Commissioning in the reformed NHS: policy into practice

Elizabeth Wade, Judith Smith, Edward Peck and Tim Freeman

March 2006

Executive summary

- In 2006, PCTs and practice based commissioners face an expansion in their overall commissioning function.
- PCTs will need to become ‘NHS Local’, a strong, legitimate and recognised body that people consider to be responsible for ‘their’ NHS.
- The expanded commissioning task comprises three sets of functions that we describe as being the ‘conscience’, ‘eyes and ears’, and ‘brain’ - this reflects core functions of governance, data gathering and analysis, and procurement.
- PCTs are responsible for deciding where to locate these functions - some will be aggregated upwards to supra-PCT bodies, others will be contained within the PCT, and others will be sub-contracted to practice based commissioners or others.
- PCTs will be the overall guardian of local commissioning activities and hence will need to develop stronger and more sophisticated governance of the ‘web’ of accountability relationships both within the local health system, and across wider civic society (e.g. Local Strategic Partnerships).
- Specifically, PCTs will need to give consideration to how they will govern partnerships, markets, their relationship with patients and the public, and the securing of clinical advice and leadership. The model of a corporate board taking advice from a professional executive committee and patients’ forum is unlikely to be fit for purpose in the reformed NHS.
- Other models for securing public engagement in PCT governance need to be explored as a matter of urgency, drawing on relevant experience within the wider public sector and NHS foundation trusts.
- There is a need for careful review of the role of professional executive committees, and for consideration to be given to additional and alternative models of gaining clinical advice and input.
- Practice based commissioning calls for a more sophisticated approach to the monitoring and management of conflicts of interest at a practice level. It might be helpful to consider practice based commissioning as a form of extended service provision in this regard.
- NHS commissioning has been a largely under-developed function to date, with little attention given to growing the next generation of commissioning specialists. In order to deliver the extended range of commissioning functions in a manner that is properly governed, there is a need for PCTs to develop commissioning capacity and capability as an immediate priority.
- To support this, PCTs should undertake a detailed skills audit to identify existing expertise within PCT and practice teams, gaps in the skill base, and plans for ensuring these are filled within the new commissioning arrangements.
- The current process of commissioning reform presents significant challenges. However, it also offers unrivalled opportunities for detailed analysis of the commissioning task, and for developing far-reaching plans to enhance the skills of the people charged with what is probably the most responsible of management activities with a health system.
1. Introduction and background

In March 2005, the NHS Alliance and HSMMC published a briefing paper on ‘Reconfiguring PCTs: influences and options’ (Peck and Freeman, 2005). The report was commissioned in the context of growing scepticism over the ability of individual PCTs to effectively and efficiently discharge their expanding range of responsibilities, particularly in relation to the commissioning of secondary care. Its purpose was to inform PCT boards and professional executive committees (PECs) about the influences on, and options available for reconfiguring commissioning functions. The report identified a range of emerging models that moved beyond PCTs operating independently as commissioners, but that fell short of total merger. Options suggested included managed practitioner networks, joint commissioning arrangements, joint policy units between PCTs and local authorities, and PCT associations.

The 2005 report concluded that the choice of appropriate options for PCT interdependence would require judgement at a local level (taking account of relevant history and context), and would in many cases involve a combination of approaches. To assist local option-appraisal, the report provided some analysis of the different emerging commissioning structures, and the extent to which each of these supported a range of different PCT functions.

This project

The purpose of this second phase of the research is to build on the first, assessing more specifically the particular policy challenges posed by Commissioning a Patient-Led NHS (CPLNHS) (Department of Health, 2005a), exploring the ways in which local health communities are responding to these, and considering what this means for the future role and configuration of PCTs. The current reforms clearly have implications for both the commissioning and providing responsibilities of PCTs. However, this report focuses on the factors influencing commissioning configuration and functions. The rationale for this focus is that:

i) the complexity and scope of the issues to be considered warrants a separate and specific analysis;

ii) changes to commissioning structures now have a defined national framework and pressing timetable, while the policy approach to provider options is one that is being left more to local determination; and

iii) Arguably, consideration of commissioning configuration should precede that of new provider models, the pattern of which should be driven by the new commissioning bodies once their own functions and objectives are more clear.

This project has entailed a review of the literature concerning: health commissioning; primary care-led commissioning; primary care organisations; public sector governance; and the development of commissioning and purchasing capacity. Interviews have been carried out with case study sites in the NHS, these being health communities known to be pursuing distinctive approaches to the organisation and development of their commissioning functions. Finally, a stakeholder workshop was held in Birmingham in January 2006 as a means of testing out early themes and findings from this study. The workshop drew together managers, clinicians and researchers who are closely involved in the management and governance of commissioning in health and social care. A full list of workshop participants is set out at Appendix A.

Policy context

With the implementation of ‘Shifting the Balance of Power’ in 2002, commissioning became a core responsibility of primary care trusts (PCTs) in England, along with the duty to improve health and develop primary care (Department of Health, 2001). Commentators observed that the success of Shifting the Balance of Power in delivering the objectives of the NHS Plan (Department of Health, 2000) would depend upon ‘… the ability of Primary Care Trusts to develop robust commissioning systems that can ensure the delivery of better, more accessible and more cost effective services’ (James et al, 2002, p.5).

Since then, the importance of commissioning functions has been reinforced, as PCTs have acquired additional responsibilities for commissioning primary care services. In the case of the new medical services contracts, this has required a shift from the traditional ‘primary care development’ function of PCTs to a more explicit relationship between PCTs as commissioners, and practices as providers of services, while the implementation of the new dental and community pharmacy contracts has presented an entirely new challenge to many PCTs. Devolution of responsibilities in areas such as prison health has expanded further the scope of PCTs’ commissioning functions, again requiring the development of new knowledge, skills and processes.

The extent of the challenge facing PCTs was emphasised at the time of their establishment, along with the need to allow them time and space to develop appropriate structures, skills and relationships (Smith and Goodwin, 2002). There has been a growing sense, however, that instead of gradually rising to this challenge, PCTs have struggled to fulfill their expanding range of functions (Bramley-Harker and Lewis, 2005; Smith and Mays, 2005). As noted above, it was in response to this fact, and the expectation that some reconfiguration of commissioning functions would be required to address the situation, that the original phase of the current research was commissioned (Peck and Freeman 2005).

Since the initial report was published, the policy context has changed significantly, following the publication of ‘Commissioning a Patient-Led NHS’ in July 2005, and subsequent supporting guidance. This policy, designed to instigate ‘… a step-change in the way services are commissioned by front-line staff…’ (Department of Health, 2005a, p1) set out the Government’s requirements for:

- universal roll-out of practice based commissioning by December 2006;
- improved coordination with social services through greater congruence of PCT and local government boundaries;
- devestment by PCTs of all responsibilities for service provision (other than in cases where there is no alternative solution);
- a progressive move towards greater use of new providers, including those from the independent sector;
- development of PCT role in ensuring access to and choice of high quality services through the performance management of contracts with providers;
- centralisation of ‘back-office’ functions (including payment) into regional or national hubs; and
- delivery of at least 15% reduction in management and administrative costs.

While the policy document stated that the changes required to deliver these outcomes ‘… may or may not involve mergers and reconfigurations’ (Department of Health, 2005a, p3), the direction of travel was made very clear: “PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum” (Department of Health, 2005a, p4). CPLNHS asserted the Government’s expectation that all these changes would be completed by the end of 2008.
In response to major concerns raised by NHS staff, trades unions and professional bodies, the Government has now stepped back from original statements regarding the compulsory transfer of existing PCT-managed services to alternative providers, emphasising that the nature of management of community and other PCT services will be down to local determination (DoH 2006a, p.13). Nevertheless, a clear marker as to the trend anticipated by the Government has been set. At the very least, the commissioning ‘arms’ of PCTs are expected to separate themselves from in-house services, and to subject them to the same performance management and monitoring regime as any other provider. They are also expected to consider the potential for greater value for money and flexibility to be delivered through alternative provider models.

Since August 2005, all SHAs have therefore developed options for local PCT (re)configuration, which collectively propose the number of organisations being reduced to anything between 120 and 160 (compared to the current 300). The Department of Health has reviewed and approved these proposals, which were subject to a 14-week consultation (concluded on 22 March 2006). Whatever the final outcome, at the time of writing it is clear that increasing interdependence and collaboration between PCTs will be required in the future, both during the transition to the new arrangements, and in the subsequent task of delivering a ‘step-change’ in the effectiveness and efficiency of NHS commissioning. Full guidance on the future commissioning framework for new PCTs is due to be published in the summer of 2006. This report seeks to assist PCTs and other stakeholders in determining what the functions of commissioning will look like post-CPLNHS, and to analyse what those functions will mean for the governance and development of commissioning.

**Defining commissioning**

‘Commissioning’ is a function that applies to the role of ‘third party payers’ in a health system, namely organisations or individuals who have responsibility, on behalf of taxpayers or insured persons, for spending resource allocated for healthcare in ways that will ensure the meeting of the health objectives of the health system, insurance organisation or patient. Woodin (forthcoming) has defined commissioning in the NHS as follows:

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

She goes on to explain that a purchaser buys what is on offer, or reimburses a provider on the basis of usage, this being a less strategic and more operational activity. She considers procurement and contracting to be activities that focus on one specific part of the wider commissioning process – the selection, negotiation and agreement with the provider of the exact terms on which the service is to be supplied. Woodin adds that procurement usually refers to the process of provider sourcing and selection, and contracting to the establishment and negotiation of the contract documentation – her overall definitions of activities related to commissioning are set out in box 1 below.

The definition of commissioning used by Woodin is similar to that of John Ovretveit (1995) who extended the understanding of commissioning to include activities which do not directly involve payment for services, such as influencing other agencies to promote the health of the population.

In exploring the functions and tasks associated with commissioning in the NHS for 2006 and beyond, we are taking the term ‘commissioning’ to embrace the various activities identified by Woodin under the headings commissioning, purchasing, procurement and contracting (see box 1).

**Box 1: definitions of activities associated with the commissioning function**

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

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

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

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

(Woodin, forthcoming)

**Figure 1: The Continuum of Commissioning Levels in the UK**

![Figure 1: The Continuum of Commissioning Levels in the UK](image)

**Level of Commissioning**


- Patient Choice
- Multi-practice or locality commissioning
- Primary Care Organisation/PCT commissioning
- Lead PCT/LHB/HB commissioning
- Single practice-based commissioning
- Joint commissioning
- National Commissioning

Source: Smith et al, 2004, p6
Levels of commissioning

International analysis of commissioning (Robinson et al, 2005) identifies three main levels at which this ‘strategic purchasing’ takes place: macro-level (through a national single health insurance fund); meso-level (regional organisations with devolved purchasing responsibilities for populations of 100,000 to 500,000); and micro-level (situations with a high degree of local decision making and devolved purchasing budgets). Within the NHS, these levels could be categorized as follows:

- macro-level – national commissioning arrangements and performance targets, pan-PCT specialised commissioning
- meso-level – PCT commissioning, joint commissioning with local authorities
- micro-level – practice-based commissioning, direct payments, patient choice

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

In a review of the research evidence concerning effective primary care-led commissioning (Smith et al, 2004), the authors concluded that rather than a single ‘ideal’ location for commissioning, there was a continuum of commissioning activity that ran across the different levels of a health system. The challenge for managers and policy makers was how to decide at which level of the system specific commissioning activities should be located. The continuum developed in Smith et al’s research is set out in figure 1.

This continuum provides a basis on which policy makers and managers can decide their specific local commissioning configuration, namely where to allocate the responsibility for carrying out the planning, purchasing and funding of a particular service or health priority. It does not however elucidate the actual nature of different elements of the commissioning function – that is, what actually happens within this activity we are describing as ‘commissioning’. The current research therefore extends this analysis, by describing in more detail the different tasks and activities contained within the commissioning function, and what these mean for the configuration and management of commissioning bodies.

This report

This report focuses on a detailed analysis of what the commissioning function post-CPLNHS will actually entail – the tasks and activities that will need to be carried out by PCTs or their agents. This analysis is set out in section 2 of the report, and is intended to offer PCTs and practice based commissioners a ‘map’ of the territory that lies ahead, along with some case study examples of how local organisations are responding to the need to redesign commissioning arrangements. Section 3 considers what theory and experience tell us about the governance arrangements that will be established in the implementation of the current round of system reforms and reorganisation of the commissioning function. In section 4 of this report, we explore the issue of how commissioning capacity can be developed and the necessary skills put in place to enable strong and effective commissioning to be carried out in the NHS. In section 5, we draw together the practical steps that are required if PCTs are to develop strong and effective commissioning within the reformed NHS.

In section 2, we

2. Commissioning in the reformed NHS

The timing and nature of the publication of CPLNHS has been the cause of some concern both within and beyond the NHS. In its review of the policy, for example, The House of Commons Health Committee concluded “the research evidence is clear that this restructuring will set NHS organisations back by 18 months, with patient services likely to be affected in the interim” (House of Commons 2006, p.6).

Consequently, the Department of Health has been keen to demonstrate how this policy fits with, and is fundamental to the delivery of, wider health system reform. In “Health reform in England: update and next steps” (Department of Health 2005b) CPLNHS is therefore presented as one of the mechanisms for strengthening the ‘demand’ side of the health service market. Emphasising that there has been significant investment in modernising and increasing the capacity of service providers (the ‘supply side’) in recent years, the document explains that maintaining these achievements through a process of continuous improvement now depends on establishing a much stronger voice for patients, and for the commissioners securing services on their behalf.

In combination, Patient Choice, Payment by Results, and Practice-Based Commissioning (PBC) are intended to provide new ‘stronger’ PCTs with the tools required to deliver a ‘patient-led NHS’. The overall commissioning framework

To some extent, the system reforms currently being enacted in pursuit of this ‘self-improving’ NHS involve a transfer of existing commissioning responsibilities and functions from one type of commissioner to another at a different level in the system (e.g. some responsibilities for service redesign will be devolved from PCTs to practice based commissioners, and some decisions about referral will move from the GP/practice based commissioner to the patient). However, there are also a number of new commissioning activities within the reformed system (e.g. supporting practice based commissioning and patient choice), so that that the overall effect is an expansion, rather than simply a re-alignment, of commissioning functions (see Figure 2).

Figure 2 does not attempt to accurately represent the actual relative distribution (current or anticipated) of commissioning responsibilities between the organisations involved. Rather, it simply seeks to illustrate that the overall size and scope of the commissioning framework appears likely to expand under the proposed system reforms. This is because all constituents of the system will be taking on new tasks that are not required in the existing framework, without necessarily losing existing functions. This is true at all levels. The individual patient, for example, in gaining increased choice, also now has more ‘work’ to do in exploring the options for exercising that choice. At the other end of the spectrum, the role of national bodies such as independent regulators will expand beyond the inspection and assurance of service standards, to include the setting of a regulatory framework (the ‘rules’) for the external market.

As noted above in the case of PCTs and practice based commissioners, the system reforms theoretically involve shifting some existing commissioning responsibilities and
functions from one to the other. It is suggested here, however, that the level of support for PBC that practices will require from PCTs, combined with the need for PCTs to review, monitor and administer PBC arrangements, means that PCTs’ total workload will not be reduced. Even if this were the case, any excess capacity would soon be absorbed by taking on the new responsibilities that PCTs now face, such as local market management, and supporting patient choice (see Figure 2).

Similarly, it might be assumed that the aggregation of tasks such as data capture and analysis at the level of PCT collaborations or alliances will allow rationalisation of information, contracting and finance functions. This may well be the case in the medium to long term. However, this research suggests that collection and analysis of data at the level required to support PBC and PbR is a relatively new task for many PCTs, actually requiring additional resources. In the short-term, therefore, any rationalisation may simply mitigate previously anticipated increases in the level of resources required, rather than actually reducing them.

Essentially, the increasing emphasis on the PCT as the body accountable for stewardship of local health care resources suggests an expansion in their overall activities and probably of the resources they themselves will require. At the same time, the responsibilities of other agencies involved in the ‘demand-side’ of the system (e.g. practice based commissioners, PCT collaborations) also appear to be expanding.

This is quite appropriate given the intention to re-balance supply and demand relationships in the NHS as part of the overall intention to ‘strengthen’ commissioning. However, this clearly has implications for the capacity and capability of the emerging organisations tasked with delivery, particularly given that another major objective of CPLNHS is to reduce management costs in PCTs and strategic health authorities (SHAs) by 15%. The subject of commissioning capability is explored in detail in section 4.

Given this expansion in the overall commissioning function in the NHS, we set out here an analysis of the nature of the tasks within this expanded function, before going on to suggest the levels of the health system at which these tasks and activities will take place, and how they will be governed.

![Figure 2: Expansion of the commissioning framework](image)

**The tasks and activities of commissioning**

Smith and Mays (2005) have conceptualised the commissioning element of a health system as its ‘conscience’ (those elements that relate to stewardship, quality assurance, public protection) and ‘brain’ (activities associated with resource allocation decisions, system and service design, planning). As a result of discussion and analysis carried out with NHS stakeholders as part of this research, we have added to that metaphor a third dimension of the ‘eyes and ears’ (the tasks that are related to keeping close to the patient experience, receiving and analysing detailed information, determining messages for subsequent action by the brain and conscience).

The responsibilities of these elements can be summarised as follows:

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

The relationship between these components is of course dynamic, as the ‘eyes and ears’ monitor and report back information on the outcomes of the interventions designed by the ‘brain’, and the ‘conscience’ reflects on this, potentially adjusting the objectives or rules of engagement, in an attempt to maintain the overall consonance of the system. The ‘eyes and ears’ will be present in a number of different places in the system (patients, GPs, nurses, information collectors and analysts, regulators etc.) and hence the specific ways in which they interact with the brain and conscience will vary according to the local health system, its configuration and governance. This issue is explored further in section 3. Figure 3 summarises the anticipated tasks of the ‘conscience’, ‘eyes and ears’ and ‘brain’ within the new commissioning framework.

This analysis demonstrates the extensive range of responsibilities that accrue to commissioners in the NHS post-CPLNHS. It also highlights the fact that the different types of commissioning functions and responsibilities do not map directly to particular levels of the health system (as set out in figure 1), but are instead distributed across them. For example, within a national but devolved system, responsibility for ‘determining overall system objectives’ lies with the government (for setting national priorities and targets), with SHAs and, increasingly, PCT collaborations (for overseeing the strategic, rational configuration of services), and with PCTs (for identifying and prioritising local needs). Likewise, the assessment of service capacity and outcomes will require both ‘hard’ data collected at a PCT or supra-PCT level, and more ‘qualitative’ data provided by
practice based commissioners on the basis of feedback from their own patients.

The Department of Health has stated that it does not expect commissioning to be the responsibility of a single organisation in a patient-led NHS, but rather a partnership between PCTs, general practice, local (and presumably national) government. It has also given strong indications that it expects the independent sector to become more involved in supporting commissioning functions particularly, though not exclusively, in the delivery of ‘backroom’ or administrative tasks (2005b). Research carried out for this project indicates that consideration of this option is already underway in some areas.

Further guidance to clarify exactly how the Department of Health sees this matrix of responsibilities working in practice is due later in 2006. However, certain things are already very clear:

i) New PCTs will be held to account for the effective use of taxpayers’ money in the interests of their local communities

ii) There will be two major hubs of commissioning activity (and risk) – the PCT and the practice-based commissioner (PBC).

iii) The relationship between these hubs will be critical to the success of the system reforms.

We therefore focus on these two types of commissioner as the basis in our analysis of what a local commissioning system might look like in 2006 and beyond.

**PCT commissioning functions**

Current health system reforms position commissioning bodies not simply as the ‘co-ordinators’ of a local NHS system but, potentially, as the only ‘pure’ NHS body existing at a local level. The policy framework points to an eventual (although unlikely) possibility of a provider network made up largely (or even entirely) of non-NHS providers (recognising here that the majority of primary care practitioners - GPs, dentists, pharmacists, optometrists - are not managed by, but rather work under contract with, public sector bodies as things currently stand). The principles of publicly funded health services are not, however, being questioned. It is the PCT that will be accountable for making sure that these principles are upheld for the local population, and it is this responsibility that encapsulates the PCT’s core commissioning functions. In effect, the PCT becomes the ‘National NHS’. This reflects the emphasis in CPLNHS on strong and effective local commissioning bodies that are, where possible, coterminous with elected local authorities, and hence identifiable to citizens as ‘the NHS in our area’. In time, the terminology itself might need to be changed to reflect this idea, with ‘Our Town NHS’, being not only more resonant for the local population than ‘Our Town Primary Care Trust’, but also a more accurate description of the comprehensive local health responsibilities of PCTs (which are clearly not only involved in the delivery of primary care services as the name perhaps suggests to the public).

If PCTs are the embodiment of the local NHS, it follows that all of the tasks set out in figure 3 will, to some extent, be part of their commissioning (and wider governance) responsibilities. It does not mean, however, that they will all be actually undertaken by each PCT. Certain functions might be aggregated upwards if they are more effectively or efficiently performed at a supra-PCT level, others might be delegated downwards (for example to practice based commissioning clusters), and some might be contracted out of the NHS altogether. We explore here what their commissioning responsibilities mean for a PCT, and the degree to which each is appropriately shared with other parties. The areas of responsibility examined are: objective setting and decision making; the management of partnerships; supporting patient choice; information collection and analysis; service specification and resource allocation; and procurement and contracting.

**Objective setting and decision making**

The ‘conscience’ functions set out in figure 3 are clearly a core part of the role of the PCT as the local NHS body accountable for the use of resource, assurance of standards, and improvement in health. These conscience functions will, in some cases, be governed by standards and frameworks designed elsewhere in the wider health system. For example, some service standards will be determined by the Healthcare Commission, market rules will, in part, be set by the Department of Health, and priority setting for healthcare resources will be influenced by the guidance and decisions of the National Institute for Health and Clinical Excellence.

Individual PCTs will, however, be held to account for the effective allocation of resources and delivery of standards within these frameworks. For this level of accountability to be reasonable and meaningful, PCTs must not only have access to effective incentives and sanctions through which to influence provider behaviour (as is the intended outcome of the reform programme), but also recognition by the wider system that they (rather than the strategic health authority or Department of Health) are the main locus for decision-making regarding the local NHS.

This research thus highlights a need for a stronger PCT, one that is enabled to stand up for its decisions, both in relation to its local population and to the Department of Health. Given that this decision-making responsibility is the crux of the organisation’s accountability to patients and taxpayers, the function is not amenable to ‘outsourcing’ or sub-contracting, whether to other NHS, or independent sector bodies.

All PCTs therefore need to establish robust decision-making arrangements that enable the organisation to be clear about its priorities and objectives, and about how these are to be met.

**The management of partnerships**

As the PCT increasingly takes on a role as ‘NHS Local’, seeking to claim legitimacy for planning and delivering services that will improve the health of its local population, so it needs to demonstrate an effective and sophisticated ability to manage a wide range of partnerships. These partnerships will take a variety of forms and will include: joint commissioning arrangements with local authority and voluntary sector bodies; lead or joint commissioning schemes with other NHS bodies; participation in formal partnership structures such as local strategic partnerships; and community planning arrangements emerging from regeneration or other initiatives.

**Supporting Patient Choice**

Within the current health system reforms, ‘Patient Choice’ is both a general policy objective (to empower patients and the public by increasing their knowledge of and influence over service delivery) and a specific initiative (which means that all patients requiring hospital treatment should already have the option to choose from at least four different health care providers and, by 2008, will have the right to choose from any provider, as long as they meet clear NHS standards and are able to do so within the national maximum price that the NHS will pay for the intervention the patient needs).
Utilising ‘consumer power’ in this way to place direct pressure on providers to improve their responsiveness is an important part of the drive to strengthen the demand-side of the health care system. However, it also poses a potential threat to the ability of disinterested, disprivileged service users, and that the ultimate effect of the policy will, therefore, be to increase inequalities in health and access to healthcare (Farrington-Douglas and Allen, 2005, p.18). There is also some evidence from international experience that publication of the type of data on performance and outcomes that the Government envisions supporting Patient Choice, may have unintended effects on provider behaviour (e.g. selection and differential treatment of patients according to the severity of their condition and risk of treatment) (Dranove et al 2003). Farrington-Douglas and Allen (2005) argue, therefore, that PCTs have an obligation to manage the Patient Choice agenda in a way that ensures equity for disadvantaged patients, and that protects against the inadvertent reduction of choice for more vulnerable individuals. They suggest, for example, that Primary Care Organisations should provide or commission information support and advocacy services that target particular groups of patients most likely to need such assistance.

Others may argue, of course, that one of the main motivations for introducing patient choice is, in fact, to give differential benefit to the more affluent, thus securing their support. It is, however, important to remember that choice is, in fact, to give differential benefit to all patients, and that the objective of Patient Choice is to achieve relatively short-term political objectives, rather than being seen as a mechanism for promoting long-term health improvements.

<table>
<thead>
<tr>
<th>Responsibilities of the conscience include:</th>
<th>Responsibilities of the eyes and ears include:</th>
<th>Responsibilities of the brain include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing the overall objectives of and desired outputs from the system</td>
<td>Ensuring that health system objectives dovetail with those of other local commissioners (e.g. those who are part of Local Strategic Partnerships)</td>
<td>Establishing the ‘conscience’, ‘eyes and ears’ and ‘brain’ of NHS commissioning</td>
</tr>
<tr>
<td>Setting minimum standards for services</td>
<td>Ensuring appropriate and mature partnerships with other health and social care organisations and agencies are in place, and proactively managed</td>
<td>Establishing structures, processes and incentives required to ensure system objectives are achieved</td>
</tr>
<tr>
<td>Evaluating and weighing the costs and benefits of different market models</td>
<td>Stewardship of public resources (including reporting and accounting for outcomes)</td>
<td>Designing incentive and payment systems that encourage providers to enter market and deliver desired service models and pathways (market development and management)</td>
</tr>
<tr>
<td>Assuring the quality of services commissioned</td>
<td>Ensuring that there are robust and appropriate methods in place for making decisions about funding priorities, and on action to be taken when brain can not reconcile demands of national priorities with available resource</td>
<td>Procuring contracting with and allocating resources to providers</td>
</tr>
<tr>
<td>Influencing patterns of demand at a macro level through public health activities</td>
<td>Ensuring the system operates in a way that does not create or increase inequalities (e.g. ensuring Patient Choice does not threaten access for vulnerable individuals)</td>
<td>Managing the performance of providers</td>
</tr>
<tr>
<td>Setting and regulating the ‘rules of engagement’ to assure the probity and ‘acceptability’ of the system (including developing nationally specified ‘core contracts’)</td>
<td>Establishing health objectives for individual patients and practice populations</td>
<td>Removing resources from providers if service levels and standards are not achieved</td>
</tr>
<tr>
<td>Ensuring that the rules of engagement allow for sufficient contestability and choice within the local system</td>
<td>Supporting individuals in making choices</td>
<td>Designing and implementing local arrangements to assure patient choice, including designing and distributing information for patients and PBCs</td>
</tr>
<tr>
<td>Registering, regulating and arbitrating in conflicts of interest within the local health market</td>
<td>National collation of data and statistics for benchmarking (e.g. QOF data)</td>
<td>Translating patient experience data into information to be used in commissioning</td>
</tr>
<tr>
<td></td>
<td>External audit of local processes (e.g. Audit Commission ‘spot-checks’ of coding and reporting under PBRP)</td>
<td>Translating patient activity data from primary and secondary care into information to be used in commissioning</td>
</tr>
<tr>
<td></td>
<td>Inspection of providers and commissioners against national standards (e.g. by Healthcare Commission, Monitor etc.)</td>
<td>Planning and designing efficient and effective protocols service models, and clinical pathways (and ensuring appropriate clinical advice and service user involvement in this process)</td>
</tr>
<tr>
<td></td>
<td>Establishing health objectives for individual patients and practice populations</td>
<td>Micro-level demand management</td>
</tr>
<tr>
<td></td>
<td>National collation of data and statistics for benchmarking (e.g. QOF data)</td>
<td>Provision of extended primary care services</td>
</tr>
<tr>
<td></td>
<td>Assessing needs of population and modelling demand for services (current and future)</td>
<td>Supporting individuals in making choices</td>
</tr>
<tr>
<td></td>
<td>Monitoring and validating activity levels, costs and service outcomes</td>
<td></td>
</tr>
</tbody>
</table>
Whatever position is accepted here in principle, in practice, PCTs will need (to a greater or lesser extent) to ensure that appropriate information is available to patients to enable them to make choices; to assess whether the professionals supporting patients in those choices are doing so effectively and equitably; and to manage the complex interaction between individual patient choice, population-based strategic commissioning, and political imperative.

The governance arrangements required to enable PCTs to fulfil these 'conscience-related' responsibilities are explored in more detail in section 3.

**Information collection and analysis**

The key to a PCT’s ability to make robust decisions about the allocation of resources will be the availability of accurate, timely and meaningful information. The responsibilities of a PCT’s commissioning ‘eyes and ears’ therefore include gathering and reporting data on: the current and future needs of the local population (and associated patterns of demand for services); the capacity and performance of the system (in terms of both activity and costs, and patient satisfaction and outcomes); and how this compares across and between localities.

The type of data that will be required include but are not restricted to:

- Demographic and epidemiological data relating to the PCT population
- Descriptions of the type, location and range of local health services
- Primary care (medical services) performance data (e.g. access targets, QOF achievement levels, referral rates, prescribing behaviour and costs)
- Other primary care (dental, community pharmacy, optometry) performance and activity data
- Information regarding the utilisation of community and mental health services;
- Secondary care activity data:
  - elective activity – inpatient and day case;
  - non-elective admissions, including information on length of stay;
  - first outpatient appointments, and follow up ratios;
  - use of diagnostic tests and procedures;
  - consultant to consultant referrals; and
  - accident and emergency attendances.
- Service quality data, including results of clinical audit, patient complaints, self assessment and independent reviews
- Patient satisfaction data
- Horizon-scanning information about new technologies, treatments and investigations

This information will have to be made available in aggregate form for decision-making at a PCT level (or supra-PCT where joint commissioning arrangement are in place), and in the form of practice based commissioning ‘information packs’ at the individual practice level. One example of how a PCT is developing a new approach to the collection and analysis of data, is set out in the box below.

Guidance has made it very clear that PCTs must avoid any increase in management and transaction costs as they implement the recommendations in CPLNHS, and that responsibility for producing information to inform commissioning must remain with the PCT, and not be delegated to practice based commissioners.

This does not necessarily mean, however, that each PCT must actually undertake this work – these tasks are amenable to being contracted out to a third party agency, being concerned with stating ‘how things are’, rather than ‘how things should be’. As such, aggregating or subcontracting these functions seems less problematic than in the case of decision-making or ‘stewardship’ tasks (see column to right for an example of this approach). What is important, however, is that there are transparent processes in place to demonstrate who is carrying out what function, and how the PCT is holding its subcontractors to account.

In addition to processing and disseminating this type of (largely quantitative) ‘activity’ data, PCTs will also need to have mechanisms for gathering ‘process’ related (perhaps more qualitative) information regarding the implementation of the new commissioning systems. For example, they may wish to obtain feedback from practice-based commissioners on their experiences of establishing new service models, in order to share relevant learning with other practices. Similarly, they may wish to obtain informal feedback on the responsiveness and behaviour of a particular provider, or on patient experiences, to inform contract monitoring and re-negotiations. This is the type of ‘front-line’ intelligence that practice-based commissioners can add to the commissioning process, but which PCT commissioners will need to access and interpret if they are to utilise it effectively in their procurement role. PCTs may facilitate this type of information collection and exchange by supporting (‘virtual’ and actual) practice-based commissioning networks and forums.

**Case study – a contracting information hub**

In Birmingham and the Black Country SHA area, PCTs are developing commercially-based support for an ‘information hub’ that will undertake the transactional work supporting contracting. This will include the provision of timely, relevant data and analysis to practices on population factors, activity levels, tariffs, spending, and activity and financial trends. The hub will not have any responsibility for commissioning decisions, which will remain the responsibility of the (re-configured) PCTs. A project board has been established, a service specification agreed, and consensus reached among all the PCTs on the funding for the service. The aim is to have contracted for and established the service by the time the new SHA arrangements are in place.

Contact: Steve Allen, 0121 695 2424 or steve.allen@bbcha.nhs.uk

**Case study – North Eastern Derbyshire PCT health numerics analysis**

North Eastern Derbyshire PCT has commissioned external expertise to develop detailed analysis of health care activity in relation to use of resources. The resulting ‘resource maps’ will offer an in-depth insight into the pattern of service and resource use by patients with specific clinical conditions within a practice population (for example, chronic obstructive pulmonary disease), and are considered to be an excellent basis upon which to start practice based commissioning discussions and plans. The intention is that this mapping of resource, drawing on both secondary care and primary care activity and financial data, will enable more meaningful co-design of services by practice based commissioners and hospital providers.

Contact: Martin McShane, Chief Executive, NE Derbyshire PCT
martin.mcs@nederbypct.nhs.uk
Service design and resource allocation

In line with their responsibilities for making strategic resource allocation decisions, PCTs must be responsible for deciding which services will be commissioned at what level, and for allocating purchasing budgets accordingly. In the context of practice based commissioning, this includes establishing indicative practice level budgets, reviewing practice based commissioning business cases and ensuring collective risk management strategies are in place across the PCT.

However, many of the ‘brain’ functions of commissioning will be carried out by both PCTs and other partners, or ‘sub-contracted’ commissioners. These include practice-based commissioners (single practices and clusters of practices), and also potentially other PCTs, a local authority commissioner, a private sector commissioner, and a third or voluntary sector commissioner. In this way, the PCT acts as overall steward of local healthcare resources, and designer of the wider health system, but passes resource and design functions out to practice based commissioners. For example, a PCT might devolve a budget for diabetes care to a locality group of primary care professionals who are acting as a practice based commissioning cluster, having a clear agreement with this group in relation to what service and health outcomes are expected to result from the service the group designs and commissions. It should be noted that the practice based commissioning group might actually provide some elements of the service covered by the overall commissioning budget and, as discussed below, such arrangements will need to be carefully considered and regulated by the PCT in its ‘conscience’ role.

Another example of devolution of ‘brain’ functions by the PCT might be the allocation of a budget to a private healthcare company for the planning, funding and management of care for a group of older people living with complex conditions. Likewise, the PCT might develop a contract with a local provider trust for it to design, purchase and manage a service such as unscheduled out-of-hours care for a local population. In all of these examples, the PCT remains accountable for the commissioning decisions of their subcontractors, and needs to have robust methods for assuring the quality of commissioning that is carried out on its behalf. This process of accountability for devolved commissioning will also require clarity about what the PCT is to provide to the sub-contracted commissioner by way of support. In relation to practice based commissioning, PCTs are required to offer support not only through the provision of information, but also through assisting practice based commissioners in interpreting these data, and in developing skills such as service redesign. With other sub-contractors, the PCT would need to work closely with them to clarify minimum requirements and acceptable service models, and to ensure appropriate integration with other service providers.

At the level of sub-PCT commissioning, therefore, there is significant potential for overlap between the commissioning or purchasing role, and that of the provider. This is not unusual or necessarily problematic, for in all systems that rely on a purchaser-provider arrangement, there is a need for providers to have a role in service design, and for commissioners to engage in, and sometime manage, how services are actually delivered. Where longer term service delivery arrangements are needed (as they typically are in the NHS) and significant competition to existing providers may be constrained (as it is in the NHS given the political reality of needing to preserve large elements of local health provision for the benefit of the population), the development of more mature (and complex) commissioner-provider arrangements is both likely and desirable, as long as the necessary governance framework is put in place to mitigate against conflicts of interest.

However, there is a question mark here as to what this framework might look like in the case of practice based commissioners. In the preceding paragraphs, we have referred to them as ‘sub-contracted’ commissioners, accountable to the PCT. Yet their entitlement within current policy to influence the PCT’s commissioning decisions means that they have in fact been given a role as commissioning decision-makers within the process to which they are accountable as providers. This places them in a less clear position in comparison with other providers and sub-contractors, raising important and complex questions of governance, which are explored further below, and in section 3.

Case study: North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium (NORCOM)

NORCOM comprises a joint sub-committee consortium of seven PCTs which has been formed to enable the PCTs to make collective decisions on the planning, procurement and review of services provided for populations larger than an individual district. The consortium also seeks to develop networks for clinical services determined to be a commissioning responsibility. A further role is to ensure an appropriate co-ordinated response to issues raised by specialised commissioning programmes and, as appropriate, to coordinate links with the South Yorkshire Strategic Health Authority. The consortium meetings are attended by PCT chief executives and senior clinicians, and is viewed as a crucial and senior commissioning forum. It has a particular role in co-ordinating priority-setting decisions for the group of PCTs, having the capacity to convene at short notice to debate and reach decisions on emerging therapies, recent examples having included Herceptin and the NICE guidance on fertility treatments.

NORCOM is hosted by Barnsley PCT, and is currently carrying out a major piece of work on the strategic future of cancer services.

Contact: Ailsa Clare, ailsa.clare@barnsleypct.nhs.uk
Procurement and Contracting

As in the case of information collection and analysis, practice based commissioning guidelines require that responsibilities for procurement and contracting (also presented here as ‘brain’ activities) must be retained at the PCT level, and should not be carried out directly by practices. These functions include developing service specifications, advertising contracts, deciding between different potential providers, and agreeing contractual and performance management arrangements. With an increasingly pluralistic ‘supply side’ that is likely to include a growing number of non-NHS providers, these more technical aspects of commissioning will often involve formal competitive tendering procedures, and the negotiation and monitoring of legally binding contracts (rather than service agreements).

Again, combining some of these functions across a number of PCTs will be appropriate, and potentially more efficient. In cases where PCTs have an established history of working in a collaborative manner to support their commissioning activity, such extended forms of aggregated arrangement are already being developed in the light of CPLNHS. One such example is the Association of Greater Manchester Primary Care Trusts’ planned ‘commissioning business service’, details of which are set out in the box below.

PCT commissioning functions – summary

In summary, it is clear is that the new PCT is the overall accountable local body in respect of what international colleagues know as strategic purchasing, and what is currently understood as ‘effective commissioning’ in the English NHS. The extent to which an individual PCT carries out ‘conscience’, ‘eyes and ears’, and ‘brain’ functions itself, or delegates these upwards, downwards or downwards to another agency is for the PCT to decide. The actual local commissioning configuration will and should vary, but what is not negotiable is that a PCT should stand to account for how citizens’ health care resources are spent and the degree to which local people’s health outcomes change as a result of those commissioning decision.

Practice based commissioning functions

Practice based commissioning (PBC) is the second major plank of the government’s policy focused on developing more effective commissioning in the NHS. It entails the allocation of an indicative budget to a practice or group of practices, this budget being intended for the commissioning (design, planning, funding) of a specific set of services as agreed with the PCT. In this way, practice based commissioning is a system of devolved micro-purchasers, nested within the overall responsibility and accountability of the PCT. As discussed above, guidance makes it clear that the PCT is the ‘sovereign’ commissioner within local health systems, being the holder of contracts with providers and the ultimate accountable body. In this way, practice-based commissioning differs markedly from GP fundholding of the 1990s, where GP micro-purchasers held budgets that they used to place direct contracts with providers. It is the governance of practice based commissioning, and its clear location within a statutory NHS commissioning body, that marks it out from GP fundholding and, this dimension is thus reflected in our analysis of practice based commissioning functions. Practice based commissioners are largely responsible for assuming some of the ‘brain’ and many of the ‘eyes and ears’ functions as set out in figure 3. Thus, the design of local services (with clinical and user input), the implementation of patient choice and the management of demand for services are core functions for practice based commissioning.

Case study: Greater Manchester Commissioning Business Service

The Commissioning Business Service (CBS) is a new venture developed by the 14 Greater Manchester primary care trusts (PCTs). The CBS has as its mission the sourcing, procurement and contract-management of the delivery of quality and cost-effective services. It will provide a service to PCTs, practice based commissioners, local authorities, collaborative commissioners, and even providers who sub-contract services. CBS services will include: the provision of off the shelf or bespoke service specifications; a detailed directory of providers and services; public health and comparative clinical data and intelligence; and the full range of operational contract management including contract compliance and resource utilisation analysis. The CBS is planned to become operational in April 2006 and is currently working on business modelling, the development of memoranda of information for each of its business areas, due diligence, the seeking of expressions of interest in providing CBS services, and the detailed design of the organisational model.

Contact: Mike Asher, Project Director - mike.asher@trafford.nhs.uk or 07767-758353

Service planning and design

As discussed above, while PCTs will retain responsibility for collating and processing routine data relating to population health needs, service utilisation and costs, a great deal of the information required to inform effective commissioning is obtained and held at practice level. Such information includes clinical data stored within practices’ patient records, as well as evidence of service quality and outcomes obtained from patients’ accounts, and/or the practice team’s own experience of dealing with particular service providers.

In addition to this ‘front-line’ feedback mechanism, primary care professionals of course bring their clinical experience and expertise to assessments of the appropriateness, safety, and efficacy of various service models. In many cases, they also bring the pragmatism, entrepreneurialism and ‘commercial’ acumen gained through running their own small businesses. Practice based commissioners therefore have a crucial role in assessing patients’ needs and experiences of care, and in analysing data about services costs and outcomes, in order to inform future service design and purchasing.

Practice-based commissioners can influence service models in several different ways:

i) through reviewing their own approach to prescribing and managing care
ii) through using their influence and ‘purchasing power’ to encourage changes in the pattern or quality of services offered by other providers
iii) through extending their own role in service provision
Prescribing and managing care

Practice based commissioners are, first and foremost, primary care professionals. As such, their fundamental roles are those of the diagnostician, prescriber of care, and co-ordinator of services for patients. These roles have been traditionally regarded as the bedrock of NHS primary care, and a feature of the health system that is envied by many international commentators (Starfield, 1998; Wilson et al, 2005). For PCTs facing a pressing need to reduce unscheduled admissions to hospital, deliver more effective management of chronic disease, and keep local health care budgets under control, this care management and ‘gate-keeping’ role assumes even greater importance. PCTs require strong and effective care managers who will assess need and make appropriate decisions about the care of individuals, but with reference to wider system objectives and available resources.

For practice-based commissioners the incentive to review approaches to gate-keeping and co-ordination now lies with the potential to re-invest any resources saved through ‘tighter’ care management (for example, through reducing avoidable admissions by identifying and monitoring patients who are heavy users of services, and proactively intervening to avoid predictable deterioration of their condition).

Of course, GPs who choose not to respond to these incentives, and decline to take on an indicative budget, still make decisions impacting on the utilisation of resources in other parts of the health care system. In this sense, it could be argued that all GPs and their teams are involved in practice-based commissioning, whether explicitly or not. This raises the question of whether practice-based commissioning should therefore be treated as a core function of general practice, an issue which is discussed in more detail below, and in section 3. The point here is that the traditional care-management and coordination role of general practice is itself one element of the practice-based commissioning process.

A new aspect of the care management role is introduced by the principle and practice of ‘patient choice.’ With patients requiring a secondary referral now having the right both to be offered a selection of possible service providers, and ultimately to book a convenient appointment from the surgery, practices have a number of new (and/or extended) roles. These include the administrative tasks associated with appointment book-ings, as well as the extension of the consultation process to include what is likely to be a more detailed discussion of the referral and treatment options than has often taken place in the past. This transition in the role of primary care practitioner from ‘decision-maker’ to ‘advisor’ may not be a dramatic revolution. Many practitioners already approach the task in this way, of course, while many patients are likely to continue to rely heavily on professionals when exercising their right to ‘choose’. However, forthcoming research into the patient choice commissioned by the Department of Health apparently suggests that patients do often make choices which are opposed to what their GPs recommended (Lloyd, 2006), and this is an experience that seems likely to become more common as more people become aware of their rights and options. The role of care management in the context of a more empowered and informed patient population may well require new approaches to consultation and decision-making at a practitioner and practice level.

The status of ‘patient choice’ also needs to be considered carefully by PCTs in the case of a practice based commissioner acting both as care-manager and, potentially, as the provider of ‘extended’ primary care (see below). As distinctions between secondary care and ‘enhanced primary care’ become increasingly blurred, it is not entirely clear whether (and at what point) patients must be offered choice between their own practice and other alternative providers of ‘specialist’ primary care services. This situation will need to be closely monitored and reviewed by PCTs.

A final but critical point to note here is that many primary care professionals other than GPs have care management and/or ‘gate-keeping’ roles and, according to the analysis above, are therefore involved in some way in the commissioning process. Many community nurses, social workers, therapists and other allied health professionals make decisions about the packages of care required by patients, and about access to secondary care services (e.g. in the case of physiotherapist triage of orthopaedic referrals). The current research suggests that clarification of the relationships between these care managers and practice-based budget holders is at an early stage. In some circumstances, the relationship may be seen as a partnership within an extended’ practice-based commissioning team, while in others certain care-management functions may be ‘sub-contracted’ to other professionals by practice-based commissioners. Given the knowledge, skills and experience of these professionals, and their potential contribution to demand management and service redesign, this is clearly an issue that requires some further consideration and development.

Influencing other service providers

As well as reviewing their own role in managing demand, practice-based commissioners will also play a part in prompting other providers to improve the quality and responsiveness of their services. With their critical position in supporting (and undoubtedly influencing) patient choice, and increasing flexibility to identify alternative providers if not satisfied with existing options, practice-based commissioners should be well placed in negotiations with NHS trusts, foundation trusts and other providers over the quality and range of services they wish to see provided. This function is likely to be carried out in partnerships with other practice-based commissioners, and supported by PCT commissioning managers.

Extending service provision

In many situations, it is likely that in planning and redesigning services, practice-based commissioners will seek to identify elements of care pathways that can be shifted out of secondary care and provided instead by themselves, or by other primary care based colleagues. Indeed, anecdotal evidence suggests that it is this aspect of the initiative (rather than opportunities to change patterns of delivery of more specialist services) that is proving most attractive to those practices actively engaging in practice based commissioning.

This trend supports the current policy to develop care outside hospitals. However (as referred to on a number of occasions above), it all also creates certain theoretical and practical problems for the operation and governance of practice based commissioning, due to the status of practice based commissioners as both commissioners and providers.

In attempting to resolve this conflation, it could be suggested that ‘practice based commissioning’ is not an accurate term for what is actually being expected of practices as they assume a budget on behalf of their
local population. Instead, the requirement that practices assess and review their own prescribing, referral and activity data as a prerequisite to designing new forms of local service delivered via a budget delegated from the PCT, could be interpreted as an extension of the core primary care services that PCTs commission from practices. In other words, the PCT is in a sense commissioning extended provision of primary and intermediate care from practices and localities, within a framework of closer review and scrutiny of current practice, and with financial incentives to design and deliver (directly or via other providers) new services.

This interpretation of practice based commissioning as a form of extended primary and intermediate care provision is lent further weight by the emergence of new practice-led provider organisations that are seeking to assume practice based commissioning budgets in tandem with setting up new organisations for delivering extended care to local people, and by the introduction of a practice based commissioning Directed Enhanced Service (a provision whereby PBC is funded as a service delivered by a practice to a PCT).

Regarding practice based commissioning as a form of extended care provision offers insights into how this activity might be appropriately governed, and might be helpful in encouraging GPs and other primary care professionals to assume a local budget. Arguably, the extension of primary care provision is crucial to any subsequent redesign of intermediate and unscheduled care, and the shift of services from hospital to community settings. Thus the capacity for PCTs to commission extended primary care within a wider framework of service redesign, would seem to make sense.

**Strategic Planning and objective setting**

Our analysis of commissioning functions suggests that the ‘conscience’ functions (as articulated here) are much less amenable to delegation to practice based commissioners than those of the ‘eyes and ears’ and the ‘brain’. This reflects the tensions between ‘population-based’ and ‘patient-focussed’ commissioning identified under previous models of primary-care led commissioning and, again, is complicated by the dual role of practice based commissioners as providers of primary care and purchasers/designers of other care on behalf of the PCT. It is however likely that a PCT would involve practice based commissioners in discharging their ‘collective conscience’ functions. This might take the form of engaging a locality or practice in the process of reviewing and setting overall local health system objectives, representing the PCT in a commissioning network or partnership, working on the process of setting minimum standards of care for a particular service, or working with the PCT on public health activities aimed at changing overall patterns of need.

**Case study – an extended practice provider organisation**

Smethwick Pathfinder operates under a legal joint venture agreement between two practices in Smethwick (a town within Sandwell PCTs) covering a population of approx 19,000. Since being established as a first wave personal wave medical services (PMS) pilot the Pathfinder has used their PMS plus contract to increase the services they provide locally to their patients, transferring care from the acute sector into local settings. This includes establishing pain relief clinics, developing a joint service with secondary care specialists and primary care staff to implement a locally based care pathway for their diabetic patients, and developing on-site orthopaedic services providing consultant input, osteopathy and physiotherapy. The organisation now wants to extend its service redesign activity and is establishing a commissioning cluster of local practices with a responsibility for 70,000 patients. The cluster is currently working with its local PCT to identify the indicative global budget and has begun analysing referral and activity data in order to identify priorities for a 3-year business plan. The new venture expects to develop services and facilities that allow patients to receive non-acute care within a variety of local settings, working in partnership with secondary care professionals to provide integrated pathways of care.

Contact: Stuart Tilsley, stuart.tilsley@nhs.net

**Conclusion – commissioning functions**

It is clear that the overall commissioning task is greater than ever before, and that it is being relied upon by policy makers to improve health and health services, assure quality, and deliver value for money in an NHS that is under significant public scrutiny. In this context, it is of crucial importance that each PCT develops the appropriate architecture for carrying out its commissioning functions. This section has identified the nature of the commissioning task in relation to ‘conscience’, ‘brain’ and ‘eyes and ears’ functions, and has explored what activities will fall to PCTs and practice based commissioners. In the next section, we consider the models of governance needed for the delivery of commissioning by PCTs beyond 2006, before going on to explore what skills will be required in order to make ‘stronger commissioning’ a reality as envisaged in Commissioning a Patient-Led NHS.
3. Governing commissioning

We have discussed so far the objectives and content of the current health system reforms, and the functions or activities that will be involved in implementing them. The third element of the policy process is the governance of the system. One interpretation of the nature of governance in health care organisations that this research team has found helpful is that set out by Contandriopoulos et al (2004) who contend that governance is related to problems:

- of securing convergence or agreement on a programme of action among a diversity of actors and organisations;
- of redistributing power in an organisational or social field that is characterised by a high level of heterogeneity; and
- of gaining sufficient legitimacy to act in the name of the collectivity.

The above categorisation of governance underlines the importance of the three groups of commissioning functions that we identified earlier in this report: the ‘brain’ (redistributing power); ‘eyes and ears’ (securing agreement from a range of sources); and the ‘conscience’ (gaining legitimacy in the name of the collectivity).

In the light of the White Paper on community health services (Department of Health, 2006a), there is clearly a need for PCTs to design systems of governance that enable various forms of intelligence (as generated by the ‘eyes and ears’ functions) to be brought together and reconciled in an open and transparent way (that equates to the ‘conscience’). The CPLNHS reorganisation is not therefore a simple ‘shuffling of the deckchairs’ on board the NHS ship, it is concerned with an expansion in the commissioning function, and with creating processes of governance that enable PCTs to act as truly legitimate and sovereign ‘NHS Local’ organisations.

The commissioning governance ‘web’

Figure 4 (p.14) sets out a possible representation of the network or ‘web’ of relationships that will exist within the health system following the implementation of CPLNHS. It attempts to demonstrate the chains of accountability for commissioning and service delivery, not for every form of organisational interaction. It does not include, for example, the requirement for provider organisations to account directly to their patients, e.g. in dealing with complaints, or to independent regulators, e.g. Monitor and the Healthcare Commission, for their standards of safety, clinical and corporate governance.

Figure 4 demonstrates that future PCT and practice based commissioners will be at the heart of a complex web of different types of interaction with other constituents of the health system, namely in different elements of governance. Some of these relationships will be statutory or contractual in nature, for example in the case of a legally binding contract between a PCT and an independent sector provider for the delivery of specific health services. In other cases, such as the relationship of NHS trusts to practice based commissioners, accountability is implicit, but not direct, (because the contractual relationship will be between the PCT and trust). A further category of relationship does not involve a hierarchy of accountability at all, but rather constitutes a partnership between commissioning and planning bodies (such as within local strategic partnerships), designed to deliver a common health or social objective. The level of complexity of the relationships between these parties also varies, from the relatively straightforward requirement for PCTs to account to their strategic health authority for their commissioning performance, to what currently appear to be highly complex and intertwined relationships between PCTs and practice based commissioners, involving both contractual and indirect accountabilities, as well as ‘partnership’ working.

External regulation of the commissioning function

One important aspect of governance within the new system will be external regulation of the commissioning function. In a system in which the PCT is the ‘sovereign’ commissioner, and where more providers will be moving ‘beyond the reaches of state-directed performance management’ (Dixon, 2005, p.9), commissioners will increasingly find themselves the focus of scrutiny and regulation, possibly from a new or reconstituted body established to undertake this task. However, pertinent issues regarding regulation of the new system are discussed in detail elsewhere (see Dixon, 2005) and, while PCTs clearly have a role in influencing national policy, they will not immediately be responsible for this element of the reforms. The focus here is therefore on the governance mechanisms required at the level of PCT and practice-based commissioning, and not on the wider regulation of commissioning.

The PCT as ‘sovereign’ in the local health system

It was suggested above that a critical test of the new system will be the extent to which commissioning organisations, having been positioned as the accountable bodies within their local health care communities, are in fact recognised as its ‘sovereign’ decision-makers and leaders. It is clear that this will not happen immediately. The operating guidelines for the NHS in 2006/07 acknowledge the organisational disruption to come, and place responsibility for overseeing reconfiguration and assuring business continuity with strategic health authorities and regional ‘transition leaders’. NHS trusts will continue to be directly accountable to strategic health authorities for performance against targets and for financial stability, while PCTs will be required to lodge any commissioning reserves with the strategic health authority for regional brokerage (Department of Health, 2006b).

In the medium term, however, the rationale for the introduction of a market-based system is that the market regulations and incentives will erode the need for direct state-driven performance management, facilitating a shift from a centrally driven, to a ‘self-improving’ system where the ‘NHS local’ PCT can be properly sovereign. The extent to which PCTs and practice based commissioners will be left to manage this market at a local level will depend, largely, on the response of the Government to early feedback. It is certainly possible that early high profile market failures, such as a GP practice or a new private provider losing their NHS contract as a result of failing to deliver services to the required specification, could trigger a retreat by politicians, whether due to real failure of the system, or to loss of nerve before ‘reformed commissioning’ has been given time to take root.

Critical issues for the governance of PCT commissioning

Assuming that the current programme of systems reform is maintained, perceptions of commissioners’ ability to manage risk and complexity will play a large part in the Government’s assessment of the level of trust and autonomy to grant them from 2008, when the reforms will have been fully implemented. It is suggested that there are five critical issues to be considered...
Governing partnerships
Whatever the outcome of the current consultation on PCT (re)configuration, one conclusion that seems inevitable is that new PCTs will be expected to work in close partnership with other bodies to ensure optimal integration and efficiency in the achievement of policy outcomes. This principle appears fundamental to the drive to achieve co-terminosity between PCTs and local authorities, and is emphasised in the white paper on community health services as a means of achieving well-being for local populations (Department of Health, 2006a).

Most of the respondents in this research supported the move towards PCT/local authority co-terminosity as a positive or logical development, specifically as a route for focusing public health activity, and for supporting joint commissioning and service delivery. The anticipated need to work in partnership with neighbouring PCTs to achieve economies of scale and to strengthen market power was also frequently referred to by those currently engaged in PCT development. Even where PCTs expect (or hope) not to be merged in the current round of reforms, they are still anticipating greater sharing of resources with other organisations – confirming the findings of the initial phase of this research where interdependence was identified as the defining element of PCT configuration (Peck and Freeman, 2005).

It might be assumed that extending or strengthening partnerships following (or as part of) reconfiguration would be relatively uncontroversial. In terms of the principle, this may well be the case. However, in order for such partnerships to deliver their anticipated benefits their processes must be robust, and their structures sensitive to local requirements. Three examples of ways in which PCTs have established arrangements for the governance of commissioning partnerships, and some of the challenges they face in managing these, are set out on the following pages

These case studies, and other evidence on the governance of partnerships (e.g. Audit Commission 2005), demonstrate that if PCTs are expecting to increase the extent to which they are working with other organisations to deliver their commissioning functions, careful consideration must be given to how these relationships are managed. They may even need to question whether a ‘partnership’ is in fact the most appropriate model for stakeholder interaction. It is possible, for example, that even when working with another statutory body, the most effective relationship to ensure a particular outcome would be a contract (or service level agreement), through which one organisation is explicitly commissioned to provide a service (rather than with) others. An increase in the use of the contract as a mechanism for influencing stakeholder behaviour is, of course, becoming increasingly common as the provider market is extended into the independent sector.

Governing markets
As we have seen, one of the of the key components of the current system reforms is to increase the number and range of health service suppliers, creating for the first time an extensive external health supply network.
The Hertfordshire JCT was formed in 2002, and is responsible for commissioning drug and alcohol, adult learning disability, and mental health services on behalf of Hertfordshire County Council (HCC) and the 8 Hertfordshire primary care trusts (HPCTs). It is hosted by and operationally managed through the performance and commissioning division of HCC’s adult care services department. The functions of the JCT go beyond transactional contracting tasks, and include strategic responsibilities such as planning, service development, monitoring and performance management. The health and social care economy’s commissioning expertise on these services is therefore concentrated within a single agency. Budgets are formally pooled under a Section 31 Agreement, and each partner then delegates commissioning responsibility to a joint commissioning partnership board, to which the JCT is accountable. The board is made up of four members of the county council, and four PCT directors (either executive or non-executive). The rationale for the JCT is based on the view that this model is more effective than the council and each PCT discharging their functions separately. Some stakeholders see potential for extending the arrangements to include integrated commissioning of community services for older people. However, even within this well-established arrangement, some of the common challenges of partnership working have been observed. These include:

- the risk that the JCT might ‘lose touch’ with local needs, and with the needs of individual service users and carers, due to its size and centralised structure;
- the range of partners and stakeholders involved means that reaching consensus is not always straightforward, and the structure is ‘high-maintenance’;
- value for money of the team, and accountability to PCTs for financial balance has been questioned;
- the complexity of the task and the knowledge, skills and resources required by the JCT may be underestimated by partner organisations, which then have unrealistic expectations of the capacity and capability of the team;
- the different decision-making procedures and organisational styles of the NHS and local authority can create tensions and imbalances in power relationships within the partnership;
- the role and responsibilities of individuals appointed to the partnership board (e.g. non-executive directors), and the knowledge and expertise required of them, may not be clear; and
- lack of involvement of some key partners (including service users and carers).

The Hertfordshire experience demonstrates that while strategic partnerships can bring many advantages, there are also a range of risks involved. Partners need to dedicate time to ensure these are addressed, and that appropriate risk-management arrangements are in place.

Contact: Mark Jordan – Head of Joint Commissioning, Hertfordshire Joint Commissioning Team - Mark.jordan@hertscc.gov.uk

Case study: Northumberland Care Trust
The North of Tyne Commissioning Consortium (covering Northumberland Care Trust, North Tyneside PCT and Newcastle PCT) is responsible for contracting with the major health care providers in the region on behalf of the three local commissioning bodies. All activities associated with contracting, invoicing, and monitoring are carried out by the consortium, which is staffed and hosted by Newcastle PCT. However, commissioning responsibility is not transferred to the consortium. The care trust and PCTs continue to undertake needs assessment, decision-making and service development work, but feed the outcomes in to the consortium for implementation at a contractual/operational level. Contracting with smaller providers (including primary care providers) is currently undertaken by the care trust and PCTs, which means there is some duplication of functions at commissioner and consortium level in relation to invoicing/monitoring/reporting etc. These arrangements are being reviewed in the context of PCT reconfiguration and it is anticipated that this joint working is likely to be extended in some way, whether through PCT mergers, or sharing of additional functions.

While demonstrating the possibilities of effective shared commissioning functions, this site also highlights potential limits to the benefits of aggregation. With responsibilities for commissioning adult health and social care services, partnership working with the local authority is crucial for Northumberland Care Trust, which has worked hard with the local council to establish strong, effective relationships. The care trust now faces tensions, therefore, between potential efficiencies to be gained through working in partnership with other PCTs, and those advantages achieved through concentrating on integration at a local level.

Contact: Sue Comick, Head of Planning and Performance, Northumberland Care Trust - Susan.Comick@northumberlandcaretrust.nhs.uk

Learning from other sectors

Similar trends towards increasing contestability and managing delivery through contracts are currently being observed in other sectors in the UK, including higher education and criminal justice. Higher education institutions operate with a significant degree of autonomy from central government (certainly in comparison with the NHS) and as such, it is down to individual institutions to develop a model of governance that makes sense in relation to overall objectives and stakeholders. A possible scenario being explored in some
higher education establishments is one in which the ‘core university’ is no longer seen as the provider of education, but has as its primary role the commissioning of courses and programmes from individual/organisational providers working under contract rather than tenure. The aim of such an approach is to offer real choice to students by commissioning programmes they want (not what academics want to teach) and by working in partnership with research funders to deliver research that funders require, while the key task of senior managers is to act as champions of stakeholders (potential students, local communities, employers etc.) (McCaffrey, 2004, p.53). Of particular relevance to the NHS of the ‘commissioning university’ model is the fundamental rethinking of both the function and purpose of the core of the organisation (University local, as per NHS local) and the renegotiation of the relationship between providers and the commissioning core. As with the NHS, universities rely on highly independent professionals to deliver their main business, and need to find approaches to governance that satisfy the needs of both clients (students, research funders, employers) and professionals (academics as individuals and groups).

In another area of public life, that of the management of offenders, a commissioning approach has similarly been implemented as a way of seeking to specify services in a more sophisticated manner, more appropriately matching services to the demands as expressed by the courts system and with a reduced reliance on providers’ shaping of the market. Details of how the market for offender services is being governed are set out in the case study to the right.

Neither of these examples from other sectors is yet sufficiently well embedded to offer an analysis of what their experience suggests for the most appropriate modes of operation for PCTs. Consequently, As Shapiro has pointed out, in discussing how the new commissioning mechanisms will work within a public service framework, “…we are moving into the realm of hypothesis” as, not only is this something new within the UK health care system but, to date, no other country seems “…to have genuinely combined the rigour and equity of central planning with the freedom and innovation of a real market economy” (2005, p.385).

**Case study: Torbay Care Trust - Commissioning Partnerships for Older People’s Services**

Torbay Council Social Services and Torbay PCT have recently formed a new care trust, responsible for delivering health and social care services to adults. They have used this organisational restructuring as an opportunity to reconsider their entire approach to commissioning services for older people, and have developed a commissioning strategy that aims to bring together commissioners, service users and service providers in partnerships with mutual benefit. One of the principal intended results of the strategy is to empower service users, both in relation to securing services to meet their own individual needs, but also in making a real contribution as decision-makers in the overall planning of local service provision. Options for allocating individual budgets are being explored to support the former objective, while proposed ‘commissioning partnerships’, involving community based organisations for older people and other representatives of local communities, are intended to place strategic decision-making in the hands of those who will use the services. The commissioning partnerships will be designed to involve all key stakeholders and, to reflect the specific needs of local areas, will be located in each of the trust’s five ‘zones’ which are based on GP practice areas. Partnership meetings (alongside other communication mechanisms such as inter/intranet sites) will provide opportunities for users, carers, providers and the trust to work together in identifying needs, agreeing preferred service delivery models, and setting service objectives, minimum standards, and outcome measures. The partnerships will initially work with an ‘indicative’ financial allocation but, over time, may well take on the direct management of the older people’s commissioning budget for their locality. Following initial consultation, plans for establishing the partnerships are now being developed by a group including a local clinician, service user, carer, councillor, service provider, and voluntary sector representative. This group is clarifying the concept and purpose of the partnerships and considering appropriate terms of reference, governance and membership, as well as the likely training and development needs of their constituents. It is hoped that the first partnerships will be established from May 2006. Anticipated challenges are: ensuring that the partnerships have real influence over decision-making and resource allocation (and are not just perceived as ‘talking shops’); and aligning or making mutually supportive links between the commissioning partnerships and practice based commissioning groups.

Contact: John Bryant – Head of Market Development, Torbay Care Trust
john.bryant@nhs.net or 07773 343743

**Case study – National Offender Management Service**

In 2003, a review of correctional services was commissioned in a context of increasing use of prison and probation services; increasing severity of sentencing practice (having a limited impact on rates of crime); improving but fragile public confidence in sentencing; and significant additional investment in prison and probation (Carter, 2003). The objective was to ensure that the additional investment was being used to best effect to reduce crime and maintain public confidence. The report recommended that effectiveness and value for money could be improved through introducing commissioning and contestability, with greater use of private and voluntary sector providers. The result was the establishment of a National Offender Management Service, responsible for punishing offenders and reducing re-offending through commissioning a range of custodial and community-based interventions. Ten regional offender managers now direct work in their regions to develop and introduce the concept of offender management. By 2006-2007 they will hold the budgets for the probation areas and prisons in their regions; commission services from prisons and local probation boards and hold both prisons and probation areas to account for their performance; and improve performance by developing contestability - allowing alternative service providers to compete for work so that regions obtain the best value for money in managing offenders.

Contact: www.noms.homeoffice.gov.uk
Where there is evidence on the management of markets in health care (albeit in a different context), it suggests that relationships based on contracts may require a more ‘labour-intensive’ approach to governance than that in ‘hierarchical’ or ‘trust-based’ arrangements. This is because managing the ‘imperfections’ in the relationship between purchasers and providers and their associated risks, requires a proactive approach to market stimulation and a high level of monitoring by the commissioner. There are also high transaction costs associated with contracting, billing, payment etc. Consequently, despite the intended aim of driving down costs through competition, total system costs can actually be greater in a ‘market’.

Another issue that will have to be taken seriously by commissioners is the fact that, in an external market, relationships between stakeholders are governed by legal and technical frameworks (including, for example, competition and contract law) that will have to be adhered to. Decision-making processes and operating procedures will need to take account of these, or be subject to legal challenge. This context raises the bar in terms of the required capacity and skills of commissioners, who must develop market management strategies that deal with the prevailing system imperfections, and follow due process, without creating disproportionate levels of bureaucracy and performance management. These are discussed further in section 4.

Governing practice based commissioning

Practice based commissioning as a specific activity has a clear defined accountability structure, with the PCT being the formal and responsible body that delegates budgetary and service design activities to practices or groups of practices. Contracts for services designed within practice based commissioning are signed by the PCT, and the PCT is thus the formal contractor for all services bought through practice based commissioning. The degree of attention that has been attached to the accountability framework for practice based commissioning is in contrast to the experience of GP fundholding in the 1990s when an accountability framework was only put in place a few years after the inception of the scheme. There are however three areas where practice based commissioning poses a governance challenge to PCTs:

i) there is a conflict of interest inherent in practices’ role as both commissioner and provider of services (where they might wish to commission services from their own practice);

ii) there is a lack of sanctions enabling PCTs to deal with poorly performing practice-based commissioners. Although practice based commissioners could be stripped of their rights to commission if they consistently failed to deliver objectives, there is no direct mechanism for dealing with inappropriate use of resources resulting from poor clinical practice (or from practices declining to take on a commissioning budget, and taking no responsibility for the impact of their ‘commissioning’ decisions in the first place);

iii) practice based commissioning calls into question some of the ways in which primary care professionals have traditionally been involved in providing clinical advice and planning expertise to PCTs.

In relation to the first issue of potential conflicts of interest, the dual role of practices as providers and commissioners will require PCTs to design and implement new models of governance in order to assure probity and transparency in the design of services and placing of contracts. In doing this, PCTs will be able to draw on the experience of previous approaches to handling the placing of contracts with practices for the development of premises, enhancing existing services, and agreeing and reviewing general/personal medical services contracts. As noted in section 2 it could prove instructive to treat practice based commissioning as a form of extended primary care provision in this regard. In so doing, PCTs could adapt existing governance models developed in the context of contracting with providers.

As Lewis and Dixon (2005, p.19) have previously identified, this approach would also help resolve the problems raised in point ii) above. If commissioning responsibilities formed part of the core contractual obligations of primary care providers, and were “...regulated through greater powers for PCTs in the giving and taking away of contracts”, PCTs would have real levers in the case of poor performance or failure.

Finally, practice based commissioning calls into question the model of the professional executive committee (PEC) as the main clinical advisory and planning forum for the PCT. While certainly not exclusively the case, many PECs have been chaired by and comprised a majority of GPs. The potential conflict inherent in this model is two-fold. Firstly, the GPs providing advice to the PCT about planning and commissioning strategy are at the same time providers of services to the PCT under contract (and possibly via practice based commissioning agreements) and may have a vested interest in the development or otherwise of certain local services. Secondly, in an increasingly diverse market of health care providers, there is a need to question what is special about NHS GPs or community staff as members of PEC. It can be argued that staff from other provider bodies, such as private or third sector organisations, should likewise be eligible to provide clinical input to the PEC (or other forum for such advice.)

The area of clinical advice to PCTs clearly requires careful thought and planning by new PCTs. Research evidence consistently underlines the importance of effective clinical engagement in any primary care-led commissioning approach, and also points to the tension that is frequently experienced between clinical engagement on the one hand and managerial and public accountability on the other (Smith et al, 2004). Thus the current dilemma facing PCTs as they seek to govern practice based commissioning in a way that does not compromise clinical engagement (or even better in a way that enhances such involvement) is not of itself original, but in the new context of NHS systems reforms, original solutions will be required (see below for further discussion).

Governing internal commissioner-provider relationships

It is important to note that just as the status and relationships between the commissioning and providing roles of practice-based commissioners must be made more transparent, PCTs themselves are going to have to similarly adopt a clear separation (and ‘quasi-contractual’ relationships) between in-house provider functions and their role as local commissioner of community health services. In this respect, practice based commissioners and PCT providers need to be treated on the same basis. A range of models are emerging within PCTs in response to the steer in CPLNHS about separating commissioning and provider functions within a PCT – two case study examples are set out overleaf.
Involving patients and the public in fundamentally different ways

As well as the direct relationships between commissioning bodies and their service providers, the accountability of PCTs to patients, and the involvement of the public in decision-making, will be fundamental elements of good governance within commissioning. The importance of this is underlined in the recent NHS white paper on community health services that notes (Department of Health, 2006a, p157):

‘At the same time as giving people greater choice and control over the services they use, we also need to ensure that everyone in society has a voice that is heard. When people get involved and use their voice they can shape improvements in provision and contribute to greater fairness in service use.’.

Effective public involvement will be key to gaining legitimacy and support for the PCT as the local NHS.

There is UK and international evidence, for example, that patients are more likely to accept decisions to deny access to specific treatments if the priority setting process is seen to be fair (Daniels and Sabin, 1998; Ham and Coulter, 2001). Thus, while calls from groups or individuals for central intervention in PCT decision-making will never be entirely eliminated, they might be reduced if there are effective systems for educating the public about the need for priority setting, and by involving them more boldly in these processes.

Research evidence paints a gloomy picture in relation to the track record of commissioning organisations in ensuring any degree of strong accountability to local populations (Smith et al, 2004). Different forms of NHS commissioning have sought to involve users and patients in their activities and decision making, yet these attempts are frequently compromised by the centrally managed nature of the NHS and commissioners’ sense of their accountability to the Department of Health in practice taking precedence over their accountability to local populations (Dixon et al, 2001; Mlewa et al, 2003). A review of the experience of NHS primary care-led commissioning concluded that there was an inevitable trade-off to be made between the managerial accountability of a statutory body and the degree of freedom to innovate and respond to local public and professional needs (Smith et al, 2004). This experience underlines the need for new PCTs to re-think carefully their approach to governance and to the involvement of the public in their decision making processes, if they are not to repeat the mistakes of the past, which in turn would preclude the new PCTs from becoming a real ‘NHS Local’.

The development of a sense of local ‘community ownership’ of the commissioning body is also important to the level of political support afforded to it and its decisions – indeed, this is about creating the ‘NHS Local’. Studies of social health insurance systems in Europe confirm the importance of such local ownership, demonstrating that high levels of support for insurance funds, and the ‘social capital’ vested in them, are associated with their subsidiarity, and connection with a particular history or tradition (e.g. employment or labour organisations) (Chinitz et al, 2004). While overall levels of support for the NHS are also high in the UK, arguably, they have a different genesis, and are focussed on the idea of universal and consistent entitlement.
rather than on identification with a local body and decision makers. On this basis, the suggestion that the PCT should become ‘NHS Local’ seems both appropriate and essential, if the PCT is to be able to make effective and legitimate local funding and service planning decisions.

Debate on the appropriate involvement of the public in public-service governance has tended to distinguish between two levels of engagement: that of choice (between personal options) and voice (in influencing collective decisions) (e.g. House of Commons, 2005). In the context of health care, the former is being addressed very explicitly through the Patient Choice policy, which gives individuals requiring a particular service an opportunity for direct involvement in decision-making over their care options. As the roll-out of this system beyond pilot sites has been very recent, there is as yet little evidence against which to test either the assumptions that patient choice will apply competitive pressure on providers and improve patient satisfaction, or the concerns (discussed on p. 7), that that it could increase inequities in access experienced by disadvantaged and vulnerable patients. It is clear, however, that there will always be compromises to be made when balancing responsibilities to both improve the health of a population, and secure optimal services for individual patients. In addition to individual choice, then, involvement of the public and (perhaps in particular) groups or communities that are at risk and highly dependent on local services, must also take the form of a collective voice at a more strategic decision-making level.

Securing appropriate ‘voice’ within NHS commissioning post-CPLNHS requires the consideration of a new approach to PCT governance, that is, of how PCTs can properly act as and claim to be the ‘NHS Local’. In statutory terms, the representation of the public in healthcare decision making is currently through the non-executive directors on the boards of PCTs, and through patient forums. The extent to which these are seen by the public as effective mechanisms for exerting influence is extremely questionable, however, and to achieve a real and sustainable form of public engagement, alternative models need to be explored.

There are already many examples of strategies and initiatives to involve the public more actively in PCT planning, from patient surveys, citizen’s panels/juries, consultation events and workshops, and service user representation on commissioning or strategy groups. Again, however, we are proposing that a more fundamental rethink of PCT governance is now required, beyond simply seeking strategies for seeking people’s views or responses to consultation exercises.

One possible model to consider here is the governance framework for NHS foundation trusts. With the concept of public ‘members’ elected governors of the organisation who, in turn, appoint the management board and directors, this arrangement could have the potential to secure a closer relationship between a local community and an NHS body than any existing alternative mechanism.

It is acknowledged that the success of this approach in promoting meaningful public engagement has yet to be seen, and that there is a degree of scepticism among observers that ‘members’ and ‘governors’ will have any real influence or power.

However, the possibility of a similar system applied to commissioning organisations does warrant further consideration. While public allegiance to and interest in NHS organisations continues to centre around hospitals, public membership of a commissioning body is, arguably, far more meaningful than membership of a foundation trust (FT). It might be expected that the active ‘constituency’ of an FT would be made up largely of individuals connected in some way through their own, or a family members’ use of the services (and therefore restricted to relatively small numbers, but not necessarily with a geographical focus). In contrast, almost all individuals have some stake in ‘Our Town NHS’ as the steward of all local health care resources.

PCTs with local governors elected by a ‘membership’ of local people may be in a better position to articulate this role, as well as being able to make claims for greater legitimacy for their decision-making than is currently the case within corporate board structures (comprising executive directors and non-executive members appointed by the NHS Appointments Commission).

While the model may not translate directly, the FT membership system provides some useful ideas for commissioners to consider. Likewise, there is learning to be gained from the experience of governing local strategic partnerships, bodies that seek to commission services on a joint basis for specific communities and interest groups, and that include elected members of local authorities, senior public officials, and community interest groups within their governing bodies. In some areas, community empowerment networks have been established as a means of co-ordinating community involvement in LSPs – this experience offers potential for the future role of PCT patients’ forums.

Finally, there may useful be examples from other health care systems. Chinizl, et al (2004) make the interesting point, for example, that competitive reforms in European social health insurance systems do not appear to have diminished collective forms of member engagement in governance. Indeed, rather than leading to a greater exercise of ‘choice’ (or ‘exit’), competition between insurers appears to have only encouraged the deployment of various mechanisms for citizen involvement, and joint decision making between stakeholders.

Securing professional advice and clinical leadership

PCTs need effective methods of securing clinical advice into their overall development of strategy and a local health market. Local primary care professionals, acting as Professional Executive Committee (PEC) members, have generally been considered by PCTs to be their most appropriate source of such advice (along with the input of public health specialists). Under current arrangements, members of PECs are typically expected to undertake this clinical advisory role as representatives on PCT strategy and planning groups. Practice based commissioning is designed to increase this type of input from primary care professionals, by re-engaging those who have distanced themselves from PCTs in recent years. However, there are some question marks emerging over the reliance on existing local primary care practitioners to fulfil this function.

As discussed above, the introduction of practice based commissioning creates potential conflicts of interest for practice-based staff (who may be involved in commissioning decisions about pathways of care in which they intend to participate as providers), thereby impacting on their ability to act as truly independent advisers.
This issue is not new to PCTs. There have always been potential conflicts of interest within PEC arrangements, for example where independent contractor members have been involved in making decisions about how best to implement and monitor the new medical, dental and community pharmacy contracts to which they were themselves subject. The point made here is certainly not intended to suggest that primary care professionals can somehow no longer be trusted to act with probity and professionalism in such circumstances, or that it is inappropriate for (potential) service providers to ever be involved in service design and planning.

However, in an increasingly open health care market, it will be important for PCTs to be able to demonstrate the transparency of their decision-making processes, and the manner in which they select and regulate providers. In some circumstances, this may require a more arms-length relationship being established between PCTs and existing local practices.

The related point has also been made that, in an NHS with a greater plurality of providers, a wider range of clinicians (including those working outside the traditional ‘NHS-family’ in the private or ‘third’ sector) should have a role to play in working with PCTs to shape a local market of care. While some other independent contractors (including dentists, pharmacists and optometrists) have taken a very active role in their local PCTs, this has not always been the case, with GPs and PCT-employed community staff forming the clinical majority on many PECs. Again, if PCTs are to be seen to be offering a ‘level playing field’ for providers, they may need to consider the place of other existing and potential providers within their decision-making structures.

There is also a third, more practical argument here, that primary care professionals have never in fact been well placed to advise on the commissioning of specialist services of which they have little knowledge or experience, such as tertiary cancer care. Collectively, these issues throw into question current professional executive committee arrangements for securing clinical advice and leadership.

However, as they attempt to capture and process the ‘facts and figures’ within a local health economy (that is, ensure their ‘eyes and ears’ function), PCTs will of course continue to require expertise in interpreting these data in the context of clinicians’ understanding of patient needs, clinical effectiveness and professional behaviour. To some extent, this advice can be drawn from service providers, in the context of more mature commissioning relationships in which purchaser and provider work together to identify good practice, and design innovative solutions to shared problems. Advice on evidence-based practice will also continue to be produced and disseminated at a national level, and will be supplemented by analysis from the public health networks. Commissioners will still require more specific and detailed clinical guidance on the nature of the local health market, however, including optimal ways of applying sanctions and rewards, alongside the ability to appraise service options from a professional perspective.

Commissioning bodies may therefore need to consider alternative options for securing clinical expertise. This might include one or more of the following:

- establishing a restructured professional executive committee - this may be based on the idea of the ‘clinical executive’ proposed by the NHS Alliance (NHS Alliance, 2006) developed further to consider the eligibility for, role of and selection to this executive;
- contracting with clinicians outside the local health economy to provide advice on specific service areas;
- developing secondment opportunities for managers and clinicians from provider services who wish to gain commissioning expertise.
- the formal appointment of ‘clinical advisers’ in the way that many PCTs contract with dental, optometric and community pharmacy advisors. Unlike PEC members, these individuals are usually professionals who work outside the PCT area, and who are contracted not to ‘represent’ their profession within the PCT decision-making process, but to provide independent advice, and to undertake specific functions in relation to the approval and monitoring of independent contractors. A similar system could be developed for other areas of service planning and monitoring whereby expertise is obtained from individuals independent of the local market, but who, unlike an entirely independent consultant, are committed to an ongoing relationship with the commissioner.

The potential contribution of clinical managers and practitioners currently working within the provider directorates of PCTs should also be considered here. The focus of these staff groups recently has been on the implications of their potential transfer out of PCTs as providers in the future. However, there may be alternative opportunities for some individuals to remain within commissioning PCTs, working in new roles as clinical/professional advisors. Again, however, such positions would be different from that of current PEC nurse and therapist members, as it would not be as a ‘representative’ of a profession, but as an individual contracted specifically to bring professional expertise to the commissioning process.

4. Developing commissioning capacity

Clarity of purpose, alongside transparent and inclusive governance mechanisms, will be critical in establishing the ‘sovereignty’ of commissioning bodies as the stewards of their local health systems. Ultimately, however, the credibility and effectiveness of commissioning organizations will hang not on the theoretical appropriateness of their structures, but on their actual ability to discharge their functions with expertise, judgment and confidence.

The successive reorganization of commissioning bodies since they were first introduced in the early 1990s has disrupted the development of commissioning as a profession or corporate function within the NHS. While a significant degree of expertise has been developed over the past 15 years, individuals have been moved frequently and spread thinly around the system with little coherent succession planning. There have been few formal training and development programmes designed exclusively for commissioning managers and clinicians; and limited attention has been paid to developing the infrastructure required to support commissioning work.

Given this context, PCT commissioning teams have risen admirably to the challenges of their role and, as seen in the initial phase of this research, have employed a variety of mechanisms to make best use of the scarce and dispersed resources available to them. However, with the spotlight now turned on their profession, questions about the underlying knowledge
and skills of commissioning teams have been brought into focus. Even where teams are seen to be well developed, the reform programme presents commissioners with a direct challenge to ‘raise their game.’ As Light points out (1998, p. 67), in the US, where healthcare purchasing has a much longer history, the importance of establishing highly expert commissioning teams has already been recognized:

*The best American commissioning groups have concluded that health care is far more complicated to purchase than anything else … Their salary and bonus packages are designed to attract the best and the brightest. They require excellent data systems analysts and programmers, clinical epidemiologists, clinical managers, organizational experts, financial specialists and legal advisers.*

The importance of specialist knowledge and skills is also being highlighted in local government in England, where commissioning and contracting are somewhat more established than within the NHS. In a recent evaluation of local government procurement, the most commonly cited obstacle to the local delivery of national procurement strategy objectives was lack of staff ability (Hughes 2005). If similar conclusions are to be avoided in future evaluations of NHS commissioning, enhancing both the breadth and the depth of expertise available to commissioning bodies must be seen as an early priority at a national and local level.

This fact has been acknowledged by the Department of Health, which has announced the launch of ‘flagship’ organisational development programmes for PCTs and GP practices to support the growth of the skills and behaviours that will be required as they take on their new commissioning roles (Department of Health 2005a, p.33). For any such programme to be effective, it must be designed with reference to a well articulated idea of what those skills and behaviours will be. This final section sets out some of the commissioning tasks that may change or emerge as a result of the current reforms, and the type of knowledge, skills and expertise that commissioning organisations will consequently require. Based on our analysis of commissioning functions and governance arrangements, the following areas of organizational and individual development emerge as priorities:

- **Leadership**
- **Data capture, processing and analysis**
- **Procurement and contracting**
- **Marketing and public relations**
- **Public engagement**

The following sections discuss why these skills are needed, and the extent to which they must be developed within the commissioning organisations themselves, or could be made available from external sources.

**Leadership**

The term ‘leadership’ is much used but often ill-defined, both within and beyond the NHS. One useful conceptualization, however, is to make the distinction between good management, as coordinating the effective application of proven solutions to known problems, and leadership, as building the capacity for groups and individuals to “learn their way out of problems that could not have been predicted” (Day 2001, p.582).

While all of the functions described above will obviously require excellent management, effective leadership, in this context supporting the emergence of new skills and processes while steering the system through a period of profound and rapid change and intense political scrutiny, will be critical if an actual ‘step-change’ in outcomes is to be delivered.

This capacity to deal with change and complexity in a political environment will be required not only from chief executives and boards, but must be a feature of the organisation as a whole, including its full range of commissioners – directors, managers, analysts, planners, and practice based commissioners. If the PCT is to be acknowledged as the embodiment of the local NHS, this leadership must be seen to be provided by the clinicians and managers whose accountability resides inside the NHS hierarchy.

How to develop this form of leadership within the commissioning function is perhaps the greatest development challenge facing new PCTs. The task to be undertaken by PCTs is at once larger and more complex that in the past and, for many individuals working within them, requires a categorically different approach to that demanded by their current roles and responsibilities. For example, a recent regional review of the future role of Directors of Nursing identified that, as the focus of PCT work moves from provision to commissioning, the role of nurse leadership in these organisations will need to shift from that of managing and developing a workforce, to one of influencing strategic change through others (Renshaw, 2005). A need was identified for both structured training and development in specific aspects of commissioning, as well as individually tailored skills development to support nurse leaders in making this shift.

In designing national programmes to support the strengthening of commissioning, it will be important for personal and leadership development to be addressed alongside important technical, analytical and planning skills.

**Data capture, processing and analysis**

Improving the ability of commissioning bodies to collate, analyse and interpret data will be critical to their success. Effective planning, decision-making, risk assessment and monitoring are all dependent on the availability of timely, accurate information that is understood by the organisation.

Many of these data sources, skills and tools are already available within PCTs, but there is often a lack of capacity to make full use of the data in a manner that is timely and appropriate for commissioning decisions.

Since the introduction of Payment by Results, much has been learned about the collection and validation of ‘hard’ referral and activity data from the secondary care sector, while the Quality and Outcomes Framework assessment process has focussed attention on the measurement of both clinical and organisational indicators in primary care. Public health specialists and epidemiologists have expertise in projecting the future disease burden and health profile of a population, while individuals involved in service redesign and trained in the ‘collaborative’ methodologies have an understanding of capacity and demand analysis at the level of services or specialties. Participants in ‘Evercare’ pilots and similar schemes have also begun to develop ways of using data to identify and manage the care of individuals likely to be frequent users of services, using techniques and expertise drawn largely from the United States.

It is becoming accepted within NHS commissioning that this type of detailed data analysis and modelling is an essential prerequisite to effective service planning and resource allocation, as witnessed by
the recent release by the King’s Fund of Department of Health-supported ‘Patients at Risk of Re-hospitalisation’ case finding tool (King’s Fund, 2006).

However, commentators continue to highlight the fact that NHS commissioning organisations are data-rich and information-poor, having relatively little capacity for timely analysis and hence use of what are extensive data collection systems.

Some support to assess and improve information requirements is being developed nationally. For example, the Audit Commission will be leading a Payment By Results assurance programme in 2006, strengthening local arrangements for monitoring data and payments, and carrying out a series of random and targeted external audits of clinical coding and reporting. The Department of Health has also developed a toolkit that allows the use of the national resource allocation formula to calculate indicative weighted capitation budgets at practice level to support the implementation of practice based commissioning. A practice based commissioning information template is also being developed, to assist PCTs in providing information to practices in a consistent format (Department of Health, 2006b).

However, responsibility for ensuring more sophisticated data capture, processing and analysis will ultimately be at a local level. The risks to PCTs of miscalculating future pressures on service utilisation take planning requirements beyond the broad assessment of future epidemiological profiles, towards the actuarial modelling techniques used by insurance companies to forecast demand and analyse risk. The challenge for new PCTs and practice based commissioners is how to choose the appropriate tools and expertise for service analysis and planning in the local context, and to determine how best to source that expertise. Options include contracting with a private company for some or all of this analytical work (as in the North Eastern Derbyshire PCT case study), training existing staff in new techniques, developing a pooled central resource for such activity with other PCTs (as in the Birmingham and the Black country case study), or a combination of all three.

**Procurement and Contracting**

As noted in section 2, commissioning is a process involving a series of specific activities, including needs assessment, service specification, procurement, purchasing, contracting, and monitoring. The relative importance and exact nature of each activity depends on the context in which they take place. For example, in England, where up to now commissioning has occurred primarily within an internal NHS market with relatively limited choice of providers, there has been a greater role for purchasing (buying or funding services in response to demand or usage), than for procurement (stimulation and identification of suppliers through advertising and competitive tendering). The policy context has also meant that contracting has involved the specification, negotiation and monitoring of service agreements rather than legally binding contracts, and has taken place within short-term (annual) cycles. In some cases, particularly in relation to primary care providers, the responsibility for securing services has until recently hardly been seen as a commissioning function at all, given the limited scope for performance management and market-exit within the nationally agreed contracts.

Consequently, current commissioning reforms, in particular the increasing involvement of the independent sector, are taking NHS commissioners into new territory. Specific areas of procurement and contracting where PCTs will require more expertise in future to deal with this include: marketing and market research; competitive tendering and contract law; supply-chain management; and strategic commissioning.

i) Market Management: marketing, market research and market development

In order to reap the anticipated benefits and minimise the potential risks of a more competitive market between providers, commissioners will need to learn how to manage this market in line with their organisation’s interests. This will involve developing a detailed understanding of the environment, and encouraging a range of potential suppliers to take an interest in the public service market place. Given the sometimes poor reputation of the statutory sector as a commissioner among ‘third sector’ providers, and the relatively limited market capacity in some areas of provision, the latter objective cannot be taken for granted, and may require sophisticated market management skills. This will include marketing the PCT itself as a commissioner.

Some techniques identified in local authority procurement include: publishing and distributing a forward procurement plan; providing information about tender opportunities on websites; holding seminars to introduce potential providers to contract opportunities; and producing guidance and running training on ‘how to bid for Council contracts’ (Hughes 2005). The concept of commissioners ‘selling’ themselves as reliable, constructive, attractive trading partners in this way may be new to those working in a PCT context, and will require expertise in advertising, communications and public relations management.

Commissioners will also need to undertake ’market research’, to ensure that they understand the environment they are operating in, and the degree of competitive advantage they hold (or otherwise). This will inform both negotiating positions, and the design of contracts. In particular, commissioners will need to think about how they ‘package’ work, potentially moving away from traditional service specifications, to ‘out-put based’ requirements, that do not assume a particular organisational or professional model of delivery.

Finally, in constrained markets, commissioners may need to engage in capacity building and market development activities, proactively supporting providers to develop their services in line with the local commissioning strategies.

ii) Competitive tendering and contract law

In a more open or external market, PCTs will increasingly be subject to challenge if their purchasing processes are not transparent and in line with formal procedures. Commissioners must therefore be fully conversant with, or have access to expertise regarding, both their internal financial instructions, EU regulations on advertising and awarding contracts, and the legal framework of competition law.

Legally binding contracts entered into with independent sector organisations create a different type of commissioning relationship from that experienced with other NHS providers. As well as emphasising the importance of properly defined service specifications, this will have implications for risk-management strategies, and could impact on the insurance and liability status of the PCT. Similar issues have been identified by foundation trusts (FTs) which, although as providers rather than commissioners, have also recently ventured
Case Study: Market Development in Torbay Care Trust

Torbay Care Trust has established the position of Head of Market Development. The remit of this individual (who brings commercial sector experience of business development) is to work with local providers in developing their capacity to deliver modern, high quality services that meet the needs of the population. The post-holder acts as a communications link between commissioners and providers, identifying common challenges and objectives, and ensuring suppliers are involved in decisions that may influence future demand, so they can adapt accordingly. The aim is to remove the perception of adversarial contracting relationships and facilitate a move towards more mature, constructive partnerships. Over the next year, the care trust will be working with local residential and domiciliary care services to develop and test outcome based reimbursement mechanisms, that will encourage providers to focus on quality, and to develop innovative approaches to rehabilitation and intermediate care.

Contact: John Bryant – Head of Market Development (07773 343 743)

outside the boundaries of the internal NHS market and into a new legislative arena. The response of several FTs has been to establish a company secretary role, equivalent to that seen within the private and mutual sector (Foundation Trust Network, 2005). In some cases this has been achieved through extending the responsibilities of existing ‘corporate affairs’ managers, but others have explicitly brought in qualified individuals with experience in the business sector. PCTs may want to consider whether it is most cost effective to develop equivalent roles for their organisations (given the wider remit of a company secretary to support all aspects of corporate governance), to buy in legal expertise, possibly as part of a broader ‘procurement’ service, or to even employ a solicitor to work in behalf of a number of PCTs. Either way, they will increasingly require access to such expertise.

iii) Supply chain management

Supply chain management is a common element of procurement within manufacturing and production sectors, in which many large global companies such as Ford and IBM no longer operate as integrated production systems, but instead effectively provide the ‘control centre’ for a network of suppliers contributing to development of their products (Department of Trade and Industry, 1998). As discussed earlier, it is not yet clear how practice based commissioners will be positioned on the commissioner/provider spectrum, nor to what extent they will be allowed to subcontract services themselves. However, whether through contracting with practice based commissioners, dealing with large companies operating on a franchise basis, or purchasing from NHS trusts working in partnership with the independent sector to deliver additional diagnostic capacity, PCTs are likely to find themselves increasingly distanced from the ‘production process’, and taking on this ‘control centre’ role in an increasingly diverse and external market. Although more usually associated with physical supplies and logistics, supply chain management will become a critical responsibility for NHS commissioners. An understanding of the theory and practice as applied in other sectors will provide important insights for PCT commissioners.

iv) Strategic Partnering

While the negotiation of service agreements within the NHS has been an annual event driven by the need for NHS bodies to balance their books each year, ‘intelligent’ commissioning in other sectors in increasingly based on the development of long-term, risk-sharing relationships with suppliers and other partners. Mechanisms used by local authorities to support relational contracting, and to reduce the transaction costs of a market-based system include the establishment of:

- approved lists and accreditation whereby potential suppliers apply to become a member of the approved list. If they meet the requirements of the list they are allowed to bid for, or be offered work for as long as their approval remains valid;
- procurement compacts, for example with the voluntary sector, where a framework for the local role of the voluntary and community sector in delivering public services is agreed, and procurement activities take place within the context of that agreement; and
- framework agreements and ‘open’ contracts, where the contracts negotiated by one council are made available to other organisations.

Arrangements such as these are increasingly familiar in other sectors and would seem to have relevance for the development of more effective and sophisticated commissioning in the NHS. PCTs will in future want to engage with some providers in sustained and mature ways, particularly those delivering complex, ongoing disease management programmes, and core local services such as accident and emergency. The increasing independence of providers from the NHS’s annual financial cycle, and consequent ability to extend financial planning and risk-management strategies over a greater period of time, will make it easier for them to enter into longer-term agreements. To take full advantage of these opportunities, however, commissioners will need to develop their own skills in long-term planning and management of contracts.

Once again, the type of expertise described above is certainly not entirely absent from the NHS. Many commissioning managers, particularly those involved in joint commissioning with local authorities or specialised commissioning for low-volume/high-need groups of patients, have extensive experience of purchasing care from and contracting with the independent sector. Similarly, individuals employed in purchasing and supplies departments will be skilled in the more technical aspects of procurement, and those involved in PFI programmes will be engaged in long-term strategic relationships with independent sector partners. As in the case of information specialists, however, such expertise may currently be fragmented across organisations and departments, and it will inevitably take some time for PCTs to develop a coherent, effective procurement function, whether on a stand-alone or collaborative (with other PCTs) basis.

External Communications: public relations and public engagement

As discussed above, establishing the legitimacy of commissioning bodies as the local NHS may require the development of new forms of relationship and dialogue with the local population.

Marketing and Public Relations

One particular area where the nature of this communication needs to be carefully considered is in the provision of information to patients in the context of Patient Choice. There are two critical issues here:
i) As ‘stewards’ of local public health, and with a responsibility for reducing health inequalities, PCTs must ensure that the operation of Patient Choice does not work to disadvantage particular groups or individuals. Farrington-Douglas and Allen (2005) argue that in order to avoid this, commissioners must provide (or commission and regulate) effective information, support and advocacy for individuals when exercising choice, and engage with communities and service users to understand why particular choices are made by patients.

ii) Under Patient Choice, PCTs and practice based commissioners will not be able to rigidly specify service options, yet will be responsible for establishing strategic commissioning relationships with providers. The information presented to patients regarding their options, and the impact this has on the choices they make, may be critically important to the ability of commissioners to manage and channel demand in line with commissioning strategies. Provider organisations, particularly foundation trusts, are already developing marketing strategies. Commissioners will need not only to monitor such advertising by providers to ensure it is appropriate, but also to develop their own communication campaigns, potentially to counteract the effects of advertising on patient demand and acute activity levels.

For both reasons, PCTs will require expertise in consumer research, marketing, tailoring information to the needs of different groups and individuals, and public relations. The Department of Health is currently consulting, and planning to produce guidance, on the regulation of marketing activity carried out by service providers, to ensure information they produce is fair and accurate, and that their advertising strategies are in line with statutory guidelines (Department of Health, 2006b).

There is no reference to the marketing activities of PCTs, but this may well be considered at a later stage, and commissioners will need to be aware of any relevant protocols.

Public Engagement

Finally, a related, but distinct set of skills will be required in commissioners if they are to be successful in establishing the PCT or commissioning body as ‘the NHS Local’. Effectively co-ordinating meaningful consultation, engaging members of the public in the complexity of decision-making, and encouraging active participation (potentially as ‘members’ of the PCT) in setting priorities and reviewing services will require individuals with charisma, political astuteness, and the ability to develop networks across communities.

Summary – developing commissioning capacity

Many of the knowledge and skill sets identified above as critical for new commissioners are already available within PCTs and other NHS organisations. However, harnessing these skills and applying them to the commissioning tasks identified above will require the redesign of many roles, and the development of staff. For example, primary care development teams, procurement and supplies professionals, corporate affairs managers, modernisation facilitators, public health specialists, and clinical managers will all have some of the expertise discussed here, but may never have seen their roles as part of a commissioning function.

An early priority for PCTs will therefore be to carry out a detailed and sophisticated skills audit, mapping the knowledge and expertise that exists among staff, establishing where major skills gaps lie, and helping individuals to see how they might fit into new structures and roles.

It has only been possible here to develop an outline of the knowledge and skills set likely to be required by PCT and practice based commissioners. There is clearly further work required in some instances to determine a detailed knowledge base and competency profile, but the framework set out above provides a basis for this task.

Where skills are not available and cannot be developed in the timescales required, there will be increasing examples of shared arrangements across multiple agencies, and of contracting out of the NHS. There is evidence that interest from the independent sector in entering the market for providing commissioning expertise, and the Department of Health is considering how this can best be channelled (2005b). What is clear is that new PCTs will face a significant challenge in relation to both the design of the local commissioning architecture (mapping functions to organisations and roles) and then in securing the necessary skills and expertise to make the new system work in an effective manner.

5. Conclusion: what needs to be done to put policy into practice?

It is clear that the overall commissioning task facing PCTs in 2006 has expanded beyond anything known to date. There is a greater range of functions to be performed and the expectations on commissioners are higher than ever before. In a more complex health system, the PCT is being looked to as the ‘sovereign’ local commissioner, and as such needs to become ‘NHS Local’, a strong, legitimate and recognised body that people consider to be responsible for ‘their’ NHS.

The expanded commissioning task comprises three sets of functions that can be considered within the metaphorical framework of the ‘conscience’, ‘eyes and ears’, and ‘brain’. This reflects the core functions of governance, data gathering and analysis, and purchasing/procurement. The PCT as sovereign local commissioner has the responsibility for deciding where to locate the many different activities that fall into the conscience, eyes and ears, and brain categories. Some of these activities will be aggregated upwards to supra-PCT bodies, others will be contained within the PCT, and others will be sub-contracted to practice based commissioners or other organisations.

The PCT will however remain as the overall guardian of all commissioning activities in its local area, and hence will need to develop stronger and more sophisticated governance of the ‘web’ of accountability relationships in the middle of which it finds itself. In developing governance arrangements, PCTs will need to give specific consideration to how they will govern partnerships (NHS, local authority and other), markets (including the relationship with providers), their relationship with patients and the public, and the securing of clinical advice and leadership. NHS commissioning has a poor record in relation to the involvement of patients and the public in decision making. New PCTs need to explore different approaches to developing strong local identity and legitimacy if they are to avoid the mistakes of the past, and become commissioning bodies that are respected at a local level and able to withstand central pressures to alter decisions made locally.

Thus the current PCT stakeholder model of a corporate board taking advice from a patients’ forum is unlikely to be fit for
In 2006, PCTs face an expansion in the overall commissioning function. Practice based commissioning calls for a more sophisticated approach to the PCTs will need to give specific consideration to how they will govern partnerships, NHS commissioning has been a largely neglected and under-developed function to the expanded commissioning task comprises three sets of functions that we the current process of commissioning reform offers an unrivalled opportunity for Practice based commissioning calls into question current mechanisms for involving The PCT will need to become ‘NHS Local’, a strong, legitimate and recognised body The PCT is responsible for deciding where to locate these functions - some will be Other models of PCT governance need to be explored as a matter of urgency and The PCT will be the overall guardian of local commissioning activities and hence will The PCT will be the overall guardian of local commissioning activities and hence will The PCT is responsible for deciding where to locate these functions - some will be The PCT will be the overall guardian of local commissioning activities and hence will The current PCT stakeholder model of a corporate board taking advice from a costs. This research increasing pressure on management and challenges of this task are not to be purpose in the reformed NHS if the PCT is to be a strong and legitimate ‘NHS Local’. Other models of PCT governance need to be explored as a matter of urgency and there is relevant experience within the wider public sector (e.g. local strategic partnerships and community empowerment networks) and within health in foundation trusts. Likewise, practice based commissioning calls into question current mechanisms for involving GPs and other primary care professionals in PCT decision making and planning, and there is a need for careful review of the role of professional executive committees, and for consideration to be given to additional and alternative models of gaining clinical advice and input. Practice based commissioning also calls for a more sophisticated approach to the monitoring and management of conflicts of interest at a practice level, and it might be helpful to consider practice based commissioning as a form of extended service provision in this regard. In order to deliver the extended range of commissioning functions in a manner that is properly governed and viewed as legitimate to local populations, there is a need for PCTs to undertake a detailed skills audit as an immediate priority. This should seek to identify existing skills within PCT and practice teams, gaps in the skill base, and plans for ensuring a proper skill base within the new commissioning arrangements. This is likely to involve a process of personal and organisational development, accompanied by sub-contracting areas of work to specialist agencies, other PCTs, practices and other providers. NHS commissioning has been a largely neglected and under-developed function to date, with few resources being targeted at the development of clinical and managerial capacity in this area, and little attention given to growing the next generation of commissioning specialists. The current process of commissioning reform offers an unrivalled opportunity for detailed analysis of the commissioning task, how it can be made real in practice, and to develop far-reaching plans to enhance the skills of the people charged with what is probably the most responsible of management activities with a health system. However, the challenges of this task are not to be underestimated, particularly in the context of increasing pressure on management and infrastructure budgets. This research seeks to add to the process of understanding and developing the commissioning function, and to offer insights into how those leading PCTs and practice based commissioning might take the next steps in addressing these challenges, and delivering effective commissioning in the reformed NHS.

Summary of report conclusions

- In 2006, PCTs face an expansion in the overall commissioning function.
- The PCT will need to become ‘NHS Local’, a strong, legitimate and recognised body that people consider to be responsible for ‘their’ NHS.
- The expanded commissioning task comprises three sets of functions that we describe as being the conscience, eyes and ears, and brain - this reflects core functions of governance, data gathering and analysis, and procurement.
- The PCT is responsible for deciding where to locate these functions - some will be aggregated upwards to supra-PCT bodies, others will be contained within the PCT, and others will be sub-contracted to practice based commissioners or other organisations.
- The PCT will be the overall guardian of local commissioning activities and hence will need to develop stronger and more sophisticated governance of the ‘web’ of accountability relationships in the local health system.
- PCTs will need to give specific consideration to how they will govern partnerships, markets, their relationship with patients and the public, and the securing of clinical advice and leadership.
- The current PCT stakeholder model of a corporate board taking advice from a patients’ forum is unlikely to be fit for purpose in the reformed NHS.
- Other models of PCT governance need to be explored as a matter of urgency and there is relevant experience within the wider public sector and within NHS foundation trusts.
- Practice based commissioning calls into question current mechanisms for involving clinicians in PCT decision making, and there is a need for careful review of the role of professional executive committees, and for consideration to be given to additional and alternative models of gaining clinical advice and input.
- Practice based commissioning calls for a more sophisticated approach to the monitoring and management of conflicts of interest at a practice level, and it might be helpful to consider practice based commissioning as a form of extended service provision in this regard.
- In order to deliver the extended range of commissioning functions in a manner that is properly governed, there is a need for PCTs to undertake a detailed skills audit as an immediate priority.
- This audit should seek to identify existing skills within PCT and practice teams, gaps in the skill base, and plans for ensuring a proper skill base within the new commissioning arrangements.
- NHS commissioning has been a largely neglected and under-developed function to date, with little attention having been given to growing the next generation of commissioning specialists.
- The current process of commissioning reform offers an unrivalled opportunity for detailed analysis of the commissioning task and to develop far-reaching plans to enhance the skills of the people charged with what is probably the most responsible of management activities with a health system.
Department of Health (2006a)  
Department of Trade and Industry (1998)  
Commissioning in the NHS: challenges and opportunities, London, NERA Economic Consulting  
Department of Health (2006a) Our health, our care, our say: a new direction for community services, London, Department of Health  
James, C, Dixon, M and Sobanja, M (2002), Re-focusing Commissioning for Primary Care Trusts: An NHS Alliance discussion paper, Retford, NHS Alliance  
King’s Fund (2006) Care for people with long-term conditions receives boost with latest tool to cut hospital admissions, press release, London, King’s Fund  
NHS Alliance (2006) The Future of Clinical Leadership in Primary Care and PCTs, Retford, NHS Alliance  
Peck E and Freeman, T (2005) Reconfiguring PCTs: influences and options, Birmingham, Health Services Management Centre  
Smith J and Goodwin N (2002) Developing effective commissioning by primary care trusts: lessons from the research evidence, Birmingham, Health Services Management Centre  
Appendix A – attendees at research workshop

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Barker</td>
<td>Chairman</td>
<td>Wakefield West PCT</td>
</tr>
<tr>
<td>Will Blandamer</td>
<td>Associate Director of Partnership</td>
<td>Association of Greater Manchester PCTs</td>
</tr>
<tr>
<td>Mike Chew</td>
<td>Deputy Chief Executive</td>
<td>Milton Keynes PCT</td>
</tr>
<tr>
<td>Andrew Coulson</td>
<td></td>
<td>Institute of Local Government Studies, University of Birmingham</td>
</tr>
<tr>
<td>Lucy Docherty</td>
<td>Chair</td>
<td>Fareham &amp; Gosport PCT</td>
</tr>
<tr>
<td>Buzz Dodd</td>
<td>Head of Commissioning</td>
<td>Southampton City PCT</td>
</tr>
<tr>
<td>Alastair Gibbons</td>
<td>Head of Adult Social Care</td>
<td>Milton Keynes Council</td>
</tr>
<tr>
<td>Jeannette McMillan</td>
<td>Clinical Services Director</td>
<td>Mercury Health Limited</td>
</tr>
<tr>
<td>Martin McShane</td>
<td>Chief Executive</td>
<td>North Eastern Derbyshire PCT</td>
</tr>
<tr>
<td>Claire Molloy</td>
<td>Director of Commissioning and Modernisation</td>
<td>Sandwell PCTs</td>
</tr>
<tr>
<td>Pauline Quan-Arrow</td>
<td>Chairman</td>
<td>Southampton City PCT</td>
</tr>
<tr>
<td>Nick Relph</td>
<td>Chief Executive</td>
<td>Thames Valley SHA</td>
</tr>
<tr>
<td>Jonathan Shapiro</td>
<td>Chair</td>
<td>Birmingham and Solihull Mental Health Trust</td>
</tr>
<tr>
<td>Robert Sloane</td>
<td>Leadership development lead</td>
<td>NHS Alliance</td>
</tr>
<tr>
<td>Michael Sobanja</td>
<td>Chief Executive</td>
<td>NHS Alliance</td>
</tr>
<tr>
<td>Rita Symons</td>
<td>Programme Lead for Choice</td>
<td>Birmingham and the Black Country Strategic Health Authority</td>
</tr>
</tbody>
</table>

Appendix B – interviewees for research

- Cynthia Bower – Managing Director, Birmingham and Black Country SHA
- John Bryant – Head of Market Development, Torbay Care Trust
- Sue Comick - Head of Planning and Performance, Northumberland Care Trust
- John James – Interim Chief Executive, Brighton and Hove City Teaching PCT
- Paula Kerr - Non Executive Director, Bedfordshire and Hertfordshire Strategic Health Authority
- Martin McShane - Chief Executive, North Eastern Derbyshire PCT
- Claire Molloy – Director of Commissioning and Modernisation, Sandwell PCTs
- Adrian Osbourne – Corporate Projects Manager, Hampshire and Isle of Wight SHA
- Denise Radley - Assistant Director for Performance & Commissioning, Hertfordshire County Council