

Understanding the new commissioning system in England:

Executive Summary

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Introduction and background

Healthcare commissioning is the process by which population needs are assessed, and appropriate health care is purchased to meet those needs from organisations providing care. Introduced in the NHS in 1990, this separation between the roles of planning and purchasing care on the one hand and providing care on the other, is claimed to support an effective and efficient health system. In 2012 there was a significant reorganisation of the NHS in England (enacted in the Health and Social care Act 2012 (HSCA12)), with the abolition of some organisations, the creation of others and a significant redistribution of responsibilities for commissioning different types of healthcare. The changes were comprehensive, affecting most types of organisation in the NHS. Not only was there a wider variety of types of organisation in the new system, but also responsibilities for commissioning some types of services were divided between a number of different organisations. Prior to the HSCA12, organisations known as Primary Care Trusts (PCTs) were responsible for commissioning most types of healthcare. After the HSCA12, different organisations assumed responsibility for different types of care. For example, responsibility for public health services was transferred to Local Authorities (LAs), whilst responsibility for commissioning care for rare diseases ('specialised services') was transferred to the new national body, NHS England (NHSE). PCTs were replaced by new commissioning organisations known as Clinical Commissioning Groups (CCGs). These were constituted as 'membership organisations', with the membership consisting of local general practices (family doctor groups). These changes (and other aspects of the reorganisation) were intended to: give front line NHS clinicians more freedom and a greater role in commissioning; increase the efficiency of the NHS by promoting greater competition between providers; focus commissioning activity upon achieving particular outcomes rather than on counting activity; create a new Arm's Length Body (NHS England) to oversee the running of the NHS; and to transfer responsibility for public health to

elected Local Authorities. In order to investigate the impact of the changes in respect of commissioning, we undertook a three year study using qualitative and quantitative methods to explore how the new commissioning system was functioning.

Study aims, objectives and research questions

This research aimed to assess the impact of the reforms on the operation and outcomes of the commissioning system. We aimed to explore:

- i. The new system at local level, investigating how the new organisations were developing, assuming their responsibilities, interacting, holding one another to account, and relating to new national-level bodies.
- ii. The main effects of the new system, seeking to demonstrate the changes that may be associated with elements of this system, as well as explicating factors which may have enabled or inhibited these changes.

In order to meet these aims, we addressed the following research questions:

1) Understanding system complexity:

- a) How are the different organisations managing their new roles and responsibilities in practice, and how are they dealing with areas of overlap and omission?
- b) What are the mechanisms by which the different parts of the health and care system are working together locally and how are they interacting with national level bodies?
- c) To what extent do local actors perceive themselves to be autonomous?
- d) To whom do they feel accountable?
- e) What is the performance regime being applied, and what is its impact?

2) The conduct of commissioning:

- a) What were the drivers for the service changes being made?
- b) What is the effect on commissioning processes of the division of commissioning responsibilities in new ways between new organisations?
- c) How are commissioners responding to the need to ensure better integration of services?
- d) How is external commissioning support being used, and what is the impact of this?
- e) What is the effect of 'commissioning for outcomes' on the commissioning process?
- f) How far is the new system enabling/inhibiting service change and development?

3) Quality & outcomes:

- a) What claims to 'success' are made by actors in each different organisation, and what evidence is there to back up these claims?
- b) What does each organisation/group of organisations claim as its main 'outcomes' and how are the new 'outcomes frameworks' operating?
- c) How have quantitative outcomes changed in the new system, and what explanatory factors can be identified?
- d) Are any aspects of the new commissioning arrangements associated with improvements in quality, reductions in health inequalities and improvements in factors which affect overall system efficiency?

Methods

The study was underpinned by a realist theoretical framework, in which the initial intentions and assumptions underlying the legislation (known as 'programme theories') were ascertained from publicly available policy documents. These assumptions were then tested against the reality of the implementation of the Act, with careful exploration of the local factors which influenced what happened. The case studies took place in two local areas of England. These were large geographical

areas, allowing us to study the interactions between all of the different commissioning organisations and between commissioners and providers. The study included four inter-related work streams:

Workstream 1

The aim of this work stream was to understand how the new organisations in a geographical area were building relationships and approaching their new responsibilities. We conducted interviews with a range of individuals working in all of the organisations with significant responsibilities relating to commissioning in each of the AT areas. These included: CCGs; CSUs; the AT; and Local Authority commissioners. Interviews focused upon experiences since the implementation of the new system, including their interactions with other organisations and the performance management regime to which they were subject.

Workstream 2

This workstream explored commissioning in more detail, through the medium of 'tracer' service areas. These included:

- Sexual health – in order to explore services where commissioning responsibilities were widely dispersed between organisations
- Dementia – in order to explore services where integration with the Local Authority was required
- Orthopaedics – in order to explore a service area in which there had been little change to commissioning responsibilities
- Specialised services - in order to explore the commissioning of services by the new national body, NHS England
- Screening services – in order to explore a complex commissioning area

Interviews with both commissioners and providers, and observation of some commissioner meetings were used to explore in detail how commissioning was conducted in the new system

Workstream 3

In this workstream outcomes were explored both qualitatively and quantitatively. For the qualitative interviews, respondents were asked to reflect upon the ways in which they felt they had been successful. We then sought to measure the impact of the changes. Firstly, we explored an issue which had arisen in the interviews – cervical screening – using a difference-in-differences approach to test if areas more affected by the changes to commissioning had suffered a greater decline in uptake than those less affected. We then expanded this analysis to explore a wide range of potential outcomes. We created three different measures of what we call 'dose of reform'. These are elements of the reforms which affect some areas more than others. Our three measures included: the extent to which new commissioning organisations had different boundaries and membership than the previous organisations; the extent to which clinicians were involved in senior leadership in commissioning organisations; and the number of Local Authorities with which commissioning organisations were required to interact. We then tested these measures against a range of outcomes derived from administrative data sets, including: measures of hospital activity; patient experience measures; and aspects of primary care quality. We used a continuous difference-in-differences approach to account for differences in outcomes that pre-dated the policy reform.

Workstream 4

In this workstream we combined the findings from the other three workstreams to generate an over-arching narrative about the impacts of the HSCA12 on the commissioning system.

In total across all of the workstreams we carried out 143 interviews, with individuals from a broad range of commissioning backgrounds, including CCGs, Local Authorities and NHS England. In addition

we interviewed staff from Public Health England and selected provider organisations. We also observed a number of meetings relevant to commissioning.

Findings

Commissioning system complexity

We found that the new system was considerably more complicated than what had gone before. In particular, we found that splitting responsibility for commissioning some types of service between multiple commissioners had led to considerable difficulties in coordination, often referred to in our interviews as ‘fragmentation’. This was particularly evident for services for a particular condition that ranged from preventive services, through locally commissioned NHS services to more specialised services. Examples include services for HIV, child mental health, and obesity. The new system divided responsibility for commissioning parts of these services between a variety of commissioners, and this had led to problems, with potential gaps in service provision.

We also found that the local commissioning landscape had become increasingly complicated, with a proliferation of new local organisations with which local commissioners were required to engage. Some of these new organisations were created by the HSCA12 (e.g. Health and Wellbeing Boards), whilst others were created in order to compensate for the loss of regional oversight consequent upon the abolition of Strategic Health Authorities. Within this more complex system, respondents described the need for ‘workarounds’ to make the system work coherently, and the importance of longstanding local relationships in this process. More recent moves towards new regional collaborative structures such as Sustainability and Transformation Partnerships/Plans (STPs) suggest recognition by policy makers of these complexities.

The loss of managerial expertise resulting from the reduction in managerial spending and the creation of CSUs was keenly felt, and the value of managers who had worked in the local area for some time and who knew each other well was frequently highlighted. It was intended that CCGs would be more autonomous than PCTs. In practice, the oversight regime for CCGs was more stringent than that for PCTs because of the fiscal pressures facing the NHS, amongst other factors. Respondents described an initial feeling of freedom, which quickly receded as the CCG assurance process developed, and oversight and assurance processes were complicated. This process, led by NHS England, put CCGs under increasing scrutiny, and required them to meet a number of national-level priorities, with limited local discretion. In the context of increasingly constrained resources, CCGs were required to maintain financial balance, and those which did not were at risk of being put into ‘special measures’ by NHS England.

The conduct of commissioning

We used ‘tracer’ services to explore commissioning practices in depth. Across all of the tracers, the fragmentation of commissioning identified in initial interviews was an issue, with particular issues affecting sexual health services. The changes embodied in the HSCA12 had acted to both facilitate and impede service developments, depending upon the exact local contextual conditions. Where there were good local collaborative relationships, the reorganisation had caused disruption and delay; where local services were felt to be suboptimal and difficult to change, the reorganisation had provided an impetus for change. The incentives to increase secondary care activity embedded within the Payment by Results system continued to dominate many areas of commissioning, driving activity and requiring commissioners to put in place specific approaches to counteract their effects. For example, much of the focus in orthopaedic commissioning was upon measures to reduce secondary care activity.

The greater involvement of clinicians in commissioning did not appear to have led to any clearly identifiable changes to commissioning practice, other than at the margins. Commissioning at national level for specialised and screening services was problematic, with particular issues identified with the move away from commissioning specialised services for particular populations towards an approach focused upon commissioning particular providers. Integration of services became an increasing focus throughout the study, with multiple new initiatives established. In general the fragmentation of commissioning responsibilities between different organisations was unhelpful in facilitating integration, although local commissioners were working hard across organisational boundaries to overcome these difficulties. Good local relationships between individuals who understand the local health and care landscape were seen as vital in this.

The creation of a market in commissioning management support services intended in the HSCA12 did not occur. We found mixed approaches to the provision of commissioning support, with some CCGs seeking to do this work themselves, whilst others contracted much of it out to their local CSU. In some areas staff from CSUs were seconded to CCGs, creating some confusion over line management.

Commissioning for outcomes proved difficult to operationalise, with the various outcomes frameworks (which changed during the study) not found to be particularly helpful in directing commissioning activity. The role of commissioners in influencing some of the outcomes in the framework was felt to be limited, and in practice the need to remain in financial balance tended to dominate. Overall, the new system appeared to have made service change more difficult, although as we have indicated in specific local contexts some aspects of the Act were found to have acted to catalyse change.

Quality and outcomes of commissioning

Focusing upon quality and outcomes that could be attributed to commissioning, interview respondents were asked to identify their perceived successes and the factors underpinning these. Increased clinical involvement in commissioning was felt to have been a positive development, although there were few concrete claims for improvements in outcomes associated with it. In general, claims to success in this area focused upon improvements in relationships between commissioners and their local providers, with clinician to clinician relationships highlighted as proving invaluable in achieving particular service improvements. However, such improvements tended to be driven by the personal interests of the clinicians involved, and only appeared to be successful where there were provider representatives also interested in the same issue. Respondents also highlighted their success in establishing their CCGs as new organisations and maintaining financial balance, and suggested that their relationships with their Local Authority colleagues had improved. Success in taking on new responsibility for primary care commissioning in 2015 and 2016 was also referred to, with respondents highlighting success in supporting quality improvement in general practices.

Prompted by the findings from initial qualitative research, the first analysis using quantitative data examined trends in cervical screening in detail in order to investigate whether the more complex commissioning arrangements for this service following the HSCA12 had had an impact on outcomes. We combined quantitative and qualitative evidence, and showed that the local issues identified by interview respondents (relating to lack of clarity over budgets, division of responsibility for commissioning and lack of mechanisms to overcome these issues) was associated with a small but larger than expected decline in screening rates in the areas most affected. This increase in commissioning complexity was, as previously discussed, an unintended consequence of the HSCA12. It arose from a number of unrelated decisions, each of which could, in its own terms, be justified. However, the net result was a system with multiple commissioners each of which was responding to

their own set of incentives and drivers, the sum of which had the potential to generate adverse consequences for the system as a whole.

We then expanded this analysis to examine the effects of three different measures of the 'dose' of the reform on 40 indicators of a wide range of outcomes. These were likely to be associated to different degrees with the changes in the commissioning system that took place after HSCA12. The three 'dose' measures reflected variability in the extent of clinical involvement in commissioning, the disruption of general practice membership of commissioning organisations and the number of LAs with which CCGs needed to coordinate commissioning activity. We used our understanding of the changes introduced to target our analysis, testing each dose of reform against those outcomes which could plausibly be associated with the underlying mechanism being explored. This analysis showed little evidence of significant impacts of the reform and, where the effects were statistically significant, the patterns were not consistently positive or negative. There is some suggestion in our findings of poorer public health or social care related outcomes associated with more complex CCG-Local Authority relationships (ie CCGs relating to more than one LA), and this requires further study. Most importantly, we found no evidence that more involvement of clinicians in CCG commissioning at Board level was associated with greater improvements a range of outcomes, including measures of hospital activity, primary care quality and patient experience.

We found some differences between the two geographical areas studied. Area 1 was perhaps less affected by the HSCA12, with the new local organisations created by the Act mapping in relatively straightforward fashion to the boundaries of the old organisations. This was found to be particularly helpful in terms of managerial support, with trusted local managers who were well known regarded as especially helpful. In Area 2, by contrast, the new organisations took on quite different configurations from their predecessor organisations, meaning that GP practices were expected to work together in different ways. There had been some problems associated with CCG formation in this Area, and towards the end of the data collection period some CCG mergers were being discussed. The increased disruption associated with the creation of new organisations had been significant, but respondents in this Area also spoke about the advantages of now working with what they regarded as 'more like-minded' peers. In Area 1, there were good pre-reform collaborative arrangements and area-wide forums, which were, to some extent, disrupted by the HSCA12. However, these previous collaborations were also useful in supporting the development of mitigating strategies to offset some of the changes. For example, the area-wide sexual health group in Area 1 was able to negotiate a cross-charging policy for out of area patients, whereas in Area 2 no such system was put in place, with Local Authorities unsure whether they would be able to obtain reimbursement for patients who had obtained services outside their home area. In Area 2, there were fewer pre-existing collaborative forums. In some service areas, the disruption associated with the HSCA12 acted to support the redesign of services which were regarded as having become 'ossified' in an unhelpful way.

Both areas struggled with funding pressures, with particular issues associated with the pressures on Local Authority funding, which had knock on effects for services commissioned across the NHS/Local Authority boundary, such as dementia services. The reorganisation of NHSE had been experienced as particularly problematic in Area 2, with respondents highlighting a loss of local attention as NHSE refocused its activity at the level of large regions to accommodate the reduction in staff and resources available to NHSE. In Area 1, by contrast, some local NHSE activity remained and was found to be helpful.

In both Areas, pre-existing and ongoing relationships between commissioners in different organisations, and between commissioners and providers were particularly helpful in navigating the

new complexities; knowing who to call was felt to be important in supporting commissioning activity in a more fragmented system.

The study design allowed exploration of changes over time. In the early phases of data collection (2015), CCGs were relatively new organisations, having been fully established only in 2013. Clinicians had genuine enthusiasm for their new roles, but their initial sense of freedom and increased autonomy became tempered by increasing performance management and financial pressures. By the end of the data collection period in July 2017, the initial turbulence created by any major reorganisation had dissipated, but rapid policy developments such as the development of new integrated care collaborations under the auspices of the *Five Year Forward View* (NHS England 2014) meant that commissioners were continuing to have to respond to a rapidly changing environment. We have highlighted the proliferation of new co-ordinating structures and programmes, such as Urgent Care Networks, System Resilience Groups and the Better Care Fund. In early 2016, local CCGs were required to co-operate with local Providers and Local Authorities to establish regionally-based Sustainability and Transformation Plans/Partnerships (STPs) (NHS England, NHS Improvement et al. 2016). STPs cover a large area, with 44 established across England. Many cover as many as ten or more CCGs. STPs were not prominent in interviewees' accounts of their work, in part because their role and remit was not yet clear, and in part because focus of the study was upon the day-to-day role and activities of CCGs. However, they formed the background context against which our later data collection occurred, with interviewees often highlighting their uncertainties about how the STP plans would affect them.

Discussion and conclusions

The changes embodied in the HSCA12 were complicated and far-reaching. Our study used a realist approach to explore how far the claimed benefits of the changes were realised in practice, and the contexts and mechanisms affecting this process. We found that the Act was successfully implemented, with a great deal of hard work and enthusiasm evident amongst our respondents. However, few of the potential benefits claimed were evident. The fragmentation of commissioning responsibilities was experienced as a particular problem, with respondents referring to complicated 'workarounds' required to manage the new complexities. There was no clear evidence that the creation of CCGs as GP-led organisations had led to tangible improvements in commissioning, although both clinical and managerial respondents were enthusiastic about the role played by local clinicians. The loss of Strategic Health Authorities as a regional tier of co-ordination was experienced as problematic. The exact impact of the changes was context-dependent, with local organisations responding to their particular local and historical contexts. Quantitative analysis did not demonstrate any consistent improvements in outcomes associated with aspects of the changes. Our study was completed before any impact of STPs had been felt, but our findings suggest that, without clear statutory roles and authority, the creation of new regional-level organisations will not automatically lead to improvements in commissioning, nor will it solve the problems that we have highlighted associated with fragmentation of commissioning responsibilities.

Recommendations for further research

This study suggests a number of issues which require further substantive research, as well as providing some methodological avenues to explore:

- The 'dose of reform' approach allowed us to explore the impacts of a large scale reform which was implemented simultaneously across a whole country. Further exploration and testing of this approach in other large scale system changes would be valuable;

- The use of qualitative evidence analysed within a realist framework allowed the explicit testing of claims made about mechanisms of action. We would recommend this as an approach, alongside more conventional pre-determined quantitative designs;
- The approach that we took, exploring interactions across health economies, provided useful information about the meso-level of inter-organisational collaboration. Cross-UK comparisons between the NHS in England, Scotland, Wales and Northern Ireland (with devolved systems taking different approaches to meso-level co-ordination and collaboration) would be of value;
- Building upon this, we have highlighted the importance of a statutory regional tier of co-ordination of service commissioning. Further study could use historical and international evidence to explore the optimum approach at this level including: responsibilities; accountabilities; and governance;
- We have highlighted the complexity of accountabilities within the commissioning system. Further study is required of how best to operationalise accountabilities, in particular, the balance between local determination of desired outcomes and national/regional requirements;
- Further study is required of integrated approaches to commissioning, in particular, between Local Authority commissioners and CCGs. Further study of how commissioners with different statutory roles and in systems with different funding models (e.g. universal versus means tested services) can work together is required. Our study suggests a possible association of poorer outcomes with more complex CCG-Local Authority relationships and this also requires further study;
- The outcomes that we studied were those available in national administrative data sets. Further study could usefully explore the most relevant outcomes to test approaches to service integration;
- We have confirmed existing evidence which suggests that general practitioner clinical involvement in commissioning requires careful management and is most likely to deliver benefits to the design and management of community-based services. Further research is required to elucidate the best approaches to this sort of clinical involvement, with a particular focus upon how such involvement should be targeted and how outcomes can be optimised at a time when GPs are under significant workload pressures.

Recommendations for policy

- The re-integration of commissioning responsibilities for geographical populations would carry with it significant benefits, with the potential to support approaches more focused upon population health and well-being as well as upon care provision. This would require legislation to adjust statutory responsibilities for commissioning.
- Our study does not support a policy focus upon involving GPs in commissioning acute care services, but there is some evidence that they may add value in commissioning community and out of hospital services.

- CCGs require adequate managerial resources to deliver their commissioning responsibilities, and this requires sufficient locally-based staff able to build relationships across organisational boundaries.
- Managers with long-term experience in a local area should be valued and rewarded. It is important that the new emphasis upon system 'transformation' and new approaches to service delivery do not prevent lessons from being learned from past initiatives.
- If the role of commissioners becomes more strategic, with providers undertaking the service design aspects of the role, the choice of outcomes against which to hold providers to account becomes even more important. The balance between patient experience, activity-based and clinical outcomes needs to be carefully considered.
- As new approaches to commissioning and new forms of contract are developed and used, attention needs to be paid to the embedded incentives at system level.
- Statutory regional oversight has a role to play in supporting local health economies to work together to deliver coherent services to their population.
- It is important that existing evidence is understood and taken into account. In particular, it is important that current moves towards greater integration takes account of the weight of evidence that integration initiatives, whilst improving patient experience, are unlikely to generate significant savings nor reductions in service activity overall.