

COMMISSIONING

Different strokes for different folks

An alternative commissioning model could ensure NHS services are more effective, say Shahid Ali and Cameron Ward

Faced with challenges like an expanding older population, policy makers often choose to spend more or do less. But there is another way – to commission services differently.

This means commissioning services that are more patient centric, effective, better quality and that lead to the best possible outcomes.

The current restructuring of the NHS can enable this vision to be delivered at scale through the NHS Commissioning Board, clinical commissioning groups, commissioning support services, Public Health England, and health and wellbeing boards. However, a change in thinking around commissioning is vital for this vision to be realised.

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THE VIEWS OF A NEW GENERATION

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Realising that medical and dental trainees were being ignored in consultations, the North West Deanery canvassed all 4,000 of its trainees to discover their views. The results revealed anxiety about the impact on their patients as well as on their careers.

The commissioning cycle (Fig 1) has been used as a rational and systematic approach to macro-commissioning services for populations in an equitable way. Commissioning is understood as an all-inclusive process, and staff involved have clear roles.

However, this approach can be too bureaucratic when used for micro commissioning, and can also be insufficiently responsive for the implementation and testing of new ideas. Lengthy, staff intensive processes can stifle the innovation needed to enable transformation at practice, CCG and national level.

As CCGs develop, clinicians are increasingly leading the commissioning process and need to make quick, accurate decisions. At the same time, the number of commissioning staff is dwindling, making revisiting the commissioning cycle a matter of urgency. So what might clinical commissioning look like in CCGs?

CCGs should not be thought of as small primary care trusts, with similar structures and processes to PCTs. Apart from anything else, it is unlikely such structures will deliver the health improvements and outcomes we need.

Clinical leaders in CCGs must work as lean, strategic commissioning units with engaged practices, clinicians and

'The alternative commissioning process is quicker and less staff intensive'

populations. The aim is to bring about a radical shift from management-heavy bureaucratic processes to a more efficient and strategic commissioning process, supported by high-quality CSSs with the right mindset.

The Ali-Cameron model

An alternative commissioning model has been developed by the authors, which builds on how GPs naturally make clinical and business decisions. GPs tend to focus on the needs of the individual patient, managing risk and making quick and accurate decisions about, for example, referrals and prescribing. This is how they manage uncertainty effectively for their practice population. Alternative commissioning provides the opportunity to scale up this thinking to the level of the CCG population and across the NHS.

Guiding principles used when preparing the alternative commissioning model include:

- patient-centred care;
- innovation;
- use of existing best practice;

- quick decision making;
- light bureaucracy;
- rapid implementation;
- integrated care delivery.

Alternative commissioning follows a process more akin to practice decision making and is likely to resonate with clinical commissioners. The process is quicker, less staff intensive and encourages innovation. It allows CCGs to test new ideas and commission on a small scale. They can then use the commissioning cycle to scale up to regional and national levels.

To achieve these changes, CCGs will require support from their in-house services or the new CSSs, which need to be ready. The core services required from CSSs will be contract management, service change, finance and data analysis, performance management and relationship management, with other support services potentially subcontracted. This is intended to streamline the support process and assist with accelerated decision making.

Public health intelligence needs to be aligned with commissioning and business intelligence to enable CCGs to become "intelligent commissioners" of services. This requires a change in the mindset of managers forming the CSSs. They must align their outlook with the new commissioning processes so support is targeted appropriately and efficiently.

How the Ali-Cameron model works

The AC model enables clinical leaders to use their clinical and business acumen when commissioning for a broader population. The model can also be represented as an alternative commissioning micro-commissioning wheel (see figure, immediate right) to help understand the inter-relationship between micro- and macro-commissioning processes.

New information tools are needed to work differently and make a success of the process. Information must be presented to commissioners in a more intelligent, more meaningful way, rather than as a mass of data. Feedback from clinical leaders points to a significant need for commissioning intelligence requirements to be met through the whole of the commissioning process, from identifying health needs and prioritisation pathway redesign, to implementation and review.

Transformational change of this kind needs to take into account several factors including organisational capacity and stability, service redesign staffing quotas and impact on other services. The impact on other areas like secondary care must be considered carefully to ensure buy-in.

In this model, health needs assessments assume great importance to identify the health needs for that CCG. CCGs will commission a wide range of services for their population but alternative commissioning places emphasis on identifying priority areas where innovative services could bring about the biggest transformation.

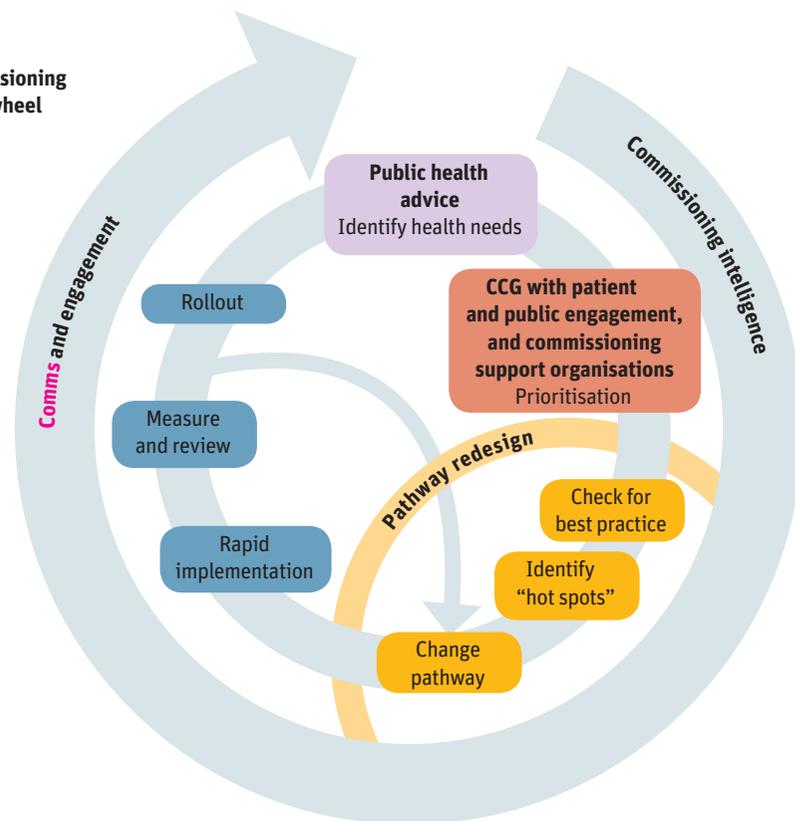
For example, the NHS currently spends 70 per cent of primary and acute care spend on managing long-term conditions; for most CCGs this is an important area from both a quality and efficiency viewpoint. Using alternative commissioning, the health needs of those with long-term conditions could form a long list; one or two specific areas could then be prioritised

COMMISSIONING CYCLE MODELS

Early working model of the commissioning cycle developed by the NHS Commissioning Board



The alternative commissioning micro-commissioning wheel



Conditions to determine a new approach to commissioning



Source: Virginia Mason Hospital, Seattle

‘Pathway redesign need not take long – an outline model and key quality outcomes could be done in one or two days’



An increasing ageing population can necessitate finding a different way of commissioning services

for innovative commissioning to improve quality of care, efficiency and outcomes.

At this point, a check could be made for existing best practice instead of trying to reinvent the wheel. Where there is no established best practice, the areas would be targeted for pathway redesign. This would mean identifying and confirming “hot spots” in the pathway, which, if altered, could transform the service. Expert change managers and stakeholders would work in a focused way to redesign the pathway.

Pathway redesign need not be a lengthy process – an outline model and key quality outcomes could be completed in one or two days. For long-term conditions, this process could involve a one day workshop for GPs, secondary care staff, other clinicians, the local authority, patients, CCG staff and CSS

staff. The workshop could consider the endpoint and the steps to achieve it. The focus would be on the clinical outcome and the experience of patients, not organisational impacts of changes in patient flow. More complex areas might need a second workshop.

It is important to agree what the ideal outcome is, and put plans in place to achieve it. For long-term conditions, this might mean a discussion on patient-centred care, care planning, telehealth and telemedicine. These discussions would need to consider the financial implications for all parties and the decommissioning of existing services. Having agreed an adjusted pathway, this would go through rapid implementation and testing, led by clinicians and supported by CSSs.

This part of the implementation requires a concerted effort from clinicians

and CSS managers to carry out implementation rapidly, and to ensure it is kept under review. Such review needs to produce timely results, using both patient satisfaction and clinical outcome measures. As long as the changes yield positive results, it could then be rolled out to more practices across the CCG and shared with neighbouring CCGs.

The AC model builds on the day to day behaviours of clinicians and should resonate with them. Working in this way could enable transformational change by micro-commissioning, which can be scaled up to the macro level using the commissioning cycle.

Microcommissioning in this way also enables decommissioning of poor quality services while improving efficiency in the system. However, the mindset of all those involved needs to change in order for this lean thinking to embed in the behaviours of managers working in CSSs or CCGs. Previous ways of working or behaviours often seen in PCTs need to change. The conditions required to determine the new approach are summarised in Fig 3; they require unrelenting maintenance.

Alternative commissioning aligns the thinking of clinical leaders in CCGs and managers in CSSs to overcome the “old ways”. It makes faster, more innovative and exciting ways to use the quality, innovation, productivity and prevention programme possible and secures quality outcomes for the patients we serve. ●

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Commissioning for the future: learning from a simulation of the health system in 2013/14
http://www.kingsfund.org.uk/publications/future_commissioning.html