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What is world class commissioning?

- There has been **little agreement as to the definition of commissioning** in the past. It does not relate to procurement functions only. A useful working definition may be 'the act of committing resources, particularly but not limited to the health and social care sectors, with the aim of improving health, reducing inequalities, and enhancing patient experience'. This definition embraces all UK countries but the processes vary. Commissioning is most evident in England.
- There are tensions in commissioning, particularly within a cash-limited market economy environment, which mean that **commissioning involves making tough decisions and trade-offs**, particularly between individual and population needs/wants.
- Commissioning takes place at **many different levels** according to local arrangements and the specialisation of services. These levels stretch from national commissioning to practices and even to individual clinician activities.
- World class commissioning is a **statement of intent**, designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way across any of the developed healthcare economies.
- The world class commissioning programme is a **set of mutually reinforcing policies, development programmes and assurance systems** put in place by the Department of Health in England. The programme describes in detail 11 competencies which have been assessed for each primary care trust.
- World class commissioning will be **robustly performance managed**.
- The world class commissioning programme is a **response to the significant challenge of moving power from providers to patients** or those who act on their behalf. It is backed by resource, commitment and political will. It represents the best chance yet in commissioning's 18-year history of demonstrating that it can make a difference to health outcomes.

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What is world class commissioning?

What is commissioning?

Mark Britnell, the current Department of Health (DH) Director General of Commissioning and System Management, said in October 2007 that 'The history of commissioning in the NHS has been turbulent since its introduction as "purchasing" in 1991: since then it has undergone seven reorganisations and has had no chance to mature as a discipline'.¹

This lack of maturity has been matched with a failure to develop a commonly accepted definition of commissioning.

The Audit Commission defines commissioning as 'the process of specifying, securing and monitoring services to meet individuals' needs at a strategic level'.² Some may find this definition too narrow, not explicitly mentioning needs assessment or market development.

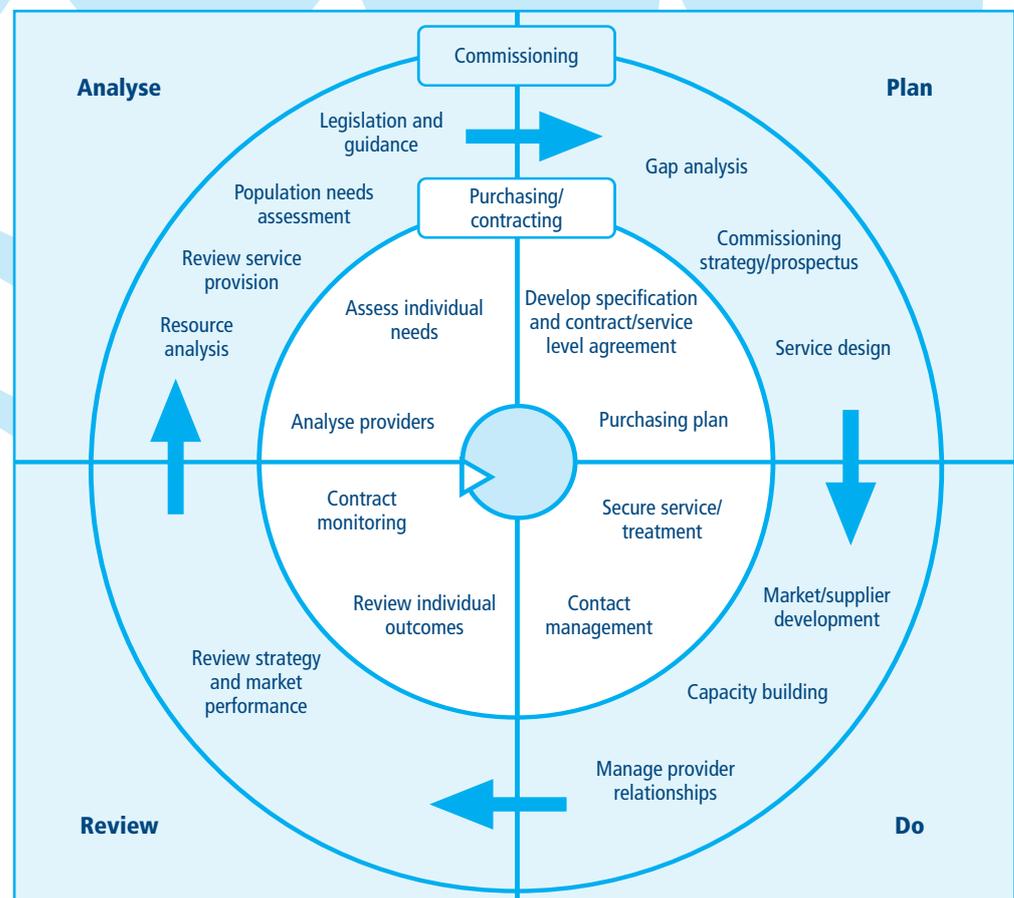
A wider definition might be the act of committing finite resources to evidence-based

interventions, particularly but not limited to the health and social care sectors, with the aim of improving health, reducing inequalities and enhancing patient experience.

These definitions, of course, are set in the context of the healthcare systems in England and Northern Ireland, as a market-based context has been increasingly eroded or extremely limited in Scotland and Wales. Perhaps the simplest definition is the best. Commissioning is simply the process used in a local context to decide how we spend available funds to improve health.

Whatever the definition, it has become increasingly clear that the concept of commissioning requires a number of separate but interlinked activities, as can be seen in Figure 1.³ It is not simply confined to procurement activities. Procurement is (or should be) a cash-driven exchange, commissioning is a needs-led/outcome-evaluated activity.

Figure 1. The commissioning cycle³

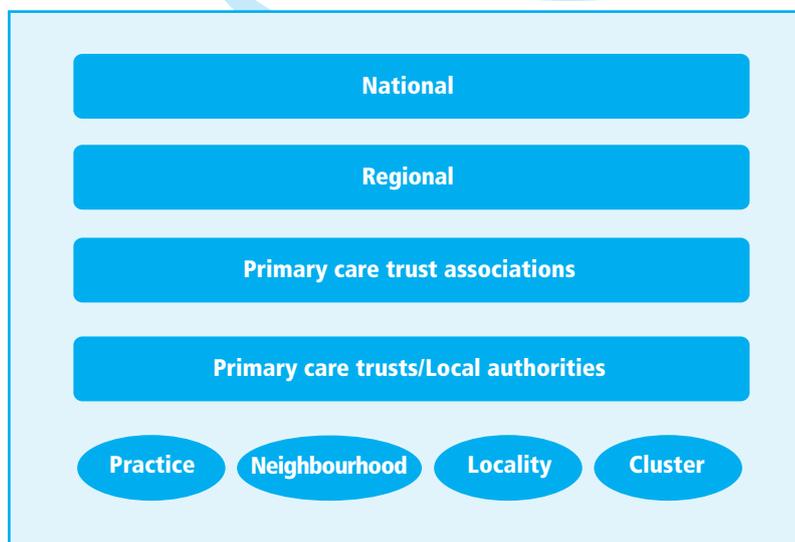


The tensions within commissioning

Inherent in commissioning, or the process of deciding how to commit resources, are a number of tensions.

- There are difficulties associated with meeting individual or population needs or wants. Often there will be trade-offs in decision-making: the ability to provide the best for an individual may be compromised by the desire to improve the health of populations; for instance, by constraining the resource committed in one disease area in favour of another. This is particularly difficult in a cash-limited healthcare system such as the NHS. The amount of resource committed to mental health or coronary heart disease requires an understanding and interpretation of local need, national priorities and affordability. The reconciliation of these difficulties rests at the heart of commissioning.
- There is an ongoing debate about the distinction between needs and wants – of a population or an individual. Garrett has analysed this in greater detail from an ethical standpoint, but the essence is that some distinguish between a want (something which one desires to have, whether or not one needs it) and a need (something which a human being must have in order to live a recognisably human life),⁴ while others set out to meet needs rather than wants. Commissioning must determine whether there is a distinction in practice and decide which to meet.
- The desire to involve both populations and patients in decision-making is a difficult and yet key element of commissioning. Commissioning requires a balance of centrally and locally driven priorities and investment decisions.
- Commissioning in a market economy context presents particular challenges that are absent in state monopoly or near-monopoly provider systems. The current NHS system in England represents an attempt to operate a market economy; that in Scotland hardly has any elements of markets. Thus, in England, market development and stimulation is a key activity of commissioning,⁵ while in Scotland it is largely absent, as commissioning in that context is about the allocation of resources within a public sector system. In England, the challenge is to identify the extent to which private sector suppliers will be part of the NHS in the future.
- The provision of healthcare involves multiple suppliers, yet patients want and need joined-up services. The DH is currently exploring how the challenge of integration can be met.⁶ The establishment of integrated care provider organisations may be one way of achieving this,⁷ but integrated commissioning has been identified as a challenge by others. Ultimately, it is impossible for all interventions that may impact on health to be provided by a single organisation. Integrated commissioning may be the only way of integrating health improvement.

Figure 2. Levels of commissioning



Different levels of commissioning

The act of committing resources in the NHS takes place at different levels (Figure 2). This ranges from national commissioning for highly specialised services⁸ to specialised commissioning, joint commissioning, lead commissioning, primary care trust (PCT) commissioning and, more recently, practice-based commissioning, which has been the subject of reinvigoration by the DH.⁹ If one accepts the wider definition of commissioning set out above, then arguably commissioning also includes, and always has, clinical activity

at individual practitioner level. The very act of referring a patient or prescribing medicines is a commissioning act. Yet integrated commissioning requires discrete activities to be drawn together in a co-ordinated way. Patients with highly specialised conditions also have common illnesses and are not mere hosts for a single disease. Acknowledgement of co-morbidities demands integrated commissioning.

Why world class commissioning?

World class commissioning is not just an aspiration to achieve excellence in a management process. The DH makes its position clear: 'Put simply, it is a statement of intent, designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way across any of the

Box 1. Department of Health vision of world class commissioning¹⁰

World class commissioning is not an end in itself, so in order to prove themselves successful, commissioners will need to demonstrate better outcomes; adding life to years and years to life.

Better health and well-being for all

- People live healthier and longer lives.
- Health inequalities are dramatically reduced.

Better care for all

- Services are evidence-based, and of the best quality.
- People have choice and control over the services that they use, so they become more personalised.

Better value for all

- Investment decisions are made in an informed and considered way, ensuring that improvements are delivered within available resources.
- Primary care trusts (PCTs) work with others to optimise effective care.

The vision for world class commissioning will be one that is developed, articulated and owned by the local NHS, with a strong mandate from local people and other partners (such as local authorities). PCTs should state what their vision for world class commissioning is locally, and what they will achieve through continually commissioning better services and delivering better outcomes based on local priorities.

developed healthcare economies ... PCTs, practices, Specialised Commissioning Groups and their partners will need to meet the new challenges of the 21st century with changing populations and advances in healthcare. Given this vision and our shared agenda, it would be wrong to describe our ambition for commissioners as anything less than world class'.¹⁰

Commissioning was first identified as a key NHS function in 1991 by the then Conservative government as it sought to implement a purchaser-provider separation of functions as part of a marketisation process led by Margaret Thatcher. It has arguably yet to meet its potential and failed to realise a desire to shift real power from providers to those representing patients' users and carers. The world class commissioning programme is an attempt to achieve this.

The DH adopted a strapline of 'Adding life to years and years to life' to underpin its world class commissioning programme. This is a term used over the years by a number of organisations including some outside the UK; for example, the Canadian government in 2000.¹¹

Commissioning is a means of achieving overall health objectives, as made clear by the DH (Box 1).¹⁰

What is world class commissioning?

The DH has identified 11 organisational competencies required to meet these objectives and set in place an assurance programme aimed at bringing this policy intent into reality.¹⁰ These 11 competencies require that commissioners at any level:

- Are recognised as the local leader of the NHS
- Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
- Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
- Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation

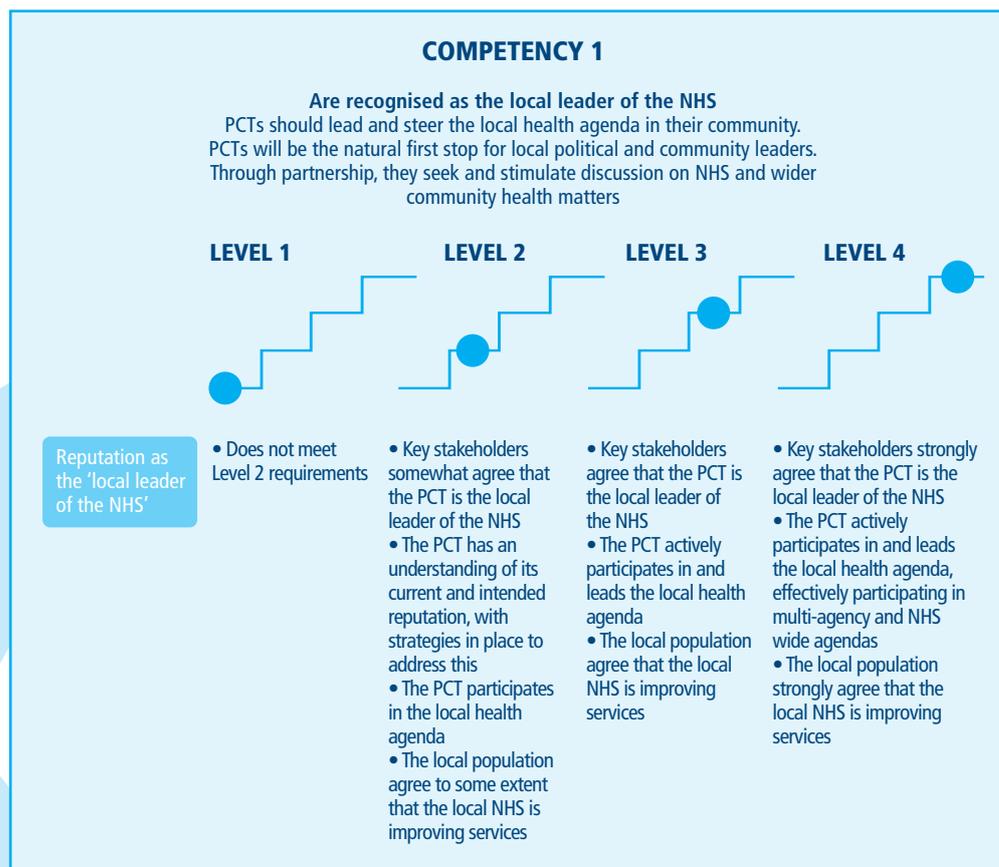


Figure 3. Indicators and criteria for world class commissioning competency 1¹²

- Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
- Prioritise investment according to local needs, service requirements and the values of the NHS
- Effectively stimulate the market to meet demand and secure required clinical, and health and well-being, outcomes
- Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
- Secure procurement skills that ensure robust and viable contracts
- Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
- Make sound financial investments to ensure sustainable development and value for money.¹⁰

These competencies are more fully described, together with associated behaviours

illustrating what successful implementation might look like, by a later DH publication aimed at giving commissioners practical tips and outlining examples of the four levels of development for each competency.¹² An example is given in Figure 3.¹²

The world class commissioning assurance system

The delivery of the world class commissioning vision and competencies will take place within a commissioning assurance system. This will drive performance and development, and reward PCTs as they move towards becoming world class commissioners.

There will be one national system of commissioning assurance, locally managed by strategic health authorities (SHAs). There will be flexibility to set local priorities. Commissioning assurance will be designed to help PCTs identify areas of development and move towards filling gaps in their capabilities.

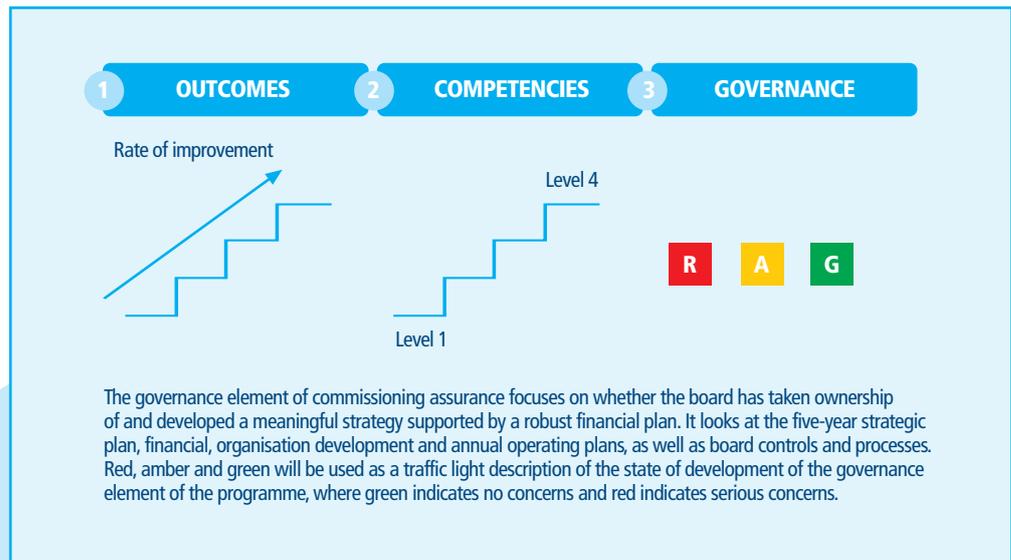


Figure 4. World class commissioning assessment process for primary care trusts¹³

The details of the assurance system are set out in the commissioning assurance handbook, which includes guidance on the content and process.¹³ The handbook is supported by a toolkit including all the tools and templates that PCTs and SHAs will need to implement the system.

The handbook includes a chapter which outlines the incentives and interventions for PCTs following the assurance system ratings. These ratings have now been completed for every PCT and published on local PCT websites (for example, the rating for Westminster PCT is available at: www.westminster-pct.nhs.uk/pdfs/Panel%20report%20Westminster.pdf). The assessment has taken place across three elements of outcomes, competencies and governance, as shown in Figure 4.¹³

Although PCTs are ultimately answerable to the DH, regulatory bodies have statutory obligations to assess them for different purposes. Commissioning assurance aims to establish how PCTs are developing as commissioners of better health outcomes and to provide a basis for future improvement. It therefore assesses a new set of organisational skills and behaviours. The primary users of commissioning assurance will be PCTs and SHAs.¹³

Since 2008, PCTs' roles as providers and commissioners have been assessed by the Healthcare Commission in two separate parts of its annual health check. On 1 April 2009, responsibility for the health check passed to

the new Care Quality Commission, an integrated regulator for health and adult social care (www.cqc.org.uk). In addition, outcomes delivered by councils working alone or in partnership are to be examined by comprehensive area assessments. It will be the DH's responsibility to ensure that these two systems are aligned with commissioning assurance.¹³

The future – will it work?

The world class commissioning programme is remarkable. It is one of the few examples of a co-ordinated set of policy, measurement, development and performance management systems from which one can conclude that (at last) the DH is serious about commissioning.

The programme is backed by significant resources and driven by committed and robust management processes. It needs to be. The weight of relative power has rested with providers, particularly large hospitals in the NHS, for decades. This imbalance of power between providers and patients (or those who seek to act on their behalf; in other words, commissioners) is not unique to the UK or England.

If the NHS is to become truly patient-centric, then commissioning must be developed and be allowed to make the critical decisions in the NHS in England. Obviously, such fundamental change requires ongoing political commitment and that is difficult to

predict, but the two main political parties remain firm in backing commissioning.

The world class commissioning programme is fundamental to the future of the NHS and its ability to survive the emerging economic situation. It is not simply this challenge that commissioning must rise to. The real challenge is to demonstrate that commissioning can and does improve population health and reduce health inequalities. World class commissioning may be a statement of intent. Now it needs to deliver, otherwise it will be judged as no more than another aspiration – an opportunity missed.

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