

Quality improvement science

Commissioning for quality improvement

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ABSTRACT

This is the fifth in a series of articles about the science of quality improvement. We examine the nature of healthcare commissioning and its role as a driver for quality improvement. We draw on evidence from previous forms of primary-care-led commissioning (PCLC) and consider how the quality of care might be improved through the processes of commissioning.

Keywords: commissioning, general practice, primary care, quality improvement

Introduction

The concept of healthcare commissioning has attracted widespread public and professional attention since the Coalition government’s reforming White Paper *Equity and Excellence: liberating the NHS* was published in 2010.¹ These proposals were revised and subsequently formalised in the Health and Social Care Act 2012 which focused on creating a clinician-led commissioning system that is sensitive to the needs of patients.²

In this article, we examine the nature of commissioning and its history, particularly in relation to commissioning as a driver for quality improvement. We then draw on evidence relating to previous forms of primary care-led commissioning (PCLC) and apply it to the establishment of clinical commissioning groups (CCGs). What does history suggest is needed for these new practice groupings to improve the quality of care through the processes of commissioning?

managed by government), the roles of planning and procuring care were formally separated from that of provision. It is the role of commissioners to secure, rather than directly provide, services that meet the needs of the populations for whose health they are responsible. There are four main steps involved in commissioning healthcare, often referred to as the commissioning ‘cycle’ (Box 1), each of which provides opportunities for quality improvement.

An assessment of need is essential to determine health inequalities and patients’ unmet needs so that services can be targeted appropriately. Joint Strategic Needs Assessments will help to identify local health needs, and commissioners need to identify inadequacies in service provision, cost, geographical distribution and quality when planning services and setting priorities.

What is commissioning?

The term ‘commissioning’ emerged from the creation of an NHS ‘quasi-market’ as part of the Conservative reforms of 1990.³ Within this quasi-market (‘quasi’ because operations of this market were closely

Box 1 Four stages of the commissioning cycle

1. Assessment of need.
2. Setting priorities.
3. Contracting with providers.
4. Monitoring and reviewing service delivery.

Services may be designed or redesigned to meet the identified healthcare needs of the population, and contracting with providers is the process by which existing arrangements may be renegotiated, or new contracts procured which can directly affect the quality of care provided. This stage of the commissioning cycle may involve 'any willing provider' mechanisms, or a tendering process.

Monitoring and reviewing service delivery is the final stage of the cycle. Commissioners require accurate and timely information on the use and costs of services, and quality of care to assist them in making informed decisions about future commissioning arrangements, and to ensure that they do not overspend and that quality is ensured or improved.

Thus, commissioners are responsible for discriminating between providers to maximise value, seeking to influence providers in terms not just of price but of service quality.

The rise of 'primary care commissioning'

Since the 1990s, commissioning responsibilities have been divided between formal NHS agencies operating on behalf of large populations (often in the region of 200 000–500 000 people) and general practices acting alone or in groups. This latter form of commissioning (primary care-led) built on the role of the general practitioner (GP) as the 'gatekeeper' to hospital services. Because the clinical decisions made by GPs (e.g. referrals, prescribing decisions) determine how resources are utilised, it was a natural step to align formal commissioning and budgetary responsibilities with those clinical responsibilities.

The 1990 reforms introduced GP fundholding as the first example of this type of PCLC. This initiative offered GPs financial incentives to reduce unnecessary utilisation of care, promote new community based services, negotiate lower prices and improve quality, for example, through faster access to hospital treatment. GP fundholders were legally autonomous commissioners with real budgets for a limited range of services. Although there were modest successes with fundholding, most initiatives focused on small-scale new services, and many GPs lacked the skills and desire to take a population-based approach to planning.⁴ Critics of fundholding argued that the system was unfair, generated inherent conflicts of interest, involved high transaction costs and fragmented the profession.⁵

Fundholding was abolished under the Labour government of 1997, and by 2002 primary care trusts (PCTs) had been introduced that included the practices in a defined geographical area and averaged

170 000 people in size. Practice-based commissioning (PBC) was an initiative launched in 2005 with the aim of improving GP engagement in the process, providing better resources for patients and using resources more effectively. It was designed to place commissioning powers in the hands of GPs, with 'notional' budgets held by the PCTs. Recent analyses of PBC initiatives have revealed that many GP commissioners focused on small-scale local pilots providing hospital services in community settings, and few took an interest in the redesigning of existing services or wider commissioning activities.⁶ It was evident that PBC seemed restricted to a small group of enthusiastic GPs in each PCT, and although there was widespread support of the initiative, this did not translate into active engagement. Conflicts of interest arose from the opportunity for GPs to be both providers and commissioners of their own service (thus subverting patient choice) and from the opportunity for PCTs to favour the services they themselves provided rather than tendering competitively for services commissioned under PBC.⁶

The future of healthcare commissioning

Under the Health and Social Care Act 2012, power and responsibility for commissioning was devolved to GPs in CCGs in order to shift decision making as close as possible to individual patients.² All GP practices belong to a CCG, established as statutory bodies with responsibility for commissioning some £60 billion worth of healthcare services in April 2013. Each CCG has an accountable officer and a chief financial officer, and each member practice shares accountability for delivering local commissioning decisions. For CCGs to function effectively, member practices need to agree shared objectives, membership criteria, a policy for information-sharing, a dispute-resolution process and formalised practice responsibilities.

The NHS Commissioning Board (which became a statutory body in April 2013 and operates as NHS England) is the interface between the government and healthcare spending. It has the role of setting and managing budgets for CCGs, providing clear national standards, supporting the development of CCGs, and holding them accountable for commissioning contracts. Certain specialist services, such as transplantation and maternity care, together with dentistry, pharmacy and general practice continue to be commissioned by the NHS Commissioning Board on a regional or national level. In addition, the NHS Commissioning Board supports CCGs by hosting clinical networks and senates, bringing together experts on certain diseases and

service areas (such as cancer or maternity services) to help inform their commissioning decisions.

CCGs have taken shape in the face of severe financial stringencies, tasked to help deliver the government's 4% efficiency target each year until 2015. Their particular challenge is to reduce the inexorable rise in emergency admissions and better meet the needs of frail older people with multiple conditions. To this end, the NHS Quality Framework incorporates relevant targets. The CCG Outcomes Indicators Set is intended to provide clear, comparative information – for patients, public and CCGs themselves – about the quality of services commissioned and associated health outcomes (Box 2).⁷

What impact has commissioning had on health services?

The different forms of PCLC discussed above have given rise to a canon of research literature, with sometimes inconsistent messages. The impact of PCLC in the past gives some indication of the likely impact of practice-based commissioning in the future.⁷

In their comprehensive review of the published evidence, Smith *et al* concluded starkly that 'there is little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services'.⁶ Given that the main policy objective of commissioning is to shape health systems around the needs of patients and, in particular, to shift funding from hospitals into the community, this is a disappointment.

Research suggests that PCLC can both reduce demand for hospital services and induce greater responsiveness from hospitals when patients are referred.⁸ However, it is outside the hospital domain that PCLC has proved most effective, with consistent evidence of the development of new services in primary and intermediate care, reductions in the costs of prescribing and new forms of quality assessment in primary care.⁵

PCLC also appears to have delivered benefits in terms of some aspects of improved service quality and reductions in costs. Yet are these benefits enough to justify continued faith in this approach to commissioning? As Smith and colleagues point out, fundholders' reductions in waiting times of around 5% look modest when compared with far greater reductions achieved across the NHS subsequently through the stringent regime of national targets.⁶

Moreover, PCLC also resulted in some negative outcomes that must be set against any benefits. That GP fundholding and total purchasing pilots resulted in service and quality inequities is generally accepted – and was inevitable given that both schemes delivered benefits that were not universal. Moreover, this was partly due to fundholding tending to attract well-organised practices from better off parts of the country, with inner-city practices particularly under-represented.⁴

Realising the benefits of PCLC

The evidence suggests that previous models of PCLC faced a number of common challenges that held back their development. These included organisational instability, clinical disengagement, insufficient management capacity and a lack of timely and accurate information on which to base their commissioning decisions.⁹ The relatively modest impact of commissioners in the past might be significantly increased if support for PCLC is improved. What is required for CCGs to commission more successfully?

Clinical engagement

Perhaps the most fundamental impediment to PCLC is the limited involvement of clinicians. Direct involvement in decisions about resource allocation places the GP in the role of rationer, a task with which many GPs feel uncomfortable because it conflicts with

Box 2 Factors likely to increase the effectiveness of commissioning

- Strong, skilled leadership.
- Organisational stability.
- A blend of incentives, financial and non-financial, to promote clinical engagement.
- Access to high-quality, up-to-date information at the practice level to evaluate and inform commissioning decisions.
- Worthwhile in-service training opportunities for those leading CCGs.
- Even distribution of the managerial resources required to underpin commissioning.
- Tried and tested mechanisms of public accountability.

their preferred role as their patient's advocate.¹⁰ Moreover, patients may be less willing to accept the advice that they do need treatment or referral if they believe the GP's decision is influenced by budgetary considerations. Engendering collective responsibility among all practitioners for staying within budget or adhering to prescribing and referral protocols will prove difficult. The extent to which they will share a commitment to the needs of the locality as opposed to those of their own practice will crucially affect the development of PCLC.

Valid information and evidence

Much of the data used to assess health needs are based on electoral wards, i.e. geographical boundaries rather than practice boundaries. Practice boundaries do not necessarily fit into 'natural' communities, nor are they coterminous with local authority boundaries used by social services and other agencies. Co-ordination of information sources can be especially difficult in urban areas where practice selection effects operate more powerfully. Technical obstacles such as the difficulties of controlling for case-mix are not easily resolved.

There appears to be no 'ideal' size for a commissioning organisation. Different population bases are needed for commissioning different services and there is little compelling evidence suggesting that bigger is necessarily better.¹¹

Just as evidence-based clinical practice applies the judicious use of the best evidence available when making decisions for individual patients, evidence-based commissioning implies the consistent use of evidence when planning populations' health services. The Quality Innovation Productivity Prevention (QIPP) initiative models good practice but does not necessarily provide robust evidence on which to base purchasing decisions.

Managerial expertise

Effective purchasing for quality in its widest sense requires a wide range of skills, including needs assessment, contracting, performance monitoring, accounting and budget management. Beyond an understanding of the processes of commissioning, some specialist knowledge is required to make strategically coherent purchasing decisions. CCGs will require support in developing a range of skills such as the stratification of patients according to risk, advanced case management, predictive modelling of 'high user' patients, handling and analysis of routine data, and more

refined assessment of service quality and outcomes.⁹ These competencies are in short supply in CCGs.

Equity and public health

It remains to be seen whether GPs and practice staff working in 'difficult' areas will have the time or the inclination to get involved in PCLC and whether the scheme will help to improve services in disadvantaged areas. CCGs in more deprived areas may struggle to defy the 'inverse care law' in which poorer quality services are associated with socioeconomic deprivation whether at individual or population level.¹² CCGs include practices at different levels of development and quality. Practices with low inappropriate referral rates or efficient prescribing policies may be unwilling to share risk with practices perceived as less developed. However, closer working between more- and less-developed practices has most potential to raise the quality of primary care in a locality.

Preventive activities risk being ignored if PCLC focuses largely on secondary care. CCGs are represented on health and wellbeing boards which plan services upstream of hospitals. In theory, practice level budgets provide a motivating 'business case' for health promotion and disease prevention.¹³ However, public health may lack for champions within CCGs. Health and wellbeing boards have yet to demonstrate their impact.¹⁴

Meaningful public involvement

A commonly stated advantage of involving GPs in the commissioning process is that they are closer to patients and therefore can help to ensure that plans take account of patients' needs and preferences.⁷ The assumption that GPs' views and priorities are congruent with their patients' needs has not been tested. It will be important to monitor how CCGs make themselves accountable to the people on whose behalf they are securing services.

Conclusion

These developments represent a continuing evolution of previous commissioning initiatives, but CCGs exist in a different world to those of their predecessors. Since 2010, the government has introduced further market-oriented reforms designed to intensify com-

Box 3 CCGOIS 2013/14 – overarching indicators:

Potential years of life lost from causes considered amenable to health care: adults, children and young people
 Health-related quality of life for people with long-term conditions
 Emergency admissions for acute conditions that should not usually require hospital admission
 Emergency readmissions within 30 days of discharge from hospital
 Patient experience of GP out-of-hours services
 Patient experience of hospital care
 Friends and family test for acute inpatient care and A&E
 Patient safety incidents reported

petition among providers, embrace the private sector and provide more rights for patients to choose where they receive treatment. The focus of commissioning is now on the creation and shaping of markets as much as on the allocation of resources directly to providers. Opponents of these reforms warn of wholesale privatisation within the NHS; markets may drive down costs but could drive down quality also. The government's regulations on competition in the NHS remain ambiguous.¹⁵

CCGs exercise influence over their constituent practices but have limited responsibilities for the commissioning of primary care. Levelling up the quality of services provided at the front line would surely be their greatest legacy in terms of population health.

The past is not always a faithful guide to the future but previous experience is illuminating.¹⁶ The new NHS environment may, in certain respects, be more conducive to effective commissioning but the historical limitations to PCLC are likely to recur. Many challenges will need to be overcome if CCGs are to survive for longer than their predecessors and contribute effectively to improving the quality of health-care (Box 3).

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PEER REVIEW

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CONFLICTS OF INTEREST

None declared.

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