

North & South Essex Local Medical Committees



**PRACTICE BASED COMMISSIONING
A BRIEFING NOTE FOR PRACTICES**



Progress to date

There has been genuine progress with PBC over the past few weeks with PCTs and practices showing a willingness to engage in this issue. The Government's commitment to 100% coverage by the end of 2006 has removed any possibility of avoidance on either side. Information systems have been tested and commissioned, although the quality of the practice level information available is still variable.

Most practices appear to be clear on the locality within which they have chosen to operate, although there is no doubt that some more adjustments to locality boundaries will be necessary over time. PCTs have held both practice and locality meetings, and in some cases have assigned managers to specific groups of practices.

Action Point:

All practices which are not planning to enter PBC alone should by now have agreed the membership of their locality commissioning group.

Some areas have been given information on indicative budgets, but this is by no means true across every PCT. Budget setting varies between PCTs with some using historical data, in accordance with Department of Health advice, some using capitation figures, and some a mixture or compromise between the two methods.

Action Point:

Practices should be clear of the methodology used in budget setting within their PCT, and if necessary should obtain clarification from their PCT on how any decisions were made. Choosing one process over another creates both winners and losers.

Work is in progress on identifying specific clinical topics for early attention, in order to clarify the work necessary to make progress in PBC, and to illustrate some "quick wins" that will make small but real changes to patient care



Problems



The guidance from the Department of Health remains vague and ambiguous, and gives little assistance to either practices or PCTs.

No new guidance is expected before December, and it is unclear how detailed this will be. For example, will guidance specify management costs and a division of responsibility between practices/localities and the new PCTs?

PCTs are struggling with an overall financial deficit and are therefore unable or unwilling to take risks, or to devolve management resources.

Practices are still occupied with the new contract and its resulting workload.

PCTs and the SHA are facing a major re-organisation that will transform the management of the NHS, but the transitional period undermines current management. It is therefore difficult for PCTs to establish PBC processes that will be sustainable under the new organisations.

Community care staff, who ought to have an important role in the planning, provision and commissioning of services, have been placed in the uncertain position of not knowing what their employment status will be by 2008.

Hospital Trusts have generally not been involved in PBC discussions, and Foundation Trusts are operating in an increasingly aggressive market.

No one appears to have addressed the difficult problem of involving patients in commissioning groups.

The division of responsibilities

There is at present no clarity over who owns this process and where responsibility lies for the various stages in the commissioning process. There is also tension over the implementation of Choose and Book, and the need to incorporate patient choice into a more controlled and managed commissioning structure.

There is an obvious need for clarity around which party has "lead" responsibility for specific parts of the commissioning process, and an understanding that lead responsibility can only be successful if all parties work together for the good of the project.



PCT responsibilities “flexible and responsive”

The role of the PCT should be to facilitate the development of commissioning groups that can operate with the minimum input from a new, larger, and more remote PCT. The new PCT should be able to depend on locality groups to inform it of issues within their areas by acting as the eyes and ears of the larger body.

Some areas where the PCT should take lead responsibility:

- Local Delivery Plan
- IT and overall information management
- Contracts with main providers
- Financial accountability
- Payments to main providers (but only with locality agreement)
- Risk management
- Allocation of indicative budgets and management resources
- Public Health
- Training and workforce issues (With SHA/WDC support)
- Premises development
- Compliance with government targets and policies

Action Point:

PCTs should not be establishing structures that are dependent on direct management of locality commissioning groups, as this will not be sustainable under the new PCTs.



Practice responsibilities “Innovative and accountable”



Practices have a duty to their patients, and also a responsibility to work within the boundaries set by their locality in order that commissioning actually makes a difference to patient care. The list below gives some of the main areas where the PCT should not take the lead, although this list could be further divided into responsibilities of practices and localities.

Practice/Locality responsibilities:

- Compliance with Local Delivery Plan (LDP)
- Adherence to locality agreement and acceptance of decisions made by locality managers
- Involvement of a variety of clinicians (nursing, pharmacy, etc)
- Data validation
- Payment authorisation (Therefore ending Trust pressure on PCTs as sole paymasters)
- Patient involvement and information to patients
- Relationships between practices in the locality
- Needs assessment (With PCT Public Health support)
- Selection of key clinical areas and priorities
- Management and clinical input including selection of lead clinicians and appointment of staff

Practice responsibilities Cont'd..

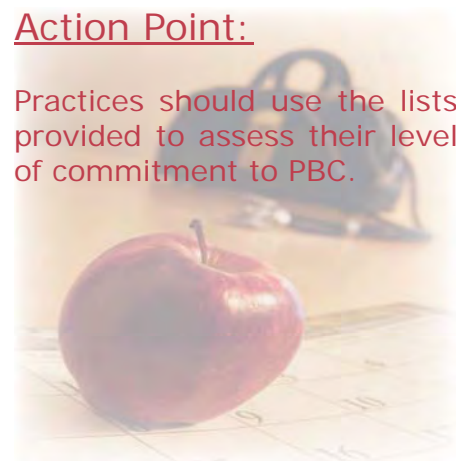
Direct negotiation with Trust clinicians

There may be areas where responsibility must be shared, such as the level of PCT monitoring and support, services that need to be commissioned at a level above the locality, the use of any savings (though this requires final PCT approval), and the pace at which PBC will expand in the locality.

Guidance on the relationship between PCTs and practices, in the form of a basic agreement, has been produced jointly by the NHS Confederation and the National Association of Primary Care.

Action Point:

Practices should use the lists provided to assess their level of commitment to PBC.



Examples of clinical areas currently being tested

Action Point:

Practices/localities should focus on achievable well-defined clinical areas where real progress can be measured.

One reason why there has been a slow start to PBC is that it requires a great deal of new thinking on all sides, and an appreciation that it needs to be broken down into practical steps, which is something this paper attempts. Another problem is the breadth of clinical issues that will ultimately be covered by PBC. The list below illustrates some of the clinical areas that are being discussed in PBC projects across the Country. This list is by no means exhaustive, but it does show how this new way of commissioning might reveal a multitude of options. How inequality can be addressed in the short term, in the midst of this rapidly changing environment, is a mystery.

A great deal of the variation between localities is driven by particular service issues such as a well-developed GpW/SI service, or a poorly performing Trust service.

GpW/SI services: Dermatology, gynaecology, ENT, drug misuse, etc.

Cardiology: improved primary care diagnostics

Orthopaedics

Paediatrics

Day Hospital management and usage

Management of DVTs

Mental health

Long-term conditions

Emergency admissions

Diabetes

Heart failure

Prescribing/medicines management

The process of initiating change



- Assess needs of population and ability to make a difference
- Plan changes within a manageable clinical area
- Agree basis of change with social services and /or secondary and community care
- Produce service specifications
- Comply with government rules re contestability, choice etc
- Advertise and promote the new service and manage referrals
- Review effect of changes and adjust accordingly

Patient Involvement

At the level of the commissioning group it is essential that patient representation is included. This will in the future be a powerful mechanism when negotiating both with the new PCTs and the main providers. A strong local alliance between clinicians and patients represents an almost irresistible lever for change.

There is no reason why patients cannot be informed of local commissioning changes and improvements through their practices. The registered list is one of the foundations of all that is good about the NHS and it could be used to access patients both in terms of their comments on changes, and also to remind them of their responsibilities as service users.

It is not yet clear how patient views will be incorporated within the new PCTs, but the re-organisation allows the opportunity for localities to send “ambassadors” to the centre to ensure that the larger PCTs are influenced by their localities.



Acute Trust and wider clinical involvement

Clinicians and managers from the Acute Trusts, and other main providers, must be involved in any changes to clinical pathways leading to altered commissioning. PBC is a clear opportunity to re-unite clinicians in planning patient care, and to empower managers to see that the necessary contractual changes allow such improvements to occur. Consultants agreeing to service changes should cement any contractual arrangements and facilitate clinical pathways that best suit patients.

Other primary care clinicians can similarly give advice on what is possible within the community, and on how changes should be implemented.



Possible quick wins for localities undertaking PBC



- Validation by practices of inaccurate or over-priced Trust data
- Management of demand and referrals, although this may be more difficult amid the "Choice" agenda
- Reduction in follow-up outpatients
- Reduction or control of non-elective admissions, possibly with help from patient "contracts"
- Development of Community services and GpWSIs to give locally responsive clinical pathways

LMC PBC Training Programme 2006

January 2006

18 - Communication Skills Max 10 Places
24 - Team Working Skills Max 10 Places

February 2006

08 - Negotiating Skills Max 10 Places

April 2006

11 - Influencing Skills Max 10 Places
25 - Rapid Reading Skills Max 15 Places

Waiting Confirmation

Assertiveness Skills
Customer Service Skills
Facilitation Skills

The above training courses are courtesy of Merck Sharp & Dohme /Wyeth Pharmaceuticals. They are open to all GPs and their Staff. The sessions will take place in the afternoon (12.30-16.30) and will last approximately 4 hours. They will be held at the LMC offices in Hatfield Peverel.

If you would like to book a place please contact the LMC office as soon as possible. Places are limited to one representative per practice and will be allocated on a first come first served basis.

Further details will follow in due course.

All Practices should have received the flyer opposite by Monday 14th November. If not, please contact the LMC office.

Places are limited so please book early to avoid disappointment.

**North & South Essex LMCs
Present**

PRACTICE BASED COMMISSIONING

WHY ME? - WHY NOW?
A Seminar for All Essex
GPs and Practice Managers

Presentations from:

Laurie McMahon
Co-founder and Head, Centre for Inter-organisational Change - Office of Public Management

Dr Brian Balmer
Chief Executive/Secretary Essex LMCs

Tuesday 6th December 2005
1.00-4.00pm
Pavilion, Walled Garden, Braxted Park Estate
Witham, CM8 3EN
A buffet lunch will be served from 12.30pm

Limited Places - Book Now!

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