THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

Commissioning - can we get it right?

Evidence and ideas for the way ahead in Wales

Contents

	Page
About this paper	1
What is commissioning?	2
· some definitions	2
· key characteristics	2 - 5
Who and where? Different levels of commissioning	5 - 9
Commissioning in the Welsh context – what do we need to do to get it right?	10 - 12
Working in partnership	13 - 15
Conclusions – the way ahead	16

About this paper

Commissioning in the NHS in Wales has never been more crucial, more complex, or more topical. That is why we are publishing this paper at this time. We do not argue the case for a particular model or approach. Our aim is rather to help inform the current debate about commissioning, in particular by highlighting existing work in this area which may provide ideas, guidance or inspiration. Some of this work may already be well-known in Wales, but some may not. On such a key topic, it is essential, in our view, that the debate draws on the widest possible range of ideas and expertise, to help us find a way forward that is right for Wales.

These are views from others rather than from us, and we are presenting them rather than promoting them. Over and above the material presented here, however, there are certain key principles which in our opinion should underpin the debate on commissioning in Wales:

- Commissioning is vital in the 21st century NHS – it is right that it is at the centre of debate
- Getting it right is everyone's business, not just the LHBs'
- LHBs have a particularly important role, however, and we must support them in developing commissioning capacity
- Any model or solution has to recognise that commissioning involves different roles at different levels
- Wholesale restructuring of the NHS in Wales is not the way forward
- Building better partnerships between health organisations is a prerequisite for any approach to commissioning to succeed

What is commissioning?

Commissioning - some definitions

Commissioning is a highly complex activity, and it is therefore not surprising that there is no single universally-agreed definition of what it covers. However, a literature survey reveals various views which, while they do not coincide exactly, overlap to a significant degree.

Woodin states that *'Commissioning...tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes.'*

Box 1: definitions of activities associated with the commissioning function

Commissioning is the set of linked activities required to assess the health care needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcomes.

Purchasing is the process of buying or funding services in response to demand or usage

Contracting is the technical process of selecting a provider, negotiating and agreeing the terms of a contract for services, and ongoing management of the contract including payment, monitoring, variations.

Procurement is the process of identifying a supplier, and may involve for example competitive tendering, competitive quotation, single sourcing. It may also involve stimulating the market through awareness raising and education. (Woodin, forthcoming)

Wade and colleagues from the Birmingham University Health Services Management Centre endorse Woodin's categories, but offer their own definition:

'Commissioning' is described as a function that applies to the role of 'third party payers' in a health system, namely organisations or individuals who have responsibility, on behalf of taxpayers or insured persons, for spending resource allocated for healthcare in ways that will ensure the meeting of the health objectives of the health system, insurance organisation or patient.'

John Ovretveit (1995) extends these definitions slightly further, to include activities that do not directly involve payment for services, such as influencing other agencies to promote the health of the population.

The Audit Commission perhaps best captures the key elements of the commissioning task in its definition:

'Commissioning is the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the private and voluntary sectors.'

Commissioning - key characteristics

Moving beyond headline definitions, what are the key characteristics of commissioning? Different commentators have given different views, a selection of which are detailed below:

1. The Commissioning Cycle – Department of Health E-book

In her introduction to the Department of Health's Commissioning eBook, Fiona Richardson suggests that the Audit Commission's definition of commissioning, mentioned above, rightly emphasises three key facets:

- The importance of meeting needs at a strategic level for whole groups of patients/service users and/or whole populations, which distinguishes commissioning from simply contracting for individual services.
- The importance of commissioning services to meet the needs of patients/service users, no matter who provides them – public, private or voluntary sector.
- The cyclical nature of the activities involved, from understanding needs and analysing capacity, to monitoring services; commissioning is an on-going process, not a one-off event.

Richardson believes that, without the word 'strategic' in the definition, any process which understands needs, plans and then develops services could be seen as commissioning. Developing a care package to meet the needs of an individual service user would count, and this is sometimes referred to as micro commissioning or care management.

However, Richardson concurs with Woodin in arguing that it is important for commissioning to provide the strategic, overreaching process to decide the future shape and direction of services.

In Woodin's view, commissioning involves similar skills and activities as planning, but crucially it also includes the market perspective. Managing the market to ensure the right mix and pattern of services to meet statutory guidelines and local objectives within the resources available is the holy grail of commissioners. She explains that a purchaser buys what is on offer, or reimburses a provider on the basis of usage, this being a less strategic and more operational activity. She considers procurement and contracting to be activities that focus on one specific part of the wider commissioning process – the selection, negotiation and agreement with the provider of the exact terms on which the service is to be supplied.

Richardson's key point about the Audit Commission definition, however, is that it rightly underlines how commissioning is a process that, above all, is cyclical. The cycle encompasses needs analysis, aligning resources to meet needs, developing services and monitoring performance.

She explains that the Institute of Public Care's (IPC) framework for joint commissioning and purchasing of public care services follows this pattern. It is based upon four key performance management elements: analyse, plan, do and review – and is relevant to all areas of public care, such as health, education, social care and housing.

The IPC approach sees effective commissioning in terms of comprehensive commissioning strategies driving contracting arrangements, with systems to ensure strategies are implemented and with effective use of monitoring to assess and evaluate progress.

The framework (below) shows the key activities involved in the commissioning cycle. The key principles of the framework are that:

- all of the four elements of the cycle (analyse, plan, do and review) are sequential and of equal importance, i.e. commissioners and contractors should spend equal time, energy and attention on the four elements.
- a written joint commissioning strategy should be developed.
- the commissioning cycle (the outer circle in the diagram) should drive the purchasing and contracting activities (the inner circle). However, the contracting experience must inform the ongoing development of commissioning.
- the commissioning process should be equitable and transparent, and open to influence from all stakeholders via an on-going dialogue with patients/service users and providers.

IPC framework for joint commissioning and purchasing of public care services:

2. Conscience, eyes, ears and brain

Smith and Mays (2005) have described the different parts of the commissioning function within a health system using the metaphor of a human being's sensory functions. Those elements that relate to stewardship, quality assurance, public protection are the 'conscience'. The 'brain' refers to activities associated with resource allocation decisions, system and service design, and planning. The third dimension is the 'eyes and ears': tasks that are related to keeping close to the patient experience. In practice this means:

- Conscience - setting out "how things should be" - what the system aims to achieve and how;
- Eyes and ears - observing and reporting on "how things are" - what the system is currently delivering;
- Brain - having processed information from both sources, identifying and implementing the optimal solutions for delivering stated objectives.

The relationship between these components is of course dynamic, as the 'eyes and ears' monitor and report back information on the outcomes of the interventions designed by the 'brain', and the 'conscience' reflects on this, potentially adjusting the objectives or rules of engagement, in an attempt to maintain the overall consonance of the system. The 'eyes and ears' will be present in a number of different places in the system (patients, GPs, nurses, information collectors and analysts, regulators etc.) and hence the specific ways in which they interact with the brain and conscience will vary according to the local health system, its configuration and governance.

3. Commissioning for Health

The joint report of the NHS Confederation, UKPHA and the LGA, *Releasing the potential for the public's health*, asked what good commissioning would look like, and how we might recognise it. The report suggests that good commissioning requires that whoever controls the commissioning function possesses the power, skills and incentives to effectively and efficiently discharge each of the commissioning functions, namely planning, purchasing, and monitoring. The authors believe that a system is likely to undertake sound commissioning if it:

- is based on good information;
- has active commissioners with power, skills and incentives to deliver;
- offers the stability to reap any benefits of long-term planning, and incentives to take account of this.

This needs to be borne in mind when considering how to respond to some of the challenges faced, such as how:

- to ensure that commissioners have the scarce specialist skills necessary to discharge the range of commissioning functions;
- commissioners can control utilisation, "manage the market" and secure benefits from active commissioning
- to ensure that services which require a particular scale of provision are commissioned effectively in a world where practice-based commissioning plays an increasingly important role;
- to ensure that commissioners' incentives are right e.g. that the long and the short term are appropriately balanced;

The report also strongly emphasises the importance of commissioning for health as well as healthcare. It asserts that health services need to be commissioned within a framework that explicitly links investment with health strategy. This requires a radical shift in the performance framework to give as much priority as possible to the proper assessment of health needs, the development of evidence-based preventative strategies backed by real investment, and the enhancement of community services, as well as effective strategies for managing acute illness. This change would enable shifts to be made both culturally and in the skills base of the workforce.

4. Better Commissioning – test questions

At the inaugural meeting of the Better Commissioning Learning and Improvement Network (LIN) in March 2004, as Richardson points out, Dr Stephen Ladyman set out four tests of fairness for commissioners:

1. To be fair to people using services – and to ensure that they get good quality care, in the right place, in the right quantity, at the right time;
2. To be fair to tax payers – and ensure that the services they are supporting are giving value for money and being targeted at the right priorities;

3. To be fair to providers – ensuring that they receive a fair return for their services and they have not been set impossible objectives or given tasks for which they are not funded.

4. To be fair to commissioners from councils and primary care trusts who are entitled to choose between the services on offer and pay a price that offers quality at a price they can afford.

Who and Where? Different levels of commissioning

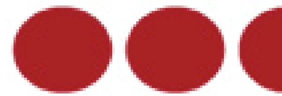
If commissioning encompasses different activities, it is made more complex still by the question of who should do it and where it should take place. Indeed, it is this question that often lies at the heart of the debate about commissioning. On this question too, different commentators have offered views and suggestions, a selection of which are detailed below.

1.The commissioning continuum – Health Foundation

The Health Foundation's document - A review of the effectiveness of primary care-led commissioning and its place in the NHS - (Smith et al 2004) considers how to select an appropriate mix of commissioning approaches according to local health needs and service configuration, and suggests that there is a need for a rigorous process to inform this choice. The key question asked by the researchers was - what attributes of a commissioning model are desirable for different service combinations and environments? The criteria proposed by Smith et al for assessing commissioning models are the ability to:

- shape different types of services, with each exhibiting different levels of complexity and scope for contestability
- offer a degree of choice of provider, contestability, and responsiveness
- manage budgets and financial risks, including delivery of financial plans
- minimise administration and transaction costs
- develop and sustain clinical engagement
- address health needs and tackle health inequalities
- improve and govern clinical quality

Smith et al selected seven commissioning models and laid them out as a commissioning continuum as follows:



The researchers tested them against the assessment criteria with the indicative rather than definitive results set out in the table below.

The appropriateness of different levels of commissioning for different services

	Commissioning level				
	Practice-based	Lead PCT	Professional network	Care pathway	Integration
Service					
First contact care					
Primary care					
Elective surgery					
A&E					
Acute care					
Tertiary/specialised care					
Public health					
Other criteria					
Choice and contestability					
Responsiveness					
Budgets and financial risk					
Transaction costs					
Clinical engagement					
Needs and inequalities					
Clinical quality					

Green boxes represent the most appropriate, blue the least.

Source: The Health Foundation, 2004

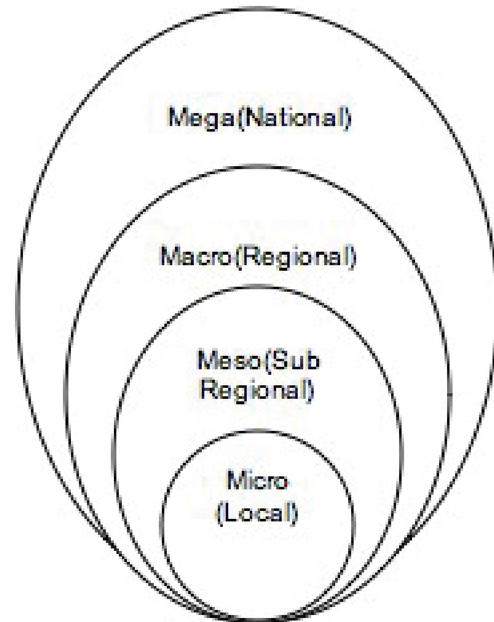
Smith et al suggest from this that each health economy should take steps to determine the most effective combination of approaches to commissioning for its local area. The steps to be taken might be as follows:

- Analysis of the service(s) to be commissioned: is the service simple or complex? Are commissioners likely to be well or poorly informed about its content and effectiveness? Is the service potentially contestable or not?

- Analysis of the context and environment: is there already a choice of providers of this service or not? Are patients likely to be willing and able to travel if local providers are not suitable?

- Analysis of the proposed commissioning model in relation to the assessment criteria in Table 2 and any additional criteria regarded as particularly important in the local health economy.

Such a process should generate a mix of approaches suitable for different services given the context of the environment and situation in which they exist.



2. From micro to macro

Robinson et al (Organisation of Purchasing in Europe 2005, and Purchasing to improve Health Systems Performance), identified three main levels at which 'strategic purchasing' takes place: macro-level (through a national single health insurance fund); meso-level (regional organisations with devolved purchasing responsibilities for populations of 100,000 to 500,000); and micro-level (situations with a high degree of local decision making and devolved purchasing budgets).

Wade et al suggest that within the NHS in England, these levels could be further described as:

- macro-level – national commissioning arrangements and performance targets, pan-PCT specialised commissioning

- meso-level – PCT commissioning, joint commissioning with local authorities

- micro-level – practice-based commissioning, direct payments, patient choice

This appears to be based on Roger Kaufman's model related to a nest of plans and actions intended to help in obtaining a ' planning perspective'. In the context of commissioning in Wales, the four levels are useful and relevant.

However, Wade et al suggest that there are different benefits and risks associated with locating commissioning activities at the macro, meso and micro levels. For example, as it sits closest to the 'end-user' of the commissioning process (the patient or client), 'micro-level' commissioning might be expected to improve sensitivity and responsiveness to users' needs. However, it is also likely to have increased 'transaction costs', due to duplication of activities by a large number of small commissioners.

In considering the Health Foundation's work, Wade et al concluded that rather than a single 'ideal' location for commissioning, there was a continuum of commissioning activity that ran across the different levels of a health system. The challenge for managers and policy makers was how to decide at which level of the system specific commissioning activities should be located.

The continuum developed in Smith et al's research (as described above) provides a basis on which to consider specific local commissioning configurations, namely where to allocate the responsibility for carrying out the planning, purchasing and funding of a particular service or health priority.

But Wade et al believe that the continuum does not elucidate the actual nature of different elements of the commissioning function – that is, what actually happens within this activity we are describing as 'commissioning'.

For example, it does not capture the inherent imbalance in relative power throughout the spectrum, and in the relationship between commissioners and providers. Governance arrangements are, therefore, essential in creating the dynamics throughout the system that either promote or hinder service development and re-design, effectiveness and efficiency.

3. The Commissioning Friend – choosing the right model/s

In The Modernisation Agency's NaTPaCT Commissioning Friend (2004), the emerging range of approaches to commissioning across the NHS were identified as:

- Independent Commissioning - individual PCTs undertake all their own negotiations;
- Joint or Collaborative commissioning -a group of PCTs create a framework within which they commission services jointly;
- Lead Commissioning - one organisation acts on behalf of a group of PCTs.

Variants of this last option are:

- Specialist Commissioning - the evolution of different approaches to managing specialised services previously managed by Regional Specialised Commissioning Groups;
- A Formal Consortium - an organisational entity is created to commission on behalf of a group of organisations and is funded by them;
- Shared Services – the creation a new separate organisation to commission on behalf of PCTs.

In considering how to choose the right commissioning model the Commissioning Friend suggests the following criteria as a way of deciding which model is right for each PCT or each service strategy:

- Clout – the commissioning organisation must have the negotiating muscle to be taken seriously.
- Credibility – what real difference is the commissioning strategy going to make and where are the short-term signs of delivery?
- Capacity – which model will create the most capacity?
- Capability – which model will maximize the skills and experience available ?
- Competition versus Collaboration – which model most suits the PCTs stance in each service ?

On this basis the following matrix was constructed to help policy makers arrive at appropriate models for commissioning:

Criteria / Form	Clout	Credibility	Capability	Collaborate/ Complete	Capacity
Pooled Commissioning					
Consortium					
Lead commissioner					
Joint/Collaborative (LAs)					
Clinical Networks					
Independent					

4. Different functions across all levels

Wade et al have extend Smith and May's concept of the anticipated tasks of the 'conscience', 'eyes and ears' by describing in more detail the different tasks and activities contained within the commissioning function, and what these mean for the configuration and management of commissioning bodies.

Their table, as shown in Wade, E et al (2006) - *http://www.hsmc.bham.ac.uk/news/alliance report 23 March 2006 - 3.pdf*, demonstrates the extensive range of responsibilities that accrue to commissioners. Crucially, however, it also highlights the fact that the different types of commissioning functions and responsibilities do not map directly to particular levels of the health system, but are instead distributed across them. For example, in England within a national but devolved system, responsibility for 'determining overall system objectives' lies with the government (for setting national priorities and targets), with SHAs and, increasingly, PCT collaborations (for overseeing the strategic, rational configuration of services), and with PCTs (for identifying and prioritising local needs). Likewise, the assessment of service capacity and outcomes will require both 'hard' data collected at a PCT or supra-PCT level, and more 'qualitative' data provided by practice based commissioners on the basis of feedback from their own patients.

Commissioning in the Welsh context – what do we need to do to get it right?

Here in Wales we are currently engaged in a very important debate about commissioning. In publishing this paper we are not making the case for a particular model or approach. The views outlined above are from others rather than from us, and we are presenting them rather than promoting them, with the aim of informing the debate.

However, we do have a clear view on three things that we need to do in Wales to help create the right conditions for tackling commissioning effectively.

1. Develop commissioning capacity, especially in LHBs

Commissioning is an issue for the whole of the NHS, not just LHBs. Across the service we need to develop expertise in commissioning.

But of course LHBs are particularly important in this respect. Commissioning had not been used to any great effect by health authorities as a lever for change and improvement. Therefore a major challenge for LHBs is how to develop commissioning into a force to help reshape health services and improve the health of the people of Wales.

It is important to remember that commissioning is not the only responsibility that LHBs bear. Indeed, we need to start from a clear understanding of their innovative nature and the demands that this generates. The key features of their role include:

- the combination of functions – managing provision, commissioning, and exercising local health leadership through influence;
- introducing a managed approach to primary care, while retaining the independent contractor status of many professionals;
- the explicit need to work across organisational and sectoral boundaries.

This represents a huge and complex agenda, which can only be achieved if LHBs are able to devote appropriate resources to their management and leadership. The key skills needed include:

- listening to the public
- collaborating across boundaries
- influencing peers in other sectors
- communications
- social entrepreneurship
- systems redesign
- public health and health economics
- strategic commissioning
- management of independent contractors
- information management and analysis
- multi-professional team building
- internal performance management
- project management.

Across the piece then, there is a need to support LHBs, and develop their capacity, to deal with this huge and challenging agenda.

This point applies in particular to commissioning. Insights from international and developing UK experience, particularly in respect of long term care, has highlighted the need for the further development of commissioning skills, such as:

- stratification of patient and population risk
- advanced case management
- predictive modelling of high use patients
- advanced data analysis
- greater refinement in assessing service quality and outcomes

LHBs have already acquired expertise in a key area of commissioning - assessing health needs - as part of their statutory responsibility, working in partnership with their local authority neighbours. While this work will continue to need to be refined and improved, it has provided a strong start to the first vital steps in commissioning. Significantly, and possibly unrecognised, this is a strength in Wales and a perceived weakness in England.

It is more in the areas of specification, procurement and monitoring that commissioning skills need to be developed. This is not just the case in Wales. It is a problem shared across the UK, which all home countries are addressing in different ways, for example payment by results in England.

Richardson (IPC) suggests that commissioning involves similar skills and activities as planning, but crucially it also includes the market perspective. Managing the market to ensure the right mix and pattern of services to meet statutory guidelines and local objectives within the resources available is the holy grail of commissioners. She explains that a purchaser buys what is on offer, or reimburses a provider on the basis of usage, this being a less strategic and more operational activity. She considers

procurement and contracting to be activities that focus on one specific part of the wider commissioning process – the selection, negotiation and agreement with the provider of the exact terms on which the service is to be supplied.

2. Avoid wholesale structural change

The growing health agenda and the fact that managerial capacity and key skills are thinly spread will increasingly affect LHBs' ability to deliver national priorities and respond effectively to the needs of their communities. The absence of a critical mass will progressively put pressure on the ability of individual LHBs to undertake simultaneously all the work now needed to address the challenges they face.

One response would be to restructure the NHS, merging LHBs into a smaller number of larger organisations. Whilst this may have its advantages, these are significantly outweighed at this point in time by some serious disadvantages.

First, having larger organisations will not in itself make for better commissioning. We know this from our recent past. When Wales had five Health Authorities, it was widely held that they did not commission services effectively. In addition they often had poor relations with their providers, found it difficult to relate to their local population, failed to handle health improvement and whole system thinking and failed to work productively with their partners in local government and the voluntary sector. They were felt to be too large and cumbersome for the job of commissioning, and for much else besides.

Second, we cannot afford to sacrifice the key strengths of LHBs. A local focus on health and well-being, coterminosity with Local Authorities, and the close involvement of other partners and the local community in tackling ill health and health improvement: all these are major assets, envied by our English colleagues. In improving and strengthening commissioning we must keep a close eye on the balance between health improvement and health service provision, and on the essential local focus needed for both. While the rhetoric of our times is about undifferentiated care and health improvement, much of our focus and activity is still directed at secondary care. To be fair, all our plans for rationalising acute services are predicated on an acceptance of the need to improve and strengthen 'out of hospital care', but this, by definition, must be local. In designing LHBs, there was great sensitivity in not losing their local focus by setting up what to some would look like the introduction of a 'regional tier' or what some would describe as regional health authorities. This, together with the issue of governance, was where the early concept of 'regional commissioning consortia' failed and from where the idea of 'commissioning partnerships' emerged. At all points in these early discussions, the characteristics of 'local' – sovereignty, accountability and visibility - were seen as sacrosanct.

Third, wholesale restructuring would be an enormous distraction, not only from the task of improving commissioning but from much else besides. Even if there were such a thing as the perfect structure – which is highly debatable – the fact remains that at this point in time, restructuring is the last thing the NHS in Wales needs. The recent experience of PCT restructuring in England has shown just how big a distraction it can be from the core business of the NHS. The cross-party House of Commons Select Committee on Health, in its report on the restructuring, delivered a damning verdict:

"The restructuring of PCTs is likely to have significant effects on their ability to undertake their core functions, including commissioning services, providing community health services, and protecting public health. The destabilizing effects are already becoming apparent: clinical staff are moving from PCTs to the acute sector because of uncertainty over their future roles. There are also well-founded concerns that patient care will suffer because of the proposed reforms......... The cycle of perpetual change is ill-judged and not conducive to the successful provision and improvement of health services."

It is worth noting that the committee's recommendations do allow for structural change locally, *"where this clearly best meets local needs".* However, what is to be avoided is "*the hugely disruptive and costly impact of another root and branch reform of the NHS."*

For these reasons then, wholesale restructuring of the NHS in Wales is not an advisable option at this time as a way of trying to improve commissioning. Moreover, we need to be sure that any new model of commissioning and the impact it has on organizational structures and working relationships brings clear added value and benefit to patient care and the processes that underpin it.

3. Focus on building proper partnerships

Partnership has long been a central feature of Welsh health policy. In our view, it should remain so, not only as policy but also as practice, as a way of tackling commissioning and much else besides.

LHBs are already actively working together to develop new ways of working together and sharing skills and expertise. In England too, as the Health Select Committee report pointed out, PCTs are beginning to work collaboratively. In its section on "The Long Term Impact on Commissioning", the report says:

"insofar as there are advantages in becoming larger, PCTs are already capturing them through successful collaborative working with one another."

Of course the irony is that it is restructuring and merger which can often put these partnerships at risk.

Whilst partnership working in general is starting to bear fruit in Wales, there is of course more still to do, especially on commissioning.

LHBs could increase their influence by working with other LHBs that commission from the same trusts. They can identify common redesign priorities and develop a shared service specifications and care pathways. There is evidence from PCTs in England that a concerted effort neutralizes opposition, and that trusts prefer the single coordinated approach.

In our view building proper partnerships is a prerequisite for any model or approach to commissioning to succeed. Along with developing commissioning capacity and resisting the lure of wholesale structural change, it is essential in creating the right conditions for tackling commissioning effectively. But of course partnership as a policy is one thing; putting it into practice is quite another. Against this backdrop, the next section gives details of work on building partnerships which may be of help in Wales as we seek to strengthen the partnerships we need for better commissioning, and for much else besides.

Working in partnership

Between NHS Organisations

Better working relationships

In the NHS Confederation report *Working Together* a number of dimensions that relate to how health organisations should work together are identified:

- Shared values, vision, goals, medium-term plans and definition of success – these need to be widely shared both organisationally and amongst the broader community.
- Genuine clinical engagement – particularly in relation to clinical pathways and investment decisions as well as key strategic decisions and their implementation.
- The shared management of risk – including the clinical risks associated with service models, early discharge, admission diversion and so on, as well as the financial and volume risks associated with Service Level Agreements, the underlying principle being reciprocity.
- Effective management of the business, including clear and transparent processes for decision-making that actually result in decisions. The basis of decision-making needs to be explicit. Decision-making processes need to include agreement on priorities, honesty about what is not a priority and an agreed process for making disinvestment decisions.
- Overt behaviours that show that there is trust between organisations and people. Developing a shared vision for services and approaching this by adopting a patient-focused approach is an important step in building trust. This may be underpinned by shared values and a common way of doing business.

Strategy is valueless without proper execution. People will have no faith in a strategy or in the organisation more generally if they are not able to get basic management functions right.

The quality of commissioning and how it is undertaken is at the heart of improving relationships.

Strengthening commissioning relationships

The Commissioning Friend summarises a study commissioned by NatPaCT – the Open Book initiative - which piloted the concept of partnering into certain NHS communities in England. The overall objective was to help develop and strengthen commissioning relationships between PCTs and Acute Trusts.

The initiative sees partnering in the English NHS as being about helping to improve PCT and acute trust business in a practical way. This is not blue sky thinking, nor is it to be confused with traditional legal partnerships. It is about supporting and strengthening commissioning relationships and work processes, with the aim of creating enhanced services and improved health and social care.

Commitment from the top was identified as critical to success. Success, failure and the scale of any benefits are all ultimately dependent on chief executives. From its work in England NatPaCT saw that successful partnering arrangements can lead to improved commissioning and working relationships between PCTs and Acute Trusts, but also potentially with the wider community. This also led to improved working environments, a better service to patients and enhanced working relationships.

Some of the key ingredients to partnering success identified by NatPaCT were:

- Genuine commitment from CEOs;
- Communication - genuinely open, honest and timely;
- Honesty – with yourself and partner(s);
- Integrity – confidence in each of the partners;
- Genuine trust in each other – you have to give trust to get trust;
- Openness – do you have something to hide? A lack of openness can give this impression;
- Resources - a partnering manager – ideally as part of modernisation team;
- A joint PCT/Acute Trust vision.
- The sharing of information – openly sharing information in a timely way;

- Monitoring, improving and maintaining efforts as well as instigating regular reviews of progress.

NatPaCT suggest that partners need to assess their own strengths and weaknesses.

Strengths from the pilots included; "a desire to improve and develop services", "the new PCT model gives potential to develop new services", "skills and knowledge of staff," and when a joint vision is in place, "we work well together".

Weaknesses have included; "a lack of a strategic vision", "no shared objectives", "lack of sharing information", "lack of openness", "history between managers", "lack of clinical engagement," "a blame culture" and in some cases, "poorly managed meetings".

Between the NHS and other partners

Local Government

Improving Health in Wales underlined the importance of developing new partnerships between local government and the NHS. Health organisations and local authorities have a key role in planning and commissioning care and a clearer distinction is emerging between these roles and service provision. Local Health Boards have a crucial role in commissioning health and health-related social care services. They lead in achieving effective local joint working across the statutory and non-statutory sectors, so as to develop strong community-based health and social care services. They will increasingly work within and across wider geographical areas.

In the joint report from the NHS Confederation, UKPA and the LGA, *Releasing the potential for the public's health*, partnership is described as the cornerstone of a range of recent policy shifts aimed at modernising institutions across the whole field of civil and public life. It reflects the growing recognition that there are links between policies on health and those, for example, on housing, the physical environment, employment and other functional areas.

There is also a recognition that issues such as deprivation must be tackled in a co-ordinated way. Tackling the longstanding, interconnected problems affecting the public's health, and in particular reducing the health gap between social groups and tackling social exclusion, can be achieved more successfully through partnership than by discrete policies in specific, functional areas.

In Wales the partnership between LHBs and Local Government is underpinned by their shared statutory responsibility for assessing local needs and preparing and implementing local strategies for health, social care and well-being.

This partnership is further strengthened by the fact that LHBs boards include elected local authority members and officers.

Patients and the Public

As a public service, the NHS is accountable for its actions to the local community. The development of patient and public involvement has the potential to offer important benefits for everyone involved in healthcare: clinicians, managers, patients and the public. It can contribute to wider understanding of demands and resources, the development of strategies for change, improved accountability, and increased co-operation between patients and providers to improve clinical outcomes.

There is a distinction between patient involvement and public involvement. Individuals may have a different perspective on healthcare as a patient (consumer), compared to a member of the wider public (citizen).

Patient involvement in decisions about their care, how it is delivered and what treatment options they wish to take, is a key part of how we should be designing healthcare in future. Patients are excellent informants on how services they use should be designed, what they value about them and what it feels like to use them. The wider public will have views about resource allocation and priorities that the service should be following.

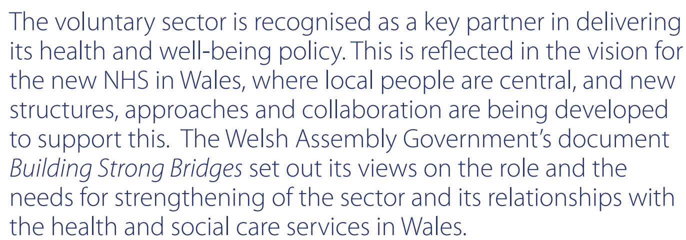
There is an obligation on NHS organisations to involve and consult patients and the public in service planning, the development of proposals for changes, and in decisions that affect the operation of services.

Engaging with the Workforce

A key part of delivering strategy and agreements to collaborate is the ability to involve clinical staff and the wider community of health professionals and support staff in key decisions, to ensure that they are behind these decisions and engaged with the process.

The Voluntary Sector

The voluntary sector makes a significant contribution to support services across Wales. It complements the statutory services across health and social care, bridges gaps and supports seamless service provision. It also acts as a main service provider for the hospice movement, mental health, drug and alcohol services. Voluntary and community organisations are valued by LHBs for their work in the representation and support of those most disadvantaged in our communities.



The voluntary sector is recognised as a key partner in delivering its health and well-being policy. This is reflected in the vision for the new NHS in Wales, where local people are central, and new structures, approaches and collaboration are being developed to support this. The Welsh Assembly Government's document *Building Strong Bridges* set out its views on the role and the needs for strengthening of the sector and its relationships with the health and social care services in Wales.

Voluntary organisations have highlighted a number of issues which traditionally prevented them from participating as a full and equal partner in the health and well-being agenda. They see the establishment of LHBs as an opportunity to expand this contribution, with a more equitable representation and participation in the work to clarify roles, remits, responsibilities and accountabilities. For this, their members need to be supported by training to help develop better understanding and local participation.

Communication, networks, and partnership working across health and social care needs to be strengthened. The introduction of health and social care facilitators within the voluntary sector is helping to overcome many existing problems. Managing and supporting the changes needed to create new roles, relationships and ways of working envisaged for the future has also been seen as important.

Conclusions - the way ahead

NHS Local – think global act local?

Commissioning is more complex than ever, involving an ever-wider range of functions, discharged at a growing number of different levels. In concluding their study, Wade et al say that in England the overall commissioning task facing PCTs has expanded. There is a greater range of functions to be performed and the expectations on commissioners are higher than ever before. The same is true of LHBs here in Wales.

But Wade et al suggest a way forward which reconciles the complex realities of modern commissioning with the need to keep a local focus. They suggest that in a complex health system, the PCT is being looked to as the 'sovereign' local commissioner. and needs to become 'NHS Local', a strong, legitimate and recognised body that people consider to be responsible for 'their' NHS. Adopting this "NHS Local" role does not mean closing the gates to the world beyond the patch, a position which in a modern healthcare system is untenable. To borrow the campaign slogan, it is more a question of thinking global and acting local. What it means in practice is that as sovereign local commissioner, the PCT has the responsibility for deciding where to locate the many different activities that make up commissioning. Some will be aggregated upwards to supra-PCT bodies, others will be contained within the PCT, and others will be devolved downwards and commissioned more locally. Just as sovereign nation states have had to adjust to a multi-level world by ceding some of their authority upwards to supra-national bodies, retaining control of many key functions at nation-state level, and devolving some decisions downwards to more local levels. The key point, as Wade et al underline, is that the PCT remains the overall guardian of all commissioning activities in its local area.

To make this work, the PCT would need to develop stronger and more sophisticated governance of the 'web' of accountability relationships in the middle of which it finds itself. In developing governance arrangements, PCTs will need to give specific consideration to how they will govern partnerships (NHS, local authority and other), markets (including the relationship with providers), their relationship with patients and the public, and the securing of clinical advice and leadership. Additionally, Wade et al believe that NHS commissioning has a poor record in relation to the involvement of patients and the public in decision-making. New PCTs need to explore different approaches to developing strong local identity and legitimacy.

This notion of the "sovereign" local commissioner, while not without its problems, is perhaps a way forward here in Wales too. It takes account of the fact that commissioning is a complex activity undertaken at a range of different levels, but simultaneously retains the strong local focus which reinforces accountability and legitimacy.

Partnership – shared problem, shared solution

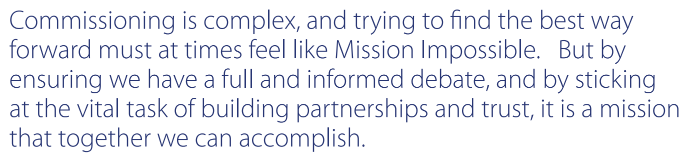
Whether or not this particular model is appropriate for Wales, it is striking that - as with other approaches to commissioning – it boils down to is building and maintaining a series of partnerships.

LHBs are already actively investigating ways of working collectively to address the capacity issue and to provide critical mass to appropriate areas of commissioning. This needs to be developed further.

But it is not simply a question of building partnerships between LHBs. In keeping with the principle that commissioning is everybody's business, close working partnerships, trust and understanding between LHBs and Trusts is absolutely critical. All partners must have regard to each other's perspective, securing the best possible service provision while taking full advantage of the potential that lies within the health community. Trusts and their clinical staff are the repository of the knowledge, intelligence and expertise with which to change and improve services. But to own the direction of travel and to be committed to change they must be seen as, and see themselves as, integral to a commissioning process that is fair, and that achieves 'testable' value for money. The commissioning strategy, in the scenario that faces Wales, must be jointly owned and delivered. Changing the commissioning process will only succeed if we change our relationships and attitudes toward each other.

Trusts are right to expect that commissioners and the commissioning processes in Wales prove themselves to be credible and effective. Similarly commissioning needs to be streamlined to become a more manageable and coordinated affair. Trusts have an opportunity here to help lead and shape the changes and secure a better future. They have extensive experience in service planning and negotiation. At all times, and by all those involved in improving commissioning, trusts must be seen as essential partners that are inside, not outside, the tent.

It is apt that we should end by calling for a renewed emphasis on partnership. The pros and cons of different models and approaches to commissioning are quite rightly being debated across Wales. But none of them can succeed unless we keep focused on the unglamorous but absolutely essential job of building partnerships across the NHS.



Commissioning is complex, and trying to find the best way forward must at times feel like Mission Impossible. But by ensuring we have a full and informed debate, and by sticking at the vital task of building partnerships and trust, it is a mission that together we can accomplish.

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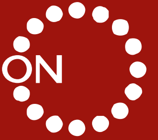

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