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Practice Based Commissioning – Are there Lessons for Wales?

A report based on two workshops:
14 February 2007 – Cardiff
28 February 2007 – Llandrindod Wells

Acknowledgement

We are indebted to the workshop speakers and participants, whose views are reflected in this feedback report. AstraZeneca organised the workshop in association with BMA Cymru Wales and the Welsh NHS Confederation.

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Content:

Introduction page 2

About the Events page 3

Summary of the Key Points page 4

Report of Proceedings
– Presentations page 5

Report of Proceedings
– Workshops page 13

Introduction

As we in Wales consider how to deliver 21st-century health services, getting commissioning right has never been more crucial.

It is important that we take an approach to commissioning that is right for Wales. But learning from experience elsewhere can help us achieve this goal. The Confederation has recently published two papers that bring together research evidence on commissioning, and that highlight experience in other countries. It is in this same spirit of looking – and learning – across boundaries that we were pleased to be involved in these events, alongside BMA Cymru Wales and AstraZeneca.

Practice based commissioning is one of the most important new policy developments in England in the past few years. So it is important that we have a full understanding of its pros and cons, to help inform our own discussions about the way forward for commissioning in Wales.

The BMA and the Welsh NHS Confederation, in working with AstraZeneca on these events, are seeking to encourage a debate on commissioning, to help inform our approach here in Wales. We do not have a view either for or against practice based commissioning, for example, but simply want the learning from this experiment to be made available to people in Wales.

This report therefore captures the views expressed by speakers and delegates. A summary of the key points emerging from the day can be found on page 4.

In presenting the outcomes from the day, there are two overall points that we would like to make about commissioning, both of which were echoed in the discussions at the events. In our view, both these points should be central in the approach to commissioning that we take here in Wales.

The first is that the local level must remain fundamental in commissioning. The local emphasis across our health policy here in Wales is a major strength, and we must build on it in our approach to commissioning. Excluding the local dimension, and focusing entirely on regional and national levels, would in our view be a grave error. Commissioning needs to take place across the health system, at local, regional and national levels.

The second key point is that debates and decisions about commissioning, at all levels of the health system, must have strong input from clinicians. Commissioning is a responsibility that can be shared by all of us in the health community, and it is vital that clinicians are closely engaged in shaping and implementing our approach to commissioning.

If we are to deliver 21st-century health services in Wales, we have to get commissioning right. These events – and this report on the outcomes – are intended to help us work out how.

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About the Events

These events were developed in collaboration between BMA Cymru Wales, the Welsh NHS Confederation and AstraZeneca. The same programme – with some differences amongst the speakers – was run at both events: Cardiff and Llandrindod Wells.

The aims of the day were to:

- Hear frontline views about Practice Based Commissioning (PBC) in England
- Identify lessons for Wales as we develop our own approach to commissioning

The chairs for the events were:

Cardiff: Dr Andrew Dearden,
Chairman, General Practitioners' Committee,
BMA Cymru Wales

Llandrindod: Mike Ponton,
Director, Welsh NHS Confederation

The speakers were:

- Dr David Bailey, Deputy Chairman, GPC Wales
- Dr Andrew Dearden, Chairman, GPC Wales
- Dr David Jenner, GP, Exeter
- Mike Ponton, Director, Welsh NHS Confederation
- Dr Tim Richardson, GP and Director of Epsom Day Surgery Centre
- John Skinner, Chief Executive, Torfaen Local Health Board
- Kevin Sullivan, Policy & Public Affairs Manager, Welsh NHS Confederation

Around 60 delegates attended the events in total. They were drawn from Local Health Boards (LHBs) mainly, along with a few GPs and representatives of AstraZeneca.

The event consisted of presentations from the speakers, plus workshops. The report of the event gives an overview of the speakers' presentations The key points emerging from the workshop discussions, as recorded by the groups, have also been listed.

The views expressed in the report of proceedings are those of speakers and participants, not necessarily those of the BMA, Welsh NHS Confederation or AstraZeneca.

Summary of Key Points

Speakers:

Mike Ponton

- The changing world means current service provision is unsustainable
- We have to rethink community services in terms of integrated care pathways
- Clinical engagement is crucial for commissioning and much else besides
- The local dimension to commissioning is essential and must not be overlooked

Dr David Jenner

- Under PBC, practices have responsibility for budget but a Primary Care Trust (PCT) has accountability, which can be problematic
- Getting the right data is essential before embarking on any reform
- Changing commissioning takes time and effort and practices need support
- GPs can be rallied to get involved in commissioning
- Payment by Results and tariffs provide big opportunities for primary care in England to take work off secondary care

John Skinner

- LHBs currently have poor information to support commissioning
- Commissioning also needs a more strategic focus and clinical input
- We are currently investing not commissioning
- Have to change commissioning to move services forward
- Regional and local commissioning can and should co-exist
- The Greater Manchester approach is a model we can learn from

Dr Andrew Dearden

- We are currently purchasing and contracting, not commissioning
- A potential Welsh model could consist of local, regional and national levels
- Purchasing decisions are currently devoid of clinical input
- A plus of fundholding was that it engaged clinicians – we must recapture this
- GPs want involvement not tokenism, money to invest not save, good data

Dr Tim Richardson

- The future model of care provided big opportunities for primary care to take work out of hospitals
- Epsom shows one possible way of doing this
- Essential to get clinicians engaged in any change
- Many GPs may want to go beyond commissioning to provision

Workshops:

- **Information** – clear and consistent data is vital to support commissioning
- **Incentives** – for GPs and LHBs, these are needed to encourage any change
- **Clinical Engagement** – commissioning needs clinical input and support
- **Commissioning skills/capacity** – at all levels we need to boost this
- **Shared problem, shared solution** – better commissioning means involving managers and clinicians, LHBs, Trusts, Local Authorities etc

Report of Proceedings

Presentations

Introduction:

Dr Andrew Dearden/Mike Ponton

The focus of the day would be on Practice Based Commissioning in England, and we would hear about the successes and the problems. But the purpose of the event was to think about commissioning here in Wales. Whilst Wales was unlikely to go down the PBC route, choosing instead to have locality or LHB-led commissioning, it was nevertheless useful to learn from PBC in England. The structures may be different, but some of the principles would be the same. There were genuine concerns and worries about commissioning but it was very important to be positive in discussing the issues in the course of the day.

Context:

Mike Ponton/Kevin Sullivan

Although the focus of the day was on PBC, commissioning doesn't stand alone. On the contrary, it had to fit into a broader context.

The key features of the changing world that the NHS faces were: an ageing population; the burden of disease shifting from acute to chronic conditions; rising clinical standards; new treatments available, such as brachytherapy and Herceptin; technology offering new possibilities; and rising public expectations, with the protests over reconfiguration plans in summer 2006 showing the strength of "people power".

Against this backdrop, the traditional way of providing services was not sustainable. Other factors included: changes to staff working hours and terms and conditions; a shortage of specialist skills; increasingly outdated facilities, such as the major hospitals built in the 1960s; and finite resources which would never be enough and which are not likely to increase by much in the future. For all these reasons, changing what we do was essential.

The kind of health service we want for patients is probably something we can more or less agree on, as were the main things we needed to do to get there:

- Focus on health – it was vital to keep our foot on the pedal when it came to improving health, and avoid losing sight of this with all the current focus on the changes in the hospital sector
- Use services responsibly – there would be limitations on service
- Avoiding unnecessary admissions – chronic conditions are a huge burden and tackling them must be central. Alternatives to acute care must be provided in the community. The solution has to be at local level
- Community care – this was the direction in which most care was moving, and the key question was how do we get the different levels right.

As for the policy context that is intended to take us in this direction, three key policy developments are of particular relevance to commissioning:

- Wanless Review: Still very influential not only because of its emphasis on achieving clinical sustainability, but also because it lay behind the Beecham Review's conclusion that partnership working was critical
- Commissioning framework: due out soon, the key question would be how will it work? How will the balance be struck between regional and national commissioning? And what role will there be for local commissioning, which is certainly needed?
- Community services framework: also due out soon, this is a recognition from WAG that it was wrong to set out a vision of acute services without a clear statement of how community services would look, as this has to be in place to make changes to acute services happen.

We need to think again about community services and we cannot simply say that Wales's integrated trusts, a form of vertical integration, are the only solution we need. Horizontal integration of services – in the form of more available in primary care – was also important. Though a key practical question to address is how to ensure that we do not simply add to primary care professionals' existing workload without taking away some of what they currently do. This kind of practical question was important to consider in the debate about local services and local commissioning.

The vision of future services described in the Confederation/BMA report *A Picture of Health* could be a reality. Kaiser Permanente, for example, showed that by having strong primary care, specialist and generalist clinicians working together, and good partnerships with social care, this could all be achieved.

What is needed to make this kind of vision a reality is: investing in engagement with clinicians, with managers as facilitators; clinical primacy in care pathways, which meant that with commissioning we need to be clear at local level about what we want; strong partnership working, putting away the baggage of the past; and finally, locality commissioning, with clarity about what patients want, based on strong local engagement with clinicians and communities. Without this engagement, all commissioning will be off target.

PBC – a GP's view:

Dr David Jenner

A "no holds barred" view of what's happening in England, from a frontline English GP, may help Celtic countries to watch and learn from the experience.

The key points about PBC, in a nutshell, were:

- Practices or groups of practices may hold and manage an indicative budget for health care – indicative means they have responsibility for the budget but the PCT still has accountability. The fact that these responsibilities are not aligned could be problematic
- Practices can use savings to improve local services (with PCT approval)
- Legally PCTs still hold the budget and the risks. This is different from fundholding. No new legislation or money is attached to PBC
- PCTs, not practices, do the contracting
- Government aspires to universal coverage by end 2006 (does not mean all practices involved).

Elements of PBC had been seen before, for example in fundholding, though they were not the same thing. Primary care incentive schemes had worked in the past, and the benefits of these were felt to have been lost, with the acute hospital still dominant.

Why was PBC devised? There were various reasons, including:

- Incentivise practices to reduce referrals, in line with the Wanless target of decreasing cost of emergency referrals by 5%
- Aligning budgetary responsibility with those who commit the resource.
- PBC is a way of shifting 5% of activity into Primary Care
- To help patients drive choice agenda
- As an antidote to Foundation Trusts and Payment by Results, which incentivise the hospital sector and drive production. PbC is meant to stop all the money going one way, as big funding increases look likely to dry up.

It was important to understand Payment by Results (PbR). Fixing the prices stops trusts from changing them, but also incentivises production, with no quality benchmarks – effectively it was payment by activity rather than by results. The tariff used for PbR covered around 80% of all activity (e.g. outpatient and inpatient procedures) but not areas such as diagnostics, mental health and community and primary care services.

The tariff system is being used to organisations' best advantage, and most GPs and PCTs do not understand tariffs and PbR fully.

Under the tariff and PbR regime, PCTs should provide finance and activity data to all practices for areas such as outpatient attendances, referral rates, use of diagnostics, prescribing and community and mental health services. They should also set up an incentive scheme worth around £1.90 per patient, with 70% of any savings against budget available to reinvest in practices, subject to PCT approval. The problem however is that PCTs don't have the money they need to invest in order to save.

The 2007 guidance budgets for PCTs are based on 2005-6 activity. Next year there will be a move to a "fair shares" formula, but no practice will change by more than 1% a year. The 2007 guidance on risk management underlines the need to budget for high-cost low-volume treatments, as well as the need to have practices commissioning together to spread the risk. Savings can be invested in practices, with PCT board approval.

It was important to understand PbR and tariffs, as well as PBC, because it represented a big opportunity for primary care. Providing services in the community rather than the hospital means practices can undercut the tariff, and at the same time move services closer to the patient. For example, in England some primary care units are being opened in front of A&E, on the principle that A&E is where people go. The units can deliver much of the care needed, and at a below-tariff cost compared to the A&E unit.

Another example is employing GPs with special interests, or consultants, to provide what were once hospital-based services in the community. Again, this can undercut the tariff, and help reduce emergency admissions. Steps like this might be too much for a single practice, but collaborative working between practices makes them feasible.

Other opportunities included: reducing follow-up outpatient attendances and inter-consultant referrals. Essentially, doing the simple stuff in primary care would make quick incisions on the secondary care budget.

For example, dermatology could be provided much more cheaply by a GP with special interests working in primary care; employing a specialist diabetes nurse saved lots of money by reducing unnecessary follow-up outpatient appointments; and a modern matron can provide case management, reducing length of stay. In all cases, there are savings, and the result is that care is delivered closer to the patient.

Taking opportunities like this brings benefits all round:

- For practices, it means they feel they are making a difference, and gives them a new set of incentives, as well as the prospect of extra income. There are risks to practices in not being involved, as the PCT may bring in someone else to commission services, and GPs will lose influence
- For the Primary Care Organisation (PCO) it means an opportunity to manage demand for secondary care, engage with clinicians, and challenge acute trust power
- For patients it means more services delivered locally.

These are the key lessons on PBC and wider reform in England:

- Don't put the cart before the horse – don't take steps such as introducing tariffs or Foundation Trusts until you know the information, or PCOs won't have a clue what they're buying as the data is useless
- Practices will need loads of support to get active as commissioners
- At least one year's investment is needed before any rewards are seen
- Clinical and managerial time in setting up must be funded
- Tariff drives production, and caps on hospital activity are needed
- Coding by trusts shows signs of gaming, so consider an independent coding unit
- Validating activity is a must – there must be evidence for why it's being done
- GPs can be rallied against a common threat – e.g. private sector commissioners
- Public health and health inequalities – must not be neglected in practice work
- Rural and affluent areas tend to overspend on tariff
- Good conflict-of-interest provision is essential, as GPs may be both providers and commissioners
- While only a few GPs may wish to do more providing of services, commissioning and resource management is everyone's responsibility.

An LHB Perspective:

John Skinner (Cardiff event)

LHBs are now four years old, and have succeeded in providing a better local focus for healthcare, as well as talking more to contractors at local level. However, whilst they are talking to trusts, they had made relatively little impact on secondary care provision.

One problem is poor information. LHBs need to rely on info from others, plus an individual LHB in many cases isn't able to translate and analyse data. The problem is one of diluting skills by spreading them amongst 22 LHBs. Some of the larger LHBs have the full suite at their disposal, but many others do not.

Lack of clinical input into commissioning is another problem, as is the lack of strategic focus. What goes on in LHBs' backyards they know, but they have very little hard info about what happens elsewhere – even within the region there is a lack of good data about capacity, for instance.

What LHBs are doing is investing not commissioning. I will know how much I have invested with my trust, and the numbers of patients involved. But I won't know the quality, the service model, or the outcomes. England has not sorted this problem out either.

We must remember the policy context, with Wanless arguing that 20% too much capacity was going through secondary care, with Designed for Life requiring the three regional plans, and with Making the Connections underlining the need to make best use of resources, including LHB management costs.

The objectives we were trying to achieve were to:

– Develop primary care
– Manage demand
– Relieve pressure on secondary care
– Improve services for patients.

To achieve these, we needed to change the way we commission services.

Looking ahead, three regional units was likely to be the favoured approach in the new framework for commissioning in Wales. The Manchester approach could be the basis for LHB commissioning in Wales. Around 14 Manchester PCTs, with a similar size budget to SE Wales, set up a unit that provided support for their commissioning work.

The key to improving commissioning was:

– To concentrate skills and resources
– To obtain better information
– To secure better clinical input, with links to National Public Health Service and clinical networks
– A stronger strategic focus, with regional units able to give a better idea of capacity and demand.

Can regional commissioning accommodate PBC? It could. The Manchester approach takes PBC as the building block. They use 20,000 as a critical mass for a practice base. They can then produce information for practices or groups of practices wanting to do PBC. The issue comes down to governance. Although the direction in Wales is regional, underneath that it can facilitate the local commissioning process.

Mike Ponton (Llandrindod Wells event)

Mike highlighted the key points from John Skinner's presentation (see above) and added the following:

Getting good information remains the problem, as it has been since at least the Griffiths report in the 1980s. We still have some way to go to improve the quality of information, and it is crucial that Informing Healthcare delivers.

A diagram illustrates the two different cycles involved in commissioning. One is planning/reviewing/assessing. The other is purchasing/contracting. LHBs are responsible for ensuring that what's commissioned is right.

Commissioning should fulfil two functions: it should be a lever for change, and it should give the NHS better control over the services provided, in particular helping to ensure we get value for money and addressing the bias towards secondary care.

The Commissioning Framework would be built around models of care, care pathways and clinical networks. While PbR was not on the agenda in Wales, care pathways could have notional costs attached to them, an approach currently being examined by NLIAH. Models of care and care pathways are also more acceptable politically than PBC – it would be better to talk about local commissioning as the term PBC was seen to be a problem.

How about the levels where commissioning should be carried out? A diagram of concentric circles, ranging from the national, through regional, to local, was shown. The local is quite rightly the rich yolk of the egg. There was no single optimum level for commissioning all services.

The confusion was over boundaries between the different levels of commissioning. Where does the role of national-level commissioners begin and end? This question was proving difficult to resolve in areas such as cancer services, for instance.

The commissioning framework would be just that: a framework. Its aims would be to concentrate skills and resources, to provide better information, to strengthen clinical engagement, and to sharpen the strategic focus. Within this framework, local commissioning had a crucial role to play, as it provided grass-roots health intelligence, and offered an opportunity for frontline clinical involvement. Primary care level is where clinical engagement is most significant, with GPs agreeing that care modelling and care pathways are the way forward. This, rather than community services provided by integrated trusts, was the best approach.

A Welsh version of PBC was an essential ingredient in the approach to commissioning. We need space in the commissioning framework for local, as well as regional and national. The question is how to keep this strong local focus.

Commissioners will have a lot of latitude, within the framework, to determine their needs and their approach. Local organisations know more than WAG about the needs of their communities. We cannot do commissioning properly without our version of local PBC in Wales.

What GPs may want from commissioning:

Andrew Dearden/David Bailey

We are currently purchasing, rather than commissioning. As a result we are getting what is available, rather than what we may need.

The Welsh context was different from England, with less private sector involvement and less capital investment. Developments in England were receiving mixed reviews, with some PCT/GP relationships working well, but others less so. We need to look at where is it working well and why.

The commissioning process, ideally, should involve the following: define need, define the system to meet need, contract, and check that it's still meeting need. Crucially, there is more to it than just the contracting, which is only one stage in what should be a commissioning cycle.

The question should be: "how many knee ops do we need?" Not "how many do we do" or "how many have we done?" We have to focus on what it is that patients require. Currently, we simply don't know. We spend hours on contracting and clauses instead. We ask much more of primary care than we do of secondary care – details in the contract, checking, monitoring, audit etc, so primary care seems to get 'over done'.

A key principle is to establish what's important as a starting point, rather than determining what's important on the basis of whether it's easy to measure.

A potential Welsh model for commissioning could look like this, with three levels:

- LHB-led commissioning groups, including local clinicians from community and secondary services
- Regional commissioning groups – for some commissioning purposes LHBs are too small, and groups will have more power to hold trusts to account
- All-Wales level – tertiary and specialist commissioning, though still with clinical input.

Problems with commissioning as it stands include: purchasing decisions are devoid of clinical input, with clinicians on LHBs only ever asked to rubberstamp already-made decisions; some gaps exist where GPs should be on LHB boards – this may be due to frustration amongst the GPs who feel disconnected from the commissioning processes, such as they are; and on a practical note, attending LHB meetings can be difficult for GPs.

Fundholding had produced some benefits. Secondary care had had to react to patient needs, with money following the patient. There was reduced need for follow-up appointments and better GP direct access to diagnostics. And there was better access to services – more provided in primary care than is the case now.

One of the big benefits of fundholding was involving clinicians. Whilst we must allow the clinicians to be clinicians alone if they want, fundholding had increased the sense of involvement in decision-making amongst clinicians.

Waiting times and overspends had rocketed since fundholding/GP commissioning ended. Moreover, valuable data from that era is now almost gone. GPs knew how many operations and referrals were taking place, whereas now data collection has to start all over again. And without the data, effective commissioning simply can't happen. There was a year of preparation for fundholding, and we need the same kind of time to prepare for any new commissioning arrangements.

What do GPs want?

- Proper involvement not tokenism. There is real apathy and cynicism about perennial change in commissioning and other areas, along with continued annoyance at the loss of data, time and commitment that GPs had carefully amassed during fundholding
- Money to invest rather than just save. GPs don't like cutting services, and we must avoid the mistakes made when long-stay psychiatric and geriatric hospitals were closed without putting community services into place. Kaiser Permanente spent years preparing for the shift towards community services. We haven't
- Good data – the key to effective commissioning.

The potential commissioning approach for Wales would consist of: LHB-led local commissioning, with significant clinical input; secondary care commissioning at regional level; and tertiary and specialised commissioning at all-Wales level.

At all levels, the key was to involve clinicians. Tell them that their time won't be wasted. Many of them lost all enthusiasm after 7 years' work went out the window and are now happy doing the day job only. It will be essential to convince clinicians that it's different this time.

Practice Based Commissioning – Developing New Services:

Dr Tim Richardson

England had seen a tripling of investment in the NHS, though the amount reaching the front line had doubled. It was also facing a huge need to reconfigure hospitals and to engage with clinicians.

Reconfiguration of hospitals was needed for various reasons. The Working Time Directive was one, as more clinical staff were needed in order to comply with the directive. As well as the cut in hours, the Calman measures had halved the amount of time specialists spent in training, which means they need highly concentrated access to patients to acquire the necessary expertise. Colo-rectal is the only cancer with enough volume to sustain service in all District General Hospitals.

Increasing specialisation was a benefit to patients. A patient's chances of survival after an aneurysm varied from 20% if they were treated by a generalist surgeon, to 80% if they were treated by a vascular specialist.

The future model of care was likely to consist of critical care centres, without A&E facilities, serving around a 500,000 population. These would be complemented by local care hospitals, providing urgent day care, outpatient services, diagnostics and step-down care. Life-threatening interventions would be split out and dealt with in highly-specialist centres, and everything else would come into primary care. We should look at Kaiser in the US with their fully integrated approach. Consultants of the future will work in the community rather than hospitals.

In Epsom, a major hospital reconfiguration was under way, and the key question was what should stay in the centre and what should come out into the community. Admissions by age and length of stay were being studied, with the conclusion likely to be that the area needed more community beds and fewer acute beds.

How will this kind of future service model be achieved? Various policy initiatives were pushing in this direction. These included:

- PBC, which would become practice based service provision
- PbR
- SPMS, which enabled practices who wanted to provide more services to do so
- APMS contracts – a warning to GPs that they must get involved
- Choice and competition
- The emergence of new providers.

Even opponents of fundholding have come round to PBC.

The integrated care partnership in Surrey involved three practices coming together. They had bought up an old cottage hospital with a good interior to become a day surgery centre, funded through fundholding. In 1997, they went into a new PMS plus contract, allowing them to provide the service, not just purchase it as allowed under fundholding. They merged with other practices to create the critical mass needed to provide services such as physiotherapy, podiatry, and clinics with visiting consultants. They found that 80% of outpatients don't need the back up of a hospital. They also carry out diagnostics and day surgery, as well as programmes for older patient management. 80% of elective care was being delivered in the centres, for their own patients and patients from other practices.

The centre saved the local PCT at least £5 million on outpatients alone. However, PCTs won't allow other practices to do it and to take work off hospitals. They were visited by the SHA and told that no money can be moved out of hospitals.

Changes such as this have to be carried out in consultation with clinicians. If you want change to happen, you have to get clinicians engaged. That's the very reason for PBC. Fundholding had been undone by GPs who didn't like it, resulting in the creation of PCTs. SPMS contracts provided an opportunity for all health professionals to offer services to the PCT.

Different models were emerging, including Central Surrey Healthcare (800 nurses and therapists who have set up an independent company). Integrated Care Services (Tim's company) promise is to provide services to the PCT more cheaply, by treating more patients in the community, with consultants and GPs working together.

The limited liability company was one possible model – another was the legal 'chambers' model which some consultants may possibly adopt.

The changes had meant new services being delivered in Primary Care: therapies, diagnostics, day surgery, specialist GP and nurse clinics, intermediate and chronic disease care. GPs had been given incentives to become providers. Information is key – if you can't measure it you can't manage it. They had demonstrated to the health authorities that they could provide services better and cheaper than the DGH.

The NHS has not been very good at isolating the different critical masses needed for different services: this is what the company analyses.

Who will provide these services? NHS clinicians, but also private providers and Foundation Trusts (though they were not necessarily the cheapest). PCTs will not be providing services. Some PCTs did provide some services, but this was not the way of the future. The PCT would become the back-office function.

Some of the changes would require significant capital (e.g. purchasing and refitting community hospitals) that would require private sector involvement, for example in joint ventures or buy-outs.

Summing up, the team had moved from PBC to total service provider, and they were more comfortable being a provider rather than a commissioner. GPs often combined good clinical skills with business acumen, so why do they limit themselves when it comes to the services they provide? Primary care can provide a much wider range of services, and this is the key to getting higher quality care for patients.

Speakers' presentations

If you would like electronic copies of the speakers' presentations please contact: lisa.nelson@astrazeneca.com

Workshops

There were two workshop sessions, in which delegates were split into 3-4 groups. They were asked to discuss a series of questions and to record/report their conclusions.

Question 1

What are the key issues to resolve for more effective local commissioning?

Information

- Reliable information and data on activity
- Information on GP referral and patient flow
- Core data set for all providers – standard information and recording system for trusts
- Availability of clean, validated data – from trusts and NHS Direct
- Skills in data analysis and interpretation are needed
- Difficulties of current system in cross-referencing data

Incentives

- No incentive at present to get involved in local commissioning
- Financial incentives needed
- What incentives are there for primary care?
- A potential incentive for locality commissioning is regenerating the primary care premises strategy

Relationships

- Distrust between health organisations
- Communication problems
- Relationship between commissioner and providers is difficult
- Fear of destabilising NHS trusts

Capacity

- Lack of time and people to do commissioning properly
- Lack of investment in premises may be a barrier too

Engaging clinicians

- Clinical engagement crucial
- Empowering GPs, rather than engaging with them – they will take responsibility
- Much GP goodwill lost after demise of fundholding
- Commissioning must be clinically-led – identify clinicians to lead
- Get secondary care clinicians involved in commissioning

Patients

- Need to engage communities with the change agenda
- Patient involvement and engagement are crucial
- Patient expectations are that a referral to secondary care is required
- Patient education about proper use of NHS services

Partnerships

- Primary and secondary care targets may be different – need to align
- NHS Direct has a role – need to clarify it
- Local authorities are key partners, especially in managing chronic conditions
- Public health involvement essential for evidence-based commissioning
- Difficult to bring in partners when we aren't sure what we are going to do

Money

- Framework needed for resources to shift from secondary care
- The structure of commissioning (i.e. shared between HCW and LHB) does not help money move to where it is needed
- Deficits could impact, and LHBs could overturn any locality or practice based commissioning decisions on financial grounds
- We are starting with deficit – but we need money to incentivise GPs
- Where do any savings from locality based commissioning go? Can't just go into deficits
- Training budget to be established from the start

From Welsh Assembly Government (WAG) and politicians

- Clear and concise policy guidance needed from WAG
- Total commitment and support needed during implementation too
- Political will and permission needed
- All political parties must be signed up to new approach to commissioning– can't change again

How would it work? Structures

- How would localities and catchments be identified?
- Would a 'locality' be defined by LHBs, GPs or both?
- Locality based networks, with social services and voluntary sector
- Is primary care – based around GP practices – really structured for locality-based commissioning?
- Strategic plan needed to structure local commissioning and identify priorities

General comments

- Commissioners don't understand what they are commissioning
- A good commissioning system needs to be structured so that all the elements support each other
- Commissioning must be based on needs assessment, which requires input from local authority and public health colleagues
- What trusts provide is based on what they think we want, not on what we know needs are
- We must be clear about our aims – improving access, reducing inequity, streamlining processes
- One size does not fit all when it comes to local commissioning – need different models
- Could we develop regional-based primary care practitioners to advise and facilitate on locality commissioning?
- PBC could give practices control to develop new and alternative provision of secondary care services in primary care
- The term 'locality' commissioning is more politically palatable than practice based commissioning?
- Who would cover the cost of commissioning consortia?
- Could PBC work without the stimulus of the market?
- How would treatments be priced?
- We need national prescribed care pathways
- Moving services from secondary to primary care would require quality standards
- How should contracts be drawn up? Tariff-based or long-term agreement? If the latter, how long should it cover?
- Is it best to introduce local commissioning as a big bang or gradually? The latter would help build confidence, as areas are gradually encouraged to join in
- Cross-border issues: Whom do LHBs commission for? Resident or registered populations.

Question 2

What would be the risks and concerns about local commissioning such as PBC?

Information

- Quantity and quality
- At LHB and Trust level there are problems with access and robustness
- Referral practice data is inadequate
- IT issues around primary/secondary care interface – Informing Healthcare must address these

Incentives

- Need incentives for primary care to get involved in local commissioning
- Improved local commissioning could mean:
  - For LHBs – hitting targets for demand management, managing people out of hospital, achieving financial balance
  - For trusts – better understanding of demand
- But building in financial incentives is difficult given deficits

Financial

- Possible increase in management costs
- Would there be funding for introducing local commissioning?
- Funding can't be provided entirely on the past levels of funding
- What can be done with any savings made?

Capacity

- Our workforce in primary care doesn't have the capacity to take this on
- Can the primary care estate cope with the increased number of services that could be delivered in primary care?

Relationships

- Unwillingness of some GP practices to work together
- How do we engage with the Trusts, given that they may be opposed, seeing local commissioning as a destabilising force?
- Practice/LHB/Trust relationship is often adversarial
- The upshot of local commissioning would be having to deal with a larger number of commissioners
- Engagement needs an honest broker

Clinical engagement

- Clinical and stakeholder engagement crucial
- Need to ensure an appropriate training environment for clinicians
- Professional-body support for local commissioning would be welcome
- Clinical champions needed to take it forward

General

- Local commissioning must not challenge accountability and sovereignty of LHB Boards
- Quality of care would need auditing and evaluating
- Training and education critical
- May be more demand on services – need to plan for this
- Politically, local commissioning must not be seen as fundholding, with its connotations of a two-tier service
- Commercialism doesn't sit well within the NHS
- Responsibility for problems could be deflected to LHBs and GPs
- Information on commissioning decision will be available to public under FOI
- Need to generate peer pressure, developing leaders within groups of practices
- LHBs must have teeth to introduce changes.

Question 3

What are the three key areas to address if we are to develop local commissioning in Wales?

The three key areas identified by each of the discussion groups:

- See what is out there already, mapping exercise, sharing progress in service development
- Collecting data
- Getting GPs on board

- Data collection
- Clinician engagement, clear policy direction and commitment
- Incentives for doctors and managers to make it work

- Requirement by WAG to shift resources
- Minimum bureaucracy
- Full involvement of all parties – LHB/Trust/HCW/GPs – incentives and sanctions for Trusts to be involved

- Information – needs assessment, and then identify providers
- Invest to save – transitional funding needed, possibly private finance
- Community nursing – Trusts shouldn't provide this

- Costing information – commission detailed info from practices to assess needs and starting point
- Premises strategy – need to invest to redesign services
- Access to diagnostics

- Legislation
- Identify practices for phased implementation
- Funding for LHB – administrative and management support

Question 4

What are the resources needed to make local commissioning work?

- Data – good quality information to assess status quo
- Leadership – champions needed, managerial and clinical
- Outcomes needed from WAG
- Clear vision at locality levels
- Need funding formula based on weighted capitation
- People – capacity, but also commissioning and data analysis skills
- Patient education and responsibility

Question 5

Which services could be redesigned?

- All of them
- Respiratory services
- Anything that doesn't need to be in secondary care
- Community-based services
- Sexual Health
- Diagnostics and therapies
- A&E, by putting primary care at front end of A&E unit
- Chronic conditions
- Physiotherapy
- Diabetes
- Intermediate care services, including pooled budgets with local authorities
- Service redesign must mean repatriation of funding from trusts – this is an essential condition for PBC or local commissioning
- Engagement and alignment of out-of-hours providers in commissioning is essential
- The Epsom model of delivering more services in primary care could be very appealing to many GPs

Practice Based Commissioning – Are there Lessons for Wales?

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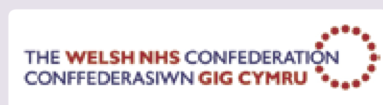

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