

Commissioning Health

Volume 2, Number 1

www.commissioninghealth.com

Summer 2008



**Mark Britnell, DH
director general of
commissioning**

Assured performance: how we'll chart our progress to world-class

If assertion were all that it takes to be world-class, then world class commissioning would already be precisely that: call it so, and hey presto, there it is!

As everyone involved in the development of commissioning knows, it isn't that simple. An ambitious adjective is just the starting point – what we need is to be able to assess the quality of commissioning in practice.

The new assurance system

Over recent months, a new assurance system has been in development and tested in PCTs in the North West. The valuable front-line lessons we gained from those tests have now been incorporated, and the new assurance system is already moving out across the country.

This new system is emphatically not about new targets (indeed, the PCTs that took part in the North West test fed back comments on how helpful and supportive the process had proved). Its aim is to help PCTs to understand their development with the world class commissioning competencies (see *Box 1* overleaf), and to benchmark their progress against their peers with the help of their strategic health authority.

Previous changes under the system reform agenda have needed quality assessment. The Healthcare Commission has played its role in assessing the quality of hospital, ambulance, mental health and care trusts.

Foundation trusts have had the watchful eye on Monitor on their applications and subsequent performance. For commissioning to reach world-class, its own assurance programme is a vital ingredient.

Local knowledge

The assurance system is a national scheme for the English NHS, and will be managed by the ten strategic health authorities. Its central aim is to create a consistent assurance system, reviewing PCT progress towards world-class commissioning. Working on the basis of an annual cycle, the assurance system will support PCTs in designing, delivering and supporting world-class commissioning.

PCTs themselves will collect various data (including metrics, evidence-gathering, '360-degree' feedback and self-certification) to support the assurance process.

FEATURE CONTINUES ON PAGE 2

Contents

Mark Britnell	1-2	Adrian Masters	6-7
M Britnell (ctd.)	2-3	Jennifer Dixon	8
Editorial	3	Nick Goodwin	9
Natalie-Jane		David Jenner	10
Macdonald	4	Helen Lockett	11
Nigel Edwards	5	Alan Maynard	12

nhsalliance

Commissioning Health is produced
with the support of





Mark Britnell, DH director general of commissioning

CONTINUED FROM PAGE 1

How the process will work

The new assurance system will measure performance in three key areas: competencies, governance and health outcomes.

Each PCT will pick a few local outcome measure indicators, consistent with their strategic objectives. Data on improvement on these local indicators will collate into a scorecard, which will benchmark PCT outcomes for example in comparison to the national average and upper

Box 1 - World-class commissioning competencies

World-class commissioners will:

- locally lead the NHS
- work with community partners
- engage with public and patients
- collaborate with clinicians
- manage knowledge and assess needs
- prioritise investment
- stimulate the market
- promote improvement and innovation
- secure procurement skills
- manage the local health system
- make sound financial investments

quartile for the NHS.

Board governance

The assurance system will also assess progress of the PCT board towards full engagement in commissioning, and towards developing a meaningful strategic commissioning plan (supported by robust financial plans).

Every area of the PCT's plans will be reviewed: annual operating; strategic; long-term financial; organisation development plans – as well as their board controls and processes.

Each area of governance will be rated as red (poorest), amber (warning) or green (best).

Panel review

Between November and December 2008, an assurance panel review day will be central to every PCT assurance. This panel review day uses structured interviews to assess the PCT's capabilities and give feedback on future development areas.

The PCT receives this information in a summary report, as well as a 'benchmark' against other PCTs, both within their SHA and nationally.

The national benchmark list will not be published in 2008-9,

Box 2 - Key areas of commissioning spend and outcome measures

- Health needs and mapping
- Outcomes and vital signs
- Programme budgeting
- Primary care
- Prescribing
- Elective care
- Non-elective care
- Mental health and learning disabilities
- Community services

but will be made publicly available in future years.

PCTs will be rated between Levels One and Four (where Level Four means 'world-class').

In this first year of the process, we anticipate that most PCTs will be assessed as being Level One or Level Two.

This new system will be implemented in all PCTs by March 2009.

Every PCT's potential for improvement will also be assessed, and a commentary provided by the review panel.

These will be expected to vary widely, and there will not be a one-size-fits-all 'right' degree of room for improvement.

Incentives

There will of course need to be rewards for high-performing PCTs, and we are currently considering how these might work. There may be lessons we can draw from the 'earned autonomy' principles that were applied to foundation trusts.

Help with strategic planning guidance

All PCTs are required to produce a strategic plan by the autumn, as stated in the 2008-9 Operating Framework.

The governance element of the WCC assurance system will include an assessment of whether PCTs have developed and more importantly, fully internalised a meaningful strategic plan for commissioning.

We can offer help in this process, through guidance on strategic planning, and information on format and content.

The world-class commissioning area of the DH website gives more details on this.

Supporting data packs

Working with McKinsey, Dr Foster and Mental Health Strategies, we have prepared data packs for all SHAs and PCTs, to support their strategic planning processes.

These focus on the key areas of commissioning spend and outcome measures (see *Box 2*, above left), and include trend and comparison data for every PCT.

Adding life to years and years to life

As key NHS commissioners, it will be PCTs, supported by SHAs that will lead the work to turn world class commissioning into a reality, in a way that ensures the needs and priorities of the local population are met.

With the NHS back in financial balance, we are now in a stronger position than ever to directly impact the health and well-being of the population by commissioning services in new and innovative ways. Ultimately, world class commissioning, will deliver better health and well-being for all, better care for all and better value for all; adding life to years and years to life.

Andy Cowper, editor, *Commissioning Health*

Welcome to the new issue of *Commissioning Health*. It's good to be back, just in time for what looks suspiciously like summer.

This is being written at an interesting mid-point between the DH world-class commissioning team outlining the new assurance system for PCT commissioning and the Darzi review. *'Waiting For Darzi'* has felt like a five-act play written by someone who hasn't heard F. Scott Fitzgerald's famous dictum from *The Great Gatsby*: "There are no second acts in American lives".

Already, some things are clear. The artificial and highly inflammable debate around polyclinics has been a classic of generating much heat but little light.

Yet perversely, and despite the efforts of both the mis-selling men from the ministry and the hype-merchant BMA-GP-Conservative coalition, a wildly sensible consensus is emerging that any conception of polyclinics that confines itself to new buildings by central, decree will miss the point in a spectacular way.

Reports in recent months from the BMA, Kings Fund, NHS Confederation and NHS Alliance have agreed that any meaningful integration may well be virtual, hub-and-spoke 'integrated care organisation'-type affairs - more than dumping down 150 new buildings. It may seem obvious, but new provision must respond to local need.

The four speakers at a recent Civitas debate all echoed the point: this isn't about buildings; it's about how we integrate the provision of care.

In some areas, probably urban, this might mean new buildings which would co-locate GPs and primary care colleagues with diagnostics, out-patient clinics and day / minor surgery-type capacity. In other words, polyclinics as envisaged in Lord Darzi's 2007 *Healthcare For London* review.

This is probably not the right model for rural areas or small towns. In those areas, it needs to be possible to commission the diagnostic and management capacity to improve the wrapping of primary care around the patient.

There is a broader point here about commissioning. 'All politics is local' is the line attributed to US Senate Speaker Tip O'Neill. If commissioning is going to make a real difference to services, then it is going to have to be rooted in its communities' needs. It is also going to have to commission for integration.

The new freedoms for top-performing commissioning PCTs that are likely to be announced in the Darzi review will be welcome. There is a real risk that if the rewarded PCTs are simply commissioning 'more of the same' - bearing in mind a criticism of lack of true innovation by foundation trusts in the recent Audit Commission-Healthcare Commission report - we institutionalise extant patterns of provision. That is surely not the point.

A big theme of F. Scott Fitzgerald's is the way that youth and promise are followed by despair and age. Commissioning is young, and it has promise. Yet if it is not about the local, the integrated, and about wrapping care around the patient more effectively and with less handovers, it may get old before its time.

Commissioning and health inequalities



**Dr Natalie-Jane Macdonald,
managing director,
BUPA Commissioning**

Although well known, the figures from the launch of *'Health inequalities: progress and next steps'*, the new report from the Department of Health, retain their power to shock.

For every tube stop eastbound on the Jubilee Line from Westminster to Canning Town, average life expectancy drops by one year. Average male life expectancy in Manchester is ten years lower than it is in Kensington and Chelsea. By the age of three (when 50% of our language is fixed), a child from a deprived background will have heard 13 million different words, whereas a child from an affluent family will have heard 45 million – and we well know how education and environment

'If commissioning cannot help us to address health inequalities, then it's of very little use'

are key determinants of health and broader social status.

Can commissioning help?

So can commissioning address these deep-rooted and not easily tractable problems? Let's phrase it another way – if commissioning cannot help us to address health inequalities, then it's of very limited use.

Health needs assessment, the baseline tool of commissioning, is vital to the planning and understanding of how local health services should be delivered.

Without understanding the local health gap, we will not be able to meet the challenges of closing it – nor to make the business case for investment in preventative care that will have a longer-term economic payback, but more importantly, improve the quality of life and life chances of those who need services most.

Data sits at the heart of all of this. Yet data on its own is neutral – it is the information we gain from it and the plans that result from that information that will make a difference.

Tightening economic climate

It will not have escaped anyone's attention that various national and international economic factors are slowing the UK GDP and thus tax revenue. As yet, the extent and magnitude of this are unpredictable.

However, the implications for all involved in health services

are clear. We are now in the era of lower growth on health spending. If efforts to improve health upstream of healthcare do not succeed, we will carry on heading towards what Derek Wanless defined as 'no progress / slow uptake' in his key 2002 healthcare funding reports for the then-chancellor and now PM Gordon Brown.

Spending our way out of trouble on healthcare could be unaffordable if we do not get serious about really using the potential of commissioning right now, today.

It can be done

Yet the report shows good news stories to celebrate. Noting its higher-than-average smoking rates, Sunderland PCT employed a midwife to set up smoking cessation services.

Using social marketing-type research and working with a specialist nurse advisor funded by Sure Start, Sunderland has seen the number of non-smoking pregnant women increase from 62% in 2004-5 to 77% in 2006-7.

Tameside Metropolitan Borough Council, which employs 9,000 people, had average sickness absence rates of 13 days (per employee per year) in 2001, making them 25th of the 36 metropolitan councils.

Yet through addressing this by a combination of new absence management standards and health promotion, they are now down to an average figure of 8.9 days – a 1/3 improvement, saving £1.5 million over three years.

All these success stories reflect methods that fit under the commissioning umbrella: finding a problem, deciding to fix it and following it through.

A velvet revolution for commissioning



Nigel Edwards, director of policy, NHS Confederation

Interview by Andy Cowper,
editor, *Commissioning Health*

How do you perceive current progress on commissioning?

NE: “Commissioning is the latest piece in a jigsaw of reform strategies which aim to improve NHS performance. As well as considering how commissioning should be introduced and quality-checked, we need to look at some broader principles of change management.

“I was reminded of this in a recent presentation by Danny Ertel of the Harvard Negotiation Team about the general issue of change management; the nature of contracts; and good long-term relationships.

“If our commissioning model leans too heavily on the primacy of the contract, we could miss the importance of high-quality relationships in the system.

“Getting the signature on the contract is not a ‘zero-sum’ game. What matters is subtle stuff about negotiation and relationships: these are the biggest challenges. Technical tools about data and measurement undoubtedly matter, but healthy relationships in the system are fundamental”.

So how can those relationships be built or sustained?

NE: “Relationship management is an interesting area. The pedigree of NHS relationship management with the IT and construction industries is not really thoroughbred (and relationships with internal NHS suppliers can be even worse). These are big issues to address, before we even get to commissioning and contracting”.

In practical terms, what are the implications of that?

NE: “There are sets of technical issues and relationship issues. In technical terms, it’s vital to be crystal clear what we want to commission. That doesn’t just involve the commissioner: they need to broker the deal with all the stakeholders - which includes providers, who do have some role in crafting the answer.

“Then in relationship management, it’s about a set of things being done to develop trust. Over and above signing the contract documents, this is about being systematic about risks; talking candidly and properly; and crucially about finding some methods other than simple incentives to get things done. We need other methods to ensure success.

“Developing trust takes time and consistency. It involves all parties getting over their fears about the others taking advantage.

“It means becoming less

short-term about strategy, and more flexible. It certainly needs to involve less bureaucratic procurement processes than are the norm in the public sector.

“Trust can easily be wrecked by short-term opportunism. If a commissioner is offered an innovative provision option, and then turns it into a tender and asks others to bid, that commissioner will (and deserves to) get found out and get a bad name”.

What else do we need to remember about the introduction of a new process like commissioning?

NE: “We need to beware of a well-established tendency to grab one policymaking instrument or tool (like commissioning), and to herald it as ‘The Answer’. NHS reform needs a balance of regulation, innovative providers, and financing and capital project reforms.

“Commissioning can help us address how primary care works with secondary care and look at contracts, quality and what’s on offer. It’s an important part of the mix, but we need to develop other parts of organisations as well”.

‘If our commissioning model leans too heavily on the contract, we could miss the importance of high-quality relationships in the system’

Commissioning and regulation: on the emerging



Adrian Masters, director of strategy, Monitor

We already know that commissioning is a policy priority. More than this, at Monitor we believe that it's essential for the future development of foundation trusts (FTs) to get commissioning right.

Commissioning is part of a package of reforms. The main aim of the package (sometimes called 'system reform') is to move the NHS on from being a centrally line-managed monolithic structure to becoming an organisation with a purchaser-provider split, with the commissioning role done by PCTs and PBC consortia choosing from a range of autonomous providers.

For the whole package of reforms to succeed, both commissioners and autonomous providers - like the FTs that we authorise and regulate - have to be working well.

Value for money

A key issue for the NHS over the next five years is how to get better value for money for the huge extra spending that began in 2000. Part of this will be improving the

control of costs: using the national tariff and stronger financial structures, both within FTs by service-level economics and across the rest of the service.

Yet perhaps the more important aspect of focussing harder on value for money is improving the quality of care commissioned by this spending and getting better quality care over the next five years. The key players in raising quality of care will be the commissioners.

Considering quality

When they're considering quality, a commissioner needs to look at their pattern of expenditure and the pattern of services that result. They have to appraise whether different expenditure would result in better services. Next they have to ask themselves, 'have we got the right providers providing the right pattern of patient care?'

Getting answers to these questions will help commissioners decide to shift their commissioning from poor providers to good ones.

It's about introducing the right incentives - whether that's about going elsewhere if provision is poor, or about incentives for improving quality further if it's already good.

Local knowledge

At Monitor, we have developed a relatively light touch approach to regulating foundation trusts. We prefer to see commissioners and foundation trusts try to resolve issues locally through

their contracts where possible.

However, if commissioners have significant concerns on quality or safety issues at a foundation trust, we want them to tell us. We've recently published a *Briefing For Commissioners* on our website (www.monitor-nhsft.gov.uk), which sets out examples of when we would expect commissioners to contact Monitor. As more FTs are approved, it is important that commissioners in the system provide us with information on serious unresolved quality or safety issues, so that we can address them early.

Monitor's role is to regulate providers, not commissioners. So from our perspective, the system has to get a performance regime for PCTs as commissioners right. Commissioners should be accountable for the absolute quality of care and rate of improvement in quality of care of the services they commission.

Quality of care

We need a performance regime based on the quality of the care commissioned. A commissioner's job is not to prop up poorly-performing providers; it's to get the best quality for their population, within their budget.

Doing this will take real effort

'The key players in raising the quality of care will be the commissioners'

challenges of a developing field

'If commissioning works well, FTs should receive more demands related to the quality of their service.'

'On the whole, providers don't feel that pressure yet'

over the next three to four years, measuring and reporting the quality of care in the system much better than is currently the case.

It's about getting the right quality measures of performance by providers, both at absolute and comparative levels.

Leading on quality metrics

There are obvious roles for the new Care Quality Commission in 2009, and indeed for providers, but leading on metrics and standards is best done close to commissioners.

At Monitor we've been very impressed with Sir Bruce Keogh's work on quality metrics and standards. We welcomed the Government's announcement that it was expanding Sir Bruce's work with cardiothoracic surgeons by preparing to publish mortality rates for NHS providers across a range of procedures.

This will improve transparency on quality and performance, so

but it will arm them with good evidence against which they can commission.

Capacity and capability

All this will require significant investment in commissioning skills, and crucially access to clinical skills to look at the right evidence, and choose appropriate incentives and quality providers.

It includes a number of different skills – risk analysis, health economics, procurement expertise, and data management.

Do we have the expertise for all this? Generally, are we taking the task of building this capability seriously enough? PCTs may have become reluctant to invest in this capacity and capability after the past couple of years of being forcefully told to cut administrative costs. Maybe the DH need some demonstration sites, to put in place the commissioner of the future, with endorsed models of resource use, systems, and people

people can make informed commissioning decisions.

Just like data on outcomes, commissioners need evidence about good-practice patterns of care – and about interventions and care pathways that work. That needs to feed into contracts.

It will require real effort to package this for commissioners in a usable format,

- a 'permission to spend'.

Commissioning will be working when clinicians develop the commissioning specifications of what PBC consortia and PCTs want their providers to do. That will make FTs' job more challenging - and it should.

If commissioning works well, FTs should receive more demands from commissioners related to their quality of service. That's what we need. On the whole, providers don't feel that pressure yet.

Time to start delivering

We're a year into the World-Class Commissioning programme, and now the Darzi clinical vision for the future in each SHA is here.

Commissioners have to get those ideas from the Darzi process into their commissioning plans for the 2009-10 annual cycle between now and Christmas, to get quality improving ideas into those commission plans. Otherwise, it'll be another year till we see really significant improvements in the commissioning process.

Evidence from this year's commissioning round showed the process becoming more professional, but this coming year I think we have to see some significant improvement.

If I were a commissioner, and working through the process of the local clinical vision for the 2009-10 commissioning plan with my SHA, I'd seek three or four ideas where we can prove real measurable improvements in the quality of care to demonstrate delivery for the population and patients.

Once the commissioning intentions are clear, we can look to the providers to respond with investment plans.

Practical integration of commissioning: where to start and where to go



**Jennifer Dixon, Director,
Nuffield Trust**

Recent policy papers (Ham 2008) have raised the issue of integrating commissioning between providers and commissioners. But is it right to integrate commissioners with providers?

Some have argued - myself included (Dixon 2007) - that NHS commissioning is so endemically weak and the distance to becoming 'world-class' is so huge that NHS commissioners really can't get ahead of their providers, stay current and commission intelligently. If you accept this, then united commissioner-providers ('payer-providers', in US terminology) may have a lot to recommend them.

If the Darzi Review introduces pilots of integrated care organisations (ICOs) as we expect, it looks unlikely that these will get far without support from PCT commissioners. I can't imagine

'If commissioning is endemically weak, united commissioner-providers may have a lot to recommend them'

any ICO pilot operating independently of the local PBC consortia or the PCT.

A role for FTs?

Alternatively a fully-formed, entrepreneurial 'go-ahead' foundation trust in the locality could also provide help the ICO to forge ahead and build the new system. But is it an appropriate role for foundation trusts (FTs) to help the new ICOs?

I would say probably yes, although how integrated care develops with strong FT backing will need to be closely watched. FTs will need to convince the system that they are very interested in reducing avoidable admissions, for example.

Slow progress with the FESC

As yet, there hasn't been much deal-making following the Framework for procuring External Support in Commissioning (FESC). I'm not sure whether this is about provider issues or about how parts of the NHS have been dealing with the providers. It could be that parts of the NHS are not developed enough to deal with FESC partners intelligently.

Clearly there is some innate and ingrained conservatism in the NHS, and in many areas, using the private sector remains complete anathema - given any excuse, some people just don't want to use them. I think this might be a significant part of the reason why there's been little movement.

Some FESC providers might offer to participate in a pilot with PCTs or PBC consortia. If so, then this should be welcomed. The Nuffield Trust is feeding in ideas to

the DH on what the specification for ICO pilots might look like. Risk-sharing could be an option: in the USA, the CSS Medicare-Medicaid project involved shared financial risk across the whole pilot, including on managing long-term conditions.

Technical aspects such as how much financial risk should the pilots bear and whether budgets will be hard (i.e. real) or soft have got to be made clearer. Many of these relate to the accuracy or otherwise of the method of current resource allocation to practices and PBC consortia - and questions of how much financial risk to bear can be answered empirically through statistical modelling.

On integration

ICOs may be useful to pilot to help developing more sophisticated intra-organisational incentives to help boost performance across a range of areas. These might be budgetary incentives to integrate more fully; or efficiency incentives for activity in terms of quantity - and importantly quality; or peer review and feedback incentives.

But they are still having to be embedded in a nationally set organisation with externally set incentives (such as central directives, regulation, competition and choice).

We do not know the best balance of competition, regulation, and central command: whether, for example, ICOs will only work best within a market with competition; or whether they can work in a system where the chief levers to increased performance are via public reporting and comparison of outcomes - processes which a harder-nosed new regulator might run.

References for this article available online

What the NHS can learn from local authorities about commissioning



Nick Goodwin, senior fellow in health policy, Kings Fund

Commissioning has been the weakest link in the English NHS since the inception of the internal market in the 1990s. Despite a history of overwhelming underachievement, the drive for greater choice, value for money, and alternative care deliverers means that effective commissioning is firmly centre-stage.

Why has the commissioning function remained so ineffective? The first argument is that commissioning has never been allowed to reach full maturity.

The lack of management expertise and commissioning skills within PCTs has been acute. Inflexibility in the rules allowing PCTs to employ more than a basic skeleton staff has meant inadequate capacity. Data sources and IT systems on which to base sound commissioning decisions have been lacking; and the clinical leadership so important in service redesign and purchaser-provider negotiations has been, at best, patchy. Continual structural reforms within the NHS have also taken a significant toll.

The lack of a truly contestable market in healthcare underscores the second argument - that inherent difficulties exist in the purchasing of health services in publicly-financed health systems.

Professor Chris Ham's recent

review of international experiences shows that in no healthcare system where the roles of commissioner and provider are separated does the function work well.

Large providers, for example, easily dominate the relationship due to the information 'asymmetry' between buyer and seller. The difficulty in defining complex health services in clear contractual terms (and by implication, in terms of performance review) also limits effective procurement practices.

Skills and competencies

The current world-class commissioning policy in England represents the most concerted attempt yet to address the first of these two problems, by concentrating on investing in the necessary skills and competencies fit for the task.

The policy also implores commissioners to begin to address the second problem through market management, to help stimulate patient choice and contestability as well as achieving value for money to ensure 'financial health' in budgetary expenditure.

Most of this agenda remains foreign territory for 'traditional' NHS commissioners; yet PCTs will soon be held to account for delivering the core competencies of the policy or face the threat of 'externalisation' to the private sector.

Since social services departments have substantial experience in managing cash-limited budgets and also in procuring services from a mixed economy of providers, it would seem apposite to take lessons from their experience. Specific areas would include their experience in evolving from providing to com-

missioning organisations, including issues such as compulsory competitive tendering; contracting out; the mechanics of market management; and achieving value-for-money through effective procurement and outsourcing of business-support services.

Given the current lack of progress with implementing practice-based commissioning, lessons from the devolution of budgets and decision-making responsibilities by local authorities to neighbourhoods and communities also seems a rich seam of knowledge to tap, especially on governance issues associated with such models.

Moreover, as individual budgets and direct payments enter the health care agenda, lessons on how to manage their uptake to fit with wider strategic commissioning priorities seem important.

Current emphasis on separating NHS commissioning from provision has also dovetailed with the perceived lack of locally democratic accountability in the way health services are delivered. This has led some commentators, including the Liberal Democrats, to debate whether health care commissioning should be transferred wholesale to local government control.

The merits of this are deeply debated but a new and deeper relationship between local government and PCTs over commissioning is clearly desirable, even essential.

References for this article available online

'inherent difficulties exist in purchasing health services in publicly-financed systems'

Escalating commissioning, and at the same time,



**Dr David Jenner GP,
PBC lead, NHS Alliance**

Lord Darzi's *Next Stage Review* is nearing its conclusion, and many strategic health authorities (SHAs) have already released their reports.

Unfortunately, however, commissioning in general, and practice-based commissioning (PBC) in particular, have not felt central in these documents.

How local is local?

Lord Darzi has set out his mantra for change in '*NHS Next Stage Review - Leading Local Change*': that it should be "clinically driven and locally led".

It's hard to disagree with that, but what might be helpful is a clear definition of what he, and the DH, mean by local.

'Any escalator of freedoms needs to engage all the local primary care clinicians who've got involved in PBC'

Because there are different kinds of local. There's local as in PBC consortia-type local; and then there's local as in SHA-type local. And by 'clinically led', does the good Lord mean PBC consortia clinical leads - or two or three clinicians on a Darzi panel in each SHA?

If ten SHAs cover the whole of England, it's reasonable to question how local they really are - and whether such big organisations are looking up to Whitehall, or looking out to their communities.

The focus on health improvement in the Darzi reports by SHA is, of course, laudable. Likewise the repeated emphasis of ministers and the DH World-Class Commissioning (WCC) team that PBC is 'here to stay'.

We need to ensure that we are clear on the leading role that PBC must play in commissioning; and that 'here to stay' is not a euphemism for 'an unwelcome guest'.

More freedom for better commissioners

The announcement of the new WCC assurance framework has come with the implication that better-performing commissioners may win some 'freedoms' (as foundation trusts do).

How could this improve matters and ensure that PBC is central to a definition of world-class?

Any escalator of freedoms with increased responsibility for top performers needs to engage all the local primary care clinicians who are enthusiasts for commission-

ing: the people who've shown faith and got involved in PBC consortia.

These are the GPs whose decisions allocate resources, and who will be crucial to making commissioning meaningful - which means locally responsive to health needs.

A simple question for the new assurance panels

There is a simple question that the SHA-chaired and convened assurance panels who will assess every PCT's commissioning capacity and capability could add into their process.

It is this: 'how can you demonstrate the ongoing participation and partnership of your locality's PBC consortia in your commissioning plans?'

PBC consortia feedback

Feedback from local PBC consortia should be mandatory as part of the PCT commissioning assessment, not optional.

The new commissioning assurance guidance outlines the possibility that PBC consortia could be the nominated partners in the PCT appraisal.

It is imperative that PBC consortia leads as partners are invited into and help inform the self-assessment part of the appraisal process

An enormous benefit of the world-class commissioning movement is the increased focus on health outcomes.

However, the assurance process for PCT commissioning potentially looks like it might become an industry in itself.

We need to be careful that we avoid putting more energy into the new assurance mechanism than we are putting into good patient care, building good relationships and ensuring good commissioning.

e, keeping it local

Commissioning to transform day and vocational services

Targets: an end and a beginning

The DH has promised us no new central targets, and again that's something of which we can be glad. We therefore need to avoid SHAs stepping into the breach to set new targets. Unfortunately, their Darzi reviews seem to have effectively created 10 different sets of new targets.

This may be in line with *Shifting The Balance Of Power* policy objectives to move to 80% of targets set locally by 2008, but it's essential that local targets are truly owned by the front-line clinicians and commissioners who will have to deliver them.

SHAs could go two ways

At best, SHAs will now take on the role of ensuring PCTs give the necessary support to local PBC consortia to respond to local health needs assessments, with innovative and challenging commissioning plans.

At worst, we could see SHAs colluding with PCTs to avoid consulting with PBC consortia as partners in the assessment process, and relying on more familiar allies in other NHS or local government organisations to feed back on their performance.

These and many other ideas will be under discussion at our conference '*PBC post-Darzi – refreshed, revived, relaunched*' on 17 July in London (see www.nhsalliancepbc2008.co.uk), with keynote speaker Health Minister Ben Bradshaw. This event is specially timed to capture the latest DH guidance from ministers, whom we believe sincerely support the concept of PBC. We hope that their support can encourage more action.

Alan Johnson, Ara Darzi and Andrew Lansley all tell us that 'PBC is here to stay', but it would be better if it were going somewhere.



Helen Lockett, R&D manager, Sainsbury Centre for Mental Health

Social contacts and being in work are good for health, and play an especially important part in recovery from mental ill-health. Yet people with mental health problems experience high levels of social isolation and unemployment. Late last year, improving employment rates among people with severe and enduring mental health problems was included in the Government's new Public Service Agreement delivery targets, making it government policy to give people with mental health problems an equal chance of achieving their ambitions in life.

Research has consistently shown both that most people who have periods of mental ill-health would like to work and that diagnosis or severity of illness are not predictors of employability. Anyone with a mental health problem can work if they have the belief in themselves and effective, ongoing support.

Adult mental health day and vocational services are crucial to give people a realistic chance of achieving their hopes and aspirations and of participating fully in their communities. Too often they are under-achieving in that regard despite costing over £150 million a year (Lockett et al, 2008).

What day and vocational

services should look like is clear. There is a readily available international evidence base that the individual placement and support (IPS) approach is the most effective method of employment support (see www.scmh.org.uk/employment/services.aspx). DH guidance is also available on how day services should now look.

Commissioners must lead the way in hearing what people want from services and driving the changes needed. But facing conflicting questions and polarised perspectives on existing services, commissioners have both a dilemma and a challenge.

How do they build on and change the configuration of services to meet both current needs and future aspirations in the absence of appreciable amounts of new money?

Sainsbury Centre has worked with PCTs and local authorities to help them to make radical changes to the day and vocational services they commission. The lessons of that experience are brought together in a new SCMH guide, *About Time* (Lockett et al, 2008). It shows, for example, that people who use services (and some of those who don't) should be involved actively as equals, at all stages of the commissioning process. This is crucial to create services that people want and that offer genuine choices.

Modernising day and vocational services is not easy. It can mean de-commissioning services that do not meet people's needs, and transferring some statutory services into the voluntary sector or to become social firms. But we have now shown that the re-commissioning process can make a real difference to people's lives.

That opportunity should be ignored no longer.

www.scmh.org.uk/employment

The Maynard Doctrine: how HES, PLIC and PROMs spell out effective commissioning

Alan Maynard is professor of health economics at the University of York



NHS primary care trusts, like health authorities before them, have proved themselves feeble purchasers. The Blair solution was to throw money at them - much of which, due to Whitehall negligence, went on pay inflation rather than service improvements for patients.

The Brown solution is 'World Class Commissioning' with a dose of Darzi word-storm and the nonsense of a NHS 'constitution'. However, if we strip away the rhetoric and evidence-free optimism of its proponents, is there a hint of good sense here?

Successful policy by accident?

Almost inadvertently, Whitehall policy wonks may be creating the building blocks for improved NHS efficiency. Achieving greater efficiency requires measurement of the costs and benefits of clinical practice.

Activity data, through Hospital Episodes Statistics (HES), have been collected and systematically ignored for decades. But slowly, commissioners and providers are realising the potential of analysing comparative activity data. Outlier or unproductive consultants can be identified and action taken to increase their activity.

Payment By Results (PbR) is payment for activity, and has little to do with efficiency. However PbR has focused attention on variations in cost and created recognition of the potential benefits of PLICs i.e. patient level information on costs. Soon, comparative patient level costing will begin to emerge by speciality.

A stroll along the PROM

With little overt public enthusiasm, ministers have approved NHS investment in patient-reported outcome measures (PROMs). Such data have the potential to illuminate whether healthcare improves patient well-being. This remarkable notion may enable the NHS to demonstrate finally whether, in Florence Nightingale's words, it does the patients no harm!

The combination of HES activity data, PLIC cost data and PROMs outcomes data has the potential to make providers more transparent and accountable. Why would a commissioner purchase from a high-cost, poor-outcome provider? If provider outcomes are poor, the commissioner could either shift their contract or pay below tariff. Hopefully, this would incentivise provider efficiency.

What are the challenges inherent in progressing to this nirvana? Firstly, there is the risk of data capture by defensive medical practitioners. The Royal College of Surgeons supports investment in PROMs; but how will it manage the relatively poor clinicians who will be identified by outcome measurement? There is an urgent need for investment in the management of the use of comparative activity, cost and outcomes data at the local level.

For the professions to use these data sensitively and rigorously, considerable investment in analytical capacity will be required. Managers and doctors generally do not have the skills to interrogate the emerging NHS data storm. Failure to invest in such skills in a timely manner will put organisations at a competitive disadvantage. The days of the administrators are numbered, as management inevitably becomes more complex and technical.

The building blocks for effective NHS reform are emerging after 60 years of wearying and inefficient reorganisations. Hopefully the NHS can be translated into a more transparent machine which is more accountable to the taxpayer, as well as producing observable excellence in patient care.

Acknowledgements

Commissioning Health is written, edited, produced and published by Andy Cowper, in association with joint sponsors BUPA Commissioning and NHS Alliance. *Commissioning Health* is distributed free of charge as an information resource to help the development of commissioning in the UK.

All material herein is © copyright 2007 and 2008: all rights reserved worldwide. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording, or otherwise without written permission of the publisher. To request extra copies, or for permission to reproduce this publication or any aspect thereof, please e-mail andycowper@hotmail.com

The contents reflect the views of the named authors, and not necessarily those of the editor, BUPA Commissioning or NHS Alliance. All information herein is correct at the time of going to press to the best of our knowledge. No liability will be accepted by the publishers and sponsors of *Commissioning Health* for any offence, distress, decisions or losses that individuals or organisations may experience as a result. Have a nice day.

www.commissioninghealth.com