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Making commissioning effective
in the reformed NHS in England



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The Health Policy Forum

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Making commissioning effective in the reformed NHS in England

Judith Smith
Richard Lewis
Tony Harrison

December 2006

FOREWORD

Reshaping health services through commissioning will probably be the most significant challenge facing the NHS over the next few years.

Successive government policy initiatives have sought to achieve widespread and sustained service reconfiguration, with a central aim of delivering patient-led services closer to where people live and work. Thus far real service redesign has been difficult to achieve and so it is therefore encouraging that commissioning is now being given such a high profile by the Department of Health.

From the perspective of the Health Policy Forum, the missing part of the jigsaw has been evidence based standards against which the effectiveness of commissioning can be measured. Put simply, how will stakeholders know if the renewed drive to strengthen commissioning is working?

This question is of concern to the bodies representing pharmacy because ineffective commissioning will perpetuate the status quo in which the pharmacy profession's considerable potential to improve health outcomes is not realised due to limited commissioning of enhanced pharmacy services. We therefore asked Health Services Management Centre at the University of Birmingham (HSMC) and the King's Fund to collect evidence about what constitutes effective commissioning, and we believe that their findings are instructive.

We are sure that the clear understanding this report offers into what constitutes effective commissioning will enable commissioners to benchmark their performance in an informed way. It will also help strategic health authorities, overview and scrutiny committees and others to performance manage commissioners. Finally and most importantly, adherence to the principles of effective commissioning will assure service users and tax payers that those who purchase health services on their behalf are commissioning services that achieve the best possible health outcomes and provide value for money.

The Health Policy Forum's steering group
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EXECUTIVE SUMMARY

This report seeks to answer the question: what makes for good or effective commissioning? It uses a literature review of commissioning in the public sector and a set of informant interviews as the basis for identifying the essential elements required of commissioning if it is to become properly effective as new primary care trusts (PCTs) are established in England in the autumn of 2006. It is intended as a research-based resource for new PCT boards as they consider how best to organise their commissioning function in the light of the new Department of Health commissioning framework.

The analysis carried out within this research identifies four key elements of effective health commissioning within the NHS market:

The identification of need and demand

Commissioners should explore what local people are demanding, as well as needing, from services in a much more serious and sophisticated manner. In doing so, PCTs can learn from the experience of the wider public and private sector about the use of social marketing, market research, in-depth public surveys, and other predictive analytical techniques.

The shaping of markets

As a consequence of the policy of patient choice, the focus of commissioners will shift from agreeing detailed volume contracts to ensuring that a proper 'menu' of services exists. PCTs will need to be proactive in stimulating and regulating a local care market, learning from the experience of social care purchasing, and this will include a need for arrangements to ease market entry for some providers, manage the exit of others, and assure transparent rules for the local market.

Holding the market to account

PCTs, as stewards of local health funding and decision making, will have to hold the local care market to account. They have to ensure that the 'commissioning basics' are in place and that resource is allocated for specifying and measuring contract outcomes. A 'bolder' approach to commissioning is required, with clarity about how services will be reviewed and what actions will be taken as a result of such reviews

Holding commissioners to account

The strengthening of the public 'voice' in commissioning requires PCTs to develop new and more radical approaches to engaging the public and patients in their commissioning, as well as developing robust approaches to assure the public of transparency and legitimacy in PCT decision making.

Immediate priorities for PCTs

Each chapter of the report concludes with what the research team considers to be immediate priorities for PCT boards as they develop a commissioning strategy and arrangements to deliver such plans. These priorities are set out overleaf:

Immediate Priorities for PCTs

Identifying need and demand

Map existing approaches to needs assessment and the surveying of demand in the PCT area for a few discrete services that encompass a wide range of service provision both within and beyond the NHS (for example, long-term conditions, first contact care for minor conditions, emergency admissions to hospital) and identify gaps within this process of data collection and analysis.

Develop a clear strategy for the assessment of both need and demand for a set of the services mentioned above, demonstrating a range of techniques that will be used, and including sources from beyond the PCT.

Consider piloting a few new approaches to the assessment of need and demand, perhaps within the context of sharing that learning with other neighbouring PCTs.

Market shaping

Develop a transparent procurement framework that sets out how all benefits (financial and non financial benefits) will be valued in the procurement process.

Agree local rules for competition management in the commissioning of (particularly primary, community and intermediate) care. Rules should define anti-competitive behaviours and acceptable market penetration by single providers.

Map the potential health market (and providers) for key local services such as those related to care for people with long-term conditions and first contact care. Set up systems to communicate effectively with these providers.

Holding the market to account

Ensure that the 'commissioning basics' are in place, and be clear about which part of the organisation (or its sub-contractors) is responsible for which element.

Develop a clear plan for how the performance of providers or a specific sub-set of providers will be reviewed (perhaps the same services as those singled out for in-depth analysis of need and demand), and how the PCT will act on and account for the results of such reviews.

Devise procedures for how the PCT (with other PCTs as necessary) will handle complex priority setting decisions, learning from the experience of other PCTs nationally. Draw on experience from other disciplines when developing these approaches, including health economics, public consultation, and the law.

Holding commissioners to account

Develop new mechanisms to engage the public and patients in the commissioning agenda for the purposes of greater public accountability, making sure that this encompasses the assessment of need and demand, the holding of the market to account, and formal accountability processes between the PCT and its local population.

Consider how the PCT might focus this renewed attention to public engagement on a few services in the first instance, given the known complexities in developing public involvement and the limited resources available both to commissioners and within communities.

Set out minimum criteria for public engagement within practice based commissioning as well as offering developmental support to practice based commissioners in this respect.

Consider the development of alternative models for the governance of practice based commissioning, paying particular attention to accountability to the public and the scrutiny and management of conflicts of interest.

Policy futures

The authors conclude their analysis of effectiveness in commissioning by suggesting that the NHS faces a mammoth task in the face of high expectations from the public and politicians. The uncomfortable question is posed: will it really be different this time, and if so, how? The authors go on to suggest that if PCTs and the new commissioning framework do not deliver the hoped for financial control and service changes in the NHS, the government will start taking a hard look at more radical scenarios for commissioning. These options are likely to include:

- a partial or full contracting out of the PCT commissioning function to commercial companies;
- developing a foundation trust model of governance and ownership for PCTs (as commissioners, beyond current proposals for community foundation trusts);
- direct elections to the boards of PCTs; and
- transferring health commissioning away from the NHS altogether to local authorities.

ACKNOWLEDGEMENTS

We would like to thank the funders of this research for enabling us to have the time and space to carry out this policy analysis at a time of significant change to NHS commissioning in England. Their enthusiastic support of our proposed approach to the project, and wise and thoughtful advice as we carried out the work, was greatly appreciated. Similarly, skilful project management by Abi Masterson enabled a very professional and constructive working relationship between the funders and researchers at all times.

At HSMC, we would like to make special mention of the tireless and detailed literature searching and website tracking work that was carried out by Ann Evans and her team, and we are grateful to Jon Glasby, Juliet Woodin and Edward Peck for providing insightful comments on the first draft of this work.

Most of all, we would like to thank the policy makers, managers and practitioners who willingly gave of their time to be interviewed for this project and to provide us with case study examples. This 'real world' input has, as ever, been invaluable.

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1. INTRODUCTION AND METHODS

Scope of the study

This report seeks to answer the question: what makes for good or effective commissioning? There has been extensive commentary about the 'failure' of NHS commissioning to be properly effective and thus bring about significant shifts in the pattern of health care, and the current financial crisis in the service can be viewed as a further indictment of the ability of commissioning to really shape and control NHS provision. For example, in 2005, the NHS Confederation pulled no punches in its assessment of the state of development of NHS commissioning:

'Commissioning has perhaps been the most significant omission in the development of health policy since 1989. This may be one important reason why the pace of reform has sometimes been slower than it could have been.' (NHS Confederation, 2005, p1)

The Department of Health policy underlined the crucial role of commissioning in explaining its reform programme in 2005:

'...the reforms are a means to improvement rather than a blueprint for how services should be delivered. They will support the development of high-quality services by embedding the right balance of incentives, transparency, plurality of providers and patient choice into the system. Better commissioning of healthcare services will be critical.' (Department of Health, 2005, p2)

This report seeks to identify the essential elements required of commissioning if it is to become properly effective as new PCTs are established in England in the autumn of 2006. The intention is that the report provides a research-based resource for new PCT boards in the autumn of 2006 as they consider how best to organise their commissioning function in the light of the new commissioning framework for the NHS (Department of Health, 2006a).

The report is based on a research project funded and commissioned by The Health Policy Forum, a collaborative venture involving the Company Chemists' Association, the National Pharmacy Association, the Pharmaceutical Services Negotiating Committee and the Royal Pharmaceutical Society of Great Britain.

It was carried out over the period March-June 2006 by a team from the Health Services Management Centre at the University of Birmingham (HSMC) and the King's Fund, London. The project comprised a review of the literature on public sector commissioning and purchasing, supplemented and informed by a series of interviews with policy makers and practitioners who are closely associated with the development and operation of commissioning within the NHS.

It should be noted that the views expressed and conclusions reached in this report are those of the HSMC and King's Fund authors, and do not necessarily reflect the views of the Forum and its partner organisations.

Methods used

The study focused on a review of the literature on health purchasing and commissioning, and specifically, on the time period 2004-2006. The intention of this review was to supplement and extend the review of the literature on primary care-led commissioning that covered the period 1990-2004 (Smith et al, 2004) carried out for The Health Foundation. On this occasion, keywords used for bibliographic searches were:

- primary health care
- commissioning
- purchasing
- contracting
- budgets
- fundholding
- effectiveness
- performance
- success
- efficiency
- achievement

Initial searches were extended by the addition of the keywords 'procurement' and 'social care'. Searches were made of the following databases: Healthcare Management Information Consortium (HMIC)/King's Fund; Medline; Embase; and Cinahl. The literature review yielded 384 items. Manual review by the research team of the abstracts of these papers led to the purposive selection of 62 papers for in-depth review. In addition, websites and 'grey' policy literature have been reviewed, including the following sources:

- Cabinet Office
- Monitor (regulator of NHS foundation trusts)
- Department of Health policy documents
- NHS Networks website
- Commissioning e-book (Oxford Brookes University)
- King's Fund/Wanless review of social care for older people
- Office of the Deputy Prime Minister procurement studies
- Centre for Public Scrutiny
- Social Marketing Institute

Findings from the literature review were used by the research team to distil four key elements that were deemed to constitute 'effective commissioning'. The themes were:

- the identification of need and demand;
- market shaping;
- holding the market to account; and
- holding commissioners to account.

These four themes were then used as the basis for a set of 12 semi-structured telephone interviews with policy makers, managers and clinicians known to be playing a leading role in the development and implementation of commissioning policy in the NHS. In addition, interviews were carried out with staff members of the four organisations funding this research. A list of those people interviewed for the study is in the appendix. Interviews covered areas including: informants' views about what constitutes effective commissioning; how needs and demands can be identified by commissioners; ways in which more plural markets can be shaped; the impact of patient choice on commissioning policy and practice; the holding of healthcare markets to account; the accountability of commissioners; and lessons that NHS commissioning might draw from the experience of purchasing and procurement in other sectors.

This report

The research team have distilled the findings of the literature review and informant interviews into a report that is focused on answering the question 'what makes for effective commissioning?' in as practical a manner as possible. Hence this report is structured around the four key elements of effective commissioning identified in this study, and each of the main four sections ends with a

set of suggested 'immediate priorities' for PCTs to act upon when developing their commissioning structure and plans in the winter of 2006-07. The report concludes with a suggestion of some possible future scenarios for NHS commissioning.

2. POLICY CONTEXT

The development of quasi markets in health

The concept of 'commissioning' was first developed in the NHS as part of the 1990 reforms to create a quasi market in health services (Le Grand et al, 1998). Commissioning in this context was designed to separate out the interests of the recipient of health care (the patient) from those of the supplier of health care (hospitals and other providers).

The regime that the quasi market replaced was one that was underpinned by a unified system for the planning and management of health services. District health authorities were charged with planning and providing care and therefore there was no clear separation of functions, nor was such a separation felt necessary to guarantee outcomes that would maximise benefits for patients.

The move to a quasi market was linked to a new strand of thinking about the management of public services. 'New public management' stressed the need to decentralise decision making from the level of the national government, to put public service providers under the same pressure to perform as in the private sector and to use competition to drive up quality and drive down costs (Buse et al, 2005).

Principal-agent relationships

Commissioning as an activity can be understood with reference to 'principal-agent' theory. In principal-agent relationships, one party (the principal) secures its interests through contracts with one or more third parties who act as the agents of the principal. However, the nature of healthcare as a commodity adds complexity to this relationship. Health care services do not lend themselves to direct purchase by patients due to in-built advantages (such as information asymmetries) enjoyed by providers (Arrow, 1963). Patients are not able to act as principals and are likely to be disadvantaged by their agents if they do. Therefore, commissioners, in the shape of institutional or general practitioner commissioners, take on the responsibility for commissioning on behalf of patients. There are two sets of principal-agent relationships: commissioners as the agents of the patient, and providers as the agents of commissioners.

PCTs pose a particular set of complexities in relation to the principal-agent relationship, for they are at once principal (commissioner) and agent (provider). They face a challenge in being an effective mediator of their relationships with patients and the public (on whose behalf they are an agent) and with providers (both their directly managed services and those provided through contracts) who hold contracts with the PCT. This (ever-increasing) complexity is at the heart of the discussion within this report. For example, in addition to the PCT role as agent for the local population, patients are becoming principals as they exercise choice of provider, and practice based commissioners are at once principals (purchasers) and agents (providers to PCTs).

The internal market of the 1990s

The first experiments in NHS commissioning in the 1990s proved inconclusive in terms of whether or not the quasi-market improved the performance of the NHS (Le Grand et al, 1998). There is some tentative evidence that productivity may have increased as a result of the 1990s market because the cost-weighted activity index used to measure NHS productivity increased more than the increase in resources during that period. However, there were efficiency increases (albeit at a lower level) in the period before the introduction of the market. Improvements in quality and responsiveness are nevertheless harder to detect. Overall, the implementation of the internal market was half-hearted, with weak incentives and a high degree of constraint on market actors imposed by central government (Le Grand et al, 1998).

The Labour government and the health market

The 1997 Labour government did little to dismantle the internal market beyond the replacement of GP fundholding with more collective forms of primary care-led commissioning in the form of primary care groups (PCGs) and PCTs. In its early years the government showed little appetite to reinvigorate the market. However, this changed from 2002 onwards with the establishment of pilot projects that offered choice of alternative providers to patients who had been waiting for over six months for elective treatment. The government has subsequently adopted more radical and potentially risky market-style incentives and structures (Dixon, 2005). In particular, the government has sought to clarify the separation of interests between commissioners and providers by increasing the emphasis on patient choice and encouraging diversification of suppliers of care, not least by pursuing national and local procurement of diagnostic and elective care from the independent sector and by actively encouraging the entry of new suppliers into the healthcare provider market.

Payment by results

New financial incentives ('payment by results') serve to increase the rewards and penalties faced by providers in relation to their success or failure to attract patients. Payment by results, based on a national tariff for healthcare resource groups (HRGs), increases the standardisation of contracting, serving to enhance the ability of commissioners to switch between competing providers. It is already exposing a range of financial pressures within NHS local health economies. This new, much tougher financial environment is requiring commissioners to focus much more closely on the achievement of productivity gains and we are witnessing a greater degree of debate about priority setting, rationing and demand management in the NHS – all of which poses a challenge to the role of commissioners in balancing need/demand and available resources.

Patient choice

The focus on patient choice has however adjusted the principal-agent relationships described above. From 2006, patients may choose directly from at least four local providers of consultant-led services and in addition, this choice includes all foundation trusts and nationally-procured independent sector services. From 2008, patients will be able to choose from any willing provider that has been accredited by the Healthcare Commission and can meet the national tariff. What this heralds is a shift towards the patient as the commissioner of their own care, or at least a co-commissioner with the GP who refers them for a specific treatment or appointment.

A primary care market

Choice of, and competition between, providers is now extending from the hospital to the primary care sector. Reform of primary care contracts since 1997 has opened the way to new providers of primary care (Lewis et al, 2001). Since 2004, 'alternative provider of medical services' contracts (APMS) have allowed the entry to the primary care market of privately owned and limited companies (Department of Health, 2004). These contracts are being used as a means of enabling private provider organisations beyond the 'NHS family' to take on contracts for general medical services in areas where the PCT has sought tenders from providers, and where traditionally, services would have been delivered by 'NHS' GPs. APMS is also being used by PCTs as a means of stimulating proposals to develop new models of primary care, including out-of-hours and walk-in services, and primary care provision for groups that are traditionally excluded from mainstream general practice.

The recent primary and community care white paper (Department of Health, 2006b) has set out a vision for a more active commissioning role in relation to primary care. In particular, national procurement of independent sector providers will take place in areas of high deprivation and low ratios of GP to population. New procedures will be introduced to allow patients to signal a 'call to action' where commissioners must respond to significant failings in local primary care, and there will be a range of measures by which the performance of commissioners will be assessed (see 4.1 for more discussion).

Information to support choice

The role of patients in choosing their service provider has led to a significant attempt to improve information flows within the NHS. Choice requires high quality information with which to compare providers' performance. Choice by patients in particular requires the provision of standardised performance indicators and access to qualitative views of other patients. Unlike practice based commissioners or PCTs, patients are not able to build up their own picture of comparative performance through exposure over time to the results of treatment by one or other provider (of course, this is a very difficult way for even institutional commissioners to judge quality).

The government has begun to invest in patient-oriented information resources, such as www.NHS.uk which offers standardised information by provider. In addition, investment has been made in a Health and Social Care Information Service which is intended to deliver high quality and reliable information to the public. Lastly, a computerised system is being implemented to allow personalised booking of hospital appointments within the GP surgery - 'choose and book'.

Whether or not patient choice will act as a powerful influence on the health system is as yet unknown. However, developments such as the Healthcare Commission/Society for Cardiothoracic Surgery in Great Britain and Ireland website for patients on heart surgery present an opportunity for people to consider much more detailed comparative clinical information when making decisions about their treatment. Evidence from the United States suggests that patients are unlikely to act on information about provider performance, although such information may provide incentives to providers to improve performance in any case (Schneider and Lieberman, 2001). Pilots of patient choice in this country suggested that a high proportion of patients were willing to choose an alternative provider once they faced a wait for treatment of six months (Burge et al, 2005). However, patients appear to show an inherent bias towards local providers when offered a choice at the point of GP referral (Burge et al, 2006).

Commissioning in an era of patient choice

Patient choice represents a significant shift in principal-agent relationships in the NHS, for it implies that patients will begin to act as principal in relation to health care providers and effectively take on a significant commissioning role themselves. Consequently, the nature of 'commissioning', when carried out by a practice based commissioner or a primary care trust acting as a patient advocate or agent is also shifting. Commissioners will no longer be responsible for directly allocating contracts to providers for those services to which choice applies (that will be the role of patients). Instead, commissioners will need to focus on their accountability for the use of resources (and achieving financial balance), ensuring that quality of care is maintained (beyond that secured through inspection by the Healthcare Commission), understanding patients' and the public's needs, securing an appropriate supply side to match those needs (ensuring a proper 'menu' from which patients can choose) and overseeing significant instances of service redesign and reconfiguration.

The detailed commissioning role in this new policy context is still evolving and further guidance has recently been issued by the Department of Health (Department of Health, 2006a). It is clear, however, that the Department of Health has switched from a predominantly supply side focus to its health reform to one that recognises a significant development agenda for commissioners, and that views commissioners as ultimately accountable for bringing resources and demands into some form of balance. In its evidence to the Health Select Committee, the Department of Health indicated that strong commissioning is an essential antidote to supplier-induced demand that might emerge from payment by results (House of Commons Health Committee, 2006). As a consequence, PCTs are now embarking on a national 'fitness for purpose' assessment.

Joint commissioning

Newly configured PCTs are, in most cases, coterminous with their local authority, specifically in order to facilitate a greater degree of joint commissioning activity across health and local government. In areas such as mental health, older people's and children's services, effective commissioning cannot be viewed as a purely NHS activity, but is fundamentally concerned with joint planning and procurement in some form of alliance with local government. Indeed, the emergence of the 'new' PCTs is leading to some debate about how the joint commissioning agenda might move forward, both in terms of potential benefits to PCTs and also in the context of the Lyons Inquiry into local government (Glasby et al, 2006).

Future challenges

The NHS is facing considerable challenges. Financial deficits and an apparent drop off in productivity, together with very tough hospital waiting time targets on the horizon, will ensure that both commissioners and providers will remain under pressure for some years to come. From 2008, the generous growth in NHS funding will begin to reduce to historic, and rather more parsimonious, levels.

The government has committed itself to greater devolution of power within the NHS. Evidence of this is the transfer of the vast majority of NHS resources directly to PCTs and the creation of arm's length foundation trusts. However, the government continues to set and monitor national performance targets and to retain key roles in market management (such as setting tariff prices and procuring new capacity on a central basis). It is currently far from clear whether or not commissioning will operate with significant local discretion, and this is a critical factor in relation to how far commissioning by PCTs in the NHS will be able to become properly effective.

3. WHAT IS COMMISSIONING?

Many authors have sought to define 'commissioning' within a health system, and it is not our business here to add further to those definitions. Instead, we identify those existing definitions which have proved most helpful to us as we have carried out this study, illustrating these with some of the views given by our project informants during interviews. In particular, we focus on what the literature and project informants deemed to be 'effective commissioning' and demonstrate how we determined the framework for subsequent analysis of the nature of effective commissioning.

Roche (2004), in a review of the functioning of PCTs, asserted that the definition of commissioning in the NHS remained contested, with some people viewing it as 'needs-based purchasing' and others considering it to be a much wider strategic planning function. She argued that a consensus did however appear to be emerging about the components of the commissioning process:

- assessing health and social care needs of the target population;
- priority setting and allocation of resources to meet those needs in line with local and national targets;
- contracting with providers or purchasing services to meet those needs and targets; and
- monitoring and evaluating outcomes.

These components closely resemble the commissioning cycle set out by Ovretveit (1995), an approach that views commissioning as an overall public health strategic planning and procurement process. Recent Department of Health guidance also closely matches this approach (Department of Health, 2006a).

Commissioning as strategic planning was a recurring theme in our informant interviews, as was the need for this to become a 'braver' and more assertive process. As one of our interviewees noted:

'We have to be strong and clear about what we want to commission and how, and we have to be brave'.

Woodin (2006, p203) has underlined the importance of commissioning as an active and dynamic function with a market-based health system, including a role in shaping and managing markets. This more assertive role is, in the context of this study, crucial to the overall effectiveness of commissioning. Woodin comments:

'Commissioning...tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes.'

These definitions highlight the importance of the first element of commissioning that we explore in this study: **the identification of need and demand**, or the determination of what it is that should be purchased with the available healthcare resource, in order that this need and demand can be met and hence individual, local or national health objectives can be achieved.

Woodin's definition also identifies the second of our key themes: **the role of the commissioner in shaping a local care market**. Key informants pointed to the importance of there being a

systematic and transparent process for mapping existing provider markets and developing plans to develop such markets. It was pointed out that when social care purchasing was established in the UK in the early 1990s, market mapping was required as a prerequisite to contracting for local services, yet in health, there appeared to be continuing reticence to actually name and hence map out health markets. This need to be explicit about the existence of a market in healthcare (and hence the role of PCTs as shapers of local markets) has been highlighted in a recent report published by the King's Fund (Timmins, 2006, p10):

'The government needs to state unequivocally that it sees a supplier market in health care as the long-term future for the national health system. It should not, as ministers have tended to do so far, state or imply an upper limit to independent sector provision. The proportion of care coming from NHS-run, private and voluntary sectors should emerge from the operation of the market.'

Our third theme related to effective commissioning, that of **holding the market to account**, came out strongly within our literature review, especially in research from social care and local authority purchasing. This was typically embedded in analysis of the application of new public management techniques to health and social care, and took the view that a market approach with clarity about who purchases and who provides enables a more effective form of accountability on the part of service providers. The need for the NHS to have a sharper commercial focus to its purchasing was picked up by two interviewees:

'Commissioning is currently effectively a gentleman's agreement in the NHS family. There is a degree of protectionism. We need separation so that commissioners don't have to take same level of interest in provider's financial and commercial health.'

'Commissioning hasn't really succeeded... something to do with the relative balance of power between commissioners and providers.'

The final theme that we selected for our analysis of what makes commissioning effective – **holding commissioners to account** – is perhaps the 'new kid on the block' in respect of discussion about health commissioning. Within discussion about health commissioning, the cycle of commissioning is often considered as some type of closed system that is logically applied by health funders. How those funders are assessed in relation to their effectiveness as commissioners, how they are governed, and how they account to stakeholders (patients, the public, providers) for their decisions, has not, within the NHS, been a particular subject of debate until recently.

In recently published research, Wade et al (2006) asserted that the PCT as a model of governance was no longer fit for purpose as a means for accounting to the public for decisions made about the allocation of resources and the purchasing (or not) of services for local populations. They suggested that a new model of governance needs to be found if the NHS is to function as what they termed 'NHS Local', a local healthcare funding and planning organisation that can become the recognised local eyes, ears, brain and conscience of the NHS. This issue of how commissioners can be held to account, and the inadequacy of current accountability arrangements was picked up in our informant interviews, for as one respondent noted about the role of the local authority overview and scrutiny committee (OSC):

'The OSC is a pretty thin proxy for feeling accountable to the public. Governance of PCTs is looking increasingly strange compared to that of foundation trusts. There is nothing to stop PCTs mimicking foundation trust style governance even if foundation PCTs have not been legally created.'

Thus we have devoted a section of this report not only to exploring the ways in which commissioners might be held to account within existing arrangements for accountability and management, but we have also sketched out some policy futures that focus on alternative models of governance for commissioning in a more explicit NHS market.

Evidence about the effectiveness of different models of commissioning is not encouraging in respect of the likelihood of the new NHS commissioning framework being able to make a difference where previous purchasing and planning policies have failed. In a review of the research evidence on primary care-led commissioning, Smith et al (2004, p46) concluded:

‘A core finding of this study is the lack of evidence about the impact of primary care led, and other, commissioning. While much is already known about process factors and organisational features associated with effective commissioning, few studies have explored outcomes, in part due to the relatively short lifespan of NHS commissioning organisations to date and also because of the difficulty of attributing change to commissioning per se, as opposed to other changes in the management and policy environment. A consideration of these confounding factors must be built into any future policy development and evaluation.’

The study cited above, in common with a review of the evidence on the NHS Internal Market by the King’s Fund (Le Grand et al, 1998), suggested that the following would be required if effective local purchasing was to be achieved: a degree of organisational stability; strong clinical engagement; the existence of a clear choice of providers; appropriate incentives to drive clinical and organisational change; effective management and information support; and appropriate system regulation (Smith, Dixon et al, 2005).

It is important therefore not to under-estimate the scale of the task facing PCTs as they work out how to make commissioning properly effective. NHS purchasing is just fifteen years old, and numerous reforms to the structure and size of purchasing bodies have been implemented in attempts to achieve ‘effectiveness’. In preparing this report, we have been clear that the most useful contribution we can make to current thinking and practice is to take the published research evidence, and the thoughts of key policy makers and practitioners, and distil a few pieces of practical advice for new PCT boards. We have highlighted these as ‘immediate priorities’ at the end of each of the four thematic sections that follow.

One interviewee in this study commented:

‘The NHS is innately conservative. It doesn’t have a commercial appetite. Therefore, it will keep the same [commissioning] process and play at the margins.’

If this view is to be dispelled, and not repeated in later studies of commissioning in a few years’ time, the NHS has to become much bolder and assertive in how it identifies needs and demand, shapes markets, holds those markets to account, and in turn holds its commissioners to account.

4 WHAT IS EFFECTIVE COMMISSIONING?

4.1 THE IDENTIFICATION OF NEED AND DEMAND

The role of needs assessment in commissioning

The separation of purchasing from providing within the NHS in 1991 was originally justified on the grounds that providers were the effective determinants of demands on resources, i.e. professionals determined which needs were met and also the ways in which they were met (Department of Health and Social Security, 1989). Thus health purchasing and commissioning emerged as a function designed to counter the power of the professionals by allowing commissioners in principle to determine which services should be provided on behalf of patients.

The first stage of a commissioning or purchasing process in health care is typically described as the 'assessment of needs' (Ovretveit, 1995; Roche, 2004). Within Ovretveit's commissioning cycle, needs assessment forms the precursor to planning, contracting, monitoring, and review, before a further stage of needs assessment is undertaken. In the 1990s, needs assessment in the NHS tended to be viewed as the preserve of public health specialists, and was one of the reasons for the location of the public health function within health authorities when these new purchasing organisations were established in the early 1990s. One of the best-known models of needs assessment is that developed by Stevens and Raftery (see box 4.1.1).

Box 4.1.1 Framework for assessing need

1. Statement of the context of the problem
2. Subcategories
3. Prevalence and incidence
4. Services available
5. Effectiveness and cost-effectiveness of services
6. Models of care
7. Outcomes and targets

Source: Stevens and Raftery, 1994

This type of approach to needs assessment emphasises the bringing together of evidence required in order to make a comprehensive assessment of need for specific clinical conditions and typifies much of the NHS planning through national service frameworks since 1997. International commentators point to the strength of needs assessment as the basis of health purchasing in the UK, seeing this as a reflection of the existence of a strong public health community and a health system predicated on a split between those who plan and purchase care for a defined population and those who provide health services (McKee and Brand, 2005).

In the context of recent discussions about the future of commissioning in the NHS, there is now a debate about how health services, and indeed commissioners, can respond to demands from patients and the public as well as to need as expressed by commissioners. The reasons for this shift are complex, but include the introduction by government of a policy of 'patient choice', whereby individual patients, with the assistance of their GPs, select the provider who will give them certain elements of their hospital care. Similarly, the extension of the direct payments system whereby certain groups of social care users can buy their own care directly using resource allocated by their local authority, enhances the focus on individual demand in counter-balance, or parallel to, need expressed by public service planners and purchasers. The direct

involvement of the public in the commissioning process has been signalled by new rights to 'petition' PCTs where the public believe that services are inappropriate or deficient (Department of Health, 2006a).

NHS commissioning is however starting from a low base in relation to designing and purchasing services in a way that properly takes account of people's needs and demands (as opposed to assessments of needs made by public health professionals). In an Institute for Public Policy Research (IPPR) paper published in 2004, Roche commented: 'there is a strong sense that the entire process of service planning and commissioning is divorced from the needs of the public'. She also suggested that provider/professional input to commissioning was lacking too, in particular those staff who actually deliver health services. 'If the very people responsible for taking forward input from those delivering services don't recognise it as important and act on suggestions, there is little opportunity for health professionals to re-shape services in response to patient needs, let alone there being real opportunities for patients to influence decisions' (Roche, 2004, p21).

Attending to both need and demand in commissioning

It appears therefore that there has been something of a move away from a focus on 'pure needs assessment' as the starting point for health commissioning, (back) towards a concern with seeking to meet the demands of patients and their families, whilst also ensuring proper clinical advice within the planning process. This attention to people's demands is important for a range of reasons, not least as a reflection of the rights of citizens and taxpayers to play a role in shaping the health services they receive, and also as a response to the Labour government's desire to ensure that there is ongoing universal (and in particular middle class) support for the NHS.

A recent analysis of NHS commissioning suggested that this new focus on individual choice and demand was one factor in the overall expansion of the commissioning task of PCTs, with new activities being required such as the provision of more information to patients and GPs, the use of market research and market analysis, and the development of local 'menus' of providers from which patients can choose (Wade et al, 2006). Furthermore, understanding what people want from the NHS depends on well organised and meaningful patient and public involvement, and proposals for how this might be better achieved have been published (Department of Health, 2006c). The vital importance of NHS commissioners paying more attention to the views of patients and the public when making commissioning decisions has been highlighted by the NHS Confederation (2005, p7):

'One key way in which the success of commissioners will be judged is how far they are able to understand the views of the public about the choices that are offered and the range of services they make available'.

The NHS Confederation goes on to suggest that this focus on seeking to understand the public's views will call for general practices to gather intelligence about patients' demands and expectations (through practice based commissioning), for PCTs to make greater use of market research methods, and for commissioners to work more closely with local government and other civic stakeholders who have a wide range of data about the profile, priorities and service use of their local population (NHS Confederation, 2005).

The importance of wider civic input into the planning and prioritisation of public services is a concern for the broader public sector, and not just a preoccupation of health commissioning. Indeed it is a key theme of the current Lyons Review of local government, a review that has published an interim report that emphasises the role of local government in 'place shaping', a wider strategic role for local government that includes: 'understanding local needs and preferences and making sure that the right services are provided to local people through a variety of arrangements including collective purchasing, commissioning from suppliers in the public,

private and voluntary sectors, contracts or partnerships and direct delivery' (Lyons Inquiry, 2006, p39).

The fact that local authorities have a duty to ensure the well-being of their local population underlines their role in needs assessment and the commissioning of local services, and as we explore elsewhere in this chapter, local authorities hold rich data that could be used much more extensively within the process of health commissioning, and typically have greater experience of market research and the exploring of the population's demands for services. The Department of Health has promised further guidance on 'commissioning for well-being' by the end of 2006.

Thus it seems that needs assessment in NHS commissioning has to (and in many cases is starting to) 'move beyond public health'. That is not to say that epidemiological data analysis is not vital as part of health planning and commissioning, but it is clearly no longer sufficient as the sole basis for making decisions about how priorities will be set and resources allocated through procurement and contracting. Many other data sources are now required, and in particular those that explore the demands and priorities of patients and the public.

Social marketing

Social marketing and traditional market research are now being considered to be important techniques to be employed alongside health needs assessment, as are more sophisticated analyses of service utilisation data in both secondary and primary care. The NHS Confederation (2005) emphasise that this new focus on commissioners determining the views of the public is not just about being able to reflect those views when making commissioning decisions, but also about being able to turn what the public want into new service models and pathways and hence bring about some step, rather than traditionally incremental, changes to service provision.

Social marketing is a term that was first adopted in 1971 by Kotler and Zaltman to refer to the application of marketing to the solution of social and health problems. MacFadyen et al (1999) describe social marketing as: 'a framework or structure that draws from many other bodies of knowledge such as psychology, sociology, anthropology and communications theory to understand how to influence people's behaviour' (p1). They go on to assert that social marketing provides a mechanism for tackling the behavioural causes of social and health problems – for example, by encouraging people to adopt healthier lifestyles. They note however that a lack of opportunity, choice and empowerment resulting from living in poverty prevents many people from adopting healthy lifestyles, and hence social marketing has a role in influencing the behaviour not just of individual citizens, but also of policy makers, media and interest groups (MacFadyen et al, 1999).

The activities of social marketing are set out as being: 'a logical planning process involving consumer oriented research, marketing analysis, market segmentation, objective setting and the identification of strategies and tactics' (MacFadyen et al, 1999, p1). In this way, social marketing represents the transfer of a discipline from private sector management – marketing – to the public services, and underlines the potential for organisations such as PCTs to avail themselves of a much wider range of intelligence when assessing needs and demands. This intelligence might include some or all of the sources set out in box 4.1.2 overleaf:

Box 4.1.2: Sources of intelligence for PCTs engaging in social marketing

- patient survey data, both national and local;
- epidemiological analyses for different levels of population;
- more sophisticated analysis of NHS routine hospital activity data;
- analysis of data about community service activity;
- analysis of data from primary care contracting, e.g. quality and outcomes framework data;
- local authority population data;
- local authority market research data;
- Healthcare Commission survey data;
- Audit Commission report data;
- Commission for Social Care Inspection report data;
- NHS service audit data;
- reviews by overview and scrutiny committees, royal colleges and other external bodies; and
- commissioned market research in relation to specific health service issues.

The theory of social marketing also points to the importance of adopting a more proactive approach whereby the PCT might seek to change people's behaviour (personal lifestyle, access to services, use of certain types of services, etc.) through its commissioning activity, rather than the more traditional purchasing approach of assessing need, procuring services to meet needs, reviewing services, etc.

Examples of proactive approaches being adopted by PCTs include: using predictive modelling of likely morbidity within specific populations (e.g. levels of diabetes within five or ten years) as a way of trying to identify patients at risk of hospitalisation (and hence commission services to pre-empt this); the application of actuarial techniques to try and understand levels of risk and need, including how people might respond to certain incentives to change behaviour and what the implications might be for NHS services (see Burge et al, 2006 and 2005); the use of market research to try and understand people's future behaviour in the context of changes to policy (e.g. likely responses to being offered a wider choice of care provider); and much more structured and in-depth surveying of patients and the public about current and projected future demands on the NHS.

Recent research from the King's Fund and RAND sets out important messages for PCTs about how they might approach the implementation of patient choice in such a way that people's preferences are accommodated and overall health system efficiency is maximised (Burge et al, 2006). This research used discrete choice analysis, expecting research subjects to consider the opportunity cost of choices they made about health services, and not just the services themselves.

This application of techniques from the discipline of health economics to the sphere of health planning and commissioning is something that PCTs will need to do more frequently as they become more sophisticated in their assessments of needs and demands. The real challenge for commissioners is, as we noted in section 2, to find a better fit between resources and needs/demands, in order that they can get a better return on the money they spend and hence create more benefit and value from the given budget. This challenge is not new – experience within social care in the 1990s offers instructive insight into the current development of a more explicit market in healthcare.

Experience from social care purchasing

Analysis of social care purchasing in the UK points out that social care practitioners were, in the early 1990s, put in the position of being supposed to act as advocates for the needs and wishes of their clients, rather than in their previous role as both assessor and provider of care, although always acting within the bounds of what was affordable (Martin et al, 2004).

In their review of the experience of social care purchasing in the UK, Martin et al (p481) warn:

‘Two principal consequences of the “new community care” are evidentThe first is the conflict for professionals between the role of custodian of social services’ resources and guardian of the interests of their clients. The second...is that they are rendered knaves in only a truncated fashion. Rather than truly harnessing knavery for the greater good, as a means of promoting the optimal use of scarce resources, the managerialist way in which the “new community care” works frequently creates pawns of the professionals.’

Martin et al (p484) offer a stark warning in that the experience of social care purchasing is that an increased focus on the demands and expectations of service users is rarely realised, being compromised in the face of a need to demonstrate ever greater cost-effectiveness of service provision. They conclude that ‘the constant spectre of restricted budgets, combined with the transformation of social work into a managerial role of correctly carrying out bureaucratic procedures, has given rise to organisational environments where the needs-led, client-centred approach of professional social work as envisaged in the 1990 NHS and Community Care Act is at best subsidiary to the core objective of minimising cost, and at worst no more than a myth’.

This experience provides a very clear caution to NHS policy makers and managers about the extent to which commissioning by new PCTs will really be able to adopt the ‘patient-centred’ approach that is being advocated in government guidance. The stringency of the current NHS financial climate similarly suggests that cost containment and value for money (the management of scarcity, in economic terms) are likely to dominate the activities of commissioners. The challenge for PCTs is how to draw together a patient or user perspective whilst having robust and defensible ways of managing scarcity, at the same time ensuring that needs are fulfilled and demands met. This challenge is explored in more depth in a forthcoming paper (Glasby et al, 2006).

Netten et al (2005) point to the fact that major purchasers of health and social care are likely to continue to be local authorities and PCTs, rather than individual service users, although at a micro-commissioning level, purchasing organisations should try to facilitate some choice and empowerment. They suggest that the sort of choices that are realistically available to users are:

- the right to choose the type of care received;
- the right to make an application for a particular provider;
- the ability to choose the content, level and timing of care provided; and
- the ability to purchase care using direct payments.

As with Martin et al, Netten and colleagues sound a warning against over-enthusiasm in relation to how far public sector commissioning can truly encompass user choice and power:

‘Characteristics of the social care market, however, mean that choice and the market mechanism are far from straightforward ways of allocating resources. Service users may not be taking part in a voluntary exchange, may not pay for services, may not receive services because they fail to meet eligibility criteria and may find it difficult to change providers when standards or preferences are not met (Needham, 2003).’ (Netten et al, 2005, p31).

It is clear that NHS commissioning, if it is to become properly effective, has to adopt much more sophisticated approaches to the identification of need and demand. In doing this, there is a need to learn from the experience of the wider public and private sector, in particular in relation to the use of social marketing, market research, in-depth public surveys, and a range of proactive planning and modelling techniques. The experience of social care purchasing is salutary however, and points to the need to reduce costs in response to budgetary pressures, as well as trying to assure a proper patient or public perspective within commissioning. For PCTs, as they develop their strategy for making commissioning effective, we can therefore set out the immediate priorities to be addressed in relation to the assessment of need and demand:

Immediate priorities for PCTs

Mapping existing approaches to needs assessment and the surveying of demand in the PCT area for a few discrete services that encompass a wide range of service provision both within and beyond the NHS (for example, long-term conditions, first contact care for minor conditions, emergency admissions to hospital) and identify gaps within this process of data collection and analysis.

Developing a clear strategy for the assessment of both need and demand for a set of the services mentioned above, demonstrating a range of techniques that will be used, and including sources from beyond the PCT. In this way, the PCT will develop a set of local exemplars for how need and demand can be assessed, with clear links back into specific service plans and purchasing.

Considering piloting a few new approaches to the assessment of need and demand, perhaps within the context of sharing that learning with other neighbouring PCTs.

4.2 MARKET SHAPING

The changing nature of commissioning

As discussed in sections 2 (policy context) and 4.1 (need and demand), the nature of commissioning will alter significantly as a consequence of patient choice. As patients increasingly select providers the focus of commissioners will shift from agreeing detailed volume contracts to ensuring that an appropriate 'menu' of providers exists. We call this activity 'market shaping' as distinct from contract management, although it is clear that where choice is not able to be exercised, more 'traditional' commissioning activities such as negotiation of contracts for anticipated volumes of care will need to be undertaken by PCTs/Practice Based Commissioners.

A key aspect of market shaping is to determine what supply-side characteristics are required given the community's needs and demands as identified by PCTs (discussed above). Commissioners will need to ensure that there is an appropriate supply of providers in order that consumers are able to meet their requirements through the mechanism of choice.

Evidence from local authority purchasing suggests that the articulation of demand (i.e. through formal tender) by commissioners is not sufficient because there may be obstacles to the supply of certain services arising from planning or financial factors outside the control or influence of social service departments. It is by no means certain that the desired supply side will emerge in response to simple market signals, and it is likely to need some active shaping. Commissioning in the future will be increasingly founded on a view of both what patients require and a strategy of how to secure an adequate supply through proactive relationships within the market place.

Determining the desirable characteristics of the local health market

Commissioners will need to identify desirable market characteristics and develop strategies to bring these about. One obviously desirable market characteristic is that of diversity of supplier. This diversity must be sufficient both to allow patients to choose from among competing providers (i.e. to face a real choice) and to receive services that are attuned to any differences in requirements that may exist within and between different sub-groups within the served population. For example, a very diverse population may need a highly varied supply side if the different needs are all to be met (assuming that black and minority ethnic populations, for example, signal to commissioners that they have different requirements). PCTs will also face an increasingly complex challenge in relation to assuring equity within their commissioning, for a risk of a more diverse supply side is that the needs of some groups may go unmet ('falling through the net'), albeit that such diversity is designed to accommodate varied needs. The importance of the PCT as an assurer of equity is underlined in the Annex to the Department of Health's recently published commissioning framework:

'PCTs will be expected to secure access to a range of high-quality healthcare services to meet local needs. This will include maintaining existing services, developing new services to deliver care closer to home and meeting patient expectations.' (Department of Health, 2006d, p12)

Proactive strategies to bring about these market characteristics may include arrangements between commissioner and provider to ease market entry. With service uptake dependent in some markets on patients' choices, and/or the degree to which people are able to access services, (the aggregate result of which will be uncertain in advance) commissioners cannot simply design and award contracts with guaranteed volumes and income streams. Instead, agreements will be required that share risk between commissioner and provider. For example, where there is a desire for commercial providers to enter the market, NHS commissioners will need to be prepared to develop longer term contracts which enable investment to be recouped, or alternatively face the fact that rates of return will be set higher where projects are more short term

(Company Chemists' Association, 2005). It should be noted that the Department of Health has recently announced a number of flexibilities for PCT commissioners to encourage and support the market entry of providers where normal market signals are likely to be insufficient (Department of Health, 2006a). These include:

- payments above tariff rates;
- guaranteed income for providers; and
- reduced capital investment for providers through PCT capital grants or joint ventures.

Such arrangements are far more likely in some market sectors than others, in particular where high barriers to entry exist (such as a requirement for significant capital investment) or where the required provider has to be nurtured and developed (for example, the development of a niche service for a particular patient group). PCTs may use their powers to provide services as a 'nursery' to bring forth new supply, ultimately divesting itself of provider responsibilities once the market has matured.

It should be noted that experience of developing and managing more diverse markets in public sectors does in fact already exist within the NHS. For example, community pharmacy could be considered to be an example of the type of market the government is seeking to create in the English NHS, with its mix of large and smaller private sector providers, operating under contract to the NHS and alongside an NHS provider sector. The Department of Health has commenced a review of how the market currently operates in community pharmacy (following relaxations to market entry requirements which the government introduced in response to a more radical Office of Fair Trading (OFT) report (OFT, 2003) which advocated abolition of control). The analysis underpinning this review should offer further insights into the operation of markets and commissioning within the NHS.

Policy influences on the shape of the local market

The nature of the market will also be determined by external constraints such as those imposed by national policy. For example, government targets for transferring NHS commissioning resources from secondary care to primary care and the policy to support 'community hospitals' represent fixed points around which commissioners will need to navigate.

However, commissioners' actions and approaches to undertaking their functions will also be shaped by cross-sectoral policy. The policy towards public sector procurement and market characteristics is increasingly being articulated by the Office of the Deputy Prime Minister (ODPM now the Department of Communities and Local Government; DCLG), the Department of Trade and Industry (DTI) and the Office of Government Commerce (OGC). While such policies have so far concentrated mainly on local government services, similar principles can be applied to health services. It is helpful in considering the future of commissioning in the NHS to look at the policy framework and learning from local authorities.

The government has, in particular, outlined the importance of public sector contracts with small and medium sized enterprises (SMEs). The government is concerned that SMEs are currently 'squeezed out of contracts' let by local government to the detriment of the general economic growth, on the basis that the government believes that SMEs will be the engine of economic growth and innovation (Hughes, 2005). The government has developed policies designed to increase the role of social enterprises, the voluntary sector and community organisations within the SME sector in providing public services in general. The recent white paper (Department of Health, 2006b) makes clear that such policies now also apply to the NHS - a social enterprise unit and fund has been established within the Department of Health. This policy is founded on a further concern that 'social' issues, such as employment or access for certain population groups, should be taken into account when letting contracts, as should the social value of awarding contracts to service user-led organisations that may have a distinct contribution to make.

A National Procurement Strategy was developed in 2003 by the Office of the Deputy Prime Minister, the DTI and the Local Government Association (ODPM, 2003). This strategy requires local government to develop a vision for procurement that blends economic, social and environmental concerns and that is founded on a mixed economy of providers including social enterprises and the voluntary and community sector.

Local government has a statutory duty to follow a 'best value' regime of procurement (Local Government Act, 1999) (see box 4.2.1). This regime requires that local authorities consider the whole life costs and benefits of any purchase. Local authorities are also required under the Local Government Act 2000 to prepare a 'Community Strategy' and have powers to promote the economic, social and environmental well-being of their communities. They are therefore able to take into account in their procurement strategies social benefits such as community safety and good workforce management, as long as they also comply with European directives (Office of Government Commerce, 2006). A Small Business Friendly Concordat and Good Practice Guidance have been issued (see Box 4.2.2) (ODPM, DTI and LGA, 2005). All local authorities are expected to comply with the concordat.

Box 4.2.1: Best Value

Best Value: Section 3 of the Local Government Act 1999 describes the general duty of best value. Section 1 sets out those authorities subject to the duty (this legislation does not include health authorities). See www.hmso.gov.uk/acts/acts1999/19990027.htm

The duty requires best value authorities to make arrangements to secure continuous improvements in the exercise of their functions, with regard to a combination of economy, efficiency and effectiveness. Under best value, local authorities are required to carry out reviews of their functions, having regard to the principles of:

- *challenge* why, how, and by whom a service is being provided;
- *compare* processes and performance with other service providers;
- *consult* users, partners, businesses; and
- use fair and open *competition* wherever practicable to secure efficient and effective services.

Source: ODPM/DTI/LGA, Small Business Friendly Concordat – Good Practice Guidance, 2005

A particular concern is ensuring that the procurement process is fair and does not present barriers to entry to SMEs and social enterprises. The concordat includes principles to underpin a fair tendering process (see Box 4.2.2) and also a checklist for commissioners for the whole procurement process. Interest groups supporting social enterprises have also issued procurement guidance to commissioners and to businesses to support the market entry of social enterprises (Social Enterprise Coalition and New Economics Foundation, 2006).

Box 4.2.2: Small Business Friendly Concordat – a Fair Tender Process

The Concordat states:

- We will apply our own rules and policies fairly.
- At pre-tender stage and during the tender process we will ensure that all tenderers have equal access to relevant information.
- We will keep the tender process as simple as possible in order to help minimise the costs to suppliers.
- If a pre-qualification stage is used we will use a Council-wide pre-qualification questionnaire containing common core questions with limited bespoke additions for each contract. We will work with regional and national partners to ensure a consistent approach to pre-qualification.
- We will assess potential suppliers against published pre-qualification and tender evaluation criteria. These criteria will be proportionate to the risks of the individual contract process. In particular the criteria relating to financial standing will not be set to unreasonably exclude newer businesses.

Source: ODPM/DTI/LGA, Small Business Friendly Concordat – Good Practice Guidance, 2005.

Determining how the market will operate

A further aspect of market shaping is to determine the operational characteristics required of the market. This is in essence a regulatory role that will be discharged by PCTs. In particular, PCTs will need to take a view on the degree of competition within their market place. While PCTs are not required by statute to tender health services competitively, there is an increasing expectation that some form of direct competition or contestability will be applied.

PCTs are likely to find themselves facing monopolies within their supply side. While some of these may be desirable (for example, a single accident and emergency service serving a given population), other monopolies may not be deemed to be in the public interest. In primary care, anecdotal evidence suggests that clusters of general practice are developing for the purpose of delivering services (Lewis et al, 2006). PCTs will need to develop and enforce policies to guide the market on conditions under which contestability will be required. This is particularly necessary given new PCT powers to offer additional financial support to providers as outlined above.

While commissioners face challenges in managing appropriate market entry, they face perhaps more serious challenges in engineering market exit. This relates in particular to the exit of hospital services (and perhaps whole hospitals) and general practitioners contracted to the NHS. Removing hospital capacity from the system has proved historically difficult due to the high degree of local and national political resistance associated with such decisions. The new relationships between commissioners and autonomous providers (whether foundation trusts or independent sector hospitals) should provide less formal dependency and therefore free the commissioner's hand to allocate resources away from any particular provider. On the other hand, the greater independence of foundation trusts may make it harder for commissioners to impose their own priorities. The same is true of other, private sector, providers. These may have their own priorities, particularly in respect of location, which make it harder for PCTs to ensure good access for all sections of the population.

However, in practice, inter-dependence between commissioners and their main providers is likely to continue. Without significant extra capacity in the system (far more than could be countenanced and afforded) commissioners effectively face a monopoly provider for the majority of their non-elective services. In the case of highly specialised services, where clinical networks are the norm, this monopoly may extend over the populations of several commissioners. In this context, commissioners are likely to focus on collaborative and challenging techniques (such as performance benchmarking) to exert influence, rather than to use real or threatened exit.

Significant changes to NHS hospital provision are likely to be secured through a planned process of reconfiguration led by strategic health authorities (if indeed they are secured), rather than through the operation of the new market-style incentives. However, the market signals generated by patient choice and payment by results may at least act as a catalyst and focus for any planned reconfiguration.

General practitioners also enjoy a relatively secure position in the market. Those that hold general medical services (GMS) or personal medical services ([PMS] with inherited rights to return to GMS) contracts are hard to 'decommission' except on the grounds of serious service failure or professional failure resulting in the loss of registration by the General Medical Council. Existing GPs, in effect, currently enjoy 'preferred provider status' (Lewis and Dixon, 2005) in the NHS, something that is likely to become an issue as PCTs are expected to develop more diverse portfolios of providers and demonstrate probity and transparency in how procurement decisions are made (Smith et al, 2006).

Ultimately, there is an ambiguity within the NHS as to what forces will generate service change. The importance of market signals generated through patient choice may be limited. Instead, more 'top-down' and collaborative planning may emerge as a significant factor. This is particularly the case as financial difficulties beset the NHS. Recent guidance, for example, emphasises the need for commissioners and providers to work in concert to ensure that planned activity is achieved in practice (Carruthers, 2006). As PCTs develop a commissioning strategy in accordance with the new commissioning framework (Department of Health, 2006a), they will need to consider how they will approach the shaping of a local care market, and immediate priorities for this will include:

Immediate priorities for PCTs

Developing a transparent procurement framework that sets out how all benefits (financial and non financial benefits) will be valued in the procurement process.

Developing and agreeing local rules for competition management in the commissioning of (particularly primary, community and intermediate) care. Rules should define anti-competitive behaviours and acceptable market penetration by single providers.

Mapping the potential health market (providers) for key local services such as those related to care for people with long-term conditions and first contact care (see chapter 4.1). Setting up systems to communicate effectively with potential local providers.

4.3 HOLDING THE MARKET TO ACCOUNT

The PCT as the governor and steward of the local health system

Smith and Mays (2005) conceptualised the commissioning function in a publicly funded health system as being that of the 'conscience' (stewardship, governance, public protection) and the 'brain' (planning, resource allocation, decision-making, service design). The metaphor of the conscience and brain was further extended by Wade et al (2006) to include a third dimension of 'eyes and ears', this referring to activities related to keeping close to the patient experience, such as receiving and analysing information about services and care, analysing these and feeding back messages to the 'brain' and 'conscience' for further action.

What this metaphor offers is an insight into the core governance and accountability function of a PCT. In a market-based NHS, which is what is now being put in place in England, the PCT assumes the role of the conscience of the local health system, and is the organisation that implements and regulates the operation of the local health market. The PCT accounts to local people and government for the priorities set, funding allocations made, services provided, and extent to which health is improved or not. In so doing, the PCT needs to be able to demonstrate that it has held the local health market to account, namely that it has got in place proper mechanisms for ensuring that providers operate regimes of clinical and financial governance, with governance to ensure probity and transparency, and in such a way that 'best value' has been provided in return for public money.

Smith and Mays (2005), Wade et al (2006) and others (e.g. Farrington-Douglas, 2006) have asserted that the stewardship and governance element of commissioning, along with the actual decision-making about funding and services, should remain firmly in the public sector, arguing that a public health system required a public body as the accountable decision maker. Farrington-Douglas (p21) notes:

'Commissioning needs to be public because it needs to be accountable. Many of the core roles of commissioning involve allocating public money and making controversial decisions about entitlement. Commissioning should be a long-term engagement with local people, not a short-term, technically specified contract.'

Clearly, many of the 'rules of the game' for the NHS market will be set and regulated centrally, for example, the Healthcare Commission sets standards for health care providers and carries out inspections to check compliance with those standards. Nevertheless, as part of PCT 'stewardship', local market regulation and management will be required within these national parameters. Indeed, as provision of health care becomes more diverse, so the need for transparent system regulation will become more important, as PCTs are required to demonstrate that their commissioning decisions are delivering care and services that are safe, appropriate, and value for money.

The PCT as assurer of choice

In the context of expanded patient choice, it could be argued that patients themselves will increasingly make procurement decisions about the services they will access, thus reducing the PCT role as a commissioner on behalf of patients. In reality however, many services will remain effectively beyond the reach of direct patient choice (much emergency care and specialised/tertiary care) and hence the PCT will have the role of shaping and then managing the local health market in a way that assures an appropriate degree of patient choice of either specific providers or of modes of care. In this way, the PCT will be designing the local 'menu' of services as set out in the previous section of this report, and subsequently ensuring that these are delivered for local people. Monitor (2005, p11) emphasised the PCT's role as shaper of the

local health market and assurer to quality and cost-effectiveness: 'commissioning must be structured in a way that facilitates access to a range of quality providers. This must be done in an environment that incentivises high performance and financial discipline'.

How far local PCTs will really be able to hold their local health market to account and thus take on the role of the legitimate and sovereign 'NHS Local' that can set priorities, commission services and assure their quality (Wade et al, 2006), remains unknown. As Wade et al (p13) noted: 'The extent to which PCTs and practice based commissioners will be left to manage this market at a local level will depend, largely, on the response of the government to early feedback. It is certainly possible that early high profile market failures, such as a GP practice or a new private provider losing their NHS contract as a result of failing to deliver services to the required specification, could trigger a retreat by politicians, whether due to real failure of the system, or to loss of nerve before 'reformed commissioning' has been given time to take root'.

Real markets have winners and losers – that is the consequence of genuine competition. In an NHS being run on market principles, it will fall to the PCT as local 'steward' of NHS resources and standards to protect patients from the impact of service failures (and/or closures) that result from competition. Only the PCT will be able to act as steward in this way, for practice based commissioners (GPs and their teams) are part of the same local health market that is held to account by the PCT. This underlines the PCT's crucial and complex role in relation to both assuring choice and mitigating service failures.

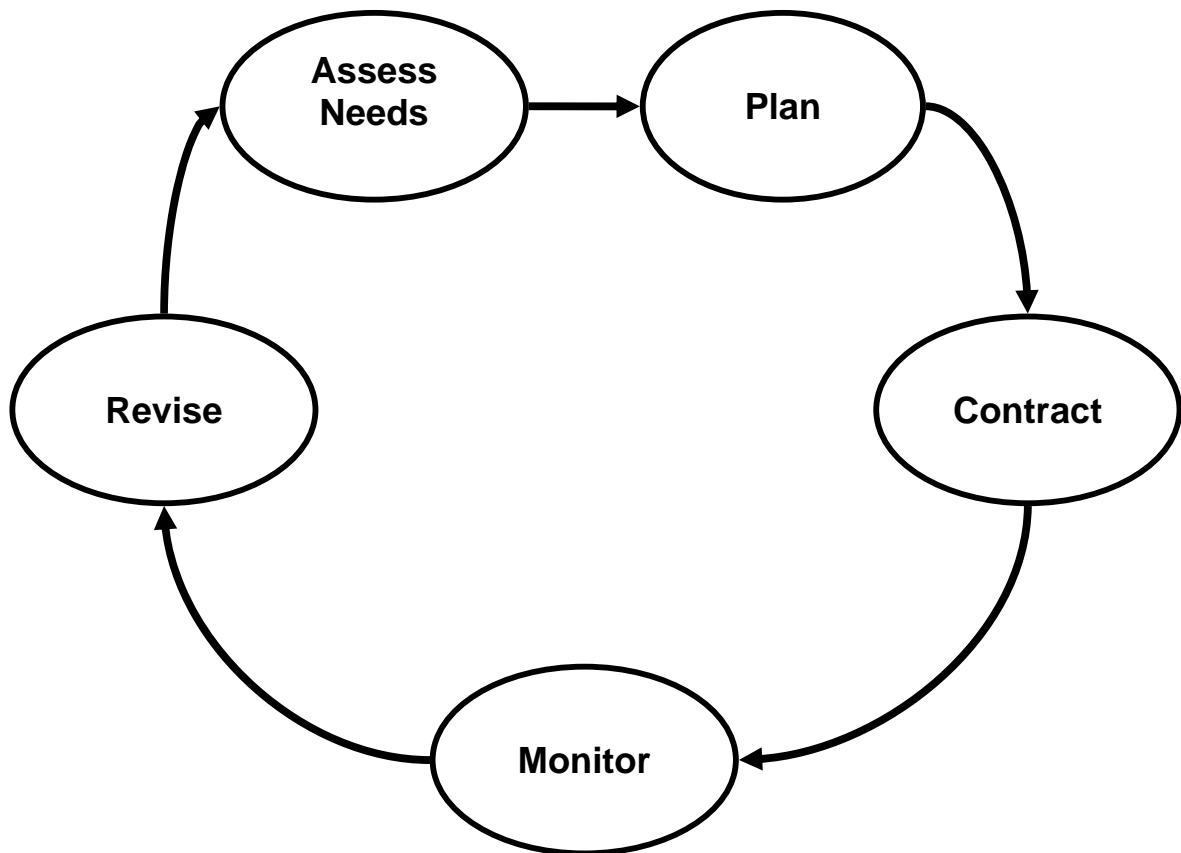
Getting the commissioning basics right

The commissioning cycle originally set out by Ovretveit (1995) has been interpreted for the NHS as set out in figure 4.3.1. This cycle makes it clear that commissioning is not purely a process of needs assessment followed by procurement/contracting, it is also about monitoring of services delivered under contracts, this process of review being the basis for revisions to services, followed by the next round of needs assessment and priority setting. However, what might on the surface appear to be a relatively straightforward process of assessing needs, contracting and review has been found in practice (in publicly funded health systems in particular) to be hard to follow through. The areas of particular difficulty typically seem to be the monitoring of contracts and the response by purchasers to signals given by such monitoring data.

Emerging NHS policy underlines the intention to have a series of 'patient triggers' or 'public petitions', which will require commissioners to review and perhaps put out to tender certain local health services, where they are found to be wanting. However, research evidence about the monitoring and performance management of health contracts in the public sector including social care sounds a clear warning bell about the PCT's role in holding the local health market to account.

Evidence from studies of contracting and purchasing in healthcare reveal a range of difficulties in relation to the effectiveness of contracting as a process for holding providers to account (e.g. Soderland, 1994; Ferlie and McGivern, 2003; Ashton et al, 2004). Woodin (2006) highlights two issues that underpin this lack of effectiveness within the contracting process: information deficits and enforcement issues. She points to the frequent failure of health commissioners in respect of making systematic use of contract monitoring data, inadequacies in contract costing systems, and a lack of attention within contracts as to how risk will be managed.

Figure 4.3.1 The commissioning cycle (Department of Health 2003a)



Until recently, NHS contracts were in fact service level agreements and not contestable in law. This has now changed, with formal legal contracts being used in cases where PCTs purchase services from NHS foundation trusts and primary care services from organisations that do not qualify as 'NHS bodies'. However, international experience of using legally binding contracts within health purchasing is not wholly encouraging in respect of effective monitoring and hence holding the local market to account. An evaluation of the use of contracts in the purchasing of health services in New Zealand (Ashton et al, 2004) concluded:

'Improved information on the use and cost of services, and greater clarity in the specification of services should both enhance accountability. However providers in New Zealand had different opinions about the effectiveness of the performance monitoring processes. Some considered the auditing processes were quite weak, probably because they tended to focus largely on process issues rather than on service outcomes....some providers considered that the quality indicators within the contracts often failed to capture the essence of service quality. Any monitoring of these indicators was therefore an unnecessary and ineffective additional cost. Other providers were more positive, noting the potential contribution that performance monitoring can make towards continuous quality improvement.' (Ashton et al, 2004, pp29-30)

What the Ovretveit cycle ultimately sets out is an approach to health commissioning that is focused on quality and outcomes. Ashton et al refer to the risk of health contracts focusing

unnecessarily upon processes rather than outcomes, and this is an issue widely discussed in the literature. For example, Chappel et al (1999) commented: 'describing the process [of commissioning] is of limited value without measurement of resulting change. One major difficulty is that the ultimate aim – improved patient outcomes, including prevention of disease – is at the end of a cascade of change' (Chappel et al, 1999, p225).

Figueras et al (2005, pp64-66) take a pragmatic approach to this issue in suggesting that health contracting should incorporate a blend of process and outcome targets that can be enforced through regulations, sanctions and/or payment incentives. In this way, they recognise that input and process measures have their place within health contracts, but they call for a move towards a more sophisticated set of measures that also address outcomes. These authors suggest that the three main types of quality requirements for effective contracts are: establishing standards of care; requiring comprehensive quality assurance initiatives; and setting quality targets (process and outcome). Measures and indicators will not of themselves be sufficient. Commentators have called for a greater degree of 'boldness' in NHS commissioning (Smith, Ham and Parker, 2005), a theme that we explored in section 3 (what is commissioning?). An example of 'bold commissioning' is set out in the case study box below.

Case study: Birmingham Own Health, Eastern Birmingham PCT

Eastern Birmingham PCT has commissioned NHS Direct and UK Pfizer Health Solutions to develop a new telephone-based service to support people at high risk of developing complications arising from living with long-term conditions, and for whom supervision of their self-management of care is required. The specification for this service was developed following needs assessment work by the commissioning director and director of public health, along with predictive modeling of likely future morbidity within the local population. The service was put in place on 1 April 2006 and in August 2006 had 785 patients enrolled. A set of detailed metrics has been put in place as a means of monitoring the progress of this new service. These metrics reflect the PCT's commitment to ensure that all commissioned services will have measures that reflect: finance and value for money; activity flows; patient and clinicians' satisfaction; clinical indicators; and organisational benefits. This monitoring includes 'real time' information about the new service, enabling rapid adjustments to be made with the providers as necessary, and providing commissioners with clinically, as well as financially, focused data.

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What this discussion highlights is the complexity of the task facing health commissioners who seek to complete Ovretveit's cycle of commissioning and hence carry out effective monitoring and revision of health services they contract. It is most likely that this very complexity, combined with a lack of commissioning management resource, has led to the general conclusion that NHS commissioning has so far 'failed to deliver' (Walshe et al, 2004; Bramley-Harker and Lewis, 2005).

It can therefore be concluded that in relation to holding the local health market to account, PCTs need first of all to seek to contract in a manner that ensures proper completion of the commissioning cycle. This will entail careful attention to the specification of quality and outcomes indicators, the collection of accurate and validated monitoring data, and the development of robust contract performance review processes that have 'teeth', and where there is both the will and capacity to see through potentially challenging and unpalatable decisions about a failure to achieve contract targets. Unless the process of contracting can achieve this robustness, it will

continue to be regarded by powerful providers as being largely toothless, and not something to be ultimately feared, or worse, open to manipulation.

The answer to this conundrum – how can a PCT successfully hold powerful providers to account through a robust process of contracting – probably lies in the aggregation of key elements of commissioning activity to a supra-PCT level. Recent studies of the organisation of commissioning (Smith et al, 2004; Bramley-Harker and Lewis, 2005; Peck and Freeman, 2005; Wade et al, 2006) have pointed to the importance of PCTs being clear about what commissioning functions they need to aggregate upwards to confederations or networks of PCTs, as well as working out what can be devolved to localities and practices. This need for ‘subsidiarity’ is proposed by Peck and Freeman (2005) as the only workable solution to the eternal tension between economies of scale and appropriate ‘localness’ within the design and function of public organisations.

One example of how a group of PCTs are organising whole elements of their contracting and purchasing activity on a supra-PCT basis is the Greater Manchester Commissioning Business Service (CBS). This is a venture developed jointly by the PCTs in Greater Manchester and that seeks to source, procure and contract-manage quality and cost-effective services on behalf of its ‘member’ PCTs, and hence achieve more effective contracting as a result of economies of scale and concentration of expertise. What is crucial to such approaches is that they are essentially ‘bottom-up’ and owned by the PCTs who remain statutorily accountable for all commissioning activity. In the case of the Greater Manchester CBS, this accountability is a fundamental part of its design and governance and it acts clearly on behalf of PCTs.

To reduce the need for extensive and expensive contract monitoring of providers, an alternative approach is to put greater onus on providers themselves. One model of this is the role of the superintendent pharmacist within corporate bodies supplying community pharmacy services. The existence of a superintendent pharmacist within corporate bodies that provide pharmacy services creates a professional lead who is identified in statute as being the overall accountable person for professional and clinical standards. Similar requirements could be explored for other professional groups within non-NHS providers, as part of an overall consideration about how best to assure standards and monitor performance within a more diverse NHS market. In NHS trust and PCT providers, the chief executive of the organisation is of course the individual who carries formal accountability for clinical governance in the organisation.

What should a PCT do to hold the market to account?

First and foremost, a PCT needs to ensure that the ‘nuts and bolts’ of commissioning are in place, and in particular that it has allocated sufficient resource to the task of specifying contract outcomes and indicators, and measuring progress in relation to those indicators. Even more importantly, it needs to be clear as to what processes it will adopt in reviewing the performance of providers, and how it will take action in response to any concerns about contract performance. This will include the clear identification of how ‘patient triggers’ will be used, ‘public petitions’ responded to, and the point at which re-tendering of services will have to take place where services are deemed to be sub-standard (Department of Health, 2006b). These procedures will need to be discussed and agreed with other local bodies that have a role in regulating and monitoring the health system, for example, local authority overview and scrutiny committees, patient forums, provider trusts, and the strategic health authority (SHA).

The requirement for a stronger outcomes focus in contracting and a ‘bolder’ approach to commissioning, both point to the more general need for a strengthening of capacity and leadership within NHS commissioning. This is a point that has been made in numerous reports and research (Bramley-Harker and Lewis, 2005; Roche, 2004; Lewis and Dixon, 2005; NHS Confederation, 2005; Wade et al, 2006). Strong PCT leadership will be required if PCTs are to hold the local market to account in an effective manner, because in some cases, unpalatable decisions are likely to have to be made about exiting providers (primary and secondary care) from

the local market, or at least exposing their service to external competition through a tendering process. The willingness of government to allow this degree of local contestability and to uphold difficult decisions made at a local level is still open to question. Whilst some PCTs have been able to make and account for potentially unpalatable decisions (such as the placing of a contract for general medical services with United Healthcare in North Eastern Derbyshire), others have found that local decisions have been overturned centrally (as with some of the Department of Health and legal rulings on the funding of Herceptin in local PCTs).

There remains a tension between the government's desire to see market signals drive the distribution of health resources (through a combination of payment by results and patient choice) and the need to ensure that patients have access to a comprehensive range of services. New commissioning guidance from the Department of Health highlights (but does not fully resolve) this tension (Department of Health 2006a). For example, while it is recognised that providers may face incentives to withdraw from services that prove unprofitable, new powers for PCTs are countenanced that would allow them to insist on continued provision where this was in the public interest (these powers already exist for Monitor in relation to the licensing of foundation trusts).

As PCTs develop commissioning strategies and explore the ways in which they will hold the local care market to account (as part of their core role as steward and governor of the local health system), they will need to address the following immediate priorities:

Immediate priorities for PCTs

Ensuring that the 'commissioning basics' are in place, and being clear about which part of the PCT (or its sub-contractors such as practice based commissioners, business support agency) is responsible for which element.

Developing a clear plan for how the performance of a specific sub-set of providers will be reviewed and developed (perhaps the same services as those singled out for in-depth analysis of need and demand), and how the PCT will act on and account for the results of such reviews.

Considering the development of local pilots of service reviews, as a precursor to setting out when the PCT intends to review and do in-depth monitoring of different services.

Devising procedures for how the PCT (with other PCTs as necessary) will handle complex priority setting decisions, learning from the experience of other PCTs nationally. The value of developing such procedures within PCT confederations or consortia is increasingly being noted.

Drawing on experience from other disciplines when developing local approaches to priority setting, including health economics, public consultation, and the law.

4.4 HOLDING COMMISSIONERS TO ACCOUNT

The public accountability of PCTs

PCTs are formally held accountable through their relationship with strategic health authorities and, through strategic health authorities, to the Department of Health. This form of accountability is essentially 'upwards' to central government rather than 'downwards' to the public that they serve. PCTs are governed by appointed boards with a majority of non executive directors that are intended to oversee the activities of the organisation and ensure that the public interest is served. The governance arrangements for PCTs have faced significant criticism over time on the grounds that they are undermined by a 'democratic deficit'.

The local public accountability of PCTs (or lack of) has been brought into relief by the creation of NHS foundation trusts. Foundation trusts are 'owned' by their members who are drawn from the public, staff and, sometimes, patients and carers (Department of Health, 2003b). Members elect governors who, together with a number of appointed governors, have a distinct role to play in the overall governance of the trust (for example, governors appoint and dismiss the chair and non executive directors). This degree of local public accountability on the provider side has emphasised the 'democratic deficit' of PCTs.

However, PCTs have been subject to a range of other forms of accountability mechanisms. PCTs have established Patient and Public Involvement Forums to bring greater coherence to public involvement in commissioning, although these forums are now due to be replaced by Local Involvement Networks (Department of Health, 2006a). The performance of PCTs is also assessed through a canvass of public opinion by Healthcare Commission surveys, and the demonstration of effective public and patient involvement is a core standard for the Healthcare Commission, in its annual Health Check of NHS institutions.

PCTs (and other local NHS bodies) are held to account by overview and scrutiny committees (OSCs) of local authorities, this accountability being part of the local authority's fulfilment of its duty to assure the well-being of the local population. This has brought a degree of local political involvement into the commissioning agenda. Evaluation findings suggest that OSCs are making some contribution to enhanced local accountability (Centre for Public Scrutiny, 2005). For example, 92% of authorities have conducted some sort of health scrutiny in the previous 12 months and 49% of local authority personnel and 45% of NHS personnel questioned felt that the OSC had made an impact.

PCTs have also been involved in partnership governance arrangements with local authorities. NHS bodies were enabled to work more closely with local authorities under the provisions of section 31 of the Health Act 1999. This Act allowed PCTs and local authorities, among other things, to delegate commissioning responsibilities to one lead organisation (Department of Health, 2000). The Local Government Act of 2000 placed a duty on local authorities to set up a Local Strategic Partnership (LSP), drawing together a range of bodies including the NHS in order to create strategies to improve the 'well being' of a local area. Following this, the Health and Social Care Act of 2001 placed a further 'duty of partnership' on PCTs to cooperate with social services departments.

Likely developments in PCT accountability

The white paper on primary and community care has signalled a number of important developments in the accountability of PCTs (Department of Health, 2006b). In particular, the role of OSCs is to be enhanced as will the role of the ward councillor in matters relating to the local health service. In addition, new powers are to be given to local communities to stimulate a 'public petition' – to initiate action by PCTs where the public believe that some or all local services are deficient. Public petitions may initiate national involvement in the commissioning of primary care

if the local response is held to be inadequate. The exact form and powers of such petitions are currently subject to consultation by the Department of Health.

These new initiatives represent a new approach to commissioner accountability; one that is based on giving patients and the public greater 'voice' to go alongside the power of individual patients to have choice. This suggests that the government believes that the right accountability for commissioners will be achieved by blending a number of different approaches: consumer rights for individuals; formal public accountability through 'voice' mechanisms; scrutiny by local elected councillors; and the collection of survey data about patient and public needs.

The accountability of practice based commissioners

However, while attempts have been made to develop the accountability of PCT commissioners, less thought has been given to the public accountability of practice based commissioners (PBCs). At one level, this is because PBCs have only 'indicative' budgets and PCTs retain formal accountability for the actions of PBCs. However, PCTs are encouraged to transfer responsibilities for designing care pathways to practice based commissioners and, if patients are to be involved in the design of care as is directed by legislation (Section 11 of the 2001 Health Act), more sophisticated governance and accountability arrangements will be required for the actual process of commissioning and service design. There is a clear policy intent that patients and the public should play a stronger role in all commissioning activity, including that carried out by practice based commissioners. What is less clear is how practice based commissioners will interpret and enact this particular element of policy.

So far signs are not encouraging. A recent survey has shown that 71% of PCTs with active practice based commissioning in their localities say that there is little or no public involvement in it (NHS Alliance and Developing Patient Partnerships, 2006). This reinforces lessons from the wider literature on primary care led commissioning which repeatedly point to the lack of attention to public and patient involvement in primary care led commissioning (Mays et al, 2001; Dowling and Glendinning, 2003; Smith et al, 2004; Smith and Goodwin, 2006). It has been suggested that new foundation trust style membership arrangements should be applied to practice based commissioning (Lewis et al, 2006) - this would represent a radical departure from the traditionally medically focused governance and management arrangements for primary care led commissioning organisations. Likewise, Wade et al (2006) have pointed to the need for a careful re-think of the role and structure of professional executive committees in PCTs, an issue which is explored in more depth in a policy paper from the NHS Alliance (NHS Alliance, 2006). A final point to note in this regard is that if the assessment of need and demand is a core commissioning function for PCTs (see chapter 4.1), so it has to be for practice based commissioners, and hence they will need to explore the ways in which they can make use of the wider set of data that is illustrated in box 4.1.2.

Immediate priorities for PCTs seeking to ensure that their commissioning operates in a way that is properly accountable are as follows:

Immediate priorities for PCTs

Developing new mechanisms to engage the public and patients in the commissioning agenda for the purposes of greater public accountability, making sure that this encompasses the assessment of need and demand, the holding of the market to account, and formal accountability processes between the PCT and its local population.

Considering how the PCT might focus this renewed attention to public engagement on a few services in the first instance, given the known complexities in developing public involvement and the limited resources available both to commissioners and within communities.

Setting out minimum criteria for public engagement within practice based commissioning as well as offering developmental support to practice based commissioners in this respect.

Considering the development of alternative models for the governance of practice based commissioning, paying particular attention to accountability to the public and the scrutiny and management of conflicts of interest.

5. POLICY FUTURES

In this section, we set out our thoughts about how NHS commissioning might be developed in the future, if it is to become more effective. In mapping out a set of policy futures, we draw on our review of the research evidence and apply our own 'blue sky' thinking.

The current interest in the commissioning function, together with the government's commitment to develop commissioning capacity, suggests that policy and practice may evolve significantly in the medium term. Developments in commissioning may take place in at least two important domains. The first of these relates to the way and degree to which commissioners are held to account (either nationally or locally) for their performance; the second relates to the relationship between PCT level and practice level commissioning. These are considered in turn below.

Holding commissioners to account

The current policy to increase the local autonomy and diversity of the NHS supply side (see section 2) will have a corresponding impact on the relationship between government and commissioners. Governments will in future, assuming supply side policies are completely implemented, have a performance management relationship only with commissioners (and not providers) of care. This implies that national and indeed local health service policy can only be directed through demand side or commissioner control, although providers of care may also seek to shape health service policy for themselves.

To date, the focus of government policy for commissioners has been to restructure and increase the size of PCTs and their predecessor bodies in the hope that this will increase their power relative to providers and to strengthen the rigour with which PCT performance has been monitored (Walshe et al, 2004). The national programme of PCT 'fitness for purpose' reviews represents the most systematic attempt so far to both identify precisely the skills required and tasks to be undertaken by PCTs. A developmental programme is planned to meet skills and competency deficits that may be exposed by the fitness for purpose reviews, and this is supported by conclusions reached in various research reports on commissioning (Smith et al, 2004; Bramley-Harker and Lewis, 2005; Wade et al, 2006).

However, the government has alternative options for strengthening commissioners and holding them to account. As described in chapter 4.1, new attention is now being paid to how the public's needs and demands for healthcare are assessed. Another option is to inculcate greater 'voice' for local consumers and public into the governance of PCTs. While OSCs have powers to monitor and comment on the work of PCTs, OSCs are essentially 'external' mechanisms of local public accountability. New structures to deliver 'internal' and participative local public accountability may also be considered i.e. within the organisational systems of governance and control of the PCT.

A radical approach to increasing 'voice' would be to develop the concept of the 'foundation PCT'. In this model, PCTs would be put under 'social ownership' as an alternative to national control and accountability of PCTs through strategic health authorities and the Department of Health. This is clearly analogous to NHS foundation trusts and similar governance structures could be constructed with independent boards of directors accountable to governors representing public, staff and other stakeholders. The foundation PCT model of course implies a loss of direct control by the Department of Health over commissioning to go alongside the increasing loss of direct control of provision; so far the centre has demonstrated little enthusiasm for such a move.

However, alternative approaches exist whereby local public accountability of PCTs could be strengthened alongside current 'upward' accountability to central government. One option is to elect some or all of the PCT board. This would provide local democratic input but would not

necessarily imply that ties to the Department of Health are broken i.e. the Department of Health could set policy for and performance manage locally elected boards. Indeed, this is precisely the system adopted in New Zealand where a proportion of the membership of district health boards is elected but has a duty of accountability to the Ministry of Health (Ashton et al, 2005). The Scottish Executive is currently consulting on similar plans for health boards in Scotland (The Scottish Parliament, 2006).

Variations of this approach would be to incorporate existing local democratic mechanisms into PCT governance – such as by giving key PCT board roles to local authority elected members (in much the same way as happened with district health authorities prior to 1991). Most extreme would be to pass all or some NHS commissioning responsibilities to local authorities to undertake and to be held accountable for to their electorates, as is the case in countries such as Denmark and Sweden. This is an idea currently subject to increasing debate (Thornton, 2006; Glasby et al, 2006).

The use of greater ‘voice’ and public accountability might also extend to practice based commissioning (an issue that has been recognised by the Department of Health in guidance). Indeed, it might be argued that public engagement might be more successfully engaged at the relatively local level represented by a practice based commissioning ‘cluster’ (a number of practices commissioning collectively). It has been argued that ‘social enterprise’ models might be useful for structuring and holding to account practice based commissioning activities, particularly ‘mutual’ models where overall control over commissioning activities could be shared between public and staff stakeholders. Such a governance model may also help to police the inherent conflicts of interest that exist between the role of a general practitioner as commissioning agent of the patient and as a profit-making service provider (Lewis et al, 2006; Wade et al, 2006).

Whether such arrangements to increase ‘voice’ and local control would result in stronger, more responsive commissioning is a moot point. Nor is it clear that real public accountability would be increased significantly (for example, voter interest in directly elected PCT boards might be low, and there has been mixed experience with the turnout in elections of governors of NHS foundation trusts). However, the example of Kidderminster where local people formed a political party as a way of gaining local political influence over health services (with high levels of turnout at elections and the securing of a number of council seats by the new party) points to the potential interest of local people in voting in an election where there is a direct link to some form of influence over local health planning and management (Raftery and Harris, 2005; Glasby et al, 2006).

A different (and perhaps more radical) set of options could focus on consumer models of accountability to strengthen the commissioning function. This would be achieved through introducing contestability or competition among commissioners. Such an approach is underpinned by the belief that putting commissioners at risk for their performance would lead to better performance and greater responsiveness to the needs and demands of patients. Performance incentives would be driven by the commissioners’ desire to avoid diminishing market share or market exit rather than through the incorporation of consumers and the wider public into the decision making machinery of the PCT.

These market style incentives could be engineered through a contestable process whereby the government lets contracts for the right to commission services to independent commissioning agents. In this model, performance against contract would be the accountability mechanism. Alternatively, a competitive commissioning market could be developed whereby patients exercised a choice of commissioner based on the quality of the benefits package offered. This latter situation is similar to that which operates in Germany where citizens are able to choose from among competing ‘sickness funds’ which are responsible for commissioning care.

Already, NHS patients in England are (in theory – Department of Health, 2006b) able to choose their practice based commissioner through their selection of general practitioner, although very few people would ever make a choice of GP on this basis – for almost all the population, the concept of practice based commissioning must surely still remain a mystery. However, the growth of practice based commissioning clusters, often on a geographical basis, suggests that choice may well be highly constrained and that commissioning monopolies are rapidly developing.

As with the reforms described above to increase ‘voice’, it is by no means certain that greater competition will increase commissioning effectiveness. Patients may not exercise choice, monopolies may persist (although these could be regulated) or choice may not be sufficient to drive up commissioning quality.

PCT-practice based commissioning relationships

Current guidance relating to practice based commissioning makes it clear that PCTs remain ultimately responsible for the use of commissioning resources and that any commissioning budget used by practice based commissioners remains ‘indicative’. In addition, PCTs retain responsibility for procuring care (i.e. arranging for purchase) albeit acting in accordance with the wishes of practices and for reaching collaborative agreements with local authorities. Practice based commissioners must ensure that their commissioning activities are consistent with the strategic direction set down by the PCT. As a consequence of these complex relationships, there is a degree of ambiguity over rights and responsibilities in the commissioning process. Furthermore, with significant deficits pertaining in many PCTs it is unclear how practice based commissioning financial incentives will be maintained i.e. if the PCT as a whole is overspent can it hold good on any promise to make resources available to any practice based commissioner, whether or not they individually have delivered savings?

The practice based commissioning scheme is not the only way to deliver incentives to practices to manage demand within finite resources. Contractual forms such as Alternative Provider Medical Services (APMS), Specialist Personal Medical Services (SPMS), and Personal Medical Services Plus (PMS Plus) all allow a wide range of existing and new primary care contractors, including those from the private sector, to agree contracts with PCTs to provide services over and above ‘standard’ general practice services. While these contracts are concerned with service provision, they allow the providers to take financial and service responsibility for a wide range of services, some of which they may deliver themselves and other which they may sub-contract to others. Thus, the contract to provide can also imply a commissioning role.

Moreover, the financial incentives under such contract arrangements are potentially far more powerful than under practice based commissioning. Budgets that are agreed are real not ‘indicative’, as are any savings or deficits that result. Under these circumstances, providers are free to use savings as they wish, subject to any specific contract terms that might be agreed, and are not tied to a reinvestment into services as they are under practice based commissioning.

One option for primary care contractors is to take responsibility for contracts to provide hospital care alongside primary care. Such providers may choose to augment their teams to include specialists, thereby reducing their need to refer on to an alternative provider, or to sub-contract care to hospitals or other specialist providers. This creates incentives similar to those in managed care organisations in the United States where multi-specialty group practices are more common than in the UK (Weiner et al, 2002). One example of this approach to commissioning is provided by Epsom Downs Integrated Care Services where a group of 16 practices have contracted to provide outpatient services for their population with a contract value of £6.8M (representing a substantial saving against historical activity levels costed at the standard NHS hospital tariff).

An alternative policy route would be to give providers of general practice services a single capitated sum per patient that covers all or most healthcare needs, i.e. PCT funding will be directly transferred to practice level commissioners. In theory, this could create a system whereby practice level commissioners will face real risk (and reward) and will have the freedom to shift resources to whatever care setting offers the best service and meets patients' choices. However this is close to the GP fundholding model that had its own flaws, not least a potential to increase health inequalities. Given the financial risks, it is likely that the scale of commissioning operation will need to increase through the development of new coalitions and partnerships between primary care contractors and/or the creation of joint ventures with other organisations in the private or social enterprise sector.

6. CONCLUSION

This research-based policy analysis was funded in order to stimulate further national and local debate about the future of commissioning policy in the NHS in England and to support partner organisations in the Forum in their thinking and discussions about the future of health policy.

As we noted at the start of this report, commissioning will only be 'effective' in the eyes of politicians and the public if commissioners are able to get a grip on the financial situation currently facing the NHS, and hence create some 'slack' for more creative activities and service development. The experience of social care purchasing indicates that financial considerations are highly likely (if not properly managed) to overwhelm any desire for more patient-focused commissioning and market development.

In carrying out this research, we have striven to produce a piece of policy analysis that can be useful to PCT boards as they seek to establish commissioning arrangements that are 'robust', 'strong', 'effective', 'fit for purpose' or any one of the terms that are being used to describe what is sought of these new bodies. Great hope is once again being placed in the ability of NHS purchasing in respect of being able to bring demand for services in balance with available resources.

We have focused our review of the literature on distilling four key commissioning activities for new PCTs (identifying need and demand, market shaping, holding the market to account, and holding commissioners to account). For each of these, we have suggested immediate priorities for PCTs to address. The composite list of these priorities is set out in box 6.1.

What this set of priorities indicates is that NHS commissioning faces a mammoth task in the face of significant expectations and public and political pressure. There are clearly new levers to be exploited by commissioners (the potential offered by payment by results, the policy of patient choice, the emergence of new alternative providers, and practice based commissioning), but these will only be able to bear fruit if key challenges are tackled. These are not new challenges; they are ones that have been repeatedly documented in the research and policy analysis literature.

Of particular note are the need for: increased investment in developing commissioning capacity, particularly in relation to the new commissioning tasks identified in this paper; sophisticated leadership skills and an organisational culture that enable courageous purchasing and market management; political support that enables PCTs to make and uphold local decisions in accordance with local, as well as national, priorities; and a blend of incentives that enables clinicians and new service providers and market entrants to redesign services in line with the needs and demands identified through commissioning.

The uncomfortable question that this review poses to the NHS is: will it really be different this time, and if so why and how? To a large extent, PCTs will employ the same people as before (such is the pattern with NHS reorganisations) and the time and resource for significant training and development is unlikely to come on stream quickly. PCTs will spend many months recovering from this latest phase of structural change, and research evidence confirms that such reorganisations have a detrimental effect on service development and staff morale, and that effective leadership and human resource management is needed over a period of years if the promised benefits of reorganisation (in this case stronger commissioning) are to be even partly realised (Dickinson et al, 2006).

More positively, recent guidance from the Department of Health has articulated more clearly how commissioners might adopt more proactive 'demand management' techniques, has begun to clarify rules that should govern commissioner-provider relations in the future and has signalled that the commissioning function is to be more valued in future (Department of Health, 2006a). Furthermore, there is a need for some pragmatism within discussions about the role of commissioning in a publicly funded system such as the NHS – providers will, often very properly, drive service innovation and improvement, so it is not just a question of having 'stronger' commissioning, but 'intelligent' commissioning that can take full account of both public user and (where appropriate) provider views.

There is a pressing need for extensive support and development to be provided to NHS commissioners within new PCTs, along with local and national political backing, and a valuing of commissioners as members of a crucial health profession. Indeed, programmes to provide such support and development are currently being commissioned by the Department of Health. For new PCT boards, establishing and developing the commissioning team, and agreeing a clear commissioning strategy that addresses the immediate priorities set out in this paper, is probably their most important task.

Given the less than encouraging history of NHS commissioning, it is likely that new PCTs have at most three years to prove that they can commission in an effective manner. Thus they will have to 'hit the ground running' and quickly establish themselves as single PCT and collaborative commissioners.

If the new commissioning framework and reconfigured PCTs do not deliver the hoped for financial control and service changes in the NHS, by 2008-09, the government will start looking hard at some of the more radical scenarios set out in section 5. On the basis of research evidence about NHS commissioning and reorganisation, policy makers, managers and clinicians would be wise to start exploring some of the potential implications of these more radical scenarios sooner rather than later. Foundation status for PCTs (Health Service Journal, 2006) and the contracting out of elements of commissioning are just two scenarios currently being aired in the press, suggesting that more radical commissioning futures may be closer than we think.

Box 6.1: immediate commissioning priorities for PCTs

Identifying need and demand

Map existing approaches to needs assessment and the surveying of demand in the PCT area for a few discrete services that encompass a wide range of service provision both within and beyond the NHS (for example, long-term conditions, first contact care for minor conditions, emergency admissions to hospital) and identify gaps within this process of data collection and analysis.

Develop a clear strategy for the assessment of both need and demand for a set of the services mentioned above, demonstrating a range of techniques that will be used, and including sources from beyond the PCT. Consider piloting a few new approaches to the assessment of need and demand, perhaps within the context of sharing that learning with other neighbouring PCTs.

Market shaping

Develop a transparent procurement framework that sets out how all benefits (financial and non financial benefits) will be valued in the procurement process.

Agree local rules for competition management in the commissioning of (particularly primary, community and intermediate) care. Rules should define anti-competitive behaviours and acceptable market penetration by single providers.

Map the potential health market (and providers) for key local services such as those related to care for people with long-term conditions and first contact care. Set up systems to communicate effectively with these providers.

Holding the market to account

Ensure that the 'commissioning basics' are in place, and be clear about which part of the organisation (or its sub-contractors) is responsible for which element.

Develop a clear plan for how the performance of providers or a specific sub-set of providers will be reviewed (perhaps the same services as those singled out for in-depth analysis of need and demand), and how the PCT will act on and account for the results of such reviews.

Devise procedures for how the PCT (with other PCTs as necessary) will handle complex priority setting decisions, learning from the experience of other PCTs nationally. Draw on experience from other disciplines when developing these approaches, including health economics, public consultation, and the law.

Holding commissioners to account

Develop new mechanisms to engage the public and patients in the commissioning agenda for the purposes of greater public accountability, making sure that this encompasses the assessment of need and demand, the holding of the market to account, and formal accountability processes between the PCT and its local population.

Consider how the PCT might focus this renewed attention to public engagement on a few services in the first instance, given the known complexities in developing public involvement and the limited resources available both to commissioners and within communities.

Set out minimum criteria for public engagement within practice based commissioning as well as offering developmental support to practice based commissioners in this respect.

Consider the development of alternative models for the governance of practice based commissioning, paying particular attention to accountability to the public and the scrutiny and management of conflicts of interest.

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APPENDIX: Project interviewees

Penny Banks	Head of Information and Reporting	Commission for Social Care Inspection
Will Blandamer	Director for Health Improvement	Greater Manchester Association of PCTs
Alastair Buxton	Head of NHS Services	Pharmaceutical Services Negotiating Committee
Dominic Conlin	Director of Commissioning	Croydon PCT
Georgina Craig	Head of Communications and Partnership Development	Company Chemists' Association
Gareth Cruddace	Programme Director: Primary Care Trust – Diagnostic and Development	Department of Health
Andrew Donald	Director of Policy and Redesign	Eastern Birmingham PCT
Stephen Fishwick	Head of NHS Service Development	National Pharmacy Association
Christine Gray	Head of Corporate Governance	Royal Pharmaceutical Society of Great Britain
Michael Hughes	Associate Professor and Director	Institute of Local Government Studies University of Birmingham
Mark Hunt	GP	Frome, Somerset
Anthony Kealy	Policy Lead: Policy and Strategy Directorate Commissioning Team	Department of Health
Jeanette McMillan	Director of Clinical Operations	Mercury Health
Jonathan Marron	Head of Commissioning	Department of Health
Eileen Neilson	Head of Policy Development	Royal Pharmaceutical Society of Great Britain
Tim Richardson	GP	Epsom, Surrey



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Judith Smith

Judith Smith is Senior Lecturer and Director of Research at the Health Services Management Centre at the University of Birmingham, with 12 years' experience of health services research and development. She has extensive experience of undertaking major policy-relevant research projects, including a three-year study of primary care organisations in the NHS published in a recent book (Smith and Goodwin, 2006), a review of the evidence on primary care-led commissioning (Smith et al, 2004) and an analysis of emerging NHS commissioning policy (Wade et al, 2006). Judith teaches and presents regularly in the UK and overseas and holds visiting fellowships in the School of Government at the Victoria University Wellington and in the Australian Primary Health Care Research Institute in Canberra.

Richard Lewis

Richard Lewis is Acting Director of Health Policy at the King's Fund, where he carries out policy analysis and research. Richard's special interests include commissioning, foundation trusts, primary care and the potential role of social enterprises in health care. He has evaluated the current government's performance on the NHS and led an independent 'audit' into the NHS. Richard is also an independent health care consultant who works with NHS organisations across the country. He joined the NHS through the national graduate management scheme and has worked at all levels in the NHS, most recently spending several years as an executive director of a large health authority in London.

Tony Harrison

Tony Harrison is a senior fellow in policy at the King's Fund. His special interests include the funding of the NHS, waiting list policy, the funding of research and development in both the public and private sector and public policy towards the pharmaceutical industry. He also works as an independent consultant for national and local health organisations covering topics such as professional regulation and the configuration of health care services. He spent four years as a non-executive director of an NHS trust.

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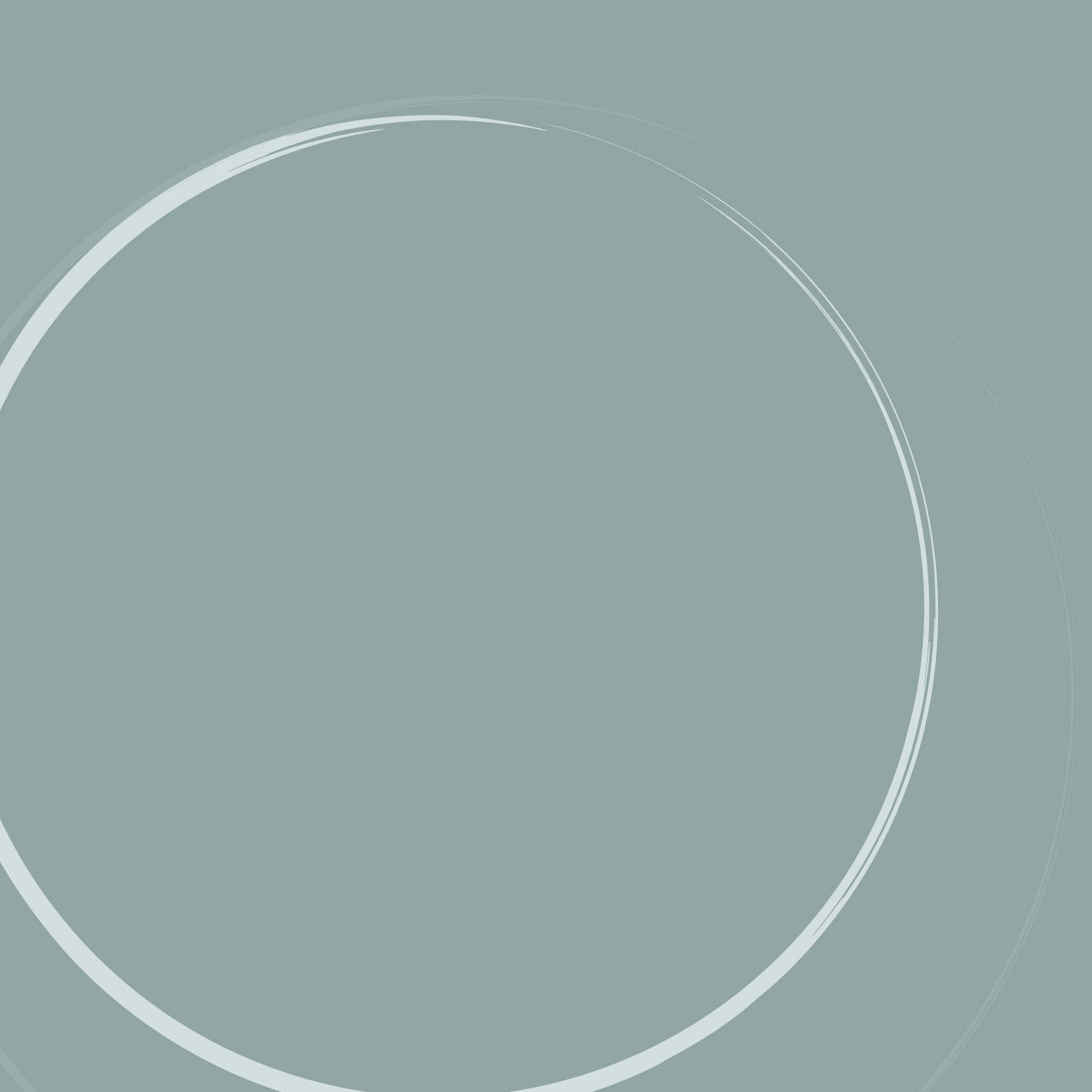
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