hfma GP FINANCE BRIEFING

Contributing to the debate on NHS finance
February 2012

Commissioning support

Foreword

The Healthcare Financial Management Association (HFMA) is the representative body for NHS finance professionals. With a long and established history, it has a track record in issuing authoritative guidance, delivering training, and helping to spread best practice in financial management.

The coalition government has put commissioning at the heart of the new structure for the NHS, as set out in the Health and Social Care Bill 2011. This briefing is designed to help clinical commissioning groups prepare for the challenges ahead in relation to commissioning support services. These are key services that will support the commissioning group to deliver their commissioning objectives and which need to be in place in time for their authorisation.

Commissioning groups will be accountable for managing a significant commissioning budget so it is important that services put in place to support commissioning are right from the very beginning.

This briefing looks at what commissioning is and the support needed to deliver it. It also gives advice on what commissioning groups may need to have in place to ensure the commissioning support they buy is effective, supports their statutory responsibilities and operates in the public interest.

The briefing is not intended to be exhaustive in its coverage, nor does it aim to set out a standard approach that all groups should follow. Instead it focuses on key issues that commissioning groups may find helpful to consider as they establish their own approach to commissioning support in the coming months.

The HFMA is active at national and local level in raising the awareness of how NHS finance works, influencing policy development and raising the skill base of those involved in financial management.

We support NHS organisations and individuals in improving financial management through periods of challenge and change. To that end, we plan to continue to release further briefings over the coming months as the transition to the new NHS continues.

We trust that you will find this bulletin helpful and would be delighted to hear your feedback. We would also welcome any suggestions you may have for ways in which the HFMA might support your practice and the development of clinical commissioning groups.

Cathy Kennedy, chair of the HFMA Commissioning Finance Group

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Overview

The Department of Health has set out how clinical commissioning groups (CCGs) need to develop in order to be authorised to commission healthcare services in the structure of the NHS proposed by the Health and Social Care Bill 2011.

To meet the requirements, CCGs will need to demonstrate their capability and competence across six key domains. One of these states that they must have in place 'collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board (NHSCB), as well as the appropriate external commissioning support'.

Given that the authorisation of commissioning groups is likely to begin this autumn, the role of commissioning support services needs to be looked at with some urgency.

CCGs will be statutory bodies with statutory responsibility for securing economy, efficiency and effectiveness for the taxpayer in all that they do. This will include the healthcare services they commission and the way that they organise and run themselves.

Particular attention is likely to focus on the way in which CCGs use their running cost allowance – the monies allocated to them to pay for non-clinical management and administrative support from which commissioning support must be resourced.

This briefing looks at what commissioning involves and the support needed to deliver it. It also considers how the need to secure commissioning support may influence the set-up and development of commissioning groups and what can be learned from existing NHS organisations. To summarise, it looks at:

- Commissioning
- Commissioning support
- The impact of commissioning support on the development of CCGs
- How much money there is to spend
- How to make sure commissioning support is effective.

There is also a case study from Staffordshire, where both pathfinder commissioning groups and the support organisation are in place.

This briefing is not intended to be exhaustive in its coverage, nor does it aim to set out a standard approach that all groups should follow. Instead it focuses on key issues that commissioning groups may find helpful as they establish their own approach to effective commissioning support and take on their new roles and responsibilities.

Introduction

The structural changes to the NHS proposed in the Health and Social Care Bill aim to give 'frontline professionals much greater freedoms and a strong leadership role' .

There is a clear emphasis on commissioning itself, rather than the functions needed to support it and this is reflected in the key characteristics – or domains.

Commissioning support aims to facilitate that focus, bringing specialist skills and knowledge to the non-clinical aspects of commissioning, and supporting commissioning groups to deliver their new roles.

Although CCGs will initially be expected to receive support from the developing NHS commissioning support arrangements, they will ultimately have the choice of how to deliver that support by either providing it themselves or securing it from another provider. However, this freedom must be managed alongside the requirement to do what is best for the public purse.

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What is commissioning and what is commissioning support?

Commissioning

Commissioning is absolutely critical to the success of the NHS – a principle that underpins the Health and Social Care Bill 2011. It determines how, where and when the public receives the healthcare services it needs.

Although commissioning has existed since the start of the NHS, reforms introduced by the Labour government to the financial regime – in particular payment by results (PBR), practice-based commissioning (PBC) and world class commissioning (WCC) – made it more prominent.

The coalition government halted the world class commissioning approach when it came to power, but through the introduction of clinical commissioning groups it has recognised the importance of getting commissioning right.

The Department defines commissioning as 'the process of ensuring that the health and care services provided effectively meet the needs of the population'. In practical terms it involves the negotiation of agreements with service providers to meet the health needs of a particular population. To find out more, see the box above.

It is important to stress that commissioning is not a one-off activity but rather a continuous cycle that adds up to a complex process. It is not something that follows a pre-set template and cannot be done once and forgotten about. Rather, it is a continuous process with many different elements.

KEY AIMS

Commissioning involves making the best use of allocated resources in order to:

- **Improve health and well-being and reduce health inequalities and social exclusion**
- **Secure access for patients to a comprehensive range of services**
- **Improve the quality, effectiveness and efficiency of healthcare services**
- **Increase patient choice by providing patients with the information they need to make informed choices about their healthcare.**

The focus for commissioning is therefore on achieving the best possible health outcomes and healthcare within the resources made available by the taxpayer.

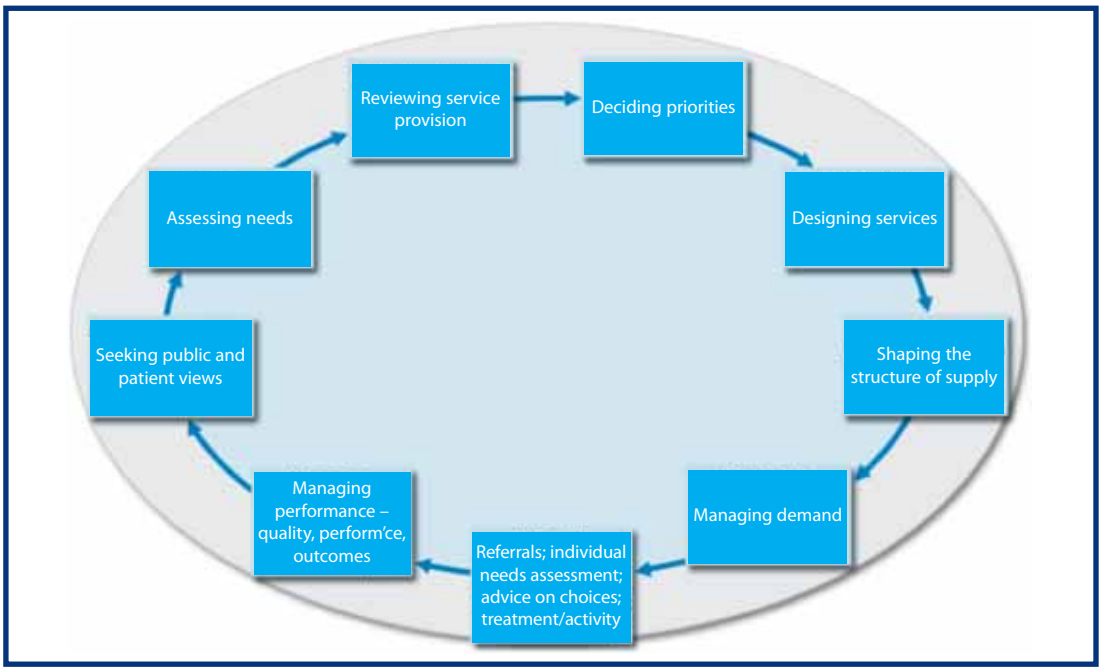
The diagram below illustrates the continuous nature of commissioning. We'll look briefly at the key activities in turn and what commissioning actually involves.

Stage 1: Plan ahead

The first stage in the commissioning cycle is to plan ahead so that you know what services are needed to meet the needs of the population. This means information will be needed to enable decisions to be taken. For example:

- Details of the population, stratified according to

It is important to stress that commissioning is not a one-off activity but rather a continuous cycle that adds up to a complex process



JOINT STRATEGIC NEEDS ASSESSMENT

The joint strategic needs assessment (JSNA) was introduced after the 2006 white paper *Our health, our care, our say* identified a need for regular assessments of the health and well-being status of local populations. This would allow meaningful objectives for local services to be established.

JSNAs are designed to 'identify the current and future health and well-being needs of a local population' and are a statutory requirement for PCTs and upper-tier local authorities. Commissioning groups will have a duty to contribute to the JSNA that will be the responsibility of local authorities.

Commissioning plans will need to be in line with local health and well-being strategies and the JSNA. Health and well-being boards will work with commissioning groups to ensure that commissioning plans meet local needs.

age, morbidity, deprivation levels and so on
- Risk assessments of demand for services.

To be able to do this well you will need to involve:
- Public health professionals
- Clinicians
- Patients
- Local community.

Validating and making use of this data to support the decision-making process requires technical informatics and analytical skills, particularly in relation to patient activity and forecasting.

Stage 2: Review of current service provision

Reviewing service provision involves looking at what is provided now and identifying any gaps or areas in which services could be improved. Again this will mean engaging with others, including GPs, clinicians and public health professionals, and referring to the joint strategic needs assessment for the area – this is currently carried out by PCTs. To find out more about the joint strategic needs assessment, see the box above.

Stage 3: Determine priorities within the resources available

We've already seen that commissioners have to secure the best healthcare possible within the resources available to them and this inevitably means tough decisions have to be made about relative priorities. Commissioners need to do this in a logical and transparent way and link it to their strategic and operational plans and budgets.

They must also take account of patient choice, local community views and other commissioning partners. To find out more about approaches to commissioning, including commissioning with partners, see the box below.

Stage 4: Procure the healthcare services needed

Once planning has been carried out, the next stage is to buy the services that are needed. The first step in this process is to ensure that the way services are designed is in line with the agreed priorities.

This may mean reshaping the way things are delivered in consultation with GP practices, other providers and the local health and well-being board. A contract must then be negotiated and agreed between the commissioner and the healthcare provider.

The NHS uses a standard contract provided by the Department for mental health and learning disability services, ambulance services, acute hospital, community services and care homes. The Department produces contract documentation and guidance each year and requires contracts to be signed before the start of the financial year.

For those services covered by the national tariff (PBR), the prices to be charged by providers are

COMMISSIONING APPROACHES

A number of commissioning approaches are likely to exist in the new regime:
- **NHS Commissioning Board (NHSCB) – responsible for some commissioning activities, including primary medical services provided by GPs, dentistry, community pharmacy, primary ophthalmic services, national and regional specialised services**
- **Individual CCGs commissioning on their own – as PCTs do now but with a smaller range of services**
- **Lead commissioner – commissioning groups will need to be able to work with and on behalf of other groups where collaboration may provide an efficient solution for the health economy as a whole, using the lead commissioner model**
- **Networks hosted by the Commissioning Board – undertaking commissioning functions on behalf of a number of CCGs, for cancer services, for example**
- **Partnership working with local authorities – in future local authorities will be responsible for public health activities and lead on health improvement and reducing health inequalities.**

also pre-determined. If you want to know more about PBR, the HFMA has produced a briefing entitled *Payment by results for GP consortia*, which is available from the HFMA's website at www.hfma.org.uk.

Stage 5: Shape the supply structure and build it into agreed contracts

Once commissioners are clear about what they want to buy, they need to make sure this is clearly specified. Where necessary, they should encourage changes in provision – for example, so that services are provided closer to home.

To be able to do this they need to work closely with providers and make use of incentives and levers to stimulate supply and manage the market appropriately. These incentives and levers then need to be built into the contracts that are agreed with providers.

Stage 6: Manage demand

Demand for healthcare services will always exceed supply and there is a limited amount of taxpayers' money with which to deliver the necessary services. Managing demand is one of the trickiest aspects of commissioning because the healthcare that patients need during the year must be matched with contracts that are agreed in advance.

Stage 7: Managing and monitoring

Although contracts are agreed at a higher level – currently through PCTs but in future through commissioning groups – each referral a GP makes is effectively a mini commissioning decision that commits financial resources. It is important, therefore, that commissioners ensure the services they have bought and to which patients have been referred are delivered in line with the specifications set out, both in terms of quantity and quality. (This is also the case for non-PBR activities, where the price is set when the contract is negotiated.)

Commissioners want to know that the services delivered meet their objectives and satisfy patients' needs and expectations. This means engaging with the community they serve; making use of patient satisfaction surveys, for example; and using these to inform the next commissioning round. This monitoring cycle also ensures patient outcomes continue to improve.

There are many transactional elements in particular to this cycle. The NHSCB is looking for commissioning groups to handle these elements through commissioning support services.

Commissioning support

In practical terms, commissioning support is likely to involve some or all of the following areas:

Delivery processes

Delivery processes cover a broad range of activities and may encompass:

- Contract negotiation with healthcare providers
- Contract management and support, including validating information to provide a basis for performance management and negotiation
- Monitoring quality and performance against quality indicators and identifying trends in outcomes
- Monitoring activity and performance to ensure that activity and expenditure is in line with what was planned.

Organisational processes

This is likely to involve developing the health needs assessment by building on collected data. It will support the forecasting of future health needs and identify gaps in service provision. The commissioning group will need access to legal services to advise in complaints, claims, legal matters, appeals and estate and property matters. This area may also include the management of information governance requirements. To find out more on information governance, see the box left.

Business advice and support

This is likely to involve business intelligence and support for service redesign through information

INFORMATION GOVERNANCE

All NHS organisations must meet certain obligations in relation to patient and public information, some of which are legal requirements. The NHS information governance framework ensures that the necessary safeguards are in place and information is only used appropriately.

NHS Connecting for Health states: 'The ultimate aim is to demonstrate that an organisation can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance and to be consistent in the way they handle personal and corporate information.'

A toolkit has been developed by the Department of Health, which enables organisations to assess their compliance against the necessary standards. NHS organisations must make an annual declaration as to the level of compliance attained during the previous year.

collection and analysis. Commissioning support may facilitate service redesign by developing clinical specifications and pathways as well as conducting service reviews.

Support processes
This relates to the core back-office functions that underpin the successful running of the organisation and are often transaction-based – finance; HR and payroll; information technology; estates management and procurement.

Engagement processes
This involves communications – handling the press and media enquiries and public and patient involvement. Engaging with stakeholders and patients may be through local consultations, health promotion and information marketing.

In order for CCGs to establish what may be needed in terms of commissioning support clear role delineation is needed.

As can be seen from all these processes, commissioning support is everything that does not involve service transformation or the overall governance of the organisation (which cannot be delegated). It supports the commissioning group in carrying out its responsibilities but calls for a clear understanding of both the commissioning process and the different roles of the CCG and the commissioning support service.

To gain authorisation, commissioning groups must decide how each of the support services will be delivered in future and develop a plan, which demonstrates the support services are affordable.

How does the need for commissioning support shape the development of a commissioning group?

Defining commissioning support
Given the range and variety of commissioning support activities identified above, commissioning groups will need to be clear about what they want and need. A clear description and detailed definition of the services required to support them in their new role will be vital.

Identifying what the commissioning group does or will do itself will provide a basis for developing plans. Commissioning groups should consider any gaps in their expertise – due to proposed size or by choosing not to undertake the support functions themselves – as well as the affordability of trying to maintain all support at a local level within the running cost allowance.

The commissioning group can look to their PCT cluster for information on this. Understanding what services are undertaken by the cluster will help define what needs to be in place in future. This process is likely to involve working with other local commissioning groups to ascertain whether services will be directly provided, shared with another commissioning group or bought in. It is possible that sharing arrangements will provide a cost-effective solution for some functions. Greater collaboration will allow costs to be shared.

Local solutions
It is important to consider what is happening in your locality or region. A number of PCT clusters are moving towards establishing district commissioning support units, so consider if the system architecture is already in place. An NHS commissioning support service will be developed for all areas, which CCGs will initially need to use. Other options, such as services provided by a local authority, might be possible in the short term but are unlikely to be allowed for all commissioning support services. To find out what's happening in South Essex, see the box below.

The development of local NHS providers should facilitate the standardisation of commissioning support services initially provided with each commissioning group and/or GP ➤ **continues p10**

CASE STUDY: SOUTH ESSEX PCT

It is expected that the South Essex PCT cluster will initially use resources currently within the PCTs to develop a South Essex Commissioning Support Unit. By working in close partnership with the strategic health authority cluster and the individual PCTs, the cluster aims to ensure a holistic and consistent approach is adopted.

The PCT cluster is undertaking a review of existing support services to identify which tasks are likely to be required by CCGs and any other customer groups in the future. This was supported by a local event in November 2011 to enable GPs and commissioning group leads to gain more insight into current PCT support functions.

Case study: Staffordshire Commissioning Support Service

Staffordshire Commissioning Support Service (CSS) is one of the first such organisations to be formed in England. It has been established to support the Staffordshire cluster of three primary care trusts, which includes seven clinical commissioning groups (CCGs).

The CSS provides all services viewed as essential in helping the CCGs and the cluster to fulfil their roles – business intelligence (the collection and analysis of patient activity), contracts management, finance, IT, estates, human resources, governance and patient engagement. It also offers support to commissioners in areas such as primary care contracting and continuing care.

Cluster finance director Tony Matthews says setting up the CSS quickly (over nine months in 2011) and getting it right first time was key. The cluster wanted to give staff clarity on their future roles as soon as possible, which led to the early development of the CSS.

'We took a decision early on to assign key commissioning support people to the CCGs, the cluster and, by default, the commissioning support strand,' he says. 'It was the right thing to do for our staff. For the organisation there was a danger that by not doing it we might lose people.'

CSS project director Derek Kitchen says the Staffordshire vision and mission were developed with its staff and customers at a series of workshops in the first quarter of 2011. These were augmented by a series of one-to-one interviews and visits to CCGs to ensure the CSS fully understood their requirements.

He adds: 'Ultimately, the CSS and its staff need to be commercially minded, so they will need to work at greater levels of responsiveness and flexibility than ever before. The CSS needs to be viable and sustainable. Until the market becomes real, the definition of viable will be: "do our customers value and want our services?" .'

The workshops first asked customers what they wanted from the CSS. They said it should be business-like, customer-focused and flexible, but also asked the organisation to foster close working relationships, understand time pressures and be an integrated body with efficient, Lean processes.

The development of the CSS has focused on four main areas: commercial strategy, including customer engagement ('voice of the customer') and staff engagement (organisational development); product portfolio; process review and transformation; and cost of production.

Mr Kitchen says the CSS organises its resources around the processes that deliver products and services. A process owner manages all of the contributing resources. This is a big step away from the management of resources in functional silos – sometimes referred to as matrix management/ownership – he adds.

The best example of this matrix management is the CSS aligned contract management teams, directed day to day by CCG but managed by CSS. The finance, business intelligence and quality staff all work for the CSS-employed CCG relationship manager.

The CSS pricing objective is to reflect value for money, with costs less than 50% of the CCG running cost allocation per head of population. The CSS will play a full part in delivering cost efficiencies required in the local health system.

Mr Kitchen says: 'A significant amount of time has been, quite rightly, spent in preparing CSS staff for the future, processes have been reviewed and Lean methodologies applied. Again, contract management is a good example, as it is a process that a number of functions contribute to in supporting CCGs to deliver the contracts they sign with provider organisations.'

Learning and development

Aligned to this is a learning and development framework and talent management strategy. The CSS has

LEARNING AND DEVELOPMENT PLAN – KEY ELEMENTS

Core skills requirements for all CSS staff:

- **Customer service**
- **Commercial awareness**
- **Change leadership**
- **IT transformation and automation**

Supplemented by role-specific training within teams:

- **Focused on delivering business objectives**
- **Linked to the product and services matrix**
- **To update or increase professional qualifications**
- **Agreed by line managers and assured by HR to ensure quality provision/efficient spend**

Underpinned by the 'Investing in your future' programme offering:

- **Personal development**
- **How to deal with change**
- **Long-term career pathway training**
- **Occupational health/coaching support**

The CSS is reviewing systems to provide a single IT platform

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assessed its mix of skills knowledge and experience, noting what capabilities the organisation can draw from now and what requirements will be needed in the CSS of the future. This led to a learning and development plan with a number of key elements (see box).

The overall aim of the talent strategy – known as 'Spot, get, keep, grow' – is to ensure at least 20-25% of people are being nurtured for senior positions as part of an enhancement to their ongoing learning and development. This will ensure the CSS not only retains people with potential, who can see progression to more senior positions, but also that it is seen as an employer offering promising people the opportunity to release and realise their potential. This is key to attracting and retaining talent and managing succession, Mr Kitchen says.

Mr Matthews says commissioning support organisations (CSOs) must secure commercial skills, particularly in their finance function. 'It wouldn't surprise me if the chief finance officers in commissioning support organisations have commercial backgrounds or are able to demonstrate commercial and marketing skills.'

The environment will change as the transitional period progresses and new structures and functions become apparent. 'The CSOs need to be light on their feet and flexible in order to adapt to a rapidly changing environment,' he adds.

Customer feedback

The CSS has created a number of ways for its clients to express their views in addition to the everyday working relationships and communication lines, which have not been removed during this development. These include:

- The CSS project board – a formal sub-committee of the cluster board, which includes CCG clients
- The CSS project director, who meets regularly with CCG chairs and cluster directors
- Two full-time CSS relationship managers – one for CCG clients, one for cluster clients
- A full-time delivery assurance manager
- A delivery assurance board at which senior managers give assurance that clients' requirements are being met, and that the whole system is being supported as it moves from the old to new system architectures.

IT capability and capacity are vital in a support organisation. The CSS is in the latter stages of a review of these, which is seeking to maximise the automation of processes and provide a single IT platform. These are principles that the CSS is keen to share as part of its IT service to clients and in working in partnership with, for example, local authorities.

Mr Kitchen says that after just under a year of development, the CSS is in a sound position. The key to this has been:

- The cluster chief executive moving quickly to set up the new system architecture by April 2011
- A dedicated, fully staffed leadership team
- Recognising the need for commercial expertise within the development project and acquiring it as interim management support – these individuals work for the project director
- Open, regular communication with customers
- Engaging with staff, involving them in the developments and being seen to deliver for staff in its organisational development
- Regular reflection and adjustment – initiatives such as the delivery assurance board and the delivery assurance manager, implemented as a result of customer and senior CSS staff feedback.

'Commissioning support services are at an early stage of development and there is a full debate about the scale at which they should be set up,' Mr Kitchen says. 'The benefits of managing production at scale need to be balanced with CCG requirements for local input and relationships.

'The approval process for CSS, the proposed national finance spine and the business intelligence debate, as well as the emerging CCG market will all influence the size of CSS. The important thing is to ensure that commissioning support is effective, lean, cost-effective and provided by staff who have the right customer-facing, responsive, flexible values. Get that right and the form and scale become a secondary issue.'

Mr Matthews adds: 'CCGs will be seen as the more glamorous end of the commissioning process, but it is important CSOs are seen as near equals. There is a danger CSOs will be seen as a sub-service to the CCGs, but they are a business-critical function working alongside the CCGs.' ■

➤ **continued from p7** practice receiving the same level of service. NHS commissioning support services or units will initially be hosted by the new NHSCB and assessed against national criteria by October 2012. A new business development unit will oversee their development, assessing applications and hosting arrangements.

National solutions

The NHSCB, currently operating in shadow form, has already identified a number of commissioning support services that may be better provided at scale for commissioning groups with large populations or for a large number of smaller organisations. These include:

- Data storage and warehousing
- Major clinical procurement ensuring a standard approach and legal compliance
- Contract negotiation
- Some aspects of IT and medicines management
- Business intelligence
- Back-office functions, including a single financial and ledger system for recording commissioning group financial transactions and to generate consistent financial information.

To this end, there may be a role for some national commissioning support services to be expertly provided through service level agreements and delivering economies of scale.

Option appraisal

A formal option appraisal provides a good approach to this decision-making process, enabling consistent criteria and detailed financial reviews to be applied to each of the possible scenarios. Taking account of both financial and non-financial costs and benefits, the commissioning group can determine in a systematic and transparent way whether each provider or scenario delivers the service required in a cost-effective way.

The NHS uses a business case approach to option appraisal, tailoring the length and level of detail to the investment or decision being evaluated. It is a formal written process, which identifies the financial and non-financial implications of investing in or changing a service. It sets out the process by which the preferred option has been selected (there are likely to be several options or solutions) and the costs associated with each.

Initial arrangements

By the end of June 2012, commissioning groups need to have identified the services to be bought in and have shadow arrangements in place for procuring products or services from a suitable supplier. As part of these shadow running arrangements, commissioning groups will need to have service level agreements in place for end-to-end commissioning support. To find out more about this type of support, see the box below.

Commissioning groups may also consider buying in specific products or services, possibly through nationally negotiated agreements tailored for local needs or reflecting specialist expertise. These are known as framework agreements.

During the authorisation process, commissioning groups will need to demonstrate they have capacity and capability to deliver their commissioning functions and have appropriate, robust and affordable commissioning support arrangements in place.

Future direction

Once established, authorised and taking on their statutory responsibilities, commissioning groups will be able to secure commissioning support arrangements through open and transparent procurement processes. Such services could be provided by the NHS, private sector, local authority (providing local strength as well as delivering value for money) or third sector organisations. They may be hosted by a commissioning group or the NHSCB, provided through a joint venture or by a social enterprise.

The NHS commissioning support services that are currently being established will need to be fully independent of the NHSCB by March 2016 at the latest. By this time, NHS providers will need to compete on a level playing field with all other support service providers to deliver commissioning support to CCGs.

END-TO-END COMMISSIONING

An end-to-end commissioning service is a full or one-stop commissioning service, covering the full range of commissioning support services currently undertaken by PCTs.

It will include a significant element of high-volume or transactional back-office processes that require sufficient scale to be affordable – for example, invoice processing, IT support, payroll and some procurement services.

It is likely that a commissioning support service will provide these services to a number of commissioning groups to deliver a cost-effective service.

How much money is there to spend?

Achieving value for money

An important consideration for any public sector organisation is value for money. In the public sector there is an expectation, set down by the Treasury in its guidance *Managing public money*, that a number of basic behavioural standards and values will be adhered to. The Treasury also emphasises that these standards should be carried out as follows:

- In the spirit of, as well as to the letter of, the law
- In the public interest
- To high ethical standards
- Achieving value for money.

As statutory organisations spending taxpayers' money, the formal mechanism for this accountability is through the accountable officer. The accountable officer must ensure:

- Economy – sourcing resources as cheaply as possible
- Effectiveness – ensuring desired goals/targets are achieved
- Efficiency – ensuring outputs/outcomes are maximised for the resources (inputs) used.

To find out more about the accountable officer, see the box below.

This means that CCGs must deliver value for money in relation to both commissioning budgets and the allowance provided for running the CCG itself.

Running cost allowance

Each CCG will be given a running cost allowance by the NHSCB. They will be free to decide how best to use this allowance to carry out commissioning activities. Set at £25 per head of population per annum , it is from this money that commissioning support services will be funded.

It will also need to cover the costs of the accountable officer and other board members, including non-executive directors and key roles in the governance arrangements of commissioning groups.

If you would like to know more about how governance might work for commissioning groups, the HFMA has produced a separate briefing entitled *Governance: managing a corporate organisation*, which is available from the HFMA's website at www.hfma.org.uk.

The ready reckoner

To help commissioning groups understand the financial implications of differing commissioning support arrangements and delivery models, the Department made available a ready reckoner in September 2011. Reflecting the size of population for which a commissioning group may be responsible, the tool takes a step-by-step approach to the costs of running the organisation.

It takes into consideration the costs of the board, audit services and publishing an annual report, as well as holding public meetings and communication. Clinical leadership and non-clinical manager support needs to be identified with the remainder of the allowance available for commissioning support services.

The tool gives a first indication of whether the commissioning group's plans are affordable and what proportion of running costs will be accounted for by commissioning support services.

With the running cost allowance identified for the anticipated population for which the group will commission services, it will also facilitate decision-making to bring proposed expenditure within the available funding.

ACCOUNTABLE OFFICER

All CCGs will have an accountable officer, a formal and specified role that already exists throughout the public sector.

Accountable to both the NHSCB and within the commissioning group, the accountable officer will be selected by the CCG itself and be formally appointed by the NHSCB at the time of authorisation.

The accountable officer will have a key duty to ensure that the commissioning group is securing continuous improvements in outcomes for patients, notably in terms of the effectiveness of the treatments received, the safety of the services commissioned and the overall quality of the patient experience.

They will also have statutory obligations in relation to both finance and information.

How to make sure commissioning support is effective

As it is likely that a commissioning group will buy in at least one service, this section looks at making sure commissioning support is effective.

In order to apply a consistent evaluation of potential providers, commissioning groups may find it helpful to look for a number of key characteristics and seek evidence as to how the potential provider demonstrates those characteristics.

Then, when a provider has been identified, certain skills will be needed to manage the bought-in service. It is important to remember that buying in commissioning support does not transfer any responsibility or accountability for the CCG's commissioning functions.

What to look for now and in the future

It may be helpful to consider several key characteristics when determining the non-financial criteria for assessing a commissioning support provider:

- Flexible and responsive to local needs – do staff have sufficient local knowledge?

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- Customer focused – do they have the right staff mix to meet customer demands? Can they relate what they do to the patient? Are relationship managers in post?

- Viable in scale – are they large enough to provide the required service(s) to specification while being cost-effective?

- Sustainable provider – do they have a commercial mindset and are they looking to the long term? Have they recognised the skills they already have in place but also what is or may be required for the future?

- Is the portfolio of products and services offered useful and adding value while recognising the interdependencies in service provision?

- Do they seek to build good working relationships and develop a sound reputation? What mechanisms are in place for regular communication, discussion and feedback?

- Do they deliver value for money? Is there serious review of what they do and do they look for constant innovation and improvement?

- Do they embrace technology and automation where appropriate?

- Is a system for review in place such that support is refined over time? Are key performance indicators in place by which the supplier is happy to be measured? Is financial reporting done to deadline, for example?

- Does the provider have the appropriate capability? This will be an NHSCB assured provider in the first instance.

Managing a bought-in service

Managing bought-in services is a very different way of delivering services. The operational day-to-day requirements and demands are left to the service provider and the commissioning group must take on the role of contract management. Good contract management delivers high-quality services while avoiding service failure and appropriately managing risk.

Procurement process

All public sector health organisations follow clearly defined procedures and rules when procuring goods or services. Normally these

arrangements are set out in the organisation's business rules, which include standing orders, standing financial instructions and a scheme of reservation and delegation.

The standing financial instructions cover the financial value at which quotations and full tenders need to be sought. For goods and services of significant value, European procurement legislation will also need to be considered. For more about this, see the box below.

A sound procurement process establishes the platform for the future of the service delivery by making service specifications clear, evaluation and contract award transparent while demonstrating that value for money has been achieved.

Service specification

A bought-in service will be considerably easier to manage if there is a clear service specification in place from the outset. Rather than focus on how the service should be delivered – that is for the supplier to determine – the emphasis should be on outputs or outcomes. This leaves the supplier free to innovate and find the best solution within available resources.

A clear specification also manages the expectations of both the commissioning group and the supplier. And it can be helpful to set out the quality measures to be used at the beginning of the process. These should be tangible, measurable and sufficiently timely to reflect performance and facilitate decision-making.

Evaluation

A thorough evaluation of the options available for providing the service involves considering the costs and outcomes or outputs, as well as comparing quality. All risks associated with each option should also be systematically assessed. This should include the risk of dismantling in-house capabilities and possible dependence on a single supplier for all support services.

Governance arrangements

The commissioning group will need to have suitable governance arrangements and responsibilities in place from the outset, both prior to authorisation and from the point at which they assume statutory responsibilities. It's worth remembering that contracting out services to another provider does not transfer responsibility. In fact, greater focus is needed as a business-critical service is being provided by a third party.

Therefore contract issues and performance need to be reported across the organisation, including to the board. It is also important to identify clearly what the board is required to sign off and what responsibilities it delegates elsewhere in the organisation. It may be that only the board can approve the termination of the contract.

This may work best by clearly identifying who is responsible for the contract on a day-to-day basis and where their reporting lines lie, as well as the escalation processes to be followed in the event of significant concerns becoming apparent.

Sharing risk

When an organisation enters into a contract for service delivery with a third party, it is important the risks associated with the contract are formally identified and monitored. Arrangements for sharing risk with the service provider through the contract itself or a risk-sharing agreement will support this.

For example, it is important to identify the risk associated with the supplier being unable to deliver the service and to have contingency plans in place for supplier failure. When things go wrong it can be costly in financial and management time and in terms of the organisation's reputation.

Understanding and monitoring the key risks – such as availability of patient information, security of personal data or non-payment of invoices – and having plans in place to mitigate those risks will support the running of the organisation.

Quality

The service provider should share a commitment to quality. This may be reflected in a commitment

EUROPEAN LEGISLATION

For goods or services with a value of more than £101,000, *Official Journal of the European Union* (OJEU) procedures must be followed. Public sector bodies must comply with European legislation and advertise for tenders by placing an advert in the supplement to the OJEU. This aims to open up the public procurement market and ensure the free movement of goods and services within the European Union.


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to maintaining local and organisation-specific knowledge and the necessary technical skills to understand what is being provided and how that will support the commissioning group to meet patients' needs.

Service level agreements and contracts

When the service is agreed and the supplier determined, a service level agreement or contract will need to be put in place. This may be based on a national core contract for products/services and could be very detailed and heavily monitored. The organisation should regularly and formally monitor the performance of the supplier to ensure that the performance standards stated in the contract are fulfilled.

If the commissioning group is reliant on the supplier to provide performance information, it should be audited to ensure its accuracy. The contract should incorporate provisions regarding non-performance as well as identifying how any disputes are to be resolved.

The financial requirements of the contract should also be clearly documented, including payment mechanisms and processes and what will happen if the service needs to change during the term of the contract. This may include changes in price as well as the actual service(s) being provided.

Regular review

It is important for commissioning groups to ensure that what was originally specified is what is being delivered. Regular formal review meetings can help to feed back performance.

Key performance indicators can also be helpful by providing regular and consistently measured feedback to both the commissioning group and the commissioning support service.

In order to ascertain whether benefits are in line with cost of service, commissioning groups could make use of exception reporting as well as independent checking. Formal market testing and use of benchmarking will ensure that value for money is secured over a longer period of time.

Communication

If both the commissioning group and the commissioning support service are to benefit from the arrangements in place, good communication channels are needed.

This may include clear points of contact from both teams – a senior leader from the commissioning group responsible for the contract with the commissioning support service; and a senior client manager at the commissioning support service assigned to deal with the commissioning group.

Problem resolution processes will also need to be in place and it can be helpful to encourage the supplier to be frank about risks and what they are doing to mitigate those risks.

If the commissioning group is reliant on the supplier to provide performance information, it should be audited to ensure its accuracy

Conclusion

Commissioning is undergoing a big change and arrangements need to be in place and operational from the go-live date of 1 April 2013, as proposed in the Health and Social Care Bill. Because clinical commissioning groups will not be statutory bodies until then, they cannot enter into full contracts for procuring their support services.

However, it is clear from what has been described in this briefing that the arrangements for commissioning support services must be in place well before this date. It is an important part of authorisation and therefore needs to be considered as clinical commissioning groups are established.

Support is available from PCT and SHA clusters, as well as from the NHSCB. Recognising the ultimate aim of open competition for the provision of commissioning support services, the NHSCB aims to put transition arrangements in place to support commissioning groups as they move through the authorisation process.

These transitional arrangements recognise that:

- The commissioning support work undertaken by PCTs is great in scope and complexity
- Articulating this into a clear specification is itself a significant challenge
- At present there are few existing providers of commissioning support outside the NHS
- A number of practical problems exist in relation to procurement timetables and existing PCT staff.

One possible solution for new commissioning groups is for the local PCT to undertake the procurement as the statutory body on their behalf. The service contract could then be transferred to the commissioning group on 1 April 2013 as planned.

However, as this generates a possible conflict of interest and requires resources to be in place, it is likely the NHSCB will host some support services until 2016 at the latest. The board becomes the source of support services until clinical commissioning groups are ready to procure such services themselves.

Whatever route is chosen by commissioning groups, they will need to look at each service needed, the model that best delivers it and ultimately what is best for patient outcomes while being affordable under the running cost allowance.

Commissioning groups will be accountable for managing a significant commissioning budget, so it is vital that commissioning support services are fit for purpose. ■

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