NHS commissioning practice and health system governance: a mixed-methods realistic evaluation

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Scientific summary

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Background

Since 1991 three main health-care commissioning structures have developed in England:

1. population-based commissioning, for geographically defined populations
2. general practice-based commissioning, under which general practices commission (other) health services for their registered patients
3. client-based commissioning, in which the patient [or her general practitioner (GP)] selects a care provider, which a commissioning organisation then pays, per episode of care.

By 2010, English health policy-makers had concluded that the main NHS commissioners [primary care trusts (PCTs)] did not sufficiently control provider costs and performance, and replaced them with GP-controlled Clinical Commissioning Groups (CCGs).

International comparisons of health systems suggest that health-care commissioners have six main media of power for exercising control over providers:

1. the managerial performance of commissioning (specifying services; procuring providers; monitoring provider performance)
2. establishing a negotiated order with providers
3. discursive control (evidence basing and ideological persuasion above all)
4. resource dependency (including financial incentives)
5. provider competition
6. juridical controls (law, regulation, contracts).

Different combinations of these media – different 'modes of commissioning' – appear to help explain health system variation in provider development, cost control, managerial development of commissioning, and medical involvement in commissioning (including extent of evidence-based practice).

Objectives

The research questions were:

1. How do English health policy-makers and NHS commissioners understand the policy aims of commissioning, and how can governance be exercised over providers through commissioning?
2. How will the reconfiguration of commissioning structures occur in practice and what shapes this reconfiguration?
3. How far does current commissioning practice allow commissioners to exercise governance over their local NHS health economies?

    i. How much room for manoeuvre do NHS commissioners have?
    ii. What are the consequences, and how do health-care commissioners try to manage them, when commissioning is distributed across different organisations and when it shifts to being client based?
    iii. How do provider managers respond to commissioning activity?

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5. How do commissioning practices differ in different types of commissioning organisations and for specific care groups? On which aspects of service provision do different commissioning organisations tend to focus?
6. What factors, including the local health system context, appear to influence commissioning practice and the relationships between commissioners and providers?

Methods

A mixed-methods realistic evaluation was carried out to elicit and test empirically the programme theories underlying English NHS commissioning practice, comprising:

1. Leximancer and cognitive frame analyses of policy documents, speeches and interviews with policy-makers and managers to elicit their programme theories of NHS commissioning
2. exploratory cross-sectional analysis of publicly available managerial data to test for associations between commissioners' characteristics and certain service outcomes
3. systematic comparison of case studies of commissioning in four English case study sites, inducting common patterns and exploring the contrasts, including the commissioning of services for older people at risk of unplanned hospital admission; mental health; public health (focusing on coronary heart disease and diabetes prevention); and planned orthopaedic surgery
4. systematic comparison of modes of commissioning patterns across the English case studies with those of a German sick-fund and an Italian National Health Service region (Lombardy)
5. action learning sets for managers and GPs from the English case study sites, and German and Italian commissioners.

Inclusion criteria

1. For English case study sites, maximum variety of pre-2012 commissioning organisations.
2. For individual informants, first-hand knowledge from the commissioner side, provider side or both of current commissioning practice or, for policy-makers, co-authorship of NHS commissioning policy.
3. For policy documents, being identified as seminal policy statements by policy-makers.

Respective data sources

1. Database of published managerial data about NHS commissioner characteristics and service outcomes.
2. Key informant interviews, grey managerial documents, action learning set meetings.
3. Department of Health (DH) and NHS websites.

Data validity was assessed by triangulation (case studies, discourse analyses), checking the internal consistency of the database and comparison with other published studies. Data were synthesised using two framework analyses (both based on the media-of-power framework mentioned above), one at cross-site level (England) and one at cross-country level. The programme theory was then compared with the synthesised empirical findings.

Results

How policy-makers and managers understood commissioning policy

Commissioning policy was understood to have a few agreed, broad aims, such as raising primary and secondary care quality and enabling patient choice of providers. Implicitly, commissioners would control providers mainly by means of commissioners' managerial performance (e.g. respecifying care pathways); discursive control (using research, monitoring provider performance); establishing negotiated orders among NHS commissioners, local government, GPs and hospital representatives; and competitive financial incentives. We combined the findings from the two discourse analyses as a set of causal propositions (stating assumed context–mechanism–outcome relationships) amenable to empirical testing and summarised in *Figure 1*. The most empirically problematic propositions were that GP commissioners would link clinical and financial decisions, that provider competition would influence provider performance, and that tariff-based incentives would reduce service costs.

The transition from PCTs to CCGs in our four case study sites was an evolution from existing organisational arrangements for GP involvement in commissioning, for example professional executive committees, referral management bodies, practice-based commissioners or a polyclinic. CCG formation depended on the degree to which GPs were already active participants in commissioning, their willingness to participate, their trust in NHS commissioning management, and their commissioning skills and knowledge. GPs gradually became more involved in commissioning and developed relationships with secondary care providers, so that commissioning work shifted to the shadow CCGs. Joint commissioning similarly evolved from existing joint health and local authority commissioning arrangements. This organisational continuity maintained continuity of local GP commissioning leaderships.

English NHS commissioning practice

English commissioners in our four case study sites deployed all six media of power but predominantly managerial performance, negotiated order and discursive control.

Management performance: Service specifications were becoming more evidence based, but existing providers still played a large part in formulating them. Commissioners relied on nationally mandated monitoring measures and on the providers to supply and interpret monitoring data. Tariff payment systems, the Quality and Outcomes Framework for paying general practices, and GP involvement in monitoring other providers made provider activity more transparent to commissioners. To cope with work overload, commissioners became more selective about prioritising their reviews of services. Cross-sectional analysis of published managerial data found that commissioners' self-assessed managerial performance was not associated with hospital performance, PCT financial performance and the other policy outcomes for which published data were available.

Negotiated order: We observed three overlapping negotiated orders in our four case study sites: contract negotiations; negotiations among GPs and between GPs and consultants; and 'micro-commissioning'. Contract negotiations were conducted at senior managerial level with little input from clinicians. National policy priorities and local historical activity patterns usually framed these negotiations. Financial negotiations were often separate from, and prior to, 'real-side' negotiations about service provision. The most important negotiated order was the 'micro-commissioning' of care pathways, mainly for non-commodified activities such as unscheduled care and mental health. These negotiations typically involved several providers, NHS and local authority commissioners, and patient representatives. They shaped service specifications, monitoring arrangements and contract specifications. They usually become more relational as trust and goodwill between the participants accumulated, with mutual recognition that they would need each other's co-operation in future.

Discursive control: The evidential discourse that commissioners used to frame contract negotiations, micro-commissioning and provider monitoring was mainly that of nationally promulgated evidence-based guidelines (National Institute for Health and Care Excellence guidelines, the mental health recovery model,

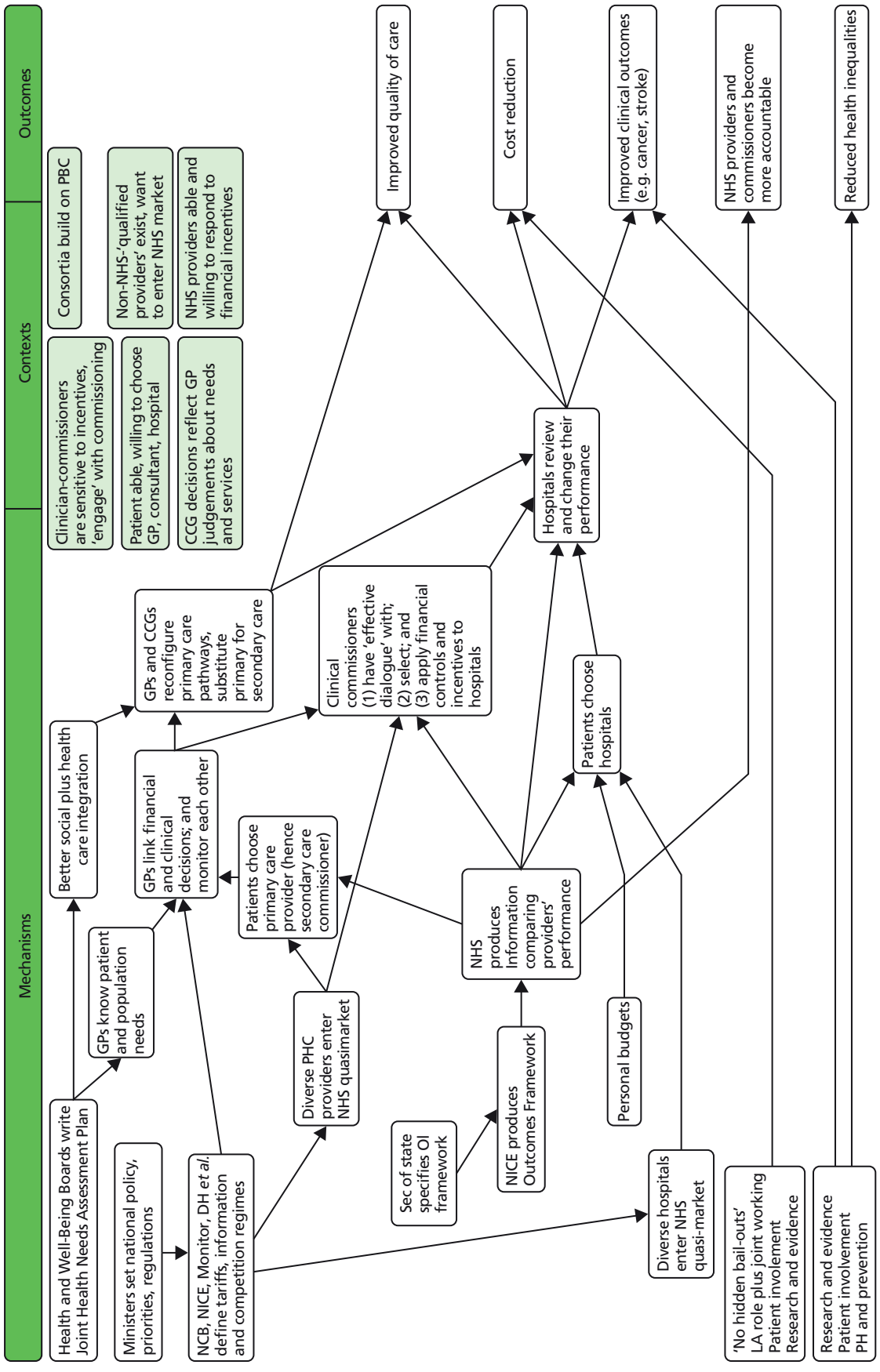

FIGURE 1 The underlying programme theory: NHS commissioning policy 2010–12 reconfiguration of commissioning organisations. LA, local authority; NCB, National Children's Bureau; NICE, National Institute of Health and Care Excellence; OI, outcome indicator; PBC, practice-based commissioning; PH, public health; PHC, primary health care.

National Service Frameworks, etc.). Where such evidence was absent or ambiguous, normative discourse was used, above all appealing to national policy mandates but also to local cultures of joint responsibility for the welfare of the NHS.

Financial incentives: Tariffs were generally recognised to give providers an incentive to increase case load. They weakened commissioners' power to control case load, case mix and who provided which services, and therefore to control costs. Commissioners responded by 'bundling' tariffs so that, above an agreed volume of activity, the marginal tariffs would be reduced by an agreed amount. The incentive effects of block payments depended on how the conditions of payment and the supply of monitoring information were specified.

Provider competition: Provider contestability was sometimes used as a means of controlling providers in our four case study sites, but its applicability was limited because existing providers were often the only credible bidders. Patient reluctance to travel and difficulty in influencing GP referral behaviour meant that commissioners did not regard hospital competition as feasible or desirable. Commissioners avoided financially destabilising their main local providers even when those providers did not comply with contracts. Our cross-sectional analysis found that the associations between competition and performance and service outcomes were more often weak, absent or in the opposite direction from that predicted by the programme theory of NHS commissioning than consistent with the programme theory (although some were consistent with the theory). These patterns were found even in PCTs with the lowest provider concentration, hence more scope for competition. Our control variables of PCT size, per capita PCT income and deprivation were generally more strongly associated with the measures of service outcome, and PCT income with PCT financial performance. The balance of evidence was against the assumption that provider competition had beneficial effects on the service outcomes studied, or that commissioners were able to use provider competition as a means of influencing providers.

Juridical controls: Standard DH contracts were used in all four case study sites, although they accommodated local variations. The more complete the contract, the less flexible was service provision.

Distributed commissioning

In our four case study sites, most commissioning was centralised through one commissioner, but two exceptions were a 'lead commissioner' (one commissioner commissioning a provider on behalf of several commissioners) and joint NHS–local authority commissioning. The stability of lead commissioning depended on how convergent the commissioners' interests were. Commissioners who withdrew from these arrangements did not necessarily weaken their bargaining position with providers. Joint commissioning was co-ordinated more at senior management levels than at the interface with providers, at which commissioners sometimes resorted to using informal, network-like working arrangements. The cross-sectional and case studies suggested that personal health budget pilots had not yet had discernible effects.

Commissioners' room for manoeuvre

Commissioners' scope for discretion in our four case study sites was constrained by vertical managerial controls and having to accommodate local government and GP requirements. The introduction of new providers and micro-commissioning tended to widen commissioners' room for manoeuvre.

Providers' responses to commissioners

National Health Service trusts' responses to commissioners in our four case study sites were never purely protectionist, and often constructive. Providers were not always able to implement their side of agreements made with commissioners, and sometimes were also unwilling. Then, negotiations would stagnate for long periods. The threat to remove resources sometimes made providers more helpful to commissioners, as did a credible threat that higher management would intervene if agreement were not reached.

Commissioning for care groups

In *mental health*, there was limited use of service specifications, monitoring, evidence basing and competition in our four case study sites. Micro-commissioning and block payments predominated. For *planned orthopaedic surgery*, standardised, well-developed evidence-based practice and outcome measures predominated; payment was by tariffs; and provider substitution was more straightforward. There was little micro-commissioning. The commissioning of services was largely irrelevant to intersectoral *prevention* work. Clinical prevention was commissioned from primary care health services much as any other service was. Little use was made of provider competition. Commissioning for the purpose of managing *recurrent unplanned admissions* was hampered by lack of predictive knowledge. Little use was made of provider competition; micro-commissioning was more practically relevant.

Different commissioning organisations' foci

Reflecting their organisational structure, and consequently whom they were accountable to, commissioning organisations in the three countries studied pursued different kinds of objective. Social health insurers needed to maintain solvency. Publicly owned commissioners pursued the goals set by government, whether at national, provincial or local level. All commissioners were interested in influencing referrals, overall service costs and (although each used different criteria) service quality. They differed more in which care groups, care pathways and aspects of provider development they gave most attention to, and their scope for selecting providers.

Factors influencing commissioning practice and commissioner–provider relationships

Three main modes of commissioning were most evident: case mix commissioning, micro-commissioning and surrogate planning. Each commissioning organisation that we studied combined elements of other modes of commissioning, but one predominated. Commissioning practice appeared to reflect four main groups of factors: the character of the commissioners' health system environment; two sets of technical factors (the service technologies at model of care level; the inherited physical infrastructure of services); the commissioners' organisational structure; and the commissioners' own actions in selecting and using the media of power.

Conclusions

In our four case study sites, commissioning practice worked in certain respects differently from the ways that current NHS commissioning policy assumes. It was often laborious and uncertain. In England, financial and 'real-side' contract negotiations were partly decoupled, clinician involvement being least on the financial side. Commissioners influenced providers (including fellow GPs) more through a negotiated order and discussions about evidence than through competitive (including patient choice) mechanisms. Commissioners routinely compared providers against national and regional benchmarks, but seldom deselected providers for that (or any other) reason. Where multiple hospitals coexisted, analysis of cross-England data suggested that a minority of their service outcomes (including some proxy clinical outcomes) improved, although more did not. Personal health budget pilots had not yet had discernible effects.

Evidence from the three countries studied suggests that each commissioning structure engenders a corresponding characteristic mode of commissioning (with variations of detail between sites). Insofar as patient choice involves the tariff system of paying providers, it weakens or removes commissioners' capacity to choose providers, whether to improve clinical outcomes or for any other reason. Commissioners influenced providers through managerial performance (transparency of provider activity data was important); by sustaining a negotiated order (in England especially, including micro-commissioning) whose disciplinary basis was evidence basing and shared ideological assumptions (whose content varied considerably between countries); and by adjusting incentives. Provider competition gave commissioners power only insofar as they could select providers. Juridical controls were marginal to day-to-day commissioning practice. Commissioners faced trade-offs between

different media of power, because these media interacted. These findings suggest a contingency theory explanation of modes of health-care commissioning, in terms of the commissioners' quasi-market and socioeconomic environment, technical factors and how commissioners exercise their managerial discretion, adapting commissioning practice in the light of providers' responses. Future research is therefore needed to examine in greater depth how these contingencies influence commissioning practice, in particular the contingencies of provider ownership (differences between corporate, social enterprise and NHS-owned providers), care settings (starting from the differences between inpatient, outpatient, intermediate, primary and social care), and how commissioning itself is organised (comparing competitive tendering for 'market' share with competition for patient referrals within quasi-markets).

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