



discussion paper

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Commissioning for quality

Key points

- Commissioners should play a defined and unambiguous leadership role in improving the quality of care across their local healthcare system.
- The three roles of commissioners are to promote quality improvement, to assure themselves that the services they commission are of appropriate quality, and to intervene where adequate quality and safety standards are not being met.
- PCTs can improve the scope and effectiveness of their quality improvement and assurance processes by collaborating with other commissioners, patients, the public and clinical staff.
- Commissioners should not rely solely on regulators and SHAs for assurance on the quality of their service providers.
- Greater clarity is required on the respective roles of regulators, commissioners and SHAs in promoting and assuring quality.
- Commissioners should take a strategic risk-based approach to prioritising quality improvement activities.

Primary care trusts (PCTs) have two key roles as commissioners: to drive up the quality of care as advocates for patients; and to drive efficiency and productivity as custodians for the taxpayer.

Our recent discussion paper, *Commissioning in a cold climate*, considered what commissioners need to do to prepare their health economies for the financial challenge now facing the NHS.¹ This paper focuses on commissioners' other key role: acting on behalf of the populations they serve to ensure local healthcare services are safe, effective and accessible and that quality of care in and patients' experience of the NHS continues to improve.

Background

This paper is based on discussions with PCT Network members at a workshop held in May 2009. At the time, the Healthcare Commission's report on events at Mid Staffordshire NHS Foundation Trust and the subsequent review of lessons learned for commissioners and performance managers by Dr David Colin-Thomé had just been published. In this context, attention was understandably focused on the role of commissioners in detecting and acting on cases of service failure. The aim of our workshop, however, was to take a broader view, and to develop a more comprehensive description of the role of commissioners in improving and maintaining quality standards.

Participants at our workshop agreed that the primary responsibility for the quality and safety of a healthcare service lies with the organisation delivering it, both with the individual staff providing direct care and with the board. However, participants were equally clear that local commissioners in PCTs and in practice-based commissioning (PbC) groups should have a defined and unambiguous leadership role in improving the quality of care across their local healthcare system. Commissioners are responsible for serving the interests of patients and the public, and are accountable for the outcomes of their planning, funding and performance management decisions, including the quality of services they secure for their local population.

'Commissioners should actively promote continuous quality improvement'

At the workshop, the roles of commissioners were identified as:

- promoting quality improvement
- assuring that the services they commission for their population are of appropriate quality and offer value for money
- intervening where appropriate quality standards are not being met.

This paper considers how commissioners might discharge these responsibilities and how they should work with the other parts of the healthcare system as they do so.

Quality improvement

Commissioners should seek to

actively promote continuous quality improvement in the services which they commission. This expectation is spelled out clearly in the world-class commissioning competencies, which specify a range of related processes and knowledge requirements for PCTs (see below).

Performing this role effectively demands excellent skills in both information/knowledge management and relationship management. It also requires a mature and sophisticated assessment of the investment commissioners should make in developing their own knowledge and understanding of specific service areas. On the one hand, commissioners require sufficient insight and expertise to know what high quality looks like, and to have an informed dialogue with providers on what is acceptable and feasible. However, good commissioners will also recognise that healthcare innovation and quality improvement

will emerge from good providers working closely with their service users and, almost by definition, cannot be fully specified.

In practice, the degree to which commissioners should involve themselves in the design and leadership of specific quality improvement initiatives will depend on the particular circumstances. Where a provider has clearly and consistently failed to keep pace with changes in practice, it may be necessary for commissioners to take the initiative in setting out what is required and demonstrating how it can be achieved. However, where a provider has a proven track record of continuous quality improvement, attempts by commissioners to specify routes to enhanced quality and service user outcomes could actually stifle innovation and ultimately be counter-productive.

Commissioning competencies

- Map and understand the strengths and weaknesses of current service innovation, quality and outcomes.
- Maintain an active database of best practice, innovation and service improvement.
- Analyse local and wider clinical and provider quality and capacity to innovate and improve.
- Share research, clinical and service best practice linked to clear specifications that drive innovation and improvement.
- Communicate with clinicians and providers to challenge established practice and drive services that are both convenient and effective.
- Set stretching targets and challenge providers to come up with innovative ways to achieve them.
- Catalyse change and help to overcome barriers, including challenging ways of thinking (e.g. in service design and workforce development) that have outlived their usefulness – and support providers who break with these.
- Translate research and knowledge into specific clinical service reconfiguration, improving access, quality and outcomes.
- Design and negotiate contracts that encourage provider modernisation, continued efficiency, quality and innovation.
- Create incentives where necessary to drive innovation and quality (for example, use of the CQUIN scheme).
- Develop relationships with current and potential providers, stimulating whole-system solutions for the greatest health and well-being gain.

Source: Extract from *World class commissioning competencies*, DH, December 2007

Commissioners must therefore strike a balance between focusing on their primary strategic role – creating appropriate environments and incentives that encourage provider innovation and modernisation – while maintaining sufficient capacity to drive quality improvement in a more proactive way where necessary.

One way in which commissioners can manage this dynamic is to ensure they work together to develop and disseminate knowledge of best practice, and to share expertise across the whole range of services which they commission. In many areas this approach is already taken, with one PCT in a region or cluster taking a lead for a particular service review or clinical pathway redesign, or with groups of clinicians working on service improvement projects on behalf of all practices in a PbC cluster. However, there is scope for this kind of joint working between commissioners to be strengthened.

Similarly, commissioners need to have well developed mechanisms for dialogue with the clinical and other care staff working in their health and social care economy who are best placed to identify opportunities for quality improvement. This will be embedded through PbC, but must reach beyond primary care into clinical communities in secondary and tertiary care settings and into social care providers and third sector organisations that have insight into the scope for improving service integration and other broader quality issues.

As well as maintaining relationships with providers and other commissioning organisations, commissioners need to have an effective dialogue with patients and the public to develop a shared understanding of what 'high-quality service' means to particular groups

and individuals, and what their quality improvement priorities are. This includes encouraging feedback from service users on their past experiences of care and current satisfaction levels, but may also involve working with people to raise their health and healthcare aspirations in order to address health inequalities and promote social inclusion.

Part of a commissioner's role in quality improvement is to ensure individuals are empowered to choose services on the basis of quality and outcomes and to constructively challenge inadequate service when encountered. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

As with relationships with providers, priorities for engagement and methods of handling this dialogue will be different with different individuals and communities. A one-size-fits-all approach to communication with the public is unlikely to be effective.

Assurance

As well as promoting ongoing quality improvement, commissioners need to assure themselves that existing services meet acceptable standards. While regulators clearly play a critical role here, commissioners should not assume that assurance from regulators and strategic health authorities (SHAs) is sufficient. This was one of the key lessons for commissioners from the investigation at Mid Staffordshire NHS Foundation Trust. As the eyes and ears of the local healthcare system, and as the

'Commissioners need dialogue with the public to understand what high-quality service means to particular groups and individuals'

agents with the most comprehensive picture of the system as a whole, commissioners in both PCTs and practices should actively monitor the quality of services delivered by their providers.

High quality care for all suggests that commissioners should measure quality across three domains:

- safety
- effectiveness
- patient experience

This requires an ability to combine both 'hard' and 'soft' sources of data for meaningful analysis.

Hard data

Large volumes of quantitative data on the quality of services are available from different sources. These include clinical outcome measures, patient reported outcome measures (PROMS), patient and staff survey results, national performance indicators, and reports of 'never events' and other serious untoward incidents. Commissioners could also consider sources outside the NHS, such as coroners' reports.

While locally defined and collected datasets provide a starting point for tracking quality improvement over time, it is crucial that commissioners have access to comparative data so they can benchmark the performance of their providers. This demands a significant degree of standardisation in approaches to data collection and reporting. Local ownership of information is important, but should not be pursued to the extent that no

‘It is a commissioning responsibility to test the quality of clinical coding’

comparable data are available.

Where national datasets do exist, or could be collated, it would be helpful for more consistent analysis to be undertaken on behalf of all PCTs to avoid duplication of effort. There is no need for every PCT to separately undertake the same routine analyses.

Consistent analysis nevertheless will still need to be supplemented by local interpretation of the data. There is undoubtedly a challenge to PCTs to have the analytical capacity to both collect and make sense of these varying sources of information to gain assurance or identify concerns. This is another area where commissioners could share expertise and resources across a number of organisations, and many already do so.

Even where analytical capacity exists, however, appropriate interpretation and use of quality-related information clearly depends on the availability and accuracy of the underlying data. A further dimension to the quantitative analysis of service quality, therefore, is to understand the quality of clinical coding. Inaccurate clinical coding does not just mean commissioners may be paying for the wrong volume, type and level of care. More significantly, it means commissioners do not know whether the care being delivered is appropriate. A recent report from the Audit Commission² showed that problems with coding data quality remain. It is a commissioning responsibility to both promote and test the quality of clinical coding as a vital part of gaining assurance of other dimensions of clinical quality.

Soft data

Assessing quality using soft or

qualitative data is just as important as quantitative analysis for commissioners. Dr Colin-Thomé’s report into Mid Staffordshire recommended:

“PCTs should ensure they are not relying on national data alone, but should seek to supplement this with local and more granular data which can then be triangulated to give a more accurate representation of quality. Data from patients and the public must be part of this data set.

“Any evidence, however early, ‘soft’ and informal that reveals consistent patient and public concern, must be investigated by the PCT.”

In many ways the use of soft data is more difficult. It requires effective listening and communication skills to get feedback from patients and the public about the quality of services, including using the third sector and community partners to solicit the views of people who may not proactively speak out. This type of engagement goes well beyond the use of patient survey techniques. Formal mechanisms such as LINKs and overview and scrutiny committees are likewise important, but not sufficient.

A recent Picker Institute report³ showed that PCTs have made considerable progress in establishing patient and public engagement mechanisms as an integral part of the way they work. However, there is still some way to go before they can demonstrate that these systematically influence decision-making.

PCTs also need to be able to develop a dialogue with clinical staff to hear directly any concerns they may have. This would include both clinical staff within the services commissioned and from referrers such as local GPs

about the quality of services. To achieve this PCTs need to build trust with clinical staff, and have the ability to manage the tensions this may cause with the management of the provider organisation.

Information obtained from service users and providers should be supplemented with site visits by commissioners as appropriate, and potentially through ‘mystery shopper’ exercises. Again, this needs to be handled sensitively, but judgements on quality can be significantly enhanced by direct observation and on-site dialogue with patients, carers and clinical staff.

Intervention in areas of concern

The Healthcare Commission’s report on events at Mid Staffordshire and Dr Colin-Thomé’s subsequent review raised, amongst many other issues, questions about the role of commissioning in improving and maintaining quality standards.

The Government responded, stating:

“It is clear from Dr Colin-Thomé’s report that the local commissioners – the PCT and practice-based commissioners – were not sufficiently aware of the poor quality of care in the hospital. They did not have access to or seek a broad range of information, including hard and soft intelligence and assessments of patient experience, to form a rounded picture of the quality of care at the trust. Nor were they assertive enough to step in and demand improvements on behalf of their patients. They accepted the situation too readily, as did the other organisations in the system.”

The events at Mid Staffordshire

provide an extreme example of service failure. However, while this situation was not indicative of the quality of NHS care in general it must be acknowledged that instances of poor, and sometimes unacceptable, practice do occur. Other high-profile cases that have gained national attention recently include Maidstone and Tunbridge Wells, Baby P in Haringey, GP out-of-hours services in Cambridgeshire and the deaths of people with learning disabilities in acute hospitals.

No doubt there are other less well known examples elsewhere. In each case where something goes seriously wrong with a service, it raises a series of questions for the commissioners:

- Did the commissioner know about the problems in the service?
- If not, why not?
- If the commissioner did know about the problems, what did they do?
- If the commissioner did act, was the action sufficient?

Where commissioners are not assured about the quality of any of the services they commission, detect early warnings of a potential decline in quality or suspect a breach of acceptable standards, they have an unambiguous responsibility to intervene. The intervention will depend on the nature of the concern, but would normally start with a discussion with the provider during established quality review procedures, unless it is too urgent to wait for a regular meeting.

Using the standard NHS contracts

The standard contracts for NHS services provide a helpful framework for commissioners to focus on quality issues, and to fulfil all three aspects of their quality role. Under

these contracts commissioners are required to agree a schedule of quality standards (some of which are nationally specified) with providers, and to develop Commissioning for Quality Improvement and Innovation (CQUIN) schemes with financial incentives for quality improvement.

For ongoing assurance, providers are required to produce monthly clinical quality performance reports for their commissioners, and the coordinating commissioner should hold a monthly clinical quality review meeting with the provider to discuss:

- the clinical quality performance report
- any matter concerning healthcare acquired infections (HCAIs)
- any serious untoward incidents (SUIs) or reports or investigations of SUIs
- any patient safety incidents or reports or investigations of patient safety incidents
- any patient deaths requiring consideration
- any complaints received in relation to the services provided
- any information, notification or advice received from Monitor or any regulator
- any joint clinical investigation report undertaken by the provider and commissioner
- any remedial clinical action in relation to breaches in quality standards and progress reports on implementation of these plans
- any service innovation and development.

The contracts also set out details of how clinical quality problems should be handled. The clinical quality review meeting can agree to take no further action where the provider

'Standard NHS contracts provide a framework for commissioners to focus on quality'

has resolved the problem and it is not likely to reoccur. However, where further investigation is needed, the commissioner and provider would normally initiate a joint clinical investigation which would report back to the clinical quality review meeting and if necessary recommend a remedial clinical action plan. In some cases a commissioner will want to ensure independent clinical input to such an investigation.

Once the remedial clinical action plan is agreed, the implementation of the plan should then be monitored. Where the plan has not been implemented due to failure by the provider, the commissioner has powers to hold back contractual payments and to issue an exception report to the provider's board of directors and the relevant SHA, regulator or Monitor. The Care Quality Commission (CQC) and Monitor have their own powers of intervention which they may use having had such a notification.

In extreme cases, where a commissioner reasonably considers that there may be an immediate and serious threat to the health and safety of patients, there is the power for the commissioner to partially or totally suspend the affected service. In such circumstances the commissioner has the responsibility to ensure alternative provision of services is put in place to allow continuity of services to their patients.

Promoting transparency, openness and accountability

Commissioners have a responsibility to report back to the local population

about the quality of services which are commissioned on their behalf. This is both to support patients to make informed choices about the services they use and to demonstrate the accountability of commissioners to local people. This type of reporting is not always easy as it requires often complex and technical information to be presented in a format which is simple and understandable, but not misleading, to lay people. However, it is potentially very powerful: the knowledge that performance data is in the public domain can have a major impact in prompting providers to improve the quality of care.⁴

As well as publishing data themselves, commissioners should also expect transparency from providers. Commissioners should monitor what issues are discussed in public at provider boards, and ensure that quality concerns are presented and scrutinised alongside reports of service development and improvement and corporate governance issues.

The new requirement for all providers of NHS services to produce quality

accounts is designed to encourage greater focus on clinical quality within provider organisations, and to improve accountability. Commissioners should influence this accounting process by discussing the content and focus of quality accounts with providers at an early stage, and commenting on the providers' proposed annual account (and potentially requesting amendments) prior to publication.⁵

The roles of regulators, commissioners and SHAs

Workshop participants expressed a strong view that more work needs to be done nationally to explore the respective roles of regulators, commissioners and SHAs (in their system management capacity) in promoting and assuring quality. There is a significant risk of overlap or gaps in the current system due to ambiguity of respective roles. This could lead to either unreasonable burden on providers or inappropriate inaction, or both.

The National Quality Board is

currently considering these issues, but in the meantime participants at our workshop developed some proposals for the respective roles of providers, SHAs and regulators and how they should work with commissioners on quality. These are outlined in the text boxes below and on page 7.

Making it happen

Most PCTs already fulfil many of the roles and responsibilities set out in this paper, but it is unlikely that many will currently do them all, or perform them all consistently well. PCTs are continuing to develop rapidly as they progress towards world-class commissioning status. Participants at our workshop identified a number of actions which would help to support this development:

- development of standardised quality measurements to support commissioning (and provision) through benchmarking. If not forthcoming nationally then these could be developed by PCTs working collectively
- greater sharing of analytical

The role of providers

Provider organisations have the primary responsibility for quality of the services they offer. Commissioners should expect the following from all types of providers, although how they deliver them will vary and should be proportionate to the scale and nature of the service provided:

- openness about the quality of care with the public, regulators and commissioners, captured in quality accounts
- understanding of quality throughout the organisation and a culture of curiosity
- strong systems of governance, accountability and internal control, with effective risk management embedded in the organisation built around quality not just incidents
- good data and information systems to assess quality of services they offer
- ability to meet minimum standards and also continuing quality improvement and innovation
- genuine engagement and involvement of patients – finding out what quality means to patients.

Providers should have a duty to see themselves as part of a whole system and to cooperate. This should include engagement in standard setting and service specification.

The role of regulators

There are a range of regulatory bodies with responsibilities for quality in the health system. The key regulatory bodies are the CQC and Monitor. It is vital for these organisations to work together effectively, avoiding gaps, duplication, ambiguity and any unnecessary burden. The recent publication of a memorandum of understanding between the CQC and Monitor is an encouraging development.

Participants at our workshop felt that commissioners should expect the following from regulators:

- clear minimum standards/registration standards which not are subject to too much flexibility in interpretation. It is important that these standards are applied throughout NHS services, including in primary care
- regulators should be clearly independent in use of their powers of enforcement, for example fines and closure. However, the best course of action needs to be developed in partnership between regulators, the SHA and PCTs otherwise there is a risk that either everyone acts or no one acts. Given the range of organisations and the range of their respective powers it is critical to have agreement about the right action to take, with coordination of responses led by the commissioner as the local leader of the NHS
- good communication is critical, both between regulators and between regulators and PCTs. Regulators have lots of intelligence which should be shared with commissioners. Regulators should have a duty to inform the relevant commissioner in all circumstances where they are taking action with providers.

The role of the SHA

Participants at our workshop felt a clearer definition of the scope of SHA responsibilities is needed. The SHA's role should include:

- leadership – through promoting the right culture rather than through command and control
- holding PCTs to account for addressing quality issues in their local health economy. SHAs should expect PCTs to act and they should intervene only if PCT action is not sufficient/appropriate
- promoting openness about quality. SHAs should support PCTs to uncover poor performance and act on it
- highlighting best practice to support learning between organisations
- supporting data management on behalf of PCTs (where requested by PCTs) for example, SUI analysis
- supporting PCTs to move beyond national targets in their approach to quality
- supporting the development of PCTs and their commissioning workforce to become local leaders of the NHS.

The SHA's role in relation to NHS trusts is clearly different than for foundation trusts. The NHS Performance Framework sets out the respective roles of SHAs and PCTs in relation to under-performing NHS trusts. However, this process is new and therefore untested. It will be important for SHAs to work closely with PCTs to ensure this system works effectively.

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| capacity and service-specific expertise across PCTs | and the public and clinical staff, e.g. through structured site visits properly coordinated with provider organisations | already funded |
| <ul style="list-style-type: none"> • sharing effective approaches to use of contractual powers to intervene in the case of quality concerns • sharing of the means of developing systematic dialogue with patients | <ul style="list-style-type: none"> • sharing of lessons from the use of CQUIN and other incentives for quality improvement, and how to avoid paying extra for what is | <ul style="list-style-type: none"> • work to ensure that provider Quality Accounts properly reflect the concerns and interests of patients and the public – using the proposed validation responsibility for commissioners. |

Conclusion

It is vital that commissioners continue to focus on driving up quality of care at the same time as delivering increased efficiency and productivity in response to the far tighter financial position we expect to face over the next few years. This discussion paper sets out how commissioners can respond to this challenge.

To some extent this paper sets out an idealised vision of how commissioners should approach their role in quality improvement, and it is important to keep this in

perspective. PCTs have a defined role in the healthcare system which is distinct from that of the providers and professionals who retain the primary responsibility for service quality and safety. Commissioners have limited resources and must target their efforts in the areas of greatest priority and where they have the most potential impact. This means taking a strategic, risk-based approach to quality, as in other areas of planning and governance.

Commissioners should take their three quality improvement roles seriously and have no doubt over

their accountability for the quality of services they secure for local people. However, they should not micro-manage their providers or expect to scrutinise all services to the same degree and in the same way regardless of scale, scope and risk.

It will be important for commissioners to learn quickly which approaches are most effective in what circumstances. If you have examples of good practice which you want to share or have other comments on this paper, please send them to David Stout, PCT Network Director at david.stout@nhsconfed.org

References

- 1 *Commissioning in a cold climate*. PCT Network discussion paper, June 2009
- 2 *Payment by Results data assurance framework 2008/09*. Audit Commission, August 2009
- 3 *Patient and public engagement – the early impact of world-class commissioning*. Picker Institute, June 2009
- 4 See Shekelle PG, Yee-Ewi Lim, Mattke S and Damberg C, *Does public release of performance results improve quality of care? A systematic review*. The Health Foundation, 2008
- 5 For more information on quality accounts:
www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Qualityaccounts

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

For further details about the work of the PCT Network, please visit www.nhsconfed.org/networks/primarycaretrust

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