



Royal College
of Nursing

Commissioning health services

A guide for RCN activists and nurses



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An introduction to commissioning

Would you like the opportunity to shape and design services based on your local knowledge, your expertise and patients' needs and preferences? With major changes taking place in the way the NHS is commissioned and delivered, new opportunities are opening up for nurses to get involved and influence and effect change for the benefit of patients and public health.

Hard decisions will be made in the current economic climate. Activists who understand the commissioning process are in a strong position to influence decisions and to protect the interests of patients and RCN members. Commissioners are increasingly under pressure to deliver improved services with fewer resources. The earlier activists and nurses get involved in these decision-making processes, the more likely it is that they will be able to have a positive influence on behalf of patients and nurses.

This resource will help you to understand the commissioning process, how it works, what it aims to achieve and, most importantly, how you can become involved.

What is commissioning?

'Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.'

(DH, 2010b)

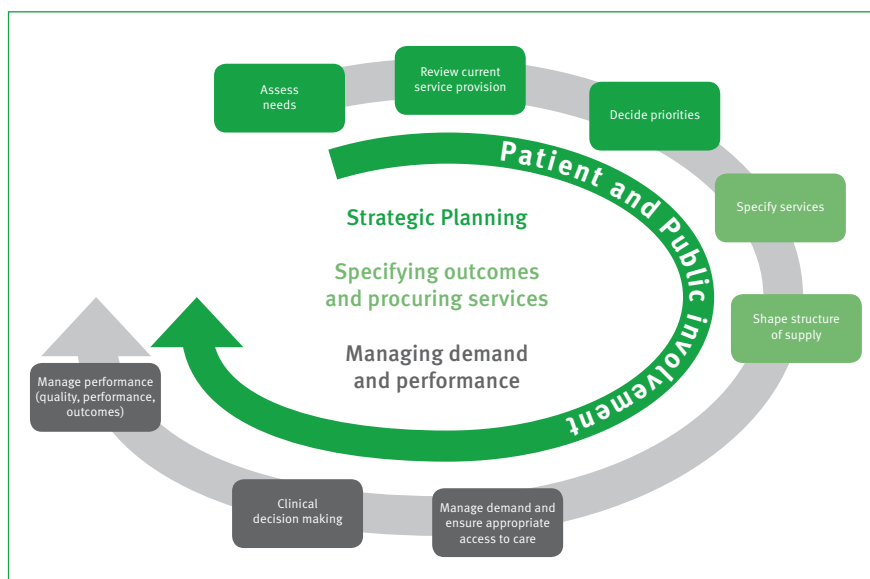
Commissioning starts with assessing needs and identifying priorities. It is a proactive and strategic process that has the potential to fundamentally redesign and change the way services are offered to your patients, and represents a crucial opportunity to influence the future and quality of nursing practice in your region.

Commissioning involves many people – both clinicians and managers – and it should also involve the public in consultation.

There are deadlines throughout the year for the production of plans, consultation and monitoring.

Commissioning is usually described as a cycle of activities with three phases (see Figure 1).

Figure 1 - The commissioning cycle



Adapted from Department of Health

Each of the three phases involves a set of activities, an example of which – relating to commissioning dementia services – can be found in Table 1.

Strategic planning – to assess local needs, commissioners and their partners work with communities and individuals to find out what their concerns are. In this way the commissioning team builds a picture of local health needs, the level of current service provision, and identifies specific areas of deprivation or need. This work is undertaken in the context of a national and local strategic framework.

Specifying service outcomes and procuring services – this can lead to commissioning decisions about whether to:

- keep an existing service as it is (status quo)
- stop funding an existing service (decommissioning)
- tender for new or refined services from existing and new providers (competition).

Commissioners set out a vision of what they want services to look like. This is based on outcomes – what benefits the services will bring to patients – and on known best practice. Based on this vision, commissioners set about procuring organisations to deliver quality services that are value for money. This involves designing the service specifications, tendering, and awarding contracts. Measures are agreed to monitor the quality and achievement of outcomes.

Managing demand and performance – service providers are accountable for delivery, quality, and the user experience. Clinicians need to be equipped for decision making, performance monitoring, quality control and measuring outcomes. This information is fed back into the next strategic review.

Table 1 - Applying the commissioning cycle to dementia services

Commissioning stage	Applied to dementia services
Strategic planning (assessing needs, reviewing service provision and deciding priorities)	<p><i>Knowledge and influences</i></p> <ul style="list-style-type: none"> - demographic changes (more people with dementia) - strategic objectives – five year strategy <i>Living well with dementia</i> (DH, 2009) <p><i>Assessment and analysis</i></p> <ul style="list-style-type: none"> - increasing local population of elderly people who have or will develop dementia <p><i>Planning and partnership</i></p> <ul style="list-style-type: none"> - policy influences – five year strategy - services working together
Specifying outcomes and procuring services (specifying services and shaping the structure of supply)	<p><i>Change and service redesign</i></p> <ul style="list-style-type: none"> - types of services needed (for example, more memory clinics) - frontline health and social practitioners need to recognise early signs - care pathways <p><i>Implementation and contracts</i></p> <ul style="list-style-type: none"> - type and place of service with agreed contracts with one, some or all of the following sectors: statutory, voluntary, independent, primary care, social care, specialist care
Managing demand and performance (managing demand and access to care, clinical decision making and managing quality, performance and outcomes)	<p><i>Outcomes and monitoring</i></p> <ul style="list-style-type: none"> - improved attitude towards dementia - services tailored towards early diagnosis, information, treatment and support - all aspects of commissioning cycle addressed in relation to QIPP (quality, efficiency and value for money) - adherence to policy and legislation (for example, mental capacity, referred place of care)

Reproduced with kind permission from the *British Journal of Community Nursing*

Central to the whole process is the involvement of patients and the public. For more information about this and all other aspects

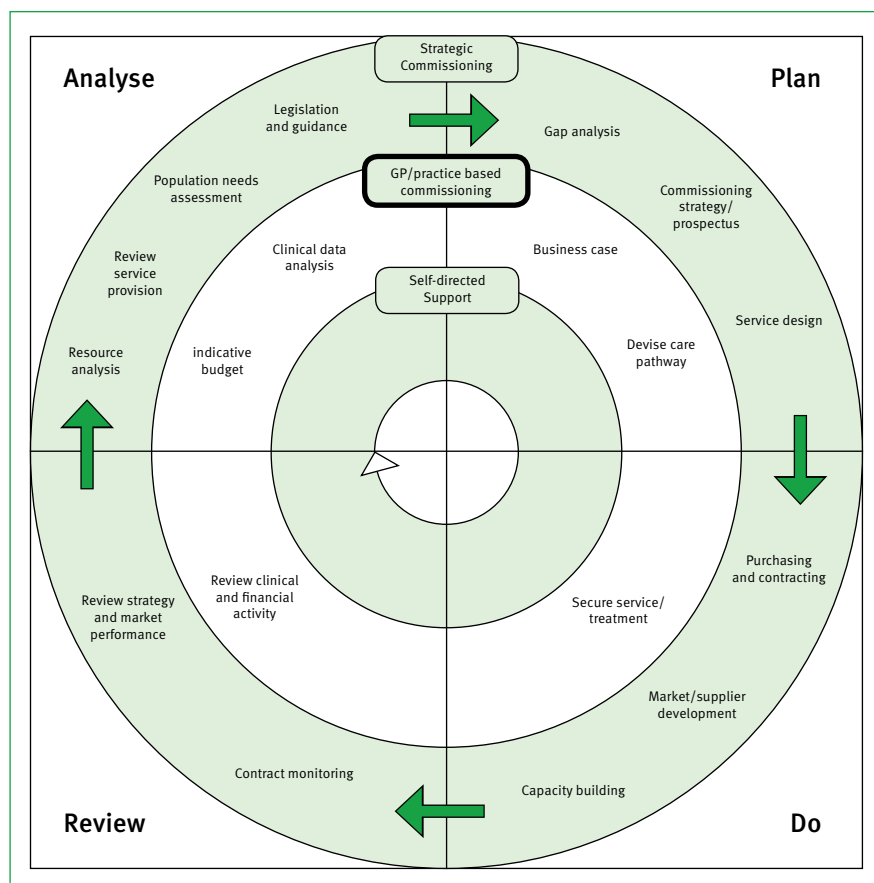
of commissioning, visit the NHS evidence commissioning specialist collection at www.library.nhs.uk/commissioning/

Who leads commissioning and where does it take place?

Commissioning for health can take place at a number of levels, and Figure 3 illustrates another version of the commissioning cycle and the activities that may take place at each level.

The phases of activity are broadly the same at all levels – analyse, plan, do and review – but the activities themselves may differ.

Figure 3: Levels of commissioning



Adapted from the Institute of Public Care

Individual patients: self-directed support (personal budgets)

This is where individual service users hold budgets and make direct payments to providers who meet their needs for social care. It is likely that this model will be increasingly encouraged and will change assessment and care management systems, having a major impact on the strategic commissioning role in the future.

Local level: practice based commissioning/ GP-led commissioning

In 2010 the coalition government introduced major changes to the commissioning process, demanding that GP consortia take on responsibility for a large part of the NHS budget (DH, 2010b). The details of how this will take place are unfolding. What is certain is that there will be new players and new opportunities for nurses to get involved with commissioning at a local level.

Strategic level: primary care trusts and specialist commissioning

In the past strategic commissioning was carried out by primary care trusts and local authorities, but the drive now is to move commissioning closer to service users and patients. It is likely that the strategic role may become more one of coordinating and leading the activities of different agencies. While strategic health authorities and primary care trusts are due to be removed by 2012/13, the need for strategic commissioning will remain.

Specialist commissioning is where there are 'high cost, low volume' areas of care, such as specialist cancers or children with heart conditions. For these care needs it makes better clinical and financial sense to commission services at a regional level. The detail for specialist commissioning is currently not clear but some are likely to come under the remit of the NHS Commissioning Board.

The NHS Commissioning Board

The White Paper *Equity and excellence: liberating the NHS* (DH, 2010b) introduced a new body – the NHS Commissioning Board – which by 2012 will take over responsibilities to:

- provide national leadership on commissioning for quality improvement
- promote and extend public and patient involvement and choice
- ensure the development of GP commissioning consortia
- commission certain specialised services
- allocate and account for NHS resources.

Why get involved?

At the local and strategic level, activists and nurses can influence commissioning in two ways:

- as clinical experts - to ensure quality and equity for patients
- as activists – to ensure fairness and equity for members in the planning of new services. Any redesign of services should be accompanied by a workforce plan.

Baldwin and Wilson (2009) suggest the following reasons:

- to protect the public as part of your professional responsibility and duty of care
- to ensure services are appropriate
- to advocate on behalf of users of services to ensure safe, equitable and personalised care services
- empowering service users to have their voices heard.

Why now?

Many changes lie ahead in the future of NHS commissioning due to the policy changes initiated in 2010 (DH, 2010b). It is essential that activists and nurses follow these changes closely and work in partnership with commissioners, who are themselves learning to operate in this new landscape. Where services are being redesigned, activists can help commissioners to consider the impact on terms and conditions. Nurses are also in a position to advise about the possible impact of commissioning decisions on clinical and health outcomes.

Who wants nurses to be involved in commissioning?

Patients do:

In a 2009 survey carried out by the RCN and National Voices, respondents ranked specialist nurses as best (compared with other health care professionals) at understanding patients' needs, designing and implementing care pathways, collecting patient feedback and being transparent. Specialist nurses were ranked number one, followed by paramedics, community nurses, midwives and allied health professionals who all achieved a middling number of respondent's votes.

Commissioners do:

Commissioners need to show that their decisions are based on what matters to patients, the public and staff. Nurses are uniquely placed to understand the

consequences of plans that involve changing or redesigning services because they are familiar with the challenges that face patients and their carers in daily life.

RCN members do:

In this time of uncertainty and change, RCN members will want to know their representatives are knowledgeable about commissioning arrangements and that they are influencing strategically on behalf of staff and patients at all levels of commissioning.

The government does:

The *Procurement guide for commissioners of NHS-funded services* (DH, 2010a, p.28) states:

‘It is good practice for commissioner boards to signal a staff engagement policy in relation to commissioning, including:

- developing and implementing commissioning strategies
- reviewing services and care pathways
- developing service specifications
- procurement.’

With the future removal of primary care trusts and strategic health authorities on the horizon, it is essential that staff engagement remains a priority. Annex B of the Department of Health 2010 publication *Procurement guide for commissioners of NHS-funded services* gives more information about commissioner responsibilities in relation to engaging staff and trade unions in changes that affect them.

Quality and the commissioning process

Under the Commissioning for Quality and Innovation (CQUIN) initiative, a proportion of trusts’ income is conditional on locally agreed goals about improvements in quality.

There are three dimensions to quality services:

- patient safety – the environment is safe, clean and risks of error are minimised
- patient experience – patients are treated with dignity and respect and are asked about their experience of care

- clinical effectiveness – clinical decisions are made on the best possible evidence of what works; measures of effectiveness include wellbeing and the ability to lead an independent life.

Providers of NHS funded services must produce an annual Quality Account, a document that is made available in the public domain. For example, Quality Accounts for your local health care providers can be found in the ‘professionals’ area of the NHS Choices website (www.nhs.uk/aboutNHSChoices).

The Quality Innovation Productivity and Prevention (QIPP) strategy is about ‘identifying efficiencies while driving up quality’ (see the Department of Health website for QIPP – www.dh.gov.uk/en/Healthcare/Qualityandproductivity).

All commissioners are expected to place an emphasis on productivity and getting the best value for money. But, importantly, commissioners must balance these concerns with quality and innovation. Every strategic health authority should have a QIPP framework for commissioning in place, which you should be able to find on your PCT website. Failing this you could contact the PCT’s organisational lead for quality or the finance director. A list of the QIPP leads for each SHA can be found on the Department of Health’s website.

The QIPP framework provides a negotiating tool for all activists and nurses who are working to ensure the clinical quality element of commissioning is robust. This is your key document to work from – the scope of the QIPP strategy has a far reaching impact on patient services, and ultimately RCN members.

Six keys to help you unlock the commissioning process

1. Network

Depending on your role and the level at which you work, there are a number of key contacts for commissioning. These include the:

- regional commissioning board representative
- local authority
- GP commissioning consortia
- local health watch.

Make yourself visible throughout your trust or organisation – and not just in your clinical field. Take advantage of regional and national events that will enhance your knowledge, give you a wider perspective and increase your credibility. Your union networks will also be useful, as well as any existing contacts within human resources or with nurse directors.

Work with other agencies (social and housing services, voluntary/charitable organisations, education, the probationary service) to extend your effectiveness. In particular, be aware of any local pressure groups that may support your position.

2. Consult and share

One of the challenges of becoming involved with commissioning is that there is no formal consultation structure for RCN representatives. The commissioning process should be a consultative one, however, so there will be opportunities for getting involved at a local and strategic level if you are able to negotiate time with your employer to do so.

Use your union contacts within the trust and talk with other regions to compare practice and share knowledge. Keep communicating with RCN members and staff, and draw on their expertise. You do not have to be the expert in every area – RCN members and staff will supply that. The skills of the activist lie in mobilising that expertise and giving it a voice.

3. Understand the commissioner agenda

The key to influencing is to understand the other party's agenda. You will need a broad knowledge of commissioner priorities. If you need help, contact the regional RCN office. Your best route for this is to have a working knowledge of the policy for meeting quality standards for your services (the QIPP strategy).

Relate these to local policy and priorities and you will capture the attention of all commissioners. In this way you can enhance, improve, and add value to what is already in the quality programme. Remember RCN members are your best resource to help you respond to any consultation. Contact specialists in the clinical areas under discussion, and gather their views about whether plans are achievable and what the pitfalls may be.

4. Speak the language of commissioning

It is important to demonstrate the *outcomes* that nurses achieve for their patients, and express these in commissioning terms. For example, to protect the work of a specialist diabetes nurse you might need to show that the presence of a diabetes nurse results in less follow-up visits and fewer re-admissions to hospital, with demonstrable benefits for patients. Find RCN members who can supply you with good examples to promote the cause and use your union networks in other trusts to find out what is happening in other regions.

You will also need to understand the joint strategic needs assessment and the health needs of the population so that you can make informed judgements about gaps in service provision.

Nurses are in a unique position. They combine clinical expertise, knowledge of local care services, an understanding of their local health economy and their clinical specialty. Such local knowledge is gold dust to commissioners who must deliver care that is closer to home. Apart

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from patients, nurses are probably the only health professionals who can offer the most insight into how services connect to each other, and what the impact of change in one part of the system might mean for another part.

5. Choose the best time

There may be times when influencing is more effective: for example, when a contract is up for renewal or when your organisation’s budgetary negotiations are being made (normally around November/December for the financial year which begins the following April). You could place an agenda item on the local negotiating committee or partnership forum within the trust to ask the employer to present information about when contracts and service level agreements are up for renewal. You might also ask for the employer to report on discussions they might be having that will involve a change of services.

When new services are being commissioned, the earlier you get involved in the process, the more you can influence the final shape of the service. At each stage of the commissioning cycle there are specific questions which you can ask (see the *Questions to influence each stage of the commissioning process* section that follows).

6. Prepare your evidence

As well as using the evidence of the joint strategic needs assessment, use the RCN membership expertise and gather two kinds of evidence:

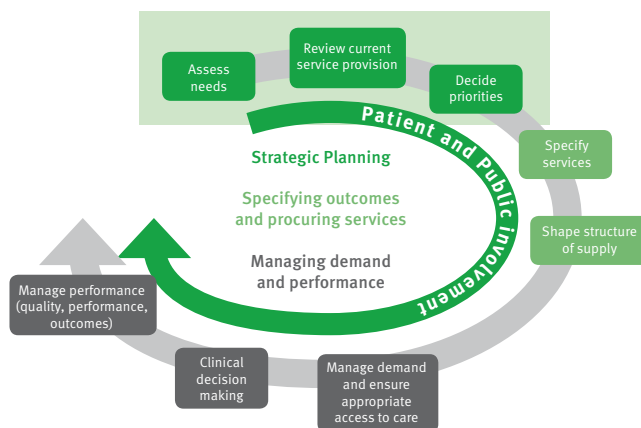
- what works in delivering best patient outcomes, based on research and best practice, and how does this evidence fit with national standards and principles and local priorities (as defined in the quality programme)
- staff and workforce evidence relating to equity, efficiency, effectiveness and value for money – particularly the likelihood of ‘unintended consequences’ to staffing arrangements of any planned change.

If for any reason you believe your voice is not being heard – or you need help with your influencing strategy – contact your regional RCN office and ask for further advice and support.

Questions to influence each phase of the commissioning process

The following questions should enable you to influence and participate at every phase of the commissioning process. You can also consult *RCN principles to inform decision making* (RCN, 2008) to develop further questions that ensure the RCN principles of quality, accountability, equality and partnership are used as part of the decision-making process.

1. Strategic planning



Adapted from Department of Health

Assessing needs

Has an assessment been carried out?

How has the local community been engaged in the process?

Have staff members been engaged?

What does the assessment reveal in terms of significant areas of deprivation?

What are the indicators that are relevant to the client group you represent?

What action is proposed to address the needs?

Reviewing services

How do current services compare to national best practice?

What measures are in place to understand this (QIPP)?

Have patients been consulted and involved?

Have staff been consulted and involved?

What mechanisms are in place to understand the impact on the workforce? For example, if staff members are being transferred to a new provider, will they require new skills or can they transfer existing skills?

Decide priorities (identifying new and changed services)

Have the public been engaged in deciding priorities?

Have staff members been engaged in deciding priorities?

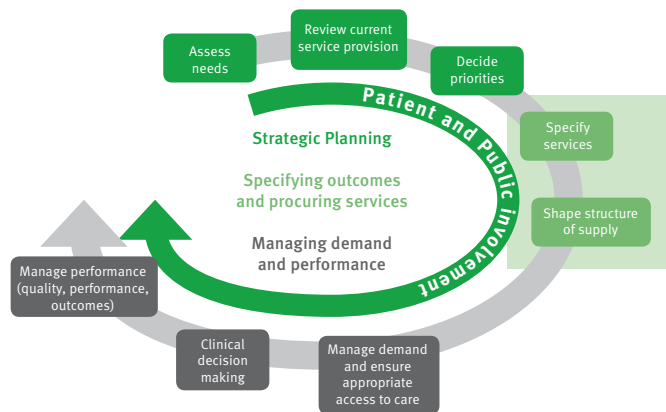
What is the workforce plan?

What is the impact on staff of any redesign? For example, relocating a service may require staff to travel longer distances; a change in service focus may require retraining or upgrading of skills.

Are there any unintended consequences in other parts of the service of this change? For example, closing eight beds on a 16-bed ward might make the remaining service unviable.

Has an equality impact assessment been carried out?

2. Specifying service outcomes and procuring services



Adapted from Department of Health

Specify services

Is the specification based on best practice?

Are the patients' best interests at the centre of the specification?

What will be the impact on staff?

How will the quality be monitored?

What will be the performance indicators?

What evidence is there that the provider offers value for money?

Shape the structure of supply

What is the procurement process?

Is the process fair and equitable?

What will be the impact on staff?

Specific questions to address proposals to tender:

Has there been a review of the quality of the existing service?

How will the quality of services be assessed (for example, which patient reported outcome measures –PROMS- and patient reported experience measures will be recorded and monitored)?

Does the provider have an appropriate strategy for maintaining a safe working environment which encompasses health and safety structures and risk assessments?
 What triggers will be included to assess whether or not to withdraw the contract?

What is the framework for professional leadership and support?

What is the organisation's strategy for recruitment and retention of nursing staff in the future?

Will the new provider take nursing students on placement, provide work for newly qualified nurses and play a part in local workforce planning?

Has there been an equality impact assessment of the change to the service, in relation to both staff and the local community?

Does the organisation have an equality and diversity policy?

What mechanism does the new provider have in place for workforce data collection which records race, gender, age, disability linked to payroll information?

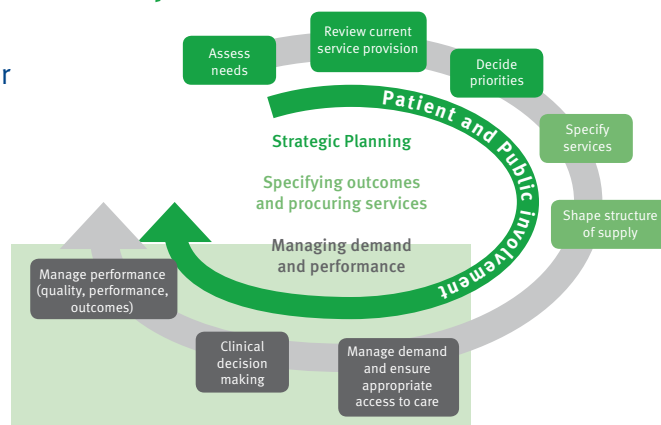
Will local staff be involved in selecting a provider? If not, why not?

What processes will a new provider put in place for staff side consultation and engagement?

What will be the impact on staff? Will there be any changes to place or pattern of work?

Have staff been made aware of the full implications (for example, locality, terms and conditions on promotion, pension issues) of transferring to the new organisation?

3. Managing demand and performance



Adapted from Department of Health

Managing demand and access

Is the service specification and monitoring process transparent?

Are patients' needs at the centre of the monitoring process?

What evidence of good practice is there on equality, diversity and human rights?

How is accessibility monitored?

Clinical decision making

How is the quality of the service being assessed?

How are patient reported outcome measures and patient reported experience measures assured?

Managing performance

What happens if a service provider is found not to be doing a good job?

Are there circumstances when a contract will be withdrawn?

What will be the impact on staff?

What provisions will be made (for example, continuation of services to patients) if the provider is no longer able to offer a safe, effective, high quality service?

Learn the lingo

We've compiled some of the key commissioning terms – using the Department of Health's *Equity and excellence: liberating the NHS* (DH, 2010b), the NorthWest Commissioning Road Map (see www.northwestroadmap.org.uk) and the IMPRESS jargon buster (available at www.impress.com) – to help you join in the commissioning conversation with confidence.

Any willing provider – a procurement model that commissioners can use to develop a register of providers accredited to deliver a range of specified services within a community setting.

Commissioning – the process of assessing the needs of a local population and putting in place services to meet those needs.

Commissioning for Quality and Innovation (CQUIN) framework – the CQUIN framework enables those commissioning care to pay for better quality care, helping promote a culture of continuous improvement.

Contracting – the legally binding arrangements that are agreed between service providers and commissioners to meet the health and social care needs of a specified population, including the quality and standards expected.

Decommissioning – the process of planning and managing a reduction in service activity or terminating a contract in line with commissioning objectives.

Disinvestment – investment in one service may involve reducing a service somewhere else. For example, improving long-term conditions management in primary care may reduce reliance on hospital-based follow-up.

HealthWatch – the local bodies that represent the views of service users and the public – will be taking over from LINKs following policy changes in 2010.

Independent sector – encompasses individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and charities.

Inputs – the resources invested into the service to deliver the outputs. For example, numbers of staff employed (source: NorthWest Roadmap).

Local Involvement Networks (LINKs) – LINKs are local organisations in each local authority area set up to represent views of local people on health and social care services. These will become local HealthWatch organisations.

Outcomes – measures the short and long term health gain of the population and the expected change in health status.

Outputs – the desired level of service from a provider, which is usually expressed in terms of service availability, speed, delivery or quality. For example, the number of sessions held, the vacancy rate of a service, or waiting times.

Processes – ways of working; for example, an equal opportunities policy is in place, or all staff are CRB checked.

Procurement – the process of identifying a supplier for service delivery. It consists of purchasing and contracting.

Patient Reported Outcome Measures (PROMs) – PROMs provide information on how patients feel about their own health, and the impact of the treatment or care they receive.

Provider – organisations which provide services direct to patients, including hospitals, mental health services and ambulance services.

Purchasing – the process of securing or buying the services.

Quality account – a report about the quality of services that must be produced annually and made public by each health care service provider.

Service level agreement (SLA) – the agreement between the commissioner and provider is in two parts: the SLA (or contract) and the service specification (see below). The SLA is a formal written agreement and is a standard document written by the Department of Health.

Service specification – part of the SLA (see above), the service specification details how and what services will be provided, including the quality standards the service should maintain. It is useful to read the service specification because it also explains how the services will be monitored.

Social enterprise – businesses with primarily social objectives whose surpluses are reinvested in the business or the community rather than distributed to shareholders.

Tender – a formal offer to provide services as a response to a specification, usually for a stated price or in accordance with a schedule of stated prices.

Unintended consequences – when services change there may be other unforeseen consequences in another part of the service, and recognising these is important for a risk assessment. For example, delivering care in the community may stop inappropriate hospital admissions but patients might place more demand on district nurses or require a different type of nursing.

World class commissioning – a Department of Health programme to deliver a more long-term and strategic approach to commissioning, with a focus on outcomes. The programme ended in 2010.

If you can't find the term you are looking for in this glossary, you can find an extensive listing of terms in the glossaries listed at www.library.nhs.uk/commissioning/Page.aspx?pagename=glossaries

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