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Briefing paper on NHS reform for discussion between local medical committees, local negotiating committees and other appropriate cross-sector forums (England only)

Distribution: Local Medical Committees, Local Negotiating Committees, Medical Staffing Committees, Regional Committees and BMA Divisions.



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1 Introduction

Recent trends in NHS reform are highlighting some weaknesses in the relationships between primary and secondary care doctors, which are being exacerbated by the new set of incentives within a range of policy initiatives. The new national tariff, the system of payment by results (PbR) and practice based commissioning (PBC) all establish inherently adversarial relations and the potential to further strain relationships. Effective collaboration between the two sectors is becoming increasingly important both in the interests of improved patient care and in order to build renewed relationships between doctors that will withstand both internal and external pressures on the NHS.

In some areas, local negotiating committees (LNCs) have invited representatives from local medical committees (LMCs) to their meetings in order to talk about the changes taking place in general practice, such as practice based commissioning (PBC); these have proven to be very positive, informative and constructive sessions. There is an increasing need for local forums to emerge within which secondary care doctors, including those from public and community health, and GPs can meet to discuss developments in NHS reform, how they are affecting respective roles, and their implications for cross-sector relationships and professional liaison. Junior doctors will also have a valid contribution to the debate and those with an interest should be included accordingly.

To encourage and support these discussions, this paper outlines some of the key developments in system reform – all of which are interdependent – that warrant discussion¹.

2 Practice based commissioning (PBC)

2.1 What is it?

Since April 2005, all GP practices with a registered patient list have had the right to receive an indicative commissioning budget from their primary care trust (PCT) and thereby be involved in PBC. The indicative budget reflects historic spend by the GP practice in terms of the health care services its patients have accessed in the previous year. In 2007-08, the minimum scope of services which must be included in the budget covers all hospital-based care, services within the scope of PbR, prescribing, community services and mental health costs, though some aspects of the budget can be blocked back to the PCT.

PCTs hold the budget and continue to be responsible for contracting with all providers, however practices are expected to manage the budget within the annual cycle and either not exceed it or, ideally, spend under it. This gives GPs the incentive to identify clinical areas and care pathways where a larger proportion of patient care can be managed in the primary or community care setting, through improved or extended services, thus ensuring the most appropriate use of secondary care and payment at national tariff prices.

A minimum of 70% of any resources freed up from the budget through such activity can be re-invested by GP practices in 'patient services' which can include equipment, training, clinical and non-clinical staff and premises development with specific PCT board approval.

2.2 How is it progressing?

For the most part, practices are working together in groups or consortia to undertake this new commissioning role; such consortia are also developing plans for extended service provision. That said, practices' involvement in PBC has been fraught with problems – for the most part stemming from PCTs' reluctance to or apparent inability to support the initiative – and as a result, it is still in

¹ NB: This paper does not attempt to deal with the approach the BMA is taking nationally in response to these issues.

the very early stages. Subsequently, in many areas, PBC is the cause of considerable frustration and disillusionment among participating GPs.

A new initiative that is likely to have an impact on the development of PBC is the framework for procuring external support for commissioners (FESC). The FESC, which has only recently gone live, comprises of a list of private sector companies from which PCTs can buy in the necessary support services in order to fulfil their commissioning function. For more information on the FESC, refer to the BMA's briefing and position statement, which can be found online at the following website address (log-on required):

www.bma.org.uk/ap.nsf/Content/frameextsupport0407

2.3 How could it be improved?

Aside from and in addition to addressing the numerous practical problems that GPs are facing in implementing PBC, closer cross-sector collaboration and dialogue between secondary and primary care clinicians, including public and community health doctors, is necessary in order for the initiative to achieve its full potential. The latest Department of Health guidance on PBC 'Practical implementation' (November 2006) sets out that where plans for commissioning impact on secondary care services, practices should 'seek the involvement' of consultants and wider secondary care clinical teams (paragraph 2.11).

GPs in many areas have tried to establish relationships with their local acute trusts in order to discuss the redevelopment of care pathways and service redesign, but these attempts have for the most part been met with resistance. This is particularly the case with NHS Foundation Trusts. Furthermore, consultants are experiencing pressure from managers not to collaborate with GPs in their plans to redesign care pathways.

The BMA's discussion paper 'A rational way forward for the NHS in England' sets out a more mature form of commissioning that is 'professionally inclusive and clinically led' as the ideal. Underpinning this approach is the ability for commissioning to transcend 'traditional institutional boundaries' and to allow 'professionals to talk across primary and secondary care'. For further background information, the paper can be accessed online at the following address:

www.bma.org.uk/ap.nsf/Content/rationalwayforward

3 Care closer to home

3.1 What is it?

Chapter 6 of the Department of Health White Paper 'Our health, our care, our say: a new direction for community services' published 30 January 2006 introduced the term 'care closer to home'. The government wishes to see a move towards more services being delivered in treatment centres, a 'new generation of community hospitals' and primary care settings and the White Paper identifies six specific specialties to lead this agenda: these are ear, nose and throat; orthopaedics; dermatology; urology; gynaecology and general surgery. In line with this agenda, the Department of Health has undertaken a demonstration project, which has followed five pilot sites for each of the six specialties listed above where care has been shifted into community settings. A report of the findings of the project will be launched in September 2007. Further details can be found online at the following website address:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/DH_4139717

As part of its ongoing work monitoring the development of the Department of Health's demonstration project, the BMA will be producing a position statement on 'care closer to home' in due course.

It is envisaged that for the most part, 'care closer to home' will be delivered by Practitioners with Special Interests (PwSIs), a term used to cover GPs, nurses, allied healthcare professionals and pharmacists. This policy does not however preclude consultants and/or staff grades and associate

specialists from delivering specialist services in the community, rather than in the acute setting. The Department of Health issued guidance on the development of the PwSI role in May 2007, which can be found online at the following website address:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Primarycare/Practitionerswithspecialinterests/DH_074419

'Care closer to home' can be seen in part as an off-shoot of PBC and related service redesign and so in many areas will be led by GP consortia and PCTs; in others it will be dominated by the private sector. The mechanism for GP practices to bid to provide any new services is through submission of a business case, which will need to be approved by the PCT before it is commissioned. Such services will be outside of the national tariff and price bands are therefore to be set locally with the help of benchmarking of costs and prices at PCT, SHA and national level.

3.2 *How is it progressing?*

The side of 'care closer to home' led by GPs is so closely linked to the development of PBC that, inevitably, it too is in the very early stages. In addition, there are a number of practical problems with its implementation such as a lack of infrastructure and in some cases the necessary workforce – both in terms of capacity and expertise – in order to deliver more care in community and primary care settings.

Though not consistently so, it is worth noting in particular the fact that GPs' reception towards the 'care closer to home' proposals has generally been more positive than that of hospital doctors. At present, clinicians in secondary care feel that their role in delivering specialist services is being overlooked and have concerns over the quality and safety implications of delivering 'care closer to home'. Some also remain unconvinced that such services are always more cost effective than those provided by the local hospital. Another important consideration is that regarding junior doctors and the potential for training opportunities within the acute setting to be diminished as a result of the shift in services.

Also emerging is the private sector's role in 'care closer to home' following a series of national procurements across the country, through which the Department of Health has secured contracts for non-NHS treatment centres to provide care to NHS patients. As these contracts tend to guarantee payment based on a fixed number of procedures per year, in order to use the contracts to capacity, a choice between other providers in the area can be absent. In addition, there is a growing portfolio of private sector companies who are looking to enter into joint partnerships with GP practices, consortia and/or other providers in order to provide primary care services, diagnostics, day case surgery and out patients, all under the 'care closer to home' banner. In return for their investment, these companies will be taking a significant portion of any profits made.

3.3 *How could it be improved?*

'Care closer to home' is a prime example of how, in the absence of a joint approach, the current programme of system reform has the potential to set secondary and primary care clinicians against each other. There may be opportunities for hospital doctors to become involved in any service provider organisations being set up by GP consortia – or vice versa – which would allow for a more coordinated and integrated approach to service redesign. This may also reduce the need for NHS providers to form partnerships with private sector investors.

In areas where private sector treatment centres exist, thereby introducing a new tier between primary and secondary care, GPs and hospital doctors will need to work particularly hard to ensure that the potential for the break-down in professional relationships is minimised.

4 Hospital reconfiguration

4.1 What is it?

Towards the end of 2006, the Department of Health indicated a wave of hospital service reconfigurations, including suggestions that up to 60 district general hospitals may be 'reconfigured'. Reconfigurations can take a range of forms including departmental reorganisations, mergers and closures of departments and hospitals and the provision of new service units. Essentially, however, reconfiguration means that the way in which services are delivered will change, such that some services will be provided in more specialist centres and others will be provided closer to the patient's home. Acute care, for example, such as accident and emergency and specialist surgery, may be concentrated in fewer locations, whilst more routine services, such as diagnostics and rehabilitation, may be provided locally in community hospitals and clinics.

4.2 How is it progressing?

Plans for hospital reconfigurations will vary from area to area, depending on the local circumstances and as influenced by a number of factors including whether or not there is a need to increase specialisation and complexity of skills and/or distribute services more fairly in terms of geography, the existence of alternative or competing services in the area and the financial position of the local health economy (PCT).

A recently published report by health minister Professor Ara Darzi, 'Healthcare for London: A Framework for Action', proposes a programme of major change in the configuration of services in London. The report can be accessed online at the following website address: www.healthcareforlondon.nhs.uk/

Health secretary Alan Johnson has asked Professor Darzi to undertake a more far-reaching review of the NHS as a whole, which is due to be completed in July 2008 and which may push the reconfiguration agenda further forward.

4.3 How could it be improved?

Any service change must be based upon a clear clinical strategy and be both planned and consensual. It is wholly inappropriate for important decisions around service change and reorganization to be made in accordance with purely political and/or financial priorities, especially those that take a short-term view. All change must be sustainable and should not create new, long term problems for the local health service and economy.

The CCSC has produced a statement on and good practice guide to hospital reconfiguration, which can both be found online at the following website addresses:

www.bma.org.uk/ap.nsf/Content/statement151206

www.bma.org.uk/ap.nsf/Content/Hospitalreconfiguration040507

In light of the nature of the national tariff and the inevitable impact on hospitals' finances where alternative services exist, GPs should endeavour to consider the possible implications of their plans for PBC and service redesign accordingly. Hospital doctors, including medical directors and relevant clinical directors, should be proactive in discussing with GPs ways in which to ensure that any plans for service redesign and the development of primary and community services will be of mutual benefit.

5 Referral management

5.1 What is it?

Generally speaking, referral management is a tool used to monitor, direct or control patient referrals. Models of referral management vary encompassing a range of different functions. Referral management centres receive referrals from primary care. In addition to analysing referral

data (as do the more basic referral information services), they may link with patient booking services, decide the treatment route for patients (including deciding between types of provider, e.g. consultant, GP with Special Interest (GPwSI), specialist nurse or alternative health provider) or even triage referrals. In some cases referral management centres may offer direct access to diagnostics and treatment for certain types of referral such as musculo-skeletal and dermatological problems.

5.2 How is it progressing?

Some GPs and LMCs have identified advantages of using referral management services, including the tracking of referrals, reduction of waiting times for uncomplicated cases and appropriate redirection of some referrals where an alternative service provider can arrange a more convenient appointment. Many also acknowledge that referral management has the potential to contribute to GPs' continuing professional development through, for example, analysis of referral patterns. Furthermore, some GPs, through PBC, are taking on some of the functions, such as referral analysis, currently provided by referral management centres.

The private sector plays a major role in referral management in certain parts of the country, as a result of national procurements, which have secured contracts with non-NHS delivered Clinical Assessment, Treatment and Support (CATS) centres and Integrated Care Assessment and Treatment Services (ICATS). These centres provide triage, assessment, diagnostic and some treatment services in a number of specialties, outside local NHS acute trusts, on referral from GPs. As with 'care closer to home' treatment centres, these contracts will tend to guarantee payment based on a fixed number of procedures per year and so in order to use the contracts to capacity, a choice between other providers in the area can be absent.

It is worth noting that in some cases, GPs see referral management centres, even CATS or ICATS delivered by the private sector, as integral to the development of PBC and service redesign, whereas these types of referral management centre tend to present more challenges to the secondary care sector.

However, clinicians in both sectors also share many of the same concerns over the direction that referral management has taken, including that it will weaken professional relationships between doctors, between patients and specialists, lead to loss of clinical autonomy, patient and professional choice, managerial rather than clinical grounds for referral, compromised patient confidentiality and/or the stability of local NHS organisations. In areas where local clinicians have not been involved in the setting up of referral management centres, these concerns are considerably heightened. Furthermore, in areas where a large volume of care is being directed towards the CATS or ICATS, the question of diminished training opportunities for junior doctors within the acute setting also arises.

5.3 How could it be improved?

The growth of CATS and ICATS services in the NHS has developed in recognition of the need to improve the interface between primary and secondary care and thus provide an environment in which patients can undergo assessment, diagnosis and treatment in an alternative setting to that of existing hospital outpatient services. Therefore, where improvements in the interface between primary and secondary care can be delivered and led by NHS clinicians, then many of the current concerns over referral management can be addressed.

The GPC and CCSC have produced some joint principles on referral management schemes, which can be found online at the following website address:

www.bma.org.uk/ap.nsf/Content/Referralmanagement