Commissioning Health

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Ben Bradshaw MP is Health Minister

Guest Editorial - Ben Bradshaw MP

I'm delighted to have this opportunity to write the guest editorial in this second edition of *Commissioning Health.*

We know that there have been impressive improvements in the health and care service in England. Waiting lists have dramatically reduced. Mortality rates from cancer are down by 17%; from cardiovascular diseases by 35%. There are nearly 80,000 more nurses and 35,000 more doctors than there were in 1997. A recent Healthcare Commission survey showed that 92% of inpatients considered that their care was either "excellent, very good or good".

As NHS leaders and commissioners, you have made an important contribution to these survey results and to the steady improvements that we have seen in the NHS over the past decade. With this additional capacity in the service, and a settled structure, it is now possible to move to the next stage of the transformation of the NHS – by concentrating all our attention on improving quality.

In recent months, Lord Darzi and his team have spoken to thousands of people who work in and use the service. A new vision is emerging of an NHS based around four over-arching themes: fairness, personalisation, safety and innovation. These four themes offer a clear framework for the development of a world-class health service that reflects the needs and priorities of the public it serves.

World Class Commissioning, with practice based commissioning at its heart, will be the underpinning delivery vehicle for the achievement of world-class clinical services and a world-class NHS. PCT commissioners, together with their partners - including practice based commissioners, local authorities, private and third sector providers, patients and the public - will be the key enablers of the four themes outlined by Lord Darzi and the overall improvements that we want to see across the service.

I want to be clear that World Class Commissioning is not an end in itself. To prove themselves successful, commissioners will need to demonstrate better outcomes for people and communities. PCTs will need a clear local vision of what they want to achieve, and use commissioning as the means of achievement.

In his article on page 2, our Director General of Commissioning and System Management Mark Britnell outlines the progress we are making on articulating the vision and organisational competencies for World Class Commissioning. It is important for PCTs to be held to account for how they commission on behalf of their local population, and they will need to access support and development that will be put in place to enable them to do this.

World Class Commissioning is one of the important keys to unlocking so many of our policy aspirations: tackling health inequalities; and shaping a health service in which the emphasis moves much further towards investing in health and well-being, joining up public health, mental health and adult social care much more closely.

The NHS has been seen as a service for the sick: we want it to become a 'keep well' service. I hope that we can continue to work closely together to deliver these shared objectives.

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BUPA Commissioning

World Class Commissioning - realising the vision for adding years

Mark Britnell is Director General of Commissioning and System Management, Department of Health

Working closely with local partners, the Department of Health is in the final stages of preparing its vision for World Class Commissioning. The document will set out what it means to be world-class, 'adding life to years and years to life', and will identify a set of organisational competencies that primary care trusts (PCTs) will need to achieve this.

World Class Commissioning will dramatically transform the way we commission health and care services in this country.

Back to black

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.

This focus on health and well-being sits at the heart of World Class Commissioning.

Ultimately, World Class Commissioning will deliver better health and well-being for all; better care for all; and better value for all.

The nature of demography, lifestyles and disease are changing, requiring new focus on long-term conditions, lifestyle consumption and an ageing population.

By delivering a more strategic, long-term and outcome-focussed approach to commissioning services, World Class Commissioning will not only ensure the NHS is able to meet these challenges, but also that it continues to set the benchmark for health and care services all around the world.

Good practice in commissioning

We know that pockets of World Class Commissioning already exist within the NHS, and we already have a lot of good reasons to be proud of what commissioning is already achieving.

Here are just a couple of examples.

Slough Primary Care Trust has developed a technique called 'Health Needs Mapping', using complex data to ensure that they fully meet the needs of their local population: pinpointing precise postcodes which require special intervention, enabling them to reach the local South Asian population in particular.

Meanwhile, Heywood, Middleton and Rochdale PCTs have joined forces with Sport England and the Big Lottery Fund to regenerate sports facilities in the community, supporting the long-term shift from diagnosis and treatment, to prevention and the promotion of well-being.

The next step, and aim of the World Class Commissioning programme, is to ensure commissioners systematically develop a world-class approach in everything they do.

The competencies will give a clear picture of what a world-class organisation will look like - such as demonstrating excellence in leadership, engagement, knowledge management and strategy development.

Commissioners will also need outstanding negotiating, contracting, financial and performance management skills.

PCTs will lead the work to turn the World Class Commissioning vision into a reality, and to apply it locally in a way that ensures the needs and priorities of their local population are being met.

However, I must stress that World Class Commissioning cannot be achieved by PCTs working in isolation. Successful PCTs will form close links with local partners including patients, the public, local authorities, clinicians and providers.

> *'Practice-Based Commissioning in particular sits at the heart of World Class Commissioning'*

Together, they will need to make tough choices on priorities and how best to deliver them.

In particular, there needs to be an open flow of communication between PCTs and their clinical partners.

Clinicians are central

Clinicians have a vital role to play in commissioning. They are closely involved in assessing local needs and shaping priorities and their professional experience of delivering care, combined with their understanding of patient needs will be crucial to designing and developing future health and care services.

Practice-Based Commissioning (PBC) in particular, sits at the heart of World Class Commissioning.

It will play a key role when it comes to defining clinical outcomes; assessing provider performance; and in some cases, delivering personalised local services.

Assurance system

In addition to the vision document, we are also developing an assurance system that will drive performance and development, and reward commissioners as they move towards world-class status.

The key principals of this are that there will be one national system, which will be developmental and strategic health authority (SHA)-led. It is likely that the system will involve some self-assessment and some peer-review, as well as some hard metrics that will be monitored by SHAs.

As with all elements of the World Class Commissioning programme, we are working closely with key NHS partners to make sure we get a system that is both effective and practical to implement.

The extent of change required will vary by PCT depending on current performance levels. What is important is that PCTs feel they have the support and tools they need to make the shift to world-class.

Support and development

The final element of the World Class Commissioning programme, a Support and Development Framework, is designed to do just that.

The Framework, which will be available early in 2008, will provide commissioners with the tools they need to drive improvements - either by sharing services and good practice; developing internal resources; or by buying in external expertise.

This is an exciting time for commissioners of health and care services within the NHS.

By implementing World Class Commissioning, they will directly impact the health and well-being of their local population and ensure the NHS remains one of the most progressive and high-performing health systems in the world.

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning

How commissioning is already improving healthcare

Sir Ian Carruthers is chief executive of NHS South West Strategic Health Authority

Public satisfaction with existing NHS services in the South West is high by national comparison.

Recent surveys in this area found 90% of patients rating NHS hospitals as 'excellent', 'very good' or 'good'.

91% of patients report that they could get an appointment with a specific general practitioner and 83% described being happy with general practitioner opening hours.

The health of the population in the South West overall is amongst the best nationally.

World-class ambitions

However, these statistics mask significant variation and inequalities in local areas and communities.

Our ambitions for the NHS in the South West is to not only tackle these unacceptable variations in health, quality and safety - but to go well beyond existing national standards and targets, to world-class performance across the region.

Local delivery

It is only at local level that this ambition becomes a reality. Assessing need; developing vision and consensus; and harnessing existing and new organisations into new services are the keys to improvement.

That is what commissioning is about. That is also why the new primary care trusts and practice-based commissioners are being asked to be trusted community leaders, working with their local population, partners and clinicians and leading the NHS locally.

There are encouraging examples of commissioners driving improvements across the South West.

After a period of uncertainty for Cornwall, the new Cornwall and Isles of Scilly PCT listened to almost 1,000 people and 40 special interest groups using innovative 'Question Time' and 'select committee'-type seminars to build consensus around '*A Healthy Future for Cornwall and the Isles of Scilly*', allowing local people to judge how their views are making a difference.

Existing good practice

The practice-based commissioning consortium in Somerset have proposed a series of workstreams to find alternatives to unnecessary emergency admissions.

'Primary Link' enables clinicians to more easily locate both health and social care resources, to help avoid admissions.

In Bridgwater Community Hospital, a clinical assessment and treatment centre offers short-stay assessment and intensive support for returning to independence at home.

In Poole, the NHS Healthcare Centre is moving services closer to home from acute settings. This is seen in practice with their ability to offer services including phlebotomy and echo-cardiography (ECG) in a local shopping centre.

Complementing the development of choice and an increasing range of innovative providers, commissioning is now set to lead the services transformation that local populations need and deserve.

www.southwest.nhs.uk

On sustaining markets for commissioning

Dr Natalie-Jane Macdonald is managing director of BUPA Commissioning

The clock is ticking. While the mechanisms are being put in place at all levels (practice-based commissioning; primary care trusts; strategic health authorities; and the Department of Health) to build the approach to commissioning, the need to make material advances in delivering results from better commissioning is pressing. The sheer scale of the task cannot be underestimated.

Commissioners must be able to achieve material and measurable improvements over the next three years in patient experience, quality of care and value for money. Through clinically intelligent redesign of services, they also have an opportunity to drive forward advances in tackling health inequalities across local communities.

There are many critical requirements to do this. A few are particularly important. The first is to break the age-old link embedded in the NHS between the acuity of a patient's condition and the place of service.

Much of the value to be unlocked is in the hospital setting, where there is a strong link between acuity and cost. Implicit in achieving this is for commissioners to have much more mature contractual relationships with acute trusts.

The second requirement is to recognise that commissioning requires proper investment to become world-class. A lack of commissioning expertise at local level is mirrored by a paucity of investment. The level of investment in commissioning may indicate the level of local commitment to making commissioning work.

'The language of commissioning suggests common purpose. However, there is real potential for conflict among the different commissioning organisations and approaches.'

And thirdly, the language of commissioning suggests common purpose. However, there is real potential for conflict among the different commissioning organisations and approaches.

Practice-based commissioners want to drive improvements for their own patients and widen the scope of services that they deliver in primary care. Commissioning hubs want to achieve economies of scale by providing brokerage for PCTs. Strategic health authorities want to achieve more effective commissioning while retaining financial balance.

All these aims are legitimate and logical. Yet we will do well to be aware of the potential for problems; not least the risk of trying to undertake so many initiatives simultaneously without clear prioritisation and programme execution that participants drown in activity.

The framework for external support in commissioning (FESC) has been suggested as a key vehicle to drive progress, but it is unlikely to be so in the medium term. The timescale from initiation to contract signature is likely to be many months, and the framework will be limited to pilot initiatives for some time.

Commissioners will therefore need to consider other, quicker means for engaging third party organisations to work with them if they decide this is what they need.

Whether it is through the FESC or other means, independent commissioning organisations need to build confidence by showing how we add demonstrable value for the commissioning services we sell.

Equally, NHS customers need to work with us to build mature and stable relationships, which work for both parties.

Rome wasn't built in a day and commissioning won't be either. However, we need to ensure that bureaucracy and process is at a level appropriate to ensure governance - but one that doesn't get in the way of NHS commissioners delivering the changes needed.

More, better data - and real budget pilots?

Dr Michael Dixon GP is chair of NHS Alliance

When it comes to front-line service delivery, commissioning has changed a lot in some places, but very little in others. Why is this?

Probably because to date, PCTs have lacked the information and firepower of acute providers - and also lacked a commissioning mechanism to enable them to become sharp-edged commissioners. That's about to change.

Risks of macho commissioning

However, there are real dangers in 'macho' commissioning. We need the grit that makes the pearl. Yet we also need to distinguish between going out to tender and exerting better pressure on current providers, which in recent years, we've failed to do.

To exert meaningful pressure, what we need is:

1. Timely information on services used and discharge summaries;
2. Robust discussions between primary care and secondary care clinicians and managers over the services we want to see and the challenges we want to address to current practice;
3. A redesign plan for primary and secondary care services; and
4. To ensure that we're getting our sums right on costs of care and the use of care in terms of demand management.

The first stage in commissioning is to ensure that local providers are committed towards improvement, and all going the same way.

We must then assess gaps in provision, if current providers are not listening or can't pass muster – by all means, we should tender for these.

Re-tender with care

However, re-tendering should be our weapon of last resort. Experience suggests we shouldn't use it unless we know what we want to improve, and what we want instead.

There's also lots of time and expense in any tender. Commissioning needs to be about improving and redesigning things; not tenders, takeovers and the rest.

Data fit for purpose

In too many cases, the data being provided for practice-based commissioning (PBC) is not fit for purpose, as our report in May with the King's Fund showed - and others since have also confirmed.

It's not just about the right data; it's about the right data in usable form so you can change behaviour in referrals and use of diagnostics, and properly check that you've got what you paid for.

I think that lots of progress is now being made in regard of these data needs.

Moreover, this is an area where private providers can be helpful - provided that they remain the servants of this process, and don't become the masters.

Several of the companies on the FESC have experience and know-how which could help PCTs to speed up commissioning in terms of the ability to access the right information for themselves and their local practice-based commissioners.

In my role as a PBC adviser to the Darzi strategy, I'm keen to establish pilots, maybe across an SHA of advanced PBC consortia with real budgets for things like elective and unscheduled care. Such a health economy-wide model could take commissioning forward quicker. It could look like a specialist sub-group of HMO-type integrated primary care and secondary care, and could commission the rest of the services that it doesn't provide from wherever needed.

There's an unwelcome element of stasis in PBC. Good things are going on everywhere, but there's no concerted push to give the body and profile needed to fully establish PBC.

> ***'It's about the right data in usable form, so you can change behaviour in referrals and use of diagnostics, and check that you've got what you paid for.'***

Towards active commissioning and real choices (

Dr Richard Lewis is a senior associate at the Kings Fund and director of health sector work, Ernst and Young

Active commissioning is by no means happening everywhere yet - but if you look hard enough, you can find it.

However, NHS commissioning generally remains relatively basic and reactive. And the skills needed for successful commissioning are not rudimentary!

Of finance and control

Primary care trusts (PCTs) are using commissioning to try to balance their finances and control their providers, with varying success. However, in many places, if providers don't see commissioning as irrelevant to them, they certainly perceive it as little more than an inconvenience.

Some very competent commissioners are going way beyond reactive commissioning, and trying to set health improvement agendas and to understand their populations' wants.

Social marketing tailored to the local population's world view can make them more likely to use services and help providers to understand what their population wants.

What patients want

PCTs may find that patients are already pretty clear about what they want, especially in those parts of the NHS with which they are very familiar. Better access to primary care is a prime example of this.

The lifestyle fit

As people are more demanding (or even consumerist), their healthcare should fit their lives and lifestyles.

I also think that in relation to this, we should rehabilitate the notion of healthcare wants.

Commissioning in the 1990s was about scarcity, and that led to many people developing a scathing view of healthcare wants as a scurrilous waste of money. Patient wants can be perfectly legitimate, in the context of prioritisation.

But commissioning can address this through greater attention to how patients can access services, and by ensuring that their desires are met.

It comes down to newer facets of delivering healthcare. Good commissioning can create and hold to account a market, within which a great variety of communities can recognise high-quality care

> *'NHS commissioning remains relatively reactive and basic.'*

Commissioners have to reflect demand, but also to shape it – these run together. Commissioning can help shape and alter the demand curve: influence patients to demand certain types of services – in particular upstream care such as lifestyle advice, health promotion and disease prevention.

PCTs need to understand in far greater detail what is acceptable and desirable to different patient groups – and to do this not through the traditional, little-attended large consultative events or asking local providers, but by using market segmentation and more sophisticated surveys and focus groups.

Making the market, and shaping supply

There will be no real commissioning unless markets provide commissioners with real choices. Otherwise, it's really just planning in a vertically-integrated system.

I see the market in healthcare as a reality, and I don't expect the Brown Government to step back from it.

We should probably ask whether the market should be 'red in tooth and claw' or tepid? In the 1990s, the radical market dreams under GP fundholding and new NHS Trusts very soon became tempered, then fossilised and were eventually put aside.

That could happen again, but some of the legislative architecture that's been put in place would require a very public recantation of market mechanisms by the Government, of a kind that I don't expect.

The logic of market mechanisms that's been publicly stated in various policy documents is difficult to wish away. And there's an extraordinary

(and why you might keep some capacity in-house)

> *'Smart PCTs might build their own commissioning skills on the back of the FESC, enabling them to take commissioning back in-house if necessary, or even to franchise their skills.'*

consensus among the main political parties that this is the right way to go.

PCTs then need to bring about a market that can meet those complex needs by shaping supply.

Pre-choice PCT commissioning brings to mind First World War generals moving resources around with a long stick on a boardmap of the battlefield.

For some services outside the choice agenda (specialist services, mental heath, tertiary care), that old-school centralised planning may remain appropriate.

The new game in town is to use more subtle commissioning arts to secure a supply in the image of what consumers want.

This clearly requires more than simply signing off contracts for pre-determined volumes, as PCTs traditionally have done with their local providers.

Incentives and accountability

Getting the incentives and the public accountability that goes with it right is daunting, and we're still struggling to understand how to do this within transparent best value regimes.

Scare stories about 'NHS privatisation' under the framework for procuring external support for commissioning (FESC) are far-fetched.

However, I also think it's wrong to see FESC as the only game in town – even though some PCT chief executives may think, 'if I want to be seen as progressive, then I have got to use the FESC'.

Caveat emptor

The NHS should ensure that any skills they buy to support commissioning are suitably advanced, and (if from abroad) appropriately anglicised to suit our system: like all sensible decisions, chief executives and boards have to choose carefully.

Wholesale outsourcing might also say more about failing to invest in developing in-house commissioning, rather than suggesting that the NHS has a second-class cadre of managers who can't learn how to commission.

Trusts might well get better results by investing the sort of money that's likely to be required under the FESC in developing their own commissioning capacity.

To commission support for commissioning, you have to understand the product being offered – as with anything you buy.

Smart PCTs might build their own commissioning skills on the back of the FESC, enabling themselves to take commissioning back in-house if necessary or even to franchise their skills. We must avoid a potential dependency culture.

There are already some exciting examples of PCTs working in concert to get depth and punch in their commissioning, such as the West Midlands Commissioning Business Support Agency.

> *'There will be no real commissioning unless markets provide commissioners with real choices.'*

Reform, inclusion and greater equality - the mental health commissioner's tale

Angela Greatley is chief executive, Sainsburys Centre for Mental Health

The drive for NHS reform affects mental health as much as any other sector of the service. Reform is about commissioning for change; developing voice and choice; dealing with providers old and new; developing new currencies; and working to ensure that the quality of the patient experience is continually improved.

Commissioners must take the lead in hearing what people want from services and driving the changes needed to offer people choice and control in their own care. The mental health National Service Framework gave a blueprint for the basis of what should be provided to the population served by each primary care trust (PCT).

Yet each area has its own population mix. The next decade needs to see commissioners get to grips with the range of service offered, and re-shape them to reflect local need. This will mean new providers doing new things and old providers also doing new things, whilst retaining the improvements brought about by the NSF (and all for limited new money). Commissioners will have to become ever-smarter to drive these changes.

Primary care is playing a greater role in changing mental health care: commissioners are in a key position to influence this development. If the Darzi reform agenda proceeds, mental health cannot be an afterthought in reshaping primary and community services: it must be in the mainstream.

The welcome expansion of talking therapies could see more services delivered in the community. Whilst new money is lovely as it brings an impetus for change, mental health must be part and parcel of the primary care agenda. This includes access to the whole range of therapies in line with NICE guidelines, and ensuring that people with a mix of mental and physical health problems receive the right kind of care.

Commissioners must take responsibility for focussing all of mental health care on helping people to live the lives they want. Employment is important to many people with mental health problems; yet mental health services still struggle to achieve change in day services.

> ***'Commissioners must take responsibility for focusing all of mental healthcare on helping people to live the lives they want.'***

Mental health providers must radically change to reflect the new priority of supporting people to find work and meaningful activity.

Change should not be confined to day services. Every part of the service should measure how well it performs in providing jobs for people with mental health problems, setting up schemes to recruit, retain, and to lead by example. Commissioners can drive this, and recognise these priorities in their contracts with providers.

As practice-based commissioning (PBC) grows, both PCT and practice-based commissioners have to explore new ways of working with other commissioners for social care and employment. Local Strategic Partnerships have a key role in primary care, work and wellbeing, but Local Area Agreements (LAAs) cover large populations. It may be helpful to explore whether at PBC level, there are opportunities for a range of stakeholders to work together at the more local level and to develop 'mini'-LAAs to underpin local agreements.

Some of commissioners' greatest challenges may lie in tackling the worst healthcare inequalities, including inequalities between and within PCTs. Those with mental health problems who become 'caught up' in the criminal justice net are some of the most excluded. Often, they are not in contact with health services, and may suffer serious physical ill health as well as a myriad of mental health difficulties. If PCTs take this population seriously (not easy as they are not the most popular patients, nor seen to be 'deserving'), they will be tackling some of the most serious problems of access and inequality. Those revolving in and out of the criminal justice system are poorly served by primary care and specialist service alike. Their families are also often affected. Here, local strategic partnerships could work together to develop a health & social care framework and to strike agreements over where resources can be invested by each agency to maximum effect. Health commissioners have a key leadership role in these partnerships.

The reform agenda is tough for commissioners, but they have an exciting role in leading and influencing local change.

Case study - commissioning specialist care for diabetes with a toolkit

Bill O' Leary is head of communications, National Diabetes Support Team

Published in 2006, the Diabetes Commissioning Toolkit was a groundbreaking initiative in providing local teams with guidance on 'how to do commissioning', as well as setting quality standards.

It contained a number of steps that, if followed, would lead to a specification for a service that truly met the needs of the local community.

Piloting work

There is always a gap between theory and practice - so three 'early implementer' sites were identified which would pilot the toolkit, see how it worked in practice and report on their experiences.

The sites chosen (Leicester, North-East Manchester and Hereford) had different demographics, prevalence and deprivation.

They were all asked to focus on main areas of the toolkit, including needs analysis, service redesign and eventually procuring the services.

Starting with needs

The first step was a needs analysis that identified the 'who, what, how many, where, when and why' of the areas' diabetes populations.

Susannah Rowles from North East Manchester said, "The project has involved a lot of time and effort, often generating more questions than answers, but it has highlighted areas where focus is needed and also the necessity of multi-disciplinary communication.

"Information is often held by many disparate individuals, and the Toolkit has helped us to link up and share information".

The need for information

The other sites' experiences were very similar: all mentioned that the information needed was often difficult to get and time-consuming to analyse.

The next step is to use the data gathered to start developing a vision of the sort of service that would meet the identified needs. This was done by holding a workshop for all the parties, including patients, who were involved with diabetes.

They were highly successful in getting local support to what was needed and agreement that services had to be remodelled.

Maggie Arter from Hereford said, "It had concerned me that I'd heard from a senior source locally that diabetes 'wasn't on the radar', so for me the aim of the workshop was to ensure diabetes remains a priority.

"The workshop is just the start of the Toolkit process, and worked really well in getting a range of people to talk and agree decisions about services locally.

"It's already had a ripple effect in a positive way. We've had really good feedback from people who attended and commissioners have started working on some of the key priorities we agreed – for example, the insulin pump service".

Nurse-led care

For Bernie Stribling in Leicester, the model of care suggested is based around a nurse-led service. "This means that all referrals would be triaged through nurse clinics. The nurse would then decide where best to see the patient – whether by GP, to patient education, to a medicine use review or a specialist.

"Right now, every secondary care referral gets seen by a doctor. Many of those referred don't need it. The Toolkit showed us where to start. We wouldn't have approached it this way without it as it makes you look at the wider picture."

Spreading the lessons

Because of the commissioning timetable, the work so far has not had an immediate impact on all aspects of what diabetes services are procured.

However, there is no doubt that the lessons learnt in the sites and the experiences they have gained will influence future commissioning decisions - both in their own locality and elsewhere.

In the light of these findings, more work has been done subsequently in order to refine the Toolkit and provide further information on how to use it. These can be seen at **www.diabetes.nhs.uk**

> ***'The lessons learned in the sites and the experiences gained will influence future commissioning decisions.'***

Case study - NICE commissioning guides: commissioning quality care for patients

Annie Coppel is Associate Director (Commissioning), Implementation Directorate, NICE

Most readers are probably aware that the National Institute for Health and Clinical Excellence (NICE) produces national guidance on the promotion of good health and on the prevention and treatment of ill health. Based on the best evidence available, NICE guidance sets the standards for the quality of care that patients should receive.

While most clinicians and other healthcare professionals are likely to have a working knowledge of NICE guidance, commissioners may be less familiar with their content. NICE guidance offers commissioners a useful source of information on the quality of care they should seek to commission for their population.

Recognising that putting guidance into practice is not without its challenges, NICE also publishes a range of practical implementation support tools. While many will be of interest and use to commissioners, a more recent addition to this suite of tools are the NICE commissioning guides - developed specifically to help people involved locally in commissioning high-quality, evidence-based care.

The commissioning guides are web-based resources, underpinned by and supporting the implementation of recommendations in NICE clinical guidelines. Each concentrates on a particular topic, offering practical advice on issues such as local needs assessment and the opportunities for clinical service redesign.

They highlight the key clinical issues and service elements for commissioners to consider, and provide information on assuring service quality. They also offer an indicative benchmark, to help commissioners determine the level of service needed locally.

Relevant sources of useful information are also signposted throughout the guides, directing users to resources for health needs assessment and related policy initiatives.

In each guide, an interactive commissioning tool enables users to estimate and inform the cost of local commissioning decisions.

Registration is required to access the tool, and is currently available to primary care commissioners in England. (Registration gives access to all tools).

These tools help users to: identify local service requirements; review current levels of commissioned activity by providing relevant extracts of Hospital Episode Statistics activity data where relevant and available; identify future change in capacity required using the indicative benchmark provided; model future commissioning intentions and associated costs; and calculate the potential set-up and recurrent costs of services to be directly provided. (**www.nice.co.uk/commissioningguides**)

Commissioners' responses

User feedback on the guides has been very positive since the first five were published.

On average, each guide has received 7,500 user sessions, and 80% of primary care trusts (PCTs) have at least one registered user of the commissioning tools.

One PCT Head of Business Support and Performance called them "an answer to a commissioner's prayer. NICE commissioning guides save a lot of work in scoping the range and quantity of service that needs to be commissioned, and are underpinned by evidence-based clinical guidelines. PCTs can make good use of them in planning and commissioning of services. They present an ideal opportunity to draw together locally the functions of public health, commissioning and quality improvement / clinical governance".

'An interactive tool enables users to estimate and inform the cost of local commissioning decisions.'

What's coming soon?

There will shortly be a new, updated release of the commissioning guides and tools. As well as including the latest data, the tools will provide access to strategic health authority commissioners, letting them view data at PCT level. A new facility will also enable practices within a commissioning group or cluster to give permission to view the data for each others' practices, and to model commissioning intentions for the group. Ten new commissioning guides will also be published over the coming months (which will also be updated annually). Forthcoming topics include cardiac rehabilitation, cognitive behavioural therapy, and bariatric surgery.

NICE is committed to involving end-users in the development of the commissioning guides to ensure they remain fit for purpose. Our Commissioning Reference Panel is an advisory body of volunteer commissioners who contribute to the development and review of commissioning guides, and from whom we can seek *ad hoc* advice.

If you are a PCT or practice-based commissioner; a GP; or involved in commissioning healthcare services in England, we would welcome an expression of interest for membership.

See the NICE website for more details: **www.nice.org.uk**

This article has been slightly abridged for publication. For the full text, see our website www.commissioninghealth.com

Case study: building capacity through community pharmacy

Heidi Wright is Head of Quality Improvement, RPSGB and Gareth Jones is NHS Liaison Manager, National Pharmacy Association

If practice based commissioning (PBC) is to achieve its full potential in delivering high-quality care and choice to patients, and provide value for money, then all healthcare teams should be integrated into the PBC process of planning, redesigning and delivery of services. Identification of local health needs, together with a more diverse provision of care, can be achieved by adopting a multi-disciplinary approach to PBC.

Collaborative working between pharmacy, GPs and primary care trusts (PCTs), for example, will increase capacity to meet demand and create innovative care pathways that best use the skills available at both practice and pharmacy level to its full potential.

The following are some examples of pharmacist involvement in care pathways and service redesign.

Chronic obstructive pulmonary disease (COPD)

Claremont practice in Devon employ a community pharmacist for one day a week to work with COPD patients.

Through domiciliary visits for the severe housebound patients, medication reviews, running COPD clinics and reviewing the COPD register, major savings have been achieved for the practice - as well as better outcomes for patients.

Diagnostic services

In Derwentside PCT, community pharmacists are providing INR services in community pharmacy-based clinics or in a domiciliary setting. This has led to a reduction in ambulance transport costs; an increase in accessibility and capacity of this service; and enables all practices to have access to community based anticoagulant monitoring (a PCT target).

Medicines management

In-depth assessment is used to develop tailored medicines management solutions for vulnerable older people living in the community in Poole. Pharmacists and pharmacy technicians provide intensive support for patients, developing pharmaceutical care plans, which enable patients to administer their own highly complex medical treatments safely.

The service works closely with secondary care to improve the patient experience after discharge and is linked through a Service Level Agreement with local community pharmacies to provide an Enhanced Pharmacy Service. Specialist nurses, GP practices and Social Care are also involved.

Long-term conditions

A practice in Exmouth has employed a pharmacist for one day a week to review certain patients with long-term conditions. Over a year, the contribution of the pharmacist has resulted in an estimated £4,566 being saved on the prescribing budget.

Medicine Use Reviews (MURs)

This is an advanced service under the contractual framework for community pharmacists. In Hampshire and the Isle of Wight, community pharmacists have been requested to use MURs to target patients currently on osteoporosis treatments. The pharmacist checks that the patient is concordant with the medication and discusses intake of calcium via diet or adjunct therapy. The MUR also includes a falls risk assessment. This service has led to an improvement in access, particularly for hard to reach at risk patients and a reduction in falls, emergency admissions and secondary care costs.

Cost minimisation and medicine management in nursing homes

In Havering PCT, a service has been designed to minimise drug wastage for nursing home residents through application of an agreed prescribing policy and structured medicine reviews by a community pharmacist.

The pharmacist identifies clinical and clerical prescribing issues for resident patients, which are then put to the GP for action. This service supports the national service framework for older people and has resulted in a reduction in the number of unnecessary medicines that elderly patients take; an improved quality of life for residents; a reduction in side effects requiring hospitalisation; a reduction in falls. This service has resulted in a 60% reduction in prescribing costs and savings have been used to recruit a GP to look after nursing home patients.

Pharmacists have a role both as local clinicians who can use their expertise to improve decisions on commissioning and redesign of care pathways, and as prospective providers of services.

PBC is not all about competition: providers need to consider that certain service proposals could be better if delivered in collaboration with other professionals. Multi-disciplinary services will need to be discussed fully with all practitioners, and are likely to be more complex to develop; but as well as helping to improve inter-professional relationships, they will potentially lead to better patient outcomes.

Service redesign is a key concept of PBC. It is not all about completely new services. Pharmacy has a major role in the development of care pathways and management of long-term conditions.

Medicines are the end point of many care pathways: as pharmacists are experts in medicines, they need to be involved in the design and delivery of these pathways. Creative use of community pharmacy can also help PCTs delivering the 18-week pathway.

Pharmacists should also be involved in the development and delivery of individual care plans, like the single assessment process.

This article has been slightly abridged for publication. For the full text, see our website www.commissioninghealth.com

Achieving World Class Commissioning

Mike Farrar is chief executive of NHS North West Strategic Health Authority

'World Class Commissioning' is an often-heard phrase nowadays, confirming the new aspirations that the Department of Health has for improving the quality and outcomes of NHS commissioning. It is an aspiration that I wholeheartedly share.

Yet I'm frequently asked whether, if we ever achieve this, that would spell an end to the role of SHAs? In my view, those who ask fundamentally misunderstand the role of an intermediate tier or a 'system management organisation' in a modern world-class health service.

Strategic health authorities (SHAs) are fully signed up to developing excellence in commissioning: indeed, most spend considerable time and resource encouraging such progress. SHAs such as those in London, West Midlands and the North West have all developed incentives and risk-based assessment frameworks, designed to lift the performance of current commissioners by setting higher standards; feeding back on and supporting capability improvements; and rewarding greater success (as defined by setting local return on investment standards with greater autonomy).

The advent of such a system of performance improvement will allow us to assess whether the theoretical policy assumptions that the dynamics created between providers (keen to secure business from patient choice), and their intelligent commissioners will deliver real improvements in quality outcomes and patient experience in practice.

This policy assumption is critical, because we are aware of parts of the world where such devolved systems have prevailed for longer than in the UK - and where on closer inspection, the absence of systems management creates downsides such as a larger gap in the quality spectrum from top to bottom; patients failed by poor-quality providers; and a lack of universal and equitable access to services.

For these reasons, the system management role is so important. The migration of SHAs from 'organisational managers' to 'systems managers' with a strategic role to ensure that the system delivers on Ara Darzi's five key principles (equity, effective-ness, safety, local accountability, and personalised care) is the vehicle to deliver this. And it is the development of World Class Commissioning in primary care trusts that allows SHAs to migrate into this systems management role.

That degree of maturity and excellence in our NHS will tell us when we are succeeding with this aspiration. Only at that stage will commissioners and SHAs alike know if we are truly becoming world-class.

Why some get more than others

David Sharp is Director of Commissioning and Informatics at Derbyshire County PCT

Derbyshire is a diverse county, urban and rural; serving both very affluent and very deprived areas. Our PCT commissioning role requires that we achieve the best possible health outcomes for the people of Derbyshire through the services we buy for them. To do this, we must spend the right and proper amount of our money on the people, districts and care groups who need our services.

The PCT intends to show in its commissioning that it can buy healthcare that meets local needs. To do this, we invest more of our resources in the areas of greatest need. This means that some areas receive a greater share of the overall resource because they need it most. Our population need more for their money, faster.

We expect of our providers no needless death; no needless pain; and no needless wait. Providers are expected and encouraged to try new things - and to do the things they have always been good at even better than before. We believe that informed commissioning delivers a huge mutual benefit to patients and providers. Derbyshire County PCT is an enthusiastic adopter of the NHS contract with providers, which we use to challenge waste and inefficiency. The value of the contract to us is the use of protocol-based prior approval schemes; utilisation reviews; and customer satisfaction surveys to bring benefits to patients.

Independent contractors are a vital part of the local health economy, covering general practice, optometry, dentistry, and community pharmacy. Through effective commissioning, we aim to maximise each of these groups' contribution, to ensure patient access to services at times that are convenient to them. We believe that NHS commissioning can create a fairer, more efficient and effective NHS for the people of Derbyshire that is able to help them to live healthier and longer lives.

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