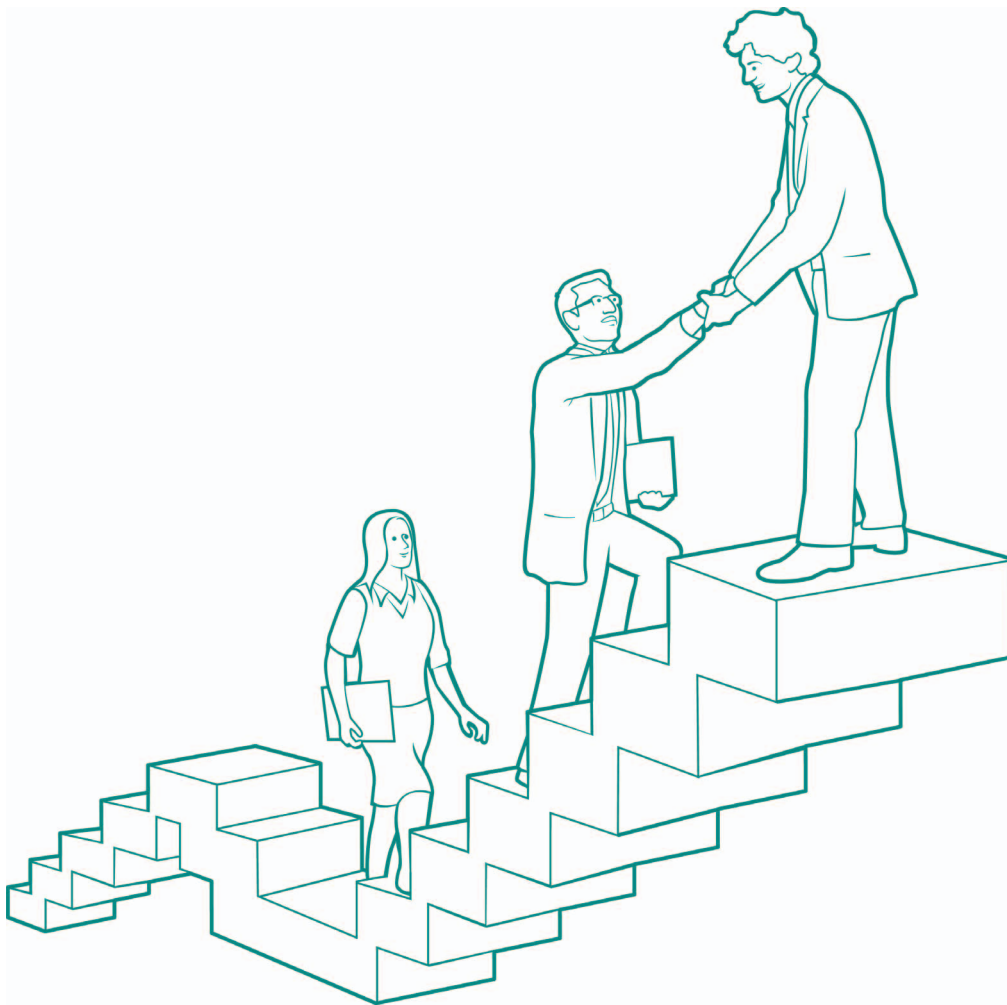


## COMMISSIONING IN TRANSITION

Issues and challenges in the transition to new forms of commissioning



October 2010

## Introduction

Key points:

- PCTs and SHAs face considerable challenges over the next two years in sustaining the delivery of effective commissioning whilst simultaneously participating in the smooth transition from one model of commissioning to another
- There are considerable risks reflected both in the structural changes affecting commissioners and from the wider financial pressures on the system
- The end point moreover is a fundamental redesign of commissioning and not merely a handover of power
- Commissioners will need to equip themselves to face the issues and tasks that this period of change will bring.

PCTs have a mission. This is a mission set out in the White Paper 'Equity and excellence: Liberating the NHS' and its companion piece, 'Commissioning for patients', to orchestrate the seemingly devolution of the role of healthcare commissioning to a suite of successor bodies, the NHS Commissioning Board, local authorities and GP-led commissioning consortia. The function of PCTs now therefore changes; their goal, requiring dignity and a sense of selflessness, to work with successor organisations in the development of a new model of commissioning; retaining elements of legacy skills, capabilities and local intelligence; facilitating change, organisation redesign and ultimately handover.

This mission is one strewn with potential bear traps and pitfalls. These are the current and enduring financial constraints on both management costs and commissioning budgets, the risk that talent may not wish to stick around for the journey, and concerns that functions and accountabilities will somehow fall between the structural gaps in the transition.

The end goal will be commissioning in a different mould. Designed and led by primary care clinicians, new forms of commissioning will require a different set of skills and tools. To be successful in the current financial climate these new forms will need to be agile, capable and responsive as quickly as can be realised.

The purpose of this paper is to examine the scale of the risks, issues and challenges facing commissioners, particularly PCTs and SHAs over the next 24 months. It maps out the tasks that these organisations in transition will need to accomplish and highlights some of the actions which may smooth the transition from one form of commissioning to another.

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## New world, new structures – disruptive innovation

Key points:

- The new system of commissioning requires a fundamental reinvention of the role, goals and measures of success
- This reinvention is not fundamentally about organisational structures. However, structural resilience will be a prerequisite for success, ensuring that vital commissioning functions do not vanish into the ether in the short term and that skills can be nurtured and retained
- The impact on staffing and spend is also significant, with the reduction of more than £0.5bn in management costs, principally over the next 24 months, and the further transition or externalisation of 20,000 staff
- By the end of this period of reform we expect to move from a system of 152 PCTs spending in excess of £50 per capita on commissioning to a system of GP-led commissioning consortia funded at less than half and possibly as low as one fifth of that amount.

### A new approach to commissioning

**Disruptive innovation is all about changing the rules of the game, bringing new and different skills and technology to bear on a problem and fundamentally challenging our mindset about how things are done.**

‘Commissioning for patients’ is not fundamentally about structures. The shift in responsibilities and creation of GP-led commissioning consortia as statutory NHS bodies is rather a catalyst for the reinvention of commissioning. This reinvention begins by shifting emphasis away from population health and towards personalisation and the

specific and complex needs of individuals. The means of delivering commissioning in this new world, as well as some of the tools and supporting technologies, need to be different from the world of PCTs. This form of disruptive innovation, advancing organisational capabilities through fundamentally new ways of working, sits at the heart of the design and delivery of this new system.

Many of the core elements of this new system are likely to require new ways of working between organisations, with different perspectives, goals and measures of success.

At its heart GP commissioners in the new system will have four main requirements:

1. Knowing what outcomes and value current spending is delivering for patients
2. Rapidly influencing and improving services by working with providers and practices
3. Improving the patient experience, delivering personalised, proactive care from start to finish
4. Developing themselves as robust and effective organisations.

To effectively deliver these requirements will require some of the skills and experience of the old system, but articulated in a different way. The questions here are focused on identifying a discrete set of personalised services which maximise individual patient experience and outcome whilst minimising the financial burden on state-funded resources, for example through anticipatory care, through predictive risk analysis, and through care navigation and management.

Figure 1: A paradigm shift

PCT commissioning		GPCC commissioning
Local leader, system intermediary	<b>Perspective</b>	Advocate, architect
Clinical and patient engagement and buy-in	<b>Design</b>	Clinical leadership and patient voice
System maintenance	<b>Strategic objectives</b>	Patient-centred health gain
Budget, targets, standards, service levels, activity etc.	<b>Measures</b>	Health outcomes and evidence
Measure, monitor, manage	<b>Ethic</b>	Influence, inform, navigate

### **The upheaval is not to be underestimated**

The NHS currently spends around £2.5bn on commissioning healthcare in England or, expressed another way, around £50 per citizen. In the transition towards new forms of commissioning, this pot of money by necessity declines and the balance transfers to new statutory NHS organisations and others.

Once management cost targets have been achieved, with a saving of between £0.5-£1.0bn, the balance of commissioning spend is likely to be split to the NHS Commissioning Board, local authorities and GP-led commissioning consortia. For the 20,000 PCT managers who remain in the post cost-reduction world the future is now uncertain. GPCCs and local authorities will be keen not to replicate PCT structures and inherit TUPE'd NHS managers lock stock and barrel. PCT staff will be similarly keen to rapidly explore viable parachute options, both as individuals and as organisations. The list of potential pathways is a long one; perhaps a future as a social enterprise or arm of the local authority to deliver commissioning services, or an NHS-family sector-based support service or through a fully externalised organisation or community interest company.

### **The key challenges for PCTs and SHAs in transition**

For PCTs and SHA commissioners there are three challenges which must be met head-on over the next few months:

- Continuing the work to ensure that health economies remain solvent in the worsening future years' funding
- Delivering on operating plan management cost savings of anything up to 75%
- Determining transitional structures to facilitate the handover of functions.

### **Solvent health economies**

Successfully delivering Quality, Innovation, Productivity and Prevention (QIPP) is not about tinkering around at the periphery of service redesign, it is about a major system overhaul and rebuild. The ongoing must-do that is QIPP means that commissioners and their partners need to reshape the way that local health services are structured, commissioned and provided. If QIPP is successful patients and the public will need to experience greater choice of healthcare provider, a higher level of personalisation of care and ever-increasing improvements in clinical outcomes.

Commissioners will need to be able to respond to this agenda to support improvements in individual organisations' performance, support the delivery of quality improvements and cost savings across the local health community, avoiding unintended consequences to patient

care; and support all organisations in achieving sustainable financial balance during a period of intense funding challenge.

### **Reduction of management costs**

The management cost reduction targets, intensified by the revised operating plan for 2010/2011 raises the stakes even further for commissioner performance; how to achieve the challenging redesign agenda outlined above, with fewer staff and potentially organisations in major structural upheaval as a consequence. For the average PCT the proposed changes to management costs imply a reduction of 40 – 50% in management resource, equating to c. £6m per PCT. For a few PCTs the change implies that more than two thirds of management staff will go. This scale of change and the timeframe within which the cuts need to be achieved represent a challenge to even the most lean and high-performing commissioning organisations.

Consequently many commissioning organisations now face the very real threat of brain drain in the face of uncertainty about the future. Loss of generic skills (finance, IT, HR, procurement) to other sectors of the economy, now picking up after the recession, as well as the loss of specific attributes such as local knowledge and specialist commissioning models and tools. A few providers, seeking to maximise their position, may have cause to see this as an opportunity – a lack of continuity on commissioning means that for the next round of contracting all previous bets are off – but most providers will share the anxiety that weak commissioning may mean wider instability across the system and ultimately a lack of financial grip and managed change.

### **Transition to new structures – Commissioning for patients**

The transition to new commissioning arrangements is a complex one. Within nascent consortia there are likely to be few GPs who have previously given a significant time commitment to commissioning, other than at the micro day-to-day level of individual patient referrals and demand management. Success in the new commissioning model will depend on having distributed leadership, with a larger number of GPs leading change within their own practices and in specific clinical areas and with generally a much sharper knowledge and awareness of commissioning spread across the primary care clinical community.

These are no small tasks, the key to success being to ensure that commissioners are efficient in form and function, aligned to current requirements and enabled to meet future ones. In the next section we turn to the key tasks required to make this happen.

## Orderly handover – the key tasks

Key points:

- PCTs now need to refocus their structures and resources to simultaneously deliver on a transitional model towards new forms of commissioning, achieve management cost reductions and increase momentum on QIPP delivery
- DH, SHAs and the Commissioning Board are critically important in giving industrial-strength clout to the QIPP agenda and in leading the intervention where health economies show signs of failing, in orchestrating clinical and leadership development programmes and in licensing/authorising GP-led commissioning consortia
- GPCCs will want to take the lead in terms of defining their own future forms and functions, pushing for early engagement in delivering effective commissioning and commencing the route to becoming an operationally effective organisation.

### Key tasks for PCTs

The immediate tasks for PCTs in working with nascent GPCCs and in continuing to deliver against QIPP and management cost savings are to successfully resolve transitional structures, allied to the management cost savings agenda, to lead the local delivery of QIPP and to resolve the unfinished business of externalisation of provider functions.

### Transitional structures and management cost savings

Our work with PCTs has concluded that issues of transitional structures and management cost savings are best resolved simultaneously. There is a risk that, in looking at management costs in isolation, PCT commissioning directorates become subjected to a salami-slicing of staffing and costs until a somewhat thin and frail set of functions emerges from the slicer. Or else, changes are adopted which, in the light of future GPCC structures and functions, begin to look at best short-term and at worst a lurch in the wrong direction.

The starting point is also a complex one. A typical PCT currently performs hundreds of functions; some of these statutory functions, mandated under the NHS Act, 2006, others grown organically around the delivery of commissioning responsibilities.

There is now a series of questions for PCTs and GPCCs to ask of these functions:

- Do all of these functions actually need to continue to be delivered either in the immediate transitional phase or in the new commissioning system?
- Where do those retained functions need to reside, now, in transition and post-2013?

- What are the opportunities now and post-2013 for efficiencies in delivering some of these functions?
- What are the new functions required by GPCCs which the PCT may wish to develop or support in transition?

The third question in particular involves exploring the scale benefits that can accrue to commissioners either by changing the existing model of provision (Is there unnecessary duplication across functions? Is the skill-mix appropriate?) or exploring opportunities to deliver commissioning services across a wider catchment. We already know from looking at PCT costs that there is a strong inverse correlation between the cost per capita of delivering effective commissioning and the size of population commissioned.

To effectively answer these questions and deliver a successful model of GP-led commissioning requires a change in the structure and functions of commissioning organisations. To deliver structural transition, particularly for PCTs faced with a >50% reduction in management costs, this may also require a short to medium term reinvention of PCT structures, and a radical overhaul of the management models required to deliver PCTs' statutory and strategic functions.

### QIPP Delivery

Most health economies already understand the need to urgently get to grips with delivering QIPP. The PCTs' role is to now accelerate the pace of transformation, moving the agenda from understanding the financial gap and the consequences of not changing the current system, to focusing on oversight of local delivery. They will need to look at the set of initiatives that will deliver short-term operational efficiencies, medium term changes in the means of delivering effective care and longer-term shifts in the balance of healthcare. This process can also be used to identify, and where possible avoid, costly intervention further downstream. To achieve this will require strong and active engagement of all health and social care partners, patients and the public in firstly understanding the rationale for change and then supporting the active implementation of that change. This is also an early opportunity for PCTs to shift GP commissioning from the touchline to the playing field. Take many health economies' models for the redesign of long term conditions for example; highly dependent on delivering a shift of care into more appropriate, often lower-cost settings, also dependent on influencing historical clinical practices around referral, intervention and support. These are ideal arenas for the strong involvement of GP commissioners and in strong contrast to PBC schemes which in many parts of the country were too often small-scale and peripheral.

## Unfinished business

PCTs also have a powerful role to play out in local health economy provider development. As well as the unfinished business around the successful floatation of community services, PCTs will want to be thinking about how to foster integrated working; redesigned contractual integration to support effective pathway working across disease areas; horizontal integration across health and local authority services; integration of health and social care needs assessment, in preparation for the advent of health and wellbeing boards. Also, in the advent of significant reduction to local authority budgets, a joint approach to commissioning will be increasingly important.

Many PCTs are also now beginning to consider potential future structures for commissioning support organisations that might exist post-2013. Options include transition into commissioning shared support services organisations, either as not-for-profit social enterprises, partnerships e.g. with local authorities, as fully independent entities or some combination of the above.

Whatever the likely future structural form, if PCTs are considering such migration rather than out and out dissolution, the key considerations are likely to be:

- What will GPCCs want to buy? Understanding the gaps in capacity and capabilities of GPCCs
- How to package the offer? Understanding how to effectively package the services that could be provided by a support organisation
- How to create a comprehensive offer? What further services and partnerships (including strategic partnerships) might be required in order to be able to offer a comprehensive and cost-effective set of commissioning services.

Legal and commercial structures will also be important for success, particularly where support organisations are considering switching staff out of NHS terms of employment.

## Key tasks for the DH, SHAs and NHS Commissioning Board

The key immediate tasks for the DH and SHAs are to oversee the industrialisation of QIPP, to facilitate the unprecedented degree of system change required to deliver solvent health economies. Further focus must also concentrate on skills and capability development for the new cadre of clinical leaders and in ensuring that GP-led commissioning consortia are fit for purpose from Day-1 of operation.

## QIPP whole-system delivery planning

Much of the work being undertaken by PCTs and their healthcare partners around the QIPP agenda is scalable and replicable, moreover the capacity no longer exists within commissioning staff to redesign methodologies and implementation plans 152 times. SHAs will take a stronger control of identifying the key QIPP delivery areas – where quality and cost benefits are both measurable and substantial – and rolling out their delivery on a SHA-wide

basis. The underpinning data and analytic architecture (for example, to support utilisation management or service redesign) can be much more effectively delivered at scale, whose implementation the SHAs can facilitate.

## Commissioning leadership/skills development programmes

Whilst GPs make commissioning decisions every day in the consulting room, articulated for example in patient-level decisions around whether or not to refer a patient or prescribe a particular drug, the acquisition of many commissioning skills by GP-led commissioning consortia will still require a structured programme of development and support. Again, given that the likelihood of success of GP-led commissioning will be enhanced if models of distributed leadership are possible, and with over 40,000 GPs in England, consideration should be given to how delivery of skills and leadership development can best be achieved. In our work across PCTs and PBCs to design and deliver development programmes the key criteria for success have been:

- Flexible content design, to accommodate differing base-level skills across different organisations and within teams
- Flexible content delivery, to allow dipping-in and e-learning content
- Root the theory in the “day job” by applying early practical application to the deployment of tools and testing of methodologies.

Like other commissioning skills that are bought-in, SHAs may also wish to consider whether they facilitate a process to ensure quality and consistency of organisational development support.

## GPCC authorisation/licensing

SHAs, and in time the NHS Commissioning Board, will take centre stage in ensuring the capability of commissioners and the outcomes delivered through the GP-led commissioning process. A likely process, already in development across several SHAs, is an authorisation process by which assurance can be given that GPCCs are fit to operate, both in terms of underpinning governance and in terms of Day-1 capabilities.

Offering early clarity on this process is helpful not only to give GPCCs insight into the range of functions that they are expected to deliver but also to set a development pathway to those GPCCs expecting to part of the first wave and wishing to identify potential gaps in experience, specialist skills or technical tools.

We have given an initial consideration for a possible pathway of GPCC development. This assumes three levels of capability:

- Level 1 – Understanding spend and outcome
- Level 2 – Actively influencing and improving health services. Able to shape the delivery of healthcare and address local variation
- Level 3 – Leading new and pro-active health services for individuals.

All levels will require a degree of achievement of underpinning consortia governance and consortia development such that the GPCC is operationally sound and has all key functions in place.

We have assembled our perspective on a possible assessment or readiness checklist for GPCCs. This is included in **Appendix 1**.

### Key tasks for GPCCs

The immediate tasks for GP-led commissioning consortia are to define future functions, structures, and roles, to lead in the transition and handover planning and in consortia capability development.

### Defining future structures, functions and roles

Many GPCCs in formation have already recognised that they must be able to define their new core competencies, taking a “no-holds barred” assessment of purpose, and to consider optimal permutations for commissioning productive services during the transition.

A key part of this process will be to recognise what options are available to consortia where they do not have the scale, skills or capability needed to function effectively or efficiently. There may well be qualitative and cost benefits in delivering certain activities at a cluster level, but the GPCC must ensure that individual consortia/localities receive a quality service.

One approach to this is to firstly examine, through detailed functional analysis, the scale of the likely functions and accountabilities required by the GPCCs, hence build up a picture of the likely functions, staffing and spend at consortia and locality level. The GPCC can then make an assessment of key gaps and areas for consortia development, which might focus on particular skills such as negotiation or financial management or tools such as risk stratification or utilisation management. It can then further assess the functions/services delivered within the consortium structure and those which could be outsourced.

### Transition and handover planning

The first challenge for GPCCs, in the effective transition and handover, is to actively court a wider degree of engagement in the commissioning process. This is vital for the early success of GP commissioning consortia, particularly with PCT capacity declining and the need to deliver QIPP, to re-shape and improve services, accelerating.

GPs, through their practice commissioning leads and consortia should engage in the commissioning process and begin to play an early and pivotal role in local commissioning to be in a position to forensically analyse the degree and pattern of spending on local services and to use this early shadow period as a starting point for future commissioning development.

### Capability development

GP leadership of consortia will require significant development of commissioning expertise and leadership capability. Besides the GP community, much of the focus within the White Paper reinforces the importance of collaboration with other clinicians in primary, community services and secondary care as a critical factor for success.

GP commissioners, with input from organisations such as the National Leadership Council, should aim to articulate their requirements for development programmes to enable GPs to lead change within their own practices and in specific clinical areas, establish a structured programme of leadership development, tailored to different roles and starting positions and focus development on ‘live’ issues through action learning, coaching and service improvement projects.

### Effective engagement

Consortia leaders will wish to focus on the wider issue of effective engagement. This will begin within consortia, across the primary care community, to motivate, inspire and enlist the clinical community who will lead many of the changes in the new model of commissioning. A second key strand will be to simultaneously begin the dialogue with patients and the public, to set the agenda for change and begin to bring community accountability to healthcare commissioning decisions.

Consortia will also wish to consider wider clinical collaboration as early as possible so that it is not seen as a tokenistic add on and allows wider clinical leadership to develop.

## Appendix 1 - GPCC Readiness Assessment

Below is Tribal's GPCC Readiness Checklist. The checklist outlines the key areas of GPCC functionality and describes associated activities for those involved in GPCC development. For many of the functions outlined below there are considerations to be made around how the function is delivered (within the GPCC or externalised/outsourced).

Key:

- 1 – Understanding health spend and outcomes
- 2 – Actively influencing and improving health services
- 3 – Lead new and pro-active health services for individuals

		Sample Actions	1	2	3
Financial Management	Financial planning	Develop financial plan, consistent with statutory duty of being within cash limits. Interpret and apply the principles of national accounting standards and NHS CB guidance. Plan activity and expenditure for the year ahead (including capacity required, funding available, commissioning goals of the GPCC, uncertainty and risks). Monitor and ensure adequate provisions for Liabilities. Prepare Annual Accounts taking account of IFRS. Identify additional sources of professional advice.	✓		
	Budgetary management	Develop and manage financial performance assurance of national and local performance targets and operational indicators. Prepare the annual budget in line with the operating framework. Financial monitoring of all budgets, analyse and financially manage budget variances. Identify responsibilities for VAT issues. Coordinate the production of daily, weekly, monthly, quarterly and year end financial statements (including cash balances, financial returns, FIMs reporting, cash flow reports including aging debtors analysis).	✓		
	Transaction processing (invoices)	Pay invoices and adhere to the Prompt Payment Code and seek to bring about maximisation of BPPC. Develop mechanisms to maintain financial systems ensuring integrity of financial ledger. Creditor and debtor management. Maintain and update contracts information system to support invoice approval and performance management of contracts.	✓		
	Modelling demand and capacity	Develop/buy-in financial analysis and modelling techniques to support longer term planning. Develop/buy-in forecasting and risk assessment methodologies.			
	Resource profiling	Plan and oversee resource allocation. Completion of annual programme budget information and analysis. Programme budgeting for agreed programmes for the GPCC strategic plan.		✓	
Information and Knowledge Management	Patient engagement	Develop public engagement strategy. Ensure public, patient and carer involvement in shaping services. Facilitate and present at public meetings and events. Using available intelligence, including surveys, polls and web forms to inform our strategies / plans. Ensure service user/carer/patient involvement in contracting through schedules.	✓		
	Data assurance	Develop process to ensure compliance with legal and best practice for security and technical specifications. Procure expert IM&T advice for the development of business cases and for implementation to support business delivery. Maintain authorised signatory database and budgetary reporting database. Interpret and implement national IMT policies.	✓		
	IT systems management	Identify responsibilities for leadership around IM&T systems. Development of IT policy. Plan and forecast IM&T spend. Align IT programmes to support strategic planning. Identify and deliver data warehousing needs / solution. Provide/buy-in input on aspects of data management and data quality. Oversee information sharing across agencies.	✓		
	Reactive analysis	Trend analysis and interpretation of key data flagging anomalies to the appropriate business leads. Extract, interpret, feedback analysis and supporting data.	✓		
	Investigative analysis	Analyse and interpret policy and technical data and its impact on service development. Analyse and interpret surveillance data. Prospective data gathering and modelling.		✓	
	Management information and business intelligence	Provide accurate board reports on performance. Benchmarking (including primary care and continuing care costs) Interpret performance requirements from the national and regional operating plans (including mapping KPIs into an integrated performance framework). Lead Local Health Community ICT development - strategy and vision.		✓	
	Evidence access	Evidence based techniques in strategic decision making. Medical direction in place, incl evidence-based approach. Policies e.g. setting priorities for investment / disinvestment.		✓	

		Sample Actions	1	2	3
Service Improvement and Leadership	Assessing need	Understand the needs of patients in the local economies they live in and commission services to meet the needs. Ensure that national, local needs and service demand are fully understood and inform commissioning and contract performance. Health needs analysis to support strategy and planning.	✓		
	Pathway improvement	Clinical champions in place to lead service change . Advisers in place for development of clinical and social care pathways. Set clinical activity and quality performance indicators.	✓		
	Medicines management	Lead, develop and implement the GPCC strategies on prescribing, medicines management and primary care pharmaceutical services. Identify responsibilities for horizon scanning in relation to medicines management and provision of pharmaceutical intelligence, corporate governance relating to the pharmaceutical commissioning. Supporting local prescribers in following current, evidence-based, best practice prescribing through local and national guidance e.g. NSFs / NICE. Effective provision of pharmaceutical advice and support to practices / clusters. Identify responsibilities for analysing prescribing data and trends (Acutes, GPCC, PBC cluster, practice and prescriber level) to inform financial management. C31		✓	
	Pathway improvement	Identify source of clinical/ financial input into joint strategic work and into the assessment of new clinical pathways. Ensure that commissioners have appropriate support systems in place to effectively deliver and monitor GP commissioning.		✓	
	Utilisation management	Coordinate responsibilities for utilisation management. Develop/buy-in systems to analysis current system utilisation and gaps/opportunities. Identify opportunities to improve efficiency through the use of IM&T solutions and training.		✓	
	Admissions avoidance	Responsibilities for analysis of admissions patterns and variation. Systems/ analytical tools identifying admission avoidance opportunities. Develop the effective commissioning of alternatives.		✓	
	Referral management	Identify responsibilities for referral management and RM strategies/plans. Source tools and methodologies to identify and address performance variation.		✓	
	Predictive modelling	Lead/buy-in support for the implementation of and ongoing running of predictive modelling tools. Provide reports highlighting areas of clinical risk/opportunity for quality/ cost improvement. Feed into commissioning planning cycle.			✓
	Health system reform	Identify responsibilities to reform plan and reform supply-side. Develop reform strategy and partner/public engagement approach and project plans. Lead on reform/transformation implementation plans.			✓
Provider Influence and Management	Payment assurance	Develop and manage work to ensure correct payments are made.	✓		
	Provider performance management and engagement	Performance management of contracts (including monitoring and evaluation). Interpret analysis of provider performance against agreed performance indicators. Scrutinise relevant provider plans, proposals and business cases, working with relevant leads in the commissioning team as necessary, identifying impact and risks. Obtain and interpret contract information on an individual case by case basis when advising and informing regarding placements and care packages. Ensure performance frameworks are in place.		✓	
	Contract negotiation	Develop and implement standard operating procedures for contract development and contract negotiation. Develop contracts using national model contract template. Develop and maintain policies, procedures and timetables for contract development. Source support to the whole contracting process.		✓	
	Quality and outcome management	Development of contract performance management tools. Monitor robust metrics for key work programmes. CQUIN programme in place. Ensure contract service specifications take account of financial efficiency, clinical quality and seek to drive continuous quality and service improvement.		✓	
	Service specification	Interpret and analyse local and national priorities and incorporate in service development and design. Ensuring that the GPCC commissioning intentions accurately reflect national requirements e.g. NICE. Align KPIs in health and social care within an overall performance framework. Challenging providers to present business cases offering new patient-centred cost-effective service delivery models aligned to plans. Ensure clinical quality, equality and clinical effectiveness in the design of services.		✓	
	Market development	Interpret and apply national policy and guidance in relation to Market Development and contracting. Market segmentation and provider analysis incorporating price sensitivity, capacity, location and suitability. Ensure that processes for competitive tendering and procurement are in place. Manage relationships with providers and potential providers (including voluntary and third sector) in all markets. Work with other commissioners to deliver joint contracts. Market development and management including brokering solutions between competing providers.		✓	

## Commissioning in transition Issues and challenges in the transition to new forms of commissioning

		Sample Actions	1	2	3
Pro-active Health Management	Patient Management Services	Develop linkages between predictive analysis, risk stratification and patient management services strategy. Identify PM services strategy based on high cost patient cohorts. Develop/source patient management solutions.			✓
Care Navigation	Care navigation	Identify responsibilities for patient experience and patient/care navigation. Develop and agree care navigation strategy, including international best-practice guidance and proposals for IT/technology support. Developing and testing approach with clinicians and patients. Operational reporting and feedback.			✓
Statutory Governance	Accountable Officer	Board structures and responsibilities defined. Appointments made. Board development plans in place. Advise on duty to consult. Secure support for Accountable Officer and corporate HQ, including governance. Support and maintain the board committee structure and operating programme. Develop escalation process for slippage or failure to meet performance targets. Develop Audit Committee reporting and support processes. Manage conflicts of interest between providers and commissioners ensuring no commercial advantage.	✓		
	Assurance to NHSCB	Complete assurance/licensing process. Address the management of corporate governance and compliance. Implement controls assurance to meet statutory requirements for health and safety, data protection, quality and diversity. Statutory returns e.g. CQC.	✓		
	Managing business risk	Policy on corporate risk management established. Risk management and crisis mitigation plans/processes in place. Disaster / business continuity plans in place. Treasury management policy. Counter fraud systems in place. Develop and maintain all financial accounts procedures, SFI, SOPs, Scheme of delegation and control process.	✓		
	Managing clinical risk	Develop and implement GPCC risk strategy. Structures in place for clinical performance management. Promotion and development of health, safety and welfare of GPCC staff. Risk, complaints and incident training including use and maintenance of systems. Establish strategies for patient safety as part of an overall quality framework (SUI reporting, incident reporting).	✓		
	Legal services	Systems to provide advise on management of complaints, claims and legal matters. Secure advise on management of FOI, data protection and information governance. Develop and implement a plan to meet litigation framework requirements and assessment regime. Process for appeals when funding decisions are appealed by clinician/patient.	✓		
	HR	Implement HR systems e.g. recruitment database, payroll and personnel information. Implement HR strategies and initiatives that enables the GPCC to meet its business objectives. Manage and share best practice performance. Identify responsibilities for devolved HR functions e.g. recruitment, staff performance management, appraisals and training. Commission Occupational Health Services. Development and implementation of HR policies to support the welfare of staff. HR policies made accessible to staff. Source professional advice to executive directors, senior managers and clinicians.	✓		
	Strategic planning	Develop strategic commissioning framework. Identify resource to develop and deliver of 5-year commissioning plans and AOP. Design and oversee implementation of clinical strategy. Establish local health priorities and ensure efficient expenditure on health interventions. Generate workforce models to inform business cases and option analysis.		✓	
	Partnerships and communications	Input to joint strategic plans including JSNA, emergency preparedness and other health strategies with strategic partners. Develop and deliver a communication and reputation strategy encompassing media and public relations, internal communications, issues and crisis management. Develop systems/processes for responding to enquiries and complaints. Ensuring consistent messages across the organisation and partner organisations. Establish press office function, including on-call media responsibility. Dealing with patients/public who phone or call in. Responsibility and approach to maintaining effective working relationships with systems partners: ambulance services, OOH providers.		✓	
Consortia Development	Transition planning and support	Write, implement and advise on all corporate policies. Plan the board agenda and workload. Ensure that corporate and local risk registers are maintained and integrated. Identify governance lead for Registration Authority matters. Establish programme management office to deliver the effective transition. Lead workforce planning across local health economy.	✓		
	Consortia, practice and personal development	Develop and review the strategy for commissioning development. Put structures in place to support professional and personal development of staff including Board and organisational development planning. Develop and deliver workforce and organisation development strategy. Development of Board Assurance Framework. Financial training. Corporate induction. Staff survey and feedback.	✓		

## About Tribal

Tribal is leading the market in the development and delivery of effective commissioning services and advice, providing commissioners with the confidence, skills and tools to lead service improvement. We provide advisory services, including transitional support and development of GP Commissioning Consortia. We also provide commissioning services, offering outsourced solutions for the delivery of expert tools and services.

- Supporting the local delivery of QIPP and system improvement
- Development of strategy and change plans for new commissioning organisations
- Organisational design and development, including commissioning skills development programmes
- Leading implementation of major change programmes.

Provision of specialist commissioning tools and services, utilisation management, invoice validation, medicines management.

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