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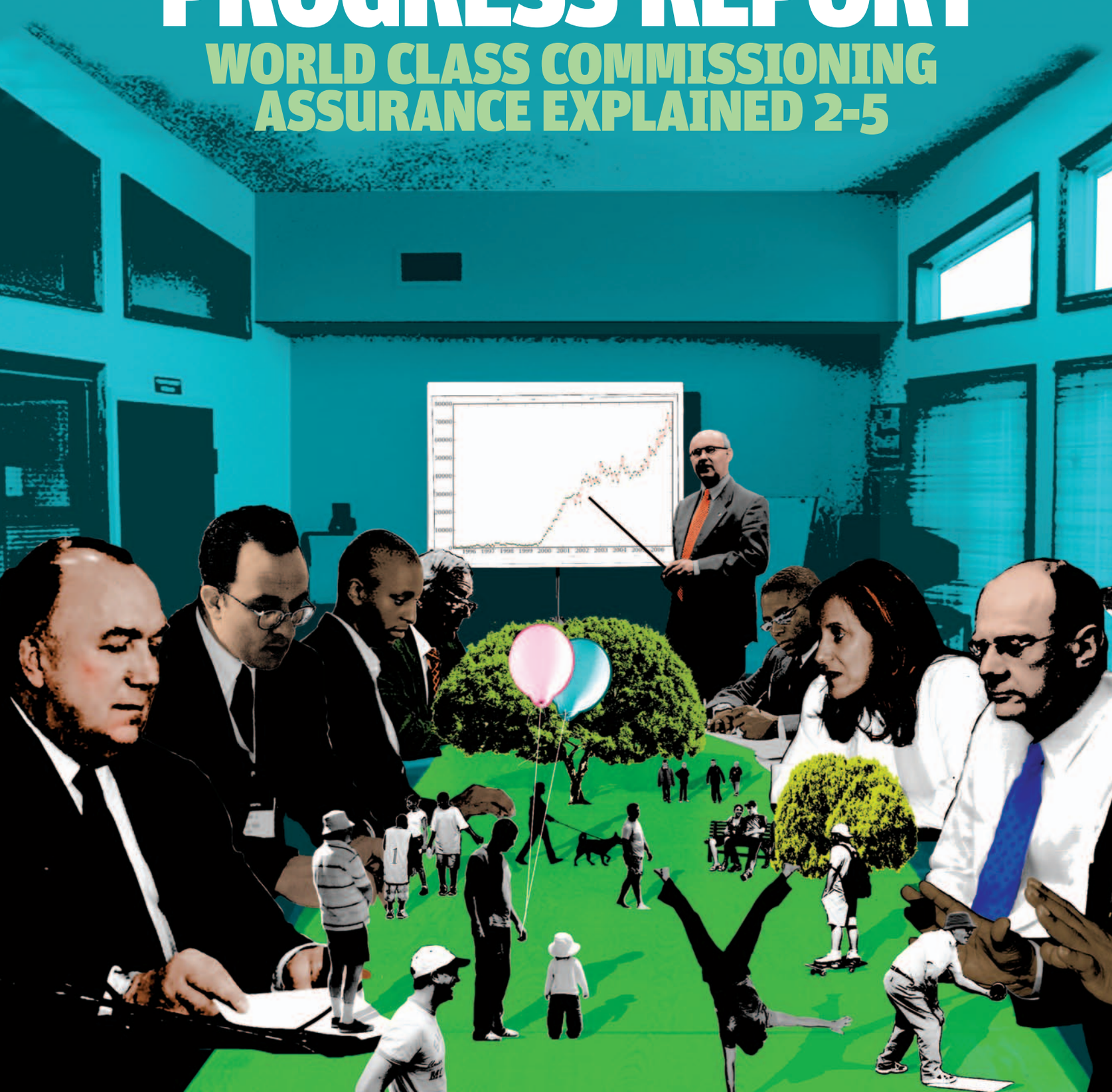
PROGRESS REPORT

WORLD CLASS COMMISSIONING ASSURANCE EXPLAINED 2-5



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COMMENT

We will put PCTs on top of the world

In December 2007, the Department of Health and the NHS launched the vision for world class commissioning.

Six months on the programme is progressing at pace. This month we saw the launch of a key element of the programme – a nationally consistent commissioning assurance system (page 2).

Assurance will be managed by strategic health authorities and will measure performance in three central areas: health outcomes, competencies, and governance. Primary care trusts will be expected to have completed the first cycle of the assurance by March 2009.

Assurance will be of absolute importance to driving performance, as will recognising and rewarding commissioners as they progress. But I must stress that world class commissioning is not an end in itself: commissioners will need to demonstrate better outcomes for the people and communities they serve.

In addition to assurance, commissioners will need a range of support and development tools and resources to become world class (page 8). Although pockets of excellence already exist, we need to ensure commissioners develop a world class approach in everything they do. Commissioners will need a high level of technical and managerial skill in areas such as leadership, engagement, knowledge management and strategic planning.

'World class commissioning is one of the most important keys to unlocking so many of our policy aspirations'

They will also need outstanding negotiating, contracting, financial and performance management skills.

SHAs will take overall responsibility for support and development, and will work in partnership with PCTs. Although most support and development will be managed locally, there may be some areas that would benefit from a nationally consistent approach. One such area is the national PCT support programme on board development.

By delivering a more strategic, long term and outcome focused approach we will radically transform the commissioning landscape and deliver an NHS which is equipped to address the main challenges of the 21st century.

As main commissioning organisations, it is PCTs, supported by SHAs, that will lead the work on delivering world class commissioning in a way that ensures the needs and priorities of the population are met. This cannot be done by working in isolation and we want to see commissioners engaging with communities (page 1). PCTs will need to work with patients, the public, local authorities, clinicians and providers.

Clinical engagement is critical to success and practice based commissioning in particular remains at the heart of world class commissioning, with practice based commissioners playing a major role, for example, in shaping clinical outcomes and driving innovation in service provision (page 6).

World class commissioning also has implications on the joint commissioning approach between PCTs and local authorities (page 9). It is essential that they work closely to decide in which areas joint work will deliver the greatest impact.

World class commissioning is one of the most important keys to unlocking so many of our policy aspirations: tackling health inequalities, shaping a service focused more on investing in health and well-being, and joining up health and social care to improve services, in particular for those with long term conditions.

With the NHS back in financial balance, we are now in a stronger position than ever to directly impact on people's health by commissioning services in new and innovative ways. Through world class commissioning we will drive unprecedented improvements in patient outcomes and ensure the NHS remains one of the most high performing health systems in the world.

Finally, the next stage review will give us an opportunity to look at a freedom and failure regime for PCTs which will be linked to world class commissioning. ●

Mark Britnell is NHS director general for commissioning and system management.

GUZELIAN

PUBLIC ENGAGEMENT

DON'T KNOCK IT

Engaging patients and the public has long been policy mantra. Now legislation is making it a reality

The Department of Health world class commissioning team's motto of "adding life to years and years to life" clearly signals its belief that without knowing patients' and the public's needs, how can commissioners and providers meet them?

Engaging the public in healthcare has long been a policy mantra but changing organisational forms has not always helped its development into the mainstream. The activist community health councils were replaced by patient and public involvement forums and the Commission for Public and Patient Involvement in Health. These, in turn, were replaced this year by the new local involvement networks.

The statutory duty to consult patients and the public regarding any major service change was legally enshrined in Section 11 of the 2003 Health And Social Care Act. This was the basis of the legal challenge to the decision in Derbyshire to award a tender for GP service provision to UnitedHealth Europe. More recently, legislation has required PCTs to work with local government in assessing population service needs. So not only has engaging the public become the correct way to commission the services they want and need, it is a legal duty for PCT commissioners.

DH patient and public affairs director Joan Saddler says Lord Darzi's next stage review has "identified four key areas – a fair, personalised, effective, and safe service".

She explains: "Patient and public involvement fits with each of those. It is not just about one-off consultations of patients, public and staff, but about using these processes across the cycle of commissioning from planning and designing services to monitoring them.

"It also depends on two things: first, is there an intention – a driver – within the local system that makes PPI a 'must do'? Second, have we got our organisation into a fit state of innovation and drive for excellence to push this through?" Her advice is to "be clear about your intentions, ensure you have the will to make PPI and staff engagement real, and ensure clarity over how you engage people."

At NHS West Midlands, programme specialist for consultation Julia Holding says that public and patient engagement is now part of the mainstream: "I've been working in this area for many years, and it feels that a long period of work has finally come to fruition." But she adds: "There's still some way to go before we get PPI fixed in the NHS psyche."

Why does she think PPI is different this time? Ms Holding quotes NHS chief executive David Nicholson's comment about "hitting targets but missing the point", adding: "It's not just about lining up numbers and throughput; what we must do using PPI is improve quality and care."

Ms Holding argues that the change in commissioning is cultural in nature: "It's not just about the health needs assessment that's fundamental to commissioning, although there are still aspects of data gathering at which we must get better. We need to engage more with the public and patients and get more feedback.

"We have to do these things in different ways. We're getting good at bits of this (data capture, service use and demographics) – but it still feels done to people, not with them. The next bit is about bridging that gap and bringing patients and the public and providers and commissioners closer together. It's not only about data, but about different sorts of intelligence – to help us really understand our population and their needs.

Ms Holding's dictum is that "world class commissioning of healthcare is basically like buying anything for somebody: you wouldn't do it without knowing a) their needs, b) their preference and c) the budget". ●

ALAMY

ASSURE THING

How can PCTs be sure they are on the right path to world class commissioning? We look at the quality assurance system developed by the Department of Health to help clinicians and managers achieve their targets

Nobody pretends that, overall, the English NHS is starting from a point of world class commissioning.

There are good bits and pieces in progress around the country, already making a difference to frontline services. But the route to world class commissioning needs a map, signposts and milestones. The Department of Health's world class commissioning team, working closely with the NHS, has developed an assurance system that can help clinicians and managers along this journey.

Sceptics have voiced concerns about the phrase "world class", fearing that it may lead critics to discuss the gap between world class rhetoric and present reality. But what should be the NHS's goal? "mediocre commissioning"? "faking it" commissioning?

There has been little, if any, serious challenge to the various elements that underpin commissioning – improving health outcomes, maximising practical use of data, assessing variations in clinical practice, and making finite NHS resources go further and do more.

The NHS needs to know how it is progressing. Echoing many key elements of the past decade's reforms, a quality assurance system has been developed with frontline staff, to help PCTs assess and understand their progress.

Just as care quality has the Healthcare Commission and foundation trusts have Monitor, the DH team has field-tested its newly launched world class commissioning assurance system to help PCTs assess their development, and understand what further steps they can take.

World class commissioning assurance is a national system for the English NHS, managed by strategic health authorities. Its core aim is a consistent system (manageable within an annual cycle) to help PCTs design, deliver and support world class commissioning.

Support and development – described on page 8 – is an important underpinning of the new assurance system. It is not "just another test", but a process in PCTs' own developmental interests.

The system will measure performance in three areas: health outcomes, competencies, and governance. For outcome measures, each PCT will select up to eight local indicators that are consistent with their strategic objectives. Data for these indicators will be used to produce a scorecard, which displays PCT outcomes in comparison with the national average and upper quartile for the NHS.

Outcomes can be defined as long term strategic objectives, referring to changes in population health which can rarely be made quickly. The options for outcomes will be based on the vital signs indicator set, which was published on the DH website in January.

Positive response

The core components of the assurance system were designed and tested with the PCTs in the NHS North West region (see box, page 5). Reflections on the test were generally positive, and participating PCTs reported having found the panel day constructive, positively challenging and valuable. Participants particularly welcomed the inclusion of health outcomes, which was seen to support the strategic shift in commissioning focus towards delivering long-term, improved health outcomes.

Kate Dixon, who leads on the world class commissioning assurance system for the DH world class commissioning team, emphasised that the NHS North West PCTs that trialled the assurance system "found the assurance process – particularly the external review panel – a challenging, but very positive developmental process".

"The credibility and quality of the five people who made up the NHS North West panel was essential: participants felt that the quality and balance of skills on the review panel made the assurance process work overall," Ms Dixon says.

So assurance will not be "done to" PCTs: they will collect data to support the assurance process themselves.

The assurance process at each PCT will culminate in an assurance panel review day,

'Participants felt that the quality and balance of skills on the review panel made the assurance process work'

TOBIAS HICKEY

where the review panel (chaired by an SHA director) uses structured interviews to make its assessment of the PCT's capabilities and offer feedback on areas for future development. These will take place in November and December this year.

These elements will then be summarised in a written report for the PCT, benchmarking them against their colleagues in the SHA and nationally. Current thinking is that the overall findings will not be publicised nationally in the first year of the system's operation (2008-09), but will be made publicly available in future years.

SHAs will implement the system in all PCTs by March 2009. A contract for consultancy to support this work has been awarded to a consortium of Ernst and Young, Kaiser Permanente, Humana, Dr Foster and Mental Health Strategies, led by McKinsey.

Measuring commissioning competencies

The world class commissioning assurance system has developed a range of measures for each of the competencies. World class commissioners will:

- locally lead the NHS;
- work with community partners;
- engage with public and patients;
- collaborate with clinicians;
- manage knowledge and assess needs;
- pioritise investment;
- stimulate the market;
- promote improvement and innovation;
- secure procurement skills;
- manage the local health system;
- make sound financial investments.

Each competency will be assessed on a combination of self-assessment, evidence and 360-degree feedback. Based on these assessments, the PCTs will be rated on levels 1-4 (where level 4 is world class). It is expected that most PCTs will be at level 1 or 2 this year. The ➔4

‘Each PCT’s potential for improvement would be very different. One size will not fit all’

3← governance element of the system focuses on whether the PCT board has taken ownership of commissioning. It examines whether the board has a meaningful strategic plan for commissioning, supported by a robust financial plan.

Assessment of board-level governance covers all the PCT’s plans: strategic, long-term financial, annual operating, and organisation development plans, and board controls and processes. Each will be rated red (least good), amber (warning) or green (best).

The governance element draws on best practice from other approaches, in particular foundation trust regulator Monitor. The PCT board controls section also reflects assurance of the PCT’s organisational capability, including ensuring information management and innovation.

The assurance programme also considers the organisation’s potential for improvement. This is provided by the review panel, included in the final written report for each PCT. Ms Dixon notes: “This is a descriptive commentary – a snapshot of where the organisation is at the time of assessment. It’s vital for SHAs to remember that they could get a similar sort of view from two very different PCTs: one could have innate strengths, but could still improve commissioning much further, whereas the other PCT may have made huge strides to get to a similar point, and might struggle to get much further on its own.

“Each PCT’s potential for improvement would be very different, as could the likelihood

WORLD CLASS QUESTIONS

Gary Belfield, DH director of commissioning, answers *HSJ* readers’ questions on the new world class commissioning assurance system.

Will this new process mean more paperwork? Isn’t it just another target in disguise?
The assurance system won’t require extensive data collection, and uses documents the PCT will already have (for example their strategic plan for commissioning) as well as underpinning plans for delivery. PCTs will spend time on self-assessment and the ratings part of the panel review day. These will focus on supporting the PCT to reflect on its commissioning strengths and areas for development.

Will league tables be published as a result of the assurance system?
In the first year (2008-09), no formal ratings will be published at a national level. The results of the assurance system will form part of a conversation between PCTs and SHAs about developing commissioning capability. From 2009-10, ratings on outcomes, competencies and governance will be published.

How will commissioners and providers be assessed on their ability to work together and with wider stakeholders to achieve world class commissioning, especially where joint commissioning has been encouraged for a long time – for example, in mental health?
Commissioners need to operate as learning organisations, seeking and sharing knowledge and skills. The first four of the 11 organisational competencies that lead towards world class commissioning are about working together, with the PCT taking a leadership and facilitation role in strategic planning.

What additional data must I collect and interpret to enable world class commissioning to be successful in the PCT?
Competency 5 stresses the importance of data management and analysis, and all PCTs and SHAs will be provided with SHA-specific benchmarking documents to provide trend and comparison data for every PCT.

The data packs use national data sets, to which PCTs already have access, and will be accessible to PCTs and SHAs as part of an electronic toolkit to support commissioners with implementing the assurance system and helping them move towards world class.

The packs will analyse data for this year and provide a foundation for commissioners to understand health needs. With this experience, by next year commissioners will know whether there are any gaps in the data and so whether any more data should be collected.

Is there any additional resource associated with the assurance system?
No, there will not be any new resources for PCTs. Commissioning is a PCT’s core business. By implementing world class commissioning, PCTs will ensure that health services are commissioned in the most effective way possible.

This will deliver better value and free additional resources to drive continuous improvement and additional investment in local health and care services.

How does the assurance system link to the operating framework and the vital signs?
The assurance system is focused on commissioning, and includes an assessment of whether locally prioritised outcomes are improving over time.

In the outcomes element of the system, PCTs choose up to 10 priority outcomes that reflect their strategic plan. These will have been agreed for the next five years with the PCT’s partners and population, and reflect population needs. Two of these are nationally consistent – life expectancy and health inequalities.

The remaining outcomes are locally chosen. They may be drawn from the vital signs, or they may differ, depending on the local circumstances. They must be supported by robust data to measure improvement.

The vital signs reflect a combination of outcomes, and interim milestones to deliver outcomes. They reflect the priorities set out in the annual operating framework for 2008-09. Performance against the vital signs is assessed in the assurance system under governance.

The greater emphasis in the assurance system is on the assessment and improvement towards longer term, locally determined outcomes.

Will there be an element of 360-degree appraisal, so that we can reflect on our level of support from the SHA?
The assurance system is for PCTs, and so includes feedback on how SHAs are included in the PCT’s commissioning function. It does not provide assurance of SHAs, and so will not include reflection by the PCT on the level of support from the SHA. The panel review day and follow-up with the SHA will provide the force for this discussion.

that they will get to world class. One size will not fit all."

Incentives and consequences

Just as the principle of "earned autonomy" led foundation trusts to the financial freedoms they now enjoy, the world class commissioning assurance system is considering appropriate incentives and consequences in three broad categories: reward, regulation and recognition.

PCTs performing at the top level of success will achieve status as a World Class PCT and a package of complementary incentives.

The 2008-09 operating framework set out the requirement for all PCTs to produce a strategic plan by the autumn. The governance element will include an assessment of whether PCTs have ownership of and developed a meaningful strategic plan for commissioning. The DH's world class commissioning team offers help in this process with guidance on strategic planning, including information on content and format.

The world class commissioning team (with Dr Foster, Mental Health Strategies and McKinsey) has prepared data packs for all SHAs and PCTs, to support their strategic planning processes. These packs include trend and comparison data for every PCT, and focus on the key areas of commissioning spend and outcome measures:

- health needs and mapping;
- outcomes and vital signs;
- programme budgeting;
- primary care;
- prescribing;
- elective care;
- non-elective care;
- mental health and learning disabilities;
- community services.

Developed with NHS South East Coast PCTs, these data packs are now available via the electronic toolkit, which SHAs, PCTs and panel members can access via the website.

Private prescription

So once a PCT's commissioning health status is diagnosed, will there be a mandate or pressure to use consultants from the private sector? Ms Dixon answers: "It will be up to PCTs, with their SHAs, to decide how to develop any capacity and capability gaps they find. We will describe development tools and resources. PCTs can address gaps through local knowledge sharing.

"PCTs will be able to club together and collaborate, like the West Midlands data warehouse. Or they can choose to learn and train individually – building internal capacity by sourcing training courses (for example, on needs analysis). Or they can buy specific support, either from suppliers on the framework for procuring external support for commissioners or from others. We're value-neutral on how they fill capacity and capability gaps."

SHAs will implement the assurance system, and Ms Dixon emphasises that the new requirements "will ask a lot" of them. For 2008-09, SHAs will be supported by teams from Ernst and Young and McKinsey.

In the next phase, the DH team will help SHAs develop their assurance and review their capacity and capability. SHAs can also take part in a simulation in July run by Humana, to support their learning and development of tailored approaches to different PCTs' circumstances.

The world class commissioning team (in partnership with the DH system management team) is developing an SHA diagnostic tool to focus on capacity and capability building. This will help SHAs identify areas to strengthen, so they can play a critical role in assurance. ●

➔ **www.dh.gov.uk/worldclasscommissioning**

ASSURANCE IN PRACTICE
THE ASSURANCE TRIAL IN THE NORTH WEST

Manchester PCT was one of five in NHS North West where the assurance system was trialled. Chief executive Laura Roberts confirms: "We found it really worthwhile. We'd have wanted to do it even if it weren't mandatory.

"It was an opportunity to look at our vital signs indicators, and choose which we should apply.

"Because our population has poor health outcomes, we could have chosen almost anything: this helped us to concentrate on where we could make the most difference quickly."

Manchester PCT was among those reconfigured 18 months ago, and Ms Roberts adds that the pilot "was a great opportunity to work as a team. It made us question: when we get into provision mode, do we adopt providers' problems rather than our commissioning role?"

Ms Roberts underlines the importance of the external assessors. "A high-quality panel is vital. We were very fortunate in that regard. One criticism of Fitness for Purpose [the 2006 PCT assessment programme] was the consistency of the assessors. This needs high-calibre assessors who understand your world."

What has Manchester PCT taken from the process? Ms Roberts concludes: "We approached assurance with a spirit of opportunity, and it gave us a chance to re-energise, re-commit, and focus our minds on a really good direction of travel."

NHS North West director of commissioning Joe Rafferty, who chaired the review panel, notes that his SHA "did not regard the assurance trial as 'Son of Fitness for Purpose' – which we'd actually found broadly positive. Our PCTs were up for trying it, having found Fitness for Purpose innovative and refreshing. We wanted to see the assurance framework as developmental, not as burdensome and threatening."

He adds: "I wanted to see how we could practically manage running this process across five of our 24 PCTs in one week. It proved arduous, but do-able. For most SHAs, it shouldn't be massively burdensome – London and ourselves have a big logistical challenge, with over 20 PCTs."

Mr Rafferty says that the review panel tried "to make it feel unlike heavy audit. The focus was on what PCTs were trying to achieve with commissioning.

"It felt positive and encouraging, rather than inspectorial."

He also warns that one problem with assurance systems "is that people get good at jumping the hurdles, when we need to be running the race and looking to the finishing line of a world class system".

PCTs should look for the positives, to create a "dynamo for change" effect, he concludes.

'We wanted to see the assurance framework as developmental, not as burdensome'

PRACTICE BASED COMMISSIONING

Practice clinicians are being seen as the linchpins of future local procurement of quality care services

A WELL O

Practice based commissioning is at the heart of world class commissioning of health and care services. The rationale is that commissioning is at its most effective when it is the product of a strong partnership between primary care trusts and clinicians, who are best placed to know about quality and the needs of their communities.

Practice based commissioning provides the means for PCTs to work closely with local clinicians to draw up strategic plans, design and commission services that build on the current clinical evidence base, maximise local care pathways, and use resources effectively. The message is that it is here to stay.

Both NHS chief executive David Nicholson and Department of Health director general of commissioning and system management Mark Britnell emphasise its importance. Mr Britnell has stressed it "will play a key role when it comes to defining clinical outcomes, assessing provider performance and, in some cases, delivering personalised local services".

Practice based commissioning has had a slow start, as the relevant consortia and groups have been learning, growing and in some cases merging. Results from recent surveys indicate much willingness among GPs; but more local support arrangements are wanted.

Reorganisations and a subsequent year of instability in the NHS hampered the growth of relationships and trust between practice based commissioners and PCTs. Now the dust has settled, it is surely time for PCTs and GP commissioners to look to the future. Where PBC is working well and producing genuine changes in services and behaviour, there are lessons to learn and foundations on which to build.

Clinical engagement

Leodis Healthcare is a practice based commissioning co-operative in Leeds, owned by its 30-practice membership of 126 GPs. Leodis covers a listed population base of just over 203,000 patients. It enjoys good relationships with Leeds PCT, and both chair Andy Harris and chief executive Chris Reid agree that their success rests on strong clinical engagement.

Dr Harris says: "From a PBC perspective, what makes Leodis work is membership and practice engagement – members must feel ownership and direct input.

"You need a robust governance structure, but also to ensure that GP members feel ownership of the governance arrangements. You do also need a subtle change in the GP mindset – people can retain their local practice's individuality, but must learn more corporate ways, especially about managing the commissioning budget on a group basis with a strategic view".

Dr Harris adds that this also has the beneficial effect of demonstrating "to the PCT that PBC can be effective – early on, we were able to change things in a very quick way".

None of this happens without PCT support, as Mr Reid emphasises: "This involves key people in the PCT executive team. Matt Walsh is the director of commissioning at Leeds PCT, and he's been key in acting as co-ordinator with other PCT executives, getting them to see the benefits."

Dr Harris adds: "That's not simply support as in 'good idea', but about meeting the real need for clinical and managerial support in PBC groups – PBC can't work without that. We have an ongoing conversation with our PCT about managerial support."

Dr Harris confirms this conversation is about resource, but adds it's "also about the PCT's capacity and technical expertise". Have they looked to the framework for procuring external support for commissioners for technical help? "We have looked, but we're going forward with our PCT to help identify areas where support is needed".

Mr Reid adds: "One example where we agreed with the PCT that locally we lack skills is developing predictive modelling tools and practice based disease registers to help manage long-term conditions. Another crucial area is public health, and we enjoy good arrangements with the PCT public health team to give us vital information to target preventive work."

Dr Harris explains they are working across a range of clinical areas where they have agreed

DILED MACHINE

business cases with the PCT to deliver dermatology using GP premises, ear, nose and throat services and enhanced services for residential and nursing home patients. "There's a city-wide evidence based diabetes care pathway which has been around for some time, and we acted as a catalyst to allow it to be effective," he explains. "It's level 3 clinical care [low complexity, traditionally delivered in acute settings], which we've taken on. One of our key

'The PCT produced a paper on earned autonomy, recognising that some groups are more mature than others'

themes is to identify level 3 low-complexity care that we can provide closer to home such as diabetes, ENT and dermatology."

Leeds PCT has been non-prescriptive, Dr Reid says: "In allowing PBC groups to storm off on our own. We moved from about 10 initial groups, and now we're at the final stages of 'storming and forming', with three to four PBC groups in total.

"The PCT also recognises the different ambition and sophistication in PBC groups, and gives different levels of funding for the different levels of strategy. The PCT is also keen on the next stage of the process, whereby PBC groups reaching development and maturity can make decisions about how to work."

He adds: "The PCT produced a paper on earned autonomy, recognising that some groups are more mature than others. It looks at how to give Leodis and other mature PBC organisations more autonomy."

Dr Harris says that the key link between practice based commissioning and world class commissioning is "for PCTs to work hand in hand with PBC groups". Mr Reid adds: "It's got to be clinically led. We hope that the Darzi review will further PBC opportunities to move forward and develop new care models."

Formal support

Developing the right governance framework will be critical. PBC consortia and groups cannot develop unless there is formal managerial and financial support.

PCTs are responsible for providing proper management support and funding for practices to deliver their commissioning activities. However, this has not got as far as practices and top policy makers would like. A 2007 survey by the King's Fund and NHS Alliance revealed that the data being provided for practice based commissioning was not always as good as it could be. Reports from the Audit Commission and others have echoed this point.

NHS Alliance chair Michael Dixon is a GP adviser to the Darzi strategy review. He says PBC "is not just about the right data; it's about the right data in usable form so you can change behaviour in referrals and use of diagnostics, and check that you've got what you paid for".

PCTs will be held to account through the world class commissioning assurance system for the quality of their support and the effectiveness of their partnerships with practice based commissioners. The levers and incentives are being lined up, and local clinicians have a chance to see what could be achieved.

The traditional partnership model has produced the responsive, well-loved general practice we know and love. However, that very partnership can be inward-looking, replicating what has been delivered in the past, while lifestyles and patterns of ill-health move on. If practice based commissioning is delivered in an inter-related manner between practices and clinicians, commissioning localities and PCTs can deliver high-quality responsive care and release resources from traditional hospital services.

Its proponents believe that practice based commissioning represents an enormous opportunity for frontline clinicians to make local health services more responsive and to improve the use of taxpayers' money. What's not to like? ●

ALAMY

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SUPPORT

EASY RIDERS

Primary care trusts will be able to call on a rich network to help find their way with world class commissioning

The Department of Health's world class commissioning team says it aims to help primary care trusts find the way, not hog the driving seat. "Ensuring that PCTs have the support that they need to improve is not the responsibility of any one organisation," says Sarah Walter from the team.

"Development may be self-managed by PCTs, directed by strategic health authorities or led by the DH, where it makes sense to do things at a national level," she says. "For example, we are working on a national board development programme. The most important thing won't be where support comes from, but to ensure that PCTs understand what their development gaps are, and have access to high-quality tools and resources to help them improve."

Commissioning support can also be found in existing structures in and around the NHS. West Kent PCT chief executive Steve Phoenix emphasises there is also the "self-help" option for PCTs. Mr Phoenix has been leading work for South Coast SHA on creating programmes for PCTs to help themselves and each other. He suggests PCTs can operate at three levels. Nationally, "many PCTs already work collaboratively on new development programmes, designed to support boards in readiness for change. This is part of what [NHS chief executive] David Nicholson calls the 'look out, not up' approach," says Mr Phoenix.

PCTs can also work regionally, as in West Kent. "We're close to agreement with Brighton and Sussex University medical school to run an MSc in health commissioning," he says. "By April 2009, we'll have a commissioning accelerated development programme, to fast-track middle managers in clinical roles who want to become generalists, to tap into their wealth of frontline knowledge and expertise in areas like community services."

The third level is local. West Kent is creating a local, PCT-run commissioning graduate development programme which will be complementary to, but not part of, the national management trainee scheme.

NHS West Midlands commissioning director Eamonn Kelly is clear that since world class commissioning is about high-performing organisations, SHAs' performance management and capacity- and capability-building objectives give them a core role in helping PCTs develop.

Mr Kelly says: "Over the last 18 months, we've been supporting a range of relevant work through the Fitness for Purpose reviews and diagnostic process. We've been holding co-production workshops on PCT self-assessment, and identifying areas for collaboration (joint working, staff development, external support).

"Our emphasis on leadership development is essential. SHAs' workforce deanery responsibility is key to making this happen. Each regional director needs to provide professional leadership – it's not just down to the director of commissioning.

"SHAs need to offer their PCTs a blend of collaboration, support and challenge. Where organisations struggle, the SHA needs to be much more closely involved".

So how supported and developed are PCTs feeling? Birmingham East and North PCT chief executive Sophia Christie admits that, until recently, she and colleagues had concerns about a lack of investment and attention in a national programme of commissioning development, "so it's positive to see good progress on the assurance framework", she says. To succeed, she argues, PCT leaders will need "clear understanding on our core purpose over the next three to five years; how to deliver that; and what people, processes and measurement systems we need to deliver".

At a national level, activities under way include the design of a national board development programme and roll-out of the framework for procuring external support for commissioners.

Simon Morgan of the DH world class commissioning team says: "The framework is a tool in the toolbox: not the solution, but one of a number of choices around the 'share, learn or buy' options for PCTs. If people choose to buy, the framework provides a list of pre-qualified independent organisations offering a variety of support (contract management, health needs assessment, procurement, engagement). They can be selected by PCTs through a local mini-competition process, and we provide templated documents to help PCTs through that."

Sarah Walter concludes: "The development challenge for PCTs is significant. All parts of the system need to work together to ensure a range of available resources, from which PCTs can pick and choose according to their specific needs." ●

DUAL PURPOSE

Joint working between PCTs and local authorities means a two-pronged attack on health inequality

Better working with local government has been a policy aim for years: it was one of the drivers behind the 2006 primary care trust reorganisation. Since April this year, PCTs and local government must provide a joint strategic needs assessment.

Anita Marsland, executive director of health and social care for Knowsley council and chief executive of Knowsley PCT, says the PCT and council have worked together formally since 2002, using section 31 of the Health Act to form a partnership between council and PCT. "We recognised that to have an impact on health inequalities and quality of life, a range of council services had to be involved," she says.

"We've been able to pool resources since 2002, with joint appointments at various levels, but always kept a close eye on our mantra – single accountability to service users and patients, but dual governance arrangements," she explains.

'Our teams are co-located, so we hope users experience seamless service'
Anita Marsland

"All our teams of social workers, district nurses etc are co-located, so we hope users experience seamless service. We have no issues with continuing care, and don't have delayed discharges – in 2000-01, that was a problem.

"In social care, we were eighth worst in 2000," Ms Marsland adds. "For the last five years, we've been a three-star council, and the PCT side is better as well. Our biggest lesson was to integrate as many 'spine' services [finance, HR and resource functions] to be as efficient as possible."

Another joint appointment is Will Huxter, strategy and commissioning director for Islington housing and social services and Islington PCT. He says: "Joint working is the best way to address health inequalities and well-being. By agreeing what services we want to improve, the money arrangements fall out of those conversations, rather than starting off talking about who funds how much of what.

"We have jointly identified demographics and service changes. We think together about implementing and planning services like dementia care, work out the 'big stuff', and then approach pooling budgets."

Nigel Walker of the Department of Health's world class commissioning team says joined-up government is "essential to any success with the new agenda", but adds: "Local politics can get in the way, as can the government's arrangement for joint funding. Most local authorities don't enjoy giving up governance of money.

"How matters are configured can vary – some like Knowsley have completely integrated. Peterborough PCT merged its commissioning functions, and transferred all local governance commissioning staff into the PCT, in 2004-05".

Mr Walker concludes that "people need to agree where they should join up services and commissioning, and where they don't need to. And joining up requires investment – Luetz's five laws on joint working [see box] are relevant." ●

'We think about services, work out the big stuff, then approach pooling budgets'
Will Huxter

LUETZ'S FIVE LAWS ON JOINT WORKING

1st law
You can integrate some of the commissioning all of the time and all of the commissioning some of the time, but you can't integrate all of the commissioning all of the time

2nd law
Integration costs before it pays

3rd law
Your integration is my fragmentation

4th law
You can't integrate a square peg and a round hole

5th law
If you integrate, you call the tune

Adapted by Nigel Walker

Find out more

● Walter Luetz, 'Five laws for integrating medical and social services', *Milbank Quarterly* 1999.
● Nigel Walker, 'Joining the dots', *Journal of Care Services Management* 2008.