

Practice Based Commissioning (PBC)

Bulletin 4 – Service Redesign and Delivery

Purpose of this series of PBC Bulletins:

- To keep PCTs up-to-date and in touch with progress and key issues
- To share information and linked examples and resources through the PCC network
- To highlight any new or important perspectives on PBC that arise during the rest of 2006/7
- To help sustain PBC development through PCT organisational change

This Bulletin builds on the Department of Health (DH) PBC guidance documents (www.dh.gov.uk/practicebasedcommissioning), the Primary Care Contracting Preliminary PBC Toolkit and other PBC Bulletins (available at www.primarycarecontracting.nhs.uk).

Key Points in this Bulletin:

- **Local commissioning and decision-making** - PBC moves power closer to the community and recognises the integration of health and social care;
- **LDP and Local Area Agreement priorities** - should be used to drive PBC service planning;
- **Clinical engagement** - engaging clinicians in the process is essential for successful transformational change;
- **Impact of the PbR tariff** - learning about PbR tariff rules will ensure detailed accurate budgetary forecasting, recording and analysis;
- **Demand management** – using demand management initiatives and techniques as a first step is more straightforward than planning new services;
- **Neutral locations** - for community services may allow for greater usage of local facilities and assist in overcoming competitive barriers;
- **Contestability** - ensuring PBC processes are consistent with the required governance and regulatory rules in relation to service tendering and provision.

Context

Redesigning health services to be delivered in different ways has never been more critical to the long term success of the NHS. The DH has recently published two key policy documents which steer the course of future commissioning in primary care. *Health Reform in England: update and next steps* (December 2005) and *Practice Based Commissioning: achieving universal coverage* (January 2006) clarified how PBC is now a critical lever for change in primary care. This was followed by the publication of *Practice Based Commissioning - early wins and top tips* (February 2006) showing a variety of successful service re-design examples for PCTs, practices and their respective clusters.

The DH White Paper - *Our Health, Our Care, Our Say: a new direction for community services* (January 2006) - emphasised that in future there would be:

- greater integration of health and social care services outside hospitals with greater joint working through new commissioning partnerships between Local Authorities and reformed PCTs.
- more control for individuals over their local health services to satisfy local need
- more involvement of patients in local commissioning decisions
- a shift in services towards prevention, for both ill-health and admissions, and greater support for self care.

The White Paper also proposes new demonstration sites for care closer to home, defining pathways and appropriate models of care in six specialties - ENT, Trauma & Orthopaedics, Dermatology, Urology, Gynaecology, and General Surgery – and particularly emphasises the shift of out-patients services into a primary care setting.

Forthcoming commissioning guidance from the DH will set out how PCTs and practices can ensure their decisions are fully informed and responsive to the public. Additionally, NICE is in the process of producing national guidelines and service specifications for delivery of clinical services in disease specific areas, ensuring that cost effective commissioning is married up with a robust evidence base.

Links to:

- www.dh.gov.uk/practicebasedcommissioning
- www.nice.nhs.uk

Cluster planning and service priority identification

Practices and PBC clusters will need to identify the services which they wish to focus on and plan any re-design opportunities or develop new services. The context of this planning process is often misunderstood by practices and many are often relatively unaware of, or involved in, this core PCT responsibility. Learning about these processes will give practices a better understanding of the wider policy drivers, local health community priorities, and also highlight the need to tackle any particular problem areas under PBC.

Links to:

- North Bradford PCT – Eccleshill Treatment Centre
- Surrey Heath and Woking PCT – Echocardiography service
- [Teignbridge PCT – Stroke service pathway](#)
- Colchester PCT – COPD and Musculoskeletal services
- Maidstone Weald PCT – Emergency Care Centre

Other good practice examples of service re-design and development can be found at:

- www.networks.nhs.uk/ideas
- www.rcgp.org.uk/PDF/innov_PatientPathwayToolkit090206.pdf

The PCT will have laid the foundations for PBC planning through existing priority setting processes and agreements. Ideally these processes will have been conducted in partnership with both individual and groups of Practices. Practices and PBC clusters should consider all service priorities carefully. They can be found within the context of:

- Local Area Agreements (LAAs) – these agreements are a key mechanism for joint planning and delivery with the Local Authority and will result in services delivering (joint) outcomes applicable to health and social care
- Public Service Agreements (PSAs) – local Public Health priorities as agreed with the Local Authority through partnership working
- The Local Delivery Plan (LDP) – The NHS local strategic planning process for health services and the wider health community
- Integrated Service Improvement Programme (ISIP) – a service priority action plan across a whole health community
- NICE guidance and the National Service Frameworks (NSFs)
- Service pre-commitments – such as Independent Treatment Centre contracts which identify any local commissioning resources already committed to ‘minimum take’ contracts in the independent sector.

Robust business planning procedures should be in place as a method of *signing off* new service ideas or developments generated by local practices or other clinicians. These procedures will be overseen by the PCT and will involve close partnership working between the local PBC cluster and the PCT itself so as not to lose sight of wider health community planning mechanisms.

Clinical engagement in determining local priorities is also essential. This should not simply operate as a group of individual practices or clinicians but may require a meeting of minds and an element of peer pressure to succeed. Effective engagement can mean:

- involvement in the decision making process of service commissioning to help review and re-design service pathways with other clinicians.
- utilising local skills in a clinical advisory capacity working with PCT managers or PBC cluster managers
- extending provision into PwSI services by providing alternative services locally.

- targeting those areas you can affect quickly, particularly where there is a good relationship with secondary care or a recognisable and urgent problem.

Key factors in ensuring that clinical leadership and engagement is successful are enablement and empowerment by the PCT or PBC cluster. Clinical leaders who are empowered by their colleagues are in ideal positions to facilitate change and become involved in the transformation of services. They need to be trained in or acquire commissioning and financial change management experience. Their knowledge and skills are well placed to be actively engaged in policy planning, implementing and networking with other stakeholders especially across primary care and acute trust boundaries. Commissioners have struggled to make a difference in the past as clinical engagement (and primary care influencing power) has often been lacking. PCT and SHA reconfiguration is meant to enhance and strengthen this process with the Fitness for Purpose diagnostic exercise as support. Further detail can be found at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4134656&chk=k/ibIY

Strategic planning is more effective with clinical involvement to guide the strategic direction and it is essential to have cross-community coordination between PBC clusters. Redesign and delivery of services should be complementary rather than conflicting, saving essential PBC commissioning resources at the same time. There needs to be sensible use of scarce resource both clinically and managerially. In advising commissioners, clinical networks help generate freed up resources and use them to target and pump prime quality enhancements or service improvements.

Links to:

- [Nottingham 'Clinical Academy'](#)
- Leicestershire Northamptonshire and Rutland SHA Enhanced Clinical Networks Programme
- Kings Fund - Social Enterprise and Community-based Care
www.kingsfund.org.uk/resources/publications/social.html
- East London Integrated Care (ELIC) - <http://society.guardian.co.uk/health/story/0..1730670.00.html>

Payment by Results

For those with a background in or knowledge of the workings of the internal market during the GPFH era PbR can be reasonably compared to previous cost per case mechanisms. Practices and PCT management support staff should familiarise themselves with the technical aspects and any likely local impact of the Payment by Results tariff.

Key features of PbR include:

- you pay for what you use
- the tariff covers the bulk of both scheduled and unscheduled care
- community and mental health services are not included
- a range of specialist services are not included
- non-elective threshold whereby transitional arrangements exist allowing additional activity (or under usage) to be adjusted by 50%
- tariff splitting rules based on the impact of length of stay (LOS) to enable primary and secondary care to share the benefit of service redesign.

Key considerations for PCT should include:

- the need to develop mechanisms to support sampled validation of activity covered by the tariff so as to eradicate inefficiencies, errors and gaming
- ensuring that Practices are fully aware of the potential impact of PbR
- working with Practices to identify areas of high impact particularly in relation to spend on outpatients
- the fundamental need to consider ways to manage the impact of the throughput imperative that underpins PbR.

Full detail on PbR, including a short guide on the basics, a code of conduct and full detail as to the scope and coverage of the tariff, can be found on the DH website at:

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en>

Demand management and additional service provision

Managing referral demand needs to be planned with alternative pathways being both clinically robust and capable of demonstrating cost-effectiveness against the related PbR tariff. There are now many examples of local referral management schemes which have had a direct and positive impact on waiting lists and commissioning resources available. Lessons have also been learned from implementing these schemes including:

- having support from local clinicians (confidence in administrative use and resultant clinical referral pathway)
- advertising widely to local practices to ensure full usage
- utilising appropriately qualified staff (Practitioners with Special Interests) to perform any clinical assessment
- evaluating from the start and feeding back to local practices as part of the monthly information pack available to practices under PBC
- ensuring that a culture of ongoing referral review is embedded into General Practice processes.

Links to:

- Broxtowe & Hucknall PCT Referral Management service
- Manchester clinical assessment service

Additionally, the recent publication from the DH has a major focus on demand management providing assessment and diagnostic tools for PCTs to assist their fitness for purpose and development programme. See the Executive Summary at www.dh.gov.uk/assetRoot/04/13/46/59/04134659.pdf.

Furthermore, the current guidance and related toolkits on implementing services delivered through practitioners with special interests are being updated. A new suite of resources is expected to be available by autumn 2006.

Links to:

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/GPsWithSpecialInterests/fs/en> for general detail.

<http://www.primarycarecontracting.nhs.uk/119.php> for details on Pharmacists with Special Interests.

Neutral ground for provision

Evidence suggests that secondary care services that can be provided in the community often have a neutral home. There are instances where local practices house cross-community services as well as providing their own. However, the range of services and the necessary complexity and care integration that can be delivered in primary care is fast growing. As practices begin to work more closely together in their developing PBC clusters, there is an opportunity to find neutral venues for these services. It is important that these are suitable and have proper quality assurance and clinical governance regimes in place. Recently, the development of LIFT buildings locally has provided a comprehensive, attractive and integrated location for both patients, professionals and inter-agencies. Whilst this is not the only solution, there is a growing trend in filling these local facilities with the type of services that are required to be delivered under local PBC plans, particularly where PCTs have entered into long term finance initiatives.

Links to:

- East Devon PCT
- Craven, Harrogate and Rural District PCT
- [Gedling PCT](#)

Contestability and transparency

New or alternative services need to be considered in the context of the local governance arrangements in the PCT or what has been designed for the PBC cluster. Many new services will become contestable to the wider market of providers. As a result, practices and PBC clusters should follow clear guidelines on primary care procurement, reflecting the essential elements of the PCTs Standing Orders, EU Directives, EU law and the mechanisms of 'open' competition.

PBC governance processes must therefore be transparent and robust, with full consideration to open tendering for services even if local practices or providers are interested in providing the service. This will break the cycle

of 'roll forward' contracts in primary care unless current providers can demonstrate they are satisfying their current contractual obligations for a quality service and delivering performance outcomes. PCTs should encourage practices to plan risk strategies for when they are unsuccessful in local tendering processes.

The NHS Purchasing and Supplies Agency (PASA) have already developed an APMS toolkit that represents a good starting point for any and all organisations involved in procurement. Further work is planned on this toolkit to make it more relevant to current commissioning environment under PBC.

Links to:

- www.pasa.nhs.uk

Service redesign and delivery - how is your PCT progressing?

- Can you demonstrate that links to both national and local priorities are in place for planned PBC redesign or re-provision?
- Have existing or planned neutral venues been identified to support alternative provision?
- Have schemes for the management of referrals been considered?
- Have you identified your top 5 (or 10) clinical and financial priorities and tailored any scoring or approval scheme to fit?
- Is there a proper process for ensuring decisions about who provides alternative primary care services is clear and transparent?
- Has patient safety been considered at all levels?
- Can you demonstrate that new or redesigned services offer improved value for money when compared to current arrangements?

Other information

The Improvement Foundation (www.improvementfoundation.org formerly the NPDT) has been commissioned by the DH to support the universal roll out of PBC focussing on the redesign of services. Wave 1 is currently underway working with with one site (a PCT and several practices) from each of the 28 SHA areas. All PCTs and practices can access the learning from the programme through local learning exchanges, web casts and resources and support through the IF website.. Wave 2 commenced in May and practices and PCTs are advised to contact their regional IF centre or SHA for more information on how to get involved. Wave 3 will commence in September.

For other resources and information, PCTs may wish to link to other agencies such as the NHS Alliance, the NHS Confederation, the National Association of Primary Care, or the Royal College of Nursing.

If you, or your PCT, would like to give feedback on this PCC Bulletin or contribute to the next Bulletin (share examples; innovative solutions to significant issues, local PBC events etc), then please contact the PBC Project Team.

Next PCC Bulletin: PBC and Patient and Public Involvement

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