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Clinical governance in action

'Commissioning in the round – a co-ordinated approach': a proposed model

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ABSTRACT

Through the 'Patient Choice' initiative, the development within health provision of a variety of providers at source, i.e. general practitioner (GP) or secondary care clinician point of referral, is anticipated to accelerate the improvement of services. It is expected that positive competition will identify and spread best practice which will become the norm. This model clearly has benefits and perhaps it is most applicable to localities which have a range of providers who can most effectively utilise the 'Patient Choice' initiative and, hence, provide effective choice for the local population. There are, however, significant issues with such a model in geographical areas such as NE Lincolnshire where there are limited secondary care providers. Within such an environment, 'Patient Choice' may lead to patients having to travel significant distances and, as well as the practical inconvenience, leading to a degree of fragmentation of services.

Within our locality we are currently developing an alternative proposal, that of 'Commissioning in the round', a co-ordinated community approach to the commissioning of services. If successful, it is anticipated that this approach will maximise the local resources currently available, while also achieving a clear direction of travel for the future development and provision of services. As a positive consequence, this approach is anticipated to maximise the range of appropriate choice of provision for our locality.

To date the proposal has received the support of our professional executive committee, as well as initial support from all health organisations within northern Lincolnshire. The document moves on from discussing the principles and the proposed model to look at the first steps with the establishment of a locality board which will develop a clinical services strategy. This strategy is intended to focus on four initial areas of:

- diabetes
- coronary heart disease
- chronic obstructive pulmonary disease (COPD)
- cancer.

By targeting these areas, the model will both address current priorities and also allow utilisation of the model from different perspectives as outlined in the document. It is anticipated that this approach, initially targeting four areas, will enhance local ownership and confidence, while allowing the refinement of the model by it being tested in the field.

As well as addressing 'Patient Choice', it is anticipated that this approach will also appropriately co-ordinate other current national opportunities including payment by results and practice-based commissioning.

Keywords: commissioning in the round, co-ordinated community approach

Background

The development within health provision of a variety of providers at source, i.e. general practitioner (GP) or secondary care clinician point of referral, is expected to accelerate the continued improvement of services. It is anticipated that positive competition will identify and spread best practice, which will become the norm.

There are, however, significant issues with such a model, particularly in a geographical location such as NE Lincolnshire, where we have limited secondary care providers. Within such an environment, 'Patient Choice' may lead to patients having to travel significant distances with a number of potential consequences including:[1]

- inconvenience to patient and family
- reduced communication:
  - between clinicians (loss of relationships)
  - concerning individual patient care
- reduced continuity of care
  - particularly for follow-up arrangements where a patient, for example, may have had surgery some distance from home and then develops complications on returning home
- 'generic'/limited referral pathways – which do not celebrate local good practice or strong working relationships – as they are required to be acceptable and implemented by a range of providers and GPs (often with no historic working relationships)
- in general, reduced partnership working across the local health and social care community
- fragmentation of the service and potential challenge to the sustainability of the local secondary care provider as 'fit' young patients travel for non-complex, elective care, resulting in the local secondary care provider managing high-risk patients and also complex cases (including non-elective care)
- direction of travel 'against the wishes of local people' – who want high-quality services provided locally.

Clearly 'Patient Choice' has a role as outlined above in supporting development of patient services, whilst also providing appropriate guided autonomy. However, within a geographical locality such as NE Lincolnshire, it is appropriate to consider whether alongside the national Choice programme a local initiative, 'Commissioning in the round – a co-ordinated approach', may provide the logical choice for the majority of services for our local population.

An alternative model

As a locality we have received regular feedback from user groups when waiting list initiatives have occurred which have resulted in patients travelling significant distances. Feedback has been that improved access has been appreciated but, ideally, it would be more helpful if better access was provided locally. We have also consistently received similar feedback from local GPs and other primary care health professionals.

An alternative approach is therefore being considered to deliver the most effective local services for the local population by a more co-ordinated approach.

Commissioning in the round – a co-ordinated approach

- Active partnership of local health and social care

by which to:

- provide limited choice of different providers at the point of referral to those within the locality
- create a plurality of appropriate services in appropriate and accessible settings within the locality – providing the patient with real choice.

The approach aims to limit or rationalise choice of provider at the point of referral to maximise the range of appropriate choice of provision – via the development of a sustainable, effective and sensitive local services.

A locality such as NE Lincolnshire, given its geographical location, is an ideal area to pilot such a model and utilise other local characteristics including:

- a strong history of partnership working and co-terminosity with the local authority
- a single secondary care and private provider.

Framework for delivery of the model

Objectives

- Commissioning in the round – a co-ordinated approach.
- A locality approach to incorporate all elements of health and social care.
- Underpinned by locality objectives (local clinical values) which drive the development of the most effective services for the locality.

Development of local clinical value

- Agreed local shared standard of care.
- Reflects:
  - national perspective
  - local perspective.
- Supports effective and appropriate utilisation of primary and secondary care (maximising resources available).
- Partnership:
  - agreed objectives
  - decide who best to undertake
  - reduce artificial boundaries.

- Key elements:
  - care pathway
  - developed in partnership
  - implemented in partnership
  - allows effective audit (and review).
- Enabled by the creation of the 'critical mass' achieved with the integration of partnership working.

Outcomes

Within the locality, outcomes include:

- a clear direction of travel with regard to the development and ongoing provision of services
- share and develop good practice
- improved relationships between professionals
- increased communication about patient care
- maximisation of local resources:
  - people
  - physical
  - financial
- a flexible and sensitive approach via care pathways (directed by local clinical values)
  - to achieve professional ownership and confidence
  - and to provide engagement of the locality which will create an identity and energy for the locality to develop more effective local services.

The model: an outline

Commissioning arrangements

The effectiveness of 'Commissioning in the round' will be determined by the effective engagement of its constituent units, for example – the practice team (see Figure 1).

The introduction of practice-based commissioning (PBC) provides an opportunity to make the 'Commissioning in the round – a co-ordinated approach' a reality with a focus on the practice team. The introduction of this programme with the opportunities for increased clinical engagement of the whole practice team, and a commissioning model, allows practices, supported by the primary care trust (PCT), to review current service provision and consider how it can be delivered most effectively in a sustainable and co-ordinated manner.

Health community approach

'Commissioning in the round' provides the opportunity to break down the traditional boundaries of primary and secondary care and enable, for a given area of care, a health community approach (see Figure 2).

This creates the opportunity for a 'critical mass' where planned and agreed changes in practice can be amplified to create significant improvements in services in a co-ordinated manner across the locality, therefore maximising ownership and confidence by

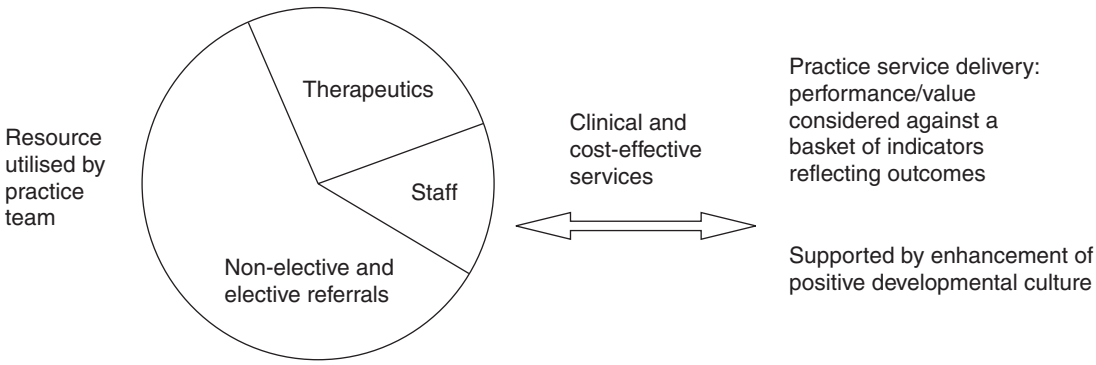

Figure 1 Engagement of the practice team

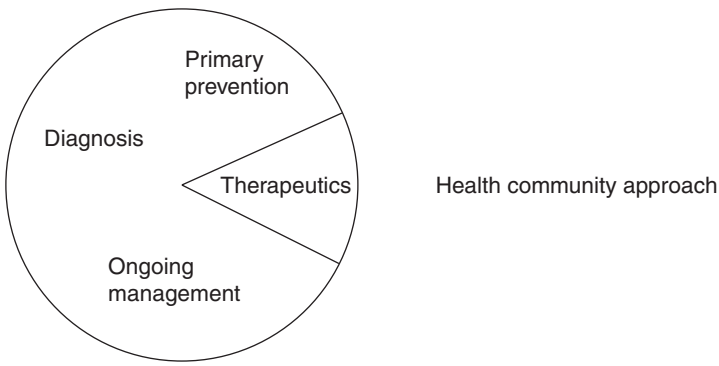

Figure 2 A health community approach

demonstrating a practical benefit within tangible timescales. Within this arrangement, the majority of a patient's care will be provided by the practice team – which will be complemented by intermittent specialist input.

The health community approach can be utilised for a disease area such as coronary heart disease (CHD) or diabetes, but also for generic models of delivery of care, for example:

- chronic disease management
- primary prevention
- emergency care:
  - community
  - specialist.

In many ways, considering the generic areas of care further enhances the benefits of the model. However, initially it may be appropriate to pilot a service area such as CHD. The review of CHD services would allow, for example, the opportunity to enhance primary prevention and make an integrated cardiac rehabilitation programme a reality.

Other initiatives, including resource-releasing elements, become an option. For example, by partnership across the health community we may standardise prescribing of statins, potentially in conjunction with a drug company. This would release significant resource to be invested elsewhere in the service.

The health community approach also prompts a potential shift in commissioning arrangements with a move from a transactional approach to one focused on shared clinical outcomes delivered by the health community.

Integration of social care and beyond

The model to date has focused on the health elements, but integration of social care and the wider community will further enhance the combined energies of health. For example, when we consider primary prevention, the health model is limited to those who wish to access it. By taking a primary prevention programme into the community, in an effective and co-ordinated manner to complement the health model, this will yield significant benefits.

In addition, it will begin to move the model of care from one focused on illness to a focus on wellbeing.

Industry

Within the locality, the opportunity to incorporate industry will again enhance primary prevention and a range of rehabilitation programmes – for example patients returning to work following a health intervention such as cardiac rehabilitation.

The locality approach also provides the opportunity of delivering an effective and co-ordinated primary prevention programme across all age groups, for example:

- Surestart
- education authority
- pre-school
- school
- industry
- working lives
- retirement
- Help The Aged

all supported by the practice team.

Commissioning arrangements

Patients' advocate

The practice team:

- who will demonstrate their services by a prospective audit programme, reflecting their anticipated outcomes
- in addition to PBC, will commission services with the secondary care providers and other enhanced primary care providers.

The primary care trust

Four principal elements:

- provide the quality assurance with regard to current services provided by primary and secondary care. This to be delivered by a basket of indicators sensitive to clinical outcomes
- in addition the PCT will engage the health community in setting objectives to further enhance local services, addressing health inequalities as appropriate
- the PCT will provide 'specialist resource' with regard to clinical leaders/management, which will facilitate the delivery of services by primary and secondary care (NHS and private providers)
- the PCT, in conjunction with PBC, will engage with the clinical networks to deliver the tertiary services.

Specialist service

This will be an active partner in the relationships outlined above, with key responsibility to deliver specialist services within their physical environment but

also, as appropriate, supporting such care in the community.

Fair provision

When we consider certain service areas, for example mental health, significant areas of support, particularly in the community setting, are provided by the voluntary sector. The creation of a community approach to the provision of services will co-ordinate and effectively integrate all services, therefore maximising energies and outcomes. This also allows the opportunity to identify funding to appropriately support such services for the patient and ensure their appropriate development in the future (compare the current scenario, where often voluntary organisations are funded by time-limited grants and have 'uncertain' futures).

Decision making

The model will facilitate community ownership and confidence with regard to difficult commissioning decisions, for example:

- low-priority policy: document which highlights, in the light of current evidence, which services should not be commissioned for the local population
- the future provision of dental services – given the current challenges relating to NHS access.

The next step

How to make the proposed model a practical reality

The underpinning principle of the proposed approach is that of the effective co-ordination of resources and expertise across the local community, to maximise the local services available. The significant opportunity of moving to this co-ordinated approach is to build on historic examples of service change which have been led by individuals and look to further support such changes by the creation of facilitatory systems across the health community. It is not the intention to maintain the status quo or create a 'comfort zone', but rather to develop an open relationship, with the sharing of quality data and supported by a positive developmental framework. The overall outcome is one of providing a positive tension that will look to support, in a co-ordinated and sustainable way, the development of local services.

Progress to date

Within the initial proposal it was recommended that we look to establish a commissioning board which would have senior membership from across health and social care, who could engage their organisations and, most importantly, deliver the intended change within their organisation. The principal responsibility of this board would be to develop a clinical services strategy which would direct the future provision of services. The overall proposal has been discussed within various arenas including the Practice Based Commissioning Network of NE Lincolnshire PCT, and joint meetings between both local PCTs and our local acute provider.

The consensus at this stage was that it was felt that such a step to establish a commissioning board was perhaps not realistic given the dynamic environment both nationally and locally with the PCT reconfiguration, our local acute trust considering application for foundation trust status and the establishment of PBC. It was recommended that the proposed approach looked to address current clinical service issues.

This approach, it was felt, would enable testing in the field of the agreed principles, and the experience gained to further refine the future model. This approach has merits, as within the health environment we are all familiar, in recent years, with the establishment of frameworks that have taken significant energies to develop, but whose practical implementation following this initial piece of work has highlighted significant issues. These issues have meant the initial objectives have never been translated into service improvement and have not made a practical impact on patient care.

As a locality, following work led by the strategic health authority and Durham University, we have identified a number of priority areas including:

- diabetes
- coronary heart disease
- chronic obstructive pulmonary disease (COPD)
- cancer.

It has been agreed that we test out this co-ordinated approach and its benefits with a focus initially on diabetes and cancer, through specific initiatives.

Diabetes

Diabetes is an area of care that has reflected significant collaborative working across primary and secondary care. To date we have established, and begun to deliver, a locality action plan which has been facilitated by an initial service review meeting (an open

meeting for primary healthcare professionals appropriately supported by the local specialist service) to ensure a health community approach. The focus of the initial meeting was around secondary prevention and a co-ordinated approach within primary care. Significant progress has been made as is reflected in part by the clinical indicator for diabetes within the Quality and Outcomes Framework.

It is anticipated that the progress to date can now be further facilitated by the introduction of a structured model of diabetes care. By this it is intended to define what services should be provided within the community and what services should be provided by the specialist service. This model clearly is a practical demonstration of the health community approach.

A health community project team pulled together a draft structured programme of care, which has recently been reviewed and considered by a further service review meeting. This meeting supported the approach that within the future provision of diabetic services within the locality, stable diabetics will be managed by extended practice teams, and only patients with identified complications, following initial community input, will be referred for further support from the specialist service. The anticipated implementation of this model will allow the effective utilisation of the practice team, as previously outlined within the model with their management of stable diabetics, providing the appropriate capacity within the specialist service to achieve timely access for patients with significant complications.

The introduction of this model represents a number of significant challenges to current behaviour within the local health community. We will have to demonstrate an effective 'push and pull' effect, with practice teams looking to pull back stable diabetics for ongoing community management, similarly complemented by the specialist service pushing out (by discharging) the same cohort of patients. In addition, practice teams, through the 52-week working year, will be required to provide a consistent and comprehensive service to all stable diabetics.

It is anticipated that the potential historic safety net of referring such patients into the specialist service will no longer be available. To achieve this outcome there is a clear requirement to ensure there is a positive developmental framework by which all local practices will be supported, if they feel it is appropriate to provide the agreed community service. It is anticipated, and currently being facilitated by the PCT, that some of our smaller practices will collaborate to achieve a 52-week per year service. In addition to this updated approach to chronic disease management, two local enhanced services will be created for the conversion of patients with type II diabetes to insulin therapy and the diagnostic provision of glucose tolerance tests.

Cancer

With regard to the provision of local cancer services, since 1999, as a local health community, we have looked to develop care pathways, initially utilising the National Cancer Guidance and, more recently, the National Institute for Clinical Excellence (NICE) referral guidelines. This has led to a range of care pathways being both initially implemented but then later refined in the light of local experiences. The introduction of the 31- and 62-day targets, as a health community, has presented a further significant challenge. For some cancer areas, the achievement requires a radical review of our historic approach. However, continued partnership working is felt to provide the solution.

Despite good collaborative working, the 31- and 62-day targets remain challenging for the colorectal care pathway. Following recent discussions it has been proposed to pilot a 'straight to test' approach for colonoscopy within an integrated care pathway. The rationale of the pilot is to support, where appropriate, the ongoing 'wait and watch' within a community setting, and support the management of non-malignant colorectal pathology by the practice team but, most importantly, where patients present with sinister features suggestive of cancer, to permit rapid access to an effective diagnostic test. It is anticipated that this 'straight to test' approach will not only empower primary care to manage patients more effectively in a community setting, but will, if successful, radically change how the current outpatient service is delivered. If the pilot is successful, only patients who are diagnosed as having significant pathology appropriate to be seen by a specialist following their initial diagnostic work-up, will be seen in the clinic. This arrangement, it is anticipated, will maximise the opportunity at the first clinical appointment for a diagnosis to be made. It should also allow, following discussion with the patient, the implementation of their management plan, therefore facilitating the achievement of the 31- and 62-day targets.

Coronary heart disease and chronic obstructive pulmonary disease

If these two areas of review are successful and the current initiatives are now in the process of implementation following health community agreement, we anticipate an opportunity to review the provision of both CHD and COPD in a similar way. With regard to CHD this, again, is an area that has demonstrated a significant partnership working over a number of years, for example the establishment of an effective rapid access chest pain service, and the introduction to primary care of access to the heart failure diagnostic care pathway. There are, however, areas that require further review, including further work with regard to a comprehensive heart failure care pathway with a more

collaborative specialist element, achieving a true 'hub and spoke' framework so that patients with heart failure can be managed in a seamless way across the primary and secondary care interface. This is also an area of care where the most effective and co-ordinated utilisation of medication can ensure, within a total resource of service provision, that there is the most effective delivery of pharmaceutical interventions, while providing the opportunity, through a shared approach, to identify elements of the historically utilised prescribing budget to further enhance other elements of the care pathway.

As a health community, we have experienced significant challenges with regard to increasing emergency admission rates. Some initial work has been productive with regard to appropriate reducing paediatric admissions in a co-ordinated and effective manner. Within the review of elderly admissions the management of COPD has been highlighted as an area that would merit further work. We hope, later in the year, that 'Commissioning in the round – a co-ordinated approach' may facilitate the most effective implementation of the action plan which supports this programme of work.

Conclusion

The paper highlights the potential benefits of the active partnership of local health and social care which, by generating a clear direction, may deliver more effective local services. Within a geographical area such as NE Lincolnshire, which is relatively isolated, with the next nearest specialist provider being approximately 30 miles away, there are clear benefits to the local community if appropriate and effective services can be provided locally. However, this managed and co-ordinated approach may have a tendency to maintain a status quo and support inappropriate inertia if the positive development tension is not generated, supported by the honest and open willingness to revisit where service provision issues have been highlighted, either in primary or secondary care. The approach, in some ways, also can swim upstream with regard to national initiatives such as 'Patient Choice' as, inevitably, by managing market forces it will limit choice to some extent. In addition, at the various organisational levels there are current national initiatives that would pull against partnerships, including pooling of budgets and other resources. This clearly includes the establishment of foundation trusts and practice-based commissioners with, in addition, the potential reconfiguration of PCTs making them less in touch with their local communities.

However, as a locality, to date we have looked to utilise a co-ordinated approach for specific areas and the 'Commissioning in the round – a co-ordinated approach' potentially provides future systems that will ensure the maximum benefit of such an approach and progress the current arrangements. This can result in individuals driving change, despite the established systems, therefore supporting such change and hence amplifying the benefits.

REFERENCE

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