Commissioning in the new NHS: how to get involved and influence service development

With the coming radical changes in healthcare commissioning, nurses should engage with local plans to develop GP consortia to ensure their voices are heard.

INTRODUCTION
The government’s recent white paper signals radical changes to the way NHS services will be organised (Department of Health, 2010), with commissioning devolved to GP consortia. Nurse involvement will ensure commissioning includes a holistic nursing perspective and that patient services are redesigned and improved.

Commissioning may seem bureaucratic, done by administrators working in isolation from the real world of care. Nurses often struggle to understand what commissioning is, and assume it has little to do with them. This article aims to demystify it by outlining some common terms and the commissioning cycle; and patient experience (DH, 2008). For the public, this can be put into a set of questions: Safety: “Will I be OK?” Effectiveness: “Will it work?” Patient experience: “How will it feel?” The DH (2008) described the “quality landscape” as having seven steps: Bringing clarity to quality: this relates to the role of the National Institute for Health and Clinical Excellence and the use of NHS Evidence to ensure a strong framework governing service delivery.

WHAT IS COMMISSIONING?
Commissioning is a cyclical activity (Fig 1). It encompasses both the general public and patients because public health activity – such as smoking cessation – is also commissioned. As such, the word “patient” is too restrictive for the range of services commissioned using NHS funds.

The cycle starts with a needs assessment of those living in the geographical boundaries of a primary care trust, as the DH currently allocates population based funding via PCTs. This is known as devolved commissioning, and recognises that it would be impossible for central government to design services flexible enough to respond to local needs. This need for flexibility is one reason why the coalition government is handing the NHS budget to GP consortia, as GPs are seen as the key professionals locally who know patients’ needs, and what should change in the system to accommodate these. Nurses must be confident about their potential contributions to commissioning, both now and in the new system, and find ways to influence commissioning decisions.

The components of the commissioning cycle are familiar to clinicians: assess, plan, act, evaluate. The only difference is the words. It is easy for nurses to familiarise themselves with the language of commissioning by being in and around it, and picking up a basic understanding of the main terms.

KEY STEPS IN COMMISSIONING
Commissioning activities consist of several technical tasks, including contracting and procurement. While these may sound complex, they can be likened to the steps taken in many everyday tasks. For example, if you buy a sandwich, you start to assess what you want – brown or white bread, with or without mayonnaise. If you wrote this down, what you wanted would be described as a specification in commissioning terms. This is an essential part of contracting – assessing then defining what is needed.

It is crucial at this stage to ensure people with relevant expertise are included; without this knowledge, commissioners rely on the provider’s quality processes and, when that is translated into millions of pounds worth of service provision, these safeguards alone may be insufficient. This is why clinicians must be involved in commissioning.

In terms of procuring a sandwich, you are likely to consider factors such as convenience, value for money and quality, and you would think about past experiences. Having weighed up all these factors, you would then buy it (or send someone else with the right information or service specification to do so). This is known as procurement. If the service is big enough, or new, a tendering process is built in that allows for providers to express their interest and a panel to then decide which best fits the criteria. Once a product or service has been procured, it vital to evaluate it to generate information for the contracting process next time. If you could not find anything to meet the exact specification at one shop you would want to remember that next time, and note whether you had to change the specification or supplier (provider).

INCLUDING QUALITY
The NHS next stage review defined quality as having three elements: safety, effectiveness and patient experience (DH, 2008). For the public, this can be put into a set of questions: Safety: “Will I be OK?” Effectiveness: “Will it work?” Patient experience: “How will it feel?”

The DH (2008) described the “quality landscape” as having seven steps: Bringing clarity to quality: this relates to the role of the National Institute for Health and Clinical Excellence and the use of NHS Evidence to ensure a strong framework governing service delivery.

PRACTICE POINTS
Nurses interested in becoming involved in commissioning should:
- Familiarise themselves with commissioning terms and the commissioning cycle;
- Find out where their local commissioning groups are;
- Build relationships with professional executive committee members;
- Shadow a nurse working in commissioning;
- Identify ideas that would improve quality for patients without extra costs;
- Find people to help them write a business case and present it to their commissioners.
Measuring quality: This has always been challenging to do, at least from the patient experience perspective. It involves establishing clinical dashboards and patient reported outcome measures (PROMs) and patient reported experience measures (PREMS).

Publishing quality: every trust has to publish a quality account each year. This demonstrates that quality is as important as finance, since financial accounts have long been published annually.

Recognise and reward: the Commissioning for Quality and Innovation (CQUIN) payment framework means that trusts sign up to deliver certain quality improvements. If particular standards are not delivered, financial rewards are withheld.

Raise standards: a national Quality Board and Quality Observatory have been established to support the quality agenda.

Safeguarding quality: the amalgamation of the regulators into one – the Care Quality Commission – and the development of new methods for regulation are part of this.

Staying ahead: this includes best practice tariffs. For example, if a patient pathway includes certain steps and lengths of stay, trusts will only be paid for that pathway, even if they deliver a different service or longer stay. The Health Innovation Council and academic health science centres have been developed to ensure that the quest for evidence based improvements is rigorously supported.

**HOW DO COMMISSIONERS DO THIS?**

Currently, PCTs have to demonstrate their capabilities as commissioners by meeting the requirements of world class commissioning. Many nurses have been involved in collecting evidence for the Standards for Better Health assessment, and this is a similar framework.

There are 11 WCC competencies, which include procurement and contracting skills, and quality and innovation; these must all be supported by self assessment and evidence to arrive at a score for each competency. This information is published each year, so the public can judge their PCT’s commissioning. It is not yet clear how commissioning competencies will be developed and assessed in the new system, if at all.

One competency covers the ability to set contracts that include quality standards which are measurable and seek year on year improvements. This presents a challenge. How do you choose which measurements describe a good patient experience? Hospital food and car parking are important to patients and are relatively easy to measure, but how do you systematically demonstrate that compassionate care is being delivered?

**WHAT DO QUALITY STANDARDS LOOK LIKE?**

All three components of quality have to be covered in these standards. One example for each area might be:

- **Safety**: reducing healthcare associated infection rates by 30%.
- **Experience**: setting up a mechanism to capture patients’ views, establishing a baseline and showing improvement of 20% by year end in three out of five categories.
- **Effectiveness**: demonstrating full compliance with NICE guidance.

**HOW ARE THEY MEASURED?**

Once standards have been developed, written into the contract and agreed by providers, they must be monitored.

This can be explained by using a manufacturing analogy. In retail, if a brand of cake is marketed as a quality product, the company that owns the brand needs to ensure that this quality is consistently met. If it does not manufacture its own products, it needs suppliers to make the cakes and package them. Each supplier is governed by health and safety legislation and has contractual requirements to deliver products. The company’s reputation stands or falls on the quality of the cakes, and it cannot afford to leave this to its manufacturers. It therefore employs people to regularly make unannounced visits to the sites, who check every step to ensure that quality is being met. This is the role of the PCT; we cannot leave quality to providers alone. We are guardians of the public purse and so have to assure ourselves that public money is being spent wisely and delivering the level of quality as described in the contract and quality schedules. Therefore we have developed processes that enable us to fulfil this role.

**Clinical quality review meetings**

First, a monthly clinical quality review meeting takes place, which is separate from monitoring activity, performance and financial contract. These are chaired by the PCT’s director of nursing or medical director, and practice based clinicians and professional executive committee members also attend. Directors of nursing and medicine and a number of other clinical staff from provider trusts are expected to attend (including those in acute, mental health and community services).

The vision is that clinical colleagues will transcend organisational boundaries, discuss care and devise improvement methods.

This may not always happen in reality, as it is extremely difficult for providers to share concerns if it results in commissioners serving performance notices for non-delivery of the requisite standard of care. For commissioners, it would be impossible to hear about clinical risks and patient care concerns and then assume that the provider will address these issues effectively. This tension can only be managed by building trusting relationships where people can have the courage to own inherent risks together and develop shared solutions to ensure patient care continually improves, and if unacceptable standards of care are not tolerated by either party.

Under the new arrangements, GP consortia will have to develop their own approach to monitoring quality. They may
be starting from a strong position in that they will have relationships with local clinicians, and be able to manage this risk together. It is too early to judge this.

**Quality reports**

PCT boards receive regular quality reports outlining the performance of their providers. These include: complaints; incidents; compliments; patient and staff survey results; and national audits and other benchmarks.

The aim is to build a picture to enable boards to assess the quality of provision by comparing providers across the PCT and analysing trends and in-year changes. This also provides them with early warning signs should a provider start to get into difficulty.

If a trend began to appear in the type of serious incidents (SIs) occurring in a particular service, the board would ask for further information to assess the cause. By their nature, SIs should be rare and isolated, so, if there was a third SI in a single year relating to a similar area, event or procedure, the board would want to see the full investigation and root cause analysis of each incident and discuss this with the provider to ensure there was not a systematic failing. GP consortia will no doubt develop their own reporting and monitoring arrangements.

**Reality checks**

Reality checks include unannounced and announced visits to services by commissioners, talking to patients and staff to establish the quality of provision.

Other measures include gaining “soft intelligence” from GPs and other providers – this includes raising their own or their patients’ concerns. Community nurses have a wealth of information about which wards discharge well in terms of giving information to patients and district nurses, providing enough dressings or equipment, and generally planning patients’ care. They also know when this does not happen, and are encouraged to complete incident forms so these issues can be raised at an organisational level, and dealt with.

GP consortia will have relationships with local nurses. They can do this by finding the right enthusiasm of one or two well motivated nurses to take a lead role in organising local health services – this means influencing commissioners to ensure services are properly developed, planned and delivered.

Some nursing teams have developed their services over the years. For example, for patients, having a catheter removed at home where they can use their own toilet and avoid a hospital visit must be a better experience. Nurses need training, the right equipment and the ability to make enough visits to ensure patients can cope without the catheter. For commissioners (and the public purse) this is a better quality service and unlikely to cost more. However, would they notice this one intervention among the many issues they address unless community nurses developed the proposal and presented it to them as a business case? For the case to succeed, it needs to involve the whole PCT, not just one or two teams. Service changes should not be based on the goodwill and enthusiasm of one or two well motivated teams but spread across the whole service.

**IMPLICATIONS FOR NURSES**

Nurses in commissioning roles can see the value of their role and their ability to bring the nursing perspective to this activity. For these, their role may be clear. However, few commissioning posts require clinical qualifications, so commissioning is not widely seen as part of the nursing career pathway.

Many nurses have taken on commissioning roles by chance but, once in such posts, they have great scope to use their nursing skills to influence commissioning. For example, developing a focus on end of life care in a commissioning organisation, and using commissioning processes to secure board approval for a care strategy in this area, supported by investment and service redesign proposals, can affect thousands of patients’ lives each year.

The disadvantage is that it takes time and effort to achieve this scale of change, with few expressions of gratitude along the way. Commissioning may not suit those seeking the instant satisfaction of providing care and seeing that the intervention has left patients comfortable, pain free and grateful.

However, as a provider, commissioning is a nursing responsibility. If nurses do not understand and get involved, they lose an opportunity to influence decisions and quality measures that affect patients. In *Ten Key Roles for Nurses* (DH, 2002), the 10th role requires nurses to take a lead role in organising local health services – this means influencing commissioners to ensure services are properly developed, planned and delivered.

**REFERENCES**


