. As more data are available and able to be linked at person-level, commissioners want to analyse demand (public health and epidemiology data, together with information about service utilisation) in far more detail. The lack of analytical skills to manipulate and investigate data has led some SHAs to develop data ‘warehouses’ or commissioning business support units that concentrate staff with specialist skills, for example, as in the West Midlands Strategic

Health Authority’s Commissioning Business Support Agency.

PCTs often receive hospital activity data some time after the event and have limited time and specialist expertise to challenge any coding. As mentioned earlier in this report, referral management centres set up by PCTs can provide detailed information about referrals, this being of value to a PCT looking to redesign services and reduce avoidable secondary care activity. This could also be of use to PCTs in monitoring quality and safety.

9. The relationship between practice-based commissioning and PCTs

The introduction of practice-based commissioning has meant that commissioning roles have been dispersed across PCTs and practice-based commissioning clusters. As noted above, the organisational structure of practice-based commissioning is undeveloped relative to that of the PCT, and relative to hospitals. This means that hospitals either negotiate with a PCT – whose capacity to influence clinical referral decisions is limited – or disparate practice-based commissioning groupings, who are largely relatively ineffective and uncoordinated. There has consequently been a lack of engagement with hospital-based clinicians to allow meaningful transfer of clinical risk to ambulatory care. Furthermore, contracts with trusts are inflexible, long-term and difficult to change. For these reasons, practice-based commissioning groups, as well as total purchasing pilots and fundholding practices before them, have been largely unable to reshape hospital services in a significant manner (Smith and others 2004; Curry and others, 2008).

Another reason might be the lack of incentives in practice-based commissioning for GPs to get involved in strategic decision-making at a PCT level. In practice-based commissioning, the budgets are ‘notional’ not ‘hard’, the financial risk for commissioning decisions still sits at the PCT,

and there are relatively few sanctions available to a PCT if a practice-based commissioner is over-spending. A PCT may strip a practice-based commissioner of its budget but, given that the budget is 'notional' anyway and arguably does not afford the GP(s) much freedom, it presents little threat to GPs unwilling to engage. Another sanction theoretically available is for the PCT to remove a GP's contract, which is an extremely blunt tool and arguably disproportionate in the circumstances.

10. The constraints of financial cycles

It is not at present possible for practice-based commissioners to transfer commissioning funds (i.e. savings) into the general medical services (GMS) budget for primary care (i.e. the general practice 'business'), although GPs may make person financial gains if they set up a limited provider company and trade through that vehicle. Conflicts of interest are inherent in these arrangements, as seen in fundholding and its variants (Goodwin, 1998). While PCTs are responsible for policing practice-based commissioning, many are struggling to put workable governance processes in place to deal effectively with such conflicts (Curry and others, 2008). PCTs also face constraints related to financial cycles, and these are explored later in this report, in relation to differentials in PCT and provider trust power and status.

11. Notional not 'hard' budgets

One reason why practice-based commissioners have 'notional' rather than 'hard' budgets is because the method of setting a budget for such groups is at present crude; the allocation methodology being an insufficiently accurate predictor of future costs. If practice-based commissioning groups were to receive hard budgets using the current method of resource allocation, many would make windfall savings through chance occurrence, and similarly others would make windfall losses through no fault of

their own. The Department of Health funded further analysis to improve the accuracy of practice-based commissioning budgets and to develop a person-based risk adjusted resource allocation model. This model is being used in the NHS for budget allocations from 1 April 2010 (Dixon and others, forthcoming).

Other reasons for the allocation of notional, rather than real, budgets to practice-based commissioners include: caution on the part of policy-makers about allocating significant sums of public money to new and unproven GP organisations; a desire for practice-based commissioners to prove capability as commissioners before assuming real budgets; an intention to shift budget allocations towards 'fair shares' before making them 'real'; and protecting practice-based commissioners from full financial risk. There is also work to be done to determine the level at which different financial risks would need to be pooled, how practices/consortia would be held to account for both financial and health outcomes, and to determine whether clinicians would be able to gain personally from any surpluses or put their personal businesses at risk in the case of deficits.

Problems related to the wider features of the English NHS

1. Weak incentives for commissioners to improve quality and reduce costs of provision

Commissioners have had incentives to improve arising from scrutiny and challenge by SHAs, by overview and scrutiny committees set up by the local authority, and by regulators such as the Care Quality Commission (for quality) and the Audit Commission (for financial management and use of resources). However, the metrics for use by regulators when assessing the performance of commissioners are still relatively undeveloped, and the prompt by regulation is less powerful than a financial squeeze or central directive.

As noted above, there is little challenge coming from local populations because local accountability is relatively weak.

This may change, as from 2011 the NHS receives practically no real terms increase in funding for frontline care and cuts in other budgets, for example, a suggested 30 per cent cut in management costs by PCTs and SHAs (Department of Health, 2009b).

2. The power differential between PCTs and trusts
PCTs, the main NHS commissioning bodies, appear to be fundamentally weaker organisations when compared with the powerful position occupied by health providers, and, in particular, hospitals. This is probably for a number of reasons. For some managers, working life in hospitals may be perceived as more exciting and challenging than in a PCT, being closer to highly specialised patient care and able to see more direct consequences of management effort. There is also some evidence that average salaries are higher in trusts than in PCTs (Belfield, 2010).

The status of hospitals relative to PCTs is different. PCTs have been described as network organisations (Peck and Freeman, 2005) that draw together a range of providers, funders and planners in a wider network of NHS and local government partnerships. This contrasts with the institutional nature of hospital trusts whose buildings, services, staff – and even name – typically embody a central position and role within the life and history of a particular community. A PCT is neither likely to be known, nor its function understood, by most members of the public, but a hospital will be well known and regarded as a critical part (and fundamental to the place-shaping) of the locality or town (Wade and others, 2006).

Analysis of NHS management has pointed to a ‘twin track’ career path, whereby there are parallel cohorts of senior managers: the one concentrated

within provider services and focused on gaining posts in ever larger acute hospitals; the other located within purchasing, funding and primary care organisations, including health authorities and primary care trusts (Smith, 2009).

Another contemporary feature reinforcing the difference in status between the two sets of managers relates to the foundation trust programme, which, hitherto, has focused largely on acute hospitals. As a result, the managers of these hospitals can argue that they are highly autonomous and fully responsible for their own ‘businesses’, and demand greater rewards and as a result have arguably higher status. By contrast, PCT executives are seen by some as responsible for implementing government priorities, a quasi-bureaucratic and, therefore, lower-status activity in the management world.

The structure of NHS finances has created a further imbalance of power between PCTs and foundation trusts. PCTs are required under the Resource Accounting and Budgeting rules to break even each and every year (Department of Health, 2001). This means that any revenue surplus made must be used up in the year immediately following and so necessarily prevents a PCT from building up significant savings to make large-scale service change. In contrast, foundation trusts have much greater financial freedoms as they are not required to break even in the year and are able to operate more like a business (building up surpluses and borrowing funds). This affords foundation trusts greater opportunities to make significant longer-term investments.

3. Payment by results

The current NHS payment regime is another factor impinging on the ability of PCTs and practice-based commissioners to strengthen their commissioning function. The way that the payment by results system of reimbursing providers for activity is established means that

the tariff for each healthcare-related group may include a number of associated procedures such as diagnostic tests. Although practice-based commissioners may be interested in undertaking some of those procedures themselves, thus cutting costs and providing a more convenient service, pricing this fairly is difficult. There is little incentive for providers to assist PCTs in 'unbundling' these tariffs, hence PCTs struggle to calculate an accurate amount. Efforts are now being made to unbundle the tariff at a national level (Department of Health, 2009c) but ambiguity remains for many component services that could be undertaken outside hospital.

A further challenge for commissioners in respect of payment by results is that the combination of patients having free choice of provider and a policy of PCTs having to reimburse 'any willing provider' means that commissioners find themselves passively reimbursing hospitals for elective activity. As noted earlier in this report, PCTs have few levers with which to control volume, other than through referral management.

Such issues with the inpatient tariff and absence of community tariff are compounded by

contractual complexities. Although PCTs theoretically have the power to decommission services and shift activity to alternative providers, the reality is quite complex. A survey by the *Health Service Journal* in 2007 revealed that the majority of PCTs had failed to decommission any services (Crump, 2008).

A discussion paper by the NHS Confederation suggests that when a service is decommissioned there is a tendency for activity to increase in other services, therefore negating any financial benefit of closing the service (NHS Confederation, 2009b). If a commissioner is successful in preventing this displacement of activity, the viability of the provider may be threatened and this may have implications for other services they are providing. There is obviously a need for alternative services to be put in place to replace those being decommissioned, but given the need for PCTs to break-even on an annual cycle and restricted access to capital investment, they have relatively little scope for making large commissioning/decommissioning decisions (NHS Confederation, 2009b).

5. THE VERDICT ON COMMISSIONING TO DATE

PCTs have been much criticised for an alleged lack of effective commissioning and failure to bring about significant change to patterns of service delivery, particularly in the acute sector and intermediate care. It could be argued that these accusations have been too harsh and that the achievements of PCTs, such as ensuring significant reductions in waiting times for treatment,¹ establishing clinical governance structures and processes to assure quality and safety (National Audit Office, 2007), putting in place new providers such as GP-led primary care centres, and bringing about financial balance following a period of significant deficit² have been under-represented. PCTs have developed extensive local public health improvement plans (along with their local authority partners) and implemented numerous national strategies for different services and client groups.

Practice-based commissioning, as with its predecessor primary care-led commissioning, seems to be effective in developing extended primary care (Smith and Goodwin, 2006; Coleman and others, 2009), and the creation of local GP consortia provides a platform upon which the next phase of clinical commissioning and provision can be built.

Achievements have not been championed enough, especially given the widespread

disruption of reorganisation of PCTs in 2002 and 2006. As noted earlier, world class commissioning results have exceeded expectations with far more PCTs gaining 'level 3' than expected, and recent research suggests that the English NHS is more productive than its equivalents in the other three UK nations (Connolly and others, 2010).

But while acknowledging there has been progress (much of it arguably a result of national guidance and targets, rather than local commissioning), it is difficult not to agree with a verdict made jointly by the Audit Commission and Healthcare Commission in 2008:

Despite the intention to move care out of hospitals and into a primary or community care setting, limited progress appears to have been made. Commissioning and contracting skills are not yet strong enough to drive this agenda, although some PCTs can point to successes [...] The incentives and infrastructure to support PBC [practice-based commissioning] are not currently sufficient to engage most GPs in commissioning.

(p5)

As the economic downturn feeds through to the NHS and the challenges posed by patients with long-term conditions continue to mount,

1. The latest waiting times date, release September 2009 showed that 93.6% of admitted patients and 97.7% of non-admitted patients completed their referral to treatment pathway within 18 weeks: <http://nds.coi.gov.uk/clientmicrosite/Content/>

[Detail.aspx?ClientId=46&NewsAreaId=2&ReleaseID=406722&SubjectId=36](http://www.audit-commission.gov.uk/Detail.aspx?ClientId=46&NewsAreaId=2&ReleaseID=406722&SubjectId=36)

2. Audit Commission, *Financial Management in the NHS 2007/8*.

it is critical that PCTs and practice-based commissioners are in a position to make bold and radical decisions. In particular, what is needed is a reorientation of services towards care at home or in the community, care that is person-centred, seamless and ‘integrated’, and high-quality (Department of Health, 2006). In tandem with this, PCTs will need to work with providers to determine the future pattern and shape of services in hospitals, examining what can be decommissioned and re-commissioned in a way that assures quality and extracts economic value for the taxpayer.

It is difficult to see how this can happen without three main factors:

- A significant prompt towards care being orientated towards the needs of patients – whether this is enacted through encouraging competition for patients by commissioners and providers, regulation, new forms of local accountability, personal budgets, central

command, or another set of incentives, financial or otherwise.

- Significant encouragement for clinicians – in particular doctors, who are responsible for most healthcare expenditure decisions – to take leadership responsibility in managing resources and extracting more value from them.
- A huge advance in the exploitation of patient-level information on costs, quality and use, to provide clinical leaders and patients with the tools to make better decisions.

The next chapter examines what needs to be done to address the problems currently associated with NHS commissioning. The factors associated with PCT and practice-based commissioning are examined, along with features of the wider health system, for it is all too easy to blame commissioning for lack of progress when other aspects of the wider system reform physiology have impeded overall improvement.

6. WHAT NEEDS TO BE DONE?

The problems identified above are not simply going to go away with time. The recent attempt at reinvigorating practice-based commissioning may have gone some way to reawakening the dying embers of interest in it but, without a more radical rethink of the way the NHS commissioning system is currently organised, it is not sufficient to tackle the key problems. Although it is likely that providers will always have the upper hand due to information asymmetry, institutional power and clinical leadership, it is essential that this upper hand is somehow mitigated by effective clinically-led commissioning, especially given the forthcoming financial and health challenges facing the NHS.

The potential solutions can be divided into two sections: those concerned with addressing problems related directly to PCTs and practice-based commissioning policy; and those that are connected with the wider features of the NHS in England.

Where ‘extended practice-based commissioners’ are referred to, this includes entities that are elsewhere described as integrated care organisations, multi-specialty groups, local clinical partnerships, accountable care organisations and provider–commissioners.

Addressing problems related directly to policy

Incentivising GPs beyond practice-based commissioning

What needs to happen in order for GPs to feel that it is worth their while to get involved in service planning and development in the way that many did through GP fundholding, locality commissioning and total purchasing during the 1990s?

Practice-based commissioning practices or consortia could be granted real risk-adjusted budgets for certain or all elements of their activity, with the promise to keep savings to invest in patient care – as explored in a recent Nuffield Trust and NHS Alliance report (Smith and others, 2009). Much like the idea of ‘accountable care organisations’ set out by Fisher and others (2007) in the United States, doing so would align financial risks with potential gains, providing a clear incentive for GPs and other clinicians. Extended practice-based commissioners would, therefore, take responsibility for the health outcomes of their registered population and would assume proper control of the service planning, development and commissioning process.

The Department of Health funded analysis to develop a person-based risk-adjusted capitation formula as a basis to set budgets for practices to commission hospital and community health services (Dixon and others, forthcoming). Such a formula is now being used to set budgets for

commissioning practices across England from 1 April 2010. The analysis shows that for the first time an empirical basis can be used to decide what population size is necessary for commissioners to cover and take on an appropriate level of financial risk – thus allowing ‘hard’ budgets to be taken by extended practice-based commissioners without undue risk, and appropriate risk-sharing arrangements to be made with the PCT, consortia of practice-based commissioners, or indeed the strategic health authority.

Whether or not the allocation of a ‘hard’ budget to practice-based commissioners would be sufficient incentive to engage GPs in commissioning in an active manner is open to question. Evidence from the past (Goodwin, 1998; Croxson and others, 2001; Mays and others, 2001; Smith and others, 2004) suggests that some direct personal financial incentive is likely to be needed, for example, allowing practice-based commissioning groups to re-route funds from the budget for hospital and community services to primary care. This was controversial in the 1990s because of potential conflicts of interest, and there would need to be stricter scrutiny of the appropriateness of this than was present then. The issue of incentives for clinical commissioning ‘beyond practice-based commissioning’ is examined in more detail in *Beyond Practice-based Commissioning: The local clinical partnership* (Smith and others, 2009).

A less radical solution would be to formalise and better remunerate clinical involvement in strategic commissioning. This might entail a contractual requirement for GP representatives to attend meetings and contribute to decision-making in return for a higher level of personal payment. The development of practice-based commissioning compacts (agreements) might go some way to achieving this, and it is essential that any formal

agreement should tackle the issue of GPs’ provider/commissioner conflicts of interest head on, enabling agreement of proportionate and flexible governance processes at a local level. This approach would be tentative and in no way adequate for the future challenges relating to demands or funding levels.

Providing clinical commissioners with practical management and strategic support

Given the undeveloped nature and small scale of practice-based commissioners, it is unlikely that many would have adequate infrastructure, skills, or even purchasing power (depending on size of population covered) to make the required impact on patient care. This support (initially, at least) must be given by the local PCT, which, ultimately, would serve practice-based commissioners with management infrastructure in a way that creates a meaningful organisation for dialogue and collaboration with hospitals and, in particular, clinical directorates. The size of population covered by the practice-based commissioning group must be large enough to take on the financial risk of a ‘hard’ budget (as discussed below), as well as have actual purchasing power if it is to have a reasonable negotiating position with local hospital providers. In some areas of the country, PCTs have this vision and are actively supporting practice-based commissioning groups that wish to assume greater responsibility and accountability, helping them to develop into serious entities that could lever change.

Engaging hospitals: extending practice-based commissioning to encompass integrated care organisations or multi-specialty groups

Practice-based commissioning groups, if developed along the lines described above, are likely to have closer contact and collaboration with doctors and managers in clinical directorates in hospitals to develop evidence-based care

pathways, outcome measures, analysis of costs and potential for efficiencies along care pathways or across services. This will help develop patient-orientated and better integrated or coordinated care. Collaboration of this nature between practice-based commissioners and secondary care clinicians is likely to spawn much greater attention to information about care pathways (cost, quality and use by patients and clinicians), as well as locally crafted financial incentives to achieve desired objectives.

A step on from this collaboration between essentially clinical directorates within two separate organisations (practice-based commissioning/primary care, and hospital/trust) could be a move to networks with shared governance, IT infrastructure and budgets, in a similar way to how integrated care organisations operate in the US. Such groups would be effectively ‘delivery systems’ that are at risk for a capitated budget based on the population covered and are able to commission services they cannot themselves provide. They might focus on the delivery of care for a specific clinical condition such as diabetes, or multiple conditions to cover the comprehensive care of an entire local geographical population. This type of development was envisaged in the Next Stage Review (Department of Health, 2008b) and termed integrated care organisation, although in a previous Nuffield Trust and NHS Alliance report it was described more fully and termed a ‘local clinical partnership’ (Smith and others, 2009). The possible migration path of practice-based commissioning towards such integrated care organisations is discussed in more detail in the Nuffield Trust/King’s Fund report that forms the second report in this series (Lewis and others, 2010).

Whatever the route from practice-based commissioning towards some form of integrated care organisation, there is a critical issue to consider about whether such organisations take

responsibility for assuring an overall ‘medical home’ (Rosenthal, 2008) for all patients, coordinating care wherever the patient goes in the health system, and/or if they focus on a specific care pathway or client group. In the case of the latter, the question to be asked is who, within the overall commissioning continuum, ensures overall coordination and management of local commissioning arrangements. Presumably this falls to the PCT as the local body responsible for improving health and ensuring service provision.

A new role for larger and fewer PCTs

Any extension to practice-based commissioning, such as delegating real and risk-adjusted budgets for the provision and commissioning of care for a local population, would have a direct impact on the commissioning role of a PCT. If all practices in a PCT area were part of an extended practice-based commissioning or integrated care organisation, this would fundamentally challenge the commissioning role of the PCT. Such a situation would require that the PCT focus on holding a local or regional network of these new organisations to account on behalf of the NHS, and might entail a shift of significant financial, analytical and other management support from the PCT into these organisations, at least initially.

In the longer term, a scenario of extended practice-based commissioners would probably lead to fewer and larger PCT/funding bodies that would focus on priority setting, funding, setting contracts with these organisations, and holding them to account for quality, cost and outcomes. It would also fall to the PCT, as now, to design and orchestrate the overall local or regional commissioning continuum/matrix, ensuring that services were commissioned at the appropriate level by the right organisation, and holding the different elements of the continuum to account for the outcomes secured, both in relation to health and value for money.

Furthermore, it has to be possible that, over time, PCTs will disappear and SHAs (or something like them) will hold the extended practice-based commissioners/ICOs to account. In turn, this administrative tier would need to be accountable centrally, perhaps to something like an independent NHS board.

However, in a scenario of mixed progress towards extended practice-based commissioners/ICOs, PCTs might need to manage a diverse situation of some devolved and ‘full health accountability’ contracts, alongside PCT responsibility for commissioning where practice-based commissioning was less developed or lacked the willingness/capacity to take on an extended role. Whether PCTs would handle this by doing such commissioning themselves, or by tendering for other organisations (for example, neighbouring extended practice-based commissioners, integrated care organisations, or private suppliers) to perform such a role, is open to question.

Any move to larger PCTs would have a potentially adverse impact on the links between health and local government at a city/county level: links which enable significant joint working and commissioning of care that seeks to address the needs of often marginalised groups of the population (people with learning disabilities, older people, services for those with mental health problems, for example). Practice-based commissioning does not have a track record of engaging in this joint provision and commissioning with local authorities, so with any development of ‘full health accountability’ ICOs would need to explore how such joint work could be sustained and further developed.

Assuring legitimacy for commissioners

A fundamental challenge noted above is how to ensure that care is more firmly directed towards the concerns of users or potential users, rather than providers or commissioners. One relevant

aspect is how to increase the local accountability and therefore the public legitimacy of commissioners, whether they are PCTs, practice-based commissioning groups as now, or extended practice-based commissioners/ICOs. This will be increasingly important for the tough resource allocation and commissioning decisions that lie ahead.

There are a number of options for boosting local accountability of PCTs (Glasby and others, forthcoming) – for example, moving NHS purchasing into local government, or having elected health boards/PCTs (as suggested by the Liberal Democrats). Another route might be to extend foundation trust status to commissioning organisations, requiring them to develop a group of members who have a say in how the organisation is run. This would at least put them on a level playing field with their provider counterparts, enabling them to behave more like a business – retaining savings, investing to save and so on. It would also go some way towards raising the profile and status of PCTs, and practice-based commissioners (and their extended/ICO successors) in communities and regions, offering local populations an opportunity to hold a stake in the decision-making of local health funders and planners and giving commissioners greater legitimacy for decisions about funding priorities.

However, since over 50 per cent of provider trusts are now foundation trusts and, therefore, not subject to performance management by SHAs, PCTs are the main local NHS organisations that in theory at least the Department of Health can influence through directives. Given the financial challenges ahead, it seems unlikely that the Department of Health would allow this line of influence to PCTs to be cut, unless there was an organisation as effective as Monitor as a regulator of PCTs, or there was another route to more accountability to the populations PCTs serve. One

such route might be to allow patients to choose their commissioner. This is discussed in more detail in the second report in this series, which explores the potential of ICOs to compete for patients within an NHS market (Lewis and others, 2010).

Allowing commissioners more financial flexibility

PCTs and practice-based commissioners would clearly benefit from having a greater degree of bargaining power with providers at the negotiation table. The complexities of decommissioning services as described above make it difficult for commissioners to register their satisfaction, or otherwise, with any given service through shifts in activity (NHS Confederation, 2009b). While foundation trusts are able to act as businesses, making medium- to long-term investment and disinvestment decisions, PCTs and practice-based commissioners are limited by the resource accounting and budgeting rules and therefore less able to shift resource across different years in ways that may have longer-term benefits. Allowing PCTs or extended practice-based commissioners to operate more like businesses (or foundation trusts) by phasing financial commitments across more than one year would enable them to more easily exercise market forces and therefore help them to stimulate the market – a key competency that remains in the world class commissioning framework.

Addressing problems related to the wider features of the English NHS

Reforming payment by results

Associated with the inflexibility of contracts between PCTs and providers is the structure of the payment by results tariff. At present, there is a need for tariffs to be unbundled to enable

practice-based and PCT commissioners to select the elements of the service they wish to alter, either by shifting activity away from an existing provider, taking on the provision themselves, or rebundling elements of service to form a new care pathway to be commissioned. Current payment by results bundles make it extremely difficult for a PCT to estimate the cost of one part of a procedure that a practice-based commissioner, or indeed the PCT, may wish to re-provide.

Although the need for changes to the tariff has been recognised by policy-makers (Department of Health, 2009b) and some unbundling has occurred at a national level, this has not yet happened for many activities/treatments, and the tariff still does not apply to many community health services. While the onus is on local health communities to work together to negotiate reasonable payments for services provided outside hospital, disagreements over what is a fair level have delayed the start of some practice-based commissioning activity (Curry and others 2008). National policy continues, therefore, to inhibit PCTs wishing to be more transformative in the way that they commission and develop new services.

In the medium to longer term, if integrated commissioner–provider organisations evolve ‘beyond PBC’, taking on a fully capitated budget on behalf of their registered populations, it may be that the financial currency is not a national tariff, but some other locally agreed set of prices. This would be a major departure of policy, and might be prompted by the need to make significant efficiency gains in the next three to five years. If such a move did take place, there would have to be concomitant evolution in measures of quality, to ensure that price competition did not occur at the cost of quality. Measures of quality of care are too undeveloped at present to allow this departure from current policy to happen safely.

Setting funding priorities and direction

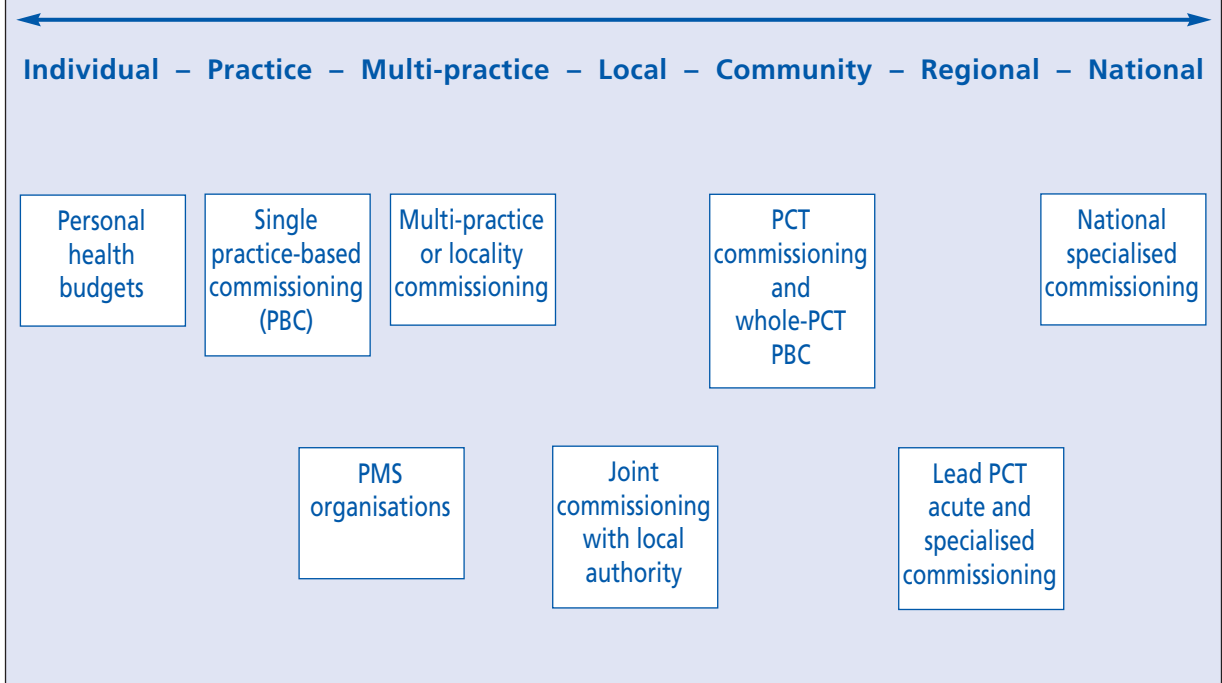
In addition to some of the clinician-focused options for commissioning at a local level, there is the potential to shift the balance of power further towards commissioners at a national level. The Conservatives have proposed an independent NHS board (Conservative Party, 2009) and there may be scope in this type of model for a national commissioning function that would set the overall broad framework for PCTs, practice-based commissioners, or ICOs 'beyond PBC', including national health outcomes and care pathways. Given their electoral mandate it is, arguably, the job of government ministers to set overall priorities and direction in the NHS. A move to devolve such a responsibility to an independent board would represent a new direction for the NHS, and would highlight the long-standing tension between having national/central priorities and locally defined spending and service plans. In other words, how far would local 'full health accountability' ICOs be able to determine their own priorities for funding and services, as opposed to implementing national directives?

A national board could play a key role in setting overall health priorities, determining core service standards (to be regulated by the Care Quality Commission) and deciding on resource allocation to commissioners (larger PCTs, who would then contract with providers and provider-commissioner/integrated care organisations). Furthermore, the National Institute for Health and Clinical Excellence (NICE) might become part of such a national commissioning and priority-setting body, given its central role in determining evidence-based guidance for NHS funders and providers. Critical to an approach with a national board and local commissioners/ICOs would be effective regulation of health commissioning and its outcomes.

What is clear is that the continuum of commissioning set out in the analysis of evidence on commissioning in 2004 (Smith and others, 2004) continues to be relevant in 2010 (see Figure 1, opposite). Some services, such as those for people with long-term conditions, are appropriate for local practice-based commissioners or ICOs, and others for regional or national purchasing arrangements. What is different in the current policy context is that, as noted earlier in the discussion on commissioning arrangements, there are signs of a move towards greater use of 'hybrid' commissioner-providers (such as ICOs), especially for community-based and ambulatory care, and as a way of drawing together the management of demand with provision of better integrated care.

The importance of having rigorous and transparent processes for deciding what services are commissioned at what point on the continuum continues to hold true. It is the job of PCTs, as local stewards of the population's health funding and outcomes, to determine where such commissioning responsibility should lie, and to hold to account the practices, local authorities, ICOs and trusts who assume either provider, commissioning, or commissioning/providing roles on behalf of a local population. Furthermore, arrangements for local commissioning have to be put in place by PCTs alongside the other elements of the overall commissioning continuum, including specialised/national and personalised/individual purchasing of care. As the shape of local clinical and PCT commissioning changes (and the organisations evolve towards larger entities), there may be implications for how and where the commissioning of specialised and personalised services takes place, and how such commissioning is governed. What is clear is that the commissioning map will continue to be complex and subject to regular

FIGURE 1: CONTINUUM OF COMMISSIONING



Source: Smith and others, 2004 (adapted)

adjustment and review, to ensure that each health economy has robust and appropriate arrangements for the planning, funding and procurement of care.

Creating a compelling narrative for the public and the NHS about commissioning

Commissioning remains a mystery to most of the population, representing as it does a function in the NHS that would more commonly be considered as ‘funding and planning’. It is clear from the analysis made in this report that the elements of commissioning as understood in the NHS (needs assessment, priority setting, service specification, procurement, monitoring and review) will be ever more critical in the

forthcoming severely constrained financial context. Indeed, in such a scenario, bringing commissioning ‘out into the open’ – helping people to know who is responsible for funding and planning what – is a pressing priority in itself.

Creating a clear and understandable account of the role and responsibilities of NHS commissioners requires that this is first of all clarified, negotiated and validated within the NHS policy and management community. Given the analysis set out in this report – which articulates the nature of the current ‘commissioning problem’ and what needs to happen if that is to be resolved – it is clear that the NHS is at a key point in time

where policy-makers need to determine ‘where next’ for health commissioning, and then set out how this will work and who will be responsible for what. Only if this happens will a compelling narrative about the role, potential and importance of commissioning be created for the NHS and the population in general. This is critical if we are to move beyond the current (arguably unfair) narrative of commissioning as inevitably and seemingly irrevocably weak, a

narrative that often conveniently blames commissioning for wider constraints in the overall system reform physiology.

The next chapter sets out to answer the question ‘Where next for NHS commissioning?’, drawing on the analysis made in this report of the evidence and experience of this function in the NHS and based on the authors’ reading of likely policy direction for the next phase.

7. CONCLUSIONS AND RECOMMENDATIONS

The fork in the road

NHS commissioning has not yet lived up to expectations, albeit that it is sometimes castigated for failings that are more to do with other elements of system reform, such as some of the vagaries of payment by results. PCTs appear to struggle to make significant strategic changes to health services, and in particular to secondary and tertiary provision. Practice-based commissioning is at best weak in terms of its ability to engage clinicians in managing services and resources. Perennial attempts to boost commissioning in its influence over service provision looks increasingly tired and possibly futile within the current NHS context.

NHS commissioning may have reached a fork in the road. One direction points towards limping on in much the same mode as it has for the last 20 years, with incremental change to policy such as changes to payment by results, offering stronger incentives for GPs to engage in practice-based commissioning and investing further in developing skills and information for commissioners.

A new and more radical approach to local clinical commissioning

Another direction points to the need to take far more decisive steps to energise the practice/locality part of the commissioning continuum and encourage groups of clinicians – those responsible for providing the bulk of quality and costs – to assume resource management

responsibility together with accountability for the health outcomes of a population. This should be rooted in a population approach to care that is oriented towards primary care and a registered population.

The suggested approach to this was set out in the Nuffield Trust/NHS Alliance report *Beyond Practice-based Commissioning: The local clinical partnership* (Smith and others, 2009). Critical to this is the engagement of hospital clinicians and managers in new forms of provider–commissioner organisations; this will not happen without the crafting of an appropriate set of incentives, and careful consideration of what level of risk is appropriate for ‘beyond PBC’ organisations to bear.

What is clear is that for ‘beyond practice-based commissioning’ to come into being, GP groups need more management support, infrastructure such as information and data analysis, and incentives to develop and engage clinicians in the community and increasingly in clinical directorates currently located in hospitals. PCTs (and perhaps also trusts, especially as groups become increasingly multi-specialty) should be providing this support and should be encouraged to do so by SHAs and, ultimately, the Department of Health, although the practicality of achieving this will be extremely challenging, given recent exhortations to the NHS to reduce expenditure on management by 30 per cent (Department of Health, 2009b).

While there is no one model of development of local clinical commissioning for the future, and

the guiding principles should be diversity and evolution, the form of the next generation of practice-based commissioning or integrated care organisations will be shaped by practical matters such as the population needed for these groups to assume financial risk of the budget, as well as the size needed to attract relevant skills and infrastructure within what will be increasingly constrained resources for management.

A new role for fewer PCTs

What is needed is a reshaping of the PCT role away from one that seeks to do most of the activities of commissioning, to one where their primary role is to design, develop, monitor and adjust the overall commissioning continuum for a given locality or region. In the short to medium term, PCTs will need to help give birth to, and nurture, extended practice-based commissioning or integrated care organisations of one form or another (Lewis and others, 2010) as appropriate to the service and local context. In this scenario, if local clinicians were not keen to move into such organisations, the PCT might contract with another organisation to fulfil such a role, as part of its role in assuring an overall effective set of commissioning arrangements for the local population.

This approach points to the likelihood of needing fewer and larger PCTs/funding bodies that would focus on specialised service commissioning (moving further towards the right-hand or national end of the commissioning continuum), and on contracting with, and holding to account, practice-based commissioners or integrated care organisations. Critical to such a PCT/funder role would be strong and clear regulation of this commissioning activity (presumably by the Care Quality Commission and local health scrutiny bodies measuring the performance of PCTs as they delegate and manage health commissioning by local clinician-led organisations).

More accountability for commissioners

Commissioning organisations, at all levels, need to become more accountable for commissioning functions and outcomes. This might be achieved by one or more different routes, including:

- much more robust clinical commissioning ‘beyond PBC’
- stronger regulation of commissioning
- enabling the public to choose their commissioner (in a similar manner to how the Dutch now choose their public health insurer)
- or by increasing local democratic accountability.

Choice of commissioner might be achieved through patients being able to select their PCT as well as their extended practice-based commissioning or integrated care organisation with which they were registered. Ability to choose between commissioners would be a very significant move for health policy in England, and would have far-reaching implications for the NHS, for example, the need to define an explicit benefit package that is funded by the NHS, as well as sophisticated risk adjustment to set accurate capitated funding for commissioners, and better regulation of quality of care and assessment of patient experience than is possible at present.

More integration of commissioning and provision

In this way, NHS commissioning would transcend the ‘twin-track’ of patient- and population-based approaches for local commissioning identified in the 1990s and again in the 2000s, and bring into being a new generation of hybrid organisations with greater responsibility for financial and health outcomes, this time hybrid not only for their population and patient focus, but also for their integrated purchaser/provider role. This might in itself help to rectify the persistent imbalance of

power between commissioners and providers, harnessing much greater clinical leadership and ownership of the organisations taking the key ‘make or buy’ decisions about healthcare and hence resources.

The ways in which the NHS practice-based commissioners might migrate towards such a model are explored in more detail in the Nuffield Trust/NHS Alliance report *Beyond Practice-based Commissioning* (Smith and others, 2009). The deeper implications of what it might mean to have multiple and possibly competing extended practice-based commissioning or integrated care organisations is examined in The King’s Fund and Nuffield Trust report *Where Next for Integrated Care Organisations in the English NHS?* (Lewis and others, 2010).

Assuring an effective continuum of commissioning

To make a reality of the more radical and hopeful prognosis for NHS commissioning, PCTs will need to increasingly reinvent themselves as the designer, resource allocator and performance manager of a local or regional health system, rather than necessarily doing the actual commissioning in terms of aligning needs/demand and local service provision. For the wider health system, and those of us who research and comment on it, the challenge will be to avoid the temptation of getting locked into a grand narrative of ‘weak commissioning’ and to identify ways of further boosting the effectiveness of commissioning at all stages along the wider commissioning continuum.

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Where next for commissioning in the English NHS?

Commissioning is an activity that is subject to much debate in the English NHS. It is often suggested that if only commissioning were to be 'strong' or 'world class', much more progress would be made in areas such as moving care out of hospital into the community, or gaining greater productivity from healthcare providers. The theory is that having commissioners focused on the funding, planning and purchasing of services will enable powerful providers to be held to account for the quality and volume of care delivered, as well as being challenged to come up with new forms of care that can replace, rather than simply add to, current services. As the NHS faces a period of major financial challenge, the effectiveness of commissioning is a pressing concern.

In *Where next for commissioning in the English NHS?* the authors, who have studied the development of NHS commissioning for over 15 years, use research evidence as the basis for examining current commissioning arrangements, analysing the nature of the 'commissioning problem', and setting out practical suggestions for how commissioning might be strengthened to meet the challenges ahead.

This report will be of interest to healthcare policy-makers, senior managers and clinicians, and others involved in commissioning, as well as academics and students in the fields of healthcare and social policy.