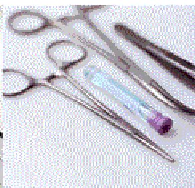

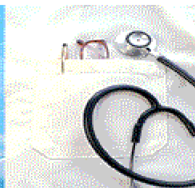

HEALTH REFORM EVALUATION PROGRAMME

REPORT SUMMARY

Implementation of the World Class Commissioning Competencies: A survey and case-study evaluation

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 (appended), 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)

Details of the methods can be found in the full report.

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 isssues 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 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.

Angela Bate [1], Cam Donaldson[2], David J Hunter [3], Sara McCafferty [1], Suzanne Robinson[4], Iestyn Williams[4]

[1] Newcastle University, [2] Glasgow Caledonian University, [3] Durham University, [4] University of Birmingham

The Health Reform Evaluation Programme (HREP) is funded by the Department of Health Policy Research Programmes and involves researchers from a range of British universities and research centres. The Programme aims to provide independent scientific evaluation of NHS Modernisation and Reform that seeks to transform their effective implementation and subsequent development, and to ensure transparency and public accountability.

Table 1. Competencies for World Class Commissioning

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

Source: Department of Health (2007). World Class Commissioning: competencies. Department of Health. London, Crown.