



BRIEFING PAPER

Number CBP 05607, 23 September 2016

NHS Commissioning before April 2013

By David Turner and
Thomas Powell

Inside:

1. What is NHS commissioning?
2. The origins of NHS commissioning, 1948–2002
3. Commissioning by PCTs, 2002–10
4. Transition to the new NHS, 2010–13



Contents

Summary	4
1. What is NHS commissioning?	5
2. The origins of NHS commissioning, 1948–2002	5
2.1 The tripartite split, 1948–74	6
Local authority services	6
Independent practitioner services	7
Hospital services	9
Financial planning and control	10
2.2 Unification and planning, 1974–91	10
New structures	10
HCHS funding	13
Primary care	14
2.3 The internal market, 1991–99	16
The purchaser / provider split	16
GP Fundholding	17
Non-Fundholder purchasers	18
Funding flows	18
Contracting arrangements	19
The emergence of primary care-led commissioning	20
Developments in primary care	20
The results of the internal market	21
2.4 From PCGs to PCTs, 1999–2002	23
3. Commissioning by PCTs, 2002–10	26
3.1 PCT geography	26
3.2 PCT funding	26
3.3 Commissioning of primary care	28
Primary Medical Services	28
GDS and PDS	28
GPS and GOS	29
Primary care in prisons	29
Vetting of providers	29
3.4 Specialised commissioning	30
3.5 The strands of NHS system reform	30
Outsourcing and the mixed economy of providers	30
Choice and competition	34
Payment by Results	34
Foundation Trusts	35
Practice-based Commissioning	36
The purchaser / provider split	37
3.6 The results of system reform	37
3.7 The “preferred provider” policy	39
3.8 Other policies impacting on commissioning	39
Quality regulation	39
Targets	40

Contributing Authors:

David Turner, Chamber and Committees Team
Thomas Powell, Social Policy Section

Cover image copyright: [Record shot](#) by [Ron Adams](#). Licensed under [CC BY 2.0](#) / image cropped.

3 NHS Commissioning before April 2013

Failing NHS bodies	40
NICE	41
National Service Frameworks	41
Personal budgets	42
Public accountability	42
Service reconfiguration	43
Integrated commissioning	43
3.9 The commissioning cycle	44
3.10 Outsourcing of commissioning	45
3.11 New commissioning levers	45
3.12 World Class Commissioning	47
3.13 Shortcomings of PCT commissioning	47
3.14 Planned cuts in PCT management costs	49
4. Transition to the new NHS, 2010–13	50
4.1 Revised Operating Framework 2010–11	50
4.2 <i>Equity and excellence: Liberating the NHS</i>	50
4.3 The Health and Social Care Act 2012	54
4.4 Procurement, choice and competition up to April 2013	58
Annex: Glossary of acronyms	59

Summary

This note looks at the development of commissioning arrangements in the NHS in England up to April 2013. It is intended as historical background to Commons Briefing Paper CBP 7206, [The structure of the NHS in England](#) (see also Library Standard Note SN06749, [The reformed health service, and commissioning arrangements in England](#)).

According to the Department of Health, commissioning is “the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.”

While commissioning in the NHS is a relatively recent development, elements of the commissioning function have been present, in one form or another, since the inception of the service in 1948.

Since 1991 commissioning has taken place in the context of the “purchaser / provider split”, whereby part of the NHS is responsible for contracting with NHS (and independent-sector) providers for the supplying of services for patients.

Under the Labour government of 1997–2010 the commissioning role came to reside with Primary Care Trusts – with some involvement by General Practitioner doctors through Practice-based Commissioning. The Labour government also encouraged greater use of independent-sector providers in the NHS and introduced Patient Choice, allowing patients to choose from a range of providers.

1. What is NHS commissioning?

Although much discussed in health policy circles, commissioning in the NHS is not widely understood. In 2010 the Department of Health (DH) defined it as:

the process of ensuring that the health and care services provided effectively meet the needs of the population.

It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.¹

Commissioning has been seen as a key means of helping achieve a wide range of policy objectives in the NHS, including:

- improved safety and quality of services;
- better value for money;
- wider patient choice;
- more personalised services;
- better integrated care pathways;²
- greater provision of care outside hospital settings (“care closer to home”);
- greater diversity of service providers;
- better control of costs;
- improved health outcomes; and
- reduced inequalities in health between different sections of the population.

2. The origins of NHS commissioning, 1948–2002

While commissioning in the NHS is a relatively recent development, elements of the commissioning function have been present, in one form or another, since the inception of the service in 1948.

The NHS has always existed to provide healthcare that is comprehensive (meeting all healthcare needs), universal (available to all) and free at the point of use (being funded almost entirely from general taxation).³ However, the service has sought to meet these constant aims through various forms of organisation, which have changed in many ways during the history of the NHS.

1

<http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/managingyourorganisation/commissioning/index.htm>

2 “Pathways of care” integrate all the elements of care and treatment in a given set of clinical circumstances (across settings and specialties) to achieve an optimal outcome in each case.

3 The NHS has always also been partly funded by National Insurance contributions. Some patient charges have existed in the NHS since the early 1950s, but they have never contributed more than a very small proportion of the service’s overall budget.

2.1 The tripartite split, 1948–74

The original form of the NHS was characterised by the “tripartite split”, between local authority services, independent practitioner services and hospital services.

Local authority services

Councils, as Local Health Authorities (LHAs), provided a range of NHS services, mainly using salaried staff (but also by means of the voluntary sector). These services were initially brigaded under Medical Officers of Health in council Health Departments.

Local authorities had a duty under NHS legislation to provide a range of “personal health services”: health centres; care of expectant and nursing mothers, and children under the age of five (particularly dental care and also including services such as day nurseries); domiciliary midwifery; health visiting; home nursing; vaccination and immunisation programmes; and ambulance services. Authorities’ public health⁴ responsibilities also included environmental health duties provided for in pre-NHS legislation.

In addition, councils had wide-ranging discretionary powers from 1948 to provide under the NHS: services for the prevention of illness; the care and after-care of people with illness or learning disability; and home help services for various categories of people.⁵

Health Departments inherited duties that local authorities already had under pre-NHS legislation regarding the “ascertainment”, “certification” and placing into institutional care, guardianship or supervision of people with a learning disability, as well as the provision of “training and occupation” for such people living in the community.

In respect of people with mental illness, Health Departments inherited responsibility under pre-NHS legislation for their initial care and committal to hospital. Furthermore, LHAs’ discretionary powers under the NHS in respect of “illness” implicitly extended to mental illness from the start of the service.

From 1960 LHAs had clear and explicit powers, which the Minister of Health (Secretary of State for Social Services from 1968) directed them to use, to make arrangements for the prevention of “mental disorder” (covering both mental illness and learning disability) and the care and after-care of people with such conditions.

Councils were also, as Local Education Authorities (LEAs), obliged to provide a School Health Service. As Local Welfare Authorities (LWAs), they had a duty to provide residential accommodation for aged and infirm people, and the power to provide other services for physically disabled people (from 1960 these duties and powers extended to

⁴ Public health practice encompasses: health protection, relating to communicable diseases and non-communicable environmental hazards; health improvement (or health promotion or health education); and healthcare public health, which is concerned with various aspects of healthcare services.

⁵ Although provided for in NHS legislation, home help services were not seen as part of the core NHS; accordingly, local authorities were permitted to charge for them.

people with “mental disorder”; further welfare powers were later added). Both of these areas of responsibility sat outside the NHS.

From 1971 unified council Social Services Departments were responsible for Personal Social Services. These encompassed services provided by local authorities as Local Children’s Authorities and LWAs, as well as some LHA services which were removed from local authority Health Departments. These LHA services included: all forms of social work hitherto provided by Health Departments; various forms of day centre and residential accommodation; and home help services (which became mandatory at the same time). In addition, the education of children with a learning disability was also moved from Health Departments, as it became a responsibility of LEAs.

Independent practitioner services

Independent practitioners, ie self-employed General Practitioners (GPs), dentists, pharmacists and opticians, provided general, direct-access services for their local populations under contract to the NHS. (There had been very strong opposition among clinicians to GP and General Dental Practitioner services being provided by salaried NHS staff.) These were also referred to as Family Practitioner Services (FPS) and “primary care” services, although the latter term did not gain wide currency until the 1970s.

Hospital-based specialist (“secondary care”) services could only be accessed by means of a referral from primary care, meaning that GPs acted as the main “gatekeepers” of the NHS.

Contractual terms for independent practitioners were determined nationally, but their contracts were with Executive Councils (ECs), local NHS bodies which were directly answerable to the Minister of Health. These included practitioners’ representatives (as well as LHA and government appointees) and mainly existed to arrange payment for contract-holders (who were entered onto local Medical Lists, Dental Lists, Pharmaceutical Lists and Ophthalmic Lists). ECs strongly resembled bodies that had existed under the pre-NHS state health-insurance scheme. They had a national representative body, the ECs Association.

Payment of GPs, in General Medical Services (GMS), was on a “capitation” basis, ie they received set fees according to the number of registered patients for whom care was to be delivered. Other fees and allowances (set out in the “Red Book”) came to be developed from 1966, when the GMS contract was significantly revised. Also from 1966, GPs received substantial payments refunding most of the cost of ancillary practice staff and premises. In addition, GPs were part of the NHS pension scheme.

As a precondition of joining the NHS, GPs were obliged to give up their right to sell “goodwill” in their practices – ie to sell a practice on at a price that reflected not just the value of its tangible assets (such as buildings and equipment) but also the number of patients on the GP’s list and the income that they represented. In exchange for relinquishing this right, GPs were compensated.

The Medical Practices Committee exercised some “control of entry” in the awarding of GMS contracts, to ensure that areas did not become over-provisioned with GPs. At the same time there were incentives for GPs to move to “under-doctored” areas (ie those with inadequate numbers of GPs). While patients could in theory choose their GP, choice was limited by practice boundaries and limits on the size of practice lists.

Dentists, in General Dental Services (GDS), were from the outset paid by “item of service” (ie using a form of “piece rate”) and received no payments for staff, premises or equipment. Dentists were, though, like GPs, entitled to an NHS pension.

General dental practitioners were able to provide services under contract to the NHS wherever they wished, competing freely for NHS patients’ business. They were also free to provide private services to their patients and to choose the balance in their practice between NHS and private work.

The Dental Estimates Board was responsible for processing, and checking, NHS payments to dentists.

Legislation passed in 1956 placed strict limits on the numbers of dental bodies corporate, ie limited companies providing dental services (both NHS and private), apparently due to concerns about ethical and clinical standards.

General Pharmaceutical Services (GPS) and NHS ophthalmic services⁶ were constituted on a similar basis to GDS, with contractors paid by item of service and able to compete freely for the custom of NHS patients. (In remote areas with no nearby retail pharmacy, GPs were allowed to dispense medicines as well as prescribe them – an arrangement that pre-dated the NHS.)

The fact that funding for primary care services was open-ended (being driven entirely by levels of demand from patients)⁷ proved to be a major source of NHS cost inflation. This was particularly so in respect of the budget for drugs prescribed by GPs, especially as the “pharmaceutical revolution” which gathered pace in the 1950s saw the introduction of a wide range of new (and effective) drugs.⁸

In 1957 an attempt was made to control the prices that the NHS paid for drugs. This was done through the Voluntary Price Regulation Scheme which the Government concluded with the Association of the British Pharmaceutical Industry. This non-statutory and non-contractual agreement later became the Pharmaceutical Price Regulation Scheme (PPRS).

⁶ NHS Supplementary Ophthalmic Services, provided by opticians from 1948, were originally intended to be temporary, until such time as an NHS eye-testing and spectacle-prescribing service led by ophthalmologists (specialist eye doctors) could be established. However, the intended ophthalmologist-led service did not materialise and optician-provided General Ophthalmic Services were constituted as a permanent part of the NHS from 1969.

⁷ Other NHS services had fixed budgets allocated to them.

⁸ Dentists also had prescribing rights, but their prescribing amounted to very little.

GDS also proved unexpectedly expensive (with a large volume of pent-up need for dental care), leading to the partial capping and then substantial cutting of the fees paid to dentists. (Charges for prescriptions, certain appliances and GDS dental treatment were introduced in the 1950s in an attempt to damp down demand.)

It was originally envisaged that many independent practitioner services would be housed in LHA health centres, along with council-provided health services. However, this was rare until the 1960s; and health centres never did become the dominant model of provision, as had been intended. Also in the 1960s, group practices in which several GPs worked as business partners (as opposed to practising single-handedly) became more common – but general practice remained largely a “cottage industry”.

Hospital services

Hospitals, which were effectively “nationalised” in 1948 (having previously been run by local authorities or charities), provided consultant-led secondary care for those with acute physical illnesses and chronic disease (including mental illness), as well as emergency services.

Larger hospitals were often focused on a particular area of clinical specialism. A very substantial proportion of beds was for chronically-ill patients, particularly older people and people with mental illness or learning disability.⁹ Many of the hospitals taken over by the NHS were small “cottage hospitals”, run by GPs in smaller towns and rural areas. At first, capital expenditure was negligible, with services being provided in the (often already very aged) estate to which the NHS had become heir in 1948.

The 1962 Hospital Plan envisaged District General Hospital (DGHs), housing a range of specialisms, as the mainstay of a comprehensive national network of modern hospitals, fully integrated with the other parts of the NHS. The Plan also involved major capital expenditure, which would resolve regional inequalities in hospital provision that the NHS had inherited – with concomitant increases in revenue funding to follow. This aspect of the Plan was, however, significantly scaled back in implementation.

It was further intended that numbers of long-stay beds would be greatly reduced, as new models of care were developed for people with long-term illnesses or conditions (including frail older people), or disabilities. A particular goal was to do away, as far as possible, with institutional models of care for people with mental illness or learning disability.

Hospitals employed salaried staff and were directly managed by local Hospital Management Committees. These were appointed by Regional Hospital Boards (RHBs), which were responsible for applying Government policy, strategic planning and budgetary control. Teaching hospitals stood outside this structure and were run by their own Boards

⁹ Long-stay hospitals provided accommodation for people classified as chronically “sick”; those in need of “care and attention” were placed in local authority residential homes.

of Governors, much as they had been in the voluntary sector before they were taken over by the NHS.¹⁰

At first, hospitals submitted claims for funding and were paid on a basis that has been described as “what you got last year, plus an allowance for growth, plus an allowance for scandals”¹¹ (with new facilities funded according to average costs).

Between 1971–72 and 1976–77 funds were allocated using the Crossman formula, which sought to address geographical inequalities by taking account of population totals, bed numbers and case-loads at the regional level.

From the inception of the NHS, its hospitals provided a small number of “pay beds” for private patients. These brought only marginal income and were at times politically contentious (being seen as a way for the better off to jump queues) but nonetheless continued to exist.

Financial planning and control

Financial planning and control in the NHS (in relation to those services with fixed budgets, ie hospital and LHA services) initially took place in the context of the “estimates” system. Under this arrangement, government departments were required to submit annual estimates of their likely cash expenditure in the coming financial year, which were then voted on by Parliament.

From 1961, spending plans were required to cover a five-year period. And they were expressed in constant price terms – meaning that, in the event of price inflation and / or pay increases, additional cash would be made available so that the planned volume of expenditure could still be delivered.

2.2 Unification and planning, 1974–91

New structures

Each of the components of the tripartite structure had in practice considerable autonomy and this arrangement came to be seen as too fragmented and poorly coordinated. In 1974 a major reorganisation of the NHS took place, with the intention of bringing greater unity to the service and improving the quality of planning. The resulting introduction of a multi-tier strategic and operational planning system represented a radical change in NHS structures.

Ambulance and public health (except for environmental health) services were removed from local authority control and placed in the hands of NHS bodies.¹² So too were a range of services which were now incorporated into what became known as “community health services”,

¹⁰ The small number of high secure mental hospitals also had their own distinctive governance structures within the NHS. Until 1960 they were run by the Board of Control and thereafter (as Special Hospitals) directly by the Ministry of Health.

¹¹ A Maynard and A Ludbrook, “Budget allocation in the National Health Service”, *Journal of Social Policy*, vol 9, 1980, p 293

¹² Between the early 1970s and the late 1980s public health functions tended to be referred to as “community medicine”.

including domiciliary midwifery, health visiting and home nursing services, as well as the former School Health Service.

Those LHA functions which had become part of Personal Social Services in 1971 remained in local authority hands and ceased to be part of the NHS. At the same time, hospital social work services were removed from the NHS and united with other social work services as part of Personal Social Services.

The health functions taken from local government were put under the control of NHS Area Health Authorities (AHAs). At the same time, these new bodies were also made responsible for running the vast majority of NHS hospitals.¹³

The services for which AHAs were responsible were referred to by the generic term Hospital and Community Health Services (HCHS) – although some of the services which AHAs ran (namely ambulance and public health services) were not strictly speaking part of either hospital or community services. AHAs were, to a greater extent than their predecessors, responsible for planning services as well as providing them.

The nature of the hospital sector was changing significantly at this time. There were dwindling numbers of long-stay beds,¹⁴ and the specialist hospitals were increasingly being absorbed into teaching hospitals or DGHs. At the same time, those diverse services that were now organised as community health services were also changing in various ways.¹⁵

HCHS were to be run on the basis of “consensus management”, involving small multi-disciplinary teams of clinicians, nurses, administrators, community physicians (ie public health doctors) and financial officers.

¹³ This included almost all teaching hospitals, which thereby lost their unique status. Those prestigious London teaching hospitals which came under AHA control were now responsible for providing a full range of services to their local populations. The London specialist postgraduate teaching hospitals all maintained their own Boards and continued to be directly accountable to the Secretary of State, but these arrangements were to change in 1982 (see below).

¹⁴ The trend towards fewer long-stay beds gathered pace in the 1980s partly because Supplementary Benefit money, from the demand-led Social Security budget, was made available to fund board-and-lodging fees for private nursing and residential care homes. Then, under legislation passed in 1990, local authorities took the lead in providing nursing-home care for older people. The fact that the NHS was left with only a residual role in this regard was seen as an erosion of the principle of a universal and comprehensive health service. The beginning, at last, in the 1970s and 1980s of the long-intended large-scale closure of mental hospitals (speeded by the introduction of new drugs) also contributed to the decline in NHS long-stay beds.

¹⁵ An NHS Community Dental Service (providing specialist services for patients who could not easily be treated in GDS, with dentists employed as salaried NHS staff) emerged out of the school dental service and services that LHAs had provided for expectant and nursing mothers, and children under the age of five. Community health services also included the remaining cottage hospitals (now known as “community hospitals”), which had previously been run by RHBs. Community hospitals developed a new role, providing services such as outpatient clinics, Minor Injuries Units and step-down beds (for patients discharged from acute hospitals but not yet well enough to return home).

AHAs were intended to be coterminous (sharing their geographical boundaries) with councils providing Personal Social Services and to undertake joint planning with local authorities, so as to facilitate better integration of services. There was also a new statutory duty on the NHS and local government to cooperate and to form Joint Committees for this purpose.

Below the larger AHAs were district management teams (although most Areas had several districts, there were many single-district Areas). Above AHAs were Regional Health Authorities (RHAs), which had responsibility for matters including strategic planning and resource allocation, as well as providing a few regional-level services (Regional Specialties).¹⁶ RHAs were essentially formed from the now abolished RHBs.

AHAs consisted of: a Chairman appointed by the Secretary of State for Social Services; local authority appointees; and RHA appointees – some of which had to be appointed in consultation with representatives of healthcare professions and NHS staff.

RHAs were entirely appointed by the Secretary of State for Social Services (Secretary of State for Health from 1988), who had a duty to consult with local authorities, and with representatives of healthcare professions and NHS staff, about the appointment of some members.

A new body, the National Association of Health Authorities in England and Wales (NAHAEW), was formed to represent AHAs and RHAs.

Further reform of NHS structures took place in 1982. The previous arrangement had come to be regarded as overly bureaucratic – all the more so given that the bodies involved had ended up making elaborate plans for growth that could not be realised, due to shortage of funds. The AHAs and district management teams were now replaced by District Health Authorities (DHAs); in consequence, the principle of coterminosity with Personal Social Services authorities was lost. DHAs were initially constituted on a similar basis to AHAs.

Further significant changes took place in HCHS in the early 1980s. Consensus management teams, which had been accused of slow and poor decision-making, were replaced in 1983 by general managers, who were to be personally responsible for taking decisions and overseeing their implementation.¹⁷

Also from 1983, DHAs were required to use competitive tendering and contracting for all non-clinical services (such as catering, cleaning, laundry and maintenance). Compulsory Competitive Tendering proved

¹⁶ Some conditions require the provision of specialised treatment for small numbers of patients. Examples include transplants, neurosurgery, specialised burns care and secure forensic mental health services. These services are very expensive and it can be difficult to predict when they will be required. They are sometimes referred to as "tertiary care". Highly specialised services (for extremely rare conditions) were organised at the national level; the Supra-Regional Services Advisory Group (SRSAG) was established for this purpose in 1983.

¹⁷ In theory, general managers could be drawn from among clinicians but in practice they tended to be managers by profession.

contentious, with some arguing that, while it cut costs, it did so at the expense of the quality of the services provided.

In 1990 the constitutions of both DHAs and RHAs were changed significantly. They now had substantially fewer members and the principle was introduced of “executive” (ie senior staff) and “non-executive” (ie lay) members sitting together. The Authorities came thereby to resemble (in this respect at least) the Boards of commercial companies. There was no longer, as there had been, a “separation of powers” between professional managers (the “executive”) and a lay Board (the “legislature”) which made policy and held the managers to account.

In RHAs non-executive members were appointed by the Secretary of State. In DHAs the Chairman was appointed by the Secretary of State and other non-executive members by the RHA. There was now no provision for the involvement of local authorities or the representatives of healthcare professions, NHS staff and trade unions in RHAs and DHAs.

Provision also existed from 1974 for the creation of Special Health Authorities (SpHAs), to carry out functions on behalf of the Secretary of State. A very small number of these were created to provide services to the NHS (or, in a few cases, direct to the public) on a national basis.¹⁸

Another aspect of the reforms was the creation in 1974 of Community Health Councils (CHCs), statutory bodies (at AHA, and subsequently DHA, level) which were intended to make the NHS accountable to the public, thereby addressing the service’s “democratic deficit”. In 1978 the statutory Association of Community Health Councils for England and Wales (ACHCEW) was formed.

The NHS reorganisation legislation also created, in 1973, the role of Health Service Commissioner (“Health Service Ombudsman”), with a remit to examine unresolved complaints about NHS services and make recommendations, but without any power to enforce compliance.

HCHS funding

Cash limits

Beginning in 1976–77 the HCHS budget (at national and local levels) was subject to the new Treasury system of “cash limits”. This meant that budgets (at first set yearly, then, from 1982–3, on a three-yearly basis) no longer included automatic full compensation for price increases and pay awards. Any price or pay rises breaching limits set by the Treasury would thus have to be funded from growth allocations or even from cuts in services.

RAWP

The funding of hospital services changed in 1977–8 with the adoption of the Resource Allocation Working Party (RAWP) formula, which aimed to secure “equal opportunity of access to healthcare for people at equal

¹⁸ In 1982 most of the London postgraduate teaching hospitals became SpHAs, with the remainder being placed under DHA control.

risk".¹⁹ In this way, longstanding regional disparities in resource allocation were to be resolved.

Each RHA was given a target level of revenue, calculated as follows:

The national average hospital bed utilisation rates by age and gender groups were applied to the population, by age and gender groups, of each area. RAWP recognised that additional need for health care over and above that related to age and gender, could not be measured directly and chose Standardised Mortality Ratios (SMRs) as a proxy measure of additional need.²⁰

Differential allocations of growth money ("betterment funds") were made to RHAs according to their "distance from target" (DFT). There was thus "levelling up", so that no overfunded region experienced an actual cut in funding.

Higher costs in London were allowed for; and in 1980 a Market Forces Factor (MFF) adjustment was included, to allow for unavoidable local variations in costs over and above London pay weighting. It would take some 20 years before RAWP was fully implemented, with the HCHS budget entirely weighted for need.

Primary care

A major aspect of the NHS that was in practice little changed by the 1974 reorganisation was primary care, with the independent practitioners retaining both their contractor status and their gatekeeper role.

FPCs

The ECs were replaced by local Family Practitioner Committees (FPCs), which were accountable to, but in practice autonomous from, AHAs (and then DHAs from 1982). AHAs / DHAs appointed members to the FPCs, as, to a lesser extent, did local authorities; the Committees also initially, like ECs, included practitioner representatives.

Like ECs, the FPCs at first had little more than an administrative role in the payment of contract-holders (they were recollectd as having been "really just pay and rations organisations").²¹ In 1985, however, FPCs were recast, being made independent of DHAs and accountable directly to the Secretary of State, who now appointed all their members (although local authorities and practitioner representatives did have nomination rights).

Like their predecessors, FPCs had a representative body, the Society of FPCs. In 1990 this merged with NAHAEW to become the National

¹⁹ Department of Health and Social Security, *Sharing Resources for Health in England: Report of the Resource Allocation Working Party*, 1976, p 7; Department of Health, *Resource Allocation: Weighted Capitation Formula* (seventh edition), 2011, p 17

²⁰ Department of Health, *Resource Allocation: Weighted Capitation Formula* (seventh edition), 2011, p 17. SMRs show the ratio between the observed number of deaths in a given population and the number of deaths that would be expected in the general population (allowing for variations in death rates between males and females, and between different age groups).

²¹ Shipman Inquiry, *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future* (Cm 6394), 9 December 2004, [para 3.16](#)

Association of Health Authorities and Trusts (NAHAT). (Regarding the creation of NHS Trusts, see below.)

FHSAs

In 1990 FPS became Family Health Services (FHS) and FPCs were replaced by Family Health Services Authorities (FHSAs). These were accountable to RHAs, which appointed the new Authorities' non-executive members, including practitioner members (in respect of which practitioner representatives no longer had nomination rights).

Unlike FPCs, the new Authorities had no members drawn from local authorities. FHSAs were run by general managers and had much greater powers than their predecessors to plan services and hold contractors to account.

GMS

A new GP contract, introduced in 1990, placed fresh demands on GMS, with payment being more related to performance in meeting targets. At the same time, the budget for GP practice staff and premises was made cash-limited (the first application of cash limits to any part of the primary care budget).

Following the introduction of the contract, it became increasingly common for GPs to join practices on a salaried basis rather than as partners.

GDS

Also in 1990 a new GDS contract was implemented, introducing registration of dental patients and an element of capitation payment (in respect of children). (At the same time the Dental Estimates Board became the Dental Practice Board.)

This led to a substantial unforeseen overspend in the GDS budget, a consequent cut in fees and a shift among dentists towards private practice, which made NHS dentistry more difficult to access in many areas. As with GPs, larger practices in which practitioners were employed as salaried staff became more common.

GPS

While primary care remained chiefly the province of self-employed professionals, GPS were increasingly being provided by "chain" businesses, ie limited companies with multiple outlets for which pharmacists worked as salaried employees. From 1987 the NHS exercised "control of entry" into the market, limiting the availability of NHS community pharmacy contracts in order to control costs.

GOS

Likewise, in the 1980s optician chains became significant providers of General Ophthalmic Services (GOS). At the same time, services available under GOS were curtailed.

From 1985 NHS spectacles (to which there had been universal entitlement) were only available to those who had hitherto been exempt from charges for NHS optical appliances. In 1986 NHS spectacles were replaced with optical appliance vouchers.

In 1989 universal entitlement to NHS sight tests ended and they were now only available to certain patients, who qualified on grounds of age, low income or clinical status.

These changes constituted a clear (albeit marginal) retreat from the principle of a universal and comprehensive service.

Prescribing

In 1985 an attempt was made to control the primary-care prescribing budget by pushing GPs towards dropping expensive branded drugs in favour of cheaper generic equivalents (which can be produced once a branded drug's patent has expired). This was done through the introduction of a "limited list" (or "white list") of drugs in certain therapeutic categories to which GPs were required to limit their prescribing. The reform was implemented despite strong resistance from the pharmaceutical industry – as well as from doctors, who saw it as an infringement of their clinical freedom to prescribe as they saw fit.

At the same time, the Government introduced: a "black list" of items that GPs were no longer able to prescribe (such as cough syrup and vitamin supplements); and a "grey list" of drugs that could only be prescribed for certain patients under certain conditions.

From 1988 the Prescription Analysis and Cost (PACT) system tracked the prescribing patterns of GPs.

Funding of primary care

Since demand-led expenditure was exempt from cash limits, the budget for FPS (other than funding for GP practice staff and premises) continued to be fully adjusted for price inflation.

From 1982–3 a firmly fixed annual overall public expenditure total was set. Unplanned variations in demand-led spending were catered for in this context by the maintenance of a large contingency reserve.

2.3 The internal market, 1991–99

The purchaser / provider split

A radical change in the organisation of the NHS came about in 1991 with the creation by the then Conservative government of the "purchaser / provider split".

HCHS providers, which had previously all been run by DHAs as Directly Managed Units / District Managed Units (DMUs), became (progressively, in a series of "waves" of applications, over several years) separate organisations, called NHS Trusts.

Different Trusts were established to provide acute hospital, ambulance, mental health and community services. Each Trust had its own management and "sold" its services to NHS "purchasers" as part of an "internal market".²² Trusts were obliged to pay (out of their revenue

²² The few SpHAs that provided clinical services mostly became NHS Trusts. One SpHa, the Special Hospital Services Authority, which had run the high secure mental hospitals from 1989, was broken up. In 1996 each of the hospitals became a separate provider SpHA and the High Security Psychiatric Services Commissioning

budgets) a capital charge to the Treasury for the use of their capital assets.

Acute Trusts were obliged to provide “core services”, to prevent DGHs concentrating on those areas of clinical practice that proved most lucrative. Trusts and those DMUs which still existed were referred to collectively as “provider units”.

Trusts were not accountable to their local DHAs; they were accountable (through the RHAs) to the Secretary of State, but not in respect of detailed operational matters.

The role of purchaser in this system fell to some GPs, and to DHAs and FHSAs, as well as RHAs in some respects (as described below).

In 1991 a body representing NHS bodies on the provider side, the NHS Trust Federation, was formed, separate and apart from NAHAT.

GP Fundholding

Under a scheme called GP Fundholding, volunteer GPs (in successive waves of development) were given cash budgets with which to buy a range of elective inpatient (admitted patient) treatments, as well as all outpatient hospital visits, for the patients on their lists.²³

In addition, Fundholders were responsible for buying outpatient diagnostic tests, drugs prescribed by their practices (effectively placing a cash limit on the previously open-ended, demand-led GP prescribing budget), and (from 1993) community health services and outpatient mental health services. Fundholding practices also effectively controlled budgets for ancillary practice staff, since, unlike non-Fundholding practices, they were not required to seek approval when they employed staff.

Fundholding thus added financial responsibility to the GP gatekeeper role. Fundholders were incentivised in this by being able to retain any surpluses they generated, to use in their practices (to the benefit of patients) as they saw fit.

Over several years, substantial numbers of GP practices volunteered to become Fundholders, either singly or in groups. Fundholding practices (which apparently tended to be in rural and suburban areas) eventually covered over half the population. They formed a representative body, the National Association of Fundholding Practices (NAFPs).

In 1995 the Conservative government began piloting a “total purchasing” model of Fundholding. This gave a number of volunteer Fundholding practices a delegated budget to purchase practically *all* services for their patients.

Board (HSPSCB) was set up within the NHS Executive to act as a purchaser. Paradoxically, the purchasing of NHS supplies was centralised in 1991, with the creation of a SpHA called the NHS Supplies Authority, since fragmented purchasing by NHS bodies had proved to be poor value for money.

²³ Elective care is planned (ie not urgent or emergency) treatment. Inpatient (admitted patient) care entails a period staying in hospital; outpatient care does not.

Non-Fundholder purchasers

Primary care (FHS) initially continued to be purchased by FHSAs, which also acted as frontline administrators of Fundholding and monitored Fundholding practices.

Almost all HCHS services which did not come under the Fundholding budget (eg A&E services, ambulance services, emergency admissions to hospital and maternity services) were purchased from 1991 by DHAs for patients of Fundholding practices.

In addition, almost all HCHS services for patients not covered by Fundholding practices were also purchased by DHAs.

Certain specialised services were purchased by RHAs or at national level.²⁴ The arrangement whereby most former Regional Specialties were now purchased by DHAs was criticised for leading to unnecessary fragmentation and complexity.

DHAs and FHSAs were both superseded in 1996 by Health Authorities (HAs), which took on all the functions of their predecessors. HAs, whose non-executive members were appointed by the Secretary of State, covered somewhat larger populations than DHAs had done.

RHAs were also abolished in 1996. This tier of NHS organisation was effectively replaced by regional offices of the NHS Executive (the central management of the NHS), although these were to play a somewhat different role to that of the RHAs.²⁵

The residual responsibility for purchasing specialised services that the RHAs had held was passed to HAs. In practice, HAs tended to group together at the regional level (through consortia or lead purchaser arrangements) for the purpose of commissioning specialised services, to reduce financial risk and improve the integrity of services.²⁶

Funding flows

From 1990–1 DHAs were “funded for their resident population as purchasers, whereas previously they were funded for services provided to a catchment population as providers”.²⁷

²⁴ The purchasing of highly specialised services at national level was undertaken from 1996 by the National Specialist Commissioning Advisory Group (NSCAG), a DH body which succeeded the SRSAG.

²⁵ The regional offices monitored NHS Trusts, without becoming involved in operational matters. They also developed the purchasing function in the NHS, approved applications for Fundholder status and set Fundholder budgets. They were not involved in resource allocation, as RHAs had been.

²⁶ Reform of healthcare arrangements for the armed forces led to a new area of specialised commissioning. Following the closure in the 1990s of hospitals in the UK run by the Defence Medical Services (DMS), Ministry of Defence Hospital Units, with DMS staff, were embedded in several NHS acute hospitals. DMS continued to provide primary care for armed forces personnel and their families, while HAs (later Primary Care Trusts – see below) were responsible for commissioning secondary and community services for them.

²⁷ Department of Health, [Resource Allocation: Weighted Capitation Formula](#), 2011 (seventh edition), p 18

Through successive reviews by RAWP and its successors,²⁸ the “weighted capitation” formula used to determine HCHS resource allocation targets became increasingly sophisticated.²⁹ In 1995 new indices of need for acute and psychiatric services (replacing SMRs as the sole proxy for additional need) were introduced – followed in 1997 by an equivalent index for community health services. This meant that the HCHS budget was now entirely weighted for need.

Fundholding budgets were made up using money extracted by DHAs / HAs from their HCHS allocations and funds allocated for prescribing by Fundholding practices. (A management and computer allowance was also provided.) At first, Fundholding practices’ budgets were based on historical levels of service usage by their patients. Latterly, in many areas, a crude form of weighted capitation was used.

Contracting arrangements

Purchasers (Fundholders and DHAs / HAs) entered into (primarily bulk-purchase) contracts with HCHS providers – although the contracts were not enforceable by law, being only internal NHS Service Level Agreements. These arrangements were drawn up locally, there being no standard national contract. The lack of a national pricing system meant that providers were, in theory at least, able to compete with each other on price.³⁰

In the original model of the NHS, where there were no such contracts, clinicians had been entirely free to refer patients wherever they thought fit. (NHS regions were compensated for treating patients from outside their usual catchment area by the retrospective adjustment of allocations according to recorded cross-boundary patient flows.) It had been an important founding principle of the NHS that patients should be able to access care anywhere in the service, as appropriate, untrammelled by the artificial boundaries which had existed between different healthcare providers in the “patchwork” pre-NHS system.

The need for contracts with providers led some GPs to conclude that, in order fully to retain their clinical freedom of referral, they must become Fundholders. If they did not do so, they would be bound by whatever contractual arrangements their local DHA / HA saw fit to make.

Allowance was made in the new system for “Extra-Contractual Referrals” (funded on a case-by-case basis). However, this arrangement was criticised for imposing a significant burden of bureaucracy and

²⁸ These were the Resource Allocation Group from 1995; and the Advisory Committee on Resource Allocation from 1997.

²⁹ Between 1990–91 and 1995–96, the Review of RAWP formula was applied; and between 1996–97 and 2002–03, the York formula.

³⁰ The types of contract used were: **Block contracts** (an annual fee was paid to the provider in return for access to a defined range of services; the contract was viewed as funding a given level of capacity and the level of capacity agreed reflected past and expected future numbers of referrals); **Cost and volume contracts** (the provider received a sum for a specified base-line level of activity; beyond that level, funding was on a cost-per-case basis where cost was agreed in advance; the base-line helped the provider to plan, while the maximum volume helped the purchaser to retain control of expenditure); and **Cost per case contracts** (there was no prior commitment by either party to the volume of cases involved and payment was for the cost of each individual treatment episode).

uncertainty on purchasers, who were obliged to set aside contingency funds to cover possible referrals of this type.

The emergence of primary care-led commissioning

In the latter years of the Conservative government, some Fundholding GPs began to purchase services collectively, as “multifunds”; these GPs were represented by the Association of Independent Multifunds (AIM).

Other GPs, who were opposed to Fundholding on principle, sought collectively to strengthen their influence on HAs’ purchasing and planning of services. This was done by means of “locality commissioning”, undertaken through Commissioning Groups. Supporters of this approach formed the National Association of Commissioning GPs (NACGPs).

In some cases, “cooperation even extended across the fundholding divide”.³¹ The numerous diverse approaches that developed were referred to collectively as “primary care-led commissioning”.

In 1997 NAHAT and the NHS Trust Federation, after difficult negotiations, merged to form the NHS Confederation, which represented all NHS bodies on both sides of the purchaser / provider split. The Confederation developed a range of networks for the different types of NHS organisation that it represented.

Developments in primary care

The FHS budget (spent by FHSAs / HAs) remained non-cash limited – apart from funding for GP practices’ staff and premises.

Although the prescribing budget for non-Fundholding practices was also still non-cash limited, from 1991–92 indicative budgets were set for practices, under the Indicative Prescribing Scheme. FHSAs / HAs monitored practices’ spending – but where an overspend occurred they had no power to do anything other than offer advice on reducing costs.

Prescribing budgets for both Fundholding and non-Fundholding practices were initially set on a historic-cost basis (adjusted for inflation), then allocated using an element of weighted capitation.³²

All GPs received a detailed breakdown of their practice prescribing costs (generated by PACT), which was copied to the relevant FHSAs / HAs.

In 1992 a second phase of the limited list (now renamed the “selected list”) exercise took place.

Legislation passed in 1997 allowed the providing of primary care services through local contractual arrangements under Personal Medical Services (PMS) and Personal Dental Services (PDS), initially run as pilot schemes. These involved contracts being held by practices rather than individual practitioners.

³¹ C Webster, *The National Health Service: a political history*, 1998, p 201

³² FHSAs / HAs used weightings to take account of the greater need of certain populations for medicines: the Prescribing Unit; the Age, Sex, Temporary Resident-Originated Prescribing Unit; and the Specific Therapeutic Age-Sex Related Prescribing Unit.

At the same time, provision was made for the employment by the NHS itself of salaried GPs and salaried General Dental Practitioners.

These initiatives provided means whereby HAs could attempt to address under-doctoring and patchy access to NHS dentistry, which were both longstanding issues of concern.

The results of the internal market

In theory, the internal market meant that purchasers could obtain healthcare services from any provider, including NHS providers other than the usual local ones and even non-NHS providers. This was intended to address the perceived problem of “producer capture” – monopoly providers of public services running those services for their own benefit and convenience rather than those of service users, with unacceptably wide variations in standards and value for money.

In practice, however, there were significant obstacles to the “entry” and “exit” of providers, and purchasers tended to stick with their usual local NHS providers. The Conservative government, for its part, did not push for greater competition. The resulting situation has been described as follows:

monogamy rather than polygamy characterised the internal market, with most purchasers and providers locked into permanent relationships in which both partners sought to modify the other.³³

The internal market was thus in practice characterised by “contestability” (the *possibility* of changing to alternative providers) rather than by actual competition between providers. The system has also been described as effectively one of “bilateral monopolies”, with each area having a monopolistic seller and a monopsonistic buyer.

Fundholding was politically controversial and also divided GPs. Many GPs opposed it on principle or did not wish to take on the added responsibility that it entailed. Many others, though, relished the freedom, commercial opportunities and financial incentives that Fundholding brought.

Opponents of Fundholding pointed to evidence that it led to:

- reduced patient satisfaction;
- high “transaction costs” (due to increased administration and bureaucracy, with so many commissioners); and
- a two-tier health service, with Fundholders’ patients receiving a faster, better service than other patients did.

It was argued that GPs lacked the expertise in areas such as public health and contracting that was needed in order to commission services effectively.

There were claims that Fundholding could encourage “cream-skimming” by GPs, ie excluding those patients who needed more costly care; however, this was not apparent in practice.

³³ R Klein, *The New Politics of the NHS: from creation to reinvention*, 2013 (seventh edition), p 163

A related fear was that there would be a tendency to “under-treat”, “under-prescribe” and “under-refer”, ie to give less care than is clinically optimal, in order to keep costs down. There were, though, local contingency funds (controlled by DHAs / HAs) available to deal with cases where any individual patient’s care was particularly expensive (costing above £6,000 per annum). This ceiling, of course, removed much of the incentive to engage in cream-skimming.

Another factor tending against cream-skimming was the way in which Fundholding budgets were set. Where this was done on the basis of past activity levels, if the reference period involved was typical, this would mean that a practice’s budget was set at a level that accounted for the cost of those patients requiring more expensive treatment. Subsequently a form of weighted capitation was used, so that funding approximated to the level of need for healthcare.

It has also been suggested that cream-skimming did not occur because of the high ethical standards of GPs. Conversely, it has been argued that non-Fundholding GPs may have been just as likely as Fundholding GPs to exclude sicker patients in order to keep their workload down.

While cream-skimming and under-treating by Fundholders did not materialise, it was noted that Fundholding practices were much more likely to be established in areas with low levels of social deprivation – where patients would tend to be healthier and less costly to treat.³⁴

Another widespread perception was that “fundholders could line their own pockets with some of the savings they made on patient care”,³⁵ although in theory this should not have been possible.³⁶

According to its supporters, Fundholding was a success, as shown by evidence that its feared negative consequences had not materialised and that it had:

- increased patient choice;
- made Trusts more efficient;
- brought down waiting times;
- reduced hospital referrals; and
- held down prescribing costs.³⁷

³⁴ Audit Commission, *What the doctor ordered: a study of GP fundholders in England and Wales*, 1996, p 10

³⁵ N Timmins, *Never Again?: The Story of the Health and Social Care Act 2012*, 2012, p 19

³⁶ Surpluses made by Fundholding practices could not be spent until the FHSA / HA had given approval to the spending plans. It was not intended that Fundholding practices would remunerate their doctors out of the practice Fundholding budget (doctors’ remuneration was supposed to be taken, as before, out of fees and allowances); and safeguards were supposed to ensure that Fundholders’ surpluses were not used for GPs’ personal financial gain. A loophole spotted by the Audit Commission was that surpluses could be spent on practice premises, thereby increasing the market value of property owned by a GP – Audit Commission, *What the doctor ordered: a study of GP fundholders in England and Wales*, 1996, p 72.

³⁷ I Greener and R Mannion, [“Does practice based commissioning avoid the problems of fundholding?”](#), *British Medical Journal*, vol 333, 2006, pp 1168–70; J Dixon and H Glennerster, [“What do we know about fundholding in general practice?”](#), *British Medical Journal*, vol 311, 1995, pp 727–30

2.4 From PCGs to PCTs, 1999–2002

Fundholding was abolished in 1999 by the then Labour government. The purchaser / provider split, though, remained – albeit with one exception (as described below) and in a modified form. It was now described as a split between the planning and provision of care; and the purchasing aspect of the purchaser / provider split was increasingly referred to as “commissioning”.

The Secretary of State’s powers of direction in respect of NHS Trusts were extended to cover all their functions, including detailed operational matters. Providers were expected to cooperate rather than compete; and annual contracts were replaced by Long-Term Service Agreements lasting three years or more.

At the same time as Fundholding ended, in 1999, Extra-Contractual Referrals were abolished. They were replaced by Out-of-Area Treatments (OATs) – which were intended to cover primarily emergency treatment provided to people who were away from home. It was argued that the right of GPs to refer a patient to any consultant they chose had thereby effectively been done away with. Under the new arrangement, adjustments were made to commissioners’ resource allocations, based on historical data on OATs activity, and designated “host” commissioners administered payments to providers.

HAs now took on responsibility for all commissioning. A substantial part of their funding allocations from 1999–2000 was in the form of “unified allocations” (or “direct allocations”). These encompassed non-ringfenced cash-limited budgets³⁸ (allocated on the basis of weighted capitation) for: HCHS; GP practice infrastructure (ie staff, premises and IT); and primary care prescribing (meaning that the whole of this area of spending was now subject to cash limits).³⁹ From 2002–03 unified allocations also included GP fees and allowances – although these remained for the time being non-cash limited / non-resource limited⁴⁰ and subject to ringfencing.

³⁸ Government departments’ cash-limited budgets came to be designated Departmental Expenditure Limits (DELs), while demand-led spending was designated Annually Managed Expenditure (AME). DELs and AME: together constitute Total Managed Expenditure; and both include Capital Budgets and Resource Budgets. DELs are set in three-yearly (Comprehensive) Spending Reviews; these began with the publication in 1998 of a review covering the period from 1999–2000 to 2001–02. AME is (as the name indicates) allocated annually.

³⁹ Indicative prescribing budgets were set for individual GP practices, based on “a mix of weighted capitation methodology, historic spending patterns and local judgement” – <http://www.info.doh.gov.uk/doh/finman.nsf/181c702d79584a960025673e003e9576/e94950b43246bf5380256b2100615641?OpenDocument>

⁴⁰ From 2001–02 Government departments (and the NHS) were under a statutory obligation to adhere to annual Resource Limits for both Capital and Revenue spending. Cash Limits relate purely to the balance of money in and out (the “current account” balance) during the accounting period (as shown in Appropriation Accounts). Resource Limits, on the other hand, also include accruals, such as: outstanding invoices; and non-cash items (eg the depreciation of capital assets) – as shown in Resource Accounts. Cash Limits continued to be set, but Resource Limits were now the primary form of financial control.

From 1999 it was Government policy that the weighted capitation formula should “contribute to the reduction in avoidable health inequalities”, in addition to achieving the longstanding objective of “equal access to healthcare for people at equal need”.⁴¹ This was initially accomplished from 2001 by means of an interim health inequalities adjustment.

HAs had to exercise their commissioning function in conjunction with Primary Care Groups (PCGs), membership of which was compulsory for all GPs – effectively involving them in a form of “universalised” Fundholding.⁴² There were 481 PCGs, with each one covering a patient population of around 100,000. PCGs were led by Boards, composed largely of GPs. The role of PCGs effectively built on the previous trend towards primary care-led commissioning.

With the demise of Fundholding, AIM merged with the NAFPs to form the National Association of Primary Care (NAPC); and NACGPs became the NHS Alliance.

PCGs began as bodies advising HAs on commissioning (“level 1” PCGs). As they developed, PCGs were expected to assume responsibility themselves for HCHS commissioning, as well as GP infrastructure and prescribing budgets, using devolved budgets (with “fair shares”, ie weighted-capitation allocations)⁴³ on behalf of their HAs (“level 2” PCGs). The PCGs were intended to be in the “driving seat”, but “their freedom to choose the route to be followed” was in practice constrained by the HAs.⁴⁴

The next stage (“level 3”) was for PCGs to become freestanding Primary Care Trusts (PCTs), rather than being constituent parts of HAs – although each PCT was still accountable to its local HA. In their most developed form (at “level 4”), PCTs contracted directly with provider Trusts and were responsible for directly managing local NHS community services,⁴⁵ but remained accountable to their HA.

Each PCT was to be run by a Board, consisting of a Chair and non-executive members appointed by the DH, along with the Chief Executive and Finance Director, and a minority drawn from a Professional Executive Committee (PEC) – originally called a Trust Executive. Members of the PEC were to be nominated by the PCT, with most in “level 3” PCTs being GPs and most in “level 4” PCTs being clinicians (including from community services). The PEC was intended to be the

⁴¹ Department of Health, *Resource Allocation: Weighted Capitation Formula*, 2011 (seventh edition), p 19

⁴² R Klein, *The New Politics of the NHS: from creation to reinvention*, 2013 (seventh edition), p 193

⁴³ HAs were required to allocate resources to PCGs using the same formula (with the exception of the MFF) used to allocate resources to HAs.

⁴⁴ R Klein, *The New Politics of the NHS: from creation to reinvention*, 2013 (seventh edition), p 193

⁴⁵ The former community health services provider Trusts were merged into PCTs as “PCT Provider Units”. The purchaser / provider split was thus (uniquely) abolished in this particular aspect of the NHS, at least for the time being.

“engine room” of each PCT,⁴⁶ but it was held to account by (and ultimately subservient to) the Board.

By 2002 all PCGs had become PCTs or (in a few cases) equivalent bodies.⁴⁷ As PCTs developed, HAs became substantially strategic planning bodies – although they did retain responsibility for the commissioning of specialised services⁴⁸ and FHS (including GP services).

In October 2002 PCTs became solely responsible for all commissioning in the NHS. At the same time, HAs were effectively abolished by being merged into Strategic Health Authorities (SHAs). The latter functioned as something akin to regional offices of the DH, acting as a policy “transmission belt” for the Department – although they were staffed by NHS employees (many from a clinical background), not by civil servants. The DH described them as “the local headquarters of the NHS”.⁴⁹

The remit of SHAs included the performance-management of NHS bodies, both commissioners and service providers alike. Each SHA had its own Board, including non-executive members. At the same time as SHAs were created, the regional offices of the NHS Executive were abolished.

⁴⁶ NHS Executive, *Primary Care Trusts: Establishing better services*, April 1999, p 13

⁴⁷ A very small number of PCT-based Care Trusts were created. These had delegated local authority functions which allowed them to commission social care as well as health services, in order to facilitate integration of the two. PCTs and PCT-based Care Trusts were referred to collectively as Primary Care Organisations.

⁴⁸ HAs took on responsibility for the commissioning of high secure mental health services following the abolition of the HSPSCB. Soon after this, the high secure hospitals ceased to be SpHAs and were incorporated into local mental health Trusts.

⁴⁹ Department of Health, *Delivering the NHS Plan: next steps on investment, next steps on reform* (Cm 5503), April 2002, para 7.3

3. Commissioning by PCTs, 2002–10

3.1 PCT geography

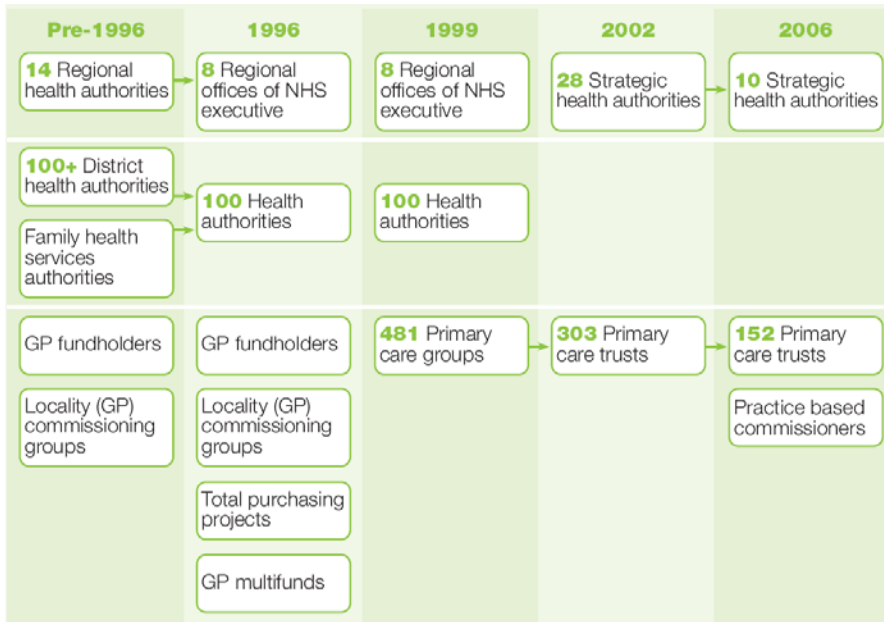
In October 2006 the number of PCTs and equivalent bodies was halved through mergers, falling from 303 to 152, each serving, on average, a population of 330,000 (the number of PCTs fell to 151 in 2010, following a merger of two PCTs). Below PCT level, some GPs were (from 2005) once more involved (although only in an indicative way) in commissioning services for smaller populations by means of Practice-based Commissioning (this is discussed further below).

Also in October 2006, the number of SHAs was significantly reduced by mergers, going from 28 to 10.

These changes followed the publication in July 2005 of *Commissioning A Patient-Led NHS*, which outlined plans for the strengthening of the commissioning function in the NHS.

The diagram below summarises how the evolution of commissioning from the mid-1990s led to this point:

The changing strategic and commissioning landscape of the NHS [to 2006]⁵⁰



3.2 PCT funding

As fully-fledged commissioning bodies from October 2002, PCTs came to be responsible for spending some 80% of the NHS annual budget. From 2003–04 they received their own allocations for this purpose, including unified allocations, as HAs had done previously. Unified allocations (which now covered three years at a time) included new

⁵⁰ Audit Commission, [Is the treatment working? Progress with the NHS system reform programme](#), 2008, p 16

need adjustments in the HCHS and primary care prescribing⁵¹ components, to take account of the objective of contributing to the reduction of avoidable health inequalities.⁵²

Where PCTs received more or less than their target allocation of funds under the weighted capitation formula, the longstanding policy of incrementally reducing the DFT in these cases was applied (through the differential allocation of growth money in the recurrent part of PCTs' spending). A "pace of change" was set for the reduction of DFT.

From 2002–03 local targets for GMS Non-Cash Limited (GMSNCL) budgets (covering fees and allowances) were set on the basis of "fair shares" / weighted capitation (using a formula devised for the purpose). The GMSNCL budget remained non-cash limited / non-resource limited, but spending against the target figures was taken into account in the setting of unified allocations. Thus a PCT which had an overspend against its GMSNCL target budget would experience a corresponding reduction in its unified allocation; and, conversely, a GMSNCL underspend would lead to a corresponding increase in the unified allocation. These adjustments to unified allocations were, like DFT adjustments, made by means of the differential allocation of growth money.

The intention of this new approach was to allow resources for under-doctored areas to grow more quickly than those for over-doctored areas. At the same time, the Medical Practices Committee was abolished, meaning that "control of entry" in the awarding of GMS contracts now passed to local commissioners. (The evolution of unified allocations in relation to primary care commissioning is discussed further below.)

In 2001–02 Resource Accounting and Budgeting (RAB) was introduced into the NHS; this reinforced the statutory duty of NHS bodies to balance their books and made it impossible to use a capital underspend to cover a revenue overspend. In 2007, however, RAB was abolished in the NHS, as the DH deemed it an inappropriate form of accounting for the service.⁵³

"Brokerage", the system whereby surpluses were moved from one part of the NHS to cover deficits elsewhere, was abolished. In 2003 the "NHS Bank" (a "mutual" organisation formed by the SHAs) was set up in shadow form to provide risk reserves for PCTs and "overdraft" facilities for Trusts. Despite the abolition of brokerage, other forms of

⁵¹ Prescribing rights were being progressively extended to non-medical professions (initially to nurses, then to pharmacists and others).

⁵² Between 2003–04 and 2007–08 weighted capitation allocations were based on the Allocation of Resources to English Areas formula; and from 2009–10, the Combining Age Related and Additional Needs formula.

⁵³ A particular problem associated with RAB was that of "double deficits" in Trusts. In the event of an NHS body recording a deficit in a given year, its budget for the following year was reduced by an equivalent amount. In respect of Trusts (but not PCTs or SHAs), at the same time the deficit was also carried forward in the balance sheet and reported as an accumulated (historic) deficit, which had to be recovered over a three-to-five-year period by recording an equivalent surplus. This double counting risked creating a downward spiral of debt in some provider organisations.

“creative accounting” persisted, as shown in 2005–6 when SHAs “top-sliced” PCT allocations to bail out Trusts with deficits.

3.3 Commissioning of primary care

Primary Medical Services

In 2004 a new GMS contract was introduced which completely revised the basis of funding for GP services. At the same time, PCTs were given an enhanced role in commissioning these services, the better to meet local needs by addressing longstanding issues such as under-doctoring.

Commissioners now contracted with GP practices rather than with individual GPs (and patients registered with practices rather than with particular named GPs). Under the new contract, fees and allowances, and practice infrastructure payments were replaced by a single “Global Sum”, determined using the needs-based Carr-Hill Formula, subject to a transitional Minimum Practice Income Guarantee.

The new GMS contract also included an element of “pay for performance”, through the Quality and Outcomes Framework, whereby GP practices received additional payment for achieving certain targets.

All contractors had to provide Essential Services – which did not include Out of Hours Services. Where a practice chose to opt out of providing Out of Hours Services, it fell to PCTs to commission them (from GP cooperatives or commercial providers). There were also Additional Services (which were normally provided by all contractors but which practices could opt out of providing); and (Directed, National and Local) Enhanced Services (which practices could opt in to providing). The ban on selling goodwill in GP practices, which had existed since 1948, was lifted in respect of all practices providing Enhanced or Additional Services.

As a result of the new contract, the former GMS Cash Limited (practice infrastructure) and GMSNCL (fees and allowances) components of PCT unified allocations were effectively combined. From 2004–05 they were unified, along with funding for PMS, Alternative Provider Medical Services (APMS – see below) and salaried GPs employed by PCTs (PCT Medical Services),⁵⁴ into a single cash-limited / resource-limited (now also referred to as “discretionary”) Primary Medical Services payment.⁵⁵ From 2005 this was made a recurrent allocation and in 2006 it was integrated into PCT unified allocations.

GDS and PDS

In 2006 a new GDS contract was introduced, under which dentists were paid by course of treatment (with a target, measured in “Units of Dental Activity”), rather than by item of service. Also, patient registration was abolished and patient charges simplified. At the same time, the Dental Practice Board was dissolved and its functions were transferred to the

⁵⁴ These types of provider could also be commissioned to provide services other than Essential Services.

⁵⁵ HCHS and FHS allocations now tended to be bracketed together as “HCFHS”, ie Hospital, Community and (discretionary) Family Health Services.

newly created NHS Business Services Authority (NHSBSA). (The NHSBSA was set up in 2005 as an executive non-departmental public body sponsored by the DH, with responsibility for certain business support functions.)⁵⁶

Instead of the NHS simply paying contractors for whatever work they had done, as hitherto, PCTs now commissioned dental practitioners to provide an agreed level of activity. As commissioners, PCTs were expected to address the longstanding problem of patchy access to NHS dentistry, as well as other issues. There was, though, some questioning of PCTs' ability to commission primary-care dentistry effectively.

Funding for GDS had been "drawn down" by PCTs from the NHS's centrally-managed revenue budget on a non-discretionary (ie demand-led) basis. From 2006 it was devolved (along with funding for PDS) to PCTs (outside unified allocations) on a discretionary basis, based on historic spending levels and subject to ringfencing (initially until 2009 but later extended until 2011). From 2010 this funding formed part of PCT unified allocations.

GPS and GOS

The GPS contract changed in 2005, allowing Enhanced Services to be commissioned; at the same time the "control of entry" restrictions were loosened. In 2006 the Prescription Pricing Authority, which processed prescriptions and payments to dispensing contractors, was closed and its functions were transferred to the NHSBSA.

In 2010 funding for GPS and GOS was devolved to PCTs, shifting to a discretionary basis as part of unified allocations.

Primary care in prisons

The funding of primary care services in publicly-run prisons in England was transferred from the Home Office to the DH in 2003. During 2004–6 PCTs took on responsibility for commissioning these services, through the various primary care contracting routes that were available to them.

Vetting of providers

Concerns about the safety and quality of clinical services led to changes in the way that the suitability of NHS primary care providers was checked by commissioners. Hitherto, only principal practitioners (ie contract holders) had been vetted by local primary care commissioning bodies. Now commissioners were required to ensure that all practitioners, including those who assisted principals in the provision of services, met appropriate standards of probity, and good professional behaviour and practice.

This was done initially through commissioners maintaining Supplementary Lists of non-contract holders who were authorised to assist in the provision of primary care under contract to the NHS. Subsequently it was achieved by means of unified Performers Lists of

⁵⁶ An executive non-departmental public body operates at "arm's length" from ministers (although ministers are responsible to Parliament for its activities) and is overseen by a board.

practitioners who were approved to provide NHS primary-care services, both under contract and as directly-employed NHS staff.

These changes were made in respect of GPs, dentists and opticians but not community pharmacists.

3.4 Specialised commissioning

PCTs' collaborative commissioning of specialised services was criticised regarding both consistency and effectiveness. During 2005–6 this area of commissioning was reviewed by a group under the leadership of Professor Sir David Carter.

Following publication of the Carter Report, new arrangements were put in place in 2007. Specialised commissioning was now overseen by an NHS body called the National Specialised Commissioning Group (NSCG); and services at the regional level were commissioned through Specialised Commissioning Groups (SCGs), which brought together PCTs across SHA areas.⁵⁷

3.5 The strands of NHS system reform

The period during which PCTs took over NHS commissioning also saw the beginning of an unprecedented increase in funding for the service, which was to double in real terms between 1997 and 2010.

At the same time, the Labour government was pursuing several strands of "system reform", which it said were necessary to ensure that patients and the taxpayer got the best possible value from this hugely increased level of spending. The *NHS Plan*, published in 2000, promised that "investment" would go hand-in-hand with "reform".⁵⁸

Outsourcing and the mixed economy of providers

In October 2000 the NHS concluded a "Concordat" with non-NHS healthcare providers, proclaiming a new era of growing cooperation.

In the years that followed, clinical and other services were increasingly commissioned from the independent sector (both for-profit and non-profit),⁵⁹ although the scale remained relatively modest. This was driven by central procurements of new providers by the DH, open tendering by PCTs and (to a lesser extent) the ability of providers to choose to enter the developing NHS "market".

This aspect of system reform meant that PCTs' broad strategic commissioning role included facilitating greater competition between providers (whilst still maintaining universal and comprehensive care, in accordance with NHS principles). This function of PCTs was characterised as "market management".

⁵⁷ Highly specialised services were commissioned at the England or UK level through the National Commissioning Group (a standing committee of the NSCG), which replaced the NSCAG.

⁵⁸ Department of Health, *The NHS Plan: A plan for investment, a plan for reform* (Cm 4818-I), July 2000

⁵⁹ Non-profit providers are also referred to as charitable, voluntary and "Third Sector" bodies. Mutual (employee-owned or customer-owned) organisations and "social enterprises" can also be set up on a non-profit basis.

Commercial and procurement bodies

In 2000 NHS Supplies was replaced by the NHS Purchasing and Supply Agency (PASA – an Executive Agency of the DH)⁶⁰ and the NHS Logistics Authority (a SpHA that supplied consumable healthcare products to NHS customers). In 2006 NHS Logistics was replaced by NHS Supply Chain, an outsourced contract with a private company overseen by the NHSBSA. NHS Supply Chain subsequently took on some functions from PASA – which was abolished in 2010.

In 2003 a Commercial Directorate and Private Finance Unit was established at the DH to develop commercial and procurement capacity. In 2009 this was replaced by a new Procurement, Investment and Commercial Division, and Strategic Market Development Unit. At the same time, regional Commercial Support Units, a National Procurement Council and an NHS Commercial Development Directional Board were also created.

Diversity of primary care providers

Under the Labour government the DH expected competitive tendering increasingly to be used in commissioning GP services. This was facilitated from 2004 by APMS contracts, for which independent-sector providers (employing GPs as salaried staff) were able to bid as well as conventional GP practices. This approach was also taken with GP-led Health Centres,⁶¹ which PCTs were required to commission as additional forms of primary care which could be accessed without being on a GP's patient list.

The Labour government saw APMS as a means of modernising general practice through overcoming the limitations of the small-business model, but it encountered opposition as a form of privatisation. The fact that some contracts were won by large corporations, including UnitedHealth UK (a subsidiary of a major US healthcare provider), caused alarm in some quarters.

NHS Walk-in Centres (open-access facilities staffed by nurses and sometimes GPs) were centrally procured by the DH, substantially from for-profit providers.

In respect of dentistry, the Labour government in 2004 lifted the longstanding restrictions on the establishment of new dental bodies corporate, meaning that GDS could potentially be provided to a much greater extent by such companies.

Independent Sector Treatment Centres

Greater diversity in the provision of acute-hospital care was sought through central procurement by the DH of Independent Sector Treatment Centres (ISTCs) to provide various kinds of elective surgical and diagnostic procedure, starting in 2003. Strict "additionality" rules prevented ISTCs from poaching NHS staff.

⁶⁰ An Executive Agency is part of a government department but has its own separate management and budget.

⁶¹ These were also known as "Darzi centres", after the Health Minister Lord Darzi.

Various justifications were given for the commissioning of ISTCs, including the need to: procure additional capacity in order to reduce waiting times; promote innovative service models; and support patient choice and contestability. It was pointed out that the NHS had always bought in additional acute-hospital capacity from the independent sector when required, through so-called “spot purchasing”. ISTCs would avoid the drawbacks of this approach, which was *ad hoc* and very expensive (costing some 40% more than NHS “reference costs”).⁶²

ISTCs were initially (in the “Wave 1” procurement) run by for-profit providers under contracts significantly to their advantage,⁶³ which PCTs were obliged to honour.

The Government claimed that ISTCs were instrumental in reducing long waiting times, citing the case of cataract surgery as a prime example. It was pointed out in response, however, that increased NHS capacity had been overwhelmingly responsible for reducing waiting lists, with ISTCs carrying out only a small number of procedures.

At the same time, it was claimed that competition from ISTCs made NHS consultants more willing to help reduce waiting times – but there was only anecdotal evidence for this.

It was also argued that ISTCs were providing care at considerably greater cost than if NHS providers had been used, and risked destabilising NHS providers, inhibiting recruitment, compromising training and demoralising NHS staff. In addition, concerns were raised about the quality of care provided and providers’ lack of transparency.

Another issue raised in respect of ISTCs was the risk of cream-skimming – ie the misuse of clinical selection criteria to avoid treating more expensive patients, leaving NHS providers with a more costly case-mix. In theory this should not have been possible, as the PbR tariff was intended to ensure that providers were paid in each case a sum appropriate to the treatment actually provided.

In practice, however, the tariff often lacked “granularity”, meaning that it attached single price bands to relatively diverse ranges of treatment episode. Where this was the case, there was the risk that providers could seek to maximise their income by only accepting the cheaper cases within a price band.

The later “Phase 2” ISTC procurement was greatly scaled down from what was originally planned. It used contracts more akin to those under

⁶² Reference costs reflect the average unit cost to the NHS of providing different kinds of secondary healthcare to NHS patients.

⁶³ Providers of the first wave of ISTCs were given **Take or pay** contracts. This meant that they would be paid the full value of their contract regardless of how much care they actually provided (which depended on referral patterns and choices made by patients). Some ISTCs carried out as little as half of the number of procedures for which they were paid. In addition, first-wave ISTC providers were paid a substantial premium – on average 11.2% above the “NHS Equivalent Cost” (ie tariff prices with MFF adjustment and the addition of fixed costs borne by the NHS outside the tariff, such as pension payments). It was said that this was intended to stimulate them to enter the market and to cover additional costs not borne by NHS providers (staff recruitment, start-up costs, bidding costs and direct taxation).

which NHS providers operated;⁶⁴ and it allowed ISTCs to undertake some training of staff.

ISTC providers constituted the core of a group of independent-sector providers of NHS services who formed a representative body, NHS Partners, in 2005. In 2007 it joined the NHS Confederation as the NHS Partners Network.

Other areas of outsourcing

During 2004–06 a centrally procured Public-Private Partnership allowed a substantial reduction in the extremely long NHS waiting list for digital hearing aids. (A subsequent Phase 2 ISTC audiology procurement took place on a much smaller scale than had originally been envisaged.)

In HCCHS, outsourcing was considerably extended, now including back-office functions (such as finance, administration, estates, human resources, payroll and IT) and clinical support services (such as pathology and decontamination).

A significant driver of outsourcing in the hospital sector was a form of Public-Private Partnership called the Private Finance Initiative (PFI). The *NHS Plan* gave a commitment to modernise the ageing NHS hospital estate by undertaking 100 new hospital building schemes between 2000 and 2010. This was achieved largely through PFI schemes, whereby private-sector bodies were contracted to finance and build NHS hospitals, and to provide on-site facilities management over a contractual period of many decades, at the end of which the asset eventually became NHS property. NHS providers tied into PFI deals were effectively obliged to pay for capital assets out of their revenue budgets over an extremely long period. Critics argued that this was a very expensive and highly inflexible way to buy both capital assets and non-clinical services.⁶⁵

Non-emergency ambulance services (Patient Transport Services) were increasingly commissioned from private-sector providers rather than ambulance Trusts.

Mental health services were a particularly significant area of outsourcing, with a growing number of mental health beds for NHS patients being provided in independent-sector (for-profit and voluntary-sector) hospitals.

In 2003–4 contracts were awarded to private sector providers for the NHS National Programme for IT, a vast nationally-commissioned programme. However, the Programme was beset with problems and fell badly behind schedule. It was finally abandoned in 2011, in favour of more localised NHS IT procurement.

Legislation allowing the “franchising” to an outside body of the management of a failing NHS Trust was passed in 2001. Two such

⁶⁴ Phase 2 contracts were on the basis of PbR; and the premium paid to ISTC providers was substantially reduced.

⁶⁵ A form of PFI was also developed for primary care, known as the Local Improvement Finance Trust model.

contracts (both with for-profit providers) were awarded, in 2003 and 2011; in both cases they were terminated early by the franchise holder.

Choice and competition

The bringing of a greater diversity of clinical providers into the NHS was partly intended to facilitate greater choice for patients – both as an end itself and as a way of improving the quality of services through competition.

Patients were given increasing freedom to choose (at the point of referral) from a range of providers for most types of elective acute care. The option of an alternative provider was piloted in 2002 and offered from 2003 to patients enduring a long wait for elective inpatient treatment. From 2006 patients were to be offered a choice of at least four providers, facilitated by the Extended Choice Network, which included Foundation Trusts (FTs – see below), ISTCs and some other independent-sector providers.

From 2007 “Free Choice” operated in certain specialties, whereby patients were able at referral to choose “Any Willing Provider” (AWP) in England, including independent-sector providers (subject to quality standards and price limits). In 2008 this was extended to all specialties.

Free Choice was facilitated by the Choose and Book system, which allowed patients to choose providers from an online menu.

From 2009 the Labour government was committed to allowing patients a free choice of GP practice, which apparently meant the effective removal of the existing system of practice boundaries (the catchment areas from which practices drew their patients).

In 2007 the NHS Principles and Rules for Cooperation and Competition (PRCC) were published; and in October 2008 the national Co-operation and Competition Panel (CCP) was set up to apply the PRCC on behalf of the Secretary of State.

Patients’ rights in respect of choice about routine elective care were enshrined in the new NHS Constitution in 2009 as legal entitlements.⁶⁶

Payment by Results

In order to facilitate choice and competition in the NHS, existing arrangements for contracting between commissioners and providers were to be replaced with a system of Payment by Results (PbR).

Under PbR, hospital providers were paid, on the basis of a standard national contract, a fixed “tariff” sum for each “spell of care” provided, so that “the money follows the patient” (a principle that the internal market had promised but had not in practice achieved). The tariff was based on the average cost of each type of care, classified by “Healthcare Resource Group”, across the NHS in England (with an MFF adjustment for unavoidable local variations in costs).

⁶⁶ Department of Health, *The Handbook to the NHS Constitution*, January 2009, pp 48–9 and 123. The Constitution is intended to set down the objectives and guiding principles of the NHS, along with the rights and responsibilities of all those involved in it (patients, staff and Boards).

PbR began on a small scale in 2003–04, covering a small proportion of elective inpatient care; but by 2005–06 it applied to the majority of such care. By 2006–07 it covered most acute care across all Trusts, including A&E services, emergency admissions and other non-elective inpatient care, and outpatient attendances. It was the Labour government's intention to extend its scope further still, to include mental health and ambulance services, for instance. However, this proved not to be straightforward, with the development of tariffs for mental health services proving to be particularly problematic.

Under PbR, there were changes to the arrangements for the funding of emergency treatment for patients away from home. OATs (which were associated with the previous, primarily bulk-purchase, system for funding hospitals) were replaced with Non-Contract Activity (relating to the new invoice-based funding system which PbR entailed).

Foundation Trusts

From 2004 NHS Trusts were able to achieve substantial "earned autonomy" (as "public interest companies" / "Public Benefit Corporations") by becoming FTs. These were still NHS bodies, but (unlike NHS Trusts) were not accountable (through SHAs) to the Secretary of State.

FTs were instead accountable directly to Parliament and were supposed also to be answerable to their local communities (through new governance structures including the recruitment of "Members" and the election of "Governors" by Members and staff). In addition, an independent FT regulator, Monitor (an executive non-departmental public body sponsored by the DH), was established. This was responsible for granting authorisation to FTs and acted primarily as a financial regulator, although it did also have some responsibility for quality matters.

In order to qualify for FT status, Trusts were required to meet certain quality criteria and to run a financial surplus. (Bodies other than NHS Trusts could also apply to become FTs, but this did not occur in practice.)

FTs were given new financial freedoms: to retain proceeds from asset disposal and any operating surpluses (to invest in the delivery of new NHS services); and to raise capital from both the public and private sectors within limits set by Monitor under its Prudential Borrowing Code.

Each FT's Terms of Authorisation stipulated "mandatory services" which it was obliged to continue providing. In addition, an "asset lock" applied, whereby assets essential to providing mandatory services could not be disposed of without Monitor's approval.

Each FT had a cap placed on the proportion of its income that it could earn from private patients (a provision that actually did not exist in respect of NHS Trusts). This Private Patient Income Cap was set at the percentage pertaining to the FT's predecessor at the time that the original legislation relating to FTs was passed in 2003.

Monitor could require a failing FT to take certain actions, including the removal of directors. Where the FT did not act as instructed, the Secretary of State could dissolve the FT and transfer its assets to other NHS bodies. The original FT legislation gave powers to create an insolvency regime for financially failed FTs, but these powers were not used.

Although FTs were still part of the NHS, their contracts with commissioners were legally binding, just like contracts with non-NHS organisations (in contrast to NHS Trusts).

A representative body for FTs, the FT Network, was formed within the NHS Confederation in 2004.

A significant number of NHS Trusts did progress along the “pipeline” to FT status (that status could also be acquired through merger with, or acquisition by, an existing FT). However, a deadline for all NHS Trusts to apply for FT status by April 2008 was not met and a large proportion of NHS Trusts did not advance to FT status thereafter.

Practice-based Commissioning

From 2005–06 GP practices (individually or in “clusters”) could, if they wished, control indicative budgets for purchasing some kinds of healthcare on behalf of their patients under Practice-based Commissioning (PBC).

These funds were initially allocated to practices on the basis of their past activity levels (using data on previous referrals). Subsequently, allocations were made on a “fair shares” basis, using a weighted capitation formula akin to that used for allotting funds to PCTs. Any savings made had to be reinvested in the practice. PCTs still controlled cash budgets and held contracts with providers – in contrast to Fundholding, where Fundholders held cash budgets and contracted directly with providers.

In 2009 the DH stated that:

Primary care trusts (PCTs) are the budget holders and have overall accountability for healthcare commissioning, however practice-based commissioning is crucial at all stages of the commissioning process.

In particular, practice based commissioners, working closely with PCTs and secondary care clinicians, will lead the work on deciding clinical outcomes. They also play a key supporting role to PCTs by providing valuable feedback on provider performance.

...

Practice based commissioning will lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want.⁶⁷

While the DH achieved its goal of “universal coverage” (meaning that the vast majority of GPs had voluntarily signed up to PBC in principle), this was not necessarily a sign of widespread enthusiasm for PBC among GPs. It did not go unnoticed that GPs had been able to claim incentive payments of at least £1.90 per patient for signing up to PBC – and, in practice, there was very little commissioning involving PBC.

In October 2009 Dr David Colin-Thomé, the National Clinical Director for Primary Care at the DH, was quoted as saying that PBC “isn’t really taking off, in any systematic way ... it’s certainly not seen as a major vehicle for change”. He reportedly added that efforts by the DH to revive the policy did not seem to be working, concluding: “I think the corpse is not for resuscitation. There doesn’t seem to be much traction.”⁶⁸ However, Dr Colin-Thomé subsequently claimed that he had been somewhat misquoted and indicated that he thought the policy could be made to work.⁶⁹

The purchaser / provider split

As noted above, from 2002 some community services were provided by PCTs themselves using salaried NHS staff employed through PCT “provider arms”.

In 2005 the Labour government proposed relieving PCTs of their provider functions, but then retreated from the idea. From 2008 the government’s policy was for provider arms to be organisationally split from “commissioning arms” by 2009 and for PCTs eventually to divest themselves altogether of their provider role, with provider arms possibly:

- being replaced by alternative providers from the independent sector, subject to competitive tendering;
- becoming independent mutual (staff-owned) “social enterprises” (under the “Right to Request” provision),⁷⁰ working under contract to the NHS;
- being reconstituted as independent Community FTs (possibly with “horizontal” integration of several PCT provider arms);
- becoming part of joint commissioning arrangements between the NHS and council social care services;⁷¹ or
- becoming “vertically” integrated with hospital service providers, through merger or joint management.

3.6 The results of system reform

In 2005 the DH stated that:

The system reform programme represents a coherent and mutually supporting set of reforms, which together provide systems and incentives to drive improvements in health and health

⁶⁸ “GP commissioning shows little sign of life - David Colin-Thomé”, *Health Service Journal*/website, 14 October 2009

⁶⁹ Health Committee, *Commissioning*, 30 March 2010, HC 268-I 2009–10, para 103

⁷⁰ One of the first such organisations in the NHS was Central Surrey Health. Social enterprises are organisations that use a market approach to achieve social, rather than commercial, ends; potential models include co-operatives and community interest companies.

⁷¹ The term “social care” encompasses social work, and domiciliary and residential care for infirm older people and people with disabilities, ie the greater part of those services previously described as “Personal Social Services”.

services, increase responsiveness to patients and help to achieve reductions in health inequalities.⁷²

However, some argued that it was unclear how the various strands of system reform fitted together and that there was in practice significant “dissonance” between them, as well as an unclear relationship with PCT commissioning.⁷³

It was readily apparent that system reform was taking the NHS much further in the direction of a “quasi-market” than the original internal market of the 1990s had and this proved controversial. Critics on the left regarded it as opening the door to wholesale privatisation of the NHS, potentially undermining its founding principles of equity and fairness – as well as entailing significant transaction costs.⁷⁴

It was widely believed that system reform, like the internal market before it, imposed substantial administrative costs on the NHS (which was historically characterised by low costs, compared to insurance-based healthcare systems). However, while this seemed intuitively very plausible, definitive data that could allow it to be demonstrated were not made available by the DH.

A 2005 study by a team at York University (which was commissioned by the DH but never published) concluded that management and administration salary costs represented “around 13.5% of overall NHS expenditure”. The study noted that the reforms implemented in the NHS since 1991 would have been responsible for significantly increasing transaction costs.⁷⁵

At the same time, some on the right saw system reform as not going far enough in opening the NHS up to competition, which could have allowed it to become more efficient and productive.⁷⁶ A particular criticism of system reform was that it had perpetuated “producer capture”, with the purchaser / provider relationship being skewed in favour of the latter.

Some studies were published which appeared to show that the growth of competition between providers in the NHS had had a beneficial effect,⁷⁷ but these findings were disputed on methodological and other grounds.⁷⁸

One standard account concludes that “the introduction of market forces had less impact than policy-makers might have hoped for” – with confusion among those charged with local implementation; limited

⁷² Department of Health, [Health reform in England: update and next steps](#), December 2005, para 3.2

⁷³ See for instance British Medical Association, “Aligning the different faces of system reform”, 27 February 2006.

⁷⁴ See for instance A M Pollock, *NHS plc: The Privatisation of Our Healthcare*, 2005 (second edition).

⁷⁵ Health Committee, [Commissioning](#), 30 March 2010, HC 268-I 2009–10, paras 34–5

⁷⁶ See for instance N Bosanquet, H de Zoete and A Haldenby, [NHS reform: the empire strikes back](#), 2007.

⁷⁷ See for instance J Le Grand, [“A much maligned reform of hospitals is working”](#), 26 May 2011.

⁷⁸ See for instance A Pollock, A Macfarlane and I Greener, [“Bad science concerning NHS competition is being used to support the controversial Health and Social Care Bill”](#), 5 March 2012.

application of PBR; loyalty of GPs and patients to local NHS providers; and providers being more anxious to collaborate than to compete. At the same time, “Conversely, the new market model did not bring about the disasters prophesied by the critics; there was little or no evidence of cream-skimming by providers and no deterioration in socio-economic equity in the use of NHS services.”⁷⁹

3.7 The “preferred provider” policy

In September 2009 the then Secretary of State, Andy Burnham, said that the NHS itself was the “preferred provider” of NHS services.

This was clarified by the DH as meaning that NHS bodies were only preferred providers where they were already satisfactorily providing services. Where NHS-provided services were poor these would be put out to tender, after the NHS provider had been given up to two opportunities to improve, with no preference given to NHS providers. Newly commissioned services could also be put out to tender with no preference for NHS providers.⁸⁰

The “preferred provider” policy did not either cut across the existing Free Choice and AWP policies or the PRCC.

3.8 Other policies impacting on commissioning

Quality regulation

Historically there was no formal regulation of NHS providers in respect of clinical quality and safety. (Accreditation of hospitals for training purposes by the Medical Royal Colleges did, though, provide some sort of checking mechanism, as did inspection of Nursing Schools. And Clinical Audit – the systematic review of the quality of services against clear criteria – had been promoted since 1989.)

Under the Labour government, regulation of all providers (NHS and independent-sector) was developed. This was undertaken by the Commission for Health Improvement from 2001; the Healthcare Commission (legally known as the Commission for Healthcare Audit and Inspection) from 2004; and the Care Quality Commission (CQC) – which also took on responsibility for regulating social care and mental health services – from 2009. With the creation of the CQC, regulation moved to a registration model, which was extended to primary care dental and GP practices.

In addition, NHS commissioners were placed under a statutory Duty of Quality in respect of the services they commissioned, as part of “clinical governance”. In 2008 legislation expressly couched this duty in terms of seeking continuous improvement in commissioned services.

⁷⁹ R Klein, *The New Politics of the NHS: from creation to reinvention*, 2013 (seventh edition), p 270

⁸⁰ Department of Health, “[The NHS as preferred provider](#)” – Letter from NHS Chief Executive to SHA and PCT Chief Executives, 13 October 2009; Department of Health, [Commercial skills for the NHS](#), 25 March 2010

While quality regulation was welcomed, it was widely perceived that lines of accountability and responsibility for oversight in the NHS had become less clear. Commissioning (by PCTs), performance management (by SHAs), FT regulation (by Monitor) and quality regulation all seemed to be cutting across each other.

There was also conflict between those who agreed that quality could be effectively promoted through regulation and those who advocated mechanisms to bring about continuous improvement in quality.

Targets

A distinctive aspect of health policy under the Labour government was the use of national targets regarding aspects of NHS performance, such as maximum waiting times and the prevention of healthcare-associated infections. All NHS bodies were obliged to meet these targets in the commissioning and providing of services.

Latterly, some targets were transformed into legal entitlements for patients, enshrined in the NHS Constitution (including the right to treatment within 18 weeks of referral – backed up by the right to be offered alternative providers to make this possible). It was also intended that other targets would take this form in future.

According to advocates of targets, the very significant reductions in NHS waiting times seen under the Labour government would not have taken place without a strict regime of “targets and terror” (ie severe penalties for managers whose services failed to meet targets). This was seen to lie behind the fact that the NHS in England was performing better than its counterparts in the rest of the UK.⁸¹ Critics, however, argued that the system of targets in the NHS risked damaging the quality and safety of care, because the targets related to processes rather than to healthcare outcomes – and only those targets for which there were financial incentives were actively pursued.

Failing NHS bodies

Legislation passed in 2009 contained provisions for dealing with failing NHS bodies. In the case of an NHS Trust or PCT, a Trust Special Administrator could be appointed by the Secretary of State. The first such appointment was not made until 2012 (in respect of an NHS Trust).

In the case of a FT that was significantly in breach of its Terms of Authorisation, it could be subject to de-authorisation by the Secretary of State, at the instigation of Monitor. This would have had the effect of returning the FT to the status of an NHS Trust under the direct control of the Secretary of State – with the option also to appoint a Trust Special Administrator at the same time. However, these provisions were never actually used.

⁸¹ S Connolly, G Bevan and N Mays, [Funding and performance of healthcare systems in the four countries of the UK before and after devolution](#), 2010; N Timmins, “How New Labour succeeded with NHS Policy”, *Financial Times*, 13 March 2010

NICE

The National Institute for Clinical Excellence (NICE – known as the National Institute for Health and Clinical Excellence from 2005)⁸² was set up in 1999 to provide evidence-based information for the NHS on the effectiveness and cost-effectiveness of healthcare interventions.

To this end, it published health technology appraisals regarding specific clinical interventions – mainly new medicines.⁸³ From 2002 commissioners were obliged to fund those interventions which NICE approved in its technology appraisals.

Cost effectiveness was assessed with reference to cost per quality-adjusted life year (QALY), with treatments costing more than £20,000–30,000 per QALY not being considered cost effective. Following the publication in 2008 of a report on *Improving access to medicines for NHS patients*, supplementary guidance to NICE Appraisal Committees effectively raised the cost-effectiveness threshold for end-of-life drugs to £70,000 per QALY.

In the case of two drugs that NICE declined to approve due to low cost-effectiveness, the NHS undertook a “risk-sharing” (or “patient access”) scheme. This meant that the manufacturers had agreed that the drugs could be used in the NHS effectively as part of long-term trials, with the NHS to be recompensed if the cost per QALY turned out to be more than £36,000. However, this arrangement appeared to be unsuccessful due to the low quality of the evidence yielded by the scheme on the effectiveness of the drugs.

From 2001 NICE also produced clinical guidelines, for the management of specific conditions; from 2003 it looked at interventional procedures; and from 2005 it published public health guidance. In none of these cases was implementation by commissioners mandatory.

In addition, in 2010 NICE began publishing Quality Standards, “concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health or care”.⁸⁴

National Service Frameworks

From 1999 National Service Frameworks set out national service standards for particular conditions (eg diabetes) and clinical areas (eg mental health).

These were intended to inform commissioning, for instance by encouraging the integration of services provided by different parts of the NHS. (The Frameworks replaced the previous system of advice from the Standing Medical Advisory Committee and Consultant Advisors to the Chief Medical Officer.)

⁸² Since April 2013 NICE has been known as the National Institute for Health and Care Excellence, to reflect its acquisition of responsibilities in respect of social care.

⁸³ Existing medicines continued to be covered by the PPRS. This remained a “profit cap and price cut” system but there was talk of the need to move to a system of “value-based pricing” (relating the prices of products to their clinical value).

⁸⁴ <https://www.nice.org.uk/standards-and-indicators>

Personal budgets

Under the Labour government the NHS began piloting several types of “personal health budget”, whereby individual patients with long-term conditions were given control of budget allocations for their care (either in an indicative form or as cash payments), allowing them to decide how those funds are spent.

Pilot schemes were conducted in over half the PCTs in England and ran from 2009 until 2012. The evaluation showed that personal budgets were associated with a significant improvement in the care-related quality of life and psychological well-being of patients but did not affect their health status *per se*.⁸⁵

Public accountability

The Labour government made major changes to the arrangements for public accountability in the NHS – which was now seen substantially as an adjunct to the developing function of commissioning. The functions of CHCs were progressively stripped away and passed to other bodies.

From April 2002 NHS bodies were expected to create in-house Patient Advice and Liaison Services. In January 2003 newly created local authority Health Overview and Scrutiny Committees (HOSCs) were given statutory powers to scrutinise the NHS; and NHS bodies were given a duty to consult the public and HOSCs on major service changes (which HOSCs had the power to refer to the Secretary of State). In September 2003 the Independent Complaints Advocacy Service (ICAS) was launched, commissioned by the DH on a regional basis from the voluntary sector.

In December 2003 CHCs were abolished. At the same time, statutory Patient and Public Involvement Forums (PPIFs) were created (one for each NHS Trust, FT and PCT), backed by Forum Support Organisations, which were commissioned by the DH from the voluntary sector. PPIFs were supported nationally by the Commission for Patient and Public Involvement in Health (CPPIH), which had been established in January 2003 as an executive non-departmental public body sponsored by the DH.

Legislation in 2007 clarified and enhanced NHS bodies’ duty to consult the public in respect of service changes. Under the same legislation, in 2008 PPIFs were replaced by non-statutory Local Involvement Networks (LINKs), which were concerned with both NHS and adult social care services, and whose geography corresponded with that of local authorities with responsibility for social services. LINKs were serviced by “hosts” which local authorities with social services responsibilities commissioned from the voluntary sector, using funds provided for the purpose by central government. CPPIH was abolished and not replaced. A voluntary National Association of LINKs Members was, though, formed.

⁸⁵ <https://www.phbe.org.uk/>

Service reconfiguration

A particular issue in hospital care was that of reconfiguring services. The two main drivers were the belief that: if more care were delivered in the community, costs would fall (for which there appeared to be little evidence); and clinical outcomes were better where services for rarer conditions were centralised and available on a round-the-clock basis.

PCTs and providers sought to merge particular services or whole hospitals, to increase catchment populations and create centres of expertise, arguing that this improved safety and quality. However, such measures were strongly challenged (in some cases by clinicians) in many areas, particularly in respect of maternity and A&E services.

A priority of the Labour government was to remove as many services as possible from a hospital setting, delivering them “closer to home”, through primary care or community services. In London, plans were developed to achieve this through a new kind of community-based care at a level between current GP practice and conventional hospitals, provided in “polyclinics”. These too proved controversial, with the commissioners accused of acting on orders from above instead of heeding the views of local communities.

In 2003 the Independent Reconfiguration Panel was set up to advise the Secretary of State on contested reconfigurations.

Integrated commissioning

From 2000 there existed (under section 31 of the Health Act 1999) a legal framework which allowed NHS bodies and local authorities to delegate functions to each other and manage their budgets jointly.

PCTs had scope to cooperate with local authorities in joint commissioning of services for people with chronic diseases or long-term conditions, where NHS and social care services needed to be closely aligned, such as mental health and learning disability services.⁸⁶

In a few cases Care Trusts existed; these were NHS bodies (PCTs or Trusts) with delegated local authority powers which provided and / or commissioned all local health and social care services. More commonly, some mental health Trusts were constituted as NHS and Social Care Partnership Trusts.

⁸⁶ The relationship between (free) healthcare and (means-tested) adult social care continued to be problematic, with a lack of clarity about their respective areas of responsibility and potential for “cost-shunting” between the two. By the 1990s, NHS “continuing care”, which did not involve the payment of any charges, even for board and lodging in a residential setting (now usually a private nursing home), was only provided in a small number of cases. Local authority funding for nursing-home care (including the nursing care element) was subject to means-testing; and self-funding residents of nursing homes were responsible for paying the full cost of their nursing care. Guidance that attempted to spell out the limits of entitlement to NHS continuing care was contested in a number of court cases. In 2001 the NHS began paying for the nursing element of nursing-home care for local authority-supported and self-funding residents. In 2007 a new [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England](#) was issued.

Joint NHS and local authority commissioning usually took place by means of pooled budgets, agreement on one body acting as lead commissioner and integrated provision of services.

From 2009 several Integrated Care Pilots, across primary, community and secondary healthcare and social care, were in operation.

Children's Trusts, which were legislated for in 2004, were intended to integrate education, social care, health and other services for children and young people (up to the age of 19). They acted principally as coordination bodies and were constituted as voluntary partnerships of public bodies (including SHAs and PCTs), hosted by local authorities.

3.9 The commissioning cycle

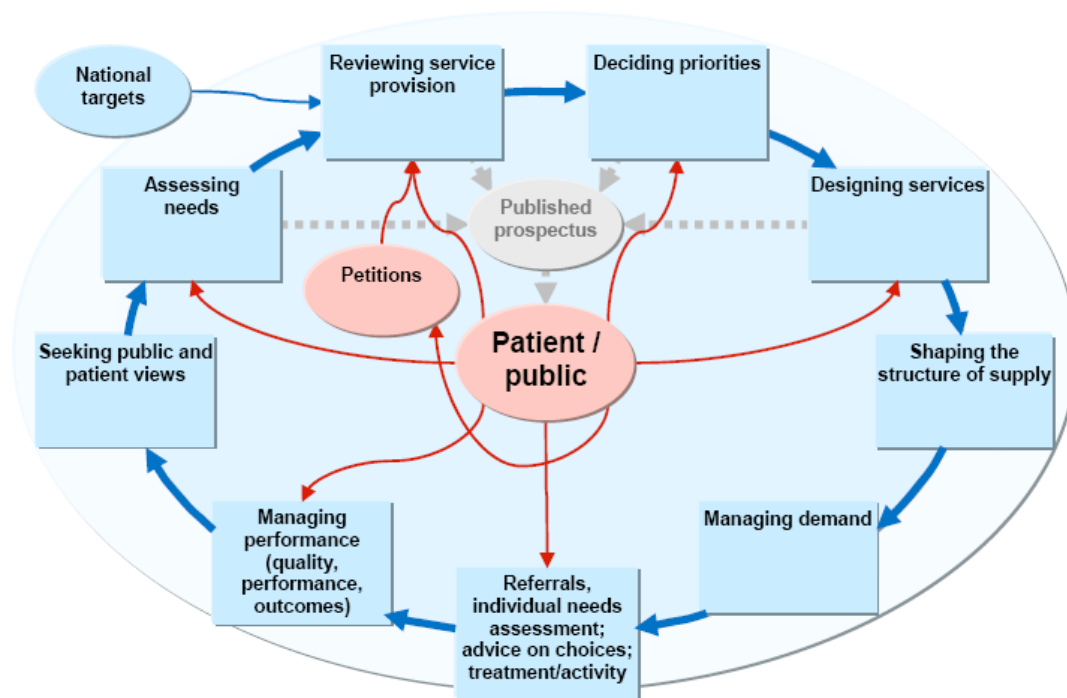
Commissioning is much more than just administering a set of contractual arrangements with service providers – it amounts to a continuous process (the “commissioning cycle”) that involves:

- planning services (identifying need; determining priorities; managing suppliers; budgeting);
- purchasing services (determining how services are to be provided; identifying providers; negotiating and managing contracts);
- monitoring services (confirming delivery; controlling quantity and quality; ensuring patient satisfaction); and
- redesigning services (to ensure that new care pathways take account of changing population needs and changing health technology).

PCTs were required, as part of the commissioning cycle, to produce a number of plans and assessments of need, and to involve patients and the public in commissioning in various ways (including through the publication of an annual “Patient Prospectus” and the NHS's public accountability structures). This was sometimes referred to as using the patient “voice”, which the DH regarded as complementing the operation of Patient Choice.

The commissioning cycle was represented in a number of graphical forms, including the following (which was published by the DH in 2006):

The commissioning cycle for health services⁸⁷



3.10 Outsourcing of commissioning

The Labour government promoted a limited form of outsourcing in respect of commissioning, through the Framework for Procuring External Support for Commissioners (FESC), which was introduced in 2007. Under FESC the services of 14 private sector companies were procured centrally by the DH, with PCTs having the option of calling on them for support in commissioning.

The DH emphasised that it was down to individual PCTs to decide if they wished to engage a FESC contractor and, if they did, which particular areas of commissioning were involved. It was made clear that, where this option was taken up, the PCT remained the actual commissioner.

There was evidence that PCTs had been increasingly turning to private-sector organisations and freelance consultants for support in commissioning. This had been the case across all stages of the commissioning function, but in particular as regards developing a strategic commissioning plan, creating and managing contracts with providers, and reviewing gaps in service provision. However, in most cases this had not been done through FESC.⁸⁸

3.11 New commissioning levers

Commissioning was supposed to be one of the mechanisms in the NHS, as then constituted, that ensured the safety and quality of care –

⁸⁷ Department of Health, *Health reform in England: update and commissioning framework: annex – the commissioning framework*, July 2006, p 6

⁸⁸ C Naylor and N Goodwin, *Building 'world class commissioning': What role can external organisations play? Results from a survey of PCTs*, 2009

alongside regulation of all healthcare providers and performance management of NHS providers.

High Quality Care for All, the final report of the NHS Next Stage Review (led by Lord Darzi), which was published in 2008, proposed giving commissioners new levers to allow them greater influence over the safety and quality of services purchased from providers. One of these was Commissioning for Quality and Innovation (CQUIN), which was a type of “pay for performance” scheme, linking payment of providers to the quality of the service provided.

CQUIN came into operation in 2009–10, with PCTs able to make the payment of 0.5% of contract values conditional on achieving stipulated quality standards. In 2010–11 the ceiling was raised to 1.5%; and the Labour government intended that it would rise by stages in future years to reach 10%.

A related innovation arising from Lord Darzi’s report was the routine collection of patient-reported outcome measures (PROMs) data. Hospitals were obliged to measure the physical and psychological well-being of patients before and after four types of elective procedure. The resulting data was published and could be used by PCTs to measure the quality of care for the purposes of CQUIN.

Further data were due to be made available through the mandatory publication of Quality Accounts. This was intended to apply initially to all providers of hospital, mental health, learning disability and ambulance services, and to primary care and community services providers from 2011.

As well as being able to make incentive payments for good quality care, PCTs had also been enabled to impose financial penalties for some types of unsafe care. Following another of Lord Darzi’s recommendations, a list of “Never Events” was drawn up; these were types of harm to patients that are both serious and largely, or entirely, preventable. PCTs were now able to withhold payment from a provider where a Never Event occurred.

In 2009 the NHS Quality, Innovation, Productivity and Prevention (QIPP) programme was announced. The programme demanded action to improve quality and make the best use of NHS resources.

Among the issues addressed by QIPP “workstreams” was that of productivity in secondary care and unacceptably wide variations in clinical practice between providers (eg in terms of length of stay and proportion of day cases). One means of addressing this was to use “best practice” tariffs, based on the costs of the best performing NHS providers for a particular procedure, rather than the average cost of the procedure across the NHS. Such tariffs were introduced for four types of procedure in 2010–11. Another refinement of the PbR regime was the introduction in 2010–11 of a 30% marginal tariff for emergency admissions.

3.12 World Class Commissioning

In 2008 the Government launched its World Class Commissioning (WCC) initiative, which sought to make NHS commissioning more professional and effective. The fact that this initiative was undertaken appeared to represent a tacit admission by the DH that NHS commissioning had hitherto been weak.

The WCC programme included the following four strands:

- A vision for World Class Commissioning;
- Eleven Organisational competencies:
 - 1) Locally lead the NHS
 - 2) Work with community partners
 - 3) Engage with public and patients
 - 4) Collaborate with clinicians
 - 5) Manage knowledge and assess needs
 - 6) Prioritise investment
 - 7) Stimulate the market
 - 8) Promote improvement and innovation
 - 9) Secure procurement skills
 - 10) Manage the local health system
 - 11) Make sound financial investments;
- An assurance system to hold commissioners to account and reward performance and development; and
- Support and development tools.

The commissioning assurance system was an annual process that reviewed PCTs' progress towards achieving better health outcomes for their populations and provided a common basis for agreeing further development. The first set of results, published in 2009, uncovered a number of weaknesses, particularly in respect of the role of stimulating and developing a provider market.

3.13 Shortcomings of PCT commissioning

Critics of PCTs argued that they lacked the capacity and the capability to conduct commissioning effectively in the face of strong and entrenched provider interests. This situation was seen as having been compounded by the disruption flowing from frequent organisational change in the NHS.

The tariff can be seen as a crude instrument in that it failed to take account of the significant variations in the cost bases of NHS providers (caused by, for instance, the cost of PFI projects or, conversely, the costs attendant on working in antiquated buildings, unsuitable for modern healthcare uses). It was seen as failing, on this basis, to provide a true level playing field on which providers could compete fairly.

It was argued that PbR provided an incentive for producers with below-average costs simply to treat as many patients as possible, regardless of clinical appropriateness, effectiveness or cost effectiveness, so as to maximise income. Such “overtreatment” would make it difficult for PCTs to control demand and costs.

Some PCTs sought to address this by using Referral Management Centres (to review GPs’ referrals), or Capture, Assess, Treat and Support centres, and (Integrated) Clinical Assessment and Treatment Services. These intercepted GP referrals, with the aim of reducing inappropriate referrals and diverting patients away from hospital service providers where appropriate.

Providers were seen to be able to “game” the PbR system by “upcoding”, ie classifying procedures in higher-paying categories than is appropriate, in order to maximise their income. Addressing this effectively would have involved devoting PCT resources to detailed checking of coding by providers.

There was also seen to be the danger that independent-sector providers would cream skim or “cherry pick” (as discussed above in respect of ISTCs).

Another perceived problem associated with PbR was that of “tariff splitting” (or “unbundling”), ie determining how the tariff sum for a patient’s spell of care was to be divided between the PCT and a hospital service-provider where that care had taken place partly in hospital and partly in a community setting. This could arise, for instance, where “step-down” care was provided after a hospital stay. PCTs were also seen as inconsistent in their commissioning activities, leading to a “postcode lottery” in some areas of care (notably in respect of decisions about funding drugs that NICE had decided not to endorse or had not evaluated).

In March 2010 the House of Commons Health Committee criticised PCTs for failing to commission effectively, accusing them of being too passive and lacking the clinical knowledge and other skills to challenge hospitals over the provision of services.⁸⁹ Constant reorganisations and high turnover of staff were said to have made a bad situation worse.

The Committee questioned whether WCC would lead to the necessary transformation of PCTs and found misplaced confidence amongst PCTs about their achievements.

The Committee also found that insufficient progress had been made in implementing the Carter Report on specialised commissioning, with many PCTs remaining disengaged from this area of work.

PCTs required a more capable workforce, higher quality management, the ability to attract and develop talent, and more power to deal with providers. The Committee cautioned against a reliance on management consultants to address commissioning weaknesses and urged that the DH determine whether use of consultants represented value for money.

⁸⁹ Health Committee, [Commissioning](#), 30 March 2010, HC 268-I 2009–10

The Committee was dismayed that the Department had failed to provide clear and consistent data on the transaction costs of commissioning. It noted the unpublished York University study regarding the likely high level of administrative and management costs in the NHS. The Committee concluded that if reliable data showed the purchaser / provider split to be uneconomic it might need to be abolished.

3.14 Planned cuts in PCT management costs

In December 2009 the Labour government published a new five-year strategy, set out in the White Paper *NHS 2010-2015: from good to great*. This included a target of reducing SHA and PCT management costs by 30% (as part of broader plans for efficiency savings across the NHS of £15–20 billion, to cope with funding restrictions). It was explained that these cuts would be “front-loaded”, with as much as half of them taking place in 2010–11.

It was stated that there had been a very substantial rise in PCT staff numbers since 2007, with some 38,000 people now working in commissioning. PCTs would not be expected to do less, but to do the same, or more, with reduced resources.⁹⁰

The *Operating Framework for the NHS in England 2010/11*, also published in December 2009, stated that:

each SHA must meet an aggregate target reduction of 30 per cent in management and agency costs by 2013/14. It will be for SHAs to determine how this is managed across PCTs. For absolute clarity, the expectation is that:

- while there is no specific target for 2010/11, most progress needs to be made in 2010/11 and 2011/12;
- co-terminosity can be used as a driver; and
- provider arms are to be included in the aggregate.⁹¹

⁹⁰ “PCTs face frontloading on management cost cuts”, *Healthcare Finance*, 21 December 2009

⁹¹ Department of Health, [*Operating Framework for the NHS in England 2010/11*](#), December 2009, para 3.52

4. Transition to the new NHS, 2010–13

4.1 Revised Operating Framework 2010–11

On 21 June 2010 the Department of Health published a revision to the *Operating Framework for the NHS in England 2010–11*,⁹² following the coming to power of the Coalition government.

It was stated that PCTs had to divest themselves of their provider arms by April 2011, with a wide range of options to be considered, possibly including a staff membership version of the Community FT model.

In addition, the Government was to develop an AWP model for community services (as already applied, at least in theory, in respect of hospital services). Many services were subsequently transferred to acute hospital Trusts or mental health Trusts and relatively few community services provider Trusts or FTs were established. In some cases services were commissioned from independent-sector (including for-profit) providers.

The Government made it clear that it would push ahead with the previous administration's planned cuts in SHA and PCT management costs. The overall ceiling for these costs would be set at two-thirds of those costs in 2008–09 and most savings would have to be achieved in 2010–11 and 2011–12. A 33% cut with a 2008–09 baseline amounted to a cut of 46% with a 2009–10 baseline. The money saved would be retained in the NHS.

The Coalition also relaxed the NHS targets regime; and it retreated from the London polyclinic plans and the implementation of GP-led Health Centres.

The new government was committed to ringfencing NHS spending, but the service would still be required to make efficiency savings of £20 billion over the lifetime of the Parliament, in order to cope with increasing costs and demand.⁹³ A prime means of achieving this was the progressive reduction of tariffs. (The PbR regime meanwhile continued to be refined under the Coalition. From 2011–12 there was no payment for any emergency readmission with 30 days; "best practice" tariffs were expanded; and the CQUIN threshold increased to 2.5% of provider income.)

4.2 *Equity and excellence: Liberating the NHS*

Despite early indications that no major changes to the NHS were planned, on 12 July 2010 the Coalition published its White Paper, *Equity and excellence: Liberating the NHS*,⁹⁴ which proposed a drastic

⁹² Department of Health, [Revision to the Operating Framework for the NHS in England 2010/11](#), 21 June 2010

⁹³ This came to be referred to as "the Nicholson challenge", after the then Chief Executive of the NHS, Sir David Nicholson.

⁹⁴ Department of Health, [Equity and excellence: Liberating the NHS](#) (Cm 7881), 12 July 2010

reorganisation. Plans were further elaborated in subsequent documents. The Health and Social Care Bill, containing the proposed reforms, was presented on 19 January 2011.

SHAs were to be abolished in April 2012 and PCTs in April 2013. The latter would be replaced by new autonomous statutory GP-led commissioning “consortia”. GPs would be obliged to join a consortium but they were to be free to make their own local consortium arrangements. Commissioning funds would be calculated at practice level and allocated directly to consortia.

The health improvement aspect of public health (which PCTs had inherited from HAs) would in April 2013 be transferred from the NHS to local government, where it had previously resided (with other public health functions) up to 1974.

Health protection and healthcare public health would be transferred (from SHAs and other parts of the NHS) to a new Public Health Service (Public Health England – PHE), which would exist from April 2012. This would be part of the DH.

Health and Wellbeing Boards (HWBs) were to be constituted as statutory committees of those local authorities with social services responsibilities, at first in “shadow” form from April 2012. HWBs would be statutory partnership boards, with NHS representation, and “take on the function of joining up the commissioning of local NHS services, social care and health improvement” from April 2013.

An autonomous national NHS Commissioning Board was to be set up as a “shadow” SpHA in April 2011 and to assume its executive role in April 2012. It would work to a “mandate” set by the Secretary of State and have a quasi-regulatory (as opposed to performance-management) role in relation to GP consortia. In addition, the Board would take over PCTs’ commissioning role in respect of primary care services and some others (including specialised commissioning, secondary and community health services for the armed forces, prison healthcare and high secure mental health services).

All NHS Trusts would have to become FTs (or become part of an existing FT) by April 2014 (it was initially intended that the deadline would be in 2013). This date was written on the face of the Bill, in a provision for the repeal of the legislative underpinning for NHS Trusts.⁹⁵ A new Provider Development Authority would oversee stragglers and shepherd them through the FT pipeline. The provision allowing the de-authorisation of FTs would be repealed; and FTs would be made subject to commercial insolvency law (just like private-sector bodies). Also, the Private Patient Income Cap for FTs would be abolished. And the provision allowing organisations other than NHS Trusts to apply for FT status would be repealed.

The new system would promote greater competition between providers, including private and voluntary sector providers as well as staff-led social

⁹⁵ There was to be a temporary exemption for any NHS Trust whose management had been outsourced through franchising.

enterprises. The stated aim was for the NHS to become a “social market”.

In “the vast majority of NHS-funded services” Any Willing Provider would be able to provide services by April 2013 (enabling “competition *in* the market”). In the rest of the NHS there would be a presumption in favour of competitive tendering for services (enabling “competition *for* the market”).

There would be a provision to allow NHS providers to be compelled to give competitors access to their facilities, in order to ease new providers’ entrance into the NHS market. (An analogous approach had been taken in respect of the former state monopoly providers of telecommunications and postal services.)

In addition, patients would have a choice of named consultant-led team for elective care (where clinically appropriate) by April 2011. Choice in maternity services would be extended by developing new provider networks. There would be choice of treatment and provider in some mental health services from April 2011. There would also be choice in diagnostic testing (and the ability to choose regarding the provision of treatment after diagnosis) from 2011. And there would be a clear right to choose to register with any GP practice without restriction – as promised by the previous government.⁹⁶

The previous government’s piloting of Personal Health Budgets would also be built on.

The FT regulator, Monitor, was to be transformed into an economic “sector regulator” for the whole NHS (akin to the regulators for the privatised utilities). It would have concurrent powers with the Office of Fair Trading to apply competition law to prevent anti-competitive behaviour, along with a remit to promote competition. (It was widely believed that this would bring the NHS within the scope of European Union competition law, concerning state aid, mergers, cartels and the prevention of monopolies.) In consequence, the CCP would be absorbed into Monitor.

Monitor would discharge its role through licensing providers (in conjunction with the CQC). It would do so in respect of FTs (whose Terms of Authorisation would be replaced by the provider licence) from April 2012. At that point Monitor would cease to be the FT regulator (except for the exercise of transitional powers of intervention in certain FTs) but it would still be the FT registrar.

Monitor would also license independent-sector providers of NHS services from April 2014 (it was initially intended this would be from April 2013).

⁹⁶ Free choice of GP, without practice boundaries, would have meant freedom for patients effectively to choose their commissioning consortium. Consortia were, though, supposed to have a geographical focus in respect of locality-based services, services for unregistered patients and services commissioned jointly with local authorities.

In addition, Monitor would set tariff prices, while the Commissioning Board would be responsible for setting the structure of the tariff.

A Health Special Administration regime, operated by Monitor, would allow intervention to ensure the continuity of “designated services” where any provider failed financially.

There were also to be changes to NHS public accountability arrangements. Local authorities with social services responsibilities would continue to have an NHS scrutiny role after April 2013, but this could be discharged by means other than a HOSC. (An initial proposal to transfer the overview and scrutiny function from HOSCs to HWBs was dropped.)

In April 2012 LINKs would be turned into local non-statutory corporate bodies called HealthWatch, which would “act as local consumer champions across health and care”. These would operate as social enterprises and be commissioned by local authorities with social services responsibilities (with whose geography that of HealthWatch bodies would coincide). HealthWatch bodies were also to be represented on Health and Wellbeing Boards, and involved in assessing local health and social care needs. At the same time, a national body called HealthWatch England was to be created, as part of the CQC, to act as a “consumer champion” for health and social care as well as providing leadership to local HealthWatch bodies.

In addition, ICAS was to be abolished in 2013, with the commissioning of complaints services being passed to local authorities with social services responsibilities, who could commission their local HealthWatch, or national HealthWatch, for this purpose if they chose. (An initial proposal simply to pass the complaints advocacy function to local HealthWatch bodies was dropped.)

The Government sought to emphasise the extent of continuity between its proposals and the various facets of system reform that the previous government had implemented. The Secretary of State, Andrew Lansley, told the Health Committee in November 2010: “What I am proposing is an evolution. I have never called it a revolution”.⁹⁷

However, it was widely believed that the size and speed of the proposed changes did mean that they were more revolutionary than evolutionary. The Chief Executive of the NHS commented that “This is massive. It’s such a big change management, you could probably see it from space.”⁹⁸

In October 2010 the Secretary of State announced a new “Pathfinder” programme to identify and support groups of GP practices that wanted to make faster progress in taking on the new roles set out in the NHS White Paper. This was intended to let GPs test different consortium designs and to identify any issues and areas of learning that could be

⁹⁷ Health Committee, *Public Expenditure*, 14 December 2010, HC 512 2010–12, para 73

⁹⁸ Health Policy Insight, [“NHS CE Sir David Nicholson's speech to the NHS Alliance conference”](#), 18 November 2010

shared across the GP community. In December 2010 the formation of the first of several waves of Pathfinder GP consortia was announced.

The impact of the cuts in administration budgets was soon being felt, with big reductions in staffing levels occurring – just as PCTs and SHAs had to prepare for the implementation of the prospective large-scale reforms.

The Operating Framework for the NHS in England 2011/12, published in December 2010, stated that PCTs were to be formed into “clusters” in the transition to the new system. The Chief Executive of the NHS explained that:

The broad role of clusters will be twofold. Firstly, clusters will oversee delivery during the transition and the close down of the old system. In so doing, they will ensure PCT statutory functions are delivered up to April 2013. Secondly, clusters will support emerging consortia, the development of commissioning support providers and the emergence of the new system. In so doing, they will provide the new NHS Commissioning Board with an initial local structure to enable it to work with consortia. In creating clusters, our aim is to maintain the strength of the commissioning system in light of the significant financial challenges ahead.

Clusters will have a single Executive Team and will be in place by June 2011 at the latest in a form that is sustainable up to April 2013, and potentially beyond that date if the NHS Commissioning Board chooses.⁹⁹

The 151 PCTs were accordingly formed into 50 clusters in early 2011.

(Following the White Paper, the Government also, in October 2010, introduced the Cancer Drugs Fund, which provided funds for drugs that had not been endorsed by NICE. It was argued by critics that the role of the Institute had thereby been somewhat undermined.)

4.3 The Health and Social Care Act 2012

The Health and Social Care Bill proved to be hugely controversial and its passage through Parliament was “paused” in the spring of 2011 for a “listening exercise”. Various alterations were then made to the Bill, which was recommitted to a public bill committee on 21 June 2011. Revised transitional arrangements were outlined in the *Shared Operating Model for PCT Clusters* in July 2011. The Bill finally gained Royal Assent on 27 March 2012.

Major reforms originally planned for April 2012 were delayed until “at least July 2012” and then pushed back further still. Healthwatch England was eventually created (as a statutory committee of the CQC) in October 2012; and local Healthwatch bodies in April 2013. PHE was established (as an Executive Agency of the DH) in April 2013; and HWBs were initiated in the same month (having existed in shadow form from April 2012).

⁹⁹ Department of Health, [“Managing the Transition and the 2011/12 Operating Framework”](#) – letter from NHS Chief Executive to NHS Chief Executives, 15 December 2010

The Commissioning Board existed in shadow form (as a SpHA) from October 2011 and assumed its statutory role (as an executive non-departmental public body sponsored by the DH) in October 2012. Since April 2013 it has been known for operational purposes as NHS England.

The ten SHAs were formed into four clusters in October 2011, with a remit to manage the transition to the new system while keeping a grip on service performance, finances and delivery. SHAs were finally abolished in April 2013, at the same time as PCTs.

Consortia became Clinical Commissioning Groups (CCGs), with some involvement of clinicians other than GPs – although GPs remained responsible for commissioning. The Secretary of State indicated that, while he still wanted patients to have choice of GP practice, there would be no abolition of practice boundaries.¹⁰⁰ Nonetheless, a pilot scheme for free choice of GP practice without practice boundaries was run in four PCTs in 2012–13.¹⁰¹

AWP was renamed “Any Qualified Provider” (AQP). While the policy remained the same, its introduction was significantly slowed, now being introduced through a “phased roll-out” from April 2012. Eight service areas were identified as priorities for AQP implementation; and PCT clusters had, by the end of October 2011, to have earmarked at least three services in which to implement AQP from April 2012.

The right for patients to choose their consultant-led team was introduced in April 2012.

An annual Choice Framework (beginning in 2012–13) would set out where exactly patients were able to make choices about their NHS treatment. And the Secretary of State’s mandate to NHS England would include a “choice mandate”.

The April 2014 absolute deadline for all NHS Trusts to become FTs was dropped, although transition to FT status for all NHS Trusts by April 2014 was still a stated “expectation”.¹⁰² After the demise of SHAs in April 2013 oversight of NHS Trusts would be assumed by a new NHS Trust Development Authority (an executive non-departmental public body sponsored by the DH). This would hold NHS Trusts to standards equivalent to those set by Monitor for licence-holders (ie FTs and independent-sector providers subject to the licensing requirement).

The provision in the Bill which would have abolished the Private Patient Income Cap for FTs was amended during its passage so that it stipulated a new cap across all FTs of 49%. This was apparently an attempt to counter the charge that the Bill would open the NHS up to the full force of competition law – but critics argued that it was another ruse to facilitate privatisation. The Bill was then further amended so that FT

¹⁰⁰ [“Lansley backs away from complete abolition of practice boundaries”](#), *Pulse*, 24 October 2011

¹⁰¹ In January 2015 the Patient Choice Scheme was initiated, under which GMS practices were permitted (but not obliged) to register patients from outside their practice boundary.

¹⁰² The provision for the repeal of the legislation underpinning NHS Trusts was still included in the Act but now with no date attached to it – so that the Secretary of State was free to decide when, or if, to put it into effect.

Governors and Monitor had a role in approving any substantial increase in private income.

The proposed new role of Monitor was recast, so that it still had a duty to prevent anti-competitive behaviour, but no explicit duty to promote competition; and it now had an overriding duty to protect and promote the interests of patients. It was also effectively to retain its role as FT regulator. The intended provision to allow NHS providers to be compelled to open their facilities to competitors was dropped. The CCP would now maintain a “distinct identity” within Monitor and would continue to enforce the existing PRCC.

The Secretary of State insisted that the recasting of the legislation had addressed concerns about the risk of choice and competition rules cutting across the commissioning of integrated care pathways (forcing them to be “unbundled”). He told the Health Committee in July 2011: “What we are doing, through amendments to the legislation, is to make it absolutely clear that integration around the needs of patients trumps other issues, including the application of competition rules.”¹⁰³ This apparently ruled out enforced AQP in this context. There had been talk of competitive tendering for whole pathways provided by a single provider or by several providers under the overall management of a “prime contractor”.¹⁰⁴

The Bill was also amended to make clear that tariff prices were to be fixed (meaning that there could not be competition between providers on the basis of price) and to rule out differing tariffs for NHS providers and private-sector providers.

NHS provider licences were to be issued by Monitor to FTs from April 2013 and to independent-sector providers from April 2014. NHS Trusts and primary care providers (and certain other types of provider) would be exempt from licensing.

In relation to clinically and / or financially unsustainable FTs, the provision allowing for de-authorisation was repealed but FTs were not after all to be made subject to insolvency law. Monitor was now empowered to: operate a “pre-failure” or “distress” regime for FTs at risk of becoming unsustainable; appoint a Trust Special Administrator to a failing FT; and order the dissolution of a chronically failed FT, with the transfer of its assets and liabilities.

Key (“hard to replace”) NHS services provided by a licensed provider were to be designated by commissioners as “Commissioner requested services” (CRS). Providers would be required by their licence conditions to continue providing these services. In the event that a provider of such services were to fail, a Trust Special Administrator (in the case of a FT) or a Health Special Administrator (in the case of an independent-sector provider)¹⁰⁵ would be obliged and empowered to maintain the

¹⁰³ Health Committee, [Report of the NHS Future Forum](#), 23 March 2012, HC 1248-ii 2010–12, Ev 26

¹⁰⁴ Health Committee, [Commissioning: further issues](#), 5 April 2011, HC 796-I 2010–12, para 157

¹⁰⁵ It was planned to implement Health Special Administration from April 2014, but the Government eventually decided not to proceed with it.

continuity of those services. The Special Administrator would also act to ensure the provision of designated Location Specific Services in a particular place. Resources to pay for service continuity would be available from “risk pools”, funded by a levy on providers and commissioners.

FT assets associated with a CRS would have to be entered on an Asset Register, allowing them to be protected along the same lines as those hitherto covered by the FT asset lock. In the first instance, in respect of FTs authorised before April 2015, all mandatory services were to be “grandfathered”, ie automatically placed onto the CRS list for a limited period (which turned out to be until April 2016). Commissioners would then have to decide which FT-provided services should be included on the CRS list.

During the transition to the new system, PCT clusters evolved into the basis for the (Local) Area Teams of the NHS Commissioning Board, effectively providing continuity in the commissioning of primary care.¹⁰⁶ Commissioning Board Regional Teams were also formed. SCGs were clustered on the same footprints as SHA clusters, prior to the Commissioning Board taking on the commissioning of specialised services.

PCTs delegated commissioning functions to Pathfinders and emerging CCGs.¹⁰⁷ “Commissioning Support Units” (CSUs), hosted by the Commissioning Board, were also formed from PCTs, to provide specialist commissioning support (including in “market development”) to the emerging CCGs. Continuity was thus also provided in HCHS commissioning. CSUs were expected to become “externalised” from NHS England by April 2016.¹⁰⁸

Several changes took place in NHS representative bodies during the controversy over the Bill. In 2011 the FT Network broke away from the NHS Confederation (after the Director of the FT Network was suspended for suggesting that the Network might leave the Confederation).¹⁰⁹ In 2012 the NAPC and the NHS Alliance formed the NHS Clinical Commissioning Coalition to support the formation of CCGs; this was to the disquiet of some NHS Alliance supporters who were opposed to the new commissioning arrangements.

¹⁰⁶ [“PCTs to survive as ‘outposts’ of new commissioning board”](#), *Pulse*, 22 June 2011

¹⁰⁷ CCGs tended to cover relatively small geographical areas, akin to those for PCGs / PCTs during 1999–2006.

¹⁰⁸ CCGs are able to choose their sources of commissioning support. Since April 2013 CCGs have been “required to procure their commissioning support in the open market in line with the EU rules that govern the public sector” – NHS Commissioning Board, [“Commissioning support: Key facts”](#), March 2013. In some cases, CCG commissioning support has been outsourced to private firms such as Capita.

¹⁰⁹ In 2014 the FT Network became NHS Providers, representing both FTs and NHS Trusts.

4.4 Procurement, choice and competition up to April 2013

The CCP reported in July 2011 that, while in theory patient choice had existed since 2008, in practice it was still not widely available. The Panel criticised PCTs for not commissioning enough services on an AWP / AQP basis.¹¹⁰

In the same month, the Managing Director of a leading private-sector provider, Care UK, complained, following the announcement of the “phased roll-out” of AQP, that the policy had been “bastardised” and that he now felt like “a jilted bride”.¹¹¹

“Phased roll-out” began with the publication, also in July 2011, of operational guidance on AQP for providers and commissioners, *Extending Patient Choice of Provider*. This set out eight priority areas for AQP implementation, with commissioners expected to choose at least three services by November 2011. In September 2012 a range of 39 services was specified as suitable for the AQP regime.

In November 2012 a discussion paper on the preliminary findings of Monitor’s Fair Playing Field Review (carried out at the behest of the Secretary of State) was published. This stated that providers believed commissioners to be “frustrating the development of a more diverse supply base and any associated benefits”, failing to put services out to tender and exhibiting “a cultural bias towards the incumbent provider”.¹¹²

In 2012 DH figures showed that 70% of providers approved under AQP to provide community and mental health services were non-NHS organisations and there was talk of a “massive outsourcing shift”.¹¹³ However, by the end of the transition to the new NHS structures, in April 2013, the roll-out of AQP was also being spoken of as something of a damp squib.¹¹⁴

It was unclear how, to what extent and how quickly matters would change under the new system in respect of both commissioning under AQP and putting services out to tender. The implications of the Procurement, Patient Choice and Competition Regulations, made in April 2013 under section 75 of the 2012 Act, were to prove highly contentious.

¹¹⁰ NHS Co-operation and Competition Panel, [Review of the Operation of 'Any Willing Provider' for the Provision of Routine Elective Care - Final Report](#), July 2011

¹¹¹ “AQP ‘bastardised’, says Care UK boss”, *Health Service Journal* website, 8 July 2011

¹¹² Monitor, *Fair Playing Field Review – for the benefit of patients: Discussion Paper*, November 2012, pp 7–8

¹¹³ Sofia Lind, [“DH figures reveal massive outsourcing shift as non-NHS providers dominate AQP”](#), *Pulse*, 14 December 2012

¹¹⁴ Crispin Dowler, “What happened to ‘any qualified provider’?”, *Health Service Journal* website, 18 April 2013

Annex: Glossary of acronyms

A&E	Accident and Emergency
ACHCEW	Association of Community Health Councils for England and Wales
AHA	Area Health Authority
AIM	Association of Independent Multifunds
AME	Annually Managed Expenditure
APMS	Alternative Provider Medical Services
AQP	Any Qualified Provider
AWP	Any Willing Provider
CCG	Clinical Commissioning Group
CCP	Co-operation and Competition Panel
CHCs	Community Health Councils
CPPIH	Commission for Patient and Public Involvement in Health
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRS	“Commissioner requested services”
CSUs	Commissioning Support Units
DEls	Departmental Expenditure Limits
DFT	Distance from Target
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
DMS	Defence Medical Services

DMU	District Managed Unit / Directly Managed Unit
ECs	Executive Councils
FESC	Framework for Procuring External Support for Commissioners
FHS	Family Health Services
FHSA	Family Health Services Authority
FPC	Family Practitioner Committee
FPS	Family Practitioner Services
FT	Foundation Trust
GDS	General Dental Services
GMS	General Medical Services
GMSNCL	GMS Non-Cash Limited
GOS	General Ophthalmic Services
GP	General Practitioner
GPS	General Pharmaceutical Services
HA	Health Authority
HCFHS	Hospital, Community and (discretionary) Family Health Services
HCHS	Hospital and Community Health Services
HOSCs	Health Overview and Scrutiny Committees
HSPSCB	High Security Psychiatric Services Commissioning Board
HWBs	Health and Wellbeing Boards
ICAS	Independent Complaints Advocacy Service
ISTC	Independent Sector Treatment Centre
IT	Information Technology

LEA	Local Education Authority
LHA	Local Health Authority
LINKs	Local Involvement Networks
LWA	Local Welfare Authority
MFF	Market Forces Factor
NACGPs	National Association of Commissioning GPs
NAFPs	National Association of Fundholding Practices
NAHAEW	National Association of Health Authorities in England and Wales
NAHAT	National Association of Health Authorities and Trusts
NAPC	National Association of Primary Care
NHS	National Health Service
NHSBSA	NHS Business Services Authority
NICE	National Institute for Clinical Excellence (National Institute for Health and Clinical Excellence from 2005)
NSCAG	National Specialist Commissioning Advisory Group
NSCG	National Specialised Commissioning Group
OATs	Out-of-Area Treatments
PACT	Prescription Analysis and Cost
PASA	Purchasing and Supply Agency
PBC	Practice-based Commissioning
PbR	Payment by Results
PCG	Primary Care Group
PCT	Primary Care Trust
PDS	Personal Dental Services

PEC	Professional Executive Committee
PFI	Private Finance Initiative
PHE	Public Health England
PMS	Personal Medical Services
PPIFs	Patient and Public Involvement Forums
PPRS	Pharmaceutical Price Regulation Scheme
PRCC	Principles and Rules for Cooperation and Competition
PROMs	patient-reported outcome measures
QALY	quality-adjusted life year
QIPP	Quality, Innovation, Productivity and Prevention
RAB	Resource Accounting and Budgeting
RAWP	Resource Allocation Working Party
RHA	Regional Health Authority
RHB	Regional Hospital Board
SCG	Specialised Commissioning Group
SHA	Strategic Health Authority
SMR	Standardised Mortality Ratio
SpHAs	Special Health Authorities
SRSAG	Supra-Regional Services Advisory Group
WCC	World Class Commissioning

The House of Commons Library research service provides MPs and their staff with the impartial briefing and evidence base they need to do their work in scrutinising Government, proposing legislation, and supporting constituents.

As well as providing MPs with a confidential service we publish open briefing papers, which are available on the Parliament website.

Every effort is made to ensure that the information contained in these publicly available research briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

If you have any comments on our briefings please email papers@parliament.uk. Authors are available to discuss the content of this briefing only with Members and their staff.

If you have any general questions about the work of the House of Commons you can email hcinfo@parliament.uk.

Disclaimer - This information is provided to Members of Parliament in support of their parliamentary duties. It is a general briefing only and should not be relied on as a substitute for specific advice. The House of Commons or the author(s) shall not be liable for any errors or omissions, or for any loss or damage of any kind arising from its use, and may remove, vary or amend any information at any time without prior notice.

The House of Commons accepts no responsibility for any references or links to, or the content of, information maintained by third parties. This information is provided subject to the [conditions of the Open Parliament Licence](#).