

BUILDING HIGH-QUALITY COMMISSIONING

What role can external organisations play?

Chris Naylor
Nick Goodwin

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Executive summary

Introduction

- Commissioning is expected to play a central role in meeting the challenges currently facing the NHS – developing better quality care and improving productivity. However, it is widely recognised that it has so far failed to become a major driver of improvement.
- In recognition of this, the Department of Health launched the world class commissioning programme in 2007. This provides commissioners with a vision of what best practice in commissioning looks like, and a set of organisational competencies which commissioners will need to develop if they are to achieve this vision. Since 2009 primary care trusts (PCTs) have been assessed against these competencies on an annual basis.
- Encouraged by government policy (in particular the framework for procuring external support for commissioners; FESC), NHS commissioners have increasingly turned to the independent sector for support with commissioning. The use of external support is now the norm among PCTs.
- The economic downturn presents a challenging environment for NHS commissioners seeking to invest in external support. The House of Commons Health Committee, among others, has expressed concern that the use of external support may not always provide value for money and that PCTs may not have the ability to use such support effectively.
- The primary aim of this research was to examine how external support is being used by PCTs and strategic health authorities (SHAs) and whether it is helping to develop more effective commissioning. The research was based on a mixture of qualitative and quantitative methods, including national surveys, focus groups and semi-structured interviews with people working in PCTs, SHAs and organisations providing support to commissioners.

How is external support being used by NHS commissioners?

- External support comes in a variety of forms from a range of very different organisations, including generic management consultancies, specialist health consultancies, freelance consultants and health insurance companies. Broadly speaking, the aim is either to improve commissioning within the NHS, or to outsource certain aspects of it to other organisations.
- External support can be provided in at least four different forms:
 - short-term consultancy projects of an essentially advisory nature
 - longer-term joint delivery models where internal and external teams commission in partnership

- outsourcing of discrete elements of the commissioning process
- full outsourcing of all or most of the commissioning function.
- Most support currently provided to NHS commissioners is based on a consultancy model, although joint delivery and outsourcing models are becoming increasingly common. The full outsourcing option has not been used so far.
- The role and nature of external support will evolve over time. The coalition government's intention to transfer commissioning responsibilities from PCTs to GP consortia may present opportunities for external organisations to be increasingly involved in supporting commissioning at this level.
- If these plans go ahead it is possible that some GPs will want to outsource full responsibility for commissioning to external organisations. It is not yet clear what safeguards will be put in place to protect public accountability and manage the financial risk that such organisations would be taking on under this scenario.

Can external support improve commissioning in the NHS?

- Levels of satisfaction among those who have used external support are reasonably high. Our case studies identified examples where external support had succeeded in improving commissioning processes. External organisations seem particularly well placed to provide support with the analysis and application of data, and with commercial skills – areas identified as key weaknesses by the 2009 world class commissioning assurance process.
- However, it is also clear that external support is not always used effectively. There are difficulties around inadequate processes for procuring support, poor working relationships and other barriers. As a result, commissioners do not always achieve what they had hoped for. The recommendations below provide guidance on how these pitfalls can be avoided.
- Providers of external support can add most value when:
 - they are used proactively to help commissioners develop towards a long-term strategic vision of how their organisation should function in the future
 - they bring something new – by introducing new skills, tools and processes or by supporting transformational change in terms of organisational structure and culture.
- This is not the way most external support is currently used. External support is often used to add extra capacity and in response to short-term imperatives.
- There is some evidence that poorer performing PCTs, whose developmental needs are the greatest, may be in the weakest position to use and benefit from the services that external organisations offer – in part because of high levels of organisational instability and in part because of limited managerial capacity or capability to implement or to act on the work produced by the external supplier. It is important to develop approaches for supporting poorer performing commissioners in becoming good, as well as for helping good commissioners to excel.
- The cost-effectiveness of external support will be the key issue over the coming years, as the NHS comes under increasing pressure to justify management expenses. Providers of external support would be advised to do more to measure the impacts of their work and demonstrate returns on investment. Increased use of risk-sharing contracts may help make support more affordable.

- Our overall assessment is that, if used appropriately, external support can play a role in raising the standard of commissioning in the NHS, and in doing so help the system to achieve the improvements in quality and productivity needed over the coming years. The recommendations below give guidance on how support can be used to maximum effect.

Building high-quality commissioning

- Our study suggests that the world class commissioning programme has been successful in focusing commissioners on what high quality commissioning would look like and what changes are needed to develop it.
- However, significant concerns exist about the administrative burden the assurance process imposes on PCTs. A particular concern is the potential for world class commissioning to become a bureaucratic exercise of ticking the box, rather than a developmental process for stimulating improvement in the quality of commissioning.
- NHS managers believe world class commissioning is an achievable goal, but will take several years to develop. A large majority (86 per cent) said it would take at least three or four years, and a quarter (26 per cent) said it would take five to 10 years.
- There is a number of structural problems that limit the effectiveness of commissioning and that might not be addressed by either external support or through the world class commissioning process.

Recommendations for commissioners

- The following recommendations will be relevant to GP commissioning consortia as well as to PCTs. It is important that GP commissioners learn from the experience of using external support in PCTs.

How and when to use external support

- Use external organisations to support long-term strategic development rather than in response to short-term imperatives.
- Use external support to add something new rather than to increase capacity to do routine tasks.
- Choose the right model for external support on a case-by-case basis, with reference to the different merits and challenges of consultancy, joint-delivery and outsourcing models.
- Avoid using external support for long-term substitution of manpower or to cover vacancies.
- Avoid focusing narrowly on technical fixes.

Procuring support effectively

- Clarify the objectives and specification for external support before issuing a tender
- For a substantial project, consider using a two-stage procurement, with a preliminary stage aiming to develop the specification more clearly.
- Consider using FESC for larger scale projects on a joint delivery or outsourcing model.

Contracts for external support

- Include clear evaluation criteria by which success will be judged.
- Explore possible risk-sharing arrangements with potential suppliers.
- Long-term contracts need to leave room for innovation and flexibility around deliverables.
- Use outcome-oriented contracts to allow more scope for change and creativity.

Building effective working relations

- Actively communicate the purpose of external support within the PCT and clinical community before the start of the project.
- Include general practitioners on the selection panel to encourage clinical engagement.
- Help commissioning staff to see external support as an opportunity for personal development.
- Build relations with a small number of suppliers over a number of contracts.
- If using a joint-delivery model, invest resources in relationship-building between internal and external teams.

Recommendations for policy-makers

- Be realistic about the timescales needed to develop high-quality commissioning. See the role of external support as enabling gradual improvement in the quality of commissioning more than rapid turnaround.
- If commissioning responsibilities are transferred to GP consortia, put appropriate safeguards in place to protect public accountability and manage the financial risks that would exist if consortia chose to outsource these responsibilities to external organisations.
- Continue to measure the quality of commissioning and encourage developmental improvement, either through world class commissioning or an alternative assurance framework.
- Give greater emphasis in world class commissioning (or an alternative framework) to the outcomes rather than processes of commissioning, and make a more explicit link to tackling the productivity challenge facing the NHS.
- Ensure that there is a quality assurance process for GP-led commissioning, as well as for commissioning occurring at other levels including local authorities and inter-PCT collaborations.
- If developing new procurement frameworks for external support, use the lessons learned from the experience of the FESC. Consider developing frameworks structured in terms of the world class commissioning competencies or similar.
- Construct procurement frameworks in a way that facilitates collective procurement of external support across a number of commissioning organisations.

Recommendations for suppliers of external support

- Measure and demonstrate the impact of services provided, including in terms of return on investment.

- Develop and market a clear portfolio of skills and services to help commissioners know what makes suppliers distinct from each other.
- Be open to risk-sharing arrangements.
- Consider how to support poorer performing commissioning organisations more effectively.

1 Introduction

Commissioning has come to play an increasingly important role in the NHS. Since the internal market was created in 1991, the NHS in England has comprised organisations responsible for commissioning health care, and separate organisations that provide it. The logic of this purchaser–provider split was to introduce competition between health care providers, with commissioners purchasing services on behalf of patients and the public from a variety of competing providers (Smith *et al* 2004). Commissioning was also designed to ensure that wider goals for the health sector were achieved – such as stimulating improvements in quality, access, and value for money. Without effective commissioning, the system therefore lacks what is intended to be a key driver of improvement, and may struggle to achieve the increases in quality and productivity needed over the coming years.

Commissioning budgets in England are currently held principally by primary care trusts (PCTs). The 152 PCTs are responsible for spending 80 per cent of the NHS budget. The core commissioning processes include needs assessment, resource allocation, purchasing services through contracts, and monitoring and review of performance.

In 2005 the Labour government put in place a system of practice-based commissioning in which PCTs are expected to commission services in partnership with local general practitioners, although the extent to which this has happened is variable (Curry *et al* 2008; Wood and Curry 2009). The current coalition government intends to involve GPs in commissioning in a more radical way by giving GPs real budgets with which to purchase services on behalf of their patients.

PCTs also commonly work with other partners to plan and purchase care, for example, with local authorities for services such as mental health care, and with other PCTs and strategic health authorities (SHAs) for more specialist services. Hence, while the PCT is at present the hub around which most commissioning decisions are made, a complex range of commissioning arrangements exists. These can be conceived as lying along a continuum, with personal health budgets at one extreme and national-level commissioning at the other (Smith *et al* 2010).

It is widely recognised that commissioning has largely failed to become a major driver for improvement in the NHS (Brereton and Vasoodaven 2010). PCTs have been criticised as being overly passive, with spending patterns being determined more by historical precedent than an objective analysis of current needs (House of Commons Health Committee 2010). While there is evidence that progress has been made in some PCTs in recent years, and that this has not always been acknowledged, it is clear that substantial developmental needs still exist (Smith *et al* 2010). These are discussed more fully in Section 3, pp 11–14.

In recognition of the need for significant improvements in the effectiveness of commissioning, the Department of Health launched two major initiatives in 2007 – the world class commissioning programme (Department of Health 2007d), and the framework for procuring external support for commissioners (FESC) (Department

of Health 2007a). The following sections describe these initiatives and how they were intended to improve the quality of commissioning.

What is world class commissioning?

World class commissioning represents the most concerted effort yet to create higher quality commissioning in the NHS. Under the tagline ‘adding life to years and years to life’, the world class commissioning policy has aspired to change the focus of PCT commissioners from being passive contractors of services towards a more proactive role in securing the best quality and value care for the populations that they serve, while also promoting population health and well-being (Department of Health 2009c). The policy represents a call to action for PCT commissioners to drive ‘unprecedented improvements in patient outcomes’ and to aspire towards ‘the most progressive and high-performing health system in the world’ (Department of Health 2007d, p 1).

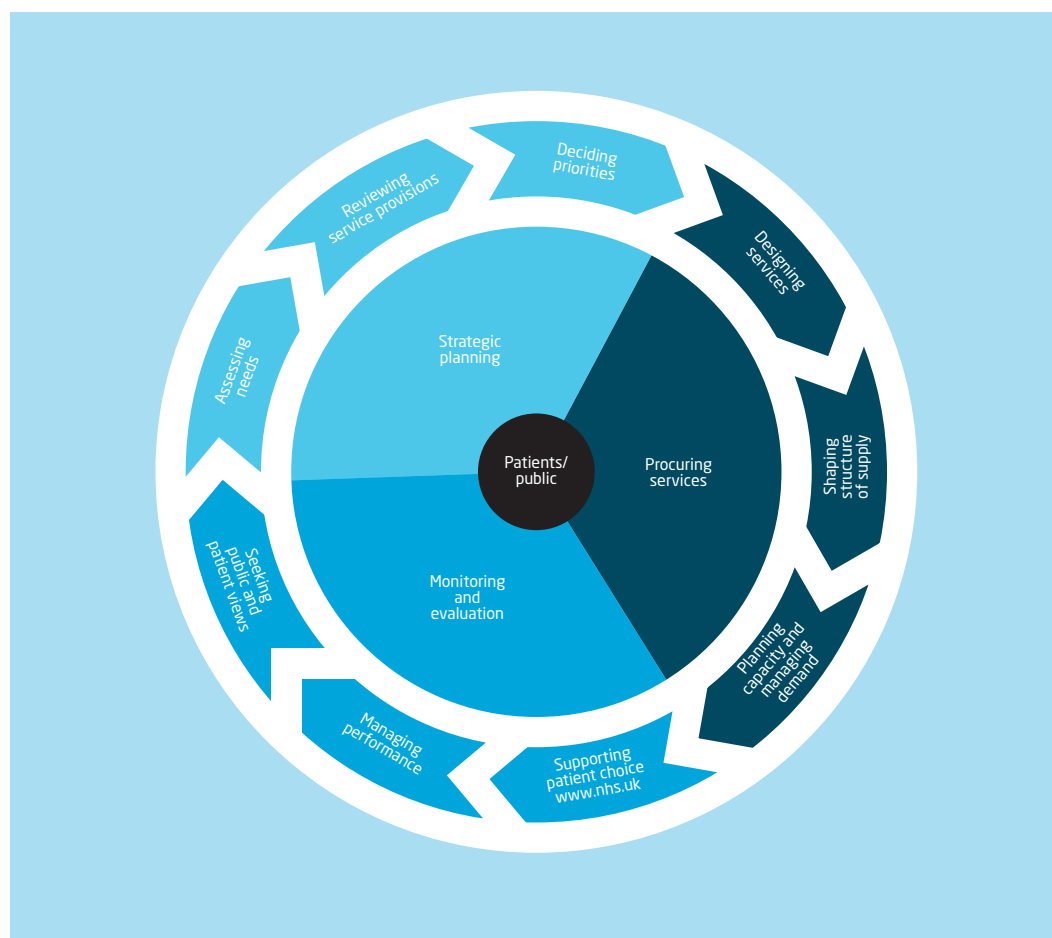
The push towards world class commissioning followed the White Paper *Our Health, Our Care, Our Say: A new direction for community services* (Department of Health 2006b) that set out key standards and reforms for the NHS. The document *Health Reform in England: Update and commissioning framework* (Department of Health 2006a) followed the White Paper and argued that effective commissioning would be the mechanism to drive health reform and that it needed to be strengthened. *The Commissioning Framework for Health and Well Being* (Department of Health 2007b) claimed that current commissioning was too focused on volume and price with not enough emphasis on outcomes and quality.

In December 2007 the *Towards World Class Commissioning* conference launched the vision for the practical delivery of more effective commissioning. The world class commissioning framework, published at the same time, provided commissioners with a set of competencies to describe what best practice in commissioning looked like (Department of Health 2007c). The framework recognised that commissioning involved more than procurement – instead it framed commissioning as a cyclical process including analysing the health needs of a population, planning what services are required to meet those needs, procuring the services, and then monitoring and evaluating the services provided (see Figure 1, p 1).

The framework describes 11 core organisational competencies that commissioners are expected to develop in their journey towards becoming ‘world class’ (see box on page 4). Since 2009 PCTs have been assessed against these competencies on an annual basis. For each competency, PCTs are assigned a score of between one and four depending on their level of development. World class commissioning is represented by achievement of level four on all 11 competencies. The results of the 2009 assurance process are described in Section 3, pp 11–14.

The annual assurance process combines self-assessment, external analysis by strategic health authorities, and a review day on which PCT board members are questioned by a panel of reviewers drawn from a mixture of backgrounds. In addition to being assessed against the 11 competencies, PCTs are assessed in terms of the health outcomes achieved, governance arrangements and potential for improvement. It was intended that this system would be a developmental process that would enable PCTs to identify gaps in their skills and areas for improvement (Department of Health 2008), although as we will show later, there are concerns that this intention has not always been fulfilled.

The election of a new government in 2010 has, however, thrown into doubt the future of the world class commissioning framework. In particular, emphasis is being placed on stripping back the commissioning responsibilities of PCTs in favour of ‘GP commissioning’ that will involve a transfer of responsibility to more local clinician-led commissioning consortia. As Ham (2010) suggests, the success of this change in policy

Figure 1 The commissioning cycle

Source: NHS Information Centre for Health and Social Care. Full diagram available at: www.ic.nhs.uk/commissioning

will depend critically on developing the leadership and management expertise required for commissioning to be effective. Hence, there is a need for a quality-assurance process to support and develop high quality commissioning, regardless of whether world class commissioning survives as a policy.

What is external support for commissioning?

It was recognised at an early stage that the vision set by world class commissioning would be highly challenging for PCTs to achieve. The Department of Health has suggested that organisations outside of the NHS may be able to play a role in helping PCTs rise to this challenge and develop towards being world class commissioners (Department of Health 2009a, p 3).

A wide range of organisations offer services to NHS commissioners to support them with various aspects of commissioning. These include generic management consultancies, specialist health consultancies, freelance consultants, and health insurance companies. The term 'external support for commissioning' includes a huge variety of services provided by such organisations. 'External support' and 'management consultancy' should not be used interchangeably because not all consultancy purchased by PCTs is in support of the commissioning function, and conversely not all external support can be adequately termed 'consultancy'. Section 4, pp 15–20 describes in greater depth the types of services currently being provided to the NHS by external organisations.

World class commissioning competencies

PCTs should be able to:

- act as the local leader of the NHS
- work collaboratively with local partners including local government and voluntary sector organisations
- engage with public and patients
- collaborate with clinicians
- manage knowledge and evidence, eg, robust assessment of population health needs
- prioritise investment according to local needs
- stimulate the provider market to meet demand
- promote continuous improvement and innovation
- secure procurement and contracting skills
- manage relationships and contracts with providers
- make sound financial plans.*

* Added in 2010

The most significant action by the Department of Health on external support was the creation of the FESC in 2007 (Department of Health 2007a). The FESC provides one route through which commissioners can engage the support of external organisations. It offers a list of 13 approved suppliers and was designed to reduce the length of the procurement process and ensure PCTs got maximum value for their investment by using performance indicators to aid management of the contract. (See Appendix A for further details on the structure of the framework.)

A particular objective for the FESC was to make it easier for commissioners to embark upon larger-scale projects, potentially involving complex joint delivery or outsourcing arrangements (see Section 4, pp 15–20). The framework is therefore significant in that it potentially enables the independent sector to be involved in decisions regarding the spending of NHS resources to a much greater extent than was previously possible.

In addition to using the FESC, commissioners are able to procure external support through a number of other routes. The Catalyst framework is widely used throughout the public sector and can be used for procuring certain forms of external support. As with FESC, Catalyst provides a shortlist of approved suppliers, but the focus is on generic consultancy rather than specialist commissioning services. The Catalyst framework does not provide some of the flexibilities in the FESC, for example the ability to use risk-sharing arrangements in which the supplier takes on some of the financial risk for the success or failure of the project. Commissioners can also use an *Official Journal of the European Union* (OJEU) procurement, where tenders are advertised for open competition in the OJEU.

The emphasis placed on using external support to improve commissioning in the NHS has taken place against a backdrop of increasing use of external consultants in the NHS, by both provider and commissioning organisations. In 2007/08 and 2008/09 the NHS spent between £300 million and £350 million a year on management consultancy, and 43 per cent of this was spent by PCTs (House of Commons Health Committee 2009;

Management Consultancies Association 2009; Royal College of Nursing 2009). This is equivalent to around £900,000 per PCT, or 0.18 per cent of average PCT expenditure (Audit Commission 2009). These figures give an indication of the scale of activity in this area, although they include other consultancy support, not just 'external support' as defined here.

By January 2010, 10 PCTs and SHAs had used the FESC to procure external support, and the total value of these contracts was £49.9 million, although this expenditure is spread over at least three years (House of Commons Health Committee 2010). It is not yet known what financial returns these PCTs and SHAs will make on these investments. Nonetheless, the House of Commons Health Committee's (2010) inquiry into commissioning in the NHS expressed concern that the FESC was an expensive way of addressing PCTs' shortcomings and questioned whether the taxpayer was getting value for money from it. The committee also doubted the ability of PCTs to use external providers effectively. These concerns provide the context for our research.

Research aims

The primary aim of this research was to examine how, in the context of world class commissioning, external support is being used by PCTs and SHAs and whether it is helping to develop more effective commissioning. Specifically, the report addresses the following questions.

- How is external support currently being used by NHS commissioners?
- What impact has external support had on those organisations that have used it?
Has it helped them to improve their commissioning activities?
- How can commissioners use external support in the most cost-effective way?
- What might the role of external support for commissioning be in future?

2 Study methods

The study was based primarily on interviews and focus groups with a range of stakeholders, as well as online surveys. The approach involved three stages:

- scoping phase
 - national survey of primary care trusts (PCTs)
- in-depth investigation
 - case studies on the use of external support for commissioning in five NHS organisations – three PCTs and two strategic health authorities (SHAs)
 - focus groups and interviews with representatives from 12 commercial firms providing support services to NHS commissioners
 - interviews with key policy-makers in the Department of Health
- validation phase
 - expert seminar
 - follow-up survey of PCTs.

We have also drawn on published academic and policy literature.

Scoping phase

The study began with an online survey of PCTs in January 2009. This was emailed to chief executives and directors of commissioning (or similar) in all 152 PCTs in England. It was also advertised on the NHS Evidence health management specialist library news alert. Respondents were asked about the following areas:

- background information on the use of external support – whether it had been used in their organisation, how many times and from what kinds of suppliers, what it had been used for, and if it had been procured using the framework for procuring external support for commissioners (FESC)
- evaluative information – whether external support had delivered the expected outcome, whether they would use it again
- future plans to use external support
- opinions on the world class commissioning programme.

A total of 96 responses were received. A limitation of online surveys is that it is not possible to calculate the response rate, since the denominator (the total number of people seeing or receiving the survey) is unknown. However, responses were received from 53 per cent of the PCTs in England, an acceptable although not comprehensive level of coverage. The results provided a backdrop for the subsequent stages of the research, and an indication of which issues needed exploring in greater depth.

In-depth investigation

A total of 11 focus groups and 10 one-to-one interviews were completed during the in-depth investigation phase. These allowed more detailed information to be collected on the use of external support. The interviews and focus groups were recorded, transcribed in full and analysed using standard qualitative methods.

On the basis of information collected in the scoping phase, three PCTs and two SHAs were selected as case studies. The PCTs were selected to represent a variety of different approaches towards the use of external support, and also to represent different geographies and socio-economic profiles. All were early adopters that had used external support on a number of occasions and/or had procured a major support project through the FESC. Table 1 shows the characteristics of the three PCTs.

Table 1 Characteristics of PCT case studies

PCT case study	Use of external support	Performance in 2009 WCC* assurance process	Geography	Socio-economic profile
1	Large FESC contract plus a history of using other external support	Upper quartile	Mixed	Mixed
2	Repeated use of external support from a range of suppliers, but not through FESC	Mid-table	Predominantly rural	Largely affluent
3	Large FESC contract	Mid-table	Urban	Relatively deprived

*WCC, world class commissioning

In the PCTs, a focus group was held with members of the senior management team and commissioners, including practice-based commissioners where possible. We also conducted focus groups with representatives of the key external organisations working in each site (see below). This allowed for information gathered from each source to be corroborated, and for further exploration of important issues.

Representatives from two SHAs involved in the procurement of external support for commissioners were interviewed. The PCT focus groups and SHA interviews were based on the same semi-structured interview schedule, which covered:

- how external support was being used
- the process of procuring external support
- the working relationship with suppliers of external support
- outcomes achieved through the use of external support
- relevant government policy
- opinions on the future of external support for commissioning.

Focus groups and one-to-one interviews were conducted with representatives of 12 companies supplying external support services to NHS commissioners. This included 10 of the 13 organisations approved to supply services through the FESC, and two other companies. These organisations varied in terms of size and type, and included large management consultancies, smaller health sector specialists, and providers of health insurance that also supply commissioning support services to the NHS. As stated above, the sample was designed to include companies that had worked in our five case study sites. The interview schedule covered the same areas as that used for PCT/SHA interviews.

Finally, two policy-makers from the Department of Health were also interviewed. These interviews provided information on the development and objectives of policy in this area, in particular the FESC, and on the central strategy for supporting improvements in the quality of NHS commissioning in future.

All interviews were analysed using a structured thematic framework. The framework was based on our research questions as well as key themes identified through a preliminary reading of all transcripts. The points made under each thematic area were summarised in a separate document for each focus group and interview. The evidence supporting each point was included in the form of direct quotations.

Validation phase

An expert seminar was organised to test ideas emerging from the research and inform our interpretation and recommendations. This was attended by approximately 25 people, with delegates selected from the NHS, the Department of Health, and organisations supplying support services to NHS commissioners.

As a further means of validation, a follow-up to the 2009 web survey was distributed to PCTs in January 2010. As well as providing an opportunity to test emerging findings, this allowed us to measure the extent to which practices and attitudes towards external support had changed over the course of the research. The responses (76) covered 40 per cent of PCTs in England.

3 High-quality commissioning: the challenge

As the Government recognises, weaknesses remain 20 years after the introduction of the purchaser/provider split. Commissioners continue to be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers.

House of Commons Health Committee (2010)

The role of external organisations in providing support to NHS commissioners has developed in a context of increasing expectations regarding what commissioning should achieve, and increasing pressure for primary care trusts (PCTs) to develop new skills and competencies. This section provides a brief overview of the weaknesses in the commissioning function and reflects on whether external support is seen as a prerequisite for building high-quality commissioning, drawing both on existing evidence and on our own research.

Commissioning in the English NHS has been subject to frequent criticism over the years, culminating most recently in the House of Commons Health Committee's (2010) report, which claimed that commissioners remain passive and ineffective in challenging the dominance of large acute hospitals, unable to create a more productive and cost-efficient health system or to enable a strategic shift of services into primary and community settings.

The problems related to current commissioning arrangements have been well documented through research and commentary since the commissioning function was established in 1991 (for example, see reviews by Smith and Goodwin 2002; NERA 2005; Smith and Goodwin 2006; Wade *et al* 2006; Curry *et al* 2008; Smith *et al* 2010). This body of evidence leads to a key observation that the commissioning function itself has not been allowed to reach full maturity for a number of reasons, including:

- the lack of adequate management capacity and expert skills needed for effective commissioning
- the lack of data sources and information technology (IT) systems on which to base sound commissioning decisions
- the inflexibility in the rules governing when PCTs can employ more than a basic skeleton staff, or raise salaries to attract new managerial talent
- the lack of autonomy to commission services outside of national requirements and targets, particularly at the level of the practice-based commissioner
- the inability to secure adequate clinical leadership and involvement in commissioning to:
 - provide the necessary insight into service redesign
 - influence negotiations with providers
 - convince other clinicians to support change

- the impact of continual organisational reforms among PCTs in comparison with provider organisations that has led to the inability to establish long-term relationships with key stakeholders, including the local community.

It has also been argued, for example by Ham (2008), that inherent difficulties exist in the purchasing of health services in publicly financed health systems where the commissioner and provider functions are separated. Large providers easily dominate the relationship with PCTs due to the information 'asymmetry' between buyer and seller. The difficulty in defining complex health services in clear contractual terms (and, by implication, in terms of performance review) also limits effective procurement practices. The power of commissioners is further limited by the weakness of their control over hospital referrals and the ability to manage demand, and the lack of appetite to risk destabilising health care providers that are failing to deliver services of an acceptable quality.

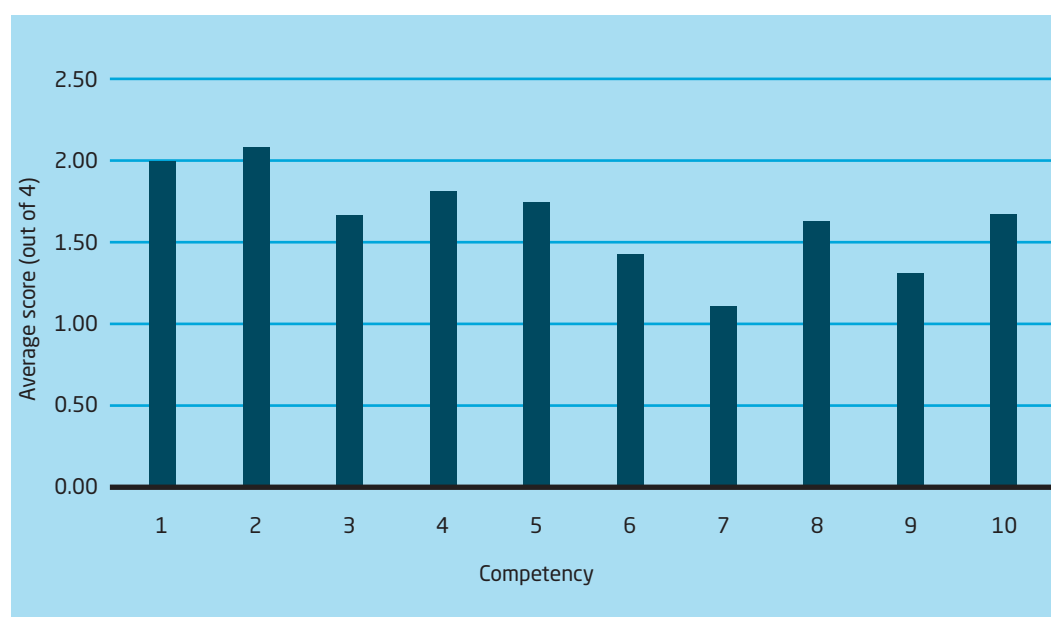
System reforms such as payment by results and the creation of foundation trusts may have exacerbated the imbalance of power, as have the operational constraints and limits on financial autonomy acting on PCTs. For example, unlike foundation trusts, PCTs are not permitted to build up surpluses or borrow funds commercially. A further structural challenge limiting the effectiveness of commissioning is the lack of professionalisation, with poor career development opportunities for commissioners, few professional training courses and high levels of staff turnover (Smith *et al* 2010).

Weaknesses in the commissioning function have been implicated in the failure to provide high quality services to patients. For example, a review of out-of-hours care by the National Audit Office identified shortcomings in the commissioning process such as limited use of information to draw up service specifications, limited clinical engagement in commissioning, and inadequate skills around market management (National Audit Office 2006).

The first results of the world class commissioning assurance process were reported in 2009 (Crump 2009). Despite examples to show that some PCTs had made 'real improvements' in the way they commissioned services, the majority of PCTs were rated poor to mediocre in respect of the commissioning competencies and so confirmed a sizeable gap between the aspirations for world class commissioning and what was being delivered. Figure 2 shows average scores across the 10 competencies. This illustrates that particular weaknesses were found regarding the ability to analyse and apply data, and in the commercial aspects of commissioning, which represented new territory for NHS commissioners, for example:

- mapping and understanding the strengths and weaknesses in the local provider market
- using the commissioner's investment power to stimulate the market, such that providers develop in line with local health needs and community aspirations
- managing relationships with providers; engaging in constructive performance discussions with them to ensure continuous quality improvement
- building relationships with potential future providers.

The interviews and focus groups conducted as part of our research included questions on the developmental needs of PCTs. Participants from in and outside the NHS highlighted very similar issues, and these mirrored quite closely some of the long-standing problems identified by the existing research literature and by the 2009 world class commissioning scores. Particular emphasis was placed, for example, on the ability to engage clinicians in commissioning, to use data to drive decision-making, and to engage with the local community. A number of commissioning skills were highlighted as needing development, including contracting and contract management, market analysis and market management, project management skills, and the ability to build mature commercial relationships.

Figure 2 2009 world class commissioning competency scores**Key to competencies**

- | | |
|--|---|
| 1. Act as the local leader of the NHS | 6. Prioritise investment according to local needs |
| 2. Work collaboratively with local partners | 7. Stimulate the provider market to meet demand |
| 3. Engage with public and patients | 8. Promote continuous improvement and innovation |
| 4. Collaborate with clinicians | 9. Secure procurement and contracting skills |
| 5. Manage knowledge and evidence, eg, robust assessment of population health needs | 10. Manage relationships and contracts with providers |

Our interviews also unveiled more deep-rooted issues related to the way in which PCTs function as an organisation. Providers of external support argued that many PCTs were too bureaucratic in their organisational structures – for example, in having structures that divided the various commissioning tasks into linear divisions or departments with their own financial budgets and staff, which ultimately led to silo-based working. Organisational culture can also be problematic. In some PCTs this appears not to embrace innovative thinking or to engender a more proactive vision for what commissioning and commissioners could achieve. These structural and cultural issues underlie the more specific competency gaps highlighted by the world class commissioning assurance process.

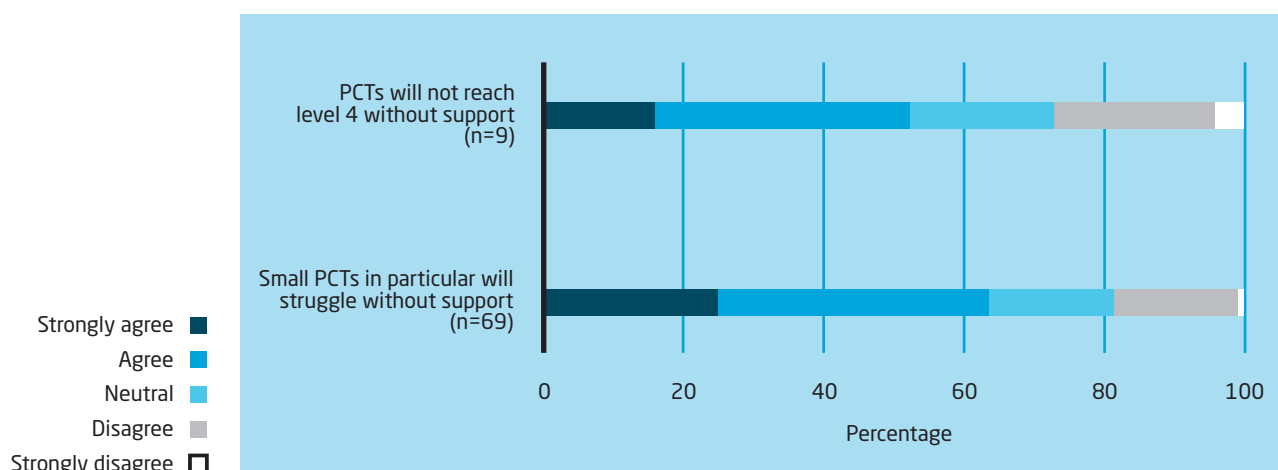
Is external support needed to meet the challenge?

The literature and the world class commissioning assurance process identify huge developmental challenges. Several participants in our interviews and focus groups (including PCT managers) suggested that many PCTs might find it difficult to reach level 4 competencies without external support.

Even though we're one of the biggest PCTs in the country and we have got good people in the building, we absolutely can't get to level 4 on our own.

PCT case study 1

To measure how widespread such perceptions are, our 2010 survey included specific questions on whether external support is a prerequisite for becoming world class. The results suggest that many senior managers in PCTs do indeed believe it will be hard for PCTs to do it on their own (see Figure 3 overleaf). For example, 52 per cent of respondents agreed or strongly agreed that PCTs would not be able to attain the highest

Figure 3 Can we build world class commissioning without external support?

level scores in the world class commissioning competency framework without external support, with only 28 per cent disagreeing. There was also a suggestion from survey respondents that small PCTs were particularly likely to struggle without external support.

Summary

The evidence suggests significant developmental needs exist if high-quality commissioning is to be developed in the NHS. Whether external support presents a cost-effective way of addressing these needs remains contested. For example, the recent report on commissioning from the House of Commons Health Committee (2010) concluded: 'PCTs clearly do lack the skills they need for commissioning and engaging consultants is one way of helping to address the situation. However, we are concerned that FESC is an expensive way of addressing PCTs' shortcomings' (paragraph 176). The report questioned whether the use of external support was likely to deliver value for money and raised the concern that PCTs might not have the skills to utilise such support effectively.

This report seeks to shed light on these key questions. The following sections therefore examine the role that external support agencies can and are playing in NHS commissioning (Section 4, pp 15–20), the impact they have had (both positive and negative) (Section 5, pp 21–26), and the lessons that can be learned on how NHS commissioners can get the best from external support (Sections 6, 7 and 8).

4 How is external support currently being used by NHS commissioners?

NHS commissioners procure support services from a range of external organisations, for a variety of purposes, and in a number of very different ways. This section gives an overview of the main ways in which commissioners are currently using external support, including illustrative examples.

The use of external support is the norm among NHS commissioners rather than the exception. Our 2009 survey indicated that around three-quarters (76 per cent) of primary care trusts (PCTs) had procured external support for commissioning on at least one occasion, with the majority of these (76 per cent) holding multiple contracts with external organisations at the time of asking. One-quarter (24 per cent) held five or more contracts concurrently. By 2010, the proportion of PCTs reporting using external support had risen to 89 per cent.

The results of the survey indicate that external support for commissioning is a relatively recent phenomenon. Of those respondents that had used external support, 85 per cent reported first doing so in 2006 or later. Interviews with suppliers of support services confirm that the business is perceived to be a growth area, with several organisations having moved into this market in recent years.

It feels like it's taking off. I mean, the number of invitations and tenders that come through the door...

External support provider

The most commonly used sources of external support are commercial sector organisations (40 per cent in our 2009 survey) and freelance consultants (30 per cent). Services are also provided by voluntary sector organisations, university-based teams and strategic health authorities.

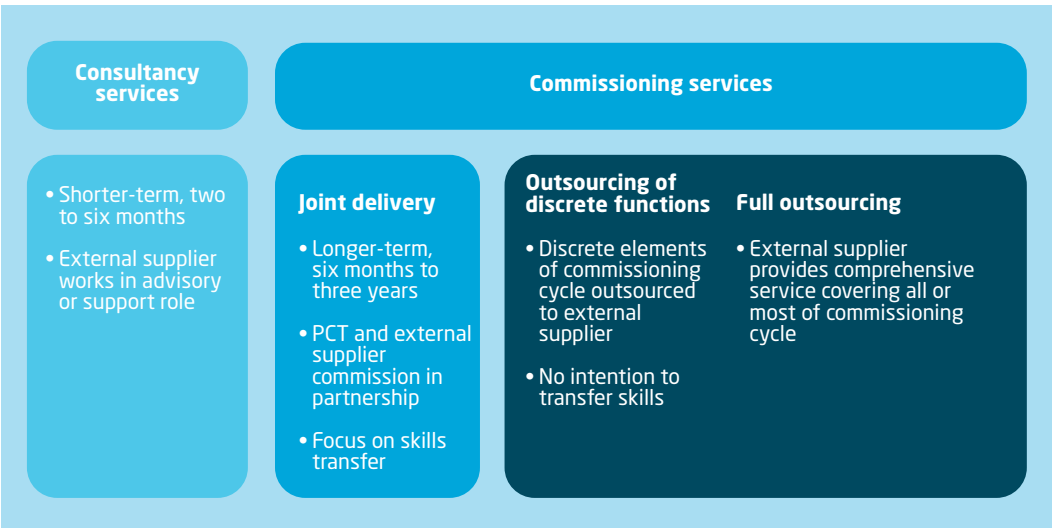
Types of external support

The term 'external support for commissioning' covers a wide range of services. Interviews with suppliers identified at least four distinct models – consultancy, joint delivery, and two forms of outsourcing (see Figure 4 overleaf).

The first distinction to be drawn is between what can be called consultancy services and commissioning services. Commissioners use consultancy services to support a range of aspects of their work, such as developing a strategic commissioning plan or redesigning care pathways. In the consultancy model an external organisation is involved for a relatively short period of time (typically two to six months) to provide advice or support in relation to a defined task or problem.

Commissioning services, in contrast, refer to arrangements where an external organisation takes on responsibility for part of the process of commissioning, either on its own or in collaboration with the NHS commissioner. It is these kinds of services that the framework for procuring external support for commissioners (FESC) was designed to help commissioners procure (although it is also possible to procure these kinds of services

Figure 4 Types of external support



through other routes, such as Catalyst). Commissioning services can be sub-divided into three types: joint delivery, outsourcing of discrete elements, and full outsourcing, each with their own merits and challenges.

In the joint delivery or partnership model, the NHS commissioner and external organisation work together to commission health services. These projects last at least six months, and can last for three years or more. There is typically a strong focus on skills transfer from the external organisation to the NHS client, the aim being that the latter should develop self-sufficiency in the targeted areas over the course of the contract. The contracts used for joint delivery work increasingly involve the sharing of financial risk between the two parties, for example, by making payment dependent on the successful delivery of savings. Under such arrangements, both organisations can be given shared financial incentives to identify and implement improvements in the quality of commissioning.

Some organisations offer NHS clients the option of outsourcing part of the process of commissioning to an external agency. Here the aim is not to help the NHS commission better, but rather to transfer responsibilities to other organisations with more appropriate skillsets. The responsibilities transferred could be discrete tasks such as invoice validation or discrete portfolios such as specialised commissioning.

Finally, it would be theoretically possible for a PCT to outsource a substantial part of the process of commissioning to an external agency. This last option is referred to here as the full outsourcing model.

These four models represent different market areas that organisations providing external support can occupy. Some organisations concentrate on supplying consultancy services, others perceive joint delivery as being their core territory, while others aim to be providers of outsourced services rather than agents of change within the NHS. It is important to recognise, however, that these are idealised types – many organisations supply services across several of these areas, and individual contracts can contain elements of consultancy, joint delivery and outsourcing.

The overall balance of the market for external support currently favours shorter-term consultancy. However, our interviews indicate that longer-term joint delivery models are increasingly being used, and there is also some growth in interest in outsourcing discrete commissioning functions. Some suppliers had expected that the FESC would encourage

more PCTs to outsource commissioning functions, but in practice it has been used mainly to support PCTs in attempting to improve their own commissioning processes through joint delivery arrangements.

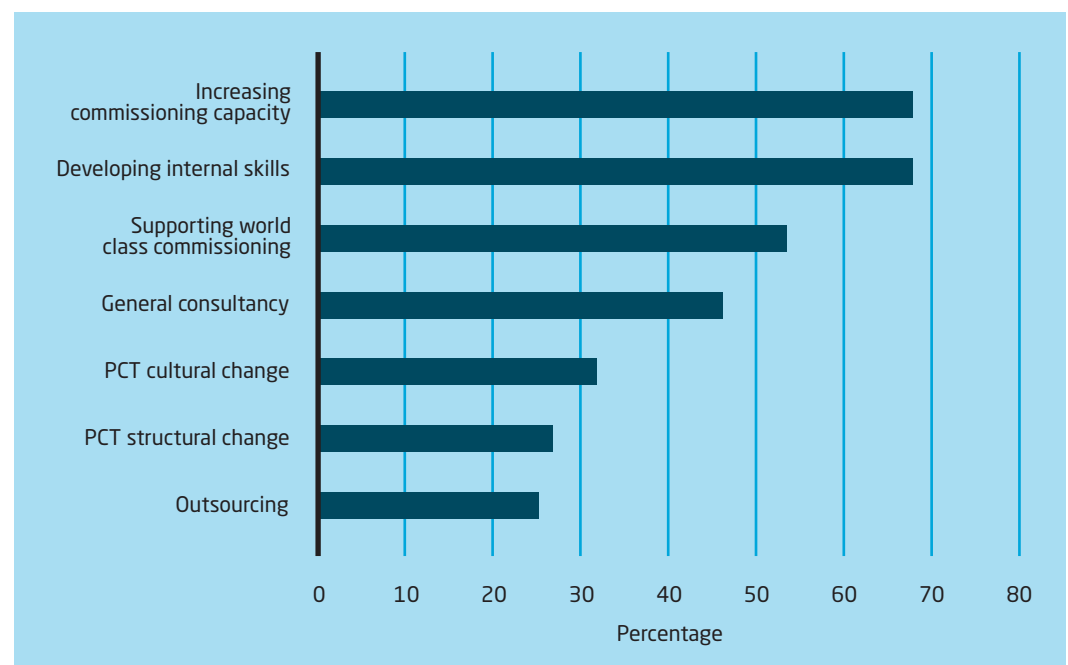
As yet there has been little interest within the NHS for adoption of the full outsourcing model, and the structures and processes that might allow this have not yet been put in place. One external support provider felt commissioners are ‘not emotionally in the right place’ to consider the full outsourcing model – perhaps unsurprisingly, given the potential implications this model carries with it for the continued existence of PCTs.

However, this could change if current plans to transfer commissioning responsibilities from PCTs to GPs go ahead, with many GPs potentially wanting to outsource these responsibilities to external organisations.

What do commissioners hope to achieve through using external support?

Our surveys indicate that commissioners use external support for a range of reasons. The most common intentions appear to be to increase the capacity of the commissioning team to perform certain tasks, or to develop internal capabilities by bringing new skills into the team. World class commissioning has proved to be a major driver for external support, with more than half (54 per cent) of respondents reporting having used external support to help them with the annual assurance process (*see* Figure 5 below). Less commonly, respondents reported using external support to achieve cultural or structural change within the PCT. Finally, one quarter reported having used external providers to outsource part of the commissioning function.

Figure 5 Aims for using external support (2010 data, n=56)



External support is used both at the strategic planning level, and with the more practical aspects of commissioning. Table 2 gives some of the most common areas for which support is sought, although this list is far from exhaustive. Where possible the world class commissioning competency addressed by each area is given. As shown, support is used across the majority of the competencies.

Table 2 Common uses for external support

	World class commissioning competency
Data analysis, eg, needs assessment; health equity audits; risk stratification and predictive modelling	5 and 6
Contract negotiation and monitoring	9
Market analysis and management	7 and 10
Clinical engagement in commissioning, including support for practice-based commissioning, eg, assisting practice-based commissioners with business case development	4
Public and patient engagement in commissioning	3
Service redesign or reconfiguration, eg, helping providers to shift care out of hospitals to community settings	8
Developing a strategic commissioning plan	6
Preparing for the world class commissioning assurance process	All
Organisational development work in support of the commissioning function, eg, developing competencies at board level	All
General financial management	11

Examples of external support

Short-term consultancy projects may focus on any of the areas listed in Table 2. An example taken from our case study sites is given below.

Example: Short-term consultancy project

The PCT in our second case study site hired an external organisation to develop a contract monitoring system. This required health services providers to complete performance templates which were converted into a dashboard providing a range of indicators on access, clinical quality, infection control, and activity. The dashboard was then used by the PCT to see if providers were performing within the parameters of the contract, and as a lever for change when providers were not performing adequately.

Longer-term projects on the joint delivery model often combine support over a number of the areas listed in Table 2. Several PCTs have procured multi-component packages of support using the FESC or Catalist framework. These contracts can be worth several million pounds over a period of up to three years, and represent a significant investment in using external support to transform the way commissioning is done. Illustrative examples of some larger-scale projects that PCTs have embarked upon using the FESC are given below.

Examples of joint delivery projects procured through the FESC

(1) NHS West Kent

Supplier: Bupa Health Dialog

Contract duration: three years with an opt out at 18 months

Key elements

The primary aim is to support commissioners in developing more collaborative care for people with long-term conditions. Key elements include:

- analytical support, using primary and secondary care data to predict individual patients' risk of future utilisation of health care resources
- using the information developed in this analysis better to inform commissioning decisions at PCT and practice-based commissioning level
- establishing systems for better engaging patients identified as being at high risk of admission in their health care, by providing telephone health coaching and more integrated services.

(2) North East Lincolnshire Care Trust Plus

Supplier: UnitedHealth UK

Contract duration: 2 years

Key elements

- Supporting the development of an integrated health and social care model for case management (focusing particularly on complex cases), including through the use of risk stratification techniques; development of integrated assessment tools; and provision of training for case managers
- Supporting a community engagement model for the care trust, in which elected community members are involved in priority setting and strategic planning
- Assisting the care trust with the world class commissioning process, for example by conducting a gap analysis and developing a toolkit to support the development of commissioning competencies

As the contract has advanced, additional work streams have been added consistent with the quality, innovation, prevention, and productivity (QIPP) agenda, focused on:

- Cost reduction
- Quality improvement
- Knowledge transfer to spread innovation

There are signs that commissioners may be becoming more receptive towards outsourcing over time. Increasingly common targets for outsourcing are invoice validation for acute care and the commissioning of specialist services (*see overleaf*).

Examples: outsourcing of discrete elements

Acute care invoice validation

With project management support from the strategic health authority (SHA), PCTs in the East of England region commissioned Humana to build and implement an invoice validation system. This will enable commissioners to identify inaccurate coding in hospital invoices and potential clinical governance issues. The longer-term intention is to use this as a platform on which to build a comprehensive commissioning data set.

Specialist commissioning

South Central SHA's Specialist Commissioning Group has outsourced the task of contracting with London-based trusts to UnitedHealth. United is responsible for managing relationships with 17 providers, and has been set the targets of improving outcomes and delivering better value for money.

5 The impact of external support for commissioning

In the current economic climate it is increasingly important that investments in external support are able to demonstrate their impact in terms of improved commissioning processes and, ultimately, improved health services for patients. A recent report from the Management Consultancies Association (2009) suggested that consultants 'have not always measured or articulated sufficiently clearly the value they add'. The House of Commons Health Committee (2010) similarly concluded in its report on commissioning that more evidence was needed to determine the real value for money of using consultancies and external support. Our research did not measure impact directly but did measure the impact perceived by those in the NHS who have used external support, including examples where it was perceived that external support had not made a positive impact.

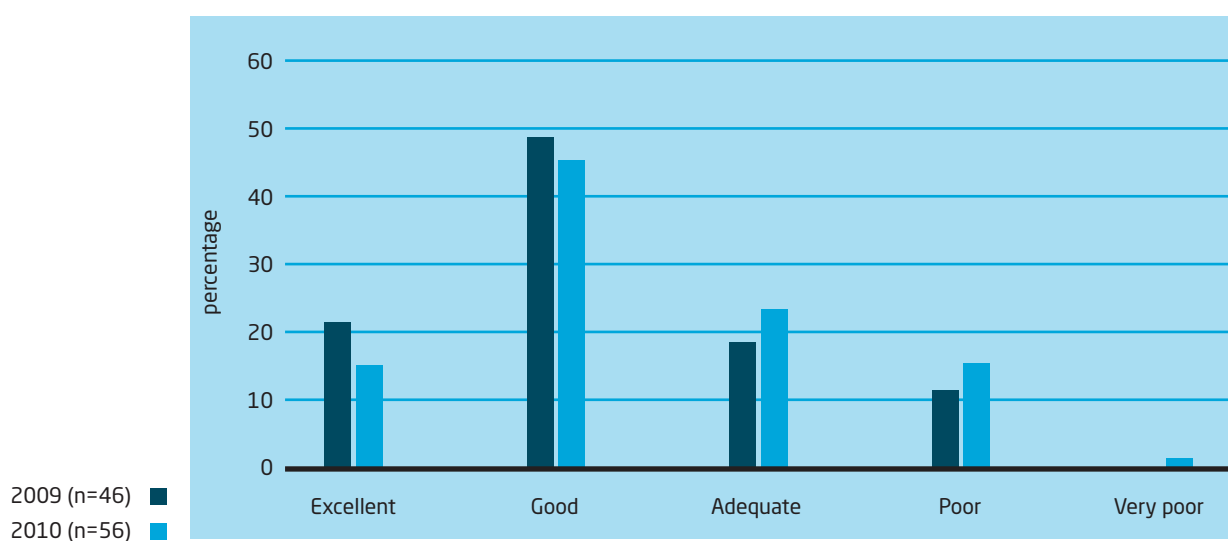
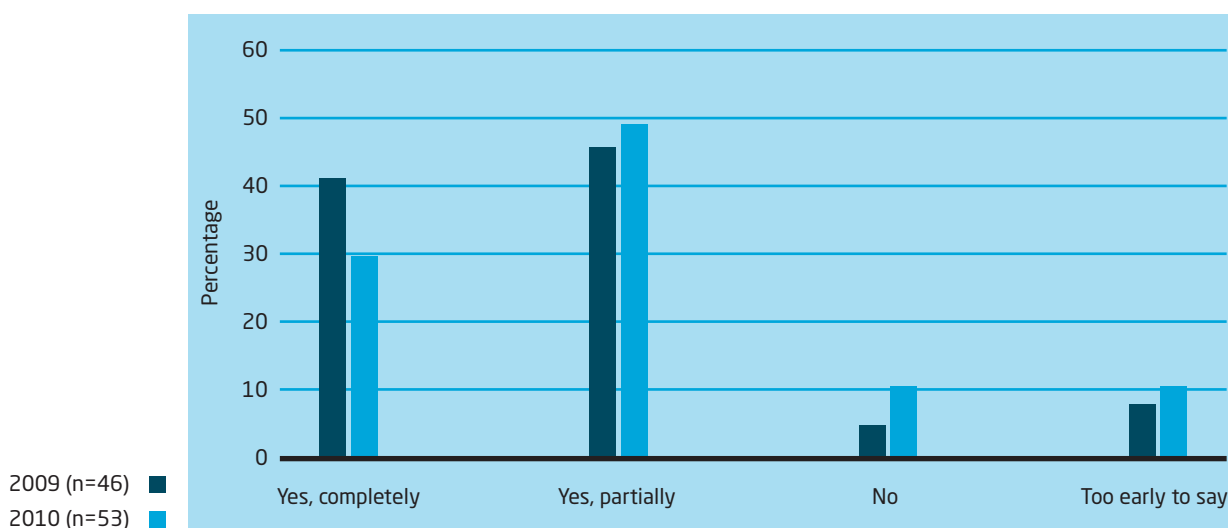
Before reviewing concrete examples of the impact of external support, it is useful to outline some of the generic ways in which participants in our research suggested external support can add value. Broadly speaking, external support can assist by introducing three things:

- **people** and skills that an NHS organisation has not got and might struggle to recruit, eg, experience of negotiating assertively with service providers
- **processes**, tools and concepts developed elsewhere or in other sectors, eg, analytical tools, or the use of 'Lean' improvement approaches
- external **perspectives** on what constitutes good commissioning – providing a constructive challenge to established ways of working, drawing on international best practice.

It can be argued that an external agency can bring some benefits simply by virtue of being external. Research participants suggested that by bringing in people with no history or 'baggage', commissioners were able to declare a fresh start, particularly with regard to relationships between the commissioner and providers of health services, where an external agency can act as a mediator. It may also be possible for external teams to work in ways that are difficult within the organisational structure of a primary care trust (PCT), for example rapidly constructing multi-disciplinary teams for specific purposes.

Survey data on impact

Respondents to our PCT surveys were largely positive about their past experiences of using external support (see Figure 6 overleaf). On the majority of occasions the service received was rated as 'excellent' or 'good' (70 per cent in 2009; 60 per cent in 2010). The majority of respondents indicated that external support achieved its goals either completely or partially (87 per cent in 2009; 79 per cent in 2010) (see Figure 7 overleaf). However, it is reasonable to question how positive a result 'partial' achievement of goals is. These figures also suggest a significant minority of less satisfied PCT customers, and there was a trend for answers to be slightly less positive in 2010 compared with 2009.

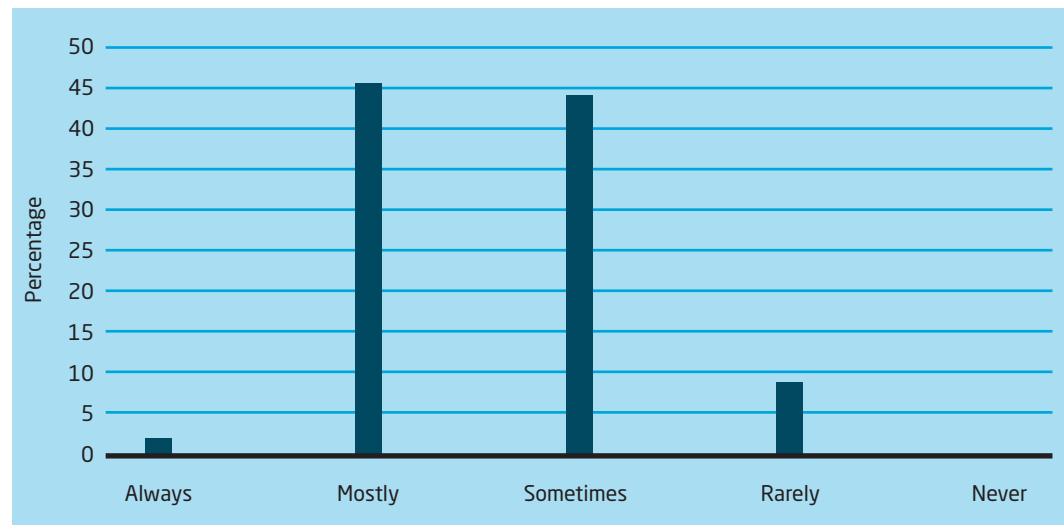
Figure 6 Overall quality of service received**Figure 7** Did you achieve your goals?

Respondents' assessments were slightly more critical when asked how often external support delivered an acceptable return on investment. The majority responded that it 'mostly' (46 per cent) or 'sometimes' (44 per cent) did so, but 9 per cent felt that it 'rarely' did, and only 2 per cent felt it 'always' did (see Figure 8 opposite). No respondents felt that external support never delivered an acceptable return on investment. Although the survey did not investigate whether PCTs were systematically assessing the benefits of their use of external support, these findings are important in the context of tightening NHS budgets and the consequent focus on productivity and cost-effectiveness.

Perceptions of impact in our case study sites

Perceptions of impact varied markedly across our three PCT case studies. In site 1, participants were generally positive about the impact of external support for commissioning. In site 2, the experience was more mixed – some projects involving external support were perceived to have had a positive impact, but others had been a source of disappointment. In case study site 3, participants disagreed about what impact external support had had, with some expressing concern that the framework for procuring external support for commissioners (FESC) project had not achieved a real, functioning partnership and might

Figure 8 How often does external support deliver an acceptable return on investment? (2010 data, n=57)



fail to have a lasting impact if skills were not adequately transferred to the PCT before the completion of the work.

I think, probably 95 per cent of the time, we've always got the product that we're completely happy and satisfied with... I can only think of one instance where the product wasn't good enough.

PCT case study 1

We wanted a step change in our performance... and I think they delivered that.

PCT case study 2

They didn't do what we wanted... there was no evidence they imported anything, added valued in that way to what we were doing.

PCT case study 2

I think when they came in, we would talk about partnership but I don't think we've achieved the partnership... when it comes to people working on the ground it doesn't feel like a partnership.

PCT case study 3

Participants across the three sites highlighted several areas in which external support had been particularly useful in supporting improvements. Key areas included:

- data analysis (competencies 5 and 6)
- managing contracts and provider relationships (competencies 9 and 10)
- engaging clinicians in commissioning (competency 4)
- wider organisational transformation.

It should be noted that these are some of the key weaknesses in commissioning highlighted in Section 3, pp 11–14.

Data analysis

External support was perceived to have made an impact in all three sites in terms of data analysis and the application of information in commissioning processes. External organisations had brought in new analytical skills not previously present in the PCTs, for example using risk stratification techniques based on the adjusted clinical groups algorithm developed at Johns Hopkins University. This allows commissioners better to understand and model levels of demand for health services in their population, and to commission services accordingly.

In the first site, the external organisation had brought in new skills around measuring patient experience, and population segmentation and social marketing approaches in order to understand better the needs of the local population. These were perceived as being particularly valuable.

They have definitely brought in skills, knowledge, experience that we didn't have.

PCT case study 1

Managing contracts and provider relationships

A key area of activity for external organisations has been around managing contracts and building mature commercial relationships with health service providers. In our case study sites the information generated through data analysis was being put to use in contract management, for example allowing the PCT to identify performance issues and challenge the way providers deliver services to patients.

What that's done is it's really provided the evidence for us to go to our providers and start challenging pathways and admission criteria.

PCT case study 3

The contract monitoring system introduced by a consultancy in the second case study site was seen as having significantly improved the PCT's ability to negotiate assertively with acute trusts. Participants in the PCT reported using it to develop more robust contracts with stronger management of provider performance.

We've got stronger contracts than other PCTs and we've got better challenges in them, we've got heavier penalties, so we're more a robust organisation for having had [consultancy] go through that over the last year and so I would say that that's a very positive outcome.

PCT case study 2

Invoice validation tools had been used in two sites to challenge invoices from acute trusts. This had succeeded in identifying opportunities for making savings on commissioning budgets, although in one site this had been at the expense of creating considerable difficulties in the relationship between the commissioner and provider.

In terms of our knowledge of the way [provider] are manipulating the data in order to get a better financial position on the contract, we're in a much stronger position now than we were 18 months ago.

PCT case study 3

Engaging clinicians in commissioning

External support was seen to have facilitated significant developments in practice-based commissioning (PBC) in two sites. In site 1 the external organisation had been involved in supporting practice-based commissioners with business case development. In the third

site, the external team was perceived to have invested considerable amounts of time in building relationships and explaining the vision for PBC, and in doing so had improved general practitioner engagement.

Organisational transformation

In two case study PCTs, external support was seen to have facilitated wider organisational transformation, for example, a general improvement in organisational maturity and self-confidence, or a clearer sense of the organisation's purpose and objectives. Participants in site 1 expressed doubt that these developments could have been achieved in a comparable time period without external support.

We are a much more mature organisation. We've got a much greater understanding of what it is that we want and what it will look like when it's really good... I think even if we'd never had FESC, because time has passed, we would be a more mature organisation now anyway – but we've matured differently, I'm absolutely sure, than we would have done had we not had it. And I think we've done it faster.

PCT case study 1

[Supplier of external support] came and in one session with the board there was a real sort of penny-dropping moment where... [we developed] a much crisper exposition of what we're about and what we wanted to achieve and that was just one of those moments, it was really quite transformational.

PCT case study 2

Outcomes of commissioning

Where external support was seen as having succeeded in supporting changes in the process of commissioning, there was some evidence that this was beginning to translate into concrete improvements in health services. In both of the FESC sites, examples were given of services or pathways that have been redesigned as a consequence of the work with external organisations. For example, in site 1, care pathways for patients with chronic obstructive pulmonary disease had been redesigned using a whole systems approach involving stakeholder consultation and analysis of population health needs.

Negative experiences

As indicated earlier, examples were also given of occasions in which external support had failed to have the anticipated impact. Participants described cases in which they felt an external organisation had not delivered what was asked of it, either because it did not have the capacity to do so or because the objectives of the external organisation were not aligned with those of the PCT. In one case it was felt that the external organisation had a pre-existing objective to develop a tool that could then be marketed to other PCTs, which conflicted with the client PCT's expectations.

They come in with this application that they want to develop, meant specifically for us, and then within about three or four months they are sending it off to other people and we haven't got any benefit from it because they were learning while they were working for us.

PCT case study 2

Several participants reported that skills transfer did not always take place as planned. Some projects were perceived to have had a limited impact in terms of learning and skills

development in the PCT, as a result of limited integration of internal and external teams (see Section 6, pp 27–35). In site 3 this was a major concern.

My main fear is, after three years will the skills transfer have taken place? And if we're not careful, if we don't watch that carefully and manage it very carefully, three years from now we'll be back to square one.

PCT case study 3

We have had situations where a team has come in, locked themselves away in an office; they've tapped away on their computers for a month and – whoosh! – out comes a wonderful product. And, normally, it is a wonderful product but was there any learning for the organisation in that? Absolutely not.

PCT case study 2

Summary

There is clear evidence that at its best, external support can facilitate improvements in the quality of commissioning in NHS organisations. In particular, PCTs appear to have benefited in terms of data analysis, managing contracts and provider relationships, engaging clinicians in commissioning, and wider organisational transformation. It is less easy to demonstrate that these improvements have translated into better quality services for patients, but further evidence on this may emerge over time as multi-year FESC projects continue into their second and third years.

It is equally clear that external support does not always deliver the anticipated improvements. There is some risk that skills transfer does not take place as planned and that the support provided fails to leave a lasting legacy. The factors responsible for the success or failure of projects involving external support are many. These are discussed in the next section.

6 Using external support successfully – barriers and enablers at the local level

This section describes factors at the local level that determine the success or failure of projects involving external support. It is aimed first and foremost at those working in NHS commissioning organisations considering the use of external support. The section begins with a brief review of published research evidence on the effective use of external support in other sectors, before discussing in detail the evidence from our own research.

Recommendations for commissioners based on the evidence presented here are given later in the report (*see* Section 11, pp 57–59).

Evidence from the literature

A small evidence base exists concerning the effective use of external consultants in a range of sectors. Reviews of the published literature highlight several factors that appear to be important (Gable 1996; Jang and Lee 1998; McLachlin 1999; Badrick and Preston 2002). These include:

- careful selection of a consulting organisation that fits the needs of the client in terms of capabilities and working style
- clearly articulated goals that are understood by both client and consultant, and which are defined in terms of the client's needs rather than the consultant's expertise and products
- identification of clear evaluation criteria by which success will be judged
- agreement between client and consultant around the best means of achieving these goals, including the requirements and expectations of both parties
- close collaboration between client and consultant, with high levels of client participation in, and commitment to, the work in which external consultants are involved
- a readiness and capacity to change in the client organisation
- strong, visible support from senior management in the client organisation, ideally with a specified individual acting as a point of liaison between the two parties
- highly developed levels of skill and competence among consultants.

As will become clear in the following sections, many of these messages resonate closely with feedback from those involved in external support for commissioning within the NHS, both from the client and the consultant side. There are also particular issues and recommendations regarding the effective use of external support for commissioning which are less applicable to other sectors.

Clarity of purpose

Key points

- Commissioners do not always have a clear idea of what support would best address their developmental needs.
- This can lead to procurement processes becoming protracted and the wrong support being provided.

The first step in the successful use of external support is clarity of purpose.

Above all, a client must be clear about why consulting help is being considered and what the consultant is expected to do, rather than simply proceeding with a vague notion that obtaining outside help might be beneficial.

McLachlin 1999

Commissioners need a clear definition of their problem and the kind of solution they want to this problem, while leaving room for potential suppliers to innovate with regard to the specifics. Suppliers of external support stressed that developing this clarity can be challenging because the nature of the product is such that ‘defining the problem you are looking to solve is half the solution and that’s actually just really, really difficult to do’. As a consequence of this, requests for support are sometimes poorly defined and require significant development from both sides, often over a period of several months. In other cases, tenders may be very tightly specified, giving the impression that the problem and desired solution have been well defined, but these can then change substantially during successive iterations of the tender process as it emerges that ‘what they asked for in the first place wasn’t what they wanted’.

Without rigorous problem-definition there may be more need for contractual changes at a later stage, which can be frustrating, costly and time-consuming for both parties. There may also be a heightened risk of buying support that fails to address genuine developmental needs with the commissioning organisation.

The mistakes that are being made... involve primary care trusts (PCTs) sometimes asking for the wrong support, asking the wrong questions. And if you ask the wrong question and you don’t get somebody who will feel that ethically or for whatever other reason they ought to be trying to answer the right question rather than providing the right answer to the wrong question, then you’ll get somebody who will happily charge you through the nose for giving you advice that you don’t really need.

External support provider

Using a two-stage procurement process

Key points

- Competitive tendering processes are not the best vehicle for clarifying the aims of external support or developing the specification.
- For substantial projects, commissioners may consider using a two-stage procurement process, with an initial stage aiming to develop the specification.

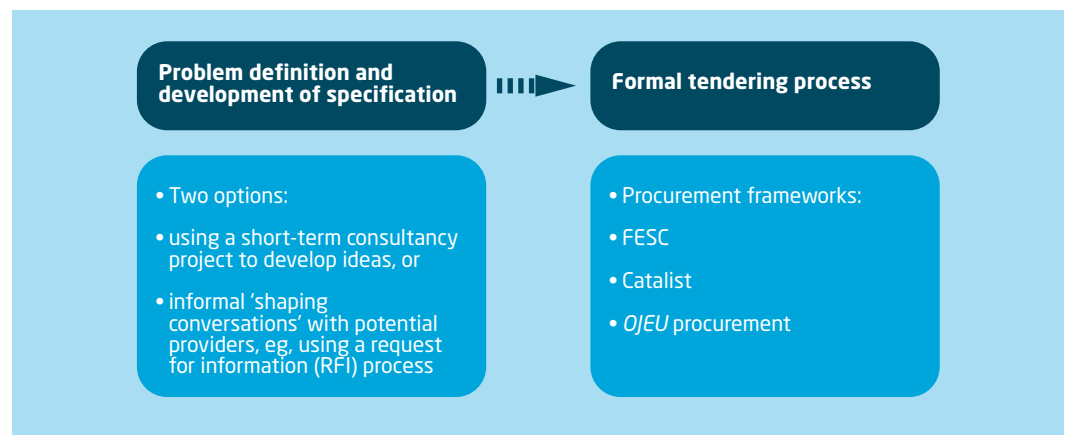
It is important that commissioners clarify their objectives before initiating formal procurement processes. There was a strong consensus from research participants that commissioners tend to start competitive tendering processes too early, using responses to successive iterations of the tender as a means of developing a clearer definition of the problem at hand. Formal tendering processes restrict communication between the commissioner and potential suppliers, and as a result are not the best channel for shaping ideas and defining problems. For potential suppliers, making substantial changes to their proposals at this stage of the procurement process imposes heavy costs. For commissioners, such a process can lead to confusion and inertia if they receive several very different bid responses and have underdeveloped processes and evaluation criteria for comparing them. Participants argued that it is therefore advisable to hold off from issuing the tender for as long as possible.

If something's gone to tender... it's very difficult to get any communication with the client and any clarification about what they really want... you do your very best to interpret what's in the tender or give an offering in good faith but actually they wanted something clearly different.

External support provider

As an alternative to using the bid process to clarify objectives and develop ideas, it may be advisable to use a two-stage process, particularly for substantial deals (see Figure 9 below). Participants recommended that before issuing a tender, commissioners should engage with the market to clarify what is needed and what the market can provide. There are two main approaches for doing this.

Figure 9 Using a two-stage procurement process for larger projects



FESC, framework for securing external support for commissioners; OJEU, Official Journal of the European Union

First, commissioners could consider working with an external organisation on a short-term basis to develop the brief for a more substantial piece of work. Our first case study site used this approach and reported that this initial stage had helped develop a clear specification for support subsequently procured through the FESC. Despite adding an extra stage, this approach may reduce the overall time required for the procurement process by making the formal tendering stage less complex. If adopting this approach, PCTs must ensure that there are no contractual restrictions on their use of the output of the consultancy work in the subsequent tendering exercise. It is also important to note that the consultancy work itself will be subject to procurement regulations.

Second, commissioners can engage potential suppliers in a less formal dialogue through a market sounding-exercise in which commissioners present their problem to potential suppliers. This may help identify issues and risks and provide commissioners with an

opportunity to test concept viability. Doing this outside of formal procurement processes leaves suppliers with more room to innovate and suggest creative solutions. One platform for having this dialogue used and recommended by participants from our case study sites is to use a 'request for information' (RFI) process. An alternative could be to hold a workshop with potential suppliers to refine the scope of the work.

A particular thing that we did... was to hold off issuing the formal tender, in effect firing the starting gun for tendering, for as long as possible. So we had quite a long and protracted and really useful, informal dialogue with about six of the companies on FESC about how it might work, and that was useful for two reasons. One, it helped us to firm up our ideas before trying to fit that into the spec, but secondly... it was a chance to potentially remove scales from people's eyes and a chance to get quite a lot of PCT people involved.

SHA case study 2

Procurement regulations do not prohibit this kind of early market engagement, but they do stipulate that potential suppliers are given equal opportunity to contribute on a confidential basis, that the process is transparent, and that the findings are not used in a way that gives unfair advantage to any supplier in a subsequent procurement. However, our research suggested that some commissioners appear to be reluctant to engage potential suppliers in this way, as a result either of uncertainty about what is allowed, or of concerns around being exploited by commercially savvy private sector firms.

Contracts for external support: retaining flexibility and sharing risk

Key points

- Contracts need to contain in-built flexibility or mechanisms for renegotiation.
- Risk-sharing arrangements may allow commissioners to maximise value for money.

A frequently reported difficulty in devising contracts for commissioning support services was that work involving external organisations is often highly fluid – particularly in the case of longer-term projects. In all three case study sites, participants reported that leaving room for innovation and flexibility around deliverables in the contract is highly desirable, but that existing NHS financial governance procedures limit the extent to which this is permissible.

You can't specify the real cutting edge; you have to specify just below. And, in fact, as it develops, you want to do different things but your contract is quite binding. And I think that's quite a difficult thing to handle with financial governance in the NHS.

PCT case study 1

Both of the sites using long-term FESC projects had found that they had needed to make changes to the contract during the course of the work in response to changed circumstances, and both had found themselves somewhat constrained in their ability to do this. Suppliers of external support reported that there are frequently many tasks which become necessary during the course of a project which fall outside the initial contract. Contracts could benefit from incorporating some process for negotiation around responsibility for performing these tasks. The use of more outcome-orientated contracts may also allow more scope for change and creativity.

Several participants felt that commissioners have not fully exploited the possibilities of using innovative risk-sharing arrangements in contracts for external support services, in which the supplier takes on some of the financial risk for the success or failure of the project. Both of the case study sites that had procured support through the FESC had utilised the scope the framework grants to include risk-sharing in the contract. For example, in our third case study site the FESC supplier is contractually bound to deliver savings of a certain value to the PCT, with savings identified in excess of this target being shared between the PCT and the external organisation. One supplier felt that, if pushed, suppliers would be willing to have more of their income dependent on performance, but that commissioners do not generally exploit this. Another felt that companies were becoming more confident in entering into these kinds of arrangement.

I think there should be a little bit more risk share... if you negotiate with us, yes, we might move on to a kind of succeed or fail penalty or whatever, but no one seems to really have the wit to do that and we're not allowed to volunteer it I don't think, to be perfectly blunt.

External support provider

As well as making external support more affordable for commissioners, risk-sharing contracts give providers of external support a strong financial incentive to make sure that the ideas generated are implemented in practice, skills are transferred successfully, and that savings identified are driven through to execution. There is also an incentive to do work outside the contract where this will be of mutual benefit. In site 1, participants felt that by introducing an element of co-dependency, with internal and external teams being performance-managed against the same outcomes, risk-sharing had facilitated closer partnership working and encouraged a sense of cohesion.

However, there is also some danger that risk-sharing can generate tension between the two parties. In site 3, disagreement over whether the external organisation had met its performance targets caused considerable damage to working relationships. A key issue is whether external organisations are given a level of responsibility and control over decision-making which allows them to deliver on key commitments. External organisations may not be willing to enter risk-sharing arrangements if they believe that the feasibility of meeting performance targets is dependent on decisions by the client that lie outside their influence. Risk-sharing therefore makes it all the more important that performance measures are tightly defined, and that contracts give external organisations an appropriate level of responsibility and power regarding the specific outcomes they are accountable for.

Building productive working relations

Key points

- Poor working relations between internal and external teams have impeded the effectiveness of support in some cases.
- Commissioners can improve working relationships by clearly communicating the aims of external support and engaging clinicians from the outset.
- Building an ongoing relationship with a small number of external organisations may avoid going through the same learning curve each time.
- Partnership working requires the investment of resources in relationship-building and adequate infrastructure.

The quality of working relations between NHS organisations and external suppliers varied significantly, but there was often at least some initial wariness within the client organisation, particularly in large-scale projects when an external team was to be embedded in the PCT for several years. This wariness can be the product of general ill-feeling towards the private sector, or of specific concerns regarding the threat that an external team poses to people's own jobs.

Some PCTs were essentially... their mindset really is that you're a consultant, and they're predisposed to not want you to succeed even as you step through the door.

External support provider

Several of our case study sites had encountered particular resistance from the clinical community. General practitioners (GPs) were concerned that external organisations would be focused on identifying savings regardless of the implications for clinical quality, and that there may be conflicts of interest. Some GPs may also have felt that savings identified by the external organisation could have been kept by GPs had they been identified through practice-based commissioning instead.

Poor working relations can make it difficult to transfer skills and can mean that the notion of partnership working does not become a reality in practice. Participants from external organisations stressed that the kind of partnership required in joint delivery arrangements represents a very different way of working and a different mindset to traditional consultancy, and that considerable effort is required to build positive working relations and a genuine sense of partnership. However, these longer-term arrangements also allow more time for this kind of relationship-building than exists in short-term consultancy.

The experience of our research participants was that while relationship problems are common, they can also be successfully overcome. Several factors appear to be important in this.

First, the purpose of using external support needs to be clearly communicated to all staff before the external team arrives. Internal staff members feel most threatened when projects have not been well defined or communicated. In one of our case studies some staff initially took the use of external support as an implicit criticism of them, and the senior management team had had to actively counter this perception. External support needs to be framed as an opportunity rather than as a threat. Working in partnership with an external team with different skills and tools can offer commissioners considerable opportunities for learning and personal development, but this will only be the case if internal and external teams are successfully integrated. Identifying named individuals for skills transfer may help with this. It is also necessary to ensure that the external team is not perceived as doing all of the 'interesting work' and leaving internal teams with more mundane tasks.

Where I think there is more resistance, and quite rightly so, is where this project hasn't been very well defined or not very well communicated, where the staff on the ground, often the commissioners of the clinicians or the analytics or whoever, will feel threatened by the fact that okay, they are here, what are they really doing here, why couldn't I do this job?

External support provider

The existence of individual champions within the PCT for projects involving external support can help to engage members of staff, as can a high level of commitment among the senior management team and board.

In addition to engaging internal staff, commissioners need to engage clinical staff, without whose support attempts to improve the quality of commissioning are likely to flounder.

Ideally, GPs should be engaged from the outset, and involved in the selection of the supplier.

GPs have got a real big role to play in the success of commissioning, obviously. If they are not involved up front in the selection of the provider, we feel that that is just delaying an inevitable relationship and you might as well form that relationship during selection.

External support provider

A second factor that emerged from our research is the value of continuing engagement with external suppliers over the long term. Commissioners can avoid repeating the process of relationship-building and mutual learning by establishing ongoing relationships with a small number of companies over multiple contracts. A comparison was drawn with the pharmaceutical industry, in which consultants will usually work with a company repeatedly throughout product development, over a period of time spanning 8–12 years. In this kind of arrangement, a much closer relationship is developed – ‘a partnership relationship rather than a transactional relationship’.

What I don't want to do is waste money, having to establish a relationship with a company every three, four months, or twice a year – or even once a year. If you take [provider] as an example, they know me; they know the PCT; they know what we're trying to achieve and our experience is they always produce a really good product. If I brought in another company and I'd never worked with them, they will have a learning curve. And I just think, having a relationship with a company that lasts more than one project is the thing that is probably quite important.

PCT case study 1

Integration of internal and external teams is essential for the success of projects on the joint delivery or partnership model. This had been most successful where the PCT had invested resources in relationship-building and encouraging interaction between the two. This includes giving consideration to the practicalities that can affect the development of effective working relationships between internal and external teams. In one of the case study sites, limitations on office space meant that it had not been possible for the external team to be located with the commissioning and finance directorates as planned. Having the external team located in a separate office had added an additional barrier to integration.

Client characteristics

Key points

- High staff turnover and organisational instability has impeded the effectiveness of external support in some cases.
- Poorer performing PCTs may be in a less strong position to utilise external support effectively.

High staff turnover in PCTs was identified by many participants as something that impeded the development of a mature working relationship between clients and suppliers of external support. The problem is not just high turnover *per se*, but the lack of succession planning leading to discontinuities and disruption of operation. New management teams sometimes want to review projects involving the private sector, and relationship-building needs to begin anew.

Similarly, in some areas the process of redrawing PCT boundaries, and the consequent changes and instability, are perceived to have set back projects to improve commissioning through external support by two years or more.

Several suppliers of external support suggested that poorer performing PCTs, which are in greatest need of improvement, may be in a weaker position to utilise and benefit from the support that external organisations can offer – in part because of high levels of organisational instability or staff turnover, and in part because of a lack of managerial capacity or capability to use or implement the work produced by the external supplier.

The better the PCT was the better they could actually take in the services that we provided.

External support provider

This concurs with the experience of our case study sites. Participants in site 3 acknowledged that the PCT sometimes struggled to ‘know what to do’ with the work produced by their FESC supplier, and the project was generally perceived as having been less successful to date than in site 1 (a high performer in the 2009 world class commissioning assurance process).

We tested this finding further using quantitative data from our surveys. By creating numerical scores from self-reported assessments of the extent to which work with external organisations achieved its goals, and the overall quality of the service received, we were able to correlate this against PCT performance, measured in terms of the results from the world class commissioning assurance process. This revealed a slight trend for higher performing PCTs to report better achievement of goals and higher overall satisfaction with external support. This trend was not statistically significant and hence must be interpreted with caution, but it does lend some support to the finding from the qualitative evidence that poorer performing PCTs may have more difficulty in utilising support from external organisations effectively.

PCTs are also subject to local political constraints, which can make it difficult to make full use of some of the outputs of external support. For example, an external organisation may identify inaccuracies in invoices from secondary care that would represent savings in the commissioning budget, but that a PCT may not be willing to act on for fear of destabilising its providers. Alternatively, the analysis conducted by an external organisation may indicate the need for secondary care reconfiguration, but this may be politically difficult to implement in practice. Commissioners need to ensure external organisations are aware of these constraints so that they can deliver solutions that are feasible to implement.

Supplier characteristics

Key point

- Suppliers of external support differ in terms of their approaches and composition. Commissioners should take care to select a supplier that matches their expectations.

The characteristics of the external team determine the effectiveness of support as much as those of the client. NHS participants in our research differed in terms of the characteristics they felt were important. Some had a preference for people with experience from other countries or other sectors who would bring in new insights and ideas. Others felt that specialist health sector experience (and in particular NHS experience)

was paramount, so that the client does not have to invest resources in educating the external team and ‘translating the language’ for them. Some suggested that the ideal balance was to have a mixed external team containing people who understand the culture and language of the NHS and people from a non-NHS background who will import innovative ideas and approaches. The message to take from these differing perspectives is that it is important for commissioners to select a supplier that matches their expectations.

An important characteristic identified by several participants was credibility in the eyes of internal staff, clinicians and health service providers. External teams lacking this authority may encounter more barriers in attempting to change the commissioning process.

Summary

Barriers exist at a number of levels and have meant that external support has not always delivered the results it could. These include barriers related to procurement practices, working relationships and the characteristics of both client and supplier organisations. In many ways, these barriers resonate with those encountered in other sectors where external consultants are used to bring about organisational change. Participants in our research identified a number of approaches that have been successfully used in overcoming these barriers, including being clear about the goals of using external support, using a two-stage procurement process, and investing in building productive working relationships between internal and external staff. Specific recommendations based on these approaches are given in Section 11, pp 57–59.

7 Deciding how to use external support – issues to consider

Having reviewed the factors that influence the success or failure of projects involving external support at a practical level, we now move on to address several more fundamental questions regarding how and when to use external support. This section synthesises advice from commissioners and suppliers of external support on the following:

- what commissioners should aim for when considering using external support
- what commissioners should avoid using external support for
- the merits and challenges associated with the different models for external support – consultancy, joint delivery and outsourcing – introduced in Section 4, pp 15–20.

Principles for using external support

Key points

- Participants recommended that commissioners adopt the following principles:
 - focus on capability rather than capacity
 - aim for transformational change in terms of organisational structure and culture, particularly for longer projects
 - use external support to work towards a long-term strategic vision for the organisation
 - avoid focusing solely on technical fixes or ‘silver bullets’.

Participants from both inside and outside the NHS agreed that external support should be used for doing more than increasing capacity to do routine work. While primary care trusts (PCTs) appreciated the extra capacity afforded to them through working with external organisations, the biggest gains were seen to lie in the additional skills and capabilities external organisations can bring in.

I would feel that I was being profligate if I was using an external consultancy to do routine, bog-standard work.

PCT case study 1

There is always a tendency that projects come up because of a lack of horsepower or lack of capacity, but they should be thinking of capability as well as capacity really.

External support provider

For larger contracts, the intention should be to go further still. In addition to bringing in extra capacity and skills, external organisations should act as change agents, effecting structural and/or cultural change with the commissioning organisation, and transforming the way it functions. This was seen as the most cost-effective way of using external support.

They have to be used as an agent for change... you don't want to spend five million quid just to get an increase in capacity or even capability, you want to do something more with it.

PCT case study 3

You really want the added value stuff, you really want something that's going to step-change your organisation. If you're going to go through all the pain of a big procurement, you've got to make sure it's going to be worthwhile, so think about the future state you want in three years and try and get that now through one of these contracts.

SHA case study 1

The ideal articulated by some participants was that commissioners should attempt to move away from using external support in response to short-term imperatives and isolated areas of weakness. Instead, external support should be used in a planned way, driven by a strategic vision of what the organisation in its totality should look like in the future. Commissioners therefore need to think in terms of long-term legacy when planning work with external organisations.

The key thing is making sure you are very clear about what it is you want in the long term. Don't just take a short-term view... Make sure that there is a legacy to any contract or any piece of an assignment with a consultant.

External support provider

A risk highlighted by many participants was of commissioners seeing external support primarily in terms of technical fixes or 'silver bullets' that can be applied independently of the wider functioning of the PCT. Several participants from external organisations indicated that PCTs tend to show more interest in purchasing tangible analytics and support tools than support for the basics of how a commissioner should operate, for example, the more relational aspects of commissioning. Although technical products such as invoice validation tools have a major role to play, there was a perception that 'you don't always need a fancy solution for all problems'. For example, building the right kind of relationship with providers and clinicians is a critical part of commissioning, and technical fixes may be of little help if the underpinning relationships are not in place. This is not an argument for avoiding using invoice validation tools or similar products, but for also paying attention to what the commissioner does with the outputs of the technical analyses.

Yes we have got tools that do support [invoice validation] but actually we need more resources to deal with the consequences of technical analysis of acute invoices and actually take those through to a logical conclusion than we do people to actually run the software and crunch numbers.

External support provider

The trouble is we're almost wanting to get them to run faster than they possibly can... us coming in with a set of tools, processes, procedures, actually went a little bit on the back burner because what they really needed was organisations that would come in and provide consultancy organisational development advice.

External support provider

How not to use external support

Key points

- Participants recommended that commissioners avoid using external support in the following ways:
 - using external support as a way of ‘getting through hoops’ or ‘passing the test’ without any real developmental component
 - long-term substitution of manpower and using external staff to cover vacancies.

Companies providing external support acknowledged that commissioners do not always use their services in the most cost-effective or ‘legitimate’ way.

External advisors of different kinds are paid to do things that they legitimately and should be paid for in my view, and also paid to do things which they should not be paid to do... you kind of think ‘why don’t you just do this yourself?’

External support provider

Using support as a means of ‘getting through hoops’ was identified as something to be avoided. For example, our evidence suggests that some commissioners see the world class commissioning assurance panels as a performance management tool rather than a developmental process. There is a danger that if commissioners see this and other national imperatives as boxes to tick rather than as opportunities for development and improvement, their use of external support will reflect this perspective. It should be noted that some commissioners reported finding that the coaching for the assurance panel provided by consultancies was a more helpful developmental experience than the assessment itself. The issue is not therefore that external support should not be used for this, but that it should be used with the right objectives in mind.

The disappointing thing is that I’d say the balance of the money that’s been spent by our clients who are commissioning us to help with world class commissioning process has been helping them get through the process of passing the test rather than real improvement.

External support provider

Similarly, interviewees from external organisations gave examples of commissioners inviting them to write their strategic commissioning plan in a very short time period, having had no prior engagement with the organisation. This again indicates that the production of the strategic plan was seen as a box to tick rather than as a crucial part of the commissioning process.

We have had a number of clients where we have been asked to basically write their commissioning plan with a week to go. Without being involved or having any dialogue with the PCT, just to get through a hoop. It means they don’t understand what commissioning is. It means they don’t understand the value of the process, they don’t understand how important this is.

External support provider

Several participants advised that the use of external staff to cover vacancies often fails to make the best use of the skills that external staff can bring into an organisation, and does not represent the best use of resources. Even where external staff are not intentionally brought in to cover vacancies, this may happen when they are in post through a process of

role creep. This is a particular danger with longer-term partnership arrangements where external staff are well integrated into the client organisation.

A recent report from the Management Consultancies Association (2009) highlighted the high cost of using consultants to fill interim management positions, and recommended that 'Consulting firms should not seek to fill a long-term role in a client organisation with expensive consulting resource'. Our research adds further support to this recommendation. External staff should not be used as surrogate employees unless as part of a long-term partnership arrangement between an NHS organisation and an external company.

Consultancy, joint delivery and outsourcing models – merits and challenges

Section 4 described the main models that exist for external support – short-term consultancy, joint delivery work and outsourcing. Our research suggests that there is a role for each of these, with each being suited to different purposes. The challenge for commissioners is to match the model against the objectives for using external support – to select the best tool for the job. Table 3 summarises the merits and challenges associated with each model.

Table 3 Merits and challenges of different models of external support

	Consultancy	Joint delivery	Outsourcing
Recommended for	<ul style="list-style-type: none"> Supporting strategic planning General organisational development Identifying needs and clarifying aims of longer-term support 	<ul style="list-style-type: none"> Delivering transformational change across a wider range of commissioning functions 	<ul style="list-style-type: none"> Specialist skills needed infrequently Skills that are cheaper to buy in than to build The more practical aspects of commissioning
Merits	<ul style="list-style-type: none"> Relatively low cost and simple to procure 	<ul style="list-style-type: none"> More opportunity and incentive for fully implementing ideas and transferring skills to PCT Risk sharing can promote partnership working and make support more affordable 	<ul style="list-style-type: none"> Can be more cost-effective than building skills internally
Challenges	<ul style="list-style-type: none"> Less opportunity for skills transfer Less opportunity to overcome relationship barriers Risk of limited legacy and poor return on investment 	<ul style="list-style-type: none"> Requires a significant investment to create real partnerships Needs the right infrastructure for partnership working, eg, shared office space Danger of role creep leading to sub-optimal use of external staff 	<ul style="list-style-type: none"> Risk of 'outsourcing a mess' – need to clarify what is required prior to outsourcing Full outsourcing raises questions about accountability and governing financial risk
Procurement routes	<ul style="list-style-type: none"> Catalist or OJEU 	<ul style="list-style-type: none"> FESC or Catalist 	<ul style="list-style-type: none"> FESC

OJEU, Official Journal of the European Union; FESC, framework for procuring external support for commissioners

Short-term consultancy

There is a range of situations where the use of consultancy appears to be useful. For example, participants from both inside and outside the NHS recommended using consultancy to clarify objectives before embarking on a more substantial procurement of external support.

However, there was some concern – including from consultants – that short-term consultancy does not always represent the best return on investment, particularly if there are inadequate incentives and mechanisms for ensuring that ideas are implemented, skills

transferred, and that the work has a lasting legacy. If the aim is to achieve more profound transformational change, longer-term arrangements may be more suitable.

I think the frustration that I would have with the smaller scale work is that I think fundamentally we're trying to change culture and transform the system to really drive the increases in quality and efficiency that the NHS is going to need to go forward, and it's quite hard to do that as a consultant, coming in and PowerPointing someone for a few weeks and disappearing again.

External support provider

Participants stressed that even in short-term consultancy projects it is important that commissioners consider what the longer-term legacy will be and how skills will be transferred. Without this there is a danger of breeding dependency – something that providers of external support acknowledged is a potential threat.

Some consultancies ... like to build in a dependency factor when working for PCTs because that is how they will generate future work... part of the measure [of success] should be what capability they transfer to you by the end of the project programme. Otherwise you are in a dilemma, you are into a spiral where you are never actually producing your own capability to do this.

External support provider

Joint delivery models

Many participants made the case that longer-term partnership working, with the commissioner and external agency sharing joint responsibility for delivering and improving commissioning functions, offers the potential to make a more substantial, lasting impact.

You get more return I think on your investment [using a longer-term partnership] because you do get that opportunity to do that skills transfer, you get that opportunity to do that growing with the organisation and you get a much better idea of the gaps and you find what you need.

External support provider

Joint delivery arrangements are increasingly based on risk-sharing contracts. As discussed in Section 6, pp 27–35 these offer a number of benefits, including making support more affordable to commissioners, introducing an incentive for building a close partnership, and making sure ideas are implemented successfully. The external company is made dependent for its income on the client organisation's actions in a way that is not typically the case in consultancy or outsourcing arrangements. However, risk sharing also requires careful definition of the measures by which the performance of the external organisation will be judged.

Joint delivery arrangements require the commissioner to take more responsibility for the success or failure of work with external organisations than would be the case under consultancy or outsourcing arrangements. If the commissioner is not satisfied with the final product, it is less easy for them to argue that responsibility for this lies solely with the organisation providing support services. It was suggested that some PCTs are deterred from this kind of partnership working for exactly this reason – it can be more attractive to hand a problem over to an external organisation and absolve oneself of the responsibility for solving it.

It is clear from our research that making a success of the joint delivery model requires significant effort from both parties. The philosophy of partnership working is not always reflected on the ground, where the internal and external teams may remain poorly

integrated. A participant from case study site 3 felt that despite the long-term nature of the FESC project, the partner organisation was, in effect, used ‘almost as external consultants to the PCT’.

From my perspective they go so far and then stop. We're not very good at carrying on or finishing pieces of work, and that might be to do with knowledge transfer, it might be because they, the [external] people come in, do a specific piece of work and then move on to something else rather than consolidate it. So I mean they've been used almost as external consultants to the PCT.

PCT case study 3

A further difficulty with this model is that skills transfer requires there to be internal staff in place for the skills to transfer to, which may require double running and hence may not always be cost-effective. In such circumstances, outsourcing may represent a more cost-effective solution.

Outsourcing

Outsourcing is not currently widely used by NHS commissioners, but several participants in our research argued that there is a case for using it more often for certain elements of commissioning. Building skills internally may not always be the most cost-effective route to take. In particular, there is a case for using outsourcing for highly specialist skills needed infrequently (eg, specialist data analysis or financial advice), for skills needed immediately, or for skills that are cheaper to buy than to build, even in the long-term.

The thing I'm trying to avoid is us trying to build something internally that we don't need because we only need to do it once a year or is such a bespoke function there's no point in me having that expert – I can buy it in and it's cheaper to buy it in. And I don't think that people understand that as a notion.

PCT case study 1

Some participants suggested that while the ‘thinking end’ of commissioning such as strategic decision-making and public health analysis should remain within NHS organisations, the more practical or mechanical functions could be outsourced – for example, claims management. However, others questioned the wisdom of splitting the commissioning function across multiple organisations, fearing that this could create ‘a disconnect between the commissioning and the analysis that informs that commissioning’.

To ensure that good results are achieved it is important that commissioners considering outsourcing certain tasks develop a clear specification of how they want the task to be performed before outsourcing it. This can be challenging, since the outsourcing option may appear to be most attractive for those tasks that commissioners have a poor grasp of, and for which they lack a clear vision of best practice. External advice may be required to develop this vision before outsourcing. Participants warned that the tendency to hand over responsibility for difficult tasks as quickly as possible must be resisted, in order to ensure that the objectives are clear, the right provider is chosen, the contract is well specified, and that the provider is then managed against this contract. Outsourcing therefore does not involve complete absolution of responsibility for a task.

There's an old saying, one should never outsource a mess, one should know what one wants to procure.

External support provider

There are a worrying number of PCTs that are looking at outsourcing as a way of boxing up a series of problems and handing it over to the private sector in the belief

that that will somehow either absolve their responsibility for those issues or that magically they will be sorted without their intervention.

External support provider

There was only limited support for the idea that all or most of the task of commissioning could be outsourced to organisations outside the NHS. This was a minority opinion even among external organisations providing support for commissioning. The majority stressed that full outsourcing would be highly complex because it would require devolution of the authority to make public spending decisions to private sector organisations. The political feasibility of this was questioned.

At the end of the day the PCT can't outsource certain problems. They're still accountable for the commissioning of services to meet the needs of their populations. They just can't walk away and say, oh we've written a big cheque out to BUPA or Aetna or United or some other organisation and our problems are all solved... our perspective would be the problems are not going away even if you outsource all of them to someone else because they have a fundamental responsibility that from our perspective you just can't outsource.

External support provider

Full outsourcing may become more common as a consequence of current plans to transfer commissioning responsibilities from PCTs to GP consortia (West 2010). Those GPs not interested in becoming commissioners themselves may seek to outsource this responsibility to external organisations. It is not yet clear what safeguards will be put in place to protect public accountability and manage the financial risk that such organisations would be taking on under this scenario.

8 The role of national policy

The previous sections focused on local factors and decisions that can determine the effectiveness of external support. This section focuses on the perceived usefulness of national policy in the area, and in particular on the world class commissioning programme and the framework for procuring external support for commissioners (FESC).

World class commissioning

Key points

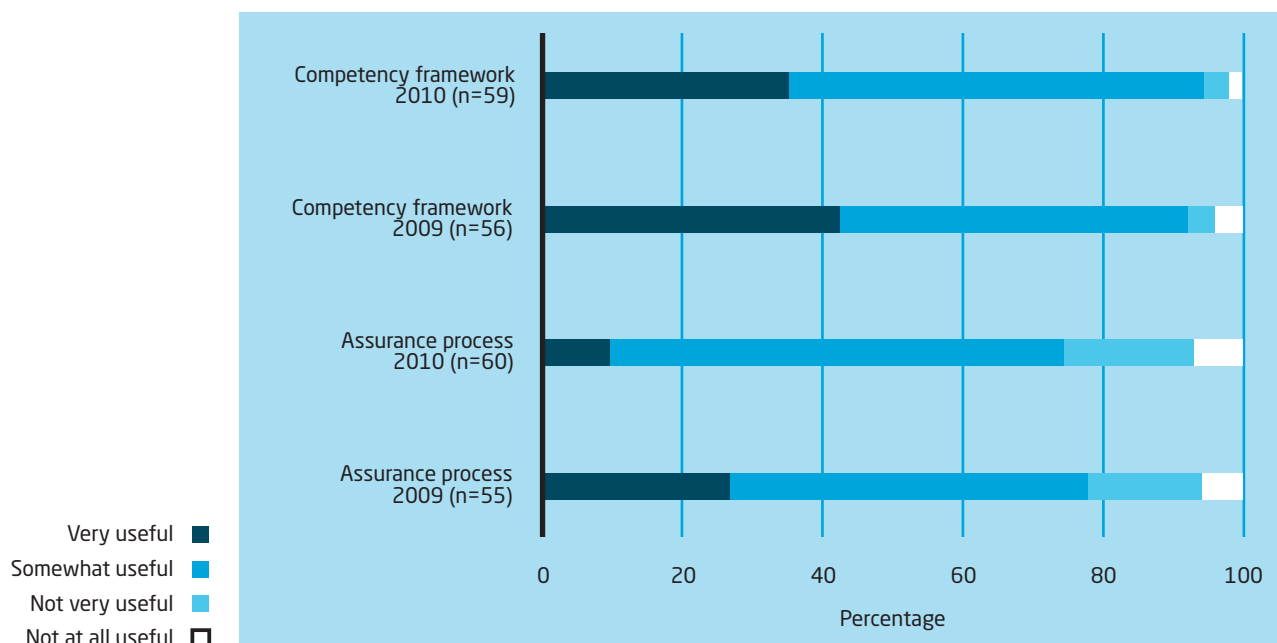
- The world class commissioning programme has generally been received positively as a catalyst for change and improvement
- Concerns exist about the burden it imposes on primary care trusts (PCTs) and whether it will succeed in stimulating improvements.
- World class commissioning may not survive future policy reforms to NHS commissioning, but the need for a performance management and assurance framework to support high quality commissioning will remain.

Our research suggests that world class commissioning has generally been welcomed as a positive approach to improving the commissioning function. The results of our surveys of PCTs in 2009 and 2010 suggest that they have found the competency framework particularly useful. The competencies have given commissioners a clear vision of what high quality commissioning would look like and a better understanding of what changes are needed. However, there was a less positive response about the assurance process, with a significant minority reporting that they found this not very useful or not at all useful (see Figure 10 overleaf).

The most common complaint about world class commissioning was that the assurance process had imposed a top-down and bureaucratic administrative burden that potentially detracted from its ability to be a worthwhile developmental process. Many felt the process could be less onerous, with less focus on ‘completing huge documents’. PCT respondents in the case studies and surveys were concerned that it may become a box-ticking exercise rather than something that embeds a new way of working in PCTs. Related to this, there was a concern that the focus on individual competencies may detract from broader structural and cultural changes that may be necessary if the quality of commissioning is to be improved.

The self-assessment process is hugely bureaucratic and time-consuming... We should be more closely judged on progress and outcomes and less on plans and process.

PCT survey respondent

Figure 10 Perceived usefulness of world class commissioning competency framework and assurance process

It would be beneficial if PCTs were required to give evidence of the structural and cultural changes they are embracing, rather than just ticking the boxes of the submission.

PCT survey respondent

There was concern among many respondents about how the assurance scores were being calculated. It was suggested that there was a need for more objectivity and consistency in marking and that more confidence might be gained (in terms of setting a level playing field) through a nationally-led process rather than one devolved to strategic health authorities (SHAs). Greater depth in the investigations to get a more comprehensive and evidence-based assessment of PCT competencies that takes account of real changes made is required, it was felt, otherwise the assurance process is 'running the risk of being rather superficial'.

It was also argued that the assurance process was costly in terms of the time and management support required, leading to concerns about value for money and the need to ensure that the benefits of the process could be measured and articulated.

Several respondents felt that assessment processes for PCTs needed a degree of alignment since they were currently over-regulated by a range of organisations working to different assessment criteria – for example, the Care Quality Commission, the Vital Signs indicators, and SHA performance management arrangements run concurrently with world class commissioning and could be merged into a single process.

There was also a commonly held view that the scope of world class commissioning needs to change in a number of ways including:

- a greater emphasis on outcomes rather than processes – for example, in terms of improving health, public perceptions and measures of the level of clinical engagement
- a more explicit link to achieving the financial challenges from 2010 onwards
- a recognition that effective PCT commissioning requires partnership across the continuum of commissioners such as practice-based commissioners, local authorities and specialist commissioners

- a need to link world class commissioning with the personalisation agenda and the future development of personal health budgets.

The FESC

Key points

- The FESC has not been widely used to date.
- The framework is perceived by some to be cumbersome, but may be the most cost-effective procurement vehicle for longer-term joint delivery and outsourcing arrangements.
- The framework may benefit from being restructured, for example, to be aligned more closely with the world class commissioning competency framework, although there are potential drawbacks to this.

The FESC was introduced in 2007 as a means of assisting commissioners embarking upon larger scale projects that potentially involve complex joint delivery or outsourcing arrangements. However, by January 2010, only 10 contracts had been signed under the FESC. There has been widespread disappointment among suppliers of external support, many of which expected the framework to be adopted more enthusiastically.

Our assumption was that lots and lots of stuff was going to come through FESC and we kind of just sat and waited for it but nothing ever really did.

External support provider

Participants in our research had conflicting views on the FESC. It is commonly perceived as being too cumbersome and time-consuming for the smaller scale, reactive work that to date has formed the mainstay of the market for external support. Other procurement frameworks such as the Official Journal of the European Union (OJEU) and Catalist are seen as being more appropriate for this kind of work.

However, participants that had used the FESC for larger scale projects were on the whole more positive. By forcing both parties to invest time up-front in defining what is required and identifying the performance indicators that providers will be managed against, the FESC provides a more robust platform for using external support on a joint delivery or outsource basis. Some argued that the process is not as time-consuming as it is often perceived to be, and that the time that is required is well spent.

I think the FESC route is probably more robust and I think it's more robust because I think you end up with an outcome or output-based contract that really is quite detailed and does deal with all those issues about risk sharing and what product's got to be delivered and when.

PCT case study 1

Proponents of the FESC see it as a route through which commissioners can develop closer, longer-term and more effective relationships with providers of external support. It enables commissioners to procure support on a scale that would not be affordable under other frameworks such as Catalist, which is based around a day rate and does not offer opportunities for sharing financial risk between the two parties.

It just allows you to have a level of partnership and a scale of contribution and interaction that you can't get through any other framework, and that will take you a long time to agree commercially through OJEU ... we're able to embed staff, have

people there full time, because of the way the contract is developed, because we're all aligned around wanting to achieve a certain number of deliverables for the PCT.

External support provider

The FESC was criticised by some for being based on an overly complicated structure, dividing the commissioning process into too many tasks and having an unnecessarily rigid accreditation framework specifying which providers are approved to perform each of these tasks. Participants had several suggestions for structural improvements, the most common being that the FESC service matrix (*see Appendix A*) should be restructured to be aligned with the world class commissioning competency framework, which is now seen as the principal driver for using external support.

Another suggestion was that the framework needed to make it easier to procure services jointly across multiple organisations, for example, so that all of the PCTs in an SHA could procure support collectively. Inter-organisational arrangements like this may be increasingly common in future.

The limited take-up of the FESC is related to some extent to a lack of clarity over its purpose. Originally conceived as a vehicle for large-scale outsourcing, in practice it has been used more for supporting PCTs to commission through joint delivery arrangements. The mixture of accredited providers reflects this lack of clarity, including companies focusing on providing specialised health commissioning services but also those providing more generic management consultancy. Disagreements over the pros and cons of the FESC are in part a consequence of different individuals' views on the merits of different models of working and the shape that external support should take in the future.

If you want a consultancy use Catalist, if you want actual embedded service change to change the performance of commissioning I think FESC is actually the only vehicle for doing that which is affordable.

External support provider

Summary

The world class commissioning programme has succeeded in giving commissioners a clearer vision of what they should be aspiring towards, but there is some risk that the improvements it delivers will not be commensurate with the bureaucratic burden it imposes on PCTs.

The FESC framework has not been used as often as anticipated, but where it has been used it has provided commissioners with a more robust and cost-effective means of entering into longer-term arrangements with external organisations.

Many of the participants in our research suggested that a better alignment of the FESC with the world class commissioning competencies is required to enable PCTs to address their competency gaps. This may have some advantages. However, given the arguable limitations of the competency framework, a closer link between this and external support procurement frameworks may serve to reinforce the potential for the world class commissioning process to regress to a box-ticking exercise in which PCTs focus on achieving competency scores more than on bringing about wider structural and cultural changes in commissioning.

9 The future of commissioning and external support

Future trends in commissioning

Participants in our research felt that commissioning was essential to a high performing NHS. Interviewees from both PCTs and providers of external support felt that the world class commissioning programme had succeeded in stimulating a necessary change in mindsets and understanding of the commissioners' task for the future. In general most were confident that commissioning would improve, and that external support would continue to be a feature in supporting such improvements.

Those of us who've been in the NHS a long time recognise that commissioning stands a chance of providing a real opportunity to reconfigure the NHS, and the tools that we've got allow them to make that decision to say the NHS doesn't need to be like it was in 1948, it actually needs to change shape because of people with long-term conditions.

External support provider

However, there was also a generally held belief from interviewees in our research that it was going to take considerable time for improvements in commissioning to translate into tangible service improvements for patients and communities, and particularly for commissioners to strengthen their negotiating powers with large providers. Hence, rather than world class commissioning inducing the step change envisaged by its architects, building improvements to the quality of commissioning is likely to be an evolutionary rather than a revolutionary process.

It's very much an evolutionary process... Getting things to a different level overnight is not very plausible, but through diligence and the constant focus on improvement you do make change over time.

External support provider

In our 2010 survey, 86 per cent of PCT managers suggested that it would take at least three or four more years to build world class commissioning effectively in the NHS, and 26 per cent believed it would take five to 10 years. Some interviewees from external organisations suggested that it may take up to 10 years of concerted effort for commissioning to reach full maturity.

A significant development in the commissioning landscape is the current government's proposal to devolve more responsibility for commissioning to GP consortia, which are likely to be smaller and more numerous than PCTs. If implemented in its most radical form, this may leave PCTs with only "residual" commissioning responsibilities. PCTs may however be able to sell their commissioning services back to GP consortia, and in doing so would place themselves in direct competition with existing suppliers of external support, and other potential suppliers such as local authorities (West 2010).

The future form of PCTs was discussed by several participants in our research. Some argued that PCTs were just too small to evolve into world class outfits and that they needed to be larger and better resourced organisations to really fulfil their potential.

Several respondents pointed to the greater size of commissioning organisations in the USA – for example, to the considerable investment and resource that was in place to interrogate data systems to provide information on which to validate payments and assure quality. The authors of a recent paper published by The King's Fund and the Nuffield Trust concluded that PCTs should be allowed to become 'fewer and larger: with their role increasingly becoming that of the designer and manager of the local commissioning continuum, and the allocator of budgets to clinical commissioning organisations' (Smith *et al* 2010, p 8). This approach might attract more skilled management capacity, better clinical leadership and clinical responsibility for the spending of public funds, and enable more clout in the local health care system (Smith *et al* 2010, p 8).

Part of the dependence that we've got on using external companies is that we haven't always got the skillsets that we need internally. And that may be because you've got too many PCTs. 'Are 152 of the things sustainable?' 'Would you get to a better position or a reduced spend on external consultancy if you had fewer but better calibre?'

PCT case study 1

Perhaps unsurprisingly, there was little appetite among participants in our research for further organisational restructuring and mergers. Nonetheless, there was recognition for the need to grow inter-PCT collaborations to share commissioning functions, to pool scarce resources, and to develop commissioning capacity and skills. Indeed, it appears that the development of commissioning collaborations is an increasing trend in the NHS, for example, to create business support agencies and commissioning hubs such as the sector arrangements in London. Interviewees in our case studies were convinced that collaborative work would be a significant feature of future commissioning arrangements, and suggested that the role and use of providers of external commissioning support might change accordingly.

Commissioning already takes place across a number of levels in the NHS, from individual-level personal health budgets, through practice-based commissioning, PCT-based commissioning and inter-organisational collaborative arrangements, and culminating in national-level commissioning of highly specialist services (Smith *et al* 2010). This continuum of commissioning is set to become increasingly important as PCTs collaborate more on some functions, and devolve others to clinical teams including groups of general practitioners. World class commissioning or similar programmes will need to reflect these changes by broadening their reach from the current narrow focus on PCTs.

In debating the future of NHS commissioning, some respondents argued that commissioner and provider responsibilities ought to be reintegrated in a style similar to US-managed care organisations such as Kaiser Permanente with foundation trusts becoming the equivalent of integrated delivery networks. A similar proposal for the development of commissioner-provider integrated care organisations has recently been explored by Lewis *et al* (2010). The evolution to such a future might see the PCT acting in a different role through the allocation of real budgets to clinically-led commissioning organisations with the power to make or buy services for local people to a specification set and managed by the PCT.

Another alternative put forward by respondents was the development of a foundation trust-like model for high-performing PCTs, allowing the best to gain more financial flexibility to retain surpluses, to attract the best talent by offering higher levels of pay, and to invest in their commissioning infrastructure across several years and so increase their bargaining power with local providers.

The future of external support

As commissioning arrangements evolve, the role of external support is also likely to change over time. In particular, the devolution of responsibility for commissioning to GP consortia could have a significant impact. If many of the commissioning processes currently performed in primary care trusts are to be transferred to a larger number of smaller commissioning consortia, the existing shortages of commissioning skills within the NHS may become even greater, and the need to acquire some of these skills from external organisations may be increased.

A further influence will be the development of the Department of Health's new regional commercial support units (CSUs). These are being established as units dedicated to supporting the information requirements of commissioners and are likely to provide data, skills and expertise similar in some respects to those currently provided by external organisations. Some CSUs have actively encouraged PCTs to utilise their services before engaging with other external organisations (NEPHO CSU 2010).

The development of CSUs appears to be designed to stimulate support for commissioners from in-house expertise within the NHS. This may put them in competition with external support provided by private companies. Although this might appear to limit the future role of external suppliers, there is evidence to show that some SHAs plan to use external organisations to support the CSU itself. It is also unlikely that the CSUs would want to reinvent certain products, such as invoice validation systems and other well developed data and analytical tools that they can potentially buy in more cost-effectively. It therefore seems likely that the development of CSUs will modify the market for external support, but not extinguish it. It should also be noted that with the election of a new government in 2010, the future of CSUs is unknown.

The economic downturn presents a challenging environment for commissioners hoping to invest in external support, with an increasing pressure to reduce management costs (Department of Health 2009a). Our survey indicates that PCTs appear to have become more cautious about using external support in the future. As Figure 11 shows, the proportion of PCT respondents to our national survey who suggested that they would definitely use external support again in the future dropped from 50 per cent in 2009 to just 5 per cent in 2010.

Over the next few years, organisations providing support will need to respond to this by doing more to measure and demonstrate the return on investment their services represent. It is possible that the use of short-term consultancy may decrease as a result of financial pressure, but that the case for transformational partnership working may become stronger as commissioners are called upon to redesign health services in response to funding pressures, and require support to do so.

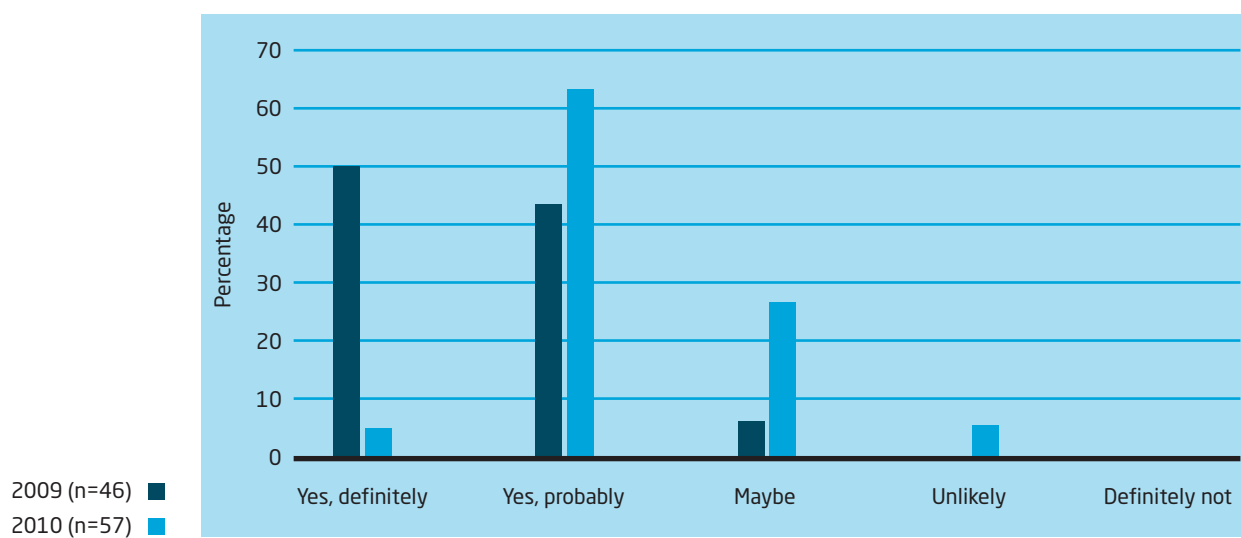
As external providers grow in experience and confidence in taking on contracts that stipulate risk-sharing arrangements with NHS commissioners, this will make such relationships more affordable. The economic climate may also mean that external organisations get more involved with larger, inter-PCT contracts, potentially brokered through SHAs and/or CSUs.

Whatever the future, the use of external companies to support commissioners on a longer-term basis, perhaps as key strategic partners, seems set to become an increasingly accepted part of the NHS commissioning landscape.

In the future, we will probably use companies on a more permanent basis because it's going to become the norm.

PCT case study 1

Figure 11 Are you likely to use external support again?



10 Conclusions

There has been major growth in the use of external support for commissioning over recent years, stimulated to a significant extent by the world class commissioning programme. The framework for procuring external support for commissioners (FESC) was expected further to encourage the use of external support, but in practice has been used in only a small number of cases. However, where it has been used it has succeeded in enabling a new kind of relationship – closer and longer-term – to develop between NHS commissioners and the independent sector.

Levels of satisfaction among those who have used external support appear to be generally high. Our case studies provide examples of external organisations improving commissioning processes by increasing capacity, bringing in new skills, and facilitating wider organisational transformation. External organisations seem particularly well placed to provide support with the analysis and application of data, and with commercial skills only recently required of NHS commissioners.

However, there is also evidence that external support is not always used effectively. Commissioners sometimes struggle to identify their needs and obtain appropriate support to address them, and processes for procuring support could be improved. It may be of little surprise that organisations seeking external support for commissioning often also find it difficult to commission the support required.

There are further difficulties associated with poor working relationships once support has been procured. As a result of these and other barriers, commissioners do not always achieve what they had hoped for – providers of external support were themselves frank about this. The recommendations in Section 11, pp 57–59 provide guidance on how best to use external support. Some of the most significant issues are discussed below.

One of the most common reasons for using external support has been to increase capacity to perform key tasks. Our research suggests that this is not the best way to use external support. In general, best value can be obtained not by using support to do ‘more of the same’, but by using it to add something new – importing new skills, tools and processes, or aiming for transformational change in terms of organisational structure and culture.

There also needs to be a shift from using external support in a reactive way to a more strategic approach. At present, much use of external support is driven by the need to respond to short-term (often political) imperatives and address isolated areas of weakness. Although there may always be some role for this, commissioners are likely to get better long-term returns by developing a strategic vision of what the organisation in its totality should look like in the future, and using external support to work towards that.

In future, the relationship between NHS commissioners and organisations providing support seems likely to evolve from an arms-length transactional relationship to one involving closer, ongoing strategic partnership – closer to the model for client/consultant relationships typical in the private sector. This may offer a more effective model for working with external organisations, although it may also increase the risk of external

resources being used inappropriately, for example, using consultants to fill interim management positions.

There is some evidence that poorer performing PCTs, which have the greatest developmental needs, may be in the weakest position to utilise and benefit from the services that external organisations offer. If this finding is accurate it raises a serious question about how significant a role external support can play in raising commissioning standards in the NHS. External organisations will need to find ways of supporting poor commissioners in becoming good ones, as well as helping good commissioners to excel.

A common concern about external support is that it would be more sustainable to build skills internally than to rely on external organisations. Two observations can be made in response to this concern. The first is that in many cases the argument for building skills internally is indeed compelling, but there may be a role for external organisations in supporting the development of these skills. Our surveys indicate that internal skills development is one of the most common things commissioners seek support with. When this is the goal, it is important to make sure that skills transfer takes place as planned. Our research indicates that this does not always happen. Resources need to be invested to ensure that internal and external teams work together closely and skills are transferred effectively.

The second observation is that building skills internally will not represent the best approach in all situations. In some cases, for example for highly specialised tasks performed infrequently, it may be more cost-effective to outsource on a long-term basis than to attempt to build in-house capability. This decision needs to be made on a case-by-case basis.

The key issue regarding external support over the next few years will be the cost-effectiveness of the services provided. Commissioners remain to be convinced that external support always offers an acceptable return on investment and there is some evidence that the financial climate is already making some think twice about using external support. They will come under increasing pressure to justify all spending on external support as NHS budgets become tighter. Providers of external support would be advised to do more to measure the impacts of their work and demonstrate returns on investment.

In the context of the colder financial climate, risk-sharing arrangements in which the supplier takes on some of the financial risk for the success or failure of the project can be expected to become increasingly important. These offer a number of attractions, including making contracts more affordable and potentially encouraging closer partnership working. There are, however, some challenges associated with risk sharing, and such arrangements make it particularly important that the measures and metrics used to evaluate the performance of suppliers of external support are clearly defined from the outset.

The results of the 2010 world class commissioning assurance process are anticipated to show that the quality of commissioning is improving. However, the scale of the challenge remains high. Considerable developmental needs still exist, and a large majority (86 per cent) of respondents to our most recent PCT survey believed it will take at least another three or four years for commissioning in the NHS to become world class, with one-quarter (26 per cent) believing it will take five to 10 years.

There is, however, optimism that in the medium-term future, high quality commissioning is an achievable goal. Our research suggests that many in the NHS and in external organisations believe that the world class commissioning programme could succeed if given sufficient time and if efforts are made to ensure it does not become an annual box-

ticking exercise for commissioners. Around one half (52 per cent) of respondents to our PCT survey also believed that external support will be needed if the goal of high quality commissioning is to be realised.

Our overall assessment is that, if used appropriately, external support can play an important role in raising the standard of commissioning in the NHS, and in doing so help the system to achieve the improvements in quality and productivity needed over the coming years. However, there are a number of broader structural challenges faced by commissioners which external support cannot address, such as the operational constraints, the limits on their autonomy relative to that of service providers (particularly foundation trusts), and the lack of development of a dedicated commissioning workforce.

The intended devolution of responsibility for commissioning to GP consortia might overcome some of these barriers, particularly related to clinical leadership and autonomy, but it is likely that the existing shortages of commissioning skills and managerial expertise will be amplified. To succeed as commissioners, these new consortia would undoubtedly need a significant amount of support from PCTs or other organisations (Ham, 2010). This may lead to a greater role for external organisations in commissioning and raises the prospect of GP consortia entering into longer-term partnerships with external support agencies. It is vital that new GP commissioning consortia learn the lessons from this research on how to make such a partnership a success. It is also important that the government puts in place appropriate safeguards to protect public accountability and manage the financial risks that will exist if consortia choose to transfer their commissioning responsibilities to external organisations.

11 Recommendations

Recommendations for commissioners

- The following recommendations will be relevant to GP commissioning consortia as well as to PCTs. It is important that GP commissioners learn from the experience of using external support in PCTs.

How and when to use external support

- As far as possible, use external organisations to support strategic development rather than in response to short-term imperatives. Have a vision for how commissioning should function in the future, and explore how external support can be used to achieve this.
- Use external support to do more than increase capacity to do routine tasks. The goal should usually be to add something new – to develop capabilities or to transform the culture or structures of the organisation. Consider entering into longer-term arrangements to achieve more fundamental change.
- Choose the right model for external support on a case-by-case basis, with reference to the different merits and challenges of consultancy, joint delivery and outsourcing models (*see* Section 7, pp 37–43).
- Avoid using external support for long-term substitution of manpower or to cover vacancies.
- Avoid thinking only in terms of technical fixes or silver bullets – external support can also help with the fundamentals, for example the more relational aspects of commissioning.

Procuring support effectively

- Clarify the objectives and specification for external support before issuing a tender. Avoid using the tendering process to do this.
- For a substantial project, consider using a two-stage procurement, with a preliminary stage aiming to develop the specification more clearly. This preliminary stage could consist of an informal dialogue with potential suppliers or a short-term consultancy project (note that procurement regulations apply to both of these options).
- Consider using FESC for larger scale projects on a joint delivery or outsourcing model.

Contracts for external support

- Include clear evaluation criteria by which success will be judged.

- Explore possible risk-sharing arrangements with potential suppliers where payment is linked to measurable improvements in commissioning performance.
- When using risk sharing, ensure that contracts give external organisations an appropriate level of responsibility and power regarding the specific outcomes they are accountable for.
- Long-term contracts need to leave room for innovation and flexibility around deliverables, including a process for regular negotiation to incorporate new tasks and responsibilities. Outcome-oriented contracts allow more scope for change and creativity.

Building effective working relations

- Actively communicate the purpose of external support within the primary care trust (PCT) and clinical community before the start of the project. Include general practitioners on the selection panel when procuring external support.
- Help commissioning staff to see external support as an opportunity for personal development, for example, by identifying named individuals for skills transfer.
- Build relations with a small number of suppliers over a number of contracts, to avoid going through a learning curve every time.
- If using a joint delivery model, invest resources in relationship-building between internal and external teams to facilitate integration.

Recommendations for policy-makers

- World class commissioning may take several years to achieve. Policy-makers should see the role of external support for commissioning as enabling gradual development through partnership working more than rapid turnaround within a short time period.
- If commissioning responsibilities are transferred to GP consortia, put appropriate safeguards in place to protect public accountability and manage the financial risks that would exist if consortia chose to outsource these responsibilities to external organisations.
- Continue to measure the quality of commissioning and encourage developmental improvement, either through world class commissioning or an alternative assurance framework.
- Give greater emphasis in world class commissioning (or an alternative framework) to the outcomes rather than processes of commissioning, and make a more explicit link to tackling the productivity challenge facing the NHS.
- Ensure that there is a quality assurance process for GP-led commissioning, as well as for commissioning occurring at other levels including local authorities and inter-PCT collaborations.
- If developing new procurement frameworks for external support learn the lessons from the experience of the framework for procuring external support for commissioners (FESC), and engage NHS and external organisations in doing so. Consider developing frameworks that are structured in terms of the world class commissioning competencies or similar.
- Construct procurement frameworks in a way that facilitates collective procurement of external support across a number of commissioning organisations.

- Seek to align the roles and requirements of those regulating and managing the performance of commissioners to reduce administrative burdens and avoid duplication of effort.

Recommendations for suppliers of external support

- Investments in external support need to demonstrate their impact in terms of improved commissioning processes and, ultimately, improved health services for patients. Suppliers should seek to measure and demonstrate the impact of services provided, including in terms of return on investment.
- Develop and market a clear portfolio of skillsets and services to help commissioners to know what makes suppliers distinct from each other, and thereby reduce the time and resources spent by all parties during procurement processes.
- Suppliers can help make external support more affordable by being open to risk-sharing arrangements.
- Consider how to support effectively poorer performing PCTs with high levels of organisational instability and less capacity to absorb/implement the outputs of external support work successfully.

The framework for procuring external support for commissioners (FESC)

FESC will deliver commissioning solutions, rather than traditional consultancy services. The business model is based around developing medium- to long-term relationships which can provide primary care trusts with vital specialist knowledge and experience. For these reasons, FESC is different to Catalist and other conventional procurement routes, which NHS organisations have traditionally used for buying consultancy services.

Department of Health 2009b

The FESC divides the commissioning process into 19 functions and eight service segments. This creates 144 potential services types, as illustrated in the service matrix in Table A1. Commissioners may choose to buy a narrow package of support which addresses only one service type (so called microservices). Alternatively they can procure support which focuses on a particular commissioning function (across all service segments) or on a particular service segment (across all commissioning functions). These are referred to as macroservices. Finally, a commissioner could seek a comprehensive package of support across all commissioning functions and all service segments. This kind of end-to-end service would be adopted only in exceptional circumstances.

The framework allows commissioners to buy these services from 13 approved suppliers (see box overleaf). Each supplier is licensed to provide only certain services, with some focusing on a small number of microservices, and others offering macro- and end-to-end services.

Approved suppliers for the FESC

Aetna
 AXA PPP healthcare
 Bupa Health Dialog
 Dr Foster Intelligence
 Humana
 KPMG
 McKesson
 McKinsey & Company
 Navigant Consulting
 Partners in Commissioning
 Tribal
 WG Consulting
 UnitedHealth UK

Table A1 FESC service matrix

Commissioning functions	Service segments							
	Acute - unplanned	Acute - planned	Mental health	Social care	Primary care	Community services	Specialist services	Ambulance services
Assessment and planning								
Assessment of health needs								
Reviewing service provision								
Deciding priorities								
Designing services								
Shaping the structure of supply								
Managing demand								
Contracting and procurement								
Commissioning of primary care services	n/a	n/a	n/a	n/a		n/a	n/a	n/a
Procurement for extended primary care services							n/a	
Contracting and procurement for secondary care services								
Performance management, settlement and review								
Payment by Results transactions								
Budget and activity management								
Performance management								
Practice-based commissioning operating processes								
Collection and analysis of patient feedback and general practitioner intelligence								
Patient and public engagement								
Compilation and publication of PCT prospectus								
Referrals and advice on choices								
Responding to patient-initiated petitions								
Development of effective engagement strategies								
Development and implementation of communications strategies								

Source: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_085468.pdf (accessed on 10 April 2010)

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