Towards World Class Commissioning Competency

A report produced for West Midlands Strategic Health Authority by the Health Services Management Centre, University of Birmingham

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Executive Summary

This paper is intended to assist the thinking of those currently seeking answers to questions, such as: What are health care commissioners required to do? What knowledge, skills, attitudes and behaviours are required to do it well? Who (either within or beyond the NHS) is most likely to possess these attributes at the moment? How should these capabilities be developed and distributed in future?

It argues that defining and validating commissioning competency will be incredibly challenging because there are no definitive answers to these questions. Existing evidence tells us little about the specific mechanisms through which commissioning competency does, or does not, lead to improved health system outcomes.

This does not undermine attempts to articulate and develop commissioning competency. However, acknowledgement of this complexity and ambiguity should be seen as the starting point for intelligent discussion of the issue.

The paper does not seek to propose any new commissioning competencies that have not been identified by other commentators, but does emphasise particular aspects of the debate surrounding commissioning competency which may have received less prominence elsewhere.

In particular, it argues that a meaningful definition of competency must take into account organisational, contextual and behavioural factors, and not focus entirely on the knowledge, skills and capabilities of individuals, or particular groups of managers and clinicians.

The paper considers the overarching objectives of the UK healthcare system, and the ways in which commissioning was originally intended to contribute to the achievement of these objectives. It also reviews a number of existing frameworks describing the activities of commissioners and the competencies required to perform these tasks effectively.

From this, fourteen domains of competency for world class commissioning are identified. It is suggested that many of the skills required for effective commissioning are already present within the NHS, although they could be more effectively mobilised. Others are well developed and clearly articulated in other sectors, but need to be more rapidly incorporated into the healthcare commissioning workforce. A third category of competencies (in particular those associated with up-stream interventions on the demand-side of the healthcare system) is still in the process of being defined as commissioning itself evolves. Developing these competencies will require innovation and creativity, risk-taking, and learning from doing.

The paper concludes that a one-size-fits-all approach to defining and developing commissioning competency is unlikely to be optimal, and reiterates that competency depends not just on knowledge and skills, but on values, motivation, and agency. This is an important message for those involved in commissioning at all levels of the system.
Foreword

I have been working in commissioning at Director level or as a Chief Executive in the NHS for over 15 years. The last 15 months have been spent in the privileged position of working for an SHA within a leadership team committed totally to commissioning development, and with colleagues in the West Midlands and from across the country who are all highly motivated towards making the NHS the best healthcare system in the world. Some months ago,

I received a telephone call from one of the most distinguished of those external colleagues during which he said to me that from his experience “people just don’t get it”. The “it” was commissioning. Whether this was a fair observation or not, I was prompted to think about the work which I should be facilitating to build that understanding where it might be missing and to continue to support PCT leadership teams in their challenge to build commissioning capacity and capability. For me, this work needed to do a number of things. First, we should have some realistic understanding of what level of contribution (to borrow the phrase) world class commissioning can be expected to make to improving population health and securing the best possible patient experience of healthcare services. I start from a position that it is one important factor but only one and that the best commissioners will understand this and demonstrate so in their behaviours. Second, what are the competencies which are required to deliver world class commissioning and how can PCTs build organisations or partnerships or support systems which can deliver all of those competencies? This is important because the health improvement or healthcare service sector is recognised as probably the most complex area in which to commission and the skills to do so are in short supply. Finally, what is the appropriate response to those who say we need to professionalise commissioning and what does this mean?

I chose to collaborate on this piece of work with the HSMC at the University of Birmingham because of the brilliance and in particular clarity which Chris Ham provides in his observation of other healthcare systems and what makes them work or not and because of the excellent work done previously by Juliet Woodin and Elizabeth Wade with Judith Smith on commissioning. I think this report, and the forthcoming accompanying review of the international evidence, more than justify the decision and I have been able to clarify my own thinking in a number of areas as a result of the reports. I am therefore very grateful to Julie, Elizabeth and Chris. I know that they would want me to emphasise very strongly that the work on competency domains and their elements is not intended to be prescriptive and PCTs should, and I know will, organise themselves to best suit their local circumstances especially the skills in their teams.

Finally, we started this work shortly before the launch of the World Class Commissioning initiative but Mark Britnell encouraged me to press on and submit the report as a contribution to WCC. We are very pleased to do so and I think you will find the conclusions support that of the work being lead by Mark and his team.

Eamonn Kelly
Director of Commissioning and Performance, NHS West Midlands
Background and introduction

The separation of responsibility for planning and funding services from the task of delivering them has been a feature of the UK public sector for many years. While the extent of this separation (and the terminology used to describe it) has varied over time, location and service area, the concept is certainly not new.

However, the recent consistency with which the role of the state has been portrayed as that of commissioner (or in some contexts ‘enabler’ or ‘place-shaper’) rather than provider is, perhaps, unprecedented. In particular, there has been a shift away from commissioning being seen as one of many functions carried out by statutory organisations, towards the description of these organisations themselves as strategic commissioners. At the same time, there has been a growing recognition that if commissioning lies at the heart of ‘what the public sector does’ the capacity, capability and profile of individuals and organisations involved in commissioning must be strengthened.

Current efforts to articulate the core set of competencies required for effective commissioning, and to accelerate the development of these competencies at a national and local level, are intended to create and embed the foundations for this strengthened commissioning function.

As discussed below, even with a more prominent role, commissioning should only ever be seen as one part of the wider architecture of public policy and provision. It is clear that a variety of factors determines the system-level outcomes achieved through public services, of which the competency of those performing the commissioning role is only one. Nonetheless, if commissioners are to play their part within the system as effectively as possible, it seems logical to suggest that a highly trained, skilled, experienced and knowledgeable commissioning workforce is required.

The literature on UK and international experience of commissioning actually provides relatively limited evidence regarding the skills and competencies required by commissioners, but nevertheless provides general support for the proposition that management skills and capacity are factors relevant to their success. A study of the UK experience of primary care-led healthcare commissioning concluded, for example: “This review has clearly demonstrated the link between adequate levels of management and analytical expertise and the achievement of commissioning objectives’ (Smith et al. 2004).

Evidence available from other sectors and contexts, while not necessarily directly transferable, also points to a relationship between effective recruitment, talent management, training and development and organisational performance, reinforcing the case for seriously exploring these factors in relation to public service commissioning.

According to research carried out by the Hackett Group (2006), for example:

...world-class procurement organizations have fully-loaded wage rates that are 41% higher than typical companies... dedicate 74% more hours/year to training of procurement staff than typical companies... [yet] see procurement operations costs that are 20% less than typical companies... and operate with nearly half the staff. They also see 133% greater return on the cost of procurement operations than typical companies.

This apparent link between investment and return no doubt seems obvious to those currently tasked with developing world-class commissioning within the NHS. However, the practical implications may be less clear. Up to now, while numerous toolkits, frameworks and models have been developed to describe effective commissioning, a common understanding of what competent commissioning really looks and feels like has somehow remained elusive. For example, the tool most recently used to assess the standard of PCT commissioning (the Fitness for Purpose framework) provides a detailed account of the activities which comprise the commissioning role. However, its focus is primarily on the tasks and processes a commissioner should be carrying out, rather than on the workforce characteristics required to perform such tasks, or on the fit between existing workforce characteristics, and the specific organisational requirements of different PCTs operating in different contexts. The observation that scores against the Fitness for Purpose framework do not necessarily correlate with performance against key national targets suggests that there is at least a prima facie case for examining other aspects of PCTs’ internal and external environments that may be relevant to their effectiveness as commissioners.

Under pressure to establish a commissioning-led health system, but in the absence of any well established specification of commissioning competencies, NHS leaders recognise the need for investment, but must first clarify exactly what and who it is that they should be investing in: What are commissioners required to do? What knowledge, skills, attitudes and behaviours are required to do it well? Who (either within or beyond the NHS) is most likely to possess these attributes at the moment? How should these capabilities be developed and distributed in future?

The following paper is intended to assist the thinking of those currently seeking answers to such questions. Its focus is on health service commissioning, but many of the issues raised may be relevant to commissioners in other sectors. Its starting point is to recognise the huge amount of effort already expended in defining the current NHS commissioning role, and the resources required to fulfil it. The Fitness for Purpose documentation referred to above, and the more recent Framework for External Support to Commissioning (FESC) specification, for example, provide an impressive level of detail and, as the range of commissioning frameworks referred to in Appendix 2 illustrates, addressing this issue has become a collective endeavour between policy makers, commissioners, providers, academics and other interest groups. The Department of Health’s framework for World Class Commissioning (also due for publication in December 2007) will clearly be one of the most important outputs of this effort. It will not only articulate the Department’s understanding of world class commissioning competency, but will also include an accountability and development framework designed to ensure this world class standard is attained.

The primary aim of this document is not, therefore, to propose a new or substantially different set of commissioning competencies to those set out in existing or emerging models. Rather, it aims to emphasise particular aspects of the debate surrounding commissioning competency, which may have received less prominence elsewhere. Specifically, it:

- Considers the nature of competency and the complex relationships between personal attributes, individual competency, and organisational performance;

1 An early draft version of this paper was shared with the stakeholders involved in developing the Department’s World Class Commissioning Framework.

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- Highlights some of the problems involved in identifying competencies for healthcare commissioning;
- Re-visits the purpose of commissioning, exploring the specific contribution that commissioning is supposed to make to the achievement of health system outcomes;
- Refers to some international evidence on what constitutes effective commissioning, and the impact it has on system outcomes;
- Collates and compares a wide range of UK-based models of commissioning and commissioning competency, alongside related frameworks from other sectors (including procurement and supply chain management);
- Synthesises the outcomes of these reviews into a model that emphasises the political and societal context within which commissioning takes place, and highlights the importance of organisational effectiveness to the development of commissioning expertise.

Some of the issues raised are complex and, as such, there is a risk they could be seen as complicating factors in an environment where rapid delivery is critical. We would argue the opposite: that without a sophisticated and realistic understanding of the complexity of the task, strategies for action are likely to be flawed. As identified in a recent Institute for Health Improvement (IHI) report on Strategic Improvement Initiatives (Nolan 2007), even with tremendous will and great ideas, strategic plans too often fall down in their execution, due to a failure to manage them effectively at a systemic level. Therefore, far from underplaying the challenge of defining and developing commissioning competency in an inherently complex environment, we suggest that acknowledgement of this challenge is the starting point for intelligent discussion of the issue.

What is competency?

The notion of competency is central to research and practice across a range of disciplines including psychology, education, human resources and general management. However, there is no clear consensus across or within these areas regarding the definition of competency, its theoretical basis, ways of measuring it, or its explanatory power as a concept. It is not possible or appropriate to explore these issues in depth here. However, it is important to clear on the definition of competency being used for the purposes of this paper, and to at least highlight some of the implications this has for developing a model of commissioning competency.

The term competent is often used to refer to the possession of the knowledge and skills that are known (or assumed) to be required by an individual to carry out a particular job role. As such, competency (the state of being competent) is seen to be achieved through the acquisition or development of one or more competencies:

"... descriptors of performance criteria, knowledge and understanding that are required to undertake work activities. They describe what individuals need to do, and to know, to carry out the activity – regardless of who performs it."  
(Skills for Health 2007)

On this basis, competencies are often used as the basis of job design, job evaluation, recruitment, training, performance appraisal, and similar individually-focussed human resource activities.

We argue here that, while the delineation of the knowledge and understanding required by individuals is clearly important at an operational level, this approach to understanding competency as the sum of individuals’ skills is limited. As such, it provides an insufficient starting point for understanding the concept of ‘commissioning competency’, to be explored in this paper.

The three key problems with this common description of competency are:

i) the focus on cognitive characteristics (knowledge and skills) and absence of reference to behavioural characteristics (e.g. motives) and affective dispositions (values and attitudes) required for effective performance
ii) the focus on individual rather than organisational-level capabilities
iii) the emphasis on describing what is required to carry out discrete tasks and activities, without accounting for their interaction with each other, or the context in which they are performed

Motivation, values and agency

To take the first point, definitions of competency that restrict their scope to knowledge, skills and understanding imply a linear and unproblematic relationship between cognitive abilities and performance which, in reality, does not exist. All managers will be aware (from reflecting on their own practice as much as from observing others), that having the ability to perform a task to a prescribed standard does not mean that it will actually be carried out to that standard consistently (or at all) in practice. Knowledge, skill and understanding only have value when demonstrated through behaviour and action, but action is mediated by values, emotions, incentives, self-perception and other factors. A definition of professional competency reflecting this point is provided by Epstein and Hundert (2002) who identify the cognitive, technical and integrative and communication skills required by doctors, but add to this a ‘moral’ dimension to medical competency “… the willingness, patience and emotional awareness to use these skills judiciously and humanely”.

The importance here of motivation as an element of competency has been highlighted by McClelland (1973), who points out that high level competencies such as using initiative, analysing and intervening in organizational processes, and making complex judgements between alternative courses of action are difficult and demanding to enact. Consequently, such abilities will often only be developed and displayed while people are undertaking activities they care about or else find intrinsically satisfying.

Other writers have identified a range of other factors that play an important role in work performance, including self-efficacy - the belief that one possesses the skills and abilities required to perform a job well (Bandura 1977); self-determination – the extent to which individuals feel they have autonomy and freedom in their actions (Miller & Monge 1986); and sense of impact – whether individuals feel they are making a difference in their organization (Ashforth 1989). If a meaningful definition of competency must take into account the application (and not simply the possession) of knowledge and skill, competency will depend on the alignment of a certain set of cognitive capabilities with these (and other) underlying motivational factors.

Organisational factors

This in turn raises the point that individual-level and organizational-level competencies are inter-dependent. While levels of motivation, agency, and perceived impact are to some extent internal characteristics of individuals, they are also clearly shaped by organizational culture, leadership and strategy. If it is accepted that affective and behavioural characteristics must be included...

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An accompanying paper exploring this evidence in detail will be published separately in early 2008 by Professor Chris Ham.
within our understanding of competency, then must the organizational and systemic features that influence individuals’ reactions to and engagement with their work. The current paper does assume this relationship, and is actually concerned primarily with such organisational level competencies. It is acknowledged, however, that at some point individual level competency frameworks must be considered to enable organisational requirements to be operationalised. In reality, it is extremely difficult to consider either organisational or individual competencies in isolation.

**Context and environment**

The third important point to make here is that, unlike knowledge and skills, which intrinsically belong to an individual or team regardless of their actual work demands, competency is highly context specific. Competency is not derived simply from the combination of a particular set of attributes, but from the interaction between those attributes, and a specific set of job requirements. A person only possesses a competency for as long as the skills, abilities, and knowledge they have enable them to perform effective action within a certain workplace environment. Thus, one might retain knowledge, a skill, or an ability, but still lose a competency if what is needed to do a job well changes. Thus, competency is integrated and relational, consisting of the “complex structuring of attributes needed for intelligent performance in specific situations” (Gonczi 1994).

**Performance outcomes**

Finally, there is a fundamental aspect to the definition of competency which explains the effort organisations expend in identifying and developing competency, and which is of particular significance in our attempt to understand commissioning competency. Boyatzis (1982) defines competencies as:

> Characteristics that are causally related to effective and/or superior performance in a job. This means that there is evidence that indicates that possession of the characteristic precedes and leads to effective and/or superior performance on the job.

This definition brings into clear relief the fact that organisations do not seek to define and measure competencies simply so that they can understand and describe their work. Rather, the aim is to identify and develop those attributes that are required for improved or superior work performance.

As such, finding the links between particular individual or organisational characteristics and particular outcomes is usually a core task in developing a competency framework.

A definition of competency that incorporates the various elements discussed above might be:

> The knowledge, skills, behaviours and characteristics required to carry out an activity, or combination of activities, in a particular environment and organisational context, in a way that leads to effective or superior organisational performance.

As discussed in the next section, when competency is understood in this way, it starts to become clear why defining commissioning competency presents such a challenge.

**Note**

The term ‘core competency’ is sometimes used in the organizational context, to describe a competency which underpins a number of its activities and is so crucial to performance that it should be kept in-house and never out-sourced (Prahalad & Hamel 1990). This is, therefore, a specific aspect of organisational competency, and is not explored in detail here. However, it will be important for PCTs to consider whether there are any core competencies for health commissioning, particularly in the context of the encouragement of PCTs to outsource commissioning activities either to external providers or to joint agencies of one type or another. One model of the commissioning process (Wade et al. 2006) used the metaphor of ‘conscience’ to describe those functions of commissioning associated with setting out what the system aims to achieve and how (as opposed to the ‘eyes and ears’ functions of observing and reporting, and the ‘brain’ function of identifying and implementing the optional solutions for delivering stated objectives). Competencies associated with the ‘conscience’ function of commissioning might be considered candidates for designation as ‘core’.

If competency refers to the knowledge, skills, behaviours and characteristics required to carry out certain tasks in particular situations, it is clear that in order to identify commissioning competencies, it is first necessary to articulate the full range of commissioning activities and the context(s) in which they are carried out. Immediately, here is an obvious challenge.

As noted above and illustrated in section A of Appendix 1, numerous frameworks have been developed in recent years by Government departments, academics and others, outlining the various stages of the commissioning cycle, the responsibilities of strategic commissioners, and the key steps in effective commissioning. The Fitness for Purpose (FFP) review process previously referred to has probably gone furthest in detailing the activities, tasks and processes entailed in PCT commissioning in particular, and this is, undoubtedly, an invaluable starting point for any exploration of healthcare commissioning competencies. However, FFP remains only one of several frameworks and has not been without its critics, with commentators arguing that some of the core functions of PCTs (in particular those associated with the creation and representation of public value and community engagement through effective ‘cultural’ performance) are missing from the model (Dickinson et al. forthcoming). It would seem fair to say, therefore, that full and consistent agreement on the activities that constitute effective healthcare commissioning has not yet been reached.

There are number of reasons for this.

**Lack of direct comparators**

One obvious one is that commissioning has a relatively short, highly unstable, and rather unique history. Contrast this with the situation of modem healthcare providers, such as hospitals and general practices (as primary care providers); like PCTs, the functions of such organisations are complex, numerous, and varied, and are evolving over time. Unlike PCTs, however, a significant proportion of their core business constitutes certain well established tasks and activities which have been repeated and improved in this country over many years, and also carried out by similar healthcare providers across the world, providing the scope to develop global standards of evidence-based practice. Healthcare commissioners in the UK not only have less internal history to draw on than their local provider organisations, but find themselves without peers carrying out directly comparable roles in other countries.
While other health care systems do of course share certain features of the UK commissioning model, the type, size, constitution and responsibilities of purchaser or funding organisations varies significantly. Opportunities for PCTs to learn directly from other ‘world class commissioners’ may simply not exist. To a large extent, commissioners are defining their roles through the process of performing them.

Organisational change an re-structuring

Many within the system would argue that our difficulties in defining commissioning roles have been exacerbated by the frequent re-organisation of the demand-side of the NHS over the last 15 years. Organisational intelligence gets lost or forgotten, and progress stalled, when energy is focussed on restructuring, and when key individuals leave the service. As a result it is possible that, in some areas, experience in and understanding of commissioning may actually have diminished, rather than steadily grown over the years.

Levels of commissioning

A further complicating factor is that health service commissioning takes place at a number of different levels within the healthcare system. While PCTs might currently hold statutory responsibilities for health commissioning in England, many other organisations and individuals are involved. In particular, current policy advocates that practice-based commissioners should take a lead role in making commissioning decisions, while certain specialist tasks should be aggregated across a number of organisations, and yet others should be shared with partners, such as local Authorities. Over time, individual service users are also likely to be more involved in various aspects of commissioning. It might be argued that this should not alter the task of specifying commissioning activities but simply means that, once specified, they must be carefully allocated to the appropriate organisations and individuals for execution. Again, however, in reality specification and implementation are occurring concurrently: commissioning activities are in the process of being designed, defined, enacted and modified by multiple actors, with different perspectives on the purpose and objectives of their commissioning role and, therefore, on the knowledge, skills and competencies they require.

Context specificity

Linked to this is a third point: that the specific commissioning tasks to be performed by health service commissioners will be determined by contextual factors, and will therefore vary over time and location. Cox (2001), for example, identifies four different possible relationships between purchasers and suppliers, determined by factors such as the structure of the supplier market, and levels of competition. As discussed above, competency depends on the context in which an activity is being carried out, so even though certain tasks and activities (e.g. ‘contracting’) might be common to all commissioners, different types of relationships with suppliers will demand different competencies and resources from the purchasing organisation for this activity to be carried out in an appropriate and effective way. For example, different competencies may be required in a large conurbation with a number of competing acute trusts, from those necessary to manage relationships in a remote rural area with only one acute provider. Similarly different competencies may be required to commission primary care from those required to commission secondary or tertiary care.

Impact of commissioning on health system outcomes

Underpinning this whole discussion is, of course, a much bigger question regarding the nature of the relationship between commissioning activity (competent or otherwise) and the achievement of health system objectives. As suggested in the introduction to this paper, while it might seem self-evident that the competency of commissioners is critical to the effectiveness of a commissioning-led health system, at best, this will only ever be one of many factors. In reality, there is no conclusive evidence base demonstrating causal links between the organisation of healthcare through the separation of purchasers and providers, the competency of those carrying out the purchasing role, and the long-term outcomes of the healthcare system. Furthermore, it would be extremely difficult to ever demonstrate such relationships should they exist, given the number of different contributing factors. Goals such as ‘high quality healthcare’, for example, will be achieved through the combined efforts of practicing clinicians, provider managers, professional organizations, researchers designing new technologies and therapies, the actions of commissioners or purchasers in stimulating changes using market mechanisms, and regulatory bodies taking action. They will also depend on factors such as the willingness of tax-payers and government to increase healthcare funding. In this context, identifying the precise contribution of commissioners in achieving such goals may well be impossible. We are certainly some way from being able to describe the causal relationships between particular characteristics of commissioners, and specific commissioning outcomes, that Boyatzis would require for a definition of commissioning competency.

In summary, despite the extensive effort that has gone into developing and articulating commissioning frameworks in recent years, there is no straightforward answer to the question ‘what are commissioners required to do?’ Inevitably, identifying commissioning competencies, or ‘what is required to do ‘it’?’ is challenging, when ‘it’ remains so contested.

This is not to say that there is nothing to be done; that no further action can be taken to identify an appropriate competency framework for commissioners. It does, however, have two important implications for the way in which this task is approached:

i) it is clear that a focus on the development of commissioning needs to remain part of a wider framework of investment in the development of the system as a whole.

ii) in the short term at least, the delineation of competencies for commissioning must depend largely upon a combination of inference, judgement and experience, rather than on hard-facts and indisputable evidence.

The remainder of this paper takes this line, combining a top-down approach (deducing competencies from the goals of the healthcare system, and the specific functions and responsibilities of commissioners within that system) a bottom up approach (building from and synthesising items identified in existing competency frameworks relevant to health service commissioning, including those in the field of procurement of non-clinical goods and services), with the expert opinion of practitioners in the field.

The next section sets out the top-down analysis, establishing an account of commissioning, which identifies its purpose and objectives as well as its main functions.
The contribution of ‘commissioning’ to the achievement of health system goals

Health system goals
The goals of health care commissioning need to be considered in the context of the goals of the health care system as a whole.

Although the organisation of health systems across the world varies considerably, and indeed has been subject to considerable reform and change over the past 25 years, a number of international organisations have identified high level health system goals which are accepted as meaningful, relevant and sustainable across many health systems, whatever their architecture.

Three examples are given below in Boxes 1–3.

Box 1. World Health Organization (Musgrove et al. 2000)

Three overall goals of health systems
- Good health
- Responsiveness to the expectations of the population
- Fairness of financial contribution

Box 2. Organization for Economic Cooperation and Development (OECD 2004)

Main health policy goals shared by OECD countries
- High quality health care and prevention
- Accessible health care
- Responsive systems that satisfy health-care patients and consumers
- Sustainable costs and financing
- Value for money

Box 3. Commonwealth Fund. (Davis et al. 2007)

Dimensions of a high performance health system:
- Quality
  - Right (or effective) care
  - Safe care
  - Co-ordinated care
  - Patient-centred care
- Access
- Efficiency
- Equity
- Healthy lives

Although these expressions of goals are not identical, can be interpreted differently, and are often in tension with each other, they suggest that health systems need to aim to achieve:
- Good health outcomes
- High quality and safe care
- Responsive and patient-centred care
- Equity and fairness
- Contained costs
- Efficient use of resources

There have been various expressions of the objectives of the NHS in both strategic policy statements and more operationally oriented documents. Appendix 2 maps a recent strategic expression of NHS principles (updated 2006) and a more operational set of outcomes in the form of National Targets and Local Delivery Plan requirements from the 2007/8 Operating Framework, against the health system outcomes listed above. The table demonstrates a high degree of consistency between the generic outcomes described above and the sorts of outcomes the NHS is expected to achieve, with the main difference being the NHS inclusion of an ‘internal’ outcome, relating to management of the health system’s own staff. This analysis suggests, therefore, that the generic health system outcomes list is a valid and relevant statement of the overall system outcomes to which commissioning in the NHS must contribute.

The specific contribution of commissioning
If these are the outcomes that the health system must produce, what is the specific contribution that commissioning must make? Indeed, why do we have commissioning at all?

Mays and Hand (2000) identify the main reasons behind the reforms which introduced commissioning into health systems as follows:
- to improve technical efficiency by allowing purchasers to select the best value provider accessible to their populations, including private and voluntary sector providers, thereby giving purchasers some control over providers
- to allow those charged with determining the future pattern of health services in relation to the needs of the population to concentrate on this task unhindered by their previous responsibilities for managing health care institutions and, at the same time, to allow the providers to manage their own affairs with the minimum of unnecessary interferences
- to act as a counterweight to decades of professional dominance of service specification and to challenge traditional patterns of resource allocation and sectional interests (active purchasing rather than passive funding or bureaucratic planning)
- to improve allocative efficiency by permitting purchasers to negotiate a new balance of services with providers
- to encourage providers to respond more accurately and effectively to the needs of individual patients in order to retain contracts from purchasers
- to facilitate clear lines of public accountability for the performance of the purchaser and provider roles in the health system
- to clarify providers’ costs and the amount spent in each service area by comparing the services and costs of each provider
- to make priority decisions more explicit

The ambition of these reform objectives set alongside the breadth of health system objectives suggests a huge challenge for commissioners and one which would, in any estimation, require extraordinary capacity and wisdom to achieve.

It is perhaps therefore unsurprising that there is little evidence of these ambitions being realised. Ham (2007), summarising the evidence from a number of healthcare systems, refers to “the lack of any working models of health care systems where commissioning is working effectively across the whole system” (p.8) Research evidence from the NHS internal market of the 1990s (based almost entirely on primary care led commissioning; there is very little evaluation or evidence from Health Authority commissioning) leads to similar conclusions. Evidence from primary care commissioning suggests that purchasing or commissioning during this period had some limited impact on the responsiveness of services - such as shorter waiting times - and resulted in some innovation in primary and community care. Clinical engagement and financial incentives were important in achieving these gains. However there was no evidence that commissioning had any significant or strategic impact on secondary care services. In relation to the efficient use of resources, there was evidence of reduced prescribing costs, but transaction costs were increased (Smith et al 2004).
The extent to which this lack of impact is the result of basic flaws in the system or a failure to invest in the capacity of commissioners is not clear. Nevertheless, the experience of commissioning during the early period of public sector reforms, together with an account of the goals it was intended to achieve, do provide pointers to the competencies likely to be required by commissioners. They suggest that commissioners will need competencies in both financial and clinical (or health) domains, will need close engagement with patients, and will need skills in prioritization which pay attention to outcomes, and the values of fairness and equity.

The next section of the paper now seeks to identify key messages about commissioning competencies through a review and summary of existing models and frameworks.

Review of existing models and frameworks

A rapid review was undertaken to identify recent models and frameworks either referring specifically, or with some relevance, to health/healthcare commissioning competencies. Those reviewed are summarised in Appendix 1.

Some of these, in Section A, are accounts of the functions or activities comprising commissioning, from which competencies at the organizational level can be inferred.

Section B sets out a small number of direct references to competencies required at the organizational level for effective commissioning, mostly derived from academic or practitioner literature.

Finally, in Sections C and D are extracts from some existing relevant frameworks which deal with competencies at the individual level. These include both health/social care specific frameworks (C), and some relating to non-health and social care sectors (D). These individual level competency frameworks are detailed documents which provide tools for job design, job grading, recruitment, performance appraisal, and so on. Due to their length, only extracts, or an overview of their key elements, are included here. While this paper is not aiming to produce an individual level competency framework, these frameworks map back to organizational level competencies and provide useful pointers to competencies which may need to be included.

The following paragraphs briefly outline the main similarities and differences between the various frameworks, and highlight certain aspects of commissioning that, in the authors’ view, may be under-represented in these existing models.

Common ground
Despite differences in terminology and emphasis, most of the frameworks in section A and some in sections B, C and D include activities which are explicitly or implicitly grouped into three phases:

- **strategy making or planning**, which includes assessments of population health needs, demands for services, the range, quality and effectiveness (clinical and non-clinical) of existing services and providers, and designing of the required services
- **securing the services**, which in most accounts is a market-based process often referred to as purchasing or contracting, involving shaping and developing the market, bringing suppliers on board (often through tendering), and establishing formal agreements or contracts
- **monitoring performance of provision**, including activity, finance, clinical and non-clinical quality

It is noticeable that many of the frameworks envisage the ‘securing of services’ phase as a primarily purchasing and contracting phase in a market environment. This is consistent with the thinking behind the separation of commissioners and providers and the new public management ethos of using competition to stimulate better use of resources. It could be argued, however, that in its broadest sense ‘commissioning’ does not only involve securing services through such mechanisms. In-sourcing, establishing joint ventures, collaboration and partnership working, and exploring other models of service production could all form part of the commissioning role but, with some exceptions, these ‘make, buy or partner’ decisions were rarely identified in the frameworks reviewed.

Areas of difference
There are three particular functions or activities which are not universally present.

Priority-setting, or prioritization, a key element of strategy making and planning, is not included in several of the frameworks, generally those which relate to local government or social care commissioning rather than health commissioning.

The prominence given to engagement with patients and public is also variable. In some frameworks it is not listed as one of the primary activities (although it is usually included in more detailed discussion of how the activity is to be conducted); in some it is included within one or more of the three phases of activity (e.g. patient feedback as part of monitoring); in others it is presented as a commissioning function in its own right (as in A3, A4, A6).

This difference is also present in the individual-level competency frameworks in section C and D. The non-health and social care frameworks pay relatively little regard to relationships with customers or end users.

In some of the functional frameworks, demand management, or care pathway management as it is also called, is an important and separate function. Again this tends to differentiate the health frameworks from the non-health ones. The emphasis given to care process and service design in the health frameworks particularly may reflect the fact that products in the health system are less easy to define than non-clinical goods and services and therefore require effort and attention to specify them. The emphasis on outcomes, rather than service inputs, in some of the frameworks, is also a reflection of the difficulty of defining the health and care ‘product.’

The distinctive nature of health (and public sector commissioning generally) is also reflected in the references to political sensitivity and political awareness in the frameworks in section B.

The non-health and social care competency frameworks are extremely detailed and helpful in their descriptions of knowledge and skills required for the supply/supplier management functions of commissioning. It is particularly noticeable that they place emphasis on relationship management with providers in the context of many of the purchasing activities that they cover. While there is some mention of this in health and social care frameworks less emphasis is placed upon it.

A final observation is that some of the frameworks refer to broader organisational attributes and managerial skills which while not commissioning-specific are considered to be important to the delivery of the commissioning task. Examples of this are “making it happen – accountability”, “leadership” (which is mentioned several times), “management, self” and
“management, team”. Indeed, the individual level competency frameworks contain many references to generic management skills such as project management, information management, planning and organisational skills. This suggests that the development of world class commissioning in England will depend on competent organisations and well developed managerial skills and leadership, as well as specific commissioning competencies.

**Areas absent from all existing frameworks**

One aspect of the commissioning role that does not come out clearly from the existing frameworks is the place of commissioners as definers and shapers of ‘public value’, and the political dimensions of this role. As discussed above, competencies associated with stakeholder engagement, public consultation, and the involvement of local communities in decision-making are identified to some degree in most of the public service specific frameworks. However, the way these activities are articulated tends to imply that commissioners’ role here is primarily in representing or creating value for service users and the public (e.g. finding out what service users want, so that commissioners can better match local supply to users’ preferences). While this is undoubtedly a fundamental part of the commissioners role, in a forthcoming paper, Williams et al (2007) suggest that commissioners also have a critical role to play in shaping people’s definition and understanding of public value; not just responding to, but deliberately influencing people’s views and expectations of what their taxes should be spent on.

This is linked to upstream work to engage individuals in improving their own health and that of their families and communities, but goes much further. It is also an inherently political role, requiring engagement with communities to explore complex societal tradeoffs, and shape perceptions of equity and social justice. Acknowledging this role is to accept the fact that public bodies do not exist only to serve individuals and communities, but also, in some respects, to constrain them. The competencies required to carry out this task effectively are likely to be drawn from a number of different competency domains, but the function itself seems to warrant separate consideration. The motivational and affective aspects of competency appear to be particularly important when considering how best to fulfil this type of commissioning role.

Perhaps somewhat surprisingly, competency in partnership and collaboration is also missing from many of the existing frameworks. Although several refer generically to “relationship management” this is usually in the context of the supply chain. There are also references to working effectively with stakeholders, which would encompass partnership with other commissioners to some extent. However, the need to commission jointly and collaboratively – either with other PCTs, with Practice Based Commissioners, and with other agencies such as Local Authorities – is such a significant feature of health commissioning that it perhaps merits inclusion as a specific competency in its own right.

In conclusion, the review of existing activity and competency frameworks suggests that:

- non-health and social care competency frameworks for purchasing and procurement are well developed, and contain many elements relevant to parts of the health and social care commissioning process
- supply-side management competencies are particularly well developed and they could be adapted and applied to the healthcare context without the need for substantial new work
- the emphasis on relationship management on the supply side is striking even within the competitive market context for which the non-health and social care frameworks were designed
- existing individual level competency frameworks do not adequately reflect elements of the health and social care commissioning task which derive from its publicly accountable nature, the political environment, and the difficulties of defining the product which is to be commissioned
- Specifically, competencies connected with the need to take difficult and potentially controversial decisions about priorities, the two-way engagement with the public and patients to both influence and respond to conceptions of public value, the need to commission in partnership, the emphasis on managing demand, and on redesigning services, all need to be further developed for health commissioning.
- There are a number of generic competencies connected with organisational and managerial effectiveness which while they are not commissioning-specific, are equally important to the development of world class commissioning.
Synthesising the material already reviewed in this paper, the following definition of healthcare commissioning competency is suggested.

Healthcare Commissioning Competency = the ability and motivation to effectively mobilise and apply generic management skills to the coordination of specific tasks and activities required for healthcare commissioning, in the context of the enablers and constraints determined by government and society.

The diagram below shows in summary form a model for commissioning competency, which reflects this and combines the main messages emerging from the top-down and bottom-up reviews described above.
At the heart of the model is a four box matrix, in blue, representing the notion that commissioners require competency in both clinical/health and financial/commercial arenas, and that they need to apply this competency to the both the demand side of the healthcare system, and the supply side. The four quadrants ‘titles’ (‘Engaging the population in their own health’; ‘Quantifying, costing and structuring demand’; ‘Ensuring services are clinically effective and high quality’; and ‘Securing services at the optimum cost’) represent a summary of the specific tasks and activities involved in each of these aspects of healthcare commissioning.

Surrounding the matrix in yellow are management skills and organisational capabilities which are fundamental to any effective organisation. Commissioning competencies need to be practiced within an organizational context which demonstrates these capabilities in order to be effective. Some of these general skills and capabilities will clearly take on special significance because of the specific demands and requirements of the commissioning tasks. **Information and knowledge management**, for example, will require particular skills around modelling and predicting healthcare costs and utilisation which would not be common to all organizations. Similarly, effective **stakeholder engagement**, while based on generic communication skills, will have to be tailored to the specific task of involving patients, the public, and clinicians.

The requirements for organisational level competency are also shaped by the external political and social context within which health commissioning organisations operate (represented by the pink border). In particular, commissioning organisations must pay special attention to the way in which prioritization and decision-making is carried out, managing clear and systematic processes, assuring compliance with legal and other requirements, and taking and communicating decisions in an open and accountable fashion. The external context also has implications for leadership style, with commissioning organisations requiring leaders able to navigate a highly politicised terrain, and manage the power relations this implies with sophistication and credibility.

Most fundamentally, it is critical to recognise that the context in which commissioning is carried out will always be an important factor determining the extent to which commissioners can influence health system outcomes. Policy-makers both enable commissioners, giving them the powers to act, and constrain them. While they can strive to improve individual skills and organisational capacity, and to influence the way in which policy is developed and implemented, commissioners can ultimately only act within the legal, political, and financial regimes established for the health system as a whole. Consequently, while the focus of the current paper is on the organisational-level, it proposes that the system-level not only shapes, but actually forms part of a comprehensive model of commissioning competency.

**Domains of competency**

In total there are 14 domains of competency identified in the model at the tasks and activities-level and organisational-level. Based on Thompson, Stuart and Lindsay (1996) competency domains are defined here as: “areas of activity regarded as important foci for performance excellence”. The critical areas of activity for commissioners to focus on, then, are:

1. Prioritisation and decision taking
2. Engaging the population in their own health
3. Quantifying, costing and structuring demand
4. Ensuring services are clinically effective and high quality
5. Securing services at the optimum cost
6. Stakeholder engagement
7. Strategy and planning
8. Collaboration and partnership
9. Information and knowledge management
10. Innovation and best practice
11. Governance, compliance and accountability
12. Project and process management
13. Leadership

The following pages develop the competencies and consider briefly where each competency may currently be found, and where it might be located in the healthcare system in future. It is important to emphasise that suggestions regarding the latter are based on a very rapid brainstorming process and, as such, are not intended to be comprehensive, prescriptive or exclusive. There will undoubtedly be existing sources of expertise not fully acknowledged; where it is proposed that expertise may be sourced from outside the organisation (from consultants, Universities, insurers etc.) this is not to suggest that PCT staff and Practice Based Commissioners could not, or do not need to develop any expertise in these areas themselves; conversely, where it is suggested that PCTs should hold the expertise, this does not preclude the possibility that situation might change over time, or vary according to local circumstances.

In particular, it is noted that the relationship between PCT and Practice Based Commissioning (PBC) level expertise and responsibilities is not well developed here. The devolution of responsibilities from PCTs to PBCs varies quite significantly across the country and, in the timescales for producing this paper, it has not been possible to explore this in any detail. As such, where ‘the PCT’ is identified as the source or recommended ‘host’ of a competency domain, in many instances this should be interpreted as a partnership between a PCT and its PBCs, to be determined at local level.

It is acknowledged that the distribution of competency within the system warrants further attention, as it not only impacts on the affordability and efficiency of the commissioning infrastructure, but also raises fundamental questions about commissioners’ ‘core competency’ (i.e. those functions that should never be outsourced).

In summary, the competency domains and their elements are currently in outline only, are not intended to be prescriptive, and will require further development with the input of a wider range of stakeholders.
Domain of competency 1: Prioritization and Decision Making

Domain elements
- Knowledge of and expertise in the use of tools, techniques, frameworks and processes for prioritization and priority-setting decision making
- Knowledge and expertise in programme budgeting
- Awareness of the role of ethics and values in prioritization
- Critical appraisal – ability to analyse, synthesise and use complex data to inform decision-making
- Cultural efficacy – ability to communicate effectively with local people to gain their trust, and engender a sense of shared responsibility for resource utilization

Where can this expertise be found?
- Public health professionals
- Primary care professionals
- Department of Health (DH) e.g. programme budgeting project
- Local Authorities
- Universities/Academia
- NICE
- Lawyers

Where should it be placed within the commissioning system?
- PCT, drawing on specialist expertise where necessary

Domain of competency 2: Engaging the population their own health

Domain elements
- Awareness and understanding of population data
- Social marketing techniques
- Communications
- Health promotion and prevention
- Community development
- Understanding of trends in citizen health-related attitudes and behaviour

Where can this expertise be found?
- Public health and health promotion professionals
- Primary care professionals
- Marketing, communications and public relations professionals
- Local Authorities and voluntary sector for community development work expertise
- Market research organisations and universities for attitude and behaviour data
- Voluntary and community sector organisations
- User representative groups

Where should it be placed within the commissioning system?
- PCT, calling on specialist resource for marketing expertise and research data as necessary

Domain of competency 3: Quantifying, costing and structuring demand

Domain elements
- Understanding of population level (including epidemiological) data
- Understanding of service utilization data and trends
- Expertise in demand management techniques e.g. risk stratification, modelling
- Understanding of referral practices
- Understanding of use of incentives in demand management

Where can this expertise be found?
- Commissioning managers
- Public health professionals
- Primary care professionals
- Private health insurers
- Provider managers and clinicians
- Universities/academia (including economists)
- Service users and user-groups

Where should it be placed within the commissioning system?
- PCT, calling on specialist expertise when necessary

Domain of competency 4: Ensuring services are effective and high quality

Domain elements
- Understanding of operational management of primary, secondary and tertiary services (operational processes, workforce issues)
- Understanding of clinical service delivery
- Knowledge of clinical effectiveness evidence base
- Expertise in service redesign (lean, capacity and demand, utilization review, process mapping, etc)
- Methods of monitoring clinical outcomes and user experience
- Management of critical incidents

Where can this expertise be found?
- Experienced Trust and Primary Care managers and clinicians
- Public health professionals for clinical effectiveness
- NHS Institute for Innovation and Improvement (NHSI)/Service improvement specialists

Where should it be placed within the commissioning system?
- PCT for clinical effectiveness, operational management
- Shared arrangements between PCTs to cover all clinical specialties
- PCT drawing on specialist resource for redesign and improvement expertise

Domain of competency 6: Stakeholder engagement

Domain elements
- Clinical engagement
- Public and patient engagement (including engagement in shaping and defining of public value with local communities)
- Consultation

Where can this expertise be found?
- Clinical professionals
- Specialists for patient engagement in some PCTs, plus CPPIH, Centre for Public Scrutiny, NHS Centre for Involvement, Local Government, Voluntary Sector

Where should it be placed within the commissioning system?
- PCT drawing on specialist advice
**Domain of competency 5: Securing services at the optimum cost**

**Domain elements**
- Understanding of what services cost
- Detailed knowledge and understanding of PBR and payment systems for non-acute, social and primary care
- Ability to understand and interpret Trust and business accounts
- Supplier portfolio analysis including power analysis
- Market development and management techniques
- Procurement processes
- Contracting processes, including incentives and penalties and performance management
- Supply-Chain Management
- Highly developed professional negotiating skills

**Where can this expertise be found?**
- Finance specialists (especially in Trusts for PBR and payment systems)
- Procurement organisations (NHS, DH, Commercial Directorate, Regional Centres of Excellence, OGC, commercial procurement specialists)
- Lawyers
- Public health professionals
- Health economists

**Where should it be placed within the commissioning system?**
- PCT for financial expertise in payment systems and accountancy
- Shared or external specialist resource for procurement, contracting and negotiating skills, with a training and knowledge transfer role in the longer term

**Domain of competency 7: Strategy and Planning**

**Domain elements**
- Understanding of the commissioning environment (national and international economic, political and social trends, European Union policies, NHS policies, wider government policies, local partner and stakeholder positions)
- Horizon scanning for new developments, changes in public attitudes and behaviour
- Understanding of the purposes and roles of strategy and techniques for making strategy
- Expertise in using tools and techniques for involving stakeholders, including patients and the public, in strategy development

**Where can this expertise be found?**
- Department of Health
- Public Health/Regional Offices
- SHA
- Universities/Academia
- Consultancies
- Market research companies

**Where should it be placed within the commissioning system?**
- PCTs, calling on specialist expertise for horizon scanning, environmental analysis, and public involvement

**Domain of competency 8: Collaboration and Partnership**

**Domain elements**
- Knowledge of responsibilities and cultures of other sectors and partner agencies
- Understanding of rationale and conditions for partnership working
- Ability to work across organizational boundaries and cultures
- Expertise in developing outcome-based partnerships
- Credibility with partners

**Where can this expertise be found?**
- NHS
- DH
- Universities
- Business sector
- Specialist consultancies

**Where should it be placed within the commissioning system?**
- PCT drawing on shared and/or specialist external resource

**Domain of competency 9: Information and knowledge management**

**Domain elements**
- Knowledge of sources of health service data, data quality and data collection processes
- Skills in use of relevant analytical and reporting software
- Expertise in statistical analysis
- Ability to understand and interpret quantitative reports
- Ability to ask the right questions
- Sensitivity to ‘soft’ intelligence

**Where can this expertise be found?**
- NHS
- DH
- Universities
- Business sector
- Specialist consultancies

**Where should it be placed within the commissioning system?**
- PCT drawing on shared and/or specialist external resource

**Domain of competency 10: Innovation and Best Practice**

**Domain elements**
- Techniques for supporting and stimulating innovation
- Best practice awareness
- Networking

**Where can this expertise be found?**
- NHSI and partners
- Academia
- Consultancies
- Commercial sector
- Health service providers

**Where should it be placed within the commissioning system?**
- PCT drawing on specialist resource
Domain of competency 11: Compliance and Accountability

Domain elements
- Operate within the law
- Operate within budget
- Comply with external audit, reporting and inspection standards and processes
- Design and operate fair and transparent decision making processes

Where can this expertise be found?
- PCT finance staff
- Public health professionals
- PCT Board Secretaries
- Lawyers
- PCT managers

Where should it be placed within the commissioning system?
- PCT

Domain of competency 12: Project and process management

Domain elements
- Project management
- Process management

Where can this expertise be found?
- Trained project managers in a variety of sectors
- PCT commissioning managers and assistants

Where should it be placed within the commissioning system?
- PCT

Domain of competency 13: Leadership

Domain elements
- See Leadership Qualities Framework
- Particular emphasis of political leadership - ability to operate effectively in a political environment

Where can this expertise be found?
- NHS and other organisations and sectors

Where should it be placed within the commissioning system?
- PCTs
- PCT shared services
- SHAs
- DH

Domain of competency 14: Culture, attitudes and behaviour

Domain elements
- Political awareness and sensitivity
- Non-adversarial relationship management
- Value base
- Motivated staff
- Team working
- Personal credibility
- Emotionally resilient staff
- Support structures for staff
- Sensitive and appropriate interactions with patients

Where can this expertise be found?
- NHS and other public sector organisations
- Human Resource and Organisational Development experts

Where should it be placed within the commissioning system?
- PCT

Implementing the framework

As noted in the introduction, the aim of this review of commissioning competencies was not to generate new knowledge about commissioners’ roles and responsibilities. It has, however, synthesised a wide variety of different perspectives on the commissioning function, and re-presented them in a form that highlights particular aspects. In particular, the model emphasises that there are (at least) three levels to consider in relation to commissioning competency: the specific tasks and activities involved in commissioning health services; the organisational-level capabilities that provide the infrastructure and the motivation required for these tasks to be performed effectively; and the political and social context that determines the way in which commissioners must discharge their responsibilities, simultaneously enabling and constraining their action.

A second feature of the analysis is that it considers where in the system competencies already exist, and where they might need to be developed and embedded in future. As noted above, this element of the framework requires further development through consultation with practitioners. At this stage, its primary value may simply be to stimulate the debate. It is already possible, however, to identify three broad categories into which the identified competency domains might fall in this regard:

i) competencies that are already present within the commissioning workforce (in particular among public health practitioners and in some partner agencies) but that could be more effectively mobilised to support commissioning in future

ii) competencies that are well developed and clearly articulated in other sectors (e.g. those relating to supply chain management), that do not need to be re-invented, but do need to be more rapidly incorporated (through training of existing staff, or recruitment/contracting of capacity from other sectors) into the healthcare commissioning workforce

iii) new competencies that are still being defined and developed, and require innovation and creativity, horizon scanning across other sectors, research and development, and new forms of partnership and engagement.
This last category seems to particularly relate to the management of the demand-side of the system, where large-scale upstream interventions (e.g. social marketing) are starting to be explored, but are yet to be tested. This is arguably the area where there is most complexity, and least knowledge and experience of exactly what needs to be done. It is increasingly clear that commissioners must find ways to initiate and support widespread changes in attitudes and behaviours, and that this will demand systematic interrogation of population data at the most granular level, alongside a re-focussing on population health at the most global. However, identifying the best way to actually intervene will require significant innovation, some risk taking, and the development of competencies through learning by doing.

With growing recognition of the scale, breadth and depth of commissioning, a question has recently been raised as to whether there is a need for a more formal recognition of commissioning as a professional discipline in its own right. This might take the form of some kind of membership organisation, or even the development of professional standards and accreditation. Again, this is a matter that requires further debate. It is clear that commissioners (as individuals and organisations) do require mechanisms for increasing their influence, profile and credibility, and for developing their skills and capabilities. Professionalisation might be a helpful step in this regard. However, the analysis set out in this paper presents some grounds for caution against a rigid or overly formalised approach. The reasons for this are:

i) It would clearly not be possible for an individual to possess all of the competencies required for effective commissioning as set out in this, and other frameworks. The idea that an individual could become a professional commissioner may undermine the notion of public sector organisations as commissioners, and divert attention away from the need for the highest degree of organisational capability to coordinate a diverse range of commissioning tasks.

ii) This approach could also reinforce the idea that commissioning is a ‘management’ function that does not concern other professionals, at a time when, in healthcare commissioning at least, the opposite message is required; primary care practitioners are being encouraged to see commissioning as a core part of their existing professional role, rather than a new profession they need to enter.

iii) The context-specific nature of competency means that different individuals and organisations will need very different development interventions in order to become competent. Defining standardised qualification or accreditation criteria might detract from more focussed activity to address very specific local development needs.

Thus while the development of a more professional approach to commissioning could only be supported, it is questionable whether the development of a new profession is the best way to achieve this at the current time.

Conclusions

In conclusion, this review has demonstrated that the NHS already possesses many of the competencies that are likely to be required for effective commissioning, although there is much that could be done to mobilise these more effectively, and to bring in new expertise from elsewhere.

However, it has also highlighted the fact that we know relatively little about the specific mechanisms through which commissioning competency does, or does not, lead to improved health system outcomes. This indicates the need for a much more sophisticated analysis of the particular sets of competencies that will be required to improve performance in particular contexts and environments, and suggests that a ‘one-size-fits-all’ approach to defining and developing competency is unlikely to be optimal.

At the same time as seeking this greater clarity though, it must be acknowledged that the complex cause and effect relationships at play here will never be fully understood. In practical terms then, commissioners must aspire to a ‘best-possible’, rather than a ‘perfect’ fit between their organisational resources and environment.

Finally, this report emphasises the fact that focussing on the commissioning function alone will never be enough to produce good outcomes – all parts of the healthcare system need to adopt appropriate competencies and behaviours for the system as a whole to work. The point was made above that competency depends not just on knowledge and skills, but on values,
Appendix 1

The responsibilities, functions, activities, skills and competencies associated with commissioning: a rapid review and summary of recent publications

A. Descriptions and models of commissioning functions and activities

<table>
<thead>
<tr>
<th>Commissioning cycle</th>
<th>Purchasing/contracting cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose, demand and supply review</td>
<td>Review market performance</td>
</tr>
<tr>
<td>Analysis of data</td>
<td>Feedback into strategy</td>
</tr>
<tr>
<td>Consult</td>
<td>Devise a procurement/commissioning plan</td>
</tr>
<tr>
<td>Conduct cost benefit analysis</td>
<td>Implement the purchasing process</td>
</tr>
<tr>
<td>Design commissioning strategy</td>
<td>Contract management</td>
</tr>
<tr>
<td>Budget management and market facilitation</td>
<td></td>
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<tr>
<td>Strategy monitoring and review</td>
<td>Contract monitoring and review</td>
</tr>
</tbody>
</table>

Cozens (2007)

Context: a taxonomy of commissioning in the Local Government context
- Strategic needs assessment
- Area profiling
- Market mapping
- Commissioning strategy
- Commissioning framework
- Provider identification and development
- Tactical procurement and call off arrangements
- Workforce planning
- Quality monitoring and review
- Managing decommissioning and market failure
- Collecting evidence of better outcomes and unmet needs

Department of Education and Skills and Department of Health (2006) Joint planning and commissioning framework for children, young people and maternity services

1. Consider the current pattern and recent trends of outcomes for children and young people in an area, against national and relevant local comparators
2. Look within the overall picture at outcomes for particular groups of children, young people and parents-to-be (e.g. disabled, special educational needs, looked after children), as they may require a differentiated approach to service provision or additional support
3. Use all this data and the views of children, young people and their families, local communities, and front-line staff to develop an overall, integrated needs assessment
4. Agree on the nature and scale of the local challenge, identify the resources available, and set priorities for action
5. Plan the pattern of service most likely to secure priority outcomes, considering carefully the ways in which resources can be increasingly focussed on prevention and early intervention
6. Decide together how best to deliver outcomes, including drawing in alternative providers to widen options and increase efficiency
7. Develop and extend joint commissioning from pooled budgets and pooled resources
8. Develop the local markets for providing integrated and other services, and produce and implement a local workforce strategy covering service and role re-design, and the necessary ways of working to support delivery
9. Monitor and review to ensure services and the joint planning and commissioning process are working to deliver the goals set out for them


Context: the commissioning cycle and effective commissioning
- Assessing needs
- Reviewing service provision
- Deciding priorities
- Designing services
- PCT prospectus
- Shaping the structure of supply
- Managing demand and ensuring appropriate access to care
- Clinical decision making
- Managing performance
- Patient and public feedback

Department of Health (2006b) Fitness for purpose commissioning diagnostic

Context: assessing the development needs of PCTs
- Strategic planning:
  - Financial review
  - Health review
  - Quality review
  - Patient experience review
  - Progress review
  - Engagement
  - Integration of areas
  - Population health goals
  - Quality goals
  - Patient experience goals
  - Financial goals
  - CPM plan
  - Contracting
  - Completeness
  - Prioritisation
  - Outsourcing
  - Financial plan

Care Services Improvement Partnership Key activities in commissioning social care, 2nd edition (Kerslake 2007)
■ Provider management
  - Data gathering and analysis
  - Strategy setting
  - Negotiation
  - Provider capability

■ Monitoring
  - Data management
  - Financial balance
  - Invoice review
  - Invoice adjudication
  - Investigation
  - Third party referral
  - Effective payment
  - Activity volume
  - Access to care
  - Patient satisfaction
  - Quality outcomes
  - Clinical processes
  - Health status

Performance management, settlement and review
  - PbR transactions
  - Budget and activity management
  - Performance management
  - PBC operating processes
  - Patient feedback and GP intelligence

■ Patient and Public Engagement
  PCT prospectus
  Referrals and advice on choices
  Patient initiated petitions
  Engagement strategies
  Communications strategies

National programme for third sector commissioning (Idea/Cabinet Office 2007)

Context: Eight principles of good commissioning

■ Understanding the needs of users and other communities by ensuring that, alongside other consultees, you engage with the third sector organisations, as advocates, to access their specialist knowledge;
■ Consulting potential provider organisations, including those from the third sector and local experts, well in advance of commissioning new services, working with them to set priority outcomes for that service;
■ Putting outcomes for users at the heart of the strategic planning process;
■ Mapping the fullest practical range of providers with a view to understanding the contribution they could make to delivering those outcomes;
■ Considering investing in the capacity of the provider base, particularly those working with hard-to-reach groups;
■ Ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers, including considering sub-contracting and consortia building, where appropriate;
■ Ensuring long-term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness; and
■ Seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs.

Commissioning Friend for PCTs (National Primary and Care Trust Development Programme 2004)

Context: key steps in commissioning

■ Health needs analysis
■ Health equity audit
■ National targets
■ Current pattern of service
■ Capacity planning
■ Comparative performance
■ Local delivery plan
■ Service level agreements


In a developed commissioning system, commissioners will be

1. Regulating the environment:
   - setting national minimum service quality and equality standards;
   - accrediting providers wishing to access public money;
   - licensing services so that a greater proportion of public money is spent on services which work and have an evidence base or whose effectiveness is being evaluated.

2. Influencing demand:
   - working with sentencers and offender managers, who commit NOMS financial resources through the sentences they pass and sentence plans they prepare, to align the services demanded by them with what is needed.

3. Allocating resources:
   - deciding which kind of services are most needed and setting priorities for investment in line with available funding;
   - selecting providers to deliver services who offer best value for money;
   - challenging existing providers to demonstrate value for money and seeing what other potential providers have to offer;
   - working towards “open book accounting” in line with OGC guidelines.

4. Creating fertile conditions for improvements in service quality and cost effectiveness:
   - working with providers so that the services delivered closely match what is needed and demanded by sentencers and offender managers;

Department of Health (2007b)
Commissioning framework for health and well-being

Context: eight steps to help drive more effective commissioning

■ Putting people at the centre of commissioning
■ Understanding the needs of populations and individuals
■ Sharing and using information more effectively
■ Assuring high quality providers for all services
■ Recognizing the interdependence between work, health and well-being
■ Developing incentives for commissioning for health and well-being
■ Making it happen – accountability
■ Making it happen – capability and leadership

(Department of Health 2007a)
Framework for Procurement of External Support to Commissioners

Context: description of the functions of commissioning for which external commissioning expertise might be procured.

Assessment and planning
  - Health needs assessment
  - Reviewing service provision (with LA)
  - Deciding priorities
  - Designing services
  - Shaping the structure of supply
  - Managing demand

Contracting and procurement
  - Primary care services
  - Extended primary care services
  - Secondary care services


In a developed commissioning system, commissioners will be

1. Regulating the environment:
   - setting national minimum service quality and equality standards;
   - accrediting providers wishing to access public money;
   - licensing services so that a greater proportion of public money is spent on services which work and have an evidence base or whose effectiveness is being evaluated.

2. Influencing demand:
   - working with sentencers and offender managers, who commit NOMS financial resources through the sentences they pass and sentence plans they prepare, to align the services demanded by them with what is needed.

3. Allocating resources:
   - deciding which kind of services are most needed and setting priorities for investment in line with available funding;
   - selecting providers to deliver services who offer best value for money;
   - challenging existing providers to demonstrate value for money and seeing what other potential providers have to offer;
   - working towards “open book accounting” in line with OGC guidelines.

4. Creating fertile conditions for improvements in service quality and cost effectiveness:
   - working with providers so that the services delivered closely match what is needed and demanded by sentencers and offender managers;
Towards World Class Commissioning Competency

- creating an environment which encourages potential providers of relevant, appropriate and effective services to offenders to work for NOMS;
- using Service Level Agreements and contract negotiations/management to drive up performance;
- promoting and applying procedures which incentivise good performance;
- building capacity to assist providers of specialist services that redress inequalities.

NERA/NHS Confederation (Bramley-Harker & Lewis 2005)

**Context:** Responsibilities of a Strategic Commissioner (includes description and rationale for aggregation which is often based on specialist skills)

- Planning
  - Short term demand forecasting
  - Long term demand forecasting and capacity planning
- Market management
- Financial, risk management
- Purchasing
- Procurement

- Supply chain management
- Patient relationship management
- Supply primary care services to practices
- Monitoring
  - Contract Management
  - Information and the back office elements of contracting
  - Benchmarking


**Context:** What is effective commissioning?

- The identification of need and demand
- Market shaping
- Holding the market to account

B. Lists of competencies at a general or organizational level

**Association of Chief Executives of Voluntary Organisations (acevo)**

**Context:** behaviours required by strategic commissioners to drive up service quality through the involvement of the third sector:

- Developing knowledge and understanding
- Building trust through communication
- Showing commitment to service quality
- Promoting innovation

**Better Commissioning LIN Commissioning e-book**

(Bamford) accessed 18.08.07

**Context:** what skills do commissioners of community care need?

- Strategic analysis
- Understanding of the supplier market
- Financial acumen
- Knowledge of negotiating techniques
- Specifying services
- Contracting skills
- Political awareness
- Ability to involve service users and build partnerships with providers

**Digings (2007)**

**Context:** commissioning skills likely to be needed in response to “Strong and Prosperous Communities” (local government)

- Population needs assessment
- Customer intelligence (“citizen insight”)
- Demand forecasting
- Market mapping
- Market dialogue
- Option appraisal
- Smart procurement
- Market shaping
- Managing through networks

**Light (1998)**

**Context:** comparison of US and UK commissioning organizations

- Salary and bonus packages designed to attract the best and the brightest
- Data systems analysts and programmers
- Clinical epidemiologists
- Clinical managers
- Organizational experts
- Financial specialists
- Legal advisers

**Wade et al (2006)**

**Context:** Developing commissioning capacity

- Leadership
- Data capture, processing and analysis
- Procurement and contracting
  - Market management: marketing market research and market development
  - Competitive tendering and contract law
  - Supply chain management
  - Strategic partnering
- External communications: public relations and public engagement
  - Marketing and public relations
  - Public engagement

**Woodin (2006)**

**Context:** review of international literature about commissioning

- Negotiation
- Political sensitivity
- Knowledge of needs and demands of the population
- Quality management
- Service improvement
- Awareness of evidence on effectiveness and cost-effectiveness of different interventions
- Team working
- Understanding of ethics
- Leadership
C. Existing Health and Social Care Commissioning Competency Frameworks

1. Communication & Relationship Skills:
   Provide and receive highly complex, sensitive or contentious information; agreement or cooperation required; Present complex, sensitive or contentious information to groups. (Communicates, e.g., funding decisions, cooperation required; Makes formal presentations to a range of organisation and staff).

2. Knowledge, Training & Experience:
   Specialist knowledge across range of procedures, underpinned by theory (Knowledge of commissioning procedures in own specific area, acquired through degree or equivalent experience and training, plus further management and commissioning knowledge to post graduate diploma level equivalent).

3. Analytical & Judgemental Skills:
   Complex facts or situations requiring analysis, interpretation, comparison of a range of options (Determines services to be commissioned taking into account funding resources)

4. Planning & Organisational Skills:
   Plan and organise broad range of complex activities; formulates, adjust plans or Strategies (Undertakes strategic planning to ensure services meet requirements)

5. Physical Skills
   Physical skills obtained through practice (Standard keyboard/use of computer packages)

6. Responsibility for Patient/Client Care:
   Assist patients/clients during incidental contacts (Contact with patients is incidental)

7. Responsibility for Policy/Service Development:
   Proposes policy or service changes, impact beyond own area/responsible for policy implementation and development for a service (Proposes changes which impact on other projects or policies/ implements policies for commissioning service)

8. Responsibility for Financial & Physical Resources:
   Procurement of physical assets or supplies for department/service (Commissions services)

9. Responsibility for Human Resources:
   Line Manager for single function or department: Responsible for teaching/ devising training programmes, major job responsibility (Line manages the commissioning team; Manages the delivery of teaching and development programmes for clinicians and scientists across the sector)

10. Responsibility for Information Resources:
    Responsible for maintaining one or more information systems, major job responsibility (Responsible for commissioning information systems)

11. Responsibility for Research and Development:
    Undertakes surveys or audits as necessary to own work

12. Freedom to Act:
    Broad occupational policies (Lead specialist on commissioning)

13. Physical Effort:
    Combination of sitting, standing and walking (Light physical effort)

14. Mental Effort:
    Frequent concentration, work pattern unpredictable (Concentration required for checking documents and analysing statistics, interruptions to deal with staffing issues)

15. Emotional Effort:
    Exposure to emotional effort is rare

16. Working Conditions:
    Exposure to unpleasant working conditions is rare

Skills for Care and Development -

This framework sets out:

- Principles of good commissioning (e.g. that individuals, communities and families are at the heart of the process)
- Values underpinning commissioning practice (e.g. that processes should be fair, equal and transparent)
- Key Roles of Commissioners (each broken down into several units and elements):

A1 - Ensure that individuals, families, and communities are able to identify and agree achievable outcomes to improve the quality of their lives

A2 - Determine the framework for commissioning services, responses and projects to achieve outcomes

B1 - Work in partnership with stakeholders to obtain, analyse and use information and intelligence to plan for the delivery of sustainable services, responses and projects which contribute to achieving outcomes

B2 - Work with stakeholders to identify the best ways to respond, secure services or undertake projects to achieve agreed outcomes

B3 - Secure the delivery of services, responses and projects

C1 - Develop and implement systems and processes to assure the quality of services, responses and projects

C2 - Demonstrate that services, responses and projects provide best value

D1 - Promote and support a culture of valuing and engaging in continuing personal, professional and organizational development and improvement in practice

D2 - Work as an effective practitioner
D. Other relevant competency frameworks and occupational standards

**National Occupational Standards for Supply Chain Management (Chartered Institute of Purchasing and Supply 2005)**

- Unit S1 Develop a supply chain strategy for the organisation
- Unit S2 Establish strategic relationships within the supply chain
- Unit S3 Improve the performance of the supply chain
- Unit S4 Commission projects to develop the supply chain
- Unit S5 Plan the flow of supplies through the supply chain
- Unit S6 Plan the procurement of supplies
- Unit S7 Plan the storage of supplies in the supply chain
- Unit S8 Plan the distribution of supplies
- Unit S9 Plan the transportation of supplies
- Unit S10 Plan the export and import of supplies
- Unit M1 Develop operational relationships within the supply chain
- Unit M2 Evaluate information on the supply chain
- Unit M3 Propose improvements to the supply chain
- Unit M4 Introduce improvements to the supply chain
- Unit M5 Plan projects to develop the supply chain
- Unit M6 Manage projects to develop the supply chain
- Unit M7 Negotiate for supplies
- Unit M8 Contract with other organisations
- Unit M9 Review the outcomes of contracts
- Unit M10 Evaluate information on the procurement of supplies in the supply chain
- Unit M11 Select suppliers for the supply chain
- Unit M12 Produce specifications for supplies
- Unit M13 Evaluate the capability of suppliers to meet supply specifications
- Unit M14 Schedule and approve the placing of orders
- Unit M15 Evaluate the performance of suppliers
- Unit M16 Schedule the flow of supplies in the supply chain
- Unit M17 Specify the requirements for the storage of supplies
- Unit M18 Select locations and facilities for storing supplies
- Unit M19 Evaluate information on the storage of supplies
- Unit M20 Specify the requirements for the distribution of supplies
- Unit M21 Select distribution methods for supplies
- Unit M22 Schedule the distribution of supplies
- Unit M23 Select methods to receive returned supplies
- Unit M24 Select transportation methods for supplies
- Unit M25 Schedule the transportation of supplies
- Unit M26 Select methods for exporting supplies
- Unit M27 Select methods for importing supplies
- Unit T1 Maintain operational relationships within the supply chain
- Unit T2 Analyse information on the supply chain
- Unit T3 Apply improvements to the supply chain
- Unit T4 Monitor the achievement of project tasks
- Unit T5 Control supplies at storage locations and facilities
- Unit T6 Complete export procedures and requirements
- Unit T7 Complete import procedures and requirements
- Unit T8 Administer contacts
- Unit T9 Analyse information on the procurement of supplies in the supply chain
- Unit T10 Verify the capability of suppliers to meet supply specifications
- Unit T11 Analyse the performance of suppliers
- Unit T12 Identify potential suppliers for the supply chain
- Unit T13 Place orders with suppliers
- Unit T14 Monitor and progress the delivery of orders
- Unit T15 Monitor the flow of supplies in the supply chain
- Unit T16 Obtain information on storage locations and facilities
- Unit T17 Obtain information on distribution requirements
- Unit T18 Monitor the distribution of supplies
- Unit T19 Monitor the flow of returned supplies
- Unit T20 Monitor the transportation of supplies
- Unit T21 Contribute to operational relationships within the supply chain
- Unit T22 Obtain information on the supply chain

**Procurement Competency Framework for the Northern Ireland Public Sector (Central Procurement Directorate 2007)**

**Competency areas:**

- Northern Ireland Public Procurement context
- Strategic Procurement
- Markets
- Tendering processes
- Contract management
- Inventory management
- Marketing/customer/supplier management
- Procurement strategies
- Project planning skills
- Construction
- IT procurement
- Knowledge of procurement/contract law
- Management (self)
- Management (team)
- Finance
- Information technology
- Information management
- Negotiation skills
## Competency framework for Northern Ireland public sector: Sample of competency areas

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Northern Ireland Public Procurement Context</td>
<td>No knowledge of competency area</td>
<td>Limited awareness of public procurement policy and associated implications and requirements.</td>
<td>Awareness of public procurement policy and associated implications. Compliance with pre-determined rules, accompanied by an understanding of the risk of non-compliance. Through experience has the knowledge and understanding of when to seek advice.</td>
<td>Understands public procurement policy, able to comply with rules through knowledge and experience. Understands risks of non-compliance. Able to review compliance options and challenge, and to recommend the preferred approach. Has the knowledge and ability to provide sound advice.</td>
<td>Understands public procurement policy, and the rationale that underpins it. Totally familiar with compliance rules, is seen as a valued source of advice on compliance options/risk of non-compliance. In co-operation with OGC/OGD’s, has the ability to contribute to the further development of policy in this area.</td>
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<tr>
<td>Government Procurement Policy</td>
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<td>Government Accounting Rules</td>
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<td>EC Procurement Directives</td>
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<td>Sustainable Development</td>
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<tr>
<td>Environmental issues</td>
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<td>Social Issues</td>
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<tr>
<td>Role of Office of Government Commerce (OGC), OGD’s Policies/procedures</td>
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<tr>
<td>Freedom of Information Awareness</td>
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<tr>
<td>4. Tendering Processes</td>
<td>No knowledge of Competency area</td>
<td>Limited awareness of procurement processes. Involvement in supporting/ administrative capacity, in line with pre-determined rules and under close supervision.</td>
<td>Able to apply basic procurement processes to routine procurement situations. Understanding of the tendering procedures (Open, Restricted and Competitive Dialogue). Some experience of negotiation but requires support. Experienced enough to know when to seek help or advice.</td>
<td>Familiar and comfortable with all aspects of procurement processes/tendering procedures. Able to provide advice on specifications, and to take the lead on procurement aspects as part of a cross-functional team. Experienced in negotiating high value contracts, commanding credibility and respect externally.</td>
<td>Totally familiar with all aspects of procurement processes, through experience and knowledge. Able to apply judgement to determine how best to apply processes to secure best value in any particular set of circumstances. Able to direct and coach others, able to command credibility with OGC/OGD’s and suppliers.</td>
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<tr>
<td>Tendering Procedures</td>
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<td>Specifications</td>
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<td>Invitations to Tender</td>
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<tr>
<td>Terms &amp; Conditions, law</td>
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<tr>
<td>Bid evaluation</td>
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<tr>
<td>Negotiation</td>
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<td>Award of Contracts</td>
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<tr>
<td>De-briefing</td>
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<tr>
<td>15. Finance</td>
<td>No knowledge of Competency area</td>
<td>No real understanding of financial management issues, no involvement in appraisal of suppliers' accounts/cost bases.</td>
<td>Limited appreciation of financial accounts/appraisal, and of supplier cost bases. Enough knowledge to know when further advice may be necessary.</td>
<td>Enough knowledge of financial accounts to be able to identify companies which are at risk. Sufficiently aware of cost bases to be able to negotiate cost reductions. Able to identify when specialist financial advice may be needed.</td>
<td>Understands profit and loss accounts and balance sheets. Able to calculate key financial ratios, to provide evidence as to companies that are at risk. Detailed understanding of suppliers cost bases and cost drivers. Aware of boundaries of own knowledge, able to judge when specialist financial advice is necessary.</td>
</tr>
<tr>
<td>- Financial accounts</td>
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<tr>
<td>- Financial appraisal</td>
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<tr>
<td>- Supplier cost base</td>
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<tr>
<td>18. Negotiation Skills</td>
<td>No knowledge of Competency area</td>
<td>Understands the principles, tools and techniques of basic negotiation. May get involved in basic negotiations under close supervision.</td>
<td>Develops well-thought through and documented negotiation plans and targets. Involves internal customers in the planning and execution of the negotiation ensuring that they understand their role and contribution throughout the negotiation process. Results consistently deliver against negotiation targets.</td>
<td>Develops well-thought through and documented negotiation plans and targets. Involves internal customers in the planning and execution of the negotiation ensuring that they understand their role and contribution throughout the negotiation process. Results consistently deliver at the upper end of expectations.</td>
<td>Develops well-thought through and documented negotiation strategies, plans and targets. Involves internal customers in the planning and execution of the negotiation ensuring that they understand their role and contribution throughout the negotiation process. Able to lead on the most complex/difficult negotiations. Able to effectively coach and develop others in the negotiation process.</td>
</tr>
<tr>
<td>- Purchasing negotiations</td>
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</tbody>
</table>

**Successful Delivery Skills (Office of Government Commerce 2004)**

**Procurement**: key skill areas

- Managing the procurement process
- Strategic procurement
- Purchasing techniques and methods
- Managing PFI initiatives
- Ethical procurement and legal aspects
- Supplier evaluation and selection
- Risk and value management
- Contract management
- Service level agreements
- Relationship management
- Commercial awareness
- Quality management
- Purchasing negotiations
- Change management

www.hsmc.bham.ac.uk
## NHS outcomes and generic health systems outcomes compared

<table>
<thead>
<tr>
<th>NHS Principles (2006)</th>
<th>Health system outcomes</th>
<th>Development priorities (D) and National Targets and local delivery plan requirements (NT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will help keep people healthy and work to reduce health inequalities</td>
<td>Good health outcomes</td>
<td>Reducing health inequalities and promoting health and well being (D)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improving the health of the population (NT)</td>
</tr>
<tr>
<td>We will work continuously to improve quality and safety</td>
<td>High quality and safe care</td>
<td>Reducing rates of MSRA and other healthcare associated infections (D)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supporting people with long term conditions (NT)</td>
</tr>
<tr>
<td>The NHS will provide a universal and comprehensive service with equal access for all, free at the point of use, based on clinical need, not ability to pay</td>
<td>Good access</td>
<td>Achieving a maximum wait of 18 weeks from GP referral to start of treatment (D)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to services (NT)</td>
</tr>
<tr>
<td>We will treat every patient with dignity and respect</td>
<td>Responsive and patient-centred care</td>
<td>Supporting people with long term conditions (NT)</td>
</tr>
<tr>
<td>We will shape our services around the needs and preferences of individual patients, their families and their carers</td>
<td></td>
<td>Patient/user experience (NT)</td>
</tr>
<tr>
<td>We will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance</td>
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</tr>
<tr>
<td>We will work in partnership with others to ensure a seamless service for patients</td>
<td></td>
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</tr>
<tr>
<td>The NHS will provide a universal and comprehensive service with equal access for all, free at the point of use, based on clinical need, not ability to pay*</td>
<td>Equity and fairness</td>
<td>Reducing health inequalities and promoting health and well being (D)</td>
</tr>
<tr>
<td>We will help keep people healthy and work to reduce health inequalities*</td>
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<td></td>
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<tr>
<td>We are committed to equality and non-discrimination</td>
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<tr>
<td>Contained costs</td>
<td></td>
<td>Achieving financial health (D)*</td>
</tr>
<tr>
<td>We will strive for the most effective and sustainable use of resources</td>
<td>Efficient use of resources</td>
<td>Achieving financial health (D)*</td>
</tr>
<tr>
<td>We will support and value our staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*duplicated where they contribute to more than one system outcome*
References

Department for Education and Skills and Department of Health 2006, Joint planning and commissioning framework for children, young people and maternity services, DIES/DH.
Department of Health 2007b, Commissioning framework for health and well-being, Department of Health, London.
Department of Health 2007a, Good Practice PCT Commissioning. Scope of Services, Department of Health.
Department of Health 2006b, PCT Fitness for Purpose Programme: Wave 1 materials Department of Health, London.
National Primary and Care Trust Development Programme 2004, The Commissioning Friend for PCTs. Whole system commissioning of acute services, NHS Modernisation Agency.
Nolan, T. 2007, Execution of Strategic Improvement Initiatives, Institute for Healthcare Improvement, Cambridge, MA.
OECD 2004, Towards High Performing Health SystemsOECD.
Skills for Care and Development 2007, National Occupational Standards: Commissioning Procurement and Contracting, Skills for Care and Development.
Williams, I., Durose, J., Peck E. D. H., & Wade, E. 2007, How can PCTs shape, reflect and increase public value?, Health Services Management Centre, Birmingham.