Stockport PCT

Health Reform in England: Update and Commissioning Framework

This paper summarises the key messages in this policy paper which can be found in full at http://www.dh.gov.uk/PublicationsAndStatistics. A number of key messages on direction of travel and implications for our own commissioning strategies and structures are discussed. There are in addition a number of consultation questions posed to which we are invited to provide a response by the 6th October 2006.

This paper therefore will also be used in a number of forums for engaging on these issues and as a vehicle for capturing a response on behalf of the PCT.

This document is planned for discussion at the following meetings in September

PBC Board	Overview and Scrutiny Committee
PEC Committee	Patient Panel
PCT Board	Provider Board

Reforms

In the foreword from the Secretary of State this document is outlined as:

> This document builds upon *Health reform in England: update and next steps*, published in December 2005. It focuses upon the development of first-rate commissioning to create an NHS where patients have more choice as well as a real voice in the design of their services. Commissioners need to work with providers to secure the best health outcomes and the best services with the best value for the public's money.
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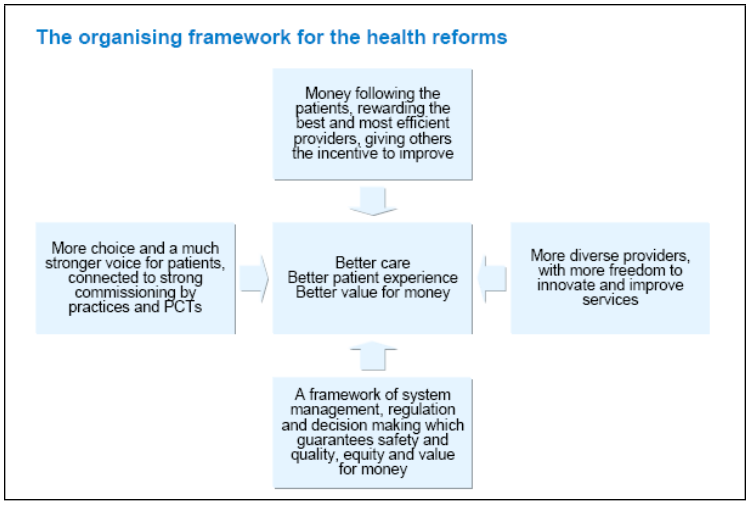
> Drawing on best practice already operating in many parts of the NHS, it outlines how practice-based commissioning will empower GPs to develop new services, flexible to reflect patients' needs and delivered closer to people's homes. This will also avoid unnecessary hospital admissions, particularly for those with long-term conditions. It describes the role of Primary Care Trusts and Strategic Health Authorities and their relationship with GP practices, and it emphasises the central importance of clinicians and other health professionals, in their relationship with their patients.
>
> Finally, it reaffirms our commitment to a diverse provider base, including strong NHS Foundation Trusts, within a regulated framework, supported by the tariff system and good information.

Why is reform so important ?

The NHS faces considerable challenges now and in the future
Rising expectations, Advances in Medical Technology, Variations in Quality of service, Ageing populations.
Meeting these challenges will require a truly patient –led NHS that uses resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible health care.

The reforms are organised into these main strategies, consisting of

- Choice and Voice
- PbR/Incentives
- Diversity and Contestability
- Quality
- Regulation



It is important to note that the primary reforms are matched to the service being commissioned, what's right for cold elective surgery for example (a choice and PbR strategy) is not the same approach required for A&E or Community services.

The drivers for achieving reform should come from three main dimensions:

1. Patient driven reform – choice and competition
2. Commissioner driven – contracting, tendering , service redesign
3. Nationally driven- standards, and regulation

None of these approaches are 'self contained' but act in concert to improve quality, patient experience and value for money. Patient driven reforms have a high profile currently in particular in the context of choice and PbR.

Choice and Commissioning

Choice is a natural feature of people's daily lives; health should be no different. Choice at referral is already in place for elective care, where we offer a minimum of 4 -5 providers including independent sector choices. Choice is also available for diagnostic tests since November last year for patients waiting more than 5 months. In November this year, 2006, the Department will publish guidance on extending choice further. The framework will cover 'free choice' and at what points along the pathway we offer choice for patients – at what 'decision points'. It will also address the information needs for patients and discuss how choice can be extended to a wider range of services.
To help in formulating this policy document the following principles are being consulted on

- Everyone is entitled to express a choice about their healthcare and services.
- Choices offered should reflect the individual's beliefs, values and preferences as well as clinical need.
- Choice should be about type of treatment as much as about the place of care.
- Choices should be offered at 'decision points' along the patient's care pathway where this improves the patient's experience and is clinically safe.
- The choices offered should be clinically appropriate and in accordance with professional guidelines and meet NHS core standards.
- Appropriate information and advice should be available to empower people to make informed choices.
- Patients exercising informed choices should also take some responsibility for their choices.
- The choices offered should be affordable within the NHS budget.
- The choices an individual makes should not prejudice the treatment they receive.

You are asked to consider and discuss the following principles

Questions for consultation:

1. Are the draft principles the right ones on which to base choice in health?

2. Are there other 'decision points' along the elective care pathway, in addition to GP referral to a consultant-led service, at which choice should be offered?

3. What should the priorities be for extending choice beyond elective care?

4. What are the 'decision points' along the care pathway in other services where people want choice?

5. How can choice help in the promotion of fairness, inclusion and respect for all members of society?

6. What should the priorities be for developing information to support choice?

To assist in considering question 2 in particular – please see the choice map below which outlines the choice points currently offered to patients. The PCT plans to add a further choice to this map for ICAT's where – when available, the PCT will actively offer a choice of assessment service as well as secondary care hospital treatment options.

Insert

Provider Development

Government intends to build on success of Foundation Trusts working with NHS Trusts to move them to FT status where possible by 2008.

A new Director of Provider Development has been appointed to oversee the roll out of FT's. The feasbility of a **'Community FT'** is being considered in response to a number of calls from PCT's. More details will follow on this in the Autumn, however this is a favoured option. There is also clear potential for NHS FT's to bid for community services if PCT's wish to bring in new or different providers of care.

In addition to FT's, new social enterprises are also encouraged and more engagement of the third sector – voluntary/charitable organisations.
A new community hospital fund has been announced (september first tranche of bids) £750m nationally to assist in development of infrastructure in support of new social enterprise initiatives.
The development of these new provider structures will strongly align to the strategic commissioning of a shift in care closer to home and the vision of service integration outlined in the White Paper on Care out of Hospital. Two key pieces of work are anticipated to be reported on in the Autumn relating to Joint Provision and principal provider for joint ventures and franchising, clinical co-location – proposals on services which should be available in A&E departments regardless of provider.

Implication for Stockport PCT: the framework reiterates the need for the PCT to establish clear separate commissioning and provider governance structures and to evidence that commissioning decisions and processes are separate from providing.

In what ways should the Provider and Commissioner governance structures be strengthened and what are the potential implications of this ?

Key immediate issues

- The PCT has yet to publish an updated commissioning strategy following from the white paper on care out of hospital – this document will reconfirm the modernised services which the PCT and provider are to a large degree already modernising and developing, however it will also set out the market management options and approaches in delivering these services –what services will be contested, gaps and how these will be commissioned and partnering /joint approaches.
- there is a 'Provider Project Board' this however has not yet fully developed and requires significant organisational development, systems, staffing and support to provide a equal structure and team with which commissioners can treat as a distinct provider in terms of contestibilty/tendering, performance, quality issues.
- Are the PCT provided services fit for purpose in terms of management support? – is there sufficient senior management expertise and, how do we provide this management support equitably without conflict of interest ?

-ability of the Provider to act as a provider in terms of bidding, business case submissions and at risk development needs to be addressed in terms of delegation.

- if the Provider has a guaranteed service level agreement with associated income and/or incentivised service agreement this may reduce the flexibility of the PCT to address financial management pressures

-Community hospital fund – bid for this fund requires a social enterprise model- this fund fits well the service model envisaged to support reform of services for older people. The PCT should consider this aspect in terms of providing a viable framework for these new services.

Regulation

The merger of HCC, CSCI, MHAC has already been announced to share learning and provide integrated regulation and economies of scale. Guidance on this new framework for Independent regulation of the NHS will be produced in the Autumn and will include elements on

- licensing
- monitoring and enforcing licensing conditions
- overseeing competition rules, refereeing unresolved disputes
- publishing information to public, assessing providers and commissioners.

Tariff

A review is ongoing on the future of the tariff post 2008-9 which again will be published in the autumn 2006. in the meantime unbundling work proceeds as a key area of development, specialist services and top ups , and early publication of the operational framework for 2007-8 is planned. Stability in the tariff is considered key for next year and as such there is a concern from commissioners that the current 'threshold' payment for emergency treatment will stand [this is set nationally with no local negotiation at 2004-5 +3.5% beyond this a 50% rate is payable CHECK- this has given the PCT a £700 pressure in 2006-7 as this threshold is ABOVE the activity required or used]

Information

Good information and information systems are vital to sound commissioning in the NHS. In 2002 the National Programme for IT was established, there is generally wide stakeholder support for this continued strategy in particular the integrated health record. Four priorities for action in the framework should be noted

- a robust infrastructure to support modernised health and social care, including a national approach to authentication, security and confidentiality;
- Choose and Book (the electronic booking of appointments);
- the Electronic Prescription Service (EPS); and
- the NHS Care Records Service.

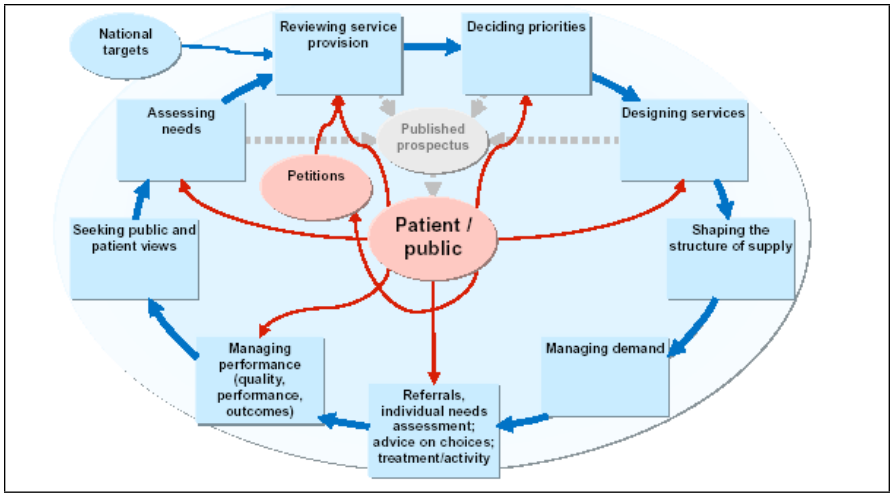
Strengthening Commissioning

Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean: the best possible health outcomes, including reduced health inequalities; the best possible healthcare; and within the resources made available by the taxpayer.

This current 'commissioning framework' focuses very much on the commissioning role of PCT's and PBC in commissioning Acute/Hospital care. The second phase of work in December will focus on commissioning primary and community care in particular.

The framework steps through this cycle and highlights the tools and approaches to be deployed for a strong commissioning organisation, at each stage the implications and development needs are identified for Board consideration.

The commissioning cycle



This cycle sets out the processes of commissioning. The strategies uses to drive reform such as improving and standardising Quality of services for example, will be delivered through a framework of tools and approaches such as information, PBC, PCT Prospectus, community voice, choice, and incentives to deliver on objectives of commissioning.

Choice and responsiveness: PCT prospectus will be developed which will includes content on

- Needs assessment
- Patient satisfaction and patient experience ratings
- 3-5 year forecast of service need and demand
- future investment and priorities for strategic direction
- service development proposals and invitations for market response
- explanation of rationale for priorities and plans.

Implication for PCT This prospectus is very similar to our LDP approach and therefore should be possible to integrate into the Autumn round of planning undertaken for 2007-8.

Community voice: Engagement of patients and public in commissioning services must be improved. The new engagement framework will have the following elements

- local involvement networks (LINks);
- overview and scrutiny committees and commissioning;
- explicit duties to involve and consult;
- a stronger national voice; and
- a stronger voice in regulation.

Local involvement networks are to be set up and used by commissioners, these will capture information, reviewing trends and highlighting concerns, as well as actively engage on prioritisation and service design. The LINK's can refer any concerns to the overview and scrutiny committee and the OSC can call the PCT to account. Monies will be made available to Local Authorities to commission a host organisation for the new LINK.

Two main areas are consulted on in the commissioning framework

Firstly the arrangements relating to the new LINKS

You are asked to consider the following questions

What arrangements can we put in place to make sure there is a smooth transition to the new system?

How can we build on existing activity in the voluntary and community sector?

What do you think should be included in a basic model contract to assist local authorities tendering for a host organisation to run a LINk?

How can we best attract members and make people aware of the opportunities to be members of LINks?

What governance arrangements do you think a LINk should have to make sure it is managed effectively?

What is the best way for commissioners to respond to the community on what they have done differently as a result of the views they have heard? For example, should it be part of the proposed PCT prospectus? (As referred to in *Health reform in England: commissioning framework* (DH, 2006c))

Secondly the issues in when a 'Trigger' for community action

PCT's are expected to respond to a public petition raised by public, patients carers or MP's (councillors will use the existing overview and scrutiny committee process)

Petitions could cover – demand for a service, dissatisfaction with provider or service.
Work is required to design mechanisms and thresholds for petitions so that these are reasonable.
Input is welcomed in particular to the following questions

Should petitions should cover only community and primary care services (including jointly commissioned services and primary care), or the whole of PCT-commissioned activity including acute services and (through the co-ordinating PCT) specialised services?

Who can petition?

How the voices of children and the vulnerable, disadvantaged and excluded members of society can be heard?

The threshold number of signatories to require a formal response from the PCT. What level of threshold should induce a review, for example a response from 1% of the public served by a PCT or 10% of the users of a service?

What should the process be for PCTs to respond to petitions?

Which measures should be used to ensure a fair and robust process in all cases, but especially when the service to be reviewed is provided by the PCT and independence needs to be demonstrated?

What are the rights of challenge to the PCT's decision?

Who will arbitrate if the response of the PCT is challenged?

Comprehensive services : the PCT has the opportunity to use new incentives to reduce the risk for providers to enter an area to provide services needed, therefore ensuring a comprehensive set of services for patients to access. These include supplement to tariff, guarantees on volumes of activity, reducing capital investment required by offering land/buildings. The further use of 'mandatory service listings' as in FT terms of authorisation is also under consideration.

Implications for PCT: are there any gaps in service provision where the PCT would consider this approach

Quality and effectiveness of care: a minimum level of quality must be specified and delivered by providers. It is envisaged that there should be a range of incentives and approaches to deliver improved quality and reduce the variation in quality between providers. Improvements in clinical outcomes can be driven through contractual standards, national or local quality bonus scheme as well as the national regulation and HCC processes which are reinforced through commissioning processes.

Implication for PCT Stockport PCT has taken this approach in establishing a minimum and enhanced level for quality – identifying over 20 core quality criteria to measure and improve and reward accordingly. Where quality is of concern PCT must publish quality improvement plan- this will feature as a key element of the quarterly report to the PCT Board on quality assurance.

Information is critical in driving effective commissioning- use of referral and utilisation information, benchmarking and use of information by the PCT/PBC Board through 'intelligent' board processes are vital.
Implication for PCT . A more systemised approach to information which demonstrates benchmarked performance on access, utilisation, referral management and quality must be a key development aim – benchmarking is the critical missing factor in much of our current reporting to the Board when comparing PCT to PCT, (PBC practices are being benchmarked and compared).

Health and wellbeing : social care commissioning, health commissioning and joint commissioning all contribute to improving health and wellbeing. Commissioning which is effective in improving health focuses on promoting needs assessment, whole system working through the vehicle of Local Area Agreements and Local Strategic Partnerships, reducing health inequalities across the population and assesses the equity impact in any commissioned service change.

Implication for the PCT : A greater focus on integrated and jointly developed and published commissioning strategy is needed between health, local authority and 'third sector' commissioning partners. Building on the LAA to develop a more co-hesive medium term strategy is a high priority for the PCT. The key areas for this focus are Older Peoples/Adult services, Childrens Disabilities and Childrens services, Learning Disabilities.

Best Value : achieving better value care through focusing care in the community to reduce unnecessary referrals and improve value for money. Strategies employed must include prevention work, appropriateness of setting/service/pathway, accurate planning and forecasting of service needs/demands, PBC engagement, securing clinically effective services, developing referral and treatment protocols and utilisation management approaches
It is recommended that PCT's consider a more 'interventional' approach if required due to challenges in the economy including

- Referral management centres
- Prior approvals
- Utilisation review

Implication for PCT: these areas are a current major focus of work for the PCT, however there are significant challenges and gaps in ensuring that the PCT has a best value approach

- Prior approvals- must be extended beyond the narrow specialist EUR policy – this was a proposal highlighted at the last Board meeting.
- Referral management /prioritisation of waits – is a critical intervention the PCT should expediate and was approved as part of delivering on the 2006-7 challenge in July 2006 PCT board.
- Utilisation Management – the PCT has yet to secure agreement for joining the GM UM service and as such has a gap in information.
- Pathways are being documented/protocols and referral routes – there is a very significant work programme which will be slowed by the management available – more joint working with PCT's in the northwest is a priority for this work to be progressed.

This is a summary of the main policy direction, guidance and implications for the PCT. Two further areas are consulted on in the framework

contracts: their role, which elements should be specified nationally and which defined locally, levels of specificity and control, and how they should be taken forward in the 2007/08 operating framework

governance of PBC: to ensure the widest possible engagement in PBC and that primary care has the maximum possible opportunity to innovate to meet patient needs, within a framework of standards and probity

Contracts

The framework sets out the importance of having a clear understanding of planned activity with providers, and identification of root causes in any over performance from this plan.

Implication for the PCT : Stockport FT contract has no agreed plan, the activity schedule represents 'last year out-turn'. This is due to the current plan for the FT to deliver around 10% elective growth in the context nationally of a 3-4% maximum. The PCT continues to set a forecast at out-turn and a plan at -8% due to the need for a radical slowing on pace of elective treatment. In this context there is no agreement on elective activity.

A new national contract will be issued in the autumn to include
Standard mandatory sections: national quality, performance, tariff , information, agreement and dispute arrangements

mandatory sections with local completion: activity profile and 18 weeks plan. if activity goes above this through provider initiation the contract will allow for PCT's to temporarily stipulate number of cases to be treated each month and payment below tariff for this over performance.
local requirements: specified pathways, local quality and incentives

additional incentives for quality are not envisaged for the 2007-8 contract however **consultation on a whether a national bonus scheme is set up – rewarding the highest performance on a sliding scale**.

a co-ordinating PCT is envisaged for each provider to manage the contract but not hold accountability for all PCT's. the contract will be drafted to represent all PCT's and ensure pathways for patients accessing services are documented.
use of 'commissioning business services' are encouraged in the development and management of contracts.

additional skills and support for PCT commissioners is being sourced nationally through independent sector specialists who can provide a whole package of support on commissioning should this need arise.

You are asked for your views on the following
(PCT contracting team and PBC team will focus on this area in particular)

Overall Approach
– Is the overall approach correct?
– Are we seeking to include appropriate controls and incentives in contracts?
– Is the proposed balance between contracts and other
mechanisms (eg choice, regulation) appropriate
> National Model Contract
– Will a national model contract be useful?
– Is the 3 level approach (standard mandatory requirements; mandatory requirements for local completion; and content for local agreement) appropriate?
> Content of the Contract
– Have we identified the right content?
– Are there other issues we should address?
– Is the balance of risk between commissioner and provider appropriate?
– How do we ensure the contract is deliverable?
– How should we best promote and enhance quality?
– Would a national quality bonus be an effective approach to
promoting quality?
> Mechanisms
– Do we need a dispute and arbitration scheme? If so how should it work?

Roles and responsibilities

Fair funding
SHA's will monitor PCT's to ensure that they allocate resources to PBC weighted to need of the area. Stockport already sets a budget using the national formula which includes these weightings.
The SHA will also continue to manage a central reserve (from PCT contributions) to bring economies into balance, this being repaid over a 3 year period. The PCT has a £600k contribution on this basis.

Strengthening PBC and Governance of PBC

PCT's must establish local incentive schemes which are as a minimum in line with national Directly Enhanced Services and ideally go beyond this where incentives will change referrals and so release funding. This incentive money will be paid as additional practice income. the PCT already has an incentive scheme in place which is funded on the basis of cash releasing impact, and focuses on elective, unscheduled care and prescribing.

the framework provided further guidance on procurement.

Existing GMS, PMS, APMS providers can develop services and secure funding from the PCT without tendering where these developments are supported and commissioned as part of a strategic case. PCT's will be expected to take two differing approaches to proposals submitted

a) single practice population – savings released for investment in priority areas will be approved by PCT's, if the proposal required 'pump priming funding' or is proposes investment not in a priority area the PCT will require formal approval. this similar to how we operate PBC in Stockport, if an advance is required for

invest to save the PBC board considers these proposals, savings achieved are paid to practices for investment in priority areas.

b) wider population – community services developed locally must be reported to the SHA demonstrating price, quality and governance. pump priming funding can be provided locally to establish a new service where this is transferring activity from secondary care to primary care. this funding is a loan repaid through lower cost provision for example. The PCT has taken this approach in ICAT's recently where advance funding for each service has been invested 'repaid' from the lower than tariff service costs over the longer term.

the framework continues to promote PBC reporting through PEC to the PCT Board. Stockport has a PBC Board reporting to PEC. the framework recommends that a separate committee is established to govern business cases from primary care /PBC which should be chaired by a Non Executive.

implication for PCT: an Investment and Business Case group will be established to over see this work and govern the approval of business cases for shift in resource. this may be separate from both PEC and PBC and report direct to Board. is this the best way of achieving required governance on investment decisions?

where services are transferred from hospital to a consortia or locality the PCT must ensure there is plurality and choice for patients in these arrangements.
the key issue for the PCT is choice of ICAT.

The role of the PEC is being reviewed in preparation for the new PCT's established in October this year in particular the relationship between PEC and PBC needs to be clarified.

accountability agreements must be in place between the PBC practices and PCT. in Stockport there is an accountability agreement for practices and the PBC Board and similarly between the Board and the PCT. the Board acts as a co-ordinating and focal point in this case. This agreement covers financial, clinical, risk and service development areas.

You are asked for your views on the following

Will the proposals in this appendix enhance quality for patients and ensure proper accountability for taxpayers' money while providing freedom for clinicians to innovate?

- some of the key issues here

management support is a critical factor in driving forward PBC. how can the PCT provide dedicated resource for this task.
incentive schemes in PBC are very much more modest that the national QoF, the real incentive for practices therefore is the opportunity to develop new services, using the commissioning resource differently. the continuation of a venture fund for covering set up costs is recommended and dedicated management resource for making a case against this fund is essential. currently there is a gap in management resource to accelerate this pace, largely these proposals are left the PCT commissioning 'development team' to research and develop whole district initiatives. Should more local diversity in approach to service development be considered and if so how can this be encouraged through PBC.

Conclusion

Throughout this document key issues and implications have been highlighted for discussion, At each of the meetings all areas will be discussed however not all questions are expected to be answered in each meeting.

Please consider these issues and questions and contribute where ever possible to the PCT response. A draft consolidated report will be provided to the PCT Board in September for consideration.

Alison Tonge
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