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Gridley, Kate orcid.org/0000-0003-1488-4516, Spiers, Gemma Frances orcid.org/0000-0003-2121-4529, Aspinall, Fiona Jane orcid.org/0000-0003-3170-7570 et al. (3 more authors) (2012) Can general practitioner commissioning deliver equity and excellence?:Evidence from two studies of service improvement in the English NHS. *Journal of Health Services Research & Policy*. pp. 87-93. ISSN: 1758-1060

<https://doi.org/10.1258/jhsrp.2011.010176>

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Can General Practitioner Commissioning Deliver Equity and Excellence? Evidence from Two Studies of Service Improvement in the English NHS

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This article was published in the *Journal of Health Services Research & Policy* in April 2012

Gridley, K., Spiers, G., Aspinal, F., Bernard, S., Atkin, K. and Parker, G. (2012) Can general practitioner commissioning deliver equity and excellence? Evidence from two studies of service improvement in the English NHS, *Journal of Health Services Research & Policy*, 17, 2, 87-93.

<http://jhsrp.rsmjournals.com/content/17/2/87.abstract>

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Abstract

Objectives: To explore some of the key assumptions underpinning the continued development of general practitioner-led commissioning in health services.

Methods: Qualitative data from two studies of service improvement in the English NHS were considered against the UK's recent moves towards GP-led commissioning. These data were collected through in-depth interviews with a total of 187 professionals and 99 people affected by services in 10 different primary care trust areas across England between 2008 and 2009.

Results: Internationally, GPs are seen to have a central position in health systems. In keeping with this, the UK policy places emphasis on the 'pivotal role' of general practitioners, considered to be ideally placed to commission in the best interests of their patients. However, our evidence suggests that general practitioners do not always have a pivotal role for all patients. Moreover, commissioning groups in England will not be subject to top-down performance management and this raises the question of how we can be sure that agreed quality standards will be met under the new system.

Conclusions: This paper questions the assumption that GPs are best placed to commission health services in a way that meets quality standards and leads to equitable outcomes. There is little evidence to suggest that GPs will succeed where others have failed and a risk that, without top down performance management, service improvement will be patchy, leading to greater, not reduced, inequity.

Acknowledgements

This paper is an output from two research projects funded by the NIHR SDO Research Programme. We are grateful to all those who contributed. The views and opinions expressed do not necessarily reflect those of the NIHR or the Department of Health. Their SDO project references are as follows:

- 08/1704/151
- 08/1610/124

Introduction

In 2010 the UK government published its White Paper '*Equity and Excellence: Liberating the NHS*'¹ outlining an intention to free the NHS from '*excessive bureaucratic and political control*' (p.9). One of the most radical proposals put forward was to abolish primary care trusts (PCTs), the bodies currently responsible for commissioning the bulk of English health services, and shift this responsibility to groups of general practitioners (GPs).

The proposed policies reflect an internationally held aspiration to 'tip the balance' of health systems towards primary care.^{2 (p.17), 3} However, they were met with unprecedented resistance and, after an independent review, substantive revisions have been put forward.⁴ Much of the disquiet centred on the potential for the reforms to open the doors to the private healthcare industry, but there was also concern that giving so much decision making power to GPs was untested, and coupling this with the abolition of existing structures risked compromising accountability and equity.

Using evidence from two research projects looking at service improvement in the English NHS (one evaluating the implementation of the National Service Framework for Long Term Neurological Conditions,⁵ the other the provision of care closer to home for children and young people⁶) this paper explores some of the reasons why commissioners had limited success in effecting major change in these areas and questions the assumption that GPs, by nature of their position as primary care clinicians, are better placed to commission health services.

Disempowering the hierarchy

The stated intention of the reforms announced in 2010 was to ‘*disempower the hierarchy*’⁷ and shift power into the hands of clinicians and patients. In the vision outlined in the original health White Paper, PCTs would be abolished and groups of GP practices (now clinical commissioning groups,⁴ or CCGs) would take on responsibility for most commissioning. A single NHS Commissioning Board would provide leadership but local consortia would be entrusted with agreeing their own priorities. The existing performance management system of top-down targets would be replaced with a new NHS Outcomes Framework, the first of which was published in December 2010. Rather than the Department of Health specifying how those outcomes should be delivered, National Institute for Health and Clinical Excellence (NICE) quality standards would be used to develop commissioning guidance for CCGs.

Taken at face value these proposals appeared to signify a clear intention to take a hands-off approach to health service performance management. The feasibility of such a move has since, however, come into question, not least because it would rely on the strength and skills of CCGs to implement best practice with no recourse to national targets. This was highlighted in a recent Kings Fund report:

*... how far providers will be accountable for delivering a good or excellent service will depend heavily on the role played by commissioners (through contracts), whose effectiveness is likely to vary considerably at a local level.*⁸

Influencing providers is an area where PCTs themselves have struggled.^{9, 10, 11}

Areas where they had most influence under the previous system tended to be those backed by government targets.^{10, 11} In particular, the acute sector waiting time targets introduced from 2001 have had unprecedented success.^{12, 13, 14}

This might suggest that, while commissioners have found themselves relatively powerless to influence some patterns of service delivery, they have been more successful where policy is supported by national process targets.

Despite their success, top-down targets have been unpopular. Specifically, they can lead to ‘gaming’, where data are manipulated or systems adapted to meet targets without achieving underlying aims.¹⁵ However, some commentators argue that ‘*Gaming does not mean that we ought to reject targets but rather that they are being taken seriously*’.^{16 (p.3130)} Moreover, research suggests that, in contrast to targets, non-mandatory guidance is not always taken seriously by those involved in implementing it.¹⁷ A shift towards the use of commissioning guidance and away from mandatory targets may therefore be risky. Local CCGs will be entrusted with ensuring that providers meet high standards and implement improvements, thus relying heavily on the competency and influence of these groups.

GP led commissioning

Doctor-led commissioning is not a new idea, nor is it one that is confined to the UK. In the USA, some doctor-led groups have held budgets for primary and secondary care since the mid-1980s,¹⁸ and in the UK, the NHS ‘purchaser and provider split’ (which created the possibility that GPs could hold their own budgets) was first announced in 1989.¹⁹ ‘Total purchasing’ pilots followed in the 1990, with fundholding

practices invited to take responsibility for, potentially, all health services for their patients,²⁰ and in 2005 practice-based commissioning (PBC) was introduced.²¹ However, evaluation of the total purchasing pilots drew no definite conclusions as to whether GP commissioning was the best way to improve health services²² and studies of PBC have been similarly equivocal.^{23, 24} The Health Reform Evaluation Programme concluded that the impact of PBC had so far been minimal¹⁰ and a study by Coleman *et al.* found that, while there was positive engagement with PBC amongst a committed core of GP ‘*activists*’, a number of barriers to their ability to influence demand and make cost savings remained.²⁵ A recent review found evidence for both benefits and negative impacts of GP led commissioning.²⁶ It could be argued, therefore, that this latest proposal to put GPs at the helm of commissioning is, like those before it, ‘*grounded more on the expectation that GPs should be able to bring about change, given their pivotal role in the system, than on firm evidence that they invariably do so*’.^{22 (p.256)} But what evidence is there that GPs actually play this ‘pivotal role’ for all patients?

Calnan *et al.* explain that, in countries like Denmark, the Netherlands and the UK, GPs are seen to have a central position in the health system as ‘gatekeepers’, with the dual role both of rationing the use of expensive specialist services and of guiding people through the health system, monitoring and coordinating their progress in order to maintain and improve quality.²⁷ In fact, GPs are not the only professionals ‘gatekeeping’ specialist services. In their study of the impact of PBC, Coleman *et al.* explained:

*A significant proportion of referrals are 'consultant-to-consultant' referrals within hospitals (in one of our study sites this amounted to nearly 60% of new referrals), and whilst PBC consortia can make representations about this, we found that it was an area in which it was difficult to make an impact.*²⁵

(p.31)

The extent to which GPs fulfil the latter role, of guiding people through the system once they are in it, has also been questioned. A recent study found a lack of ownership amongst UK primary care teams of some conditions (such as dementia, multiple morbidities and mental health problems) and recommended GPs take a more proactive approach to care management.²⁸ The two studies drawn upon in this paper shed further light on GPs' roles in care coordination, and on the barriers and facilitators to health service improvement in two different service areas: long-term neurological conditions (LTNCs), and children's healthcare 'closer to home' (CCTH).^{5,}

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Methods

Both studies were funded by the National Institute for Health Research Service Delivery and Organisation programme and undertaken by [details removed] between 2006 and 2010. One was an evaluation of the implementation of the National Service Framework (NSF) for Long-Term Neurological Conditions;²⁹ the other a study of health care delivered 'closer to home' for children with a range of conditions, recommended in Standard 6 of the NSF for Children, Young People and Maternity Services.³⁰ Both were multi-methods studies including case studies of service

systems. PCT case study areas were purposively selected to give a range of demographic, geographic and service characteristics and primary data were collected through qualitative interviews. For the LTNCs study, we interviewed 151 professionals and 71 people with LTNCs across six PCT areas. For the CCTH study we interviewed 36 professionals and 28 parents (including one extended family member) of children receiving CCTH (i.e. services that prevent hospital admission or reduce length of stay) across four PCTs. This paper, therefore, draws on data obtained through in-depth interviews with a total of 187 professionals and 99 people affected by services in 10 different PCT areas across England.

More details of our samples and approach to recruitment can be found in the full published reports.^{5, 6} In brief, professionals in relevant organisations (health, social care or voluntary) were approached to take part in telephone interviews and a ‘snowball’ method used to identify further relevant stakeholders until data saturation was reached. A number of these organisations then invited people with neurological conditions (for the LTNCs project) and parents of children receiving CCTH (for the CCTH project) to take part in face-to-face interviews. Responses to these invitations came directly to the research team. Interviews were semi-structured, guided by a list of topics, audio recorded and transcribed. Data were then analysed thematically using the Framework approach, whereby text is summarised into a matrix arranged by categories and participants.³¹ Ethical approval for both studies was granted via the National Research Ethics Service and informed consent given by all participants.

Results

In the first part of this section, we explore some of the reasons why PCTs had limited success in effecting major change in both the implementation of the NSF for LTNCs and paediatric CCTH, and consider the implications of this for future commissioners. We then turn to the interviews with patients and parents to explore some of the assumptions underpinning the argument for GP-led commissioning.

Light touch guidance is ‘*not a priority*’

The evidence from both studies supports the argument that PCTs were not powerful enough to implement guidance or substantially change patterns of service provision without the support of performance managed targets. In both cases, the policy recommendations under study had little impact. The professionals we spoke to attributed this in large part to the relatively low priority ascribed to these ‘light touch’ National Service Frameworks, and the inability of those tasked with leading reforms to rally support for them. The NSF for LTNCs set out optimum quality standards across health and social care and required PCTs to lead locally on their implementation. These standards, termed Quality Requirements (QRs), were all evidence-based and widely supported by specialist voluntary sector and patient groups. However, no system of performance management accompanied the framework and there was no clear guidance on how achievement of the QRs should be measured. The aspirational wording of the document, which specified outcomes such as, ‘A person-centred service’ (QR1), led staff interviewed to describe it as ‘*woolly*’, ‘*vague*’ and ‘*just not practical*’. Comparisons were made between the LTNCs agenda and other policies and targets that were felt to have more force. As one manager explained:

I have to say, in the scheme of things, this is not a priority. There are no national targets against this. We've got, we are absolutely flat out trying to get the cancer targets sorted out, the rapid access chest pain clinics, the sexual health attendance targets, the 18 week target, and frankly, if it hasn't got a target, we haven't got the time to do it.

(Acute Trust Manager)

The NSF's lack of targets made key staff members reluctant to give up their time to attend meetings and prioritise action. Interviewees pointed out that, while targets are unpopular, they are also the incentives that drive their organisations. Without strong performance management there was nothing to compel PCTs, local authorities or acute trusts to improve services:

... the reason we're still here talking about it four years later is because there were no targets. And although people say that we don't like targets and we don't like lists but to be honest if there's no targets it's not on the execs' – it's not on the exec directors' radar.

(PCT Commissioner)

We are well aware [that the NSF] doesn't come with any penalties for non-compliance or rewards for the Trust in achieving it. ... Management know about the NSF, but it's way down their list because there are no incentives or penalties to do anything about it.

(Acute Trust Clinician)

In each area a single PCT officer or small group was tasked with implementing the NSF as part of a wider portfolio of work, but all struggled to encourage key professionals, both within their own organisations and beyond, to engage in the process. It was not uncommon for local implementation teams to have little or no involvement from senior strategic health or social care staff with the authority to agree and support developments, meaning plans for implementation could not be taken forward.

In contrast, objectives underpinned by targets and financial incentives for the Long Term Conditions Programme, a similar sounding but actually quite distinct area of service improvement, did see results. The priorities for this agenda were backed by a Public Service Agreement (a nationally set target) to reduce hospital emergency bed days by five per cent in three years³² and there was a clear financial incentive for commissioners to do this, as under Payment by Results each emergency bed day came with a price tag for the PCT. The Department of Health surpassed its target in 2008, achieving a reduction in emergency bed days of 13 per cent,^{33, 34} whereas the impact of the LTNCs NSF was patchy and limited.⁵

The National Service Framework for Children was another 'light touch' NSF setting best practice guidelines for children's services including Standard 6, which emphasised the need to provide health care closer to home. Despite its different focus, professionals cited similar barriers to implementation in this policy area. A consultant paediatrician summed up the problem as follows:

I think it has had some impact, but it's pretty limited really. And the main reason I say that is because when that was introduced it didn't have specific targets which, which would have driven some outcomes. For example, if there had been a target in the National Service Framework that any child that needed speech and language therapy should be seen within twelve weeks and that was, there was financial penalties to organisations for not providing that, then there would have been, that would have resulted in real change. But the National Service Framework is a very good document describing some very good aims for, for, for improvement of child healthcare, but it wasn't backed up with any specific penalties or incentives for doing it.

(Acute Trust Clinician)

The absence of performance management mechanisms or financial incentives was similarly seen by commissioners as the major block to this agenda:

So it's a bit of a "yes it would be nice to, wouldn't it" kind of approach ... but if you don't do it is anybody going to get sacked, probably not.

(PCT Commissioner)

In both studies, GPs reportedly played only a marginal role in the implementation of the guidance in question. Certainly, there appeared to be very little GP interest in implementing the NSF for LTNCs via practice-based commissioning, although this was still in its fledgling stages at the time of our fieldwork. In the CCTH study, there

was evidence that some GPs were actively resisting changing patterns of service provision:

... some didn't even think to use [the care closer to home service] at all, and some of that was about GPs, I suppose, perhaps, perhaps we had some GPs saying, you know, if I think this child needs referring in [to hospital] then that's where they're going ...

(PCT (Provider Services) Clinician)

This was in direct opposition to the national policy aspiration to deliver more care outside of hospital, and again raises the question of GPs' role in achieving national priorities (or setting their own). For GPs to have legitimacy in setting priorities for their local populations, they must understand the needs of that population and be motivated to meet them. The above evidence suggests that current commissioners and providers can lack this motivation. The rationale behind giving GPs commissioning responsibility is the assumption that they are closest to the patient, having a better understanding of their needs and thus greater motivation to meet these needs without the push of mandatory targets. Evidence from our interviews with service users, however, would suggest GPs are not always in this position.

GPs do not always have a pivotal role in care coordination

Our study of services for people with LTNCs found that GPs were usually only marginally involved in the management of this group. While sometimes highly valued and often instrumental in the initial recognition of illness and referral for diagnosis, GPs' involvement tended to tail off once people accessed more specialised care and

it was unusual for them to take an active role in care coordination. A number of the people we interviewed felt that they themselves, or their (informal) carers, were the only people with an overview of their care. Where care coordination was professionally managed, this was usually the job of a specialist team or nurse (not affiliated with a general practice). GPs were not, therefore, 'in the driving seat' of these patients' ongoing care.

The general view from those we interviewed was that this was not a failing of the primary care system itself; rather it was a reflection of the generalist role of GPs, who were not expected to have the specialist knowledge necessary to manage LTNCs:

I think it's one of those illnesses a lot of doctors don't know a lot about it anyway. ... And it's not like flu, or anything, you know, the stuff that comes up regular, you know what I mean?

(Man with brain injury after Encephalitis)

Interviewer: *And what about your GP, do you regularly see ...?*

Not about the MS.

Interviewer: *Right. Do you ever see the ...?*

Not about the MS, no. Because, you know, 'cause it's such a specialist thing, like with any other condition I suppose, they don't, you know, they'll

say, "Oh, you'd better speak to your neurologist," or, you know, "You'd better speak to your MS nurse."

(Woman with Multiple Sclerosis)

Your GP practice, you just more or less collect your prescription from him and go with the general aches and pains, because they don't know your medication and one or two of the doctors there will admit to me that they don't know what to do with me.

(Woman with Parkinson's Disease)

GPs also appear to take a back seat in the ongoing coordination of care for children with long-term health conditions. In our CCTH study, we found that parents tended to view community children's nurses or, failing that, hospital based specialists, as their first port of call. GPs' roles tended to focus on the initial rationing of services rather than the navigation of ongoing care. Again, parents attributed the limited involvement of GPs to their lack of specialist expertise:

... I've been to the GP three or four times with [child] and normally it's, I think you better go to the hospital just to, just to make sure.

(Father of child with genetic disorder)

Father: *... I think from [the GP's] point of view he probably is a little bit detached, isn't he?*

Mother: *Yeah.*

Father: *Cos it is [hospital] and us and [hospital] and, you know, the community team rather than too much of the GP involved.*

(Parents of child with Leukaemia)

It seems that for children with a range of ongoing health conditions, as well for as adults with LTNCs, GPs do not always play a pivotal role in their care.

Discussion

What implications do these findings have for the proposed UK health service reforms, and for health service commissioning more broadly? First, there is the question of how effectively health needs can be met if best practice standards are not backed by targets or incentives for implementation. We have seen through research in two very different areas of health care that guidance, without targets or financial incentives, is not always seen as a priority by those tasked with implementation. What is there to indicate that GPs will be more motivated to ensure the NICE quality standards are met than their predecessors were to implement 'light touch' NSFs? The NHS Outcomes Framework stated that a 'quality premium' would provide a financial incentive for commissioning groups to achieve certain outcomes, but which outcomes and how this will work has not yet been agreed.^{35, 36}

The second issue is whether equity will be achieved if CCGs are entrusted with setting their own priorities at a local level. GP-led commissioning *has* produced some innovative developments, but success has been patchy.^{24, 25, 37} Wyke *et al.* found that total purchasing pilots '*emerged as selective purchasers, having responsibility for*

service areas they wished to devote their energies to’.^{22 (p.245)} Similarly, Curry *et al.* cautioned that GP commissioners may be more interested in pursuing their own areas of interest than improving all areas of service delivery:

In other words, evidence exists of a potential for conflict in practice-led commissioning between the needs-based priorities of local communities with priorities that are based on the observations and preferences of individual GPs.^{24 (p.8)}

Local enthusiasm may have the potential to drive improvement, but if local enthusiasts (the GP ‘activists’ identified by Colman²⁵) drive forward developments in their preferred fields is there a risk that other areas in need of improvement may be neglected? Mannion identified a number of potential benefits to GP led-commissioning, but also some limitations including increased inequalities between geographical areas. He concludes that:

The absence of prescriptive central guidance concerning the implementation and operation of consortia may result in the development of a wide variety of local approaches and outcomes, which will need to be monitored, and strategies put in place to ensure that the benefits are maximized and any deleterious consequences are mitigated.^{26 (p.13-14)}

We have seen that GPs do not always have a pivotal role in care coordination for people with ongoing health conditions. Moreover, studies have shown consistently that GP commissioners are not good at public and patient involvement. In the total

purchasing pilots, GPs saw themselves as '*agents for their patients*' without the need to actually involve them in decision making.^{22 (p.245)} Similarly, studies of PBC found only a limited commitment to public and patient involvement, and only rudimentary involvement arrangements in place.^{24, 25} The recent UK White Paper set out a vision which claimed to be '*genuinely centred on patients and carers*',^{1 (p.8)} but the reforms it proposed may actually give power, not to patients, but to a small group of already powerful providers. In response to concerns, the government has pledged to ensure that patients and carer are efficiently and effectively involved in CCGs, although at time of writing precisely how this will be achieved remains unclear. The revised proposals also specify that all CCGs must have some representation from secondary care. Nevertheless, the broad thrust of policy remains the same and offers continuity with previous attempts to put GPs at the helm of health service commissioning. As such, the risks identified in this paper remain pertinent.

Conclusion

This paper questions the assumption that GPs are best placed to commission health services in a way that meets quality standards. There is little evidence that GPs will succeed where others have failed and a risk that, without top down performance management, GP-led commissioning could lead to greater, not reduced, disparity in service quality.

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