

bmj.com For all the latest articles on the NHS reforms, visit the microsite at [bmj.com/nhsreforms](http://bmj.com/nhsreforms)

# Hospital service reconfiguration

## The battle for hearts and minds

Will Andrew Lansley's four tests for reconfiguration make decisions less controversial?

**Helen Barratt** and **Rosalind Raine** discuss the challenges they raise

Proposals to reconfigure NHS hospital services are always contentious. In 2001, Dr Richard Taylor won a parliamentary seat on the strength of his campaign against the decision to close acute services at Kidderminster Hospital.<sup>1</sup> More recently, plans to centralise surgical services for children with congenital heart disease have prompted opposition across the country.<sup>2</sup> The Independent Reconfiguration Panel (IRP) advises ministers about re-shaping hospital services and, by the end of 2010, it had undertaken 17 full reviews of contested proposals for health service change in England and offered written advice on several others.<sup>3</sup>

During the 2010 general election campaign, the Conservative party promised to stop "centrally dictated" reorganisations of NHS services.<sup>4</sup> Writing in the *Daily Telegraph* on 21 May 2010,<sup>5</sup> days after the coalition government came to power, the secretary of state for health, Andrew Lansley, declared a moratorium on such programmes. All proposals—even those at the implementation stage—were put on hold and planners were instructed to demonstrate that plans met four new tests: support from general practitioner (GP) commissioners, strengthened public engagement, consistency with patient choice, and clear evidence for change.

One high profile reconfiguration affected by the moratorium was the proposed downgrade of acute services at Chase Farm Hospital in north London (box). We provided academic input to the review of these proposals. In this article, we draw on this experience to reflect on the difficulties of applying the Lansley tests and propose ways to strengthen the evidence base to aid decision making.

### Clarity on the clinical evidence base

The research evidence used to justify reconfiguration focuses on volume-outcome relations. A growing body of research shows improved

patient outcomes when a range of procedures—including surgery for colorectal cancer<sup>11</sup> and elective repair of aortic aneurysm<sup>12</sup>—are carried out in larger units that serve bigger populations. However, much of this research has been done in the US, where organisational differences may limit transferring the findings to the NHS.<sup>13</sup> Furthermore, many of the studies are poorly controlled for the effects of confounding variables.

In contrast, an English study of retrospective data from ambulance call-outs for immediately life threatening symptoms found that increased journey distance to hospital was associated with increased mortality.<sup>14</sup> After case-mix was adjusted for, every additional 10 km in straight line distance was associated with a 1% absolute increase in mortality. These findings reflect the performance of emergency services between 1997 and 2001, and journey time may be less relevant now that paramedics

commonly start definitive treatment.<sup>15</sup> In addition, the results may apply only to patients at high risk of immediate death. Indeed, preliminary data suggest that centralising specialist hyperacute stroke units across London is associated with reduced mortality compared with national rates.<sup>16</sup> This is likely to be because patients receive rapid access to thrombolysis. Findings such as these highlight the need for a thorough understanding of the interaction between geographical access and patient outcomes.

These data are largely drawn from observational research. Although such studies have limited power to demonstrate causality, experimental designs of major service reorganisations are usually not feasible.<sup>17</sup> In these circumstances, the case for change often relies on a combination of observational research evidence and expert clinical consensus.

### Consistency with patient choice

This test is defined by the Department of Health as the extent to which proposals affect patients' ability to choose between providers, settings, and interventions.<sup>18</sup> However, research suggests that choice of provider is not, in fact, a priority for patients having elective care; respondents placed it as the 11th most important aspect of their healthcare in a list of 16 items.<sup>19, 20</sup> It may be even less important for patients needing emergency care.<sup>21</sup>

Moreover, the germane question is whether the plans are consistent with patient choice when people are presented with a trade-off between the perceived advantages and disadvantages of the current service compared with reconfigured services. Such trade-offs have not been formally examined but are likely to be influenced by community loyalty to local hospitals. Hospitals have an important social role, helping the public to

maintain trust in the NHS.<sup>22</sup> Mixed methods (qualitative-quantitative) research exploring determinants of public opinion and the importance of the various components of the trade-offs (for example, proximity versus improved

survival) would help us gain a better understanding of public and patient priorities. This could in turn inform future service reconfigurations.

### Strengthened public engagement

Meaningful engagement requires that the public should be able to affect decisions.<sup>23</sup> Intensive stakeholder engagement and clear messages about the need for change help build a legitimate case for reform.<sup>24</sup> In reality, commissioners have been criticised for consulting on service redesign after decisions have been made.<sup>3</sup> To meet this test, commissioners are recommended to seek the views of local involvement networks and health overview and scrutiny committees.

**The public is often deeply suspicious that reforms are a cover for cuts. This may be a particular concern now that the NHS is under pressure to make savings**

## Chase Farm reconfiguration

Proposals to downgrade services at Chase Farm Hospital in north London were first raised more than 15 years ago.<sup>6</sup> They included replacement of the emergency department with an urgent care centre and consolidation of women's and children's services at Barnet and North Middlesex Hospitals, which are six to seven miles away. Other places will be grappling with similar decisions.<sup>7</sup>



**2007: In opposition the Conservatives vowed to save Chase Farm services**

**JULY 2009** Work began on implementing the proposals, including building work on the North Middlesex site to accommodate increased patient flows. However, implementation was put on hold while the proposals were assessed against the four new Lansley tests

**MAY 2010** A panel of clinicians (mostly local GPs) was convened to review the clinical evidence underpinning the plans. The panel concluded that no change was not a possibility because the current situation was both "unstable and unsustainable" and would result in declining quality of care and worsening health inequalities.<sup>8</sup> All local GPs were invited to comment on the panel's conclusions. Patient and public engagement was sought through a series of public meetings and a supplement in local newspapers explaining the rationale for the proposals. Local involvement network representatives were included in assessing the strategy against the patient choice test

**JANUARY 2011** The strategic health authority, NHS London, concluded that the four tests had been met and that the reconfiguration could recommence



**MARCH 2011** The health secretary held a closed meeting with local MPs and Enfield council representatives (above), who were opposed to the plans. Afterwards, Mr Lansley invited this group to submit alternative options to maintain services at Chase Farm

**MAY 2011** The secretary of state referred Enfield Council's report to the IRP. The report did not include an alternative plan, but requested more investment in healthcare for the borough<sup>9</sup>

**NHS  
London**

Beyond this, however, strengthened patient engagement remains challenging to quantify.

The previous government introduced several reforms aimed at increasing public involvement and local scrutiny of healthcare, and the IRP, established in 2003, was part of this.<sup>25</sup> The panel provides independent advice on reconfiguration proposals when local agreement cannot be reached, and its members include clinicians, management representatives, and lay members with experience in delivering health service change. One of the main reasons why reconfiguration proposals are referred to the panel is that commissioners have failed to convince affected communities of the clinical case for change.<sup>3</sup> However, there is little research or consensus on the best methods to secure public engagement.<sup>26</sup>

In terms of the economic rationale for change, the public is often deeply suspicious that reforms are a cover for spending cuts.<sup>27</sup> This may be a particular concern now that the NHS is under pressure to make efficiency savings.<sup>28</sup> In reality, the economic case for reconfiguration is seldom clear cut because it depends on the costs that are included (such as transaction costs and, where relevant, repayments on private finance initiatives). In addition, long time frames, uncertainty about the future, and changing conditions make it difficult to predict future costs. Even if the changes are likely to save money and not harm health outcomes, public acceptability may be tempered by other important determinants of patient and carer experience such as travel times and costs.

Effective public and patient engagement requires explicit presentations of the clinical and financial risks, benefits, and implications of service change. The way that such information is framed is also important because it affects the way that it is interpreted.<sup>29</sup> The media sometimes exploit this by using sensationalist language to raise fears about large numbers of lives being put at risk, often with little or no supporting evidence.<sup>30</sup> As part of strengthening engagement, commissioners and providers must therefore disseminate transparent, comprehensive information in a form that can be understood by all sections of the affected community.

#### Support from GP commissioners

The fourth test reflects the coalition government's commitment to devolve decision making power to general practitioners. At the time of the Chase Farm review, commissioning groups were not yet established in the three main affected boroughs, so this test was assessed by inviting all local general practitioners to indicate whether they agreed with the recommendations. Response rates and percentage levels of support were then described for each borough.<sup>31</sup> However, in south Hertfordshire, which is also affected by the Chase Farm reconfiguration, the two general practice consortiums were asked to submit a written indication of their corporate views about the proposals, as suggested in the Department of Health guidance.

Since the Chase Farm decision commissioning groups have been broadened to include other

health professionals, and the government will need to think again about how best to obtain the views of local GPs. A dichotomous indication of GP support is relatively simple to obtain. However, this gives no indication of the strength of their views. Such data could be obtained by asking GPs to provide more in depth information and respond to questions using a Likert scale. This approach is obviously more resource intensive and requires more sophisticated analytical techniques.

#### Additional drivers for change

Reconfiguration schemes are commonly driven by additional factors that are not scrutinised by the Lansley tests. These should also be taken into account when evaluating the rationale for change. First is the shift towards greater provision of services in community settings because of factors such as increasing day case surgery and a higher burden of chronic disease as the population ages.<sup>28</sup>

Workforce related factors that may affect patient safety are also important. The implementation of the European Working Time Directive tends to drive reconfiguration proposals in acute services with high emergency workloads.<sup>32</sup> It is argued that consolidation of acute services is required to ensure both a critical mass of junior doctors to maintain adequate standards of patient care and sufficient numbers of patients for satisfactory clinical training.<sup>33</sup>

Several royal colleges are also lobbying for higher levels of senior staffing to promote safer

practice.<sup>34 35</sup> They argue that achieving this without service reorganisation would require a substantial increase in consultant numbers. Once again, it is not possible to apply experimental methods to prove such assertions. We therefore have to rely on observational data, and here there is some evidence of worse outcomes in patients who are admitted to hospital during evenings and weekends when fewer consultants are available.<sup>36</sup>

### Future decisions

The Department of Health guidance does not set thresholds for meeting the four new tests, arguing instead that the process should be locally led and designed.<sup>18</sup> Furthermore, many of the requisite data are qualitative and require value judgments about their importance, relevance, and representativeness.

Research evidence will always comprise but one determinant of reconfiguration decisions, and there will be a trade-off with other factors, including local and national political concerns. Although organisations including the British Medical Association, the NHS Confederation, and the King's Fund have called for the IRP to become the final arbiter, thus distancing politicians from decisions,<sup>37</sup> it is naive to expect politicians not to support their constituents' concerns, even in the face of clinical consensus, particularly in marginal constituencies.

The relevance of the research evidence is also likely to be contested by stakeholders with different perspectives and values. It is therefore crucial to pay close attention to the transparency, comprehensibility, and comprehensiveness of the evidence and to ensure it meets the needs of all decision makers

Furthermore, there is room to strengthen the evidence base through a programme of national research that is generalisable to local circumstances. For example, a better understanding of the relation between geographical access and patient outcomes would be valuable. We would also benefit from a better understanding of what concerns the public and the trade-offs that patients and their families are prepared to make when considering major service change.

Another problem is that the four tests could produce conflicting outcomes. For example, the evidence may suggest clinical benefits from reconfiguring services on fewer sites. But this could reduce patient choice of provider. It may be more acceptable and transparent to define the relevant components of benefit and

patient choice and their order of priority with local stakeholders before plans for reconfiguration are made.

Finally, changes set out in the NHS Bill could raise additional challenges. The extent of involvement of multi-disciplinary clinical commissioning groups, clinical networks, and senates, as well as the potential role of the National Commissioning Board, is currently unclear and will need to be considered. Without regional structures to guide the process, it is unlikely that single commissioning groups will have the resources to conduct the necessary analyses required to assess the case for change or wield sufficient power to initiate reform across large geographical areas. Decisions concerning service integrations involving multiple hospitals may also be influenced by the promotion of competition between trusts.

**Helen Barratt** research training fellow  
h.barratt@ucl.ac.uk

**Rosalind Raine** professor of health care evaluation,  
Centre of Applied Health Research, University College  
London, London WC1E 6BT, UK

We thank Jonathan Wolff and Steve Morris for their advice and comments.

**Contributors and sources:** HB is a speciality registrar in public health and RR is UCL Partners programme director in population health. The article is based on a review of the evidence underpinning the consolidation of acute hospital services and the authors' experience of providing independent academic input into the review of the Barnet, Enfield and Haringey clinical strategy. The views expressed are those of the authors. Both authors drafted the article. HB is guarantor.

**Competing interests:** Both authors have completed the ICMJE uniform disclosure form at [www.icmje.org/coi\\_disclosure.pdf](http://www.icmje.org/coi_disclosure.pdf) (available on request from the corresponding author) and declare no support from any organisation for the submitted work and no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; they provided academic input to the review of the Chase Farm decision.

**Provenance and peer review:** Not commissioned; externally peer reviewed.

- Gulland A. Doctor wins seat in fight to save hospital. *BMJ* 2001;322:1443.
- Dreaper J. Big response to children's heart surgery consultation. *BBC News* 2011 Aug 24. [www.bbc.co.uk/news/health-14631351](http://www.bbc.co.uk/news/health-14631351).
- Independent Reconfiguration Panel. *Learning from reviews: an overview*. IRP, 2011.
- Jeffreys B. Tories rule out forced NHS closures. *BBC News* 2010 Apr 13. <http://news.bbc.co.uk/1/hi/health/8617460.stm>.
- Lansley A. The NHS must put patients first. *Daily Telegraph* 2010 May 21. [www.telegraph.co.uk/health/7747870/The-NHS-must-put-patients-first.html](http://www.telegraph.co.uk/health/7747870/The-NHS-must-put-patients-first.html).
- Lister S. The politics of NHS reconfiguration. *BMJ* 2011;343:d5311.
- Timmins N. Battle over A&E unit seen as test case. *Financial Times* 2011 Mar 2. [www.ft.com/cms/s/0/2c3d53ce-4507-11e0-80e7-00144feab49a.html#axzz1Y0zInQw](http://www.ft.com/cms/s/0/2c3d53ce-4507-11e0-80e7-00144feab49a.html#axzz1Y0zInQw).
- Barratt H, Riordan J. *Barnet, Enfield and Haringey clinical strategy: clinical review panel report*. 2010. [www.behfuture.nhs.uk/publications/docs/clinical\\_review\\_panel\\_final\\_report.pdf](http://www.behfuture.nhs.uk/publications/docs/clinical_review_panel_final_report.pdf).
- Independent Reconfiguration Panel. Initial assessment

- of Barnet Enfield Haringey clinical strategy: report and referral from Enfield Council. IRP, 2011.
- Kmietowicz Z. Health secretary makes U turn over service closure at London hospital. *BMJ* 2011;343:d5848.
- Van Gijn W, Gooiker G, Wouters M, Post P, Tollenaar R, van de Velde C. Volume and outcome in colorectal cancer surgery. *Eur J Surg Oncol* 2010;36(suppl 1):S55-63.
- Young E, Holt P, Poloniecki J, Loftus I, Thompson M. Meta-analysis and systematic review of the relationship between surgeon annual caseload and mortality for elective open abdominal aortic aneurysm repairs. *J Vasc Surg* 2007;46:1287-94.
- Mayer E, Purkayastha S, Athanasiou T, Darzi A, Vale J. Assessing the quality of the volume-outcome relationship in uro-oncology. *BJU Int* 2009;103:341-9.
- Nicholl J, West J, Goodacre S, Turner J. The relationship between distance to hospital and patient mortality in emergencies: an observational study. *Emerg Med J* 2007;24:665-8.
- Spurgeon P, Cooke M, Fulop N, Walters R, West P, Barwell F, et al. *Evaluating models of service delivery: reconfiguration principle*. National Institute for Health Research Service Delivery and Organisation Programme, 2010.
- UCL Partners. *Our progress*. [www.uclpartners.com/about-us/our-progress](http://www.uclpartners.com/about-us/our-progress). 2011.
- Black N. Why we need observational studies to evaluate the effectiveness of health care. *BMJ* 1996;312:1215.
- Nicholson D. *NHS reconfiguration guidance*. 2010. Department of Health, 2010. [www.dh.gov.uk](http://www.dh.gov.uk) (search for gateway reference: 14543).
- Fotaki M, Roland M, Boyd A, McDonald R, Scheaff R, Smith L. What benefits will choice bring to patients? Literature review and assessment of implications. *J Health Serv Res Policy* 2008;13:178-84.
- MORI. Public perceptions and patient experience of the NHS. Report submitted to the Department of Health. 2004. [www.dh.gov.uk/assetRoot/04/11/81/09/04118109.pdf](http://www.dh.gov.uk/assetRoot/04/11/81/09/04118109.pdf).
- Appleby J, Dixon J. Patient choice in the NHS. *BMJ* 2004;329:61-2.
- Fulop N, Walters R, P, Spurgeon P. Implementing changes to hospital services: factors influencing the process and 'results' of reconfiguration. *Health Policy* 2012;104:128-35.
- Picker Institute. *Accountability—public views and what to do about them*. Picker Institute Europe, 2008.
- Thorlby R. Managing health reform through an economic downturn. Nuffield Trust, 2011.
- Department of Health. The NHS plan. Stationery Office, 2000.
- Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, et al. Systematic review of involving patients in the planning and development of health care. *BMJ* 2002;325:1263-5.
- Fuchs V, Milstein A. The \$640 billion question—why does cost-effective care diffuse so slowly? *N Engl J Med* 2011;364:1985-7.
- Palmer K. Reconfiguring health services: lessons from south east London. King's Fund, 2011.
- McKee M, Raine R. Choosing health? First choose your philosophy. *Lancet* 2005;365:369-71.
- Randhawa K. London A&E closure "puts 500,000 lives at risk." *Evening Standard* 2011 Jan 27. [www.thisislondon.co.uk/standard/article-23917930-london-a-and-e-closure-puts-500000-lives-at-risk.do](http://www.thisislondon.co.uk/standard/article-23917930-london-a-and-e-closure-puts-500000-lives-at-risk.do).
- Barratt H, Raine R. Barnet, Enfield and Haringey clinical strategy: report assessing the level of support for the strategy amongst general practitioners. 2010. [www.behfuture.nhs.uk/publications/docs/beh\\_gp\\_support\\_report\\_30\\_11\\_2010.pdf](http://www.behfuture.nhs.uk/publications/docs/beh_gp_support_report_30_11_2010.pdf).
- Temple J. Time for training: a review of the impact of the European Working Time Directive on the quality of training. Medical Education England, 2010.
- Royal College of Paediatrics and Child Health. *Modelling the future II: reconfiguration and workforce estimates*. London: RCPH, 2008.
- Royal College of Obstetricians and Gynaecologists *The impact of the working time directive on O&G services*. RCOG, 2009.
- College of Emergency Medicine. *Emergency medicine consultants workforce recommendations*. CEM, 2010.
- Royal College of Physicians. RCP position statement on care of medical patients out of hours. 2010. <http://old.rcplondon.ac.uk/professional-issues/Pages/RCP-on-care-of-medical-patients-out-of-hours.aspx>.
- Ham C. Politicians have ducked hard decisions on the NHS for far too long. *Observer* 2011 June 19. [www.guardian.co.uk/society/2011/jun/19/nhs-politicians-have-ducked-hard-decisions](http://www.guardian.co.uk/society/2011/jun/19/nhs-politicians-have-ducked-hard-decisions).

Cite this as: *BMJ* 2012;344:e953

# GP led commissioning

## Time for a cool appraisal

The government has identified GP led commissioning as critical to tackling the twin challenges of service change and improved efficiency, but does the evidence bear this out?

**Judith Smith** and **Nicholas Mays** investigate

**G**eneral practitioner led commissioning is a policy with which the English NHS has held faith since 1991. The establishment of over 250 clinical commissioning groups comprised primarily of general practitioners (GPs) represents a central plank in the English NHS reform programme currently being debated in parliament.<sup>1</sup> It is proposed that from 2013, commissioning groups will gradually assume responsibility for £60bn (€72bn; \$95bn) of funding from primary care trusts when they are abolished and be accountable to an NHS Commissioning Board. We use the evidence on previous GP led commissioning initiatives to highlight the likely limitations of new commissioning groups and suggest some changes.

### What is GP commissioning meant to solve?

The perpetual desire to strengthen commissioning reflects frustration at the seeming failure of different purchasing arrangements to shift care from hospital to community settings and reduce the rates of avoidable emergency admissions.<sup>2</sup> Instead the NHS has seen an inexorable rise in emergency admissions over the past decade<sup>3</sup> and an expansion of secondary care spending and activity.<sup>4</sup>

The desire to halt this trend and develop alternative forms of care, especially for frail older people with complex conditions, is now stronger than ever. The NHS faces an unprecedented 4% efficiency target for each year until 2015. GP led commissioning is a key part of government plans to meet these challenges.

### What is the rationale?

The rationale for GP led commissioning is that GPs, given their gatekeeping role in relation to expensive secondary care and diagnostics and knowledge of patients on their practice lists, are well placed to purchase health services on behalf of the local population. They are considered to combine an individual patient focus with a broader population perspective.<sup>5</sup> The theory is that by holding budgets for referral

and treatment decisions, they can be encouraged to develop the more community based care that has so far eluded the NHS. This belief is rooted in wider analysis of the value of involving clinicians in the management of health services.<sup>6</sup> The downside is that devolved purchasing increases transaction costs, loses the economies of commissioning at scale, and makes it harder to manage financial and service risk.<sup>7</sup> Furthermore, GPs will also become responsible for rationing local healthcare and have to account for difficult investment and service decisions. The primary-secondary care divide of the NHS is also perpetuated, and the thorny issue of who commissions and improves primary care remains unresolved.<sup>8</sup>

### What does the evidence tell us?

Commissioning needs to engage GPs while assuring transparency of interests

History has shown that while GP commissioners start with a strong desire to be nimble clinically focused organisations, they are usually rushed by policy makers into becoming larger statutory bodies with wide ranging responsibilities and are then deemed bureaucratic and distant from local professionals. This happened with primary care groups and primary care trusts,<sup>9</sup> and a fundamental issue for clinical commissioning groups is how to avoid this process and stand a chance of maintaining the engagement of GPs and other clinicians.

GP commissioning requires local family doctors to sign up to a minimum set of activities, including working to common protocols for referral for specialist opinion; sharing of clinical and activity data; adherence to collectively agreed pathways of care for long term conditions; and abiding by local policies for prescribing drugs and diagnostic tests.<sup>10</sup> Research highlights the importance of crafting an appropriate balance of incentives for GPs and

avoiding overly burdensome governance that risks GPs perceiving commissioning groups as belonging to the state rather than local doctors.<sup>11</sup> However, GPs also face inherent conflicts of interest when deciding whether to “make or buy” local health services that can be provided by general practice, services in which they are likely to have a personal financial interest.<sup>12</sup> One way to achieve this would be for a subset of local GPs to take on the role of formal commissioners of healthcare for the local population. This role could be separated from that of smaller collectives of other local GPs taking on budgets for managing chronic disease and extended primary care, with the possibility of using any savings to reinvest in local services.

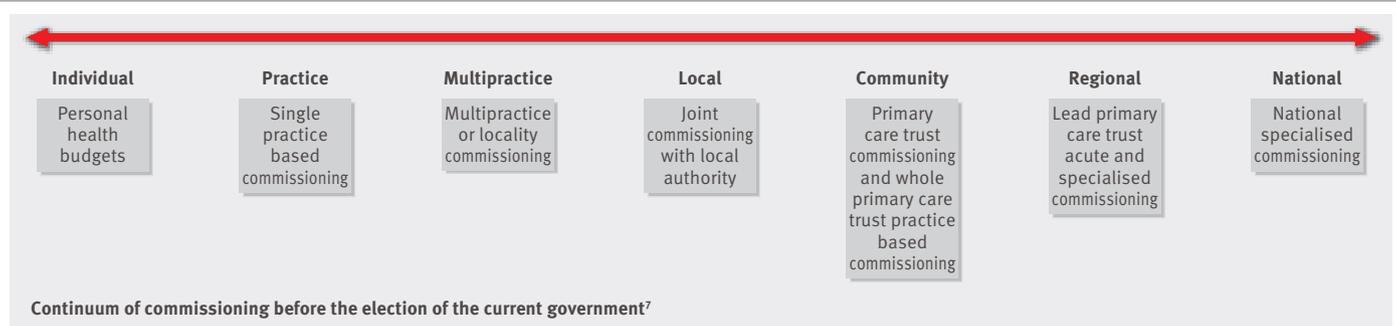
Commissioning will struggle to make a difference beyond primary care

Evidence shows that GP led commissioners focus foremost on the development of primary care, this being of most direct relevance to general practice teams. Examples include the provision of specialist community nursing care; new primary care based diagnostic services; and

**As with total purchasing pilots in the late 1990s, GP led commissioners continue to report difficulty in changing acute care contracts and funding flows**

services to support people living with long term conditions. A comprehensive review of primary care led commissioning found little evidence of impact on the way that hospital care was delivered, except in encouraging some increase in responsiveness of services, such as shorter waiting times or improved information from hospitals to GPs about treatment of their patients.<sup>7</sup>

Subsequent analyses have confirmed this,<sup>2 12 13</sup> challenging current proposals to make GP led commissioning the main vehicle for health purchasing and relying on it to bring about major service change at a time of tough financial constraint. As with total purchasing pilots in the late 1990s,<sup>14</sup> GP led commissioners continue to report difficulty in changing acute care contracts and funding flows and



seem drawn to concentrate on those services that they know and can control best.<sup>2 12</sup> Possible levers to help with this task include continuing the reform of the NHS payment system to enable commissioners to bundle payment across primary and secondary care services; clear national standards for urgent and chronic care, developed and implemented by the Commissioning Board; and the use of greater supply side competition to make providers more responsive to commissioners' wishes. Furthermore, it is worth experimenting with the allocation of population based budgets to groups of primary (and ideally also secondary) care clinicians seeking to develop integrated care, making them jointly accountable for managing and improving services such as urgent and chronic disease care.<sup>15</sup>

**With the removal of primary care trusts and strategic health authorities, commissioning groups will be left with a daunting range of responsibilities**

**Extensive management support will be needed** Commissioning is hard to do, in whatever form.<sup>8 16</sup> It requires sophisticated support, such as needs assessment, modelling of demand for future care, service specification, contracting and procurement, and assessment of service quality and outcomes. Some studies have highlighted a link between levels of management support and progress in terms of commissioning outcomes.<sup>14</sup> Recent analysis by a leading US commentator points to the need to invest heavily in management support if devolved commissioning in the NHS is to succeed,<sup>17</sup> a point also made in a review of NHS commissioning in 1998.<sup>8</sup> However, the NHS currently faces a reduction in management costs of over 40%, making it likely that such support will be hard to find.

With the removal of primary care trusts and strategic health authorities, commissioning groups will be left with a daunting range of responsibilities. Critical to success is recognising that there is a continuum of commissioning from the individual to national scale (figure), with financial and service risk allocated according to the scope and scale of a particular serv-

ice. Commissioning groups might decide what risk they are ready to handle, but they will need to be held to account for this by the Commissioning Board through its proposed process for authorising commissioners.<sup>18</sup> Commissioning support is therefore likely to be shared across commissioning groups and other organisations, with different arrangements for services according to the level of financial risk, building on the existing spectrum of support arrangements developed for primary care trust and practice based commissioning, and mitigating the known diseconomies of scale inherent in devolved purchasing.

Without such support, commissioning groups will be unable to make much more than marginal changes to local services, and any change is likely to be mainly in primary rather than secondary care.

**Governance and accountability will prove tricky** Good practice in the governance of public organisations requires that funds are spent in an accountable and transparent manner. GP led commissioners have found it difficult to develop effective arrangements for accountability to the public and patients.<sup>14 19</sup> Likewise, it has been shown that nurses and other non-medical staff struggle to have a meaningful influence on the decisions taken by GP commissioners. This poses a significant risk that decisions may be made without the debate expected of public funding bodies, GPs' views may dominate even where other clinicians are involved, and there may be inadequate mitigation of the conflicts of interest inherent in GPs making decisions about the funding of local health services.

Commissioning groups will thus need carefully crafted governance arrangements that can build public and professional confidence in their decisions and of their GPs as advocates for their patients, while securing necessary buy-in from GPs and other clinicians. Groups need to operate as fully fledged public bodies capable of withstanding judicial review of what

may prove to be contentious funding and service development decisions. There will also need to be robust arrangements for the local commissioning and performance management of primary care provision, developed in concert with the Commissioning Board. Proposed amendments to NHS legislation set out requirements for lay and specialist clinical involvement in governance. Putting these in place, and simultaneously engaging frontline clinicians in commissioning, is a big challenge.

**Way forward for reform**

English NHS policy is unusual in its attachment to the idea of GPs leading the purchasing of healthcare at local level. The evidence suggests that GP led commissioners will find it extremely difficult to move beyond the incremental development of community services and engage their general practice colleagues in setting wider funding priorities and making substantial change to secondary (and also primary) care. To stand a reasonable chance of success the focus should be placed on how GPs can be central to reshaping the provision, rather than commissioning of local health services.

One solution is to take forward experiments with what has been termed a local clinical partnership<sup>20</sup> or an integrated care organisation<sup>15</sup>—where a funder (primary care trust cluster, outpost of the NHS Commissioning Board, or a subset of local GPs acting as the formal commissioning group) would allocate a population based budget to a collective of GPs and other clinicians with which to deliver a range of services for local people. This would entail a departure from what has, for two decades, been understood as GP commissioning. Research evidence, together with modern care and financial needs, makes such a rethink about the realistic potential of GP commissioning timely.

**Judith A Smith** head of policy, Nuffield Trust, London W1G 7LP, UK  
judith.smith@nuffieldtrust.org.uk

**Nicholas Mays** professor of health policy, London School of Hygiene and Tropical Medicine, Department of Health Services Research and Policy, London, UK  
Contributors and sources: JAS and NM have both carried out extensive research and policy analysis in healthcare

commissioning, medical groups, and primary care led commissioning. This article draws on research evidence on GP involvement in commissioning in the UK and elsewhere over 20 years. JAS had the idea for the article and prepared the first draft. NM commented on and edited subsequent drafts. JAS is the guarantor.

**Competing interests:** Both authors have completed the ICJME unified disclosure form at [www.icjme.org/coi\\_disclosure.pdf](http://www.icjme.org/coi_disclosure.pdf) (available on request from the corresponding author) and declare no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years (other than having received funding for independent health services research from the Department of Health Policy Research Programme and the National Institute of Health Research); and no other relationships or activities that could appear to have influenced the submitted work.

**Provenance and peer review:** Not commissioned; externally peer reviewed.

**Accepted:** 24 January 2012

- 1 Department of Health. *Equity and excellence. liberating the NHS*. DH, 2010.
- 2 Smith JA, Curry N, Mays N and Dixon J. *Where next for commissioning in the English NHS?* Nuffield Trust, King's Fund, 2010.
- 3 Blunt I, Bardsley M, Dixon J. *Trends in emergency admissions in England 2004-2009*. Nuffield Trust, 2010.
- 4 Audit Commission. *More for less? Are productivity and efficiency improving in the NHS?* Audit Commission, 2009.
- 5 Ham C. Population centred and patient focused purchasing: the UK experience. *Milbank Q* 1996;74:1:91-214.
- 6 Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K, Born K. *High performing healthcare systems: delivering quality by design*. Longwoods, 2008.
- 7 Smith JA, Mays N, Dixon J, Goodwin N, Lewis RQ, McClelland S, et al. *A review of the effectiveness of primary care-led commissioning and its place in the NHS*. Health Foundation, 2004.
- 8 Light D. *Effective commissioning: lessons from purchasing in American managed care*. London: Office of Health Economics, 1998.
- 9 Smith JA, Walshe KMJ. Big business: the corporatization of primary care in the UK and the USA. *Public Money Manag* 2004;24:87-96.
- 10 Smith JA, Dixon J, Mays N, Goodwin N, Lewis RQ, McClelland S, et al. Practice-based commissioning: applying the evidence. *BMJ* 2005;331:1397-9.
- 11 Locock L, Regen E, Goodwin N. Managing or managed? Experience of general practitioners in English primary care groups and trusts. *Health Serv Manage Res* 2004;17:24-35.
- 12 Curry N, Goodwin N, Naylor C, Robertson R. *Practice-based commissioning: replace, reinvigorate or abandon*. King's Fund, 2008.
- 13 Audit Commission, Healthcare Commission. *Is the treatment working? Progress with the NHS system reform programme*. Audit Commission, 2008.
- 14 Mays N, Wyke S, Malbon G, Goodwin N, eds. *The purchasing of health care by primary care organisations: an evaluation and guide to future policy*. Open University Press, 2001.
- 15 Goodwin N, Smith JA, Davies A, Perry C, Rosen R, Dixon A, et al. A report to the Department of Health and NHS Future Forum: integrated care for patients and populations: improving outcomes by working together. King's Fund, Nuffield Trust, 2012.
- 16 Figueras J, Robinson R, Jakubowski E, eds. *Purchasing to improve health system performance*. Open University Press, 2005.
- 17 Casalino L. *GP commissioning in the NHS in England: ten suggestions from the United States*. Nuffield Trust, 2011.
- 18 Department of Health. *Developing clinical commissioning groups: towards authorisation (draft)*. DH, 2011.
- 19 Dowling B, Glendinning C, eds. *The new primary care, modern, dependable, successful*. Open University Press, 2003.
- 20 Smith JA, Wood J, Elias J. *Beyond practice-based commissioning: the local clinical partnership*. Nuffield Trust, NHS Alliance, 2009.

Cite this as: *BMJ* 2012;344:e980

## FROM BMJ BLOGS Peter Bailey

### The emperor's finery

It was not, of course, in relation to the NHS that Prime Minister Tony Blair famously said, "I only know what I believe." His assertion was in defence of military action in Iraq despite the millions on the streets saying, "Not in my name." It is however a convenient method of ignoring the troublesome masses who disagree and it has a hint of direct communication with higher powers as an infallible guide to action.

Are we seeing something similar now with the health bill? I am observing from the sidelines, having retired three weeks ago after 28 years and many tens of thousands of consultations as a general practitioner. I have also served on more than my share of committees and danced the quadrille with managers, hospital consultants, and politicians all trying to square the circle of funding and demand. What I see is an outpouring of concern for the fundamental core of the National Health Service being expressed by its users and its practitioners, united in disbelief as the unholy coalition pushes on with reforms that no one believes will achieve the improvements in productivity that are necessary in order to secure the future stability of the service.

Sceptics and unbelievers are surplus to requirements when a dogged policy of face saving is to be pursued. One can imagine the emperor, having been unnerved by the

shrill cry from the little boy sitting on his father's shoulders drawing attention to the imperial nakedness, hastily calling together a crisis meeting of such courtiers whose acquiescent views could be assured, in order to bolster his confidence in his belief that he is indeed dressed in finery.

I may be wrong of course. Exclusion of the BMA and the Royal College of General Practitioners from the Downing Street meeting chaired by David Cameron this week may indeed be necessary in order to allow a rigorous analysis of the risks and benefits of pursuing the bill without the inconvenience of dissent clogging up the free flow of belief.

On a positive note though, I think that it is not too late to make a decision to retain a key load bearing element in the structure of the NHS: dedicated NHS managers who are public employees with no conflict of interest and only the public and the ideals of the NHS to serve. Let us keep the primary care trusts, and build on the involvement of clinicians in decision making that we were working on long before the bill distracted us. It seems probable to me that a majority of doctors, nurses, and patients would support this step; politicians could have their faces saved and we could all get on with the day job.

Peter Bailey is a retired general practitioner, Cambridge

➤ Read this blog and others at [bmj.com/blogs](http://bmj.com/blogs)

