

NHS Overview and Scrutiny Briefing Note

Commissioning in the NHS

✉ David.Turner@kent.gov.uk
☎ (01622) 694196

1 February 2007

Defining “commissioning”

The term “commissioning” is now widely used within the NHS and it is recognised that it refers to something crucially important. However, it is difficult to give a concise definition of commissioning, since it actually covers a range of activities that have changed over time – and are continuing to change as a result of major NHS reforms.

Put at its simplest, commissioning can be said to consist of purchasing health services through contracts with suppliers. But commissioning is more than just administering a set of contractual arrangements – it amounts to a continuing process that involves:

- planning services (identifying need; determining priorities; managing suppliers; budgeting);
- purchasing services (determining how services are to be provided; identifying providers; managing contracts);
- monitoring services (confirming delivery; controlling quantity and quality; ensuring patient satisfaction).

The original NHS model

Historically, the purchasing of services within the NHS was chiefly about buying aspects of primary care from independent contractors – General Medical Practitioners, General Dental Practitioners, pharmacists and opticians. These groups were initially made up of self-employed professionals in very small-scale businesses. NHS pharmacy and optical services have come increasingly to be provided by corporate High Street chains; but General Medical Practice and General Dental Practice have remained, up to now, largely “cottage industries”, with very little provision of NHS services by corporate (shareholder-owned) organisations. GPs in particular have been very closely tied in to the NHS, despite their independent contractor status – especially after their contractual arrangements were revised in the 1960s.

Within secondary care, services were overwhelmingly provided “in-house” by NHS suppliers – the hospital sector having largely been, in effect, nationalised when the NHS was established in 1948. However, there has always been some purchasing of secondary care from private-sector providers at the margins, to supplement NHS capacity.

The “internal market”

The NHS reforms of the early 1990s brought about for the first time a “purchaser–provider split” within the NHS. Hospitals were put under the control of NHS Trusts, which acted as “providers” of acute services, functioning independently of District

Health Authorities (DHAs). Trusts' services were "purchased" through contractual arrangements with the DHAs and some GPs (fundholders – who were able to control NHS budgets in respect of their patients).

The "market" element of these arrangements was, though, somewhat watered down. This model of commissioning in practice amounted to, as one health-policy academic has put it, "monogamy, rather than polygamy ... with most purchasers and providers locked into permanent relationships in which each partner sought to modify the other".¹ Providers were guaranteed financial stability by the fact that purchasing of health services took place through "block" contracts – with volumes of work defined and paid for in advance by purchasers.

Following the change of government in 1997, GP fundholding was ended (in 2000); but the purchaser–provider split was effectively retained, albeit with new purchasing bodies – Primary Care Groups, which mostly became freestanding Primary Care Trusts (PCTs) in 2002.

Commissioning and the New NHS

The far-reaching reforms that are currently being implemented in the NHS mean that commissioning is again changing, and is becoming even more central to the way that the NHS operates. The key reforms that are impacting on commissioning are as follows:

- ***Payment by Results (PbR)***

Block contracts for services from acute hospitals have substantially been replaced by "cost and volume" contracts. Under these, Trusts are paid for each "spell" of care actually provided, according to a fixed national "tariff", based on average costs across NHS providers. (There is some adjustment in the tariff to allow for unavoidable differences in costs between regions – using the Market Forces Factor.)

It is intended that the scope of PbR will be extended to cover as much of hospital care as possible (including emergency care) and other areas, such as mental health.

By its very nature, the national tariff disadvantages those Trusts with above-average costs and favours those with below-average costs.

Under PbR, "underperformance" (lack of patient referrals or insufficient patient throughput) can financially destabilise a Trust. Conversely, "overperformance" (treatment of more patients than are specified in a contract) can financially destabilise a PCT that lacks funds to pay for all the treatment undertaken.

To ensure that Trusts are adequately compensated for handling more difficult and costly cases, "Healthcare Resource Groups" (HRGs) are used to classify together cases that are clinically similar. However, the limited number of HRGs means that they can only approximately reflect actual case-mixes. There are also concerns about how spells of care are allocated to HRGs –

¹ Rudolf Klein, *The New Politics of the NHS* (fifth edition, 2006), p. 163.

providers will have an incentive to “upcode” (*i.e.* overstate the complexity of a case) or even to “overtreat” (provide more care than is clinically necessary) in order to boost their income.

Another issue associated with PbR is that of “tariff unbundling”. This arises where a PCT and a Trust have to agree how to split a tariff payment in respect of a spell of care that is divided between the Trust and primary care. This situation usually happens where a patient is discharged after hospital treatment into some form of “stepdown” care, because he or she is not yet fully recovered.

- ***Patient Choice***

From 1 January 2006, all patients needing planned hospital care should have been offered a choice of four or more providers (usually including at least one private-sector provider) from a local (Primary Care Trust) menu, where clinically appropriate, at the point of referral.

In addition to the four or more local-menu options, since 31 May 2006 patients have been able to choose from a national menu encompassing the “Extended Choice Network”. The Network includes all NHS Foundation Trusts, all centrally-accredited Independent Sector Treatment Centres (ISTCs; see below, under “‘Mixed economy’ of providers”) and other centrally-procured Independent Sector providers.

Under “Free Choice”, which will be introduced in 2008, NHS patients will be able to choose any healthcare provider (NHS, private or voluntary-sector/charity/not-for-profit/“Third Sector”) that meets appropriate standards (certified by the Healthcare Commission) and is prepared to provide care at the NHS tariff rate. The plan is apparently for the PCT in the area where each provider is located to contract for services on behalf of all the other PCTs whose patients choose to use the provider’s services.

The DoH is working on next steps in the implementation of Patient Choice and options on future policy. Among issues that may be considered are the possible extension of Choice to hitherto excluded areas (such as mental health and maternity services) and the consideration of other “choice points” along the “patient pathway” (*e.g.* consultant-to-consultant referrals and referrals into tertiary services). The application of Choice to primary care is apparently also under consideration by the DoH.

- ***Practice-based Commissioning (PbC)***

GPs are now able to take responsibility for the budgets in respect of their patients, under a system that is similar (although not identical) to GP fundholding. Commissioning is effectively devolved from the PCT to the GP practice. Where GPs are able to make savings in commissioning services for their patients, the money saved can be reinvested back into their practice.

Involvement in PbC is voluntary – since GPs are independent contractors, they cannot be obliged to participate. However, the government expects and intends that all GPs will wish to take up the opportunities presented by PbC.

- ***“Mixed economy” of providers***

The government is seeking to break what it calls the “monopoly” position of in-house NHS service-providers and bring about “contestability” of services by creating a “plurality” of providers. In consequence, NHS clinical services are increasingly being provided by non-NHS (for-profit and, to a lesser extent, non-profit) providers.

Private providers have already been centrally procured in significant numbers by the Department of Health (DoH). These have mostly been in the form of ISTCs, from which PCTs have been obliged to buy services on terms that are substantially different to those under which NHS providers must operate. ISTCs are able to choose which patients they wish to treat; they are paid significantly above the national tariff; and they are not bound by PbR – they are guaranteed the full value of their five-year contract, regardless of how many patients they actually treat. A second wave of ISTCs is planned (including Integrated Clinical Assessment and Treatment Services), and central commissioning of these by the DoH is well underway.

PCTs are now required to commission acute services locally from private providers, in order to facilitate Patient Choice; and to pay any providers from the Extended Choice Network that patients choose to use. From 2008, PCTs will have to pay whichever providers (NHS, for-profit or non-profit – anywhere in England) are chosen by patients under the Free Choice policy.

In 2005, the government retreated from plans to oblige PCTs to divest themselves of their role as a provider of services and become purely commissioning bodies. But there is still clearly an expectation on the part of the DoH that PCTs should attempt to contract out the provision of clinical services where possible. And PCTs are expected to achieve a clear organisational separation between their commissioning function and their service-provider function.

PCTs are also clearly being encouraged by the DoH to put General Medical Services out to tender and to consider using Alternative Provider Medical Services contracts in order to engage for-profit corporations in place of both traditional GPs and GPs who are salaried PCT employees.

- ***Foundation Trusts***

Foundation Trusts (FTs) are NHS Trusts that have been granted a form of “earned autonomy”, giving them a number of major freedoms that ordinary Trusts do not possess. The government expects all acute Trusts to be in a position to apply for FT status by 2008. In addition, all in-house NHS providers in primary care are expected, once they have separated organisationally from their PCT’s commissioning arm, to become “Community Foundation Trusts”.

Contracts between PCTs and FTs are legally binding – unlike contracts between PCTs and ordinary Trusts, which are only “Service Level Agreements” between NHS Bodies and, as such, are not enforceable in law.

FTs are also unlike other Trusts in not being accountable to the Secretary of State or their local Strategic Health Authority. FTs are subject to a body called “Monitor” (effectively a market regulator concerned primarily with FTs’ financial health) and have their own distinctive governance arrangements, which are intended to make them accountable to their local communities. FTs arguably have much greater freedom than ordinary Trusts to adjust what services they provide in response to the pressure of competition within the NHS “quasi-market”.

Commissioning in the future

A number of problems and issues in respect of commissioning can be seen arising out of the operation of the reforms listed above:

- ***Are PCTs fit to undertake commissioning?***

It is widely recognised that commissioning is an underdeveloped function within PCTs – which have tended to lack the skills and expertise necessary to discharge this role adequately. One response to this on the part of the government has been to indicate that such skills and expertise can be bought in from the private sector (possibly from the same corporations that are also taking over GP practices and providing other clinical services for the NHS). The government has, however, denied that it intends to outsource PCTs’ commissioning function completely.

One PCT (Hillingdon, in London) is currently considering outsourcing of this kind on a major scale.

- ***How does PCT commissioning fit with Practice-based Commissioning?***

PbC appears to mean that PCTs are being expected effectively to devolve their commissioning role to GP practices – although PCTs still hold all moneys (GP commissioners only have “indicative budgets”) and contracts with providers.

This raises issues about whether the whole commissioning function can, or should, be devolved in this way. If only some aspects of commissioning are to be devolved, which are they, and how could this be achieved? If all commissioning is eventually to be done by GP practices, will PCTs then become redundant organisations?

It has been suggested that “strategic commissioning” (meaning high-level, longer-term functions such as market-management, reconfiguration of services, public health and assessment of health needs) can only sit with PCTs. However, this has been disputed by Prof Julian Le Grand, the chief architect of the government’s health reforms, who has argued that it smacks too much of old-fashioned “central planning”. He argues that the functions placed under the heading of “strategic commissioning” can be dealt with by GP commissioners or (in the case of market-management) regulatory bodies,

such as Monitor and the Healthcare Commission.

- ***How does commissioning fit with Patient Choice?***

There does seem to be a tension, if not a contradiction, between the idea of commissioning (whether done by PCTs or GP commissioners) and the expanding frontier of Patient Choice.

If the scope of Choice develops as the government apparently intends it to, the role of commissioners in the NHS seems to become one of issuing patients with virtual “vouchers” to “spend” in the “quasi-market” of competing providers. Choice then seems to become a kind of “individual commissioning”, with commissioners playing the role of demand-managers, attempting to counterbalance powerful providers (chiefly NHS FTs and corporate private providers).

It has been argued that commissioning GPs, as “gatekeepers” regulating access to services, are well placed to fulfil the role of demand-managers. The elaboration of patient pathways (outlines of how different conditions are to be dealt with) by commissioners is also relevant to the task of managing demand. Questions do arise here about whether it is appropriate to mix the financial and economic issue of managing demand with the essentially *clinical* tasks of gatekeeping healthcare services and mapping out optimum patient pathways.

- ***How does commissioning relate to reconfiguration of services?***

The government has made it clear that it is determined to see specialist acute services centralised, and a substantial number of other services pushed out of the acute sector and into primary care. There are a number of issues concerning how these policies relate to the various strands of system reform in the NHS.

As noted above, it has been argued that reconfiguration of services is a part of the “strategic commissioning” role that PCTs need to play. However, Prof Le Grand has argued that reconfiguration could be allowed to take place in the NHS “quasi-market” through investment decisions taken by providers, acting in response to market forces – just as happens in “conventional markets”.

- ***How will commissioners ensure access to services and tackle health inequalities?***

Concern has been expressed that the move to a “quasi-market” in the NHS will compound health inequalities by undermining universal and comprehensive access to healthcare on the basis of need – which is actually the chief goal of the NHS. This could occur as a result of some sections of society (who are usually those most in need of healthcare) being less able or willing to exercise Patient Choice. At the same time, there could be “cherry-picking” or “cream-skimming” by providers, i.e. catering for those who are cheapest, easiest and most profitable to treat (who are those least in need of healthcare).

The DoH, however, believes that good commissioning practice will enable PCTs to guarantee equitable access to services on the basis of clinical need, in spite of countervailing forces that might emerge from the various strands of NHS reform.

The government says that it intends to ensure there is “voice” as well as “choice” within the new NHS. Communities are supposed to be able to articulate their needs, and criticisms of how the NHS is meeting them, through: the community governance arrangements of FTs; the planned new patient-and-public-involvement mechanism of Local Involvement Networks (LINKs); and Health Overview and Scrutiny Committees (HOSCs). Both LINKs and HOSCs, the government intends, will be focused much more in future on scrutiny of commissioning than on scrutiny of service provision.

The DoH has suggested that rigorous management of contracts can minimise “cherry-picking” and “cream-skimming” by providers. And where there are gaps in provision, PCTs, as commissioners, might be able to use various forms of incentive to induce providers to cater for populations that are underserved. These may include the PCT:

- paying a supplement to the tariff, to cover set-up or development costs;
- providing guarantees within the contract, for instance regarding minimum income;
- reducing the capital investment required from the provider, for instance by supplying facilities.

These are, of course, reminiscent of the enhanced terms that the DoH has itself given ISTCs, in order to “pump-prime” independent-sector provision.