

# Role of the voluntary sector in providing commissioning support

*Research report*

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## Key Points

- Achieving high-quality commissioning requires expert commissioning support. NHS England's vision is that this support comes from a range of providers including voluntary sector organisations.
- There are some areas of commissioning support where the voluntary sector offers particular expertise, including needs-assessments, business intelligence, service re-design, and public and patient engagement.
- Commissioners, commissioning support units (CSUs) and the voluntary sector itself are enthusiastic about expanding its role in the provision of commissioning support. However, despite recognition of the sector's added value, some commissioners and CSUs concede that their knowledge of voluntary sector organisations is limited. There is also recognition that they could be clearer about what support they would look to the voluntary sector to provide.
- Voluntary sector organisations recognise that they need to be more explicit about the services they offer and their impact, and need to demonstrate how they can support wider commissioning agendas such as efficiency gains and integration, alongside improving patient outcomes and experience.
- Voluntary sector organisations interested in providing commissioning support are faced with a great deal of local variation. This leaves some unsure of how to enter the market and who to market their services to – either direct to commissioners or through other local stakeholders such as CSUs or strategic clinical networks.
- Much of the commissioning support currently provided by the voluntary sector is on a *pro-bono* basis. However, providing services on a consultancy-style basis may become more common as organisations develop their packages of support.
- There is a role for umbrella organisations who could assist in sourcing and completing bids for new work, or facilitating collaboration between organisations.
- Development of the lead provider framework (to be launched in 2014) is an opportunity for commissioning support suppliers, CSUs and voluntary sector organisations to formalise their joint offer to commissioners.



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## Recommendations and action points

### Voluntary sector organisations

- Maintain/build relationships with both your local clinical commissioning groups (CCGs) and CSUs.
- Clearly articulate how you add value to the commissioning process.
- Give CCGs and CSUs an explicit menu of options and packages of support. Target your approach, for example to what CCGs' commissioning intentions/priorities for the next year are.
- Consider partnering with other voluntary sector organisations to share resources for sourcing and responding to bids, and to offer commissioners a range of services.
- Think about the sustainability of the service you are offering and have a strategy for when you want to charge commissioners or CSUs.

### CCGs

- Maintain links with the voluntary sector through patient and public representative groups, and ensure that this expertise is adequately fed into your commissioning decisions.
- Ensure commissioning plans and intentions are easily accessed.
- Be clear about what services you might purchase from the voluntary sector and consider how you can create a clear, accessible entry process.
- Consider providing opportunities for local voluntary sector organisations to promote excellent commissioning, at local events for example.
- Consider including in your contract with commissioning support suppliers a requirement to involve voluntary sector organisations.
- Do not limit commissioning support requirements to large-scale contractual arrangements with CSUs; there may be pieces of work where the voluntary sector is best placed to lead the work.

### CSUs

- Consider what role the voluntary sector could play in your commissioning support offer.
- Be open to where the voluntary sector can add value.
- Be clear about what services you might purchase from the voluntary sector.
- Consider how you can create a clear, accessible entry process.

### NHS England

- Actively promote the role the voluntary sector in commissioning support and consider making it a requirement of the lead provider framework.
- Ensure that contractual mechanisms do not preclude the involvement of the voluntary sector in the commissioning support market.
- Consider the needs of the voluntary sector in the development of a supplier list. Develop new ways in which the diversity of providers can be easily accessed.
- Support capability- and capacity-building of the voluntary sector to be more involved in commissioning support.
- Demonstrate best practice in engaging and involving the voluntary sector throughout its own commissioning processes.



## 1. Introduction

Seven months into arguably the most significant reorganisation of the NHS since its creation, organisations from across sectors are still evolving and trying to understand how they will work alongside each other in the reformed system.

The reforms were designed to establish high-quality commissioning, led by clinicians and assisted by experts in commissioning support. While the number of clinical commissioning groups (CCGs) now seems fairly stable, the market for those supporting commissioners is still emerging. National policy-makers intend to create a competitive market for commissioning support where informed customers are able to choose from a range of high-quality providers. This vision includes harnessing the expertise of the voluntary sector, who can support commissioners in achieving many of their overarching aims such as improving care for those with long-term conditions whilst meeting efficiency savings, alongside delivering improved patient outcomes and experience.

However, as this research explores, despite enthusiasm for voluntary sector involvement in commissioning support from commissioners, local stakeholders and the voluntary sector itself, expanding its current participation is not without difficulties. Stakeholders lack awareness of what the voluntary sector can offer and where the gaps in current provision are. In addition, there are implications for the voluntary sector regarding capacity and brand identity, and perceptions of conflicts of interest for a sector commonly associated purely with service provision.

The voluntary sector will need to demonstrate its added value if it is to be seen as an essential component of successful commissioning and a credible partner by the group currently dominating the market – commissioning support units (CSUs). Despite positive messages from various sector leaders about collaboration, there are a number of barriers the voluntary sector will have to overcome if it is to substantially strengthen its presence and take advantage of the flexibility commissioners have to source their commissioning support.

### **Purpose of this report**

This report has been researched and written by the Nuffield Trust, who were commissioned by Macmillan Cancer Support and partner organisations NHS England, Neurological Commissioning Support and ACEVO (Association of Chief Executives of Voluntary Organisations), as part of their collective work to explore the role of the voluntary sector in the new commissioning structure.

This report was researched in a number of ways. First was participation in an event held on 9 September 2013, supported by Macmillan Cancer Support, NHS England, Neurological Commissioning Support and ACEVO, and hosted by Primary Care Commissioning.

The event brought together representatives from across the voluntary sector (large, small, provider, quasi-commissioner etc), CCGs, CSUs, local authorities, local Healthwatch and NHS England. The event will be referred to as ‘the voluntary sector and commissioning support event’ for the remainder of this report.

The purpose of the event and this report is to explore:

- what support CCGs and CSUs *want* and *need* from the voluntary sector and what the ‘value-add’ is
- what commissioning support services the voluntary sector *can* offer
- how a partnership between the voluntary sector and commissioners can uniquely help to resolve challenging scenarios commissioners encounter
- the necessary next steps to ensure strong collaboration between commissioners, commissioning partners and the voluntary sector.

Second, the content of this report has been guided by interviews with key policy-makers, academics, and providers and purchasers of commissioning support. A literature review of key policy documents and other publications was also conducted. Case studies are included to illustrate the various ways in which voluntary sector organisations are engaging with commissioning.

The report begins with a brief description of the current commissioning support landscape, including research evidence about what types of support commissioners want and how they are likely to be contracting with providers in the future. It then goes on to discuss the voluntary sector offer and the challenges associated with their participation in the market. It concludes with some learning points for the voluntary sector, CCGs, CSUs and NHS England.

## 2. Context

### Commissioning

Commissioning is the process by which decisions are made about what services should be purchased to meet the health needs of a population. In the new structure of the NHS, clinical commissioners are central to the majority of commissioning decisions. See the appendix for further information about the commissioning process, how decisions are made and the roles of the various organisations involved.

CCGs are responsible for the majority of NHS commissioning including most hospital, community and mental health services. NHS England has retained responsibility for primary care and specialised commissioning, and local authorities are responsible for public health and social care services. These organisations all require commissioning support.

### Commissioning support

Commissioning support services facilitate commissioners in their decision-making process through the provision of advice, information, data analysis, and other services or expertise that commissioners need. NHS England has grouped together seven elements of commissioning support (Figure 1).

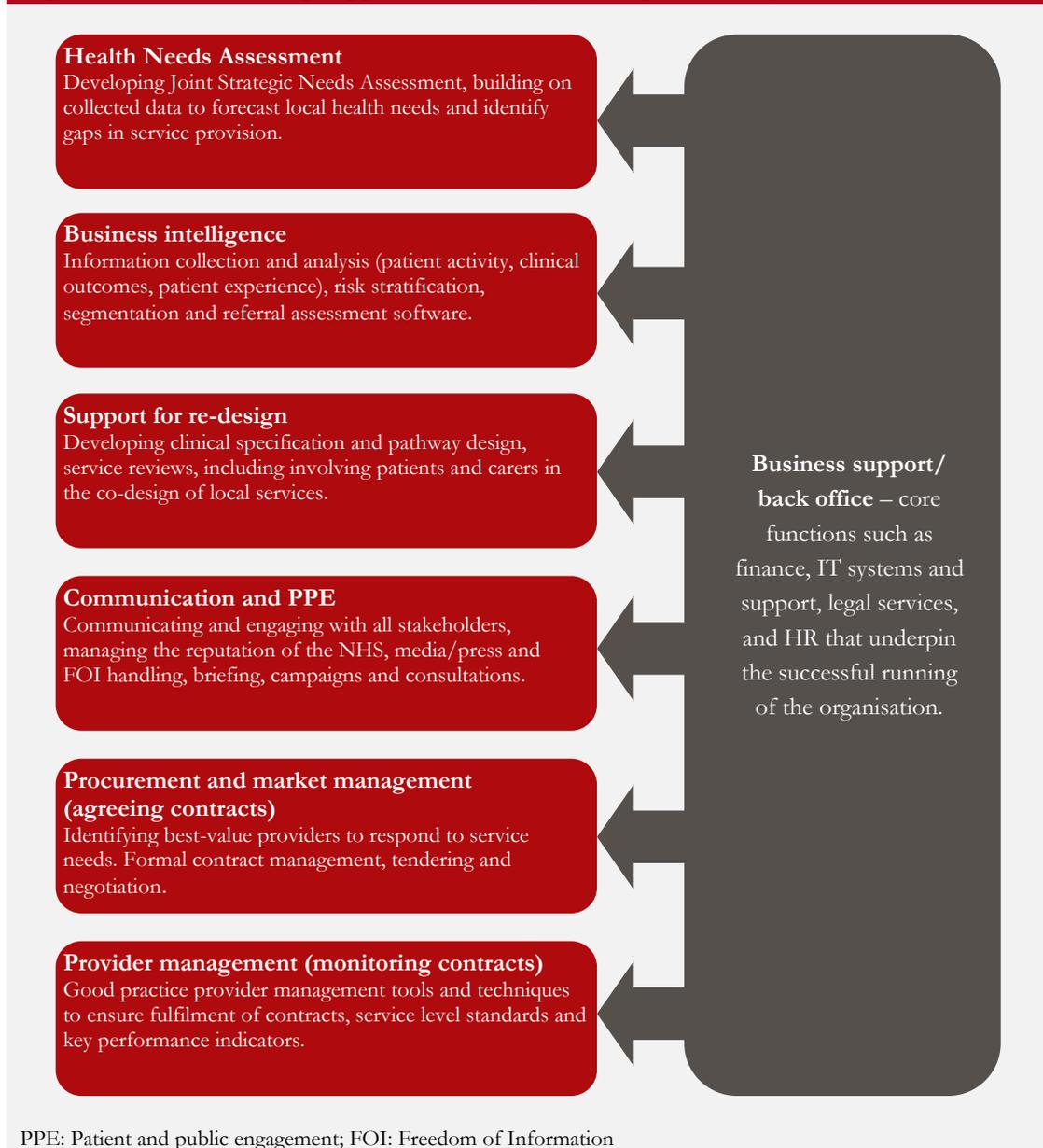
In addition to being a complex process in itself, commissioning takes place at a number of levels: from individuals as commissioners with personal health budgets, to the commissioning of specialised services at the national level (Smith and others, 2004). The potential for voluntary sector organisations to contribute to these processes exists at all levels. Bristol City Council, for example, has contracted a local voluntary sector organisation to provide individuals in receipt of personal health budgets with support in choosing a provider of services; acknowledging that for many service users, commissioning their own health services is a new activity.

CCGs have been given £25 per head of the population to spend as a management allowance. From this, groups can decide whether to outsource their commissioning support requirements or to invest it internally and have a larger in-house team. CCGs have flexibility around who they source their commissioning support from, as long as it can be justified in terms of value for money, quality and certain other requirements (see NHS England, 2013, for more information).

It is estimated that the 211 CCGs in England are spending approximately £500m on services provided by CSUs, with NHS England spending approximately £45m (NHS England, 2013). Although commissioners can use in-house services – and some rely on them entirely – the majority buy some external support. Before the creation of CCGs, research suggested that around 90 per cent of primary care trusts (the previous commissioning bodies) had procured external support on at least one occasion and the majority of these held multiple contracts with a variety of organisations (Naylor and Goodwin, 2010). If outsourced, it is usually provided in one of the following ways:

- short-term consultancy projects providing advice or support
- longer-term joint delivery models where commissioning takes place in partnership
- outsourcing discrete elements of the commissioning process
- full outsourcing.

Figure 1: Commissioning support elements (NHS England, 2012)



The market for commissioning support is being shaped by NHS England. The vision is that there will be a diverse range of providers, with commissioners making choices based on quality, range of services and price. The market will not be regulated by NHS England except where they perceive that the actions of a CCG or CSU could cause a market failure, that is, if a CCG were to withdraw all its purchasing from a CSU, or a CSU was planning to substantially reduce its offer to CCGs. At present, the range of providers to choose from is limited.

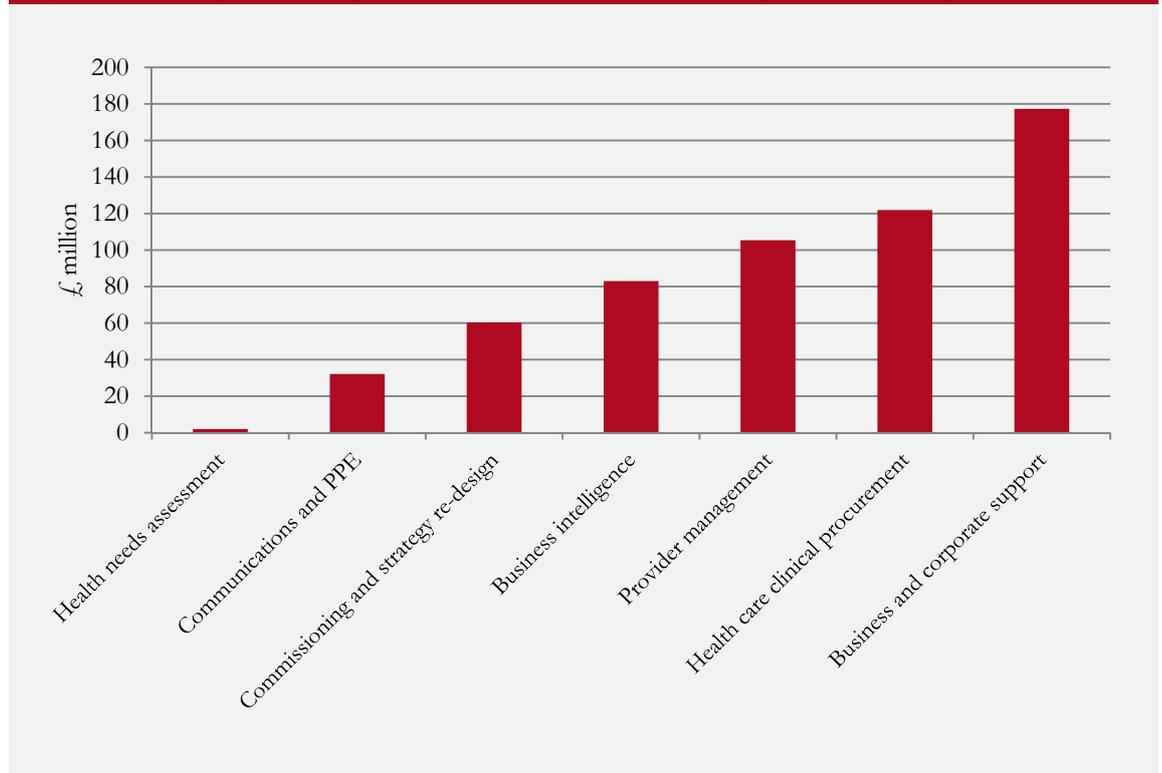
**Box 1: Support for local authorities and NHS commissioners**

Neurological Commissioning Support (a not-for-profit organisation) audited and reviewed neurological services across both health and social care for NHS Surrey and Surrey County Council. The audit covered neurology services but also focused on specific conditions such as: multiple sclerosis, Parkinson's disease, motor neurone disease, acquired brain injury and epilepsy. The work covered a number of areas:

1. **Audit of health and social care services in Surrey** using Neurological Commissioning Support's audit and evaluation tool, Quality Neurology. A number of focus groups and interviews with service users and carers were conducted as well as in-depth audit days with professionals to develop baseline performance.
2. **In-depth audits in Parkinson's disease and epilepsy** highlighted solutions for emergency care usage.
3. **Development of a Joint Strategic Needs Assessment** on neurological conditions chapter enabled inclusion within the overall Surrey Joint Strategic Needs Assessment as a direct result of this work. It lists a series of recommendations for how Surrey commissioners can improve the services they provide and better meet the needs of the local population.
4. **Development of joint neurology strategy** that will inform the five-year commissioning intentions of NHS Surrey.
5. **Identification of 'complex' patients and use of telehealth.** This was the first time a local complex care pathway for neurology had been designed in Surrey. The risk stratification tool, ArtemisICS, was used to identify patients likely to be admitted to hospital over the next year. These people were given a case manager or specialist nurse, and linked into the virtual ward scheme to keep them closely monitored.
6. **Development of informed vocational rehabilitation, end-of-life and psychology workstreams.**
7. **Support for the specialist neurology rehab pathway review** in West Surrey.
8. **Work with the South West London & Surrey Trauma Network** to plan and inform a major trauma rehabilitation stakeholder event.

### Providers of commissioning support

CSUs are one of the many new organisations created by the recent NHS reforms and they began undertaking their statutory duties in April 2013. Approximately half of the £1bn or so available from within CCG running costs is being spent on CSUs, and the other half funds a mixture of in-house provision, shared services with other CCGs, or services from the independent or voluntary sectors (NHS England, 2013). Figure 2 illustrates the services CCGs anticipate purchasing from CSUs, showing that there is a clear focus on business and corporate support. At the moment, they are hosted by NHS England; an arrangement that is expected to continue until 2016. There are currently 18 CSUs across the country, with the largest serving a population of five million and 20 CCGs, and the smallest serving a population of 1.4 million and five CCGs (Campden Health, 2013).

**Figure 2: CCG planned expenditure on NHS CSUs by category (NHS England, 2013)**

In order to begin establishing themselves as sustainable, independent and commercially viable organisations, CSUs are required to make a minimum of five per cent surplus, with a number already making substantially more than that. Indeed as previously described, CCGs are not the only purchasers of commissioning support; a few CSUs are generating 30 per cent or more of their budgeted turnover from sources other than CCGs, including the private sector (Campden Health, 2013).

In the delivery of their services, it is common for CSUs to partner with or outsource discrete pieces of work to private sector consultancies where they do not have the expertise in-house (Campden Health, 2013). It is this model which is also being used to work with the voluntary sector.

There are two main ways in which the voluntary and independent sectors can participate in the delivery of commissioning support: they can contract or engage directly with CCGs and other commissioners, or they can sub-contract or partner with CSUs. They could also partner with one another to deliver commissioning support services. The future of the contractual framework for commissioning support is currently under consultation and being designed by NHS England.

**Box 2: Supporting the commissioning process**

Macmillan Cancer Support is working with the NHS to re-design parts of the cancer pathway in a number of areas across the country.

One example of this is its work in Staffordshire. Macmillan is working with five CCGs, two local authorities and local public health colleagues from Public Health England to transform the way services are commissioned for people with cancer and for those at the end of life for all long-term conditions across the county of Staffordshire, including the unitary authority area of Stoke-on-Trent. It will do this work through the development of a Prime Provider model, so that patient care is commissioned and managed through a single provider who will be held accountable for the entire patient experience and clinical outcomes. Services will then be sub-contracted with NHS, private and voluntary sector providers to deliver care that is integrated and seamless for patients.

By offering a seven to ten year contract it will enable a transformation in service design and delivery focused on the patient and outcomes along an integrated pathway, and not on individual providers.

This partnership project has been selected to take part in the national Integrated Care Pioneers Programme, which will see 14 local areas demonstrate the use of ambitious and innovative approaches to deliver person-centred, coordinated care and support

### 3. Voluntary sector involvement

The voluntary sector has long been a provider of commissioning support in one form or another, although it is often not labelled as such. Traditionally this involvement has been advice on user experience with regard to a specific condition or patient group, or acting as a conduit for patient and public engagement. However, the voluntary sector also provides commissioners with data analytical support and clinical expertise, and some are getting increasingly involved in transformational change and system re-design. The recent compact between ACEVO and the CSU Network is recognition that the voluntary sector has a significant role to play in commissioning support (ACEVO and CSU Network, 2013).

#### Areas of expertise

Often the contribution of the voluntary sector is narrowly focused on support for patient and public engagement. While this is a key area, the voluntary sector offers expertise in terms of its clinical knowledge and legitimacy through its close relationship with service users. As opposed to more general commissioning support offered by other providers, the voluntary sector has the potential to provide expert, niche advice that is firmly grounded in the needs of patients. Participants in the research for this report felt that the voluntary sector could add considerable value in many ways, as set out in Box 3.

#### Box 3: Areas of commissioning support where the voluntary sector can add value

1. Use of data and patient and stakeholder engagement to identify current unmet need, anticipate future trends, and contribute to decision-making that is evidence-based.
2. Use of best practice in terms of data analysis; appropriate use of national and local datasets and up-to-date knowledge of valid process and output measures.
3. Bring condition-specific expertise to quantitative data analysis.
4. Translate data into practical next steps and anticipate the impact on patients.
5. Bring understanding to the patient journey across care settings.
6. Act as a neutral and trusted broker to initiate dialogue with service users.
7. Provide access to clinical expertise.
8. Involve local partners and advocates.
9. Collate the expertise of various voluntary sector organisations to provide evidence about a group of service users (and not only a single disease or age group).

#### Box 4: Developing tools to support commissioning

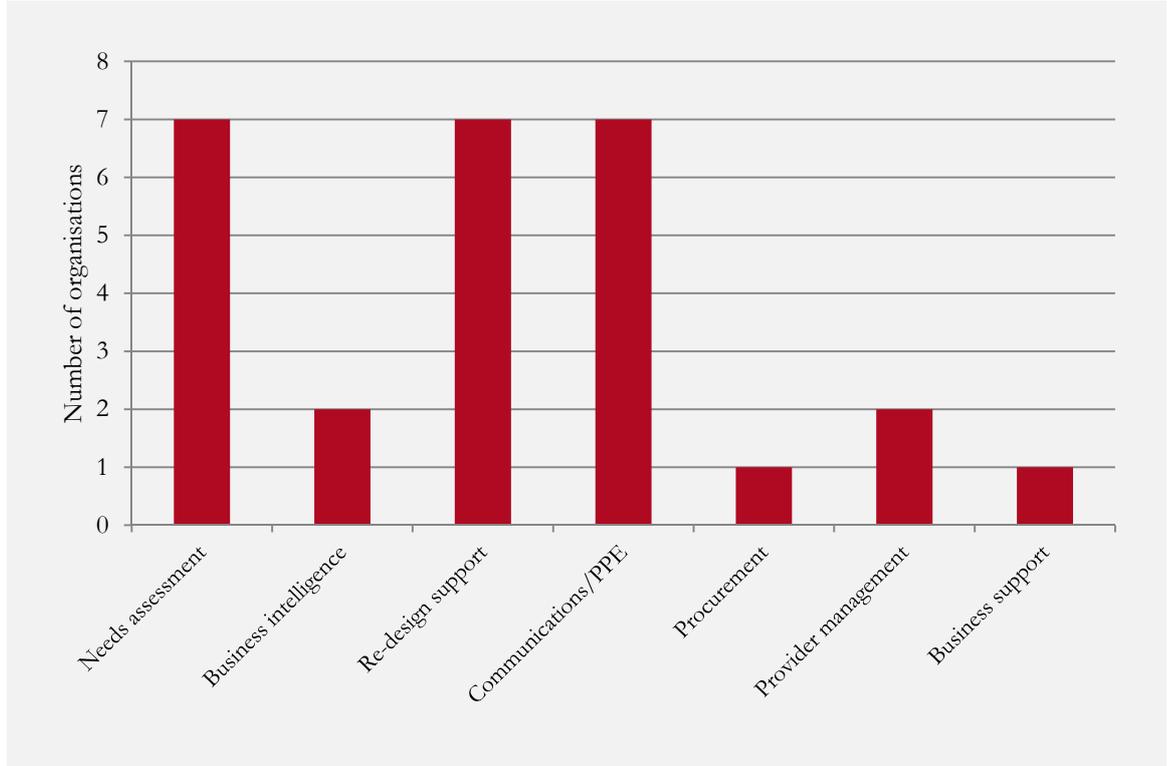
- Arthritis Research UK is funding research to develop the MSK Calculator to support musculoskeletal health. The MSK Calculator will provide commissioners, Health and Wellbeing Boards and others with information about the prevalence of musculoskeletal conditions in their area, combining local data with modelling techniques. This is the first time that a local dataset of this kind has been available. The tool will be free to all within the NHS and local government, as well as third sector organisations.
- Carers Trust has developed the Carers' Hub, a resource that provides a local needs assessment and tools for those commissioning or developing services for carers. The Carers' Hub can be used in consultation with carers and local carers services as a tool to map local carer need and service provision. It can be used to inform Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies, and other audit and planning processes, and maximise resources through the development of more efficient services and partnerships. It can also help monitor local progress on strategy implementation.
- Using pump-priming funding which it won, Neurological Commissioning Support has invested in developing clear documentation to help spread both best practice in terms of neurological care, and their offer to commissioners and CSUs.
  - Get e-QIPP-ed for neurology [www.ncssupport.org.uk/wp-content/uploads/2012/03/826-NCS-QIPP-publication-FINAL-NO-MARKINGS.pdf](http://www.ncssupport.org.uk/wp-content/uploads/2012/03/826-NCS-QIPP-publication-FINAL-NO-MARKINGS.pdf)
  - A ten-point plan for better commissioning [www.ncssupport.org.uk/wp-content/uploads/2012/01/Improving-the-quality-of-neurology-care-A-ten-point-plan-for-better-commissioning1.pdf](http://www.ncssupport.org.uk/wp-content/uploads/2012/01/Improving-the-quality-of-neurology-care-A-ten-point-plan-for-better-commissioning1.pdf)

### Current provision

While it seems unlikely that no one voluntary sector organisation could, or would want to, provide end-to-end commissioning support, it certainly has the capacity to contribute to the majority of NHS England's seven defined areas of support (see Figure 1 on page 9). A small number of voluntary sector organisations are well-known for providing some of these services (see the boxed examples throughout this report), but in a recent stakeholder mapping exercise conducted by Primary Care Commissioning and supported by NHS England, only nine of the 30 organisations contacted were actually providing support (Stimpson, 2013). As Figure 3 illustrates, provision is currently concentrated in a few service areas. Additionally, familiarity with the different types of commissioning support as identified by NHS England is sparse (Stimpson, 2013).

The vast majority of voluntary sector provision of commissioning support appears to be provided to commissioners or commissioning support organisations *pro-bono*, delivered as part of their charitable aims. The most common instances where organisations have been paid for the full or partial cost of providing their services are where organisations have provided materials, run an event with service users or managed a whole service re-design programme.

Figure 3: The range of services being provided by nine voluntary sector organisations (Stimpson, 2013)



#### Box 5: Large-scale commissioning support programmes

Macmillan Cancer Support is working in direct partnership with seven CCGs across South Yorkshire, Bassetlaw and North Derbyshire to support their strategic direction and the services provided to people living with and beyond cancer. It has resulted in a Survivorship Programme that spans organisational boundaries and moves away from a ‘one size fits all’ approach. It aims to improve patient experience and outcomes, as well as develop effective resource utilisation.

As part of the project, Macmillan funded local clinical champions to facilitate implementation at CCG level, enabling the strong engagement and ownership required across all sectors. Each of the CCGs are running projects to develop, test and evaluate a variety of support components of a ‘recovery package’ – a combination of interventions to improve care for people living with and beyond cancer.

More recently, the programme has been bringing together learning from all of the projects in each CCG locality to inform the development of a service specification for survivorship across primary and secondary care. This service specification will reflect a comprehensive, clinically safe and acceptable after-care service.

The partnership with Macmillan Cancer Support has enabled close links between commissioners and service users, and demonstrated how the organisation can support commissioners in the development of tailored services.

## 4. Exploring future provision of commissioning support

### Supporting key areas of commissioning

At the voluntary sector and commissioning support event, four areas of commissioning support were selected for in-depth discussion. Following is an outline of the key scenarios considered. As the event was attended by representatives from voluntary sector organisations, CCGs, CSUs, local Healthwatch, local authorities and NHS England, a range of perspectives are covered.

#### **User involvement**

User involvement was one of the most commonly cited ways in which the voluntary sector could add value to the commissioning process, particularly given the multitude of patient groups represented.

There was a general recognition that for user involvement to be relevant and to avoid being tokenistic, it needed to take place as early as possible in the commissioning process and involve an adequate number of patients. For example, if the clinical input has already been fed in and a new strategy has been agreed, it may be too late to suitably factor in the patient perspective. Equally, participants felt it was important that commissioners engaged with a sufficiently diverse range of patient groups, which might differ from those normally consulted with. Many voluntary sector organisations have well-developed local patient networks, and it was suggested that engaging with them would enable commissioners to capture the patient voice.

It was also agreed that the voluntary sector could play an important role in supporting service users to understand the objectives commissioners are trying to meet. For example, helping users understand the case for change, envision how services could be improved and try to move beyond a pre-determined preference for existing services (which, it was argued, is often the case).

In order to engage meaningfully with patients, participants felt that a cultural change was needed, where service users moved from being seen solely as recipients of care, to individuals who have a valuable contribution to make to the design and delivery of care. Patients could be involved in exploring new ideas and testing the effectiveness of new solutions, for example. The voluntary sector was seen as well placed to support this cultural shift.

As well as the voluntary sector, both CSUs and Strategic Clinical Networks (set up by NHS England to improve health services for specific patient groups or conditions) were also identified as being important in facilitating user involvement.

#### **Decommissioning**

Decommissioning services is an important part of the commissioning process. The involvement of the voluntary sector, and patient and public representatives, from the outset of the process was seen as essential – before any recommendation around decommissioning of a service has been made. As well as providing advice and data

intelligence, the voluntary sector was considered to provide a valuable role in supporting commissioners in the communication and dissemination of this information to health care staff and the public. This was seen as likely to help public acceptance and understanding of the case for change.

The involvement of the voluntary sector was also understood to add a degree of legitimacy to the process, demonstrating that the process had been consultative and patient representatives had been involved. However, there was a concern that this could be taken advantage of if, for example, voluntary sector involvement had been superficial and its input disregarded, but they were still named as part of the process to gain external validity. Involvement in decommissioning was also identified as a potential reputational risk for the voluntary sector, if the process was judged at the end to have had a negative impact on patients.

### **Specialised commissioning**

While NHS England is responsible for specialised commissioning, participants at the event recognised the critical interface between specialised and CCG commissioning. For example, while a lot of cancer services are commissioned through specialised commissioning, much cancer care and support is also commissioned at CCG level. Some participants called for clarity around the division of commissioning responsibilities. Participants debated who was ultimately responsible for a patient pathway that spanned different commissioning organisations. The split in commissioning responsibilities was identified as a potential risk to delivering joined-up patient care, particularly for those with multiple conditions. It was suggested that the voluntary sector could be useful in facilitating a collaborative approach to commissioning, helping to “glue the system”.

The involvement of patients in the design and delivery of the patient care pathway was seen as critical and something the voluntary sector is well placed to support. It was also suggested that the voluntary sector could support commissioners to monitor and understand how their decisions affect patients through the direct involvement of users. There was also some discussion about whether the voluntary sector could support patient advocacy and assist service users in getting their voices heard (for example in providing feedback or complaints), particularly in specialised services where the responsible commissioner can be difficult to access.

### **CCG strategic planning**

Strategic planning processes that lead to the development of commissioning intentions was another area where participants felt that the voluntary sector could provide support. These processes range from inputting into and shaping the Joint Strategic Needs Assessment, to supporting the development of a shared understanding of the commissioning priorities across the commissioning partners (for example CCGs, NHS England and local authorities).

Much of the discussion at the event centred around relationship-building and ensuring that a range of perspectives are considered. It was suggested that the strategic planning process should include CCGs, CSUs, social care organisations, community and voluntary sector organisations, community services, patients, carers and the often excluded groups (such as homeless people). It was recognised that it can be difficult for commissioners to get all these voices heard and considered, but that voluntary sector organisations should be considered as a useful partner for commissioners to access a variety of perspectives.

Other points raised included the need for commissioners to be open to different types of evidence; for example, qualitative feedback from a small number of patients representing a specific group. Some participants suggested that developmental work was needed with some patient groups and voluntary sector organisations so that they understood the language of commissioning and have enough confidence to be able to fully participate.

#### Box 6: Collaboration with the voluntary sector during a pathway re-design

The Inflammatory Bowel Disease pathway in Stockton-on-Tees was improved through a partnership approach involving GPs, patient groups, secondary care, commissioners, academia and Crohn's and Colitis UK (a national charity that works to raise the profile and standards of care for people with inflammatory bowel disease).

This partnership approach, which was led by the primary care trust but with close support from Crohn's and Colitis UK, allowed innovative solutions to be developed and implemented. It led to improvements in the patient journey including more choices for follow-up appointments, including in primary care settings, and improved education of GPs to enable better and quicker diagnosis, to reduce unplanned admissions. The project also developed an area-wide register of services. This led to a more prompt, reactive service and better access to referrals to specialist teams within acute trusts.

### Defining the offer

A strong message that came through in this research was for voluntary sector organisations to have clarity about their offer to commissioners or CSUs. Voluntary organisations need to communicate the ways in which they add value in comparison to general commissioning support and be able to demonstrate impact (Gamsu, 2011). Some organisations are already thinking about this and are considering marketing a consultancy-style set of services, promoting specific commissioning support products.

Participants at the voluntary sector and commissioning support event also recognised the need for CSUs and commissioners to be clearer about what support they would like the voluntary sector to provide and how best these organisations should make their approach and promote their services.

It may also be useful for interested organisations to consider how their offer fits in to broader agendas being considered by commissioners. At a separate event held recently, representatives from CCGs, CSUs, NHS England, voluntary and independent sector providers, and local authorities indicated that commissioners wanted support in achieving broad strategic aims, including:

- Quality, Innovation, Productivity, Prevention (QIPP)
- emergency planning and urgent care
- 24/7 services
- integration
- response to provider failure
- delivery of the recommendations of the Francis Inquiry report.

(Accelerated Solutions Event cited in NHS England, 2013)

**Box 7: Packaging the offer**

Disability Rights UK has developed a programme of work entitled ‘user-driven commissioning’. New pathways have been co-produced on the basis of people’s wants, needs, assets and insights. A range of local workshops explored the impact of lived experience on positive outcomes in health, independent living and quality of life, alongside integration and productivity gains. A range of budget-pooling projects have begun to shift economies of scale away from block contracts; quality has been put on a more equal footing with price in negotiations of service level agreements; and peer support has become a defined element to assess, specify and co-deliver improved access and discharge pathways in mental health, for example.

Disability Rights UK is now extending this approach into the NHS to achieve greater parity between medical and non-medical aspects of NHS care and to pilot payment profiles or at least incentives linked to Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs). They are also seeking to establish a ‘right to peer support’ centrally in the new NHS e-referral system (Integrated Customer Services Platform) and locally at GP level.

Turning Point is well-known for its model of community engagement and service integration that supports commissioners to better understand the needs of communities and inform their commissioning decisions. The Connected Care methodology is based on research undertaken by the local community through recruiting local residents and service users as Community Researchers. Once evidence has been gathered, Turning Point works with commissioners and the local community to create a series of proposals for service re-design. The Connected Care team have worked in 18 areas to date, have trained 268 community researchers and given 10,838 people a voice in shaping their local services. Connected Care has been cited as a model of good practice in the Department of Health’s ‘Vision for Adult Social Care 2010’. Turning Point has also established a Community Leadership Network, funded by the Department of Health, which supports individuals to become champions for their community.

**The value of local partnerships**

The voluntary sector has a history of working to influence and lobby decision-making organisations or individuals, something that could be described as the sector’s traditional model of operation. Although these influencing and engagement-type roles are different from the types of commissioning support activities being described in this report, they are an important way in which commissioners and voluntary sector organisations can build relationships with one another and may lead indirectly to the provision of more formal commissioning support services. Some CCGs have actively set up voluntary sector forums or committees to ensure engagement of the sector.

**Box 8: CCG engagement with the voluntary sector**

South Devon and Torbay CCG sought support from the voluntary sector in establishing a model of contracting that would enable a range of organisations to bid for services and support the voluntary sector to be able to put forward competitive tenders. Part of this process has included working with the voluntary sector to design the service specifications, using their local skills, knowledge and expertise.

The CCG has also established a Voluntary Sector Engagement Group that includes the Chief Officers of the two local Councils for Voluntary Services and Torbay's newly-formed Community Development Trust. These three organisations are working strategically with the CCG to enhance their networks and to achieve the CCG's aims. They are also discussing possible future alliance contracts, whereby the Voluntary Sector Engagement Group acts as 'umbrella' contract managers across a whole service delivery.

There are a number of organisations that provide guidance to clinical commissioners (see the appendix); organisations which the voluntary sector could seek to work closely with. These include local Healthwatch groups, Health and Wellbeing Boards (set up to bring together various local stakeholders and facilitate the development of Joint Strategic Needs Assessments) and Strategic Clinical Networks. These bodies have a role in local commissioning decisions, and as such provide another opportunity for the voluntary sector to develop its commissioning support activities. However, it seems that there is a great deal of local variation in terms of the influence of these different bodies and therefore it is difficult for the voluntary sector to determine where to focus their attention. For example, there are differing views on the strength of local Health and Wellbeing Boards, with some feedback from the voluntary sector and commissioning support event being that commissioners may be too dependent on these other bodies liaising with the voluntary sector rather than liaising directly themselves. Also, participants stated that while some had found success in contacting commissioners directly, others found CSUs a more useful route of access.

### Box 9: The role of Strategic Clinical Networks

As part of the recent NHS reforms, Strategic Clinical Networks have been set up across England to provide focused, clinically-led support on cancer, cardiovascular disease, maternity and children's services, and mental health. Hosted by NHS England local area teams, the Strategic Clinical Networks will work with partners across primary, secondary and tertiary care; Health and Wellbeing Boards, patients and carers, CCGs, other networks, the voluntary sector, and colleagues in social care, to advise commissioners, support change projects and improve outcomes.

Strategic Clinical Networks are already working with voluntary sector organisations to support local commissioning. For example, the South West Strategic Clinical Network is working with Rethink Mental Health who run the local mental health alliance to ensure that service user's perspectives are fed into commissioner decisions. They are also working with Neurological Commissioning Support to audit neurology services; this work is key to their aspirations of providing strong commissioning advice and making real improvements in patient experience and outcomes.

The Northern England Strategic Clinical Network is working with Macmillan Cancer Support, with plans in 2014 to do an audit and gap analysis of cancer survivorship services and support, to inform local commissioning decisions, and to share good practice and learning opportunities across the network.

## Market development and contractual models

Establishing a contractual relationship with commissioners and charging competitive rates for commissioning support services is a consideration for voluntary sector organisations who want to provide a substantial amount of commissioning support. It may also become more of a necessity as many voluntary sector organisations struggle to sustain themselves during this period of economic austerity, and may therefore be in less of a position to offer *pro-bono* support, as has often been the case to date. Certainly there appears to be an acknowledgment by NHS England and CSUs that if a voluntary sector organisation has been asked to provide a specific service, they should be compensated for this work, just as arrangements would be made with independent sector organisations.

The contractual mechanisms by which commissioning support providers can engage with commissioners and CSUs remain under development. NHS England is exploring how to best design mechanisms to facilitate entry into the commissioning support market for all providers. This includes developing a lead provider model, and possibly supplier lists (see Box 10). It is worth noting that it is not yet known whether these mechanisms will have a significant impact on the voluntary sector. CCGs – both those who procure commissioning support and those who have in-house support – will continue to contract out smaller, individual pieces of work that fall outside the lead provider model to a range of providers. Equally, CSUs who become lead providers may still continue to use the voluntary sector for specific activities outside of the framework.

NHS England is currently consulting on different contractual models and producing guidance for CCGs around how they can change their current commissioning support provision arrangements (either to increase or diversify their outsourcing, or to bring the services in-house). In April 2014 they will launch the lead provider framework which will

run until the autumn. Providers will then be accredited onto the framework and it will be live for CCGs to use in April 2015. The basic tender process lasts for approximately three months and so by autumn of 2015, the plan is that CSUs will begin to move out from NHS England hosting.

As part of the applications for the lead provider framework, commissioning support suppliers applying for lead provider status will need to describe their approach to partnering and state who their partner organisations and sub-contractors are. This is an opportunity for commissioning support suppliers, CSUs and voluntary sector organisations to formalise their joint offer to commissioners. However, there are time limitations. The process will commence in March 2014, with applications being submitted from April 2014. As yet, it is not known when the framework will be revised again, although there is an expectation to build some flexibility into the framework that allows partnerships and sub-contracting arrangements to be regularly refreshed.

It is not yet determined what form CSUs will take once they are no longer hosted by NHS England. They could be social enterprises, staff-led mutuals, customer-owned, CCG-owned or they could be sold to commercial companies. CSUs have expressed a preference to being independent, either as a social enterprise or as a mutual (Campden Health, 2013).

#### Box 10: Contractual models

##### **Lead provider model**

NHS England is in the process of developing a new lead provider framework agreement. In this scenario, CCGs would hold a contract with one organisation to deliver all or some of their commissioning support. In order to offer customers a diverse but specialist range of services, the lead provider will need to actively seek out key partners and, where necessary, demonstrate sub-contracting arrangements. The main advantage of this model is that it speeds up the process by which commissioners can procure services because they do not have to follow the lengthier full OJEU process.

NHS England is currently engaging with stakeholders to design the qualification standards the lead provider, and their sub-contractors, will need to meet. They are also specifying the minimum services the lead provider will need to demonstrate they can offer (likely to be end-to-end commissioning support). The plan is to launch the procurement process through OJEU in March 2014 and so any partnerships between potential lead provider organisations and sub-contractors will need to be established before then. It is envisaged that the majority of those who successfully gain lead provider status will need to secure sub-contracts with smaller niche organisations such as voluntary sector organisations to ensure they offer commissioners the services they need.

There are two points of note. First, the service framework being drawn up cannot possibly cover all eventualities. The framework will predominantly cover general commissioning support. Therefore, there is still space for the voluntary sector to provide support to CCGs and CSUs on specific areas of work outside of a lead provider framework. Second, CCGs that deliver the majority of commissioning support in-house may not want to use the framework and may continue to outsource with multiple contracts.

### Supplier lists

It is possible that NHS England will create supplier lists, where organisations who are not looking to become a lead provider could demonstrate they meet some basic good practice criteria, in order to give CCGs and others confidence in approaching them for work. These lists often work well for those services that are of lower value but are potentially high volume.

A couple of voluntary sector organisations consulted with for this research felt that if these lists were created and their organisations were accepted on to them, it would help them to promote their work and increase their legitimacy with buyers. This was their experience with previous supplier lists held by the Department of Health. In order to sit on the list, it will be important for voluntary sector organisations and others to demonstrate they have a valuable offer, and that they can meet the basic criteria which will be set out in due course.

For more information, *Towards Commissioning Excellence* outlines a wider variety of options (NHS England, 2013: 27).

### Key challenges

The voluntary sector and commissioning support event provided an opportunity to explore perceptions of the barriers faced by commissioners, CSUs and the voluntary sector itself in increasing the sector's involvement in commissioning support. These include:

- “The roles of... commissioning support units vary from region to region and can be confusing and challenging to engage with.”
- “Being taken seriously as a key provider.”
- “Capacity to manage a high number of relationships.”
- “Aligning charity priorities with those of the CCG.”
- “Describing the ‘offer’ for the NHS given the wide variation of [voluntary and community sector] organisations.”
- “Commissioners being in a state of flux.”

Some of this feedback is explored in more detail below.

### Entry into the market

The first barrier voluntary sector organisations may face is a lack of knowledge about where the power lies locally. Information about CCG in-house provision versus external outsourcing is not readily available, and the involvement of other local stakeholder groups, such as Strategic Clinical Networks and Health and Wellbeing Boards, will differ. With limited capacity and resources, and a great deal of local variation, some voluntary sector organisations are not sure where to start promoting their services. This issue becomes more complicated for organisations spanning a larger area. With the number of commissioning organisations having increased since the creation of CCGs, potential providers of support may find it harder to keep track of what is being prioritised in a specific area. Organisations could target areas where they identify under-performance related to their patient group, or keep abreast of CCGs' commissioning intentions and priorities, which will be published on their websites.

There is also a question of size and whether commissioners and CSUs will be content contracting with multiple voluntary sector organisations. It may sometimes be appropriate for voluntary organisations to collaborate with one another where they are offering complementary or similar commissioning support services. Umbrella organisations could play an important role in facilitating partnerships within the voluntary sector, as well as signposting organisations and providing guidance (see Box 11). For example, FPM – as part of their membership of the BOND Consortium that aims to facilitate better relationships between commissioners, service users and voluntary sector service providers – published a series of documents that explain the different collaborative structures available to voluntary sector organisations (see Box 11, available at [www.youngminds.org.uk/training\\_services/bond\\_voluntary\\_sector/sustainability](http://www.youngminds.org.uk/training_services/bond_voluntary_sector/sustainability)).

Another barrier expressed by some attendees of the voluntary sector and commissioning support event was about penetrating the existing relationships between some CCGs, CSUs and other providers of commissioning support. This barrier was recognised by some CSUs who acknowledged they were uncertain about the range of local voluntary sector organisations in their area. One CSU had tried to address this by starting a database of interested parties, with online forms available to all organisations interested in registering. NHS England has also created Choice App, an online site which CCGs and others can use to scan different providers ([www.cschoices.england.nhs.uk/](http://www.cschoices.england.nhs.uk/)). However, at present only two voluntary sector organisations have registered on it.

#### **Investment, capacity and identity**

There is a strategic decision for the voluntary sector as to whether to invest and risk charitable money to support improved commissioning. Organisations will need to consider whether this is the best route to promote improving patient outcomes and experience, rather than through other avenues such as influencing activity or service delivery.

A small number of voluntary sector organisations are leading the way in terms of establishing themselves in the market, but it has taken considerable investment of resources. One of these organisations – Neurological Commissioning Support – was kick-started by a grant from their founding charities and was then successfully awarded a grant by the Department of Health which they invested in internal capacity and infrastructure. Over the past four years they have grown and become a sustainable business. This initial start-up phase is, and is likely to continue to be, a struggle for some voluntary sector organisations. While there are a limited number of grants available to support this kind of work (i.e. Innovation Excellence and Service Development grants), they can come with certain conditions that some voluntary sector organisations are unable to meet, for example a guarantee of return in a specified number of years.

Another consideration for those voluntary sector organisations who may start charging for their services are the implications on their charitable status and brand identity. Reputational risks are also a potential concern if, for example, involvement includes unpopular decisions around prioritisation of health resources and being involved in decommissioning local health services.

### Box 11: Signposting and guidance

Regional Voices is a partnership of nine networks that promotes voluntary and community organisations that improve health, well-being and care across England. Collectively it covers 25,000 organisations. Regional Voices has produced a series of resources, four of which are particularly relevant for voluntary sector organisations interested in providing or expanding the amount of commissioning support they provide:

- *Who's who?* A list of names and contact details for each of the key stakeholder organisations, broken down by region. [www.regionalvoices.org/whoswho](http://www.regionalvoices.org/whoswho)
- *Clinical commissioning. A guide for the voluntary and community sector.* A guide to key policy areas and local partners. Available alongside other useful guidance. [www.regionalvoices.org/ccgs](http://www.regionalvoices.org/ccgs)
- *Towards More Effective Commissioning.* Examples of how voluntary sector organisations and social enterprises have worked creatively with commissioners to co-produce solutions to entrenched health difficulties (led by Voluntary Sector North West). [www.vsnw.org.uk/activities/health/commissioningproject](http://www.vsnw.org.uk/activities/health/commissioningproject)
- *A Healthier Perspective.* A practical toolkit to support commissioners and the voluntary sector in understanding how they can work together in commissioning health services (produced by RAISE). [www.raise-learning.org.uk/](http://www.raise-learning.org.uk/)

The BOND Consortium (Better Outcomes, New Delivery), led by the charity YoungMinds and including other specialist voluntary sector organisations, has delivered commissioning support to local authorities, NHS commissioners and schools. Their support has focused on building greater awareness and better relationships between commissioners, service users and voluntary sector service providers. The BOND Consortium was set up as a two-year project, funded by the Department for Education.

One of BOND's activities has been to establish the Youth Wellbeing Directory, a free online directory of voluntary sector service providers that will be launched in November 2013. It can be accessed by commissioners and service users and provides a map of local services and comparative tables. The directory also lists how service providers meet a series of standards (the ACE-Value Standards) covering accountability, compliance, empowerment and values. These values are self-assessed but providers must undertake a comprehensive registration process that requires submission of evidence. The aim is that commissioners and service users can use the standards to compare organisations.

Following their involvement, BOND has seen a number of new service contracts being awarded to the voluntary sector, between the value of £2.5m and £4m.

### Developmental support

For some voluntary sector organisations, competing for commissioning support contracts – either from a CCG or a CSU – will be a new venture. Others may be interested in scaling-up the work they currently provide on an ad hoc basis. In both situations, there are a number of areas where organisations such as ACEVO could usefully support their development. This could include sharing best practice in terms of writing bids, presenting to commissioners and other parts of the procurement process. The Department of Health has funded Neurological Commissioning Support to provide a voluntary sector commissioning support mentorship programme, and they have provided training and mentoring to a number of organisations.

Some small-to-medium voluntary sector organisations are also joining up with one another, in recognition of the fact that some commissioners want to tackle an issue such as long-term conditions management or frailty, rather than a specific disease. Asthma UK, for example, is working with the British Lung Foundation to establish a Respiratory Commissioning Support Organisation with the support of Neurological Commissioning Support. Networks such as ACEVO could also facilitate or promote this as an option for voluntary sector organisations, if they can demonstrate the benefits of collaborative working to their members.

Opportunities for relationship building across sectors were also identified as vital for diversifying the providers of commissioning support. Following the voluntary sector and commissioning support event, some participants commented that they had more confidence in engaging effectively with organisations from different sectors.

### **Possible contractual barriers**

At present it appears likely that only a few voluntary sector organisations could consider immediately sub-contracting with CSUs or would be accepted on to a supplier list (although the detail is yet to be decided by NHS England). This is because, in both situations, organisations will need to demonstrate that they have well-established services – something which only a few organisations are in a position to do at the moment. There is some uncertainty as to whether voluntary sector organisations could be listed as potential partners to lead providers without having to meet the formal requirements stipulated for sub-contractors or suppliers. In addition, the time limit for establishing these partnerships is extremely short.

It is not yet clear how many commissioning support services will be part of the lead provider framework, or how much CCGs will use it. This is potentially another local variation that voluntary sector organisations will need to calculate. There is also a concern that the framework may lead CCGs to assume that all commissioning support relationships (regardless of the value of the work) should sit within the framework, therefore limiting the amount of smaller, niche projects being undertaken, which could be best-suited to the expertise available in the voluntary sector. However, this could be off-set if there is a requirement under the framework for suppliers to demonstrate a range of services through partnerships with more specialist and niche organisations.

### **Conflicts of interest**

A key concern raised during this research from both purchasers and providers of commissioning support was how the involvement of voluntary sector organisations could lead to conflicts of interest, as some voluntary sector organisations are significant providers of services. As one commissioner involved in this research explained, procurement decisions are sometimes challenged by unsuccessful bidders and the involvement of a service provider in the commissioning process could be deemed to have influenced the final decision. Another example is where an audit of local service need and provision debates the decommissioning of a service: if that service is run by a voluntary sector organisation, their involvement could again be seen as a conflict of interest.

However, NHS England has given reassurances that it is possible to overcome these concerns. The establishment of rules around transparency, keeping progress well documented, clearly separating commissioning support and provider arms of a voluntary

sector organisation, and the inclusion of a number of providers at particular points in the process to assure the independence of decisions, are a few ways in which this can be achieved. It should also be noted that not all voluntary sector organisations operate as service providers, which was presumed by many NHS representatives at the voluntary sector and commissioning support event.

## 5. Next steps

Enthusiasm was expressed by purchasers and providers of commissioning support, and other organisations present at the voluntary sector and commissioning support event, around the inclusion of the voluntary sector. The innovative work some voluntary sector providers are already doing illustrates the value of their expertise and how their offer is unique from other providers. As the compact between ACEVO and the CSU Network recognises, a strengthening of the voluntary sector's role in the market is mutually advantageous.

However, it is also clear that there are a number of challenges and, as the commissioning landscape continues to evolve, these may again change. If voluntary sector organisations are going to make the most out of the current opportunities to further their charitable aims and support the best possible commissioning for patients, there are a number of practical steps that should be taken by the voluntary sector and other key stakeholders.

The suggestions below reflect feedback from the attendees at voluntary sector and commissioning support event and supplementary interviews, and are intended to provide some thoughts on how these challenges might be overcome.

### Voluntary sector organisations

- Maintain or build relationships with both your local CCGs and CSUs. Some CCGs will have a patient representative committee, or liaise with a local voluntary sector umbrella group.
- Clearly articulate and communicate how you add value to the commissioning process and what you bring that complements the commissioning support CCGs may already be accessing (either externally or in-house).
- Give CCGs and CSUs an explicit menu of options and packages of support. Think about how your offer is presented: make sure it is branded as commissioning support. Consider how you can relate your services to wider commissioning agendas such as promoting quality in health care or making efficiency savings.
- Target your approach:
  - What are CCGs' commissioning intentions/priorities for the next year?
  - Which board members are responsible for your particular clinical issue?
  - Is the CCG using CSUs, independent organisations or providing its own support in-house?
- Consider partnering with other voluntary sector organisations to share resources for sourcing and responding to bids, and to offer commissioners a range of services.
- Make the best use of marketing tools such as the Choice App from NHS England.
- Think about the sustainability of the service you are offering and have a strategy for when you want to charge commissioners or CSUs.

### CCGs

- Maintain links with the voluntary sector through patient and public representative groups, and ensure that this expertise is adequately fed into your commissioning decisions at the earliest possible point.

- Ensure commissioning plans and intentions are easily accessed.
- Be clear about what services you might purchase from the voluntary sector.
- Consider how you can create a clear, accessible entry process for partnering with a range of voluntary sector providers.
- Consider providing opportunities for local voluntary sector organisations to promote excellent commissioning, at local events for example.
- Consider including in your contract with commissioning support suppliers a requirement to involve voluntary sector organisations – both local and national.
- When identifying commissioning support requirements, do not limit this to large-scale contractual arrangements with CSUs. There may be pieces of work where the voluntary sector is best placed to lead the work.

### CSUs

- Consider what role the voluntary sector could play in your commissioning support offer, recognising the value the partnership could bring to your customer offer.
- Be open to where the voluntary sector can add value to the services that you already offer.
- Be clear about what services you might purchase from the voluntary sector.
- Consider how you can create a clear, accessible entry process for partnering with a range of voluntary sector providers.
- Explore your local voluntary sector by having, for example, an online partnership system where organisations can upload a profile of their skills that you can use when looking for external support.

### NHS England

- Continue to actively promote the role of the voluntary sector in commissioning support and consider making it a requirement of the lead provider framework.
- Ensure that the lead provider model or other contractual mechanisms do not preclude the involvement of the voluntary sector in the commissioning support market.
- Consider the needs of the voluntary sector in the development of a supplier list or another way to promote and endorse the quality of voluntary sector services.
- Continue to develop new ways in which the diversity of providers can be easily accessed, through the use of the Choice App, for example.
- Support capability- and capacity-building of the voluntary sector to be more involved in commissioning support and promote examples of best practice.
- Demonstrate best practice in engaging and involving the voluntary sector throughout its own commissioning processes (for example primary care and specialised commissioning).

## 6. Conclusion

The voluntary sector and commissioning support event, and subsequent interviews identified clear enthusiasm for greater involvement of the voluntary sector in commissioning support. The voluntary sector provides in-depth knowledge of specific conditions or population groups, and its close connection with service users means that its advice is often firmly grounded in the patient perspective. This relationship with service users, coupled with expert clinical knowledge and analytical capability, means that the voluntary sector has a great deal to offer to commissioners (directly or through CSUs).

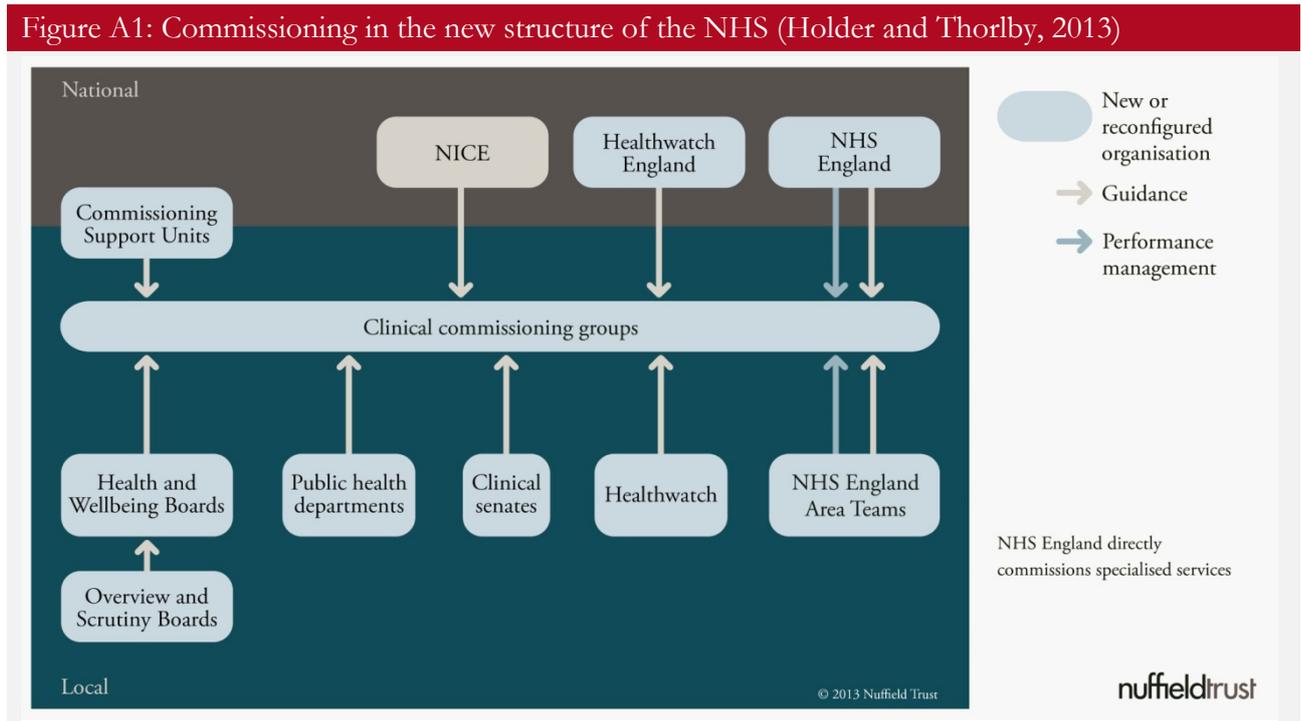
There are, however, a number of challenges that could potentially limit their involvement. There is considerable local variation both in terms of commissioning priorities and the involvement of different stakeholder organisations. Entry into the market is difficult because of this issue, but also because of the established links between some commissioners and their existing providers. Achieving a diverse market for commissioning support also assumes that voluntary sector organisations have the capacity and resources to promote themselves, despite many already struggling to find funding to meet their current activities. It also requires commissioners and CSUs to recognise the ways in which the voluntary sector adds significant value.

Support from umbrella organisations could be essential in helping some voluntary sector organisations recognise the potential of the market and how they can establish themselves within it. They could also facilitate collaboration amongst voluntary sector providers which would for some providers strengthen their offer to CCGs and CSUs.

Achieving excellent commissioning where the health and care needs of the population are met, and patient outcomes and experience are the highest priority, requires commissioning support services that offer expert advice and guidance. It is clear that the voluntary sector can offer a range of expertise and should be a part of this process. However, ensuring their place in the market requires the attention of all the stakeholders involved in commissioning support.

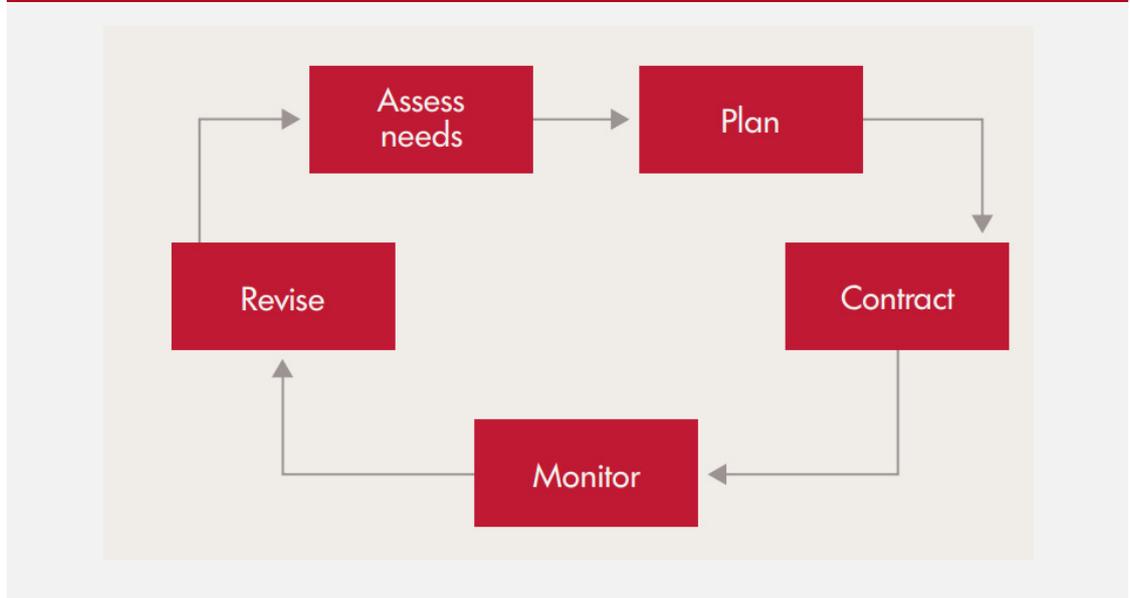
## Appendix: The commissioning process

Commissioning is the process by which decisions are made about what services should be purchased to meet the health needs of a population. In the new structure of the NHS, clinical commissioners are central to the majority of commissioning decisions. These groups do not work in isolation and will either seek support from, or are required to have regard to, guidance from a range of local and national bodies, some of whom are discussed in more detail below (see Figure A1).



Commissioning is a cyclical process, usually structured as an annual programme (see Figure A2). Those responsible assess the needs of a population and explore how effectively these are being met by existing services. Gaps in service provision or the identification of underperforming services leads to a planning process whereby new services are designed and contracted for. These new services are monitored against agreed outcome measures and revised where necessary. This in turn may require an updated needs assessment, and the cycle continues. The process is aided by statistical data analysis and input from local stakeholder and patient groups. Where commissioners do not have the expertise in-house, they will purchase commissioning support to either manage the whole process or assist with certain tasks. This can also include organisational functions such as back office support.

Figure A2: The commissioning cycle (Department of Health (2003), adapted from Øvretveit, 1995)



Although Figure A2 presents a neat picture of an annual commissioning cycle, an in-depth study of commissioning for long-term conditions observed a complex set of overlapping activities taking place in parallel to one another (Smith and others, 2013). Both the technical tasks (such as data collection and reviews of evidence) and relational activities (such as consultations with user groups) were hugely resource-intensive. The study suggested that progress through these tasks was particularly slow where there was a lack of capacity in the commissioning organisation.

In addition to being a complex process in itself, commissioning takes place at a number of levels: from personal health budgets to the commissioning of specialised services at the national level (Smith and others, 2004). The potential for voluntary sector organisation to contribute to these processes exists at all levels.

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