HFMA introductory guide to NHS finance

Chapter 16: Commissioning

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Overview

This chapter explains what commissioning is, what it aims to achieve and what it involves in practice. In particular it works through the 'commissioning cycle' and explains what each step involves.

16.1 What is commissioning?

The Department of Health and Social Care has described commissioning as 'the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers'. However, what it boils down to in practice is commissioners negotiating agreements with service providers (in the NHS, private and voluntary sectors) to meet the health needs of a particular population. Contracting is one element of the commissioning process, as can be seen later in the chapter, in figure 7.

16.2 The aim of commissioning

Service quality is the focus for NHS commissioners and the organising principle that underlies all that they do. This means that the overarching goals for commissioning are to achieve the following within available funds:

- improved health outcomes
- reduced health inequalities
- improved provider quality
- increased productivity.

Commissioners are constrained by the fact that demand for healthcare always exceeds the level of funds available and so there is a need for them to make choices and to prioritise availability of services. This involves a focus on local needs, targets and desired outcomes together with reviewing services in the search for greater effectiveness, economy and efficiency. As a result, not all NHS services are available everywhere in the same way.

NHS commissioners are also expected to achieve improvements in relation to the five domains set out in the *NHS outcomes framework*[226] and follow national planning guidance issued each year.

NHS outcomes framework domains

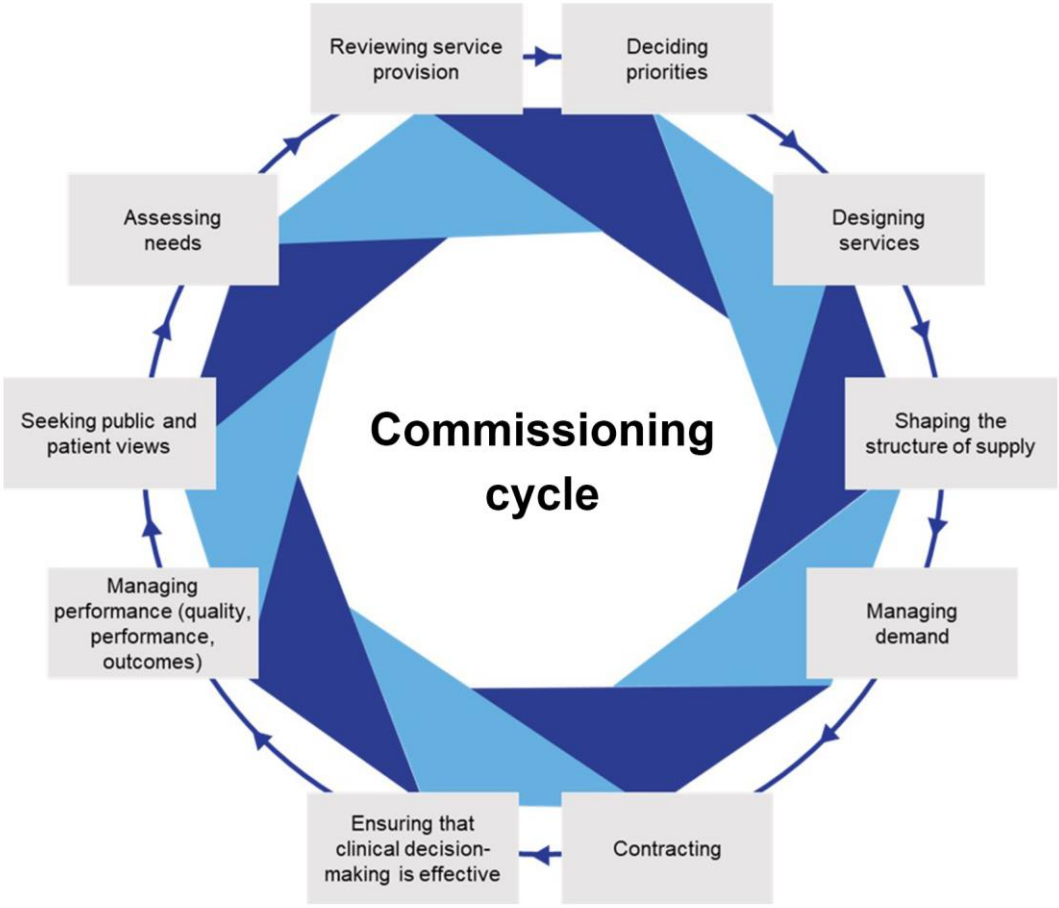
Domain 1	Preventing people from dying prematurely.
Domain 2	Enhancing quality of life for people with long-term conditions.
Domain 3	Helping people to recover from episodes of ill health or following injury.
Domain 4	Ensuring that people have a positive experience of care.
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

[226] NHS Digital, *NHS outcomes framework,* February 2021

16.3 The commissioning cycle

Commissioning does not follow a pre-set template and cannot be done once and forgotten about – rather it is a continuous process with many different elements. It is only by going through the entire process – often referred to as 'the commissioning cycle', that a realistic commissioning plan can be drawn up and an associated budget developed. This cycle is shown below in diagrammatic form[227]:

Figure 7: The commissioning cycle



These activities are usually grouped into three key phases – planning, procurement and managing/ monitoring.

Planning

Assessing health needs

Assessing health needs involves planning ahead so that an integrated care system (ICS), and the organisations within it, know what services are needed to meet the requirements of the population served. This cannot be done in isolation – commissioners must work with others across the ICS and within the wider community (for example, local authority and public health professionals, local authority Health and Wellbeing Boards (HWBs), patients and the local community) to gather the

[227] Adapted from a version that appeared in the Department of Health's 2006 guidance *Health reform in England: update and commissioning framework*

information they need. Providers should also be involved in this process to highlight areas where services could be developed or challenges that need addressing such as waiting lists, for example.

In looking at needs, it is important that the focus is on commissioning services that will result in good patient outcomes. For example, the test of effective commissioning for knee operations could be whether or not patients can return to work or drive again rather than the number of operations that are carried out over a set period of time. As we will see later, this outcomes focus involves thinking about developing new and innovative ways of contracting which incentivises providers to deliver the desired outcomes.

There are a number of tools that can help commissioners to decide where to focus attention which cover both individual organisations and wider population management for local systems, including:

- benchmarking data – for example, through the NHS Benchmarking Network who carry out a wide range of benchmarking projects across commissioning and provider sectors
- CCG outcomes indicator set – produced and maintained by NHS Digital, this provides comparative information about the quality of health services commissioned and health outcomes achieved. It contains indicators from the NHS outcomes framework that can be broken down to CCG level and other additional indicators – for example, linked to the National Institute for Health and Social Care Excellence's (NICE) quality standards
- system transformation diagnostic reports which draw on a wide range of information sources and datasets from across the NHS and local government to identify high-impact areas where system level focus could improve outcomes and performance
- atlas of variation - maps that place health economies into quintiles of performance for individual outcome and efficiency measures.

Reviewing service provision and identifying gaps or areas where change is needed

This stage involves:

- looking at outcomes from services – in other words, are services delivering what they should?
- reviewing the latest guidance and assessing its impact – for example, from NICE
- analysing feedback from service users
- being aware of any guidance or recommendations that inspectors or regulators have issued – for example, CQC
- using the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) – both led by the HWB established by the local authority (see chapter 8).

Deciding priorities

This involves commissioners taking decisions within their ICSs about exactly how to spend the limited pot of money that they have available. Inevitably, not all needs can be met and so relative priorities must be established in a logical and objective way. Commissioners need to link these decisions to national priorities, performance targets (national and local), business rules (how providers of NHS services are reimbursed) as well as their overall objectives, plans and budgets. They must also take account of patient choice and the views of the local community and other partners. Another consideration is the need for openness and transparency in the approach to deciding priorities so that everyone can understand why decisions are made and see that the approach is objective and impartial.

Procurement

Once planning has been carried out, the next stage is for commissioners to contract for the services that are required whilst bearing in mind the need to provide for both competition and patient choice. This may involve a procurement exercise that will take into consideration those services already provided and the underlying relationship with service providers themselves.

Designing services

The first step in this process is to ensure that the way services are designed is in line with the agreed priorities. This may involve reshaping the way things are delivered in consultation with ICS partners, GP practices and other providers. This is where NHS England and NHS Improvement's commissioning guidelines and model care pathways fit in.

Shaping the structure of supply

Once commissioners are clear about what it is they want to buy they need to make sure this is specified clearly so that service providers know exactly what they are expected to deliver. In some instances, commissioners may also need to encourage changes in provision to meet the requirements of their population – for example, so that services are provided closer to home or in different ways or to fill gaps in the range of services available. This involves working with ICS partners, local authorities and potential service providers to:

- develop service specifications
- understand any barriers that might prevent potential providers from coming forward and (in some cases and where it is appropriate) addressing them
- identify incentives that could stimulate supply – for example, using multi-year contracts that recognise that the level of work will increase gradually, or that service changes will be incremental or staged.

Managing demand whilst ensuring appropriate access to care

Managing demand is one of the trickiest aspects of commissioning as the care and services that patients need during the year must be matched with contracts that are agreed in advance, available capacity and financial resources. Effective demand management is therefore inextricably linked to shaping the supply of services and ensuring that the services that are available are clinically appropriate. It also involves reducing clinical variation in referrals made by GPs and in consultants' clinical practice.

Patient activity tends to be classified in two main ways – non-elective and elective:

- non-elective activity is the consequence of individuals feeling unwell, becoming unwell or having accidents and may occur as patient attendance at GP practices, urgent care centres or accident and emergency departments, either self-presenting or conveyed via the ambulance service. Patients may subsequently require admission to secondary or tertiary care for further investigation or treatment. Generally speaking, non-elective activity has to be dealt with at the time of presentation and is inherently unpredictable
- as the name suggests, elective or planned care consists of interventions or interactions that are known about and planned in advance. At primary care level this may be through regular appointments, follow ups or health checks. In relation to community and outpatient services it consists of booked appointments, while at secondary and acute care it will be planned admissions for procedures or investigations. NHS providers plan elective care in conjunction

with assessments of their capacity but this can be affected by increases in non-elective patient activity which reduces overall system capacity.

In practical terms, managing demand means that commissioners must:

- have access to reliable, timely activity monitoring information – for example, in relation to referral patterns
- anticipate in-year changes – for example in screening programmes, care pathways, new providers, NICE guidance
- have activity management plans in place
- identify and follow best practice
- ensure that enough resources are devoted to health promotion and education, preventative measures and communication
- have effective communication plans in place – for example, the use of social media to encourage patients to access the appropriate part of the healthcare system
- be prepared to review services for effectiveness and value for money, and restrict access to or decommission services that give less benefit.

Increasingly, commissioners also look beyond the costs of individual treatments that may be needed during a year to consider the likely total cost of patient care across several years (this may include social care costs). There are a number of tools and techniques that commissioners can use to 'join up' information so that they can assess future demand in this way – for example:

- risk stratification – to identify patients with long term conditions who may need closer management or those who use hospital services regularly and are more likely to have re-admissions
- predictive modelling – by identifying the probability of future events affecting groups of patients, interventions can be planned and executed.

Contracting

Contracting is a key stage in any procurement process but, unlike other sectors of the economy, the NHS uses a standard contract[228] for the commissioning of all NHS clinical services (except primary care[229]). This contract can be adapted to suit a broad range of services and delivery models – in other words the standard contract provides a framework that can then be added to locally.

The healthcare services that are covered by the contract may be provided by NHS or other public or private sector providers (i.e. by 'any qualified provider'). Contracts should be signed before the start of the financial year with any disputes resolved swiftly. Contracts have traditionally taken a variety of forms, from 'block[230]' to 'cost per case'. In the longer term, block arrangements are generally constrained by capacity, whilst cost per case arrangements can flex to meet demand. In the short term, both will be constrained by capacity to meet the expected levels of activity. Commissioners must enforce the standard terms of the contract.

The Covid-19 pandemic meant that all contracts were moved onto a block payment basis, as activity levels were dramatically affected. These arrangements remained in place until March 2022. From 1 April 2022, the majority of contracts moved on to an aligned payment and incentive approach. This

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[228] NHS, *2021/22 NHS Standard Contract*, May 2021

[229] The standard contract is not used for primary care services provided by GPs, dentists, opticians and community pharmacists – these are governed by separate contracts and form part of NHS England and NHS Improvement's direct commissioning activities – see chapters 4 and 6 for more details.

[230] Largely based on historical patterns of care, a block contract allows a healthcare provider to receive a 'lump sum' payment to provide a service irrespective of the number of patients treated or the type of treatment provided.

model consists of a fixed payment that covers the majority of activity, with a variable element to incentivise particular policy priorities.

See chapter 19 for more about how NHS services are paid for.

NHS England and NHS Improvement is responsible for reviewing and updating the standard contract documentation. Details are available on its website.

In letting contracts, commissioners must also consider how and when to introduce competition to improve services. To help commissioners in this area NHS England and NHS Improvement have developed choice and competition guidance[231].

It is recognised that competition does not support the collaborative approach of ICSs. NHS England and NHS Improvement have consulted on changes to procurement rules[232,233] to reduce unnecessary competitive tenders and support the development of partnerships.

The role of GPs

With their detailed knowledge of patients' needs, GPs are at the forefront of demand management, specifying services and developing new care pathways. They can also influence how their patients behave – for example, by encouraging self-care and preventative measures and by educating them about which services should be accessed when (for example, when to use pharmacy services rather than minor injuries units). This can help reduce the number of referrals and improve the overall quality of patient care.

However, GPs also need to be mindful of actual and potential conflicts of interest. There are two central issues here: individual commissioning decisions taken by GPs and commissioning decisions taken by the CCG and wider ICS.

It is important to promote the choices open to patients, particularly if the GP is also a service provider. For example, the GP may be part of a consortium that operates a private clinic to which patients could be referred. It would therefore be appropriate for a patient to be made aware of these facts so that they can take this into consideration when making a decision about their treatment or care.

On a larger scale, there is the potential for conflicts of interest to arise in commissioning decisions taken by CCGs and ICSs – for example, in relation to service reconfiguration. This can be particularly challenging when redesigning local services where those who provide the services may also be involved in the decision making around what is needed.

Managing and monitoring

Ensuring effective clinical decision-making

Although contracts are agreed by NHS England and NHS Improvement or CCGs, each referral that a primary care clinician (usually a GP) makes is effectively a mini commissioning decision that commits money. Ideally, those making these decisions need to:

- recognise the broader context
- be aware of service options
- be able to justify their decisions

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231 Monitor, *Procurement, choice and competition in the NHS*, May 2014
232 NHS, *NHS provider selection regime: consultation on proposals,* February 2021
233 Department of Health and Social Care, *Provider selection regime: supplementary consultation on the detail of proposals for regulations,* February 2022

- accept peer review of performance
- understand the implications of their decisions.

In reality, most clinicians will make a decision based on their clinical judgement and the needs of the patient. The CCG therefore plays an important role in providing clear thresholds and pathways to enable the GP to refer patients into the right service, once the level of need is established.

Managing performance

Commissioners need to ensure that the services they have bought are delivered in line with the specifications they set out in their contracts in terms of quality, quantity, and price. They must also review performance in relation to:

- achieving national standards
- quality – the NHS standard contract between commissioners and providers allows for a proportion of providers' income to be conditional on quality, innovation and the achievement of local quality improvement goals
- never events – there is a national set of 'never events'234 that must be included as part of contract agreements with providers. Any such events must be reported to the CQC via the national reporting and learning system235 as well as to the relevant commissioner. Examples include wrong site surgery; retained instrument post operation; wrong route of administration of medication and a patient falling from a poorly restricted window
- key performance indicators – regular review of performance against national and local key performance indicators (for example, the time taken from referral to the commencement of treatment) helps to keep service delivery on track and identify potential issues for greater focus
- outcomes – the achievement of defined outcomes for patients are closely monitored. For example, review time against minimum cluster review periods for mental health patients
- activity management – for example, analysing referrals to providers or agreeing an extension to a provider's waiting list to keep activity within the agreed contract.

Undertaking patient and public feedback

Every CCG has a duty to prepare an operational plan before the start of each year that shows how it intends to use its budget and improve outcomes for patients. These plans are prepared with ICS partners to ensure consistency across all organisations in terms of priorities and assumed activity levels. As mentioned earlier, these plans are discussed with the relevant HWB to ensure that they reflect the JSNA and JHWS. CCGs (and NHS England and NHS Improvement) are also under a duty to ensure that people who receive services 'are involved in its planning and development, and to promote and extend public and patient involvement and choice.' This means making use of patient satisfaction surveys and using these to inform the next commissioning round. To ensure that this information is available, the requirement for patient feedback is often built into service specifications.

16.4 Effective commissioning

To be effective commissioners need to:

- have the necessary skills and experience (either themselves or via commissioning support units/ services – see chapter 4)
- engage with a broad range of clinicians

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234 NHS England, *Revised never events policy framework*, March 2015
235 NHS Improvement, *NRLS reporting,* accessed April 2022

- improve community engagement
- ensure choice for patients.

They must also have access to information and skills that will support their decisions. To help them in this area, a national information system known as the 'secondary uses service' (SUS)[236] collects patient level activity information from providers and makes anonymised data available to commissioners.

Other important sources of information include:

- population risk assessments
- referral patterns – CCGs monitor variations in referrals and query referral practice where appropriate
- details of past spending patterns and how this compares (for example, with other GP practices)
- information to monitor actual activity against plans and expenditure against budgets
- additional data made available by service providers.

These other sources of information are particularly important as CCGs do not have access to identifiable patient data: whilst ensuring patient confidentiality this means that understanding pathways and individuals' use of different services can be challenging. This situation is exacerbated when working with other public services such as local authorities.

16.5 Who are the commissioners in the NHS and how do they approach their responsibilities?

The *Health and Social Care Act 2012* led to the creation of NHS England (now operating as NHS England and NHS Improvement) and GP led clinical commissioning groups (CCGs) both with a role in commissioning services for patients. The creation of CCGs placed primary care clinicians at the heart of the commissioning process – they are fully accountable for managing the funding they receive from NHS England and NHS Improvement and negotiating contracts with providers of services. NHS England and NHS Improvement also directly commissions some services itself and others jointly with CCGs.

Local authorities are also involved as they are responsible for health improvement and public health spending and are parties to pooled budgets[237] with CCGs. These organisations' structures, accountabilities and roles are described in chapters 4, 5 and 8 but it is worth noting here that they can use a number of different approaches – for example:

- NHS England and NHS Improvement commissions some services – see chapter 4
- CCGs commission services themselves – see chapter 5
- where it makes sense for the health economy as whole (for example, to achieve economies of scale), CCGs may work together collaboratively. This may mean using a lead commissioner approach where a single contract is negotiated by the lead commissioner with the local service provider and is managed across all member CCGs. NHS England and NHS Improvement has produced a model collaborative commissioning agreement for CCGs to use when working together in this way
- partnership working with local authorities. Since April 2013, local authorities have been responsible for public health activities and lead on health improvement and reducing health

[236] NHS Digital, *Secondary uses service (SUS)*, 2021

[237] A type of partnership arrangement where NHS organisations and local authorities contribute an agreed level of resource into a single pot that is then used to commission or deliver health and social care services.

inequalities. They also jointly commission some services with CCGs through pooled budgets (see chapter 8).

The *Health and Care Act 2022*[238] will establish integrated care boards (ICBs) and abolish clinical commissioning groups (CCGs). The functions, staff, assets and liabilities of CCGs will be transferred to ICBs. However, there will be a greater emphasis on collaboration, with the ICB becoming the statutory commissioning body within an ICS.

Key learning points

- Commissioners negotiate agreements with service providers to meet the health needs of their population
- The aim is to improve health outcomes, reduce health inequalities, improve provider quality and increase productivity
- Commissioners have to make tough choices as demand for healthcare services always exceeds the level of funds available
- Commissioning is a continuous process with many different elements grouped under three phases – planning, procurement and managing/ monitoring
- A standard NHS contract is used by commissioners for all providers of secondary and community services
- Commissioners must ensure national standards (for example, as set out in the NHS Constitution) are met by providers
- Contracts allow for a proportion of providers' income to depend on quality
- 'Never events' must be included as part of the contract agreements. When they occur they must be reported to the Care Quality Commission
- The key players in the commissioning field are currently NHS England and NHS Improvement, CCGs and local authorities.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects, including a section dedicated to commissioning. It also highlights e-learning courses that are available. The directory of resources can be found here.

[238] UK Parliament, *Health and Care Bill*, July 2021 – the Act was not available to reference at time of publication