ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

This report presents findings from an evaluation of the World Class Commissioning initiative introduced under New Labour in 2007. World Class Commissioning (WCC) comprised a set of competencies, an assurance system and a support and development framework. The evaluation included:

i) A national telephone of Primary Care Trust Commissioning Directors
ii) Case studies in three Primary Care Trusts (PCTs)

Findings from the telephone survey

- In total 70/152 PCTs participated in the survey (46%)
- Half of the PCTs had a formal process in place for disinvestment decisions
- The use of analytical tools to aid commissioning was high. For example, 85% used programme budgeting data in priority setting. A similar proportion used predictive tools such as PARR and demand forecasting models.
- Half reported difficulties recruiting high quality staff for commissioning positions and identified skills gaps as a barrier to effective commissioning
- 28% had used the Framework for Procuring External Support for Commissioners (FESC), the complexity of the process being a significant barrier to take-up.
- 64% agreed or strongly agreed that practice based commissioning clinicians were actively involved in commissioning. Where respondents strongly agreed that clinicians had an active role in commissioning this was in the form of leading and shaping priority setting and service re-design (examples included transforming community services; redesign of care pathways; disinvestment and decommissioning). It is however difficult to assess the depth and quality of engagement through a survey.
- Further issues identified were problems with access to robust information and the necessary skilled capacity for interpreting this; information asymmetry with providers and thus difficulty in challenging existing practices; and need for stronger engagement at general practice level.

Findings from case studies in 3 sites

WCC was welcomed by local implementers as clarifying the remit and responsibilities of the PCT and helping to orientate the whole of the organisation toward
commissioning. The detailed specification of commissioning made commissioners feel the role was valued.

PCTs were able to use the competencies to reflect on and evaluate the strengths and weaknesses of their commissioning processes.

Another welcome feature was the shift in focus from performance targets to population health and outcome measures. However, some doubt was expressed about there being any causal link the competencies and actual improvement in the health of the local population.

**The assurance system**

For all participants the assurance system was experienced as involving a substantial amount of work in addition to the ‘day job’ of commissioning. Participants felt that demonstrating commissioning distracted from the activity of commissioning.

The construction of a league table showing relative performance was seen as meaningless. Absolute performance was regarded as the relevant measure. League tables were also seen to introduce competition between PCTs which was unnecessary and could hinder the sharing of support and expertise.

PCTs experienced problems with the quality of local information systems, capacity for collecting high quality and timely data and its use for ‘intelligent’ commissioning.

**Working in partnership with providers**

PCTs found it difficult to work in partnership with acute providers, especially Foundation Trusts, because of the greater power wielded by these organisations in the local health economy. Payment by Results was seen as rewarding activity and working against the policy objective of moving care out of hospitals. The expectation that the PCT would stimulate the market was viewed as increasing hostility between the PCT and providers.

**GPs and Practice Based Commissioning**

Relationships with GPs were varied and influenced by the quality of previous relationships and commissioning history.

Both GPs and PCTs agreed that GPs lacked commissioning skills.
Financial incentives were successful in securing GP involvement in Practice Based Commissioning.

GPs involved in Practice Based Commissioning advised that although ‘all practices’ in an area might be involved, this frequently involved only one GP from each practice and it was difficult to gauge accurately the extent to which their involvement was indicative of that of other GPs within each practice. There was a suggestion that engagement across the GP population was somewhat superficial and this appeared to be due to lack of financial incentives:

**Framework for Procuring External Support for Commissioners (FESC)**

FESC was viewed as cumbersome. While external support was valued, PCTs preferred to make arrangements themselves.

**Implications for future commissioning arrangements**

The competency approach is valued by commissioners. It is seen to aid clarity; give a sense of being valued; and facilitate self assessment of performance.

There needs to integration between any assurance system and the activity of commissioning.

The power imbalance between PCTs and acute providers; and the way Payment by Results may not always be consistent with key objectives of commissioning, have been reported by a number of academic studies and the House of Commons Health Committee. GPs may be better positioned to work in partnership with providers. Placing greater onus on providers to build partnerships with GPs and achieve the objectives of commissioning may also be fruitful. There is a risk that there are not sufficient numbers of GPs keen to undertake commissioning and who possess the relevant skills to succeed.
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1. INTRODUCTION, AIMS, AND OBJECTIVES

1.1. COMMISSIONING

The commissioning of health services in England has been the subject of much policy and academic debate which has accompanied a number of reforms that have taken place over recent years. The role of commissioning has been well articulated by Smith and Mays (Smith and Mays 2005) and updated by Wade (Wade, Smith et al. 2006), who conceptualise it as the ‘conscience’ (setting out what the system should aim to achieve and how) and the ‘brain’ (identifying and implementing the optimal solutions for delivering these aims) of the health care system. In fulfilling this role, commissioners are expected to: assess local health needs; plan and secure health services; improve health, within the framework of NHS standards and guidance; remain accountable to the Secretary of State, and adhere to the financial duties stipulated in the NHS Act 1999 (Department of Health 1999).

Primary Care Trusts (PCTs) were established in England in April 2002 and were charged with undertaking the commissioning role. However, the focus of much of the debate surrounding commissioning has pointed to significant weaknesses with respect to how well it has been undertaken by PCTs. The literature has shown that commissioners often lack critical capacity, capability, and time for commissioning ((Ham 2004; Smith, Mays et al. 2004; Bravo Vergel and Ferguson 2006; Ham 2006; Maynard and Street 2006; NAO 2006) and also suffer from real or perceived “democratic deficit” and a lack of profile and credibility in the broader public consciousness (Glasby, Smith et al. 2006; Williams, J. et al. 2007).

Successive waves of policy reforms have attempted to address the perceived poor performance in commissioning. These began in December 2005 (Department of Health 2005), with the introduction of initiatives to support patient choice and commissioning (see Health Reform in England: update and commissioning
framework (Department of Health 2006). This was followed by the white paper Our, Health, Our Care, Our Say (Department of Health 2006), the Commissioning Framework for Health and Well-being (Department of Health 2007) and by structural reforms, including the merging of PCTs in 2006 and the introduction of practice-based commissioning (PBC) in 2006/7. Further initiatives such as the World the Class Commissioning (WCC) programme (Department of Health 2007), introduced in 2007 alongside the Framework for procuring External Support for Commissioners (FESC) (Department of Health 2007), were put in place with the specific aim to strengthen commissioning. As pointed out by Ham (2007), these reforms that focus on the ‘demand-side’ (i.e. commissioning), were seen as crucial in sustaining commissioning and ensuring countervailing power to the supply-side strengths of entities such as Foundation Hospitals. However, following the election of the Coalition Government in 2010, WCC has been terminated and major reforms to commissioning are proposed in the NHS White Paper ‘Liberating the NHS’.

1.2. WORLD CLASS COMMISSIONING (WCC)

The WCC programme consisted of four elements; the vision, competencies for WCC, an assurance system and a support and development framework. The vision cast the national direction of better health and wellbeing through the provision of better care and better value that would be delivered locally through a set of commissioning competencies. Specifically, the competencies identified 11 organisational competencies that PCTs were expected to develop to improve their commissioning ability. Each competency was further divided into three sub-competencies. These competencies are listed in the Table 1 below.
### Table 1. Competencies for World Class Commissioning

<table>
<thead>
<tr>
<th>Heading</th>
<th>Sub-competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Locally lead the NHS</td>
<td>Reputaiton as the local leader of the NHS</td>
</tr>
<tr>
<td>2    Work with community partners</td>
<td>Creation of local area agreement based on joint needs</td>
</tr>
<tr>
<td>3    Engage with public and patients</td>
<td>Influence on local health options and aspirations</td>
</tr>
<tr>
<td>4    Collaborate with clinicians</td>
<td>Clinical engagement</td>
</tr>
<tr>
<td>5    Manage knowledge and assess needs</td>
<td>Analytical skills and insights</td>
</tr>
<tr>
<td>6    Prioritise investment of all spend</td>
<td>Predictive modelling skills and insights to understand the impact of changing needs on demand</td>
</tr>
<tr>
<td>7    Stimulate the market</td>
<td>Knowledge of current and future provider capability</td>
</tr>
<tr>
<td>8    Promote improvement and innovation</td>
<td>Identification of improvement opportunities</td>
</tr>
<tr>
<td>9    Secure procurement skills</td>
<td>Understanding of provider economics</td>
</tr>
<tr>
<td>10   Manage the local health economy</td>
<td>Use of performance information</td>
</tr>
<tr>
<td>11   Efficiency and effectiveness of spend</td>
<td>Measuring and understanding efficiency and effectiveness of spend</td>
</tr>
<tr>
<td></td>
<td>Reputation as a change leader for local organisations</td>
</tr>
<tr>
<td></td>
<td>Ability to conduct constructive partnerships</td>
</tr>
<tr>
<td></td>
<td>Reputation as an active and effective partner</td>
</tr>
<tr>
<td></td>
<td>Public and patient engagement</td>
</tr>
<tr>
<td></td>
<td>Improvement in patient experience</td>
</tr>
<tr>
<td></td>
<td>Reputaiton as leader of clinical engagement</td>
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<tr>
<td></td>
<td>Understanding of health needs trends</td>
</tr>
<tr>
<td></td>
<td>Use of health needs benchmarks</td>
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<td></td>
<td>Incorporation of priorities into strategic investment plan to reflect different financial scenarios</td>
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<td></td>
<td>Alignment of provider capacity with health needs projections</td>
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<td></td>
<td>Collection of quality and outcome information</td>
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<td></td>
<td>Negotiation of contracts around defined variables</td>
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<td></td>
<td>Creation of robust contracts based on outcomes</td>
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<td></td>
<td>Implementation of regular provider performance discussions</td>
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<tr>
<td></td>
<td>Resolution of ongoing contractual issues</td>
</tr>
<tr>
<td></td>
<td>Identifying opportunities to maximise efficiency and effectiveness of spend</td>
</tr>
<tr>
<td></td>
<td>Delivering sustainable efficiency and effectiveness of spend</td>
</tr>
</tbody>
</table>

Reference (Department of Health 2007)
The support and development framework was established to better equip commissioners by providing access to the required tools, facilitating knowledge sharing, and providing national guidance on board development. The assurance system was used to assess PCT performance across each competency on a scale from one to four, level four representing ‘World Class’ performance. More detail on the competencies, the assurance system and their evolution is provided in Chapter 3 of this report.

1.3. RESEARCH BACKGROUND

Initially, the proposed research intended to understand, develop and evaluate commissioning through the context of the WCC agenda and commissioning competencies. It was hypothesised that greater knowledge was required about: how PCT commissioning and PBC functioned; the use and usefulness of initiatives and guidance established to aid commissioning; how well-placed commissioners were to respond to these initiatives; and the real or perceived impact of the initiatives on commissioning, as well as the local health care system. The original aims of the research were therefore to:

1. develop a conceptual model of commissioning detailing the commissioning structures and processes, and key relationships between commissioning entities within the NHS and other agencies.
2. examine commissioning performance against the competencies embodied in WCC and assess the use of frameworks and tools that have been established to aid commissioning.
3. identify barriers and challenges to WCC and introduce change through participatory action research to develop commissioning in line with the requisite competencies.
4. evaluate and assess how other aspects of health care reform impact on commissioning effectiveness and vice versa.

However, the proposed reforms set out in the ‘Liberating the NHS’ White Paper (Secretary of State for Health 2010) and the changes to the context of health care commissioning amongst other things, the withdrawal of WCC and the Competencies,
had a major impact on the research intentions. Whilst the early phases of the research were successfully completed, the impact of the reforms (notably the proposed demise of PCTs and termination of WCC) meant that it was not possible to conduct the participatory action research. As a result a decision was made in conjunction with the funder (DH, Policy Research Programme) to use the data collected through the research to date to examine the evolution, implementation and interpretation of WCC and the competencies.

As with many of the commissioning reforms, there has as yet been no formal evaluation of the WCC programme. Little is known about what impact the WCC programme and competencies had on the effectiveness and performance of commissioning. Research that has been conducted highlights the need for further in-depth study which appreciates and fully accounts for the organisational context in which the WCC programme and competencies were introduced.

1.4. RESEARCH AIMS

This research therefore aims to explore the development and implementation of WCC and the competencies in the English NHS and draw implications for future commissioning arrangements. In order to address this, the research proposed the following questions:

1. What was the rationale behind the implementation of WCC and how was it introduced?
2. How did PCTs respond to and implement WCC?
3. What lessons can we draw from WCC to inform future commissioning arrangements both nationally and internationally?
1.5. RESEARCH OBJECTIVES

As such, the re-worked objectives of the research were to:

1. Understand why WCC was introduced, how it was intended to improve PCT/PBC commissioning, and what it involved
2. Provide a snapshot of PCT responses to the introduction of WCC
3. Conduct in-depth case studies in PCTs on the interpretation and implementation of WCC
4. Assess the strengths and weaknesses of WCC
5. Identify lessons and learning for future commissioning policy and practice both nationally and internationally.

The research was conducted in three phases that correspond directly to the research objectives outlined above:

- Phase I: in-depth one-to-one interviews with key informants and analysis of secondary data sources were undertaken to examine the rhetorical rationale underpinning the introduction of WCC.
- Phase II: a national telephone survey of PCT Commissioning Directors was used to examine the extent of the introduction of WCC and the receptiveness of PCTs to its implementation.
- Phase III: in-depth interviews were conducted with PCT commissioners, representatives from PBC, Strategic Health Authorities (SHAs), acute trusts, and patient groups in three case study sites to explore participants’ perceptions of the introduction and impact of WCC within the commissioning context.

Although each of these phases largely involves collection of data on perceptions of what occurred in deciding and implementing WCC, the project reported here was funded as part of a programme of work on evaluating NHS reforms. Indeed, a complementary project, led by researchers at the University of Sheffield, was funded to examine the impact of WCC on health outcomes, the hope being that the combination of the two projects would provide a comprehensive view of such impact and how it was achieved. (For more detail on this affiliated project please see http://www.shef.ac.uk/scharr/sections/hsr/mcru/pct).

The rest of the report sets out the methods adopted in undertaking this research, the results as they pertain to the above phases, and a discussion of the findings, their implications and recommendations for future policy and practice developments,
drawing lessons for the future of NHS commissioning to be undertaken by the proposed GP consortia.
This chapter sets out how we approached this research and its design.

2.1. RESEARCH OBJECTIVES

As outlined in Chapter 1, the research objectives were to:

1. Understand why WCC was introduced, how it was intended to improve PCT/PBC commissioning, and what it involved
2. Provide a snapshot of PCT responses to the introduction of WCC
3. Conduct in-depth case studies in PCTs to understand the interpretation and implementation of WCC
4. Assess the strengths and weaknesses of WCC
5. Identify lessons and learning for future commissioning policy and practice both nationally and internationally.

2.2. RESEARCH DESIGN

The research was conducted in three phases involving empirical data collection to understand and explore the impact of WCC and the competencies on commissioning practice. Each of these phases corresponds directly to the research objectives outlined above. The research phases and objectives are summarised below in Table 2.

In Phase I in-depth one-to-one interviews with key informants (experts, instrumental in the shaping or analysis of national WCC policy) were used to explore the perceived stimulus and aims of the WCC programme. This was supplemented by an analysis of secondary data sources which examined the rhetorical rationale underpinning the introduction of WCC. An analysis of themes was used to: provide a rich description (Geertz 1973) of why WCC was introduced, how it was intended to improve...
commissioning, and what it involved; and assess its strengths and weaknesses. The results of Phase I are detailed in Chapter 3.

In Phase II a national telephone survey of PCT Commissioning Directors was carried out to examine the extent of the introduction of WCC and the receptiveness of PCTs to its implementation. Quantitative and qualitative responses were analysed using SPSS and thematic analysis respectively to provide a snapshot of PCT responses to the introduction of WCC. This was supplemented by a literature review of secondary data sources to verify or contest the findings. The results from this phase are described in Chapter 4.

In phase III, in order to go beyond the macro-trends explored in phase II, in-depth interviews were conducted with PCT commissioners, representatives from PBC, Strategic Health Authorities (SHAs), acute trusts, and patient groups in three case study sites to explore participants’ perceptions of the introduction and impact of WCC within the commissioning context. This was supplemented a respondent validation exercise with a subsample of interview respondents, to verify and reflect on our findings. An analysis of themes was used to understand the interpretation and implementation of WCC; and assess its strengths and weaknesses. The results from this phase are presented in Chapter 5.

2.3. RESEARCH ETHICS AND GOVERNANCE

Each component of the research was assessed by the National Research Ethics Service. The key informant interviews and survey were judged to be ‘service evaluation’, and as such did not require formal research governance approvals. With respect to the survey, the research governance leads in each PCT (n=152) were contacted and informed of the intention to carry out the research. Four research governance leads indicated that they did not wish their PCT to participate in the study and they were excluded from the recruitment process. The in-depth case
studies were reviewed by a local research ethics committee and received a favourable opinion. Research governance approvals were sought in each of the case study sites. In all cases, informed written or oral consent was obtained from participants prior to their involvement in the research. All data were anonymised and stored securely. Every effort has been made to ensure that no individuals are identifiable in the dissemination of these data.

Table 2. Summary of research phases and objectives

<table>
<thead>
<tr>
<th>Research phase</th>
<th>Objectives addressed (numbers in parenthesis correspond to objective numbers above)</th>
<th>Methods of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>To understand why WCC was introduced, how it was intended to improve PCT/PBC commissioning, and what it involved; assess its strengths and weaknesses; and identify lessons and learning for future commissioning policy and practice both nationally and internationally (1, 4, and 5)</td>
<td>in-depth interviews and literature review</td>
</tr>
<tr>
<td>Phase II</td>
<td>To provide a snapshot of PCT responses to the introduction of WCC; and identify lessons and learning for future commissioning policy and practice both nationally and internationally (2 and 5)</td>
<td>National telephone survey and literature review</td>
</tr>
<tr>
<td>Phase III</td>
<td>To conduct in-depth case studies in PCTs to understand the interpretation and implementation of WCC; assess its strengths and weaknesses; and identify lessons and learning for future commissioning policy and practice both nationally and internationally (3, 4 and 5)</td>
<td>In-depth interviews and respondent validation exercise</td>
</tr>
</tbody>
</table>

2.4. RESEARCH METHODS: DATA COLLECTION

Both quantitative and qualitative research methods were employed. Each of the methods used in the phases is discussed in detail below.
2.4.1. KEY-INFORMANT INTERVIEWS

Interviews allow respondents to report on their own experiences and express what they ‘think’ or ‘feel’. This can yield rich, deep data that is useful for exploring a range of perspectives around a particular event or phenomenon. As such, interviews were used in this research to explore the perceived stimulus and aims of the WCC programme.

Sample

The selection of participants balanced both theoretical and practical considerations. Participants were selected using a mix of practical sampling strategies including snowball sampling (identifying participants from other participants), and judgmental sampling (selecting the most appropriate participants for the topic at hand). Participants were identified on the basis that they were directly involved with shaping national WCC policy or had knowledge of the creation of the vision and competencies for WCC.

Seven people were approached to take part in the interviews. Where they declined, their reasons were noted and they were asked to suggest another potential participant. In total, data were collected from 6 participants.

Data collection

Participants were approached by email and were sent information on the project, a copy of the interview questions, and asked about their availability for participating in an interview. Participants were offered a choice of interview either face-to-face at their chosen location, or via telephone. All interviews were conducted by telephone and took place in April and May 2009. Two members of the research team (IW and SM) acted as interviewers. The length of interviews ranged from 30 to 45 minutes and were audio-recorded (to avoid the recognised problems associated with note taking (Britten 2000)) and transcribed. Before commencing the interview, the interviewer verbally outlined the information on the project and participants were
asked to provide oral consent giving permission for the interview to be recorded and transcribed. Consent was noted by the interviewer on the interview schedule. Copies of the email sent to potential participants, and interview schedule are provided in Appendices 1 and 2 respectively.

The interviews were used to investigate the development of the commissioning competencies: where they had come from, literature underpinning them, barriers and facilitators to their achievement, and their perceived added value to the commissioning process. An interview schedule was used to guide the interview and served to prompt the researcher to probe the participant. The schedule consisted of structured questions. The ordering of questions varied and they were never delivered verbatim. As such, the schedule was used to guide the interview in an informal but purposeful way (Mason 2002). The interview schedule in its most recent form is reproduced in Appendix 2.

2.4.2. NATIONAL TELEPHONE SURVEY

In contrast to the interviews conducted above, descriptive surveys offer a quantitative method of data collection that is designed to measure attitudes, knowledge and behaviour in larger samples of the population of interest (Bowling 1997). A descriptive survey was therefore used to enable us to capture a picture of PCT responses to the implementation of WCC and the commissioning tools, techniques and processes that were in place in PCTs across England at the time.

Sample
The population of interest was Commissioning Directors. All 152 PCTs in England were approached and invited to participate in the research. Recruitment took place during March-July 2009. Initial contact was made in writing to the Chief Executive of each of the PCTs, detailing the research and requesting the name of the Director of Commissioning. Non-responders were followed up at least four times by telephone.
In total 77 PCTs responded and within these, 70 Directors of Commissioning were surveyed.

**Data collection**

The survey was developed and refined by the project team in consultation with national commissioning experts from the Nuffield Trust and NHS commissioners. It was piloted on three Directors of Commissioning and changes were made to ensure clarity of questions. The survey was comprised of series of closed-ended, attitudinal questions (rated using Likert scales) and free text questions, and was designed to be undertaken in ten minutes. A copy of the survey is available in Appendix 3. In summary, it focussed on the following broad themes:

- commissioning tools and processes
- information and data support for commissioning and implementing WCC
- processes for priority setting
- disinvestment activity
- the extent of engagement of stakeholder groups in WCC
- barriers and facilitators to achieving WCC competencies

The survey was administered by telephone as part of a larger telephone survey that was being conducted by The University of Sheffield to evaluate the effect of commissioning processes on outcomes (for more on this research see: http://www.sheffield.ac.uk/mcru/pct.html). The survey interviews were undertaken by experienced researchers from the University of Sheffield between May-November 2009.

**2.4.3. CASE STUDY INTERVIEWS**

A case study design was adopted for this stage as it is a method of choice where ‘the study of phenomenon is not readily distinguishable from its context’ (Yin 2003: p4).
One of the main characteristics of case studies is that they strive towards a holistic understanding of cultural systems of action (Feagin, Orum et al. 1991).

Sample

Case study sites were selected on the following criteria: geographical area, PCT commissioning competency score (total), population size, ONS classification of local and health authority areas, existence of formal partnerships (e.g. joint commissioning arrangements in place), existence of lead commissioning organisation, current PBC activity levels, make-up of health care providers, extent to which PbR implemented, and other aspects of socio-economic context. These criteria were applied in the order reported. In terms of geographical area, PCTs were identified from the three areas proposed in the project proposal where the research team were located. These were: the North East, the North West, and West Midlands. A list of the PCTs in these selected areas is presented in Table 3.

Table 3. PCTs in the target areas

<table>
<thead>
<tr>
<th>Region</th>
<th>PCT</th>
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<th>Region</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE</td>
<td>Co Durham</td>
<td>WM</td>
<td>Sandwell</td>
<td>NW</td>
<td>Cumbria</td>
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Following this, the selected PCTs in Table 3 were ranked by the above criteria in order (i.e. first by commissioning competency score, second by population size, and third by ONS classification etc) until the list was exhausted. A decision was made to select PCTs in terms of varied competency scores in order to contrast one high
scoring PCT with two mid scoring PCTs, whilst ‘controlling’ for the other criteria. Three PCTs were selected after applying the first three criteria. These are defined below in Table 4.

Table 4. Case study sites

<table>
<thead>
<tr>
<th>Criteria</th>
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<th>B</th>
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<tbody>
<tr>
<td>Geographical area</td>
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<td>NW</td>
<td>WM</td>
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<tr>
<td>commissioning competency score (total)*</td>
<td>16</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Population size</td>
<td>~200,000</td>
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*as taken from (HSJ 2009)

Data collection

Data were collected using in-depth semi-structured interviews at all sites. Interviewees were selected using a mixture of judgemental sampling (selecting the most appropriate participants for the topic at hand), and quota sampling (selecting participants on the basis of their experience or characteristics). Participants were identified on the basis that they were involved directly or indirectly in the implementation or interpretation of WCC in the PCT. The roles of participants selected included: Chief Executive Officers, PCT Board members, commissioning directors, finance directors, service improvement leads, public health specialists, SHA representatives, acute trust providers, local authority representatives, GP executive committee members, patient group representatives, PBC members, and non-executive directors.

Participant roles were identified from each PCT using the Binleys database (Binleys 2009) and approached by letter inviting them to participate in the research. The letter was accompanied by a written information sheet and calendar for them to indicate their willingness and availability to be interviewed (either face-to-face or by telephone). Non-responders were followed-up by email and telephone until we recruited the minimum quota for each PCT and data saturation was reached.
Thirty-eight interviews were conducted in total, and took place between September 2009 and January 2010. Two members of the research team (IW and SM) acted as interviewers. The length of interviews ranged from 34 to 74 minutes and all were audio-recorded and transcribed. Before commencing the interview, the interviewer asked the participant to re-read the information sheet and provide written (or verbal consent in the case of telephone interviews) giving permission for the interview to be recorded and transcribed. Copies of the letter sent to potential participants and the information sheet are provided in Appendices 4, and 5 respectively.

Interviews sought to draw on respondents’ experiences, opinions, beliefs, feelings, knowledge and perceptions (Patton 1987) and used a series of semi-structured questions to explore participant’s perceptions and experiences of commissioning in their locality and provided an insight into the planning, strategy and operation of commissioning activity. Views on the competencies, their strengths and weaknesses, how they impacted on commissioning, as well as the impact of health policy and other health initiatives on commissioning were also sought. An interview schedule was used to guide the interview and served to prompt the researcher to probe the participant. The questions were never delivered verbatim and the ordering of questions was varied and revised throughout the course of conducting the interviews to incorporate new concepts as they emerged from the interviews.

2.4.4. RESPONDENT VALIDATION EXERCISE

A respondent validation exercise was used in the third phase of the research, following feedback of research findings to gather reflections on the interpretation and implementation of WCC and identify lessons and learning for future commissioning policy and practice.
Sample
A convenient sample of PCT Executives and Directors from one case study site who had been involved in the research was convened to form a small focus group.

Data collection
The focus group was held as part of a routine organisational meeting. Prior to running the focus groups, participants were given information on the purpose of the research and specific issues that would be discussed. This was communicated via email and reiterated verbally at the beginning of the focus group. Additionally, participants were given the opportunity to opt out if they felt unwilling or unable to take part. The focus group lasted for 30 minutes and run by one member of the research team (SM) who acted as the moderator and facilitated the focus group. A presentation detailing the interim results and topic areas to be covered during the focus group was given at the beginning of the focus group. (A copy of the presentation is given in Appendix 6). The focus group was recorded (with participants’ oral consent) manually through written minutes in order to keep track of what people were saying as well as who was saying it and how they were saying it. Following this, participants were invited to discuss anything privately and also given the opportunity to contact the researchers in person or via email. In addition, for those not able to attend the focus group, they were issued with an electronic copy of the presentation and asked to send or email any specific comments directly to the researchers.

2.5. RESEARCH METHODS: DATA ANALYSIS AND INTERPRETATION

2.5.1. QUANTITATIVE ANALYSIS

The data from the national survey were input into SPSS worksheets for ease of analysis. A range of descriptive statistical techniques were used to analyse this data.
and to report quantitative response. Free text responses were categorised into emergent themes and reported alongside the quantitative data.

### 2.5.2. QUALITATIVE ANALYSIS

In this research, the free text responses from the survey, transcribed data from the interviews (key-informant and case study), formed the formal data for analysis. The approach used in this study drew on the work of Miles and Humberman (1994), to ensure that a systematic refining of data analysis and the development of inductive categories was an ongoing iterative process of interpretation. These categories or themes provided a detailed descriptive analysis of what was happening in the data.

**Transcribing data**

In this research, interview data were transcribed verbatim. One member of the research team (SM) transcribed one interview (from each of the key-informant interviews and the case study interviews) to become familiar with the data and decide upon the extent of notation required for subsequent analysis. All other interviews were outsourced and transcribed by qualified transcribers with whom the researcher team communicated. In each case, the transcription was conducted following a number of useful conventions outlined by Rapley (2007). The work of transcriber was reviewed for quality by reading the transcription alongside the audio recording. This not only offered a useful exercise for checking the quality of the transcription but also provided a way of getting to know the data. Mistakes in the transcripts were corrected. However, some transcription details were omitted in the presentation of the analysis in the interests of readability.

**Analysis of themes**

In this research, the transcribed data from the interviews were read and re-read several times by the members of the research team. In each case, the data were openly coded by one member of the team (SM) to categorise significant remarks or
observations in the data (Bryman 2004). This involved reviewing and asking questions of the text, such as: what the item of data represents, what is happening, what people are doing, what people are saying they are doing, and what kind of event is going on? (Lofland and Lofland 1995). A constant comparative approach, comparing data categories to ensure all data relevant to each category were identified and examined, was used to identify and label common categories emerging from the interview accounts (Pope, Ziebland et al. 2000). At this stage, joint data sessions were also held with other members of the research team to examine the analysis and supportive evidence and confirm (or revise) codes (AB, IW, SR). Following this, the data were further explored and the codes were refined. Finally, these codes were further interrogated to identify common threads that tie all other categories together into a story (Gibbs 2002). The coding was facilitated using memos and computer assisted qualitative data analysis (NVivo 8).

The themes that emerged from the coding of the data were used to build an account or description of what participants said and develop a ‘thick description’ (Geertz 1973) of what was happening in the data. The descriptive results were presented through the respondent validation exercise to a sub-set of original participants in order to verify the findings, and to the project steering group to enhance reflexivity.
3. PHASE I FINDINGS: THE GENESIS AND DEVELOPMENT OF THE WORLD CLASS COMMISSIONING COMPETENCIES

3.1. INTRODUCTION

In order to contextualise findings presented in later sections of this report, this chapter explores the conception, development and early implementation of the WCC competency framework. It therefore addresses the research objective of understanding how WCC was intended to improve PCT and PBC commissioning. Specifically it addresses the following questions:

- What were the main drivers and aims of the WCC, and the development of a competencies-based approach in particular?
- How was the programme, as conceived, intended to bring about those ends?
- What was the intended approach to implementation and support?

The chapter begins by exploring the origins of the competencies and the drivers and aims underpinning them. It then traces the process by which the competencies were developed and implemented, as well as how these were initially received. The discussion presented here is based primarily on the key informant interviews outlined in section 2.4.1. However, use is also made of secondary sources such as policy documents and commentaries relating to WCC, as well as the broader literature on health care commissioning.

3.2. ORIGINS OF WCC

The WCC reforms reflected the overall strategic priorities laid down for the NHS in England under the previous Labour Government (1997-2010). These included: raising clinical quality standards; enhancing choice and responsiveness; improving population health (including the promotion of well being and self care and the
reduction of health inequalities) and; maximising efficiency in the organisation and delivery of services (Department of Health 2005; 2006; 2007c). By 2006, the preferred definition of commissioning was: ‘the cycle of assessing the needs of people in an area, designing and then securing appropriate service’ (Cabinet Office, 2006: 4). With specific application to the English NHS commissioning has since been described as: ‘...where an organisation, and/or a group of clinicians, acts on behalf of a population to decide which health services to buy, using tax funds allocated by the Department of Health according to a formula based on health needs. It entails decision-making about needs assessment, resource allocation, service purchasing, monitoring and review’ (Smith et al, 2010: 6).

By the time WCC was launched in 2007, PCTs had become the focal point of the English commissioning landscape and as allocators of approximately 80% of the NHS budget were positioned as the key counter-weight to traditionally powerful provider agencies (Talbot-Smith and Pollock, 2006). The expectation was that PCTs would ensure the personalisation of care and satisfy the demands of the educated health care consumer, whilst simultaneously reducing health inequalities and improving overall population health (Wade et al 2006). They were also required to achieve savings and efficiencies, adhere to regulatory and performance frameworks, and stimulate and manage markets, whilst working in partnership with a range of statutory and non-statutory bodies (Baxter et al 2007, Talbot-Smith and Pollock 2006, Ham, 2006).

As set out in the report introduction (section 1.2), WCC contained four key elements: a vision, a set of commissioning competencies, an assurance system and a support and development framework (Department of Health, 2007). In 2008 the assurance process was launched and this involved assessment of PCT commissioning capabilities with regard to: selected outcomes, governance arrangements, and the competencies (Walker, 2009). Each of the eleven competencies contained sub-components designating the skills, knowledge and behaviour associated with high
commissioning performance. The government’s description of the competencies refers to them as ‘the knowledge, skills, behaviours and characteristics that underpin effective commissioning’ (Department of Health, 2007: p.3).

The competencies were thus expected to provide the necessary platform for improved PCT commissioning. Alongside WCC, practice-based-commissioning (PBC) retained a key role in the government’s vision for the English NHS. Introduced in 2005, PBC involved indicative budget deposit from PCTs so that GPs could commission services on behalf of their patients. Through PBC, it was expected that health care professionals would be incentivised to design and procure services for their patients (Department of Health 2006a, Smith et al 2005). PBC was therefore seen as pivotal to the delivery of both patient choice and care closer to home (Curry and Thorlby, 2007). However, the extent of ‘fit’ between WCC and PBC has been questioned, as preoccupation with the former has diverted PCT attention away from the latter (Gillam and Lewis, 2009).

3.3. KEY INFORMANT INTERVIEW RESULTS

Interview data was collected from 6 participants (4 males and 2 females). Participants could be divided into the following roles: DH senior leads/advisors (3), PCT Chief Executives (1), and representatives from the NHS Confederation (1) and Kings Fund (1). Of those interviewed, two had been part-authors of the competencies whereas others had been involved in early consultation and amendment – either as experts or representatives from Strategic Health Authorities and Primary Care Trusts. All were engaged as having insight into the rationale and aims of the competencies and/or the process of their introduction. Given the modest size of the interview sample (n=6) and therefore the potential for respondent identification, no identifier is attached here to verbatim quotations. However, included quotes are only intended to be illustrative and indication of the pervasiveness (or otherwise) or views expressed is provided throughout. Where our
findings echo those of other recent research, we have acknowledged this and highlighted the consistency and alignment of findings. As the competencies were a new initiative there was insufficient literature for an extensive review, so it was deemed appropriate to draw upon and reference other literature in this way. The results are discussed under the following themes presented below:

- Drivers and aims of the WCC competencies
- Conception and early development of the competencies
- WCC as a mechanism for change
- Implementation
- Early responses to WCC

3.3.1. DRIVERS AND AIMS OF THE WCC COMPETENCIES

When WCC was launched in 2007 the NHS, like most health care systems, faced considerable challenges resulting from: changing patterns of health and ill health; the need to shift from a ‘sickness’ to a ‘health’ service; persistent health inequalities; the need to deliver fewer services in acute settings, and; the growing gap between demand and resources. The role of commissioning in meeting these challenges was articulated by the government in its vision for WCC: ‘PCTs, practices, Specialised Commissioning Groups and their partners will need to meet the new challenges of the 21st century with changing populations and advances in health care. Given this vision and our shared agenda, it would be wrong to describe our ambition for commissioners as anything less than world class’ (Department of Health, 2007)

Commissioning was thus seen as the last piece of the reform jigsaw which, if effective, would provide the levers to improve and redesign local systems. However, WCC was a relatively late addition to the wave of reforms set out in the 2005 document ‘Health reform in England: update and next steps’ (Department of Health, 2005) in which much of the emphasis had been on supply side and/or transactional reforms such as Foundation Trusts and Payment by Results. WCC has in fact been
characterised as a belated response to the perverse effects brought about by these other reforms with, for example, the introduction of payment by results making it more difficult to shift care out of the acute and into the community sector (Powell et al, 2010).

Interviews with key informants all suggest that the WCC agenda in general and development of the competencies in particular, were underpinned by a number of broadly accepted propositions about the current state of commissioning in the England NHS. Firstly it was agreed that commissioning is currently not well specified. Interviewees considered the development of the competencies to have been a response to a general lack of detailed understanding of the skills and behaviours that make up the commissioning role. In other words, if commissioning was to become a crucial driver of health care improvement and redesign, its component elements would need to be specified in more detail:

“We’ve never really invested properly and taken sufficiently seriously the demand side … but in order to do that we need to articulate more clearly what it is that we think commissioning actually is, what it involves and what you need to be able to do to do it well.”

Respondents noted that terms such as ‘commissioning’, ‘purchasing’ and ‘procurement’ were used ambiguously and interchangeably, and that development of more robust definitions - and ensuring these were widely communicated and understood - would be beneficial. Being more specific about the remit and requirements of commissioning was intended to focus organisations, to professionalise commissioning and to facilitate development of commissioning skills.

The implementation of WCC also reflected a widespread belief that the development of commissioning had been neglected and that current commissioning practice had suffered as a result:
The other thing that triggered the introduction of the competencies was the general worry that PCTs just weren’t good enough and that if we left them to their own devices we might end up with twenty or thirty improving but one hundred and twenty not.”

Respondents reported that commissioning was considered a weak link. An unpublished Cabinet Office Review - which had been critical of many aspects of NHS commissioning practice - was seen as having helped lay the ground for the WCC initiative. Overall, interviewees felt there to be a perception that many of the skills and capacities required for commissioning were not currently in place within PCTs and this echoes previous research (Smith and Goodwin, 2006). Commercial and market-management skills and information management capabilities were considered to be particularly lacking. Such skills as were present were considered to be unevenly distributed across the country’s commissioning organisations leading to variations in system performance. Therefore, although interviewees equated many of the competencies with general management good practice, these more technical and market-related dimensions of WCC were considered to constitute a new requirement for those working within the NHS:

“I think there are elements of [WCC] which people did feel are new and we’re sort of starting from scratch a little bit. They would be the market-making, procurement, contract management because some of that really was new to PCTs who hadn’t necessarily put anything out to tender before and hadn’t necessarily had to manage real competition between NHS and non-NHS providers.”

Partly as a result of this commissioning underperformance, and partly due to other factors, acute hospital trusts were seen as exercising undue influence over local health care organisation and delivery. Given their centrality to the reform programme envisaged by the government, PCTs in particular were seen as critical to
redressing this system imbalance, and the competencies were envisaged as a means of achieving this:

“In the rhetoric of world class commissioning it’s all about improving the quality of care and adding life to years and years to life, but I think there’s also a strong element in there about gaining leverage over the acute sector and therefore better enabling PCTs to control resources.”

The importance of bolstering the commissioning function is supported by the published evidence base which suggests that health care commissioners have traditionally had little impact on the activities of the acute sector (Smith et al, 2004). The competencies were therefore considered part of an attempt to embed the requisite information, skills and resources to enable them to exercise effectively the powers imputed to them (Allen et al 2009). As noted, this was seen as particularly important in light of the unforeseen consequences of reforms to other parts of the English NHS which had exacerbated system imbalances. Two interviewees made specific reference to the predominance of the acute sector in the public’s perceptions of the NHS, and the implications of this for PCT attempts to exercise greater control:

“I think that it’s quite difficult to overcome because every time ... you go out to tender for a service, for example, then the local people, the local clinicians whip up the local politicians and you know, and we haven’t really got over that. In the end the public trust the services that they know and the change management is difficult but equally it’s not well addressed I don’t think.”
“Competency One was in part driven by the fact that most people recognised who their local authority was but didn’t know who their healthcare leader was and the PCT’s authority and standing across communities was probably not as authoritative as it could be, so the idea there was that we would task them clearly with being the local leader of the NHS.”

These comments echo concerns over the wider legitimacy that PCTs require in order to act authoritatively on behalf of their patient populations, especially where this involves, for example, moving services out of hospitals (Glasby et al 2006, Williams, 2007). By emphasising the importance of leadership (i.e. via Competency One), WCC was considered a direct attempt to address this legitimacy and profile deficit.

Concerns over the overall performance of PCT commissioners, and the legitimacy deficits from which they suffer, were seen as having damaged perceptions of commissioning as a career option within the NHS. In other words, commissioning was considered a relatively low-status profession when compared to equivalent management roles in the acute sector. One of the drivers of the commissioning competencies was therefore seen as being the need to improve the professional status of PCT commissioners and to make a career in commissioning attractive to high-quality managers:

“We need to make [commissioning] more professional. It needs to feel like more of a career path.”

The aspiration to improve quality of care for patients is at heart of WCC and the concern with outcomes is embodied in the WCC strap-line ‘adding life to years and years to life’. The emphasis on improving outcomes – in terms of both overall health and health inequalities – reflects a concern that commissioners hitherto had focussed more on means rather than ends. Interviewees articulated this in terms of the need to:
“... get PCTs to focus on long-term health gain rather than the short term focus on contact in secondary care which has been the focus for the previous ten years.”

“It’s [about] changing the cultural mindset and ambition of PCTs to go from buying and managing contracts to actually improving performance and managing health.”

The advent of a reduced NHS budget was seen as supporting the need to professionalise commissioning as well as to drive de-commissioning. This, it was felt, was reflected in two changes to the competencies and their implementation. Firstly, the late addition of an eleventh competency relating to financial investments was seen as a reflection of the need for cost containment. Secondly, interviewees noted that the timescales within which improvements to commissioning practice were expected to be demonstrated had been shortened following the economic downturn, and the subsequent need for efficiency gains to be more quickly achieved.

These drivers of the competencies, expressed as a series of aims, were therefore seen as including the following:

- To provide greater specification of what WCC entails
- To provide a framework for assessing current commissioning performance
- To help instil and embed those skills and behaviours within PCT (and other) commissioning organisations
- To help to transfer power away from the acute providers sector, and
- To raise the professional status and legitimacy of the health care commissioning role
Those interviewees that had been directly involved with the development of the WCC competency framework were asked to recall how this had taken place. From these discussions it was clear that the Department of Health’s appointment of a Head of Commissioning in 2007 was instrumental in the eventual decision to adopt a competency-based approach. Once this was agreed, from 2007 onwards, a small Department of Health team set about producing the draft competency framework. However, this work was hampered by the relative absence of a formal evidence base – both on the skills and behaviours that constitute effective health care commissioning, and in relation to the impact of commissioning on outcomes more generally (Light 1998; Chappel, Miller et al. 1999; Figueras, Robinson et al. 2005; Ham 2008; Ham 2008). This was acknowledged by interviewees:

“Could you ... demonstrate all those competencies and have excellent governance, and still fail to improve your health outcomes? I think time will tell on that. I’m not clear that there’s a strong literature link between development of and demonstration of competencies and improvement of health outcomes.”

“You make some kind of logical links between saying ... if we get better at doing this well it’s going to lead to better outcomes but I’m not sure that there is very much evidence that very explicitly makes those links.”

In the absence of a strong evidence base, interviewees indicated that the process had been driven by a number of other factors and considerations. These included the views and experiences of a small group of individuals - the group that drafted the initial version of the competencies did so with little external evidence or input. This approach was based on an ‘initial trawl’ of the health care commissioning literature which confirmed the paucity of published evidence upon which to base the competencies. This approach was not published as a review, nor was the research...
team able to obtain access to any written documentation of the review. The implemented approach was summed up by one of those responsible for the initial drafting of the competencies:

“We didn’t come to the competencies based on the research literature, we came to them based upon where we connected as a small group of people and the direction of travel that we thought PCTs should be encouraged to go.”

The draft competency framework as initially devised was therefore primarily a reflection of the views and experience of those working with the Department of Health’s Head of Commissioning, supported by private sector management consultants. These individuals were from predominantly NHS backgrounds, and their experience included competency-based work carried out in NHS Strategic Health Authorities in England. Those interviewed also cited previous experience with local and national service improvement agencies as instrumental in shaping the approach adopted, as well as conversations conducted with commercial corporations considered world leaders in elements of commissioning included in the competencies:

“We were given assurances ... that everything in those competencies is happening somewhere in the world.”

The concern to draw on examples of good practice led the DH to solicit a review of good practice in sectors such as banking and retail.

“We don’t tend to look out into the upper sets of business and say: is that transferable? Should we be looking at doing those sorts of issues? And I think that has been a helpful thing added into this process.”
Aspects of the design and intended implementation of the competencies also reflected previous NHS initiatives that were perceived as having been successful. The most frequently cited of these was the Foundation Trust certification process:

“The process that Monitor go through to approve an FT - even though it looks very financially driven - is actually seen as a way of motivating the acute trust to improve itself ... and so we wanted to create that system for world class commissioning, a similar one holding them account but also really inspiring them to develop.”

The assurance model was thus envisaged as the commissioning equivalent of Monitor’s process for granting Foundation Trust status to provider NHS organisations. Reference was also made to the National Primary and Care Trust and Development Programme (NatPaCT) as an important exemplar of a competency based improvement programme, and the approach to assessment of the Health Care Commission. Overall it was felt that these precursors informed the WCC model of self-assessment, partner feedback and external panel assessment combined within an overall assurance system.

Finally, interviewees emphasized the importance of the subsequent NHS consultation phase in shaping the WCC initiative. This was referred to as ‘co-production’ by a number of interviewees:

“Every time I went anywhere to speak I collected names and email addresses so by the end we were working with about three to four thousand people who were interacting with us and so when we talk about this being a co-production, we really do mean it was a co-production with the NHS.”

Thus ‘three or four months’ of extensive, informal dialogue was undertaken with SHAs, PCTs and other stakeholders. This final phase of development also threw up the issue of WCC and its compatibility with PBC. In order that the former did not
detract from continued development of the latter, progress on increasing local GP commissioning was more formally embedded into the WCC assessment process (Gillam and Lewis 2009).

Interviewees indicated that the number of competencies fluctuated during this period, reaching as many as 20 or 30 before being eventually being synthesised into 10 (later to become 11). The process by which the individual competencies were identified was therefore considered to have encompassed:

- An initial listing of the activities undertaken by NHS commissioners
- A review of relevant systems and practices in other sectors
- Learning from previously developed NHS competency frameworks
- Consultation with PCT commissioners.

In the absence of substantive evidence on the benefits of health care commissioning, those designing the WCC agenda had clearly sought to adapt learning from other settings. However, frameworks and practices developed in other settings cannot be simplistically adopted in health care settings. For example, public choice theory and transaction cost economics have been helpful in unravelling procurement (den Butten, 2007), supply chain (Williamson 2008), and contract management issues (Kelman 2002) but do not provide an adequate framework for navigating the complex, inter-sectoral, multi-level governance issues associated with human services commissioning. Clearly, some insights can be identified from the theory and practice of components of the commissioning cycle in other public sector contexts (for example (Parker and Hartley 2003; Brown and Potoski 2004; Bovaird 2006). Of particular relevance are areas of procurement, supply-chain management and market management as practiced in commercial sectors. However, a number of authors raise concerns regarding the validity and risk involved in importing commercial practices into organisations such as the English NHS (Dawson and Dargie 2002; Johnson, Leenders et al. 2003; Allen, Wade et al. 2009). Similarly, whilst much
of the prescriptive material on commissioning is actually drawn from strategic management literature e.g. (Porter 1996; Mintzberg, Ahlstrand et al. 1998; Cueille 2006) what is often missing is a deeper understanding of how this strategic management literature can be more readily applied in public sector contexts.

3.3.3. WCC AS A MECHANISM FOR CHANGE

Although the key informant interviews suggested that there was a fairly scant evidence base for the competencies, those involved in their development remained confident that they could be expected to meet the aims as listed in section 3.2 of this chapter. Respondents were therefore asked to explain how they thought these improvements would be triggered by the introduction of WCC - in other words, what they considered the actual mechanism of change to be. There were multiple strands evoked in interviewees responses and this was reflected in characterisations of the competencies as, for example: ‘a checklist’; a ‘ladder’; ‘a development process’ a ‘framework’ ‘aspirational goals’ and ‘tools’. This may reflect divergent opinions of the competencies and how they operate or, alternatively, might reflect a multiplicity at the heart of the competencies themselves. The following sub-sections focus on three themes discussed by interviewees: the attempt to adopt a self-improvement model of change; the dual focus on skills and behaviours; and the role of the assurance process in bringing about change and improvement.

Self-improving organisations

The competencies were unanimously seen as operating primarily at an organisational rather than individual level. This was to reflect an emphasis on embedding good practice rather than compartmentalising commissioning in general – or specific commissioning tasks and behaviours – into individuals or smaller groups:
“It needs to be clearer that this is what PCTs do. It’s not just a couple of people in a room at the end of the corridor doing commissioning, the whole organisation does it. So I suppose the competencies were part of that process of trying to articulate more clearly that this is what a commissioning organisation looks like.”

“Our starting point was that we wanted these to be organisational competencies and that ... PCTs would then drill down and produce individual competencies if that’s what they felt was the right thing to do.”

The focus on the organisational level reflected a perceived desire for WCC to avoid micro-level prescriptions for practice. This was designed to be compatible with policy rhetoric supporting decentralisation of decision making and resource allocation, and the promotion of locally driven solutions to the demands and challenges facing health care systems (Department of Health 2005):

“Part of the shift in the environment ... meant that the way we had to operate centrally was through influence and enabling policy, and enabling tools. So we see the world class commissioning stuff as a set of tools to enable PCTs to take greater initiative for their own self improvement.”

This focus on enabling and the promotion of self-improvement granted a prominent role for PCTs themselves to devise organisational development strategies and to lever in the necessary external support.

**Skills and behaviours**

Whilst no respondent felt that any of the individual competencies were erroneous or inappropriate, three areas of potential lack were identified: quality, joint commissioning, and public health. In each instance it was felt that a greater focus on one or more of these dimensions would have improved the competencies as an overall reflection of good commissioning practice. Interviewees made reference to
the dual dimensions of *behaviour* and *skills* which were seen as roughly corresponding to the first and second halves of the competency framework:

“The competencies are a curious mixture of behaviours and skills ... you need to behave as leaders, you need to see yourself as local leaders of the NHS, and these are the skills, the technical skills that you need to do those things.”

The rationale behind these dual dimensions of technical skills and capabilities on the one hand and role/behaviour specification on the other appears to rest on a number of assumptions. The market stimulation and management competencies assume that a plurality of (and competition between) health care providers will bring about long term quality and efficiency gains although in health care. This draws on elements of New Public Management (NPM) thinking whereby outsourcing and marketisation of functions are seen as solutions to inefficiencies and poor quality in public service provision (Lewis, Smith et al. 2009) as well as new institutional economics in the role conceived of local commissioners (Boston, Martin et al. 1996). As well as this, the competencies also appear to be driven by a civic renewal agenda, drawing on communitarian frameworks (Johnson and Percy-Smith 2003; Williams, Durose et al. 2007). However, it is not entirely clear how this strand of communitarianism and community cohesion is to be incorporated into the NPM model, or how the separate functions were expected to be dispensed by the PCTs and others. Overall, these discussions suggest that the theoretical or empirical basis for the WCC competencies was complex and potentially conflicting.

Whether as descriptions of *behaviours or skills*, the competencies were characterised as a means of professionalising commissioning, by ‘focussing attention’ on the function’s core requirements. A strong association was therefore made between identification of competencies and improving the professionalism of practice:
“It really will have an impact because the competencies together just make the whole thing much more professional.”

The notion of ‘professionalisation’ was a recurring theme of the interviews and this was seen as conferring enhanced managerial status, as well as referring to actual improvements in commissioning practice.

The assurance process

The assurance process was seen as a key mechanism for bringing about the WCC aims. In particular the importance of ‘demonstration’ was reiterated, both by designers and implementers of the programme:

“I think the demonstration through the WCC process and the assurance is actually very helpful. Yeah we say we do it but actually can we prove it?”

Responses confirmed the general view that the commissioning function in the English NHS was currently not well performed (Wade, Smith et al. 2006). The initial assessment process was therefore calibrated to reflect a broader belief that PCTs were not currently ‘world class’ and that fundamental improvement was required. At the outset this was clearly envisaged as taking place over a fairly lengthy period of time and therefore the model was one of a staged process of gradual improvement, charted through multiple iterations of assessment, feedback and support. By focussing on the competencies and governance arrangements, it was envisaged that the building blocks for a longer terms outcomes-focussed approach would be laid and that in this time the expectations of performance levels (and the calibration of panel scoring) would increase. ‘World class’ performance was therefore considered a relative and moving standard that would imply increasing gains over time and it was therefore expected that the assessment process would get incrementally more demanding.

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Respondents also noted that the assessment process would need to evolve in order to avoid gaming and/or box ticking and therefore to remain an effective measure of actually capacity and practice. Indeed, the danger of the exercise becoming principally one of box ticking was later raised by a parliamentary select committee in a critical report on WCC (O’Dowd 2010). More positively, the aspirational nature of the competencies was expected to inspire higher levels of performance:

“The theory was if we put competencies out there then we also have aspirational levels within them, so quite early on we decided that we would have levels within each competency, we would give people aspiration and also some reason to focus on things.”

The combination of ‘demonstration’, ‘holding to account’, and ‘inspiring’ that was attributed to the assurance process was not universally accepted by interviewees. For example, some failed to see how the incentive structure rewarded excellence (as opposed to mere lack of failure) whilst others cast doubt over the likelihood that a competency-based approach could be expected to engineer the scale of change envisaged:

“What I’m talking about is not really other models of commissioning, it’s other models of massive organisational change over a short period of time. So how do you get an entire workforce to up its game quickly and consistently across a dispersed management system? Do we know anything about that? Does anyone know anything about that or is this a complete experiment?”

Three interviewees made the distinction between demonstrating competencies on the one hand, and the range of factors required to actually bring about change and improvement on the other. For example, one noted the gap between demonstrating
competency and demonstrating commitment and cited the issue of public engagement as a traditional example of tokenism in NHS management practice:

“In the end that’s the difference between applying the competencies superficially and applying them and actually really meaning and delivering on them.”

Another interviewee agreed that competence did not imply motivation, and that wider contextual factors could hinder the actual application of PCT capabilities:

“Competence [is] not just a set of skills ... There is also an element of motivation to do something and the environment enabling you to do it and you can’t be competent unless all of those things come together ... it is theoretically possible to be excellent in terms of those definitions and what you do and yet still not deliver if the organisational culture, will and motivation isn’t there to do it and if the wider environment doesn’t enable you to do it because other parts of the system don’t work or create barriers for you.”

Two other interviewees highlighted the absence of actual metrics in the competencies as a threat to both the rigour and the legitimacy of the framework. Concern was also expressed over the process for selecting metrics to measure individual PCT performance. For example in clinical areas where metrics were generally considered weak (for example mental health), their centrality to overall measures of performance were seen as having the potential to distort priorities. Similarly the absence of reliable or valid metrics threatened to effectively de-prioritise potentially important service areas.
3.3.4. IMPLEMENTATION

A PCT representative described the staged process that they had adopted to implementation of the WCC initiative:

“Our line was: year one, get the governance sorted; year two we’re showing some real improvement around our competence and that’s really starting to show some threes and maybe even the odd four here and there across the patch, and then; year three we’d actually be able to show some meaningful shifts in the outcome indicators.”

However, all interviewees agreed that PCT commissioners would be unable to achieve against the competencies without external input and support and this is in line with the Department of Health’s (2007: p4) assertion that ‘commissioners will need to engage with development and training organisations to improve capability’.

Whilst competencies 1 – 4 were generally considered to be challenging, competencies 6 – 11 were considered to require greater levels of external, technical support. The Framework for External Support for Commissioning (FESC) was identified as a key element of the required support infrastructure although not one that had entirely resolved the matter:

“I don’t think there is actually a clear national strategy for how we get from where are now to where we’re going, that’s my perception … My big concern is that we just haven’t got time for everyone individually to figure this out and duplicate effort and for the market to just sort of emerge and … we probably do need a bit more central direction around this.”

These sentiments reflect a tension in the government’s approach to implementation of WCC between autonomy and self-improvement on the one hand and economies of scale on the other. According to interviewees this tension had been played out in the process leading to the decision not to put in place a national support and
development programme. This decision was seen as primarily a response to objections from Strategic Health Authorities and recognition of the ethos of autonomy, self-improvement and localism that WCC was expected to reflect.

At the time of research, schemes developed in some regions of the country were being prepared for broader roll-out, the principles of a ‘share, buy, learn’ approach were being advocated, and regional commercial support units were set to become important sources of support. However, there remained a general perception that development had proceeded on a PCT-by-PCT basis and that whereas external involvement had increased NHS skills and capacity in some instances, this was not the case across the board. One interviewee expressed concern at the ‘amateurish’ nature of PCT commissioning – primarily as a result of lack of resources and development – in comparison to good practice from elsewhere.

The problems resulting from this lack of central direction and support were considered to have been exacerbated by changing timescales. Whereas the WCC agenda as initially conceived and sold to PCTs was a medium to long-term project in which improvements would be necessarily gradual, political and economic pressures had intensified the need to show improvements. Respondents expressed concern that sufficient time was unlikely to be made available for PCTs to attain a position of high performance within these revised timeframes. Finally, a lack of clinical engagement and support – despite attempts to connect WCC and PBC – was identified.

3.3.5. EARLY RESPONSES TO WCC

Despite these critical comments in relation to the implementation of WCC, respondents were unanimous in citing the broadly positive early reaction to the competencies from implementing PCTs. Those who had led the development and implementation cited an unpublished, internal evaluation that indicated the
competencies to have been ‘transformational’ with regard to commissioning practice, and external research has supported the general picture of an initiative that was well-received (Powell, Millar et al. 2010):

“In the whole the kinds of things we’ve heard from PCTs about the whole world class commissioning programme are not universally but largely positive ... no-one’s been saying to us this is ridiculous or unfair ... It felt as though it was actually measuring something relevant and important, and not just a tick box ‘have you got a policy on this?”

In support of this claim, it was further noted that internal and external assessments of PCT performance hadn’t exposed substantial disparities in perception. Although, as noted, respondents were either cautious or critical about some aspects of the competencies and their implementation, the ‘co-production’ approach was deemed to have brought benefits:

“I spend a lot of time going around the country and engaged boards in a way that I think they may have not been engaged before and it’s led to a much greater understanding of the raison d’etre of PCTs than they had before. I think they now realise that they are a priori commissioning organisations.”

3.4. POSTSCRIPT

At the time of research, respondents were divided over how robust WCC, and the competencies, were likely to be to changes in government. Some expressed concern that a changing political climate threatened the legitimacy of the WCC agenda, and that perceptions of the competencies’ impermanence (with a general election looming) in particular would weaken PCT commitment to implementation. These concerns proved to be well-founded when the new coalition government announced
ambitious plans to reform the NHS, and to relocate the commissioning function (Secretary of State for Health 2010). This appears to have been driven, at least in part, by the Health Select Committee’s highly critical report of PCT commissioning in which both WCC and its implementation were questioned:

‘It is not clear to us that WCC is going to address the lack of capacity and skills at PCT level and weak clinical knowledge. Furthermore there are concerns that WCC will be no more than a ‘box ticking’ exercise whereby people expend a lot of energy merely demonstrating they have the right policies in place, rather than actually transforming patient outcomes and cost effectiveness’ (Health Select Committee 2010; Paragraphs 148 - 150).

‘… we are concerned that FESC is an expensive way of addressing PCTs’ shortcomings’ (Health Select Committee 2010; Paragraphs 176)

There is, as yet, little to suggest that any aspects of the competencies will survive the planned government reorganisation (O’Dowd 2010). However, this is not to say that many of the concerns and skills which the competencies sought to address and promote will not remain valid in the new commissioning arrangements.

3.5. SUMMARY AND KEY DISCUSSION POINTS

Overall, the key informant interviews revealed a number of important issues relating to health care commissioning and competencies as a tool for service improvement. Although interviewees expressed varying levels of support for the WCC initiative, each acknowledged there to be both strengths and weaknesses to the competencies and their implementation. Problems identified – for example relating to incentive structures, lack of evidence and metrics, resources deficits and lack of clinical engagement – were offset by a general perception that the competencies were an important and timely step in the progression of the commissioning function. Some
interviewees – especially those less directly involved in the development of WCC - acknowledged some general limitations of competencies as a model of improvement, including their limited impact on motivation and environmental factors. In other words, the gap between demonstrating skills and resources and actually doing commissioning were seen as potentially substantive. However, interviewee responses also suggested that the competencies were intended not just to serve as an intervention at the level of organisational practice, but also as a means of raising the broader profile and status of commissioning more generally.

Discussion of the approach to policy development and implementation produced a number of tensions in relation to the competencies. The need to improve commissioning was a policy agenda that was widely agreed to have been driven largely by the centre, and the model adopted – i.e. the competency framework and the assurance process – was presented as the work of a small team of Department of Health officials. However, subsequent phases of development and implementation drew on broader policy networks from within and beyond the NHS, and the process of consultation undertaken prior to roll-out was considered to have distinguished WCC from previous, more top-down reforms. Following this period of policy ‘co-production’, further tensions had clearly emerged in the broader process of implementation. The first of these related to the role of central organisation in the provision of support to PCTs. The benefits of economies of scale and sharing of good practice were subordinated to principles of local determination and responsiveness. Subsequent concerns over variation at local level were exacerbated by changes in the political climate – although WCC had initially been intended as a locally driven process that would bear fruit over a medium to long-term period, political and economic pressures had resulted in demands for a centrally driven demonstration of short-term impact.
4. PHASE II FINDINGS: THE NATIONAL PICTURE

4.1. INTRODUCTION

This chapter outlines the findings from the telephone survey undertaken in phase two of the study, where data was collected between May and December (2009). The aim of the survey was to provide a snapshot of PCT views and practices around the WCC competencies. Questions focused on a number of elements which related to the themes of the WCC competencies including:

- PCT and PBC support for WCC
- approaches and methods used to support WCC
- barriers and facilitators to achieving WCC competencies.

Data reported in this section include those taken from the closed ended questions and also thematic analysis of the open-ended qualitative responses.

4.2. NATIONAL SURVEY RESULTS

A total of 67 Directors of Commissioning (or equivalent senior posts) from across the 152 PCTs in England took part in the survey (response rate 44%). The average number of years respondents had held their current position was 2 (2.15 sd; range 3mnths-13 years). In terms of the commissioning arrangements it was suggested that on average there were around 56 GP practices (range 0-150 practices) in PBC groups and an average of five PBC groups (range 0-16 groups) per PCT. Fifty five (89%) respondents stated that they had joint commissioning posts within their organisations, with only three PCTs reporting that they had one single commissioning agency for health and social care. Respondents were compared to non-respondents in terms of PCT size, index multiple deprivation score,
surplus/deficit position and proportion of population aged 75+. There was some under-representation of smaller PCTs and PCTs in deficit participating in the study.

The results from the survey are discussed under the following headings:

- Support for commissioning
- Practice based commissioning
- Barriers and facilitators to WCC

### 4.3. SUPPORT FOR COMMISSIONING: POLICIES AND ARRANGEMENTS

The survey findings suggest that 85% of respondents reported they had an explicit formal process for prioritisation within commissioning for new services. In recent years there has been a shift towards more transparent and open approaches to commissioning and in parallel a growing interest in the use of evidence based decision making and priority setting (Williams and Bryan 2007) (Sanderson 2002; Russell and Greenhalgh 2009). The use of technical approaches that draw on quantifiable clinical, epidemiological, financial and other data are increasingly being used to aid decision making and commissioning activity (Coast, Donovan et al. 1996). However, only 47% of PCTs reported having had any such process in place for disinvesting in existing services. This is consistent with the broader literature on disinvestment and also the use of clinical guidelines and health technology assessment which tend to focus on evidence around new developments (Elshaug, Hiller et al. 2007; Pearson and Littlejohns 2007).

An in-depth study of priority setting activities across English PCTs suggests that commissioners often perceive it to be easier and more contained to focus on new developments (Robinson, Dickinson et al. 2011). One reason for that is the fact that it is easier to engage individual stakeholders in an exercise around extra resource allocation and/or the development of new services – rather than making more difficult decisions on disinvestment which means a loss or reduction of services in at
least one area (Robinson, Dickinson et al. 2011). The fact that disinvestment could well create losses to a number of stakeholders means that resistance to such endeavours is often strong. Further, savings and additional benefits may take time to be realised and as such this could well increase the cost and will to pursue disinvestment activity (Gallego, Hass et al. 2010).

4.3.1. TOOLS USED TO AID COMMISSIONING PROCESSES

Technocratic approaches are often seen as an important and necessary aspect of priority setting and decision making under resource scarcity. Techniques such as PBMA, and economic evaluation have received a lot of attention in recent years and have been advocated as tools to support priority setting in health care (Mitton and Donaldson 2001; Bate and Mitton 2006; Elshaug, Hiller et al. 2007; Peacock, MItton et al. 2009) This telephone survey asked respondents about the different tools they used to aid their commissioning processes.

Results from the survey suggest that the use of such tools was high with all respondents stating that PCTs used at least one of the approaches outlined in Figure 1. With 81% of PCTs suggesting they use at least four or more of the different approaches to help inform their commissioning decisions. The most common approach used was programme budgeting data with 85% of respondents reporting its usage in priority setting. The number of respondents who reported usage of Programme Budgeting and Marginal Analysis (PBMA) was a little less at 63%.

Programme budgeting was suggested as the most widely used technique by PCTs. This result is probably not that surprising given the fact that the Department of Health have advocated the use of programme budgeting, with the WCC competencies making reference to both programme budgeting and PBMA. The Department of Health have also developed a number of programme budgeting software packages which are freely available to commissioners. A recent study by
Robinson et al (2011) found that commissioners had mixed views on the influence such techniques had on priority setting and resource allocation decisions. With commissioners expressing concerns about the inability of the techniques to come up with the ‘right’ answer to the decision making question posed. However, studies have shown that technocratic approaches are useful at a number of levels, one they can help in identifying areas for investment and disinvestment and also, as in the case of PBMA, act as a facilitator to the process of decision making (Peacock, MItton et al. 2009).

Figure 1. Illustrating methods used by PCTs to aid commissioning

4.3.2. RECRUITMENT OF HIGH QUALITY STAFF

One of the criticisms relating to the quality of commissioning is the ability of PCTs to attract and retain high calibre staff (Health Select Committee 2010; Smith, Curry et al. 2010). Further, the Darzi review raised concerns around the lack of analytical skills of many NHS managers (Department of Health 2008). One of the areas of interest in our survey was to explore PCTs’ abilities to recruit high quality staff and to explore what if any challenges they face in this area. The survey data suggested that there was only a mild trend in difficulties recruiting staff for commissioning positions, with
a slightly higher proportion of PCTs experiencing difficulties than those not (50% to 40% respectively). However, hiring quality staff, lack of appropriate staff, access to specific skills and skills gap were all identified as barriers to effective commissioning by a large number of respondents (see section 4.5 below for further discussion). Figure 2 demonstrates respondents perceptions on staff recruitment.

**Figure 2 Perceptions on recruitment of high quality staff for commissioning posts**

![Bar chart showing perceptions on recruitment of high quality staff](chart)

**4.3.3. FRAMEWORK FOR PROCURING EXTERNAL SUPPORT FOR COMMISSIONERS (FESC)**

The survey explored the extent to which PCTs had used external support via the use of the Framework for procuring External Support for Commissioners (FESC). FESC was introduced as part of the WCC commissioning reforms, in recognition of the lack of capacity and skill within PCTs. FESC allows PCTs to ‘buy in’ external support from a list of approved suppliers who can support PCTs across a number of commissioning functions (Naylor and Goodwin 2010). Our survey data suggests that there was a relatively low uptake, with only 28% of PCTS suggesting they had used the framework to procure external support. Respondents suggested the following themes in relation to the lack of uptake of FESC was due to ‘adequate in-house skill’,
‘too time consuming’, ‘complexity of the process’, ‘too costly’, ‘irrelevant’, ‘buying in support from other external routes including other PCTS’. The House of Commons Select Committee (2010) raised concerns over the complexity and high cost of the FESC process. The most common areas where FESC had been used included: procurement; specialist commissioning functions; highlighting best practice; care pathway re-design; and relationship building.

Our study only asked about the usage of FESC as a mechanism to engage external support in commissioning and PCTs may well involve private sector organisations and consultants to support them in their commissioning activity via other means. For example, other studies have noted that procurement frameworks including Official Journal of the European Union (OJEU) and Catalist are often more appropriate for some commissioning activity, especially around more small scale reactive work (Naylor and Goodwin 2010).

A national study conducted by Naylor and Goodwin (2010) found that WCC has been a driver for external support and over half of PCTs surveyed have used external support to help them with the assurance process. They also go as far as to say that PCTs would not be able to attain the highest level scores in the WCC competency framework without external support. Much of the outsourcing work identified in both our survey and Naylor and Goodwin’s (2010) study tends to be around joint delivery arrangements and supporting and strengthening the existing commissioning capacity, rather than adoption of a full outsourcing model. This could well change under the new commissioning arrangements with some GP consortia possibly wanting to outsource commissioning responsibilities to external organisations (Naylor and Goodwin 2010). However, private sector consultancies such as McKinsey and Ernest and Young suggest that commissioning support is more likely to come from NHS organisations and/or social enterprises, and that increasing more commissioning consortia ‘risked fragmenting the market, making deals potentially smaller and less attractive for private sector (Dowler 2011: p11).
Respondents were asked to rate their perceptions of how actively involved PBC clinicians are in driving strategic change through commissioning. Our survey results suggested that there was a positive uptake of practice based commissioning with 64% of PCTS agreeing or strongly agreeing that practice based clinicians were actively involved in commissioning. Figure 3 below outlines the respondents ratings of in relation to PBC clinicians involvement.

**Figure 3. Perceptions on PBC involvement in commissioning**

Some respondents suggested that PBC clinicians are actively involved on a number of boards including: the Executive board; Darzi groups; Clinical Leadership Boards and debating forums. Where respondents strongly agreed that clinicians had an active role in commissioning, it was noted that this involvement was very much about leading and shaping priority setting and service re-design - examples included transforming community services; redesign of care pathways; disinvestment and decommissioning. Other respondents noted that whilst there was some engagement
taking place this was through more informal rather than formal routes. There was also some suggestion that whilst strong engagement may be evident at PBC level ‘more needs to be done to increase awareness and engagement at the individual practice level’ (respondent comment). It is, arguably, difficult to assess the depth and quality of engagement which respondents report through a survey. Respondents are likely to differ in their definition of clinician engagement, from token attendance at meetings at one extreme, to considerable involvement and influence in decision making at the other. A more in-depth account of observed PBC engagement is provided by the phase III case study findings in section 5.4.

4.5. BARRIERS AND FACILITATORS TO WCC

The survey posed two open ended questions which related to barriers and facilitators to achieving WCC competencies. Both barriers and facilitators to WCC tended to relate to a number of key themes which included: engagement and involvement; organisational and cultural barriers (both structural and relationship issues); Information, knowledge, capacity and skill of the work force; lack of strategic planning; financial barriers; national policy and political climate. Figures 4 and 5 below outline some of the respondent’s comments on the main facilitators and barriers to achieving WCC competencies for the different themes identified in this study. Further discussion on the barriers and facilitators to WCC can be found below.
4.5.1. INFORMATION, KNOWLEDGE SKILLS AND CAPACITY

Wells et al (Wells, Abadi et al. 2007) suggest that ‘the key to good commissioning is effective, timely information and the capacity and capability to interpret that information.’ Findings from our survey would support this claim, with key themes around facilitators and barriers to achieving WCC competencies, being the need for robust and clear information and the capacity and skill to analyse and interpret information. WCC competencies place weight on the need to use data to drive decision making. However, qualitative data from our study would suggest a number of PCTs struggle to gain high quality information and lack the capacity and skill around data interpretation. Others have voiced concerns over the availability and use of relevant and robust data to inform commissioning, with many staff within PCTs being unable to analyse data effectively and have suggested this is one of the barriers to effective commissioning (Smith and Goodwin 2002; Health Select Committee 2010); (NERA 2005); (Smith and Goodwin 2006); (Wade, Smith et al. 2006); (Curry, Goodwin et al. 2008); (Smith, Curry et al. 2010); (Naylor and Goodwin 2010).

There is also further suggestion that this lack of skill leaves commissioners ill equipped to challenge providers. Likewise there is often a reluctance among providers to provide all relevant information – this information asymmetry and lack of power base (for commissioners) may well lead to inefficiencies and make decisions around disinvestment and pathway re-design even more difficult, with commissioners lacking the information and skill to challenge existing practice. Indeed the passive role of commissioners who have not been able to tackle the dominance of providers has been heavily criticised by the House of Commons Select Committee (2010) who suggest that commissioners lack both the levers and drivers to instigate change. In our study a related barrier identified was the lack of leadership and managerial skill to negotiate some of the non-technocratic elements of
commissioning such as governance, engagement, organisational power, politics and culture.

Smith and colleagues also note that one of the challenges for effective commissioning is the lack of professionalisation, with commissioners often having poor career development opportunities around professional development and high levels of staff turnover (Smith, Curry et al. 2010).

### 4.5.2. ENGAGEMENT AND INVOLVEMENT

Engagement and involvement with a wide range of internal and external stakeholders including providers, government, interest groups, local authority representatives, citizens and the media is vital to successful commissioning (Dickinson and Ham 2008); Ham and Dickinson 2008; (Williams, Dickinson et al. 2011). A high number of respondents from our study identified engagement and involvement with stakeholders including the public, clinicians and provider organisations from across the health economy as both a barrier and facilitator to achieving WCC. One of the weaknesses of WCC commissioning processes tends to relate to the lack of clinical engagement with more effective clinical leadership having the potential to enable more ‘clout’ in the local health care system (Smith, Curry et al. 2010); (Department of Health 2010). The importance of putting clinicians in the driving seat has been recognised by government in their recent move to introduce GP led commissioning across England (Department of Health 2010). Findings from our study suggested that there was strong engagement from PBC in commissioning activity. However, some respondents suggested that more needs to be done to increase the engagement and awareness of GPs at the practice level. In contrast, a study which asked practice based commissioners about their feelings in relation to their engagement with PCT commissioners suggested that PBC did not feel very, or at all, engaged by their PCT (Wood and Curry 2009). Other studies have suggested that PBC has had partial success in encouraging GPs to become more
engaged in commissioning and that engagement in commissioning and budgetary
decision making tends to be ‘limited to a small group of enthusiastic GPs in each
PCT’ (Curry, Goodwin et al. 2008). There has also been some criticism over the lack
of integration of PBC into the wider commissioning functions and agendas of PCTs
(Health Select Committee 2010).

Whilst GP engagement is indeed vital to commissioning it is not on its own sufficient
for truly effective commissioning which will require engagement from frontline
clinicians from across the health and social care sector (Wortham 2007); (Robinson,
Dickinson et al. 2011). Likewise effective commissioning will also require
engagement and involvement with other stakeholder groups from across the health
care economy. Research demonstrates that whilst pockets of good practice exist
around engaging and involving other stakeholder groups (such as public, patients,
community providers, and local authority colleagues) generally such activity is
relatively weak. Engagement can be costly, time consuming and complex to design
and execute (Abelson, Forest et al. 2003). However, as Bruni et al (2008) note this
may well be offset against the time and resource that could be spend defending
unpopular decisions that are taken without consultation. Further, implementation of
resource allocation decisions will be difficult without the support of those who need
to implement the change which is often not commissioners but providers of services.
Thus, engagement with different stakeholders is important and needs to happen
throughout the commissioning process (Robinson, Dickinson et al. 2011).

4.5.3. STRUCTURES AND ORGANISATIONAL BOUNDARIES

As noted above one of the identified barriers to effective commissioning was that of
organisational boundaries and structures. Comments tended to relate to the
complexity of the commissioning landscape and the perverse incentives of other
government policies – with particular reference to payment by results – which it is
suggested encourages productivity and can act as a disincentive in relation to over
policies around commissioning more community rather than hospital based services. There is some evidence to support the claim that the current system in England provides incentives to direct money from primary care and impact on needs based funding (Street and Maynard 2007). Further, some respondents noted that for their locality the idea of a market is somewhat notional in that often large acute trusts are the monopoly provider within a region. Respondents also suggested that if large scale change is to be achieved then a more system wide approach to commissioning is needed- that is clear about prioritisation –i.e. ‘what needs to be provided and what does not.’

This is contrary to the current government reforms which are taking responsibility from PCTs and moving to GP consortia, which will in-effect mean the 152 PCTs being replaced with a greater number of smaller commissioning bodies. Delamothe and Godlee (2011) note that commissioning over smaller populations will bring some new challenges including: the fact that having a few expensive patients could place a big hole in already stretched budgets; more GP consortiums means more commissioning skills are needed and as research shows such skill is currently in short supply; denied economics of scale and the potential for smaller consortiums to cut corners (or not be able to provide) on high quality infrastructure and management systems – which could well jeopardize their sustainability (Delamothe and Godlee 2011). A study by (O’Dowd 2011) on the handling of commissioning budgets in the US by groups of doctors demonstrates that underestimation of the importance of ‘high quality professional management support in their early days – such as data and information technology systems experienced analysis and other management and financial expertise’ (O’Dowd 2011) led to bankruptcy for a number of groups.

4.5.4. NATIONAL POLICY AND POLITICAL CLIMATE

National policy around commissioning especially in relation to WCC was viewed as both a facilitator and barrier to effective commissioning. For some the focus on WCC
and the assurance framework allowed for a clear focus on ‘important’ and ‘relevant’ aspects relating to the commissioning function. In contrast, others suggested it was merely a bureaucratic ‘tick box’ exercise that distracted focus on other important aspects of commissioning. As noted above the focus on WCC competencies may have led a number of commissioners to focus on resource allocation around new spend rather than focus on core budget spend and reallocation of resources and disinvestment.

As noted above policy around payment by results was also seen to impinge on the commissioning function. The way the system reimburses providers for activity was seen by some as a perverse incentive that was actually encouraging productivity, and reducing the engagement of providers who had little incentive to engage in reduction or redesign of services which could well involve losses for some providers. As Smith et al (2010:28) suggest ‘PCTs have few levers with which to control volume’ and often find themselves passively reimbursing providers rather than being able to proactively decommission or shift activity to alternative providers.

4.6. SUMMARY AND KEY DISCUSSION POINTS

The telephone survey presented here attempts to provide a snapshot of views and practices around WCC. The response to the survey compares well to other recent surveys of PCTs in England (Robinson, Dickinson et al. 2011); (Naylor and Goodwin 2010). Findings corroborate a number of features that have been highlighted by commentators in relation to the national commissioning landscape (Naylor and Goodwin 2010); (Smith, Curry et al. 2010); (Health Select Committee 2010). The study identified a number of key themes to enable effective commissioning which included aspects around: the role of national policy in incentivising effective commissioning; the need for robust and accessible information; adequate skill to analyse and interpret information; and the engagement and involvement of key
stakeholder groups including: clinicians at all levels, local authority and other local providers.

The 2009 WCC assurance process confirmed that the quality of commissioning by PCTs was largely poor to mediocre (Health of commons select committee 2009:30). Our study highlighted some of the commissioning activity in operation across England and some of the barriers and facilitators to achieving successful WCC. However, we need to be mindful about the limitations of telephone surveys and how respondents perceptions may well differ from the actual reality of commissioning. A recent telephone survey conducted by the Audit Commission suggested that PCTs perceptions on the effectiveness of commissioning practice are at odds with the actual reality of commissioning (Health of Commons select committee, 2010). Having said that, the majority of our findings do seem to support a number of other studies and reports that have explored the current PCT commissioning practices in England.

**Key Discussion Points**

- The majority of PCTs had an explicit formal process for prioritisation within commissioning for new services but much less in place for disinvestment activity;
- Technical approaches are being used to aid decision making and commissioning activity;
- Whilst there was a perception of strong engagement in commissioning at the PBC level more needed to be done to increase awareness and engagement at the individual practice level;
- Barriers and facilitators to effective commissioning – included:
  - Engagement and involvement of key stakeholders individuals and organisations from across the health economy
  - Structure and organisational barriers – with the emphasis on the need for greater partnership working and cross organisational buy in - whole system approach
  - Information, knowledge, capacity and skill – having effective, timely robust information is key to good commissioning as is the capacity and skill to analyse and interpret information
o National policy – can act as a lever to aid and develop effective commissioning – but it can also provide perverse incentives and act as a barrier to commissioning
5. PHASE III FINDINGS: THE INTERPRETATION, IMPLEMENTATION AND PERCEIVED VALUE OF WORLD CLASS COMMISSIONING IN PCTS.

5.1. INTRODUCTION

Building on the previous chapter which details the macro, national response of PCTs to WCC, this chapter sets out the findings from three PCT case study sites in which in-depth interviews were conducted to explore decision-makers’ perceptions of the introduction and impact of WCC within the commissioning context. Specific questions addressed within this chapter include:

• How did PCTs respond to and implement WCC?
• What were the associated strengths and weaknesses of WCC?

As outlined in the methods section 2.4.3, 38 interviews were conducted in total across the three case study sites. An overview of the case study sites is given in Boxes 1, 2, 3, and summary of the roles of interviewees are given in Table 5.
Box 1

Site A
This PCT cluster serves a population of approximately 800,000 in the north of England. The population is spread across both urban and rural areas. The PCT is supported by over 100 GP practices, over 150 community pharmacies and three large secondary care providers.

The level of deprivation, including homelessness and child poverty within this population is significantly worse than England average. The population experience higher instances of circulatory diseases, respiratory diseases, cancer and mental health issues than the national English average. Smoking, alcohol abuse - particularly binge drinking and teenage pregnancy are also higher than in other areas in England.

In terms of WCC this site notes an increased competency score on all individual competencies and moved from being ranked in the top 50% of PCTs in year one, to the top 25% in year two.

Other notable contextual features include:
- Two of the secondary care providers are well established foundational trusts who are perceived to hold a strong and powerful position within the health economy.
- Historically, relationships with the SHA in this site were based around stringent control and performance management. Subsequently, the PCT appear to adopt a similar approach during initiatives such as PBC.

Box 2

Site B
The PCT served a population of approximately 200,000 in the north of England, with almost 50,000 of these over retirement age. The PCT has an established relationship with the city council and a history of jointly funded commissioning posts; the area has one main secondary care provider.

The patient population experience higher levels of deprivation, unemployment, teenage pregnancy, smoking rates, alcohol and drug abuse and general ill health, than the national average in England. Inequalities in health are marked with contrast between affluent areas and deprived areas, ethnic minority groups in the area tend to be concentrated within small areas.

In terms of performance in the WCC assurance process this site was ranked in the top 10% in both years one and two.

Other notable contextual features include:
• Previous working arrangements were described as ‘parochial’ and there was a high level of variance between electoral wards. Efforts have since been made to improve collaboration and shared work arrangements were in place at the time of research.

• The PCT has made significant efforts to ensure at least one GP from each of the 50 practices in the area was engaged with PBC.

**Box 3**

**Site C**
The PCT served a population of roughly 250,000 in a de-industrialised midlands city. The PCT shared commissioning arrangements with a neighbouring PCT, taking on lead commissioning responsibility for acute and mental health services respectively. PCT boundaries are coterminous with the local authority boundaries, and contained approximately 60 GP practices and two community hospitals.

The patient population suffer from higher than average rates of mortality from circulatory diseases, respiratory diseases and cancer. The PCT were also faced with disproportionately high numbers of smoking adults, alcohol related admissions and adult obesity.

In terms of WCC assessment this site remained in the top 25% of PCT in both years one and two, although their relative ranking was lower in year two.

Other notable contextual features include:
• The existence of relatively powerful single providers – most notably via the one large acute hospital on the patch, but also in areas of primary care and mental health provision. This meant that there was little or no market or competition for the provision of NHS services.
• The high profile media exposure of the PCT over its decision to withhold funding for a specific, expensive treatment. This had implications for the public and media perception of the PCT and attitudes of PCT staff towards external communications.
• The PCT was active in fostering PBC - reflected in widespread involvement of GPs and the development of a ‘super-cluster’ of GP commissioning.
Table 5. Interview Participants

<table>
<thead>
<tr>
<th>ID number</th>
<th>Role</th>
<th>PCT site</th>
<th>ID number</th>
<th>Role</th>
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<tbody>
<tr>
<td>1</td>
<td>PCT Executive</td>
<td>A</td>
<td>21</td>
<td>PCT Non-Executive</td>
<td>B</td>
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<tr>
<td>2</td>
<td>PCT Director</td>
<td>A</td>
<td>22</td>
<td>GP/PBC representative</td>
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<td>3</td>
<td>PCT Director</td>
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<td>23</td>
<td>GP/PBC representative</td>
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<td>4</td>
<td>PCT Director</td>
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<td>GP/PBC representative</td>
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<td>5</td>
<td>PCT Director</td>
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<td>SHA representative</td>
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<td>6</td>
<td>PCT Director</td>
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<td>26</td>
<td>PCT Director</td>
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<td>8</td>
<td>PCT Non-Executive</td>
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<td>27</td>
<td>PCT Director</td>
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<td>9</td>
<td>GP/PbC representative</td>
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<td>28</td>
<td>PCT Executive</td>
<td>C</td>
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<td>10</td>
<td>PCT Director</td>
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<td>Acute Trust representative</td>
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<tr>
<td>11</td>
<td>PCT Director</td>
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<td>30</td>
<td>PCT Director</td>
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<tr>
<td>12</td>
<td>SHA representative</td>
<td>A</td>
<td>31</td>
<td>PCT Executive</td>
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<tr>
<td>13</td>
<td>PCT Executive</td>
<td>B</td>
<td>32</td>
<td>GP/PBC representative</td>
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<tr>
<td>14</td>
<td>PCT Director</td>
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<td>33</td>
<td>PCT Executive</td>
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<td>15</td>
<td>PCT Director</td>
<td>B</td>
<td>34</td>
<td>GP/PBC representative</td>
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<td>B</td>
<td>35</td>
<td>PPI</td>
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<td>17</td>
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<td>36</td>
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<td>20</td>
<td>PCT Executive</td>
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<td>PCT Non-Executive</td>
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The role of Directors could be divided into functions such as: commissioning, finance, public health, or other (contracting, information, organisational development, service planning/modernisation, service leads). This further disaggregation has not been shown here to avoid the potential identification of respondents. Although 38 interviews were conducted ID numbers are allocated up to 39, the intention was to conduct one further interview with an interviewee who had been allocated ID number 7. Attempts to schedule an interview were unsuccessful and as such this ID number is not included in the listing.
5.2. CASE STUDY INTERVIEW RESULTS

An analysis of themes was used to analyse empirically the interview data. Codes were developed from the interview data to label common concepts as they emerged. In total 36 codes were identified from which 11 broad themes were generated. Figure 6 illustrates the themes and sub themes generated from them. These were:

- The interpretation of WCC
  - WCC as a way of elevating the importance of commissioning
  - WCC as a way of structuring commissioning
  - WCC as a way of improving commissioning outcomes
  - WCC as a way of performance managing commissioning

- The implementation of WCC
  - resources (time, money, human capacity)
  - role of evidence and knowledge (nature of data and information, information systems and management)
  - partnerships, relationships and engagement (local authority, SHA, providers, PBC and GPs, patients and the public)
  - policy coherence (central control, constant change, policy alignment)
  - organisational culture (ways of working, power, leadership)

- The perceived value of WCC
  - the WCC initiative
  - the competencies

The themes were used to construct a description of the interpretation, implementation, and the value of WCC as perceived by the decision-makers interviewed. This is presented under the above headings using anonymised verbatim quotes by way of illustration.
Figure 6: illustration of themes and sub themes
5.3. THE INTERPRETATION OF WCC

Participants described the interpretation of WCC in four main ways. In summary, WCC was perceived to offer a way of:

- elevating the importance of commissioning
- structuring commissioning
- improving commissioning outcomes
- performance managing commissioning.

Each of these is discussed in turn below.

5.3.1. WCC AS A WAY OF ELEVATING THE IMPORTANCE OF COMMISSIONING

The introduction of the WCC programme in general and the competencies in particular, was recognised as being a positive progression in national commissioning policy and in line with the development of commissioning locally within PCTs. WCC and the competencies were recognised by participants as providing a welcome focus for commissioning and clarification of the PCT role. The competencies in particular were praised by respondents as orienting the focus of the whole organisational toward commissioning, with some participants arguing that this focus had been lacking in the past and was therefore overdue. As such, commissioners were optimistic about the introduction of the WCC initiative and with it associated a sense of being valued. These views are reflected in the quotes below:

“In a sense it gives a certain focus to what we’re doing”,
(ID8, PCT Non-Executive, Site A)
“What they’ve done is given people focus in terms of what makes us excellent and what standards we are working to” (ID33, PPI, Site C).

“When was the last time as a commissioner you got any specific development? When was the last time as a commissioner people said actually you’re really important? (ID26, PCT Director, Site C)

Not surprisingly therefore, initial comments about WCC and the competencies tended to be favourable, with the majority of participants largely agreeing with the underpinning rationale:

“The competencies that are in here are not unreasonable things to think we should have to do to be good commissioners” (ID3, PCT Director, Site A).

“I think they’re fairly comprehensive. I think as an overview that it’s absolutely fine” (ID12, SHA representative, Site A).

However, these views were tempered by statements that indicated that although respondents generally agreed with the principles of WCC and the competencies; they were also underwhelmed by them. As such, the approval of the WCC programme and competencies by respondents tended to be limited by the use of conditional statements in their responses. This can be seen both in the quotes above and below with the use of terms ‘the competencies […] are […] not unreasonable’, ‘I have no quarrel with’, and ‘I think they’re adequate’.
“I think you’d be fairly hard pushed to...to disagree with the competencies. I think they’re fine. I have no quarrel with any of the particular headings and the sub-sets within them all seem to have a logic to them and what have you...so no great problem with it” (ID24, GP/PBC rep, SiteB).

“I think they’re adequate” (ID14, PCT Director, Site A).

The tempered response to the WCC programme could in part be explained by the perception that the majority of respondents considered the content to be common knowledge, or ‘common sense’, that is: a description of what was already being done in commissioning in PCTs:

“’I think they’re basically common sense...how we should be working. I don’t think any of us can argue with, that is what our day job is about” (ID 34, GP/PBC, Site C).

5.3.2. WCC AS A WAY OF STRUCTURING COMMISSIONING

Respondents also acknowledged that whilst WCC was a reflection of current commissioning thinking and practice in PCTs, this needed to be formalised in a structured process and WCC potentially offered this:

“There needs to be a process and PCTs need to be held to account” (ID5, PCT Director, Site A).

The competencies in particular, were viewed by participants as offering this structure for the commissioning process. PCTs were able to use the competencies to reflect on and evaluate their existing commissioning process and its associated strengths and weaknesses. The disaggregation of the commissioning process into
discrete elements was perceived by some as useful in self-assessments of performance. This is illustrated in the following quotes:

“we took a view when they were first put forward that...we looked at these and how we fitted into it...and identified where we think our strengths and weaknesses are in each of them” (ID8, PCT Director, Site A).

“they’re good really, to identify those competencies and be specific about whether or not those competencies exist” (ID9, GP/PBC, Site A).

However, others emphasised the importance of considering the competencies within the entire WCC programme. These respondents suggested that the competencies were interlinked and even overlapping, and the perceived risk of separating commissioning into discrete elements was likened to removal of a ‘cornerstone’ from a building:

“to be honest I think it’s quite dangerous to start separating some of these [competencies] out because you need to do them all and, you know, if you’ve got one of them that isn’t being done properly then, it’s like the cornerstones of a building, you know, if you start taking a cornerstone out the whole building get’s inherently unsafe” (ID1, PCT Executive, Site A).

5.3.3. WCC AS A WAY OF IMPROVING COMMISSIONING OUTCOMES

Another welcome feature of WCC was the shift in focus from performance targets to population health and outcome measures. The competencies were considered by respondents to have lifted commissioners’ attention away from the minutiae of targets to the broader purpose of commissioning – improving the health of the local population:
“It sort of switches peoples mind onto what the outcomes are … life expectancy, alcohol smoking, … it’s nice to have that recognition that this is what commissioning is about” (ID27, PCT Director, Site C).

“When World Class Commissioning came in and said you’ve got to focus on health outcomes it just flipped the whole thing right over.” (ID15, PCT Director, Site B)

The explicit assumption was that achieving the competencies would ultimately result in better health outcomes:

“Well, I think it would ultimately, it should lead to better health outcomes, that’s a bit difficult to measure at this point in time obviously” (ID16, PPI, Site B).

However, the majority of participants were sceptical that the implementation of the competencies would actually deliver the changes and improvements in commissioning practice that were intended in the development of WCC (as outlined in Chapter 3). In particular, some respondents also recognised that there was not necessarily a causal relationship between the adherence to, and implementation of, the competencies and improvements in local population health. As such, respondents highlighted that it was possible to follow due process and provide the requisite evidence to demonstrate fulfilment of the competencies, yet not necessarily improve commissioning or ‘make the difference that [the PCT] ought to be making’. These arguments are demonstrated through the following quotes:

“I think it’s just a whole list of things that either the Government or the Strategic Health Authority demand of people that don’t really generate any change” (ID24, GP/PBC, Site B).
“You could go and find evidence of lots of things in an organisation and it might still not be making the difference that it ought to be making” (ID1, PCT Executive, Site A).

5.3.4. WCC AS A WAY OF PERFORMANCE MANAGING COMMISSIONING

Despite most respondents welcoming the use of the competencies in providing a structure and process for commissioning they also expressed concern that the strict adherence to the implementation of the competencies potentially resulted in the organisation being consumed by the ‘process’ and losing sight of the wider objectives of WCC and broader aims of commissioning:

“Every year feels almost as though you’re on a treadmill of actually feeding World Class Commissioning if you’re not careful rather than getting on with commissioning in a world class manner and that’s what worries me” (ID36, PCT Director, Site C).

The process of implementing, delivering and assessing the competencies within PCTs was interpreted by many participants as being a job in itself. One way of managing this job was to allocate commissioners to work on specific competencies in isolation. Respondents commonly reported that PCTs allocated a lead officer to oversee performance within each competency, working to satisfy individual elements of the competencies rather than considering the whole process. These views are reflected in the quotes below:

“This is definitely a process that has to have somebody assigned to it in the PCT” (ID12, SHA representative, Site A).
“The way that we’ve chunked it up is we’ve got a lead director for each competency … and then beneath that, where it’s necessary we’ve got different leads for each area … so that’s how we approach that and we have also similar arrangements for the three governance competencies if you like” (ID33, PCT Executive, Site C).

As such, respondents emphasised that the focus of WCC for PCTs was as much about demonstrating the achievement of the competencies as actually developing and achieving the competencies:

“Well I think that the whole concept of World Class Commissioning in its original vision was absolutely fantastic… I think where it is now is very, very disappointing. I see a number of organisations now who are doing like commissioning by numbers where they constantly almost trying to manufacture evidence to demonstrate that they’ve got a tick in the box … People become focused on this now as another performance management tool on PCTs” (ID13, PCT Executive, Site B).

“The team saw it as another set of documents I have to complete, another set of things that you can be beaten over the head about not achieving” (ID26, PCT Director, Site C).

Furthermore, the ranking of the relative performance of PCTs based on their achievement of the competencies was perceived by respondents as counterproductive insofar as it would encourage competition rather than discrete improvements in performance:
"I think that the problem is and I’m not sure if that’s a part of how it’s being used but I don’t see World Class Commissioning, I don’t see that it’s supposed to be a competition as to where you fit in a league table. Almost by having a league ‘this is where you fared in the country’ I think that’s in some respects counter-productive to the thing.” (ID21, PCT Non-Executive, Site B).

5.4. THE IMPLEMENTATION OF WCC

As reported above in the interpretation of WCC by PCTs (section 5.3), the WCC initiative was initially perceived by PCTs as progressive and developmental, and commissioners were optimistic about its introduction. However, the translation of WCC from policy to implementation within PCTs was not without its challenges. Themes emerging from the analysis of the interview data centred on the challenges faced by PCTs in implementing the WCC initiative, the competencies, and the assurance process. In summary these challenges were discussed within the interviews in terms of:

- resources (time, money, human capacity)
- role of evidence and knowledge (nature of data and information, information systems and management)
- partnerships, relationships and engagement (local authority, SHA, providers, PBC and GPs, patients and the public)
- policy coherence (central control, constant change, policy alignment)
- organisational culture (ways of working, power, leadership)

Each of these themes is discussed in more detail in the following sections.
5.4.1. RESOURCES

Resources were frequently identified by participants as a barrier or obstacle, both in commissioning in general and in implementing WCC specifically. The term ‘resource’ was often used generically as a catch all to describe money, time, and human capacity (staff). Participants readily stated that WCC was not sufficiently well resourced and they expressed concern that the organisation lacked money, time, and human capacity to enable the effective implementation of WCC.

Time

Participants referred to time in two main ways. First, the amount or quantity of time available for undertaking WCC was not sufficient, i.e. it was often lacking. Second, the notion that time, as a general resource, was scarce and therefore time spent on WCC was time foregone that could have been spent doing something else.

Participants expressed concerns that the time frames for implementing WCC and, in particular, realising the competencies were unrealistic and that whilst they recognised the value of the competencies and that they were potentially achievable, this would take longer than policy and politicians allowed: “policies take time” (ID25, SHA representative, Site B). Additionally, time frames were suggested as being driven by other political milestones, such as the budget. The lack of time was therefore identified as being something over which the PCT had little or no control and consequently demands on time were often greater than the limited time available. Participants noted that:

“Because we don’t have many resources we’re all working flat out and things tend to be very last minute, eleventh hour” (ID16, PPI, Site B).
In relation to time spent on WCC, participants regularly voiced, as illustrated in the quotation below, the need to ‘get on with the day job’. This contrasts with the opinions presented through the key informant interviews (section 3.3.1), which suggested that demonstration of these competencies is the ‘day job’ and will lead to the further development of commissioning.

“So again this assertion that WCC should be part and parcel of our everyday job and not involve extra work is wrong” (ID33, PCT Executive, Site C).

However, the notion that WCC was an addition to the day job was, in the main, restricted to the WCC assessment and assurance process which was viewed by some as a ‘distraction’:

“I feel that we spend so much time ticking boxes and chasing you know, attainment in performance league tables rather than focusing on the day job” (ID3, PCT Director, Site A).

“we’re in danger of death by regulation [...] the World Class Commissioning it feels like we’re being asked to do the same thing twice [...] we’re doing the job twice and actually it’s the same work but it’s still double the effort if that makes sense” (ID37, PCT Director, Site C)

In extreme cases, the process of assessment and assurance was viewed as particularly laborious and “completely debilitating” (ID13, PCT Executive, Site B). The reasons provided for this were that the assessment was overly restrictive in both the amount and types of evidence that organisations were permitted to include as part of their self assessment; the level of detail required for the self assessment in addition to that available in routine organisational strategic documents; and the fact that the assessment required reflection and demonstration of what had been
achieved within the last year in contrast to routine organisational documents that were forward looking.

Additionally, revisions to the assessment and assurance process between years were viewed by participants as further exacerbating the amount and levels of time and effort spent on demonstrating commissioning rather than doing commissioning. This can be seen in the quotes below:

“There is too much pulling up of the plant just to keep checking how the roots are doing” (ID13, PCT Executive, Site B)

“There is an anxiety that people are doing stuff just to be able to produce evidence for the assessment process” (ID14, PCT Director, Site A)

As such, the assessment and assurance process was considered by participants as a burden to commissioning – presented as a set of ‘hurdles’ which they repeatedly had to overcome.

“If you set up more hurdles...people aren’t going to feel that they want to keep jumping over hurdles, they’re going to say I think I will just give up altogether” (ID9, GP/PBC, Site A).

Money
Participants referred to money in two main ways. These related to both to the lack of money but also the lack of perceived autonomy or freedom to make resource allocation decisions.

Reductions in funding for PCTs were anticipated, though the changing economic climate resulted in more severe reductions in operating budgets. Compared to previous years in which PCTs had experienced a growth in funding, the reduction in
monetary resource was seen by participants as impacting on their ability to continue
to commission existing services. Participants highlighted that the allocation of
resources was expected to become a more contentious issue as the organisation
adjusted to lack of growth funding. The ability of PCTs to allocate resources was
already seen as a challenging issue. As illustrated in the quotes below, some PCTs
noted the lack of control they were able to exert over the allocation of resources:

“There wasn’t the money to spend on the things we’d identified as outcomes that were important, or that were key things in the strategic plan because there’s still all the things that you have to do, you know, the government policy is ‘though shalt do’, then that’s the first call on the money. The local discretion stuff by and large was not funded in the way that we would have hoped.” (ID1, PCT Executive, Site A).

**Human capacity**

The majority of discussion about resources focussed on human resource capacity,
with many participants identifying that the commissioning agenda and WCC
specifically required management staff “in order to make it work” (ID8, PCT Non-
Executive, Site A) yet PCTs lacked both the numbers of people required to undertake
commissioning and the appropriately skilled people to implement WCC successfully:

“The other thing I think that’s going to hamper us in this is that the organisation is not adequately resourced to do what it’s been asked to do. Currently management costs are about 1% of turnover and if you look at most major complex organisations, the management costs will be significantly more than that. Our management costs are less than the acute hospitals that we’re dealing with, and that’s got an impact on how much then we can invest in information services, how much we can invest in public health, it’s; if the centre of the Department of Health and Central Government wants to move quicker in making commissioning work, it’s going to take more resource than we’ve currently got.” (ID5, PCT Director, Site A).
“the issue is, there is a huge shortage of people with appropriate procurement skills, not just with NHS expertise, but just generally, I mean it’s an issue nationally” (ID8, PCT Non-Executive, Site A)

The lack of capacity for developing and implementing WCC was perceived as being further hindered by the high staff turnover experienced by PCTs. As noted in Chapter 4, the average duration a Director of Commissioning held their post for was two years. This is likely to have negative consequences for the organisation in terms of relationships and learning. Specific issues stemming from continual staff changes included: lack of leadership for commissioning, being unable to sustain momentum in commissioning, and the loss of tacit knowledge in building and maintaining the organisational memory around commissioning. Furthermore, staff commitment to the organisation was eroded through continual change. These views are represented in the quotes below:

“they’re [PCT commissioners] today’s people, they’ll be gone soon so permanent reconfiguration isn’t helping commissioning” (ID36, PCT Director, Site C).

“I’ve mentioned the fact that we’re a very small organisation really, managerially, a very small resource. [...] PCT’s will probably get re-organised and when that happens, generally speaking, you’ve got sort of, two years of, well two of chaos, two years of trying to keep an organisation again that’s going to change anyway and then it’s about creating a new organisation again, that’s going to have its impact.[...] it’s hard then not to think short term, you know, [...] The other thing it will have an effect on as well is, stuff looking at their job here, looking at the job in another part of the system and thinking ‘would I be safer, for example, if I went to work for an acute hospital trust right now, because the chances are, they’re not going to be reorganised in the same way as the PCT’ so potentially we could lose some good staff over the next six months.” (ID5, PCT Director, Site A)
5.4.2. ROLE OF EVIDENCE AND KNOWLEDGE

The WCC assurance process was underpinned by the need to provide evidence in order to demonstrate the successful implementation of the competencies. As such, the competencies themselves appeared to draw heavily on data and information:

“Too much of the NHS is made of intuitive or emotive decisions, isn’t based on fact, isn’t based on knowledge. So actually if we improve our ability to work with knowledge and health intelligence we will improve over four or five of the competencies.” (ID31, PCT Executive, Site C)

Discussion by PCTs about the availability and data requirements for implementing WCC tended to sway between the ‘it’s probably the traditional sort of information overload...’ (ID36, PCT Director, Site C) to ‘but it’s not enough’ (ID15, PCT Director, Site B). However the major focus for discussions about data was not on the availability of data but on issues around the nature of available data and the availability of systems to support the generation of data and its translation into information and knowledge:

“We have quite good information but I think we just need to build on the information that we’ve got and build up better knowledge” (ID24, GP/PBC, Site B).

Nature of data and information

Available data were not always fit for purpose, particularly with respect to what was needed within the context of WCC. As illustrated below, participants highlighted that the information generated through nationally or locally collected routine data was not always immediately useful or applicable to the specific setting it needed to be applied to.
“The first half, data is always typical in the NHS, we have so many nationally defined data sets that they never quite give us the information we want, they give us, you know, some information but it’s never exactly what you’re looking for” (ID1, PCT Executive, Site A).

The usefulness of routine data was also critiqued by respondents with reference to their consistency and comparability. The quotes below illustrate that lack of consistency, or asymmetry, in the collection of information and the recording of outcome measures created complications for PCTs as to how best manage and interpret the data. PCTs recognised that this was hindered by a number of factors including insufficient data systems, and immature clinical and public involvement environments.

“One of the things that we’ve identified is the information is being gathered in a variety of different ways which doesn’t make it easy to collate or otherwise kind of make any sense of” (ID32, GP/PBC representative, Site C).

“We have asymmetry of information […] you can’t compare like with like because it isn’t like with like. Okay a hip replacement in one hospital might be similar to a hip replacement in another but when you get down to complex care it’s much more difficult to enable us to do that so the systems aren’t in place, the information isn’t in place.” (ID25, SHA representative, Site B)

Furthermore, the accuracy and quality of these routine data were also queried. This was linked to the nature of the data themselves, but also to the fact that good quality data would often have to be paid for. These points are reflected in the following quotes:
“...there are some areas that are extremely hard to measure like smoking prevalence. [...] so we’re relying on synthetic data rather than accurate real data and that’s a problem as well” (ID1, PCT Executive, Site A).

“Accuracy can be a problem, so you know, if we want accurate data from GPs for example, we have to pay them for it [...] so the quality of data is, is a significant issue” (ID1, PCT Executive, Site A).

Finally, PCTs made reference to the fact that many of the routine data and information available were limited in their application to future commissioning decisions as they were often outdated:

“In terms of the timeliness around some of the health improvement work, our performance on some areas is determined by data that’s never younger than eighteen months old, [...] it’s useless” (ID1, PCT Executive, Site A).

Similarly, research data and evidence were not considered anymore useful in the context of WCC. Respondents argued that the implications of research data were not readily evident and the outputs from research required further work to translate them into meaningful knowledge or ‘management language’ for commissioning purposes:

“... so we look at that and we look at the evidence and we say alright then so if you’ve got coronary heart disease and if we did that smoking intervention how many life years would we gain?. But you can’t find that, what you find is [...] something, that doesn’t convert into management language, [...] so we’re kind of modelling and guessing” (ID15, PCT Director, Site B).
However, respondents recognised the difficulties involved in collecting data, particularly with respect to primary prevention and public health outcomes:

> “some of the preventative and public health stuff [...] is really quite hard to articulate in terms of outcomes,” (ID37, PCT Director, Site C),

and that the strength of the evidence base around acute care outcomes, pharmaceuticals, and devices therefore tended to focus attention toward commissioning in these areas.

As a result, PCTs tended to rely more on locally generated data and experiential evidence. Additionally, formal and informal networks were cited as useful for sharing information and data on outcomes; as well as best practice that could be adopted, adapted and introduced in different contexts. Examples included NHS evidence and email groups:

> “There’s kind of a [...] yahoo network where they share information and that’s...that’s probably the best network I’ve come across and there’s a whole hard core of enthusiastic members [...] who you know contribute regularly on...on a lot of the latest information on kind of cost effectiveness...” (ID27, PCT Director, Site C).

**Information systems and management**

As suggested above, the available data often required manipulation or amending in order for use within WCC, with terms such as ‘pick our way through’, ‘distilling’ and ‘knit together’ being used to describe this work.

> “We’re probably overwhelmed with a lot of information but it’s not always easy to pick our way through it” (ID24, GP/PBC, Site B).
“We’ve just gone through things like QIPP papers, we’ve gone through the national priorities, say the public health document […] one of the issues is that there’s a lot of different documents coming all over the place and it’s how do you bring those together and we’ve just had the strategic commissioning group talking about that there needs to be a process of bringing that together and then distilling that…”

(ID32, GP/PBC representative, Site C).

Respondents recognised that this required systems as well as people and skills:

“We’re still struggling in terms of capacity. Not necessarily capability but in terms of capacity to synthesise a lot of data and information and turn that into intelligence […] We are struggling to make sense of all the data. We’re data rich, I think, and intelligence poor.” (ID25, SHA representative, Site B).

The development of information systems and capacity to assist with data management were things that PCTs were investing in but the majority of respondents highlighted that they were at an embryonic stage and needed to be developed further over time:

“We’re making significant investment in information systems; we’ve got quite a big, information set up, but some of the, you know, some of the basic information systems aren’t there, and it’s going to take time to develop” (ID5, PCT Director, Site A).

Within the context of implementing WCC, one site in particular had developed local capacity around health intelligence though participants also acknowledged that they needed to develop better processes for applying and feeding knowledge into commissioning activities and the planning cycle in a way that would improve commissioning and health outcomes:
“The next bit that we need to develop even further is about okay, we’ve got this wealth of information about what, about what’s out there, what difference is it making to what we commission now, how has it actually changed what we’re commissioning? Some of it has [...] but it needs to be fed into the main stream service planning and commissioning. It started but it’s not as far down the line as we want.” (ID36, PCT Director, Site C)

As such, whilst there were systems in place, PCTs were not necessarily making full use of the intelligence that they generated and this information was not yet informing decision-making and resource allocation.

5.4.3. PARTNERSHIPS, RELATIONSHIPS AND ENGAGEMENT

Across each of the case study sites, PCTs tended to refer to partnerships in the context of commissioning and WCC in terms of the formal relationships and engagement strategies that they had developed with local health and non-health organisations and stakeholders. Participants considered relationships to be fundamental to the success of commissioning and WCC in particular:

“actually you can have the most perfect structure and the wrong people and it doesn’t work and you can have an awful structure with the right people and it does work” (ID29 Acute Trust Rep, Site C).

However, they also emphasised that ‘good’ relationships were not always easy to establish and that differences in organisational culture and objectives, and historical disputes between organisations, hindered the creation of partnership working and good relationships. The relationships most frequently discussed by participants in the context of WCC are presented in more detail below. These included: the Local Authority, SHA, providers, PBCs and GPs, patients and the public.
Local government

The extent of partnership working with the local authority varied across the case study sites with only one site drawing out this relationship. That is not to say that partnerships with the local authority did not exist in the other sites, but they did not explicitly refer to them.

The PCT in case study site B readily recounted partnership with the local council and noted having tripartite meetings on needs assessment which involved social care agencies. Where partnership arrangements were or had been in place, these were sustained and maintained through formal arrangement such as the joint funding of posts, rather than informal mechanisms:

“we used to have an extremely productive relationship with our council which related really to the old Adult Director of Social Care, [...] we set up a series of Partnership Boards that we commission through and they range in success. Some are very, very successful and with that Section 75 agreement we had a joint appointment for commissioning between us and Adult Social Care.” ID15, PCT Director, Site B.

“we’re very much linked to our local authority. We’re co-terminus with our local authority [...] and we do a lot of partnership working. Our Director of Public Health is a joint appointment.” (ID14, PCT Director, Site B)

SHA

As above, the extent of partnership working with the SHA varied across the sites. The involvement of the SHA in commissioning and the implementation of WCC was not uniform. In the main, respondents from two of the case study sites (including those within the SHA) perceived the SHA to be removed from the commissioning process and thus WCC:
“I mean what we try to do, as an SHA, we may be different from others, we’re quite hands-off, we’re quite light touch” (ID12, SHA Rep, Site A).

“I think they’re very distant. I don’t know if they’ve given their support on World Class Commissioning” (ID15, PCT Director, Site B)

“The SHA is a different beast because they have a different role and to be honest we use them where appropriate and we feed their beast because they want lots of information out of us but I wouldn’t say that they were a part of the commissioning process” (ID14, PCT Director, Site B)

Conversely, respondents from the other case study site appeared to have a more collaborative relationship with the SHA and the SHA reportedly provided high levels of practical support around WCC to the PCT:

“I think in the longer term the SHA are doing an awful lot to support PCTs competencies” (ID31, PCT Executive, Site C)

In all cases, however, the relationship with the SHA was less focussed on partnership working and more on the hierarchical relationship that existed between the DH, SHA and PCT and the view that the SHA acted as the go-between from the Department of Health to the PCT:

“I think there are often some challenging issues because the SHA is really the conduit via which some of the Department of Health edits are passed on to the poor souls that have to deliver them on the ground and they don’t always match exactly what we were doing and when we were doing it...” (ID8, PCT Non-Executive, Site A).
Providers

Partnership working with providers whilst welcomed as a more sustainable approach to commissioning, was perceived as being impossible by respondents for the following reasons: there was a perceived imbalance of power between the PCT and acute providers, the organisations worked toward achieving different objectives, and they were in competition with one another.

In terms of power, large providers, and Foundation Trusts (FTs) were viewed by the PCT as powerful organisations, defined in terms of being rich in resources, particularly money and capacity:

“The difficulty is they are quite powerful organisations and they’ve got a lot of resources in terms of management, you know, structures that they can afford to pay so they’ve got more resources than the PCT in many ways and more expertise.” (ID9, GP/PBC, Site A)

“I think historically, everybody finds [FT name], very challenging as a body to deal with because historically, going back to my earlier point, they ruled the roost, they’re the biggest, the best and nobody would doubt that they provide excellent services, but they just think everything should be done their way to their agenda” (ID8, PCT Non-Executive, Site A).

Respondents noted that the power of the FTs was a result of existing organisational structures and the underlying objectives of the FTs, namely, that they are “set up to suck in business” (ID3, PCT Director, Site A). As such providers were seen as the key organisations within the health economy that were driving and controlling commissioning negotiations and decisions:

“The power that large providers have got, it’s quite awesome really... you know the tails been wagging the dog in commissioning for a long time” (ID36, PCT Director, Site C).
“The rules of the game for commissioning are completely against pathway re-design in terms of looking at prevention because the hospitals are set up to suck in business and as they suck in business the money follows the patient and we have to pay them. So you’ve only got what’s left over to spend on anything else.” (ID3, PCT Director, Site A)

WCC was not seen to ease the adversarial relationship that this power imbalance created between the PCT and acute providers. In fact competency seven which required PCTs to stimulate the market was deemed by some participants to encourage greater competition and hostility between providers and PCTs, (see further below, section 5.5.2).

PBC & GPs
Practice based commissioning (PBC) was introduced in 2005 and therefore PCTs had existing established formal relationships with GPs. The introduction and implementation of WCC and the competencies further formalised and cemented these relationships with both PCTs and GPs recognising that in order to improve commissioning these relationships needed to be more proactively developed. Participants reported widespread acceptance of the requirements to develop PBC and readily identified its potential benefits and the underpinning rationale. It was evident that, perhaps spurred by the competency requirements, PCTs undertook a lot of work to build the levels of partnership working and engagement with PBC:

“We did a lot of work around clinical engagement and with GPs who have a manager to commission, and not just around competency three ... it was about developing better pathways for our patients...”(ID26, PCT Director, Site C)
“We have done an awful lot of work on PBCs and they both want the engagement or as say compared to some people which is excellent.” (ID30, PCT Director, Site C)

“So there’s a lot of work that’s gone into PBC and I think you can’t get far in this conversation without thinking about the importance of PBC because the, the gate keepers of so many pathways for individual patients and clients sit in general practice” (ID1 PCT Executive, Site A)

However, respondents from both PCTs and general practice identified several barriers to partnership working, for example the clinical-management divide:

“Generally speaking the clinical fraternity don’t have huge value of managers” (ID26, PCT Director, Site C).

First, in some localities, it was evident that there was a spectrum of relationship quality across GPs. This is denoted by the variation in the level of involvement and trust in the first quotation below. It was evident that the quality of previous relationships and commissioning history had a bearing on the level of PBC engagement. The second quotation reports the need to ‘build bridges’ suggesting that previous relationships required a degree of nurturing. This variation in depth and quality of engagement of GPs with commissioning will likely have implications for the next era of commissioning. Those GPs who have worked closely and in partnership with their Trusts could have an advantage over others who have been less actively engaged.
“in one of the PCTs the GPs felt very close to the Trust but so close in fact that almost they were dictating what would [...] in another one of the Trusts there is a lot of mistrust from GPs at what we were doing, lack of engagement and the feeling that they weren’t valued.” (ID1, PCT Executive, Site A)

“it’s the first time that we’ve all got together sort of on a locality basis to talk about needs focused commissioning you know Practice Based Commissioning but we sort of built some bridges with some practices I think.” (ID 22, GP/PBC representative, Site C)

Second, there was a skills-gap between GPs and the PCT with regard to commissioning, with GPs acknowledging that PCTs have developed skills, experience and capability in commissioning that was not available or resourced within PBC groups, and PCTs highlighting that they had to invest in training for GPs in order to equip GPs to better engage with them. PCT participants identified commissioning skills which are currently lacking in PBC and which were perceived as residing in PCTs:

“We don’t want to take the whole commissioning role...we’re not resourced enough, we’re not capable enough...so we need to work in partnership with the PCT” (ID32, GP/PBC representative, Site C).

“...they don’t necessarily have sort of those leadership skills either and there’s commissioning skills and power tends to be directed at those kind of groups of people who don’t have the skill set to be able to deal with...corporate kind of requirements.” (ID27, PCT Director, Site C)
“...clinicians are not planners and they’re not...they don’t have any comms background, don’t have a planning background, they don’t know about system redesign necessarily, they know about their patients or what their specific kind of thing, not strategic thinkers necessarily and in order to get a decent strategy or a decent plan or you need a whole set of other kind of skills and the whole philosophy of the document seems to translate clinical engagement equals good planning and it doesn’t.” (ID27, PCT Director, Site C)

Third, it was noted that GPs required incentives to engage in commissioning, which tended to be manifest in monetary terms:

“If our colleagues said to me ‘do I have to join in with this and take on real budgets?’ the answer is no, you don’t have to. So it’s about how do we incentivise people to do it and I think that’s where the incentives haven’t been right at the moment to get it taken wholesale by all practices. [...] you know money attached to PBC it would always be an incentive and there isn’t a lot attached to it” (ID32, GP/PBC representative, Site C)

“We had to pay them. That always makes them more involved. We spent a long time facilitating like the leadership...” ID15, PCT Director, Site B)

Where PBC and WCC offered a means by which GPs could gain financially by controlling their own budgets, this was seen as a key driver for GP engagement in commissioning rather than a desire to be involved in commissioning per se.
GPs involved in PBC also advised that although ‘all practices’ in an area might be involved, this frequently involved only one GP from each practice and it was difficult to gauge accurately the extent to which their involvement was indicative of that of other GPs within each practice. PBC was not compulsory and groups were awarded indicative, rather than real or hard, budgets. There was a suggestion that engagement across the GP population was somewhat superficial and this appeared to be due to lack of financial incentives:

“I think that practice based commissioners would be keen to hold their own budgets” (ID12, SHA Representative, Site A).

“Now, the sooner we take the budgets on more will happen” (ID32, GP/PBC representative, Site C)

“if you give them hard budgets then there is much more of an incentive to get them” (ID34, GP/PBC representative, Site C)

Concerns were raised about the anticipated success of GP engagement, and the limiting of clinical engagement to that of GPs. It was noted that little consideration had yet been given to the impact, if any, that GP engagement was making; qualified
by noting the perceived lack of incentives. It was noted that the scope of PBC was currently restricted and did not include other relevant health professionals.

“What I’m not sure about is how much impact that clinical engagement has actually had on changing clinical practice in Secondary Care reasons why PBC didn’t work...lack of incentives...” (ID30, PCT Director, Site C)

“We have less of a link in terms of commissioning intentions with dentists, with pharmacists and eye health care professionals and I think that’s partly because they don’t have Practice Based Commissioning.” (ID25, SHA Representative, Site B)

Across the case study sites there was some evidence, of reluctance on the part of both GPs and PCTs to fully commit to engage with one another around commissioning and WCC due to the level of investment required on both sides. These three challenges of fragmented relationships, skills gap, and the absence of aligned incentives have not been resolved through the curtailed WCC initiative. They will need to be carefully addressed and managed to avoid further tensions and hindrances to successful commissioning in future.

**Patients and the public**

Patient and public engagement was often discussed with respect to formal mechanisms of engagement such as through non-executive members of the PCT board and the overview and scrutiny committees, but also through supplementary engagement activities to establish communication and develop relationships with the local population. The active nature of work required to establish and develop these relationships and investment required to maintain communication was apparent across all the case study sites:
“we’ve done a lot of work to establish relationships with a lot of different public groups” (ID1, PCT Executive, Site A);

“we do a number of different things, we run or we support a number of forums which...which give us the ability to gain that PPI” (ID33, PCT Executive, Site C).

Participants recognised that engagement was still in its infancy and that more work was required to enable more appropriate and effective engagement in order to implement WCC:

“determining how to make sure that information is available and that it comes from the right sources and it’s used by the right people so it’s in its infancy stage so at the minute what we tend to do is we engage with them on an ad hoc basis” (ID16, PPI, Site B).

“I think we are still very much at the early stages of truly involving, engaging...and we’re not using the knowledge that the public as a collective and patients as a set of individuals have.” (ID25, SHA representative, Site B)

“There are challenges in terms of how we move from the relationships we have to what we need” (ID1, PCT Executive, Site A)

Moreover, respondents noted that they lacked the expertise required to initiate and further develop these relationships in a meaningful way, and that WCC lacked guidance on how to best do this in order to meet the competencies.

“...the relationship stuff so when you’re trying to work out how you’re going to collaborate with clinicians, engage with the public and patients, work with community partners ‘cause it doesn’t really tell you how, it just tells you the what’s, you know, that you do these things and then they have those results. It doesn’t tell you the how” (ID1, PCT Executive, Site A)
5.4.4. POLICY COHERENCE

A number of the challenges in implementing WCC policy were attributed to issues associated with the policy itself. The articulation and fit of the policy against the health economy environment and context was perceived to contain a number of challenges. These issues included: central control, constant change and policy alignment.

Central control

Issues of central control were discussed with reference to: local autonomy, performance management and development support. Translation of strategies and initiatives from ‘the centre’ to the PCT level was identified as a challenge. The generation of national strategy was recognised as necessary and in some cases PCTs were advocating for more tasks to be undertaken centrally. However PCTs argued that the local implementation of WCC was hindered somewhat by a lack of freedom at the local level to adapt WCC to the specific local context.

Much of the discussion of the influence of central control focussed on the assurance process and performance management. The assurance process was perceived as being heavily prescribed by the Department of Health:

“They need a lighter touch from the centre, so the effort that’s going to have to go in to feed the beast; you know, as part of the assurance process which ends with a two day review from an external panel, we have to fill in and submit huge amounts of documentation and you know, it’s just a very cumbersome process…” (ID5, PCT Director, Site A).

“Do we need to be doing all the work? That’s what worries me […] We spend a lot of time feeding World Class Commissioning.” (ID36, PCT Director, Site C)
As above, respondents described WCC as being very time intensive, requiring a large amount of work in addition to the ‘day job’, that they suggested was not recognised by the ‘the centre’:

“I don’t think the scale and nature of the change is probably understood at the centre”. (ID5, PCT Director, Site A)

Finally, despite the extent of central control, participants noted that central support for implementing WCC was lacking. As part of the national support and development strand of WCC the Department of Health had developed a framework for securing external support for commissioning (FESC). Whilst many respondents were aware of FESC, very few had actually utilised it, preferring to seek external support for WCC independently:

“The only aspects of FESC that we’ve used kind of indirectly was some of the board development stuff and that...we didn’t go directly through the FESC route but we...rather we worked directly with people who are on the short list” (ID13, PCT Executive, Site B)

“No we haven’t used FESC, [...] we’ve tended to; if we need to buy in additional help, we’ve just tended to organise it ourselves, it’s been easier to do[...] it’s just cumbersome, difficult to use.” (ID5, PCT Director, Site A)

**Constant change**

When discussing policy, in addition to commenting on the actual policy document, aims and direction, participants frequently remarked on the constancy and rate of change in the policy environment.

“Everybody that I’ve ever met and I’ve been working within the NHS as a non-executive now for over 15 years, seems to accept and expect that the NHS will always be in constant change” (ID8, PCT Non-Executive, Site A)
“We all know that the NHS is a political whipping post, isn’t it? It is a fact of the matter.” (ID21, PCT Non-Executive, Site B).

“There will be a change of Government in less than 12 months, it’s hard to see out of that, that there won’t be some sort of major structural change again” (ID5, PCT Director, Site A)

Continual change was seen to impact negatively on PCTs ability to maintain and sustain focus and momentum in commissioning. Change was often short term and was seen to generate inconsistent, disruptive patterns of working:

“Something comes out, there’s a spotlight thrown on it and its flavour of the month, it’s you know top of the agenda for a number of months, and we can’t work like that” (ID5, PCT Director, Site A)

“With an election looming we’re getting policy changes on the hoof and you have to be able to respond to all that so your day job isn’t necessarily your day job.” (ID14, PCT Director, Site B)

Furthermore, the result of constant change was the erosion of commitment, drive, and trust within the organisation.

Policy alignment

The implementation of WCC was also recognised as being somewhat hampered by existing health policies that created perverse incentives within the health care system and limited the ability of PCTs to address the competencies. Respondents highlighted that there were several other policies in addition to WCC that they had to implement or operate within, the goals of which were rarely explicitly aligned with one another:
“I say if I was to stand back from WCC and just think about the other regulation I’d be...I’ll be thinking, you know, why on earth aren’t we trying to align this far more really.” (ID37, PCT Director, Site C).

“It (Darzi NS Review) is good in that it gives more GPs more Primary Care provision. I think it puts a mandated financial pressure into the system that’s helpful in that it ensures we spend money on Primary Care but unless you’re able to turn the tap off from Acute Care where do you get the money from?” (ID14, PCT Director, Site B)

Payment by results (PBR) was singled out by participants as one policy in particular that prevented PCTs from addressing some of the core issues fundamental to the WCC agenda such as the need to deliver fewer services in acute settings. PBR encouraged increased activity within the acute sector that PCTs were unable to control due to the fact that through PBR they had to pay for this activity on a tariff basis. However, some respondents from acute sector organisations disputed the claim that they were maximizing activity due to financial incentives.

“The two things that have stopped us being able to save the money are firstly we don’t have control over the capacity because that’s an FT’s business. If they want to open beds they can open beds [...] and we pay for them at the tariff.” (ID1, PCT Executive, Site A)

“It’s putting perverse incentives into the system where [...] I mean in unscheduled care we’re paying hand-over-fist to the Acute Sector. There doesn’t really seem to be a great deal of real increase in activity [...] we’re incentivising people to see more and more patients, just count them differently. So I think, you know, payment barriers of policy need to reflect what we’re trying to do with ensuring care closer to home, giving patients more choice, making sure that we deliver high quality care to patients.” (ID14, PCT Director, Site B)
“The message I’m giving out in this organisation is that actually stop your moaning about the people coming through the front door, etcetera, etcetera, [...] you know the commissioners will always say why would Acute Trusts stop people coming through the front door because the incentive and the contract is you get paid more.” (ID29, Acute Trust Representative, Site C)

Furthermore, participants noted that many of the policies that they were implementing did not account for the context in which the PCT was operating. Specific reference was made to the economic climate and the fact that policies that had been written during a time of growth were no longer fit for purpose:

“The NHS, all the policies are still taking time. See the policies that the DH drafted up till the end of last year, early this year were written in a time of growth. Now we’re not” (ID25, SHA representative, Site B)

In fact the research itself was impacted by these three aspects of policy coherence. The focus of the project at the outset was competencies for WCC. However, over time this initiative was increasingly overshadowed by the dominance of financial control. Seasoned participants were aware of the likelihood of the initiative being sidelined and advised us accordingly:

“I think finances and the domination of finances on all sides compared with activity, quality and outcomes might impede it.” (ID25, SHA Representative, Site B)

“The biggest risk I suspect is the risk that a new administration will decide it simply isn’t going to...it isn’t going to run with this agenda.” (ID1, PCT Executive, Site A)
5.4.5. ORGANISATIONAL CULTURE

The impact of organisational culture on the implementation of WCC and the competencies was described with reference to: ways of working, power and leadership.

Ways of working
The existing processes and ways of working embedded within an organisation had implications for how PCTs implemented WCC. The hierarchical nature of PCTs and the strength of their dissemination and communication strategies impacted on the extent to which WCC and the competencies were embedded throughout the organisation, and thus the extent to which all staff were engaged:

“I don’t think they’re embedded. I bet they’re only two tiers down so I think if you went to a band 7 and said to them tell me about this, your role in this, it’s probably not that embedded” (ID15, PCT Director, Site B).

The extent to which staff were engaged in the implementation of the competencies was also reinforced by the silo approach that tended to dominate ways of working in PCTs. The quote below illustrates this demonstrating how, when implementing the competencies, the PCT adopted a fragmented approach, dividing responsibility for them between different directorates and people within the organisation.

“The way that we’ve chunked it up is we’ve got a lead director for each competency and it really is whichever of the lead directors seems the most appropriate because I do know the competencies range around a number of different issues and then within that we also have a lead, an overall lead officer for each competency and then beneath that, where it’s necessary we’ve got different leads for each area” (ID33, PCT Executive, Site C).
Additionally, successful implementation of the competencies was hindered where existing organisational practices or structures did not reflect some of the competency requirements. As reflected in the quote below, some of these requirements were seemingly relatively minor and not central improving commissioning per se. Nevertheless, processes had to be adapted to meet the requirements of the competencies.

“And there’s some funny things in here like to get a green in some places so the Board must have approved this, the Board must have approved that. Now some of the things are things we would never ask our Board to approve because the business works in a slightly different way” (ID33, PCT Executive, Site C)

Power

The concept and influence of power has been implicitly touched on within some of the other themes covered above. Despite the fact that PCTs were tasked with commissioning and implementing WCC, decision-making was also influenced by other organizations, notably the Department of Health, Foundation Trusts and GPs, (through PBC groups), and the public which were therefore considered to exert power over commissioning.

Specifically, respondents referred to the power of the centre and FTs with respect to the implementation of WCC. The power of the centre to control and influence commissioning was explored above in section 5.4.4, and impacted upon the PCT in terms of the extent of the autonomy and freedom that they had to implement WCC. Similarly, as discussed in sections 5.4.3, and 5.4.4, the FTs were perceived to be powerful in terms of being historically strong and stable organisations, and able to control commissioning through PBR:
“Even though theoretically the PCT’s had the power and the authority, the FT’s just steamed rolled them and got some very good contracts out of it” (ID8, PCT Non-Executive, Site A).

“You can’t destabilise your local provider” (ID22, GP/PBC, Site B).

“I mean in this year, from a contracting and commissioning point of view I have to say to you it’s been a total unmitigated disaster, both for them and for us [...] I spent the money achieving the activity and they haven’t got the money to give me.” (ID29, Acute Trust representative, Site C).

Leadership

Leadership was defined in terms of a myriad of responsibilities and those in leadership positions noted that their responsibilities extended to all aspects of commissioning:

“In that sense the full responsibility for all aspects of the organisation [...] just about all the full aspects of a commissioning cycle from the needs assessment, engagement with patients, examination with evidence, production of strategy, execution of strategy, [and] managing (ID13, PCT Executive, Site B).

As such, leadership was perceived as central to the successful implementation and development of WCC, and both nurturing and authoritative leadership styles were highlighted as essential:

“I suppose to create the environment and circumstances for it to be done successfully” (ID1, PCT Executive, Site A).
“We’ve got a strong clinical lead [...] I think he’s got an awful lot of, what’s the word, credibility and is held in high esteem and I think actually having that key lever has led to above progress.” (ID30, PCT Director, Site C).

Changes in leadership personnel were therefore seen to hinder the effective implementation of commissioning:

“Unfortunately they’re an organisation that have had probably something like eight Chief Executives in the last then years, they’re at a point on the curve behind most” (ID31, PCT Executive, Site C)

“Leadership yeah. We don’t do too badly but I think...I think because of the changes [...] I’ve had three different directors since I’ve been here.” (ID16, PPI, Site B)

Furthermore, the importance of leadership was recognised by the fact that PCTs were making efforts to develop leadership skills throughout the organisation. This was evidenced in all the case study sites in the form of training courses and programmes which were perceived as ways of empowering and enabling commissioners to become leaders.

5.5. PERCEIVED VALUE

The perceived value of the WCC initiative is implicit in how participants responded to and discussed the initiative in the above sections on its interpretation and implementation. This section explores this in more detail, examining the perceived value of both the WCC programme overall and the specific competencies in improving commissioning and achieving the aims of WCC.
5.5.1. THE WCC INITIATIVE

The value of the WCC initiative in improving commissioning and achieving its aims was considered in terms of the competencies in general, the assurance process, and the support and development framework.

With respect to the competencies in general, participants who had an active role in PBC were quick to note that the competencies for WCC were designed with PCTs in mind rather than PBC groups:

“Competencies are great for a PCT organisation but not necessarily for a PBC organisation I don’t think” (ID22, GP/PBC, Site B).

Overall, however, as described in section 5.3, WCC and the competencies offered a way of formalising commissioning which raised its profile as well as the professional status of commissioners. Furthermore, WCC went some way to legitimate the difficult decisions that commissioners had to make. However, much of this perceived value was bound up in the vision of WCC as opposed to the implementation of the competencies. Whilst the competencies were focussed on improving the commissioning process and it was acknowledged that process changes could lead to actual changes in health status, participants argued that there was no evidence of a causal relationship between the adherence to, and implementation of, the competencies, and improvements in local population health. Thus the value of the competencies was questioned in terms of the fact that it was possible to follow due process and not necessarily improve commissioning or make a difference to health outcomes or population health.

The assurance process has been discussed in detail in section 5.3, with respect to the perceived additional burden that this placed on the organisation in terms of time and human capacity, and specifically, that it focussed attention on the process of
assurance and away from the ‘day-job’ of commissioning. As such, respondents began to question whether this time and human capacity could otherwise be used to greater value. Furthermore, the value of the performance ranking that resulted from the assurance process was questioned. In particular, the use of the competency scores to nationally rank PCT performance was highlighted as creating an undue focus on process outcomes rather than explicit health outcomes. PCTs expressed a preference for outcomes that could clearly be linked to demonstrable improvements in healthcare for the local population. Additionally, the ranking system was criticised on the basis that it compared relative as opposed to absolute changes in competency scores and thus if all PCTs improved their competency scores at the same rate, perceptually the PCT performance would seemingly remain unchanged. Such ranking was therefore considered to be meaningless.

“it's about relative rather than absolute performance, and for me that just makes the whole thing meaningless, because actually we should be looking for everybody to get better, and if everybody gets better relative performance is irrelevant, [...] just because I'm better than the guy down the road, is breeding competition, it's not breeding improvement in performance.” (ID3, PCT Director, Site A)

Finally, the value of the WCC support and development programme and the ‘framework for securing external support for commissioners’ (FESC) in particular are detailed in section 5.4.4. FESC was considered to be difficult to negotiate and cumbersome to use. Whilst participants valued the support of external organisations they tended not to use FESC and sought external support indirectly.
5.5.2. THE COMPETENCIES

When discussing individual competencies respondents tended to refer to those competencies that, as an organisation they were most competent in, or they were most closely aligned with:

“We do much better at competencies one to five than we do on competencies what were six to ten” (ID31, PCT Executive, Site C).

“I mean obviously number three is the thing that jumps out the most and it’s just the thing that we’re mostly involved in” (ID16, PPI, Site B).

“Obviously my perspective is practice based commissioning and some of them are not really things we can deliver really. I mean we’re sort of, obviously, can deliver collaboration with clinicians really, that’s, I suppose, our prime.” (ID9, GP/PBC, Site A).

Aside from this, participants tended to focus on those competencies that they perceived to offer little or no value in improving commissioning and achieving the aims of WCC. In particular, competencies one (locally lead the NHS) and seven (stimulate the market) were consistently highlighted.

‘I suppose the controversial things are stimulating the market, and I know that’s the sort of big debate really’ (ID9, GP/PBC, Site A).

With respect to stimulating the market, PCTs lacked knowledge on how to achieve this and questioned how well positioned they were to do so successfully. Respondents questioned the value of creating additional competition within the health economy in terms of the inefficiencies this would create in the system. The
concept of having two separate providers with sufficient capacity to be able to generate real competition within the market would require duplicate premises, staff and overheads. This was considered wasteful in that it would generate slack in the health economy that would ultimately have to be picked up by the system. Furthermore, the concept of being able to create ‘true’ competition was raised, as well as trade-offs between the effort required to put this in place versus the outputs:

‘I’m not convinced that competition is the right way in the NHS because it isn’t true competition because the NHS does have the monopoly on service provision in the main...true competition for me is around the edges in the NHS and also the amount of work, time and effort it takes to put even those bits of competition in place...and the work that it’s created has been immense for the output (ID30, PCT Director, Site C).’

Moreover, as a competency, it ran counter to the notion of encouraging partnership working and other competencies:

“Competition can work in your favour but it can also be detrimental and I’m far more interested in encouraging preferred suppliers and long term preferred suppliers. In business large organisations who are successful develop long term preferred suppliers who they share success and help and support and encouraging them to become highly efficient, highly competitive but help them do so which is far more constructive, (ID28, PCT Executive, Site C).”

“I do think that some of it is very reductionist and so... if you take that whole systems approach which is basically one and two and then you get them in to stimulate the market and secure procurement skills they actually contradict each other.” (ID15, PCT Director, Site B)

With respect to locally lead the NHS, as a competency, PCTs nationally scored highly on it in both years one and two (as it consistently ranked in the two highest scoring
competencies, (NHS Confederation 2010), yet respondents disputed its usefulness. They argued that ability to improve against this competency was bound up in the historical and existing structures and cultures within the NHS and measuring successful leadership and the impact of local leadership was spurious:

“[locally lead the NHS] Um yeah, yeah, that’s a good aspiration, it’s not the traditional way the NHS has been run, it’s been run by a lot of top down sort of priorities and targets so whether that will actually happen is interesting.” (ID9, GP/PBC, Site A)

“…sort of intangible really - I mean how do you measure being a local leader?” (ID30, PCT Director, Site C)

5.6. SUMMARY AND KEY DISCUSSION POINTS

- WCC was welcomed initially and seen to raise the status and profile of commissioning and professionalise the role of commissioners
- The initiative was considered to formalise existing commissioning processes providing a framework to structure commissioning around. As such it was considered as progressive rather than a step change
- WCC legitimated the decisions for which commissioners were responsible
- WCC encouraged a shift in both mindset and resources towards health outcomes rather than targets; however the focus on the process of performance management with WCC created an undue focus, at commissioner level, on the assessment process which distracted efforts from improving the commissioning processes themselves, and the improvements in health outcomes and population health that were initially intended
- Challenges to the implementation of WCC hindered the ability of commissioners to achieve the desired improvement in commissioning and the aims of WCC. These included:
  - the lack of available resources for commissioning such as time, money, and human capacity
- inappropriate and poor quality data, and a lack of information systems and capacity for generating data and interpreting knowledge

- poor partnership working among stakeholders within the health economy which was hampered by organisational structures and cultures

- the dominance of the centre in exerting control over commissioning, subjecting commissioners to continual changes that destabilised commissioning, and developing policies that lacked coherence and alignment with WCC

- the effect of organisational culture with respect to historical ways of working, power relationships, and leadership in driving and sustaining momentum for commissioning

- It is therefore necessary to address the deeper contextual factors, as well as the structures of the health economy to substantively improve commissioning practice.
6. DISCUSSION AND CONCLUSION

6.1. INTRODUCTION

Since this research was commissioned there have been radical changes proposed for the NHS in England. Following the election of the coalition Government in May 2010, WCC has been abandoned and the Health & Social Care Bill, which at the time of writing is continuing its passage through Parliament, sets out the new direction for commissioning. The reforms signal a significant shift in the scale and scope of clinician-led commissioning together with a series of organisational changes for the wider English NHS. The key changes include: the abolition of SHAs and PCTS, with the majority of commissioning functions passing to GP commissioning consortia; and a new national commissioning board independent of the Department of Health; and changes to the public health function which, locally, will be transferred to local government and nationally, to a new organization, Public Health England, being established within the Department of Health (Department of Health 2010; Secretary of State for Health 2010).

This final chapter offers a discussion of the key findings that arose from the study, comparing and contrasting them. Drawing on the literature, and highlighting the implications, lessons learned and recommendations for future commissioning. Discussion of the findings is presented under the following headings: policy development, policy implementation, and competencies as a method for change.

6.2. POLICY DEVELOPMENT

The research highlighted two main issues related to the policy development of WCC. These included the level of centralised control (i.e. the DH) in the development,
implementation, and monitoring of WCC, and the extent to which the policy and its implementation would fulfil the aim and intentions set out in the WCC vision.

6.2.1. CENTRALISED CONTROL

Conception of individual competencies, i.e. the decisions as to why specific competencies were chosen for inclusion in the WCC initiative and the reasons for these, has not been widely reported in the policy literature. Our research findings, as reported in Chapter 3, indicated that a small Department of Health group formulated the first draft of the competencies, with minimal external involvement or evidence base. The group’s first draft included: their views and experiences; a review of the competencies embodied within the National Primary and Care Trust and Development Programme (NatPaCT); the input of commercial corporations considered world leaders in elements of commissioning; and examples of good practice from the banking and retail sectors.

Our findings suggest that policy formulation around WCC was driven by a small number of individuals at the centre and followed a largely directive and top down approach to policy development. However, this was not a view shared by those involved in drafting the competencies, who referred to the extensive though informal NHS consultation phase as an example of co-production of the WCC initiative. During this phase there was evidence from interviewees that changes were made to the competencies but the degree to which the ‘NHS’ was genuinely and systematically involved in the co-production of the competencies is not clear and thus questionable. Certainly, any involvement did not appear to be extensive.

The exertion of central control, or ‘politics’, in commissioning has been well documented both in UK healthcare organisations (though much of this refers to former organisational incarnations of PCTs) and internationally, (Hunter 1993; Klein, Day et al. 1996; Checkland 1997; McDonald 2002; Ham and Robert 2003; Mitton,
specifically, the challenges and constraints presented by top-down policy-making are articulated by Matland (1995). particular issues include a failure to acknowledge the impact of earlier actions in the policy making process, and the need to adequately consider implementation barriers.

Hunter (Hunter 2011) notes that the top-down imposition of health policy is not only inherent within the British political system, but is being replicated by the new Coalition Government in its reforms of the NHS, whilst it simultaneously advocates liberating the NHS to be free to determine its destiny on a local basis, thereby strengthening local democratic legitimacy and demonstrating the government’s commitment to localism. The tension between the desire to reduce central control and the risks posed by the freedoms offered by locally driven policy making is further reiterated by Hunter who goes on to point out that whilst the Government reforms represent a proposed reduction in nationally led activity, centralised control over quality, finance, regulation and other operations will actually be strengthened through the worm of various national bodies including Monitor, Care Quality Commission (CQC) and National Institute for Health and Clinical Excellence (NICE) (Hunter 2011).

Despite the political rhetoric, the switch to clinical commissioning resembles top-down change and inevitably will be subject to the risks outlined above. It is essential that central and local commissioning bodies work together to address and minimise potential implementation barriers for new commissioners. As a national institution funded through general taxation, the NHS is inevitably subject to strong government control, and although it has been argued that local authority and clinical leadership may increase the NHS is likely to remain a centralised institution (Williams, Dickinson et al. 2010). This, as yet unresolved, tension between dominant central control and locally driven policy appears to persist in the amendments to white paper. Sir David Nicholson, NHS Chief Executive and CEO designate of the NHS Commissioning Board,
insists that the new Board will be the ‘N’ in the modernised NHS, whilst simultaneously giving ‘pride of place’ to clinicians and keeping the needs and wishes of patients at its heart (Department of Health 2011). It will be a tall order ensuring optimal balance between these three competing aims.

6.2.2. FULFILMENT OF POLICY AIM AND INTENTIONS

As described in Chapter 3, the aim of the WCC initiative and the 11 competencies was to improve commissioning and meet the challenges faced by the NHS. Thus the expectation, from a policy perspective, was that the four elements of WCC (the vision, competencies, assurance process, and support and development framework) would lead to improvements in overall population health, reduce health inequalities, and achieve savings and efficiencies. The competencies in particular were expected to provide the necessary platform for delivering these improvements in PCT commissioning, with each of the 11 competencies detailing the skills, knowledge and behaviour associated with high commissioning performance.

However the extent to which WCC and the competencies were developed with the overall aim of WCC explicitly in mind was not clear from the key informant interviews. In the main, the competencies tended to focus on process as a means to achieving health outcomes, rather than measurable health outcomes per se. However, it could be argued that, given that public health gains such as those described in the aim of WCC will not be achieved solely through the NHS or in short time horizons, it is not surprising or realistic to expect the WCC competencies to reflect these. Indeed, responses from participants in the national survey and case study interviews indicated that whilst commissioners welcomed the focus of WCC on health outcomes and improving the health of the local population, they questioned whether the competencies would deliver the improvements in commissioning that were intended in its initial development, arguing that there was no clear causal relationship between the implementation of the competencies and the outcomes outlined above. Moreover, despite indications that commissioning performance in
PCTs (as judged against the competencies) improved over the two years in which they were assessed (NHS Confederation 2010), it is impossible over this short time period to link any improvements in commissioning performance against the competencies to health outcomes. This is not to say that the competencies did not contribute to improvements in health outcomes or may have done had WCC remained.

This is not the first time commissioning initiatives have been terminated prematurely. For instance, Mays et al (2001) recount the development of GP fund holding from the inception to abolition of total purchasing pilots (TPP), which promptly followed the election of Labour Government in 1997. Inevitably their findings detailed that there was little opportunity for TPP to become established and therefore achieve their aims of improving services. They caution against the NHS being driven by the latest political agenda and advocate that NHS organizations require time to become established and effective. Research evidence shows that the impact of organisational restructures can be felt for around 18 months (Peck, Dickinson et al. 2006).

Regardless of the structures and initiatives that replace PCTs and WCC, the public health challenges remain alive and are possibly even more problematic. The organisations replacing PCTs, and specifically those charged with delivering the public health functions which are now fragmented across not only GP consortia, but also local government, Health and Wellbeing Boards, and Public Health England at the centre, will need to successfully identify and manage the structural, process, and cultural levers required/necessary to explicitly meet these challenges.

6.3. POLICY IMPLEMENTATION

The research highlighted three main issues concerned with the implementation of the WCC policy. These are: organisational structures and culture, engagement, and knowledge and capacity.
6.3.1. ORGANISATIONAL STRUCTURES AND CULTURE

As noted in Chapter 5, organisational boundaries and structures limited the ability of PCTs to effectively commission and implement WCC. In particular, these can be described in terms of both intra-organisational fragmentation (with respect to the way that PCTs implemented WCC within the organisation) as well as inter-organisational fragmentation (with respect to the way PCTs were able to implement WCC across organisations). It was not uncommon for specific competencies to be aligned with specific people within the organisation. This silo approach to the implementation of WCC meant that commissioners were working to satisfy individual elements of the competencies rather than considering the whole process. Furthermore, the complexity of the commissioning landscape impacted on the ability of the PCT to commission collectively with other organisations.

Whilst WCC encouraged partnership working across organisations, the reality was that this was inhibited by organisational structures. There was some evidence of partnership working through PBC (as discussed in the engagement section below), and to varying degrees (across case study sites) with the local authority, although the latter was largely limited to funding joint posts in public health. It is surprising that PBC was not accorded greater emphasis given the strong evidence base promoting clinical engagement, in particular that of GPs, for successful commissioning (Le Grand, Mays et al. 1998; Smith, Mays et al. 2004). Partnerships with providers, and FTs specifically, were not discussed. Indeed with respect to FTs the opposite was noted. Often portrayed as powerful monopolies, the FTs were seen as unwilling to work in partnership with commissioners and thus inhibited the implementation of WCC. Moreover, existing government policies also provided perverse incentives that maintained these fragmented structures and discouraged partnership working. PBR in particular was perceived by PCTs as inhibiting collective commissioning – by providing incentives to direct money from primary care (Street and Maynard 2007) and ‘sucking’ resources into the acute sector. As such, the acute sector had little
incentive to engage in commissioning decisions with PCTs. A recent study by Robinson et al (2011), highlights that the lack of engagement of the acute sector in commissioning activity around resource allocation, was partially driven by the different organisational structures and the perverse incentives of government policy such as PBR.

These concepts of intra and inter organisational fragmentation are not new or isolated to WCC. Côté (2002). argues that intra-organisational fragmentation and isolation is an inevitable consequence of the “silo-effect” which stems from decentralised management and results in a department’s interest taking precedence over the well-being of the organisation. Furthermore, Checkland (1997) identified problems of inter-organisational fragmentation in the UK health service in the early 1990s revealing that there was little interaction between stakeholders within and across healthcare organisations.

The current and future challenges faced by the NHS, namely, those of changing patterns of health and ill health, persistent health inequalities, and the growing gap between demand and resources, should be the focus of not only those responsible for commissioning health and health care, but also those delivering and consuming it. A whole system response is needed to address such complex issues. It could be argued that by devolving commissioning responsibility to GP consortia, these issues will be elevated in the eyes of clinicians. Furthermore, with clinicians rather than managers taking the lead, GP consortia may be well placed and possess the necessary credentials to work in partnership with the relevant stakeholder organisations and engage meaningfully with the acute sector and FTs. One element of risk lies in the assumption that sufficient numbers of GPs are keen to undertake this work and possess the requisite skills to succeed.

If it succeeds, GP commissioning may therefore be better positioned to address the power imbalance between primary and secondary care. However, the downside is
that the structural changes involved in these commissioning reforms are also likely to lead to greater fragmentation in commissioning, with a larger number of GP consortia than there were PCTs, the NHS commissioning board which is new and untested and local government involved in commissioning. It is not clear how consortia will work within the health economy to effectively commission health care that meets the needs of the population or how their role and responsibilities will relate to the other commissioning organisations.

The influence of culture and relationships is consistently identified by participants throughout this report as core to commissioning performance. It is essential that development of these ‘softer’ aspects of commissioning is facilitated and not overshadowed by a sole focus on the structural and financial aspects of the changes. This has been recognised in recent literature, with particular reference to the skills and role of leadership and the need for political skills and acumen (Dickinson, Freeman et al. 2011).

6.3.2. ENGAGEMENT

Engagement and involvement with a wide range of internal and external stakeholders, including providers, government, interest groups, local authority representatives, citizens and the media, is seen to be vital to successful commissioning (Dickinson and Ham 2008); Ham and Dickinson 2008; (Williams, Dickinson et al. 2011). In our study a high number of respondents identified engagement and involvement with stakeholders as both a barrier and facilitator to achieving WCC.

In particular, findings from our study suggested that clinical involvement was important for effective commissioning and a high number of respondents from the survey and case study sites suggested that there was strong engagement in commissioning activity from PBC. However, some respondents suggested that more
needed to be done to increase the engagement and awareness of GPs at the practice level. However, these results are in contrast to previous research which asked practice based commissioners about their feelings in relation to their engagement with PCT commissioners, the results of which suggested that PBCs did not feel very, or at all, engaged by their PCT (Wood and Curry 2009). Furthermore, other studies have suggested that PBC has had only partial success in encouraging GPs to become more engaged in commissioning and that engagement in commissioning and budgetary decision making tends to be ‘limited to a small group of enthusiastic GPs in each PCT’ (Curry, Goodwin et al. 2008). Additionally, there has also been some criticism over the lack of integration of PBC into the wider commissioning functions and agendas of PCTs (Health Select Committee 2010). Integrated care is highlighted as a key theme in the Coalition Government’s change agenda and one that has been endorsed by the NHS Futures Forum (NHS Future Forum 2011). Our report notes that both inter- and intra- organisational fragmentation had a detrimental impact on the co-ordination of commissioning. We also note that these are not new concepts or ones which are peculiar, or confined to WCC. Endeavours to implement integrated care could be subject to the same challenges.

The lack of clinical engagement in commissioning has previously been highlighted as one of the weaknesses of WCC and it has been argued that more effective clinical leadership has the potential to enable more commissioning ‘clout’ in the local health care system (Smith, Curry et al. 2010). The importance of placing clinicians in the driving seat has been recognised by government in their recent move to introduce GP led commissioning across England (Department of Health 2010). Whilst GP engagement is indeed vital to commissioning it is not on its own sufficient for truly effective commissioning which will require engagement from frontline clinicians from across the health and social care sectors (Wortham 2007; Robinson, Dickinson et al. 2011)). Likewise, effective commissioning will also require engagement and involvement with other stakeholder groups from across the health care economy.
Research demonstrates that whilst pockets of good practice exist around engaging and involving other stakeholder groups (such as public, patients, community providers, and local authority colleagues) generally such activity is relatively weak. Engagement can be costly, time consuming and complex to design, execute and sustain (Abelson, Forest et al. 2003). However, as Bruni et al (2008) note, this may well be offset against the time and resource that could be spent defending unpopular decisions that are taken without consultation. Further, implementation of resource allocation decisions would be difficult without the support of those who need to implement the change which is often not commissioners but providers of services. Thus, engagement with different stakeholders is important and needs to happen throughout the commissioning process (Robinson, Dickinson et al. 2011).

As highlighted above the proposed commissioning reforms have resulted in large scale structural changes to commissioning, taking responsibility from PCTs and moving to GP consortia, which in effect means the 152 PCTs being replaced with a greater number of smaller commissioning bodies. Commissioning over smaller populations will bring some new challenges including: the fact that having a few expensive patients could place a big hole in already stretched budgets; more GP consortia means additional commissioning skills are needed and as research shows these are in short supply; denied economies of scale and the potential for smaller consortia to cut corners (or not be able to provide) on high quality infrastructure and management systems – which could well jeopardize their sustainability (Delamothe and Godlee 2011: p237). This suggestion was confirmed by members of the focus group, who also highlighted that an increasing the number of commissioning bodies risks reducing the depth of knowledge at each organisation. A US study by O’Dowd (2011) on the handling of commissioning budgets by groups of doctors found that these groups underestimated the importance of ‘high quality professional management support in their early days – such as data and information technology systems experienced analysis and other management and financial expertise’ (O’Dowd 2011) the consequence of this was that a number of these groups became
bankrupt. Moreover, should GP consortia choose to hand over commissioning responsibility to private companies. These companies will ultimately be accountable to their shareholders rather than local communities.

6.3.3. KNOWLEDGE AND CAPACITY

Wells et al (2007:11) suggest that ‘the key to good commissioning is effective, timely information and the capacity and capability to interpret that information.’ The NHS still suffers from data illiteracy and an absence of analytical capacity to use data, even routinely collected data. The constraints of knowledge and capacity on commissioning have been widely reported in the literature both nationally and internationally. In terms of PCT commissioning, it is has been claimed that commissioners lack basic information for commissioning as well as the management capacity to deal with it and the analytical skills to be able to interpret it (Whitfield 2004; Nolan 2005; Edwards, Goodwin et al. 2006). As such, lack of knowledge and capacity represent barriers to commissioning (Ham 2004; Mitton and Patten 2004; Smith, Mays et al. 2004). It has been further suggested that this lack of knowledge and capacity leaves commissioners ill equipped to challenge providers, thereby rendering the role of commissioners as passive in the decision-making process. This inability to tackle the dominance of providers has been heavily criticised by the House of Commons Health Committee (2010) who suggested that commissioners lack both the levers and drivers to instigate change.

Findings from our study would support this, with two of the key themes around facilitators and barriers to achieving WCC competencies being the need for robust and clear information and the capacity and skill to interpret this information to generate knowledge. WCC competencies emphasise the need to use data to drive decision making. However, our research highlighted that many PCTs struggle to gain high quality information and lack the capacity and skill around data interpretation. Moreover, WCC, through a necessity to provide evidence for the implementation of
the competencies within the assurance process, highlighted the dichotomy faced by commissioners of being data rich but information poor.

In recognition of this lack of knowledge and capacity, the previous government introduced FESC alongside WCC which was intended to increase the availability of external resources that could help facilitate commissioning. Results from our study suggest that there was very limited uptake and support for FESC across PCTs and that they did not perceive they were well supported in implementing WCC, despite the presence of FESC. This runs counter to the findings from a national study conducted by Naylor and Goodwin (2010) who found that WCC has been a driver for external support and over half of PCTs surveyed have used external support to help them with the assurance process. The authors go as far as to say that PCTs would not be able to attain the highest level scores in the WCC competency framework without external support. However, the extent to which this external support was obtained through FESC is not clear. The barriers to non-usage of FESC identified in this research included the complexity and high cost of the process.

These findings support the concerns raised by the House of Commons Health Committee (2010) who voiced concerns over the cost-effectiveness of FESC. Much of the outsourcing work identified in both our research and Naylor and Goodwin’s (2010) study tends to be around joint delivery arrangements and supporting and strengthening existing commissioning capacity, rather than adoption of a full outsourcing model. This could well change under the proposed new commissioning arrangements with some GP consortia possibly wanting to outsource commissioning responsibilities to external organisations (Naylor and Goodwin 2010). However, private sector organisations such as McKinsey and Ernst and Young, who might be expected to benefit from any out-sourcing, suggest that commissioning support is more likely to come from NHS organisations and/or social enterprises, and that increasingly more commissioning consortia ‘risked fragmenting the market, making deals potentially smaller and less attractive for the private sector’ (Dowler 2011:11).
It could be argued that FESC represented a low cost way of developing and supporting knowledge and capacity for commissioning. However, international research has shown that constraints in decision-making around lack of knowledge and capacity need to be addressed through specific operational processes, and supported by strong leadership and change management (Gibson, Martin et al. 2004; Mitton and Patten 2004; Reeleder, Goel et al. 2006). As such, the lack of leadership and managerial skill to negotiate some of the non-technical aspects of commissioning (such as governance, engagement, organisational power, politics and culture) identified in this research, could further hinder the acquisition of knowledge and capacity for commissioning experienced by PCT commissioners.

Although it remains to be seen how the new NHS structure will develop, assuming the changes get Parliamentary approval in their existing form, if these new arrangements are not established in such a way as to adequately overcome these problems, then GPs and their emerging consortia should expect to also struggle with these issues. A range of possibilities confront future commissioning, which may include but are not limited to: GPs being either more confident leaders or more ably positioned in the new structures to negotiate with FTs, GPs may outsource the majority of the commissioning work either to private companies such as McKinsey or to the residual body of ex-PCT managers. Robinson et al. (2011) raise concerns that the use of private sector organisations could increase activity in the commissioning industry and subsequently spend. However, it is not yet clear if, and in what format i.e. potentially social enterprises, PCT managers will be available to provide commissioning support. They might reinvent themselves as social enterprises.

6.4. THE ROLE OF COMPETENCIES AS A MECHANISM FOR CHANGE

The use of competencies is widespread in public services and is increasingly embedded in human resource management strategies. This evaluation therefore
adds to a growing body of knowledge on the role of competencies in public service improvement. Put simply, a ‘competency’ is a capability, of either an individual or organisation, usually containing elements of skill, knowledge and attitudes (Boyatzis, 2008). In health care the development of competencies has been seen as a means of improving the quality of management (Horton, 2000), and the WCC competencies are not the first instance of their use within the English NHS (see for example the National Primary and Care Trust Development Programme (NatPaCT): www.natpact.nhs.uk).

As explained in Chapter 1, the 11 WCC competencies were structured to contain sub-components which detail process and knowledge requirements and example outputs. This specification was crucial in enabling performance assessment (and management) via the assurance process. In line with the broader competency model, the intention was therefore to ‘specify representative behaviour exemplars that demonstrate mastery of the general competency domain’ (Shewchuk, O’Connor et al. 2005). As already noted, case study data support the claim that the 11 competencies and their sub-components were considered to be relevant to the work of commissioners and an appropriate reflection of the activities and behaviours involved in the commissioning role. However, a recurring theme of the interviews was the potential for the energy directed towards performance in the assurance process to distract commissioners from their day-to-day practice, and for organisations to concentrate on central expectations at the expense of local priorities.

This recalls the claim of Boyatzis (2008) that ‘intent’ is the difference between competencies and mere behaviours: i.e. that action alone does not signify competency. In a similar vein, Virtanen (2002) argues that technical skills should be accompanied by values-based competencies which specify the ethical dimensions of management in a public sector setting. Although the commercial sector provided much of the inspiration for the selection and development of the competencies,
public management is clearly not the same as private management. The WCC competencies, although not purely technical or instrumental in nature, perhaps fall short of a full account of the social values expected of health services commissioners. This relative gap in relation to the ethics and intentions that should drive practice may be one reason why WCC has been vulnerable to charges of becoming a ‘box ticking exercise’ (Health Select Committee 2010). It also reiterates the tension between centrally driven and performance managed processes and the simultaneous emphasis on ‘self-improving’ organisations. The focus on WCC competencies gradually shifted over the course of this study. This was in part due to the shift in political emphasis away from the competencies, and partly as participants attributed barriers to the wider health system within which commissioning takes place.

The early stage of the evaluation, and the Coalition Government’s subsequent decision to re-organise NHS commissioning, mean that it is not possible to measure the extent to which the WCC competencies are a reliable predictor of performance. Indeed there are few published studies examining the link between competencies and performance (Boyatzis 2008). This concern was raised in the early project interviews where respondents noted the heavy reliance in WCC on assumptions about the transformative power of management competencies as part of wider performance management regimes. Although subsequent interviews with implementers give grounds for cautious optimism, overall the message appeared to be that despite the competencies themselves having some ‘face validity’, the jury remained out on their likely success in bringing about the changes envisaged.

This links to a further concern over competencies as an intervention in complex systems such as the NHS. Our evaluation underlines the importance of human resources-based interventions being integrated into broader service improvement strategies if they are to be an important vehicle for organisational and cultural change. Furthermore, performance management against a rigid competency
framework may not allow for the dynamic, flexible management styles that characterise successful health care organisations (Greenhalgh, Robert et al. 2004). In particular, the role of health care commissioners is highly politicised – in a way not experienced in the equivalent private sector roles – so that relationship management and sense-making skills become more prominent (Noordegraf 2000). The increasing frustration expressed within case study sites during the lifetime of the research process may be a reflection of this disconnection between a fixed performance framework and a complex and fast-moving environment.

Another way of understanding the WCC competencies is as part of an ongoing process of professionalization of the commissioning role. This was indicated by early respondents who identified the need to raise the status of NHS commissioning, not least as a career choice for talented managers. Our study provides some support for this claim inasmuch as some respondents felt that the greater specification afforded to the commissioner function would help position their role on a more formal and professional footing. However, there was less of a consensus over whether the assurance process would enhance the broader status of commissioning organisations (in a way analogous to Foundation Trust certification). Clearly, the relatively brief lifetime of WCC and the assurance process makes any definitive statements about impact on the perceptions of commissioning impossible. However, the proposed government reforms, including the decision to abolish PCTs, must cast some doubt over its success as a means of legitimising PCT commissioning.

In summary, the timescales of this evaluation, notwithstanding those of the WCC programme itself, prevent substantive insight into the value that competencies add to organisations and outcomes, or into whether assurance processes of the kind adopted in WCC can be expected to bring about competency development. The connection between competencies and performance in health care management remains one that is not fully established and there was little opportunity for WCC to affect a raise in the professional status of commissioning before it was discontinued.
However, the WCC story was by no means universally negative and the case studies indicated a significant current of support for the basic notion of a competency framework informing the commissioning role.

6.5. LESSONS AND RECOMMENDATIONS

The trajectory of commissioning and WCC was heading in the right direction but there were contextual barriers such as misaligned policies that pushed and pulled against each other, and constant organisational/structural change that made it almost impossible to undertake such transformational change in such a politicised setting. That is not to say the competency approach, which was not based on much solid evidence, was without weakness. This lack of an evidence base, combined with the centrally driven, top down approach to development, implementation, and assessment of WCC, may indeed have resulted in the perceived ‘failure’ of WCC. However, there are some enduring aspects of commissioning that still require development, and, in that sense, although not all aspects of the competencies were successful across the board, it appears to have started out as a valuable programme that may have brought about significant improvements if it had been given the time and resources to bed in.

Our evaluation suggests that the WCC initiative has considerable value for current and future NHS commissioning. While it may not have survived long enough to prove itself and offer demonstrable impact and health improvements, over its short life it has raised a number of important issues and concerns. These will not disappear simply because WCC no longer exists. As noted earlier in this chapter, the structures and initiatives that will replace PCTs and WCC will continue to face the commissioning challenges that dominated PCTs and that WCC sought to address.

The policy changes and resultant turbulence within the case studies during the period of this research somewhat reduces the ability to deliver specific and explicit
recommendations. Rather we have adopted a flexible approach to generate insights and guidance for policy makers. In spite of this, we have articulated these insights in such a way that they can be interpreted as generalised recommendations for both policy makers and those involved in future commissioning. As such, recommendations that will be pertinent to policy makers and those involved in future commissioning, have been drawn from this research:

- **Adoption of a system-wide focus to commissioning**
  - Centrally developed policy must be aligned to ensure that commissioning organisations are not subject to numerous initiatives that contradict each other. A consolidation of policy packages and a reduction in ‘policy churn’ will minimise distraction and provide opportunity for development, without requirement to respond to constant policy changes.
  - System incentives, both financial and non-financial should be aligned to support policy objectives. Perverse financial incentives meant that PCTs were relatively powerless in implementing commissioning. GP consortia may be able to act against such incentives but will also require strong leadership to do so.
  - Integrated care will rely on partnership working and it is imperative that timely and tailored support is provided in conjunction with carefully aligned structures and incentives to best mitigate against intra and inter organisation fragmentation.

- **Coordinated commissioning support**
  - GP consortia must be afforded realistic levels of funding and support to develop commissioning. Systematic support is required to provide ensure sufficient capacity, tools and processes are in place to enable commissioning. It is important to recognise that consortia will likely present a range of commissioning skills, depending on the extent of their involvement in PBC.
  - Commissioning support must be appropriate, easily accessible and of a timely nature. The FESC process was considered by PCTs as overly complex and did not necessarily provide the specific support that they needed.
  - There is a need for an increased role for education to ensure that organisations are equipped with not only to the hard commissioning skills but also the management of non-technocratic elements of commissioning such as governance, engagement, organisational power, politics and culture.
• Need to protect against the loss of organisational memory
  – There is a need to ensure that the learning, development and efforts invested in current commissioning organisations are not lost. Human resource skills will also have a role to play, as prevention of rapid role turnover will be pivotal to preventing drain of organisational knowledge.
  – It is imperative that commissioning roles and skills with enduring relevance are maintained and best distributed across new commissioning organisations. It is evident that clinicians’ current skill portfolio lacks a number of key commissioning skills and as such they will require the support of their PCT colleagues. This will need to be conducted in a timely manner to ensure that personnel with the required skills have not withdrawn from PCTs.
  – The WCC framework was largely perceived as a valuable tool, and appeared to improve PCTs commissioning skills over the short assessment time. Given that many of the PCT level key commissioning skills will still be required in the new era of commissioning there is potential to further explore how beneficial elements of the WCC framework can be retained and built on rather than abandoned.
7. REFERENCES


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London, King’s Fund.


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Williams, I., J. Durose, et al. (2007). How can PCTs shape, reflect and increase public value?, Health Services Management Centre, University of Birmingham.

Williams, I., D. J., et al. (2007). How can PCTs shape, reflect and increase public value? Birmingham, Health Services Management Centre, University of Birmingham.


Appendix 1

Dear [name],

I am currently working under the supervision of Professors Cam Donaldson and David Hunter on a research project examining the World Class Commissioning Competencies. As part of this and to inform the literature review, I would like to conduct a small number of informal interviews with key people involved in commissioning.

I would be most grateful if you would allow me to interview you either in person, or by telephone. I anticipate that the interview will take approximately 45 minutes. I will send a copy of the interview questions in advance, should you be willing and available to attend interview.

Please advise your availability for Tuesday 5th May, Wednesday 6th May (am only) and Thursday 7th May. Alternatively call me on the number below to discuss.

I look forward to your response,

Kind Regards,

Sara

Sara McCafferty
Research Assistant
Institute of Health and Society
Newcastle University
21 Claremont Place
Newcastle Upon Tyne
NE2 4AA
Tel: 0191 222 3824
Fax: 0191 222 6043
# Appendix 2

## Framework for Phase 1 interviews

### Competencies for World Class Commissioning: the readiness of PCTs and PBCs

1. **Request consent PRIOR to beginning any audio recording**
   
   Please tick to indicate consent for: recording of interview
   
   use of anonymised quotes

2. Please describe your involvement, if any, in the development of the World Class Commissioning Competencies.

3. Can you provide any insight into the origins / rationale behind the introduction of the competencies?

4. Are you aware of any specific literature which references the introduction of the competencies or their underpinning rationale?

5. Are you aware of any specific events (or individuals) that triggered introduction of the competencies, if so please describe?

6. The competencies are effectively standards to be achieved – what is your understanding of how the system is expected to actually achieve these both at an individual level & an organisational level?

   (use of external support/ consultancies? why)

7. The majority of PCTs have not achieved the highest ratings on most competencies – how can improvement best be facilitated (& over what timescale)?
<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>What do you think the greatest barriers to implementing the competencies will be?</td>
</tr>
<tr>
<td>8</td>
<td>Do you think the competencies will add value to the commissioning process and if so, how?</td>
</tr>
<tr>
<td>9</td>
<td>Do you have any further general views on the Government’s commissioning agenda for the NHS?</td>
</tr>
<tr>
<td>10</td>
<td>Are there any other points you would like to add?</td>
</tr>
</tbody>
</table>
General Processes and outcomes of commissioning

This is an exploratory study, which aims to generate a snapshot of views and practices around the World Class Commissioning Competencies. We will be exploring key issues in more detail at a later stage, and are currently interested in your perspective of commissioning within your PCT. All responses will be anonymised.

<table>
<thead>
<tr>
<th>1. What is your position in the PCT?</th>
<th>Director of Commissioning or equivalent</th>
<th>Other, please say</th>
</tr>
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</table>

<table>
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<tr>
<th>2. How many years have you been in this position in your PCT?</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>3. To your knowledge how many practices are in Practice Based Commissioning Groups?</th>
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</tr>
</thead>
</table>
4. To your knowledge how many Practice Based Commissioning Groups in your PCT?

5. Are you using the Framework for procuring External Support for Commissioners (FESC)?
   - Yes
   - No

IF YES, which aspects? If NO, why not? Eg time constraint

6. Does your organisation have an engagement (with the public) strategy?
   - Yes
   - No

6a. Has the strategy been signed off?
   - Yes
   - No

7. Do you have joint commissioning posts (for example, head of joint commissioning, joint director of public health)? If yes, please list all you are aware of.
   - Yes
   - No
How would you rate your level of agreement or disagreement with the following two statements where 1=strongly agree, 2=agree, 3=neutral, 4=disagree and 5=strongly disagree?

8. Our PBC clinicians are actively involved in driving strategic change through commissioning

    IF AGREE, which aspects?

9. Our PCT has faced challenges recruiting high-quality staff for all positions in commissioning

    IF AGREE, what skills and experience have you had trouble recruiting in?

10. Do you use any of the following methods to aid the commissioning process?

<table>
<thead>
<tr>
<th>Method</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>National Programme Budgeting Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Budgeting and Marginal Analysis (PBMA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Effective Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predictive Risk modelling tools such as PARR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand forecasting models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact forecasting for service development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Does your organisation have an explicit process for priority setting for new services?  
   Yes [ ]   No [ ]

12. Does your organisation have an explicit process for disinvesting (decommissioning) existing services?  
   Yes [ ]   No [ ]

13. What do you see as the three main barriers to achieving World Class Commissioning Competencies? Please list in order of importance.
   i.  
   ii.  
   iii.  

14. What do you see as the three main facilitators to achieving World Class Commissioning Competencies? Please list in order of importance.
   i.  
   ii.  
   iii.  

Thank you very much for your help
Appendix 4

Institute of Health and Society
University of Newcastle upon Tyne
21 Claremont Place

Letter of invitation to participants

STUDY TITLE: Competencies for World Class Commissioning: the readiness of Primary Care Trusts (PCT) and Practice Based Commissioners (PBC).

Dear Sir/Madam,

I am writing to invite you to take part in the above research study; other member’s of your Trust’s senior management team are being approached concurrently. This research is funded by the Policy Research Programme at the Department of Health.

Before you decide to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take the time to read the attached participant information sheet carefully and discuss it with others if you wish. Please do not hesitate to contact me if there is anything that is not clear or if you would like more information.

The research is designed to establish how PCT commissioning and PBC currently function, to assess the usefulness of initiatives and guidance established to aid commissioning and the impact these initiatives will have on commissioning as well as...
the local health care system. The initial phase of the research will consist of interviews with key personnel to help us understand how commissioning currently functions in your PCT, the process and relationships which underpin this process and the barriers to effective commissioning. There will be a particular emphasis on how the competencies for world class commissioning are used and impact commissioning if at all.

This invitation is for the initial phase only, and asks for attendance at one interview. You may be approached at a later date for follow up interview in the final phase of the research. Taking part in the interview is entirely voluntary and you are free to withdraw at any time, before the interview you will be asked to sign a consent form.

All information that is collected during this research will remain confidential; no responses from any interviewee will be directly attributed to any individual. Any audio tapes used for the interviews will be destroyed upon transcription. Transcripts will be anonymised and kept in a secure location until the study has been completed, when they will be destroyed. In the unlikely event of malpractice being discovered it will be dealt with according to standard procedures.

Your contribution will provide an important input into the study’s aim to examine current commissioning practice against the competencies and identify strengths and weakness of the processes used, including identifying barriers that are hindering world class level performance. This research hopes to provide policy-makers and practitioners with timely, formative feedback on good practice in implementation and actively disseminate findings within policy, managerial and academic communities.

I have attached a calendar sheet for you to highlight the most convenient times when you are free to participate. The interview should take no longer than 60
minutes. If you require any further information or wish to discuss the project, please do not hesitate to contact Sara on 0191 222 3824.

Thank you for taking the time to read this letter.

Prof Cam Donaldson PhD
Health Foundation Chair in Health Economics, NIHR Senior Investigator
Director of Institute of Health and Society

Sara McCafferty
Research Assistant
sara.mccafferty@ncl.ac.uk
Tel: 0191 222 3824
Appendix 5

Participant Information Sheet

Study title: Competencies for World Class Commissioning: The readiness of Primary Care Trusts (PCT) and Practice Based Commissioners (PBC).

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The National Health Service (NHS) has been subject to significant change as a result of government priorities for efficiency and equity. These changes are aimed at strengthening local, sustainable health care systems that deliver better care and patient experiences, as well as better outcomes and value for money.

Recently, initiatives such as World Class Commissioning and the Framework for procuring External Support for Commissioners (FESC), have been announced to strengthen commissioning. Yet, greater knowledge is required about how PCT commissioning and PbC currently function and thus, what will be the real or
perceived impact of these initiatives on policy objectives, outcomes, and on the local health care system.

The Department of Health’s Policy Research Programme (PRP) has commissioned this research project, to undertake an evaluation of commissioning practice and the impact of recent health care reforms across the NHS in the North East, North West and West Midland areas of England. The purpose of this study is ultimately to improve commissioning; the findings will be used to model current commissioning practice and identify, devise, implement and review improvements to remedy real and perceived deficiencies in commissioning. Results will actively be disseminated throughout policy, managerial and academic communities.

Why have I been chosen?

We would like you to participate in this study because we wish to seek the views of key staff with knowledge and insight into how recent reforms around commissioning, such as the introduction and assessment of the competencies, are impacting your organisation.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You will be given a copy of the consent form to keep. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

We wish to interview you about your experience of recent commissioning reforms, particularly with respect to the competencies and your perspective on how these reforms have been implemented in your organisation. The study will undertake face-to-face or telephone interviews. With your permission, it may ask for a follow up
interview at a later date, in the third year of the research. Each interview will last up to a maximum of 60 minutes.

The interviews will be undertaken by members of the research team. These are experienced researchers who are trained and qualified in this research method. We will endeavour to conduct the interviews at your workplace to minimise disruption to your schedule.

**Will my taking part in this study be kept confidential?**

All information that is collected during this research will remain confidential; no responses from any interviewee will be directly attributed to any individual. Any digital recordings of interviews will be destroyed upon transcription. Transcripts will be anonymised and kept in a secure location until the study has been completed, when they will be destroyed. In the unlikely event of malpractice being discovered it will be dealt with according to standard procedures.

**What will happen to the results of the research study?**

Two of the principal research objectives are to provide policy-makers and practitioners with timely, formative feedback on good practice in implementation and actively disseminate findings within policy, managerial and academic communities.

There will be an opportunity to attend a focus group where the aggregate interview results will be reviewed to check whether the research team's findings accurately reflect your view. We will pursue a wide range of dissemination activity, incorporating active knowledge transfer events with defined stakeholder communities throughout the life of the project.
Who is organising and funding the research?

The research is being organised by Newcastle University and sponsored by North Tyneside PCT. The research is funded by the Policy Research Programme at the Department of Health.

What indemnity arrangements are in place?

This study is covered by Newcastle University’s insurance policy for negligent harm.

How can I get further information?

Please ask Sara McCafferty (tel 0191 222 3824 email sara.mccafferty@ncl.ac.uk) if you have any questions or would like more information about this invitation.

Thank you for your help.
Commissioning Challenges

Dr Angela Bate
Sara McCafferty
Institute of Health & Society, Newcastle University

Background & Aims

- Purpose of the research project
- Healthcare context
- Purpose of the presentation

Findings (National Survey)

Key Informant Interviews (Conception)
National Survey

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>Factor</th>
<th>Barrier</th>
</tr>
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<tbody>
<tr>
<td>Strong, frequent collaboration, good relationships</td>
<td>Engagement, clinical, organisational, patient &amp; public</td>
<td>Weak, inconsistent involvement, limited relationships</td>
</tr>
<tr>
<td>High</td>
<td>Flexibility of providers</td>
<td>Low</td>
</tr>
<tr>
<td>Timely, clear, good awareness of population needs</td>
<td>Provision of information (and knowledge)</td>
<td>outdated, inadequate, unclear priorities</td>
</tr>
<tr>
<td>Local flexibility, autonomy, WCC, assurance process</td>
<td>National Policy</td>
<td>perverse incentives, central bureaucracy, stringent performance management</td>
</tr>
</tbody>
</table>

Casestudy Findings

- Interpretation
  - elevating the importance of commissioning;
  - structuring commissioning;
  - improving commissioning outcomes;
  - performance managing commissioning.
Slide 5

Interpretation statements

• “… what they’ve done is given people focus… in terms of what makes us excellent…and what standards we are working to”

• ‘I think they’re basically common sense… how we should be working. I don’t think any of us can argue with, that is what our day job is about’ (ID005, Site C).

• ‘Um…I think they’re adequate’

Slide 6

Interpretation statements

• ‘there needs to be a process and PCT’s need to be held to account’

• ‘this is definitely a process that has to have somebody assigned to it in the PCT’

• ‘the team saw it as ‘another set of documents I have to complete, another set of things that you can be beaten over the head about not achieving again’, you know the usual ‘oh crikey’…”

Slide 7

Implementation

• Implementation
  – resources
  – data, information, and knowledge
  – relationships and engagement
  – politics
  – organisational culture
  – perceived value

Slide 8

Implementation Statements

• ‘the organisation is not adequately resourced […] currently management costs are about 1% of turnover and if you look at most major complex organisations, the management costs will be significantly more than that.’

• ‘we have so many nationally defined data sets that they never quite… never quite give us the information we want, […] it’s never exactly what you’re looking for’

• ‘it’s the underlying financial situation that drives the attitudes around the contracting and commissioning process…”

Slide 9

Slide 10
Implementation Statements

• “There will be a change of Government in less than 12 months, it’s hard to see out of that, there won’t be some sort of major structural change again” (PR006) and “the biggest risk I suspect it that a new administration will decide it simply isn’t going to run with this agenda”
• “the way that we’ve chunked it up is we’ve got a lead director for each competency (okay) … and then beneath that, where it’s necessary we’ve got different leads
• “I think the reality is that for people to achieve these […] an organisation must have lots of money to invest in developing itself to meet those and a health economy that’s ready to move with it as well…”

Feedback

• Integrity of findings
  – Anything missing or anything we should add?
  – Anything you think we have not interpreted correctly?

Follow up

• Which, if any, of these identified factors will continue to be a barrier for Commissioning?
• What three lessons or recommendations can we share with new GP commissioners?