

Discussion paper

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Improving the quality of commissioning GP services



An Inquiry into the Quality of General Practice in England

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**This paper was commissioned by The King's Fund to inform
the Inquiry panel.**

The views expressed are those of the authors and not of the panel

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1 Introduction

Eighty per cent of all patient contacts take place in primary care, and a large proportion of the total £102 billion budget (2010/11 planned) is spent, or committed, by primary care clinicians through direct treatment, prescribing or onward referral (Department of Health 2009a).

This report encompasses both the traditional, patient-facing duty of primary care and the role of primary care in managing demand and costs throughout the rest of the health care system. The detail and examples that it cites are exclusive to the NHS in England, but we believe that the prescription we offer is relevant to systems in the rest of the United Kingdom and beyond. Our focus is unashamedly on medical services and the role of GPs, although if truly integrated primary care is to be realised, it must include all professionals working in the sector.

A definition of commissioning

It is helpful to start with a definition of commissioning. Woodin defines commissioning in the UK context as a term describing 'a proactive strategic role in planning, designing and implementing the range of services required'. The commissioner decides which services or health care interventions should be provided, who should provide them and how they should be paid for, including working with the provider to implement changes. This is contrasted with a purchaser, who 'buys what is on offer or reimburses the provider on the basis of usage' (Woodin 2006).

Similarly, the House of Commons Health Committee (www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf) provides a helpful description of the role of a health service commissioner as 'to be the advocate for patients and communities, securing a range of appropriate high-quality health care services for people in need [and] to be the custodian of tax-payer's money; this brings a requirement to secure best value in the use of resources'.

We support both of these descriptions, and will be interpreting the term in the same way for the purposes of this paper.

Definitional note

When we started writing this paper the responsibility for addressing all of these issues lay squarely with primary care trusts (PCTs). However, early coalition policy (Coalition Government 2010) shows that this can no longer be assumed. Lacking a suitable, readily understood alternative, we have continued to use the term 'PCT' on the understanding that the reader will take it to mean 'PCT or the organisation that succeeds them in commissioning primary care'. This also allows us to distinguish between commissioning 'of' primary care from 'commissioning 'by' primary care, for which we use the terms 'clinical commissioners' and 'clinical commissioning'.

Quality in general practice

Historically, research has concentrated on the quality of care delivered in general practice and less on the role of commissioning in driving improvement. So, the key question we are looking to address is whether commissioning can drive up quality in primary care and beyond. We have broken this question down into the following elements, and have allocated a section of the report to each.

- What is the primary care commissioning 'problem' (Section 2)?
- What do we expect from primary care (Section 3)?
- What progress has there been to date (Section 4)?
- What needs to happen next (Section 5)?

Quality in health care has been defined in a number of ways. Roland (2010) identified some key dimensions of primary care, including some at an individual level (access, quality of care and quality of interpersonal care) and some at a population level (equity and efficiency). We will return to these definitions in Section 3.

A further helpful approach is to look at a range of themes or domains of quality. Raleigh and Foot (2010) suggest that there are a number of domains that are common to most quality frameworks (safety, effectiveness and patient experience), with others less common (efficiency, capacity, value for money). They suggest that, given the severe financial challenge now facing the NHS, the 'development and use of indicators on productivity, efficiency and value for money, alongside measures of quality such as patient experience and outcomes, will become increasingly critical'.

We therefore argue that the primary care commissioner should be working to ensure and assure the delivery of primary care services that meet all of the key domains of quality, at individual and population level, in terms of:

- outcomes (safety and effectiveness)
- patient experience
- productivity
- efficiency and value for money.

However, there is less agreement about how to define and identify primary care that is of high, acceptable or poor quality. We will explore this when we look at what a commissioner should expect of primary care.

2 Defining the primary care commissioning 'problem'

Many of the problems that are inherent in commissioning primary care are common to all forms of commissioning. Certainly, primary care has its peculiarities – such as the independent contractor mode. But the really important difference is that those delivering primary care have come to be seen as part of the solution to the entire NHS commissioning challenge. This is a core theme of this paper, which be explored in later sections. In this section we focus on the provision aspect of primary care. Our main argument is that, up until now, these services have largely been purchased rather than commissioned.

The problems of commissioning in general

The NHS has found the practice of commissioning immensely difficult. The purchaser-provider split was put in place in 1990, and was followed by two decades of learning. Early mistakes were inevitable, but several studies support the view that the commissioning function has yet to reach full maturity, and that the necessary skills remain in short supply (Goodwin 2009). The necessity of introducing the world class commissioning programme in 2008 tells us a great deal about prevailing standards, introducing as olympian ideals what should have been routine practice.

The House of Commons Health Committee report on commissioning (www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf) did not mince its words. 'As the Government recognises, weaknesses remain 20 years after the introduction of the purchaser/provider split. Commissioners continue to be passive, when to do their work they must insist on quality and challenge the inefficiencies of providers, particularly unevidenced variations in clinical practice.'

The recent King's Fund/Nuffield Trust report cites numerous reasons why commissioning has failed to deliver what was expected or desired (Smith and Thorlby 2010). It argues that, while the verdict on commissioning is positive in terms of implementing national plans and strategies and targets, questions must asked about whether such achievements result from national direction and performance management, rather than from the actions of commissioners operating at a local level.

Capacity and competence

In recent years, a number of researchers (including Smith and Thorlby (2010)) as have highlighted this lack of capacity and capability, and the impact of organisational turbulence. Indeed, the central message of the House of Commons Health Committee Report (www.parliament.uk/business/committees/committees-archive/health-committee/) was: 'Weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge, and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff.'

We would argue that lack of skills and competence in data capture, processing and analysis remain among the most telling areas of weakness. But for many PCTs the problems extend at least partly to a lack of essential management skills – not least, the ability to articulate and formalise the techniques required to commission, along with project management, quality

management, contracting, writing and communications, analysis, and marketing capabilities. The lack of formal qualifications in commissioning and a generalised reluctance to invest in individuals has seriously hampered progress towards a 'world class' standard.

National policy and strategy

The first inkling that primary care was to be commissioned rather than just administered came with the advent of personal medical services (PMS) pilots in 1997, followed by a new general medical (GMS) services contract (2003/4). What these had in common was a shift towards a contract entered into collectively by the GP practice (rather than the individual GP) and held by a local commissioner rather than by the Secretary of State for Health. However, little thought had been given to the skills and organisation needed by health authorities – and later, by PCTs – to carry out this new role.

A succession of policy initiatives continued with the strategy of PCTs taking a more interventionist role in primary care – particularly with the added stimulus of enhancing choice and competition. In 2006 came the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006). This mandated PCTs to 'actively commission additional practices' in under-doctored areas, as well as to shift care closer to home through 'effective commissioning', but there was little guidance about commissioning core primary care services.

The weakness was recognised in 2008 when, as part of Lord Darzi's NHS Next Stage Review, the Department of Health published its *Vision for Primary and Community Care*], which included programmes to improve commissioning of primary and community services. This was followed by support guides to 'help PCTs become world class commissioners of primary care services' (Department of Health 2009b). So it was not until very recently that the Department of Health made clear that PCTs had to take their commissioning role of primary care seriously, and that the competencies of World Class Commissioning applied to the commissioning of all care – not just the acute sector.

Indeed, the impetus to improve quality of care in general practice needs to be seen against the background of a complex policy and organisational environment. Over time, primary care commissioners have been required to deliver on a widening range of initiatives, some of them entirely unprecedented (for example, Improved Access, Choose and Book and annual appraisal of GPs), as well as a range of enhanced services, both national and local. When it came to implementing practice-based commissioning (PBC), the skills that had been developed in GP fundholding in the mid-1990s had long diminished.

It might be reasonable to argue that there was little energy or capacity left within the PCTs to address the routine problems of quality within primary care, such as clinical variation, efficiency of practices or poor patient experience. The sheer volume of primary care contractors (often more than 50 per PCT) also made the prospect a near impossible logistical challenge, given the limited resource and capacity of PCTs to respond.

Lack of local strategy

Despite an increased emphasis on primary care at national level, there is evidence that PCT strategy for primary care has been poorly articulated and has tended towards short-termism. Even a cursory web search of

published strategies (there is little in the way of academic research on strategy in this context) shows huge diversity of interpretation of what a strategy should include.

We might expect to see in such a strategy a fully rounded view of primary and community services and the opportunity for improving care – perhaps including reference to tactics to address quality variation, or to improve services, by stimulating choice. More commonly, we are faced with a draft document that begins with bland statements about patient-centredness followed by a list of initiatives that will be carried out in the coming period.

What is lacking is an understanding of how sustained change is achieved – investment in systems, in workforce, aligning incentives and motivating teams – and an appreciation of how the PCT will use the range of available levers in order to make this happen. A clear view of what the different parts of the system are expected to contribute in order to achieve lasting change is usually lacking. This lack of sophistication has led to role confusion, with PCTs and primary care teams unsure whether they are market managers, performance managers, development partners or, in some cases, a provider of support services.

Leadership

Intimately related to strategy is leadership – although, interestingly, 'strategy' barely rates a mention in the NHS's own leadership framework (NHS Institute 2007). PCTs have failed to invest adequately in the competence of leaders generally, including the teams commissioning primary care.

Both the Department of Health and The King's Fund gave testimony to the House of Commons Health Committee that commissioning was a less attractive career option than hospital management, and that this led to a weaker leadership – particularly at middle-management level. There is evidence to show that leadership can affect the quality of patient care, including safety, and also that transformational leadership (focusing primarily on change) may be in conflict with the type of performance management necessary for accountability in health care (Firth-Cozens and Mowbray 2001).

Poor leadership affects relationships throughout the organisation, and regular changes of role or personnel undermine the relationships of mutual trust and respect between contractors and commissioners that underpin successful commissioning. Taken together with the organisational turbulence of the past decade, we start to understand the lack of progress.

Contractual levers and weaknesses

As we know, most GP practices are independent contractors currently working to a nationally agreed contract administered by PCT commissioners. The contract provides a 'global sum', which is determined by linking the amount paid to a practice to the needs of its registered patients. The 2004 contract also introduced the Quality and Outcomes Framework (QOF), designed to provide financial incentives that reward practices for providing high-quality care.

The scheme is voluntary, but nearly all practices take part. Currently, QOF payments account for up to one-third of average practice earnings (National Audit Office 2008).

PCTs have had little contractual leverage over these activities, but where quality is an issue rules concerning GP practices delivering 'enhanced services' have at least provided some potential for focusing on care services 'outside' the core contract.

- **Directed Enhanced Services (DESS)** These are services or activities provided by GP practices that have been negotiated nationally – for example, providing extended opening hours, improving treatment of heart failure. Practices are not contractually obliged to provide these services, but most do. Payment is at a nationally agreed rate.
- **National Enhanced Services (NESS)** These are services that a PCT commissioner, using national specifications, can choose to commission from a practice – for example, minor injury services and enhanced care for the homeless. Again, payment is at nationally agreed rates.
- **Local Enhanced Services (LESS)** These are locally developed services designed to meet local health needs – for example, enhanced medical care of asylum seekers, and specific services for people with learning disabilities (Royal College of General Practitioners 2007). They are commissioned by PCTs, and fees are locally negotiated.

As an alternative to the national contract, a Personal Medical Services (PMS) contract allows GPs and other NHS staff to contract with their PCT commissioner directly. One of the key aims of the PMS was to enable individual contracts that were appropriate to the specific needs of local populations, and to improve the quality of GP services in under-doctored areas (Department of Health 2003). Key elements of this contract are:

- locally negotiated contracts with PCTs, to provide services outside the scope of GMS that meet the needs of the local population
- an increase in practices that are not necessarily traditional GP partner-led, as NHS trusts and other health care professionals (including nurses, pharmacists and dentists) can also be contracted
- the ability for PCTs to employ GPs directly, on a salaried basis
- payment for PMS providers through a fixed annual rate for the provision of services negotiated with their PCT, rather than a global sum'.

Since 2004, the differences between PMS and GMS contractual arrangements have decreased. In 2006, 37 per cent of all general practices operated under PMS (NHS Information Centre 2008), and the number has continued to rise.

While GMS and PMS practices provide care for nearly 100 per cent of the population in England, two other contracts were also introduced in 2004. Alternative Provider Medical Services (APMS) allows PCTs to commission primary care from commercial or voluntary providers, or from foundation trusts – though research by The King's Fund found that the use of alternative provider medical services contracts (APMS) by PCT commissioners has so far been limited (Walsh *et al* 2007).

Meanwhile, Primary Care Trust Medical Services (PCTMS) allows PCT commissioners to provide general practice services themselves, although the model is no longer encouraged.

However, as the importance of effective and high-quality primary care

commissioning has gained momentum, the inherent weakness of these tools and levers has been exposed. As Ham (2008) pointed out, 'the difficulty in defining complex health services in clear contractual terms (and by implication, in terms of performance review) also limits effective procurement practices' (Ham 2008).

This complexity has revealed capacity and capability gaps across PCTs, compounded by repeated and sustained organisational turbulence, with changes in organisations every two or three years (Smith and Thorlby 2010). This has mitigated against having staff in post in senior commissioning roles who understand primary care sufficiently to use the contractual mechanisms as levers for change, rather than as a way of paying GPs for routine care. In other words, most commissioners have not generally sought to proactively use these contractual levers to redesign the way general practice does business with the NHS – an issue we return to in Section 4, when we look at what progress commissioners have made in improving the quality of GP services.

Even this administrative function has proved challenging for many, with the management of local PMS contracts proving to be more resource intensive than many had anticipated (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003195). Although this research dates back to the first-wave pilots, experience would suggest that the picture has not been transformed in the intervening years.

Even simple systems to ensure that contracts are regularly reviewed, or to validate payments for enhanced services, are not standard in all PCTs. A recent benchmarking survey by the national advisory body has shown that 90 per cent of respondents said they had no dedicated team for monitoring primary care performance against contracts (Gainsbury 2009).

Lack of consensus on quality

General practice is an established discipline, with high professional standards and an extensive UK and international community of research, education, training and policy-making about quality general practice. However, when examining the literature, we quickly run up against the problem that the profession's own perspective about what is important in improving primary care is only one of many. Greenhalgh and Eversley (1999) set out a number of perspectives, including patient, professional, gatekeeper, prescriber. They argue for a post-modern approach that would incorporate this range of perspectives into a project to set a local framework for quality, delivered through a learning-based approach to improvement.

Meanwhile, others have noted a lack of consensus about what quality general practice looks like (see Department of Health 2005). Added to this is an evolving view of what primary care is for. This is explored in Section 3.

Role conflict for GPs

The introduction of practice-based commissioning in 2004/5 presented some theoretical and practical challenges for PCTs and GPs. Asking GPs to act as commissioners by allocating budgets, and providing some incentives to free up money by redesigning care, is a reasonable formula – but overcoming three intrinsic problems has proved more difficult than first thought.

- **Performance managing the commissioning function** As we

have seen, and as we argue later (see Section 4, p 19), there is a question mark over the use of contractual devices to commission care – particularly to drive quality of provision. Using the same techniques (incentives and performance metrics) to ascertain the quality of commissioning revealed the fundamental weaknesses of this approach. Redesigning care is risky and difficult, and does not lend itself to quantitative measurement. The temptation has been to fall back on process measures (providing an action plan, attending training, and so on) and minimise risk by limiting freedom to make changes.

- **Managing the conflict of interest** From the early days of PBC it was clear that, in the minds of GPs, redesign meant doing more in the GP practice or in a company set up by GPs for the purpose. This created the potential to financially reward individual GPs and practices, through commissioning actions. Meanwhile, commissioners, trusts and non-NHS providers regarded GP involvement in strategic commissioning decisions with suspicion. The response was to create cumbersome decision-making processes that acted as a drag on innovation, integration and service change. Some four years on from policy initiation, there remained significant barriers to effective implementation. For example, it reportedly took almost one year for proposed business cases resulting in actual change to services (Wood and Curry 2009).
- **Transferring the systemic weakness of commissioning** If PCTs suffered from a fundamental lack of capacity and skills, there was every reason to believe that these would be present in the new system too. Clinical engagement in commissioning is essential, as is alignment of clinical and resource decisions. However, there was never any evidence that clinicians would bring to the table the necessary skills in data management, contracting, needs assessment, procurement or any other key skill. Indeed, PBC, with its thirst for regular budget and activity reports, governance, management support and service redesign skills, stretched existing resources even more thinly – with 80 per cent of respondents to a survey in 2009 confirming that they did not have the skills needed to carry out PBC (Wood and Curry 2009).

These problems have undermined PBC, as it is currently constituted (Curry *et al* 2008), and have led to a significant rethink. A reshaped policy of 'clinical commissioning' emerged in 2009 (Department of Health 2009a). This made clear what was expected of PBC – but also what practice-based commissioners should expect of PCTs. It also led us towards the idea that GP commissioners should look 'in the round' at the quality of care offered for local patients, rather than just focusing on what was happening outside of the surgery walls.

This meant building on 'best practice' sites and a recognition that GP-led organisations were uniquely placed to affect change through peer-led improvement. It was a wholesome and much less expensive approach than performance management, and one with a better chance of success, according to the evidence from previous forms of GP-led commissioning (Mays *et al* 1988, 2001).

This benefit extended beyond clinical variation and, for PCTs, into resource utilisation (via prescribing and referral management schemes). This potential looks like being recognised in the emerging coalition plans on GP commissioning, discussed in Section 5.

Having described why primary care services have not generally

been commissioned effectively to date, we now go on to explore what commissioners might expect from primary care.

3 What we expect from primary care

This section explores our expectations of primary care, its multi-faceted role in the modern NHS and the complex challenge this sets for commissioners.

The legitimacy of primary care as a public service rests on meeting the needs and expectations of those who use it. For the previous two governments, this meant an emphasis on choice and responsiveness. However, the strategy of using choice and consumerist behaviour to drive up standards takes time, and may never be quite enough to assure every dimension of quality. So, for the foreseeable future, we are likely to need professional commissioning to address the unexplained variations in quality of care that we still see in general practice.

Another expectation that we have of primary care in general – and GPs in particular – is that it should manage the resources in the system, by controlling costs and managing demand for expensive treatments: especially acute hospital care. Increasingly, this goes beyond the traditional and much-envied gatekeeper role (House of Lords 2000). A final expectation, much less well-articulated in policy until the 2006 White Paper (Department of Health 2006), is that primary care should provide a platform for extended care – that is, care formerly carried out in hospital.

We can therefore identify the four expectations of primary care as:

- choice and responsiveness
- managing variations
- controlling costs and managing demand
- extended care.

This section investigates each one of these four roles in turn.

Choice and responsiveness

The most recent policy initiative towards consumer choice (Department of Health 2010) promises to remove one of the original 1948 principles of primary care: practice boundaries. That the government is prepared to take this risky step with relatively little evidence of a significant problem, or a mandate, tells us something about the ideology of choice. The NHS Constitution (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf) promotes a consumerist attitude towards NHS services, and early coalition policy indicates that choice seems likely to remain central to the government's promise to the electorate (Coalition Government 2010).

Despite the centrality of choice to the Thatcher, New Labour and coalition projects, an enthusiasm for choice in primary care has yet to become the core of local primary care strategy. When PCTs last reviewed practice boundaries (at the time of the new GP contract in 2003/4), the emphasis was on ensuring coverage rather than maximising choice. Meanwhile, the 2008/9 Next Stage Review (Department of Health 2009) required every PCT to commission at least one additional GP practice, even in PCTs where there was no evidence of need for such an investment. Although it was

dressed up as an access improvement, the underlying aim was to introduce choice and competition.

Certainly anyone working in primary care during this period will recognise that contractors have taken the threat of competition from non-traditional providers seriously. However, as a means of spurring improvement through competitive behaviour, the effect of this requirement may not have the expected outcome, as GPs appear to be moving increasingly towards working together, in federations, rather than competing among themselves (Lakhani *et al* 2007).

One reason for this disparity between centre and local is the difficulty of measuring choice, so in recent years the emphasis for commissioners has been on access rather than choice. Certainly the National GP Survey points to widespread variation. For example, in a typical PCT the percentage of patients who said it was 'very easy' to get through on the phone ranged from 7 per cent to 64 per cent (Department of Health 2009c).

Certainly the long-term legitimacy of a publicly funded health service depends on a public perception that the service is at least comparable to that offered in the private sector. So, choice will be with us as a driver for national policy and local action. However, improving the patient experience is at the heart of quality improvement in primary care, as there is no point in better access or life-prolonging treatments if the experience is perceived as poor.

Managing variation

A key role for any primary care commissioner doing their job well is to understand and focus on what appears, at first glance, to be unexplained variation in care delivery. Wilson *et al* (2006) set out five dimensions of primary care, under two main categories, that we might seek to measure and effect that may give us a way to understand variation:

individual dimensions, comprising access, quality of care and quality of interpersonal care

population dimensions, comprising equity and efficiency.

Despite an extensive research effort, consensus on absolute benchmarks of each dimension of quality has proved elusive (Department of Health 2005). On occasion, a commissioner might be faced with a systemic, widespread failure of all contractors on one of these dimensions, such as with the introduction of a new national target. However, achieving a local consensus on standards and indicators of quality is a major undertaking that takes up much of the energy, skill and resource available – even where there is an appetite for such an inclusive approach.

So, rather than aspire to an idealised standard, commissioners have tended to take a pragmatic approach to the variation that they find among their own contractors. A focus on variation per se recognises that performance of providers against almost any quality marker tends to be a normal distribution, with performance clustered around a mean.

Of course, some of this variation is explicable, and the problems of controlling for differences in patient need are real and complex. Some of the parameters of need are well understood (for example, age, sex and location), while others (such as deprivation, ethnicity and gender) are less so. The interplay of these factors creates a level of complexity that is only

crudely mediated by practice-allocation formulas.

Regardless of the methodological challenges, commissioners of primary care should be concerned with variation at two levels:

- Why do my practices not achieve the quality of care that others in the country are able to achieve given similar expressions of need?
- Why do some of my practices do worse than other practices in my PCT – particularly where the inputs are similar and there is no clear evidence of significant difference in patient need?

Keeping in mind Roland's five dimensions (Roland 2010, Department of Health 2010), we now take a brief look at the evidence for this unwarranted variation in each of these areas.

Variation in patient experience

The National GP survey (Department of Health 2008) offers a wealth of evidence indicating that patients can discriminate between a good and a bad experience (Department of Health 2009c) and revealing that the experience itself is highly variable. Table 1 includes data from a selected survey that shows that there is considerable variation in response to questions about the patient's experience of care in their practice. The researchers surveyed 54 practices, with an average of 252 responses per practice.

Table 1: Patient responses to questions about their experience of care

	Response	Average	Minimum	Maximum	Range
Rating of doctor asking about your symptoms	'Good' or 'very good'	88%	62%	97%	35%
Rating of doctor listening to you		88%	63%	98%	35%
Rating of explaining tests and treatments		80%	49%	95%	46%
Rating of involving you in decisions about your care		74%	44%	93%	49%
Rating of doctor treating you with care and concern		84%	59%	96%	37%
Confidence and trust in doctor	'Yes'	94%	84%	99%	16%

Source: Department of Health 2009c.

Variation in clinical care

For evidence of variation we have a readily available standard dataset, in the form of the Quality and Outcomes Framework. Leaving aside disputes over the precise contribution of this initiative to improvements in health (McGovern *et al* 2008), one clear and consistent piece of evidence of variation is the proportion of patients that practices recorded as exceptions – that is, those that are not excluded from the count through non-attendance or informed dissent.

According to the NHS's own analysis (NHS Information Centre 2009), variation is detectable at strategic health authority, PCT and practice level. For example, North East SHA has the highest exception rate for asthma but the lowest for coronary heart disease. Between PCTs within one SHA, we find an overall exception rate of 3.46 per cent, within a range of 4.01–7.33 per cent (2007/8). However, it is between practices within PCTs that the variation is most striking, with the overall exception rate across all indicators ranging from 0 per cent to 59.52 per cent (2008/9).

Variation and equity

Equity for commissioners in general, and for primary care in particular, is a troublesome concept with no national frame of reference or measurement. One recent piece of research (Aspinall and Jacobsen 2005) asked public health clinicians involved in commissioning to identify the different aspects of equity that they would include in health equity audits. The resulting ranking accordingly gives us six dimensions of equity:

- geographical (90 per cent)
- age (59 per cent)
- deprivation category (73 per cent)
- gender (47 per cent)
- social class (63 per cent)
- ethnicity (42 per cent).

Each of these dimensions presents a significant challenge to the competence and capacity of PCTs to commission in a way that reduces inequity. Evidence from the Audit Commission (2010) reinforces the view that inequality is not satisfactorily addressed by commissioners for health, either alone or in partnership with other agencies. Some £21 billion of central funding was allocated in 2009/10 using a needs-based formula, but there is little to show that this has resulted in any systematic shift of resources to deprived areas. Indeed, some of the extra money that has been directed to deprived, 'spearhead' PCTs has found its way instead into funding for higher hospital costs.

Variation in efficiency

The challenges of tackling variation in demand are significant. Complexities of definition and measurement, combined with weaknesses in key skills such as data analysis and mapping, have led commissioners to look at other aspects of variation. PCTs have settled much more comfortably on the inequities of resource that have evolved between practice based contracts since 2003/4. Results from an informal survey in December 2009 found that 41 per cent of PCTs were launching an imminent review of PMS contracts, while 67 per cent had plans to obtain better value (Nowotny 2008).

Meanwhile, Haringey PCT published data showing that the average cost per patient of a PMS contract is £91.93 (ranging from £60.20 to £145.56), compared to £69.44 (range: £52.12–91.25) for GMS contracts (Haringey PCT 2009).

Indeed, many PCTs are now looking at variation in costs for GMS and PMS contracts alike, and seeking to reduce variation. The concern is that this process is being run as a cost-reduction measure without looking at why the variation in costs and efficiency is taking place and whether this is actually linked to differential performance in service delivery and outcomes.

A practice perception of variation

Are those practicing in surgery concerned that they may be better or worse than their neighbours? Many practices publish statements about aspiring to provide 'high-quality' care, but there is no widespread take-up of formal quality programmes or of documented quality systems. The vast majority of practices are independent businesses where partner take-home pay is related directly to expenditure, so all practices will, understandably, want to control costs.

The commercial argument for investing in quality can be powerful where suppliers feel that they are in competition and risk losing market share, or foregoing opportunities for growth. In primary care, the absence of a culture of choice and exit means that this mechanism operates only weakly in primary care. Step costs around staff and premises, or simply contentment with the practice configuration mean that many practices are happy with their list size. They have no desire to grow, and no strong incentive to attract new patients with promises of a better-quality service or a bigger range of services.

Nevertheless, while there is little evidence of any widespread movement among primary care contractors to systematically address their own weaknesses, it is now relatively common for PCTs and practice-based commissioners to publish practice-level, comparative data on quality markers. This is despite the fact that there is often no real agreement about whether those quality markers are the right ones to use. However, GP commissioning organisations and federations are beginning to explore the potential to address variation through peer pressure, and this possibility is linked to a broader perception of the role of PBC and GP commissioning organisations.

Controlling costs and managing demand

For a long time, commissioners have been familiar with the unexplained variation in prescribing costs and have made resources available to address this in the form of prescribing advisors and incentive schemes. Beyond this, the one thing we can say for certain about the internal market and the various initiatives to increase its efficiency is that the evidence on whether this has been successful is decidedly mixed (Le Grand *et al* 1998).

GP fundholding was the first policy designed to engage GPs in the management of elective hospital costs. The review by Kay (2002) highlighted the range of opinion and conclusions about the scheme, and noted a weakness in evidence for controlling costs. Some years earlier a review of the scheme's effects on prescribing (Baines *et al* 1997) had found that, in the short term, many early-wave fundholders had managed to secure economies in their prescribing by switching to cheaper, generic drugs, but that such savings may not have been sustainable.

The total purchasing extension of fundholding in the late 1990s saw GPs taking responsibility for purchasing all hospital care, and showed mixed results. One review (Mays *et al* 1998) concluded that single practice and

small multi-practice pilots were more likely than large multi-practice pilots to report achieving their objectives. Organisational development issues were also significant – an experience borne out by similar experiments in other countries (Rodríguez and Pozzebon 2010). Fragmentation of decision-making and the emerging inequity between fundholders and non-fundholders were also identified as drawbacks (Goodwin 2001).

The policy response was the introduction of primary care groups. Early reviews showed that the organisational challenges were uppermost in the minds of the new boards (made up of managers and clinicians). At this stage the first signs emerged of a more corporate approach to managing costs – particularly for prescribing (Smith *et al* 2000). Primary care groups began to get to grips with some aspects of demand for secondary care, with the review of low-priority treatments and work to determine treatment thresholds.

The evolution of larger primary care trusts tackled some of the organisational shortfalls but (we would argue) at the expense of a diminution of clinician engagement. Thus when practice-based commissioning was introduced it was very much a case of PCTs permitting (or not, in many cases) clinicians to engage in resource management rather than as a natural evolution of clinical commissioning.

The policy showed some early successes in managing overall costs and achieving reductions in hospital utilisation (Audit Commission 2007a). Once again a lack of application to develop effective organisations has hampered progress, and more time is likely to be needed than is available (Audit Commission 2007b). However, the doubts that PBC can deliver on the scale needed have been confirmed by recent review reports (Curry *et al* 2008, Wood and Curry 2009, Smith *et al* 2009), borne out by a loss of impetus for the whole PBC movement.

Despite these doubts, a commissioning model driven by GP decision-making is now the centrepiece of NHS reform under the Coalition government. Success will depend on learning the lessons from PBC and our previous forays into clinical-led commissioning, and must address the weaknesses of commissioning as a whole.

A platform for extended care

A 'primary care-led NHS' and the ambition to shift care from hospitals to primary or community settings probably pre-dates the 'GP as commissioner' concept. The Tomlinson Report (HMSO 1992) is one of the first manifestations of this approach, and government took up the mantra of a 'primary care-led NHS' shortly after. Certainly GP-authored articles charting an unplanned shift of workload started to appear in the 1990s, and continue to this day (Pedersen and Leese 1997).

After almost two decades, it is hard to argue that any substantial shift of patient activity has taken place. A routine trawl of PCT plans at the time of writing reveals that the NHS has not given up. Shifting care out of the high-cost hospital environment to a supposedly lower-cost setting is central to the financial strategies of every PCT in the credit crunch NHS. What is much less apparent is what mechanisms (investment strategies, workforce development and skills enhancement) by which this is to be achieved.

The 2003/4 reform of the GMS contract made some progress, by establishing a mechanism for remunerating GPs for this work via enhanced services. However, instead of working to develop existing providers, PCTs were directed to use procurement to secure new providers as a means of stimulating competition and to bring in private-sector capacity. What was missing was a consistent and comprehensive strategy to build on existing primary care workforce, infrastructure and management, to provide the platform for such a shift.

The very real danger for patients and clinicians has been a lack of integration of care, as providers seek to transfer costs and activity from one setting to another without sufficient reflection on the effect on patient experience.

Enabling primary care to meet the four expectations described in this section – choice, variation, managing demand and building a platform for extended care – will take a co-ordinated effort by newly appointed GP commissioners and the partners that they choose to work with and will challenge those tasked with rewriting and managing the primary care contract. Doing it within a very constrained resource environment, which will require industrial-scale change, is a significant challenge indeed. The next section explores the levers that are currently available to achieve this.

4 What progress has been made to date?

We have looked at the problems inherent in primary care commissioning and at the expectations that we have in relation to choice, variation, demand management and on creating a platform for the shift of care from the acute sector. Before we go on to discuss how we might address these, it is worth quickly reviewing the array of levers and tools that are available to those commissioning primary care. These levers can be categorised as:

- performance levers
- resource levers
- competition levers
- remodelling levers.

Performance levers

It can be argued that performance management is the dominant paradigm for commissioning primary care. Focused principally on reducing variation in care, it entails a set of rewards and sanctions applied to some or all providers, to address specific problems. We can explore some of the elements of this paradigm.

The GP contract

At the heart of the relationship between commissioner and provider is the GP contract. As we saw in Section 2, the core of the GMS contract is a block payment that permits termination only where performance is exceptionally low. The ability to determine additional and enhanced services – although this contains an element of performance-related-pay – has similar drawbacks as a performance lever.

The Quality and Outcomes Framework is a comprehensive performance management system that provides financial reward for achievement against a set of clear parameters. There is evidence of an improvement in recording of disease, which is normally a first step towards improving care. However, some analysis (Campbell *et al* 2007) has shown that the rate of quality improvement in the period since the introduction of QOF is not significantly better than that in the preceding period. So, at best, QOF seems to have accelerated underlying trends towards quality improvement and to reward practices for their current good performance.

PMS contracts (comprising 43 per cent of GP practices) offer greater leverage, with PCTs giving higher payments in exchange for improved outcomes or targeted health interventions. But according to the recent PCC benchmarking survey there is a significant premium: on average, costs for PMS are 27 per cent higher than those of GMS contracts, and in many cases this does not seem to be accompanied by superior quality provision or health outcomes (NHS Primary Care Commissioning 2009).

The lack of opportunity and success that PCTs have had in managing performance through these existing contracts strongly suggests a case for contract reform. We return to this in Section 5, when we consider what needs to happen in the future.

Balanced scorecard

The use of a balanced scorecard determining a range of quality indicators is a refinement of the performance levers. Its original use was as a strategic planning tool, designed to promote a holistic view of an organisation (Kaplan and Norton 1996). A significant number of PCTs have developed balanced scorecards as a way of reconciling a multitude of targets and drivers.

This is an improvement on an approach that allows different departments (premises, medicines management and contracting) to implement their own regimes. But it remains a performance lever – as the NHS's own guide on its work (Primary Care Contracting 2006) makes clear – and, as such, takes little heed of research about what actually changes clinician behaviour. It is also bureaucratically onerous, and therefore costly, and unless the quality indicators are accepted as markers of good quality care by the commissioners and providers alike, such an approach becomes little more than a tick-box exercise, and lacks credibility with clinicians.

Incentive schemes

For some time, GPs have been the beneficiaries of incentive rewards for achieving cost reductions and quality measures in prescribing. The advent of practice-based commissioning saw an extension of these principles into other areas. Practices or collaboratives were offered rewards for achieving outcomes, or for participating in initiatives including data validation, patient reviews, production of plans, or managing demand.

There is evidence that use of contracting sanctions remains a last-resort tactic for PCTs (Scoggins *et al* 2006). This is partly because the sanctions regime is relatively crude compared to the ability to offer incentives to performance. Performance management is towards the transactional end of the management spectrum, whereas application of sanctions threatens the relational aspect on which long-term improvement thrives. A commissioner may buy short-term compliance in one area at the cost of longer-term problems, leveraging performance across a range of quality dimensions.

We would suggest that the use of performance levers to create change is likely to be here to stay, and will and should always form part of the accountability relationship between commissioners and providers. It is the approach, though, that has limitations – and these need to be understood by those that use them. Not all practices respond to these stimuli: there are a range of reasons, relating to culture, practice life cycle (partners nearing retirement), ability, and so on. Also, some incentive-based approaches can exacerbate variation, as large, well-run practices are best placed to take advantage of benefits and resources.

Resource levers

Another approach is the selective provision of resources – not as a reward for performance, but to address specific weaknesses. This type of intervention has a long history and a variable evidence base to match the diversity of programmes. Many of these programmes have been effective and good value, helping to reduce variations in care and to build the much needed platform for shifting care from the acute sector.

- **Training** Training, whether for professional groups or multi-

disciplinary teams, has long been a staple offering from PCTs – and before that, from health authorities – although in many areas practices have successfully argued for this budget to be transferred to practice level. PCTs have sponsored or delivered programmes to improve basic skills, clinical quality, customer care and to meet individual development needs.

- **Premises** PCTs, and health authorities before them, have shaped and brokered – and, on many occasions, funded – investment in premises. The primary care estate is variable, but no more so than the rest of the NHS. Paul Corrigan argues that the long-term solutions to this problem are through bigger and better facilities and delivery units (Corrigan 2005). These are starting to emerge – particularly in urban areas.
- **Systems improvement** PCTs have also used programmes to improve specific aspects of delivery. For example, all PCTs have offered support to practices to improve access, including expert advice, analysis, facilitation and support, stopping short of providing additional workforce to actually answer the phone or see patients. The PRIMIS programme, run by the University of Nottingham, gives PCTs the opportunity to support practices on data quality, using similar methods (University of Nottingham 2010). The implementation of Choose and Book systems is another example.
- **Workforce** PCTs are less likely to directly provide workforce than other forms of support (except as a last resort), but some still offer support for recruitment and human resources. Where national targets need to be met – such as for vascular risk-assessment checks – PCTs may go as far as providing peripatetic staff and letting these out to practices in need, through agency-type arrangements.
- **Practice management** Ineffective management is often at the root of poor quality (Blakeway-Phillips 1992), and the role of practice manager now demands a highly skilled professional (Colin-Thome and Chambers 2009).

Outside of providing topic-based training, few PCTs have themselves sought to develop or invest in this increasingly vital component of improvement, although some would encourage practices to make their own investment in this. However, until recently, a significant number of practices would not have viewed having such a professional as essential. Indeed, one of the obvious benefits of an increasingly federal approach to general practice is that these costs can be shared by a number of practices with the very clear and obvious benefits enjoyed by all.

Competition levers

After almost two decades of market-driven reforms of public services, PCTs have begun to understand how competition can stimulate change. Some of these ideas have been tried out in primary care, to improve choice and quality through the stimulus of competition. These can be divided into two broad categories: supply-side measures and demand-side measures.

Supply-side measures

Throughout the last decade PCTs have increasingly used their procurement powers to bring new providers to meet specific needs – or simply, in the

case of the national EAPMS procurement, to stimulate competition. Walk-in centres, urgent care centres and new practices have altered the landscape for patients, and there are signs that GPs are beginning to respond to the perceived threat of having large, well-funded, commercially aware providers on their doorstep.

Demand-side measures

Demand-side measures have generally been less successful than their supply-side equivalents. PCTs lack the skills and resources to encourage patients to behave as consumers by switching to practices that are responsive, easy to access and offer a full range of services delivered in a pleasant environment. New proposals to abolish practice boundaries should inject a further measure of competition in the primary care market.

Fortunately for policy-makers, although progress is slow, experience in the acute sector shows that we need only relatively small numbers of patients to switch services for the system to have the desired effect. The effect is that practices that are not preferred raise their game and compete to win back the 4 or 5 per cent of their list that has chosen to exercise choice and register elsewhere.

There is little understanding of how far people are selecting their practice based on what might be called the 'patient offer': the combination of opening hours, range of services, good premises, telephone access and so on. The marketing skill required to understand patient motivation is probably out of reach of most practices and PCTs. A further problem involves those practices that lack the will to engage with the market and choose to continue with stable, or even declining, lists – such as where a single-handed GP is near to retirement.

Even after years of poor quality and unresponsive care, decommissioning a failing practice is still a difficult and traumatic process. But failure of providers is an essential ingredient of competition. It is the salt in the recipe – unpalatable on its own, but essential for the success of the dish. This creates a different set of problems for the commissioner, sometimes – in extreme cases – necessitating drastic and urgent action (Corrigan 2005) in the form of a practice of last resort or an intensive support team. Managing in real time to address an urgent problem is not something that commissioning organisations are geared for, and a single failing practice can absorb a great deal of the capacity available for commissioning.

Remodelling levers

Remodelling means changing the shape of local primary care provision, with the aim of improving the patient experience by replacing worn-out premises and/or offering additional services in a local facility. These projects can be expensive and protracted, but offer an opportunity to build the platform for care outside of hospital. They fall under two main categories: consolidation and federation.

Consolidation

Consolidation entails gathering together several (usually small) practices into one larger unit. At first, this unit might simply be a building that accommodates practices, with their contracts, staff and other infrastructure remaining intact. However, over time, practices may

grow together or be encouraged to take advantage of economies in management, records, IT and other functions that eventually mature into a single contract.

The polyclinic is the most obvious recent manifestation of this idea, regarded by many as a natural and desirable process leading to better care, better value for money, reduced unwarranted variation and reduced commissioning costs. Others argue that the general practice model can continue to meet needs as long as the practices achieve a critical mass (Morgan and Beerstecher 2009).

Other consolidation options exist. For many years, individual or groups of successful providers have been asked to take over a failing practice, or to absorb its patients. Consolidation is a reasonable response by commissioners to the failure of a provider. Some PCTs are looking to actively promote this process, unable to wait for natural ageing to take effect. An example of this is the Heart of Birmingham PCT's franchising strategy (Heart of Birmingham PCT 2009).

Federation

Federation entails allowing GP practices to come together to carry out functions that are beyond the means of a single practice, including diagnostic services, managing long-term conditions, quality management, teaching and research. This is the model currently championed by the bodies representing the profession (Lakhani *et al* 2007). Its attraction for GPs is the continuation of independent contractor status. This might extend to commissioning, resource management and other factors that take the federation towards an integrated health care provider.

This approach has the potential to drive up quality through peer support and peer review, including benchmarking, education initiatives, resource targeting on all aspects of quality including patient experience, clinical quality, and resources utilisation. However, practices working in this way will need to be mindful of the need to balance their role as peer developers, supporters and challengers with the ability to maintain positive and close working arrangements between practices and consortia, as both are essential for successful PBC.

5 Ways forward

This section considers what needs to happen to address the weaknesses that remain in commissioning primary care.

The challenge

This review has highlighted that commissioning of primary care services has suffered from systemic and persistent weaknesses. Clearly, there is no simple solution to improve the quality of the commissioning. Those charged with the task will need to make intelligent use of all available levers, paying much closer attention to the complementarities and tensions between the different approaches. However, the solution to this not inconsiderable challenge is not just about how commissioners optimise use of levers. It is also, fundamentally, about a new paradigm within which the commissioning of primary care can take place.

We suggest that a new model is needed that harnesses the professionalism, entrepreneurship and competitive nature of GPs to address the widespread variations in care and efficiency. Alongside this, it is essential to improve the alignment of clinical and resource decisions to manage demand and so expenditure. To make this work, we must support clinical commissioners with the skills and systems to make a difference.

Finally, we need to find a way to invest in additional capacity to deliver care outside of hospital – not just in terms of buildings and equipment, but in clinical workforce and in the ability to carry out the redesign in a way that maximise benefits and minimises unintended consequences of change.

A new paradigm

The paradigm we are seeking is a model of integrated care delivery that joins up effective commissioning (and decommissioning) of acute care, with improved provision of care in the community.

Existing PBC collaboratives – with some honourable exceptions – are not operating at such an advanced level. The recent King's Fund/NHS Alliance report (Wood and Curry 2009) found that while the commitment to PBC

was high, there remained a number of fundamental issues that would need to be addressed if PBC were to be used as a vehicle for delivering improved services within or outside of primary care. Fifty-two per cent of respondents cited as an issue lack of clarity about the vision for PBC, and how it would be used, while 56 cited confusion about the respective roles of PCTs and practice-based commissioners. Addressing this lack of clarity is an essential first step for policy-makers.

PBC was founded on the dual roles of practices as providers of list-based primary medical care and commissioners of individual care, through referral and shared care. The next iteration of policy, currently branded 'GP commissioning', will be a clinical commissioning model that must rest on a foundation of good quality primary care in order to be credible. Accepting responsibility for improving primary care will need to be a condition of participation. Under this approach, using a remodelling lever such as consolidation or federation of GP practices (as described in Section 5), is probably a necessary first step.

The integration of provision and commissioning at the level of primary care contractor is currently being tried out in a number of small-scale pilots (Department of Health 2010). The aim is to look beyond traditional boundaries to explore new, integrated models. These pilots tend to be specific to a particular disease or sector (for example, mental health), but will add to our understanding of how to deal with governance issues such as conflict of interest and patient representation.

The integration of the 'make and buy' decisions at the door of a group of primary care clinicians working with others is also one of the fundamental recommendations of a recent Nuffield Trust/NHS Alliance publication (Smith *et al* 2009). In this model, the clinical commissioning organisation would take on the responsibility for the commissioning of primary care, as well as all other services, and would have at its disposal the array of levers described in Section 4.

What sets this approach apart from the current arrangement is the degree of clinical leadership and ownership in taking on the responsibilities, working with effective management in implementation. Past experience (Mays *et al* 1988, 2001) shows that this sort of process is far more acceptable to those whose services are being commissioned if it is led by peers.

However, moving to this paradigm does require a considerable effort in change management to realign commissioning roles and responsibilities. Some specific reforms will also be needed, and this is explored in the rest of this section.

Contract reform

One of the fundamental weaknesses of the contract, and a consequence of the way it was implemented, is a lack of consensus over what constitutes standard GP care. For example, it is quite conceivable that one practice might provide phlebotomy or electrocardiography (ECG) as part of core service, while in the next this is either not available, or has to be paid for as an enhanced service.

Defining the core care – at least for major chronic conditions – should be central to the next contract revision. This needs to be linked to GP rewards, ideally through proper alignment of budgets rather than a complex performance system.

A view emerging from a number of academic and frontline clinicians is that we will perpetuate these difficulties for as long as we continue to have a national contract. They cite the preferred option moving forward as having a nationally negotiated framework, but with the contract detail being developed and negotiated locally, in response to the commissioners' requirements. This would then mirror the way in which we handle acute commissioning with the use of national model contracts, with the detail negotiated and signed up to locally.

Accountability

Those leading these changes also need to acknowledge that formal responsibility for commissioning of primary care services rests with the PCT, and that any formal performance management requirements for primary care would continue to sit with the PCT in the short term. As well as being highly variable in terms of size and competence, almost all the PBC organisations that have emerged in the past five years are characterised by a relatively narrow stakeholder base (locally practicing GPs), and weak governance.

Until now, governance has been focused on separating out the provider and commissioner functions. However, this is not a viable approach in an integrated organisation. Governance structures need to build on the shared interests of all those engaged in health and well-being, including colleagues in provider organisations and commissioners in local authorities. In short, it needs to be boundary spanning. The new organisation will need to be representative of its constituents and similar to a co-operative or social enterprise in structure.

One way of achieving this is to develop an entirely new type of GP-organisation running on a set of principles – some new, and some familiar, to include:

- improved accountability through an organisation that is properly constituted, with mechanisms to involve all stakeholders
- a principle of mutuality with member practices
- a community interest model of funding. The new organisation would need to be established on a not-for-profit basis, and service delivery by GP practices or GP-owned companies would need to be properly specified and monitored
- supporting functions that are contracted to other organisations under service-level agreements or broader partnership arrangements
- a strong public health function, working closely with the new organisations but retaining a local critical mass rather than being dispersed among them.

Another issue to be considered is the place at which the first level of accountability should take effect. The thinking emerging from some quarters is that this should actually sit at the level of the clinical commissioning organisation. This would result in the contract with the practice being held by the clinical commissioning group rather than the PCT.

However, there are some cautionary notes to making this change. Such a move would significantly change the nature of the relationship between the practice and the clinical commissioning organisation.

Moreover, while this thinking is gaining some momentum, other commentators are highlighting a number of real risks in such a radical shift in final accountability. One of the prizes in this model is the peer-led relationship between provider and commissioner, which would need to be built on mutual respect, professionalism, expertise and openness. If the commissioning group had the ultimate ability to apply formal contractual sanctions – potentially involving removal of that contract – then this may risk a threat to the positive and open relationship that is so critical to success, and which is in part why PCTs have struggled to commission effectively.

On the other hand, without this tension there is a risk that the relationship between commissioning and provider arms may become rather cosy, with clandestine agreements to the benefit of the core providers and group members developing as the networked organisation becomes self-serving and less open to external governance and review.

It may be possible to find a middle way. This could comprise formal contract-holding responsibility being held by the independent NHS board, but with the clinical commissioning group playing a clear role in ensuring appropriate primary care by adopting a range of approaches to peer review and challenge.

Early signals from the coalition government might suggest that the PCT – probably a larger and more distant entity – may hold a residual commissioning role, including that for primary care. The PCT, although responsible for commissioning primary care, may do so with the contract being technically held by the independent NHS board. In this circumstance it could look for an agreement between the clinical commissioning group and the tier above as to how far the clinical commissioning group would apply its commissioning powers, and the point at which it would hand over to the tier above to apply the formal contractual ‘performance management’ levers.

Investing in capacity and capability

Under this model, commissioning will need to be truly clinician led, but will critically require strong and effective management support working in partnership. It is highly likely that there would be capacity and capability issues at the level of the clinical commissioning consortium. These will need to be addressed, and must not be compromised in the pursuit of responding to pressure on management cost reductions. It is essential to skill up those clinicians who want to lead on this sort of commissioning, as is finding effective backfill support. To turn practising clinicians into full-time clinical managers will run the risk of losing the prize of peer-led commissioning. This must be protected.

Investing in information

PCTs can be criticised – and rightly so – for failing to invest in management information systems. They have been slow at taking advantage of a burgeoning marketplace for information systems and tools that allow much more active clinical management of patients, including allowing clinicians to select the most cost-effective and convenient treatment in real time. GPs may be better placed to implement and make use of these tools than PCTs. Many products already exist, or are already on trial, and relatively limited funding is needed. Reforms could be quickly brought into place that facilitate investment in such tools.

6 Conclusion

The model set out here has obvious attractions for general practice – not least, the protection it offer against competitive forces (Corrigan 2005). Meanwhile, for commissioners, the problem is a mirror image. There are attractions in having a powerful, well-resourced organisation, capable of disciplining its members and of delivering significant change – but how does one gain leverage over a federation that is able to act as a collective negotiator?

The organisational form chosen for such a model to be delivered will require some thought. Experience around the country, both from enhanced PBCs and integrated care organisations, suggests that a not-for-profit or social enterprise form might offer greater promise. There are many reasons for this, but they include the fact that public funds would not be redistributed to group members as profit. This would enable local communities to see that their local commissioners are spending money on priorities that have relevance directly to them, thus maintaining a real sense of NHS ‘ownership’.

Nevertheless, this paradigm may be viewed as a direct clash with the current policy drive around competition and choice, and might be seen as creating a situation where the tier above the clinical commissioning group – currently the PCT – faces a monopoly supplier in primary care to join the monopolists of mental health and acute care.

However, there is another way of seeing this. If one seeks to replace the dogma of choice and competition with a more directly accountable relationship to local communities, then this in itself may offer a greater and more powerful potential to better develop public engagement and voice in local priority setting and redesign activities. (An example might be in a community interest company form, where a part of the constitution of the new organisations is to respond, or be held accountable, for care quality by patients’ themselves.) Seen in this way, it would be providing a solution to the current democratic deficit and a better way of influencing commissioning and delivery.

The attractions of an integrated primary and community care system are therefore significant from the points of view both of the patient and of a financially challenged NHS. The evidence from our NHS history, with previous iterations of clinician-led organisations, and from other countries (Smith *et al* 2009) suggests that the best potential to deliver on the commissioning agenda is created by aligning responsibility for population health outcomes with the ability and freedom to make decisions, with clear accountability to the tier above for what it achieves.

The benefits of choice in driving up quality and minimising costs are demonstrated in many markets, but the evidence for a powerful effect in a wholly public service is much more limited. Furthermore, the forces impelling towards federation and integration are powerful. Short of legislation preventing co-operation between practices, there is little that can be done to prevent it. Perhaps it is time to concede that strategies other than choice and competition offer greater potential for improving the quality of primary care, and that the new paradigm of integrated clinician-led commissioning and provision is where we now need to go.

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