Commissioning high quality care for people with long-term conditions

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Glossary of terms/abbreviations

AQP	Any Qualified Provider
CCG	Clinical Commissioning Group
CHFT	Calderdale and Huddersfield Foundation Trust
CQUIN	Commissioning for Quality and Innovation
CSED	Care Services Efficiency Delivery
DSN	Diabetic Specialist Nurse
FESC	Framework for procuring External Support for Commissioners
GP	General Practitioner
HES	Hospital Episode Statistics
HRG	Healthcare Resource Group
LES	Local Enhanced Service
LTC	Long-term condition
MAU	Medical Assessment Unit
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NPM	New Public Management
NSF	National Service Framework
PBC	Practice Based Commissioning
PbR	Payment By Results
PCT	Primary Care Trust
SLA	Service Level Agreement
SNA	Social Network Analysis
SUS	Secondary Uses Service
UK	United Kingdom
WMAS	Wirral Memory Assessment Service
WTE	Whole Time Equivalent
WUTH	Wirral University NHS Hospital Trust

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Contribution of authors

Dr Judith Smith (Director of Policy) was the Principal Investigator, developed the research proposal, provided expert advice and facilitation within case study sites, carried out interviews, was involved in data analysis and report-writing, and edited this final report.

Dr Sara Shaw (Visiting Senior Fellow) developed the research proposal, carried out interviews and observations, was primary contact for one site, and was involved in data analysis and report-writing.

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Dr Rebecca Rosen (Senior Fellow) provided expert advice and facilitation within case study sites, undertook the social network analysis, and was involved in report-writing.

Ian Blunt (Senior Research Analyst) undertook quantitative data analysis, provided specialist data analytical advice to colleagues within case study sites, and was involved in report-writing.

Dr Alisha Davies (Specialist Public Health Trainee) undertook appraisal of public health evidence and literature review within case study sites, and was involved in report-writing.

Elizabeth Eastmure (Project Manager) carried out project management, ethics and research governance, and supported report-writing.

Professor Nicholas Mays (Professor of Health Policy, LSHTM) provided methodological advice and strategic direction, took part in analysis, and acted as critical reader of the final report.

Executive Summary

Background

Commissioning is the term used to describe the process of aligning resources to the health needs of a population (within a defined budget), putting in place cost-effective services to meet those needs, and monitoring the quality of services to ensure that they fulfil the standards set out in contracts.

One of the most influential pieces of analysis of health care commissioning is Øvretveit's (1995) commissioning cycle, in which the stages of needs assessment, planning, contracting, monitoring and review are repeated annually. This model has been promoted by the Department of Health to the primary care trusts (PCTs) which were responsible for commissioning health care at the time of this study. Other analyses have examined the continuum of agencies which carry out commissioning, placing PCT commissioning at a mid-point between personal health budgets and specialised commissioning at national level (Smith et al, 2004), and the need to balance formal, transactional aspects of commissioning with more relational processes.

Much of the existing research and literature focuses on the organisation of commissioning and specific aspects of the commissioning cycle, such as contracting. Less attention has been paid to the practice of commissioning, although relevant literature exists on three themes, concerned respectively with practice (how people make sense of institutional requirements within real situations), networks (how different parties work together to plan and manage services), and management (how commissioning skills are applied).

Aims

The aim of this research was to explore how NHS commissioning could be enacted to improve care for people living with long-term conditions. The objectives were to:

1. identify the organisation and processes associated with effective commissioning;
2. identify an appropriate set of outcomes, some developed in association with commissioners themselves;
3. draw on experience from other sectors and international health systems in developing commissioning within study sites, developing and disseminating good practice guidance as a result; and

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4. consider how the learning from this research could be more widely applicable in the NHS.

Methods

A cohort of 'high performing' PCT areas was identified, from which three were selected as case study sites: Calderdale, Somerset and Wirral. Within each PCT area the study examined the whole 'commissioning community', including provider organisations. The research focused on specific developments in relation to two long-term conditions: diabetes in all three sites, to allow cross-site comparison; and one other condition selected by local commissioners (stroke in Somerset and dementia in Calderdale and Wirral).

An initial orientation and mapping phase was followed by a main data collection phase lasting 15 months. Seventy-one semi-structured interviews were carried out to examine commissioning practice, and a further 21 focused on the impact on local commissioning of wider health service reforms. An additional 20 telephone interviews with lead contacts in sites tracked developments on a regular basis. Twenty-seven commissioning meetings were observed, and over three hundred documents analysed. Where possible, quantitative data were collected on service provision, activity levels, costs and patient experience at the start and close of the fieldwork.

A questionnaire survey was used to carry out a social network analysis of patterns of influence on GP clinical practice in relation to diabetes care, this being an attempt to explore how far the activity of commissioners influences the clinical practice of GP giving care to people with long-term condition.

The study was a comparative multi-case study project, within which the researchers offered supportive intervention and consultancy in sites as part of the research process. Interventions included facilitating meetings and workshops, evidence review, and data analysis. These interventions aided the establishment of collaborative working relationships between the research team and sites, especially given the rapidly changing policy and organisational context.

Qualitative and quantitative data were analysed within and across sites and service areas, to develop an understanding of the day-to-day practice of commissioning, including what factors facilitated or inhibited progress.

Emerging findings were presented for validation at two workshop events (in May and November 2011) bringing together representatives from each study site with members of the research team and advisory group.

Results

The practice of commissioning was studied in relation to six specific service developments:

1. The development of a strategic plan for diabetes care in Calderdale
2. A transformation of dementia services in Calderdale
3. Redesign of the Somerset Diabetes Service, including a new intermediate tier of nurse-led care
4. Establishment of an Early Supported Discharge service for stroke patients in Somerset
5. Review of the diabetic podiatry service in Wirral
6. Establishment of a new Memory Assessment Service in Wirral

Seven cross-cutting themes emerged:

The scope of commissioning – findings challenged the model of a 'commissioning cycle' of sequential tasks. Developmental commissioning, over many years, was running in parallel with annual contractual aspects of commissioning. Deciding the scope and scale of commissioning work was an essential first step. Co-ordination and support for implementation were significant parts of commissioning practice.

The labour of commissioning – an extraordinary amount of effort went into commissioning across all six service areas, made up of technical and relational tasks. Effective commissioning required a combination of senior strategic leadership and day-to-day project management input from dedicated commissioning staff. This labour seemed often to be disproportionate to the anticipated or actual service gains.

Identifying the commissioners – commissioning tasks were undertaken by managers and clinicians from providers, GPs, and representatives of third sector organisations, as well as by PCT commissioners. The contribution of different parties varied according to the stage in the commissioning process. Clinicians had a role as experts and champions for change, and GPs' role as decision-makers was evolving.

The question of money – the role of money in commissioning practice was observed to be intermittent and at times peripheral. The organisational structure of PCTs encouraged a separation of financial and contractual aspects of commissioning from developmental processes. A limited role was observed for NHS financial incentive schemes, but the

majority of spending on the services studied was absorbed in block contracts. Anticipated cost savings from service redesign in relation to long-term conditions were in some cases hard for commissioners to reconcile with pressure for immediate efficiencies.

The scale and pace of change – the change brought about through the commissioning processes observed tended to be incremental rather than radical – it was cautious, carefully paced and non-disruptive. Success seemed to come where commissioners were tackling 'bite-sized' commissioning tasks as part of a wider local plan for service delivery.

External drivers of commissioning – external drivers played a powerful role in shaping commissioning practice in each of the six service areas. National 'guidance' provided top-down impetus to get things done, presented templates for services, and provided a national framework to facilitate local decision-making and identification of priorities. External support organisations were available for commissioners to call on to help their work. External drivers were mediated by local circumstances, particularly existing patterns of service provision.

Working in a context of uncertainty – the study took place at a time of significant change to the structure of the National Health Service in England, as plans were being put in place to shift commissioning responsibilities from PCTs to GP-led clinical commissioning groups. Commissioning of care for people with long-term conditions managed to continue in the face of loss of PCT management and analytical capacity and a sense of uncertainty about the future.

The social network analysis of influences on GPs' practice in diabetes care had a low response rate (21%) overall, although higher in Calderdale (44%). The main sources of advice and influence on diabetes care were found to be GP colleagues, specialist nurses, and hospital consultants. PCTs were only occasionally cited by GPs as an influence on their practice.

As previous research has found, tracking the impact of commissioning through quantitative data (concerning activity levels and clinical outcomes) proved challenging, because of long time lags between intervention and change, and because of difficulties in attributing impact to commissioning rather than other factors.

Conclusions

Commissioning for long-term conditions seems to differ from elective services, and requires an approach which represents a blurring of the purchaser-provider split. However, the effort involved in commissioning has to be worth the outcomes, and relational aspects of commissioning work must leave room for transactions that assure such outcomes (e.g. contracting, review, decommissioning).

The research suggested that the following activities, amenable to measurement, were associated with effective commissioning:

- Commissioners acting as convenors of multiple local interests and stakeholders
- Focus by commissioners on overall setting of priorities for health spending, rather than a few services at the margins
- Commissioners getting the right balance between relational and contractual aspects of commissioning
- A strong focus on monitoring of activity, financial performance and quality, and using this to inform review
- Shared risk across providers and a long timescale for development in relation to delivery of care for long-term conditions
- Support for commissioning managers
- Adequate clinical involvement in commissioning
- Specific and measurable objectives for any newly commissioned or re-commissioned service
- A programme of review and re-commissioning of the services that cost most money

The Report

1 Background

1.1 Policy on commissioning

1.1.1 New public management and the emergence of purchasing

Health systems are complex entities and include a number of fundamental functions and roles, the main ones being:

- principal funder (e.g. taxpayer or individual fee-paying patient);
- third party payer (e.g. health insurance organisation or statutory health authority);
- provider (e.g. hospital, GP); and
- government.

In tax-funded, publicly run systems such as the English NHS, third party payers and providers were traditionally based within the same organisation[1].

During the last two decades of the twentieth century however, reforms took place in many developed healthcare systems, leading to changes in the third party payer role and its relationship with the provider role. These reforms aimed to improve service efficiency whilst increasing responsiveness to users, and entailed the introduction of market-like mechanisms into public services, along with other management reforms[2].

The development of health purchasing as a function was an important part of reforms, influenced by 'new public management'[3] (NPM). NPM ideas emerged in the late 1980s and led to a drive towards: 'greater competition in the public sector'; 'explicit standards and measures of performance'; and 'disaggregation of units', all of which are features of what are now known as a commissioning or contracting system.

1.1.2 Purchasing in the NHS

In the UK in 1991, the Conservative Government introduced an internal market into what had previously been an integrated and directly managed public health care system, where health authorities had acted as both funders of health services, and managers of hospital, community health, and mental health services[4]. Health authorities and general practitioner

(GP) fundholders took on a new purchasing role, and provision was separated and strengthened through the creation of semi-autonomous NHS trusts.

his separation of purchasing from provision, often referred to as the purchaser-provider split, was based on the principle that those who fund and purchase care (now known as the commissioners) should concentrate on assessing needs, planning services, and ensuring that an appropriate mix of services is available for a specific population[5]. Predicated on a belief that health providers (hospitals, doctors, general practices, etc.) have greater knowledge about health services than those who use them, a dedicated commissioning function was intended to help overcome this asymmetry of information, with the commissioner (e.g. primary care trust, GP commissioner) acting as an agent for the patient or member of the public, deciding how best to spend taxpayers' money to meet the local population's health needs.

After political devolution in the UK in 1999, the healthcare systems of the UK diverged, with Scotland and later Wales returning to a more integrated system, while England developed the market-based system further[6].

Attempts to strengthen the purchasing function have been a feature of a number of health care systems, as witnessed by the introduction of health plans, managed care and the 'accountable care organisation' in the USA[7,8,] the move to a system of competing private health insurers in the Netherlands, and various experiments with commissioning and contracting in the English NHS. The drivers for such reforms vary, but include the desire to control (and maximise value from) public spending; seeking to improve the responsiveness of public services to the needs of patients; and political ideas associated with the New Right[9].

1.1.3 Health purchasing and commissioning

Academic analysis[10] distinguishes commissioning from purchasing or contracting, suggesting that commissioning has a more strategic and proactive intent, to influence and shape what is offered by providers. Woodin[11] explained the more strategic intent of NHS commissioning as follows:

> 'A commissioner decides which services or health care interventions should be provided, who should provide them and how they should be paid for, and works closely with the provider implementing changes. A purchaser buys what is on offer or reimburses the provider on the basis of usage.' (p203)

As experience and evidence have accumulated about the implementation of internal market reforms in public services since the 1990s, academic

analysis has examined the theory and practice of commissioning and contracting, mostly in the UK context[5,12,13]. One of the most influential analyses of health care commissioning (in terms of how it has been used by the English Department of Health to conceptualise and describe what is expected of commissioning[14]) has been the work of Øvretveit and his presentation of commissioning as a cycle of activity[10]. This cycle (set out in Figure 1 below) is a simplified model of what in practice is far more complex.

Figure 1. The Commissioning Cycle
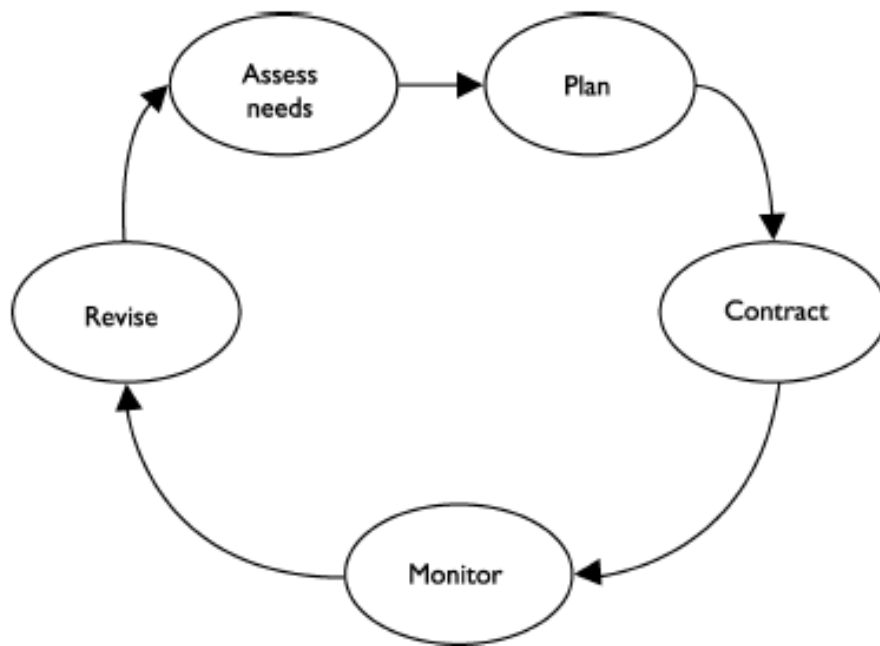
Source: Adapted from Department of Health (2003)[14]

1.1.4 Commissioning in the international context

What the English call 'commissioning' is usually described as 'strategic purchasing' in other health systems such as the Netherlands and Germany, or 'planning and funding' in those countries that have abandoned the purchaser-provider split of an internal market and seek a more integrated approach, as in New Zealand or Scotland. What is common is a desire to lever change in the provision of services, and to try and align funding with needs.

Health care commissioning is something that, in the international literature, is regarded as being very difficult to do. In a comprehensive review of the evidence on health care purchasing in 2000, Mays and Hands[15] summed it up thus:

> '*Purchasing health services is inherently difficult in publicly financed health systems since purchasers are continually faced with the multiple and frequently conflicting explicit and implicit expectations of politicians, central government officials, managers, clinicians, patients and the public for the health system*.' (pp30-31)

Likewise, a major review of health care purchasing in Europe[16] found that there was significant diversity across European countries in how they organised health funding and planning, and noted that these varying approaches were a result of a complex interplay of historical, cultural and economic factors within individual countries. For example, some countries rely on social insurance funds to purchase health care, others place this function within local or regional government, and others (like the NHS) establish specific health commissioning bodies within the publicly funded health system.

One of the conclusions from Figueras et al's work was that no single approach to commissioning would necessarily suit all forms of care, for whilst some health care purchasing is best done at a local level (e.g. primary care and chronic disease management), other elements will require a regional or even national approach (e.g. very specialised hospital services, public health programmes such as 'flu prevention). This need for 'levels of commissioning' was underlined in a review of the evidence on health care commissioning in the UK[17]. A 'continuum of commissioning' in the NHS was identified as set out in Figure 2.

Commissioning tends to lack profile and legitimacy in the eyes of the public. It falls to commissioners to lead the process of developing health service strategy for a local area, and to take and be accountable for (potentially difficult) decisions about resources and services. However, in comparison with well-known health institutions such as hospitals, commissioners are typically invisible to the general public, and reported as 'NHS bureaucrats' in the media. Current plans in the English NHS to place family doctors at the centre of health care commissioning[18] are intended to overcome this anonymity and low level of legitimacy of commissioners.

Figure 2. Continuum of commissioning in the NHS in England in 2010
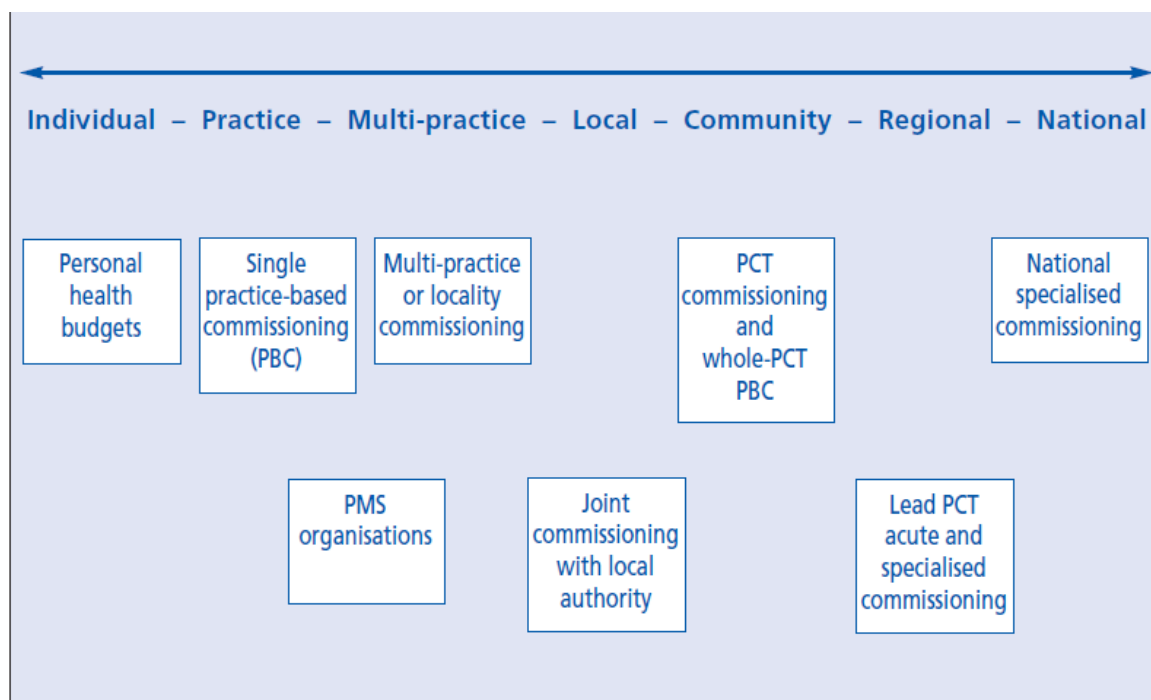
Source: Smith et al 2004, adapted[17]

1.1.5 Relational and transactional contracting

The literature exposes the complex range of activities entailed within commissioning (see Smith and Woodin1 and Figueras and colleagues[16] for more details). Within such analysis, contracts and contracting feature strongly, especially in research carried out in the 1990s and early 2000s. The rationale for this was summed up by one research group as follows:

> 'Contracts are the most visible and practical part of purchasing. They are a key tool that defines the relationship between principals (purchasers) and agents (providers). They can be used to reflect the purchaser's health objectives and the health needs of the population, and to make clear what services are to be provided and under which terms.'[19]

Although it is sometimes argued that better constructed, legally enforceable contracts would help health care commissioners to exert the influence they seek with providers[20], the constraints faced within formal contracting within health care (along with the costs of operating such a system) suggest that other factors are often more important[1]. Some of the limits to contracting include: information deficits; costing issues; monitoring of quality; and enforcement processes.

The other factors deemed to be important alongside transactional aspects are referred to as the 'relational' aspects of contracting, as compared with the 'transactional' element of formal contracting. Relational aspects include: trust; common values; and established and new networks[21,22]. Researchers have observed that trust and informal contact play an important part in commissioner-provider relationships in healthcare, alongside more formal processes of negotiating and working within a service contract[3,23]. As Walsh[9] put it:

> *'The development of trust is central to the maintenance of social systems, and the danger of contract is that it undermines trust, through basing contracts on punishment for failure. If we undermine trust then we may find that the making of agreements, and ensuring that they are kept, will become very costly*.'

Such relationships need to be understood with reference to the distribution of power within the system[24]. In health systems, this is often explored in relation to the powerful position of providers (especially hospitals) that hold significant expert knowledge, control technology, control what is ordered and thus exert institutional power[25]. 'Provider capture' is therefore a risk for health care commissioners and the transactional nature of contracts will be needed to increase their influence over providers.

1.1.6 Commissioning care for people with long-term conditions

Commissioning care for people with long-term conditions appears at first sight to be more amenable to a relational, rather than transactional approach, involving as it frequently does multiple providers across primary, secondary and social care, and over extended periods of time - indeed, for a lifetime, in many cases.

What might previously have been termed 'commissioning' or 'contracting' for care for people with long-term conditions is now more typically discussed in health policy and management literature in terms of 'integrated care'. Drawing on experience with managed care in the US, and the approaches to funding and providing care used by 'integrated delivery systems' such as Kaiser Permanente and Geisinger in the US, this literature focuses on how funders can incentivise providers to take on financial and service risk, and deliver care and/or health outcomes to specified standards.

There are clearly echoes of New Public Management here, but arguably in a more relational context where the providers and funders share risk within an overall contract to a 'higher level' funder, thus sharing incentives to develop services in a joint and 'integrated' manner[26]. The transactional element persists, however, through the need for sophisticated approaches to payment, assessment and sharing of risk, and careful use of contracts to specify desired outcomes and incentives linked with their achievement[27].

This leaves open a question as to how far a 'pure' purchaser-provider split can operate in a health care system, and in particular for complex and enduring chronic conditions.

1.2 Overview of long-term conditions

1.2.1 Long-term conditions

This section sets out the main national policy guidance in relation to long-term conditions generally, and diabetes, stroke and dementia, which were the conditions examined in detail. Appendix 1 lists the main guidance documents and resources relevant to the study.

The Department of Health published a National Service Framework (NSF)[28] for long-term conditions (LTCs) in 2005 which had a vision to improve the lives of people with LTCs by:

- planning services around individual patient needs;
- supporting people to live independently (self-care); and
- delivering integration of health and social care.

Although the NSF focused on neurological conditions, the recommendations were more broadly relevant to long-term conditions and provided the direction for a series of subsequent Department of Health publications and initiatives on health and social care. These have provided guidance on ways to achieve the objectives, such as delivering care closer to home, personalised budgets, individual care planning, and promotion of self-care through patient education and support and telehealth.

One of the workstreams of the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP)[29] programme for England concerns long-term conditions, and in particular work to slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their own conditions. Under QIPP, PCTs are expected to lead programmes for care of long-term conditions which include 3 key components; (i) risk profiling to ensure commissioners understand the needs of the population, (ii) neighbourhood care teams – to integrate health and social care, and (iii) maximise self-care.

1.2.2 Diabetes

The Department of Health published a National Service Framework for diabetes[30] in 2001 which had a vision to:

- reduce the number of people developing diabetes and improve the lives of those with diabetes;
- deliver services that are patient-centred, developed in partnership, equitable, integrated and focused on delivering the best outcome for the patient; and
- enable people to manage their own condition.

The NSF for diabetes set out 12 standards of care and was followed by a delivery strategy[31] outlining a ten-year programme of change to the infrastructure, systems and services, from 2003 to 2013.

Diabetes has remained a national priority with annual reports examining progress on delivery of the NSF for diabetes being produced since 2004[32,33,34,35,36,37] and National Diabetes Audit reports examining progress in diabetes care[38,39].

Resources have been produced by the Department of Health to support various aspects of the commissioning[40] and delivery of diabetes care and self management support[41,42,43,44]. Guidelines from the National Institute for Health and Clinical Excellence (NICE) cover clinical aspects of management and prevention of both Type 1[45] and Type 2[46,47] diabetes[48,49,50,51]. In 2011, NICE developed a set of 13 quality standards for diabetes in adults[52].

Diabetes care is a clinical domain within the Quality and Outcomes Framework (QOF) for primary care in the NHS. Performance indicators reward general practices for keeping a register of diabetes patients and for achieving targets on clinical care[53].

1.2.3 Stroke

The Department of Health published a National Strategy for stroke in 2007[54] to provide a quality framework supporting the development of stroke services at a local level over a 10-year period. The strategy identified 20 quality markers for raising the quality of stroke prevention, treatment, care and rehabilitation. Implementation of the stroke strategy was a Department of Health 'Vital Sign' national requirement for PCTs from 2008-09 to 2010-11[55].

To support commissioners and providers, the Department of Health set up the Stroke Improvement Programme. In 2010/11, they launched the Accelerating Stroke Improvement programme to 'provide renewed emphasis and urgency' to this work, including specific measures around early supported discharge.

In 2007, 28 regional Stroke Networks were formed across England, to support improvements to care[56]. NICE clinical guidelines and accompanying

implementation guidelines have been produced, concentrating on the acute phase of stroke care rather than rehabilitation.

Stroke care is a clinical domain within the Quality and Outcomes Framework (QOF) for primary care. Performance indicators are used as the basis for rewarding general practices for keeping a register of stroke patients and achieving targets on clinical management[53].

In 2011, NICE published a set of 11 quality standards for stroke[57]. These will be reflected in the new commissioning outcomes framework proposed as part of current reforms to the NHS[58], and inform further developments of QOF and the Commissioning for Quality and Innovation (CQUIN) Payment Framework[59].

1.2.4 Dementia

The Department of Health published a National Dementia Strategy (NDS) in 2009[60] which aimed to:

- increase awareness of dementia;
- promote early diagnosis and intervention; and
- radically improve the quality of dementia care.

The strategy set out 17 objectives to improve the quality of services for people with dementia, with an implementation plan[61]. The strategy was informed by earlier policy documents on care of older people and mental health, including the 2006 NICE clinical guidance on the management of dementia[62] which highlighted the importance of supporting carers, coordination of health and social care, use of memory assessment services as a single point of referral for all people with a possible diagnosis of dementia, care planning and staff training.

Guidance for the implementation of the strategy was revised in 2010 and four priority areas were identified : (i) ensure early diagnosis and intervention, (ii) improve the quality of care in general hospitals (iii) and care homes, and (iv) to reduce the use of antipsychotic medication[63].

Dementia care is a clinical domain within the Quality and Outcomes Framework with two performance indicators on dementia: (i) keeping a register of dementia patients and (ii) ensuring patients are reviewed within the past 15 months[53]. NICE quality standards for dementia were published in 2010.

Having reviewed the main policy guidance relating to the three clinical conditions used as the tracers in this research, a brief assessment is now made of literature concerning 'commissioning practice', as this was the particular focus of the study.

1.3 Commissioning practice

Much of the existing research and policy literature focuses on the organisation of commissioning and what needs to be done with regard to the key areas covered by the commissioning cycle (Figure 1)[14]. Less attention has been paid to the process of enacting commissioning. The research reported here has focused explicitly on the practice of commissioning, and three related areas of the literature are of particular relevance.

1.3.1 Commissioning as practice

The concept of 'commissioning as practice' highlights the role of human action in getting things done in complex organisational work[64]. Rather than seeking to expose local commissioning practices as 'good' or 'bad', such work starts by considering how people 'make sense' of and enact commissioning[65]. Sense-making is a continuous process as actors (local managers, clinicians and other professionals) simultaneously shape and react to local organisational concerns[66] and environments[67,68], taking cues from these to help them decide what information is relevant to commissioning[69].

The literature on 'commissioning as practice' recognises the multiple spaces in which commissioning takes place[70], that much of policy is 'what professionals do in the field'[71] and that individuals and groups involved in commissioning have their own agendas and frames of reference[72]. These all guide what is done in the name of commissioning. The practice of commissioning should therefore be understood as 'the property of a kind of community created over time by the sustained pursuit of a shared enterprise'[73,74]. It is this collective development that makes effective commissioning possible, by 'inventing and maintaining ways of squaring institutional demands with the shifting reality of actual situations' (Wenger[73]p46).

1.3.2 Commissioning networks

A focus on 'commissioning networks' recognises the importance of local social networks and institutional relationships to determining how commissioning is enacted locally. It draws on process theory[75] and social network theory[76,77], acknowledging the significance of networks and horizontal linkages that tie participants together within commissioning communities[78]. Such networks are vital as:

> "*No single actor, public or private can have all the information needed; no actor has sufficient overview to make the application of instruments*

effective; and no single actor has sufficient action potential to dominate a particular governing model" (Laws & Hajer[74] p413).

This focus on networks draws attention to a diverse group of people involved in commissioning including planners, senior executives, middle managers, administrators, clinicians, independent sector representatives and service users. It also highlights the need for the role of an 'animateur' within commissioning, whereby an individual (typically a manager) can influence and bring together a disparate group of people over whom they have no direct managerial control, in order that a network is formed, maintained and used as part of the process of commissioning in order to bring about service change[79].

The processes and networks shaping healthcare have been explored in the context of the NHS (e.g. Exworthy and Frosini[80] and Bate et al[81]). Little attention has however been given specifically to the networks that form around the commissioning process (e.g. regarding the role of leaders within and outside the commissioning process in negotiating and supporting changed clinical practice).

1.3.3 Managing commissioning

The literature on 'managing commissioning' focuses not simply on the skills and tasks required, but on how these might be applied. Recent research has encouraged a shift away from thinking simply about the codification of skills[82] to understanding the ways in which 'the job of being a commissioning manager is carried out from day to day' (Checkland[79] p12). Those commissioning managers most able to address the practical difficulties of commissioning work (e.g. engaging with multiple stakeholders, negotiating change) have, as noted above, been characterised as 'animateurs', working to 'align objectives and ensure that the right people behave in the right ways at the right time, and contribute to a particular overall objective' (ibid p15). The successful 'animateur' role involves changing perceptions as well as bringing about specific action in a specific time frame. It therefore overlaps with transformational leadership[83] and management of diffusion of innovations[84].

1.4 Summary of chapter

This chapter has examined the origins of commissioning within public services and health care in particular, and explored the ways in which the Department of Health in England has sought to make the care of people with long-term conditions a policy priority, and thus shape the work of local commissioners. The literature on the practice of commissioning points to

the complexity of getting policy into commissioning practice, given the multiple players involved, the need for skilled management and co-ordination of many and competing interests, and the tendency to focus on inputs to, rather than outcomes from, commissioning.

This complexity represents the focus of the research reported here, where a detailed observation of the practice of commissioning care for people with long-term conditions in three areas of the English NHS was undertaken as the basis for trying to determine what helps or hinders effective commissioning practice.

2 Methods

2.1 Research aims and objectives

The overall aim was to explore how NHS commissioning can be enacted to improve care for people living with long-term conditions.

The objectives were to:

1. identify the organisation and processes associated with effective commissioning (i.e. commissioning to bring about good outcomes);
2. identify an appropriate set of outcomes, some developed in association with commissioners themselves;
3. draw on experience from other sectors and international health systems in developing commissioning within study sites, developing and disseminating good practice guidance as a result; and
4. consider how the learning from this research could be more widely applicable in the NHS.

2.2 Approach

The research was guided by the academic and policy literature summarised in Chapter One.

The methodological approach was that of comparative multi-case study research. Whilst the original intention had been for the study to be grounded in Lewin's work on action research[85] which he described as a 'spiral of steps involving planning, action, and fact-finding about the result of the action', what transpired was a set of in-depth case studies within which the research team undertook some facilitation and development activities. This developmental work was designed to enable greater collaboration between researchers and people in the case study sites, and was also a way of fostering acceptance of the study team at a time of major policy and organizational change.

2.3 Project management

2.3.1 Research governance and ethics

The study was approved by the NHS Outer South East London Research Ethics Committee (Ref: 09/H0805/40). Research governance approval was secured from each of three participating case study sites. It was agreed

with the research ethics committee and with each case study site that organisations would be identifiable, but individuals would not. To assure individual anonymity in presenting findings, illustrative quotes have been labelled with broad categories (e.g. PCT Manager), and case study location removed.

2.3.2 Project Management Group

A project management group was established at the outset of the study (see Appendix 2). The group met every four to six weeks to review progress, plan work and discuss emerging findings.

2.3.3 Research Advisory Group

To provide on-going input to the study from a range of expert advisors, a Research Advisory Group brought together NHS commissioners, user/carer representation, experts on private sector commissioning, and academic and international input (see Appendix 6).

The Research Advisory Group met four times, providing advice on research plans, tools, emerging findings and reports (see Appendix 6 for detailed Terms of Reference). Meetings were supplemented with email exchange on specific areas. Members also participated in two cross-site workshops (see below) during which they acted as discussants, responding to presentations from participants (from our three case study sites and the study team) and contributed knowledge and expertise.

2.4 Selection of sites and service areas for study

2.4.1 Site selection (January to March 2010)

A cohort of candidate sites was identified as 'high performing commissioners' using a set of quantitative metrics related to the processes and outcomes of commissioning. Potential sites that had been the focus of extensive study by other research teams were excluded. The cohort was verified by a panel of experts and invitations to participate were sent out to PCT chief executives.

The aim of site selection was not to create a definitive ranking of performance, but a broad list of potential study sites where 'performance' appeared better than would have been expected when compared to similar organisations.

Table 1.   **The quantitative metrics**

Measure	Description	Application (combined commissioning score is sum of each component score)
World Class Commissioning. Competency Score 2008/09. Department of Health Published May 2009	Summary scores on Competency scales (combined score across 10 competencies of WCC, values ranged from 11 to 23)	Summary competency score (missing values given 10, i.e. 1 point lower than recorded minimum) was divided by the average score (16.50) and multiplied by 30.
Annual Health Check. Quality of Service rating 2008/9 Care Quality Commission Published Oct 2009	A summary of the various elements used by the Healthcare Commission presented as a four point ordinal scale Excellent/Good/Fair/Weak. The score subsumes elements of the Core Standards assessment and achievement of national of targets	Four categories Excellent/Good /Fair/Weak weighted 4/2/3/1, then divided by the average PCT score (2.52) and multiplied by 10.
Annual Health Check. Use of Resources rating 2008/9 Care Quality Commission Published Oct 2009	Summary of findings from Audit Commission on the use of resources on a four point ordinal scale. The results on this scale are felt to be sensitive to problems on some very specific indicators of financial management - namely forecast breakeven position.	Four categories Excellent/Good /Fair/Weak weighted 4/2/3/1, then divided by the average PCT score (2.51) and multiplied by 10.
Annual Health Check. Core Standards Assessment – Declaration on Commissioning Standards 2008/9 Care Quality Commission Published Oct 2009	Declarations of compliance with a subset of core standards are especially relevant to the commissioning process. In practices most PCTs declared themselves as compliant on all 9 standards.	Score 1 if compliant with 7 standards or fewer, 2 if compliant with 8 standards and 3 if compliant with all 9 standards. This score was then divided by the average score (2.74) and multiplied by 10.
Quality and Outcomes Framework- 2007/08 Information Centre	Summary of each PCT's individual practices' achievement across all QOF domains. The very skewed distribution of QOF scores –	Total score/available points as a proportion, then divided by the average score (0.97) and multiplied by 10.

Measure	Description	Application (combined commissioning score is sum of each component score)
Published Sep 2008	whereby Almost all PCTs average 95% - makes this difficult to interpret.	
Local market conditions: Degree of market concentration 2007/08 Calculated by Nuffield Trust based on Hospital Episode Statistics	The Herfindahl-Hirschman Index (HHI) is a standard economic measure of market concentration – the aim being to distinguish PCT according to the breadth of secondary care providers that they use.	Values range from 0 to 1 – with the higher values having the greatest concentration ie fewest providers. HHI was inverted so that high values are "good" (ie many providers in the market) and then divided by the average score (0.54) before multiplying by 10.
Patterns on Ambulatory Care Sensitive (ACS) admissions to hospital 2007/08 Calculated by Nuffield Trust based on Hospital Episode Statistics	ACS conditions are potentially avoidable by good preventative and community care. This measure analysed admission rates for ten high-volume ACS conditions. Rates were indirectly standardised for age and sex then standardised for deprivation using a simple linear regression against the index of multiple deprivation.	PCT average of standardised residuals from regression versus IMD score (negative values mean observed less than predicted) were transformed to an integer scale from 1 to 9, where higher values are "better". This was divided by the average score (5.55) and multiplied by 10.
Programme budgeting information: Client groups with extreme expenditure Calculated by Nuffield Trust based on Department of Health Programme Budgeting data	This measure looked at whether individual PCTs had an unusually high or low proportion of their total spend concentrated in any of the 21 programme budgeting areas. The interpretation is that good commissioning organisations areas will not have a lot of extreme expenditure. Most PCTs had a few such examples – for some PCTs (especially inner London) these scores were over 10 out of 21).	The information was scored by counting the number of programme budget areas where the share of a PCT's expenditure exceeded a threshold (a z score of +/- 1.6) based on the distribution of how much all PCTs spent in that area. PCTs with fewer than 5 extreme areas scored 4, between 5 and 7 scored 3, between 8 and 10 scored 2. PCTs with more than 10 extreme areas scored 1. This was then divided by the average score (3.84) and multiplied by 10.

Information was collated for 152 PCTs using the most recent data available in autumn 2009. Two hundred indicators for each PCT were summarised into the eight high-level aggregate markers shown in Table 1. The weights and assumptions used to combine such diverse information sources onto a common scale is set out in the rightmost column.

The resulting combined scores were normally distributed, with clear upper and lower tails (Figure 3, with the 'best performing' 20% highlighted in red). Figure 4 presents the combined scores for each PCT in the top 20%, displaying the fraction contributed by each component as well as noting whether a site was excluded or was one of the three ultimately included in the study. A sensitivity analysis found broad consistency in ranking over a range of weighting schemas.

Figure 3. Distribution of combined commissioning scores for 152 PCTs
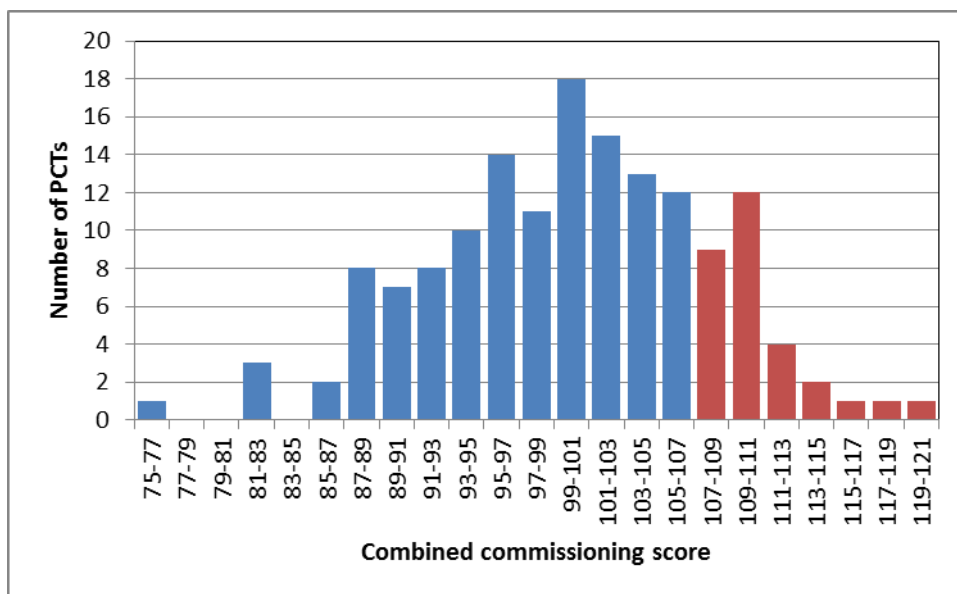
Figure 4. Composition of combined commissioning score for top 20% of PCTs
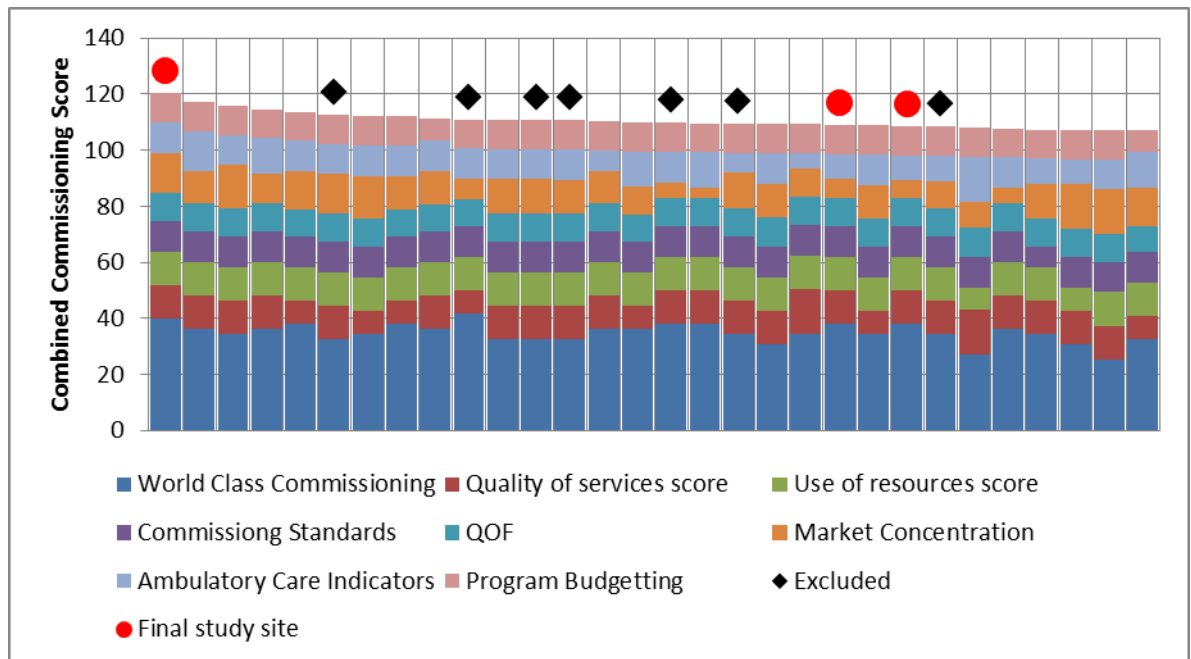
Calderdale, Somerset and Wirral agreed to participate, providing a mix of rural and urban sites in different locations in England (see Figure 5).

Figure 5. Location of the three participating commissioning communities

Map data ©2012 GeoBasis-DE/BKG (©2009), Google, Tele Atlas - Terms

2.4.2 Selection of long-term conditions for study

Within each of the participating 'commissioning communities' (the area covered by a single PCT) the research focused on two long-term conditions. To allow comparison across sites, diabetes was selected as a condition across all three sites. For the second condition, PCTs were invited to identify a long-term condition for which there was a specific local commissioning initiative: dementia was selected in Calderdale and Wirral, and stroke in Somerset.

2.5 Data Collection

2.5.1 Orientation and mapping of activities (March to November 2010)

A total of ten days of initial fieldwork in each site involved observation of meetings, shadowing of senior commissioning managers, informal discussion with commissioning staff, and collection of key documents. These initial data were used to develop a profile for each site, mapping the individuals, institutions, interactions, events and documents forming the commissioning activities relevant to the study. This phase helped shape the research plan and tools for subsequent in-depth case studies, and enabled the research team to develop rapport with local stakeholders.

Once initial orientation work was complete, workshops were held to feed back early findings to the PCTs, and agree the focus for research work in each site. In each case this was an identified commissioning development relating to diabetes and the selected condition.

Workshops in Somerset (October 2010) and Wirral (January 2011) were each attended by ten to twelve people. In Calderdale (December 2010), the approach was different, given a focus on 'strategic transformation' and close working with neighbouring commissioners in Kirklees. Members of the study team met with those leading the programme of transformation during a planning meeting in December 2010.

2.5.2 Data collection (November 2010 to January 2012)

Data were collected over a 15-month period, and are summarised in Table 2 below.

Table 2.   **Summary of qualitative data collected in case study sites**

	Calderdale	**Somerset**	**Wirral**	**Total**
First round interviews on commissioning practice (spring 2011)	10	16	16	42
Second round interviews on commissioning practice (autumn 2011)	10	10	9	29
First round strategic interviews (spring 2011)	3	4	7	14
Second round strategic interviews (autumn 2011)	3	3	3	9
Update interviews (throughout 2011)	10	8	12	30
Total number of interviews in site	36	41	47	124
Meetings observed (throughout 2011)	8	12	7	27
Documents	128	133	84	345

Data were drawn from:

Interviews on commissioning practice: with those directly involved in commissioning (42 at the start and 29 at the close of fieldwork), including commissioners and providers. These people included: commissioning managers, public health specialists, practice-based commissioning GPs, nurse specialists, directors of commissioning and strategic development, and hospital or PCT service managers. Interviews were semi-structured (interview schedules in Appendix 3). The majority of interviews were face-to-face, but where this could not be arranged they were by telephone.

Strategic interviews: an additional set of interviews with senior managers and clinicians in the sites (e.g. chief executives of PCTs, finance directors, directors of commissioning, clinical commissioning group chairs, and directors of adult social services) explored the wider change facing the NHS[19], and examined how this was affecting commissioning practice locally (12 interviews in the spring of 2011, nine follow-up

interviews in late 2011). Interviews were semi-structured (interview schedules in Appendix 3), and carried out by telephone.

Update interviews: to track local response to NHS reforms and restructuring, a total of 20 'update interviews' by telephone took place with lead contacts (senior commissioning managers). Interviews were informal and unstructured.

Observations: We attended a range of meetings that broadly reflected the different activities summarised in the cycle of commissioning. Twenty-seven meetings were observed, including: one-off multi-agency planning workshops (e.g. for dementia services in Calderdale and Kirklees); standing committees set up to support and monitor the implementation of new service developments (e.g. the early supported discharge stroke service in Somerset); regular senior level commissioning meetings at which overall commissioning activity was planned and reviewed by managers, practice-based commissioners, and public health colleagues; and service review sessions at which ideas were developed for a specific client group or service area, such as with dementia services in Wirral, and diabetes in Wirral. Table 14 sets out the example of the early supported discharge service in Somerset, and the range of formal activities and events involved in the commissioning of that service.

Time spent with commissioners before and after meetings gave some additional access to informal accounts of commissioning work.

Documents: 345 documents (e.g. minutes of commissioning or service planning meetings, plans for the services which we were examining in detail, business cases for new developments related to the service 'hooks' we focused on, service specifications for existing and new services in the areas under examination in the research, and service level agreements) were collected and analysed.

Meetings and formal interviews were recorded with consent, except for two where consent for recording was not given and detailed notes were taken instead. Supplementary field notes were also taken at meetings. In total, over 5000 pages of field notes were made.

Where possible, data were collected on service provision, activity levels, cost and patient experience at the start and close of fieldwork. Data on utilisation of care services were tracked in all three sites using national-level Hospital Episodes Statistics data for a range of outcome measures, including elective and non-elective admissions, outpatient attendance, and length of stay. The analysis was based on anonymised person-level records extracted from national hospital episodes data (April 2001-March 2011) supplied by the Information Centre for Health and Social Care. Rates of admission were directly standardised by age to adjust for changing age

structure of the population over time. Age specific rates were calculated using Office of National Statistics population estimates for the relevant year, and overall rates were standardised to the European Standard population. GP practice level QOF data, Department of Health survey of memory services and programme budgeting data were also examined as appropriate.

2.5.3 Facilitation and development activities in case study sites

Participants were encouraged to find opportunities for researchers to work alongside them to provide support with their commissioning work. This was intended as a way of fostering collaboration between researchers and local commissioners, particularly given the rapidly changing policy and organisational context.The support varied between sites and is summarised in Table 3.

Interviews were carried out (in autumn 2011) with those members of the research project team who carried out the facilitation and development inputs to the study, and informal discussions with lead contacts in each site were used to review these elements of the study. A reflection on the use of facilitation and development activities within the case study sites is set out in Chapter 6.

Table 3. **Summary of facilitation and development activities undertaken in the three sites**

	Service area	Action undertaken
WIRRAL	Diabetic podiatry service	**1) IT/data management** Discussion between IB and Head of Community Podiatry about their paper based diabetic podiatry register, commenting on emerging plans as they moved from a paper-based system to EMIS Web. **2) Community service specification** JS and AD worked with lead GP for diabetes and others in the commissioning team to support development of a service specification for shifting the service into the community provider. AD reviewed guidance on diabetic podiatry for commissioners and wrote a paper outlining options for commissioning. AP attended meeting in Wirral in March 2011, but a decision was made that a service specification was not needed, as the commissioners were more interested in a full community podiatry service (rather than diabetic podiatry).
	Memory Assessment Service	**1) Next steps meeting** JS facilitated a 'next steps' meeting involving senior stakeholders allied to the service. Initial pre-meeting was held by JS with the PCT lead to design the session. JS then undertook facilitation of the meeting in May 2011. The meeting involved reviewing plans, looking at data about the service and considering the wider context of dementia services. It was agreed that the commissioner would focus on three areas: • Extending work to reduce the prescribing of anti-psychotic drugs in care homes • Modeling future service demand, need and capacity within a programme budget approach • Determining a set of outcome indicators that could be linked to CQUIN for dementia care.
	Other	**1) GP Consortia meeting** Following an invitation to JS/JD, RR presented at an initial meeting of GPs for one of the three new GP commissioning groups in Wirral, in March 2011. **2) General advice on improving the use and distribution of data** SS and IB discussed the use of data to analyse activity with Assistant Director for Performance and Information, and also offered advice on the dissemination of information to senior managers, GPs and other relevant groups.
	Service area	Action undertaken
CALDERDALE	**Diabetes** Developing a strategic plan for diabetes services	**1) Advice on predictive risk modelling** In June and July 2011, GL provided advice on setting up predictive risk modelling for diabetes, and about the commercial and open access tools available. Calderdale had considered spending £800k on a commercial product but were advised they could get an equivalent option at no direct cost. **2) Guidance and support on data analysis in relation to preparation of business case**

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	Service area	Action undertaken
		IB, and AP attended a meeting of commissioners from Calderdale and Kirklees in June 2011 to discuss plans for overall redesign of 'diabetes system' across Calderdale. Plans were developed to review previous work which had taken place in Calderdale, and to draw up an outline business case. IB provided advice on the use of data to measure performance around diabetes. It was agreed that Nuffield Trust would provide further advice and support as plans developed locally, however, for local reasons, input was delayed until the meeting in November (below). **3) Facilitation of meeting on Level 5 Diabetes services** In November 2011 JS facilitated a meeting to discuss the future of Diabetes Level 5 (Diabetes Specialist Nurse) services across Calderdale and the southern part of Kirklees. The meeting was seen as a starting point to look at opportunities to work jointly on remodelling service provision. Those present agreed a timetable of future meetings for working on a business case for presentation to CCGs.
	Dementia Developing a transformational programme of change for dementia services	**1) Organisational development support** **First stakeholder workshop March 2011:** JS and RR facilitated a 'transformation workshop' on dementia services in Calderdale and Kirklees, at the request of the mental health trust and as part of the wider Calderdale and Kirklees long-term conditions service transformation programme. The research team had a role in negotiating the aims, scope and format of the workshop, as well as facilitating the workshop itself. Vanessa Saliba prepared a summary of public health evidence on dementia interventions, as background to the workshop. This evidence was used by RR in her workshop presentation. JSm facilitated the generation of themes for further work and bringing together different agendas across diverse groups. 15-20 areas were identified by workshop participants for further development. **Second stakeholder workshop May 2011:** Stakeholders reviewed the top 10 priorities identified by the team leading the work, based on the 15-20 issues aired in the first workshop. This second workshop was facilitated by RR, with the purpose of identifying a small number of projects that could deliver QIPP savings to present to the local Transformation Board. In preparation for this second workshop, AD reviewed the evidence on effective interventions for people with dementia, met with staff from the mental health trust to discuss this evidence base and explored how to use it at the workshop.

	Service area	Action undertaken
SOMERSET	Somerset Diabetes Service	**1) Diabetes Education Day (December 2010)** RR co-presented, with the local GP diabetes lead, an overview of diabetes services in Somerset at a GP diabetes education event. The meeting aimed to raise awareness among GPs about the goals of the Somerset diabetes commissioning strategy (ie about the introduction of community diabetic specialist nurses) and encourage GPs to use the service and address local variations in practice. **2) Monitoring usage of all tiers of Somerset Diabetes service** Somerset were concerned that too many people were using the new service. Somerset supplied raw admission data for IB to analyse. In January 2011, IB undertook new analysis, standardising by area and presented this analysis to Somerset colleagues. **3) Next steps meeting, (March 2011)** RR and AP facilitated a meeting to feed back the research team's thoughts on how local services were evolving and how local managers and clinicians might continue commissioning work as new arrangements for GP commissioning were introduced. The main issues raised were: • Need for clinical audit to ensure that the current service was being accessed by the right people • Need to focus on certain metrics for monitoring purposes • Need to develop a plan for shifting control and leadership of the service to GP commissioning groups **4) Diabetes pathway** AP had some editorial input during summer and autumn 2011 into the Somerset diabetes pathway document, and design of a questionnaire for clinical audit of the diabetes service.
	Stroke: early supported discharge service	The team was asked to facilitate a workshop on early supported discharge for stroke patients but the action researchers were unable to do so on the proposed dates.

Key

AD   Dr Alisha Davies

AP   Dr Alison Porter

GL   Dr Geraint Lewis

IB   Ian Blunt

JS   Dr Judith Smith

RR   Dr Rebecca Rosen

SS   Dr Sara Shaw

VS   Dr Vanessa Saliba

2.5.4 Social Network Analysis

Health care commissioning is fundamentally concerned with trying to influence the delivery of care to patients. In relation to long-term conditions, GPs (and their teams) are typically the main professionals co-ordinating and giving such care. As part of this research into the practice of commissioning, the team examined what it was that seemed to influence GPs in their practice of long-term conditions' care.

Social network analysis was therefore employed to describe the network of professionals and resources used by local GPs to develop their clinical skills and knowledge of local services in relation to three areas of diabetic care. This element of this study was grounded in work by Moreno[86] which uses 'sociograms' to depict interpersonal relationships within groups. Granovetter[86] initiated studies on the flow of information through networks, with similar work in the context of primary care by Scott and others[87]; and Keating and others[88].

The original plan to undertake 30 telephone interviews with GPs in each site was modified (after consultation with the advisory group and agreement from the SDO Programme) with the aim of obtaining a more complete picture, covering all GPs in each site. A questionnaire (see Appendix 4) was piloted on five GPs from outside the study areas, and combined with an *aide memoire* for each study site, listing relevant local clinicians.

The survey was distributed to all GPs in the three study areas in three phases (June to November 2011):

- an email with a link to an on-line version of the questionnaire
- a second email to non-respondents

- a paper questionnaire with covering letter and stamped envelope to remaining non-respondents

Additional questionnaires were distributed opportunistically at meetings of GPs in each study site.

2.6 Analysis and interpretation of all data

Qualitative and quantitative data from all aspects of the study (interviews, observations, documentary analysis) were analysed within and across sites and service areas, to develop an understanding of what factors remained constant across different long-term conditions and which varied according to the specific condition.

A thematic framework was developed, guided by Hammersley[89], as a means of organising data and investigating connections between inputs, processes and outputs to/from commissioning. Informed by existing literature (see Chapter 1), this framework analysed data on the five key processes (driving change forward; addressing local people's needs; specifying services and agreeing contracts; measuring and promoting service quality; and completing the commissioning cycle with review) and five resources (people/organisations, data, money, ideas, time) allied to commissioning practice.

A series of six working papers (each up to 65 pages) was produced and updated regularly by the research team to describe in rich detail the commissioning practice relating to each of the six service areas being tracked. These were a core part of the process of data analysis, and included extensive local and detailed data. As such, they were retained as confidential to the core research team, as the papers would reveal the identity of individuals granted confidentiality during the research process.

Through a series of five analysis workshops (June 2011 to Jan 2012), the research team:

- developed the overarching themes which are presented in Chapter 5;
- linked analysis of qualitative and quantitative data from case studies;
- considered the implications of emerging findings for commissioning practice more widely.

The emerging analytical framework was also informed by discussion with members of the advisory group.

The different types of data - documents, interviews, observations - added to the analysis in different ways. Observations provided a way in to identifying and analysing practice. Documents offered a way to explore the context within which commissioning communities (and specific commissioning

activities studied) were undertaking their work, and how this work was carried out. Interviews enabled the research team to examine the different perspectives and reasoning allied to commissioning practice. Data were analysed thematically, using the thematic framework to guide coding of different datasets, and guiding the researchers to write an analytical account of each 'research hook' (area of commissioning activity). These accounts focused on commissioning practice, as well as the context within which it occurred, and provided the basis for further in-depth exploration of commissioning within and across the sites.

The original intention was to link social network data with qualitative data on the commissioning process. However, the social network analysis survey response rate was too low to allow a complete social network map to be developed across all three sites (see Appendix 5). A descriptive statistical analysis of responses was undertaken, with network mapping carried out only for Calderdale, the area with the highest response rate.

Quantitative analysis assessed the outcomes of commissioning in each of the study sites with a particular focus on the extent of preventable emergency admissions (a proxy measure for health) relative to comparable PCTs. Anonymised person-level Hospital Episode Statistics data were used to calculate age/sex standardised rates of emergency admissions for the specific conditions being studied.

2.6.1 Validating findings and writing up

Two workshops (May 2011 and November 2011) were held, bringing together representatives from each site with the study team and members of the Research Advisory Group. They provided a forum for presenting and checking emerging analysis through a mix of formal presentations (by representatives from sites and the study team), informal discussion and small group work. Cross-site workshops were attended by 33 people in total from all three sites (some of these people attended both workshops). Drafts of the report were sent to lead contacts and senior PCT executives in each site for review and comment.

3 The sites

3.1 Background to the sites

Characteristics of the study sites are summarised in the table below. Further details are given in late sections of this chapter.

Table 4. **Characteristics of participating study sites**

	Calderdale	**Somerset**	**Wirral**
Population (2010 mid year estimate, ONS)	202,741	525,186	308,837
Level of deprivation[90]	Higher than England average	Lower than England average	Higher than England average
Total spend on healthcare 2010/11 (Final resource revenue limit)	£347 million	£859 million	£624 million
Overall spend per weighted head of population[91]	£1,651	£1,643	£1,685
Long term conditions included in the study	Diabetes Dementia	Diabetes Stroke	Diabetes Dementia
Numbers of people diagnosed with diabetes per year[92]	Not significantly different from England average	Not significantly different from England average	Significantly higher than England average

3.1.1 Calderdale

Calderdale is in West Yorkshire, with a population of 202,741 (2010 mid-year estimate) and the PCT and the local authority are coterminous. Nearly half the population lives in the main town of Halifax in the more built-up eastern side of Calderdale. The more affluent west covers Pennine valleys and villages such as Hebden Bridge and Todmorden. Around the north and west of Calderdale, hills form a natural barrier, but transport connections are stronger towards Huddersfield in the south.

The population as a whole is growing slowly, but a rapid population growth is projected for the 65+ age group. Ten per cent of the population comes from minority ethnic groups, particularly Pakistani/Kashmiris, and most of these live in certain wards in Halifax.

The health profile of Calderdale is similar to the England average for most indicators, but deaths from smoking and early deaths from heart disease and stroke are higher than average. There are health inequalities within Calderdale by gender, deprivation and ethnicity.

Table 5. **Overview of key stakeholders in Calderdale**

SHA	NHS Yorkshire and Humber (in the North SHA cluster since Oct 2011)
PCT	NHS Calderdale Headquarters are in Halifax
Cluster arrangements	NHS Calderdale has gone into a cluster with NHS Kirklees and NHS Wakefield, under the leadership of the former Chief Executive of NHS Kirklees
Primary Care	27 GP practices. All are members of Calderdale CCG. All practices belonged until 2011 to the former PBC consortium.
Community health	Community health services for adults are provided by the local acute trust, Calderdale and Huddersfield Foundation NHS Trust.
Secondary care	Acute care is delivered at the 614-bed Calderdale Royal Hospital in Halifax, which is part of Calderdale and Huddersfield Foundation NHS Trust (CHFT). CHFT also has a hospital in Huddersfield, which serves the majority of neighbouring Kirklees.
	Mental health care is delivered by the South West Yorkshire Partnership Foundation Trust (SWYFT), which also provides services to Kirklees, Wakefield and Barnsley, and has its headquarters in Wakefield.
Independent sector	Spire Elland Hospital is a private hospital which offers a limited range of treatment to NHS patients through Choose and Book
Voluntary sector	Voluntary sector organisations active in Calderdale and relevant to the study include the Diabetes UK, the Alzheimer's Society and Dementia UK.
Local authority	Calderdale Metropolitan Borough Council (single tier)

The main health care organisations in Calderdale are shown on the map below. The map shows the location of Kirklees, the PCT area with which NHS Calderdale is engaged in cross-border work, described in more detail later in this report.

Figure 6. Map of Calderdale and Kirklees PCTs

◎	CMHT / MH ward in Calderdale Royal Hospital	
◎	PCT HQ	
✪	Council HQ	
●	GP practice	
1	Calderdale Royal Hospital (CHFT)	
2	Huddersfield Royal Infirmary (CHFT)	

3.1.2 Somerset

Somerset is a predominantly rural county with a population of approximately 525,186 (mid-2010 estimate). The biggest centres of population are Taunton (59,779), Yeovil (42,557) and Bridgwater (36,079). There are localised areas of deprivation within Somerset, particularly in the west of the county.

Life expectancy for Somerset as a whole is higher than the England average, but there is a nine-year gap in life expectancy between more and less affluent areas within the county.

The age profile is slightly older than the UK average, with 24.80% of the population of retirement age, compared with 19.25% in England and Wales as a whole. The proportion of the population aged 75+ is 10.21% (England and Wales 7.84%). The proportion of the population over retirement age is particularly high in the west of the county. The proportion of black and minority ethnic people is low at 2.9% (England and Wales 13.0%).

The two issues of an ageing population and the rural nature of the area cause particular concern for the delivery of health care: both diabetes and stroke are more prevalent with age; and the dispersed nature of the population presents challenges for the delivery of local care.

Table 6. **Overview of key stakeholders in Somerset**

SHA	NHS South-West (in the South SHA cluster since Oct 2011)
PCT	NHS Somerset formed 2006 by amalgamation of four smaller PCTS. Headquarters in Yeovil.
Cluster arrangements	NHS Somerset has formed a cluster on its own and retained the same Chief Executive
Primary Care	76 practices. All are part of Somerset Clinical Commissioning Group. 9 area-based federations within the CCG. Until April 2011, all practices were part of Wyvern Practice Based Commissioning Consortium.
Community health	Somerset Community Health, acquired by Somerset Partnership Trust in 2011. Runs 13 community hospitals (with consultant input from acute trusts), and delivers care through community and school nurses, health visitors and therapists.
Secondary care	700-bed Musgrove Park Hospital in Taunton (Taunton and Somerset NHS Foundation Trust)
	150-bed Yeovil District Hospital (Yeovil District Hospital NHS Foundation Trust)
	c10% of secondary care delivered at Royal United Hospital FT, Bath and at Weston General Hospital, both out of area
	Mental health services are delivered by Somerset Partnership Trust
Independent sector	Independent sector providers held contracts with NHS Somerset totalling £72 million in 2009/10. Include Shepton Mallet Treatment Centre
Voluntary sector	Voluntary sector organisations active in Somerset and relevant to the study include the Stroke Association and Diabetes UK
Local authority	Somerset County Council and five District Councils (two-tier)

The main organisations involved in the delivery of health care in Somerset are shown on the map below.

Figure 7. Map of Somerset PCT

		PCT HQ
		Council HQ
		GP practice – Bridgwater Bay Health federation
		GP practice – Taunton and Area federation
		GP practice – Chard, Crewkerne and Ilminster federation
		GP practice – South Somerset Healthcare federation
		GP practice – North Sedgemoor federation
		GP practice – East Mendip federation
		GP practice – Central Mendip federation
		GP practice – West Mendip federation

○	GP practice – West Somerset federation
	Community hospital
	Community hospital with stroke unit
1	Yeovil District Hospital NHS Foundation Trust
2	Weston Area Health NHS Trust
3	UK Specialist Hospitals Ltd (Shepton Mallet ISTC)
4	Taunton and Somerset NHS Foundation Trust
5	Royal United Hospital Bath NHS Trust
	Somerset Partnership NHS Foundation Trust HQ

3.1.3 Wirral

Wirral has a resident population of more than 330,000 people, covering 25 wards. The population has 18.5% of residents aged 65 and over (compared with 15.9% in England). Over the next 25 years the number of people aged over 75 in Wirral will increase by 50%.

This is an area of real contrast: west Wirral being a 'nice dormitory' and east Wirral much more deprived. There is a wide variation in health outcomes with an 11-year gap in life expectancy between the most and least affluent wards and inequalities across Wirral.

Over the last ten years there have been decreases in heart disease and stroke, and cancer. However, death rates from all causes and in early death rates remain above the England average.

Table 7. **Overview of key stakeholders in Wirral**

SHA	NHS North-West (in the North SHA cluster since Oct 2011)
PCT	NHS Wirral formed in 2006 from two existing PCTs. Headquarters in Birkenhead.
Cluster arrangements	NHS Wirral has gone into a cluster with NHS Central and Eastern Cheshire, NHS Warrington, and NHS Western Cheshire, under the leadership of the former Chief Executive of NHS Wirral.
Primary Care	57 GP practices. Three CCGs formed: Wirral Health Consortium, 24 practices, 155,000 patients Wirral GP Commissioning consortium, 27 practices, 128,000 patients Wirral NHS Alliance, 6 practices, 32,000 patients However, in 2012 they will amalgamate into a single CCG for Wirral.
Community health	Community health services are delivered by Wirral Community NHS trust, which hopes to achieve foundation status by 2014.
Secondary care	Wirral NHS University Teaching Hospital Foundation Trust (WUTH) runs the main acute hospital for Wirral at Arrowe Park, which has 917 beds. Specialist cancer care is delivered at Clatterbridge Centre for Oncology. Mental health care is provided by the Cheshire and Wirral Partnership Foundation Trust (CWP), which also provides services in West Cheshire and Central/Eastern Cheshire.
Independent sector	Spire Murrayfield Hospital is a private hospital which offers a limited range of treatment to NHS patients through Choose and Book
Voluntary sector	Voluntary sector organisations active in Wirral and relevant to the study include the Older People's Parliament (advocacy organisation linked with Age UK), Diabetes UK and the Alzheimer's Society
Local authority	Wirral Metropolitan Borough Council (single-tier)

The main organisations involved in the delivery of health care in Wirral are shown on the map below. The map indicates the three CCGs into which GP practices formed themselves initially; these CCGs do not have clear geographical boundaries but are overlapping. From March 2012 however, the three CCGs have committed to forming a single CCG for Wirral that maps onto the area of the former PCT.

Figure 8. Map of Wirral PCT
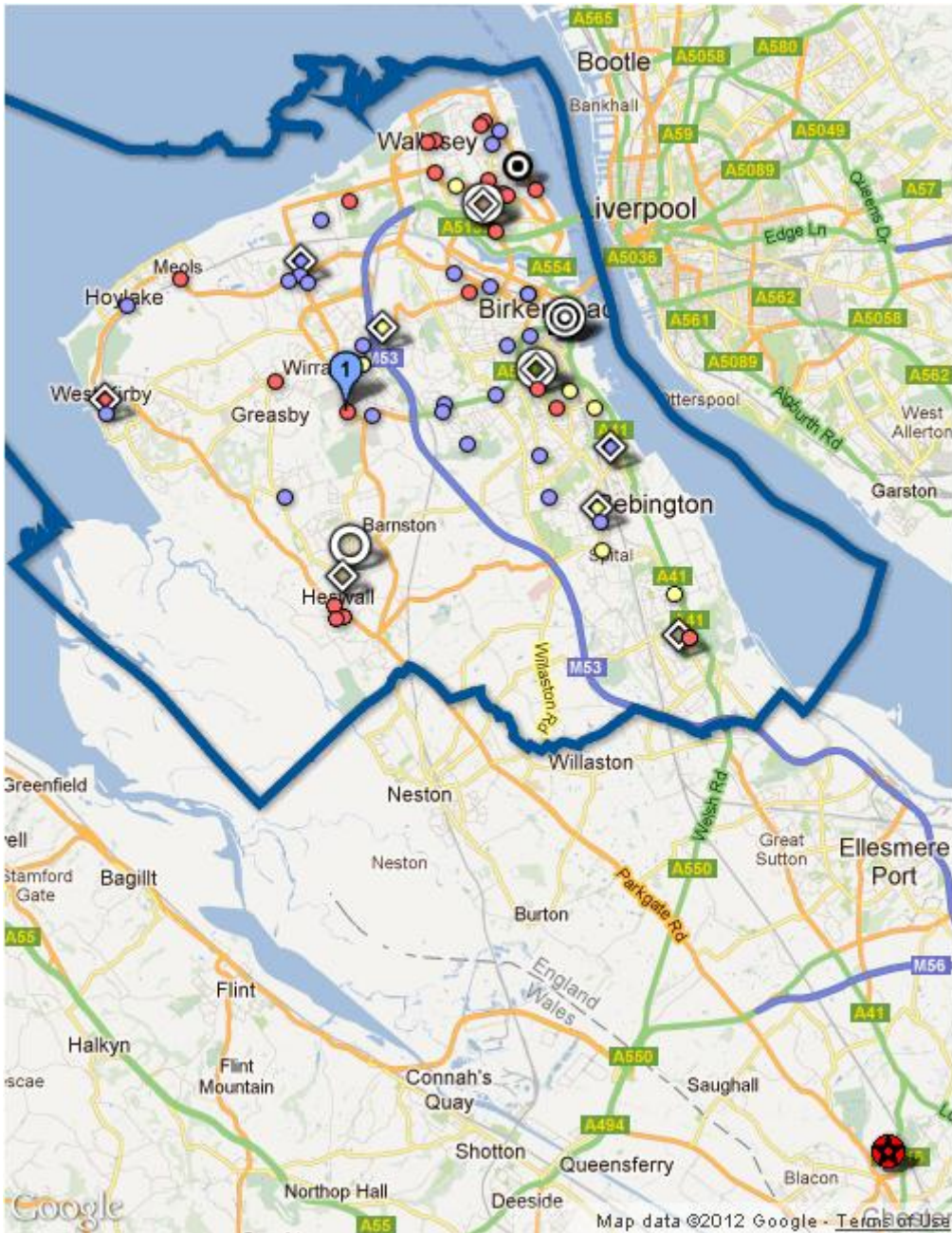
◎	PCT, Wirral Community NHS Trust and Council HQ
◉	CMHTs
◈	Podiatry clinic

	(Podiatry clinic and CMHT co-located)
	GP practice – Wirral Health Commissioning Consortium
	GP practice – Wirral NHS Alliance
	GP practice – Wirral GP Commissioning Consortium
	Alzheimer's Society
	Wirral Hospital NHS Trust
	Cheshire & Wirral Partnership NHS Trust HQ

3.2 Impact of wider health system reforms on the sites

3.2.1 PCT commissioning

This research took place against a backdrop of major policy and organisational change to the NHS in England. When the study started in March 2010, the main local commissioning bodies in the NHS were 152 primary care trusts (PCTs), statutory organisations with responsibility for improving the health of the local population by using public money to plan and purchase health services. PCTs were also responsible for managing community and other health services.

The PCT model was based on a belief that local commissioners would be able to assume financial risk for a defined geographic population, providing community health services and buying others. In 2008/9 the NHS operating framework[93]required all PCTs to create an internal separation of their commissioner and provider functions. Guidance from the Department of Health in 2009[94] *Transforming Community Services* set out how community services were to be split from direct PCT management and this sparked the development of local plans to 're-house' community services, a process that was under way when our research started.

3.2.2 Practice-based commissioning

In addition to PCT commissioning, the Labour Government had introduced a form of primary care-led commissioning in 2005[95]. This enabled a general practice or (more commonly) a group of practices to ask their PCT to delegate an indicative (not real) budget to them, with which they would then plan and commission a defined set of services for patients registered with local GP practices. Whilst practice-based commissioning was voluntary for GPs, PCTs were required to put in place the framework and structures within which practice-based commissioning could develop. The logic for practice-based commissioning was that it would enable: patient choice (practices would be able to commission services more responsive to patient needs); financial flows whereby 'money would follow patients' as GPs helped patients choose which services to use; and improved support for people with long-term conditions, whose care GPs typically co-ordinate.

3.2.3 The NHS White Paper of 2010

The NHS White Paper *Equity and Excellence: Liberating the NHS* published by the Coalition Government in July 2010 [18] had the reform of NHS commissioning as a core element. It proposed that all PCTs be abolished in April 2012 and that new clinical commissioning consortia – later changed to clinical commissioning groups (CCGs) comprising GPs and other health professionals - be put in their place. The intention is that these new groups will take full responsibility for both the clinical and financial outcomes of their referral and commissioning decisions, and become the local statutory commissioners of NHS care, responsible for over 60% of NHS resource and the outcomes associated with this expenditure. The rationale for the move to CCGs is that they will bring about stronger clinical engagement in NHS commissioning, it being assumed that family doctors are well placed to act as agents of the patient and make decisions about the services that are funded and provided for a local population.

The proposals for CCGs were subsequently modified during the parliamentary process and at the time of writing, the plan is for CCGs to start to assume commissioning responsibility from April 2013. There is to be a process of authorising CCGs as fit and ready for commissioning[96], led by a new NHS Commissioning Board (NHSCB), an independent body at arm's length from government. The NHSCB is to guide the development of the new commissioning system and then act as its headquarters. It will also carry out some commissioning, including of specialised services, and primary care. Guidance on the development of the NHSCB[97] sets out its role as follows:

> *'the Government proposes establishing an NHS Commissioning Board whose role will include supporting, developing and holding to account an*

effective and comprehensive system of clinical commissioning groups.'
(p5)

Other changes announced in the NHS White Paper include the move of public health functions to local government in April 2013, the establishment of an economic regulator for the health sector (Monitor), the creation of new mechanisms for public and patient engagement in the NHS (Healthwatch), and a stronger emphasis on competition and choice as levers for service change and improvement[98].

3.2.4 The policy 'pause'

Following the publication of the NHS White Paper in July 2010, there followed a period of consultation, after which the Health and Social Care Bill was presented to Parliament. During the process of legislative debate, an unusual decision was taken to 'pause' the Bill for a period of two months, to enable further consultation (May-June 2011). Following this 'policy pause' further amendments were made to proposals[99], including the broadening of clinical involvement in commissioning, more robust arrangements for governance of CCGs, a slightly slower timetable of implementation of reforms, and a heightened role for new Health and Wellbeing Boards designed to oversee joint commissioning across the NHS and local government.

3.2.5 The economic context

The other important contextual factor during the research was economic. The period from 2011-2015 is one of the most challenging ever faced by the NHS, as the recurrent resources available to PCTs to spend in 2011/12 fell by 2.3 per cent on average in real terms, with a minimum cut of 0.3 per cent and some PCTs facing a reduction of 2.5 per cent. Providers faced the challenge of making a 4 per cent overall efficiency saving at the same time as they experienced a 1.5 per cent cut to the tariff by which they are paid, in effect flat funding[100]. Thus local commissioners were faced with having to make planning and investment decisions with increasingly constrained budgets.

3.3 The response of the sites to policy changes

3.3.1 Overview

This context of major change at all levels of the health system, from Department of Health (many responsibilities moving to the new NHS Commissioning Board), abolition of strategic health authorities and PCTs,

the move of the public health function to local government, and establishment of clinical commissioning, was evident throughout the fieldwork carried out for this study. Likewise, the need to address the 'Nicholson Challenge' (the need to make £20billion of efficiency savings in the NHS by 2015, named after the NHS chief executive who first described the scale of the challenge) and find what the NHS calls 'QIPP' savings (the Quality, Innovation, Productivity and Prevention programme) was a constant refrain during interviews and fieldwork observations.

It should be noted that at the same time, local government was also experiencing major change, as spending cuts took effect, and local authorities responded by developing new strategic and spending plans, making staff redundant, and altering the range of, and eligibility to, many services including social care.

Once the NHS White Paper had been announced, and the consultation completed (in October 2010) the NHS embarked on the implementation of many of the changes set out in the White Paper, even though they were still subject to the passage of legislation. In the three case study sites, the winter of 2010-2011 saw the start of discussions about how the changes might be implemented.

In the spring of 2011, it was clear from this research that despite the protracted political and policy debates at a national level about the direction and feasibility of the NHS reforms set out in the 2010 White Paper, the transition to new NHS organisational arrangements was continuing apace in the three PCTs. Interviews with PCT chief executives, directors of commissioning, local authority directors of adult care/social services, and GP commissioning leads were dominated by accounts of the ways in which former commissioning structures were being wound up, and new arrangements put in place ready for the 'reformed NHS'.

3.3.2 Calderdale's organisational response to the White Paper

In Calderdale, the PCT chief executive moved to a new post in March 2011, at which point the PCT started to form a 'cluster' with NHS Kirklees and NHS Wakefield, this 'clustering' having been encouraged by the Department of Health as a way of gaining economies of scale with management expertise and capacity at a time when PCTs were under notice of abolition. From October 2011, the board meeting of the new PCT cluster replaced NHS Calderdale board meetings, the cluster chief executive being the former chief executive of NHS Kirklees.

Local GPs in Calderdale decided to form a Calderdale-wide clinical commissioning group, building on their existing practice-based commissioning consortium. Thus Calderdale experienced change to PCT management arrangements from early in the research study, and within

months of the White Paper being published. This became increasingly evident as the research fieldwork progressed, for PCT managers changed roles, taking on wider areas of responsibility, including the support of clinical commissioning work.

3.3.3 Somerset's organisational response to the White Paper

In Somerset, the PCT as a commissioner remained relatively stable throughout the period of our research, for in response to the White Paper, a decision was reached that Somerset should form a 'cluster on its own'. The PCT retained the same board and executive directors, and commenced work on a programme of governance review and the delegation of budgets to GP commissioners. Prior to April 2011, all GPs in Somerset were part of Wyvernhealth.com, a practice-based commissioning consortium operating as a company limited by guarantee. Following publication of the NHS White Paper in 2010, the consortium made plans to dissolve in March 2011, establishing in its place an interim GP Commissioning Group Board. The Somerset Clinical Commissioning Group has supported the development of nine federations (groups of general practices) which form the localities of the main CCG, and through which the work of the CCG will be organised.

The particular change that faced the PCT in summer of 2011 was the transfer of its community provider services including 13 community hospitals (Somerset Community Health) to the Somerset Partnership NHS Foundation Trust (a mental health and learning disability care provider).

3.3.4 Wirral's organisational response to the NHS White paper

On 1 June 2011, NHS Wirral moved into a cluster with three other PCTs (NHS Warrington, NHS Western Cheshire, and Central and Eastern Cheshire PCT). The chief executive and commissioning director of the new cluster were the former chief executive and commissioning director of NHS Wirral, so this lent some continuity to the senior management and clinical commissioning community in Wirral.

Prior to April 2011, there were three practice-based commissioning groups in Wirral. Following publication of the NHS White Paper in July 2010, local GPs decided to form three clinical commissioning groups, but in a configuration different from the previous one used for practice-based commissioning groups. The proposed new CCGs were not defined on a geographical basis, but rather according to GP affiliation - and varied in size, with one of 150,000, one of 130,000 and the third being among the smallest of CCGs in England, at 31,000. In February 2012 however, it was announced that a decision had been made to merge the three nascent CCGs into a single Wirral-wide group[101].

3.3.5 Summary

The three sites provided contrasting backdrops for the study of commissioning. They varied in population size – Somerset having over twice the population of Calderdale, and with Wirral in the middle. They also varied in geographical size, with the large rural area of Somerset creating particular challenges for health care delivery when compared with the other two sites.

This research took place at a time of NHS reorganisation following election of a new government and publication of an NHS White Paper in 2010 and many of the research subjects were in the process of closing down a commissioning organisation (PCT or practice-based commissioning consortium), and creating a new commissioning body (clinical commissioning group) or oversight body (PCT cluster).

4 Results – the practice of commissioning in selected service areas

4.1 The service areas selected for study

The detailed practice of commissioning care for people living with long-term conditions was observed using 'research hooks'. These were six distinct pieces of commissioning activity selected for in-depth study, two from each PCT, one being an aspect of the overall commissioning of care for people with diabetes, and the other being part of the commissioning of care for the locally selected condition (stroke in Somerset, and dementia in Calderdale and Wirral). The full set of selected service areas was:

- A strategic plan for diabetes services in Calderdale

- The transformation of dementia services in Calderdale

- The Somerset diabetes service

- The Early Supported Discharge Service for Stroke in Somerset

- The diabetic podiatry service in the Wirral

- The Wirral Memory Assessment Service

Details of the methods used for observing the practice of commissioning within these six services is given in Chapter 2, and an analysis of the themes emerging from the observation is set out in Chapter 5. In this chapter, we present an overview of each service area studied, setting out how each of the six commissioning activities developed during the calendar year of 2011. This chapter concludes with commentary on the main similarities and differences observed in the detailed study of the six services, setting out the themes that are explored in depth within Chapter 5.

4.2 A strategic plan for diabetes services in Calderdale

In Calderdale, concerns about current diabetes service provision included the high number of patients being treated in the Diabetes Centre run by the local acute trust, this centre having significant waiting lists, especially for routine annual reviews. There was also lack of clarity about how patients were defined as being appropriate for each level of care, and in particular about how patients should 'step up' or 'step down' between levels.

Calderdale signed up (with NHS Kirklees) to be part of a national pilot site for the Diabetes Year of Care[102] initiative, yet the initiative never spread beyond the three practices (of 27) which signed up (by contrast, in neighbouring Kirklees 83% of practices joined the Year of Care programme). However, in 2010 Yorkshire and Humber Public Health Observatory classified Calderdale as a 'low spend, good outcomes' PCT for diabetes care, and their general practice performance on diabetes-related indicators such as HbA1c control was significantly better than the national average, although performance was below the national average on rates of complication such as lower limb amputations.

Discussions about developing a more modern and general practice-based model of diabetes care dated back to 2007, but there had not been consensus about taking this forward. A small number of clinicians (both GPs and specialists) had driven discussion about developing diabetes services, but they had yet to get this onto the main agenda of the local clinical commissioning group, where, as with the PCT previously, the more pressing priority had been developments that could release significant efficiency savings.

Limited staff support was available in the PCT to carry out work on redesigning diabetes care, and this got more difficult as management resource in the PCT was reduced following NHS White Paper changes.

Although there were no significant changes to the main provision of diabetic services in primary or secondary care during the period of our fieldwork, one specific part of the service was re-tendered: the delivery of patient education for people with Type 2 diabetes.

In November 2011, a workshop was held (as part of the action research for this study) to discuss how specialist diabetic nursing support for Calderdale and Kirklees might be developed further (given that two very different service models operate in the two boroughs, although sharing an acute provider). At around the same time, the local commissioning support unit in Calderdale undertook more analysis of data on admissions and outpatient attendances, helping local clinical commissioners to build a case for more work on redesigning diabetes services. Work on diabetes is being carried out in the context of a 'transformational programme' of work across Calderdale and Kirklees, which aims to bring about the redesign of health and social care services.

Summary:

During fieldwork for this study, it was clear that local clinicians and managers in Calderdale had not yet reached a consensus about the priority to be afforded to redeveloping diabetes services. Some promising signs

emerged however, as clinical commissioners sought to move this up the commissioning agenda in late 2011. In addition, an opportunity was being taken to undertake development work with NHS Kirklees about the future role and remit of diabetes specialist nurses.

4.3 The transformation of dementia services in Calderdale

In December 2010, Calderdale and Kirklees Health and Social Care Economy Transformation Board began a programme of work to develop community-based health and social care services for people with dementia. This work built on the 'Leading as Peers' strategic planning alliance between commissioners and providers which had run since 2009.

A senior manager from NHS Kirklees led the 'vulnerable adults' work stream which includes dementia, although much of the day-to-day work on planning and co-ordinating plans to develop dementia services was led by a senior manager from the local mental health trust. The Nuffield Trust provided support in designing and facilitating two major stakeholder planning workshops for dementia services in Calderdale and Kirklees held in March and May 2011. The workshops entailed exploration, with patient and carer representatives, clinicians, managers and other health and social care staff, of current service provision for people living with dementia, and the identification of opportunities for 'transformational change' in local services.

A set of 16 proposals from the first workshop led to the identification of three priorities at the second stakeholder event: developing an integrated pathway of dementia care that is focused on GP practices; improving early recognition and diagnosis of dementia in primary care; and care navigation for people with dementia. The workshops drew upon evidence reviews prepared by Nuffield Trust staff, including consideration of the impact (clinical and systems) associated with different potential interventions in dementia care.

These workshops resulted in a plan for a pilot project to develop integrated care for people with dementia, based on a model of specialist support to general practice, and including access to earlier and faster diagnosis and more effective long-term management of care.

GPs have had a role in the service development, but the main impetus appeared to come from the mental health foundation trust, supported by local government and PCT commissioners. The rationale for the work drew on the National Dementia Strategy, in seeking to carry out early diagnosis and intervention, and prolonging the time that people with dementia can remain in their own home with as good a quality of life as possible.

At the end of project fieldwork in December 2011, there had been no observed change to contracts in relation to dementia care as a direct result of the transformation work, but it was acknowledged by local managers that such changes might follow as a result of decisions of the Transformation Programme group focusing on vulnerable adults.

In parallel to the work being carried out as part of the Transformation Programme, NHS Calderdale and Calderdale Council worked together to implement a local dementia strategy, published in 2010 and including the development of a new specialised home care and respite service, personal budgets for social care, and the funding of independent advocacy for older people with mental health needs.

Summary:

Calderdale had a strong concern for 'transformation' of services across the wider PCT cluster area. In dementia care, this work was led by the mental health foundation trust which assumed the 'convenor' role often ascribed to PCTs, drawing together a wide range of local stakeholders to review current service provision, develop options for service development, and prioritise a specific area of work for piloting in one locality.

4.4 The Somerset Diabetes Service

Somerset commissioners have worked with local hospital, community health, and general practice providers over a number of years to develop a new model of care that entails a shift from acute provision to a nurse-led community based service for people with intermediate care needs. This was initiated as a result of concern about increasing prevalence of diabetes, a desire to ensure cost-effective services, and a wish to improve performance in relation to national benchmarks of quality and outcomes.

The service covers adults with Type 1 and 2 diabetes, and seeks to increase the overall capacity of the local diabetes care system, whilst assuring equity of access and quality of care. The new service has three tiers: level 1 is delivered by GPs and practice nurses; level 2 by specialist community-based nurses and dieticians together with a few GPs with enhanced training in insulin initiation, supervised by hospital consultants; and level 3 delivered at hospital clinics by consultants and specialist nurses. There are guidelines to inform when patients should 'step up' or 'step down' between the different levels of care. Diabetes specialist nurses also deliver patient education programmes and training in diabetes care for primary care practitioners.

This research observed the implementation of the new model of care, this being led by a project manager funded by the PCT, together with

considerable input from the nurse consultant based in the community health service. One GP (also a member of the commissioning group board) had a formal role in leading the development of the Somerset Diabetes Service.

It took three years from the initial needs assessment work to the launch of the new service in April 2010, during which time detailed service modelling, specification, and guideline development took place. The transfer of staff from one employer to another (from hospital to community) proved to be slow and complex. Two groups were monitoring and reviewing the implementation of the new service - one focused on strategic commissioning and the other, involving mainly clinical staff, on pathway management and implementation. In this way, the commissioner appeared to be operating at both strategic and operational levels.

A significant amount of effort went into collecting and analysing data to assess the performance of the new diabetes service, and it took a lot of effort to improve data flows across the different elements of the service. Regular six-monthly performance reviews were carried out, led by commissioners and based on indicators set out in a Somerset Diabetes Service Performance Framework. Progress with changing the model of care was not as rapid as had been hoped for, and although some clinical measures were improving, it was acknowledged there was further to go.

Summary:

This was an ambitious programme of change to the provision of diabetic care across the PCT area, entailing a shift of care (and staff) from secondary care to community health settings. The process of commissioning this change took three years from initiation to implementation, and even after that, progress was not as rapid as hoped for. The PCT demonstrated extensive planning, dogged project management, and significant clinical and staff engagement. They remained involved in implementation and review, ensuring that momentum was maintained.

4.5 The Early Supported Discharge Service for Stroke in Somerset

The Early Supported Discharge Service provides multidisciplinary care in the community to patients who have been discharged from hospital following a stroke, in line with a model of care promoted by the Department of Health. Impetus for the service came from needs assessment work that showed Somerset to have a high rate of reported stroke compared to the regional average, and relatively long length of hospital stay compared with the national average. It was also sparked by national activity focused on

improving care for people experiencing a stroke, in particular the National Stroke Strategy[54] , the Accelerating Stroke Improvement Programme[103] and the Quality Innovation Prevention and Productivity Programme[29].

This new service builds on the stroke pathway of care developed in Somerset in 2009 and was rolled out in Somerset over the period November 2010 to March 2011. Most of the care is given by therapists employed within the community health service, Somerset Partnership Trust. Nursing input is also given, through a Stroke Co-ordinator, and the overall team of staff work in a virtual manner along with hospital consultants who retain overall clinical responsibility for patients in the scheme, until their discharge back to GP care. Up to six weeks' home care funded by Somerset County Council is also available to patients in the Early Supported Discharge scheme.

Some patients enter the service from an acute hospital and others from one of the three specialist stroke rehabilitation wards in community hospitals. The Early Supported Discharge service aims to benefit patients by allowing them to move as soon as possible from the hospital to their home environment, undertake therapy in a 'real' setting and thus improve outcomes. The aim is for 40% stroke survivors to be supported by the Early Supported Discharge service, and for it to result in shorter length of hospital stay and associated cost savings. These indicators mirror those set out in national guidance for stroke services.

The PCT played a central role in designing and implementing the new service, and dedicated project management support was allocated by the PCT for this purpose. Hospital doctors, the community health provider and therapy staff have been closely involved in developing the service. GP involvement was less in evidence, although GPs from the clinical commissioning group took a leading role in strategic review of stroke care in late 2011. The community provider (now part of Somerset Partnership Trust) employs and co-ordinates the staff delivering the new service, and runs the community hospitals from which many patients are referred for early supported discharge.

The final trigger for the service to be initiated was notification from the strategic health authority in the summer of 2010 that all PCTs in the South West should have a service in place by March 2011. Thus local needs assessment and planning was given impetus by a regional directive.

Although intended to be cost-neutral in the long term, the Early Supported Discharge service had £50,000 of resource from NHS Somerset to help with initial staffing costs. During research fieldwork, there was no service specification or contract in place for the service, its resources being included in the main financial framework between the PCT and the community health provider. An operating policy had been agreed as an internal document to

guide the practice of those delivering the new service. This service was set up through discussion and negotiation within the NHS and not put out to tender.

The PCT was holding the acute trusts and the community provider jointly accountable for the target of 40% stroke patients being referred to the service. In February 2012, the Early Supported Discharge service was not yet achieving target numbers of referrals, especially in respect of discharges from acute hospital care. Two inter-agency groups were overseeing the new service, one focused on the commissioning and implementation of the service and the other more operational and only involving providers. There was also a stroke pathway group providing oversight in the context of other stroke services, and performance monitoring was taking place in PCT-provider contract monitoring meetings.

Summary:

This is a relatively small-scale service which entails the use of (mostly) existing resources to relocate therapeutic care for stroke survivors from hospital or community hospital settings to people's own homes. The impetus for the service was both local and national, and there is a desire to achieve the national target of 40% people receiving the new service. Commissioners have led the service development, working closely with providers. Although entailing small numbers of patients to date, a significant amount of commissioning effort and management time has been expended on this service.

4.6 The diabetic podiatry service in the Wirral

Diabetic podiatry was identified as a concern for patients and clinicians in the Wirral during a research feedback workshop held by Nuffield in January 2011, and the research team was asked to focus on this as a marker for the commissioning of care for people with diabetes. The main concern about the service was the need to ensure an effective recall and review service for Wirral residents, based on reliable data. Operational issues dominated the discussion about diabetic podiatry, although there was also a longer term aspiration to improve data collection and analysis within the service and hence address variation in referral from general practice to the community service.

The diabetic podiatry service entails routine foot screening of low-risk patients within general practice, with at-risk and high-risk patients being screened by community podiatrists working in community clinics. General treatment is given by community podiatrists in local clinics, whilst the care of high-risk patients is managed by a consultant-led team in the acute hospital who discharge people back to community care once an acute episode has been treated.

The Diabetes Modernisation Group (made up of providers, commissioners and service user representatives) was the forum within which concern about diabetic podiatry had primarily been discussed, this group dating back to the original implementation of the Diabetes National Service Framework in 2001. The group was chaired by a GP with a special interest in diabetes, and programme management support was provided by the PCT.

The main problem associated with the Diabetic podiatry service was the Wirral Diabetes Register, a database of patients with a diagnosis of diabetes. Issues with the maintenance and ownership of the register led to it being deemed unfit in early 2011 for the purpose of recall and review of diabetic foot care patients. The community health provider agreed to host a register of patients needing foot checks within the community podiatry service, from April 2011. However, following a series of thwarted attempts to implement a new IT system for community podiatry, this remained problematic, and at the end of our fieldwork, work was ongoing (by the PCT, community provider, and with oversight from the Diabetes Modernisation Group) to try and put in place an electronic system of recall and review of diabetic patients.

Throughout fieldwork, the focus of the work on diabetic podiatry was largely reactive, being concerned with data accuracy within primary and community services, an issue that appeared at times to distract from the strategic picture of planning, developing and purchasing an overall service for patients in line with local needs. A lack of time and resource for needs assessment and service modelling, together with organisational changes resulting from implementation of national policy, meant that commissioners found it hard to focus on planning for this small, yet vital, area of work.

The emergence of new clinical commissioning groups (the plan was for three CCGs at the time of our fieldwork, although subsequently merged into one from March 2012) lent additional uncertainty to the plans for podiatry provision, as people pondered the likelihood of three different approaches to the commissioning of diabetes care in Wirral.

Contracting for diabetic foot care in Wirral was complex, with community and acute podiatry being commissioned through separate contracts, as part of wider service agreements between the PCT and the community and acute trusts respectively. In addition, the acute trust sub-contracted with the community provider to deliver sessions of podiatry within its multidisciplinary team, and GPs were contracted to take on low-risk patients for foot screening through a local enhanced service. The complexity of these contracts (having its roots in the piecemeal historical development of services) came to the fore towards the end of our research when the new clinical commissioning groups started to push the PCT to review arrangements with a view to having a clear service specification for community podiatry, as a basis for implementing the new Any Qualified

Provider policy where patients can choose who delivers their (in this case podiatry) service.

Summary:

Diabetic podiatry is a relatively small, yet vital, element of overall diabetic care, being fundamental to the overall health and quality of life of people living with diabetes. This research revealed how a service can become somewhat marginalised, especially when split across different providers, and its operational problems left to fall through organisational cracks. Furthermore, the service was commissioned in a complex manner which appeared to militate against a strategic review of local needs and how the service might meet these.

4.7 The Wirral Memory Assessment Service

Dementia was nominated by Wirral commissioners as an area where significant commissioning energy was being expended, and within this, the Wirral Memory Assessment Service was suggested for detailed study. This service provides assessment and monitoring for people who have suspected or diagnosed cognitive impairment, and emerged from a former 'memory clinic' that had been based in a single location in the North of the Wirral.

The new service focuses on earlier intervention, extended voluntary support, and has enhanced capacity to meet predicted need. It was launched in October 2010 by the local mental health trust and delivers an assessment, diagnostic and treatment service from six hospital- and community-based clinics throughout Wirral. The service is delivered by clinical nurse specialists with administrative support, and with sessional input from consultants in old age psychiatry. Diagnosis is made, and a care management plan formulated, by the multidisciplinary team as a whole. Further support is provided by the Alzheimer's Society who employ three outreach workers and a volunteer coordinator.

NHS Wirral led the planning and purchasing of the new memory assessment service, working closely with NHS and voluntary sector providers. Further impetus for the new service was given by the Department of Health Clinical Services Efficiency Delivery Programme which sets out an approach to remodelling services in a way that seeks to improve quality of care and reduce waste of resources. The Wirral Older People's Parliament also helped shape the new service, and the Overview and Scrutiny Committee of Wirral Council formally reported concerns over dementia care which added further urgency to the work.

In commissioning the new service, PCT managers in Wirral sought to work in a collaborative manner with local providers, the local authority (as commissioner and provider of social care) and user groups, and starting with needs assessment, then proceeding to review of current provision, and design of new services (with providers) to meet identified needs. Detailed modelling of future service needs was carried out, reviewing current dementia registers held by GPs, and needs assessment data held by the local authority. This revealed that some 50% people with dementia had not had access to an early assessment and formal diagnosis of dementia.

Research revealed a high level of partnership working and trust between organisations involved in developing the new service. There was evidence of effective senior clinical and managerial leadership of the both the overall dementia service and the Memory Assessment Service, and of individuals remaining committed to these, even amidst significant local and national organisational change.

A three-year service specification was developed for the memory assessment service, and there was an intention to move towards commissioning for specific outcomes in future, with a lead provider who might in turn sub-contract with other providers such as the voluntary sector. The service forms part of the local Commissioning for Quality and Innovation payment framework, which enables commissioners to reward service excellence, and it is being formally accredited by the Royal College of Psychiatrists' Memory Services National Accreditation Programme.

As fieldwork ended, a working group was being established in Wirral to bring together providers with new clinical commissioners to review and plan services in line with the local dementia strategy. Regular monitoring of the service revealed that demand for early assessment and diagnosis was outstripping supply, and additional funds were sought from the PCT to enable continued provision (a predicted drop in drugs costs for the service mitigating medium to longer term cost concerns). A formal review of the service confirmed the value it was giving to patients and carers. The review also led to revised activity levels (with a tolerance of 10%) being confirmed between the PCT and the mental health trust (as a way of managing rising demand), and an extension of the target time for increasing diagnosis of dementia to 70%.

Summary: The Wirral Memory Assessment Service was an example of commissioners assessing needs, working with providers and user groups to review current provision, then redesigning the service, and decommissioning previous provision in the process. The new service was implemented in a timely manner, and met existing and pent-up demand, as it soon became a victim of its own success with rising usage beyond planned resource levels. Strong partnership working characterised the

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commissioning approach, along with clarity about service modelling, costing, contracting and review.

4.8 Overview of the six service areas studied

This observation of the practice of commissioning care revealed a number of important themes that are explored in depth in chapter 5 of this report. A core objective of our study was to explore the extent to which an examination of the practice of commissioning enabled the identification of a set of measures of effective commissioning. It is therefore important to consider the progress that commissioners made in each of the six service areas studied in depth. A summary of the research team's conclusions about this are set out in table 8 overleaf:

Table 8.   **Overview of progress made in each of the six service areas**

	Model of care Is care being delivered in line with good practice models?	**Service quality and efficiency** Are health care services being run well?	**Outcomes** Is the population happy and healthy?
Calderdale diabetes	Relatively traditional model of care still in place - a significant proportion of care being delivered in the acute sector, few GPs or practice nurses with specialist skills to undertake extended roles in community settings.	Mixed story: per capita spend on diabetes care is among the lowest in the country; but concerns about length of waiting lists for Diabetes Centre.	HbA1c control is good. Performance less good in terms of complications.
Calderdale dementia	Plans fit aspirations of National Dementia Strategy and follow award-winning good practice model (Gnosall in Staffordshire[104])	Too early to comment on impact of this development on service quality and efficiency	Too early to comment on impact of this development on patient health and experience
Somerset diabetes	Audit suggests care is being delivered at the 'right' level The service is running below its target for new diagnoses. The service is performing slightly below target for the provision of patient education	Cost savings were anticipated from reduced complications and length of stay, rather than from a shift in provider *but* length of stay for patients with diabetes is increasing. Reduction in outpatient appointments and increase in contacts with Diabetes Specialist Nurses in the intermediate service – but both less than expected Diabetes prescribing costs per patient increasing	HbA1c control is improving –but still below performance of national comparator groups. No change yet to diabetes complication rates – but may be too soon to judge impact.
Somerset stroke	Yes, up to a point: the new service has been implemented but is not reaching the	No discussion yet of any efficiency savings resulting from the ESD service. Cost of	Reported patient satisfaction is high (though patient numbers surveyed

	Model of care Is care being delivered in line with good practice models?	Service quality and efficiency Are health care services being run well?	Outcomes Is the population happy and healthy?
	intended target numbers. Also, in detail, the service deviates slightly from the recommended model (Consensus Statement) in that it is on an in-reach model rather than outreach from acute trusts. Level of input not consistently as high as level recommended in Royal College of Physicians guidelines (45 minutes per day from each therapist) – though this may reflect patient needs. Particular limitations on availability of speech and language therapists, which may be limiting patient numbers.	delivering service has not yet been identified as discrete sum. Changes in length of stay and time on specialist ward may be associated with ESD – but not possible to be conclusive about cause and effect as yet. Detailed work has been shared with providers on the potential reduced LOS and linked to the application of the stroke tariff for acute stay and rehabilitation phase with potential efficiency savings	are still low) Cannot yet identify any change in clinical outcomes – but this is very challenging in the short term. Although standardised measures of activities of daily living (Barthel and FIM FAM) measures suggest improvements in patient movement and functioning, it is not possible to use this data to make a direct comparison with patients receiving therapy in hospital setting. Small numbers going through service so far mean that inferences should still be made with caution.
Wirral Diabetic Podiatry Services	Yes. The service is structured around a care pathway that identifies low risk, at risk and high risk patients and directs them to appropriate system level to provide appropriate foot care. However problems persist with assessing need and addressing variations in practice, particularly across primary and community settings. The Diabetes LES continues after five years when usual NHS commissioning	NHS Wirral was comparable to England in the delivery of foot screening in primary care[105]. However, concerns persist about data management, referral systems and referral variation. Inconsistencies in data mean that they are not able, as yet, to identify numbers of patients using the community service, nor the associated cost.	Cannot yet identify any change in: clinical outcomes, patient experience and referral activity across primary/community pathway. However, indicators have been recently in community podiatry contract with a view to future assessment of patient reported outcomes and experience.

	Model of care Is care being delivered in line with good practice models?	Service quality and efficiency Are health care services being run well?	Outcomes Is the population happy and healthy?
	practice might have expected this to have been embedded in main contracts.		
Wirral Memory Assessment Service	Yes, the focus is on evidence based interventions in terms of cost effectiveness and clinical effectiveness of the treatments. WMAS is designed to comply with the NICE guidelines on dementia. The overall approach to commissioning and delivering care is grounded in a joint approach to developing high quality health and social care and to meeting the strategies and outcomes of the National Dementia Strategy.	Regular review of service (activity, costs, patient/carer experience), combined with iterative approach to commissioning, allows commissioners to adapt to changing circumstances (e.g. drug costs). Staffing and prescribing budgets are kept strictly separate. On-going modelling work has predicted future savings as a result of the knock on effects of early intervention and of reductions in drug costs. But these are unlikely to come to fruition in the short term. CQUINs in place (and being met) for CWP contract and focused on outcomes relating to the overarching dementia pathway.	Yes, up to a point. As predicted, there has been a significant rise in new cases of dementia referred to the service. Clinicians, patients and carers all report good levels of satisfaction with the service. This is affirmed through RCP assessment, CQUINs and Alzheimer's Society review/case studies. There has also been a reduction in antipsychotic prescribing in care homes. However, the impact on the wider dementia care pathway – particularly in terms of admissions to acute and care homes - remains unknown.

What is clear from detailed study of the service areas is that a significant and sustained effort was going into the practice of commissioning, something the research team termed 'the labour of commissioning'. Many events were held to review, plan and implement new models of care, lots of people were involved and consulted, and various groups appeared to have responsibility for overseeing and ensuring implementation of new developments.

The overall sense was one of an extensive and at times cumbersome machinery for commissioning, with much effort on the needs assessment, service design and specification aspects, and yet less attention to 'cutting the deal' and making (and carrying through) tough decisions about what to provide (or stop providing) in the future. How far this effort was worth the 'labour' expended, and what this has to offer future policy and practice on commissioning, is examined in chapters 5 and 6.

Other themes that emerge from the detailed study of commissioning practice include the tendency of commissioners to engage in the implementation and project management of new developments that they have commissioned, arguably taking on a role one might ascribe to the providers, if the 'purity' of the purchaser-provider split were to be respected. The muddying of the split between commissioners and providers was also evident in the relative lack of mention of money and contracts in the (mainly relational) commissioning activities observed. This suggests that as well as (or in place of) a split between those who purchase and those who provide, there is a division of activity between those who do the relational aspects of commissioning and their colleagues (typically in finance and at senior levels of commissioning management) who close the financial deals and 'make the numbers stack up'.

Finally, it is of note that some of the services studied made significantly more progress than others. This was in part a consequence of where the local commissioners happened to be in the commissioning cycle when we carried out our year of observations. This core question of the effort and reward entailed in NHS commissioning of care for people with long-term conditions is examined in detail in the next chapter.

5 Results – analysis of the practice of commissioning

In this chapter, analysis of the findings of the research is presented within the following themes:

- The scope of commissioning

- The labour of commissioning

- Identifying the commissioners

- The question of money

- The nature of change

- External drivers of commissioning

- Working in a context of uncertainty

- The results of social network analysis of GPs' diabetes practice

- Tracking the impact of commissioning

5.1 The scope of commissioning

This research tracked the practice of commissioning services for people with long-term conditions in three PCT areas. The observations of the research team challenged the notion of a neat 'commissioning cycle'. Processes of commissioning often ran in parallel, and stretched out over several years. Activities which are not typically included within the commissioning cycle were also observed.

5.1.1 The 'cycle of commissioning'

The majority of commissioners interviewed were aware of the annual 'commissioning cycle' [14] and talked about it as a useful device. Interviews and observations revealed a more complex set of processes over a longer period of time. What was observed for each selected service area was necessarily framed by the work that commissioners were engaged in at the time of the fieldwork:

- In the Wirral Memory Assessment Service, the Somerset Diabetes Service and the Early Supported Discharge service for stroke in Somerset, the research captured the launch and initial operation of a redesigned service.

- In Calderdale, both the diabetes service and the dementia service were in the earlier stages of commissioning activity, the focus being on prioritisation of resource and service planning.

- In Wirral, the existing diabetic podiatry service was the subject of some revisions and improvement to service delivery, but without a major shift in the model of provision during the fieldwork period.

5.1.2 Contractual and developmental commissioning

Commissioning was enacted through two different and complementary sets of processes (Table 9). The management of contracts generally operated in line with an annual commissioning cycle, involve large sums of money and was the responsibility of a minority of PCT staff. In contrast, developmental work to review, redesign and re-specify provision tended not to follow a neat cycle, involved a relatively small proportion of the PCT budget, and had intensive input of commissioner time (see section 5.2).

Table 9. **Contractual and developmental commissioning processes**

Contractual processes	**Developmental processes**
Generally involves two parties	Multiple parties involved
Clearly defined roles for each of the parties involved	Roles subject to negotiation and change; individuals may have multiple roles
The separate interests of the parties are acknowledged and overt	The separate interests of the parties are implicit
Focus on fixing and formalising what happens in relation to services	Open to fluidity and change
Working to a fixed timetable	Potentially open-ended
Financial incentives and penalties identified as a tool of change	Little discussion of money

These two aspects of commissioning were observed running alongside each other and periodically becoming intertwined. For example, during the course of commissioning the new Early Supported Discharge service for stroke in Somerset (Figure 9), the PCT worked with various organisations to develop a performance management framework, which then became part of the contractual arrangements for delivering the service. The observations in this research suggest that successful commissioning lies in ensuring that the two aspects of commissioning are connected appropriately at the right time.

Figure 9. Staged development of the Somerset Early Supported Discharge for Stroke service

In Somerset, the new Early Supported Discharge Service began running in November 2010, and was rolled out in stages over the following six months to cover the whole county.

Over 100 patients had been cared for by the end of the fieldwork period. Eligibility criteria were refined during the first few months of operation, and an operational plan agreed as a working tool for the provider.

Close monitoring of the service by the commissioners over its first 12 months informed the development of a service specification, which was finalised in December 2011.

The service was covered by a pre-existing financial framework between the PCT and the community health provider.

5.1.3 The starting point for commissioning

Across all six service areas, the research revealed a complex mix of factors shaping the decision made by commissioners to address a particular area of service provision, guided by a range of local factors and external drivers (see Table 10).

The role of local factors varied. For example, the drive for redesign of stroke services in Somerset came from the need to deliver on national requirements[54], but in Wirral, the work on diabetic podiatry was largely reactive to local events:

'*I suppose this has been quite a reactive change rather than us sitting there thinking what are the needs of our population? It's come about through identifying that something's not working very well. Some of which has come about through a complaint and some of which has come about through just doing a bit of digging around…So I suppose we weren't really assessing needs in terms of looking at what the population needs or what's kind of out there, we were kind of assessing the need in terms of its failing*.'

PCT manager

Table 10. **Overview of the drivers and starting points for commissioning work**

Start date*	Hook	Key drivers	Tangible starting point
2007 -	Somerset Diabetes Service	Desire to increase capacity in health care system to cope with rising prevalence of diabetes, and reduce inequalities across the county in clinical outcomes and in access to care	Demand mapping exercise for diabetes care
2008 -	Wirral diabetic podiatry service	Complaints from clinicians and service users regarding recall and review for diabetic foot care; and commissioner concerns about the existing model of provision	An External Quality Assessment of the diabetes register at the acute trust with the formal report then actioned by the Diabetes Management Group
2009-	Wirral Memory Assessment Service	Limited capacity and accessibility of previous GPSI-led memory clinic limited range of support in previous model and high levels of emergency admissions for people with dementia	Memory Assessment Service identified locally as a priority work stream[106]; pilot work with the DH CSED programme highlights early diagnosis and intervention as a priority area for dementia care in Wirral
2009 -	Somerset stroke Early Supported Discharge service	Need to decrease length of stay in acute hospitals to meet targets for time spent on specialist wards	Stroke pathway identifies Early Supported Discharge as an aspiration
Sept 2010 -	Calderdale – diabetes strategic plan	Desire to shift to a more 'modern' way of delivering diabetes care and long waiting lists in Diabetes Centre	Report to Clinical Executive on whether diabetes service redesign should be prioritised
Dec 2010 -	Calderdale transformation of dementia services	Vision for transformational change being led from the top; low levels of diagnosis; duplication of assessment processes across providers; and over use of hospital beds by patients with dementia	Transformation initiative started

* Developmental work on commissioning across all six service areas has been on-going since the date indicated

Progress with commissioning appeared most straightforward where there was clear local consensus about the need for change (see Table 10). This consensus was particularly evident with the Somerset Early Supported Discharge service for stroke, the Somerset Diabetes Service and the Wirral Memory Assessment Service. In contrast, there appeared to be little consensus on drivers for the service changes studied in Calderdale, presenting a challenge for commissioners (see Figure 10).

Figure 10.   Case study – developing consensus for action on diabetes in Calderdale

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Redesign of diabetes services in Calderdale has involved a long running debate about what the problem is that commissioners and providers needed to address and what the appropriate way forward might be. Calderdale performs well in terms of clinical outcomes, despite having a model of care which one respondent described as 'old fashioned'.

As one PCT senior executive reflected: '*There remain some tensions in terms of whether diabetes is or should be a priority. I guess the reason for that is when we look at the world through a particular lens, the lens of some of the benchmark information that we have in relation to costs and outcomes, then we do relatively well in terms of diabetes, in terms of spend and outcome*' .

These tensions made it difficult to develop and manage consensus across the commissioning community.

Deciding the scope and scale of commissioning work

It was observed that an early step in commissioning practice was to decide on the scope and scale of the commissioning work to be undertaken. Commissioners made decisions about dividing up health care into manageable units for commissioning. They did this by drawing boundaries around service areas, and to an increasing extent as CCGs and PCT clusters began to have an influence, set geographical boundaries as well. These units of work needed to be big enough to justify the labour of commissioning (see section 5.2), whilst not being unwieldy. With the Wirral Memory Assessment Service, the Somerset Diabetes Service and Early Supported Discharge service for stroke in Somerset, commissioners responded to existing service provision, structure and pathways and, along with providers (see section 5.4), identified manageable areas of work.

In Calderdale things were less clear cut. During project fieldwork, an emphasis on 'transformation' of all care services across the PCT cluster was reflected in ambitious ideals, rather than concrete and manageable commissioning developments in diabetes or dementia care. In Wirral, diabetic podiatry formed a small area of commissioning work (one of many

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Project 08/1806/264

within the commissioner's portfolio) that seemed to have suffered from slipping though the gap between existing commissioner and provider structures and processes (Figure 11).

Figure 11.   Community based podiatry service at the intersection of two services

Community-based diabetic podiatry

Diabetes care
pathway
contracts
service specifications
performance management regime

Community podiatry
pathway
contract
service specification
performance management regime
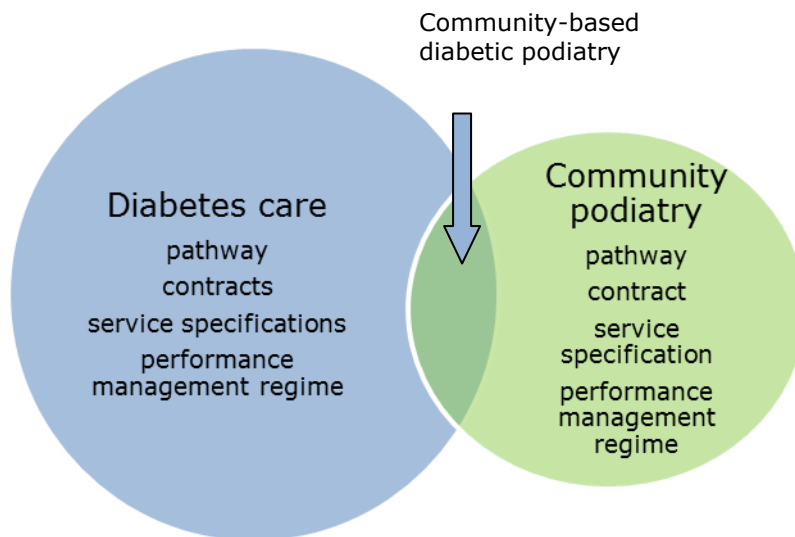
Keeping an eye on the bigger picture

Commissioning was observed to work more effectively where there was a clear and agreed strategic vision. Hence, whilst identifying manageable units of commissioning work, commissioners also needed to keep a constant eye on this wider vision, including local population needs and overall commissioning priorities. This was observed to be working particularly well in relation to the Wirral Memory Assessment Service where an overall plan for dementia care in the local area had been developed[107], and which informed the commissioning of the new Memory Assessment Service.

Public health and needs assessment

Needs assessment played a role in enabling commissioners to determine priorities for investment. For example, one clinician involved in the development of the Somerset Diabetes Service described moving to and fro between problem identification and formal needs assessment when planning the service:

‘*We mapped it for 2017 and 2027 which I have still found invaluable in terms of mapping where I need my services to be, knowing where our*

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growing, ageing and obesity populations are going to be...They're very specific [geographical] *areas. So that's always useful if you get an area coming to you saying, you know, 'We need services.' 'Yes you do, but actually there are bigger priority areas, and I can't ignore those.' ... So that was a really, really good exercise'*

Community provider, clinician

As highlighted in Table 10, such public health data tended to support and legitimise existing commissioning plans, rather than drive them from the outset.

5.1.4 Co-ordination and facilitation as a significant part of commissioning practice

A significant part of commissioning practice appeared to involve commissioners working as 'animateurs'[79], actively managing disparate groups of people over whom they had no formal managerial authority. Commissioners (both middle and senior managers) were observed acting as 'conductors of an orchestra', to develop and sustain strategic partnerships. They worked to build consensus on needs, priorities, and solutions, and co-ordinated the contribution of others to specific commissioning tasks such as the design of performance management frameworks. It appeared that the process of meeting, talking and working together was used by commissioners to develop trust and consensus among those organisations and individuals who in turn would be responsible for implementing changes to service.

The 'animateur' or conductor role was most visible in the two Somerset hooks and Wirral Memory Assessment Service. It was identified not just in group activities (meetings and workshops), but also through relationships between individuals:

'*I think we've always worked together.* [The commissioners have] *understood mental health. So they've never come across with some weird and whacky ideas or beliefs, they've always asked opinions, they've always sought out our view on service delivery, and they've never come across as being kind of punitive in their approach to us.*'

Provider trust, senior executive

Timescale

Each of the six service areas involved work to redesign services. This took much longer than the suggested annual commissioning cycle, with starting points stretching back as far as 2007 (Table 10).

The early phases of development work were observed to be particularly time-consuming, with a minimum of one year typically spent on assessing

needs, reviewing evidence, and planning a new service specification. However, it was observed that slow and steady progress in the early phases could rapidly pick up pace, once a commitment was made to proceed with service redesign, even where a formal commitment to funding had not been made. Both the Wirral Memory Assessment Service and the Somerset Early Supported Discharge Service for stroke came together with impressive speed once a start date was decided. Details of a service model, referral procedures and staffing requirements were worked out within a matter of months.

5.1.5 Formalising arrangements between commissioners and providers

Observations highlighted a level of formalisation coming into the relationship between commissioner and provider as funding and contracting came to the fore, supported by a number of commissioning tools (see Table 11, also section 5.2).

Table 11. **Formalising arrangements for delivering the Wirral Memory Assessment Service**

Tool	Parties	Time period	Detail
Service specification	Between Cheshire and Wirral NHS Partnership and NHS Wirral	1st October 2010 and 31st March 2013	Set up via the standard NHS Contract
CQUIN scheme	Opportunity for CWP to earn additional payments from NHS Wirral	2010/11	Worth £285,000 - covers e.g. carers being offered a carer's assessment, proportion of patients being diagnosed with dementia following a GP referral. For whole dementia pathway.
Block contract	Between CWP and NHS Wirral	Year to 31st March 2012	£40.2m for delivering of all mental health services
Service level agreement	Between NHS Wirral and Alzheimer's Society	1st April 2010 to 31st March 2013	To provide outreach support to service users and carers
Dementia Dashboard		Under development	To support monitoring of Wirral Memory Assessment Service - through metrics and audits

For three of the service areas – the Wirral Memory Assessment Service and the two Somerset cases – an evolutionary process was observed to be

working well, allowing commissioners and providers sufficient flexibility to ensure problems were identified and addressed along the way. For example, reflecting on the decision to introduce a new community-based service for intermediate diabetes care in Somerset, a commissioner described the benefits of this approach:

> 'So I think there was a view that we would test a negotiated move of resource from secondary care to a community setting with Somerset Community Health being the provider because they were the county wide provider of community services...... I think there are advantages in having a county wide provider and a county wide pathway as well.'

> PCT senior executive

Where there was a historical legacy of service delivery which had never been formally specified – as in the case of the Wirral diabetic podiatry service - there were more challenges:

> 'it's no wonder that the providers have, you know, struggled to provide a service that the GPs are satisfied with, when we've not really told them....not really, really pinned them down as to what we're expecting'

> PCT manager

In Calderdale, the work to redesign both dementia and diabetes care was at such an early stage of development that formal arrangements for new models of care were not yet in place.

5.1.6 Closing the commissioning cycle with review

Monitoring and review of services are identified as two separate stages in the commissioning cycle[14] This research revealed these activities to be often intertwined. Commissioners reported that they judged the success of a commissioning development according to three categories:

1. Is the service running smoothly/efficiently? e.g. in terms of value for money, delivering target activity, reduced waiting lists, positive feedback from patients

2. Is the service delivering desired clinical outcomes? e.g. improved HbA1c control for diabetic patients, reduction in levels of complications

3. Is this the right model of delivery and, if not, should it be discontinued, revised, or re-commissioned? e.g. is the current provider the best one to deliver the service efficiently and meet desired clinical outcomes?

In interviews, commissioners and providers across all three sites tended to emphasise the first two categories, with much less focus on the third. Providers tended to monitor aspects of their own service delivery, for their own purposes, and to meet requirements placed on them by commissioners (see Figure 12).

Figure 12.   Monitoring of the Wirral diabetic podiatry service

The focus of the work observed was on resolving operational problems within the service: waiting times; tracking patients and data management. Monitoring had been discussed by the provider in terms of processes: for example number of patients not attending; complaints received; and nail clinics held. Acute providers were involved in monitoring those aspects of the services which were delivered in hospital and worked with community podiatry managers to improve systems. The manager of community podiatry service reported quarterly to the general manager at the acute trust on performance against a range of key indicators, such as number of foot screenings completed. The commissioner of the service at NHS Wirral was clear that in the future there needed to be more attention to clinical outcomes.

Where several providers were involved in delivering a service, commissioners had the role of looking across the whole care pathway to review performance and activity. For the Somerset Diabetes Service, the PCT managed the performance framework, in which each indicator was the responsibility of one or more providers.

A challenge that commissioners faced in monitoring outcomes and carrying out review of services was when and how to decide to continue or decommission a service:

'*I think there's always the argument that it takes much longer than you expect to get the results. So at what point do you say, 'was this right?' I'm not sure the NHS always has a good history of reviewing services in that way*'

PCT senior executive

There were signs in Somerset of commissioners beginning to consider these questions in relation to both the diabetes service and the early supported discharge service for stroke. One commissioner suggested the transition to GP-led commissioning, and associated changes in the rules around tendering, might provide greater opportunity for radical decision making:

'*I think the fact that now any willing provider and tendering, options to go out to tender, are there – gives you an opportunity to go back and say, 'Is this right?' So I think that it's a process that we are learning*

about, to do it effectively. But I think... once the GP consortium becomes more established, I think that's going to be an opportunity to go back and really challenge ourselves around "is this a good investment?"'

PCT Senior executive

Across sites, the availability, quality and timeliness of data shaped the monitoring and review process (see section 5.2).

5.2 The labour of commissioning

An extraordinary amount of effort was observed going into commissioning across all six service areas. Rather than an ordered technocratic process of purchasing and planning services, our fieldwork captured wide-ranging and overlapping tasks, roles, events, tools and data sources.

5.2.1 Tasks

Many interviewees described technical and managerial tasks which formed the basis of much of their commissioning work. These tasks tended not to take place in a linear way (see 5.1) and were often supplemented by considerable relational work which 'oiled the wheels' of the commissioning process:

'*Some of the technical stuff would be, if you were starting off with a blank sheet of paper, developing a specification and then... sharing that with others, sharing it with a potential provider, then developing a set of outcome measures. Then talking to information teams and staff, getting those agreed, then getting a system in place for collating them. So then it's the other part of it which is all the sort of relationship building, communication, emails, telephone conversations, meetings ... that go on really. And I think it's probably maybe, I don't know, 50/50. It's really difficult to say because it will vary depending on where you are up to in the process.'*

Provider trust, senior executive

Technical tasks of commissioning

Table 12 summarises the technical tasks of commissioning undertaken in this study. Some tasks were observed directly and others were reported as having been carried out prior to fieldwork, or were particularly sensitive (e.g. contract negotiations) and therefore not open to observation.

Table 12. **Overview of the technical tasks of commissioning undertaken in relation to each of the studied service areas during the fieldwork period***

	Calderdale diabetes	Somerset diabetes service	Wirral diabetic podiatry	Calderdale dementia	Somerset stroke	Wirral memory assessment service
Needs assessment exercise	●	●	●	●	●	●
Review of evidence base		●	●	●	●	●
Modelling/ mapping demand		●		o	●	●
Preparation of business plan		●			o	●
Preparation of service specification		●	o	o	o	●
Negotiation of contract		●	●		o	●
Preparation of performance management framework		●			●	
Collection of performance management information	O	o	o	o	o	o

- ● Tasks which were completed before the end of the fieldwork period. The scale of the task, particularly in relation to review of the evidence base of good practice, varied greatly between services observed.

- o Tasks which were still under way at the end of the fieldwork period.

Where most progress was observed with redesign of long-term condition services – Wirral Memory Assessment Service and stroke and diabetes services in Somerset - the widest range of technical tasks was undertaken as part of the commissioning process. In the two Calderdale service areas and in diabetic podiatry in Wirral, the fieldwork period covered tasks mainly concentrated at the early stages of commissioning and the technical tasks recorded in Table 12 above appeared to reflect this.

Relational tasks of commissioning

Alongside technical tasks, commissioning staff were observed carrying out a range of relational activities (see Figure 13). These complemented the technical tasks, allowing them to be carried out effectively. Whilst the technical tasks of commissioning tended to be practical and focussed on specific services, relational tasks were part of a wider programme of strategic planning, discussion and change.

Figure 13.   Overview of relational tasks of commissioning observed

- Bring commissioning 'communities' together
- Communicate effectively with providers and other stakeholders
- Liaise with third sector organisations about patient and public needs and expectations
- Facilitate consensus building on commissioning plans
- Secure prioritisation and funding
- Lead and sustain change and development
- Identify opportunities for funding and service development and use them
- Encourage best practice and relevant organisational/behaviour charge
- Keep up to date with and communicate evidence on best practice
- Keep up to date with and communicate national guidance and drivers for change

These relational tasks entailed commissioners in negotiating, planning, and developing consensus, as well as managing change. Commissioners worked with colleagues from a range of local health and social care organisations to agree the detail of how a service would be delivered in future:

'*lots of work has been going on* [around the service] *in the last however many months around the systems and processes, and we're finding that, and I would say that's probably where the bulk of it's gone, particularly in terms of referral process...In terms of pulling it all together I would have thought until you've got the service spec signed off it will continue if not get more intense*.'

PCT Manager

5.2.2 Roles

A wide range of individuals and organisations was involved in commissioning across the six service areas, including service users, hospital

and mental health trust managers, GPs and specialists, and local authority representatives (see section 5.3).

In the three service areas where the research revealed the most progress - Wirral Memory Assessment Service and the two cases in Somerset - a great deal of labour by staff at all levels was observed. There were two distinct types of role: effective strategic leadership (e.g. identifying clear priorities and ensuring the commitment of local providers, clinical staff and other interest groups); and hands-on labour aimed at implementing change.

For example, in Somerset, dedicated project management staff (one specialising in stroke, the other in diabetes) worked under the leadership of a senior commissioning manager. The Somerset project manager with responsibility for bringing the Early Supported Discharge service into existence identified her own role as essential in keeping the development process going:

> '*I think that just having that key person that's able to coordinate efforts across everybody and actually just keep on, keep saying 'Right we've got another meeting in a fortnight, have we done what we said we were going to do?'.... Just keeping that persistence as well has allowed it to move forward very quickly*.'

> PCT Manager

Whilst three of the service areas studied provided examples of commitment to service change, others highlighted that there was not always the capacity in the system for someone to dedicate time and energy to bringing about change through commissioning (see Figure 14).

Figure 14.   Case study–lack of capacity to enable change

In Wirral, the PCT programme manager who had day-to-day commissioning responsibility for diabetic podiatry also provided commissioning support for community equipment, the wheelchair service, retinopathy, cardiovascular disease LES, and stroke services – all within a 0.6fte position. As a result the time available for diabetic podiatry was constrained by other priorities and workload.

In Calderdale, the lack of dedicated staff time within the PCT to spend on strategic commissioning work on diabetes was one factor inhibiting progress on working up plans and a business case for service redesign. Calderdale is a small PCT and staff numbers were low even before a round of early retirement and voluntary redundancies triggered by current reforms, leaving the PCT '*stretched, absolutely stretched*' (PCT senior executive). Commissioning staff therefore focused their time and labour on other service areas – such as dermatology and COPD – which provided more obvious opportunities for bringing about efficiency savings.

5.2.3 Activities and events

Across all six service areas researchers observed formal activities through which the tasks of commissioning – both the technical and relational – were put into practice (see Table 13). Such activities required a tremendous amount of labour in terms of management and administrative time, as well as attendance and participation by relevant stakeholders.

With the transitions taking place following publication of the NHS White Paper in July 2010[18], some meetings were reviewed to fit with new priorities (e.g. the Department of Health's Quality Innovation Productivity and Prevention Programme) or revised commissioning structures and processes (e.g. emerging clinical commissioning groups).

Table 14 on page 97 shows in more detail the activities involved in commissioning one particular service development in Somerset.

Table 13. **Formal activities and events taking place as part of the process of commissioning in the six service areas**

	Type of activity	Who was involved?	Purpose/role of activity	Example
One off events	Large scale consultation/ strategic planning meetings	Commissioners, providers of health and social care, third sector organisations, patients and carers	Sharing ideas and building consensus on future commissioning developments Making connections between different stakeholders in the commissioning community	Two workshops on transformation change to dementia services in Calderdale and Kirklees, involving over 80 people (patients, commissioners, clinicians and managers from mental health, community and acute trusts, and local government officers
	Consultation events with patients/carers	Commissioners and patients/carers, possibly third sector organisation in support role, providers may attend as appropriate	Getting feedback on detail of service proposals	Somerset commissioners worked with the local Cardiovascular Public, Patient and Carer Involvement Forum to refine plans for the service.
	Workshop and planning events	Commissioners and providers, external input	One off meeting to review progress/data and develop plan of action	Wirral Memory Assessment Service Next Steps workshop involving six key stakeholders and facilitation from the Nuffield Trust
	Review meetings/pathway meetings	Commissioners and providers of health care – managers and clinicians (multi-lateral)	Reviewing progress with new developments, ensuring all sections of care pathway working together	Somerset Diabetes Service Pathway management group
Events running in	Joint strategic planning meetings	Commissioners from PCT and local authority, providers, representatives of service users and carers	Setting local priorities for action, sharing information on resources and development	Wirral Older People's Services Network (formerly Joint Commissioning Group for Older People)
	Regional network meetings	Commissioners from across a number of PCTs	Sharing information on best practice	Avon Somerset Gloucestershire and Wiltshire Stroke and Cardiac Network
	Local network meetings	Commissioners, GPs, secondary care providers, patient representatives	Discussing local needs, difficulties with service provision, possible solutions	Calderdale Diabetes Network

Project meetings / task and finish groups	Commissioners and providers	To progress development of new service	Somerset Diabetes Project meeting Task and Finish Group developing the Wirral Memory Assessment Service
Contract management meetings	Commissioners and providers of health care (bi-lateral)	Checking performance of provider against contract and quality of care. Held regularly. Functions may be split across different series of meetings.	Joint Contract Group Meeting between commissioners and managers of Cheshire and Wirral Partnership to review quality of delivery of all mental health services, including dementia care.
Meetings of clinical executive groups (various names and identities)	Clinicians, senior commissioning managers and finance staff from PCT, local authority senior staff	Making decisions about funding and priorities for commissioning	Calderdale Clinical Executive group

Table 14. **Overview of formal activities and events involved in commissioning of the Early Supported Discharge Service in Somerset***

Activity	Purpose	Time	Driver	Participation
ESD project meetings	Review evolving service; undertake some performance monitoring; discuss individual case histories. – final meeting in Jan 2012	Monthly meetings (every two weeks in the early days) lasting up to 2½ hours	Led by staff from NHS Somerset	Attended by up to 15 people, the majority of them staff from the community health provider who were involved in delivery of the service
Stroke Clinical Pathway Group	Review the full picture of stroke services in Somerset – including performance monitoring of ESD from Jan 2012	Bi-monthly	Convened and chaired by staff from NHS Somerset	Up to 13 people, including senior managers from the PCT and provider organisations and senior clinicians, including a GP from the CCG.
Operational Meetings	Discuss practical aspects of service delivery	Bi-monthly, from July 2011	Co-ordinated by Somerset Partnership	Therapists and management Staff from provider organisations (Somerset Partnership, two acute trusts), project manager from PCT
Contract meetings	Monitor performance	Monthly	Performance team at PCT and managers from providers	Bi-lateral between the PCT and managers of provider services
Workshop event	Plan next steps in developing the Early Supported Discharge service	One off half day event	Convened and chaired by NHS Somerset	c30 people: two commissioners, senior clinicians from acute trusts, therapy and nursing staff from community health service and acute trusts. Staff from a similar local service also invited to make a presentation
Stroke review meetings	To plan and oversee a review of the whole stroke pathway on behalf of the CCG	A series of three meetings during November and December 2011	Chaired by stroke lead GP, facilitated by NHS Somerset	CCG GP lead, managing director of CCG, two senior managers from PCT, two acute stroke consultants, Directors of Operations for acute Trusts, three consultant nurses, manager from partnership, Stroke Association

* Includes all events taking place during the fieldwork from April 2010 to October 2011.

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In addition to these formal activities, commissioners across all six service areas in the study participated in a range of informal activities, such as email communication and informal meetings with colleagues, which added further to the labour of commissioning.

5.2.4 Tools

A range of tools in the form of documentation was observed being used by commissioners to help them plan and carry out their work. These documents were distinct from external papers – such as NICE guidelines - but often incorporated external resources or provided a direct response to them (see section 5.6). Table 15 (not exhaustive) summarises the tools most commonly used by commissioners in this research, and their function.

Table 15. **Tools commonly used by commissioners in their work**

Type of tool	Function	Calderdale diabetes	Somerset diabetes	Wirral diab podiatry	Calderdale dementia	Somerset stroke	Wirral MAS
Local strategic plan	Setting overall direction and priorities		●		●		●
System modelling	Estimating patient flows and associated costs	●	●			●	●
Business case	Supporting decision making by a committee about whether or not to proceed with a development	●	●				●
Financial incentive scheme	Lever to improve performance/ensure compliance by providers		●	●			●
Care pathway	Provides a coherent picture of how patients (should) move through various components of the health care system.	●	●	●		●	●
Service specification	Detail of what care will be provided to patients – nature, quality, volume		●			●	●
SLA or contract specific to this service	Formalising what service is provided for what price (and penalties for non–delivery)		●	●		●	●
Performance monitoring framework	Mechanism for reporting data which will confirm compliance with service specification in order to meet requirements of contract		●			●	●

These tools were generally reported in interviews as being valuable to commissioners. However, they could also require considerable, sometimes disproportionate, time and effort. For example, considerable energy was

put into producing detailed business cases, often involving work on the part of providers as well as commissioners, a point noted in other research[25]. Commissioners regarded such processes as necessary to enable formal approval for prioritisation and spending, reflecting that it can be hard to '*get stuff through business planning without a massive business case, which is very time consuming*' [PCT manager].

5.2.5 Data

A striking amount of labour went on the collection, management and sharing of data on service activity. This was a major task for commissioners and providers, even where systems were running smoothly. The Wirral Memory Assessment Service provided an example of where data handling appeared to work well and fed productively into commissioning (Figure 15).

Figure 15.   Case example - using data to inform the development of dementia services in Wirral

NHS Wirral appeared to place a high value on using data to support evidence based decision making to inform commissioning. An economic evaluation of the strategic commissioning plan produced quality-adjusted life years (QALYs) for each programme. The PCT had reasonable access to primary care data (with a localised electronic health record in place for several years) and the PCT and the acute trust shared a data warehouse. In 2008, the World Class Commissioning Panel was "*impressed by the broad range and granularity of information that is routinely used to influence and support commissioning decisions*".

Work on dementia services combined intelligence from the Joint Strategic Needs Assessment with data on demographics and spending. To plan dementia services, commissioners began by analysing data, modelling possible scenarios, and developing options to enable more proactive care (e.g. early diagnosis). Participation in the Department of Health Care Services Efficiency Delivery programme facilitated this process, enabling commissioners to gain knowledge and experience of system modelling.

However, a different story was evident in relation to diabetic podiatry in Wirral, where problems with data characterised many observations. These problems reflected wider challenges of accessing and handling of data (see Figure 16), which added considerably to the labour of commissioning.

Figure 16. Key challenges of data handling for the labour of commissioning

> *Magnitude of the task of collecting and reporting up to date data*
>
> The Performance Management Framework for the Somerset Diabetes Service included 75 different indicators spread across 17 categories, relating to 4 acute trusts, the partnership trust and GPs. The PCT's project manager for diabetes was responsible for collecting, collating and reporting on them to the bi-monthly Diabetes Pathway Management group and the six-monthly Diabetes Commissioning Group. Some of these data had to be collected and processed manually.
>
> *Incompatible data systems*
>
> NHS Wirral had faced many challenges in trying to extract Read Code data from GP practices on the status of their diabetic patients in order to find out which patients fell into each risk category for foot care. Data management was such a concern in relation to the diabetic podiatry service that the search for an 'ideal data system' seemed to have become an end in itself, rather than an adjunct to the delivery of the service.
>
> *Inadequate data systems*
>
> In Calderdale, systems were not able to provide a complete picture of current activity levels in the dementia service as a starting point for discussions between the provider and PCT on service review. A senior clinician resorted to going through records by hand*: 'I actually did a hand count about a year ago, which is where, when I quote the figures about how many people are going through, that's because I sat down for a weekend and actually went through a year's worth of referrals and counted them up and showed much higher activity than appears to be showing on the performance data…. So that's a major concern.'* [Clinician]
>
> *Inconsistent ways of categorising or recording activity*
>
> There was a commonly reported difficulty with monitoring diabetes-related health service activity. In Calderdale and Somerset, the coding system was not recording diabetes as a secondary diagnosis which presented challenges in getting any baseline estimate of activity levels and service needs: "*the coding of the diabetic admissions into secondary care is a bit of a murky business in that, you know, they tend to get coded for the symptoms that are causing the admission and the diabetic coding is the secondary coding. And the extent to which diabetes had led to the admission is not clear from the coding systems, and so it's quite difficult to track* ' [PCT Senior Executive]

5.2.6 Proportionality, scale and cost

The scale and intensity of the commissioning work observed raised questions about whether it was proportionate to the impact on service delivery, quality and patient care. This study did not set out to measure the impact of commissioning in relation to the labour involved, nor did it seek

to assess the costs of 'the labour of commissioning'. However, our fieldwork allowed some reflection from participants on these issues.

Developmental work

Across all three sites interviewees discussed whether the more developmental tasks of commissioning - such as meetings and preparation of reports to inform decision making - were as productive as they might be. One PCT manager reflected that:

> '*it's taking far too long…if you think again just in terms of the timeline, you know, all the meetings that were involved, this took people away from other things. And the work involved in writing up papers, doing the presentations, struggling with putting together a programme*'.

Stakeholder participation

All six service areas had high levels of stakeholder involvement in commissioning. This was largely regarded by interviewees as appropriate in the early stages of service planning. However, questions were raised about the extent of this involvement further along in the commissioning process (see section 5.3) and whether this distracted from decision-making:

> '*But the thing with all these groups is that if they're just allowed to carry on forever, quite often they degenerate into sort of large talking shops...I mean we had this with the [name of group] a few years ago when all and sundry seemed to have invited themselves to a meeting and you could get nowhere because there were about thirty people attending, who all wanted to have their say about the issues. And* [another GP] *and I sort of stitched up a plan and tweaked the terms of reference and sort of savaged the numbers of people that were allowed to attend, and then we started to get some useful work done again*'

> GP commissioner

Costs

The total cost of running the process of commissioning (as opposed to delivering the service) was not quantified by commissioners. In fact, the cost attached to commissioning was rarely mentioned.

Table 16 provides an indication of total management costs in each of three PCTs in 2010/11 as a proportion of net operating costs. Comparison of those percentages across the three PCTs suggests that Somerset, the largest commissioner in population terms, may have benefited from some economies of scale since it had the lowest operating costs, and is the only

one of the three with costs below the anticipated CCG per capita management cost allowance of £25.

Table 16. **PCT management costs per weighted head of population 2010/11**[107,108,109]

Commissioning area	Cost (£) per head	Population	Total management costs (£)	Management costs as % of net operating costs
Calderdale	£31.53	204,572	£6,392,000	1.90%
Somerset	£17.78	506,669	£9,008,000	1.06%
Wirral	£28.47	361,187	£10,283,000	1.59%

The cost of the labour associated with individual commissioning developments is difficult to calculate due, in part, to the high levels of indirect costs, such as attendance at commissioning meetings by hospital consultants and managers whose time is not is not billed to the commissioners. So the cost of participation in the activities summarised in Table 13 tends to be hidden and/or absorbed into the operational costs of the employing organisations.

5.3 Identifying the commissioners

A simplistic model of commissioning might identify commissioners as the people planning and funding services to meet local health care needs and distinct from those who provide services. This research reveals that the picture is more complex, with multiple and ambiguous commissioning roles across the six service areas and people dipping in and out of the commissioning process at different times and for different reasons.

5.3.1 The multiple roles involved in commissioning long-term condition services

In all six service areas, the tasks of commissioning were not carried out exclusively by people working for PCTs and with 'commissioner' in their job description. Managers and professional staff from provider trusts and local

authorities, GPs and other clinicians, and to a lesser extent patients and third sector organisations also played a role. The contribution of different parties varied according to the stage in the commissioning process (see Figure 1), allowing, for instance, for service user input to needs assessment and planning, or specialised input by finance staff to contracting.

Figure 17. **Summary of observed contributions to the commissioning process**

LINks

Public health expertise

Local clinicians across primary, secondary and community care, with expertise in the long term condition

Lead commissioning manager (PCT/CCG)

Strategic management (PCT/CCG/Cluster)

CCG representatives

Local authority / social care

Provider organisation/s

Voluntary and independent sector

Service users and local residents

Lead PCT/CCG commissioner

Specialists within both commissioner and provider organisations with in-depth knowledge, skills and expertise of contracting and procurement

Public health expertise

Quality/contract review managers

Lead commissioning manager (PCT/CCG)

Provider organisation/s

Service users

Strategic management (PCT/CCG/Cluster)

Needs assessment   Planning

Contracting specification and procurement

Monitoring   Review

Consensus development   Service redesign   On-going performance management and quality improvement

---

Having a range of people contributing to the process of commissioning appeared to support effective redesign and procurement of services. There were however ambiguities. For example, a number of groups were involved in planning local service developments and feeding into decision-making (as in the workshops about the future of dementia services in Calderdale) but there was no evidence of a clear link to how such involvement might influence subsequent budgetary decisions, nor discussion about any conflict of interest on the part of providers taking part in such workshops (see 5.4).

Though the research team did not have an opportunity to observe such activities directly, it seemed that contracting involved a shift to much more focused involvement (see Figure 17), with a small number of highly specialised individuals. A clinician who was heavily involved in developing a diabetes service described the process of specifying and agreeing contracts as a tricky one, liable to reveal tensions between parties who had previously been working side-by-side:

> '*And from there we developed the plan further. And at that point it then split, because the plan then went off to commissioning to be turned into a commissioning plan and went off to have the finances put towards it. So at that point in the process, because up until then we'd had clinicians and commissioners around the table, which was, you know, really, really powerful for all of us. But for a very short period of time, the clinicians and the commissioners sort of split at this procurement time, which sort of led to a slight wobble in the process...*'

> Community provider, clinician

The monitoring and review stages of commissioning involved multiple inputs into decisions about how and when the success of a service should be measured. Commissioners and providers were observed working through a mix of formal (e.g. reporting numbers) and informal (e.g. negotiation and discussion) processes to review performance, particularly in the two Somerset services and the Wirral Memory Assessment Service.

5.3.2 Organisations involved in commissioning

Providers as partners in commissioning

In all six service areas, providers were observed taking an active part in discussions about health care needs and service redesign. Providers had expertise and knowledge which commissioners valued as essential to service development. The principle of 'active partnership' was summarised by one senior executive who made a clear distinction between contracting - where a distance between purchaser and provider is considered necessary - and other functions of commissioning, such as needs assessment and service design:

'[commissioning and contracting] *are very separate and I think unfortunately people, because they conflate it, say, "Oh we can't have providers in the room when we're doing commissioning". Well of course you can and of course you should because actually if you're going to get the people who have, particularly the frontline staff, the clinicians...So it's very much a collaborative, inclusive process that then produces the model of service and also looks within that about affordability'*

Senior executive, acute/mental health trust

This distinction resonated across sites. Partnerships between providers and commissioners were most commonly concerned with needs assessment, generating ideas and service planning. For example:

'[the manager] *met with us and shared really quite a lot of sensitive information about what the DSNs are doing and where the money is going, and what kind of appointments they're generating and clinic levels of activity etc. across the trust. And then looking at that was quite happy for us to then do some ongoing work about pushing the redesign agenda with the diabetes specialist nurses, even before the decision was made to give the provider services of the PCT, to give that contract to* [acute trust]*. So potentially they could have been losing some income and resources. [...] So they were quite up for a more radical agenda, looking at different ideas'*

GP

Providers were also observed taking an active role in developing approaches to service monitoring. For example, designing a performance framework for the Early Supported Discharge service in Somerset was a team effort:

'*Very painstaking process doing it, as you can imagine, but everybody's kind of had an equal share in determining what that would look like*.'

PCT manager

Providers taking a lead role in commissioning

In three cases, the position of provider organisations in the commissioning process was particularly prominent (see Table 17). Staff from the provider brought specialist knowledge of clinical care and specific skills in project management, co-ordination and leadership.

Table 17. **Examples of provider prominence in commissioning for long-term condition services**

Wirral Memory Assessment Service	The clinical team at the partnership trust was instrumental in driving forward changes. Working with the PCT/CCG clinical leads and others, the clinical team played a lead role in planning, designing, developing and accrediting the new service. Whilst oversight rested with the commissioner, the provider team worked hard to be identified as partners working with a support service delivered by the Alzheimer's Society.
Somerset Diabetes Service	A consultant nurse working for the community health provider had a lead role in designing the new model of care. She researched good practice models and promoted them to colleagues in Somerset, reflecting the view locally that '*she's very keen to see care in the community, very keen for patients to have access to local services, is incredibly educated and knows exactly what she's talking about and is passionate about diabetes and has really, really helped actually*' [GP commissioner]
Transformation of dementia care in Calderdale	The mental health provider trust instigated work on dementia as part of the local transformation programme, an initiative which brought together senior managers from health and social care commissioners and providers both Calderdale and Kirklees. A senior executive from the trust described how the trust took the initiative: '*We started off when we first went to the transformation board last December* [2010] *and said, "Can we do some work on dementia, under the umbrella of the transformation board?"*'

Where providers took the lead in driving change, partnership work was generally described as productive:

> '*This is where commissioners can be a really helpful partner in terms of bringing another perspective to problems and saying, "Have you looked at this?" or "Could we do such and such to help you?" It does feel like the conversations are very much about partners helping each other work with situations rather than adversaries trying to screw every little last advantage out of each other*.'

Provider trust, manager

Providers appeared to have a mix of reasons for taking a lead role in commissioning, including individual enthusiasm (especially on the part of clinicians) and/or addressing the provider's strategic objectives. There was also an element – especially in relation to the work carried out on dementia in Calderdale – of providers stepping in to help fill a gap left by limited capacity and resources on the part of commissioners.

Sub-contracts and managing pathways

Commissioners were, in each case, working with a range of providers for a single service area, something that seems to characterise long-term conditions. This raised questions about how responsibility for quality and effectiveness of care might best be addressed either as a collective responsibility or through a hierarchy of lead contractor and sub-contractors. The task of ensuring that the *whole* service was managed was identified as one that was likely to grow in significance:

> '*I do think commissioners have a role in doing that in the future, particularly with things like any qualified provider etc, you know, they do commission and are explicit about whose responsibility is it to actually make sure that those things are covered off, particularly when people are moving between different providers*.'

> Senior executive, provider trust

Commissioners for the Wirral Memory Assessment Service had already begun to think about how best to manage the wider dementia service. In the short term, contracts were in place with two providers to deliver the service: one with the mental health trust; and the other with the Alzheimer's Society. It was envisaged that in the future, the commissioner might contract for specific health outcomes, perhaps with the mental health trust which would, in turn, sub-contract for outreach and carer support.

The role of the third sector

In all six service areas studied in this research, third sector organisations played a part in the commissioning process, particularly in terms of contribution to discussion about needs and service development. There were various mechanisms by which this took place (see Figure 18).

Figure 18.   Examples of third sector involvement in commissioning

In Wirral, an advocacy organisation called the Older People's Parliament had raised concerns about the diabetic podiatry service, writing letters to commissioners, requesting meetings with providers and having discussions at planning groups.

In Calderdale, third sector organisations such as Dementia UK and local carers' groups were invited to take part in the workshop events to discuss transformation of dementia care, and they fielded a significant number of participants, including patients and carers.

In Somerset, a representative from Diabetes UK had input into the redesign of the Somerset Diabetes Service and retained involvement in the oversight and review of the service by attending meetings of the Diabetes Pathway Group, where he took an active role in discussion.

In Wirral, the Alzheimer's Society was commissioned by NHS Wirral to assess local needs for people living with dementia, which subsequently fed into the development of the Memory Assessment Service.

Voluntary sector organisations were regarded by commissioners as a useful source of specialist knowledge, adding a vital perspective to that of commissioners and statutory providers.

Joint commissioning across health and social care

In all three sites, PCTs were observed working in partnership with the adult social care departments of the local authority to plan and commission services across health and social care. In Wirral and Calderdale in particular, the PCT had developed strong strategic partnerships for joint commissioning of health and social care services for adults. Strategy was supported though joint management posts and processes (see Figure 19). In Wirral, three locality teams brought health and social care practitioners together to deliver better integrated care, while in Calderdale, work was under way to develop integrated care teams that would provide intermediate care to prevent hospital admission and facilitate early discharge from hospital.

Figure 19.   Summary of initiatives supporting joint work across health and social care in Calderdale relevant to the commissioning of dementia services

Two joint commissioning posts were in place, with staff dividing their time between the council and the PCT and carrying out work on dementia services and other areas of care. A local dementia strategy was produced jointly by the NHS Calderdale and the local authority in 2010 (see section 4.2), under the direction of the Local Strategic Partnership (a forum for health and social care managers to plan services in a joint manner). The strategy set out an overall direction for dementia work in Calderdale, and was accompanied by an action plan outlining first steps for putting it into practice. Responsibility for delivering each of the objectives within the strategy was allocated to either a middle manager or programme manager in the local authority/PCT (one of whom had a joint post).

Whilst positive reports of joint commissioning were given in project interviews, there were challenges to working across health and social care, relating particularly to:

1. Lack of joint budgets across health and social care*: For example, under the NHS Operating Framework 2011/12[93], PCTs were allocated a non-recurrent sum of money (in Calderdale's case, £2.5 million) which they were then expected to transfer to local authorities to be spent on social care services to bring about health gain. Calderdale Council had earmarked £150,000 to spend on services for people with dementia and their carers. However, the lack of joint budgets led to extensive discussions about the mechanisms for allocating this money, with commissioners struggling to reconcile an overall policy direction of integrated working for dementia care with the divide between NHS and social care budgets and contracting arrangements.

2. Local reorganisation of health and social care following the 2010 NHS White Paper[18]. In Wirral the strategic arrangements in place for joint commissioning were thrown into question with the emergence of three clinical commissioning groups each with potentially different priorities and ways of working (subsequently merged into a single group in February 2012). Similarly in Calderdale there were anxieties that working across the PCT cluster would distract from existing partnership arrangements developed between the local council and health commissioners.

5.3.3 Individuals involved in commissioning

Commissioning managers

Commissioning managers employed by PCTs played a central role in all the commissioning practice observed. In the case of the three service areas that had progressed furthest – the Wirral Memory Assessment Service and the two Somerset hooks – the impact of specific managers on progress was palpable. In all three cases there was a senior manager (second in line to a PCT director), supported by project managers and administrative support. These senior managers were budget holders and decision-makers, providing strategic vision, maintaining relationships and ensuring that the right parties were brought into the commissioning process at the correct time. More junior staff members determinedly kept the service development process moving forward (see section 5.2).

Following the implementation of proposals set out in the NHS White Paper in 2010[18] the research team noted a shift from PCT managers acting as decision makers and budget holders to PCT managers providing a more supporting role to clinical commissioning groups and their lead GP commissioners. However, challenges remained across all sites particularly with regard to how best to ensure that the knowledge, skills and expertise of local commissioners was not lost.

Specialist commissioning skills

Commissioning managers were observed bringing in support from appropriately skilled people as required, from within the PCT or from external organisations (see Table 18).

Table 18. **Examples of specialist skills used by commissioners, and their source**

Specialist skills	Drawn from	Example
Needs assessment	Public health colleagues within PCT	Data on variation in diabetes prevalence across Somerset
	Third sector partners	Alzheimer's Society report on prevalence and need for NHS Wirral
Review of evidence base and identification of good practice models	Provider organisations	South West Yorkshire Partnership Trust led review of evidence base on interventions for people with dementia
	Regional networks	Avon, Gloucester, Somerset and Wiltshire Cardiac and Stroke Network was forum for sharing information on good practice in relation to Early Supported Discharge Services
	External partner organisations	Nuffield Trust provided input to SWYFT's review of evidence base on dementia services
Contract negotiation	Finance colleagues within PCT	Input from NHS Wirral finance team to negotiations re delivery of Memory Assessment Service
Financial modelling	Finance colleagues within PCT	Calderdale Business Intelligence Unit modelled costs of secondary care associated with diabetes diagnosis
Design of pathways and clinical aspects of model of care	Clinicians from primary and secondary care and community health providers	Somerset clinical leads drafted pathway for diabetes care

Specialist finance and contracting staff within PCTs provided skills, experience and knowledge, particularly for technical tasks (see Table 18). These staff played an important role in ensuring that contracts were effective and legal, and undertook some of the tougher and more technical aspects of contracting:

> *'Negotiating at the highest level contracts, so it's quite difficult to focus on detail but there was a very, very protracted and painful exercise that we went through as part of mobilisation where we were trying to get the money out from secondary care to represent the anticipated shift... And that negotiation was carried out by our finance people and our commissioning people together'*

PCT manager

Clinicians as experts

Clinicians have particular skills and expertise to bring to commissioning, and GPs, specialists and other senior staff all make a contribution. For example, consultant nurses were instrumental in designing the Somerset Diabetes Service, a consultant psychiatrist drove the development of the Wirral Memory Assessment Service, and a consultant therapist had a leading role in setting up the Early Supported Discharge service in Somerset. Positive views were expressed about clinicians working in partnership with PCT commissioners, particularly with regard to the provision of specific clinical knowledge:

> '…*and that's where I think you get the real benefit of working in partnership with people like a consultant psychiatrist who's so passionate and committed to the service...but over time we're also going to get that clinical perspective from the GPs as well because they're there every day seeing their patients.*

PCT senior executive

Figure 20.   Case study of involvement of secondary care consultants in the commissioning of the Somerset Diabetes Service

Three secondary care diabetes consultants have been involved in the development of the Somerset Diabetes Service, one each from the two Somerset acute trusts, and a third from the acute trust in neighbouring Bath, which takes a small number of Somerset patients. The Bath consultant brought experience from a more established service redesign initiative in his patch. All three consultants attended meetings of the Diabetes commissioning group, reporting on activity in their hospital and discussing broader issues such as medicines management policy.

The consultant from Taunton and Somerset Foundation Trust was paid by the PCT for two sessions a month to be the clinical lead on the new diabetes service, including chairing a bi-monthly Diabetes Pathway Management Group. But with limited time available, alongside a busy clinical workload, the consultant has found the scope to make this leadership role more than a nominal one is fairly limited: '*I find it hard to keep, I don't keep tabs on what's happening on a day to day basis. So that makes it harder to lead the whole service, because I don't really have that intimate knowledge of it*.' [Acute trust clinician]

GPs as decision makers and leaders

During the fieldwork, GPs appeared to be taking on an increasing role in commissioning. For example, in Somerset, one GP with a special interest in stroke led a review of all stroke care on behalf of the CCG during November and December 2011, with the support of PCT staff.

Demands on GPs' time meant that it could be a struggle for PCT commissioners to keep them actively involved in commissioning, both

under the old structures and in the new arrangements. CCG board members in particular found that the demands on their time were relentless. For instance, in Somerset such demands led to one GP clinical lead for stroke stepping down from the position towards the end of the fieldwork, though a different GP quickly took up the role.

The progress made towards GP leadership of commissioning was as staged transition which varied site-to-site. One PCT commissioner described how PCT staff were able to initiate and work up plans for redesigning services before discussing them with GPs on the CCG board:

'*We have a time where the GPs, just the GPs, are all together, the 10 consortia GPs. And that's a great time to take in pieces of service redesign or pathway developments because you can have really good clinical debate that's very non-threatening and just very supportive. Then we're encouraging our GPs to take papers to the commissioning executive, which is acting as the board now.*'

PCT manager

Interviewees perceived that whilst there was potential for clinicians to lead change and improve services, many were concerned about potential loss of focus due to GPs' generalist role and a lack of time for the intensive work previously carried out by PCT managers. One example was given as follows:

'*The mental health commissioner lives and breathes mental health in terms of the commissioning. A GP consortia [sic], although they will have leads, won't be breathing and living mental health. They will have other responsibilities within their portfolio as well as their own clinical responsibilities.   So I think it will be hard for them to get that kind of lived experience of mental health services and commissioning it in that, in that role*'

Manager, provider trust

Local clinical champions

Some of the most positive activity in terms of service redesign was observed as being associated with individual 'local clinical champions'. These clinicians (from both primary and secondary care) typically had a vision for a new model of service delivery, and a degree of status and position within the local commissioning community which allowed them to bring others on board with new ideas (see Table 17).

This role of clinicians as 'champions of change' was reported in interviews as being valued by commissioners, enabling them to 'sell' potential service changes to the wider clinical community in a way that they were not able to

do in their own managerial role. As one commissioner involved in planning diabetic care described:

> '*A GP taking a paper into the consortium is very different from a manager taking the paper in*'
>
> PCT manager

GPs and secondary care doctors were observed acting as influential peer-to-peer educators in the commissioning process, encouraging behaviour change amongst colleagues in terms of clinical practice and referral patterns (see the report on the social network analysis in section 5.8). For instance, in Wirral, the consultant psychiatrist and his team worked with local practices and residential homes to promote the new Memory Assessment Service, while in Somerset the GP lead for diabetes promoted the new model of care to other GPs through a regular newsletter and speaking at training and networking events.

5.3.4 Multiple roles and interests

Some concerns were expressed in interviews by commissioners about clinicians and providers taking an active part in specifying new services, with a perception that that there was scope for potential conflicts of interest. Clinicians themselves also talked about the complexities of having 'two hats'. Table 19 gives examples of multiple roles held by GP commissioners.

Table 19. **Examples of GPs' multiple roles within commissioning**

Discontinuing a Local Enhanced Service	As commissioning leads, GPs will need to consider what tasks continue to be covered by LES and what should become embedded in routine work, without additional payment. As one PCT commissioner reflected: '*Now that's going to be really hard for them to decide, isn't it, because if it's going to take money out of their practice, how are they going to make that decision? I don't know. And I think it's a real conflict of interest for them*' [PCT manager]
Establishing a new service	A GP in Somerset had a dual role in the establishment of the new Somerset Diabetes Service: (i) as a commissioner (sitting on the board of the CCG (and formerly the PBC consortium), and consortium, of which she is a board member, and through her role as the clinical lead GP for diabetes in Somerset , tasked with informing and involving fellow GPs in relation to new services and new treatments; she is also funded to do this work on behalf of the PCT) and (ii) as a provider - as a practising GP, and as a lead in her local GP federation.
Negotiating multiple roles as 'clinical lead'	Clinicians who had an active role in commissioning widely described themselves as having two or more roles, which could be a source of tension or ambiguity. One Wirral GP described the complexity of his multiple roles in commissioning under the previous structures: '*I found myself actually attending meetings on both sides of the argument here. I was summoned to a meeting of the hospital Trust to try and advise them on how they could sort this out. And then the following day I was summoned to a meeting of the commissioning group to advise them on how they could extract the money or the nurse, which was quite interesting!*'" [GP commissioner]

5.4 The question of money

One of the national objectives of commissioning is to achieve value for money in the delivery of services[110]. It was therefore surprising that this research observed money as having a rather intermittent, and at times apparently peripheral, role in the practice of commissioning.

5.4.1 Where does money feature in commissioning?

Discussion of money – whether costs of services or potential savings – was intermittent within the commissioning practices observed. Those observed to be taking an active role in commissioning spent a remarkably small proportion of their time talking about the costs of service delivery or potential savings (in both interviews and meetings). Commissioners were aware that achieving 'value for money' in service delivery should be an outcome of commissioning decisions, but this did not necessarily translate into active use of information on costs.

Where money did feature in discussions, it tended to be early in the commissioning process (when potential savings or efficiencies were identified in order to justify or initiate service redesign) or later, when payment systems were considered to be a lever for implementing the redesigned service and, potentially, changing clinical practice.

During the intermediate stages, when service redesign and development was actively under way, money featured less in discussions. All three PCTs had an organisational structure for commissioning that separated out the negotiation and management of contracts from strategic development and service design work, with different staff involved in the two types of role. Fieldwork for this study tended to capture the latter, partly because participants guided us to what they perceived to be the significant elements of commissioning work, and these rarely included contract negotiations (see 5.1).

Separate financial and service development processes

In all sites, the architecture of commissioning appeared to keep financial processes and functions separate from those of service development. For example, in Wirral the Diabetes Modernisation Group had a formal role in planning developing diabetes services but did not control the budget for service delivery:

> '*My understanding is that the modernisation team isn't a commissioner. It doesn't hold the budget so when things have been identified or things have needed to be put in place in terms of podiatry care for diabetic patients, it's been discussed there, we've come up with action plans, we've made changes and that's how it's been doing*'

Community provider, manager

Similarly, in Calderdale, the Transformation Programme Group which discussed the redesign of dementia services, and its parent Transformation Board, had no authority to make decisions about spending, but could simply make recommendations to be enacted by constituent organisations.

5.4.2 How does money feature in commissioning?

Money featured in four principal ways within the commissioning process:

- block contracts;
- financial incentive schemes;
- uncosted provision; and
- short-term or opportunistic funding.

Unsurprisingly, these tended to be associated with technical tasks and tools allied to strategic commissioning and contracting (such as business cases

and contracts, see 5.2), all of which featured information about current/planned spending related to the six service areas.

Block contracts

A significant proportion of the spending on care delivered by provider trusts in all six service areas was through block contracts (see Table 20).

Table 20. **Overview of block contracts / financial frameworks across sites**

Study site	Diabetes	Dementia / stroke
NHS Calderdale	Diabetes care is currently delivered by Calderdale and Huddersfield Partnership Trust but *not* under a block contract. However, there has been some discussion of the scope for shifting to community provision under a block contract as a way of containing costs.	Memory clinic and other dementia care services delivered under main contract with South West Yorkshire Partnership Trust (£15.8 million). Cost of memory assessment and other dementia work not itemised separately.
NHS Somerset	Level 2 diabetes care – including Diabetes Specialist Nurses and patient education- is delivered under the main contract with Somerset Partnership Trust (£129 million – delegated to the CCG) Specialist diabetes care delivered under main contracts with Taunton and Somerset Trust (£184 million), Yeovil District Hospital (£74 million), Royal United Hospital Bath (£23 million) and Weston General Hospital (£14 million). Cost of diabetes care not itemised separately.	Contract with Somerset Partnership Trust (£129 million – delegated to the CCG) covers stroke rehabilitation of which Early Supported Discharge Service is a part. Main contracts with Taunton and Somerset Trust (£184 million) and Yeovil District Hospital (£74 million) cover clinical supervision for stroke Early Supported Discharge service. Cost of ESD not itemised separately in any of these contracts.
NHS Wirral	A block contract with Wirral Community NHS Trust runs for three years from April 2011 and covers delivery of community podiatry. In 2011 the contract value was £1,880,000 (recurrent) and £375,000 (non-recurrent). The total value of the contract with the community trust is £57 million.	A block contract with Cheshire and Wirral Partnership runs for three years from 1 Oct 2010 and covers delivery of the Memory Assessment Service. The value of the contract for NHS Wirral is £38 million. A dedicated service specification hones in on the detail for the service, which has a current cost £960,000.

For commissioners, the use of block contracts meant that it could be difficult to extract information on costs relating to a particular element of service delivery. There was also less pressure to examine current services and to consider alternative approaches to provision. For example, as one clinician from the mental health provider organisation in Calderdale reflected, '*it's a block contract so nobody's really interested at this point in time*'.

From a provider perspective there were also disadvantages to using block contracts in relation to adapting the service to meet demand:

'*But the problem is about differences in financial flows really because obviously if you're an acute trust you get* [Payment by Results] *for caring for somebody with dementia, whereas ours is just a block contract. Now in a PbR world if our demand exceeds the contract that we had in place we'd just get more money for every person that came through the door and then we'd be able to adjust our resources to cope with the additional capacity needed to do that, but because we're on a block contract we don't have that luxury*.'

Provider trust, senior executive

For mental health services, the focus on block contracts was due to change with a switch to Payment by Results for mental health services in England from 2012-13. Mental health providers within this research were already beginning to prepare for such a change by mapping out predicted financial flows.

Whilst block contracts were regarded as problematic by many commissioners, they were regarded positively by those working on diabetes care in Calderdale where there had been discussion of moving the delivery of intermediate level diabetes care by diabetes specialist nurses to a block contract model as a possible way of saving money (i.e. by shifting away from fee-per-contact).

Financial incentive schemes

Supplementary payments and incentives were observed being used by commissioners to bring about changes in service provision and improvements in quality (see Table 21). These took two forms:

CQUINs – Commissioning for Quality and Innovation, an incentive scheme for secondary care providers

LES – Local Enhanced Service – an incentive scheme for GPs

Table 21. **Overview of CQUIN and LES incentive schemes in the six service areas**

Hook	Commissioning for quality and innovation payment	Local Enhanced Service
Calderdale diabetes	No CQUIN for adults with diabetes (though Calderdale is in the Yorkshire and Humber regional CQUIN scheme for children with diabetes)	No LES re diabetes
Somerset diabetes service	No CQUIN scheme for diabetes	LES for insulin initiation and management for Type 2 patients since June 2010. Worth £175 for each patient started on insulin.
Wirral diabetic podiatry	No CQUIN scheme specifically relevant to diabetes	LES for management of Type 2 diabetes patients, including an element of foot care in all Wirral localities since 2008. Practices receive £10 payment per patient for managing low risk foot care.
Calderdale dementia	CQUIN for acute trust (CHFT) for early assessment and diagnosis of dementia (re: all patients 65+) since April 2011 worth 0.14% of contract – part of local CQUIN scheme worth £1.82 million across all CHFT commissioners South West Yorkshire Partnership Trust local CQUIN 2011/12 for reduction in average length of stay for inpatients with dementia diagnosis, and reduction in excess bed days (50+) for inpatients with dementia – part of contract with NHS Calderdale for local CQUINs work £295,000 in total	No LES re dementia
Somerset stroke Early Supported Discharge service	No CQUIN on the stroke Early Supported Discharge service	No relevant LES
Wirral Memory Assessment Service	Cheshire and Wirral partnership – 2011/12 CQUINs for diagnosis and assessment of dementia patients, training and support for dementia champions, reducing number of dementia patients cared for in hospital. The total potential value to CWP is c.£285,000 (or 0.45% of their contract)	No relevant LES

In addition to locally agreed quality payments for hospital care, there were a small number of nationally mandated CQUIN schemes which, from April 2012, were to include dementia CQUINs on the identification, assessment and referral of patients in acute hospitals with dementia. In any one PCT area in March 2012. CQUIN schemes total 1.5% of the income of provider trusts[111].

Financial levers allowed for some adjustment to the nature and quality of service delivery and to changing clinical behaviour. In primary care, the Diabetes Local Enhanced Service in Wirral was an example of a lever used to help to standardise practice on routine foot screening in primary care:

'But now it's mandatory. If they want to do the LES, and they are all doing the LES, then they have to do it, because prior to April 2011, some of them did and some of them didn't.[...] So then this is what they've signed up to, to do routine foot screening. And anybody they identify as at risk or high risk it has to be referred to the community podiatry service for foot screening'

PCT manager

Uncosted provision

There were two examples of uncosted service provision observed in this research (see Figure 21).These cases are drawn from sites where relational commissioning appeared to feature more strongly (see 5.1) and where the impact of commissioning was more noticeable than in other service areas studied in detail in this research (see 5.9).

Figure 21.   Examples of uncosted provision

Early Supported Discharge service for stroke in Somerset

There was no formal arrangement with the local authority to be reimbursed for their social care contribution to the Early Supported Discharge service for stroke. This uncosted provision was seen as a sign of how money moves around the system: *'it's all about swings and roundabouts, we don't get too hung up about the pennies really because in the end it all comes out in the wash'* [Local authority manager]

Wirral Memory Assessment Service

Senior clinical time was committed to the service in the first year without any cost attached: the mental health trust agreed to provide this using sessions of consultant time from existing resources. Provision for diagnostic appointments was made by booking into regular community consultant clinics with clinical supervision of staff also undertaken as part of usual work. This uncosted provision was regarded by commissioners as facilitating the launch of the service and by providers as a means of securing funding for the new service.

Short-term funding

Commissioners in all three sites were observed making opportunistic use of short-term funding to support their commissioning plans. Such funds tended to be non–recurrent and from an external source such as the Department of Health. Commissioners allied to the Wirral Memory Assessment Service showed themselves to be adept at making use of opportunistic funding when redesign services (see Figure 22).

Figure 22.   Case study of short-term and opportunistic funding enabling commissioning plans for the Wirral Memory Assessment Service

HM Treasury 'invest to save' money was secured in 2008 to support staff employed by the Alzheimer's Society and thereby ensure local dementia outreach and carer support. This was later supplemented by funding from the Third Sector Innovation fund and, given the success of the service, ultimately led to a formal contract between NHS Wirral and the Alzheimer's Society.

In September 2011, £75,000 of recurring funding was received for Memory Services as part of a wider Department of Health initiative to provide additional funding support to social care via PCTs. At the close of our fieldwork commissioners and providers had together agreed that this would reinforce their commitment to enhance the potential social care element of the new memory assessment service with plans, for instance, to include a social work post within the memory service.

5.4.3 Uncertainty about money

Commissioners dealt with considerable uncertainty about the costs of existing models of service. This uncertainty appeared to result from:

Poor coding in relation to diabetes, with treatment delivered in the acute sector to patients who have complications of diabetes potentially not coded (see 5.2.5). This was described as an on-going national problem.

Costs being absorbed into block contracts (see 5.4.2), with the costs of specific components of care for diabetes, dementia in Calderdale and stroke in Somerset not easily identifiable.

Medication costs for dementia, with a rise in total costs due to an alteration of NICE guidelines in 2011 and an anticipated reduction in cost per patient as some commonly prescribed drugs come off patent in spring 2012, commissioners in Wirral and Calderdale were left with considerable uncertainty over future costs of services.

Uncertainty of financial information was a persistent problem, with financial implications of service redesign or re-commissioning often unclear and with

commissioners compelled to continually grapple with a lack of clarity over costs.

5.4.4 Long term and short term efficiency savings

In all six service areas studied, potential cost savings were thought likely to accrue in the long-term, over five to ten years (see Figure 23). This was particularly the case for dementia and diabetes - both conditions with steadily increasing prevalence - and the emphasis was on containing costs in the face of rising demand. However, whilst commissioners often undertook reviews of the existing empirical evidence to support their commissioning plans, there was little indication of what financial savings might be realised. This was due on the one hand to the financial predictions in the existing literature being sparse and, on the other, to the diffuse nature of potential long-term savings resulting from commissioning decisions (which may extend across the whole health care system and into social care).

Figure 23.   Examples of anticipated long-term cost savings from changes to services for people with long-term conditions

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Diabetes

- reducing amputations through improved diabetes care
- increasing level of low risk foot care undertaken by nurses and health care assistants in general practice

Dementia

- increasing the number of people with dementia able to live at home for longer through, for instance, outreach, carer support and telehealth initiatives
- reducing the number of emergency admissions of people with dementia to acute care

Stroke

- increasing supported discharge and reducing hospital admissions
- reduced readmissions to hospital and less use of social care

---

In the short term, commissioners in all three sites focused on anticipated benefits in the quality of care. All PCTs were active in implementing the Department of Health Quality, Innovation, Productivity and Prevention (QIPP) programme, though to varying degrees. QIPP had the most impact in two service areas studied in this research (see Figure 24). It did not feature as strongly in Wirral.

Figure 24.   The impact of the Quality, Innovation, Productivity and Prevention (QIPP) Programme

In Somerset, PCT commissioners secured the status of the Early Supported Discharge service as one of Somerset's main QIPP programme schemes for 2011-14, which meant that additional development funding was made available for the service, to be spent, among other things, on funding a nurse to work on improving pathways and referral.

The Somerset Diabetes Service was also included in the PCT's QIPP programme, and incorporated efficiency measures into its performance management framework, which were reported on in regular Early Supported Discharge for stroke project meetings.

In Calderdale, commissioners focused, throughout this research, on work that was 'QIPPable' across the commissioning community. As a result priority was given to work capable of producing short-term savings, such as COPD and dermatology, and thereby inhibiting progress on diabetes work. Since redesign of diabetes care was likely to produce, at best, long term savings, it slipped down the agenda and *'you've got to look quite hard to find diabetes in our QIPP plan. It's implied rather than explicit'* [PCT senior executive]

5.4.5 Matching finance to demand

In two of the service areas studied – the Somerset Diabetes Service and the Wirral Memory Assessment Service - considerable work was undertaken by commissioners and providers to review and address rising demand. Both services had responded to national strategic aims to increase early diagnosis and case finding in order that interventions could be offered to patients earlier. This led to increased costs, both in terms of service provision and medication.

This on-going review of activity levels and costs fitted with the iterative approach to commissioning adopted in Wirral in particular (see 5.1)

'we've got a really, some really critical commissioning decisions to consider because…the vast, vast majority of the referrals that we see are perfectly appropriate, they will see people, they will assess them, and a high proportion of those people go on to actually end up with some form of diagnosis and therefore need monitoring and prescribed drugs as well as everything else that we're attempting to provide through the third sector in the local authority. So it's a vicious circle if you like, because the more staff that we have, if we can find the funding for those posts, the more assessments they can undertake, and they may well lead in to more people needing, you know, ongoing treatment and prescribing. So there are some commissioning, ethical discussions to be had about how we move it forward into next year'

PCT Senior Executive

Commissioners in both of these services used a combination of technical tasks (e.g. system modelling, needs assessment, see 5.2), relational work (e.g. liaising regularly with providers) and commissioning tools (e.g. business cases, iterative service specification) to inform decisions about how best to respond to demand in light of the available money.

5.5 The nature of change

In principle, commissioning is a mechanism that allows the possibility of making fundamental changes to health care provision, through de-commissioning and re-commissioning of services. This research revealed much more activity towards the incremental end of the continuum of change – cautious, carefully paced, and non-disruptive. Success seemed to come about where commissioners were tackling discrete, 'bite-sized' commissioning tasks as part of a wider local plan for service delivery.

5.5.1 Dimensions of change

The process of bringing about change through commissioning had three dimensions:

- *The scale of change*: the geographical area to be covered by the commissioning development, the provider organisations and service areas involved, and the size of the patient group covered.

- *The pace of change*: the time taken for the development to progress through all the phases of the commissioning process.

- *The degree of change*: the extent to which change represents a shift of provider (decommissioning/re-commissioning), a change in the model of care, a reduction in spending and/or a service adjustment to meet increased demand.

Table 22 below gives examples of what may encourage or inhibit change in these three dimensions. Material is used from all six service areas studied and reference is also made to NHS Kirklees, which had a role in work on the development of a strategic plan for diabetes in Calderdale (see Chapter 4).

Table 22. **Aspects of change influencing commissioning of long-term condition services – examples from across the six service areas studied**

	Change inhibitors	Change facilitators
Scale	*Working across the boundaries of an established commissioning community* Transformation work on dementia in Calderdale and across the cluster has involved trying to build new relationships across organisations which have not previously worked together. Has taken time to build these and difficulties with finding a scale that people can connect to. CCGs leading move back to more local focus for development work.	*Coherence between large scale vision and smaller scale action* Somerset Diabetes Service – overall vision for change with smaller parcels of work within it *Linking with 'footprint' of acute providers* Work designing a new model of intermediate (nurse-led) diabetes care across the footprint of Calderdale and Huddersfield Foundation Trust reduced complexity and facilitated buy-in from FT staff. *Planned phased implementation* Early Supported Discharge service in Somerset rolled out in three stages, allowing refinement of model in each patch in turn.
Pace	*Lack of staff/resources* Difficulties with progressing work on diabetes in Calderdale partly due to lack of capacity among programme management staff *Transferring staff around the health care system* Delays of c.9 months in setting up aspects of Somerset Diabetes Service because of negotiation over transfer of nurses from one employer trust to another. *Actual and perceived lack of data* Problems with the Diabetes Register in Wirral, combined with slow progress in transferring to an electronic system meant a lack of accessible data on diabetic foot care	*Dynamic leadership* Senior manager and senior clinician working together in Wirral to drive the development of Wirral Memory Assessment Service *Dedicated time from project management staff* Project manager in Somerset spent up to 75 % of her time on developing the ESD Service – moved it from outline plan to full implementation in about 4 months, and time input then reduced. *Co-operative working among professionals* Good relationships built up between clinicians, managers and commissioners involved in the Somerset Diabetes Service through regular meetings and joint tasks, e.g. writing clinical guidelines *Enthusiasm for change in practice among clinicians*

	Change inhibitors	Change facilitators
	Working across many organisations and decision structures Next steps on planning dementia transformation work across Calderdale and Kirklees have faced problems in bringing the right people together at the right time. *Technical limitations on speed of change* Wirral community diabetic podiatry services delivered under an SLA between provider and NHS Wirral which can only be changed with 12 months' notice	GPs in Kirklees were very receptive to taking up initiatives for diabetic patients such as care planning and diabetic foot care *Focus on achieving deadlines* In the month before the launch of the Wirral Memory Assessment Service in Oct 2010, rapid progress made on developing and agreeing service specification, transferring staff, finding venues, and getting costs formally agreed
Degree	*Caution about disrupting the local health economy* In Wirral shifting provision in an evolutionary way allowed commissioners of the Memory Assessment Service to minimise instability in other parts of the healthcare system *Easier/more appealing to start a new service than to decommission* New aspects of diabetic podiatry set up in Wirral without decommissioning old service *Financial constraint* Early Supported Discharge service designed to cost no more than existing model	*Financial opportunity – start up funding* £300,000 of investment from PBC budget to get the Somerset Diabetes Service set up *Engagement/buy-in from professionals and public* Enthusiasm for new Wirral Memory Assessment Service from across primary and secondary care as well as voluntary sector *Emergence of new structures and decision makers* One Wirral CCG is exercising its freedom to re-commission community podiatry service

5.5.2 Planned evolutionary change

This section focuses on the three services where the launch of a remodelled care service was observed: the two services in Somerset, and the Wirral Memory Assessment Service. All three were commissioned in an incremental manner, with the detail of service specification and contract to follow once the service had been running for a while. In Wirral this approach was referred to by commissioners as '*intelligent commissioning*' (see Figure 25).

Figure 25.   Intelligent commissioning to support the Wirral Memory Assessment Service

Commissioners in Wirral adopted what they described as 'intelligent commissioning' to develop and implement a new memory assessment service. The emphasis was less on contracting and more on using high quality data and intelligence to inform commissioning on an on-going basis as it was impossible to accurately predict demand for the service until the service was in place and utilisation could be tracked. It also allowed tracking of impact on wider aspects of the health care system, such as admission to hospital.

For the Wirral Memory Assessment Service this meant significant modelling work at the outset to establish health needs, and gaps in current services. This was followed by the development and refinement of a service model, working closely with social care, mental health providers and service users, and then the new service was specified and commissioned.

Figures for activity and costs were not written into the original service specification but were reviewed over the course of the first year of the new service. Four hundred and twenty-two patients were transferred from the previous memory clinic, and the target is 800 new cases per year added to the team caseload, with a tolerance of 10%. There is an ambition to reach a diagnosis rate of 70% of people with dementia by 2015.

At a meeting attended by CCG leads, service providers, and PCT commissioners one year after the start of the service a business case was presented. This set out service modelling, caseload, anticipated future costs and staff requirements. There was also discussion of how the service could develop to link more closely with GPs on a 'shared care' basis.

The emphasis throughout has been on "*working in partnership, joint commissioning, integrated commissioning...looking at what you need to commission much more from an intelligence basis*" [PCT Senior Executive].

A similar approach was adopted in Somerset where the Early Supported Discharge service for stroke was consciously set up with 'learning in

practice' intended to feed into and refine the decisions about how the service should be delivered:

'*I think the idea of doing it in phases has worked well. I think it would have taken us much longer to do it had we attempted to do it in one big bang, because I think the fact that we've done it on a developmental basis has allowed us to build our confidence…. use that confidence to demonstrate the benefits*.'

PCT manager

The staged build up of the Early Supported Discharge service for stroke entailed building up staff capacity in the community over a period of some nine months, whilst at the same building confidence in the service among the hospital staff who transfer patients into the service.

The Somerset Diabetes Service was also the subject of carefully paced implementation, informed by modelling of numbers before the launch in April 2010. Since then, it has been the subject of formal review every six months, which has allowed ongoing refinement to the model of service delivery.

Relational work

Shifting provision in an evolutionary way allowed commissioners working in the two Somerset service examples and the Wirral Memory Assessment Service to minimise the risk of introducing instability to parts of the health care system. A focus on 'staged change' afforded commissioners and providers time to work together and to iron out problems as and when they emerged (see section 5.1 and 5.2.1). This approach required careful and skilled management on the part of commissioners, particularly in the case in terms of relationships across the commissioning community (e.g. with providers, independent sector, service users).

Much of the change process was driven by commissioners. However, providers often had a stake in this process involving investment of time, energy and resource in service development without necessarily having any guarantee that their service would be commissioned by the PCT in the future (see, for example, Table 17).

Changing contracts

Commissioners across the three sites were aware that changing contracts – either in scale or through changing provider – could put providers at financial risk or otherwise disrupt the local health economy. Such disruption was something commissioners were cautious about. Whilst shifts in the scale of contracts were observed (for instance, in relation to delivery of diabetes care in Somerset), only one example of de-commissioning was documented in this research. In Wirral the contract for delivering a memory

clinic delivered by GPs with Special Interests was terminated on 30 September 2010, with a new service delivered by Cheshire & Wirral NHS Foundation Trust starting on 1 October 2010.

5.5.3 Large scale vision and small scale action

Effective commissioning required moving from strategic planning to implementation. Across the three sites this appeared to be one of the most challenging parts of the commissioning process requiring considerable labour (see section 5.2). As one commissioner described, this shift involved:

> '*the translation of the information and the intelligence that we developed into actual clear actions and plans...something that's coherent and doable*.'

> PCT senior executive

In the three cases where remodelled care services were launched, action seemed to be taking place in a way which was rooted in a vision for the particular service. For example, the Wirral Memory Assessment Service was introduced as part of a coherent, large-scale programme of change for dementia care involving parallel strands of work and requiring senior commissioners continually to focus on both strategic direction and practical implementation (see Figure 26).

Figure 26.   Combining strategic planning and actionable change in relation to dementia care in Wirral
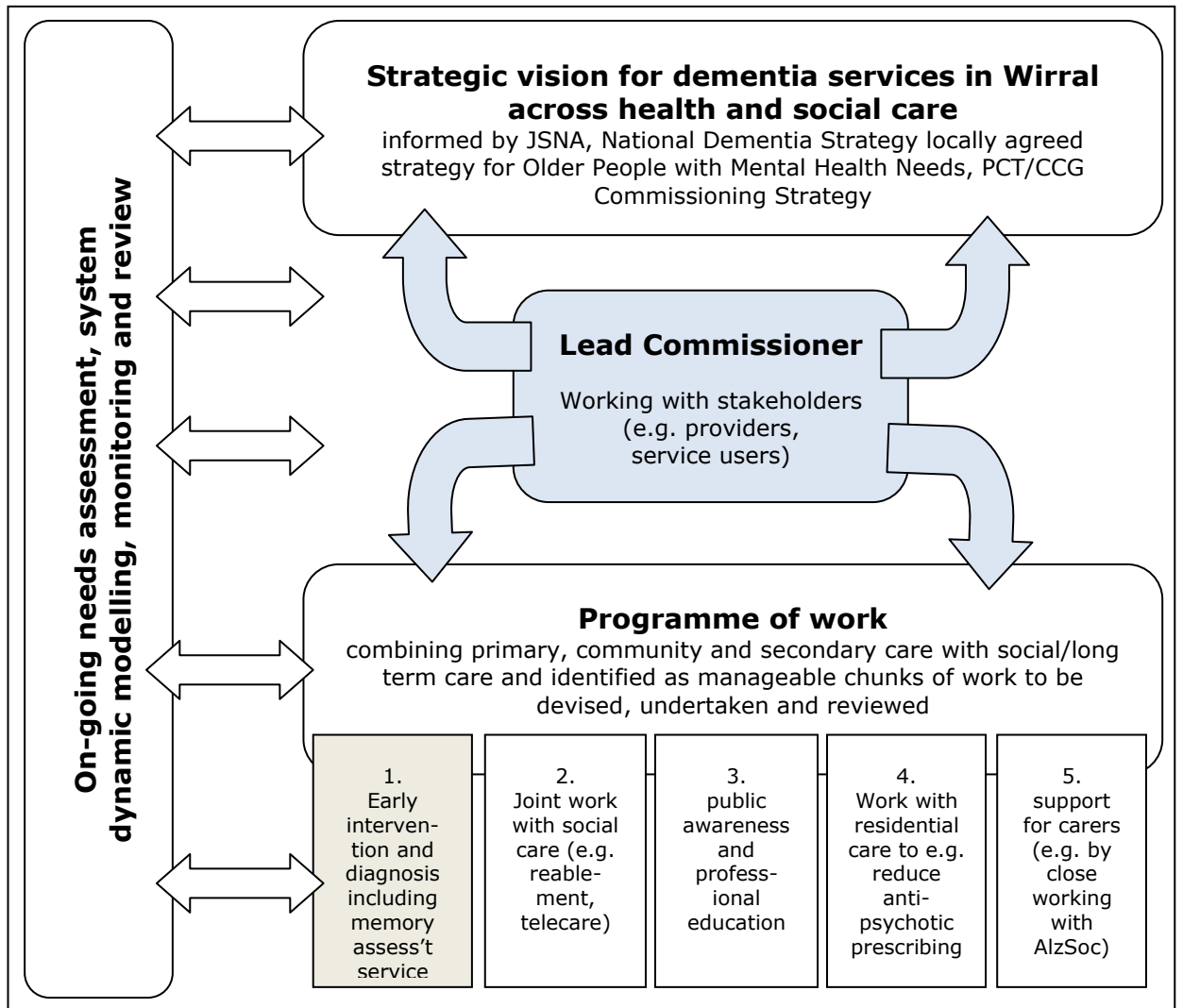
The Wirral Memory Assessment Service was only one small part of dementia provision in that locality. A similar picture was evident in Somerset (see Figure 27).

Figure 27.   Case study – linking strategy and action in Somerset

The Somerset Diabetes Service combined an overall vision to shift care out of the acute sector into the community, promoting the role of primary care in diabetes, and supporting patients to self care alongside ambitious, yet specific and actionable, and programmes of work including setting up of new community-based Diabetes Specialist Nurse teams. There was also a desire to develop and promote a patient pathway document (as guidance for clinicians); expand patient education, and establishing a Local Enhanced Service for insulin initiation in primary care.

The overall vision for stroke in Somerset was for increased public awareness of stroke symptoms, rapid diagnosis and treatment, specialist care in the acute sector, and earlier discharge from hospital, along with rehabilitation and support. The development of an Early Supported Discharge service was therefore one of a series of parallel initiatives including, for instance, redesign of care pathways within acute hospitals, increased funding for specialist clinical staff, and the provision of stroke co-ordinators working in the community. The service was designed to improve the overall stroke care pathway and, in late 2011, was reviewed as part of a broader review of all stroke services in Somerset.

Problems matching strategic vision and local action

In the case of the other three service areas studied in this research – the two in Calderdale and the Wirral diabetic podiatry service – the linking of strategic vision and local action appeared more problematic. The reasons for this broadly reflect the inhibitors to change outlined in Table 22. The following were of particular relevance:

- the strategic vision was either still under debate (e.g. diabetes in Calderdale) or in the process of being formed (e.g. dementia in Calderdale and diabetic podiatry in Wirral)

- changes on the part of commissioners were reactive, responding to specific problems around service delivery (e.g. clinician and patient complaints), rather than tied in to a broader clinical/commissioning strategy (e.g. diabetic podiatry in Wirral)

- a lack of the essential combination of senior clinical *and* managerial champions for change to lead developments, plus dedicated staff time to work on the labour of commissioning (e.g. diabetes in Calderdale and diabetic podiatry in Wirral)

- ambiguity about which geographical area the initiative was covering, and so which decision making structures and service provision it was relevant to (e.g. dementia in Calderdale)

When tracking the development of the Wirral diabetic podiatry service, it was hard to identify a clear vision or overall plan for diabetic services.

Rather, a series of small scale, piecemeal changes appeared to be taking place with little co-ordinated change to the whole diabetes service. In contrast, work in Calderdale was complex in strategic terms, because of the parallel programmes of work through the overarching transformation programme for care of vulnerable adults across the Calderdale, Kirklees, Wakefield cluster (see sections 4.2 and 4.3). While Calderdale's local dementia strategy and associated action plan did provide the combination of an overall vision with a list of tasks, it did not seem to reflect a shared vision in the commissioning community on the appropriate scale and pace of change.

5.5.4 Allowing time for change

As noted above, completing the different 'stages' of commissioning took considerably longer than the annual commissioning cycle (see section 5.1): the commissioning observed involved work stretching over several years.

The early phases of commissioning long-term condition services – focused on needs assessment, evidence review, service planning, and stakeholder discussion/agreement - appeared particularly lengthy (see 5.1). One clinical commissioner was more critical of the pace of change, questioning the process that is based on meetings and consensus whereby:

> '*it takes years and years to do anything and [...] you've got to wait for the next meeting and another month for that and another month for this*'.

Clinical commissioner

Changing clinical practice

Commissioners' role in shifting models of care was not simply about designing the service model, working out details of the how different elements of care would be provided, and arranging funding. It also entailed working with clinicians to change practice. Yet the social network analysis (see 5.8) showed that GPs may change their practice in relation to diabetes care in response to a wide range of influences, with that of primary care colleagues, and secondary care clinicians being most influential – but rarely by direct communication from commissioners.

A gradual process of change in clinical practice was observed in the two Somerset service areas. For instance, the pace of change in the Somerset Diabetes Service proved, at least in the first 12 months of the service, to have been slower than hoped for by the commissioners, despite the work which went into changing practice (see Figure 28). In contrast, Wirral

Memory Assessment Service quickly proved successful in attracting referrals from GPs despite little publicity of the new service.

Figure 28.   Case study – changing clinical practice in the Somerset Diabetes Services

New roles for specialist nurses

The diabetes specialist nurses in the community health service took on an expanded role in managing patient care, and also worked with GPs and practice nurses to educate them on diabetes care, as well as delivering patient education. Peer education was below target in the first year because of capacity issues, but built up in the second.

Changing secondary care contacts

Acute hospitals were expected to reduce the number of contacts they had with patients, which caused some concern to clinicians and managers at the start of the service: '*there was this tension between, "actually we need to pull some activity out of secondary care", which kind of came along quite quickly... suddenly, well in order to make this work we've got to take 40% out, 40% out of activity, out of secondary care. And that was always unrealistic.*' [Acute trust, clinician].

Influencing GP practice

Implementing the new model of diabetes care required GPs to change practice. The lead GP worked to influence her peers through education events and newsletters – but she was aware that new models of care would need careful 'selling' to some of her peers: '*If you tell someone "we have got to do this", then…most people were, "hang on, I'm not going to do it". And it's the same if you put out new guidelines, if you say, instead of doing this which has been done in Somerset for the last 20 years, you've now got to do that, then you do get a lot of resistance*' [GP commissioner].

Financial incentives

One of the tools for changing behaviour among Somerset GPs was a Local Enhanced Service for insulin initiation, though take up was not high in the first year (9/76 practices), with the mandatory training course thought to present a barrier.

5.6 External drivers of commissioning

External drivers played a role in shaping the commissioning practice observed in each of the six service areas. National guidance from the Department of Health or its agencies (e.g. NICE) provided impetus to get things done, as well as presenting models of what to do, setting a framework for local commissioning. The research revealed how such drivers are mediated by local circumstances and existing patterns of service provision.

5.6.1 Categories of external drivers potentially shaping commissioning

A range of external drivers was identified as potentially shaping the local practice of commissioning care for long-term conditions. These drivers fell into three broad categories: 'must do' directives; 'should do' guidance on best practice; and 'could do' support (see Figure 29). Performance management frameworks and audit regimes cut across 'must do' and 'should do' categories, as mechanisms for encouraging compliance with, and response to, external drivers.

Figure 29.   Examples of external drivers guiding local commissioning

MUST DO directives	SHOULD DO best practice guidance	COULD DO optional support
Follow policy directives, e.g. NHS Operating Framework, QIPP	Implement NICE guidance, e.g. clinical guidelines	Take up guidance/support from independent sector, e.g.Alzheimer's Society, Diabetes UK
Implement national strategies and frameworks, e.g. National Stroke Straetgy, National Dementia Strategy, National Service Framework for diabetes	Take up best practice pathways/models of care, e.g. from NHS Diabetes, NHS Institute, Royal Colleges.	Accreditation e.g. RCP Memory Assessment National Accreditation Scheme
Make changes following inspection and quality assessment visits,	Implement national targets, e.g. waiting times	National evaluations or pilots, eg DIabetes Year of Care, Care Services Efficiency Delivery programme, Diabetes Year of Care pilot
Follow NICE technology appraisals	Use online data resources, eg. National Diabetes Information Service to identify examples of good practice and access performance data	Health profiles and information resources e.g. Diabetes Community Health Profiles, Public Health Observatory data
Implement and monitor performance fand incentive frameworks e.g. Qualiy and Outcomes Framework, local CQUINs	Implement local CQUIN schemes and LES	

The number of external drivers to which it was expected that local commissioners would respond appeared overwhelming. Some were generic in scope, but most were specific to the particular long term conditions we were tracking.

5.6.2 'Must-do' drivers

The category of 'must-do' drivers refers to those directives which have a mandatory status and originate with the Department of Health, or related statutory bodies. 'These informed commissioners of what they needed to do and when and included:

- Overall strategic priorities and direction (e.g. the annual Operating Framework for the NHS, national strategies for specific services)
- Clinical aspects of care, including medication (e.g. NICE guidance)
- Standards and requirements around quality improvement and efficiency (e.g. material from the NHS Institute for Innovation and Improvement, guidance from the national QIPP programme)

For each of the long-term conditions examined– diabetes, dementia and stroke - a single national strategy [30,60,54] shaped the work of the PCTs, guiding them towards relevant research evidence, objectives and recommendations for service development, commissioning, and implementation plans.

By their very nature, 'must do' drivers were relevant to all commissioning communities. However, the local response to them varied, as would be expected in a system of devolved local commissioning. 'Must do' drivers often set timescales for commissioning work. For example, in Somerset, a directive from the Department of Health (mediated by the Strategic Health Authority) expedited the establishment of the Early Supported Discharge service for stroke: whilst local discussions had been on-going for two years, commissioners were rapidly required to meet national expectations for early supported discharge.

As well as informing commissioning, external drivers could have a role in legitimating existing commissioning plans. For example, the National Dementia Strategy was published two years after work on the Memory Assessment Service in Wirral began and was a welcome affirmation for commissioners of their plans and achievements.

5.6.3 'Should do' drivers

'Should do' drivers were used extensively in the service areas studied (see Table 23), reflecting the wide range of best practice guidance that is available to commissioners. For example, the National Diabetes Information Service website[112] alone provides a gateway to 21 commissioning tools and 19 supporting documents.

Table 23. **Examples of 'should do' drivers shaping local commissioning**

Driver	Example
Clinical Guidelines	**NICE clinical guidelines:** advice from the National Institute for Health and Clinical Excellence on the most effective forms of treatment, based on evidence review. Includes, for example CG10 and CG119 on the delivery of high quality foot care for diabetic patients.
	Map of Medicine: Online resource of evidence based care pathways for 300 conditions, including diabetes, stroke and dementia. Commercial product but free access available to NHS staff via website of NHS Institute for Innovation and Improvement[113]
	National Clinical Guidelines for Stroke (2006): published by the Royal College of Physicians – recommends implementation of Early Supported Discharge services
Toolkits	**Dementia Commissioning Toolkit :** published in July 2011 as a resource for commissioners to use, if they wish, to support the process of commissioning dementia care
	Audit commission Diabetes Costing tool: This profile provides those involved in commissioning and delivering care for people with diabetes with an overview of spend on key areas of the care pathway. It can be used to help identify potential scope for improving efficiency and effectiveness of treatment.
	NHS Diabetes *Commissioning Diabetes Foot care Service* describes key features of good diabetes foot care, information on the key actions/intervention needed to provide effective and efficient care, and gives a template for service specification
Performance management frameworks and dashboards	**Diabetes E** is a standardised, web-based self-assessment quality improvement tool, provided jointly by NHS Diabetes, Diabetes UK, and NDIS.
Good practice examples/evidence review	**Yorkshire and Humber Improvement Partnership** published a handbook of good practice in dementia care across the region
Audits and self – assessment framework	**Accelerated Stroke Improvement Programme**: A Department of Health programme, introduced in 2010, to provide 'renewed emphasis and urgency' to the existing Stroke Improvement Programme. Audit category (ASI9) introduced in 2011/12 relating to the access to and availability of Early Supported Discharge services

There was variation in the way that commissioners chose to respond to these 'should do' drivers and differing degrees of success in terms of using such guidance (see Figure 30).

Figure 30.   Case study: Consensus report on Early Supported Discharge for stroke and the development of the service in Somerset

A consensus report on the best way to run an Early Support Discharge service for stroke (staffing levels, type of intervention etc), was produced by the Nottinghamshire, Derbyshire, and Lincolnshire Collaboration for Leadership in Applied Health Research and Care (CLARHC), drawing on evidence and expert opinion. It was not mandatory, but proved to be an influential good practice guide promoted by the Department of Health in 2011, and was cited in the Accelerating Stroke Improvement programme.[103] The consensus report was publicised after the ESD service development in Somerset had already started. The Somerset ESD was found to deviate from the CLAHRC guidance in a number of minor ways and one major one, namely that it recommends that a service should be run as outreach from an acute hospital, whereas the Somerset ESD is run as in-reach from community hospitals. The consensus report formed the basis of much of the discussion at Somerset's workshop on future developments of the ESD service in August 2011, where those attending were invited to discuss the applicability of its recommendations to Somerset. Responses were written up and fed into the formal review of the Stroke Pathway towards the end of the year. It remains to be seen if the model of provision will change as a result.

The time required to identify, read, interpret and then put into practice these (and other) external drivers was extensive (another element in the 'labour of commissioning'), with selectivity necessary on the part of commissioners. Where there were problems with staff capacity – as, for example, in the Calderdale diabetes work – it was unsurprising that 'should do' drivers perhaps featured less than in say Somerset, where there was more dedicated staff time available to the commissioning of diabetes care. The more reactive approach to diabetes commissioning in Calderdale could also account for less evident use of these 'should do' drivers'.

5.6.4 'Could do' drivers

'Could do' drivers provided a source of optional support, advice or practical help which commissioners could access to assist them in their work (see Figure 29). In all three sites there were examples of resources from national support organisations that had helped commissioners in their role (see Figures 15 and 31.

Figure 31.   **Case study of Diabetes Year of Care in Calderdale**

From 2007-2010, NHS Calderdale, NHS Kirklees and the Calderdale and Huddersfield Foundation Trust formed one of three national pilot sites for the Year of Care project, which was a partnership between Diabetes UK, National Diabetes Support Team, the Department of Health and the Health Foundation.

The project had two components: the first was about primary care working with patients on structured care planning and shared decision making, and the second was about ensuring a choice of local services.

In Calderdale, the target number of three practices signed up, though one dropped out and GPs struggled to recruit patients to the pilot in the remaining two. The initiative did not spread beyond the initial practices, unlike in Kirklees where the majority of practices adopted this way of working, perhaps encouraged by a financial incentive scheme. In Calderdale, according to the Year of Care report, effort from local co-ordinators was undermined by a lack of clear vision from the PCT board and a lack of a whole service pathway for diabetes.[114]

A reduction in the availability of external organisational support for commissioning was noted. For example, both the Department of Health Care Services Efficiency Delivery programme (a key impetus for the initial work developing the Wirral Memory Assessment Service) and the Yorkshire and Humber Improvement Partnership (whose work informed the dementia planning in Calderdale) came to an end in March 2011.

In some cases, making use of external drivers required funding. For instance, NHS Wirral funded the provider of the Memory Assessment Service to undergo the Royal College of Psychiatrists' Memory Services National Accreditation Programme, allowing for formative development of the service, external peer review and, ultimately, an early quality maker for the service.

5.6.4 Working with existing local patterns of provision

External drivers generally provided a useful framework for commissioners. However, this research identified a number of mediating factors that commissioners needed to account for when implementing specific guidance or directives, whether drivers were 'must do', 'could do' or 'should do'.

National guidance, by its nature, tended to promote standardised models of working. It was observed how these were interpreted and fitted to local circumstances: geographical boundaries, previous history of primary care-led commissioning, existing hospital configuration and demography all played a part. The single biggest factor shaping how external drivers unfolded in local commissioning was existing patterns of service provision: in other words, who was already providing what care, how and where.

The impact of structural reorganisation following publication of the 2010 NHS White Paper, and the drawing together of PCTs into 'clusters' brought these local mediating factors sharply into focus. This was most evident in Calderdale where three PCTs merged into a 'cluster' and services started to be planned on this wider geographical basis, as was seen for dementia.

In relation to diabetes care in Calderdale, there had been some discussion of copying a model of community based diabetes care from one locality in neighbouring Kirklees, which shared a single acute provider with Calderdale, but had a different model of provision for community services. However, it was not proving easy to transfer a model of care from one location to another, because of the challenges raised by having to fit in with existing patterns and structure of provision. This importance of the configuration of existing services was explained by one respondent as follows:

> '*There's always a core pathway around your acute provider with some flexibilities around a local delivery depending on your community services and your skills available and so on. [Community services] are commissioned differently. They are paid differently for different things, so you can't just standardise, it's difficult. You trip over these knots all the time....Community matrons work differently, the district nurses work differently. The referral processes are different*.'

> PCT manager

5.6.5 Balancing local and national priorities

In all three sites, commissioners had to find the right balance between local and national priorities. However, national and local priorities were not necessarily inconsistent and commissioners (along with their partners in provider trusts and local government) clearly had scope to identify those service areas where active commissioning and redesign of services could take place. For example, the work on the Somerset Diabetes Service appeared to have been a 'bottom up' initiative, reflecting ideas coming from GP practices. These ideas in turn influenced the priority setting of the local practice-based commissioning consortium:

> '*And then they* [the PBC consortium] *had recruited, they'd got all sort of 75 practices involved, and they sort of asked them – 'so what do you want to do next?' And I think, slightly to their surprise, they said diabetes.*'

> Acute trust clinician

The increasing role of GPs in commissioning may present new challenges when balancing national and local priorities. This may be particularly the

case in areas where PCT clusters have created new alliances of commissioning and provider managers (and in particular clinicians) who have not previously worked together:

'*I sit on lots of groups and meetings where there's a Kirklees GP and a Calderdale GP and they have very different viewpoints and that is always going to make it...you can't do a one size fits all*.'

PCT manager

5.7 Working in a context of uncertainty

This study took place at a time when significant changes to the organisation and structure of the National Health Service were taking place. Work was under way to establish new clinical commissioning groups (CCGs) with new support organisations, delegate large health care purchasing budgets from PCTs to CCGs, move the public health function from PCTs to local government, set up new local health and wellbeing boards to guide joint commissioning, form 'clusters' of PCTs, and establish new 'Healthwatch' structures for public and patient involvement. PCTs were in the middle of this structural change, and were losing many management staff, with those remaining assuming broader roles. The extended and contested passage of legislation to implement the proposals in the 2010 NHS White Paper provided additional uncertainty.

5.7.1 The impact of health service reforms on PCTs

The NHS reforms played out differently in the three sites. In Somerset and Calderdale, single clinical commissioning groups were formed, bringing together all the GP practices in the area. In Wirral, GPs initially formed three separate CCGs, although in March 2012 it was announced that the three CCGs were to merge into a single borough-wide group

Wirral moved into a cluster with three other PCTs in June 2011, with Wirral PCT's former chief executive taking over as chief executive of the cluster. Calderdale PCT 'clustered' with two neighbours (NHS Kirklees and NHS Wakefield), under the leadership of the former chief executive of NHS Kirklees, following the departure of the NHS Calderdale chief executive for a new post some months earlier. Somerset's 'cluster' consisted of NHS Somerset alone, and so continuity was maintained, with the same chief executive and senior management team.

Senior managers in the PCTs reported spending a significant proportion of their time on implementing reforms to commissioning, as illustrated here (in February 2011):

'my job has changed absolutely and entirely in the last six months, I focus more or less 100% of my time now on transitional issues and have been doing probably since the autumn and by transitional issues I would include delivering the community trust into a separate form, working with the GP commissioners to develop their support arrangements, working with public health and the local authority to think about how we're going to position those.'

PCT senior executive

The programme of reforms was described by senior managers and clinicians as being particularly complex, and unlike anything they had experienced in previous NHS reorganisations. As one PCT senior executive said:

'we're just finding, even in the PCT, that even, not all the senior management can keep all this complexity in their heads'.

Participants also noted the particular pressure of having to handle major organisational transition at the same time as new limits were placed in NHS funding:

'Well I think we are going through this cultural change where we've been in a system which has been getting, you know, 10% growth, and I think, I don't think that message has got through to everybody yet. And so I think that's, that's a big part of kind of what's going on at the moment, I think, and changing people's expectations, changing their view about how things are going to work in the future...a lot of my time, I think is now being spent dealing with the implications of those sort of changes.

PCT senior executive

The complexity of the changes was summed up by one PCT executive as 'managing in a vacuum':

'So I think we're in a very sort of murky, foggy area at the moment and it's quite difficult to see any sunshine'.

5.7.2 The shift to GP-led commissioning

The shift from commissioning by PCTs to a system where GPs would hold budgets and lead the statutory commissioning organisations was the central focus for senior managers and clinicians interviewed. In the spring of 2011, some participants reported that PCTs were seeking to involve GPs in meetings about the commissioning of services, clearly viewing this as an important precursor to full-blown GP commissioning:

'I would hope…that we have much stronger clinical commissioning, so we've done quite well with it. So we've had GPs involved in all our programmes. But there's nothing like it being their budgets.'

PCT senior executive

At the same time, managers were being seconded from PCTs to work within fledgling GP commissioning groups, helping them to set up governance structures, and to start the process of developing commissioning plans:

'We've worked through what the board structure should be for the interim GPCC and the first…interim GPCC board meeting happens next Wednesday. Everybody is recognising that it's an interim board and that that board is unlikely to be what the final board is, that will be authorised to be the GP Commissioning Consortia, because we just don't know enough about what the accountability arrangements are going to be'

Non-medical CCG manager

In each of the three PCT areas studied, plans to develop new CCGs were well under way in early 2011, and by the autumn, groups had fully functioning boards, along with executive arrangements for involving local practices in their planning and service development work and they were in the process of receiving delegated responsibility for some or all of the PCT commissioning budget. One reason for this apparently enthusiastic embracing of plans for clinical commissioning was that some local GPs reported having wanted to assume what they perceived as 'real' responsibility for primary care-led commissioning for a long time. As one clinical commissioning group lead GP noted:

'when we had the opportunity to do GP commissioning, I was one of a number of voices saying, 'We've got to do something different, for ten years we've just recreated the bureaucracy that the last reforms were trying to get rid of, have we really got an opportunity to do that this time?'

GP clinical commissioning group lead

 The move to GP-led commissioning was frequently reported as a positive development, being seen as 'going with the grain' of national policy and the desire of local GPs. However, concern was aired about the cost to the NHS of funding such GP involvement:

'Because of the expensiveness of that time it's going to be a massive, massive figure which we are not spending in commissioning at the moment. We don't have a budget for that, and it will be several hundred thousand. But once we start paying all these board members, the board doesn't do the clinical commissioning, the board just does what a board does, there is going to be a massive cost within this system'

PCT senior executive

As well as the issue of the cost of paying GPs to 'do the work of commissioning', participants reflected on how far GPs were doing commissioning in a manner that differed from that of the PCT managers who had gone before them. One PCT senior executive explained how the process of negotiating contracts with local trusts was operating in the autumn of 2011:

> *'I used to lead this with* [the PCT director]. *It's now led by the CCGs, with me in the shadows offering comment and advice'*

Involvement of GPs 'at the negotiating table' of the strategic contracting process for 2012-2013 was a theme across all three sites, with GPs' involvement moving from 'presence at meetings' to more central engagement in the business of commissioning.

In the later stages of the research, GPs were observed being drawn into the 'labour of commissioning' previously the domain of PCT managers. For example, one GP clinical commissioning group lead noted:

> *'We are like the PCT I think. If you look back in the history as* [practice-based commissioning group] *we were quite often accused by certain members in primary care of being just like the PCT. Now we realise we have to be just like the PCT in terms of the functions. Maybe not the responsiveness or the communication style and the rest of it which was probably an irritant to primary care, but actually to take on commissioning responsibility and take on £700 million budget. We've got to have the same checks and balances as the PCT does'*

This tension between having to do the work that the PCT previously did, and wanting to be somehow 'different' and more responsive to primary care colleagues, was a theme common across the three sites.

While the transition in Somerset and Calderdale was to a single CCG, in Wirral three distinct CCGs were preparing to take over responsibility for commissioning (although it subsequently turned out that they were to form a single CCG with three constituent local consortia, after the conclusion of fieldwork for this study). From early in 2011, the three Wirral CCGs were each beginning to set their own priorities and make their own choices in service delivery. For example, two of the three Wirral CCGs decided to decommission professional development nurses, one of whose roles had been to train practice nurses in foot screening and referral for diabetic patients.

5.7.3 The challenge of clinical commissioning to local partnership working

Caution was expressed about clinical commissioning in respect of the potential impact on established partnership working and joint commissioning across health and local government. Respondents talked about the strong relationships that had been built up across PCTs, local councils, and other organisations over five years or more, allowing strategic commissioning for groups such as people with dementia.

These relationships were thought to be under pressure as a result of the wider changes to NHS organisation. This was on account of the emergent nature of GP commissioning and the time it would take to become established, and it was assumed by a number of respondents that GP commissioners would focus initially on the clinical services closest to their own experience, taking longer to engage in wider joint commissioning. As one council senior manager noted:

> 'the professional orientation of general practitioners, in fact, like the head teachers, makes it unlikely that they will collaborate in the way that an overarching borough body, like the local education authority or PCT or whatever might have done, with overall authority. I think we will atomise it and I think that the council will be having to devote a lot more effort into getting the relationships and the joint commissioning to work.'

> Council senior manager

Challenges were already being felt to other aspects of partnership working. Patient and user organisations reported finding it increasingly difficult to keep 'a foot in the door' with commissioner organisations, as long established contacts were moved to different roles or simply had less time available to maintain links.

5.7.4 Impact of health care system reforms on the labour of commissioning

Despite the dominant nature of NHS organisational changes in 2011 and 2012, it was striking to observe the extent to which the 'labour of commissioning' continued. The annual cycle of business planning, contracting with providers and negotiation of the financial envelope for the coming year was a major preoccupation for PCT cluster executives and GP commissioners in the autumn/winter of 2011-2012, as was the concern about delivering on national commitments to the QIPP (NHS efficiency) programme.

GP Commissioners

Local managers and clinical leaders were clear about their role in 'keeping the show on the road,' new clinical commissioners were being drawn into to the work of the PCTs. For PCT executives, this was reported as being about the GP commissioners 'learning the ropes':

> *'I think there are a few that are starting to sort of appreciate what challenges, which probably even they wouldn't have done a few months ago. I think we're making progress, but it is an enormous, enormous learning curve for them'*

> PCT senior executive

GP commissioners likewise acknowledged the learning that needed to take place, and reiterated what they saw as the potential to bring their perspective and experience to the business of commissioning:

> *'It's* [contract negotiation and monitoring] *a different feel than many of the* [former practice-based commissioning] *meetings. It's a very different skill, isn't it? It's very much learning process. Personally, I enjoy it. But I enjoy the challenge of that kind of thing, and that's a personal thing. So it is, I suppose, challenging, nerve-racking in that sort of way, but personally I enjoy that, yes.'*

> GP clinical commissioning group board member

Commissioning support

GPs interviewed in this research expressed concerns about how the necessary management and analytical support would be made available within new structures. In all three sites, early retirement and voluntary redundancy schemes operated in 2010 and 2011, and along with the loss of staff to new posts in provider trusts, this left gaps which the remaining PCT staff were stretched to fill. In Wirral, the workload for remaining staff increased as a result of having to liaise with three emerging CCGs, each with apparently different priorities and ways of working.

In Wirral and Calderdale in particular, the research identified a negative impact on staff as a result of the loss of colleagues, a range of new tasks generated by the transition process, and the unsettling uncertainty about the future, with work on service development being slowed down:

> '*At the moment, people are so disillusioned, it's really taking the focus away from the day job...We're busy trying to develop a specification for our commissioning support offer. So again a lot of what PCT staff are doing is not the day job as such, it's some of the transitional work that needs to be done as part of closing down the PCT and CCGs taking over.*'

PCT manager

Research fieldwork took place alongside the operational roll-out of national commitments to extending the choices people have over their healthcare. These developments were felt particularly in Wirral, and had a direct impact on the labour of commissioning (see Figure 32). This new stream of work created considerable uncertainty and potential variation as well as potentially multiplying the labour involved for the commissioning support staff in Wirral.

Figure 32.   Case study – extending patient choice in Wirral

In Wirral, three CCGs had formed in 2011, and this was observed to be having an impact on the technical tasks of commissioning. As 'commissioning support', the PCT worked with all three CCGs. For example, the PCT responded to a request from one of the CCGs to develop a new specification for community podiatry, based on recent Department of Health guidance[102] and with a view to extending patient choice to Any Qualified Provider.

This new stream of work involved: gathering evidence about diabetic podiatry services; reviewing current provision; and developing a service specification. The intention was for the lead CCG to re-commission the service from Any Qualified Provider. The other two CCGs were planning on considering the new specification, amending it as appropriate to the needs of their population, and implementing it as a contract variation with the existing provider (see Chapter 4).

This was however superseded by the decision to merge the three Wirral CCGs into a single organisation, but the interaction of national policy on choice (Any Qualified Provider) and local commissioning remains a challenge for CCGs.

5.7.5 The provider perspective on reforms

The planned NHS reforms appeared to facilitate a shift to a more contractual model of commissioning driven by the CCGs (at least for small-scale services), and a loss of some of the relational aspects of commissioning which previously characterised work with PCTs. For providers, one reading was of the reforms as an unpleasant disruption. For instance, a secondary care clinician working with the three Wirral CCGs described how moves were afoot to change commissioning patterns locally, in a way which seemed a big shift from the previous style of relationship between commissioner and provider:

'We were with four different consortia and one of them wants to do things very differently. Already we have had approaches to decommission services and there's no talk between them and us, it was as a letter out of the blue: "We want to decommission this", you know, things not necessarily following process either. Then we've got two consortia saying, "Oh no, we want to do one thing" and one consortia saying "We want to

do another". So that's causing a lot of disgruntlement amongst quite a few people at the moment [...]. As secondary care we have to react.'

Provider trust clinician

A more positive perspective was presented elsewhere, by a manager from another mental health trust in Calderdale who saw the ambiguity in who was currently leading commissioning as an opportunity:

'one of the things that is apparent is that there is opportunity for provider-led innovation. Now I'm not a big fan of provider-led innovation, which is all about the old days of 'we are businesses'...But provider-led innovation around system reform that gives us a greater resilience as the whole system, around collaboration, I think there's a big opportunity.'

Acute trust, senior executive

5.8 Social network analysis of GPs' diabetes practice

In each of the three PCTs, all GPs were surveyed about the sources of information for their clinical practice in treating diabetes, and the factors influencing any change to their practice. This was intended as a way of offering another angle on the way in which commissioning for long-term conditions is enacted, and in particular how GPs gain and use knowledge when considering a change to their clinical practice.

5.8.1 Response rate

The overall response rate to the social network analysis survey of GPs in the three sites was 20.9%, varying from 44.4% in Calderdale to 16.0% in Somerset (see Table 24), from a range of large and small practices.

Table 24. **Number and percentage of responses for all three PCTs**

PCT	No.	%
Calderdale	56	44
Somerset	67	16.0
Wirral	43	17.1
Total	**166**	**20.9**

5.8.2 GPs' reported interest in diabetes

26.5% of respondents reported a particular interest in diabetes, and 18% reported seeing diabetic patients from other doctors in their practice. 14% reported being involved in service redesign and/or in commissioning. These proportions differed slightly between the three PCTs, as summarised in Table 25 and illustrated in Figure 33 below for all three PCTs combined.

Table 25. **Respondents from all three PCTs with a clinical or developmental role in diabetes care – number (percentage)**

	All areas	Calderdale	Somerset	Wirral
Interest in diabetes	44 (26.5%)	16 (28.6 %)	18 (26.9%)	10 (23.3%)
Involved in commissioning diabetes care	11 (6.6%)	5 (8.9%)	4 (6.0%)	2 (4.7%)
Involved in service development of diabetes care	24 (14.4%)	8 (14.3%)	3 (4.5)	12 (27.9%)
Sees diabetes patients of other GPs in own practice	24 (14.4%)	8 (14.3%)	3 (4.5%)	12 (27.9%)
Sees diabetes patients of GPs in other practices	8 (4.8%)	2 (3.6%)	2 (3.0)	4 (9.3%)

Figure 33.   Percentage of respondents with a clinical or service development interest in diabetes care
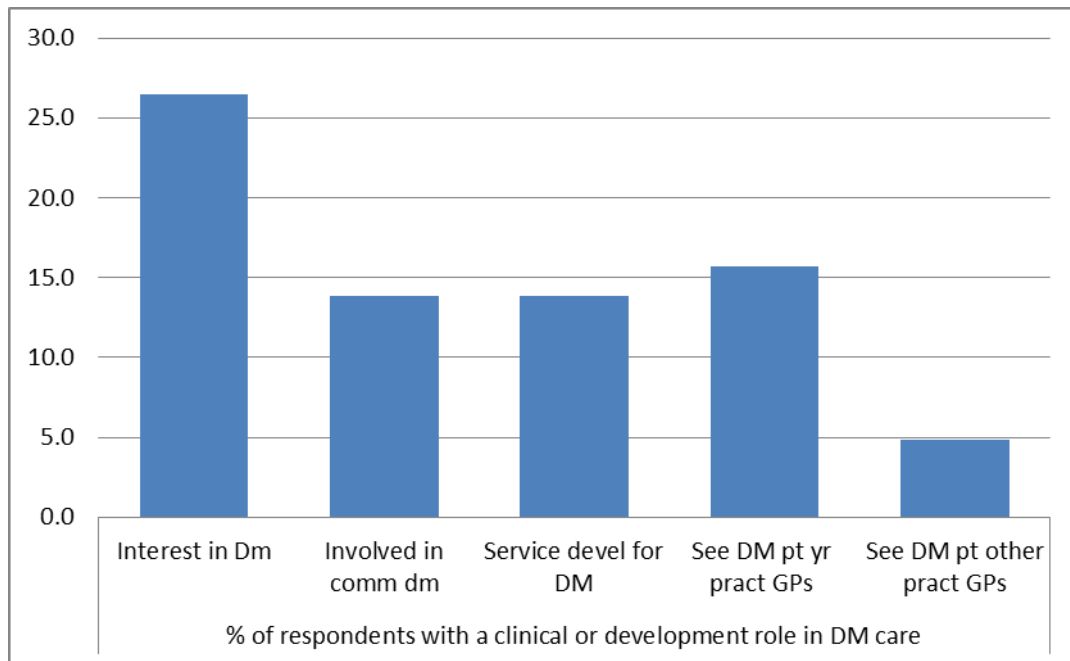
5.8.3 Sources of support on diabetes care

GPs were asked an open question about who they would turn to for advice about a complicated patient. The most common responses were a GP or practice nurse colleague in their own workplace; a diabetic specialist nurse; a named hospital consultant. People in PCT roles were nominated by very few respondents, although GPs with a PCT lead role in diabetes *were* nominated in their wider roles as a GP with special interest in diabetes or as a practice colleague.

The next three questions asked more specifically about which people, during the last 12 months, had enabled GPs to improve their knowledge about a) self management support b) new diabetic medications and c) insulin initiation. Figures 34-36 show the percentage of respondents who reported being supported by different categories of person across all three PCTs.

Figure 34. **People enabling improved knowledge of self-management support by % of respondents nominating each category of person. All three PCTs**
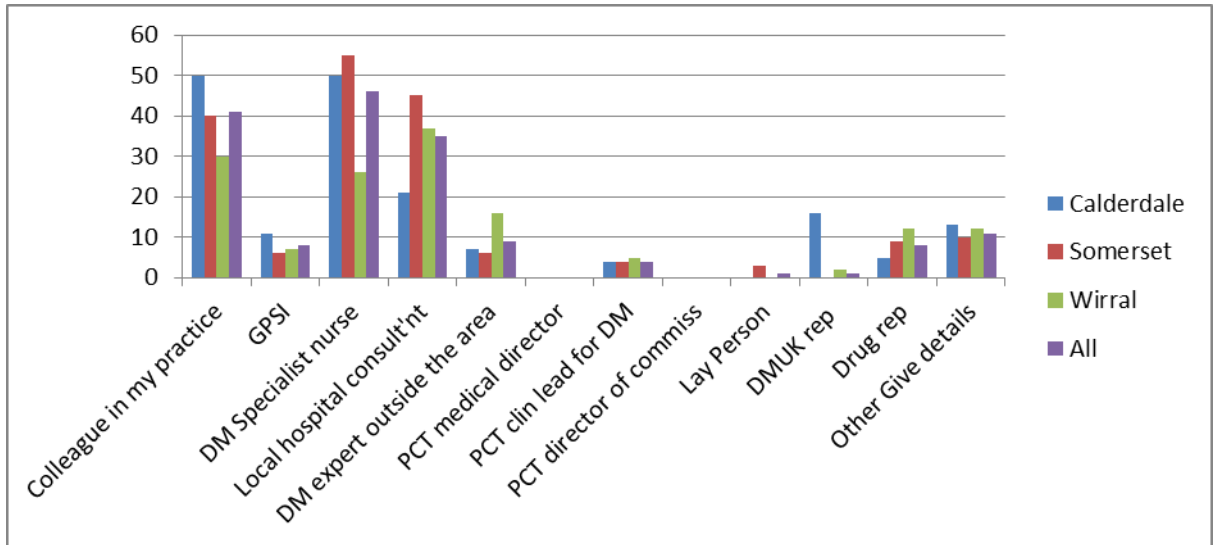
Figure 35. **People enabling improved knowledge of new medications for diabetes by % respondent nominating each type of person. All three PCTs**

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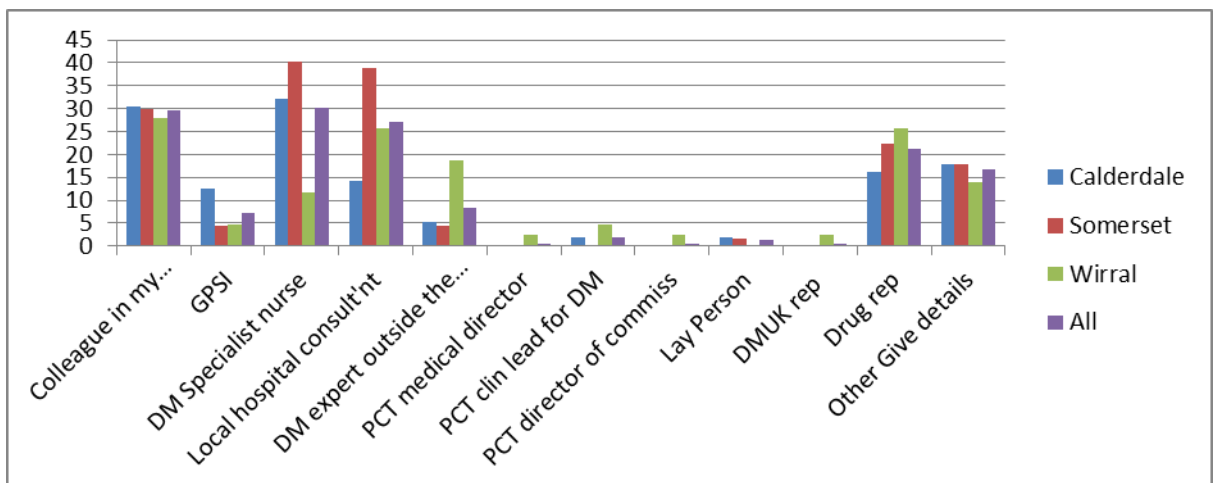
Figure 36.   People enabling improved knowledge of insulin initiation by % of respondents nominating each category of person. All three PCTs
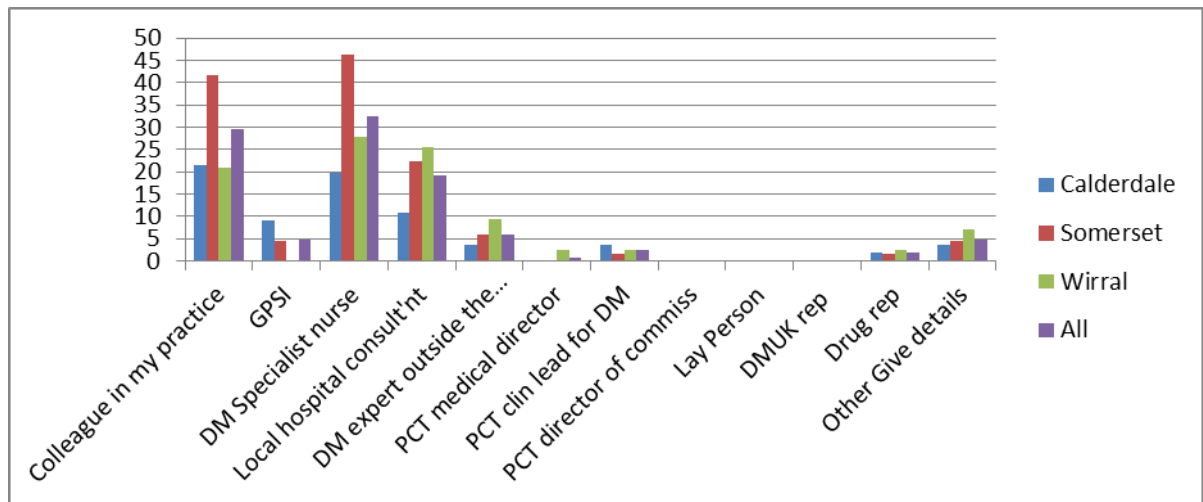
The results suggest that diabetes specialist nurses play an important role across all three areas of diabetes care, particularly in Somerset where an extensive, specialist nurse-led intermediate service had been commissioned. The proportion of GPs in Somerset reporting that diabetic specialist nurses had helped them improve their knowledge (55% in relation to self-care, 40% in relation to new medications and 46% in relation to insulin initiation) was consistently higher than the proportion reporting turning to a colleague in their practice (40%, 30% and 42% respectively).

Support from diabetic specialist nurses was also widely reported by Calderdale GPs (by 50% in relation to self-care, 30% in relation to new medications and 21% in relation to insulin initiation) and they turned to their practice colleagues in identical proportions. Diabetic specialist nurses were least likely to be reported as supporting knowledge improvement in Wirral (26% in relation to self care, 12% new medications and 28% insulin initiation), where GP colleagues and hospital consultants were the most frequently reported groups supporting knowledge improvement on the part of GPs.

5.8.4 Changing clinical practice

The proportion of GPs (all sites) reporting that they had changed their practice in relation to each domain of care over the previous 12 months is shown in Figure 37 below. Even where a GP had received support to improve their knowledge in one of the three domains of care, this did not necessarily lead to a change in clinical practice. For example, 147 respondents (89%) nominated at least one person as having helped them

improve their knowledge in relation to self-management support, but only 54% reported having changed their practice in this domain.

Figure 37. **Percentage of respondents who changed their practice in relation to self management support new medications and insulin initiation in the previous year**
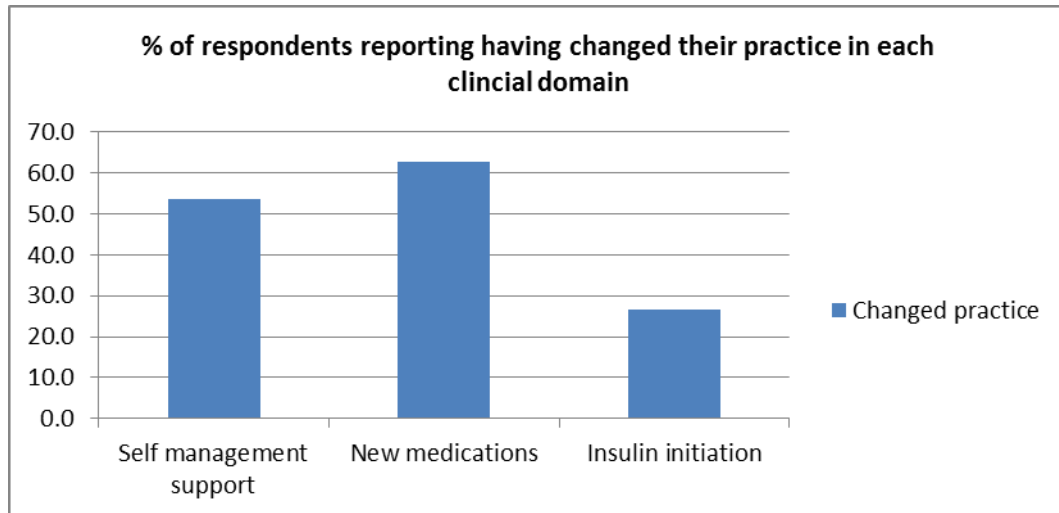
5.8.5 Resources contributing to improved knowledge of diabetes services

GPs reported using a wide range of resources to improve their knowledge of diabetes, with local education courses and NICE guidance most commonly mentioned across the three PCTs (see Figure 38). On-line resources including education modules and the commercially available online resource *GP Notebook* were also widely used. The *British Medical Journal* was mentioned by approximately 20% of respondents, with the journal *Prescriber* and the British National Formulary also cited as written sources of knowledge. Prescribing guidance and letters from hospital doctors were each mentioned by around 20% of responders.

Figure 38. Percentage of respondents reporting use of each resource by PCT
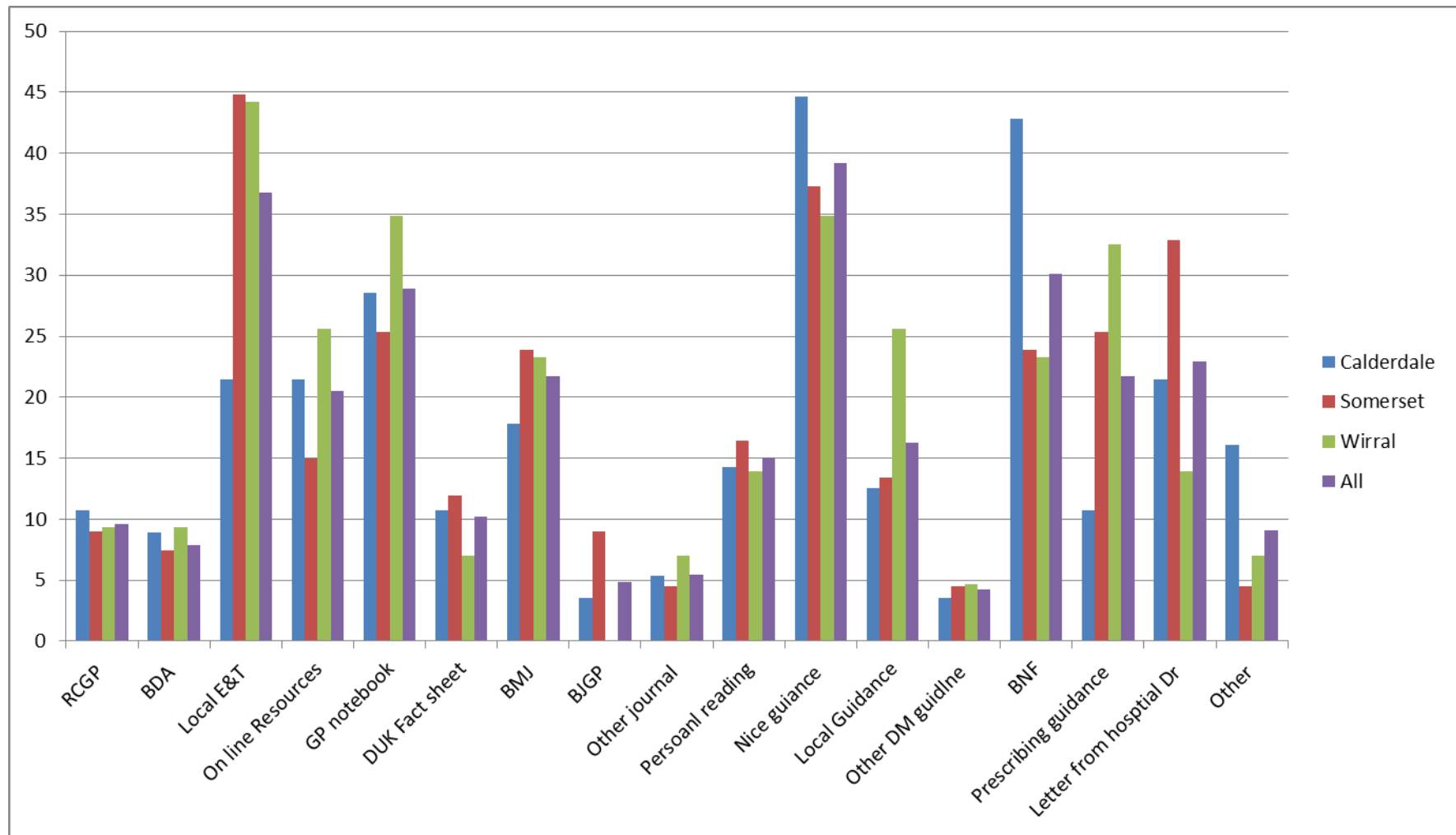
5.8.6 Network analysis in Calderdale

Data from Calderdale, the area with the highest response rate, were used to construct a social network map showing which clinicians were reported as having helped improved GPs' knowledge about diabetes care. Responses nominating hospital consultants or others from outside Calderdale were not included.

Eight GPs were named as sources of knowledge, though two of those did not describe themselves as having a particular interest in diabetes care. In most cases, it was GPs within their own practice who were using them as a source of knowledge. Diabetes specialist nurses and consultant diabetologists were both widely cited as sources of knowledge, and the map suggests that there are strong relationships between particular clinicians and groups of GPs in a practice.

In only four practices were responses received from all the practice's GPs, so the relationships and clusters around specific GPs depicted below are incomplete.

Figure 39.   Key to social network map:

A square represents a clinician who was named as a source of advice and information on diabetes.

A circle represents a GP who named others as a source of advice and information on diabetes.

Numbers 1 to 19 represent the practice in which responding GPs work, and the letters differentiate GPs in the same practice. So, for example, 9a, 9b and 9c are all GPs working in the practice.

☐ 101 – 106 Diabetic specialist nurses
☐ 501 – 503 Consultant diabetologists

Three GPs (5a, 17b and 19c) have both a square and a circle, since they were named as sources and also named others as sources of information and advice. 'Missing' numbers arise (e.g. 11a) if a GP from practice 11 responded to the survey but did not report seeking advice from anybody.

GPs who reported that they had a particular clinical interest in diabetes are shown with a green circle or square. GPs who reported that they did not have a particular clinical interest in diabetes are shown in red.

Figure 39: Network map of relationships that have are reported to have helped improve knowledge about diabetes care in Calderdale

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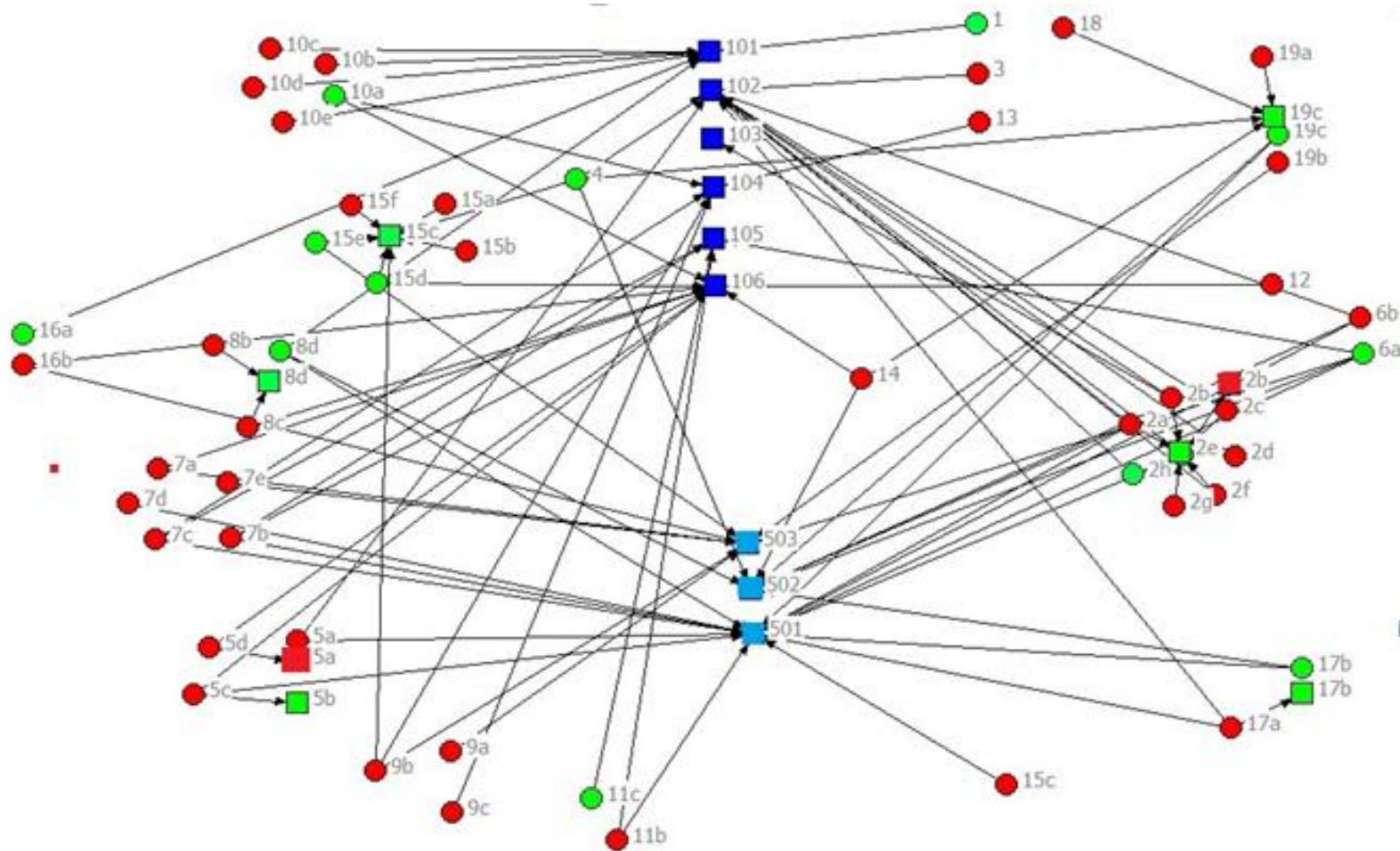
5.8.7 Social network analysis results in the context of the study

Only a small proportion of the GPs who responded to the survey were involved in commissioning diabetes care, but more than twice as many identified themselves as taking an active part in service developments around diabetes, perhaps in the kind of role described in earlier sections of this chapter as one relational aspect of commissioning. Earlier sections of this chapter examined the need for any remodelling of care for long-term conditions to be supported by increase change in GP knowledge and practice.

Findings from the social network survey suggest that clinical specialists have an important role in communicating information to GPs, though increased knowledge does not necessarily lead to change in practice. GPs with a particular interest can also have a role in informing and advising their peers within the practice. The survey suggests PCTs have very little direct influence on GP practice in relation to diabetes, though influential clinicians may in fact also have a PCT role which has not been reported in the survey. The low response rate to the Social Network Analysis survey means that the results should be treated with some caution.

5.9 Tracking the impact of commissioning

5.9.1 How can the impact of commissioning be measured?

The ultimate goal of commissioning is to produce an impact on health and well being outcomes for the population served. However, measuring this impact presents profound challenges, and this study proved to be no exception.

There are four aspects to consider when measuring the impact of commissioning:

- the process of commissioning in itself;
- the extent to which commissioning has succeeded in remodelling the delivery of health care;
- the impact of commissioning on the quality of health care and the performance of providers; and
- the impact on clinical and system outcomes.

Process can be measured through the needs-analyses performed, contracts managed, protocols introduced, financial balance etc. There is some evidence that English PCTs were successful in these terms[115]and some international evidence of commissioners having impact in these areas[2].

The extent to which commissioning has succeeded in remodelling the delivery of health care can be measured in terms of new services commissioned, existing services altered or old services decommissioned (although previous research evidence suggests PCTs have been slow to focus much time or attention on decommissioning[117]). This is the aspect of commissioning which is central to the results and analysis presented earlier in this chapter. Progress observed for the specific service areas studied in this research is summarised in Table 26.

Table 26. **Progress with the labour of commissioning in each of the service areas**

Hook area	Impact on remodelling of healthcare delivery
Calderdale dementia	No shift to new model of care provision yet, but some progress made and some relevant developments going on in parallel (outside the focus of our fieldwork)
Calderdale diabetes	No shift to new model of care provision yet, but some progress
Somerset Diabetes Service	There has been effective remodelling, but shift between providers not yet as great as hoped – work continuing
Somerset Early Supported Discharge	There has been effective remodelling, but still work in progress and subject to review
Wirral Diabetic Podiatry	No shift to new model of care provision yet, but some improvements to operation of existing service
Wirral Memory Assessment Service	There has been effective remodelling. The service is so effective at diagnosing new patients that review and revision is taking place

In terms of outcomes, the impact of commissioning remains stubbornly hard to detect: it is notoriously difficult to identify robust causal links between commissioning activity and health outcomes[117]. Typical confounders are:

- long time-lags between care being delivered and outcomes being achieved;

- outcomes being the culmination of a number of factors, many of which are outside the control of health services such as employment and housing;
- inability to distinguish commissioner performance from success of the provider in delivering the service; and the
- inability to separate the contribution of the commissioner and providers to any decisions to change services, irrespective of provider performance.

A study by Woodin and Wade found that there was no conclusive evidence demonstrating causal links between the separating purchasing from provision and the long-term outcomes of the health care system[118], and concluded that it would be extremely difficult to ever demonstrate such relationships should they exist. Nevertheless, there has been a trend for shifting the metrics used to assess commissioner performance away from structure and processes and towards 'hard' outcomes[119,120]. The implications of the methodological barriers described above can be seen in the current proposed arrangements whereby the national outcome goals set out in the NHS Outcomes Framework are to be translated by the NHS Commissioning Board[121] into its own Commissioning Outcomes Framework (COF)[122]. The COF is intended to describe how CCGs will be held to account for the improvement in outcomes in their locality.

The link between commissioning and outcomes becomes even more oblique when considering the impact on outcomes caused by a particular service or change in delivery. This can result in the temptation to apply the 'ecological fallacy', where changes across a whole population are mistakenly attributed to a subset that used a particular service. While this can be avoided through sophisticated person-level analyses[123], study at that level of precision means it is the performance of the service, rather than the commissioner, that is being evaluated.

Clearly, the choice of measures used when attempting to detect any impact of commissioning is critically important. Smith and others[13] grouped outcome measures into two sets as follows:

> **impact on indicators of performance**, such as waiting times and access, elective referral rates, non-elective acute hospital admissions, and prescribing.

> **impact on system outcomes** including equity, efficiency and appropriateness, cost containment, provider responsiveness, responsiveness to patients and the public, and health outcomes.

The first set is particularly amenable to quantitative analysis, and is the main focus of this section. They are also predominately based on effecting

change in the pattern of secondary care activity, which is an area in which commissioners have traditionally struggled to have an impact[13].

5.9.2 Is there evidence of a global impact on secondary care utilisation in the sites?

Since much of the effort in commissioning for long-term conditions is focussed on trying to keep people out of hospital wherever possible, data on hospital admissions provides useful scope of measuring the impact of commissioning. The Hospital Episode Statistics (HES) data[124] provides pseudonymised person-level data on all hospital inpatient admissions in England. These were uses to monitor admissions patterns in each of the three sites over a ten year period between April 2001 and March 2011.

Utilisation patterns are expressed as directly standardised rates per 100,000 population. This is a technique that standardises for differences in the age structure of the site populations, age being the strongest factor in the likelihood of admission. The rate for England is shown for comparison. The figure below shows the directly standardised rate of inpatient admissions by quarter for 10 years in each site. The upper plot is emergency admission and the lower is elective.

Figure 40.   Number of elective and emergency admissions per quarter in each site between April 2001 and March 2011.
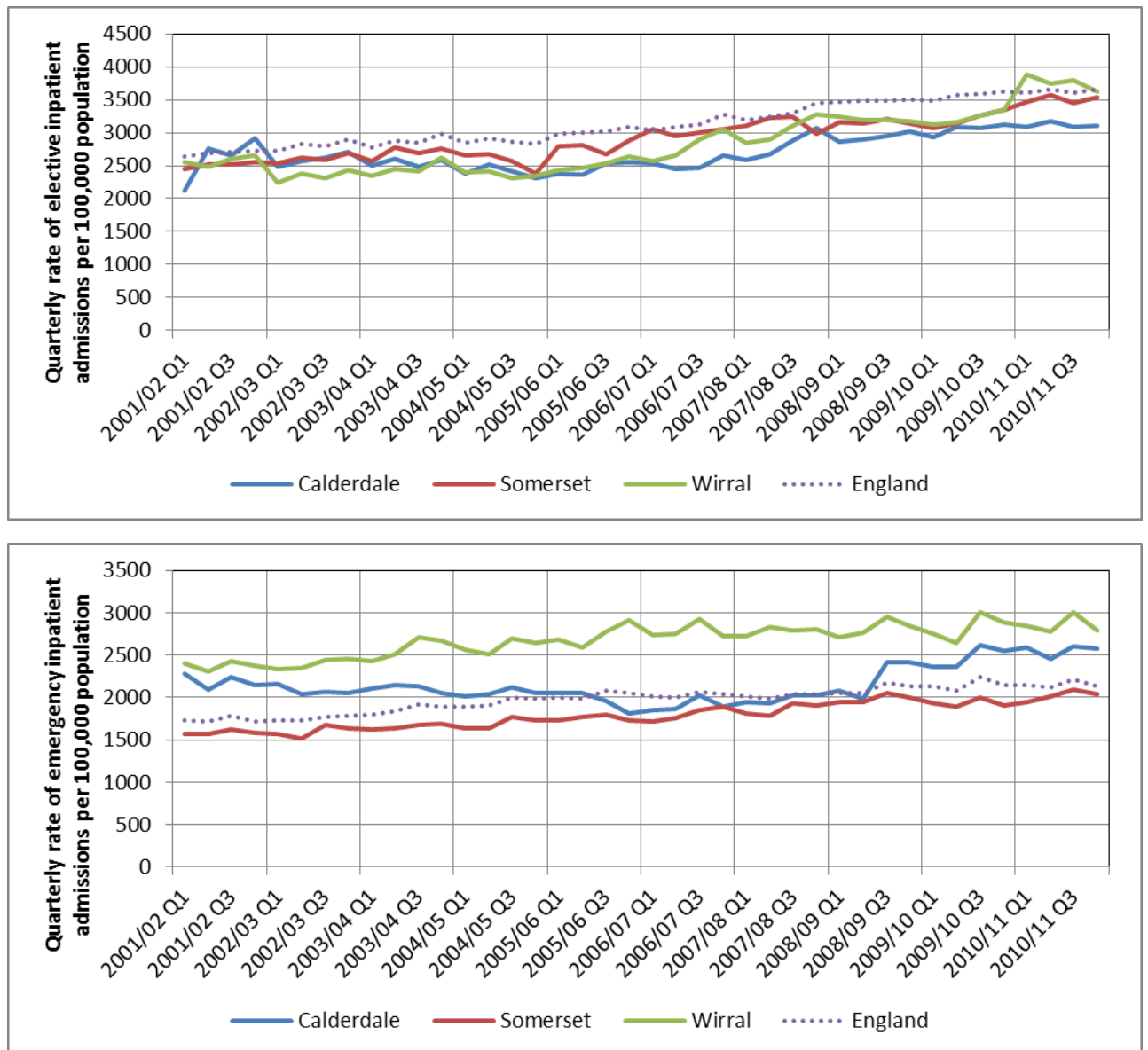
Figure 40 shows the directly standardised rate per 100,000 population of elective and emergency inpatient admissions in each site. In both cases the site trends are broadly in line with the England-wide pattern of rising admission rates, even though the three PCTs were chosen as high performing commissioners. Rates of elective admission show more similarity between the sites than emergency admissions, although it is possible that factors for which the data are not standardised (for example, deprivation) play a greater role in emergency admissions than elective.

There is no indication of any reduction in the rate of hospital admissions – as a result of commissioning activity or otherwise - beyond quarterly variability. The rate of emergency admission in Calderdale decreased slightly between 2001 and 2009, in contrast to increases in England and the other two sites, but then experienced a sharp increase from Q3 of 2008/09 onwards.

5.9.3 Is there quantitative evidence of impact for each specific service area examined in this research?

While there is no evidence of global impact on hospital admissions from commissioning within the three PCT areas, it might be expected that more specific measurement related to the service areas examined would show some impact.

Trends in hospital outpatient attendances relating to diabetes were plotted. In most providers these attendances are identified as being delivered under the 'diabetic medicine' speciality. In others they appear to be delivered under the 'general medicine' speciality and so are grouped with many attendances that will not be related to diabetes.

Diabetes-related attendances under 'general medicine' were distinguished from other attendances by using pseudonymised person-level HES data to create a cohort of people in each of the sites that have received a diabetes diagnosis[i] from inpatient treatment (even when their diabetes was not the cause of that treatment). The estimated number of people with diabetes was found to match the numbers on GP practice diabetes registers[125] to within 10% in all sites and appeared broadly reliable.

The 'likely diabetes attendance' outpatient usage for this cohort was then monitored over time alongside the attendance under 'diabetic medicine' for all patients. This approach produced similar numbers of outpatient attendance by month as those reported by NHS Somerset for diabetes clinics in secondary care for the period April to November 2010. Results are shown in Figures 41 and 42.

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[i] Defined as ICD-10 codes E10-E14 appearing in any diagnosis position from inpatient hospital spells between April 2001 and March 2011

Figure 41. **Monthly number of outpatient attendances likely to relate to diabetes in Somerset by provider**
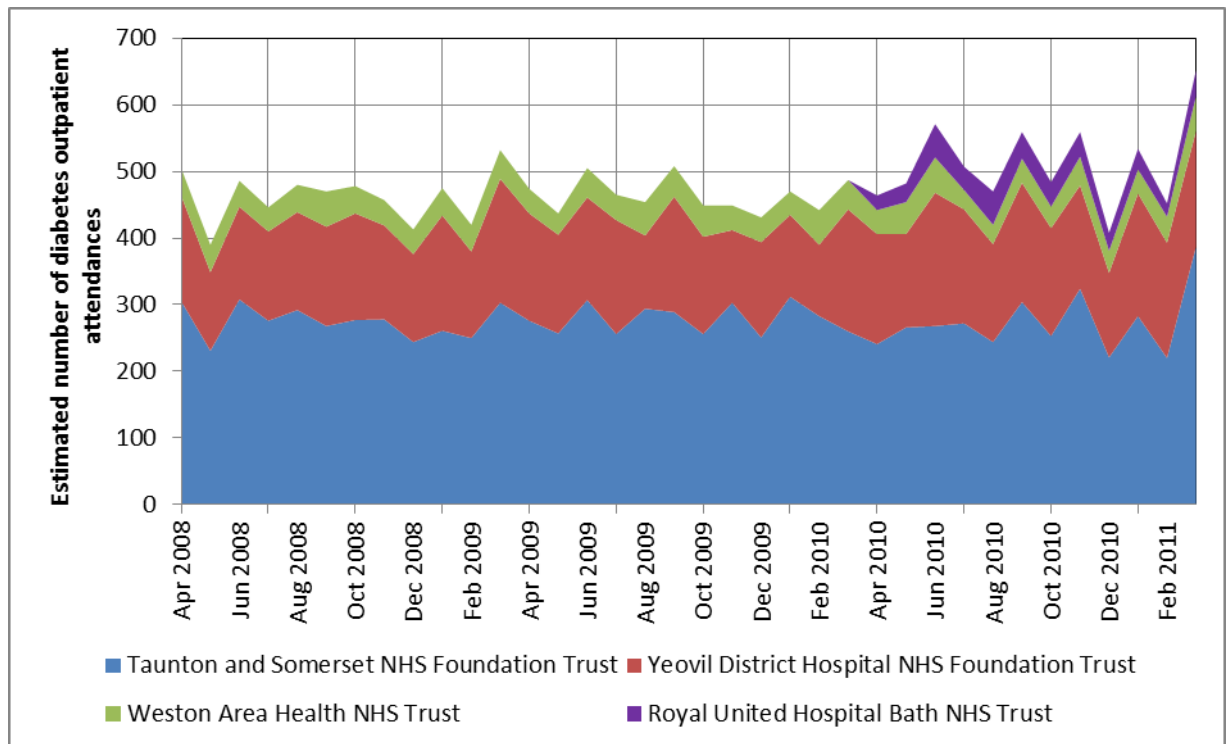
Figure 41 shows the monthly estimated number of outpatient attendances related to diabetes between April 2008 and March 2011. The HES data contained very low attendance numbers for Royal United Hospital Bath until April 2010, which is clearly a wider issue than diabetes care as HES recorded (for residents of Somerset using RUH Bath) nearly a 40% increase in all outpatients between 2009/10 and 2010/11 and a 67% increase in medical outpatients attendances. Based on information from NHS Somerset, it seems likely that outpatient activity for diabetes continued at RUH at similar levels throughout 2008-2010, and simply was not captured in the HES database. RUH were excluded from the analysis to prevent this discontinuity distorting the results.

Somerset's own assessment of its diabetes service (the June 2011 twelve month service review) suggested a transfer of clinic attendances from secondary care to primary care, with attendances at secondary care providers falling by about 1,000 between 2009/10 and 2010/11 while attendances under Somerset Community Health rising by more than 2,000 in the same period. Table 27 compares the numbers of diabetes clinic attendances with the estimate number of diabetes-related outpatient attendances.

Table 27. **Number of diabetes clinic attendances reported by NHS Somerset (Selected performance measures June 2011) and estimated number of outpatient attendances related to diabetes calculated from HES data**

		2008/09	2009/10	2010/11
Primary care	Somerset Community Health	Not reported	500	2754
Secondary care	Diabetes clinic attendances across providers (excluding RUH Bath)	Not reported	6780	5716
	Estimated "Likely diabetes" outpatient attendance	5551	5571	5726

Table 27 shows that the numbers of diabetes clinic attendances and estimates of diabetes outpatient attendances were similar in 2010/11. However, the number of likely diabetes attendances in 2009/10 was around 1000 lower than diabetes clinic attendances, which means that the number of clinic attendances fell 16% between the two years whereas the estimated number grew by 3%. The disparity arises from the number of cases at Yeovil District General Hospital, which is much higher in numbers reported by NHS Somerset. It should be remembered that these numbers were derived using very different definitions and NHS Somerset should have access to more detailed local information than appears in national datasets. On the positive side, both measures show a reduction in diabetes outpatient activity at Taunton and Somerset and Weston Area Health.

Diabetes outpatient attendances by the residents of Calderdale (Figure 42) are all with a single provider – Calderdale and Huddersfield Hospitals NHS Trust. Similar to RUH Bath there is a discontinuity that is more likely to be caused by changes in recording systems than service provision. Unlike RUH Bath, this discontinuity is not observed in the total outpatient appointments or within 'general medicine' for the cohort of patients without a diagnosis of diabetes. Attendances reducing almost by half from April 2009 onwards – whatever its cause – was specific to the group of patients with diabetes diagnosis attending under the 'general medicine' specialty. After the discontinuity, the number of estimated attendances declines steadily by about 9 per month ($p < 0.000$) until January 2011 where it appears to rise sharply. These patterns do not appear to relate to changes in commissioning arrangements at the site.

Figure 42.   Monthly number of outpatient attendances likely to relate to diabetes in Calderdale
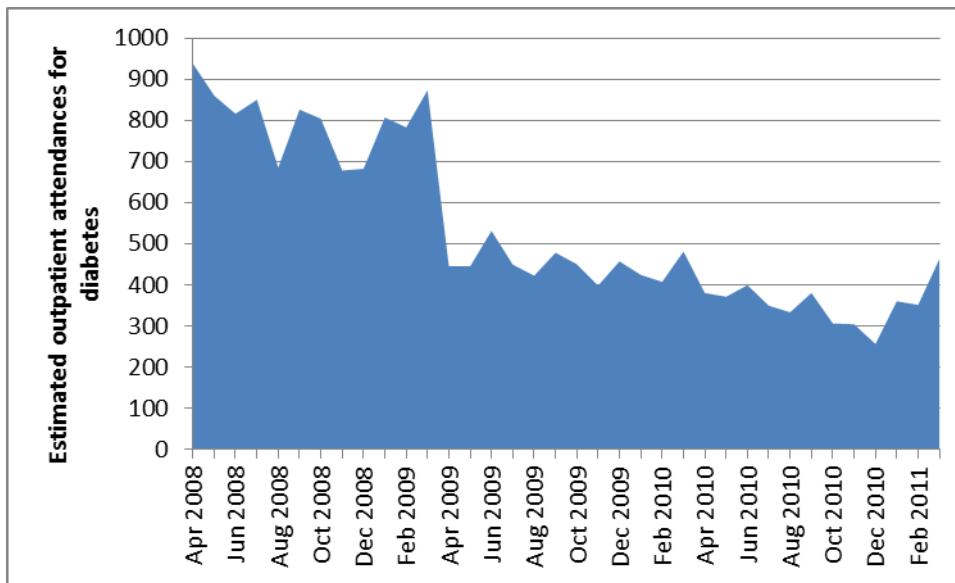
Some commissioning efforts are simply not operating on a scale to have a measurable quantitative impact at population level. The plan for the Early Supported Discharge service for stroke in Somerset is to build up the service to work with 324 people per year (40% of the estimated 810 people who survive a stroke in Somerset each year), which would be large enough to allow some measure of impact. At present, though, the numbers are not yet up to those levels: from April to June 2011, the Early Supported Discharge Service worked with 29 stroke patients. The impact of smaller programmes such as this could be monitored by tracking the individuals that use the service at the person-level (and comparing outcomes to a similar group who do not use the service, but at that level of precision would become an evaluation of the service itself.

Figure 43 shows the directly standardised rate of emergency admissions because of complications of diabetes between April 2008 and March 2011. This is regarded as an ambulatory care sensitive condition[126] where admissions can potentially be prevented by good quality primary care.

Figure 43. **Directly standardised rate per 100,000 population of emergency inpatient admissions for complications of diabetes**
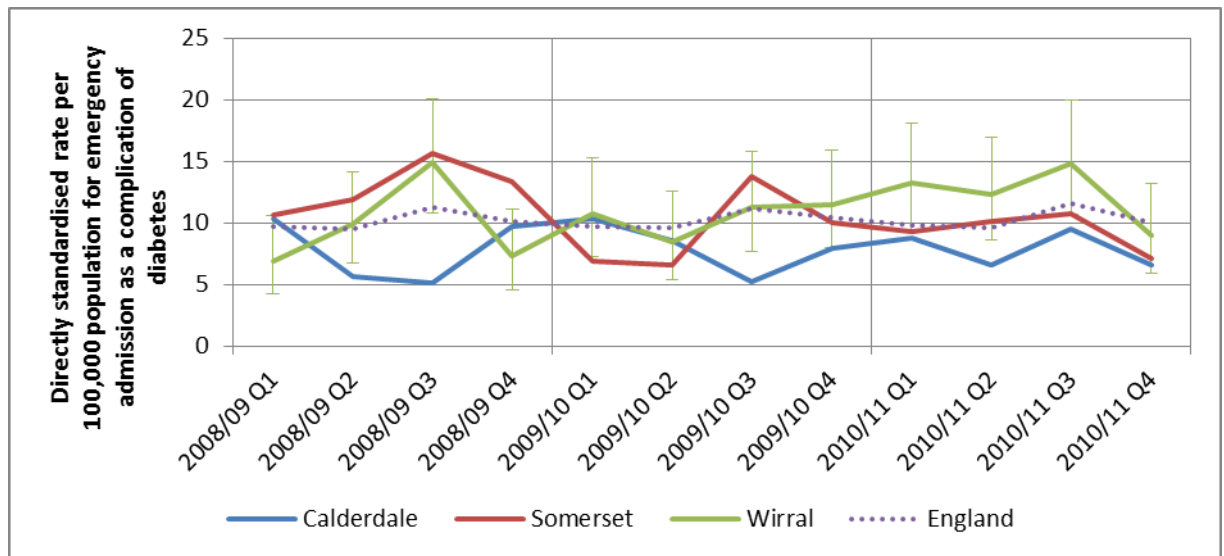
The results presented in Figure 43 show that in Calderdale, Somerset and England the rates of emergency admission for complications of diabetes did not change notably over the period. In Wirral they appeared to increase. However, the 95% confidence intervals (shown for Wirral) show that this was not statistically significantly different from the all-England rate.

Not all of the service areas subject to detailed study had a primary objective of reducing secondary care activity. The revised dementia service in Wirral aimed to increase the number of people with dementia whose condition had been diagnosed. A survey by the Department of Health[127] showed that the number of memory service users in Wirral increased from 491 in 2008/09 to 504 in 2009/10 and an estimated 660 in 2010/11.

The number of people with dementia whose diagnosis is recorded can be monitored through GP practice dementia registers, which are reported annually through the Quality and Outcomes Framework (QOF). Figure 44 shows the proportional growth in the number of people on practice dementia registers since 2006/07 as reported in QOF[128]. This trend is presented for NHS Wirral, and for comparison NHS North West and all of England.

Figure 44.   Growth in number of patients on GP dementia registers reported in QOF for Wirral, NHS North West and England between 2006/07 and 2010/11
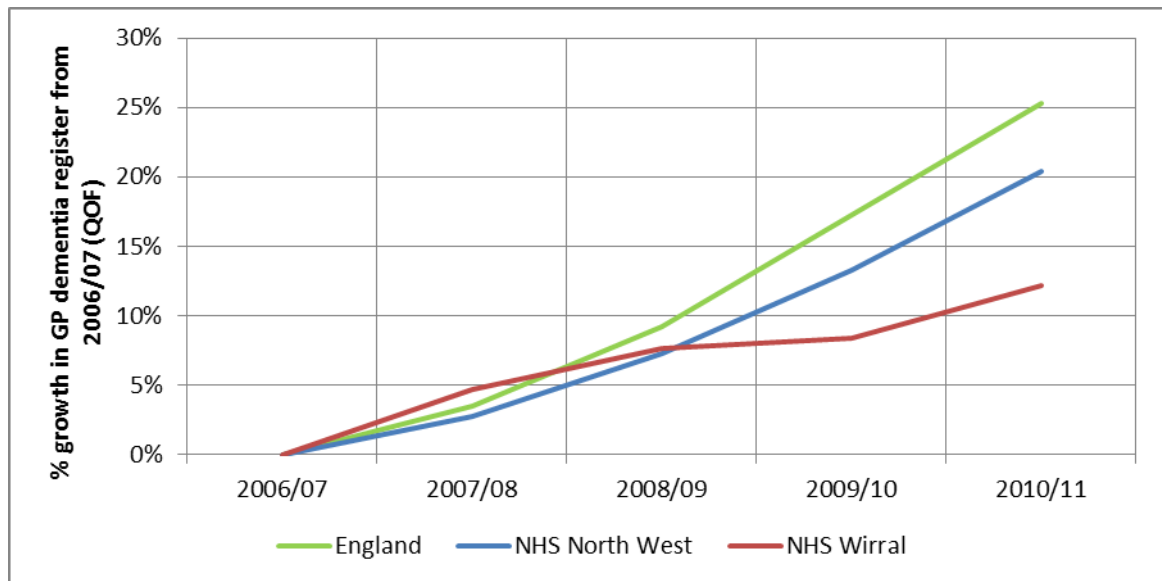
Between 2006/07 (the baseline year) and 2008/09 the dementia registers grew by similar degrees in all three areas. However, in 2009/10 the dementia register in NHS Wirral did not grow notably, while the growth trend for NHS North West and England continued. Growth resumed in Wirral the following year at a similar rate to previously. This apparent pause in recording new diagnoses of dementia in Wirral coincides with a period of significant change in the dementia service, and returning to the initial trajectory following the implementation of the new dementia service.

However, further investigation is required to confirm whether newly diagnosed individuals received their diagnosis as a result of using the new dementia service before a robust link can be established between commissioning activity and outcome

One aspect of dementia work in Calderdale has been reducing length of stay in hospital for patients with dementia. A toolkit produced to support commissioners of dementia services in the South East of England[129] identified the average length of inpatient stay for patients with a diagnosis of dementia as a key performance indicator. This measure is presented for Calderdale and Wirral in Figure 45. Note that this measure focuses on the diagnosis of dementia as noted in secondary care while the patient is staying in hospital. The patient may or may not already have received a diagnosis of dementia in primary care. Length of stay is calculated for hospital spells resulting from emergency admission, which make up the majority of spells where a dementia diagnosis is recorded (91% in Calderdale and 95% in Wirral).

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Figure 45. **Average length of stay for patients with a diagnosis of dementia (first three diagnostic positions) following an emergency admission for Calderdale and Wirral discharged between April 2008 and February 2011**
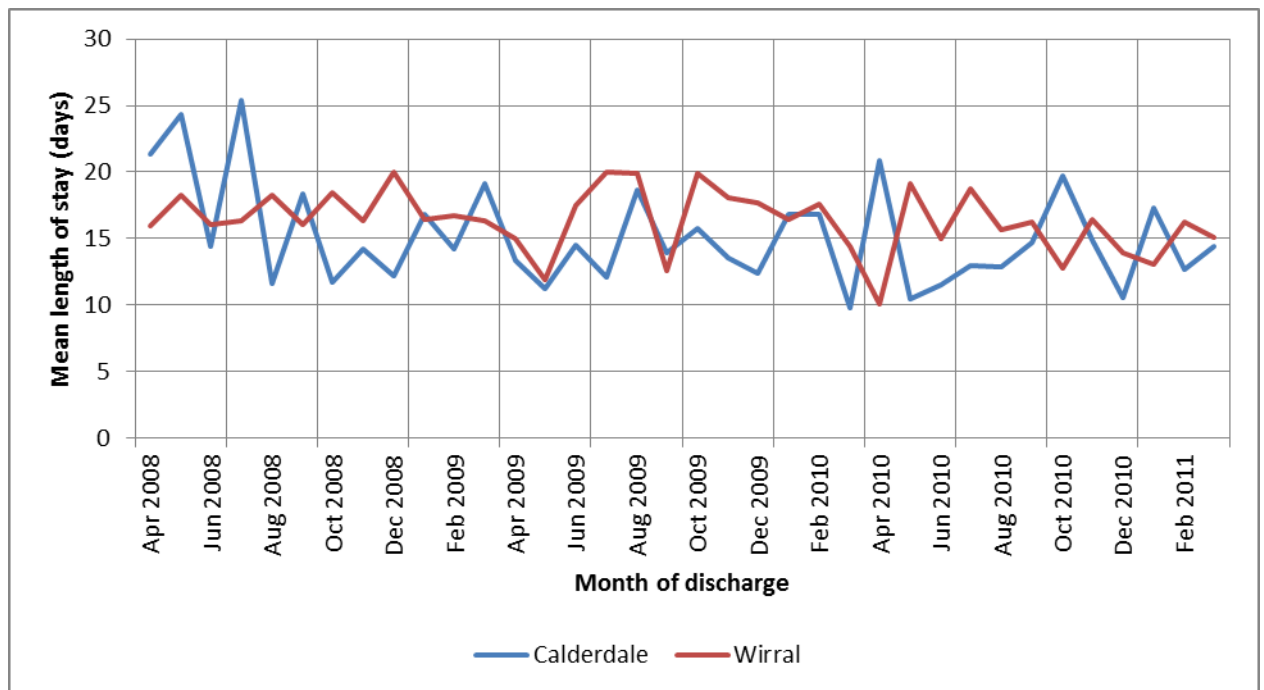
An ordinary least squares regression fitted against both sites shows the mean length of stay decreased slightly over time (0.07 days per month in Wirral, and 0.12 days per month in Calderdale). Neither trend was statistically significant, although Calderdale did come close to achieving significance at a 95% confidence level (p = 0.058).

5.9.4 Did the higher performing commissioner metrics change after site selection?

The World Class Commissioning scores for PCTs were issued for a second and final time by the Department of Health in August 2010. The assessment framework had been revised to make it more targeted and focused on quality and productivity but the four-level scoring system has been retained[130].

The Annual Health Check (AHC) was replaced by the Care Quality Commission (CQC) in 2009/10 with the 'Periodic Review'. While this featured many of the same performance indicators as the AHC, it did not contain either the Core Standards Assessment element or trust-level aggregate ratings – three of the key components that had been used to identify the sites as 'high performing commissioners'.

The Quality and Outcomes Framework, Programme Budgeting information and HES-derived measures like market concentration and emergency admission for ambulatory care sensitive conditions were all available for 2009/10 and 2010/11. However, given that components totalling more than half of the combined score had either changed substantially or were no longer available, scores could not be re-calculated to explore changes from the measure used to select sites. This in itself reflects a core challenge in assessing the effectiveness of NHS commissioning – standard measures change regularly, and hence robust comparisons are hard to make over time.

5.10 Chapter summary

Where local commissioning practice was observed as being effective, leading to a remodeled service with specific objectives for improvement, it was observed that the following factors appeared to be in place - what might be considered to be both the 'science' and 'art' of commissioning:

- a combined awareness of the make-up and interests of the local population and commissioning community, with national priorities and policies;

- a strong vision for the development of the long term condition service combining both external and local priorities;

- an ability to horizon scan for likely external drivers relevant to the service area;

- a willingness to select relevant national work and to adapt it for best possible use locally; and

- effective managerial and clinical leadership (particularly at second—in-line level), including an ability to translate external drivers into actionable and achievable local goals.

6 Discussion and implications

In this chapter, the main findings of the study are summarised in relation to the original research objectives, and reflections are made about the strengths and weaknesses of the research. The original research objectives were to:

- identify the organisation and processes associated with effective commissioning;

- identify an appropriate set of outcomes for commissioning;

- draw on experience from other sectors and international health systems in developing commissioning within study sites; and

- consider how the learning from this research could be more widely applicable in the NHS.

The chapter ends with consideration of how the findings of this study relate to previous research, and suggestions are made about areas for further investigation.

6.1 The organisation and processes associated with effective commissioning

6.1.1 The multiple and labour-intensive processes associated with NHS commissioning practice

This research revealed multiple and labour-intensive processes associated with 'commissioning'. Whilst the commissioning cycle described by Ovretveit[10] and adapted by the Department of Health[14] provides a useful guide for PCTs and clinical commissioners, this research demonstrated that commissioning activities do not follow a neat series of 'stages' over an annual cycle. Some activities clearly align with the cycle, while others were conspicuous by their absence. In particular, it was observed that commissioning by PCTs did not always include active review of services (based on analysis of performance data) and subsequent changes to the following year's contracts. This may have been due to the difficulties of identifying effects in this research, as discussed at the end of the previous chapter.

Commissioning activities not usually identified as part of the commissioning cycle were also observed. Of particular note was the commissioner's role in convening and co-ordinating service development across a range of interest

groups, and supporting service implementation. This organisational development work was often concerned with marginal, rather than core, activity. For example, lots of effort had gone (over many years) into trying to improve diabetic podiatry services in the Wirral, yet the main diabetes service remained hospital-focused despite the use of additional local financial incentives by commissioners to encourage the provision of services that elsewhere would often be core primary care business. In a similar vein, extensive commissioning management effort went into the design and implementation of the early supported discharge stroke service in Somerset, with only a small number of patients being entered into the service.

What was not observed in this research was either a focus by commissioners on exploring the overall priority to be accorded to respective programmes of service and expenditure for long-term conditions, or an attempt to change this in response to demographic, clinical effectiveness or other criteria. Relatively little mention was made of either programme budgeting data, benchmarking of overall programme expenditure against regional and national norms, or in-depth assessment of data on patient and carer experience of services, with the exception of the Wirral Memory Assessment Service, and Somerset Diabetes service.

As for decommissioning of current services, this was rarely encountered, with the exception of the ending of the previous memory clinic in Wirral that was replaced by the newly commissioned Memory Assessment Service. This focus on commissioning additional (and usually marginal) services was perhaps understandable in the context of significant expansion in funding of the NHS over the period 2002-2011. However, given the focus on the 'Nicholson Challenge' from early 2009 onwards, one might have expected more use of productivity, programme budgeting, and other financial and service outcome data to determine what should, and should not, form part of the local 'service menu' for the next period. Previous research does however point to reluctance on the part of commissioners to use such techniques, and little taste for explicit prioritisation[131] .

6.1.2 The relational and transactional balance within NHS commissioning

As noted in Chapter 1, commissioning within public services typically entails a balance between 'transactional' and 'relational'[21,22] aspects, with the former being concerned with the design and implementation of formal contracting and review processes, and the latter with focused on the engagement of local stakeholders, building of trust, and attempts to locate contracting work within strong and effective inter-organisational relationships.

This research revealed that, at least when commissioning care for people living with long-term conditions, PCT managers displayed a clear preference for relational rather than transactional commissioning. This was evident in the time and energy devoted to stakeholder engagement, planning workshops, routine review meetings, and carrying out the role as convenor of the local commissioning system. Indeed, it was often hard to tell, within such workshops and meetings, who was the commissioner and who the provider, such was the collaborative and relational feel of much of the commissioning activity observed.

This relational commissioning was seen to work well in some cases, in particular where it took place within clear boundaries, and it was understood by the different parties that there was a time when talking and exploration had to stop, and a contractual arrangement made between the commissioner (or most typically the PCT's senior finance staff) and the provider. An example of this approach was the memory assessment service in Wirral, where extensive consultative work took place as part of the review of the previous service, and design of the new approach based in extra-care centres and other community-based facilities. However, a time came when the old service was decommissioned, and a new one put in place, and subsequent review meetings were focused on how to improve the service for users, carers and staff, and on the issues of activity, funding, and modelling of future service needs and capacity.

This example from the Wirral, along with the work on diabetes and stroke in Somerset, may have been assisted by the particular local geography (a well defined population and community), the sustained nature of relationships between the different organisations, and the commitment and energy of a small number of managers and clinicians who had been able to work on the service development over a number of years.

In other cases, such as dementia services in Calderdale, and diabetic podiatry in the Wirral, extensive and thoughtful work to design and develop local care appeared to get stuck at the point of being translated into contracts that would lead to significant (rather than marginal) change. This calls into question the value of the time and effort expended by managers, clinicians and others on relational aspects of commissioning. This is striking in that the NHS market reforms of the 1990s, and the introduction of general management before that, were intended to move the NHS from what had been regarded as the rather stultified and cosy consensus management approach from 1948-1990[132]. The observations of commissioning practice within this research suggest that consensus management is alive and well in the NHS. The question that follows from this is how far such an approach helps or hinders the achievement of effective commissioning practice, and whether (in the area of long-term conditions at least) commissioning is moving (appropriately perhaps)

beyond the purchaser-provider split. This issue is examined in more detail later in this chapter.

A further issue raised by the predominance of relational commissioning practice within these three case study sites is whether the NHS can afford such commissioning labour, particularly at a time of reducing real-terms expenditure[133] , a requirement to reduce management costs by 46%[134], and a need to demonstrate 4% productivity gains each year from 2011 to 2015[135]. The example of dementia services in the Wirral suggests that commissioning needs to rediscover an appropriate balance of the transactional and the relational, a balance that was exhorted in 2007 through the World Class Commissioning programme[136]   .

6.1.3 Does this amount to effective commissioning?

Guidance from the Department of Health on the implementation of 'World Class Commissioning' in 2009 appears to represent the most concerted recent attempt by English NHS policy makers to specify what is meant by 'effective commissioning'. This set out that effective commissioning was:

> 'the process by which primary care trusts (PCTs) secure best value and deliver improvements in health and care services, to meet the needs of the populations they serve.' [DH, 2009, p2][137]

Assessments of 'best value' (interpreted in this study as commissioners exploring the cost-effectiveness of their proposed service developments) were not very much in evidence within this study of the commissioning of care for people living with long-term conditions. As explored in chapter 5, money and resources were infrequently mentioned in the commissioning activities observed, and financial deals appeared to be struck in parallel to relational commissioning labour. Relatively little commissioning activity was observed as being focused on the monitoring and active review of service performance ex post, albeit that commissioners in Somerset (diabetes and stroke) and Wirral (dementia) were engaged in active review and challenge of these services ex ante.

Delivery of service improvement ahead of implementing service change was the element of the World Class Commissioning definition most in evidence in the practice observed in this study. There were extensive attempts to target investment on changes deemed to offer the potential of service improvement. Examples included the work to try and resolve long-standing concerns about the diabetic podiatry service in Wirral, a review of diabetic specialist nurse provision in Calderdale and Kirklees, the introduction of the early supported discharge service for stroke in Somerset, and the implementation of a major new care pathway for diabetes care in Somerset. It should be noted however that much of this work, despite (in some cases)

several years of commissioning labour, was still in the foothills of implementation.

Attempting to meet local needs was much in evidence in the commissioning practice observed in the three PCT areas. This was enacted through workshops, consultations, and many meetings. More formal needs analysis by public health specialists or health economists was less evident, although it was clearly happening elsewhere within local health care systems, for it featured in strategy documents and business plans. This parallel nature of health needs assessment (also likely due to the scarcity of such skills) was similar to financial managers negotiating contract deals away from the core commissioning work that involved clinicians, middle managers and others.

In relation to the Department of Health definition of effective commissioning, this research revealed activities that form part of such good practice. This was however partial and sporadic, and it was not always apparent how this practice would feed into a wider local programme of service design, implementation and review. The 'messiness' of the commissioning cycle was evident, with only some examples (e.g. the memory assessment service in the Wirral and the new diabetes model of care for Somerset) pointing to how such messiness could be unravelled and knitted into a coherent programme of commissioning for a specific service, and in a way that led to actual service change at some scale.

Where the practice of commissioning was able to demonstrate such effectiveness, it relied heavily on the co-ordination, drive and sustained commitment of one or two influential individuals who were able to draw together complex programmes of work, engage different organisations, and doggedly drive the process of commissioning through its cyclical process to meet the knotty challenge of putting plans into practice and, where appropriate, decommissioning services.

6.1.4 What helps or hinders effective commissioning practice?

The cycle of commissioning

The cycle of commissioning appears to have the virtue of lending some order and routine to commissioning. Amidst the reorganisation of local commissioning bodies pursuant to the NHS White Paper of 2010, the commissioning cycle, with its requirement for business planning, commissioning intentions, contract negotiations, and achievement of productivity targets, appeared to confer a reassuring constancy to a rapidly changing local health system. This was particularly evident in how PCT commissioners (PCT cluster commissioners by late 2011) were focused on drawing new GP commissioners into the annual round of negotiations. There was very little evidence of attempts to challenge this cycle and the way in which it was being enacted.

In the context of commissioning of services for people with long-term conditions, the cycle of commissioning appeared to force a dividing up or (in New Public Management terms) a 'commodification' of services, in order that contract currencies could be calculated. This suggests that there may be a disjuncture between the observed relational and continuous nature of care for people with long-term conditions, and the nature of current NHS contracting that appears to be better suited to more for elective and easily commodified services. It may be that services for people with long-term conditions are inherently difficult to commission through traditional cost and volume contracts, and require a different approach to risk-sharing and contracting, along with a longer-term commitment to fund a programme of work, in return for which certain outcomes are promised by local clinicians and managers.

Skilled commissioning managers

This study reveals the critical importance of skilled managers who can work in an effective manner with local clinicians and others, persistently driving forward major areas of service development, and ensuring that necessary engagement work can be translated into actual changes to what patients and carers experience. Whilst some of these individuals may be located within provider organisations, this research demonstrated the value of senior commissioners being largely separate from provider interests, able to take a population perspective, with a degree of 'clout' conferred by holding budgets to fund services[138]. Critical to the skills of these individuals was the ability to operate across boundaries and disciplines, the 'boundary spanners' described in earlier work about effective primary care led commissioning[139].

That earlier work cautioned about the potential isolation of such boundary-spanning roles, and the current research revealed that effective middle manager commissioners seemed to have more and more work put on them (especially given the tough financial climate) and had little time and space for reflection, or to access personal support and development. It was striking how the managers leading large areas of long-term condition commissioning were quick to form a strong bond with the research team, and embrace the concept of case study research including the provision of development and facilitation support. They talked in interviews of how much they had valued the support of the researchers, both in relation to enabling regular reflection on progress made and obstacles encountered, and the provision of specific technical advice and organisational development support.

Accurate and timely data

Commissioners interviewed in this research called frequently for better and more timely data about local needs, services, costs of provision, and patient and carer experience. There was a strong impression of data being in

existence, yet somehow being 'elsewhere' and problematic to access in a manner that would make them easy to use in service design, development and review work. This reinforced the sense of finance and contracting as very separate from needs assessment.

In some cases, data problems appeared to have become the pretext for inability to crack long-standing service problems, as was seen with the diabetic podiatry service in Wirral, where the problems in developing an electronic register for recall and review of patients appeared to be intractable, thwarting the development of such a service. However, where data were available, as in the analysis of dementia services, past present and future for Wirral, and in modelling and reviewing the new memory assessment service, they appeared to be a powerful tool with which commissioners could add 'grit' to relational meetings about service development.

Meetings and workshops

Meetings and workshops appeared to be the default action pursued by local commissioning managers when faced with resolving a particular service issue. Whilst some of these meetings took the form of one-off stakeholder workshops at which people from a range of organisations explored options for improving a service, others were standing forums that had in some cases existed for as much as ten years. Some of the observations for this study confirmed work by Peck et al [140]about commissioning meetings and boards as 'ritual', appearing to have the involvement of different people and interests as a core purpose, rather than operating with clear objectives and/or time limits.

In their role as 'local system leader', commissioners assumed a role of convenor or chair, drawing together different interests to review, plan and discuss local health care provision. In Wirral and Somerset, this convening role typically operated at PCT level. By contrast, in Calderdale, there was from the outset a focus on strategic planning across PCTs and local authorities, most notably both Calderdale and Kirklees. Once NHS Calderdale joined with NHS Kirklees and NHS Wakefield in June 2011, it was apparent that this wider area focus was to continue. Thus it was that a programme of 'transformation' for long-term conditions care was planned for the cluster of three PCTs. Fieldwork for this study raised questions about how such high-level, strategic planning effort can be translated into local commissioning decisions. In particular, despite extensive strategic planning discussions in Calderdale, the location of decision rights about funding and contracts did not always appear to align with this higher level 'transformational' debate. How far new clinical commissioning groups would

engage in, and then enact, such strategic discussions was unclear at the end of fieldwork for this research.

The involvement of clinicians

The involvement of clinicians is cited in the literature as a critical factor in bringing about change within health care systems[141]. This had clearly been embraced by the PCTs in this study, for a clinician was often identified as the lead or chair for a piece of commissioning work, and the presence of doctors, and to some extent nurses and other professional staff, was deemed essential to the majority of service planning and review meetings across the period of the research. Following the NHS White Paper of 2010, there was an apparently greater emphasis on having clinicians (especially GPs) in lead roles and to try and make sure there was a 'lead CCG GP' involved in each programme of activity.

Indeed, GP commissioners interviewed reported a desire for an even more clinically-focused approach to commissioning, and some expressed a desire for a different and more patient service-centred culture within PCT clusters and CCGs. How far this was possible was open to question however, with some GP commissioners reporting pressure to 'become like the PCT', a trend observed in Chapter 5 where an examination was made of how the sites adapted to change experienced as a result of wider health system reform.

A particular feature of the involvement of clinicians within the commissioning practice was the blurring of their commissioner and provider roles. Whilst this complexity is a core element of the role of a GP commissioner (i.e. based on the idea that a GP's experience as a provider of generalist primary care gives them particular insight into the wider healthcare needs of their patients), in this study, it was noted that specialists were drawn frequently into commissioning.

This may represent a blurring of the purchaser-provider split and it was at times difficult to discern the extent to which an individual's interests as a provider might be influencing their activity as a commissioner. This question of the degree of influence of clinicians (as providers) on commissioning was also significant in that the managers supporting commissioning (for example service reviews) were typically middle managers and not PCT directors, and thus arguably might find it difficult to challenge the views of senior clinicians. This research also revealed a tendency on the part of provider trusts to field a senior clinician at contract review or negotiation meetings, both to feed in expert clinical opinion, but also, it appeared, to ensure an appropriate degree of influence for the trust within discussions

The role of national guidance

It was clear that local commissioners drew frequently on national guidance, both to support their planning and service development work, and to lend priority to specific health issues. In a publicly funded health care system, national guidance is clearly intended to assure some consistency of focus and priority across multiple and diverse local health communities. How far such guidance influences local commissioners goes to the heart of the national-local tension in health commissioning and planning, and entails inevitable choices by PCTs as the 'brain and conscience' of the local commissioning system[142] Local commissioners have to decide how far to be the agents of nationally determined policy and enact national guidance, and how far to craft local priorities that meet the specific needs of the local population.

The existence of multiple local commissioners in the NHS in England is the result of policy designed to assure that funding and planning decisions can be matched as closely as possible to local needs (see Chapter 1). However, this research reveals that this risks different NHS organisations carrying out almost the same commissioning work in parallel to one another, and hence using valuable management time and resource. Workshops attended by the research team in relation to diabetes and dementia in the study sites often covered very similar ground, appraised the same national and international evidence, and revealed largely common issues about current and desired service provision.

This reinforces the message about the extent and cost of the 'labour of commissioning', particularly in relation to specifying and designing and services. Whilst this is often justified in terms of the need to engage local clinicians, managers and others, a question remains about the cost (financial and human) of such efforts, and how far it may detract from the time and resource needed for decision-making and implementation.

Lack of clarity about outcomes

In making assessments of the overall impact of each of the six service areas examined in depth within this study, the most striking finding was the lack of clarity about anticipated outcomes from commissioning activity, and hence the difficulty for the PCTs (and indeed the research team) in making judgements as to how far commissioning intentions had been realised, or not. Just as with the focus on service planning, design and specification as elements of the commissioning cycle, and the more limited focus on monitoring and review, so there appeared to be a relative lack of attention to assessing impact and outcomes.

Respondents emphasised the need for more extensive and timely data to inform their commissioning decisions, and it appears that as a prerequisite

to this, commissioners would benefit from a clearer sense of the outcomes expected of them. In this respect, the proposed NHS Outcomes Framework[121] and its associated Commissioning Outcomes Framework[143] would appear to offer the possibility of a more robust framework for local commissioners to establish and monitor desired outcomes from their 'commissioning labour'.

In the next section, the assessment of the organisation and processes of commissioning care for people with long-term conditions is used as the basis for identifying a set of outcomes for measuring 'effective commissioning' in future.

6.2 Activities and indicators of 'effective commissioning'

This analysis of the organisation and processes associated with effective commissioning revealed that whilst inherently 'messy' and labour-intensive in terms of its practice, the work of commissioners does comprise a set of activities which point to what an 'effective commissioner' should do. These activities are set out here, each linked to suggested indicators that could potentially be used to assess the effectiveness of health commissioning.

It should however be noted that these activities and indicators are suggested as the basis for developing local commissioning practice in a way that suits the local context and needs, and not as a definitive checklist by which all commissioning should be judged.

Table 28. **Activities associated with 'effective commissioning', and suggested indicators of effectiveness**

i) Acting as the convenor of multiple local interests and stakeholders, bringing them together to work on specific service priorities and developments, and hence playing a role in the development of the overall local health (and social) care system.

Measure: Regular surveying of health provider, local government and user organisations about the performance of commissioners, including the extent to which NHS commissioners engage then in discussions, and take account of such input.

ii) Ensuring a clear focus on the overall setting of priorities for health spending for a local community, reviewing spending across different programmes, and resisting the temptation to concentrate on a few services at the margins.

Measure: Evidence of how the commissioner has used national and regional benchmarking data about programme budgets and service performance as a way of reviewing and amending overall funding and commissioning priorities.

iii) Getting the right balance between relational and transactional commissioning, knowing when to halt the engagement, specification and design activity (the 'labour of commissioning'), and move to implementation, challenging the status quo as necessary.

Measure: Review of the number of meetings and workshops involved in a specific programme of commissioning, with some estimate of the cost of this, and evidence of the changes made to commissioned services as a result (a cost-benefit analysis of commissioning).

iv) Keeping a focus on the monitoring of activity, financial performance, and quality of services commissioned, and using this information to inform regular review of the overall programme of commissioning, and to feed into the next cycle of service planning and development.

Measure: Production of regular public reports about the activity, financial performance and quality of services commissioned, linked to intended commissioning outcomes, and with evidence of how such monitoring is being used to inform the next phase of local service development.

v) Using an approach to commissioning that suits the particular service - long-term conditions are less amenable to the 'commodified' purchasing of items of service which works for elective care, and are likely to need a more relational approach based on contracts that enable shared risk across a range of providers, and/or a longer time horizon for assessment of success.

Measure: Describing in the commissioner's annual report how different approaches have been used for specific services, and setting out ways in which risk-sharing across providers is to be used as a way of securing improved commissioning outcomes.

vi) Identifying and supporting key individuals who play a pivotal role within local commissioning, in particular the middle managers who work closely with GP commissioners, providers and user groups to take forward specific areas of commissioning work.

Measure: Evidence of clearly identified lead managers for core commissioning areas, and of investment in the training, development and support of these managers, and data about their retention.

viii) Ensuring that there is adequate clinical involvement in commissioning discussions and activity, and that this is based on robust governance that can clarify the wider provider interests of these clinicians, and account for how such interests are mitigated.

Measure: Regular surveying of local GPs, specialists, nurses and other NHS staff about their involvement in commissioning, and their perceptions of the utility of such involvement.

ix) Ensuring that any newly commissioned (or re-commissioned) service has a set of specific and measurable objectives, along with details of how data will be collected and used to measure such objectives.

Measure: Documented objectives and measures for all newly commissioned services, including how these services perform in relation to adherence to NICE guidance of clinical and cost-effectiveness.

x) Having a programme of review and re-commissioning of those services that consume most of the resources, to ensure that commissioning effort is not disproportionately focused on relatively small budgets and services. This programme should indicate how it relates to national guidance and strategies, and when all core services will come up for review.

Measure: Publication of an annual commissioning plan that includes information about the rolling programme of review of services, and reports of those services reviewed in the past year, and actions taken as a result.

6.3 Developing commissioning within the study sites

6.3.1 The study design

The study was designed explicitly on the basis that there was a need for detailed examination of the day-to-day practice of commissioning care for people living with long-term conditions, what was termed in the research protocol as the 'nitty-gritty' of commissioning. The rationale for this was that there was already a significant body of literature about the organisation and governance of commissioning (see Chapter 1) but that much less attention had been paid to what commissioners actually do, and hence trying to understand why they made progress or not.

This research therefore sought to identify examples of high performing commissioning organisations (PCTs) and to observe their commissioning practice in detail. Furthermore, a multi-site case study approach was adopted, including the use by the research team of facilitation and

development activities within sites, as a way of exploring how these apparently high performing organisations might seek to improve their commissioning practice, if offered a range of support and advice from a team of experienced researchers.

The decision to focus on a set of tracer conditions was based on a desire to concentrate the attention of the research team on the day-to-day practice of commissioning care for people with long-term conditions, and to avoid the distraction of the wider organisational and policy issues that dominate existing research in this area. The identification, within these conditions, of six 'research hooks', services areas for detailed study, represented a further attempt to focus on the detailed day-to-day practice of commissioning. This division of services into specific areas of commissioning proved critical to enabling the researchers to track the detailed work of commissioners within what are large and potentially unwieldy clinical areas, remain focused on this amidst significant organisational change (pursuant on the 2010 NHS White Paper), and assess a mix of both ambitious (e.g. a new diabetes pathway for Somerset) and more modest yet long-standing (e.g. diabetic podiatry in Wirral) commissioning objectives.

Whilst the use of six specific service areas made the study manageable, and gave the researchers a window onto the practice of commissioning, it did mean that they made the majority of their observations at what might be termed a 'middle management' or operational level of commissioning. In early 2011, this was recognised as a potential limitation of the study, in particular given the extensive organisational change happening across the NHS following the 2010 White Paper, and hence a decision was taken to supplement these observations of day-to-day practice with additional interviews with senior managers and clinicians in the three sites. These interviews were intended as a way of tracking wider developments that were affecting local commissioning, and locating the detailed observed practice within a set of national and local organisational changes.

The decision to work with high performing organisations was useful in a number of ways. It appeared to facilitate recruitment to the study, with PCT chief executives clearly flattered to have had their organisations identified as successful and hence appropriate for the study. Once recruited to the study, the chief executives and their teams demonstrated significant commitment to the research (particularly in the two sites where teams remained relatively constant throughout), providing consistent support to the researchers, responding quickly to requests for information and fieldwork interviews, and engaging enthusiastically in project workshops.

This study took place at a time of significant management upheaval in the NHS (July 2010-January 2012) following publication of the 2010 NHS White Paper. It is impossible to know how the research would have worked out with 'low performing' organisations, but the fact that two of the three PCT areas retained consistent leadership over this period, with their chief executive moving to be lead of their new 'PCT cluster' from June 2011,

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suggests that their reputation for performance added a degree of protection at a time of change and uncertainty.

One consequence of the decision to focus on tracer conditions, and within that on specific pieces of commissioning activity was that while the research captured the detailed labour of commissioning carried out by (mainly) middle managers, there was less opportunity for the research team to build the same rapport with senior managers and commissioners in the three PCTs. This may explain why the research team encountered some reticence about observation of contract negotiations and senior strategic discussions about funding and priorities - relationships and trust had not with been established with these people to anything like the degree with those managers leading the day-to-day commissioning work.

An objective of this research was to draw upon experience from overseas and other sectors when undertaking action research into the practice of commissioning. The drawing together of a research team that included people with experience of working in the health systems of New Zealand, Wales, Canada, Australia and the US was one way in which a broader and more international approach to helping develop commissioning practice was built into the research design. Likewise, the project advisory group included experience from the local government and private sectors, and colleagues based in the Netherlands and the US. The advisory group was particularly influential in directing the research team to take a broader public sector view of commissioning for long-term conditions, encouraging exploration of partnership working, changes taking place in local government, and alternative approaches to user and public engagement in commissioning.

International input from the advisory group was instrumental in encouraging the detailed examination of the service areas (this came from the Dutch member of the advisory group who had carried out extensive work into the fragmentation and integration of care for chronic disease). Whilst the research team implicitly drew on the experience of each member in its observations, actions, and analysis, the use of specific international and other-sector experience was less extensive than had been anticipated when scoping the project. This was most likely a result of the significant organisational turmoil within which the research was undertaken (following publication of the 2010 NHS White Paper[18] and the consequent focus of the development and facilitation aspects of the study on supporting transition, helping to run strategic planning meetings, and undertaking analytical work. This last work in particular was informed by international experience, as in the giving of advice about the options for predictive risk modelling for long-term conditions, which drew extensively on US-UK collaborative work undertaken by the Nuffield Trust[144].

6.3.2 Development and facilitation input to sites

As set out in Chapter 2 (Methods) the research set out with the intention of adopting an overall action research approach, but in reality this took the form of a range of development and facilitation activities offered by the research team to the sites as a way of fostering collaboration and understanding between researchers and local stakeholders. The approach of offering some development support to sites was found to have a number of strengths, the main ones being:

- it helped the research team to gain and secure access to the sites, even during organisational change, for there was a clear sense of reciprocity in the design of the study, with an offer of a number of days of input from senior Nuffield staff (and at a time when the NHS had scant resources for external development and advice);

- through the regular on-site presence of researchers, sustained contact with managers through fortnightly update phone calls, and involvement in numerous local development and planning meetings, trust was built and familiarity developed;

- the project funding and design allowed the researchers to bring the sites together on two occasions for a full one-day workshop at which results and findings from the study were fed back and refined, ideas for the next phase proposed by colleagues from sites, and learning shared across the three PCTs;

- managers within the PCTs felt able to access the research team for informal feedback and advice on a regular basis; and

the research team was able to offer much-needed capacity at a time of reductions in NHS management expenditure - sites asked for data analytical skills, such as for predictive risk modelling, critical appraisal of evidence and the development of service specifications, and more than anything, for facilitation and challenge in meetings and workshops.

6.3.3 Reflections on how the research helped develop commissioning

The focus on specific tracer conditions, and within these a set of defined service areas, ensured a steady gaze being kept on the 'nitty-gritty' of commissioning practice, and helped avoid any temptation to stray into study of the wider changes to the NHS being implemented over the period 2010-2012 (except where they had a direct bearing on the commissioning practice of the PCTs). The provision of development and facilitation support to sites by the research team was also critical in enabling the building of strong and reciprocal relationships between the researchers and local commissioning managers, and hence in facilitating access to observe meetings and workshops. The research team was able to secure the

ongoing co-operation of the sites in the study, despite organisational change, and the offer of support was an important factor in this.

Managers and clinicians in the sites clearly appreciated having at their disposal a free resource in terms of advice, facilitation, and data analysis. In this way, the building into the research design of a support role by researchers proved important not only in relation to helping local commissioners develop their practice, but also in helping the execution of the study, thus enabling richer and more sustained insights by the research team. The research team were seen as 'useful' to the sites, even when (and perhaps as a result of) the significant organisational turmoil in which they found themselves. It was however hard, within a relatively short study, and where initiatives were developed for small populations, to track the specific impact of the commissioning developments.

The research provided a rich and detailed insight into the work of commissioners, and the extent to which they were carrying out the different tasks associated with the 'cycle of commissioning'. Analysis of this observed practice enabled the research team to develop pointers as to how commissioning might move forward in the NHS, with a stronger emphasis on setting clear objectives and tracking outcomes, and being alive to the need to keep a check on relational commissioning which is likely to crowd out the transactional and 'tough' elements. From the close-up assessment of the work of commissioning, important insights were gained into the operation of the NHS market, and these were used to set out potential implications for the local practice of commissioning and research (see sections 6.4 and 6.5).

6.4 What does this mean for local health care commissioning more generally?

6.4.1 The effort involved in commissioning has to be worth the output and outcomes

This study has revealed that the practice of commissioning is typically labour-intensive. In particular, as enacted by PCTs, it entails extensive stakeholder engagement, reviewing current service provision, discussing the design of future provision, developing specifications for new care contracts, and working with clinicians and others to influence them to adopt new practices. The commissioning challenge centres on drawing different professionals and interests together around the common cause of a service for a specific clinical condition, and bringing about integrated services that can better meet patients' needs.

Whilst the 'labour' of commissioning was observed to be extensive and resource-hungry, what was less evident was the articulation of clear objectives for commissioning, and activity focused on assessing outputs and outcomes, in other words, the impact associated with such commissioning labour. This leads us to question how far a health care system can afford this labour of commissioning, and a model of commissioning that calls for the different stages of the 'Ovretveit cycle' to be carried out in a systematic manner, and how it will keep check on the cost-effectiveness of its commissioning practice.

The implication of this observation is that commissioners need to be attentive to the cost of their practice, and display rigour in setting clear and measurable objectives for a programme of commissioning work. They need to keep a check on the process of commissioning, ensuring that resource expended is proportionate to the intended service development. They also need to be mindful of when they need to stop consulting and engaging, and move to the procurement phase of their work, in effect 'cutting a deal'. This tougher aspect of commissioning appeared often to be absent from the practice observed in this research and/or taking place (via senior finance colleagues) in parallel to the service development and consultative work led by commissioning managers.

At a time when NHS management resource is being reduced by 45%, support and capacity for commissioning will be under significant strain, and this research suggests that choices will have to be made as to how much of the engagement and developmental work commissioners will be able to do. Indeed, it would seem that attention will have to be given to determining a programme of activity that addresses a few core commissioning priorities, with time and resource focused judiciously on these areas, and a careful project plan used to guide progress and enable decision making at critical points.

In a publicly funded health care system, commissioning has to demonstrate its worth in relation to its ability to improve health and health services, and to do this within constrained resources. This research took place in a context of the NHS shifting from a time of significant investment in health care, to a new period of relative austerity and effectively flat funding. This begs a question as to how far the expanded role of commissioning as convenor and developer of the local health care system is sustainable for the next phase. Commissioning may in future need to assume a more disciplined approach whereby progress can be clearly measured, and value for money demonstrated in a public and transparent manner.

6.4.2 Commissioning for long-term conditions seems to differ from elective services, and requires a more sophisticated approach

This research concentrated on the commissioning of care for people with long-term conditions. A question therefore has to be asked as to how far services for this client group call for and/or result in an approach to commissioning that differs from that used for other services. Our observation of the practice of commissioning care for people with diabetes, dementia and stroke suggests that these services call for a more complex approach to planning, procurement and review that do those that are more easily 'commodified' within a purchaser-provider market. By their nature, these services are provided over months and years, by a range of professionals, and are not easily split into single episodes. It is for this reason that pilots such as the Year of Care[115] have been developed for diabetes services, as was piloted in Calderdale over the period 2007-2010.

The traditional NHS cycle of commissioning - with its apparently sequential and logical progression from needs assessment, to specification, procurement, contracting, review and re-commissioning – appears more suited to specific episodes of care, and to a situation where a funder can place a single contract with one or more providers. Services for people with long-term conditions seem on the other hand, to call for a greater degree of provider involvement in planning, along with a stronger awareness of patient and carer experience across organisations and time. As noted before, this adds to the labour of commissioning, and requires the commissioner to engage in a convenor and organisational development role, seeking to draw together a pathway of care across services and organisations.

In this research, we observed some of the tensions that arise where an element of a wider service is parcelled off for commissioning, as with diabetic podiatry in the Wirral, which appeared somewhat abandoned from the wider diabetic service, caught between contracts and providers. In other cases however, the long-term condition was observed to have an overall commissioning strategy, within which aspects of care were commissioned as entities, as with the memory assessment service in Wirral, which in turn formed part of the overall dementia strategy for the area.

International experience in planning and funding care for people with long-term conditions confirms the trend towards having different approaches to contracting for such care. For example, there have been experiments in commissioning 'chains of care' in Sweden[145]. In New Zealand, health care funders and providers are experimenting with 'alliance contracting' as they seek to bring about better integration of services for older people and those living with chronic disease. Alliance contracting is an approach drawn from the construction industry and entails the funder and providers committing to a single 'alliance contract' within which risk and gains are shared as part of

an overall agreement to achieve specific outcomes, and trust is regarded as the cornerstone of the approach, with rights to litigate the contract given up.

Another example from overseas that is being explored in a number of health care systems where funders want their providers to work together in new arrangements to share risk and commit to joint outcomes (health, patient experience and financial) is that of the 'accountable care organisation' [146] which originates from the USA. There are demonstration sites of accountable care organisations, with some based on a hospital that takes responsibility for primary and community health services in delivering overall health outcomes for a local enrolled population, and others rooted in primary care organisations that reach into hospital care, retaining responsibility for patients when in acute care, with specialist care sub-contracted to the main accountable care organisation.

In England, there has been experimentation with new forms of commissioning care for people with long-term conditions, echoing the Swedish, New Zealand and US examples above, as commissioners attempt to draw together a range of providers into a single contractual agreement where gains and risks are shared. Examples include the cardiovascular service for the people of Knowsley[147] and the Connected Care pilots supported by the charity Turning Point which co-ordinate community input to joint commissioning[148].

These examples reinforce the impression gained in our research that long-term conditions appear to call for an approach to commissioning that can engender co-operation across organisations and services. This is not surprising, for patients and carers experience services across organisations, but the approaches are challenging for NHS commissioners in that they move beyond the traditional NHS market form of commissioning which is based on a model of contracting for episodes of care using a standard national tariff.

6.4.3 Commissioning appears to have moved beyond the purchaser-provider split

Commissioners of services for people with long-term conditions seem increasingly to be working as the local health care system convenor. Their role appears to have extended into a new service development and implementation roles, along with service review and planning. Thus the 'cycle of commissioning' seems to have had at least one new stage added (that of convening local stakeholders, together with supporting implementation of service change) with a consequent blurring of the conventional distinction between the roles of purchaser and provider. The

apparent simplicity of quasi-market articulation of purchasers calling the shots in how they specify contracts, procure services, and monitor performance has, based on our research, developed into a more nuanced relationship where funders and providers work together to try and solve complex service delivery problems, drawing in a range of stakeholders across what has formerly been called the 'purchaser-provider split'.

The NHS management community seems therefore to be more comfortable with relational contracting that operates in a more consensual manner, focusing on keeping the system going, trying to resolve problems with existing service provision, and delivering the current requirements of NHS policy. Our research found less evidence of the transactional aspects of commissioning being central to commissioners' discussions about how to develop care for people with long-term conditions.

In part, this appears to be because the use of contracts and funding mechanisms to engender change seemed to be debated elsewhere (in contract negotiations led by senior finance personnel and commissioning directors), and leads us to conclude that NHS commissioners may (especially when assuming a role of local health care system convenor) be less comfortable with challenging the status quo, decommissioning, and seeking new providers.

This divorcing of the more relational (service review, design and development) aspects of commissioning from the transactional aspects (contracting and performance monitoring) within the local practice of commissioning, calls into question how far the NHS market operates as a market in the way that policy makers may have intended, or whether elements from the cycle of commissioning are taken and applied in a manner that helps clinicians and managers to shape services for the future.

Another analysis of this apparent separation of the relational and transactional aspects of commissioning could be that NHS managers (especially middle managers charged with commissioning specific services) have become so 'embedded' within the local health system that they find it hard to adopt a more separate or objective position and use the levers of contracts and funding to negotiate service change with providers. Thus the blurring of the purchaser-provider split seems at times to take place at the level of the managers themselves, as well as within the activity of commissioning. In similar vein, senior managers and clinicians from provider organisations were observed to assume a 'commissioning' role. How far it matters which managers assume commissioning roles in a local health care system is open to debate.

Our research focused deliberately on the commissioning of care for people with long-term conditions. It is therefore impossible to assert that NHS commissioning as a whole is moving beyond the purchaser-provider split. In

the area of long-term conditions however, it appears that the 'pure' purchaser-provider split may have been found wanting, and local managers and clinicians are developing more relational approaches to commissioning that draw together multiple providers to plan and develop new forms of care. What remains to be seen is how such arrangements will be enacted through contracts, tough decisions made about investment and disinvestment in increasingly financially constrained times, and how providers will be held to account for the performance and outcomes of services for people with chronic disease.

6.4.4 Commissioning will require specific attention and support as it develops

This research revealed that core elements of the practice of commissioning are highly valued by local clinicians, managers, and representatives of patient groups. These include:

- thoughtful and critical review of current service provision for a client group;
- discussion of how such provision might be developed and improved for the future;
- design of new service specifications;
- commissioning of services in line with such specifications; and
- support to put these new services in place within the local health system.

It seems more difficult for the local management community to bring into commissioning practice the 'tough talk' of numbers (activity and finance), performance (how far services are delivering in accordance with regional and national benchmarks), and removal of services that no longer meet local needs.

At a time of constrained resource for management support in the NHS, and a proposed shift to a new model of commissioning with GPs in the lead, it would appear that commissioners will require significant support in working out how to preserve what has worked best to date, and which elements of their 'commissioning labour' might be redundant, or at least a luxury that can no longer be afforded. This is likely to include consideration of how far the 'commissioning cycle' is helpful for NHS commissioning, or at least for which services it makes most sense. For long-term conditions, clinical commissioners may wish to examine experience from other sectors (e.g. Connected Care from the third sector) or overseas (e.g. chains of care from Sweden[146], or alliance contracting from New Zealand[149]) as alternative ways of aligning providers' interests with those of commissioners in ways that can

assure the achievement of shared goals for health outcomes and financial performance.

Our offer of development and facilitation support to sites in this study revealed the areas in which local commissioners who had been assessed as relatively high performers appeared to feel a need for additional input as they set about commissioning care for people with long-term conditions. Most notably, they sought assistance with the design and facilitation of service review workshops, chairing of meetings at which the future direction of a specific service needed to be determined, distillation of public health and other research evidence to support service development plans, and exploration of different approaches to the use of predictive risk and other data analytical techniques. It is of note that even in a context of PCT commissioning, local managers and clinicians took up offers of additional support. They also sought regular informal feedback about their performance from members of the research team, and used monthly update phone calls by the researchers as an opportunity to talk through what was helping or hindering their practice.

This seeking of assistance and use of such opportunities as a basis for reflection suggests that commissioners, given the complexity of their task, value having expert advice and support. As commissioning adapts to meet the requirements of a new policy context, and with less capacity available as a result of financial constraints, the judicious provision of practical and technical support for commissioning, along with organisational and personal development input for the managers and clinicians in lead roles locally, will be important.

This research has revealed the practice of commissioning to be at once laborious and yet likely to be critical to the development of effective local networks of providers and commissioners. It is a complex and at times contested process, and much less 'neat' than the cycle of commissioning indicates. Commissioning encapsulates activities that lead to decisions about what health services are provided locally and how. The commissioner as conductor of the orchestra is perhaps relatively invisible when things are going well, but ultimately accountable for the quality and performance of the local health care system. The way in which commissioners practise their craft goes beyond the theory as set out in government policy about the stages of commissioning, at least when seeking solutions to some of the complex challenges presented by long-term conditions and care that transcends numerous organisations and professionals.

The challenge for the next generation of commissioners is to examine the commissioning practice of their predecessor PCTs and practice-based commissioners to decide in a critical manner which elements of that labour are important for the next phase, and what aspects could be left to providers or abandoned all together.

6.5 Implications for future research

6.5.1 This research in the context of previous studies

The findings of this research illuminate the day-to-day practice of commissioning, and help demystify what is often a rather opaque and under-acknowledged function within the management of the NHS, certainly in comparison with roles such as managing a hospital, being responsible for the finances of an organisation, or advising on human resource issues. As explored in Chapter 1, much of the existing research into NHS commissioning is concerned with the organisation and governance of commissioning. For example, there have been numerous studies tracking the introduction of new forms of commissioning, and other research into the practice of primary care-led commissioning, but few that seek to answer questions about the day-today activities of commissioning, such as 'what do commissioners do?', 'who does the commissioning work?', 'what seems to help or hinder commissioning practice?'

The research reported here starts to answer these questions, giving a picture of what PCTs were doing as they sought to commission care for people with long-term conditions, who they worked with, the importance of the role of the middle manager (confirming the findings of Checkland et al[79], what achievements they made, and what seemed to facilitate these. It also reveals how national policy guidance (clinical and managerial) was implemented and mediated at a local level, and giving an insight into how commissioners were dealing with one of the frequent organisational changes to which they have been subject in the NHS for over two decades. This study is distinctive in its focus on the day-to-day practice of commissioning, and its examination of all stages of the 'commissioning cycle', for there have been some studies concerned with contracting, procurement and the more transactional aspects of commissioning[150,151].

The study reveals how the relational aspects of commissioning are predominant, at least in the commissioning of care for people with long-term conditions. Transactional elements of commissioning appeared to be left to those in other departments such as finance or information, and thus the 'cycle of commissioning' itself appears to have been itself divided up into manageable tasks for different groups of people, calling into question how far the synergy of a cycle of activities (service design, procurement, contracting, review) can be maximised for the benefit of a population. Furthermore, as with the work of Sampson, O'Cathain and others[152], this research has demonstrated how hard it is to get commissioners to move from the aspirational to the specific, and set out clear objectives with associated measurements of outcomes.

6.5.2 Implications for future research

This examination of the day-to-day practice of commissioning care for people with long-term conditions in the NHS in England highlights a set of questions for future research, given the apparently persistence of English politicians in putting faith in commissioning to deliver improved health, greater efficiency, and services that meet local needs. These questions include:

- what will commissioners do (and have the time and resource to do) as management resources are reduced? Will there be a shift from the relational to the transactional, and if so, what will be the implications for the culture and practice of NHS management at a local level?

- will GP commissioners have the time and inclination to engage in the extensive labour of commissioning carried out by PCTs, and if not, who (if anyone) will do it? Will future contracts place greater and more explicit responsibility on providers for service improvement and development?

- how will commissioners set priorities and decommission services, in a time of constrained expenditure on the NHS, when it appears that they are more comfortable with work to improve and expand services at the margin?

- will the new NHS Outcomes Framework lead to a sharper focus on setting specific objectives for more clearly defined pieces of commissioning work, and enable more systematic assessment of the fruits of the commissioners' labours?

- how will commissioners initiate and track progress with contracting for whole care pathways, as experiments in integrated care gain momentum?

- how will GP commissioners work with their managers and commissioning support providers - including data analysts, finance specialists, and public health experts - will they draw these activities into a more coherent cycle of commissioning that has a strong focus on outcomes and effectiveness?

In a publicly funded health care system, with goals of value for money, and equity of access and outcomes, there is an inescapable need for a commissioning or planning role that acts as agent for the patient and population, deciding what is to be spent, how, and to what effect. This is an intrinsically difficult role, as shown by international analysis[16]for outcomes are hard to measure and demonstrate, and commissioning does not take place in isolation - it interacts with other mechanisms such as payment systems, the management of providers, and the degree of competition operating in the health care system. This research team was privileged to have the opportunity to observe the hard and complex work of commissioning relatively close up, and to explore the experience of those

engaged in the work. Analysis of this commissioning labour provides the basis for calibrating the expectations placed on health care commissioning in the NHS and elsewhere, and offers insights into how this difficult role might be performed in a more effective manner in the future and what achievements it might reasonably be able to deliver.

Appendix 1 Selected national policy documents, developmental resources and clinical guidance documents related to commissioning care for people with long term conditions (LTC) (from 2001 to 2011)

Year	Author and Title	Key themes and aims of the guidance
2005	Department of Health "*Supporting people with long term conditions: An NHS and social care model to support local innovation and integration*"[153]	Development resource pre-empting the publication of the NSF.
	Department of Health "*The National Service Framework for Long-term Conditions*"[28]	Policy document promoting patient centred care, self care and integrated services.
2006	Department of Health "*Supporting people with long term conditions to self care: A guide to developing local strategies and good practice*"[154]	Development resource for commissioners and providers to develop local strategies to deliver self care for patients with LTCs including staff training, patient education and access to self care guidance.
2007	Department of Health "*Long term conditions National Service Framework; Good practice and examples*"[155].	Development resource providing examples of good practice addressing the quality requirements from the NSF for LTCs.
2008	Lord Darzi/ Department of Health "*High Quality Care for all: NHS next stage review final report*"[ii][156]	Set strategic direction for supporting people with LTCs: care closer to home, personal health budgets, care planning, named care co-ordinator
	Department of Health "*Supporting people with long term conditions: commissioning personalized care planning – a guide for commissioners*"[157]	Development resource to help local services and commissioners to develop strategies to support self care for patients with LTCs.

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2009	Department of Health "*Improving the health and well-being of people with long term conditions. World class services for people with long term conditions: information tool for commissioners*"[158]**Error! Bookmark not defined.**	Development resource for commissioners.
2010	Kings Fund "*Managing people with long term conditions*"[159]	

Table 29. **Selected national policy documents, developmental resources and clinical guidance documents related to commissioning diabetes care (from 2001 to 2011).**

Year	Author and Title	Key themes and aims of the guidance
2001	Department of Health "*National Service Framework for diabetes: standards*"[30]	Policy document focusing on primary prevention, patient centred care and self management.
2003	Department of Health "*National Service Framework for diabetes: delivery strategy*"[31]	Development resource for commissioners. Key elements included development of local diabetes leads/champions and networks, the need to audit provision, and investment in staff development for those who care for people with diabetes.
	Department of Health "*Guidelines for the appointment of general practitioners with special interests in the delivery of clinical services: diabetes*"[41]	Development resource for commissioners.
2004	NICE "*Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults: (Clinical Guidance (CG) 15)*"[45]	Clinical guidance. Specific focus on patient centred care, multi-disciplinary teams, education, blood glucose control, arterial risk-factor control and late complications.
	NICE "*Type 2 diabetes; Prevention and management of foot problems (Clinical Guidance (CG) 10)*"[48]	Clinical guidance. Focused on primary prevention, diagnosis and management of foot problems in adults and children with type 2 diabetes in primary and secondary care.
2006	Department of Health "*Diabetes Commissioning toolkit*"[40]	Development resource for commissioners providing guidance on needs assessments, generic specifications for diabetes care, signposting, recognised quality markers and suggesting key outcomes.
	Department of Health "*Care planning in diabetes: Report from the joint Department of Health and Diabetes UK Care Planning Working Group*"[44]	Development resource providing guidance for commissioners and professionals on how to put care planning into practice. Care planning allows patients to have active involvement in how their condition is managed and allows you to have active involvement in deciding, agreeing and owning how your diabetes is managed

	National Diabetes Support Team and Department of Health "*How to Assess Structured Diabetes Education: An improvement toolkit for commissioners and local diabetes communities*"[42]	Development resource for commissioners commissioning patient education programmes.
2007	Department of Health "*Working together for better diabetes care*" [43]	Development resource providing guidance on partnership working between clinicians in primary and secondary care, and improving patient engagement.
2008	NICE "*Type 2 Diabetes: full guidance (CG 66)*" [46]	Clinical guidance.
	NICE "*Diabetes in pregnancy: CG63 (re-issued July 2008)*"[50]	Clinical guidance.
	NHS Institute for Innovation and Improvement. "*Focus on: Inpatient care for people with diabetes*"[160]	Inpatient care. Outlined strategies to improve the prevention and treatment of acute foot problems in hospital.
	NHS National Diabetes Support Team, Department of Health and Health Foundation "*Getting to grips with the Year of Care: a practical guide.*"[161]	Development resource for commissioners and providers to implement Year of Care programmes
2009	NICE "*Type 2 Diabetes: newer agents (a partial update of CG 66) short guideline: CG87 (CG 87)*"[47]	Clinical guidance.
2011	NICE "*Diabetic foot problems Inpatient management of diabetic foot problems (CG 119)*"[49]	Clinical guidance. Key components of inpatient care for people with diabetic foot problems.
	NICE "*Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population: Public Health Guidance 35*" [51]	Public Health Guidance.
	NICE "*Diabetes in adults quality standard*"[162]	**Developmental resource** for clinicians, managers and patients, setting out thirteen aspects of what a good quality service should look like

Table 30. **Selected national policy documents, developmental resources and clinical guidance documents related to commissioning stroke care (from 2001 to 2011).**

Year	Author and Title	Key themes and aims of the guidance
2004	Royal College of Physicians, "*National Clinical Guidelines for Stroke, Second edition*"[163]	**Clinical guideline** on the management of stroke.
	"Stroke in childhood: Clinical guidelines for diagnosis, management and rehabilitation"[164]	**Clinical guideline** on the management of stroke in childhood.
2007	Department of Health "*National Stroke Strategy*"[54]	**Policy document.**
2008	NICE "*Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) (CG 68)*"[165]	**Clinical guideline.**
	NICE. "*Service for the diagnosis and initial management of acute stroke Implementing NICE guidance Commissioning guide*"[166]	**Developmental resource.** Provides support for the local implementation of NICE clinical guidelines through commissioning.
	NICE. "*Service for the diagnosis and initial management of transient ischaemic attack and non-disabling stroke. Implementing NICE guidance Commissioning guide*"[167]	**Developmental resource.** Provides support for the local implementation of NICE clinical guidelines through commissioning.
2010	NAO "*Progress in Improving Stroke Care*"[56]	**Audit report.**
	Department of Health "*Life after stroke: commissioning guide*"[168]	**Developmental resource.** Provides support for the local commissioners and providers to improve care of those after a stroke.
	Department of Health. *Stroke Quality*"[57]	**Developmental resource** for clinicians, managers and patients, setting out eleven aspects of what a good quality service should look like

Table 31. **Selected national policy documents, developmental resources and clinical guidance documents related to commissioning dementia care (from 2001 to 2011).**

Year	Author and Title	Key themes and aims of the guidance
2001	Department of Health "*National Service Framework for Older people*"[169]	**Policy document** included a chapter on mental health and older people. This included a consideration of dementia, advocating early diagnosis and intervention.
2005	Department of Health and the Care Services Improvement Partnership "*Everybody's Business. Integrated mental health services for older adults: a service development guide*"[170]	**Developmental resource.** Sets out characteristics for services providing older peoples mental health care, including memory assessment units (for early diagnosis and community mental health teams).
2006	NICE "*Dementia: Supporting people with dementia and their carers in health and social care. (CG 42)*" [62]	**Clinical guidance.** Outlined key priorities for implementation including support for carers, coordination of health and social care, use of memory assessment services, care planning and staff training.
2007	The National Audit Office "*Improving Services and Support for People with Dementia*"[171]	**Audit report.** Recommended investment in services for early diagnosis and intervention, improved specialist community services, and hospitals to enable long-term cost savings from the prevention of unnecessary transition into care homes and shorter stays in hospital.
2009	Department of Health "*Living well with dementia; A National Dementia Strategy*"[60]	**Policy document** focusing on early diagnosis and intervention, and providing high quality care. Also provides advice and guidance for commissioners and providers in the planning, development and monitoring of services.
	Department of Health "*Living Well With Dementia: A National Dementia Strategy - Implementation Plan*"[61]	**Developmental resource.** Sets out how the Department of Health intends to support delivery through its national and regional structures.
2010	National Audit Office "*Improving Dementia Services in England – an Interim Report.*" [172]	**Audit report.** Identified concerns about the level of funding available to develop dementia care, lack of clinical leadership, and poor integration of services.
	Department of Health "*Quality outcomes for people with dementia: Building on the work of the National Dementia*	**Policy document.** Sets out key priorities for delivery of the NDS.

	Strategy"[63]	
	Department of Health "*Nothing ventured, nothing gained: Risk Guidance for people with dementia*"[173]	**Developmental resource**. Guidance on best practice in assessing, managing and enabling risk for people living with dementia.
	NICE "*Dementia quality Standard*"[177]	**Developmental resource** for clinicians, managers and patients, setting out ten aspects of what a good quality service should look like
2011	Department of Health "*Living well with dementia Good Practice Compendium – an assets approach.*"[174]	**Developmental resource**. Examples of good practice in dementia care and delivery towards the NDS across England.
	NICE "*Dementia. Supporting people with dementia and their carers in health and social care. (updated March 2011). (CG 42).*"[175]	**Clinical guidance.** CG 42 updated with NICE technology appraisal of drugs for Alzheimer's disease. All other guidance remains unchanged.

Appendix 2: Project Management Group

Membership

Name	Position
Martin Bardsley	Director of Research, Nuffield Trust
Ian Blunt	Senior Research Analyst, Nuffield Trust
Alisha Davies	Public Health Trainee on placement at Nuffield Trust
Elizabeth Eastmure	Project Manager, Nuffield Trust
Nicolas Mays	Professor of Health Policy, London School of Hygeine and Tropical Medicine
Alison Porter	Senior Research, Nuffield Trust
Rebecca Rosen	Senior Research Fellow, Nuffield Trust
Sara Shaw	Senior Lecturer, Queen Mary University of London and Visiting Senior Research Fellow, Nuffield Trust
Judith Smith (PI)	Director of Policy, Nuffield Trust

Appendix 3: Interview Schedules

FIRST ROUND STRATEGIC INTERVIEWS
Schedule for interviews with senior informants with a strategic perspective

1. **Can you describe to me current healthcare commissioning structures and practice in this area in relation to long term conditions?**

   Who are the different organisations involved? What are the relationships between the organisations? What's working well? What's not working so well?

2. **The expression 'cycle of commissioning' is sometimes used to describe the kind of processes which your organisation is involved in. What form would you describe the cycle of commissioning as having in this area?**

   Which aspect/process do they put the emphasis on? Do they think the idea of a cycle corresponds to reality?

3. **How are GP commissioning consortia developing in this area?**

   What role is the PCT(or cluster) playing? Who are the leading/influential people, Role of external organisations (eg consultancies)? Sense of common purpose between GPs/diversity of aspiration and interest? How might the development of GP consortia evolve over the next 12 months?

4. **In what other ways do you think current NHS reforms are going to have an impact on commissioning over the next 12 months or so in this area?**

   Clustering, End of SHAs; New regulators; National NHS commissioning board; Restructuring of public health; Continuing operation of the PCT

5. **What do you think the picture of healthcare commissioning will be like in this area in 3 years' time?**

   How stable and organised will the system be? Who will be the key players? What roles will they have? What changes are their likely to be in terms of patient experience?

6. **What do you feel are the key challenges facing your work at the moment?**

   In terms of responding to change/restructuring? In terms of delivering health care?

7. **Is there anything else you would like to add?**

FIRST ROUND HOOK INTERVIEWS
Schedule for interviews with key informants involved in each hook

1. **Can we talk about the work that's underway here on [describe 'hook']? Could you tell me about how the idea came about?**

   From external guidance/policy or originated locally, What were the triggers for working on it; Role of money/financial incentives; Key people/organisations; Back story/context; Fitting in with the bigger picture of planning/service provision

2. **Taking a look at this diagram of the cycle of commissioning [show diagram], can you talk through the various stages and what has happened?**

   How far have they got; Has there been a logical flow from one stage to another; How closely has reality reflected the cycle

3. **Who has been involved in the work?**

   Which people/ which organisations? What has respondent's role been? How have involvement/roles changed over time? Why these people?

4. **How have the various people/organisations involved worked together on [the hook]?**

   Who has been leading the work/making sure it happens? Who has been doing the routine work to implement the ideas? Different agendas/expectations? Professional identities? Can you give examples of working together?

5. **How will you judge whether the work you are carrying out has been successful?**

   What are they hoping to achieve? What are the mechanisms by which they will measure success? Do the different players involved have different perspectives on this?

6. In relation to [the hook], what do you think has worked well so far?

Under control of respondent or outside their control? What do you think has facilitated this?

7. And what has not worked so well in relation to the hook?

Things which have already happened/scope for improvement from now on? What do you think has inhibited progress?

8. Looking forward, how do you see this project developing?

Hopes for the future (process, outcomes); Changing roles/personnel; Potential threats (external); Potential risks (inherent)

9. Is there anything else you would like to add?

SECOND ROUND OF INTERVIEWS
Schedule for interviews with senior informants with a strategic perspective

1. **When we talked previously, the health service reforms in this area had led to [*state of play at time of first interview*]. How have things progressed since then?**

   - *Formation of GP consortia*

   - *Formation of commissioning support structures*

   - *Clustering*

   - *Impact on remaining PCT functions and staff*

   - *Specifically affecting work on long term conditions*

   - *Achievements in terms of efficiency savings*

2. **Have things progressed in the way you anticipated?**

   - *If no, what has been different?*

   - *More difficult or more straightforward?*

   - *What has caused things to be different from what you anticipated?*

3. **At the time of the last interview, you felt that [*whatever they said in the last interview*] seemed to be the main challenges facing the health economy locally. Looking ahead now, would you say these are still the same?**

   - *If not, what new challenges would they identify?*

   - *Specific challenges in relation to long term conditions*

   - *How sustainable are current models of commissioning activity?*

SECOND ROUND INTERVIEWS
Schedule for interviews with key informants involved in each hook

1. **When we interviewed you before, [fill in the gap] was happening. How have things moved on since then – where are we at now?**

   Achievements, Challenges; Variations from plans; Change in clinicians' professional practice; Contribution to efficiency savings; If little progress, why not?

2. **What are the plans for progressing work on [the hook] over the next six months?**

   And in the longer term? How much confidence do they have that this will happen? What might inhibit progress? What do you think might help progress? Sustainability of current model of commissioning activity?

3. **How do you think the current health service reforms have affected this area of work?**

   Impact of cuts to funding for commissioning support? Impact of people leaving? Progress with CCG(s)? Can you give examples? Do you think that your colleagues would feel the same?

4. **While we've been researching commissioning, we have noticed that it's not easy to sum up what commissioning is in a way which everyone would agree on. How would you define commissioning?**

   If they need prompting, ask them to think specifically about what is going on around the hook? Who are the commissioners?

5. **Our project has had an action research model – in other words, we have tried to give something back during the research by providing feedback, support and so on. How do you feel this has worked out in practice?**

Have they been aware of this? If so, did our input meet their expectations? Do they think our input has made any difference? If so how/what?

6. [only if relevant] **A question which asks them to fill in the gaps on the hook – any missing facts or queries we have**

SECOND ROUND OF INTERVIEWS

Draft schedule C for interviews with key informants who weren't previously interviewed during the first round

1. **Can we talk about the work that's underway here on [describe 'hook']? Could you tell me about how the idea came about?**

   From external guidance/policy or originated locally? What were the triggers for working on it? Role of money/financial incentives? Key people/organisations? Back story/context? Fitting in with the bigger picture of planning/service provision?

2. **Taking a look at this diagram of the cycle of commissioning [show diagram], can you talk through the various stages and what has happened?**

   How far have they got? Has there been a logical flow from one stage to another? How closely has reality reflected the cycle?

3. **Who has been involved in the work?**

   Which people/ which organisations? What has respondent's role been? How have involvement/roles changed over time? Why these people

4. **How have the various people/organisations involved worked together on [the hook]?**

   Leadership/domination? Who does the donkeywork? Different agendas/expectations? Professional identities? Can you give examples of working together?

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5. How will you judge whether the work you are carrying out has been successful?

What are they hoping to achieve? What are the mechanisms by which they will measure success? Do the different players involved have different perspectives on this? Impact of the work on clinicians' professional practice?

6. In relation to [the hook], what do you think has worked well so far?

Under control of respondent or outside their control

7. And what has not worked so well in relation to the hook?

Things which have already happened/scope for improvement from now on

8. Looking forward, how do you see this project developing?

Hopes for the future (process, outcomes)? Changing roles/personnel – including impact on clinicians' professional practice? Potential threats (external)? Potential risks (inherent)? Sustainability of current model of commissioning activity?

9. Is there anything else you would like to add?

Appendix 4: Social network survey

Networks of advice and influence on care for people with diabetes

This survey is about who you turn to for advice about managing patients with diabetes. It also about which people, organisations and events have influenced your knowledge and clinical practice in three areas of diabetic care: Self-management support for patients; use of new medications; and insulin initiation. Findings from the survey will improve understanding of how information about best practice and changes to local services can best be communicated through professional communities of practice.

The results will be used to develop a 'social network map', identifying people who are central to the dissemination of knowledge about diabetes care and the links between them and other local clinicians. In the questions below, you are asked to name individuals who inform or advise you. These names will not appear in the resulting social network maps or research reports, which will maintain the anonymity of survey respondents and the people they name.

GP Name………………………………... Practice Name…………………………………..

Number of Partners in practice .... Number of salaried GPs in the practice..........

Are you a GP partner ☐   A salaried GP   ☐

Number of nurses in the practice ....

1. Do you have a special clinical interest in diabetes   Yes ☐   No ☐

2. Are you involved in commissioning diabetes services?   Yes ☐   No ☐

3. Do you have a service development role for diabetes?   Yes ☐   No ☐

4. Do you see diabetic patients referred by other GPs Yes ☐   No ☐
   in your practice ?

5. Do you see diabetic patients referred by GPs from   Yes ☐   No ☐
   other practices?

6. If you needed advice on the management of a complicated diabetic patient who would you turn to? (please provide name, job title and organisation)

   (eg: Dr Bill Smith, GP. Keepwell Practice, Jill Brown, practice nurse, Keepwell Practice)

   ....

....

....

We would like to know which people have improved your knowledge about three areas of diabetes care *over the last 12 months.*

In each of questions 7 – 12, please tick as many of the boxes as apply to you. You may name clinicians from the local area or from further afield. There is a list of local GPs and diabetes specialists at the end of this document as an *aide memoire.*

7. During the last year which, if any, of the following people have enabled you to improve your knowledge in relation to **self-management support for patientswith diabetes**?

	Yes	Please give name(s) and job title
Colleague(s) in my practice	☐	....
GP w special interest in diabetes	☐	....
Diabetes specialist nurse	☐	....
Local hospital specialist(s)	☐	....
Diabetes expert outside this area	☐	....
PCT Medical Director	☐	....
PCT clinical lead for diabetes	☐	....
PCT Director of commissioning	☐	....
Lay person	☐	....
Diabetes UK representative	☐	....
Drug reps	☐	....
Other	☐	....

8.   If you have improved your knowledge of self-management support for people with diabetes during the last year, has this led you to change your clinical practice?

Yes   ☐   No   ☐

9. During the last year which, if any, of the following people have enabled you to improve your knowledge **about new diabetic medications including non-insulin injectables such as Exenatide**?

	Yes	Please give name(s) and job title
Colleague(s) in my practice	☐	....
GP w special interest in diabetes	☐	....
Diabetes specialist nurse	☐	....

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Local hospital specialist(s)	☐	....
PCT Medical Director	☐	....
PCT clinical lead for diabetes	☐	....
PCT Director of commissioning	☐	....
Diabetes expert outside this area	☐	....
Lay person	☐	....
Diabetes UK representative	☐	....
Drug reps	☐	....
Other	☐	....

10. If you have improved your knowledge of diabetic medications during the last year, has this led you to change your clinical practice?

Yes ☐   No ☐

11. During the last year which, if any, of the following people have enabled you to improve your knowledge of **where to refer patients for insulin initiation**

	Yes	Please give name(s) and job title
Colleague(s) in my practice	☐	....
GP w special interest in diabetes	☐	....
Diabetes specialist nurse	☐	....
Local hospital specialist(s)	☐	....
Diabetes expert outside this area	☐	....
PCT Medical Director	☐	....
PCT clinical lead for diabetes	☐	....
PCT Director of commissioning	☐	....
Lay person	☐	....
Diabetes UK representative	☐	....
Drug reps	☐	....
Other	☐	....

12. If you have improved your knowledge about where to refer people for insulin initiation during the last year, has this led you to change your clinical practice?

Yes ☐   No ☐

13. Overall, who do you think were the three most influential people in relation to improving your knowledge and understanding about local services for people with diabetes?

....

....

....

14. Overall, which were the three most influential information sources, courses or other resources in relation to improving your knowledge of diabetes care during the last year?

(please provide name, role and organisation)

1. ....

2...

3...

15. This table asks about which organisations, courses and other resources have helped you to improve your knowledge about three areas of diabetes care *during the last year*

If none, please write none in the top row of the relevant column

Name of potential influencing organisation or activity	During the last year, who has helped you to Improve your knowledge about supporting people with diabetes to self- manage their own condition ?	During the last year, who has helped you to improve your knowledge about new medications for diabetes including non-insulin injectablessuch as Exenatide ?	During the last year, who has helped you to improve your knowledge about local services for insulin initiation?
RCGP			
British Diabetes Association			
Local education course			
On-line study unit			
GP notebook or other on-line 'text-book'			
Fact sheet from Diabetes UK			
British Medical Journal			

BJGP			
Other journal (pls give name)			
Other personal reading			
NICE guidance			
Locally developed guideline on DM			
Other diabetes guidelines			
BNF			
Prescribing guidance			
Letter from a hospital consultant			
PLEASE ADD IN ANY OTHER RESOURCES YOU HAVE USED			

Appendix 5: Analysis of Social Network Data

Data collected through postal surveys were entered into an excel spreadsheet and reconciled with results from the from survey monkey questionnaire which were also downloaded into an excel spreadsheet.

Under the modified research proposal, survey data were to be used to map the social networks of GPs in relation to knowledge and skills on diabetes care and to develop social network maps depicting the position of the PCT clinical leads, local commissioners and others within the informant networks of local GPs.

In practice, the response rate was too low to allow a credible and complete social network map to be developed across all three PCTs, so with agreement from the steering group, a descriptive statistical analysis of responses was undertaken.   The number and proportion of GPs responding to different questions was calculated for the three PCTs combined and for each one separately. The analysis was focused on three domains: whether the respondent had a special interest in diabetes care and/or involvement in commissioning diabetes services.   The people who had helped respondents to improve their knowledge and understanding of diabetes care in the last year; and the resources they use (e.g. online resources; journals, seminars etc) to improve their knowledge and understanding of diabetes care. .

In addition to the descriptive statistical analysis presented above, results from Calderdale GPs – were the response rate was 44.5% - were used to develop a social network map. The response rate in the other two PCTs was considered to be too low to permit meaningful analysis of any networks. The survey data was used to develop a 54 x 54 cell grid in which the reported links between responding GPs, local DNS, hospital consultants and others were recorded. Data was entered in binary form (0 for no relationship and 1 for reported relationship) and transferred to UNICET software for further analysis. The data were used to visualise the reported links between services and to create a social network map using the UNICET visualisation software through Netdraw.

Appendix 6: Advisory Group – Membership and Terms of Reference

Membership

Name	Position
Celia Davies	Professor Emerita at The Open University Lay Member, Royal Pharmaceutical Society
Jennifer Dixon (Chair)	Director, Nuffield Trust
Nick Goodwin	Senior Fellow The King's Fund
Nicholas Hicks	Chief Executive and Director of Public Health NHS Milton Keynes
Richard Lewis	Director, Ernst and Young Senior Associate at the King's Fund
Robin Miller	Senior Fellow, Health Services Management Centre, University of Birmingham
Simon O'Neill	Director of Care, Information and Advocacy Diabetes UK
Sue Roberts	Clinical Lead for the Year of Care Programme, Diabetes UK; National Clinical Director for Diabetes [2003 – 2008]
Douglas Smallwood	Chief Executive Diabetes UK
George Solomon	General Practitioner; Lead GP of the Black Country GP Consortium
Bert Vrijhoef	Professor Chronic Care, Maastricht University Medical Center/Tilburg University, The Netherlands

Terms of reference

The project advisory group will provide expert intelligence and advice to the research team undertaking the project, with a particular focus on ensuring that project content and approach are focussed on the practical and current issues facing health commissioners and providers

The project advisory group will be chaired by Dr Jennifer Dixon, director of the Nuffield Trust.

Project advisory group members will be invited to provide peer review commentary on draft research instruments (e.g. questionnaires) and on draft reports where they feel able. They will be acknowledged within reports, where members of the advisory group feel comfortable with this.

The project advisory group will also provide advice on the overall content and presentation of messages emerging from the project.

The project advisory group will meet a maximum of 6 times during the course of the project, with email discussion in between as required.

Project advisory group members will also be invited to take part in two one-day national workshops, which will bring together representatives from all three study sites in order to distil common learning from the project.

Project advisory group members will be funded for travel expenses, but not for their time, which is being given by their host organisations.

Members of the advisory group will be named in the 'Acknowledgements' section of any published reports arising from the research project.

Final decisions about content and publication of project reports remain the responsibility of the Director of the Nuffield Trust, as is usual for Nuffield publications.

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