Challenges and lessons for good practice

Review of the history and development of health service commissioning

March 2016
Acknowledgement

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1 Introduction

1.1 Background
This paper sets out the findings of a review of the international literature on commissioning systems. The King’s Fund undertook the research and main authorship with additional local ‘Australian’ context and content provided by The University of Melbourne. This forms part of the work commissioned by the Australian Government, Department of Health to support the development of commissioning capacity and capability amongst the new Primary Health Networks as part of a contract led by PwC.

1.2 Aims and methodology
The purpose of the review was to identify the key features of commissioning systems, highlighting best practice as well as key challenges and risks. This includes outlining different approaches taken within different systems. Given the considerable experience of commissioning in the English National Health Service (NHS), much of the literature and discussion focuses on this system (and its evolution), but it draws on findings from other countries where possible. The review also makes use of international examples and case studies to illustrate the themes of the review. Figure 1 provides an overview of the history of commissioning in England.

This paper draws on the findings from a review of the literature. This approach was purposive and non-systematic – beginning with a formalised search strategy and purposively selecting literature to inform pre-formed analytic themes. The research team were open to inductively derived themes, and the discussion draws on these as appropriate.

It is empirically challenging to isolate the impact of commissioning from other factors on the cost or quality of care. There is limited academic research or formal evaluations of commissioning. In England, the frequency with which changes have been made to commissioning structures has also made it more difficult to determine its impact. Therefore, in conjunction with the formal search strategy, the team also drew upon the extensive ‘grey’ literature on commissioning – previous publications by The King’s Fund, policy documents and commentaries from other expert stakeholders. Based on this intelligence, further commentary and analysis is provided to weigh the arguments (and evidence where available) and present the challenges and opportunities of commissioning.

1.3 Overview of Findings
Commissioning aims to strengthen the role of clinicians and other local stakeholders in strategic planning and purchasing, and increase the use of market forces. Effective commissioning is often regarded by policymakers as crucial to achieving high quality care that is responsive to patients’ needs and ensures value for money. Commissioning has been used for this purpose in primary care in a number of international contexts, particularly England.

Understanding commissioning is becoming increasingly important in Australia because of its inclusion in the Primary Health Networks (PHN) program. In this context, commissioning is characterised by a strategic approach to procurement that is informed by the baseline needs assessment and associated market analysis undertaken in 2015-16. Commissioning will enable PHNs to plan and contract medical and health care services that are appropriate and relevant to the needs of their communities. It is also expected that commissioning will include ongoing assessment to monitor the quality of services and ensure that contractual standard obligations are met.

Commissioning is a relatively new approach in the Australian context and it is expected that commissioning capacity will continue to develop over time (Australian Government Department of Health 2014).

There is little formal evidence on what ‘effective commissioning’ is and how it can be achieved in practice (Shaw et al 2013) – as such, there is no ‘blueprint’ for successful strategic commissioning (Williams et al 2012a). Gardner et al (2016) recently undertook a systematic review of the international literature on commissioning, and found there to be limited evidence of the impact of commissioning on quality, outcomes and value for money. They also found that there is no preferred model that can be
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**Figure 1**  **Key stages of development in the English NHS commissioning system**

(Naylor et al 2013; Curry et al 2008)

**Internal market introduced, 1991**

The concept of an ‘internal market’ in the NHS was introduced by the NHS and Community Care Act 1990. The market reforms which followed (implemented in 1991) were based on a purchaser – provider split. The government argued this would help increase service responsiveness, promote innovation, and – by giving purchasers budgets with which to buy services – challenge the monopolistic influence of hospitals (House of Commons Health Committee 2010).

**GP fundholding, 1991 – 1997**

Following the introduction of the internal market, responsibility for purchasing health services was put in the hands of district health authorities and GP fundholders. Legal accountability remained with the managerially led health authorities; however GP fundholding enabled GPs to opt to control the budget for a defined range of elective care, outpatient and community health services, either on a single practice basis or through multi-fund groups composed of several practices. Participation in practice-based commissioning was voluntary but by 1997 approximately half of all practices in England had become fundholders.

During this period, 88 total purchasing pilots (TPPs) were also established (in 1995 and 1996) enabling GP-led groups to manage the budget for a wider range of services than was possible under GP fundholding. In principle, sites could take responsibility for the entire budget for hospital and community care, although none did so in practice.

In 1997, the new government decided to abolish the internal market and both GP fundholding and total purchasing were abolished in 1997. The government highlighted concerns that the uptake of fundholding had been greater in more affluent areas and that it led to inequity of access to services for patients.

**Primary Care Groups, 1999 – 2002**

Primary Care Groups (PCGs) were made up of GPs and other professionals including managerial staff. They took on the role of commissioner, but also the delivery of some community services.

The original intention was that PCGs would progressively take on more responsibilities from health authorities over a 10 year period, ultimately becoming fully autonomous primary care trusts. However in 2001, the government decided that all primary care groups would move straight to full primary care trust status from 2002.

**Primary Care Trusts, 2002 – 2012/13**

Primary Care Trusts assumed full commissioning and public health responsibilities. They were also responsible for the direct provision of community services and sometimes other services, such as mental health services. Health authorities were abolished and replaced by Strategic Health Authorities with responsibilities including the provision of a strategic framework and supporting performance improvement.

In many cases the transition to primary care trust led to a reduction in the level of clinical involvement, although clinicians retained some influence through professional executive committees.

During this period (in 2007) the government introduced the world class commissioning program to develop the commissioning capability of primary care trusts, defined by a set of 11 competencies (see Figure 2).

**Practice based commissioning, 2005 – 2012**

Practice-based commissioning was introduced in 2005 in response to limited clinical involvement in primary care trusts. It intended to engage GPs and other primary health care professionals in commissioning health services in order to stimulate improvement and innovation in primary care.

Participation in practice-based commissioning by individual GP practices was voluntary, although primary care trusts were given responsibility for achieving ‘universal coverage’. Practices which did choose to participate
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Figure 1  Key stages of development in the English NHS commissioning system

were given an ‘indicative’ commissioning budget with which to commission and provide services. Given this budget was indicative rather than fully devolved, primary care trusts remained legally responsible for the money and its administration (Curry et al 2008).

Clinical Commissioning Groups, since 2012/13

The implementation of the Health and Social Care Act 2012 saw the commissioning functions previously performed by primary care trusts split across three organisations – clinical commissioning groups, local authorities (which control the public health budget) and NHS England’s area teams (responsible for commissioning primary care and specialist services).

Clinical commissioning groups, which became fully operational in 2013, are statutory bodies and with responsibility for control of real budgets. Membership of a clinical commissioning group is mandatory for all general practices in England. They are accountable to NHS England, as the national commissioning organisation and non-departmental body of the Department of Health.

duplicated in Australia or elsewhere. The authors do discuss the value of establishing a clear policy framework to clarify the priorities and deliverables of commissioning agencies. The world class commissioning program in England in the late 2000s did seek to describe the skills and activities involved in best practice commissioning, as reflected by the world class commissioning competencies against which commissioners were assessed (see Figure 2 below).

However, definitions of what constitutes effective commissioning evolve over time. In practice, commissioning is considerably more ‘messy’ than envisaged by policy makers. Commissioning involves an evolutionary process of service review and redesign, often spread over several years, and in partnership with providers and other stakeholders. It is difficult to disentangle the impact of commissioning from the impact of the services and initiatives that are commissioned. For this reason, there is very limited evaluation or evidence around the impact of commissioning itself. There are case studies that describe the process of commissioning, and how it has evolved over time in response to challenges and other policy changes. We can draw lessons from these case studies. The process of commissioning involves an extraordinary amount of work and – in lieu of a solid evidence-base – it remains unclear if this investment is redeemed in quality improvements and cost savings.

Commissioning tends to be a labour intensive process often undertaken in partnership with providers. This blurs the distinction between those purchasing and delivering health care, which is emphasised in much commissioning policy until recently. The amount of work and extent of partnership working required is considerable. For instance, policy makers in England have more recently emphasised the value of ‘place based systems of care’, where commissioners and providers work in partnership and providers take on a much greater role in strategic planning and budgeting (Ham & Alderwick 2015; Ham & Murray 2015). It is clear that commissioning (and contracting) can neither be undertaken by transactional means alone, nor indeed by purely relational activities.

To reflect the complexity of commissioning, the findings from the evidence synthesis are analysed under the following themes:

- Contracting options – including procurement and market stimulation
- Payment mechanisms
- Options for balancing local and national commissioning
- Governance and accountability
- Leadership and collaboration – including relationships with providers
- Priority setting and decision-making processes
- Stimulating improvement

This is followed by a conclusion which, drawing on the evidence and case studies covered in the review, outlines the key challenges and critical success factors for commissioning:
**Challenges**

- One of the challenges of designing a successful approach to commissioning is the limited evidence that links commissioning with quality improvement or cost containment.
- Historically, many of the failures of commissioning approaches are explained by commissioners’ lack of skills and capabilities to undertake strategic planning, complex contract negotiations and to fully understand the needs of their population. Lack of adequate clinical engagement has also been a key issue in the past.
- Although a matrix commissioning approach is needed to meet the health needs across an entire population, there is a danger that the resulting fragmentation can act as a barrier to integration of care.
- The benefits of commissioning, in particular the ability to drive improvement and contain costs, must be great enough to outweigh the high transaction costs associated with the commissioning process.

**Success factors**

- Commissioners must have a defined role in strategic planning and purchasing at a local level, with sufficient influence and autonomy to undertake their responsibilities.
- Clinicians and the public should be actively engaged in commissioning and strategic planning to ensure that decision-making reflects the needs of patients and the population.
- Commissioning and contracting are not substitutes for establishing trust across stakeholders and investing in high-quality relationships, particularly with clinicians and the public.
- Commissioning systems need to allow for local flexibility; local commissioners must be able to adapt depending on a range of factors including the quality of local relationships and the degree of competition between providers.

There are also particular challenges that should be considered in applying the international literature to the Australian context in general and to the PHN program in particular:

- PHNs play a critical role in the Australian health system. However they have limited leverage to set the agenda for GPs or health services such as hospitals in comparison to their international counterparts (e.g., Clinical Commissioning Groups). The success of commissioning in achieving changes to health service delivery in this context is likely to be dependent on relationships to a greater extent than in the international literature.
- PHNs have several funding streams available to them: core operational and flexible funding and programme specific funding. PHNs may also be eligible to receive innovation and/or incentive funding. (Australian Government Department of Health 2014). Of these funding streams it is likely that the majority of commissioning work will initially take place around the flexible funding stream. PHNs operate in a range of contexts and the kinds of activities that they engage in.
- Commissioning systems need to allow for local flexibility; local commissioners must be able to adapt depending on a range of factors including the quality of local relationships and the degree of competition between providers.
2 Findings

2.1 Definitions of commissioning

There has been little agreement as to the definition of commissioning. It is not simply a procurement function, but also incorporates a strategic or planned component. A working definition from Sobanja (2009) may be ‘the act of committing resources, particularly but not limited to the health and social care sectors, with the aim of improving health, reducing inequalities, and enhancing patient experience’.

The commissioning process is often described as a cycle. Øvretveit’s (1995) describes commissioning as a set of activities (assessment of need, planning, contracting and review) that are repeated annually. This description of a cycle has been promoted in the English NHS since the late 1990s (Smith et al 2013). Commissioning was also designed to ensure that wider goals for the health sector were achieved – such as stimulating improvements in quality, access, and value for money (although commissioning is not exclusive to the health sector; in England Local Authorities have long established commissioning functions). Therefore, without effective commissioning, the system lacks what is intended to be a key driver of improvement, and may struggle to achieve the increases in quality and productivity needed over the coming years (Naylor & Goodwin 2010).

There are tensions in commissioning, particularly within a cash-limited market economy environment, which mean that commissioning involves making tough decisions and trade-offs, particularly between individual and population needs/wants. Commissioning takes place at many different levels, according to local arrangements and the specialisation of services. These levels stretch from national commissioning to GP practices, and even to individual clinician activities.

This section sets out the evidence on some of the different aspects of commissioning. In the next section we provide a concluding commentary on challenges and features of success. As mentioned earlier, much of the descriptive and empirical research on commissioning is derived from the NHS in England. For reference, Figure 1 provides an overview of the history and evolution of commissioning in England.

In Australia we have seen the development of the commissioning function in primary care from initial developments around Divisions of General Practice, to Medicare Locals and now explicitly in terms of PHNs. What the English experience demonstrates is that it takes time to establish and develop appropriate commissioning functions and we should expect that this will also apply to the Australian journey.

The lack of formal evidence, alongside the importance of local history and context, means that a ‘blueprint’ for successful strategic commissioning is not currently available for adoption (Williams et al 2012a). One of the most formal articulations of the ambitions of commissioning in England was the world class commissioning framework. The majority of the – albeit limited – evidence on commissioning is derived from evaluations of this framework. We continue to refer back to this approach throughout the report. Figure 2 describes the world class commissioning framework in more detail. The development of this framework was helpful in setting out expectations of what high quality commissioning would look like in an English context and PHNs may find it helpful to have a similar sort of framework to develop local approaches against or at the minimum develop a shared understanding amongst PHNs of the application of this framework to PHNs.
Commissioning has been expected to play a central role in meeting the challenges facing the NHS in England – developing better quality care and improving productivity – since the early 1990s. However, it is widely recognised that it was not entirely successful in driving improvement. In recognition of this, the Department of Health introduced the world class commissioning program in 2007 to develop the capabilities of those commissioning health services (McCafferty et al 2012).

This provided commissioners with a vision of what best practice in commissioning looks like, and a set of organisational competencies which commissioners would need to develop if they are to achieve this vision. From 2009 primary care trusts were assessed against these competencies on an annual basis (Naylor & Goodwin 2010). Specifically, 11 organisational competencies were identified that primary care trusts were expected to adopt to improve their commissioning. These were considered to be the knowledge, skills, behaviours and characteristics that underpin effective commissioning (Department of Health 2007).

1. Recognised as the local leader of the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money (Department of Health 2007)

These competencies intended to overcome the perceived deficiencies in commissioning health care. The framework recognised that commissioning involved more than procurement – instead, it framed commissioning as a cyclical process that included analysing the health needs of a population, planning what services are required to meet those needs, procuring the services, and then monitoring and evaluating the services provided.

With the election of the coalition government in 2010 and the ensuing structural reforms to the NHS, world class commissioning was abandoned. The most common complaint about world class commissioning was that the assurance process had imposed a top-down and bureaucratic administrative burden that potentially detracted from its ability to be a worthwhile developmental process. Although the assurance process was criticised for being overly bureaucratic, research suggests the program has generally been received positively as a catalyst for change and improvement. It has been effective in giving commissioners a clearer idea of what high-quality commissioning looks like (Naylor & Goodwin 2010).
2.2 Contracting options – including procurement and market stimulation

Summary points

- A range of procurement routes and contracting options are available to commissioners; the appropriate approach will depend on relevant regulations alongside the nature of the service and the desired outcomes.

- The most appropriate procurement or contracting approaches may also change over time in response to changing priorities or the external environment, for example to promote competition or as a result of more limited budgets. We should therefore expect that PHNs will need to regularly reflect on their contracting approaches and whether they are the best options in the face of changing contexts.

- There is a need to balance standard contracts with local flexibility. PHNs are designed to meet local needs so this is a strength of contracting at this level. However flexibility will still be important for PHNs that cover areas with diverse needs.

- Contractual arrangements provide the ‘infrastructure’; they are not a replacement for building trust and relationships between providers and commissioners. This is particularly important in the Australian context as relationships will not only underpin the successful delivery of contracts but also be key to health providers’ likely engagement in contracting processes.

In a system that relies on a direct funding relationship between the state and providers, command and control is the predominant mechanism for organising the delivery of public services. In an emerging market relationship however, contracts are a necessary assurance for purchasers or commissioners who have no direct involvement in the delivery of care. PHNs differ from the former Medicare Locals in a number of ways, but a key point is that PHNs will be commissioning-only organisations that will not typically be involved in the provision of services. This fact means that the major levers of PHNs are through contracting and engagement mechanisms.

Health systems that are structured around an internal or ‘quasi’ market and the separation of purchasers and providers, typically rely on contracts to hold providers to account for activity and increasingly the quality of care. Although in practice these may also be quasi contracts, as in practice they are not legally binding and in many cases they are not fully enforced. Contracts intend to allow for greater alignment and understanding between those paying for, and those delivering services. While contracting has often been seen as a purely technical task (Bennett & Ferlie 1996), there are examples where it has actually been used as a lever for service improvement and innovation (Addicott 2014). In England, the Health and Social Care Act 2012 made it clear that contractual relationships between commissioners and a range of providers would continue to be essential to the structure of health services in England.

Here we describe a range of contracting mechanisms in use, and how contracting and procurement can be used to stimulate the market and ensure transparency. Contracting and procurement have been prolific in the English NHS for over two decades and there is considerable learning from this experience, from both good practice and the numerous challenges that have been faced. We also draw upon lessons from other countries that will be highlighted throughout this review.

2.2.1 Procurement and market stimulation

A key feature of a quasi market approach to public administration is reliance on competition as a means of controlling costs and improving quality. Providing patients with choice about their care has been an explicit goal of many health systems in recent years, and competition has been viewed by governments as a way of both providing that choice and giving providers an incentive to improve. On balance, the possibility of competition has not affected service outcomes in the ways that English NHS commissioning policies assumed (Sheaff et al 2015). The extent and process of competition and market stimulation in the procurement and delivery of public services is ultimately reliant on national competition laws (and in some cases international
laws, such as European Union (EU) competition rules, and government regulations.

In England, there have been significant changes to the original internal market of the early 1990s: fixed prices, explicit patient choice, a focus on the roles and competencies of purchasers through world class commissioning and emerging competition through regulatory arrangements. Taken together it seems that the NHS has, over the last few decades, thought increasingly about how commissioners might use markets, and how those markets might operate and be structured for the benefit of patients and taxpayers. At the moment however, it is worth noting that much less attention is being paid to these market principles and there is a greater focus on partnerships between commissioners and providers, integration and local systems of care. A shift away from focusing on competition has also involved the re-assertion of control by national bodies (the Department of Health and increasingly the Treasury) and a focus on improvement of support for providers in the face of financial and performance pressures (McKenna & Dunn 2016). We will discuss shifts such as these in more detail in later sections.

Rules on procurement and tendering are often introduced to ensure and clarify the conditions under which commissioners are required to test the market when they let contracts (Ham & Murray 2015). These rules are designed to ensure that anti-competitive practices are tackled and new care providers are able to enter the market.

The relationship between regulators and commissioners is key in ensuring that services are commissioned to the letter of sector regulations and national and international laws (Collins 2015). Despite the existence of competition laws and procurement regulations, there are ongoing debates regarding how much flexibility the regulations really give commissioners to decide whether to competitively tender a service. In England, not all NHS commissioned services are subject to procurement and open competition. Monitor (soon to be called NHS Improvement) is the financial regulator of NHS services and their most recent guidance on the sectoral regulations states that ‘it is for the commissioner to decide which services to procure and how best to secure them in the interests of patients’ (Monitor 2013). Commissioners can decide whether to tender based on their assessment of the quality of existing services and the needs of their populations. They also need to follow an appropriate process in making these decisions.

Stimulation of the provider market is a key part of commissioners’ role in ensuring that services meet the needs of their local population and that, where desirable and appropriate, patients are given a choice of provider. For services where choice is important, commissioners will have a particular role in encouraging provision, potentially involving providers from a range of sectors, and developing strategies to address key gaps. In Australia, the market management function will look very different across the country according to levels of provider availability and competition.

In the late 2000s in England, the ability to ‘effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes’ was identified as one of the core competencies that commissioners were required to demonstrate in order to achieve the world class commissioning standards identified by the Department for Health (2007). See Figure 2 above for more detail on world class commissioning.

On this basis, we might suggest that commissioners have a role in market stimulation through showing an awareness of the shape of provision in their area and working effectively with local provider organisations. Most significantly it would also mean using knowledge of future needs to influence improvement and service design to secure required outcomes. In England, evaluations of the program determined that commissioners were largely unable to meet the market stimulation competence of the world class commissioning framework, demonstrating the difficulties that commissioners have in market management (Naylor & Goodwin 2010). If PHNs are to be able to fulfil this role, they will need to engage with current and potential providers and a range of other relevant stakeholders within their communities to do this.

### 2.2.1a Procurement Routes

Within a commissioning process, procurement refers to the ‘acquisition’ aspect of this commissioning cycle, whereby commissioners identify, select and contract with providers and monitor their performance in delivering these health-care services (Sanderson et al 2015). A formal and transparent process of procurement is necessary for managing resources through a contractual route and ensuring
a competitive process where desired. This process is essential in health care, where commissioners must use their purchasing power to effectively manage resources across a diverse range of providers that deliver defined services. This section discusses procurement in the context of commissioning health care services, rather than all procurement undertaken by health care commissioners (which would include the purchasing of other services, goods and supplies).

The purchasing of health care services across EU member states, including England, is subject to EU Procurement rules. These set out the regulations and processes commissioners must follow in procuring public services. Each member country must apply these rules through their own national procurement laws. In essence, EU procurement rules state that the objective of procurement must be to secure the needs of patients who use the services and to improve the quality and efficiency of services. A specific condition within this objective is that services must be provided in an integrated way (including with other health care services, health-related services or social care services).

In addition to EU procurement rules and UK procurement laws, commissioners of health services in England must also comply with NHS regulations. The regulations set out a number of objectives for commissioners when procuring services, including securing the needs of patients and improving the quality and efficiency of services. They also set out a number of principles that commissioners must respect when they procure services, mirroring general EU and UK procurement law, including transparency, proportionality and non-discrimination. One key difference between the NHS regulations and the general rules is that NHS regulations can be enforced by regulators rather than the courts. The procurement process in the English NHS must adhere to the general requirements outlined in Figure 3.

**Figure 3  General Requirements for Procurement**

(Monitor 2013)

- to act transparently and proportionately, and to treat providers equally and in a non-discriminatory way
- to procure services from one or more providers that are most capable of delivering commissioners' overall objective and that provide best value for money
- to consider ways of improving services (including through services being provided in a more integrated way, enabling providers to compete and allowing patients to choose their provider)
- to maintain a record of how each contract awarded complies with commissioners' duties to exercise their functions effectively, efficiently and economically, and with a view to improving services and delivering more integrated care
- requirements about where and how to publish a contract opportunity where a commissioner decides to advertise a contract
- a requirement to make arrangements for providers to express their interest in providing services
- a prohibition on awarding a contract for services where a conflict of interest affects or appears to affect the integrity of the contract award
- a prohibition on engaging in anti-competitive behaviour unless this is in the interests of people who use health care services
- a requirement to establish and apply transparent, proportionate and non-discriminatory qualification criteria
- a requirement to ensure that those providing commissioning support and assistance act consistently with certain requirements in the regulations
- a requirement to publish information about contracts that commissioners award
- various requirements to protect the rights of patients, set out in the NHS Constitution, to choose who provides their health care.
Findings

Whilst some of these requirements are specific to the policies and laws that NHS commissioners must operate within, the general principles can apply to the procurement of public services within any legal jurisdiction that relies on competition and market stimulation. These rules provide a framework for commissioners when deciding what services their patients need and how to go about securing them. The framework is relevant whenever commissioners are awarding new contracts or making material variations to existing contracts. It is for commissioners to decide, while acting within the framework of the regulations, what services to procure and how best to secure them in the interests of patients. The regulations do not require commissioners to follow a prescribed process every time they procure services. The PHN Program draws its administrative authority from the Commonwealth of Australia (Commonwealth of Australia 2014, 2013, 2015).

Part of the procurement requirement in the EU is a process of competitive dialogue. This process allows for bidders to develop alternative proposals in response to a client’s outline requirements. Only when their proposals are developed to sufficient detail are tenderers invited to submit competitive bids. The main tension noted in this process is attempting to balance the requirements for transparency and confidentiality of commercially sensitive information.

A review of the competitive dialogue process (across the whole of the public sector) concluded that the process was generally viewed positively by the public and private sector, with advantages including the scope for maintaining competition, the development of good working relationships between the public and private sectors, and the imposition of discipline of the process, and its ability to deliver good solutions and a ‘better deal’ for the public sector. However, the review also noted the importance of the process being carried out properly (and only on appropriate projects) and, where this is not the case, the risk of it becoming burdensome and expensive (HM Treasury 2010).

As the regulator of NHS services in England, Monitor (2013) sets out some key questions (see Figure 4) that commissioners should ask themselves when deciding whether they should follow procurement rules for commissioning a service, and how to interpret the process.

**Figure 4 Key questions that commissioners should ask themselves**

(Monitor, 2013)

<table>
<thead>
<tr>
<th>Procuring services within the framework of the regulations: Key questions commissioners should ask themselves</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are the needs of the health care service users we are responsible for? Are those needs currently being met? Have they changed since services were last reviewed? What level of engagement with the local community, patients and patient groups, clinicians and others should we undertake?</td>
</tr>
<tr>
<td>• How good are current services? How can we improve them?</td>
</tr>
<tr>
<td>• How can we make sure that the services are provided in a more joined-up way with other services so that they are seamless from the perspective of the patient? How can we get the professionals that are responsible for different elements of a patient’s care to work together more effectively for patients?</td>
</tr>
<tr>
<td>• Could services be improved by giving patients a choice of provider to go to and/or by enabling providers to compete to provide services?</td>
</tr>
<tr>
<td>• How can we identify the most capable provider or providers of the services? Is the current provider the only provider capable of providing the services?</td>
</tr>
<tr>
<td>• Are our actions transparent? Do people know what decisions we are taking and the reasons why we are taking them? Do we have appropriate records of our decisions?</td>
</tr>
<tr>
<td>• How can we make sure that providers have a fair opportunity to express their interest in providing services? What do we need to do to make sure that we do not discriminate against any providers?</td>
</tr>
<tr>
<td>• Are there any conflicts between the interests in commissioning the services and providing them? If so, how can we manage them to make sure that they do not affect or appear to affect the integrity of the award of any contract at a later point in time?</td>
</tr>
</tbody>
</table>
Figure 4  Key questions that commissioners should ask themselves

- Are our actions proportionate? Are they commensurate with the value, complexity and clinical risk associated with the provision of the services in question and consistent with our commissioning priorities?

It is worth highlighting the limited evidence on the impact of procurement on quality and costs of health care services (this is distinct from evidence on the procurement of other goods, services and supplies). There is some anecdotal evidence of improvements – for example commissioners using procurement to gain greater leverage over incumbent providers in isolated cases. When GPs in England were given control of their prescribing budgets under the GP Fundholding scheme they achieved one-off savings by – among other things – increasing the use of generic drugs. However, once these approaches had been implemented, prescription cost growth among this group returned to the same level as for GPs not involved in the fundholding scheme. In New Zealand, primary care commissioners achieved greater savings on their prescribing budgets than in the UK, which they reinvested in the primary care infrastructure. Commissioners in England continue to focus on prescribing practice as an area for improvement and have had some positive results by appointing prescribing advisors to support GPs and by encouraging groups of GPs to peer review their prescribing data (Smith et al 2004).

In general however there are very few high quality studies of the impact of procurement processes for individual health care services. Furthermore, some procurements incur high transaction costs, particularly for complex groups of services (for example, management contracts and integrated care contracts). Anecdotally, questions have been raised regarding whether procurement is actually a sensible route for tendering increasingly complex groups of services within integrated local systems. Such a process may be challenging or nonsensical for tendering integrated services in cases where at least some of the services are delivered by a local monopoly. In these cases, commissioners will need to explore alternative contestability requirements in order to achieve value for money.

2.2.2 Contracting options

Procurement and contracting are part of the same process. Once a provider (or group of providers) has been identified, the delivery of services will be underpinned by a contractual agreement. However, it is likely that the form of the contractual agreement will be specified before the procurement process begins, or might guide the commissioner on the procurement route (ie whether competitive tendering is necessary or appropriate), or might be refined during the process of competitive dialogue.

As with the procurement route, the form that contractual arrangements take will depend on the nature of the service and the particular outcomes required by the commissioner. In all cases the contractual arrangement will be one of the primary mechanisms the commissioner has for holding provider(s) to account for delivery, and therefore selecting the appropriate option is key.

The fundamental question for commissioners is how, having identified their population’s health care needs and decided on priorities, they use their purchasing position within the economic framework of the NHS to get value for patients. There are a number of possible contractual routes, with varying complexity:

- **Specified direct contract with a single provider** – individual contract for an agreed set of services
- **Framework agreements to stimulate choice** – ‘framework’ contract with a number of providers which sets the terms but not the level of activity for each
- **Contracting services for a care pathway** – different contractual models to support integrated care across a pathway
- **Contracting for a population** – contract with a provider or group of providers to manage care to a single set of outcomes for a particular population, within a single budget

### 2.2.2a Specified direct contract with a single provider

For many services, commissioners will enter into individual contractual agreements with provider
organisations for an agreed set of services. For example, in England a commissioner might enter into a contract with the local hospital to deliver a wide range of acute services. The contract underpinning this arrangement will specify the nature of the services provided and the volume to be delivered over the period of the contract. It will also set out the other key terms of the agreement, including arrangements for reimbursing the provider (see separate section on payment mechanisms) and the measures which will be used to monitor the provider’s performance.

The use of a standard or traditional contract has the advantage of ensuring consistency between different areas and reducing the resources and costs associated with extensive negotiations between providers and commissioners at a local level (Allen et al 2015). However, in some circumstances the standard contract can act as a restriction on local organisations by making it difficult to introduce changes or innovate in the way that care is delivered (Grafton Group 2013).

2.2.2b Framework agreements to stimulate choice

For services where patient choice is a priority, commissioners may also enter into an agreement with a number of provider organisations for the same service. This form of ‘framework’ contract will set out the conditions on which the service is provided, but will not specify volumes required. The level of activity undertaken by each individual provider (and the associated payment) in practice will depend on where patients choose to go.

In England, procurement laws and NHS regulations enable commissioners to procure ‘any qualified provider’ (AQP) to deliver certain services, where patient choice is appropriate. Under AQP, any provider which is assessed by the commissioner as meeting the required quality standards, and which can deliver the service to NHS prices, is eligible for providing the services. These providers can enter into such a framework agreement and patients are able to choose from any of them. Over time, the range of services covered under an AQP contract have been extended because:

- it gives patients the right to choose to be treated in the place that is most appropriate to their needs
- it drives quality up and provides levers for the best quality providers to grow
- it encourages innovation by making it easier for new providers to offer services (NHS Confederation 2011).

Before providers can compete to offer a service, they need to be assessed using a nationally defined qualification process. This is to ensure that they meet the quality standards, meet the terms of the NHS contract and accept the NHS price for the service. Providers must also confirm they are capable of delivering the commissioner’s service requirements, and can comply with referral protocols (NHS England Commissioning Board 2012). Patients can choose from amongst all the providers who have met these requirements. Providers will still need to register with local commissioners, but this will be mainly for the purpose of confirming adherence to local requirements. Commissioners cannot refuse to accept qualified providers unless providers reject the price offered, refuse to agree to any reasonable additional local standards or fail quality standards.

2.2.2c Contracting services for a care pathway

Commissioners may contract for pathways of care, where they want to use their tools to strengthen integrated care, improve quality and reduce costs. There are different contractual tools in use for managing these relationships.

In a prime contractor model, the commissioner contracts with a single organisation (or consortium) which then takes responsibility for the day-to-day management of other providers that deliver care within the contracted scope or pathway. The prime contractor does not deliver care directly, but manages this supply chain through individual sub-contracts with each of the providers to deliver the specific contracted service. The prime contractor takes responsibility for designing a delivery model and patient pathway that will most effectively meet the terms of the contract.

It uses the terms of the sub-contracts to stimulate and incentivise the necessary behaviours and performance it wishes to see across other providers. Typically – but not exclusively – the prime contractor is allocated a capitated budget to manage all care for the specific population or disease group. To varying
 extents, a proportion of this budget is ‘at risk’, dependent on the prime contractor (through its supply chain) meeting stipulated outcome measures (Addicott 2014). Figure 5 provides a case of such a context.

A variation on the prime contractor model – the prime provider model – stipulates that the contracted organisation also provides services directly. The intention is to limit further fragmentation that could be caused by introducing a new organisation (ie the integrator) into the landscape. Instead, the intention is that the prime provider has greater leverage for transformation by directly building its provider capacity and delivery model to meet the terms of the contract (Addicott 2014).

**Figure 5  Prime contract model – Musculoskeletal services in Bedfordshire**

(adapted from Addicott 2014)

Bedfordshire clinical commissioning group (CCG) is under some financial pressure. Musculoskeletal care is its fourth biggest area of spend, largely driven by a reliance on hospital-based services, and the CCG wanted to make a more substantial impact on reducing spend. Initial analysis suggested that the CCG was paying a large amount of money without a proportionate improvement in outcomes. There were access problems, and a regular failure to meet waiting time targets. Patients reported uncoordinated and inconsistent care and variations in communication, and had no central point of contact.

**Why a prime contract?**

The CCG wanted a greater focus on managing the musculoskeletal referral pathway and providing more care in the community. Realising it did not have sufficient experience of pathway management, nor the incentives to do this itself, the CCG decided to commission and incentivise an organisation to manage the pathway. The ambition was that a single prime contractor would have greater ability to align incentives across the pathway through a program budget and overarching outcomes.

**Progress**

Following a formal procurement process, the CCG appointed a consortium led by Circle Clinical Services Ltd as the prime contractor. The CCG has a direct contractual relationship with Circle, which manages the contracts within the supply chain. In practice, the CCG has continued to play a brokering role with local providers as Circle establishes their sub-contracts. The CCG holds a standard NHS contract with Circle; however, Circle cannot issue NHS standard contracts because it is not a statutory NHS body.

**Payment model and contract terms**

The prime contract arrangement is underpinned by a capitation-based funding formula, incorporating risk/gain-share and additional financial incentives for delivering improved patient and clinical outcomes. The annual budget started at £26.5 million in the first year, increasing approximately 1.3 per cent each year over the course of the five years.

Circle receives 95 per cent of the contract value up front, for which it takes full financial risk. An additional 2.5 per cent is paid to Circle to cover management costs. For this sum, the Circle consortium must deliver the basic service specification. Circle can retain the first 5 per cent of any surplus from this 95 per cent at the end of the year. Anything over 5 per cent is split 50/50 with the CCG. This serves as a further financial incentive to the CCG to improve the quality and efficiency of care.

**2.2.2d Contracting for a population**

For a whole population (or a sub-set of the population), a commissioner may want to enter into a single contract or agreement with a range of providers to manage care to a single set of performance metrics and within a single budget. The key difference from the prime contractor model is that the commissioner(s) and all providers within such an alliance share risk and responsibility for meeting the agreed outcomes. They are not coordinated by a prime contractor or integrator, and there are no sub-contractual arrangements; all organisations within the alliance are equal partners.
and must instead rely on internal governance arrangements to manage their relationships and delivery of care. Alliance contracting is a fairly recent development in the English NHS; most examples come either from the construction industry in Australia or from health partnerships in New Zealand (Gould 2014; Timmins and Ham 2013).

There is a longer history of alliance contracting in New Zealand. Recent successes in population-based funding through District Health Boards demonstrate the value of collaborating across commissioners and providers to achieve health outcomes at a population level. This has also seen resources shift from hospitals to primary care services, reflecting the intention to shift more care into the community. However, there is limited evidence to date regarding whether there has been a shift in service provision to follow this shift in resources (Cumming 2016).

The intention of the alliance approach is that integration and collaboration are formalised through the contract, as commissioners and providers within the alliance are legally bound together to deliver the specific contracted service. As such, they should be incentivised to innovate and identify efficiencies across the system, rather than solely within their organisation. This is distinct from an alliance of providers that might come together informally for a time-limited period on a particular project. An alliance contract typically binds commissioners and providers together to share risk and rewards. This approach is a step towards new provider models, such as Accountable Care Organisations from the USA, whereby providers take greater direct control of a capitated budget (Addicott 2014).

A contract of this type carries both greater risk and greater reward for providers, who are accountable for their own performance and that of other providers within the alliance. Success is judged by the performance of the alliance overall rather than the performance of single organisations within it. The members of the alliance will need to decide a governance framework through which the money can flow and decisions can be made, as well as a model of service delivery. Given the mutual dependencies, an alliance contract might be most suitable where there are well established provider relationships (Addicott 2014).

Innovations in commissioning and contracting are still in development and it is too early to draw firm conclusions. However, it is clear that the process of developing prime contracts, alliance contracts and related approaches needs considerable investment of time and resources as well as work to develop effective relationships between commissioners and providers. Commissioners often need expert advice from lawyers and others in taking forward these innovations, and the preparatory work also consumes substantial funds (Addicott 2014).

Work on the technical aspects of commissioning and contracting needs to go hand in hand with the relational aspects. Research shows that prime contracts and alliance contracts will only work where commissioners and providers work collaboratively and openly, based on a shared understanding of what they are seeking to achieve (Addicott 2014). Among other things, this means investing in the development of system leaders. This is discussed in more detail later in the paper.

2.2.3 Contracting for quality and outcomes

Making contract-holders accountable for achieving and improving outcomes seeks to mitigate concerns around ‘cream-skimming’ – where a contract-holder does the bare minimum within the budget in order to maximise profit above all other considerations. Commissioners can additionally link outcomes to incentive payments – that is, stipulating within the contract that a proportion of the budget is paid dependent on achieving a certain threshold on these outcome measures. If the contract-holder does not achieve the threshold, it does not receive that allocation of the budget.

Outcomes can be weighted, depending on their likely impact on the overarching ambition or their ‘value’ (Porter 2010). In order to stimulate continual improvement, the thresholds might become more ambitious over time, the proportion of the budget that is at risk might increase, and/or the outcome measures themselves might change over the life of a contract to reflect longer term ambitions.

In England, ‘Commissioning for Quality and Innovation’ (CQUIN) was introduced as a quality framework in the 2009/10 contract, which provided financial incentives to achieve specific quality targets. There are also provisions in the standard contract which allow commissioners to impose financial penalties for breaches of nationally specified events and other aspects of poor quality care. Local commissioners can also negotiate
additional CQUIN targets and financial penalties to include in their contracts with local providers. Allen et al (2015) found that, although financial incentives may encourage quality improvements, the costs associated with implementing the contractual regime may be too onerous. If payment for quality improvement and penalties for failure to meet targets is to be continued, the national system (and therefore the contract) needs to be streamlined and simplified, so that less effort to negotiate and monitor varying targets is required at local level.

Commissioners commonly express dissatisfaction with the performance measures available for incentivising innovation or collaboration. Many recent developments have been driven by a greater focus on outcome-based contracting, which shifts greater responsibility onto providers to design suitable care pathways to achieve these outcomes. Some outcome measures might relate directly to clinical outcomes, while others could focus specifically on incentivising collaboration.

All of these considerations need to be made through reviewing current evidence and in consultation with clinicians, patients and the wider community. Engaging clinicians in developing outcomes is important to ensure their longer-term buy-in to the transformation program and to its ultimate success. Similarly, agreeing outcomes in consultation with patients, carers and the wider community is vital for developing and communicating the focus and ambition of the program, rather than being driven by contract and procurement technicalities. Commissioners and others involved in the program must have a clear understanding of the desired outcomes and be able to articulate them to a range of audiences.

As an example, Webster (2016) suggests that such an approach could benefit the provision of out-of-home care services for children and young people. Such service areas require collaboration between a range of providers, all working towards shared outcomes. However, in this and other services areas, much more sophisticated data informatics are required to fully monitor and improve the quality of care. PHNs are in a position to work with providers to bring together existing data and work with providers to establish and monitor outcomes.

The process of developing and agreeing outcomes is time-consuming and resource intensive, and is likely to require continual consultation. Engaging with relevant stakeholders to discuss and agree the desired outcomes is a vital step in contract development, and should not be sidestepped or undervalued.

As more outcome-based contracts develop, there will be a greater pool of existing frameworks to draw on. However, while these resources will prove valuable, they are not a substitute for local engagement and developing outcomes that reflect local priorities.

Outcomes should be few, clear, concise and readily communicated. Ultimately, they will be operationalised into a greater number of key performance indicators. Outcomes can be specified at the outset for contract design and/or procurement purposes, while the more detailed key performance indicators and thresholds can be negotiated in partnership with the contracted provider(s) or integrator. Some common higher-level contractual outcomes include:

- patient experience and satisfaction with services
- early detection and intervention, to support people to recover and stay well
- supporting people to manage their condition, and increasing patient involvement in decision-making
- improved patient outcomes (including survival rates)
- reducing emergency admissions to hospital
- delivery of co-ordinated and patient-centred care, demonstrating joined up working
- effective information-sharing, including use of technology (Addicott 2014).
2.3 Payment mechanisms

Summary points

- One size does not fit all; different services require different approaches to payment. It is important that function is determined before form in order to ensure that the most effective payment mechanisms are used.
- Payment by Results systems incentivise activity and are therefore potentially inconsistent with policy aimed at reducing hospital admissions. This is a challenge that PHNs will be faced with given that activity based funding mechanisms are used in GP and acute services. It is therefore important that PHNs think about how they can invest flexible funding to achieve a reduction in inappropriate use of health care resources.
- Quality incentives can be effective but they will not always be so without careful design and planning. Sharing experiences of where this has been done successfully by PHNs will be useful in supporting the development of more effective quality incentives.

Some commissioners use activity-based systems primarily for budget allocation, planning hospital services and for monitoring and benchmarking performance. This approach is common in decentralised health systems and in countries without a full purchaser-provider split. Case-mix tools are one component of their methodology for allocating budgets to sub-national governments (eg in Australia, Denmark and Sweden) or to regional hospital or health boards (eg in Finland and some Canadian provinces), or within a hospital or hospital network (eg Hong Kong) (Appleby et al 2012).

Decentralised countries may give local authorities flexibility over how to use case-mix payments, if at all, and only mandate activity-based payment for a relatively small share of hospital activity, for example for patients treated outside the local area (cross-boundary flows), or to create incentives for regions or boards to increase elective surgery for procedures with long waits. Many other countries use case mix as their main method of paying for acute hospital admissions (eg the United States, Germany, some states in Australia, France, the NHS in England, Netherlands and some regions in Denmark) (Appleby et al 2012).

It is important to note that in most of these countries, activity-based payments account for considerably less than 100 per cent of funding for public hospitals. Activity-based payment is combined with other types of payment currencies (global budgets or block contracts, fee-for-service, bundled payments, pay-for-performance). Here we describe some of the different approaches.

2.3.1 Block payments

Block budgets or contracts continue to account for a significant but varying share of public hospital income. In the United States and Australia, rural hospitals that provide critical access, but would not be financially sustainable under case-based payment, are paid via block contracts. Other countries have reduced the share of activity-based funding for hospitals at certain times. For example, this occurred in Sweden (Stockholm County) and Norway when they needed to control activity growth in order to live within budget constraints (Street et al 2007; Busse et al 2011). There is a spectrum of practice on global budgets contracting: at one end, global budgets are set or adjusted over time in sophisticated ways using measures of activity (including cost-weighted case mix), other measures of patient need and measures of efficiency. At the other end of the spectrum, global budgets may simply represent historic expenditure on a particular service with negotiated adjustments influenced more by availability of funds and relative negotiating power.

2.3.2 Payment by results

Under a payment by results model, providers are paid on a ‘per case’ basis, with prices fixed, in advance. In England, this is done by assigning treatments and procedures to a ‘healthcare resource group’ (HRG), which are groups of health care activities that are clinically similar and require similar levels of resources. Prices for activities in each group are set nationally by the Department of Health and detailed in a national tariff. In England, an important feature of payment by results is that prices contained in the national tariff are set on the basis of the average (mean) cost of providing a particular procedure (Maybin 2007). In other countries, for example in the Netherlands, local price setting is used as well as national tariffs in order to provide some price competition within the system (Charlesworth et al 2012).
Challenges and lessons for good practice

2.3.3 Bundled payments

Many countries are dissatisfied with the limitations of activity-based payment systems for patients with chronic conditions, with multiple conditions or complex ongoing needs. In spite of a widespread consensus that setting-based activity payments work against optimal management of care for these conditions, there has been relatively little innovation in payment models for chronic illness (Tynan and Draper 2008). More generally, countries are looking for payment methods that may provide more powerful incentives for service change – to encourage patient care in the most appropriate, cost-effective settings and to facilitate coordination or integration along patient pathways. The objectives of this new phase of hospital payment reform place greater emphasis on whole-system efficiency (rather than hospital efficiency), cost containment and care co-ordination for individual patients across settings.

The United States, the Netherlands, Germany and Sweden are among a growing number of countries experimenting with contracting for a whole pathway or episode of care for a particular condition. The Netherlands is evaluating a large-scale initiative to contract doctor-led care groups under adjusted capitation payments for a year of care for selected chronic conditions: diabetes, chronic obstructive pulmonary disease and vascular risk management (de Bakker et al 2012). In Gesundes Kinzigtal in South West Germany, bundled payments have been used successfully to incentivise providers to deliver more efficient, integrated care (Charlesworth et al 2012). In the United States there have been pilots of bundled payments based on ‘episode treatment groups’ that encompass physician, acute hospital, post-acute inpatient and ambulatory care costs from referral or admission to recovery for an extended episode of care (Appleby et al 2012). Sweden (Stockholm County) has piloted extended episode payment for joint replacement, combined with patient choice and provider competition, finding initial gains in productivity and activity (Health Care Incentives Improvement Institute 2012). Bundled payment pilots in the United States have typically left activity-based and fee-for-service payment systems in place and used these as building blocks for attaching prices or setting budgets for care bundles. Payer contracts often share gains with
providers and may share losses of bundled payments (Appleby et al 2012).

In spite of the conceptual attractions of bundled payments, there is caution about the very complex technical and operational issues to be worked out in defining episodes, setting payment rates and case-mix adjustment, choosing how to allocate incentives to the different providers involved in an episode, and drawing the boundary between other payment streams and methods if unintended effects are to be avoided.

For chronic conditions, there is some international experience and evaluation of bundled payments for year of care, including mental illness. Pilots have been carried out by Medicare and some private sector integrated health systems in the United States. The evaluations of the Netherlands’ year of care initiative found that the scheme sought to reduce fragmentation within primary care and bridge the division between primary and specialist care for chronic disease patients, where the traditional ‘gatekeeper’ role for GPs is inappropriate. The bundled payment goes to a principal contracting body – the care group – which is responsible for organising care and accountable for its delivery. Initial findings point to some benefits in provider collaboration, care co-ordination and compliance with clinical guidelines. However, the scheme has high administrative burdens (though these may be mitigated over time by innovation and adaptation in ICT systems) and has seen wide cost and performance variation across care groups not explained by differences in the amount of care provided. It has also given rise to concerns among payers about market concentration and power of larger provider groups and about ‘double funding’ (via the bundled payment and via the traditional payment methods for GPs and hospitals) and cherry-picking of less complex cases by care groups, and has not yet produced changes visible to patients (Struijs and Baan 2011; de Bakker et al 2012).

2.3.4 Capitation

Some US and Dutch health researchers have concluded that bundled payment developments should not be seen as the desired end-point for payment reform. Rather, they could best serve as a bridge from current highly fragmented care and activity-based reimbursement to a future scenario in which provider groups would be willing and able to move to a risk-adjusted capitated payment model and take clinical accountability for the continuum of care for a defined patient population, accompanied by performance-related pay (Pham et al 2010; de Bakker et al 2012).

The United States is the country with most experience of capitated payments. This derives originally from the method used to pay multi-speciality groups in California, such as Kaiser Permanente. Capitated payments in Kaiser Permanente grew out of the model of pre-paid group practice. Rates paid to medical groups are adjusted for age, gender and health status and the scope of services covered may vary from some to all (called global capitation). This form of payment creates incentives for medical groups to manage care effectively and to invest in the prevention of illness and not just treatment services.

One lesson from managed care programs in the US in the 1990s was the need for medical groups to have the expertise to take on these sorts of capitated budgets. Medical groups and integrated delivery systems operating under global capitation take on a budget for the population of patients or members they serve and this is neither formed from, nor disaggregated into, disease-based budgets. This enables these groups and systems to focus on people with co-morbidities and complex needs and avoids the risk of creating silos of care based on single diseases or conditions. However, this model has been criticised for limiting choice of provider (Shortell et al 2014).

The United States has also seen a new phase of experimentation with capitation payments to medical groups or managed care systems. Unlike earlier capitation contracts, these new pilots usually blend capitation with activity-based payment and quality incentives and share gains and losses with providers. Also, patients are typically given the choice of obtaining care from non-group providers even though their own medical group remains responsible for total costs of their care (Frakt and Mayes 2012). Global capitation requires there to be an organised provider of care, with a range of expertise, able and willing to accept the financial and clinical risks involved.

The experience of the United States in the 1980s and 1990s when medical groups took on capitated budgets at risk under contract with health insurers contains a number of lessons. One of the most important is the need for providers to demonstrate
they have the capabilities to manage the terms of the contract and deliver the expected outcomes. Commissioners and providers may need some support to manage these new responsibilities (Shortell et al 2014).

Figure 6 below illustrates the relationship between the degree of bundling of payments and the continuum of organisations able to accept these payments. Any move towards global capitation would need to take heed of this lesson and ensure that integrated medical groups and delivery systems had the capability to work in this way.

**Figure 6 Organisation and payment methods**

(Commonwealth Fund 2009)

Innovations in payment systems – if used wisely – have the potential to stimulate innovations in service provision and the way in which providers are organised. Failure to recognise this insight risks repeating what happened in the United States where many medical groups went bankrupt because they lacked the capabilities to take on the responsibilities they were offered (Appleby et al 2012; Shortell et al 2014).

A capitated budget seeks to align financial incentives and allow providers to collectively manage the distribution of activity and funding across the system. The capitation payment is ideally based on a weighted formula, adjusted over time according to population projections and/or any ambitions to reduce overall spending for the service. The transfer of financial risk onto providers can introduce strong incentives to limit activity or cut corners on quality. To address these concerns, commissioners could build risk-sharing terms into the financial incentives of the arrangement (ie making a proportion of the overall budget dependent on the providers collectively achieving the agreed quality and outcome measures). The Alzira model (Figure 7) illustrates this capitation model.
Figure 7  Alzira model (Spain)
(Charlesworth et al 2012; NHS Confederation 2011)

Overview
The Alzira model is a good example of a healthcare system based on capitation payments. Under this model, a vertically integrated provider is paid a fixed sum on a per inhabitant basis in return for providing the local population with universal access to a full range of health services.

The model
The Alzira model is a public private partnership model in which a single, private sector contractor provides hospital and primary care services to a local population. It is named after the town in Valencia where the first hospital was managed under an administrative concession which setting out responsibility for the full range of health services, the first of its kind. The Alzira model is now operated by a number of hospitals across Valencia.

A key principle of the model is integrated working between primary and secondary care, with primary care as an integral part of the system. Incentives are aligned across the system, including primary care, to ensure that care is delivered in the most appropriate setting.

Payment system
The model is supported by a capitation system of payment whereby each area is allocated an annual budget by the region, determined in accordance with the population service and the scope of services provided (some costs are excluded, such as some pharmaceutical prescriptions and medical transport costs). The private contractor is paid a fixed annual sum per inhabitant for the duration of the contract which must cover all costs, including payroll, consumables and utilities. In return, the contractor takes responsibility for running the health department and must provide free and universal access to the full range of services it provides. To dis-incentivise hospitals from treating people who live outside of the local area, hospitals are only reimbursed 80 per cent of the cost per non-resident.

In 2003 the contract was updated to include a profit share agreement between the contractor and local government in order to secure the financial sustainability of each. Under the revised terms, the hospital may retain profits of up to 7.5 per cent of turnover but any surpluses above this level are returned to the local government.

The cost per patient is much lower than in districts with a traditional model of provision and payment. However, there has not been a formal evaluation to determine whether or not the service is more efficient that others, or if care is of a higher quality.

2.3.5 Incentive payments
Many countries supplement activity-based payment systems with financial incentives for quality and other dimensions of performance, such as waiting time reductions and coordination between hospitals and doctors in the community. Several countries have implemented a policy of non-payment for readmissions within a defined period (United States, Germany and England). Denmark, like England, introduced patient choice of alternative provider if waiting times guarantees are not met. A wide variety of pay-for-performance schemes for hospitals use pay rewards or penalties for achieving some combination of absolute levels of performance standards or improvement of performance on a mix of indicators. The Australian State of Victoria introduced powerful performance incentives by making payment for additional activity conditional on waiting times improvements (Street et al 2007). Many countries in Europe, including England, France, Estonia, Hungary and Sweden, have also used pay-for-performance schemes in primary care, which have been used to reward quality and encourage improvements in prevention services (Charlesworth et al 2012).

There is very limited rigorous evaluation of whether or not pay-for-performance schemes for hospitals
improve quality, and it is difficult to assess the evidence given the wide variation in approach (Petersen et al. 2006). One review found that ‘the use of explicit incentives is still quite recent, the collective knowledge base regarding their design and effectiveness is limited and so their development remains largely a learning-by-doing process’ (Custers et al. 2008). There is some evidence that the Quality and Outcomes Framework (QOF) in England (introduced in 2004), a program designed to incentivise quality in general practice, has led to modest improvements in the quality of care for certain conditions, but that the pace of improvement was not sustained once goals had been reached. It also highlighted the risk of unintended consequences, such as a decline in quality for aspects of care not linked to targets (Campbell et al. 2009).

The US Medicare system has evaluated controlled demonstrations of paying performance bonuses to hospitals based on a combination of absolute standards and improvement over time in 30 quality measures across five disease areas. Despite initial improvement in scores, after five years there was no difference in performance compared with control sites. Evaluations suggest that quality incentives need to be of sufficient magnitude to have an impact. Medicare’s pay-for-performance scheme for hospitals (called ‘value-based purchasing’) has been estimated to change hospital revenue by a fraction of one per cent for two-thirds of hospitals (Werner and Dudley 2012). There is some evidence that performance incentives can have greater effects if they are tailored to the specific circumstances of the hospital. For example, a given financial incentive may have less effect on a hospital that is in financial difficulty or a hospital that faces stronger competition (Werner et al. 2011; Jha et al. 2012).

The Commonwealth Fund and the Kaiser Family Foundation recently published the results of a survey of providers’ views on the organisation and funding of primary care in the US. Primary care physicians were negative about the impact of financial penalties for patients admitted or readmitted to hospital unnecessarily, probably because this type of performance management might threaten both their clinical autonomy and their income. Unsurprisingly, those who were most positive were those who had received quality-based payments (Ryan et al. 2015).

Although incentive payments and penalties are designed to stimulate performance improvement, they are generally unpopular and evidence on their impact is uncertain. Alternative payment mechanisms (such as capitation) may present a more appealing option for providers within new care models, empowering them to develop pathways and deliver care using their expertise. Giving professionals more clinical and financial control might have a greater impact on the quality of care than rewarding or penalising performance.

Experience of activity-based hospital payment and pay-for-performance has also provided a number of insights into the difficulties involved in their implementation and in devising better alternatives. As casemix payment systems have become more complex, some hospitals have struggled to identify the necessary information and produce the required data. Performance data can be hard to derive from existing administrative data which usually records what is done rather than the outcomes that resulted (with limited exceptions such as mortality data). Even where outcome data are available, differences in patient mix mean that patient scores need to be adjusted to enable meaningful comparisons over time or across hospitals. Pay-for-performance systems have significant start-up costs for initial planning and data gathering and ongoing operational costs. This can be a barrier to implementing such payments across whole systems, even in health systems with detailed individual patient reporting to insurers. Research carried out by The King’s Fund has shown that these costs may be high and difficult to meet in a time of financial stringency (Greenwald 2011; Ham et al. 2011).

Some evidence suggests that performance payments are more effective in changing behaviour where they are based on process rather than outcome indicators that are less directly related to provider performance (de Bruin et al. 2011). But if process measures are used as a proxy, they may not be well correlated with outcomes (Bhattacharyya et al. 2009).
### 2.4 Balancing local and national commissioning

#### Summary points

- Commissioning should take place at different levels, depending on the nature of the service – forming a matrix approach to commissioning. PHNs will need to carefully plan these levels around different population groups, places and in combination with a range of related government-funded services.
- Clarity as to the role and responsibilities of different organisations involved in commissioning services across this matrix is critical. This will also be critical to minimising the reporting burden of commissioning on participating organisations.
- Commissioners will need ongoing support from other bodies, and there may be opportunities for local commissioners to share these support functions.

Research suggests that commissioning systems should allow for different health and care services to be commissioned at different levels. Some strategic planning and commissioning can be done within a smaller locality. However, complex, specialist or expensive services may need to be considered across a larger footprint to allow for sensible allocation of scarce resources. Decisions about the level at which commissioning should take place should be driven by the nature of the service, for example the level of demand or the number of places where the service can be delivered efficiently (Ham 2008a). Where flexible and patient focussed responses are required, commissioning by primary care clinicians may be the most appropriate. However for specialised areas such as cancer services, which require a population based approach, commissioning at a higher – potentially national – level is likely to be more suitable (Goodwin and Smith 2002).

This multi-level approach to commissioning is sometimes described as a matrix approach. One study into practice based commissioning in England (in the late 2000s) proposed a matrix model whereby primary care trusts took responsibility for strategic, population-wide commissioning, with real budgets for specific service areas devolved to GPs and Practice Based Commissioning clusters, giving them greater freedom and stronger incentives to innovate in terms of the care provided for patients (Curry et al 2008). However, this approach requires that different organisations not only commission at different levels, but also that individual commissioning organisations are sufficiently flexible to commission at multiple levels, depending on the particular service. For example, clinical commissioning groups in England need to be able to commission some services at an organisational level, some at sub-clinical commissioning group or locality level, and others at a higher level, in partnership with other clinical commissioning groups.

Of course, operating a multi-level system in practice is dependent on having clarity about the roles and responsibilities of the different organisations involved. This issue has been highlighted within the English system, where there is some evidence of uncertainty between the roles of NHS England (the national commissioning body) and clinical commissioning groups (local GP commissioners) (Allen et al 2015).

Given the need to commission different services at different levels, no commissioning system should be either entirely devolved, or wholly centralised. However, striking the right balance between the two is vital. Delegation of commissioning responsibility on the basis of subsidiarity should help ensure that the system is as accountable to the local population as is possible. This principle has been one of the leading arguments for the greater involvement of primary care clinicians in commissioning services. In England, where GPs are frequently in post for many years and have regular contact with their local populations, it has been argued that GP commissioning (in the form of Practice Based Commissioning) could lead to more patient sensitive commissioning (Dixon 2007).

However, devolution of commissioning also raises some challenges. One potential disadvantage is the greater potential for variation in local practice. Whilst this allows a more tailored approach, it also increases the scope for inequalities of access between areas. It is also argued that the potential for economies of scale is lost when commissioning is delegated (Figueras et al 2005), and that there may be a trade-off between the greater responsiveness of local commissioning units and the increased bargaining power of larger commissioning organisations (Furness et al 2008).
It is worth noting however that even where the procurement of services takes place at the most local level, there is still scope for the much wider range of skills and resources involved in commissioning to be shared across multiple organisations. Commissioning Support Units – which provide support functions to GP commissioners in England – work across multiple commissioners. Some of this function may be provided at a national level, but may also be locally augmented by local alliance arrangements. As an example of this, Victoria has a PHN alliance arrangement that aims to share evidence and guidance across the six PHNs in the state and also play a role in influencing important shared stakeholders. Where commissioning is delegated to a very local level, it is important to consider how access to the full range of skills and resources required will be available, and whether there is a market available to support this.

The benefits of devolution or distribution of commissioning responsibility should also be carefully balanced against the risk of fragmented commissioning. Reforms to the English health and care system in 2012 which split responsibility for commissioning of health and care services amongst a number of bodies including NHS England, clinical commissioning groups and Local Authorities (see Figure 8 below), have been criticised for producing a fragmented system which makes the delivery of integrated services more challenging (Ham et al. 2015a). Distribution of commissioning responsibility in this way also increases the need for stakeholder management across all organisations, making the delivery and implementation of transformation plans more difficult.

Figure 8  Commissioning responsibility in England following the 2012 Health and Social Care Act
(adapted from Naylor et al 2013)
2.5 Governance and accountability

Summary points

- Local commissioning organisations are held to account through a range of external relationships, as well as internally through governance arrangements. Governance arrangements tend to be complex and can vary widely between individual organisations. It is important to balance some consistency of structures with local flexibility.
- Transparency and preserving public confidence are critical. If PHNs want to make significant and sustained changes to local patterns of care then they will need to engage local communities in order to gain the legitimacy to influence partners.
- Involving clinicians in commissioning provides valuable clinical insight but runs risk of conflict of interest. PHNs have a formalised mechanism of clinical engagement through their governance structure, but will have to undertake significant work to ensure that this is effective and reaches clinicians beyond this group.

Commissioning organisations are typically held to account for their performance through a range of external relationships. These reflect their upward accountability to national government and regional bodies, as well as downstream accountability to patients and the local population. Commissioning organisations are also held to account for performance internally through their governance structures, the design of which will vary between organisations.

This section outlines the internal and wider system mechanisms that can be used to hold commissioners to account for their performance.

2.5.1 External accountability arrangements

Commissioning organisations are likely to be accountable to a number of different external bodies. Between them, these bodies hold commissioners to account for their performance through a combination of management, scrutiny and regulation (Maybin et al 2011). The exact nature of these relationships will depend on the responsibilities of the commissioner, as well as the make-up of the wider system.

In England, local commissioning organisations are accountable to NHS England, the national commissioning body. As part of this role NHS England makes an annual assessment of their performance on the basis of an assurance framework which outlines the key elements of a ‘well led effective clinical commissioner’. Their performance is also measured using an outcomes indicator set (see Figure 9) which is designed to reflect the national priorities for health as set out in the NHS Outcomes Framework (see Figure 10 below). Prior to the introduction of clinical commissioning groups, the world class commissioning framework was used by the Department for Health to hold commissioners to account and reward their progress towards achieving the competencies.

Figure 9 Clinical commissioning group outcomes indicator set

(Health and Social Care Information Centre)

The indicators are structured around the five NHS Outcomes Framework domains.

- **Domain 1, Preventing people from dying prematurely** – captures how successful the NHS is in reducing the number of avoidable deaths.
- **Domain 2, Enhancing quality of life for people with long-term conditions** – captures how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible.
- **Domain 3, Helping people to recover from episodes of ill health or following injury** – captures how people recover from ill health or injury and wherever possible how it can be prevented.
- **Domain 4, Ensuring that people have a positive experience of care** – looks at the importance of providing a positive experience of care for patients, service users and carers.
- **Domain 5, Treating and caring for people in a safe environment and protecting them from avoidable harm** – explores patient safety and its importance in terms of quality of care to deliver better health outcomes.
Figure 10  Clinical Commissioning Group Assurance Framework 2015/16

(NHS England 2015)

The framework consists of the following components:

**Well-led organisation:** this will assess the extent to which a clinical commissioning group:
- has strong and robust leadership
- has robust governance arrangements
- involves and engages patients and the public actively
- works in partnership with others, including other clinical commissioning groups
- secures the range of skills and capabilities it requires to deliver all of its commissioning functions, using support functions effectively, and getting the best value for money
- has effective systems in place to ensure compliance with its statutory functions

**Delegated functions:** specific additional assurances will be required from clinical commissioning groups which have taken responsibility for delegated functions:
- Governance and the management of potential conflicts of interest
- Procurement
- Expiry of contracts
- Availability of services
- Outcomes

**Financial management:** the monitoring of a clinical commissioning group’s financial management capability and performance will be continuous throughout the year, including an assessment of data quality and contractual enforcement:
- Financial performance
- Financial controls
- Financial governance, resources and processes

**Performance:** delivery of commitments and improved outcomes. A key focus of assurance will be how well clinical commissioning groups deliver improved services, maintain and improve quality, and ensure better outcomes for patients.
- Performs against the range of measures in the delivery dashboard

**Planning:**
- Has an assured annual plan
- Is performing to plan in year 1
- Has an assured System Resilience Group plan
- Has an assured Better Care Fund plan that complies with Guidance for the operationalisation of the BCF in 2015-16
- Has a long term plan to implement the 5 year forward view

Commissioners are also held to account for how they manage their budgets and the extent to which their investments represent value for money. This is likely to involve scrutiny of their accounts. Each country will have to consider these scrutiny arrangements in light of existing regulatory structures. Within the English system, clinical commissioning groups are required to present audited accounts to NHS England, who will, in turn, present a consolidated version, together with NHS England’s own accounts, to the National Audit Office (Maybin et al 2011).

In addition, the 2012 health reforms established Monitor (previously a regulator of providers) as the ‘economic regulator’ for the whole health system. Monitor was given the power to investigate any individual or organisational practices that it suspects might prevent, restrict or distort competition, or be...
an abuse of a dominant market position. It was given the power to:

- issue directions to organisations to take (or stop) particular actions
- issue fines following an infringement
- apply to a court to disqualify directors of an organisation (in the case that an agreement or practice has prevented, restricted or distorted competition)
- refer a particular market to the Competition Commission for investigation (Maybin et al 2011).

Collaboration between commissioners and other local stakeholders raises a new set of issues regarding accountability relationships. As discussed elsewhere, joint arrangements can help local organisations produce coordinated strategies and have greater influence over providers. However, these arrangements can also put pressure on commissioners’ time due to a lengthened decision-making process and a requirement for extra meetings with external partners. There is also evidence that where commissioning organisations have accountability arrangements in place with multiple bodies there is a risk of misalignment – and at times a conflict – between their respective agendas. Commissioners need to manage these external relationships as well as internal ones, while maintaining members’ influence over the decision-making process (Holder et al 2015).

2.5.2 Public and patient accountability

Ultimately commissioners are responsible to their local population for investing public money in services on their behalf. This means that commissioners should not only be proactive in engaging public and patient representatives in decision-making, but that they should be subject to scrutiny by bodies which represent the interests of local people.

In England, these powers of scrutiny are held by local authorities, which can determine how they are exercised locally. Local authorities may require officers of NHS commissioners to attend meetings to answer questions and to comply with requests for information, and (in relation to a specified set of services) have the right to refer cases of service change to the Secretary of State for Health. A second source of public scrutiny is local Healthwatch organisations which represent patient and public interests. Clinical commissioning groups are legally bound to allow Healthwatch representatives to enter their premises and observe their activities, and are required to respond to their reports (Maybin et al 2011).

There are also obligations on commissioners to support public scrutiny, including the requirement to hold meetings of the governing body in public, and to make board papers publicly available. Public accountability is also facilitated through information on commissioners’ performance. In the past, world class commissioning framework scores were publicly available and used by external organisations to create league tables (Ham et al 2015b). Information on clinical commissioning group performance is also publicly available now and will soon include a ‘CCG scorecard’ produced as part of the clinical commissioning group assurance process (NHS England 2015).

PHNs have community advisory committees in their formal governance arrangements and a key challenge will be in considering how to leverage these resources and others to ensure effective community engagement and scrutiny.

2.5.3 Internal governance

Commissioners are also held to account through their internal governance arrangements. In principle, the stronger that an organisation’s internal governance arrangements are, the less likely central government will feel the need to intervene. Although in practice this has not always been the case. Governance arrangements should enable the delivery of the organisation’s objectives in a way that is transparent, with clear processes in place for making decisions and involving key stakeholders.

Commissioners are also likely to be subject to internal scrutiny by external appointments to their board or governing body. In order to be able to hold the organisation to account in a meaningful way, it is key that these appointments are both informed and sufficiently independent) (Likerman 2006).

The degree to which commissioners’ governance arrangements are prescribed nationally will depend on the particular system, but some form of variation between individual organisations is inevitable. For example, PHNs are governed by skills-based boards. They also have GP-led Clinical Councils and
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representative Community Advisory Committees that report to the Board on locally relevant clinical and consumer issues. While the structure is consistent across PHNs composition would be expected to vary between PHNs based on local needs. Arrangements should also have room to evolve over time, for example to accommodate new members or to support collaboration between organisations. In the case of clinical commissioning groups in England, there are fewer specific requirements on how individual groups should be governed compared with primary care trusts. Consequently the structures and distribution of responsibility is quite different and complex across different clinical commissioning groups (McDermott et al 2015). Unlike their predecessor organisations, for example, clinical commissioning groups are not required to have a board with non-executive members. However, there are other requirements on clinical commissioning groups, some of which are laid out in legislation, such as the makeup of governing body members, and others are specified by NHS England, for example the governance arrangements required for primary care co-commissioning.

As membership organisations, local GP practices are represented at various levels within the clinical commissioning group governance structure through practice representatives. All GP practices must be a member of a clinical commissioning group. Every clinical commissioning group is required to have a governing body. These are chaired by an elected GP chair and include a combination of member representatives (most commonly GPs), members of the executive team, lay members and representatives from other local partners. Clinical commissioning groups are managed by an executive team and wider support team, who are employees of the group. Clinical commissioning group executives are led by an accountable officer who is legally accountable for the group’s activities. Accountable officers may be clinicians, but in practice are more often professional managers. Most commissioners have some form of member council that comprises either all practice representatives (in smaller groups) or locality representatives (in larger groups) (Naylor et al 2013).

2.5.4 Conflicts of interest

Where clinicians are directly involved in commissioning, particular consideration should be given to the potential for conflict of interest. Conflict of interest can threaten the quality of patient care, for example by influencing the commissioners’ choice of provider, or incentivising a particular type of clinical activity which may somehow benefit the clinician, but may not be in patients’ best interests. Importantly, there does not need to be an actual gain for a conflict of interest to arise, a potential conflict or the perception of impaired judgement is sufficient (Imison et al 2011). Indeed, perception amongst local patients and the public of there being a conflict can have a very damaging impact on the public’s confidence in the organisation and undermine its position as a leader of the local health system (see separate section). This issue arose in the context of GP fundholding in England, where there was a growing perception that GPs were using savings from commissioning – intended for reinvestment in health services – for their own gain (see, for example, Gainsbury 2011; Brown 1996). This concern contributed to the abolition of the scheme.

All clinical commissioning group constitutions must contain details about management of conflicts of interest, defining what constitutes a conflict and how the clinical commissioning group will respond. Typical arrangements for the management of conflicts include the following:

- The clinical commissioning group will create and publish a register of members’ interests.
- The accountable officer will ensure that for every interest declared, arrangements are in place to manage potential conflicts, and that these arrangements are agreed in writing.
- These arrangements may, for example, describe when an individual should withdraw from a specified activity, and how the individual’s engagement in that activity will be monitored.
- Conflicted individuals will be excluded from the relevant parts of meetings; when more than half of the members of a meeting are required to withdraw, the chair will determine whether or not the discussion can proceed.
- When insufficient individuals remain unconflicted, the decision in question will be made either by a different sub-committee or group within the clinical commissioning group, or by an ad hoc group that could include members
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- When it considers it prudent, the governing body can seek additional scrutiny of commissioning decisions, by either the clinical commissioning group’s own audit committee or external individuals (Naylor et al 2013).

2.6 **Leadership and collaboration – including relationships with providers**

**Summary points**

- Commissioners have an important role in leading the local health system. For PHNs to do this they will need to expend significant time and resource in developing relational capital in order to be identified as a leader of the local health system.
- Collaboration with providers, other local partners and communities is vital for effective commissioning and involves nurturing relationships as well as formal structures. PHNs have a governance structure that supports the development of these relationships, but efforts will need to go beyond just the existence of these structures.
- In order to deliver comprehensive health and care services across a population, commissioners will need to work in partnership.

Commissioning organisations are typically held to account for their performance through a range of external relationships. These reflect their upward accountability to national government and regional bodies, as well as downstream accountability to patients and the local population. Commissioning organisations are also held to account for performance internally through their governance structures, the design of which will vary between organisations.

This section outlines the internal and wider system mechanisms that can be used to hold commissioners to account for their performance.

**2.6.1 Leadership**

Commissioning organisations are often described as leaders of the local health care system. In 2007 the English Department of Health required Primary Care Trusts to be visible leaders of the local NHS and the ‘natural first stop for local political and community leaders’ in order to meet the standards for world class commissioning (Department of Health 2007). Critical to this leadership role is the ability to develop and articulate a clear vision for the local health and care system, and to win the support of key stakeholders in delivering that vision and driving change.

In order to provide this leadership effectively, commissioning organisations must have the appropriate skills and capacity. A study to identify learnings from medical groups in the United States highlighted the broad range of skills needed by those leading such organisations, from communication and public relations to risk management and organisational development (Thorlby et al 2011).

Concerns have been expressed about leadership in clinically-led commissioning organisations, with leaders themselves reporting inadequate support and training to do the job. A survey of clinical commissioning group governing body members and practice representatives indicated that only 35 per cent felt they had received the training and development that they needed to fulfil their role, and 46 per cent believed they had the support necessary to make robust, evidence-based decisions. One reason for this was pressure on GP time making it difficult for them to complete formal training. There is also a significant issue about sustainability and succession planning for when the current leaders step down (Holder et al 2015). Dawda et al (2016) also highlight the support that PHNs will require in executing their role. In addition to being allowed time to mature, PHNs will also require ongoing resources to achieve the necessary operational capabilities. Many commissioning teams are likely to require a period of training and support in order to able to deliver these roles effectively.

PHNs can learn not only from international lessons, but also from local experiences in contracting hospital services in Australia. The Commonwealth Department of Health has a role in building on these existing capabilities in a staged way, so PHNs can avoid many of the pitfalls of international commissioning examples (Booth & Boxall 2016).

Leadership by commissioners also relies on them having the autonomy and flexibility to drive a local agenda alongside national health priorities. In England for instance, it was intended that clinical commissioning groups would have greater freedom...
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than their predecessors, and many have begun experimenting with alternative approaches to commissioning and contracting, particularly as a way of driving more integrated care (Addicott 2014). However, fragmentation across a commissioning matrix, with responsibility split between local and national bodies poses a potential challenge to local leadership; strategic oversight of the commissioning process remains difficult, and transformational changes cannot be easily implemented because of a lack of coherent strategic oversight (Ham et al 2015a). This again reinforces the need for local commissioners to have sufficient skills and capabilities to lead on implementing the strategic vision.

O’Brien et al (2016) describe early experiences of commissioning in South Australia, reflecting on the time it takes to establish the necessary competencies and relationships. This reinforces the point that commissioning is a more sophisticated activity than merely contracting and procurement – it is a complicated endeavour that emphasises a strategic approach to organising and delivering care across a population.

We make the point throughout this review that contracting and procurement are not substitutes for the relational elements of commissioning. This is not to suggest that these features are not important. However, commissioners that invest too many resources in the technocratic elements of commissioning in a myopic way run the risk of ignoring the more strategic population-level focus. Again, it is this strategic element that is the added and necessary benefit from introducing formal commissioning into a health system (Robinson et al 2016).

For PHNs the message here is that it is important to consider which other stakeholders (eg local government, state government, human services, peak bodies) have an interest and involvement in priority areas and how they might work collaboratively through joint arrangements.

2.6.2 Collaboration between commissioners

Where responsibility for health and care services is split between organisations, or where services need to be delivered across larger populations, collaboration between individual commissioners is necessary to determine the needs of the local population and develop an appropriate strategy for delivering services. Single agency commissioning is not sufficient to tackle current financial challenges or the demands around long-term condition management (Dickinson et al 2013a). In England, clinical commissioning groups (responsible for commissioning most local healthcare services) and local authorities (responsible for commissioning social care services) increasingly work together to support the delivery of more integrated services and overcome the fragmentation challenge of matrix commissioning.

Although the intention of joint commissioning is to deliver better outcomes for patients, there is very little evidence to support the impact on outcomes (Dickinson et al 2013a; Dickinson et al 2013b). Local arrangements vary but tend to involve the transfer of budgets and commissioning responsibility from one organisation to the other to achieve a set of shared priorities (although statutory responsibilities do not change). A range of models have been put forward to implement integrated commissioning arrangements between health and social care, tailored to local circumstances, on a more systematic basis across England (Humphries & Wenzel 2015). Collaboration between individual commissioning bodies or the development of networks may also be necessary where commissioning skills and capacity are in short supply (Goodwin & Smith 2002). In England, economies of scale in clinical commissioning group running costs and ability to redistribute resources among members has led to a growing number of shared governance structures. Certain senior leadership posts and decision making committees are shared across two or more commissioners. In 2014 the government legislated to make it easier for clinical commissioning groups to work together through joint committees (Ham et al 2015b). Reinforcing the point made earlier, clarity of the roles and responsibilities of each is key to the success of partnership working between these organisations. Figure 11 below illustrates these joint commissioning arrangements in the south west of England.

2.6.3 Collaboration with providers

Collaboration between commissioners and providers (potentially from a wide range of sectors) is also necessary throughout the commissioning process, from the specification of services through to the implementation of changes in delivery or
improvements in quality. Evidence suggests that a collaborative effort between commissioners and providers is particularly important through clinical engagement during contractual negotiations. Service redesign is an area where clinical engagement can have a real impact as it offers insights that technocratic commissioners may lack (Smith and Goodwin 2006). Carlisle et al (2016) describe the necessity of involving providers and the community in designing and commissioning GP after-hours services. The authors credit this collaborative approach and meaningful engagement to the early successes of the transition. Indeed, the perception that clinicians may be better able to carry out this role is one argument for clinical engagement in commissioning (Dixon 2007).

Within this context, commissioners’ ability to strike the right balance between nurturing long-term relationships and using formal mechanisms (such as procurement) to secure services and monitor performance is critical. An evaluation of health reforms in New Zealand, for example, found that too much attention was focused on the legal form of commissioning contracts and not enough on the relationships between providers and purchasers. The result was an environment in which negotiations were ‘acrimonious’ and transactions costs high (Ashton et al 2004). Williams et al (2012a) also suggest that structural solutions alone cannot deliver effective relationships and will not be effective when relationships are neglected. Commissioning cannot be separated from either local or national politics.

More recent reforms in New Zealand have instead ‘encouraged’ GPs to affiliate with District Health Boards – which are responsible for coordinating care across a locality. Figure 12 provides an overview of the Canterbury District Health Board in New Zealand, demonstrating their success in working across providers.

Provider autonomy is also important. Whilst commissioners will use contracting and contestability to drive innovation and service improvements, providers need the management and financial flexibility to respond to contract requirements and incentives (Ham 2008a) and to changing market conditions.
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Challenges and lessons for good practice

Figure 12  Health and social care integration in Canterbury, New Zealand
(adapted from Timmins & Ham 2013)

Canterbury District Health Board (DHB) is a high-performing health care organisation that has focused its quality improvement work on integrating health and social care to tackle growing demand for hospital care from an ageing population.

The board serves just over 500,000 people and delivers care through 9,000 staff employed across a range of hospital, community, and primary care providers. While working within a framework set by the Minister of Health in Wellington, the DHB has greater freedom in how it uses its resources than NHS organisations typically have. The majority of the DHB’s members are elected locally, with a minority appointed by the minister.

Canterbury decided to focus on integrating health and social care because of concern that unless action was taken to stem growing demand for hospital care, increased hospital capacity would be needed, which was not affordable. The DHB’s leaders responded by developing a vision for the future based on the notion that there was ‘one system, one budget’, and that all those involved in the system needed to work together to improve care. This resulted in a commitment to build on the strengths of primary care in Canterbury and, particularly, to invest in services that would help avoid hospital admissions and facilitate early discharge where appropriate. These and many other initiatives enabled the DHB to stem the increase in hospital use. They also helped the system cope with the effects of the 2011 earthquake, which destroyed some of the hospital capacity in Christchurch.

These results were achieved through sustained investment in providing staff and organisations under contract with the DHB with the skills needed to improve care and develop innovative models of provision. Training was provided for more than 1,000 staff in quality improvement methods such as Lean and Six Sigma. Arrangements were also made for some staff to visit other organisations that had used these methods (such as Air New Zealand and New Zealand Post). The training and visits proved important in building momentum and staff commitment to make the changes needed. Experts in process engineering were also engaged to support clinicians and managers to redesign care pathways and work flows in order to cut waste and improve performance.

Canterbury’s improvement journey also benefited from organisational stability and continuity of leadership. The DHB’s achievements were recognised in a report from the New Zealand Auditor-General in 2013, which rated Canterbury’s management control for the previous financial year as ‘very good’ – one of only two district health boards to receive this top rating. Its financial information systems were described as good (no other health board did better), while Canterbury became the only health board, and one of only four per cent of all New Zealand public bodies, to be judged to have ‘very good’ service performance information.

Those wishing to create a system of truly integrated health and social care must have a clear vision. In the case of Canterbury, the mantra ‘one system, one budget’ is firmly held and articulated.

Sustained investment is needed to provide staff and contractors with the skills needed to innovate and to support them when they do.

New forms of contracting may be needed. In Canterbury, this meant the price/volume schedule (the equivalent of the NHS tariff) was scrapped and the budgets for hospital departments were re-built from the base up.

In practice, the success of new commissioning structures, or attempts to bring about transformative service change, hinges on the quality of local relationships, and therefore variation between areas in the speed with which these can be achieved is inevitable. Evidence shows that the success of relationships is strongly influenced by local context and whether or not there is a history of partnership working. Research following the introduction of practice-based commissioning in
England found that success in implementation was dependent on the quality of existing working arrangements; where these had been characterised by mistrust, the introduction of practice-based commissioning exaggerated tensions (Curry et al 2008).

In many countries (including England and the United States), recent policy means there is now a greater focus on commissioners and providers working in closer partnership to plan, commission and deliver care. Figure 13 (below) describes some of the approaches being encouraged by central government in England.

**Figure 13 The Five Year Forward View and new care models in England**

The NHS five year forward view (Forward View), published by NHS England and other national NHS bodies (NHS England et al 2014), sets out a shared view on how services need to change and what models of care will be required in the future. Its key arguments are that much more attention should be given to prevention and public health; patients should have far greater control of their own care; and barriers in how care is provided should be broken down. This means putting in place new models of care in which care is much more integrated than at present.

The Forward View differs from many other plans by arguing that England is too diverse for ‘one size fits all’ solutions. Instead of setting out a blueprint for the future, it outlines a number of care models that may be adapted in different areas to put in place services fit for the needs of local populations. There are two models that particularly blur the boundaries between commissioners and providers.

**Multispecialty community providers**

One of the models of care described in the Forward View is the multispecialty community provider (MCP). This involves the development of federations, networks and super partnerships to enable general practices to operate on the scale required to deliver a wider range of services. These services will include those provided by some specialists alongside other professionals such as nurses, therapists, pharmacists, social workers and psychologists.

MCPs will use their budgets to take ‘make or buy’ decisions. This will mean delivering services directly where possible or commissioning services from other providers. There will be a blurring of the distinction between commissioners and providers to enable GPs, in partnership with other clinicians, to deliver more integrated services in the community.

Integrated commissioning will be needed to implement the new contract for MCPs. This means bringing together funds currently controlled by clinical commissioning groups and NHS England (for primary care provision), as well as some of the funds controlled by local authorities if social care is to be delivered by MCPs. Plans by NHS England to develop co-commissioning with clinical commissioning groups already indicate the direction of travel, and it will be important to ensure commissioners have sufficient resources to take on these additional responsibilities.

Potential conflicts of interest also need to be managed, for example practices involved in bidding to provide services under the terms of the new contract should be excluded from commissioning these services. It will also be important to develop transparent governance and accountability to avoid any suggestion that GPs are gaining inappropriately through their involvement in MCPs.

**Primary and acute care systems**

Another care model outlined in the Forward View is primary and acute care systems (PACS), described as ‘single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services’. It is suggested that these might be formed in a number of ways including hospitals opening their own GP surgeries with registered lists and MCPs taking over the running of hospitals.

Research into the role of acute hospitals in emerging integrated care systems in England illustrates the complexities of bringing primary and secondary care together (Naylor et al 2015). Perhaps most important are longstanding cultural differences between GPs and their teams on the one hand and hospital clinicians on the other, as well as differences in the way that these services are commissioned, contracted and organised.
## Challenges and lessons for good practice

### Figure 13 The Five Year Forward View and new care models in England

Bringing mental health and other community services into PACS adds to the challenge of aligning the contributions of different professions behind a common purpose.

PACS are similar in some respects to health maintenance organisations and accountable care organisations in the United States. Experience in the United States shows the potential benefits of a single organisation (real or virtual) taking responsibility for the health of a defined population with a capitated budget. These benefits include the ability to focus on the health of the population and not just the treatment of sickness, and to use the capitated budget flexibly to meet that population’s need.

In the current context in England, PACS that encompass community services, GPs and social care also have the potential to speed the flow of patients into and out of hospitals to remove some of the blockages that are behind pressures in the urgent and emergency care system. To realise these benefits, PACS will need to heed the warning signs from the United States by understanding the factors that caused some integrated delivery networks to fail in the 1990s. These factors included inadequate attention to change management processes. This prevented emerging networks from emulating the achievements of long established integrated systems like Kaiser Permanente (Burns and Pauly 2012).

As large integrated providers, PACS would pose fundamental challenges to commissioning as currently organised. Ham et al (2013) argue that strategic commissioning would be needed to counteract the power of fully integrated providers whether real or virtual and to ensure they are held accountable for the delivery of defined outcomes. This includes avoiding an acute hospital mindset dominating primary and community care providers working within PACS. Innovations in care models may therefore require commissioning to be organised differently if they are to deliver on their promise.

### 2.6.4 Public and patient engagement

Engagement with patients and the public is often described as a core part of commissioning. In practice however, commissioners have often found this difficult. As part of the world class commissioning program, primary care trusts in England were evaluated on their ability to ‘proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health’ (Department of Health 2007). A survey of primary care trusts by the Picker Institute Europe in 2009 found that world class commissioning had helped bring about a positive change in commissioners’ attitude to public and patient engagement, with many adopting a more systematic approach.

However, the survey also noted that commissioners were still unable to show whether and how patient and public engagement was influencing commissioners’ decisions. There was a concern expressed that much of the commissioning process looked at user involvement in terms of ‘data needs’ for commissioning, and still gave more weight to surveys and one-off consultations than to ongoing dialogue. Many of the existing involvement methods seemed to be much more targeted at gathering feedback from users than at creating opportunities to directly shape health services (Parsons et al 2010).

Research on practice-based commissioning in England identified two main challenges with public and patient engagement: ensuring patients had a clear understanding of the commissioning approach, which requires investment in education; and finding an effective way to engage them (Curry et al 2008).

Many large-scale procurements have been challenged or delayed by lack of patient and public engagement (Addicott 2014). Particularly where commissioning decisions may mean a change in service provision, patients and the public quite rightly have an interest in the process and outcome. Procurement rules typically dictate a formal process of consultation and engagement. Commissioners should stay continually engaged throughout the various stages of public consultation and through the process of competitive tendering and dialogue. Rather than regarding procurement rules or competition laws as burdensome or an excuse for inertia, commissioners could use these tools to use engagement activities to refine their ambitions and the technicalities of the contract.
As well as direct engagement, for example through consultation process, engaging the public in commissioning often means working with patient representative groups. The degree to which representative bodies facilitate true engagement depends on their powers and responsibilities, as well as their composition and internal governance arrangements. A study of the new local Healthwatch organisations in England (introduced as part of the 2012 reforms – see Figure 14 below) found that their introduction had led to more extensive engagement with local communities than had taken place previously. However, it also noted several factors important in the effectiveness of Healthwatch organisations, including skills and capacity, as well as good governance arrangements. Having good local accountability for governance and ways of working was essential in ensuring their credibility (Gilburt et al 2015).

**Figure 14  Overview of Healthwatch in England**

Healthwatch England and local Healthwatch were established following the Health and Social Care Act 2012. Healthwatch England have an appointed staff, who are responsible for the operation of the organisation, managing the local Healthwatch networks and develop an evidence-base on quality of care. Local Healthwatch organisations may also involve volunteers. These bodies are intended to act as the independent consumer champion for health and social care, providing people with information about their local services and strengthening their ability to influence and challenge the way in which they are provided.

Local Healthwatch are independent organisations commissioned directly by local authorities to deliver a series of statutory activities. Many of these are similar to those performed by local Healthwatch’s predecessor, Local Involvement Networks, however other functions are intended to provide a greater influence over local decision making. There are mechanisms in place to enable Local Healthwatch to escalate issues if it considers necessary.

Local Healthwatch organisations also act as patient representatives on Health and Wellbeing Boards, statutory bodies hosted by local authorities which bring together the NHS, public health, adult social care and children’s services.

Functions undertaken by local Healthwatch include:

- influencing the provision and commissioning of health and social care services – in addition to participating in the Health and Wellbeing Board, activities include taking part in committees and groups run by providers, responding to consultations, representation in commissioning groups, sharing information
- enabling local people to monitor the quality of local care services and consider improvements – including through 'enter and view' visits to local providers
- obtaining and making known views of local people on their needs for, and experiences of, local services – includes proactive activities, such as community events, and reactive measures for collecting feedback
- making recommendations on local service improvements for commissioners, providers, Healthwatch England and other stakeholders – activities include collating feedback into reports
- providing advice and information about access to local services – specific activities include helplines, drop-in sessions, one-to-one meetings
- formulating views on the standard of provision and improvement and sharing these with Healthwatch England
- making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, in certain circumstances justify doing so, making recommendations to the CQC directly); and to make recommendations to Healthwatch England to report on particular issues.

Healthwatch England’s role is to provide leadership and support, including through promoting standards and good practice, rather than to manage the performance of the individual organisations.
2.7 **Priority setting and decision making**

**Summary points**

- Elements of priority setting will be undertaken at a national and local level. For PHNs, their responsibility will focus on the flexible and specific programme funding streams and to ensure that the six agreed priority areas for targeted work are prioritised within commissioning plans.

- Cost-effectiveness analysis using robust information and data plays an important role in making comprehensive and defensible commissioning decisions. However, in practice other considerations such as historic service provision, provider sustainability and paying attention to disadvantaged communities also have an influence.

- Commissioners should actively and regularly engage with their local community in priority setting and communicate the outcome and impact of commissioning decisions.

As described earlier, local commissioning organisations play a key role in leading local health and care systems. Core to delivering this leadership role is the development of a vision for local services, which meets the health and care needs of the local population, and translating that vision into a set of clear priorities. This vision must also reflect nationally set objectives, as well as external factors such as budgetary pressures. It is inevitable that this process of priority setting will involve balancing the meeting of local needs with the need to comply with centrally determined priorities (Furness et al 2008).

Priority setting is a fundamental part of the commissioning function. However, it is not a single activity but rather involves a series of distributed tasks. Although commissioners are expected to undertake priority setting activities, they are rarely in a position to take control over all of its dimensions. In practice, there is very little evidence or guidance on what priority setting involves. In particular, there is a limited understanding of the models and processes that commissioners use, and how effective these have been in practice (Robinson et al 2011).

Often, explicit priority setting processes have been developed in relation to spend of ’new money’ (eg flexible funding) and little consideration has been given to these activities across areas of the core spend. If PHNs are to think differently about models of service delivery, they will need to consider resource allocation decisions across different funding streams.

### 2.7.1 Tools for priority setting and decision making

Commissioners’ decisions about how to prioritise investments should, where possible, be based on robust clinical and financial evidence, and an assessment of value for money. It is important that commissioners put in place a clear and transparent method for allocating budgets; these need to be visible and perceived to be fair, both by those involved in the process and external observers.

In England, some priorities for investment are determined at a national level to be implemented by commissioners locally. The NHS mandate is one of the main mechanisms through which the government sets out its objectives for the NHS in England; however local commissioners are also expected to commission in line with a number of other specific policy objectives (for example, extended opening hours for GP practices). As with some other policies, this ambition is supported by dedicated funding.

The National Institute for Health and Clinical Excellence (NICE) also has an influence on local commissioning priorities in England. NICE is responsible for evaluating and providing guidance on new technologies and interventions. NICE’s methodology is based on expert panels taking evidence-based decisions on the effectiveness of new drugs or other interventions. On the basis of this evidence, the cost per Quality of Life Year (QALY) is calculated and the recommendation follows.

QALYs have two dimensions. The first is the length of life – months or years – that the patient can expect following treatment. The second is the quality of that life. The quality is measured on a scale ranging from 0 (death) to 1 (perfect health). The scale takes into account mobility, pain or discomfort, anxiety or depression and the ability to pursue the usual activities of daily living. The working threshold for NICE is that a new drug or technology cannot exceed £30,000 per QALY. The NICE decision may be to recommend or reject the use of a particular new drug or to limit its use to a specified sub-group of
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patients. The recommendations that flow from these technology appraisals are mandatory for NHS commissioners, and the NHS Constitution enshrines the right of patients to drugs and treatments that have been recommended by NICE (Klein and Maybin 2012).

However, NICE’s reliance on Quality Adjusted Life Years (QALYs) continues to be conceptually and methodologically controversial, making NICE vulnerable to political pressure. NICE acknowledges that social value judgements have to inform its decisions, but it is not clear how they do so (Klein & Maybin 2012).

Research has found that in practice, most commissioners have formal arrangements for priority setting, but these focus mainly on investment of new monies, rather than core spend or disinvestment. Commissioners in England have made some progress in establishing priority-setting processes and they have used many different methods, procedures and models (Robinson et al 2011). There are a range of tools that can support commissioners in setting priorities locally. Primary care trusts in England for example developed a number of different approaches. These included:

- **Programme Budgeting and Marginal Analysis (PBMA)** – like the approach used by NICE, PBMA emphasises cost effectiveness. This involves outlining the way in which existing resources are used under various program headings and then contemplating possible changes and comparing the gains (or losses) in health benefits that can be achieved by changes at the margins. The first step in this model is to set out how existing resources are used under various program headings – for example, cancer or mental health services (Brambleby et al 2008). Then changes in the pattern are considered, comparing the gains (or losses) in health benefits that can be achieved by changes at the margins. Unlike NICE, PBMA is not dependent on the use of QALYs: at a program level the necessary information may not be available. But the aim is the same, ‘to maximise benefits to the community’ with an on cost-effectiveness. However, as one of the key exponents of the PBMA approach explains, ‘an ethical rather than economic, framework, may be more appropriate to take account of criteria relating to equity and fairness when deciding how to allocate healthcare resources’ (Donaldson 2008). So those involved in any PBMA exercise have to decide what criteria – beside cost-effectiveness – to apply when making a final judgement. There have been a number of large PBMA initiatives conducted in the Australian context. For example, ACE Prevention was a large, 5-year study funded by the National Health and Medical Research Council (NHMRC). ACE Prevention is the most comprehensive evaluation of health prevention measures ever conducted world-wide, involving input from 130 top health experts.

- **Modified Portsmouth Scorecard** – this approach is at the other end of the spectrum from PBMA and relies more heavily on qualitative judgements. This approach involves scoring funding proposals against a set of weighted criteria, including strength of evidence (scoring up to 40 points), magnitude of benefit (up to 40 points), patient acceptability (up to 40 points), whether it is a national requirement or target (up to 40 points), whether it is addressing health inequalities (up to 20 points), whether it is the only treatment (up to 20 points) and the strength of local feeling (up to 10 points) (Klein and Maybin 2012). This model, in contrast to PBMA and some others, is not driven principally by economistic, health-maximising aspirations, and its dependency on qualitative judgements appears to be even greater than that of the other models. But it does have the advantage that it can be applied to micro developments rather than programs.

Robinson et al (2011) found that, in practice, commissioners use a range of sources of evidence (including structured tools) to make investment decisions. The most common of these are local epidemiological and economic data, used to undertake needs assessment on the basis of population level health data (see Figure 15 below).
Challenges and lessons for good practice

Figure 15  Rating of the influence of different tools and processes on investment decisions

(Robinson et al 2011)

<table>
<thead>
<tr>
<th>Tool</th>
<th>Influence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiological data</td>
<td>7.51</td>
</tr>
<tr>
<td>Review of local economic data</td>
<td>6.82</td>
</tr>
<tr>
<td>Other decision support tools</td>
<td>6.72</td>
</tr>
<tr>
<td>Predictive modelling</td>
<td>6.28</td>
</tr>
<tr>
<td>Programme budgeting</td>
<td>5.92</td>
</tr>
<tr>
<td>PBMA</td>
<td>4.52</td>
</tr>
</tbody>
</table>

Robinson et al’s (2011) study in the NHS found there to be widespread weaknesses in the way that evidence was used in priority setting. Many respondents stressed the challenges of benchmarking and finding sufficient evidence for decisions. One of the most commonly cited weaknesses related to priority setting not being as ‘rational’ as hoped, and instead subject to other, more political considerations. Furthermore, priority-setting processes have been found to focus much more on the allocation of funding for new service developments rather than decisions around core spend and disinvestment/withdrawal of services (Puffitt & Prince 2012). Figure 16 below provides a suggested process for carrying out a health needs assessment for priority setting.

Figure 16  Steps in carrying out a health needs assessment

(Gupta 2011)

Step One
Getting started:
- What population?
- What are you trying to achieve?
- Who needs to be involved?
- What resources are required?
- What are the risks?

Step Two
Identifying health priorities:
- Population profiling
- Gathering data
- Perceptions of need
- Identifying and assessing health conditions and determinant factors
Figure 16  Steps in carrying out a health needs assessment

Step Three
Assessing a health priority for action:
- Choosing health conditions and determinant factors with the most significant size and severity impact
- Determining effective and acceptable interventions and actions

Step Four
Planning for change:
- Clarifying aims of intervention
- Action planning
- Monitoring and evaluation strategy
- Risk-management strategy

Step Five
Moving on/review:
- Learning from the project
- Measuring impact
- Choosing the next priority

However, while we know quite a bit about how many commissioners use the different decision-making tools when setting their priorities (Robinson et al 2011), we have no systematic knowledge about the relationship between the use of the different methodologies, the composition of the panels involved in the process and the outcomes. And we know even less about how decisions about priorities translate into policies that affect individual clinicians and patients directly.

2.7.2 Priority setting and rationing

The notion of priority setting is frequently conflated with that of rationing. This is to miss an important distinction. Priority setting describes decisions about the allocation of resources between the competing claims of different services, different patient groups or different elements of care. Rationing, strictly speaking, describes the effect of those decisions on individual patients. Giving priority to service A when allocating resources does not tell us anything about whether patients in services B, C or D are deprived of potentially beneficial interventions or suffer a loss in the quality of care. The distinction between priority setting and rationing is also helpful as a reminder that decisions that eventually determine who gets what – the resources devoted to individual patients – are taken at all levels of the health system (Klein & Maybin 2012; Williams et al 2012b).

In England, the starkest and most visible form of rationing is the ‘exclusion list’. The Secretary of State is required by law to promote a ‘comprehensive’ health service, but at no point has that phrase been defined in terms of a list of treatments that should be provided by the NHS. NICE guidance and national policies impose certain requirements on commissioners, but for the most part they must decide what treatments to make available in the context of local need and their finite budget. None publishes a full list of what it does fund for local NHS patients, but many now list the treatments they will not fund (Moberly 2011).

Such exclusions tend to be justified on the grounds that the treatments represent poor clinical value (they do not offer enough bang for their buck, or simply not much bang at all), or that they are not clinically necessary because they are principally cosmetic, for example. Surgery for lower back pain, hysterectomies for heavy menstrual bleeding, and grommets for middle ear conditions are common examples of the first group. Examples of the second group include cosmetic surgery such as breast enlargement or reduction, tattoo removal or the removal of varicose veins.

Similar work has been done on low value interventions in Australia (eg Elshaug et al, 2012), although a recent study by the Grattan Institute
reports that a key challenge for health organisations remains in dissuading clinicians from continuing to carry out particular practices. This highlights the pervasiveness of ways of working in the face of robust evidence concerning particular procedures and the need to invest in engagement as a way of changing clinical practice.

2.7.3 The science and art of priority-setting

Commissioners in England are legally required to allow for exceptions to general policies on treatment funding. This means commissioners must have a system that allows patients to argue for a treatment that they have explicitly decided not to fund for particular indications (an exceptional funding request), or which is not normally provided and for which there is no policy about its funding (an individual funding request).

In a publicly funded health system, commissioners have a responsibility to sensibly allocate finite resources. Over time, as well as commissioning new services, drugs and technologies, this will necessarily require some care to be decommissioned. Such rationing decisions are not always straightforward or transparent. Klein and Maybin (2012) suggest that rationing takes many forms. It could be a headline-catching refusal by commissioners to fund particular treatments (rationing by denial), or to fund them only for particular patients (rationing by selection). Alternatively, patients may be put off a service by obstacles to access (rationing by deterrence), or shunted off to another institution (rationing by deflection). Rationing by dilution refers to a situation where a service may continue to be offered but its quality declines as cuts are made to staff numbers, equipment and so on. This form of rationing may be the least visible, but it may also be the most pervasive.

Decisions that determine who will eventually get what are taken at all levels within the system: central government determines the overall budget for the health service, commissioners and providers decide between competing priorities when allocating funding, and clinicians decide how to allocate their limited time and resources. In practice, commissioning has worked in certain respects differently from what commissioning policy has assumed. In reality, it has often been laborious and uncertain (Sheaff et al 2015).

While requirements and tools should ensure that priority-setting and rationing decisions by commissioners are explicit and in the public domain, the picture is much more opaque in the case of providers and so called ‘bedside rationing’. We know least about precisely those areas – hospitals – where some of the most critical decisions about the allocation of resources to patients are made. Knowing that there are staff cuts and budget pressures does not in itself tell us about their impact on patients.\(^1\)

The criteria used in making such decisions vary with the level at which they are made. In making decisions about allocating resources between different services and interventions (priority-setting), utilitarian principles tend to be used: the aim is to maximise the impact for the whole population. In making decisions about which patients should be treated and how (rationing), more individualist or social, ethical criteria are invoked. The tension between population-based and individual-orientated criteria lies at the heart of much of the controversy in this area (Klein & Maybin 2012).

This lack of clarity is even more amplified in local commissioning organisations. Wye et al (2015) refer to the ‘art of commissioning’, and acknowledge that previous (and limited) studies of commissioning find that most decisions are made in various forms of meetings, rather than through a transparent and replicable prioritisation process. That said, however, commissioners are concerned to ensure that priority-setting decisions are defensible to scrutiny and challenge. Despite the formal tools available, Wye et al found that commissioning is a largely pragmatic process, which involves pulling together the appropriate knowledge and information that would satisfy competing agendas. Commissioners in England rely on a range of knowledge:

- local clinicians’ knowledge of services

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\(^1\) The King’s Fund is currently undertaking a project to understand how current financial pressures impact on commissioner priorities and patient access to care. An overview will be available on The King’s Fund website in March 2016 (http://www.kingsfund.org.uk). And the detailed findings from this project will be published towards the end of 2016.
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- analysts’ information about service referral rates
- service users’ experiences of their condition
- NICE clinical guidelines
- NHS Improving Quality guidance on best practice
- Public health data on trends
- Health Service Journal (a leading weekly professional journal) for examples of similar pathways devised by other commissioning organisations.

Prioritisation is not a purely mechanistic process. In practice, prioritisation decisions are heavily influenced by a range of factors. As well as the national or more ‘objective’ policies or protocols, commissioning decisions are driven by providers (particularly clinical decision-making and referral patterns), historical commissioning patterns, political arguments and public opinion. Policy-makers and commissioners should seek to understand the range of features that impact on commissioning decisions, in order to be transparent and minimise their influence where possible.

Based on their study of priority setting in English primary care trusts, Robinson et al (2011) suggest that commissioners will need to consider the following factors when making resource allocation decisions:

- Commissioners will need skills in needs assessment, decision analysis, economic evaluation and stakeholder engagement.
- Dedicated resources will be required to establish evidence, engage a range of stakeholders and manage the forums and organisations responsible for decision-making.
- A key aspect of priority setting is the implementation process. Commissioners need to consider processes of implementation in a context of complex delivery systems.
- Commissioners will need to ensure they can establish the necessary local legitimacy, particularly when making difficult and unpopular decisions. Clinical leadership is important for establishing this legitimacy.

2.7.4 Information and data

In his final report on operational productivity and performance in the English NHS, Lord Carter highlighted the problem of imperfect data being reported by NHS providers and stressed the critical importance of investing in systems which support the collection of accurate data for performance management. The report also emphasised the importance of having a ‘single version of the truth’, with all relevant partners and stakeholders having access to the same information (Carter 2016). This information should be used by commissioners in the development of performance metrics for contracts with providers, as discussed below.

Similarly, accurate information on performance and quality is key to driving improvement. Research on productivity in the NHS which included a review of some key productivity improvements since the 1980s identified more accurate performance metrics, better comparisons and understanding of performance and variation as the common factors driving improvement. Amongst their recommendations for increasing future productivity, the researchers suggested that commissioners focus on making use of benchmarking data and evidence from NICE and other sources to illustrate the opportunities for improvement available to commissioners (Alderwick et al 2015).

In making decisions on how to invest in services, commissioners need accurate and timely information on population needs, as well as on the outcomes achieved by different services or interventions. This enables commissioners to determine whether or not services are of appropriate quality and safety, and whether or not they represent value for money. This information should be used on a systematic basis to inform all commissioning decisions. Where high quality information is not available, there is a risk that decisions will be made on the basis of other factors – for example, in the context of practice-based commissioning in England, in the interest of individual GPs (Curry et al 2008). Recognising the need for commissioners to have access to robust data, and to share information with other local organisations, the Surrey Strategic Partnership in England developed ‘Surrey-i’, an online information portal and data warehouse. ‘Surrey-i’ collates a wide range of information on the local area, including data on employment, transport, and health, and plays a key role in the development of a Joint Strategic Needs Assessment by the Surrey Health and Wellbeing Board (Surrey-i 2016).
For commissioning organisations this is a question of both having access to appropriate and robust data (which decision makers can have faith in), and having the skills and capacity available with which to use it. Figure 17 illustrates a complex procurement program that recently failed, partly because of poor quality data. Priority setting and decision making are core to the commissioner role and therefore having adequate skills and capacity to provide the supporting information and analysis on an on-going basis is vital.

As discussed later in this paper, this highlights the need for commissioners to invest in expertise or to seek support for these activities outside of the organisation.

Figure 17  Procurement of older people’s services in Cambridgeshire, England

(adapted from Addicott 2014, Perkins 2016, Illman 2016)

Cambridgeshire and Peterborough clinical commissioning group is the second largest CCG in England, with 108 GP practices, more than 800 GPs and a registered population of almost 900,000. It is organised into eight local commissioning groups, which have decision-making authority and manage resources through delegated budgets. A member of each local commissioning group is represented on the CCG governing body. The eight local commissioning groups form four broad systems, each of which is distinct, with different health care requirements and issues, and a diverse range of services within their boundaries.

The CCG felt there was considerable scope for improvement in the delivery of older people’s services. The local health economy faced numerous challenges, including an increasing number of older people (particularly the older old) and significant financial constraints (with minimal or no growth in health and likely reductions in local authority spend). Addressing these challenges led the CCG to consider a radical new approach, aiming to develop outcome-based commissioning and promote innovation.

Cambridgeshire and Peterborough also has a broader unstable provider mix: all three acute trusts have been subject to scrutiny by Monitor and/or the Care Quality Commission; there has been high turnover among senior leaders; and some local relationships are strained, partly due to financial stress. More generally, care for older people across Cambridgeshire and Peterborough has been fragmented and reactive, and focused on measurement of specific processes rather than outcomes. These problems have manifested in failure to achieve accident and emergency department targets, delayed transfers, high rates of hospital occupancy, challenges in sharing information, and pressure on limited resources in community and primary care services.

The CCG went out to tender for a new provider of older people’s services because it wanted to develop new solutions to longstanding system issues and because of the scale of its ambitions and the financial value of the contract; clear interest from a wide range of potential providers; and the discipline provided by the procurement process. The contract encompassed a population approach for people aged 65 and over, with the budget covering coordination of emergency hospital care, mental health services and end-of-life care for this group, including community specialist palliative care. The team quickly realised it would not be feasible to distinguish between older people and adults, and separation would have created an artificial boundary. As such, the contract included community health services for older people (over-65s) and adults.

The contract was finally signed in November 2014 after a 15-month procurement process that cost more than £1 million. It was strongly opposed by local campaigners and trade unionists after several private bidders expressed an interest. Opponents feared it would mean transferring thousands of staff into the private sector. In practice, a number of private providers initially expressed an interest in the tender but withdrew during the process because of the steep financial efficiencies required by the contract.

UnitingCare Partnership, a consortium of existing NHS providers, was ultimately selected as the preferred bidder. This was an £800 million contract over five years, worth approximately £160 million in the first year. The payment model was essentially a ‘year of care’ capitated approach for the population aged 65 and over, combined with a new ‘payment by outcomes’ system worth up to 15 per cent of the total contract value in the latter years of the contract.

The deal was one of the largest ever tendered by NHS commissioners, and also attracted attention for being
Figure 17  Procurement of older people’s services in Cambridgeshire, England

An early, highly ambitious example of outcome based contracting, in which an element of payment depended on achieving agreed clinical outcomes. The CCG developed an outcomes framework based on seven domains.

1. Ensuring that people have an excellent and equitable experience of care and support, with care organised around the patient.
2. Treating and caring for people in a safe environment and protecting them from avoidable harm.
3. Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information-sharing. Pathway domains.
4. Early intervention to promote health, wellbeing and independence.
5. Treatment and/or support during an acute episode of ill health.
7. Care and support for people at the end of their life.

Eight months after going live, the contract collapsed because commissioners and providers no longer considered it to be financially viable. UnitingCare Partnership handed the £800m, five-year contract back to Cambridgeshire and Peterborough CCG.

The provider and the CCG have so far refused to give any substantive explanation about how and why the deal collapsed or where responsibility for its failure lies. We could speculate that the financial and clinical data that was scrutinised during procurement was inadequate – evidenced by the number of private sector bidders that considered it too high risk and withdrew from consideration. Furthermore, there are questions regarding whether the commissioners or providers had access to sufficient robust data to be accountable for the outcome measures in the contract. Senior politicians have now called upon the National Audit Office and the Public Accounts Committee to conduct an investigation into the contract and its failure.

Commissioners frequently rely on legal firms to assist with contract development, on management consultancies to help understand their population and define the contract value, and on actuaries to assess financial risk and support procurement. This level of support all adds significantly to the cost of procurement and the contract development process – costs which might be prohibitive for less financially stable commissioners, restricting them to a traditional cycle of contracting and commissioning. While bespoke solutions are essential, and will be a significant factor in the eventual success of transformation programs, considerable time and resources are being spent on building these solutions. Yet the cost and resources involved in buying expertise to replicate these models across the country is not sustainable or defensible in the long term. As such, alternative models of support may be required, such as developing learning communities or increasing the support provided by existing organisations (Addicott 2014).

2.7.5 Stakeholder engagement

Engaging a range of stakeholders in the process of decision-making is key. As discussed elsewhere in this paper, clinical engagement is particularly important in understanding the needs of the local population and ensuring that decisions are made on sound clinical evidence. The knowledge that clinicians have been involved in these processes can also lend commissioners weight in negotiations with providers. In a study of practice-based commissioning in England, some commissioners reported that the process had produced a slight shift of power in their relationship with local providers; they felt that practice-based commissioning had given them more ‘clout’ when negotiating contracts because hospital staff listened more closely when they realised GPs were behind the decisions (Curry et al 2008). The experience of GP fundholding in England in the 1990s also demonstrated that more detailed information and ‘micro level’ clinical influence could have a positive impact on purchasing, however it also highlighted the risk of increased transaction costs (Smith et al 2004).
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Patients and the public should also be involved in setting priorities and decision-making. In England, the public perspective is provided on NICE decisions at a national level through a Citizens Council made up of 30 members of the public who are intended to reflect the demographic characteristics of the UK. The role of the council is to offer a public perspective on ‘moral and ethical issues’ for NICE to take account of when producing its guidance.

Robinson et al (2011) found that priority-setting tools were being used by commissioners not only to help with the process of decision-making, but also as a means of promoting evidence-based debate with clinicians, patients and the general public about health spending and services at a local level. Patients and the public can be involved in priority setting and decision making through representative bodies, such as the local Healthwatch organisations introduced in England as part of the 2012 health reforms. A review of these organisations found that they are adopting a number of approaches to influencing commissioners, including challenging them on their engagement and consultation activities, and getting involved in tendering and contracting processes. It also noted that the success of these organisations in having an impact was partly dependent on the receptiveness of local stakeholders, including commissioners, and varied between areas (Gilburt et al 2015). As such, it is important that they have a clear and transparent remit and mechanisms for inputting into strategic decision-making.

Local commissioners also adopt various mechanisms for involving the wider public in decision making, for example through formal consultation on proposed service changes. However, when it comes to rationing or ‘de-commissioning’ decisions, evidence suggests that the public is ambivalent about having direct involvement in such decisions. Some evidence shows that while there is support for the opportunity to be involved, most people think that rationing and prioritising decisions should be taken by doctors (Klein & Maybin 2012).

However, experience suggests that in the case of service transformation or closure, stakeholder engagement can make decision making more difficult. For example, changes proposed as part of the special administration process at Mid Staffordshire NHS Foundation Trust was met with significant public resistance, including through a judicial review (Ault 2014). Although de-commissioning is an inevitable output of the prioritisation process, particularly where budgets are under pressure, in practice commissioners have often struggled to implement decisions to stop providing a particular service or treatment due to protests from the local population, or resistance from politicians.

Figure 18 below describes how the internationally renowned Southcentral Foundation in Alaska engages with community members.

Figure 18  The Southcentral Foundation: An example of community engagement in decision-making
(adapted from Collins 2015)

Nuka System of Care, Alaska
Southcentral Foundation is a non-profit health care organisation serving a population of around 60,000 Alaska Native and American Indian people in Southcentral Alaska, supporting the community through what is known as the Nuka System of Care. It was developed in the late 1990s after legislation allowed Alaska Native people to take greater control over their health services, giving them a role in designing and implementing services. Southcentral’s mission is to work together with the Native Community to achieve wellness through health and related services.

Community involvement
Southcentral refers to its community as 'customer-owners' rather than patients or service users. This concept has multiple dimensions, including the expectation that people should take responsibility for their well-being, and that the community has a role as shareholders of the system.

Alaska Native people are actively involved in the management of the Nuka System of Care in a number of ways. At the governance level, the tribal authority appoints Southcentral non-executive board from the Alaska Native community, ensuring representatives from across the region’s Native tribes.
Southcentral has developed a range of methods for engaging customer-owners in the strategic planning cycle, including:

- discussing future priorities with the community through its annual gathering and its elders' council
- planning sessions with village communities. Involvement of customer owners on a number of joint operating boards and advisory committees, which meet periodically with the senior leadership team to provide feedback to the organisation

Over time, customer-ownership has become a key plank in Southcentral’s philosophy: a concept that shapes how employees and the community engage with each other, and that provides a frame of reference for strategic and operational decisions. Customer-ownership also appears to offer powerful governance in a system that is not subject to performance management by external bodies as they might be in other systems.

**Responsiveness**

Southcentral’s measures of performance include a strong focus on whether the primary care teams support people in taking ownership of their care. It has developed a large number of mechanisms for collecting feedback and measuring satisfaction. These include:

- a simple online system for submitting feedback or raising concerns via Southcentral’s website
- five optional online satisfaction surveys after every visit to a primary care clinic
- Special events and focus groups on particular issues.
- a 24 hour hotline

There are also processes in place for ensuring feedback is reviewed by its improvement team and responded to quickly, and Southcentral has also invested heavily in methods for communicating back to its community. This includes:

- the maintenance of an in-house public relations team to help communicate its story to the Alaska Native community
- banners throughout the primary care centre, which remind customer-owners of the organisation’s vision and values and their roles in promoting health and wellness
- its bi-monthly newsletter, Anchorage Native News, which has been running since 2006
- social media and email updates
- series of annual picnics and parties
- its annual gathering, first held in 1999, which brings together 2,000 to 2,700 community members each year

Southcentral seeks to build a trusting relationship with the local community by ensuring that it explains the changes made in response to their feedback, and communicating the organisation’s successes in delivering what the community asked of it. This makes transformation easier.
2.8 **Stimulating improvement**

**Summary points**

- Commissioning and procurement have the potential to improve quality of care, although evidence is limited and mixed.
- Commissioners can use contractual levers to hold providers to account for quality and improvement, as well as for activity.
- Financial incentives (bonuses and penalties) should be introduced carefully, with consideration of proportionality and attribution.

The scope for driving improvement is one of the key features that distinguishes commissioning from either contracting or procurement (both of which form part of the commissioning process). Part of the commissioner’s role is to translate national and local priorities into strategic plans for delivery by local providers (and other stakeholders). Contracts that are agreed with providers reflect those priorities, describe the measures by which performance will be measured, and outline the terms of payment. Approaches to contracting for quality, inducing the use of incentive schemes, are set out in the first section of this paper. The role of financial incentives and penalties in driving improvements are covered in the section on payment mechanisms.

Commissioners have a number of mechanisms available to support these processes, and it is likely that different commissioners will make use of different approaches depending on the context in which they are working. There may also be a role for other stakeholders in the system to drive quality, such as professional associations, regulators, community interest groups and other national bodies.

2.8.1 **Competition and patient choice**

The scope for driving improvements in financial, operation and clinical performance is one of the primary arguments used to support competition and choice in health and care services (Frosini et al 2012). Running a competitive procurement process enables the commissioner to identify a set of quality standards and only select a provider (or providers) that demonstrates it can fulfil them. Providers compete with one another for the opportunity to deliver the service and once a contract is awarded, the risk of losing it or failing to win it again when the contract is re-tendered gives the provider an incentive to continue delivering at (or above) the required quality standards, as well as more efficiently. For services where the patient can choose between providers, in principle this provides a further incentive to providers to deliver a high quality service as they are in competition with a number of suppliers, all of which have met the minimum standards required by the commissioner.

However, there is mixed evidence on how well these mechanisms operate in practice, and the extent to which they drive improvements in quality. The strongest evidence that competition in the English NHS delivered improvements in performance comes from two econometric studies of the relationship between provider competition and patient outcomes; a review of these studies noted that while death rates fell for all hospitals, they fell more rapidly in hospitals located in more competitive markets (Propper & Dixon 2011). However, what is not clear is whether competition caused this improvement in quality; this could be explained by other factors, for example, decisions to consolidate certain services in fewer hospitals to achieve better outcomes (Ham 2014).

A 2010 study in England concluded that the overall impact of patient choice on the NHS was limited (Dixon et al 2011). Whilst policies on patient choice had introduced some competition between providers, particularly for patients at the boundary between geographical areas, in general the degree of competition was dependent on local dynamics and in many cases providers were collaborating rather than competing. The research did not find that providers were analysing patient choices in order to identify areas for service improvement, however choice did appear to provide a motivation to maintain their reputation to ensure that patients returned or influenced others by speaking highly of their experience. Nonetheless, the survey results also suggested that choice has an intrinsic value; 75 per cent of respondents said choice was either ‘very important’ or ‘important’ to them, and, contrary to GPs’ perceptions, older respondents, those with no qualifications, and those from a mixed and non-white background were more likely to value choice (Dixon et al 2010).
Of course, the effectiveness of any policy on patient choice is also dependent on patients being aware of having a choice between services, and there being a suitable range of providers from which to choose. Importantly, successful implementation of a market also relies on effective market regulation (see separate section) and on commissioners having enough power and influence to negotiate with providers on equal terms. Because of their limited capabilities in these areas, commissioners have often been described as the ‘weak link’ in internal market reforms (Ham 2014).

2.8.2 Relationships and engagement

Whilst contractual mechanisms are important, it is clear that commissioners’ ability to drive improvements in performance is also reliant on effective working relationships. This incorporates a range of issues. Good relations with providers enable commissioners to identify and share innovation and good practice. They also support the commissioner in challenging existing practice, understanding providers’ potential, and in developing stretching performance targets. Research into contractual approaches used to support the delivery of integrated care found that developing different contractual and commissioning approaches is not a substitute for building good relationships across local stakeholders and will not necessarily address conflicts between providers and/or commissioners (Addicott 2014).

Engaging clinicians and the public is also key. As discussed earlier, the involvement of clinicians in the development of outcomes is important in securing long-term buy in to the process of change and its ultimate success. Although the process of developing and agreeing outcomes is time-consuming and resource intensive, there are no shortcuts to this process; engaging with relevant stakeholders to discuss and agree the desired outcomes is a vital step in contract development, and one that should not be sidestepped or undervalued (Addicott 2014).

As highlighted above, the importance of relationships relative to other mechanisms for stimulating improvement will depend on the context. In England for example, clinical commissioning groups are membership organisations (local GP practices are members) which commission acute and community care, however they also have a legal duty to promote quality in primary care. As membership organisations, the importance of preserving good relationships means that the use of contractual sanctions can be difficult. Research on the role of these commissioning organisations in supporting the development of general practice in England found that the role does not rest on a formal, hierarchical relationship between commissioning leaders and member practices, but depends instead on influence, persuasion and professional credibility (Naylor et al 2013). Peer review can also play an important role in driving quality improvement, particularly where clinicians are directly involved in commissioning, for example in primary care led commissioning. A review of practice based commissioning in England, for example, found that GPs were more willing to examine their referral and prescribing practices through peer review (Curry et al 2008). Similarly, research on the role of clinical commissioning groups in the promotion of quality in general practice found that peer review was used in different formats, with particular importance placed on providing comparative performance data to member practices and facilitating various forms of peer-to-peer dialogue to explore the possible reasons for variations (Naylor et al 2013).
3 Conclusions

This section sets out the challenges and success factors for commissioning, including highlighting some of the key messages identified in section two above.

3.1 Challenges and risks

Summary points

- One of the challenges of designing a successful approach to commissioning is the limited evidence that links commissioning with quality improvement or cost containment. PHNs should work to carefully design and evidence their approaches and share success stories with one another.

- Historically, many of the failures of commissioning approaches are explained by commissioners lacking the skills and capabilities to undertake strategic planning, complex contract negotiations and to fully understand the needs of their population. Lack of adequate clinical engagement has also been a key issue in the past.

- Although a matrix commissioning approach is needed to meet the health needs across an entire population, there is a danger that the resulting fragmentation can act as a barrier to integration of care.

- The benefits of commissioning, in particular the ability to drive improvement and contain costs, must be great enough to outweigh the high transaction costs associated with the commissioning process.

3.1.1 Capacity and capability

Commissioning involves a broad range of activities from assessment of need, through to procurement and contract management. As discussed earlier, in 2007 the Department of Health in England identified a set of 11 organisational competencies that primary care trusts were expected to meet in order to achieve the standards of world class commissioning standards across this range of activities. Evidence shows there is a direct link between the ability of organisations to secure sufficient management and organisational capacity and the achievement of commissioning objectives (Goodwin 2006). This should mean investing time and resources in the recruitment of those with the right expertise (Ham 2008b). However, experience shows that acquiring the full range of skills required can be challenging for commissioning organisations, and gaps in capability and failure to provide adequate training opportunities has been an obstacle to progress. An assessment of the introduction of a purchaser provider split in New Zealand for example found that the lack of capacity in terms of legal expertise and experience of designing contracts was a significant obstacle to progress in establishing effective commissioning (Ashton et al 2004).

Similarly, an assessment of commissioning by the House of Commons Health Committee in 2010 concluded that weaknesses in commissioning were largely the result of a lack of skills within commissioning organisations, in particular in relation to data analysis and clinical analysis (House of Commons Health Committee 2010).

In response to these gaps, commissioners have often looked outside of their organisations for support. Encouraged by government policy, in the late 2000s commissioners in England increasingly turned to the independent sector for support with commissioning. Research on the use of external support by commissioners found that this was generally met with high levels of satisfaction, but was too often used to provide additional capacity or respond to short term priorities, rather than being used to provide new skills or tools (Naylor & Goodwin 2010).

In the current English system, commissioners receive support in many areas from commissioning support units, some of which are provided by independent sector organisations. In 2015 the government introduced the commissioning support lead provider framework, involving NHS and private sector providers, in order to encourage the development of a market for commissioning support services. The financial cost to commissioners is very high and requires considerable upfront investment. Commissioners should enter into such arrangements with their eyes open to the challenges. The costs associated with procurement and developing new
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3.1.3 Structural change

Evidence shows that frequent structural changes and changes within the wider health and care system have a damaging impact on commissioning. Managing change inevitably requires time and resources and consequently risks distracting leaders and organisations away from their core purpose (Goodwin & Smith 2002). There is also a danger that regular organisational changes result in the loss of valuable skills and corporate memory.

Moreover, commissioning is successful where commissioners, providers and a number of other local stakeholders are able to develop and nurture relationships over the long term (Goodwin & Smith 2002). In England, the impact of regular reforms on the structure of commissioning, compared with relative stability amongst provider organisations, has made it particularly difficult to establish these relationships (Naylor & Goodwin 2010). In England, the transfer of some public health commissioning teams from the NHS to local authorities as part of the 2012 health reforms has been a significant positive shift, particularly in terms of developing new cultures and relationships. Analysis shows that an advantage of the transfer has been the increased ability for public health teams to engage with the local public, including on wider determinants of health. However, it also noted that the change in culture for teams moving from the NHS to a local authority had been significant, particularly in terms of increased political accountability (Ham et al 2015a).

3.1.4 Fragmentation of commissioning

Whilst commissioning can be undermined by a lack of autonomy, there is also a risk that by sharing commissioning responsibility with many local organisations it becomes too dispersed. Fragmentation of commissioning in this way can act as a major obstacle to integration between different health services, and between health and social care. This runs contrary to the direction of travel of most health and care policy which is increasingly focused on providing more patient-centred care.

As mentioned earlier, fragmentation of commissioning is a particular criticism of the current system within England, where health and social care commissioning is carried out by a large number of local organisations (clinical commissioning groups

contractual approaches are high and the process is difficult, time-consuming and resource-intensive, and likely to require dedicated teams or programs to drive significant improvement (Addicott 2014).

For example, the Cambridgeshire and Peterborough clinical commissioning group described in Figure 17 spent in the region of £1 million on setting up the transformation program (including £800,000 on staff costs). When done at scale, it is unlikely that planning and contracting for this level of transformation can be successfully achieved within existing resources. These contractual vehicles intend to shift some commissioning responsibilities and risk onto providers (or integrators). It is unclear whether providers have the skills to manage these responsibilities and this level of risk, and they may need ongoing support from commissioners. These commissioners will need to consider what investment they can make in developing and supporting new contractual models (and contractors), particularly if the decision is made to go through procurement (Addicott 2014).

3.1.2 Competition and choice

Delivering competition and choice in practice is a significant challenge. Aside from the capacity and capability of commissioners, there are a number of reasons for this which sit outside of commissioning organisations' control. For example, the geographic reach of large acute providers can make competition unrealistic in practice. Other factors, for example rurality, appear to affect the likelihood of patients exercising choice. Research on patient choice in England found that patients living in small towns or rural locations were more likely to choose a non-local provider than those in cities, large towns or suburbs, possibly as a result of being equidistant between multiple providers (Dixon et al 2010).

Choice is usually presented in the clinical relationship between doctor and patient, rather than a direct dialogue with the commissioner, although commissioners are responsible for making available a range of options from which patients can choose. The evidence on competition and choice is limited in general, and the influence of commissioning on this agenda is largely unknown. The emphasis on competition is largely driven by the political standpoint of the moment, although in the case of the UK it has been promoted at different points by governments of different ideologies since the 1990s.
and local authorities) as well as at a national level by NHS England. This is a particular issue for conditions where there are significant issues around co-ordination of care across primary, secondary and tertiary services, such as in complex cancer treatment or sexual health services (Ham et al 2015a). The introduction of co-commissioning in 2014, a policy which gives clinical commissioning groups the option of working with NHS England to commission GP services, is likely to re-define the boundaries between different commissioning organisations once more. As the use of co-commissioning increases, it is likely the problems regarding fragmentation will increase (Holder et al 2015).

3.2 Key features of success

Summary points

- Commissioners must have a defined role in strategic planning and purchasing at a local level, with sufficient influence and autonomy to undertake their responsibilities. While PHNs are not public organisations, they do have a delegated responsibility to commission services at the local level and will need to develop good relationships across other commissioners and providers of public services to undertake this role effectively.

- Clinicians and the public should be actively engaged in commissioning and strategic planning to ensure that decision-making reflects the needs of patients and the population.

- Commissioning and contracting are not substitutes for establishing trust across stakeholders and investing in high-quality relationships, particularly with clinicians and the public.

- Commissioning systems need to allow for local flexibility; local commissioners must be able to adapt depending on a range of factors including the quality of local relationships and the degree of competition between providers.

3.2.1 Commissioner influence and autonomy

Critical to the success of commissioning is ensuring that commissioners have appropriate power, influence and scale to motivate and challenge providers to deliver services which meet their objectives. The ability for commissioners to do this effectively is fundamental to the concept of a commissioner-provider split, and weak or passive commissioning is one of the primary arguments used against such a system. This issue was highlighted by the experience of practice based commissioning policy in England which gave GPs a notional budget with which to 'buy' services, whilst primary care trusts retained responsibility for actual budgets. A review over three years into practice-based commissioning highlighted the problem of a 'hybrid' model where primary care trusts were often unwilling to let go of responsibilities to voluntary, non-statutory groups that they regarded as unaccountable users of public funds. The researchers concluded that in order for the model to work, real budgets need to be devolved to GPs in order to strengthen budgetary accountability and the financial incentives associated with it (Curry et al 2008).

The skills and capability of commissioning organisations is an important factor here (see previous section). In its assessment of primary care trusts in 2010, the House of Commons Health Committee highlighted the problem of gaps in commissioners' ability to analyse data effectively (when faced with providers' reluctance to be transparent about their performance) leading to an information asymmetry which allowed providers to resist change (House of Commons Health Committee 2010).

A further issue is whether or not commissioners have access to a sufficient range of levers to both incentivise providers and hold them to account. This is partly about autonomy and partly about scale. Research on commissioning across a number of European countries found that commissioners were frequently being undermined by hospitals appealing directly to national health departments for contracting conditions (Figueras et al 2005). Too many requirements from central government (or politicians) can restrict the ability of local commissioners to exercise control locally. The House of Commons Health Committee highlighted the problem of mandated payment systems and nationally set quality standards, which left commissioners with limited freedom to agree payment for services. The committee proposed increasing the ability of commissioners to offer more evidence-based financial incentives as one way to
help to address this issue (House of Commons Health Committee 2010).

3.2.2 Clinical engagement

The evidence presented in this paper shows that clinical engagement is fundamental to successful commissioning. This is particularly important in developing priorities, collaborating and contracting with providers and in implementation of service changes. Policies aimed at maximising the role of clinicians in commissioning are based on the belief that front line clinicians are best placed to make decisions about the needs of patients, and that clinicians are likely to exert more influence over providers when it comes to implementing changes. Successful involvement of clinicians requires commissioners to invest in building relationships with these groups and to take steps to ensure that they are incentivised to engage. However, evidence suggests that maintaining clinicians’ enthusiasm in commissioning can be challenging. Research found that aside from those actively engaged in commissioning boards, GPs had little interest in being involved in primary care trusts (Goodwin & Smith 2002). A review of practice-based commissioning in England sought to address the gap in clinical engagement by giving GPs ‘notional' budgets. This review found that the policy had been partially successful in encouraging GPs to become more engaged in commissioning and budgetary decision-making, but noted that this was generally limited to a small group of enthusiastic GPs in each commissioning organisation (Curry et al 2008). Early research on clinical commissioning groups suggested that they were more successful than their predecessors in engaging clinicians (Naylor et al 2013), however a follow up report argued that this engagement is at risk for a number reasons, including waning levels of engagement from GP leaders (those most closely involved in the work of the clinical commissioning group) and significant pressures on GPs’ time and capacity (Holder et al 2015).

The structure and organisational form of commissioning functions can also play a role in engaging clinicians and maintaining their involvement over time. This is likely to be easier where front line clinicians are given commissioning responsibility. Whilst this type of approach helps to embed clinical knowledge, it also introduces a new set of challenges. This includes ensuring that the clinicians involved have the commissioning and leadership skills required to undertake commissioning effectively. This reinforces the point that GPs and other clinicians require significant training and support to enable them to deliver the very different role required as commissioners.

3.2.3 Effective stakeholder relationships

As highlighted throughout this paper, successful commissioning is dependent on commissioning organisations working collaboratively with a range of stakeholders, in particular providers and the public. Collaboration between commissioners where commissioning responsibility and budgets are shared is also key in delivering more joined up services for users.

There is strong evidence to suggest that effective commissioning requires a collaborative effort between commissioners and providers, especially through clinical engagement during contractual negotiations (Curry et al 2008). However, this relationship building should be carefully balanced against the use of more formal arrangements and mechanisms. It is important that collaboration between commissioners and providers does not undermine commissioner autonomy and their ability to motivate and challenge providers in the delivery of services (see previous section).

Public and patient engagement is also fundamental for commissioners in ensuring that their decisions meet the needs of the local population. Commissioners need to be proactive in working with representative groups and engaging the wider public in the decision making process.

The evidence set out in this paper, particularly from within the NHS, highlights a number of issues which require careful consideration in the development of any commissioning system. These include balancing national and local interests; ensuring that commissioning organisations are close enough to their local population to be able to respond to their particular needs, whilst ensuring that the system does not become too fragmented, and that commissioners have sufficient autonomy and influence in their dealings with providers. A further learning is the importance of collaboration amongst commissioners, and between commissioners and providers. The evidence demonstrates that contracts and payment agreements are no substitute for
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developing and nurturing these relationships. Similarly, commissioning should involve regular and meaningful engagement with patients and the public, as well as public scrutiny.

At an organisational level, having access to the appropriate range of skills (either internally or externally) is fundamental to successful commissioning. As set out in this paper, research shows that the engagement of clinicians is of particular importance, and that when clinical input is lacking the process is undermined.

Commissioning health services is underpinned by contractual agreements and payment mechanisms, the form of which can vary widely. Each of these are important levers for commissioners in the achieving their objectives, for example the delivery of more integrated care, and approaches should be tailored and adapted as necessary.
4 References


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