

# Summary report

## A review of the effectiveness of primary care-led commissioning and its place in the NHS

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### Background

This report sets out the findings of a review of the evidence on the effectiveness of primary care-led commissioning and its place in the UK National Health Service (NHS). The principal aim of the review was to identify the organisational and process factors associated with effective primary care-led commissioning and also their relevance to other approaches. The project was funded by The Health Foundation and took place over the period February-August 2004.

The project primarily involved a review of the published research evidence on primary care-led commissioning in the NHS, including an exploration of evidence from the four countries of the UK, and, where appropriate, making international comparisons. The literature review was supplemented and tested out in a series of semi-structured interviews with 34 individuals known to have been closely associated with the development and operation of primary care-led commissioning in the UK over the period 1990-2004. Following synthesis of the findings of the literature review and interviews, two stakeholder workshops were held in the summer of 2004 as a way of further testing out and refining project conclusions. These workshops involved policy makers, managers and clinicians from health and social care from across the UK.

This report is intended to contribute to the development of effective commissioning and service improvement in health and health services. Its focus is on the distilling of key messages from the research evidence and the setting out of challenges for NHS managers, clinicians and policy makers as they seek to develop more effective commissioning and service planning.

### What is primary care-led commissioning and what is its rationale?

Terms such as 'commissioning', 'purchasing' and 'contracting' entered the NHS lexicon in the late 1980s with the introduction of the NHS internal market and the purchaser-provider split. The internal market of 1991 was designed to introduce competition between strong

monopolistic health care providers. In the absence of consumers with the necessary information and expertise to act as a countervailing force, there was a need for an informed critical agent, the purchaser, who could act for the patient as well as ensuring that the public's goals for the health sector were achieved. Purchasing was seen as the opposite of passively paying the bills for the care which providers had chosen to provide. Instead, services were to be specified up-front on the basis of quality and value-for-money, and only those who could meet the requirements would be asked to provide the service.

'Commissioning' was the term used in the later 1990s for an activity that was argued to be more sophisticated and strategic than purchasing, encompassing an assessment of the health needs of the population, the buying of services to meet those needs, and a range of strategic efforts to promote health (Ovretveit 1995). The term 'primary care-led commissioning' appeared soon after, reflecting the emergence of a range of different approaches to the purchasing and commissioning of health services that involved GPs in key leadership and decision-making roles – approaches that had their origins in the introduction of GP fundholding in 1991. Our suggested definition for primary care-led commissioning, based on this review of the evidence and our understanding of contemporary health policy, is as follows:

*'Commissioning led by primary health care clinicians, particularly GPs, using their accumulated knowledge of their patients' needs and of the performance of services, together with their experience as agents for their patients and control over resources, to direct the health needs assessment, service specification and quality standard setting stages in the commissioning process in order to improve the quality and efficiency of health services used by their patients.'*

In this definition, primary care-led commissioning inextricably involves decision making power over the use of resources devolved either to practices or to groups of practices, along with associated accountability for the use

of those resources. The term need not include the contracting of services as long as the decisions on needs and services are shaped directly by primary care clinicians who take responsibility for the use of resources.

### Primary care-led commissioning: the UK context

The study examined the development of primary care-led commissioning in each of the four countries. From 1991–1997, commissioning policy was largely consistent across the four countries of the UK. Since 1997, there has been considerable divergence in the approach to health services commissioning in each of the UK countries, as follows:

- In England, the purchaser-provider split has been largely retained, and primary care trusts have become the main local commissioning body (yet they are also providers of community and primary care services), currently charged with developing new forms of devolved practice-led commissioning.
- In Northern Ireland, local health and social care groups have been created as a method of creating effective clinical and public engagement in the commissioning process. The groups have however struggled to secure GP involvement, and the overall development of commissioning is hampered by broader political uncertainty.
- In Scotland, the quasi-market was abolished and commissioning and providing roles integrated. Newly introduced community health partnerships are expected to breath new life into primary care led services and are viewed as key forums for determining local health and social care priorities and plans.
- In Wales, the purchaser-provider split has been retained, albeit with a strong emphasis on partnership working with local government and the engagement of local communities, and health planning and commissioning being focused on 22 local health boards.

### Assessing the impact: a review of the evidence

The selection and application of future models of commissioning needs to be informed by lessons from past experience. This review examined those service areas in which previous primary care-led commissioning organisations appeared to have had the greatest positive impact in relation to: indicators of performance such as waiting lists and waiting times, investigation rates, referral rates, and use of pharmaceuticals; and the achievement of system outcomes such as equity, efficiency, cost containment, responsiveness and appropriateness. The evidence reviewed was mainly concerned with GP fundholding, GP commissioning, total purchasing pilots, and primary care groups and trusts. In addition, the experience of independent practitioner associations (IPAs) in New Zealand and managed care organisations in the USA provided additional data.

It should be noted that evidence concerning the impact of primary care-led (and indeed other forms of) commissioning is limited in its nature, due to the regular organisational change experienced by purchasing and commissioning bodies in the NHS over the period 1990-2002. This made the assessment of health impact and outcomes by researchers in the 1990s extremely difficult, and led to a much stronger focus on process and implementation issues. The literature also lacks studies comparing primary care-led commissioning with other models such as health authority purchasing. Our review of the evidence on the impact of primary care-led commissioning can be summarized as follows:

- There is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services.
- Primary care-led commissioning (where clinicians have a clear influence over budgets) can however secure improved responsiveness such as shorter waiting times for treatment and more information on patients' progress, as was seen within GP fundholding.
- There is research evidence to show that primary care-led commissioning made its greatest impact in primary and intermediate care, for example in developing a wider range of practice-based services, stimulating new forms of peer review and quality assessment within and across practices, enabling new forms of specialist primary care, and building new community-based alternatives to hospital care.
- Given a sustained opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change longstanding working practices in the local health system, as demonstrated by many of the innovations secured through total purchasing projects.
- Primary care commissioners can effect change in prescribing practice, with financial incentives playing a key role, as demonstrated through GP commissioning and fundholding.
- Primary care-led commissioning increases transaction costs within commissioning.

### Improving primary care-led commissioning: applying the evidence

Research into primary care-led commissioning has tended to focus on monitoring and assessing the implementation and early development of new commissioning schemes. Thus there is an extensive evidence base on the organisational features, process factors and contextual characteristics associated with more or less effective primary care-led commissioning. This evidence draws on GP fundholding, total purchasing, GP commissioning, primary care groups and trusts, health maintenance

organisations in the USA, and New Zealand IPAs. What the evidence tells us about facilitating effective primary care-led commissioning is as follows:

- There is no ‘ideal’ size for a commissioning organisation – different population bases are needed for commissioning different services.
- Adequate levels of management support are vital to the success of commissioning, as was vividly demonstrated by the experience of total purchasing, where schemes with higher levels of support were seen to be more effective in terms of outcomes.
- Timely and accurate information is required for commissioning – NHS routine data could be exploited to a much greater degree as a source of analysis of patient flows and pathways.
- Real and meaningful clinical engagement in commissioning is crucial, the power of this is demonstrated by the experience of PCGs, Bradford North practice-based commissioning scheme, NHS Collaboratives and the IPAs of New Zealand.
- There is a careful balance to be struck between ensuring clinical engagement and assuring appropriate public and management accountability for commissioning decisions
- Primary care-led commissioning organisations have struggled to engage patients and the public in a meaningful way.
- Local health commissioning/funding bodies face a difficult challenge in enabling primary care-led commissioners to have the headroom to commission according to local as well as national priorities.
- Whilst commissioners need to have effective strategic relationships with providers, they also need to have the ability to shift activity elsewhere – ‘contestable collaboration’.
- Commissioning organisations need a degree of stability in the wider policy context – they have never been given a sustained chance to prove their worth.

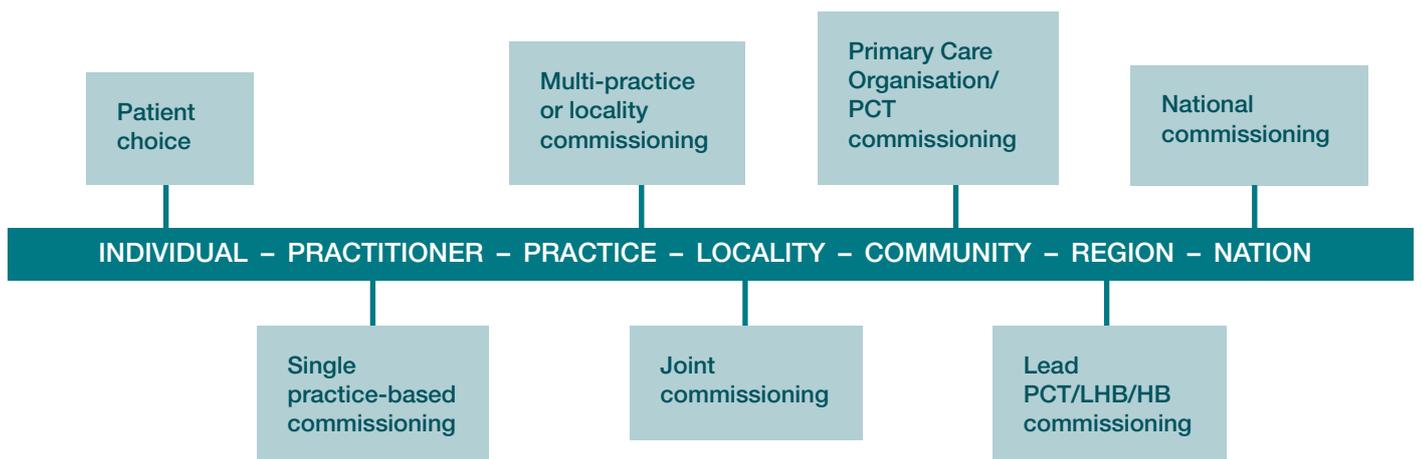
- A single organisational solution to commissioning is neither possible nor appropriate.

**The continuum of commissioning models in the UK**

Primary care-led commissioning should not be considered in isolation from other approaches to commissioning and planning, but rather seen as part of a continuum of models to be selected and used by funding and commissioning bodies, as appropriate to local health needs and service configuration. The evidence tells us that primary care-led commissioning has particular relevance for primary, intermediate and some routine secondary care services where there is a clear interest on the part of primary care clinicians in bringing about local innovation and change. For those clinicians and managers with the responsibility for selecting appropriate methods for carrying out needs assessment, resource allocation, service purchasing, and service review (those working in primary care trusts, health boards, health and social services boards, local health boards), the ‘menu’ of commissioning models is shown in figure 1 as a continuum of approaches from the individual patient level to that of a whole nation’s population.

Interviews and stakeholder workshops carried out for this project revealed an increasing interest on the part of commissioners in using approaches to service development that bridge the commissioner-provider separation. These are not in themselves commissioning models, but are a part of the overall process of organizing commissioning in a local health economy. For example, there was a view that new managed care approaches to the delivery of chronic disease management, professional clinical networks, and care pathways were methods of service integration that were closely related to the activity of commissioning. Many of these models of service integration, for example Scottish managed clinical networks, Californian chronic disease management

**Figure 1: The Continuum of Commissioning Levels in the UK**



organisations, and Arizona health plans, focused on specific disease areas for disadvantaged communities and are more developed in countries other than England.

### Choosing an appropriate mix of models for effective commissioning

If the key challenge facing local commissioning organisations (primary care trusts, health boards, health and social services boards, local health boards) is how to select an appropriate mix of commissioning approaches according to local health needs and service configuration, there is a need for a rigorous process to inform this choice.

The key question is what attributes of a commissioning model are desirable for different service combinations and environments? The assessment criteria developed for application to commissioning models have been drawn from our review of the literature and representing dimensions of performance that were deemed to be important by the stakeholders involved in shaping the conclusions of this study. The criteria proposed for assessing commissioning models are the ability to:

- shape different types of services, with each exhibiting different levels of complexity and scope for contestability
- offer a degree of choice of provider, contestability, and responsiveness
- manage budgets and financial risks, including delivery of financial plans
- minimise administration and transaction costs
- develop and sustain clinical engagement
- address health needs and tackle health inequalities
- improve and govern clinical quality

The research team selected seven commissioning models (patient choice, single practice-based commissioning, multi-practice-based commissioning, primary care trust/primary care organisation (PCO) commissioning, PCO lead commissioning and national commissioning), and tested them against these assessment criteria during the stakeholder workshops. The models were tested firstly for appropriateness to specific services and then for their ability to fulfil the remaining assessment criteria. The results are indicative rather than definitive, and are set out in tables 1 and 2 overleaf. This suggests that each health economy should take steps to determine the most effective combination of approaches to commissioning for its local area. The steps to be taken might be as follows:

1. Analysis of the service(s) to be commissioned – is the service simple or complex; are commissioners likely to be well or poorly informed about its content and effectiveness; is the service potentially contestable or not?
2. Analysis of the context and environment – is there already a choice of providers of this service or not; are patients likely to be willing and able to travel if local

providers are not suitable?

3. Analysis of the proposed commissioning model in relation to the assessment criteria in Table 2 and any additional criteria regarded as particularly important in the local health economy.

Such a process should generate a mix of approaches suitable for different services given the context.

### Messages for policy makers and managers

In concluding the study, a set of messages for policy makers and managers is distilled, and specific challenges are made for the health systems in each of the four countries of the UK.

- There is little evidence to show that any primary care-led (or other) commissioning approach has made a significant impact on the way hospital care is delivered, except in relation to waiting times for treatment. This challenges health funders and planners to find more powerful and sophisticated ways of exerting required changes from health providers.
- Primary care-led commissioning has been shown to be effective in the area of primary and intermediate care and in encouraging greater responsiveness in elective hospital services. There is significant potential to build on this experience of service development and innovation, this time within a stronger framework of public accountability and national health priorities.
- Primary care-led commissioning may be effective as part of a continuum of commissioning models, and particularly appropriate for 'simple' and community-based chronic disease management and primary care services. Other models of commissioning are required for more specialised and complex services, including the development of more integrated forms of service provision based on managed care techniques and approaches together with care pathways. The challenge for funding organisations is rigorously to select an appropriate blend of approaches and to be clear about how and for what reasons that selection has been made.
- There is a need for more systematic assessment of the impact of models of health commissioning, including the an examination of their ability to achieve specific service and patient quality objectives which can be monitored in a rigorous manner.
- To achieve this, commissioning organisations need a degree of organisational stability. Providers have had relative stability for some 15 years whereas commissioners have been subject to numerous major imposed reorganisations.
- Commissioners need new and more advanced forms of support, in particular in developing a range of new skills and competences such as the stratification of patients according to risk, commissioner-led advanced case management, predictive modelling of high user patients,

handling and analysis of routine data, and more refined assessment of service quality and outcomes.

- Policy makers need to ensure that commissioning organisations have sufficient headroom and freedom to develop and implement local as well as national commissioning priorities. This is vital if local clinicians are to feel engaged with commissioning and service development activities.
- Clinical engagement and the appropriate use of incentives are crucial to effective primary care-led commissioning and service development at all points

along the commissioning continuum, and in particular within those approaches closest to the patient.

- The legitimacy and accountability of commissioning organisations needs to be made clear within whatever blend of models is applied within a health economy, and needs to be balanced with the necessary engagement of clinicians.

What then does this analysis of the research evidence about effective commissioning and service development have to offer the health systems of the four UK countries?

**Table 1: Relative effectiveness of commissioning approaches – different services**

	Patient choice	Single practice-based	Multi-practice-based	Joint or horizontally integrated	PCO/PCT	Lead PCT/LHB/HB	National
First contact care	Effective	Effective	Effective	Effective	Effective	Ineffective	Ineffective
Primary care	Ambiguous	Effective	Effective	Effective	Effective	Ineffective	Ineffective
Elective surgery	Effective	Effective	Effective	Ineffective	Effective	Ambiguous	Ambiguous
Accident & emergency	Ineffective	Ineffective	Ambiguous	Ambiguous	Ambiguous	Effective	Ambiguous
Acute care	Ambiguous	Ambiguous	Effective	Ambiguous	Effective	Effective	Ambiguous
Tertiary/specialised care	Ineffective	Ineffective	Ineffective	Ineffective	Ineffective	Effective	Effective
Public health	Ineffective	Ineffective	Ineffective	Ambiguous	Ambiguous	Effective	Effective

**Table 2: Relative effectiveness of commissioning approaches – assessment criteria**

	Patient choice	Single practice-based	Multi-practice-based	Joint or horizontally integrated	PCO/PCT	Lead PCT/LHB/HB	National
Choice, contestability, responsiveness	Effective	Effective	Ambiguous	Ambiguous	Ambiguous	Ineffective	Ineffective
Budgets and financial risk	Ineffective	Effective	Effective	Ambiguous	Effective	Effective	Effective
Transaction costs	Ineffective	Ineffective	Ambiguous	Ambiguous	Ambiguous	Effective	Effective
Clinical engagement	Ambiguous	Effective	Effective	Ambiguous	Ineffective	Ineffective	Ineffective
Needs & inequalities	Ambiguous	Ambiguous	Ambiguous	Effective	Effective	Ambiguous	Ambiguous
Clinical quality	Ambiguous	Ambiguous	Effective	Effective	Ambiguous	Ambiguous	Ambiguous

Key:  = effective  = ineffective  = ambiguous or context-specific

### Challenges for the English NHS

- Can PCTs that involve provider organisations truly act as commissioners of care, contesting the level and quality of services delivered?
- Can space be created for the development of local commissioning models and priorities when PCTs are faced with an extensive set of national targets and performance indicators? Is the NHS prepared to tolerate the local variation that will result from this 'letting go'?
- How will clinicians be re-engaged and incentivised in the commissioning process, given the evidence that this has been largely lost over the past few years? What if local practitioners do not want to take up practice-based commissioning? How will this process of development be resourced?
- Is there real interest in commissioning to reduce health inequalities and to achieve public health outcomes? If so, is the current set of approaches to commissioning adequate to this part of the commissioning task?
- How will the experience and learning from service redesign and modernisation activity be integrated fully into the commissioning process?
- How can local people be properly involved either as citizens or consumers in commissioning and have a true voice in determining health priorities?

### Challenges for the Northern Ireland NHS

- Are local health and social care groups feasible (LHSCGs) as a method of commissioning, given the current political context in Northern Ireland?
- Can LHSCGs that involve provider organisations truly act as commissioners of care, contesting the level and quality of services delivered?
- To what degree is it possible (or desirable) to have a system based on a purchaser-provider split in a health system which is tightly integrated and geographically coherent?
- Can space be created for the development of local commissioning models and priorities when LHSCGs and boards are faced with an extensive set of national targets and performance indicators?
- How will GPs be re-engaged with the commissioning and service planning process?

### Challenges for NHS Scotland

- Is the right set of incentives in place to achieve the changes required through community health partnerships (CHPs)?
- How will primary care based and secondary care clinicians be engaged in planning processes for CHPs? What are the incentives for them to engage?
- Is there a 'right size' for CHPs? Is there potential to consider lessons from the development of other primary care organisations on the right size for planning and delivering different services?

- Is there no scope for contestability of provision of any services in Scotland? Where does patient choice enter the system?
- Why not enable a greater range of incentives and levers within the health system through delegating budgetary control to a range of subsidiary organisations rather than simply to acute and primary care operating divisions?
- For example, why not allow NHS boards to experiment with different approaches to commissioning based on CHPs such as practice-based, care pathway and commissioner-provider commissioning at CHP level (devolving the entire capitated budget to CHPs in some areas), or to managed care networks?

### Challenges for NHS Wales

- In the context of an overall policy of community engagement and partnership working with local government as the key levers for addressing health inequalities, how will the health service delivery agenda be tackled?
- What will be the response to public concern about waiting times for treatment? Is there scope for increasing contestability of provision of acute elective services in Wales? Where does patient choice enter the system?
- Is there scope for a broader range of commissioning models, including the use of practice-based commissioning to engage clinicians and the development of national targets for key service delivery areas?
- Which commissioning models will be used to reconfigure health services when there is no evidence to date that a public health commissioning approach is likely to achieve this?

### Further information

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