

Commissioning high-quality care for people with long-term conditions

Research summary

Judith Smith, Alison Porter, Sara Shaw, Rebecca Rosen, Ian Blunt and Nicholas Mays

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What exactly do commissioners in the NHS do? As the new NHS and Social Care Act 2012 puts so much weight on commissioners influencing the performance of providers of care, analysis of what commissioners do, and how they might be more effective, is very timely. The analysis in this report draws on in-depth research in three primary care trusts: Wirral, Calderdale and Somerset. The findings are used to identify what appears to help and hinder effective commissioning, and offer useful insights for clinical commissioning groups as they begin their work from April 2013.

Key Points

- This study explored what commissioners actually do to commission care for people with long-term conditions, and how this might be improved. The research was based on 15 months of detailed observation from November 2010 to January 2012 in three commissioning communities: Calderdale, Somerset and the Wirral. These sites were selected because on various indicators they appeared to be at the forefront of commissioning practice.
- In all three primary care trust sites, commissioning NHS care for people with long-term conditions was observed to be a very labour-intensive activity, characterised far more by ‘relational’ work (for example developing collaborative relationships and consensus with stakeholders) than harder edge critical challenge of providers. Commissioners tended to adopt a convenor role in the local health economy, drawing together different organisations to plan, contract and review care provided.
- The labour of commissioning by primary care trusts was often focused on making small but marginal service changes, for which the effort involved did not always appear proportionate to improvements in services or outcomes secured. Activities did not fit a neat annual commissioning cycle, but were found to overlap one another, and extend over a much longer period. Providers were closely involved in commissioning, and sometimes led areas of work to review and design services.



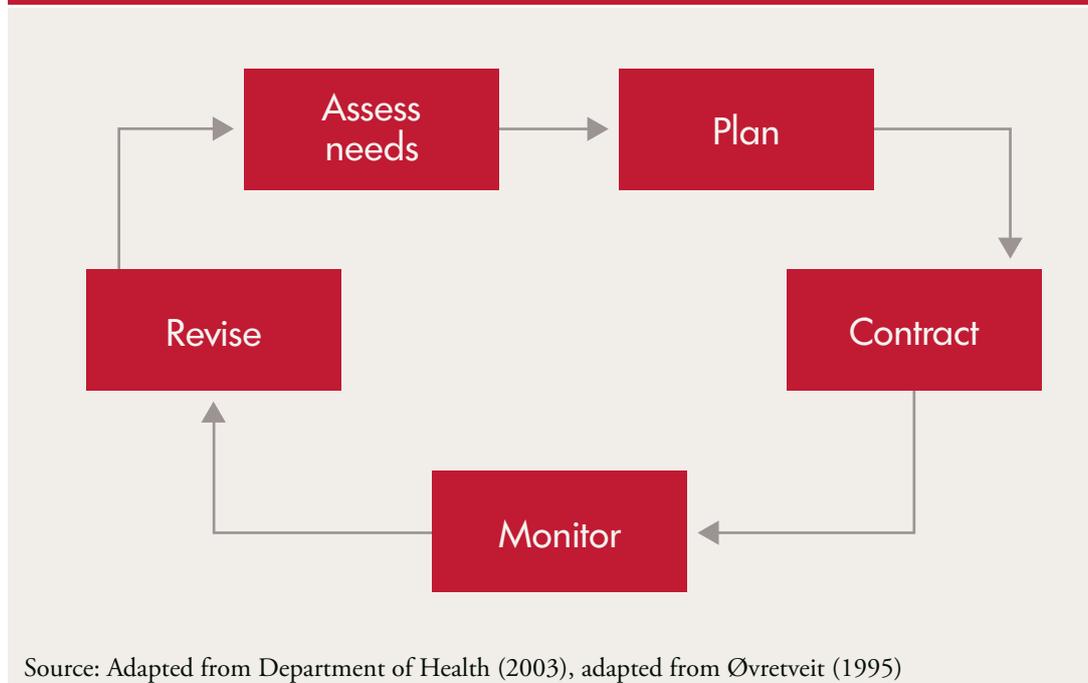
- In discussions about commissioning services for people with long-term conditions, financial matters seemed frequently peripheral, possibly because the services discussed were paid for using a block contract. This suggests that negotiations about finance took place elsewhere, possibly between finance directors of the primary care trust and the relevant provider, rather than commissioning or service managers.
- The effectiveness of commissioners in bringing about new or reshaped services was inhibited by: lack of resources to invest in supporting change; significant turbulence, for example staff turnover and organisational restructuring resulting from reforms in the Health and Social Care Act 2012; lack of data (real and perceived); and ingrained caution about destabilising local providers.
- Given constrained resources over the coming decade (Roberts and others, 2012), clinical commissioning groups will have to have a focused set of priorities and be able to justify them to local stakeholders such as HealthWatch and Health and Wellbeing Boards, including why they are concentrating on the redesign of certain services and not others within a particular time period.
- In the light of the Francis Inquiry Report, the quality of NHS-funded care provided to the population will come under greater scrutiny and commissioners will need to make judicious use of peer review and other data to support their decisions.
- GP-led clinical commissioning groups will take over responsibility for funding, planning and procuring health services for their local communities. As part of this role they will have to justify the way in which they commission care for people with long-term conditions. Clear goals, monitoring and review, with effective challenge of providers (backed up with data) are axiomatic. But so will be exploration of new forms of contracting and risk-sharing to ensure that the effort of commissioning is worth the cost – a question we are still asking after two decades.

Background

Commissioning is the process of aligning resources with the health needs of a population, within a defined budget. The model of commissioning used in the NHS derives from the concept of New Public Management (Ferlie, 1996), which makes a distinction between providers and purchasers of public services, and emphasises the importance of specifying standards and using contracts to secure and monitor provision of care.

One of the most influential analyses of health care commissioning is Øvretveit's (1995) work, which identifies a 'commissioning cycle' within which needs assessment, planning, contracting and review are repeated annually, as set out in Figure 1. The emphasis in Øvretveit's work on the broad functions of commissioning has been reflected in much of the research and policy analysis on the topic. Less emphasis has however been given to the detail of how commissioning is carried out in practice.

Figure 1: The commissioning cycle



Commissioning can take place at a number of levels, ranging from personal health budgets held by individual service users, to the commissioning of highly specialised services at a national level (Smith and others, 2004). The focus of the research reported here is on commissioning of primary and secondary care services at a local level; this was led by primary care trusts, the organisations which were, from 2002 to 2013, the local statutory purchasing bodies for the majority of NHS care in England, often working with GPs acting as 'practice-based commissioners'.

Since the late 1990s, commissioners in the English NHS – latterly primary care trusts – have worked to guidance from the Department of Health which promoted the Øvretveit cycle of commissioning. In April 2013, primary care trusts are being replaced by 211 new statutory GP-led clinical commissioning groups, which will take on similar commissioning responsibilities. Clinical commissioning groups will be charged with funding, planning and procuring health services to meet the needs of their local population. A new NHS Commissioning Board will oversee and support the new system, and will also directly commission primary care and specialised health services.

The research

The aim of this research was to explore what NHS commissioners actually do to commission care for people with long-term conditions, and how this process might be improved. The objectives were to:

- identify the organisation and processes associated with effective commissioning
- identify an appropriate set of outcomes for effective commissioning
- draw on experience from other sectors and international health systems
- consider how the learning from this research could be more widely applicable in the NHS.

The research was a comparative case study project, with three in-depth case studies of ‘commissioning communities’: Somerset, the Wirral and Calderdale (subsequently expanded to include Kirklees; details in Table 1). Each case study was based on a primary care trust, but included other organisations involved in planning, funding or delivering care.

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The three sites were drawn from a cohort of primary care trusts identified as ‘high performing commissioners’ using a set of quantitative metrics related to the processes and outcomes of commissioning (for full details, see Smith and others, 2013). The aim was to identify a broad list of potential study sites where ‘performance’ appeared better than would have been expected when compared to similar organisations. The cohort was verified by a panel of experts, and invitations to participate were sent out to the primary care trusts’ chief executives. The first three to respond positively were selected.

An initial orientation phase was followed by an in-depth examination of commissioning practice from November 2010 to January 2012. Qualitative data were collected through interviews (92), observations of meetings (27) and documents (345). Quantitative data were collected on activity levels, costs and patient experience.

Within each site, the research focused on the commissioning of care for people with long-term conditions: diabetes in all three sites (to allow comparison), and a second condition chosen by each primary care trust: dementia in Calderdale and the Wirral, and stroke in Somerset.

In Calderdale, the primary care trust did not have a provider arm, and community health services were provided by the local acute trust. In Somerset, community health services (including community hospitals) transferred from the primary care trust provider arm to the local mental health trust in 2011. In the Wirral, the primary care trust did not have a provider arm, and community health services were delivered by a local NHS community trust.

Table 1: Characteristics of participating study sites

	Calderdale	Somerset	Wirral
Population (2010 mid-year estimate, Office for National Statistics)	202,741	525,186	308,837
Level of deprivationⁱ	Higher than England average	Lower than England average	Higher than England average
Overall spend per weighted head of populationⁱⁱ	£1,651	£1,643	£1,685
Long-term conditions included in the study	Diabetes Dementia	Diabetes Stroke	Diabetes Dementia

i Association of Public Health Observatories/Department of Health (2011)
ii Association of Public Health Observatories/Department of Health (2010)

For each of the service areas studied, primary care trusts identified a specific commissioning development in progress, which could be tracked in detail by the research team. A summary of the six commissioning developments is given in Table 2.

Table 2: The six commissioning developments selected for detailed study

Site	Commissioning development tracked	Stage of development	Providers
Calderdale	A strategic plan for diabetes services Review of provision of diabetes care and discussion of strategic remodelling of the service.	Discussion and planning	GPs Community health Acute trust
Calderdale	A strategic review of dementia care A 'transformational review' across two primary care trust areas (Calderdale and Kirklees), including NHS services, social care and third-sector provision. Emphasis on early intervention and supporting independence.	Discussion and planning	Mental health trust GPs Two acute trusts Third-sector providers
Somerset	Somerset diabetes service Remodelling diabetes care into a three-tier service: intermediate care delivered by nurses in community clinics, enabling step-up to consultant care and handover to GP care as appropriate.	Commenced operation	Four acute trusts Community health GPs Third sector-providers
Somerset	Early supported discharge service for stroke Establishment of a service delivering intensive therapy at home to patients recovering from a stroke.	Commenced operation	Four acute trusts Community health
Wirral	Diabetic podiatry service Review of diabetic podiatry service to resolve longstanding operational problems, including records management and referral across organisations.	Discussion, planning, modelling	GPs Community health Acute trust
Wirral	Memory assessment service Establishment of a new community-based service for diagnosis and treatment of dementia. New service located in community clinics led by nurses and supported by psychiatrists.	Commenced operation	Mental health trust Third-sector provider

Findings

Based on our detailed tracking of the commissioning developments set out in Table 2, we identified the following seven themes, which characterise the practice of commissioning care for people with long-term conditions as observed in this study:

1. The scope of commissioning
2. The labour of commissioning
3. Identifying the commissioners
4. The question of money
5. The scale and pace of change
6. Directives and guidance for commissioning
7. Working in a context of uncertainty.

We examine these themes here, then consider the implications of this analysis for the new clinical commissioning groups.

1. The scope of commissioning

Our research challenged the notion of a neat annual ‘commissioning cycle’ as suggested by Øvretveit. Instead, we observed a more complex set of overlapping activities, typically running in parallel rather than sequentially, and taking place over a longer period of time – many years in some cases. Activities that are not usually included within the commissioning cycle model were also observed, including the convening of local organisations in order to plan services, and supporting the implementation of service change.

The majority of commissioners we talked to were aware of the model and talked about it as a useful device, but reported that commissioning tasks did not often run in the suggested sequence. For example, the Early Supported Discharge Service for Stroke in Somerset had already been running for some months (covered by existing contractual arrangements) before the transactional aspects of the arrangement were formally agreed between commissioner and provider. Monitoring of activity levels, and lengthy discussions between commissioners and providers during the implementation phase, informed the preparation of a service specification and performance management framework once the service was already operating.

The review stage of the commissioning cycle seemed to present particular challenges to commissioners, who seemed reluctant to set out hard plans and timetables for evaluating whether a service model was worth continuing with.

Our focus on particular developments highlighted the difference between these examples of active recommissioning, and those service areas which were being left to ‘tick over’, with the same model of care continuing under annually renewed contracts. For each development, there was a tangible starting point such as a demand mapping exercise or an external quality assessment. This led to an additional commissioning task, not identified in the commissioning cycle – of drawing a boundary around a particular ‘parcel’ of health care to make it a manageable unit for commissioning. This often proved to be a complex task, reflecting the fact that care for people with

long-term conditions can straddle multiple providers. Commissioning seemed to work most effectively where commissioners were able to negotiate ‘bite-sized’ service changes and fit these into a bigger strategic vision of change.

“ Commissioning seemed to work most effectively where commissioners were able to fit ‘bite-sized’ tasks into a bigger strategic vision

2. The labour of commissioning

A huge amount of effort was observed going into commissioning across all six service developments, in terms of strategic planning, service review, and hands-on work (typically by middle managers within primary care trusts) to implement and support change.

Commissioning work included both technical tasks (for example data collection, modelling of future service needs, review of evidence, contract negotiation and analysis of patient experience data) and relational activity with stakeholders (for example service review workshops, planning meetings, consultation with user groups, encouraging best practice and relevant organisational change, and project management support). We observed a large amount of labour going into these relational tasks, with commissioners primarily the convenors and coordinators of NHS planning and development work in the local area.

In the case of three of the service developments, a lack of capacity within the primary care trust for undertaking both the technical and relational labour of commissioning appeared to be a factor inhibiting progress. In contrast, most progress had been made in bringing about new services where there was a key commissioning manager, as one interviewee observed:

‘Just having that key person that’s able to coordinate efforts across everybody and actually just keep on, keep saying... “Right, have we done what we said we were going to do?”... Just keeping that persistence.’

The scale and intensity of the commissioning work observed in this study raised questions about whether it was proportionate to the impact on service delivery, quality and patient care.

3. Identifying the commissioners

As noted earlier, the theory of public service contracting identifies commissioners as the people planning and funding services to meet local health care needs, distinct from those who provide services (Ferlie, 1996). In this research, we observed that the tasks of commissioning were not carried out exclusively by people working for primary care trusts with ‘commissioner’ in their job description. Managers and professional staff from NHS provider organisations, along with local authority staff, GPs and other clinicians also played a role, as did, to a lesser extent, patient representatives and third-sector organisations.

The contribution of different parties varied according to the stage in the commissioning process, with the widest range of contributors at the needs assessment and review

stages, and a much smaller group taking part in the more formal transactional tasks of contract specification and procurement.

One manager from a provider trust reflected on the extent to which they and the commissioners seemed to be working together towards common goals:

'It does feel like the conversations are very much about partners helping each other to work with situations rather than adversaries trying to screw every little last advantage out of each other.'

In three of the commissioning developments studied, the provider organisations were particularly prominent in the process. Providers brought specialist knowledge of clinical care and national developments, along with ideas about new models of care. In some cases they offered specific skills in project management, strategic planning, coordination and leadership. For example, the clinical team at the local mental health trust was instrumental in the development of the Wirral Memory Assessment Service. Similarly, in Calderdale, staff from the mental health trust convened a series of planning workshops to carry out a strategic review of the broad picture of dementia care locally.

4. The question of money

A core objective of NHS commissioning is to achieve value for money in the delivery of services, paying careful attention to both the quality and cost of services commissioned (Department of Health, 2007). It was therefore surprising that we observed money as being an intermittent, and at times apparently peripheral, focus of attention in the day-to-day practice of commissioning. Although commissioners were mindful of the need to get value for money and often referred to the national Quality, Innovation, Productivity and Prevention (QIPP) programme, information on costs did not appear to form a core part of the daily business of commissioning.

In relation to all six developments, commissioners assumed that savings would accrue in the long-term (over five to ten years) through, for example, reduced hospital admissions, and use of outreach and telehealth to support home care. The emphasis was on containing costs and increasing quality of care in the face of rising demand, particularly for dementia and diabetes.

A significant proportion of the spending on care for all six service areas was through multi-million pound block contracts held with mental health and community health providers (see Table 20, p119 of Smith and others, 2013 for more detail), and this meant that commissioners sometimes found it difficult to extract information on costs relating to a particular element of service delivery. There was also less pressure to examine services and consider alternative approaches to provision.

Our research revealed that the organisational structure of primary care trusts appeared to encourage a separation of financial and contractual aspects of commissioning from the more relational service development work. While it typically fell to middle managers to undertake the main labour of commissioning, financial deals for block contracts were negotiated by finance directors and their teams as part of the wider financial settlement between the primary care trust and its main providers. This highlights the apparently limited scope for commissioners to use finance as a key lever for influencing providers, as set out in the theory underlying the current model of NHS commissioning.

5. The scale and pace of change

Commissioning has the potential to bring about fundamental changes to health care provision through discontinuing some services and procuring other new services. We observed an approach to change which was, however, much more incremental and cautious. The scale and pace of change were inhibited by lack of resources to support project management and staff transfers, lack of data (actual and perceived), the challenges of working across many organisations, and caution about disrupting the local health economy. The key facilitators enabling change through commissioning appeared to be a combination of dynamic and sustained leadership by senior managers and clinicians, planned and phased implementation, and commitment from local clinicians, managers and the public.

 **The scale and pace of change were inhibited by lack of resources to support project management**

Success seemed to come about where commissioners were tackling discrete, ‘bite-sized’ commissioning tasks as part of a wider local plan for service delivery. The Wirral Memory Assessment Service, for example, was introduced alongside parallel strands of work (such as a reduction in the use of anti-psychotic medication in care homes, and the commissioning of Extra Care housing) that formed an overall strategy for dementia care in the local area.

In some instances, the linking of strategic vision and local action was unclear. The reasons for this included: the strategic vision was still under debate (e.g. diabetes in Calderdale, dementia in Calderdale); commissioning was reactive, rather than proactively driving the service (e.g. diabetic podiatry in Wirral); or there was ambiguity about which geographical area the initiative was covering (e.g. dementia in Calderdale).

6. Directives and guidance for commissioning

National directives and guidance played a powerful role in shaping local commissioning practice across all six service developments. These fell into three broad categories: ‘must do’ policy directives and national strategies from the Department of Health; ‘should do’ guidance on best practice from the National Institute for Health and Clinical Excellence (NICE) and other national bodies; and ‘could do’ support from a range of academic, professional and patient organisations, for example, the standards for diabetes care set out by the charity Diabetes UK. Some external drivers, such as the Quality and Outcomes Framework, were generic in scope, but most were specific to the particular long-term condition.

The time required to identify, read, interpret and put into practice external drivers was extensive – another factor contributing to the ‘labour of commissioning’. Selectivity was clearly needed on the part of commissioners, along with an ability to balance the national and external with locally determined priorities.

7. Working in a context of uncertainty

This study took place at a time when significant changes were taking place to the organisation and structure of the NHS in England. Work was under way to establish new clinical commissioning groups, along with a network of commissioning support organisations. There were also changes to organisations carrying out public health, joint commissioning with local authorities, and public and patient involvement. One result was that established relationships between the primary care trust and a range of other local stakeholders were disrupted.

Senior managers in all three primary care trusts reported spending a significant proportion of their time on implementing the reforms. As one noted in 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.'

What was striking was that commissioners did manage to get on with the job, even in the face of major uncertainty, and when some managers were facing redundancy. Regular reorganisation over the past two decades (Smith and Curry, 2011) may have made NHS commissioners accustomed to handling uncertainty.

Discussion

Broad findings

The findings from our research paint a picture of NHS commissioning, at least for long-term conditions, that is far removed from the competitive and market-focused approach intended at the inception of the NHS internal market in 1990, and reiterated in the 2010 NHS White Paper. Where local commissioning practice was observed in this research as being effective – that is, leading to a new or reshaped service with specific objectives for improvement – a number of factors appeared to be in place:

- a coherent plan for the development of the service, combining a clear strategic vision for improved care and value for money, with a series of 'bite-size' projects forming a plan for implementation
- clarity of roles and responsibilities, with clinicians and other providers active in the planning and development elements of commissioning, yet ceding influence to the commissioners when it came to service procurement
- effective and sustained managerial and clinical leadership within the commissioning organisation (particularly at second-line level), including an ability to translate external drivers into actionable and achievable local goals
- commissioners able to link the relational and transactional aspects of their role, ensuring an appropriate degree of contestability alongside necessary collaboration.

This research underlined the difficulty of trying to measure the impact of health care commissioning, given the complex and overlapping activities that constitute commissioning, and the fact that other factors (such as the payment mechanism, the nature of contracts for the service and lack of outcome measures for the service) also have an influence. Given the focus in this research on the practice (as opposed to

outcomes) of commissioning, it made sense to use proxy measures to determine the degree of effectiveness of commissioning practice. Activities associated with effective commissioning practice, together with suggested measures, were developed as part of the research and are shown in Table 3.

Table 3: Activities associated with ‘effective commissioning’, and suggested measures of effectiveness

1	Acting as the convenor of multiple local interests and stakeholders Measure: regular surveying of local providers and users about the performance of commissioners, especially in taking account of local advice and views
2	Ensuring a clear focus on priority setting for health spending, resisting the temptation to concentrate commissioning work on a few services at the margins Measure: evidence of use of regional and national benchmarking data on finance and service performance, and making changes to commissioning priorities
3	Getting the right balance between relational and transactional commissioning, knowing when to move on from engagement and planning, to implementation Measure: review of number of meetings involved in a programme of commissioning in relation to service changes made, with cost–benefit analysis of commissioning labour
4	Keeping a focus on the monitoring of activity, financial performance and service quality, and using this to inform review of the overall commissioning portfolio Measure: production of regular public reports about activity, financial performance and quality of services commissioned, benchmarked against national standards, and information about how this is being used to inform future commissioning plans
5	Using an appropriate commissioning approach for the type of service in question (for example, emphasis on relational contracting and shared risk for long-term conditions, item-of-service purchasing of elective care) Measure: brief description of approaches used in commissioner’s annual report, linked to changes in outcomes for the specific services
6	Identifying and supporting key individuals who play a pivotal role in local commissioning, in particular middle managers who work closely with clinical commissioners Measure: evidence of clearly identified lead managers for core commissioning areas, and of investment in training, development and support for these individuals, and information about their retention
7	Ensuring that there is adequate clinical involvement in commissioning discussions and activity, with robust governance Measure: regular survey of local clinicians about their involvement in commissioning and whether they think it is useful
8	Ensuring that any newly commissioned (or recommissioned) services have a set of specific and measurable objectives Measure: documented objectives and measures for such services, including comparison with NICE benchmarks of clinical and cost-effectiveness
9	Having a programme of review and recommissioning for those services which consume most resources, to ensure proportionate focus of commissioning effort Measure: publication of an annual commissioning plan including reports of service review, actions taken as a result and plans for the forthcoming year

Implications for developing effective commissioning

Commissioning effort has to be worth the outcomes

Given management cost reductions of some 40 per cent, clinical commissioning groups will have to be very selective about how they allocate their time and effort, such as between marginal and major service developments. The 'labour' of commissioning will have to be justified in relation to outcomes for local services and people, in part as measured by the clinical commissioning group's performance against the new Clinical Commissioning Group Outcomes Indicator Set. The suggested 'process' measures of commissioning effectiveness set out in Table 3 may be helpful here.

The Francis Inquiry Report's assertion that commissioners should commission to improve the quality of care, and assure core and enhanced standards (Francis, 2013), adds further weight to the need for commissioning labour to be directed towards the service areas that matter most. To do this, commissioners will need to consider carefully how they might use information from a range of sources (such as from commissioning support units and local peer reviews of clinical services) so that they can form a detailed and accurate picture of the quality of care given by local providers, and thus set priorities and specific goals for improvement.

Commissioners have to know when to stop consulting and make a decision

Meetings and workshops often appeared in this research to be a 'ritual' (Peck and others, 2004), with the process of involvement of different people and interests almost being the core purpose, rather than the outcomes, namely task-related objectives with time limits. Clinical commissioners will need to be brave enough to 'cut and run' and make a decision when they feel they have undertaken enough consultation and engagement, even if this flies in the face of ingrained NHS (provider and commissioner) culture that favours extensive involvement and consultation as a way of reviewing and making changes to services.

Clinical commissioners could arguably make a virtue of having less management resource at their disposal, using this to justify the development of clear guidelines about how they will go about local commissioning, and explaining the circumstances under which they will exert their right to halt (or shorten the overall extent of) consultation, make a decision and move to procurement. The local practice of commissioning is rarely codified in the NHS (apart from the technical elements of procurement, the specification of contracts, and the setting of priorities for investment), but a greater degree of explicitness regarding the purpose and functions of local commissioning could serve to manage expectations among providers and others.

Lessons could be gleaned from the experience of World Class Commissioning (Department of Health, 2007) where codifying the tasks of commissioning at a national level did lead primary care trusts to reflect on the range of their work, and to attend to neglected areas such as priority setting and public engagement (McCafferty and others, 2012). What was less helpful about World Class Commissioning was its use as a national assessment tool, leading to a focus on process at the expense of outcomes. The measures suggested in this research are intended as a developmental tool for local commissioners to use alongside the new

Clinical Commissioning Group Outcomes Indicator Set (formerly the Commissioning Outcomes Framework; NICE, 2013), rather than a suggested framework for national assessment of commissioning.

Commissioning is a tough and lonely task if done well

Skilled managers are critical to effective commissioning, these being individuals who can work productively with clinicians and others, persistently driving forward major areas of service development, and ensuring an appropriate balance between the relational and transactional elements of commissioning. These senior commissioners need to be largely separate from local provider interests, able to take a population health perspective, and have a degree of ‘clout’ conferred by holding budgets to fund services. Such commissioners need to be skilled as ‘boundary spanners’ (Williams, 2002), yet will need significant support if they are not to become isolated and ‘burned out.’ Commissioning can be a lonely role, especially when it does the ‘tough work’ of transacting new or changed services that are likely at times to threaten professional and provider interests, or prove unpopular with some in the wider community.

 **Skilled managers are critical to effective commissioning... driving forward service development**

Data are presented as problematic, yet are the key to the solution

Commissioners in this research frequently called for better and more timely data about local needs, services, costs of provision, and patients’ and carers’ experience. There was a strong perception of such data being in existence and used for needs assessment and service specification, yet problematic to access and use in real-time for review and performance management with providers.

A core role of clinical commissioning groups will continue to be to secure effective data about population health needs, requiring an effective relationship with public health colleagues in local government. This research points to the importance for clinical commissioners of ensuring that their in-house support, together with expertise from the commissioning support unit, is able to obtain and provide the timely data on service costs, activity and quality that they will need to make robust challenge of provider performance.

The role of providers in commissioning needs careful thought

This study underlined the importance of involving clinicians in local service development. Primary care trusts often identified a lead clinician to chair a programme of work, and reported that the value of this is securing legitimacy and expertise for the particular project. But engaging providers in the work of commissioning represents a blurring of the purchaser–provider roles, as with the use of a hospital consultant to lead a review of a service, or a GP to be chair of a clinical commissioning group. While there are clear benefits to this, in terms of clinicians driving change, there are also risks; including potential conflicts of interest, for example providers using senior clinicians to help ward off change being proposed by commissioners.

This issue is, however, more complicated for clinical commissioning groups, for they themselves are providers. From April 2013, groups of primary care providers will make commissioning decisions, working with acute, mental health and community health providers, as well as commissioning support units. The role of providers and other organisations in commissioning will need careful thought, as the complexity revealed in this research would seem to be set to grow. Where long-term conditions are concerned, however, it would be worth commissioners considering new approaches to the role of providers in making service changes (including payment and incentives), as we explore in the final section of this paper.

There is a need for clarity about the outcomes of commissioning

In making assessments about the overall impact of each of the six service areas examined in depth in this research, the most striking finding was the lack of clarity about anticipated outcomes from commissioning activity, and hence the difficulty for primary care trusts (and researchers) to judge how far commissioning intentions had been realised. Just as there was a more limited focus on monitoring and review (compared with design, specification and engagement), so there was a relative lack of attention to addressing impact and outcomes. The new Clinical Commissioning Group Outcomes Indicator Set would appear to offer the possibility of a more robust framework for local clinical commissioning groups to establish and monitor desired outcomes from their ‘commissioning labour’, and this will need careful scrutiny by Health and Wellbeing Boards, and Healthwatch bodies, among others.

 **The most striking finding was the lack of clarity about anticipated outcomes from commissioning activity**

Implications for policy

The purpose of commissioning needs to be clearly articulated

The English NHS has placed significant faith in commissioning to allocate scarce resources in a way that meets local need, and assures local people that services are of an appropriate level of quality.

If commissioning is to prove its worth in the future more than the past (House of Commons Health Select Committee, 2011; Smith and Curry, 2011), it needs to have a clearly defined role and remit against which its progress can be measured. This role and remit need to be set out by the NHS Commissioning Board as overall steward of the new commissioning system, explaining both the purpose and the limits of commissioning as a function. As part of this, the role of clinical commissioning groups (and their GP members), and the NHS Commissioning Board itself, must be articulated to the public. A clear timetable for local public reporting of commissioning costs and outcomes will be required, addressing measures such as those suggested in Table 3.

Commissioners will need support to make tough decisions

Clinical commissioning groups will not have the resource to collaborate with providers and other stakeholders as extensively as primary care trusts.

They will need intelligence from commissioning support units to challenge providers on quality and value for money, where necessary, in contracts and procurement of services for their populations. The role of commissioners as convenors may have to adapt, or at the very least be scaled back. Commissioners will have to be highly selective about the priority areas for detailed review and specification in any one year, using benchmarking and other data to keep tabs on the performance of other services.

They will need high-quality public health and needs assessment advice, sophisticated and real-time data about services, accurate comparisons with national benchmarks, efficient payment and invoicing systems, and support for modelling and planning future care. In addition, they will need support in undertaking consultation and engagement activity, accessing and analysing patient and public experience data, providing local system leadership, and handling procurement within a cultural context of collaboration.

Commissioning for long-term conditions may require a more sophisticated approach

The apparent simplicity of commissioning as a two-sided transaction across the 'purchaser-provider split' has been revealed by this research to be far from the reality of day-to-day NHS commissioning practice, at least where long-term conditions are concerned. Local commissioners are developing an alternative approach based on closer working between providers and commissioners.

Services for those with long-term conditions are not easily 'commodified' within a purchaser-provider market. These services are provided over months and years, by a range of organisations and professionals, and it is hard to split them into single episodes. The traditional cycle of commissioning used in the NHS 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. This research showed some of the tensions that can arise when an element of a wider service is 'parcelled off' for commissioning, as with diabetic podiatry in the Wirral, which was found to be caught between different contracts and providers.

International experience in planning and funding care for people with long-term conditions confirms the trend towards exploring different approaches to contracting for care. These include commissioning 'chains of care' in Sweden (Ahgren, 2003), using 'alliance contracts' for integrated care in New Zealand (Stephenson, 2000), and the 'accountable care organisation' as a way of sharing financial and service risk at primary care level in the USA (Fisher and others, 2007). Similar experiments are underway in the NHS in England, embracing the ambiguity of provider and commissioner roles in planning and developing local services. For example, the accountable lead provider model entails a provider being awarded a contract for a whole service or pathway of care across organisations (Corrigan and Laitner, 2012), and other outcomes-based approaches such as Capitated and Outcome-based Incentivised Contracts (COBIC; www.cobicsolutions.co.uk) are being trialled for mental health and other services.

What is common to these alternative approaches to contracting care for long-term conditions is a new way of sharing financial and service risk. The providers of care take on some or all of what would have been the commissioner's risk; being responsible for assuring a set of services that will meet the needs of a particular local group of patients, such as the frail elderly, or vulnerable families. Thus learning and evidence about different approaches to payment reform need to be drawn into discussion about optimal ways of commissioning care. Critical to this is finding ways of ensuring that incentives for developing new approaches to care are located clearly with the providers whose practice will need to change.

The regulation of commissioning will need careful consideration

In the reformed NHS, commissioning will take place within the regulatory framework determined by Monitor, the new health sector regulator. To date, regulation in the English NHS has been largely focused on providers, but from April 2013, the operation of the wider NHS market will be subject to regulation by Monitor, and this will include the behaviour of commissioners. Monitor is likely to have an interest in the way in which clinical commissioning groups procure services, their use of tendering, the operation of the 'any qualified provider' policy, and the existence of conflicts of interest on the part of those commissioning care.

The complex and nuanced nature of commissioning care for people with long-term conditions revealed by this research will thus present a particular challenge. New models of contracting, such as accountable lead provider or alliance contracting, are worth trying to see if they can offer patients an appropriate balance of choice of providers and integration of services. At the heart of this will be the crafting of arrangements that ensure that providers are incentivised to deliver care that is well coordinated and of high quality, while avoiding the risk of monopoly provision that compromises choice.

Conclusion

NHS managers have evolved a labour-intensive and highly collaborative approach to commissioning care for long-term conditions that blurs the purchaser-provider split. This draws closely on the expertise and experience of providers. The effort expended on commissioning needs to be justified by the extent to which it results in better outcomes for patients.

From April 2013, the NHS enters a new phase and clinical commissioning groups will have to justify the way in which they commission care for people with long-term conditions. Clear goals, monitoring and review, with effective challenge of providers (backed up with data) is axiomatic. But so will be exploration of new forms of contracting and risk-sharing, to ensure that the effort of commissioning is worth the cost – a question we are still asking after two decades.

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