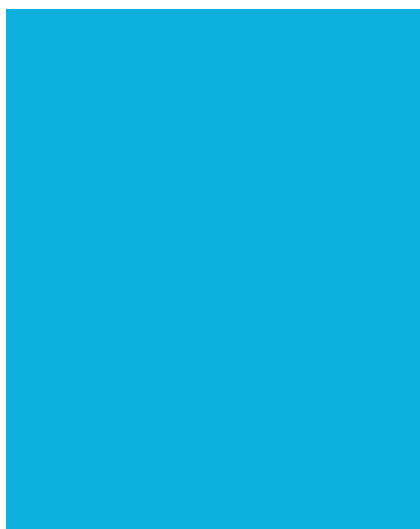




**Commissioning Board**  
*A special health authority*

Developing commissioning  
support

Towards service excellence



# Developing commissioning support

*Towards service excellence*

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## Overview

*Equity and Excellence: Liberating the NHS* said that clinical commissioning groups (CCGs) will have the freedom to decide how to carry out their commissioning functions and what support they use to help them.

It also made clear that we want the new commissioning system to be better and more efficient than anything that has gone before. This will only be achieved by doing things differently. This document outlines our plans to support the system, and especially NHS staff who currently undertake commissioning roles, to create the best possible support for CCGs. We want to be sure that, from the outset, CCGs have access to the full range of commissioning support they will need which is delivered in a cost effective way so that they can get the best value from their running cost allowance. It also outlines how we will support the concept of a customer focused and responsive system where all players are business-like in their quest for efficiency.

Commissioning comprises a complex set of activities. Whilst CCGs cannot delegate or subcontract their responsibility for overall commissioning, it is inevitable that both CCGs on a local level, and the NHS Commissioning Board (NHS CB) at a national level, will need some support so that they can make the right commissioning decisions, and that these decisions lead to better outcomes for patients.

‘Commissioning support’ will bring the specialist skills and knowledge to the non-clinical elements of commissioning so that clinicians can use their strengths to focus on leading change and improvement locally. In this document, we make the clear distinction between commissioning itself and commissioning support.

Over the past year, we have been working closely with clinicians and NHS staff to explore how we can give CCGs the greatest possible choice of commissioning support whilst maintaining stability during the transition. This engagement has shown positive progress in a challenging and changing environment but highlighted the complexity of reaching the end state where CCGs would have a choice of high quality and flexible support services from a diverse and customer driven market, subject, of course, to them undertaking the necessary procurement processes to test the capability of these suppliers.

In order to reach this end point, it is critical that we do retain the skills which have been developed within both the NHS and other sectors.

At present, commissioning support is undertaken predominantly by NHS staff working in PCT clusters from where we expect the majority of this support to be

sourced. These staff are working hard to develop sustainable independent models of commissioning support which will be made available to CCGs in the future. In some instances, especially in larger CCGs, elements of commissioning support will be delivered in house. In other cases, one CCG may host a service on behalf of other CCGs. Some services may be delivered through staff led enterprises or joint working arrangements and joint ventures with local authorities or the independent or voluntary sector.

We are encouraged by these developments. However, we recognise that there would be a potential risk in requiring all staff to have established such independent commissioning support offers by April 2013. This is why we have secured up to an additional three years NHS hosting by the NHS CB so that NHS staff have sufficient time to develop effective and efficient services that will be sustainable in the long term.

In agreeing to host commissioning support the NHS CB will need to ensure that the services begin to operate effectively, with the right customer focus and with sufficient input and buy in from local CCGs.

They will also need to operate at a viable scale so that CCGs and the system as a whole can secure value for money. This will be more important for some critical commissioning support functions where the evidence clearly suggests that they should be developed across a much bigger geography, such as business intelligence, communications and engagement, major clinical procurement and back office support.

In order to maximise access to scarce expertise and minimise the cost, these services are likely to be co-ordinated nationally. Local flexibility and sensitivity will continue to be some of the overriding principles in designing their operating models and it is likely that these national services will use the local teams of NHS commissioning support services as their interface with CCGs.

The period of continued NHS hosting will ensure that, from the outset, CCGs have access to the right capacity and capability in order to carry out their commissioning functions during the transition and are able to demonstrate this through the authorisation process.

It will also allow the right discussions and engagement to take place between potential suppliers of commissioning support from all sectors – including the NHS, independent and voluntary sector, and local authorities – so that a blend of new and innovative service offers begin to emerge that combine the best talent from across the health industry.

We are clear that local authorities have a key role to play, particularly where joint commissioning arrangements mean that the best commissioning support arrangements will support both the CCG and the local authority. In putting the new arrangements in place, we must aim to strengthen joint working not to dilute it and for that reason it will be important to ensure that we get the right commissioning and commissioning support input from both CCGs and from local authority commissioners. In the longer term, the key challenge will be to ensure that commissioning support arrangements support delivery of integrated and personalised outcomes across the NHS and local government interface.

The transition to the end state is complex and will take time. The purpose of this document is to help those leading change on the ground move forward to a future where all CCGs, and the NHS CB, can get access to the right commissioning support they need.

## Chapter 1: Context and vision

*The new NHS commissioning model will be clinically led, underpinned by clinical insight and a real understanding of the local healthcare needs of patients and the public. Clinical commissioning groups (CCGs) and the NHS Commissioning Board (NHS CB) will be uniquely placed to bring a focus on quality and outcomes and realise a step change in the patient services. They will work closely with key partners, especially local authorities through their health and wellbeing boards.*

*Commissioning support is the assistance which commissioners (both CCGs and the NHS CB) can draw on – from a range of sources - to help them deliver their functions. Good commissioning support will help CCGs and the NHS CB to concentrate better on the clinical and locally sensitive aspects of commissioning, and to make the best use of the resources available to the NHS for delivering improvements in healthcare. In many instances, this commissioning support may be secured jointly with their local authorities.*

### **The context of the reforms and the NHS commissioning architecture**

The Government's ambition is for the NHS to deliver health outcomes among the best in the world. This ambition is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role.

At the heart of these proposals is the development of clinical commissioning groups (CCGs), supported by the NHS Commissioning Board (NHS CB). CCGs will unleash the potential of clinical leadership to improve outcomes and achieve the best value for money through the most effective use of resources. By April 2013, subject to the approval of the Health and Social Care Bill, the whole of England will be covered by established CCGs. Some will be ready and willing to take on all of the commissioning responsibilities for the population they serve; others will be established to operate in shadow form.

CCGs will be responsible for commissioning the majority of local health services and they will have statutory obligations for obtaining advice from other health and care professionals and involving patients and the public in doing this. They will work closely with their local authorities through health and wellbeing boards to undertake a Joint Strategic Needs Assessment and to then determine their



commissioning plans. They will also be responsible for bringing together the skills and clinical advice of different professional groups. This will ensure that they harness the potential of clinical leadership and stakeholder engagement to design integrated services that will deliver the best quality of care and health outcomes, and maximise improvements to their population's health.

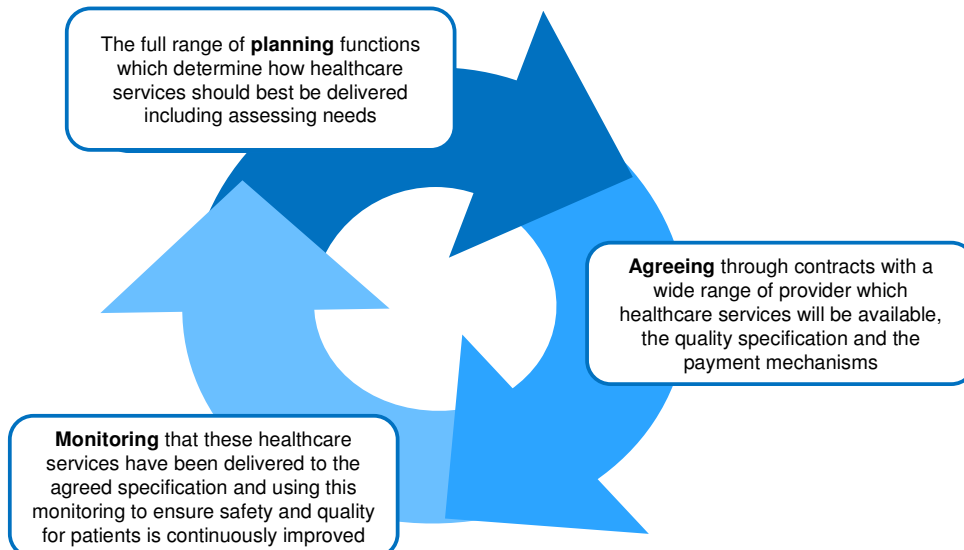
The NHS CB, already operating in shadow form as the NHS CB Authority, will begin to assume its formal responsibilities once it is established (likely to be between July and October 2012). It will have a significant role in supporting and developing CCGs to realise their full potential and that services are developed that will support not only CCGs but also the NHS CB, who will also be responsible for directly commissioning some services like military healthcare, highly specialised services, prison health services, primary care and some public health services.

The Health and Social Care Bill also establishes health and wellbeing boards on a statutory basis in every upper-tier local authority in England. Health and wellbeing boards will create the opportunity for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together and develop better integration to improve the health and wellbeing of the people in their area.

Whilst overall commissioning of public health services will be the responsibility of local authorities, NHS commissioners (notably the NHS CB) will commission some services like national screening and immunisation programmes on behalf of Public Health England.

## Understanding commissioning and commissioning support

Commissioning is not a single activity, but a complex set of functions, processes and tasks, which have both transactional and transformational elements. At its simplest it can be described in the three phases shown below:





Both CCGs and the NHS CB will require support in undertaking both the **transactional** (e.g. contracting and procurement) and the **transformational** functions (clinicians leading change and improvement through service redesign, and engaging with local stakeholders to set agreed priorities) associated with good commissioning. As a result, they are likely to need external support, including from the independent, charitable and voluntary sectors, with the necessary specialist skills and knowledge in order to succeed as commissioners. This assistance that CCGs or the NHS CB buy in or share can be defined as **commissioning support**.

There is no prescribed model for commissioning support: CCGs and their populations will have varying needs. The final decisions on the shape of commissioning support will be a matter for CCGs themselves. Some larger CCGs may undertake for themselves some activities that some smaller CCGs may consider more appropriate to either share or else secure from external suppliers. In some instances, CCGs may work together, either with a shared model between them or with one hosting a service provided to others.

Commissioning support might aid commissioners in delivering any element of their commissioning functions, but is likely to represent a number of different activities, which can be drawn from the examples below:

- **‘One stop’, commissioning support:** It is likely that these commissioning support services will be shared by a number of CCGs supporting the development of collective power, for example, in negotiating with major healthcare providers, and have some commonality of services around their activities linked to clinical networks of care. These services will be delivered directly to CCGs and are also likely to secure specific products and scale services from other commissioning support suppliers. These services are likely to be built on medium to long-term arrangements. In many instances this ‘end to end’ service is likely to be delivered by the most local commissioning support services. But importantly, CCGs will have the freedom to secure all commissioning support from wherever they choose and will be interested in comparing this offer across a range of such suppliers;
- **Specific products and/or services:** These activities are currently delivered by a range of suppliers. Products and services might be used directly by CCGs, or they may be part of a wider end-to-end commissioning support service for individual or groups of CCGs, for example, risk stratification and patient segmentation tools. As suggested by the Kings Fund in their publication *‘Building high quality commissioning: What role can external organisations play?’* they are best used as part of wider strategic initiatives. There may be some products and services where it would be sensible for the NHS CB to develop “framework” call off arrangements for either single products or a range of products;

- **Support for running an organisation:** Many activities simply support the running of organisations. Some must always be carried out by the organisation itself, for example, key decision-making activities; others, particularly those that are highly transactional, such as paying staff, managing IT equipment and so on, may be carried out by external suppliers or shared with other organisations;
- **Commissioning support for scale services:** These are services that should be delivered for larger populations or for a large number of organisations. These functions are discussed later.

None of these activities constitute commissioning functions in their own right but will be able to support CCGs or the NHS CB in carrying out their statutory responsibilities. The specific services which are likely to be delivered through commissioning support are described in more detail in Chapter 2.

There is also a range of functions currently carried out by PCTs, which constitute support for provision, rather than for commissioning. These are often joint ventures between the NHS and independent sector. They include, for example, services which identify individual patients at risk and create tailored packages of care for them which are of higher quality and may be more cost effective. For instance, identifying patients with significant chronic illness who can be supported by a Community Matron in improving their health and reducing crisis episodes; or alternatively identifying the best referral pathway for a specific patient can significantly improve outcomes and be an efficient and effective use of resources.

This document does not cover these direct provision functions. These will be part of services commissioned from suppliers and would not be included in the running cost envelope.

## Developing a vision for commissioning support

Over recent months, we have worked with a broad range of NHS stakeholders, including CCG Pathfinders and with potential suppliers to create a vision for commissioning support:

*A vibrant, dynamic and innovative service sector, which provides customer focused support and choice to CCGs and the NHS CB and helps them to go the extra mile, by supporting the local focus on improving outcomes and increasing value (outcomes per healthcare pound spent) on behalf of their population.*

*Commissioning support must enable CCGs to harness techniques, thinking and ways of working from other sectors in order to allow them to deliver best value, timely and evidence based commissioning decisions. In this respect,*

*commissioning support will feel different to current approaches. It will support working differently and will enable those taking commissioning decisions to do so with accuracy and acuity by operating against best practice standards.*

*Commissioning support will be an attractive sector for talented staff who will be able to develop expertise and skills as they innovate and have rewarding careers.*

Our engagement has suggested that to be successful, future commissioning support will need to be characterised in the following ways:

- It will be customer focused, designed around the needs of CCGs and the NHS CB. This will require customers to have a vision for what they are trying to achieve so that commissioning support can strategically respond, rather than being a source of tactical skills to supplement CCGs;
- In the early period of development, it will support and enable clinical commissioners to manage the transactional aspects of what they do, without them becoming embroiled in the detail of the workflow;
- As commissioning support and its customer base matures, it is expected that the focus will rapidly shift from activity to the delivery of improved quality and outcomes for patients;
- It will operate within a competitive and market environment, built on industry best practice<sup>1</sup>, tailored to the distinctive requirements of clinical commissioners;
- It will harness the strengths of effective partnerships across commissioning and support suppliers, including those from the independent and voluntary sectors and local authorities, to achieve innovation and cost effectiveness.

## **Drawing on what has worked**

Existing public and private sector partnerships have demonstrated the successes that can be achieved through a combination of talent. By bringing the skills and expertise of the NHS with the products and knowledge of the local government, the voluntary and independent sectors, we are confident that a blend of innovative service offers will emerge. But in order for them to thrive in the new system, they will need to be underpinned by an effective supply chain delivery:

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<sup>1</sup> British Standard 11000 'Collaborative business relationships – a framework specification' may help emerging commissioning support services to think through their interactions with other organisations for maximum benefit to all. The framework is designed to support organisations of any size to apply best practice principles to its own ways of working, to get the very best out of its business relationships.

- For many services, it is anticipated that commissioning support staff will work closely with commissioners. Day to day arrangements will be built on long-term arrangements between commissioners and commissioning support suppliers. It will allow for partnership working between NHS and external organisations that combines the best of public, private and voluntary sectors, and local government, to deliver innovative, efficient and sustainable support services for CCGs;
- For some specific activities commissioners will be able to ‘call off’ products and services through pre-procured framework arrangements that are flexible and are co-developed with CCGs to ensure they meet customer needs;
- There is also potential for niche commissioning support offers to develop, providing specialist subject matter expertise for particular services or functions, for example in the areas of mental health, continuing care and safeguarding or health economics and specialist procurement advice.

The specific delivery models are likely to vary depending on the nature of the service and the way in which CCGs, or the NHS CB, have articulated their needs.

## Summary

To deliver the vision, there is a real need for the NHS CB to set a very clear direction during the transitional period. The changes set in train are complex, yet must be implemented rapidly and with precision.

To meet these challenges we will need a strategic approach to the development and a managed transition towards greater choice in commissioning support. Implicit in this is the need to coordinate support, as well as developing a clear understanding of the current constraints and opportunities that are likely to influence the emerging solutions. This will mean striking the balance between ensuring that CCGs already advanced in their development are able to access a wide range of sources of commissioning support services as soon as possible, whilst ensuring that sufficient development support is in place for those who may need it. For this reason it is vital that the broadest range of stakeholders – across the NHS and health industry -are involved and that they in turn are strong advocates of the importance of getting this work done quickly and effectively.

The next chapter describes the evidence that has helped to shape our strategy and the implications for how commissioning support develops in the short term.

## Chapter 2: Developing the evidence

*We have carried out work to help design commissioning support for the future. This has allowed us to:*

- *Consider the lessons to be learned from the current system;*
- *Understand the emerging requirements of the new system and the capacity and capability which exists to support commissioners;*
- *Consider how commissioning support might be delivered to best effect in the future.*

*Given the new focus on quality and outcomes for patients and the need get best value from NHS resources, future commissioning support services will need to focus on supporting delivery and being effective in combining or networking services across a broad geography.*

### Where we are now and lessons learned

Most of the current commissioning support capability in the NHS in England sits within PCT clusters. Other NHS organisations, such as the commissioning support units and procurement hubs, also provide a range of scaled up commissioning support services for the NHS.

However, in carrying out their current commissioning functions PCT clusters sometimes call on support from complementary and niche services provided by voluntary and independent sector bodies and local authorities. Indeed, many of the more successful commissioning support services already in operation have been achieved through the public and private sector working together. This support, particularly from the independent sector, tends to be in the form of specific tools and processes rather than delivering the whole end-to-end commissioning function which pulls together the differing elements of support.

In the past few years the capability and experience of NHS commissioning organisations has been greatly developed, often through joint working and collaborating imaginatively and creatively with other support suppliers. In some cases, close working with the independent sector has brought valuable insights from international best practice and has led to the development of a number of applications and methodologies, which have complemented skills in the NHS. This partnership working with industry will continue to be an important element of

commissioning support in the future and there is every reason to be optimistic about the potential to develop these arrangements into commissioning support services that could assist CCGs in transforming the way health and healthcare is planned, purchased and delivered.

Transforming commissioning support services to ensure success will have two stages. Firstly, redesigning, standardising and reducing duplication where appropriate to ensure the 'basic' support is delivered effectively and efficiently; and secondly, developing new commissioning support offers in ways which will support innovative, clinically focused commissioning as CCGs start to develop their role.

CCGs, as buyers of commissioning support, will benefit from the lessons learned from earlier work to improve the process of buying services from the independent sector. These include the need to be able to describe clearly the services required, allowing sufficient time to run the procurement exercise and establishing adequate contract management arrangements once the contract is agreed. Over the coming months, we will be looking to develop a number of workshops that will support CCG development by allowing knowledge and skills transfer, alongside some practical discussions about how the NHS and other sectors - including independent, voluntary and local government – can complement each other in the future to create a variety of innovative arrangements.

Work has been undertaken over the last year to gain a better understanding of the current commissioning support landscape and to assess more formally the opportunities for rapid transformation and improvement of current commissioning support functions. A summary of this work is included at Appendix A. The key points are described below.

## **Meeting the challenge**

### **1. Working with future customers**

#### Understanding the needs of pathfinder CCGs and the NHS CB

We have worked with Pathfinders and those developing the direct commissioning function of the NHS CB to understand their views and likely needs of a future commissioning support system. We have been able to test and validate the emerging messages through a series of 'confirm and build' events at which a broad range of stakeholders were involved in co-designing and establishing key principles for commissioning support. The key messages are:

- The priority for Pathfinders is clinically led development of new, more effective pathways which will improve the quality of the overall patient experience;



- They appreciate the newness of their role, the implications for them as customers, the need for development of a new supply chain, the demands of the timetable for authorisation and for setting up of commissioning support;
- Pathfinders have a good appreciation of the potential benefits to be achieved by delivering some commissioning support services at scale and from standardised operating models and systems. However:
  - They want to see the evidence around the cost benefits and to understand better the benefits which pooling scarce expertise can bring, particularly around the quality and flexibility of services and supporting service innovation;
  - They are concerned about how these services will be delivered at scale whilst retaining a quality relationship with them as customers;
- Framework agreements for commissioning support can be helpful where:
  - They lead to real benefits from a simplified procurement process;
  - CCGs are able to make significant clinical input into specifications;
  - The process is sensitive and flexible to local requirements;
- They understand the impact of CCG size and the constraints of running costs on the extent to which they will be able to make, share or buy commissioning support;
- They recognise the importance of commissioning for the wider health of their population and that commissioning support services tailored to this kind of commissioning may need to be different.

#### Developing CCGs as 'informed customers'

We are working with a range of key stakeholders in order to support the development of pathfinder CCGs as 'informed customers' of commissioning support as an integral part of the overall CCG development programme. CCGs will need to be able to describe the support services required, manage the process to test the capability of suppliers and be able to manage the SLAs or contracts that they have in place with suppliers.

As described earlier, we will be looking to establish a series of workshops for CCGs to engage with all potential suppliers to discuss some of the lessons learned to date and think about how the different service offers can complement each other in creating new and customer focused arrangements.



PCT clusters that are more advanced in developing commissioning support services have recognised the need to work closely with their Pathfinder CCGs to develop service support and have considered how they can build partnerships with other sectors to ensure that the combination of public and third party expertise can drive the best outcomes. This has helped both parties in their thinking as customers and suppliers of commissioning support.

There is a role for some commissioning support services, which purchase a range of more specialist products and services on behalf of their local CCGs, to effectively act as the intelligent buyer.

#### Affordability and running costs

We have worked closely with Pathfinder CCGs, SHA and PCT clusters to think through the financial implications of different commissioning support arrangements and delivery models, within a running cost envelope for CCGs of £25 per head of population. A 'Ready Reckoner' running costs tool was published in September 2011<sup>2</sup>, although it is not definitive and all CCGs will retain flexibility in how to structure their costs. It allows developing CCGs to think about how they can use bought-in support functions to maximise the resources available for clinical and quality design issues. The challenge for developing commissioning support is to offer services that are affordable within the running cost allowance. Commissioning support suppliers will need to demonstrate added benefits and economies of scale, whilst operating within a model that is sensitive to local needs. PCT clusters and Commissioning Support Services (CSS) will continue to want to look to make the best use of funding to improve patient outcomes and the best value for every pound of taxpayers' money spent.

We are working with pathfinder CCGs to define a range of potential scenarios that can be used to help identify the minimum spend likely to be used to buy in commissioning support for different sizes of CCGs. Clearly, the smaller the CCG the greater the percentage of running cost likely to be used on commissioning support in order to secure the required economies of scale as opposed to large CCGs who would be able, if they wished, to have more of these functions in house.

## **2. Developing the model**

### Sorting and grouping the commissioning support functions

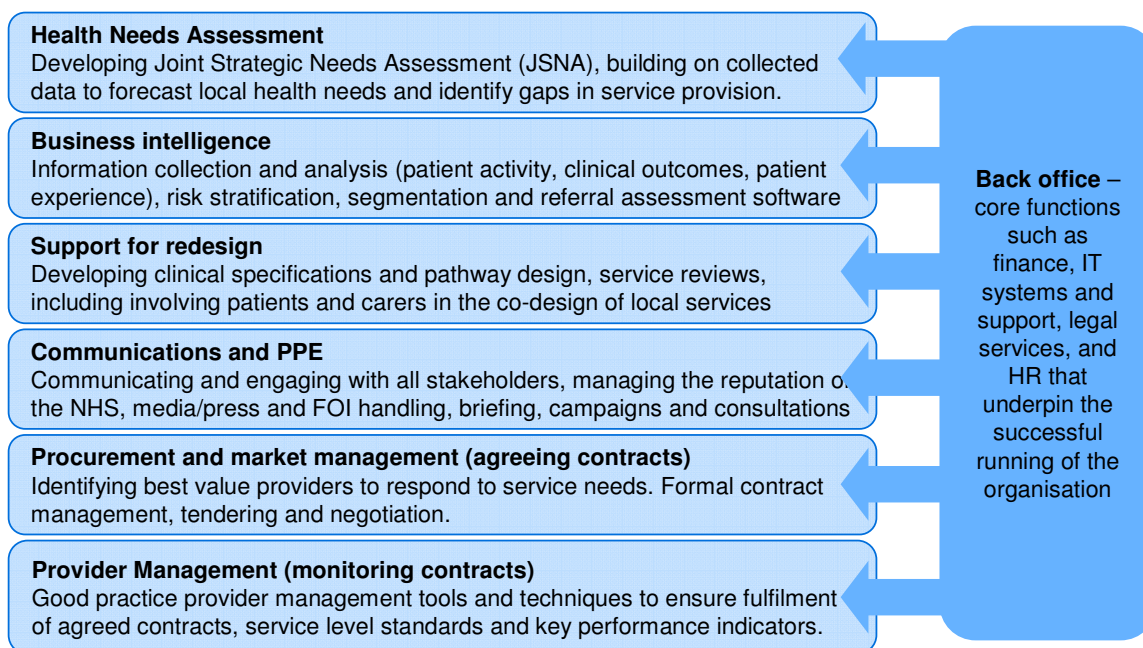
The activities which constitute commissioning support, while relatively intuitive to some, have not been systematic, understood or widely debated. It is clear that

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<sup>2</sup> 'Ready Reckoner' clinical commissioning groups running costs tool, Department of Health, 14 September 2011, [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_129992](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129992)

many functions are currently spread across a wide range of organisations with variable capacity, capability and standards. In order to make progress with shaping commissioning support as a highly professional but affordable component of the new commissioning architecture, it was essential to define the key categories or functional groups spanning commissioning support.

This analysis suggested that commissioning support could be broadly described in six categories that could be used as building blocks for future services.



Back office functions can be considered as a seventh category of commissioning support that underpins all of the six core categories.

Work is ongoing to establish which elements of Health Needs Assessment and Business Intelligence for NHS commissioners might be secured as part of a 'core offer' from Public Health England (PHE) and which components might be provided by NHS commissioning support functions. The core offer would be funded from the ring-fenced public health allocation to local authorities. This is currently being tested with CCGs and more information is expected to be published early this year.

CCGs will require a range of information and intelligence support via both the population public health advice service from local authorities and other commissioning support services. It is important to note that although there are some similarities in the nature of these services, they will have a different focus. We envisage that the public health teams will provide a largely strategic population focus, synthesising data from a wide variety of sources and applying their public

health skills to draw the implications of that data for the local population. Commissioning support services are likely to focus more on commissioning processes and clinical systems, including detailed analysis of referrals and activity, procurement and business processes. Both will be essential for driving improvements in services.

The categories were used to define activities for the commissioning support stock take (see Appendix A) which revealed a tension between locally provided delivery systems and the opportunities to improve expertise and efficiency by using more strategic, scaled delivery systems. On this basis, an analysis was undertaken to consider the basis for considering the types of activities that could be delivered most effectively at scale.

#### Appropriate scale for delivery

An option appraisal was undertaken to inform discussions about the optimal scale for delivering some commissioning support activities. Most of the commissioning support categories can be described as a mix of transactional activities that can be scaled up and a range of (potentially more transforming) activities that need to be delivered at a more local level. The results of the underpinning research<sup>3</sup> were distilled into a framework to inform decisions about the most appropriate population size for which commissioning support functions should be carried out.

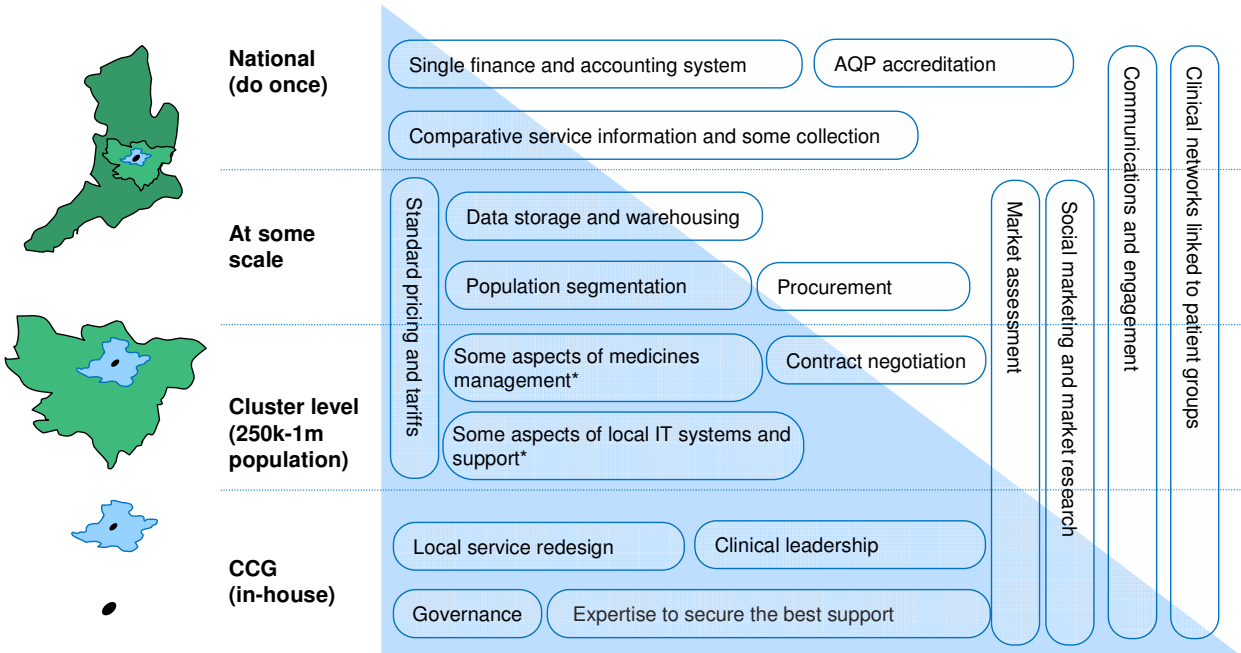
The appraisal was carried out against the following criteria:

- Local knowledge of context and business rules required;
- Visibility and buy in/ relationship management;
- Links to other functions;
- Scarcity of skills available to the NHS;
- Minimum team required for expertise/resilience;
- Economies of scale;
- Level of duplication and transactional costs per time undertaken;
- Development costs compared to running costs.

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<sup>3</sup> M Goold and A Campbell (2002) Designing Effective Organisations: How to create Structured Networks

Combining the work from the options appraisal and evidence from current practice allows us to estimate some of the optimal scale arrangements for some activities. Some illustrative examples that could be used to support local discussions include:



\*Clearly, some functions have aspects which need to be conducted at all population levels, for example medicines management or IT. However the diagram is intended to help inform local discussions about which aspects of these it makes sense to carry out at any particular level.

The most significant conclusions from the work are:

- Business intelligence should be provided from a small number of units:** There is a range of business intelligence functions that could be standardised and scaled up. The evidence from South Central, West Midlands and East Midlands suggests aspects of business intelligence would be delivered most effectively by operations that cover an average population of around five million. If these sized units were replicated nationally this implies that these aspects of business intelligence could be provided from up to 10 units. The operating model would require some activities to be delivered at scale whilst other activities should still be provided more locally;
- Clinical procurement should be carried out at a scale that is appropriate to the nature of the service:** thus, for example:

- **Third sector contracting, learning disability services and localised community services, such as those that focus on vulnerable groups with the poorest health outcomes** are sensitive to local knowledge and should be procured at local level, supported by specialist commissioning expertise;
- **Complex, large-scale contracts** should be procured through shared / lead commissioner arrangements, which serve multiple CCGs to avoid large rise in transaction costs. This will enable scarce expertise, capacity and capability to be combined. The former SHA regions of West Midlands, East Midlands, London and North East, where strong commercial skills are provided centrally, have supported the development of large-scale complex collaborative procurements that leverage benefit from standardisation, whilst retaining engagement of commissioners.

However, even where it has been decided that clinical services should be most effectively carried out at a local level there may still be elements such as the technical aspects of procurement that are most effectively carried out at scale. Thus procurement is the transactional process, not redesign. In order to procure, a detailed specification of requirements is needed to ensure that the procurement actually achieves the required outcomes.

This can be a major undertaking and quite often it is the lever for really thinking through service requirements usually for the first time and it may be that this leads to redesign as part of developing the specification. Major clinical procurements are increasingly used to put in place networks of services, and often they are the end point of a major redesign of clinical services.

Expert procurement will ensure that:

- The process is legally compliant;
  - The right people are involved at the right stages, for example in agreeing specifications, short listing potential suppliers and making the final decisions (this is a key part of the process);
  - The specification clearly articulates the requirement. This will mean engaging with the people who have local knowledge and insight to ensure it is right.
- **Back office services can effectively be provided from shared services:** There is a compelling evidence base that significant savings can be achieved through systematically implementing shared back office services. More detail on back office is provided in Appendix A but the table below summarises some of the work to show the range of savings achieved by over 100 organisations

over a period of five years. It identifies the level of efficiency savings attributable to each of the back office functions.

These savings are typically generated within the private sector through ‘invest to save’ programmes (typical payback periods of two to three years) and a significant reduction in the workforce<sup>4</sup>. There is already a range of back office services within the NHS and provided commercially. The challenge is to ensure that the potential efficiencies are harnessed from existing service suppliers.

Business function	Finance	IT	HR	Procurement
Range of savings	30-50%	25-40%	30-50%	25-40%

## Key indicators for the successful design of commissioning support

The findings from the various analyses provide a direction for developing commissioning support services for the future. Some of this is intuitive and is ‘informed common knowledge’.

In the context of limited running costs, successful commissioning support will need to take account of the following themes:

**Overall approach:** The largest of CCGs, and even the NHS CB itself, will not deliver best value by doing everything in house:

- Commissioning support can make a significant contribution to the QIPP challenge by ensuring that every penny is spent to increase value for patients and by enabling clinicians to concentrate on the clinical aspects of commissioning;
- Both customers and suppliers of commissioning support must recognise that while the early win will be in more efficient transactional services, the prize is for commissioning support to become highly relevant to helping CCGs and the NHS CB deliver better outcomes and value for patients and taxpayers.

<sup>4</sup> QIPP national workstream: Back office efficiency and management optimisation, NHS Foundation Trust Network, November, 2010



**Working with future customers:** Commissioning support cannot develop in a vacuum, so constant CCG engagement will deliver benefits and ensure that support offers match commissioning ambitions:

- The NHS CB can support CCGs to further develop as 'informed customers' of commissioning support, able to put in place, manage and harness the potential of commissioning support in delivering against their challenges;
- During the transition commissioning support services should increasingly be delivered in a new way to CCGs, supporting their transition and providing the capacity which will support them through authorisation;
- Creating access to a range of commissioning support models and suppliers that is flexible and meets customer needs will be essential;
- Commissioning support can add most value in helping to achieve strategic goals when it is designed into the commissioners operating model – commissioning support cannot be an afterthought or second order consideration.

**Working with current NHS commissioning support:** Moving the sector from the current model to vibrant commissioning support, capable of operating as customer focused and responsive entities, requires transformational change and should not be viewed as business as usual:

- PCT clusters need to develop mechanisms that ensure business continuity during the transition, and at the same time working together to actively create space for the development of CCGs and commissioning support;
- Each emerging commissioning support service offer should have clearly defined and dedicated leadership team, with a clear remit to develop viable and customer facing services, and with the capability to take the NHS CSS through the transitional period, on to hosting and eventually to a freestanding entity fit for the future.
- In developing commissioning support, groups of PCT clusters will need to consider where partnering with external organisations can benefit and complement their skills and expertise in ensuring CCGs have access to the best in class commissioning support and to ensure a sustainable business model;
- Whilst CCGs develop their functions during the transition, they need continuity of NHS commissioning support services. However, these services need to be reshaped to enable rapid transition and to aid their future sustainability;



- Incentives need to be created to retain and develop staff ready to drive and deliver sustainable commissioning support services that will meet the needs of CCGs and the NHS CB;
- In developing services for transfer out of the NHS, we should ensure they are the best that they can be, including ensuring that efficiencies are realised before they are transferred.

**Working with the voluntary and third sector, local authorities and the independent sector:** There are real opportunities for all sectors in combining their respective strengths and capabilities, particularly in developing new 'hybrid blends' of commissioning support arrangements:

- CCGs, emerging commissioning support services and local authorities need to work together to develop the emerging PHE information and intelligence offer into their ways of working and understand the relationship to scale opportunities;
- Commissioning support is about the activities and processes that will support all those involved in joint commissioning and should be looking to strengthen the decision making process between CCGs and local authorities. In December 2011, a paper was circulated to SHA and PCT clusters, and CCG and local authority leads (enclosed at appendix B) clarifying the role of local authorities, both as a key partner in and potential provider of commissioning support, and reiterating the importance of continued collaboration.
- All sectors have examples of innovation, specialist knowledge and added value to bring to CCGs and the NHS CB by bringing expertise and adaptable products from other service sectors.

**Appropriate scale for delivery:** Services should be delivered at the most appropriate scale to ensure the right balance of cost benefits, quality and flexibility. A number of services should be delivered at a specific population level for certain customer numbers to maximise expertise and minimise cost and a few would benefit from being developed within a national framework:

- Not all future commissioning support services will occupy the same geographic or functional footprint as a PCT cluster. This will in many cases not deliver viable, appropriate or effective services.
- A small number of services should be designed and delivered at national level to achieve economies of scale and make best use of scarce expertise;
- This will require a rigorous approach to standardisation, reliability and specification so that local service offers can be delivered alongside them with real meaning and relevance. This sort of redesign is important because many shared service approaches have fallen below expectation in the past, because they have often patched over problems, allowed custom and practice to

dominate and not embraced a culture of continuous improvement linked with customer need;

- Whatever the scale at which services are delivered, the customer interface must be right and characterised by local responsiveness and relevance. It is likely that local NHS commissioning support services will become the customer interface for the nationwide offers. The nationwide offers are expected to provide 'business to business' support that can be utilised and built upon by local NHS CSS teams.

## Summary

This chapter has described the key areas where commissioning support can add real value to commissioners. It has highlighted some of the findings of initial analysis into existing and future need, which strongly suggests that in securing the right expertise and efficiency, large parts of commissioning support workflow must be managed at scales beyond traditional geographical boundaries.

At the same time, commissioning support offers need to be provided in ways that are sensitive to local needs. It has emphasised the critical need for suppliers - both NHS and external - and customers to be in active dialogue throughout the period of the transition; they have much to learn from each other. Additionally, it highlights the need to ensure that flexible access to commissioning support is available to those CCGs who may be more advanced in their development.

Finally, suppliers of commissioning support, particularly those originating from the NHS, need to think about partnerships that may radically enhance the offer to commissioners, particularly in helping the system move from input/output management to commissioning for outcomes. This may include forming partnerships. This programme will need to be underpinned by a formal programme of transformational change.

## Chapter 3: The strategic direction for commissioning support

*Clinical commissioning groups (CCGs) will be deciding where they will access commissioning support from. The NHS Commissioning Board (NHS CB) has a significant role in ensuring that services are developed which will support CCGs in delivering their commissioning functions.*

*To be authorised, CCGs will need to demonstrate that they have the capacity and capability to deliver their commissioning functions. To support CCGs through authorisation it is proposed that the NHS CB will:*

- *Build the capability of the NHS staff who deliver the majority of current commissioning support so that CCGs are supported through authorisation and to help provide the best possible choice of commissioning support for the future. This will require the development of viable, customer facing commissioning support. The involvement of external suppliers in building this capability will be an important factor in developing support;*
- *Look to support CCGs in exercising their choice of NHS commissioning support so that they can choose a service that best meets their needs.*

### Setting the direction

It is important that the NHS CB ensures that services are developed which will support both itself and CCGs in the efficient and effective delivery of their commissioning functions. The NHS CB also has a role in overseeing the transition of NHS staff and functions into the new arrangements to optimise the ability and prospects of the NHS CB and CCGs in driving the improvements in outcomes, which, across the NHS and local government, we all want to see.

The imperative during the transition is to prepare CCGs and the NHS CB to carry out their commissioning duties as well as they can from April 2013. Commissioning support is an important element in this. In developing commissioning support, we need to ensure that:

- There are systems in place which will provide the necessary support to CCGs as they assume delegated responsibility for commissioning functions and build up a track record of delivery;

- CCGs are able to demonstrate through authorisation that they have the capacity and capability to deliver their commissioning functions, that they have developed the ability to determine what commissioning support they need, the range of available sources to access it, have appropriate service level agreements (SLAs) in place with their choice of NHS 'one stop' support services and have begun to think about any additional services they may need from other suppliers if they wish to procure any specific products or services;
- Commissioning support is an attractive proposition for talented and experienced people currently working in the NHS who have skills and expertise in commissioning. This includes providing opportunities to partner with external suppliers of commissioning support where this can contribute to the transfer of skills and development of NHS staff;
- Existing NHS staff are given the opportunity to develop commissioning support which will both support CCGs through authorisation and has potential to be part of a viable commissioning support offer after 2013;
- In line with good practice, we ensure that those elements of commissioning support which are currently delivered within the NHS are supported to become lean and efficient;
- During the transition, CCGs and staff in PCT clusters should put in place shadow arrangements which put their relationship on an early customer-focused and business like footing and demonstrate, well in advance of authorisation, how these arrangements will work. If, during the transition, staff in PCT clusters can demonstrate that they have developed a viable and independent model with commitment from CCGs, then SHAs and the Business Development Unit (described later) should support them in understanding the process for moving to a freestanding and sustainable model as soon as practicably possible;
- Opportunities exist to explore and implement innovative models of commissioning support such as joint ventures, partnerships and social enterprise schemes to combine the best of NHS and external knowledge and expertise.

To develop vibrant commissioning support, it is important to ensure that suppliers from all sectors have the opportunity to contribute to its development. As now, all approaches and processes must comply with procurement, competition and employment law. This requires a clear direction to be set and for there to be real involvement from key stakeholders. Different sectors will want to consider how they participate in the development of commissioning support:

- **The NHS sector**, which provides the majority of commissioning support now, needs to make the transition from statutory function to freestanding enterprise.

- **Local authorities** and health and wellbeing boards have specific roles around the joint commissioning agenda, working in partnership with CCGs and, in the case of local authorities, a statutory duty to provide population healthcare advice to CCGs ensuring that public health needs are reflected in the health and wellbeing agenda for the local population. Local authorities have a clear role to play both as a key partner in health commissioning but also as potential partner in, and provider of, commissioning support. In the same way that emerging services from PCT clusters must be clear about their offer and build customer focused and responsive models, so too must local authorities be clear about their contribution and how they can add most value to CCGs.
- **The voluntary and third sector** is likely to want to develop niche services in special interest areas. There are also a number of support streams being developed across government to support the development of the third sector in general and as suppliers;
- **The independent sector** is likely to develop offerings based on their assessment of CCGs' needs and the opportunities which they see in terms of their own development. It can play a role in providing services direct to CCGs, but also to commissioning support services and is likely to be crucial for the future in terms of bringing innovation, specialist knowledge and adding value by bringing expertise from other sectors, and sometimes other countries and health traditions;

## Developing the NHS commissioning support offer

For 'one-stop' commissioning support and some scale services there is a particular issue about resilience during and immediately after the transition. During the transition, the NHS staff who might deliver commissioning support in the future are variously involved in delivering the current day-to-day commissioning requirements, developing CCGs and developing commissioning support.

Making the transition from where we are now to the future vision for commissioning support is complicated for a number of reasons:

- Managing the transition between systems requires new and discrete functions to be developed by CCGs and the NHS CB. Their core focus must be on improving quality and patient outcomes;
- The organisational models for delivering commissioning support in the future will be very different from the current models. Not only will new roles, capabilities and new business models need to be developed, but the need to be more efficient and effective will often break the historic geographical patterns of delivery;

- CCGs need to be supported through authorisation, including demonstrating that they have sufficient commissioning support in place to deliver their functions, are able to articulate their requirements for the future and have a plan for demonstrating how they will procure and manage their commissioning support in future.

Once established, CCGs will be statutory public bodies and will be subject to the procurement rules that govern the public sector. This means that during the period 2013 –16, while the NHS CB is hosting commissioning support, as CCGs become clear about their requirements and are ready to do so, they will need to formalise their commissioning support arrangements through formal procurements. The trajectory for moving towards these formal arrangements needs to be worked through in light of CCG readiness and the established timetables for public procurements.

The way in which commissioning support is delivered may be a factor in how services are eventually procured. For example, the way in which CCGs source and contract with ‘one stop’ suppliers may well be different to the way in which they procure specific products and services, just as the procurement rules will differ depending on whether a CCG sources a NHS or non-NHS supplier.

In some cases, more advanced CCGs may wish to call on specific products and tools delivered by a wide range of suppliers and there may be opportunities for PCT clusters to undertake a procurement process on behalf of prospective CCGs with a view to transferring the contract to the new statutory body at April 2013.

Careful consideration will need to be given to the potential conflicts of interest that might transpire under such arrangements and the capacity needed to run such a procurement. The 12/13 NHS Operating Framework asks SHA clusters to oversee and aggregate CCG demand for such support to ensure sensible approaches across the appropriate scale.

Over the next few months, we will work with a range of national stakeholders and CCG leads to test a broad range of procurement scenarios and provide working guidance to CCGs on how best to tackle the technical aspects of procurement.

There are clearly a number of conflicting and complex tensions, so to give NHS staff time to develop the best and most efficient commissioning support models, the NHS CB will be ‘hosting’ some commissioning support from 2013 until no later than 2016.

‘Hosting’ means that the NHS CB would be the employer of NHS commissioning support staff, who would provide and develop commissioning support services for



CCGs but with the right governance in place and an emphasis on supporting the service to become freestanding as soon as is practicably possible.

During the hosting period, it is proposed that commissioning support would operate at arms length from the NHS CB, with clear leadership in place that can move the commissioning support service to a freestanding and sustainable basis as soon as practicably possible. This approach will ensure that:

- CCGs can develop as commissioners and as informed customers before deciding how and when they will secure their commissioning support through more formal procurement arrangements;
- The NHS sector can move to models which have the potential to be sustainable in the future, either through focused development or by creating the opportunity for staff led enterprises or joint venture arrangements with other sectors;
- Other sectors have the opportunity to contribute to developing NHS offers – potentially as partners, or develop offers of commissioning support in their own right.

During the transition, the NHS CB will identify the commissioning support services it will host. These services will eventually be supported to move to a more independent freestanding status and so the NHS CB has a vital role to play in ensuring that these services are effective, efficient and viable. In developing these services, it will be really important to understand some of the difficulties which emerged under the old system and ensure that we really do create something new and responsive, delivered by the best people and fit for the future.

Some commissioning support services will be ready and able to become independent at an earlier date and will be encouraged and supported to do so, although this will be critically dependent on whether CCGs are ready to undertake a procurement. There will also be some services that can be secured through separate suppliers, particularly for discrete products and services.

At the outset, the NHS CB will work with current NHS staff to help develop resilient and viable commissioning support services. This will include working with CCGs to help identify product and service lines and establish viable business plans. The NHS CB will also work with pathfinder CCGs to ensure that services are developed in line with their needs and requirements, including supporting choice of NHS commissioning support supplier in supporting CCGs through authorisation. CCGs will be able to choose their local NHS commissioning support ahead of April 2013. SHAs will work with CCGs on a case by case basis to ensure that decisions are made carefully and sensitively and that HR and other operational implications can be worked through and handled appropriately.



NHS staff are also likely to need to develop relationships with suppliers from other sectors (independent, local authority, voluntary) to identify products and services that are potential components or complementary offers to end-to-end offers for CCGs.

CCGs may also wish to host their own commissioning support and/ or share it with other groups through collaborative arrangements. Where CCGs choose to operate in this way these services will be tested through authorisation process to assure both the NHS CB and CCGs that these embedded or shared commissioning support arrangements do not pose financial or operational risks for CCGs or the NHS CB.

## Managing risk

The introduction of professional commissioning support to aid CCGs and the NHS CB represents a change in how commissioning is intended to work. It is, however, important to ensure that this change does not bring about:

- Any inadvertent risks associated with making staff redundant who CCGs and commissioning support services subsequently wish to retain as part of a commissioning support role;
- A lack of customer buy-in;
- Inadequate procurements that fail to meet the necessary rules and regulations

In order to make the new commissioning architecture work, we need to be mindful of the inevitable risks associated with large-scale change processes. We need to actively manage the risks relating to customer buy-in, procurement and hence reduce potential associated redundancy issues during the period of hosting by the NHS CB.

It is our intention to guard against these risks by taking the following steps:

- The NHS CB will host some – but progressively fewer – commissioning support functions from 2013 until no later than 2016. The hosting arrangement is a 'safety net' to ensure that there are effective services available to support CCGs until they are able to procure support;
- The NHS CB is likely to only host those functions which are likely to be viable in the longer term i.e. services are delivered at the right scale, are developing an identifiable and 'bought in' customer base and have clear plans in place to move towards freestanding status;
- All potential hosted functions will be assessed against clear, open and transparent criteria by October 2012 – the outline process is described in

Chapter 4 and in the planning guidance that accompanied the 12/13 NHS Operating Framework;

- Where NHS commissioning support services are hosted by CCGs and shared with other groups, then these will also be assured using the same – or similar - criteria to make sure that CCGs are not taking on unacceptable risk. The 12/13 Operating Framework asks prospective CCGs who are preparing for authorisation to be clear about any such arrangements, and to have worked through their do, buy, share options before the end of January 2012 ;
- From April 2013, CCGs will need to prepare to secure their commissioning support through formal procurement once NHS CSSs move to freestanding status. Where an alternative provider is selected through procurement the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) is expected to apply;
- Prior to April 2013, pathfinder CCGs and staff in PCT clusters can either form shadow arrangements with shadow contracts and terms with NHS CSSs, or for the most developed CCGs consider entering into commitments with non-NHS suppliers that run beyond April 2013 where early procurements can be undertaken robustly and safely by PCT clusters on behalf of CCGs in line with CCG's needs;
- For the duration of the hosting arrangements, each arms length commissioning support service will be led by a senior individual who will be accountable for its success and for delivering responsive services to its customers, run within an explicit governance framework. These will be distinctive and accommodated separately from the NHS CB field force. The 12/13 Operating Framework asks SHA and PCT clusters to ensure that each emerging CSS is operating at arms length from the PCT cluster, and with clear leadership in place, by the end of March 2012.

The hosting model is a temporary vehicle that will exist only until CCGs are able to secure commissioning support through formal arrangements and no later than 2016. The model during hosting is intended to ensure that both CCGs and potential commissioning support suppliers work along the lines of the future arrangements such that:

- Hosted commissioning support suppliers will serve a customer base. This will be predominantly CCGs but also the NHS CB for some services. CCGs will buy commissioning support from their running costs, hence there is expected to be an exchange of funds between CCGs and the NHS CB, or any other supplier that they choose to source support from. Further work is taking place to establish those services that could be considered a 'free good', for example from Public Health England;

- The arrangements will be underpinned by local SLA arrangements for commissioning support, built on a proposed national core contract specification. The 12/13 NHS Operating Framework asks SHA and PCT clusters to ensure shadow SLA arrangements in place between CCGs and their choice of NHS CSS supplier before the end of March 2012.;
- CCGs should be clear and specific about their commissioning support requirements and that they are satisfied that the arrangements they put in place meets their requirements.

### **Nationally defined commissioning support services**

The evidence base has shown that it makes sense to bring some functions together to generate considerable economies of scale in terms of:

- **Cost** - unit costs fall as volume increases as a result of skilled staff being able to apply their skills over a greater volume of output;
- **Quality** - as volume of output increases, the quality of service increases, driven by staff being able to specialise and develop high levels of expertise and greater investment in processes to support effective working;
- **Scope** – sharing knowledge between services means that bringing services together is more efficient than having multiple suppliers delivering individual services.

It is clear from discussions with Pathfinder CCGs that the principles and rationale for delivering some services at significant scale is well understood and accepted: it will allow them to influence and concentrate on the aspects of commissioning where they can add most value (their core business). However, there is also a clear message that the focus should be delivering customer focused services and maintaining responsiveness, even where services are delivered at scale.

We have identified four specific function sets that we believe are critical to the future smooth running of commissioning, where there is real potential to generate considerable savings if they are delivered at scale and where there is a risk of the services becoming unsustainable during the transition if there is not a clear path for scarce and expert staff. These are:

- **Business intelligence services**  
Building on some of the excellent NHS and scaled up services that already exist across the country we will consider ways to use capacity and specialist skills more effectively whilst ensuring that customers' needs are being met. Significant local intelligence will be required in order to take good scale products and to interpret them in ways which will enhance local work. This is

likely to be a network arrangement, with many staff located at all levels in the system;

- **Back office functions**

Work is ongoing to consider the potential for a single financial and ledger system across the whole of the commissioning architecture. It is also likely that other back office functions such as IT, estates management, HR and payroll may also benefit from a minimum specification or standard that CCGs could use to contract with the existing wide range of NHS and independent sector suppliers. We do not envisage a single national function for these services, but rather that a coordinated approach will be taken;

- **Major clinical procurement**

The commissioning support stocktake exercise<sup>5</sup> identified gaps in the capacity and capability of current contracting and procurement services. While local knowledge and clinical expertise are important, specialist skills, including the use of standardised tools to support ensuring processes are legally compliant, can be provided at scale and procurements can benefit from the support and input of an expert team;

- **Communications and engagement**

Communications and engagement are critical commissioning support functions, some elements need to be delivered locally to be most effective. However, some aspects of these services could be organised and delivered at a national or sub-national level in order to deliver significant advantages to customers in financial and quality terms. We will continue to work with senior communications colleagues, PCT clusters and CCGs to identify how we can coordinate nationally the best model, which delivers a local service, but through the most appropriate infrastructure.

## **Operating scale activities**

Significant development work needs to be undertaken to model how scale activity might work to best support clinical commissioners and the NHS CB in the future. It is also important that the development of emerging 'one stop' commissioning support offers are not held back because of confusion about what is in or out of scope.

Over the next few months, an intensive work programme will define the most appropriate model for each of the areas above. This includes testing the design and requirements with a broad range of stakeholders, particularly with CCGs. The key objectives initially will be to establish the business case for a national

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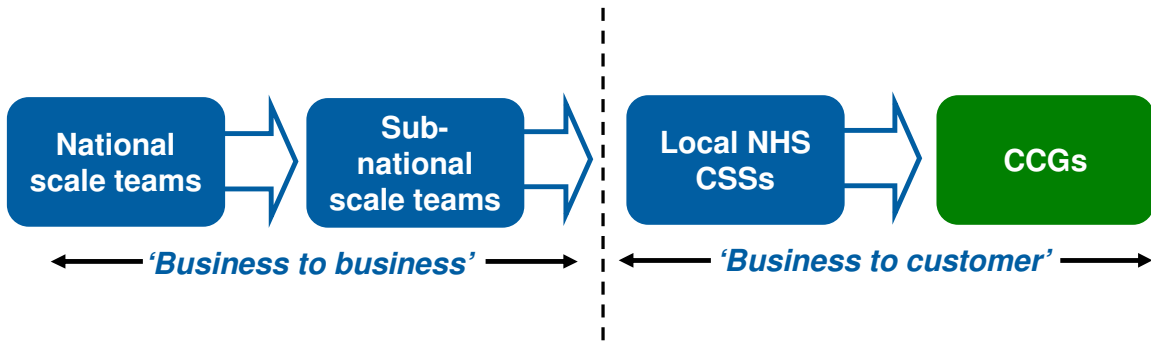
<sup>5</sup> See Appendix A

infrastructure model, both through a detailed assessment of the benefits, including economies of scale and expertise, and to ensure that customers accept the principles and are likely to buy the service.

We are establishing a small team for each service, led by a senior individual, to do this to a common set of principles. The teams will work to develop these services with emerging commissioning support service leads from PCT clusters (and services which already operate at scale), building on what they already propose, using their expertise and encouraging collaboration to create the right national framework.

Early engagement has shown how important it will be for the scale services to be embedded in and the commissioning support services as part of an integrated offer.

Many of these core activities can be standardised and scaled up across a number of national or sub-national platforms. This will provide ‘business to business’ support, where local NHS commissioning support services will be the customer for these services, as illustrated below. Potential models will be tested with CCGs and other stakeholders shortly.



There has already been considerable feedback about the proposed communications and engagement proposals. People are understandably concerned about the case for change, the economic business case and the ability to be locally sensitive. These are reasonable concerns, which are relevant for each of the proposed ‘at scale’ offerings. To give assurance on business viability, operational rigour and customer responsiveness, all NHS commissioning support business plans will be reviewed to provide assurance on customer engagement and strategic coherence. The process is described in Chapter 4. The communications and patient and public engagement model will undergo the same process of rigorous assessment to establish fitness for purpose and will be developed, as the others, with both CCGs themselves and the emerging CSSs in PCT clusters.

## Summary

This chapter has described a framework for a managed transition towards a vibrant system of commissioning support on the basis of managing the risk to CCGs and the NHS CB of a relatively immature supply side that is heavily dependent on existing PCT cluster staff. In managing this risk, the NHS CB will temporarily host commissioning support offers which can show they are on the way to being viable as freestanding entities.

The following chapter describes the business review process that will be used to ensure that commissioning support offers are built on sound assumptions, rooted in customer insight and responsiveness and are able to deliver on what they say they can.

## Chapter 4: Developing business readiness in NHS commissioning support offers

*The NHS CB has a role in building capability in NHS staff who deliver the majority of current commissioning support to help provide the best possible choice of commissioning support for the future. This requires viable, customer facing commissioning support*

*The NHS CB will consider hosting emerging commissioning support services which can demonstrate reliable plans for delivering a sound and viable business model which meet the challenging mobilisation timelines to be ready for procurement.*

*This section sets out the expectations, conditions, processes and timeline for developing NHS commissioning support to be in a position to enter into procurement as soon as is practicably possible.*

### Road map

Developing the new environment for commissioning support is a major undertaking. Huge cultural change is required, both in developing technically able, customer focused suppliers, and in ensuring that customers are skilled in understanding their own commissioning support requirements.

Commissioning support services will need to structure their business models in a way that supports CCGs in decision making, and develop a more positive ethos of seeking innovation through new partnerships.

In taking on these relatively new and emerging models there are a number of risks that the NHS CB needs to guard against. The criteria to be used for determining the suitability of commissioning support services for hosting have been shared with SHA and PCT clusters.

Similarly, where CCGs plan to host their own commissioning support and share this with other groups, it is proposed that CCG-hosted services go through a similar process to NHS CB hosted services (as part of the authorisation process), since the NHS CB will need to be confident when authorising a CCG that the CCG can manage any potential risk.



## Developing business ready NHS supply

Developing viable commissioning support will require a well-planned and resourced development strategy. The step change from public sector delivery models to sustainable business has precedence in other sectors. There is a body of evidence that suggests that successful outsourcing of this type is most likely to happen when organisations undergo a thorough preparatory period to create lean and rigorous strategic and operational management.

The assurance process will ensure that emerging organisations and their products and services are ‘fit for purpose’ and will reassure the NHS CB that financial or operational risks are being addressed.

The assurance process will be part of the next stage of the business review which will support emerging CSSs to prepare for their future, including the period of NHS hosting. It will also support CCGs in demonstrating their commissioning arrangements through authorisation and ensuring that they have properly articulated their requirements ahead of any procurement activity.

The assurance process will be underpinned by the following key principles which have emerged through various discussions with stakeholders over recent months:

**Focus attention on highest risk elements** – ensure that effort is concentrated where it adds most value

**Recognise excellence** – leave room for the best to shine, in order to drive overall improvement

**Minimise administrative demands** – be as light touch as possible, wherever possible drawing on existing evidence

**Be nationally consistent** – treat like things the same

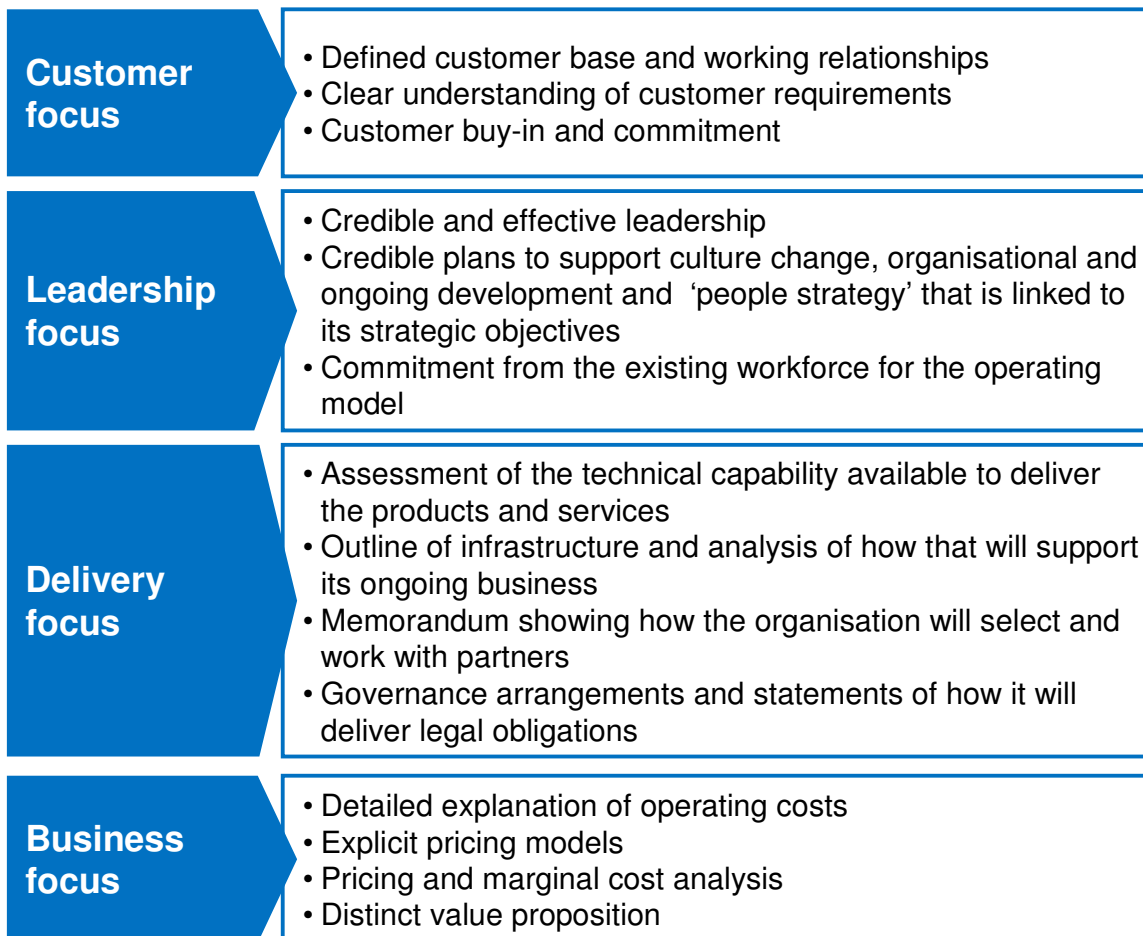
**Add value to CSOs** – underpin a developmental path, both prior to and after being hosted by the NHSCB

**Add value to CCGs** – produce clear and actionable insights underpinning quality based choice

We want to make this process empowering and enabling. Unlike previous approaches to assuring commissioning, the intention is not to create identical offers but instead to seek diversification. It is not intended to focus intensely on commissioning competencies but rather to consider how these are deployed with a view to customer sensitivity and ultimately to determine the viability of the proposed vehicle for delivery of commissioning support.

**Preparing to meet the challenge**

The assessment process and criteria for checkpoint one and two for NHS commissioning support services that plan to be hosted by the NHS CB was circulated to SHA and PCT clusters in December 2011. It described four domains which they will be assessed against:



These domains have been generated on the basis of feedback from design and confirm events and from the experience of moving other public sector organisations to freestanding arrangements. It is likely to be challenging for CSSs to meet the full range of criteria in the short term so it is likely that a small number

of domain characteristics (those relating to governance, workforce plans, leadership, order book) will carry more weight than others for the assessment ahead of hosting. These diagnostic characteristics will indicate support offers that are likely to have sufficient momentum to achieve freestanding status.

## Business planning process

The business planning process will operate on the basis of a series of key checkpoints:

- The first of these will be an environmental check to assess the preparedness of the commissioning support offer to work with a clear customer base using dedicated staff but also evaluating the operational relationship between the PCT cluster(s) and arms-length commissioning support services in terms of ongoing business continuity. SHA clusters will be essential in providing input and situational awareness in relation to this step;
- The remaining checkpoints will focus specifically on migration to an independent entity capable of managing effectively and sustainably in a competitive environment.

Commissioning support services will be required to develop three supporting documents:

The **Prospectus**: customer-facing information to support discussions with potential customers, *by December 2011* setting out:

- A statement of the key objectives for the commissioning support service; including a description of the business need;
- A description of the scope of core offer/services to be supplied;
- Issues of timeliness and time criticality;
- Identified key risks, critical success factors and how they will be measured;
- Indicative people migration strategy;
- Handling plan for communication with the main stakeholders.

It is anticipated that the prospectus will be developed with the knowledge of potential CCG clients, taking account of their needs/requirements and be clear that CCG authorisation planning is geared with the commissioning support development timeline. A suggested outline prospectus will be co-produced with emerging commissioning support services and CCGs.

The **Outline Business Plan** (OBP) *by the end of March 2012* will be the document that sets out the commissioning support services detailed options for the future. The prospectus will be the first chapter of the OBP and the body of the

document will test the feasibility of the proposed commissioning support service against its organisational strategy, options for delivery, business aspects, innovation and partnership, overall affordability and achievability of the plan. At this stage, particular emphasis will be placed on ensuring that options for developing commissioning support are rigorously and objectively tested such that all elements of risk management that need to be undertaken in order to progress to the next stage are in hand.

The **Full Business Plan** (FBP) by the *end of August 2012* will describe the business model fully and comprehensively against an indicative framework which will be outlined shortly.

### **Supporting commissioning support through business planning – the role of the Business Development Unit**

These proposals are intended to give emerging NHS commissioning support services the opportunity to construct viable business models, either directly or in close partnership with local government, the independent or voluntary sector. It is clear that there needs to be a strong emphasis on the establishment of new culture and business design, which will require a comprehensive approach to organisational design.

For this reason, it is our intention to put in place a series of support measures that will operate through a **Business Development Unit (BDU)**, which will both assess applications for hosting and support the development of commissioning support services on their journey to freestanding status. The BDU will have two major roles and comprise a small core team supported by more specialist skills and expertise:

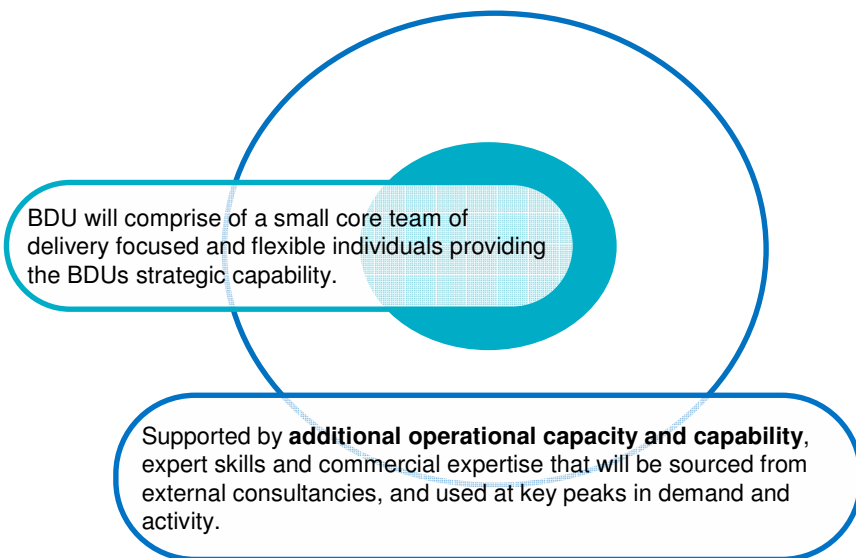
**Assure (on behalf of NHS CB)**

Providing **assurance** both to the NHS CB and to CCGs that the models of commissioning support are capable and sufficiently commercially robust and that potential commissioning and financial risks are manageable, and that:

- emerging models of commissioning support are suitable for hosting.
- hosted commissioning support services are being properly run.

**Develop & Transform**

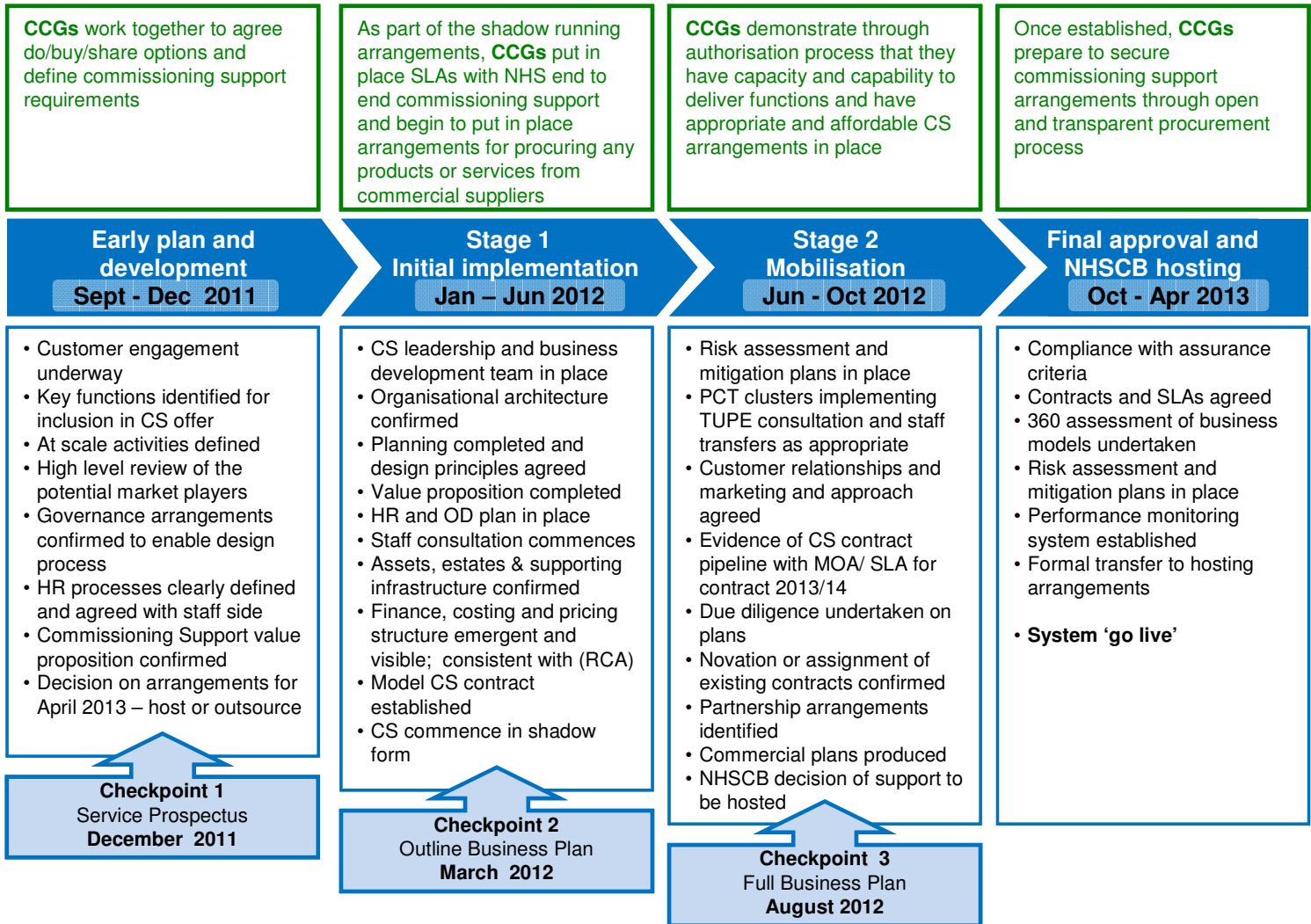
- Supporting the **development** of excellent and responsive commissioning support which will help CCGs and the NHS CB carry out their commissioning responsibilities.
- **Transforming** services, developed from within the NHS, which will be markedly different the PCT model, to provide the choice commissioners need and driving significant culture change, responsiveness, redesign and enhanced technical skills.



The BDU will operate initially to ensure that the very exacting time line for business review is delivered and to ensure that there is a parallel development strand picking up and resolving the business needs of teams as they go through the process. This is generally summarised in the figure below. It is intended to maximise development by April 2013, thereby minimising the hosting period by the NHS CB.

The BDU will ensure that there is strong and regular feedback to CCGs and other stakeholders throughout the life cycle of the review, ensuring that there are ‘no surprises’ and that commissioning support offers only fail at the checkpoints by exception.

The BDU will oversee the emerging national scale offers, ensuring their evolution is coordinated with the emergence of commissioning support services which are formed through PCT clusters. The BDU will also include business expertise in order to support and develop all emerging commissioning support services in their preparation for becoming sustainable in the long term.



Where applicants for hosting do fail at a checkpoint, they will be supported to seek remedial assistance from other NHS teams, the independent, voluntary or local government sectors either to re-establish their trajectory or to continue under new leadership.

## Establishing an HR framework

Putting in place the supporting arrangements for staff in transferring to the NHS CB and to other organisations will require significant work and careful consideration. Work is ongoing to establish the necessary arrangements that will need to be put in place.

Implicit in the approach to developing viable commissioning support is that commissioning support is likely to be delivered by a reduced number of services and by a reduced cohort of NHS staff. This is part of the wider drive to reduce costs, both as part of the QIPP initiative and of reforming the commissioning sector.

Any transfer that may occur of staff to hosted options is expected to commence later in 2012. For those CSSs transferring to the NHS CB, the NHS CB People Transition Policy will set out the process and timescales. Phase 2 of this framework is expected to be published after the Health and Social Care Bill receives Royal Assent. This will build on local HR Frameworks and governs the appointment of staff into the NHS CB and has been developed in partnership with the Trade Unions.

## Summary

This chapter has outlined the process for ensuring that only those emerging commissioning support services which are able to meet the criteria will be eligible for hosting by the NHS CB and that there will be a similar risk assessment for commissioning support services that are hosted by CCGs. The development taken forward by PCT clusters and the emerging NHS commissioning support leads over the next few months will be critical and have long-term implications for staff.

The content of this section and the emerging detail is important for all staff with an interest in commissioning support. PCT clusters will need to prioritise the business review process equivalently to the development of CCGs; this means that senior staff should be identified to drive this work where this has not already taken place.

Done well, the business review will be the catalyst for transforming commissioning support to a set of business-like operations. The process will help emerging NHS commissioning support to operate within a framework that will establish sustainable services for the future.

This is a complex journey and the next section lays out the anticipated next steps that different parts of the system need to put in place to ensure delivery of this very tight timeline.



## Chapter 5: What happens next?

*There is much to be done collectively to develop strong commissioning support for CCGs. This chapter sets out the relevant roles and responsibilities for each key stakeholder in determining the vision for commissioning support.*

There is a tight timetable for ensuring that commissioning support is in place to be fully prepared for CCG authorisation during late 2012-13 and go live on 1 April 2013. There is a particular urgency and responsibility for supporting the development of the NHS sector, where we expect the majority of this support to be sourced.

At a **national level**, we will continue to work with stakeholders to develop our programme of work. This will include:

- Co-producing the detailed criteria which will determine whether commissioning support services are developed enough to be hosted by the NHS CB;
- The development of the detail of the HR framework which will operate alongside these arrangements;
- The detailed processes which will support the development of commissioning support;
- Establishing distinct work programmes to take forward the national infrastructure models and articulate the scope and nature of the services which they cover;
- Establishing a Business Development Unit to assess and support the development of NHS supply for commissioning support;
- Co-producing workstreams to continue support the development of informed customers.

There is a great deal to be done by the wider system to help to develop commissioning support further. This is set out below:

### **Potential NHS commissioning support suppliers should:**

- Where they wish to be hosted by the NHS CB or CCGs, ensure that business plans will meet the requirements of the NHS CB's business review timeline as described above and within the planning guidance accompanying the 12/13 NHS Operating Framework;

- Develop plans that support the development of a more business approach, looking critically at issues of viability and being open to working with other potential suppliers of commissioning support if this increases the likelihood of viability;
- Work with CCGs to understand their commissioning support requirements and support them through the authorisation process;
- Develop an understanding of how their offer will relate to other parts of the commissioning support supply chain and the delivery impact of this (for example by engaging with local authorities and the public health team to establish what they are providing);
- Identify gaps in core offerings and ensure that they have plans in place to address them within the necessary timescales;
- Build a customer focus and ensure that they have long term programmes of work in place to achieve the necessary culture change to be responsive organisations;
- Put in place a people plan to support the future development of commissioning support services;
- Work closely with their SHA clusters to ensure that there is a shared understanding of the emerging business model, strengths, weaknesses and risks.

**SHA clusters should:**

- Flag to the BDU any intentions of CCGs wishing to host commissioning support or secure provision from any alternative NHS commissioning support service, or non-NHS products and services, before end of Jan so that alternative strategies can be put in place;
- Ensure that SLAs are in place between CCGs and their choice of NHS CSS from the beginning of April 2012;
- Support resilience during transition and, where necessary, make structural changes to do so whilst taking account of the future model;
- Support shared learning between CCGs;
- Work with emerging commissioning support to oversee the development of sustainable operations, ensuring that the necessary service expertise, culture change and planning takes place and that they meet the timescales set out for the business review;

- Work with the BDU to facilitate the bringing together of NHS and other commissioning support offers to ensure that coherent, efficient and effective models can be developed;
- Ensure that the range of development offers are understood and appropriately targeted;
- Identify risks and issues with emerging commissioning support offers and facilitate resolutions that will both meet customer requirements and support the development of commissioning support overall, including where CCGs wish to choose their NHS commissioning support up to April 2013;
- Support the implementation of local HR policies;
- Ensure that independent sector offers are given access to CCGs.

**PCT clusters should:**

- Work with CCGs to agree their do/buy/share options and ensure that emerging commissioning support offers truly meet CCGs' needs before end of January;
- Work closely with CCGs to determine whether they require alternative or additional external commissioning support from non-NHS providers by end of March 2012, and with SHA clusters to aggregate demand;
- Establish a distinct commissioning support function operating at arms length and ensure that the commissioning support aspect of operations are headed up by good leaders and have an articulated plan for delivery;
- Ensure that emerging CCGs have the necessary commissioning support services to support them through authorisation and consider where CCGs may want or need access to additional support beyond the scope of the existing NHS offer;
- Work across cluster boundaries to achieve economies of scale where possible as part of developing viable models of commissioning support;
- Support CCG development, in particular to help them develop the skills to become intelligent customers of commissioning support;
- Co-ordinate the development of commissioning support with Local Authorities to ensure that any arrangements strengthen existing joint commissioning processes.

**Pathfinder CCGs preparing for authorisation may wish to:**

- Work with potential commissioning support suppliers to help to define and describe their commissioning support requirements and prepare to put in place SLA arrangements with their choice of NHS CSS by the end of March 2012;
- Work with other Pathfinder CCGs to understand the commissioning support functions that can best be shared and how to share them and flag any intentions to host commissioning support to SHA clusters as soon as possible, with a view that these will go through similar assurance tests as part of the commissioning support business review or CCG authorisation;
- Use the 'Ready Reckoner' tool to think through how they will use their running costs to deliver their functions efficiently and effectively, including where it makes sense to share some of these with other groups;
- Work together to develop a collective view of how any scale commissioning support offers will operate flexibly that enables local input and influence from CCGs on the ground.

**Independent and third sector suppliers may wish to:**

- Develop offerings based on their assessment of need and the opportunities they see in terms of their own development;
- Explore the potential for developing niche offers in special interest areas;
- Consider their role within the commissioning support sector and how they can provide maximum value to CCGs and the NHS CB;
- Consider how they can effectively work with prospective NHS suppliers of commissioning support to develop offers that will be more than the sum of their parts and bring added value for commissioners.

**Local authorities and health and wellbeing boards may wish to:**

- Work to understand the separation of commissioning decisions about populations and the support functions that enable those decisions to happen. On that understanding, work with potential commissioning support suppliers to consider how their services can complement or supplement developing services in a manner that complies with procurement and competition law;
- Consider their role in the joint commissioning agenda and how they can work with commissioners and NHS commissioning support to add most value for commissioners in a manner that complies with procurement and competition law;
- Work with commissioners and NHS commissioning support to ensure that there is effective public health input into the shared health and wellbeing agenda and

more generally into the development of strategies to improve the health of the population.

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