

**Birmingham East and North  
Primary Care Trust**

**DRAFT  
Commissioning Strategy**

**That promotes**

**“B R I S K”**

***(Bold Processes, Redesign, Investment,  
Sustainability and Knowledge)***

**2008/09 – 2012/13**

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## **Executive Summary**

This updated Commissioning Strategy provides a local overarching framework for Birmingham East and North Primary Care Trust (BENPCT) commissioning approach and provides strategic direction for Local Commissioning Delivery Plans (LCDPs) over the period 2008/09 – 2012/13.

Birmingham East and North PCT (BENPCT) is one of 153 Primary Care Trusts within the English National Health Service. As a PCT it is responsible for the wise investment of public money to secure health improvement, access to health services and where appropriate the provision of health services to a local population of some 438,000 people.

The PCT is also the lead commissioner across the city for Mental Health, Learning Disabilities, Sexual Health and Addiction Services.

The PCT has a well-established and close working relationship with Birmingham City Council. The Chief Executive Officer (CEO) has developed and led the Birmingham Health and Wellbeing Executive for the last three years and is a core member of both the Birmingham Summit and Executive.

BENPCT has a clearly stated core purpose of 'Working in partnership to tackle inequalities and improve the health and well being of local people' and the PCT has four audacious goals which provide the core framework for investment and development:

- To be so responsive to the population we serve that no one waits for the high quality care they need
- That the health and well being of the population will have improved so much that people will enjoy ten more years of healthy life
- That people regard us as the first choice organisation to work with and for
- Our communities will have the most involved, informed and empowered partnerships in the country

It is important in strategic context terms to understand that commissioning is only one element of a comprehensive health reform programme which requires changes to the following: -

- Transactional Reforms (Money following the patients, rewarding the best and most efficient providers, giving others incentives to improve)
- Demand side reforms (More choice and much stronger voice for patients)
- Supply side reforms (More diverse providers, with more freedom to innovate and improve services)
- System management reforms (A framework of systems management, regulation and decision making which guarantees safety, quality, fairness, equity and value for money)

The above will enable safer and high quality services, better patient experience and better value for money. This is at the heart of commissioning within BENPCT and the system management changes will be reminders of how the PCT needs to commission to demonstrate world class commissioning in the future.

Critically important to the delivery of world class commissioning is the development of clear service strategies and the development of the role of Practice Based Commissioners and how their commissioning plans drive local service development and redesign.

The need to create an integrated planning process will be key to enabling commissioning to be effective. There is a danger as Commissioning is further devolved that it becomes fragmented and that commissioning plans are so locally focused that they do not reflect the strategic framework of the PCT or national requirements.

The Local Commissioning Delivery Plans (LCDPs) will provide a framework for all commissioners to set out their plans, describe how they propose to deliver those plans as well as demonstrating the link to strategic PCT objectives and national requirements. The plans will also set out the anticipated benefits and will reflect the "BRISK" processes.

These documents will be the driving force behind commissioning decision-making and will be significant in future planning and development. All Practice Based Commissioners will need by June 2008 to have produced their three year LCDPs for sign off.

In revising this Commissioning Strategy, BEN PCT continues to be mindful of the need to engage patients, the public its staff in the process of development and implementation of this Strategy. BEN PCT is keen to ensure that it tests out this strategy with all interested stakeholders to ensure that the strategy reflects real population needs and preferences. Effective patient, public and staff involvement will support commissioners in delivering greater choice, continuity of care and provision of services in community settings. The procurement of an external partner to develop new relationships with the public, patients and staff will be key to this.

BEN PCT therefore fully embraces the increased focus on appropriate and real dialogue with its communities and is committed through its procurement of a strategic partner to demonstrate delivery in this area. This will not only deliver on our statutory obligations but will embed ongoing consultation and dialogue at different levels in commissioning from specific services to whole community initiatives managed and delivered across a range of public, private and voluntary sector partnerships.

The PCT is committed to supporting an increasing plurality of provision in appropriate circumstances this includes working with the third sector. All providers will be expected to set out their credentials to demonstrate they have the appropriate track record and skills to provide the relevant services.

A key local driver in developing the PCTs commissioning role is to take a number of its present initiatives that are focused on commissioning for prevention and health and well-being and scale up these developments to a level where larger segments of the population are able to access these services as part of mainstream commissioning and delivery.

The NHS Next Stage Review (Darzi Review) has been developed in consultation with service clinicians. There are now eight national agreed clinical pathways for the following areas:

- ❖ Staying Healthy
- ❖ Children's Services
- ❖ Planned Care
- ❖ Acute Care (Unplanned)
- ❖ End of Life Care
- ❖ Long Term Conditions
- ❖ Mental Health
- ❖ Maternity & Newborn

In the West Midlands a ninth pathway for the treatment of Dementia has been developed.

These care pathways are increasingly important and the PCT will be using the pathway work to inform commissioning strategies and plans in these key areas and further examples of the development plans to implement service improvements within these themed areas is set out in the main body of this document.

**DRAFT**

## 1.0 Introduction

This updated Commissioning Strategy provides a local overarching framework for Birmingham East and North Primary Care Trust (BENPCT) commissioning approach and provides strategic direction for Local Commissioning Delivery Plans (LCDPs) over the period 2008/09 – 2012/13.

In particular the strategy includes: -

- A vision of commissioning in the BENPCT area
- A strategic framework for the PCT as commissioners to deliver World Class Commissioning
- Information on local Health Needs
- Identifies forecasts of future needs and outlines a process for future investment
- Sets out overarching commissioning priorities
- Signals potential development opportunities for providers



Figure 1: Map of commissioning area

Birmingham East and North PCT (BENPCT) is one of 153 Primary Care Trusts within the English National Health Service. As a PCT it is responsible for the wise investment of public money to secure health improvement, access to health services and where appropriate the provision of health services to a local population of some 438,000 people.

Geographically, the PCT covers seventeen wards along the eastern half of Birmingham City Council, Britain's second city and the single largest metropolitan authority in Europe. The registered population is diverse, with significant differences in profile at ward level; Washwood Heath is 70% black and ethnic minority (mainly of Pakistani or Bangladeshi Muslim origin) with less than 15% over 60s and some 30% under 16 year olds; in contrast, Sutton Four Oaks has only 5% ethnic minority (mainly Indian) and 25% over 60s, with only some 15% under 16s.

The diversity of demography is reflected in significant disparities in socio-economic status across the PCT area. Not surprisingly, this disparity is again reflected in significant inequalities in health status and mortality with an over 6 year difference in average life expectancy between some wards. Whilst this illustrates the most extreme differences, each local area has distinct characteristics, within a majority deprived area.

The PCT is a complex organisation. Its core role of commissioning involves some 150 managers, from both clinical and general management backgrounds responsible for some £630m of investment each year. The PCT also host the specialised services commissioning function for all seventeen West Midlands PCTs and this team of some forty people are responsible for £680m expenditure for which the PCT is budget holder and the accountable body.

The PCT is the lead commissioner across the city for Mental Health, Learning Disabilities, Sexual Health and Addiction Services. We employ two hundred and sixty staff in Estates, ICT, Finance and Contractor and Financial Services, who work across the city supporting the three Birmingham PCTs and in some cases also Solihull Care Trust. As a provider of Community Health Services, we deliver a range of core Community Nursing Services, Demand Management Services, Rehabilitation, End of Life Care and nurse led urgent care, employing over nine hundred clinical staff from a variety of professions and including a number of medical and non-medical consultants. Many of our staff live or have families locally.

The PCT has a well-established and close working relationship with Birmingham City Council. The Chief Executive Officer (CEO) has developed and led the Birmingham Health and Wellbeing Executive for the last three years and is a core member of both the Birmingham Summit and Executive. The PCT participates actively in employer and economic forums and are a Board member of Digital Birmingham. The PCT manages a range of integrated Intermediate Care services on behalf of the Directorate of Adults and Communities (Birmingham City Council) and have a joint estate development programme for the future delivery of this rehabilitation focused programme. The PCT has also invested significantly in our relationship with our main acute provider, the Heart of England NHS Foundation Trust, now a single organisation operating through three local hospitals. Our collaborative programme of clinical re-design and improvement (Working Together for Health) has been the subject of academic commentary as a Kaiser Beacon site since 2003 (by Universities of Birmingham, Warwick and Toronto) and has been identified by the University of Toronto as an exemplar of system improvement alongside Jonkopping in

Sweden, Veteran's Administration in the USA, Henry Ford Health System and Inter Mountain Healthcare, USA.

More recently we have brought our partnership commitment to commercial relationships and are currently exploring appropriate legal forms to recognise our shared investment of knowledge, expertise and time with UK Pfizer Health Solutions and NHS Direct. This PCT is also developing its first social enterprise project with a group of social entrepreneurs.

The PCT is the local commissioner of primary care services, most of which are provided by small independent contractors. The PCT works with some eighty-two general medical practices of which thirty-three are single partner practices. These practices have been encouraged to collaborate at a local level in six locality groups to deliver practice-based commissioning each covering between 55,000 to 100,000 people. We are in the process of developing further our relationships with other key contractors (dentists, pharmacists and opticians), building on our learning with family practice. A number of local independent medical and other practitioners are employed on a sessional basis by the PCT as Clinical Directors or Clinical Leads.

BENPCT has a clearly stated core purpose of 'Working in partnership to tackle inequalities and improve the health and well being of local people' and the PCT has four audacious goals which provide the core framework for investment and development:

- To be so responsive to the population we serve that no one waits for the high quality care they need
- That the health and well being of the population will have improved so much that people will enjoy ten more years of healthy life
- That people regard us as the first choice organisation to work with and for
- Our communities will have the most involved, informed and empowered partnerships in the country

These strategic goals are underpinned by a set of principles which guide how the PCT works. These are that the PCT is collectively and personally committed to:-

- The best interests of the whole and caring about the (perspective of the) individual
- Investing wisely to do the right thing
- Purposeful partnerships
- Innovation for transformation, committed to maintaining and improving core activities.

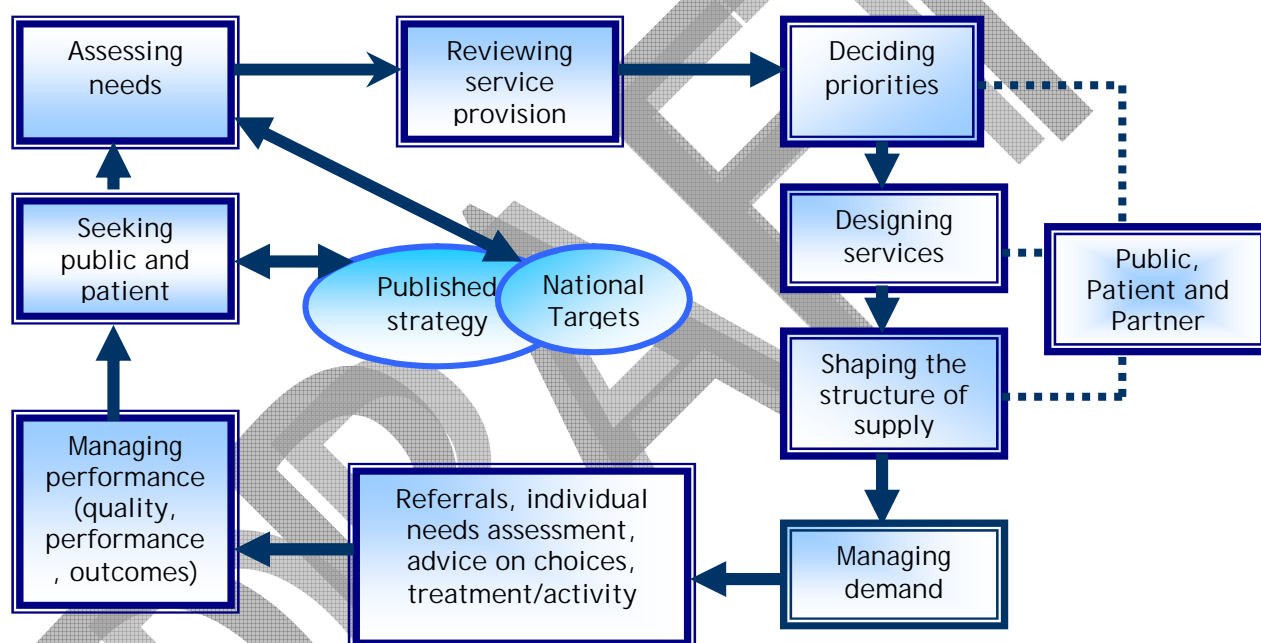
To deliver the PCT's core purpose and goals BEN PCT has recently revised its key strategies which drive delivery of its objectives and sustained improvement. In effect these strategies have been designed for sustained high performance, the strategies are:-

- Quality Safe Services
- Promoting health and empowering people

- Extending Working Together for Health
- BRISK Processes (Bold, Redesign, Investment, Sustainability, Knowledge)
- Consistently fit for purpose – Buildings, People, IT

## 2.0 Aim

The aim of this strategy is to deliver the above using the commissioning process. This process is the only process by which the PCT would fulfil its purpose and deliver its four big goals as described in section one. This will be achieved by ensuring all elements of the commissioning process are systematically implemented alongside service redesign, underpinned by its core strategies



The PCT is also continuing to develop Practice Based Commissioning (PBC) through the Locality Model, BENPCT has created six PBC Localities formed from cluster of General Practitioners aimed at securing greater and more effective engagement of clinicians in the redesign and commissioning of services.

In addition, the PCT is working jointly with colleagues in other areas across the city to develop consistent commissioning approaches on a city wide basis through Local Area Agreements (LAA) and through a series of Joint Commissioning Groups which are the delivery arm of the Health and Well-being Partnership.

This strategy is only the start point for the PCT's future commissioning intentions, as there is a need to involve a range of other stakeholders in the commissioning process to deliver the aspirations outlined in this strategy. There will be a need to engage in dialogue with the public, patients and key local representative bodies. This dialogue will need to be in the context of wanting to set out the evidence of need for healthcare interventions in local populations whilst listening too, local voices about the types of services and choices they

want. Only then will commissioning of services be truly relevant and responsive to the local populations needs. This dialogue will also create the environment where real discussion can take place about major service changes. This strategy will be supported by work presently being commissioned by the PCT to create a new relationship with patients, public and staff.

The direction set out in this commissioning strategy takes account of a set of new relationships that will be required to support the PCT in the delivery of its core purpose and goals.

### **3. Strategic Context**

The NHS Plan set the policy direction for the NHS covering a ten-year period. The plan set out a major agenda around system reform to allow for more choice, increased competition between providers for services, increased quality and safety through more effective governance systems and an increase in the range of services to patients. Although the NHS has achieved major changes in for example reductions in waiting lists there are still problems and shortfalls in the system and in services to patients. These problems can only be resolved through strengthening the commissioning function within PCTs.

Primary Care Trusts were introduced across the city in 2002 and reorganised in 2006, they have four core functions: -

- To improve the health of the population
- To deliver stronger commissioning
- To continue to provide services where appropriate
- To ensure services commissioned provide value for money

NHS System management requires strong commissioning to act as advocates for the population and the communities served underpinned by a strong public health evidence base. Stronger commissioning should reflect real needs that are fundamentally about provision of the most relevant services closer to an individual's home whilst making best use of taxpayer's resources. Commissioning based on place will also be factor because where a person lives may influence their uptake and access to services. This may require the commissioning of a different type of service even though the intended outcomes may be the same across the PCT area.

It is important in strategic context terms to understand that commissioning is only one element of a comprehensive health reform programme which requires changes to the following: -

- Transactional Reforms (Money following the patients, rewarding the best and most efficient providers, giving others incentives to improve)
- Demand side reforms (More choice and much stronger voice for patients)
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- System management reforms (A framework of systems management, regulation and decision making which guarantees safety, quality, fairness, equity and value for money)

The above will enable safer and more high quality services, better patient experience and better value for money. This is at the heart of commissioning within BENPCT and the system management changes will be reminders of how the PCT needs to commission to demonstrate world class commissioning in the future.

The introduction of the World Class Commissioning programme reinforces the above by providing a set of Eleven Competencies for commissioners to aspire to which are based on the reviews of 'Best Commissioning' both nationally and internationally. This programme will include a development programme to support PCTs in their quest to become 'World Class' but this will be balanced with an Assurance Framework and assessment process which will challenge PCTs to think differently and do things differently. This will also be reinforced by ensuring Governance through the Trust Board is robust and that both Executives and Non-Executives are up to the challenge of delivering World Class Commissioning which will ensure world class services to the population it serves.

#### **4 Public Health Needs in Birmingham East & North**

BEN PCT serves a population of 438,000 people

The diseases, which are responsible for the majority of deaths of our residents, are Circulatory Disease (38%), Cancer (26%) and Respiratory Disease (14%). Our population has particularly high rates of infant mortality, teenage pregnancy and low male life expectancy when compared to the national average.

When looking at morbidity and mortality rates, a number of stark health inequalities are apparent. Residents living in certain Wards of the PCT (e.g. Washwood Heath, Stockland Green, Kingstanding, Shard End) have significantly higher standardised mortality rates than others (e.g. the four Sutton Wards). Within the PCT, a number of 'hotspots' have been identified which have especially high excess mortality rates. There is also evidence that coronary heart disease is under-diagnosed in certain parts of the PCT.

The greatest number of potential years of life lost (PYLL) occurs as a result of heart disease, lung cancer, strokes and liver disease. The Quality and Outcomes Framework for General Practice has revealed that the most frequently recorded conditions in all of our PCT localities are hypertension, diabetes and coronary heart disease. Indeed, most chronic liver disease is linked to alcohol misuse, which in turn is associated with deprivation. Alcohol is a contributable factor to many deaths from cancer, injuries and suicide, as well as mental health, brain damage and foetal abnormalities. Additionally, binge drinking prevalence estimates are worryingly high in some of our Wards. Estimated levels of smoking, obesity, binge drinking and insufficient intake of fruit & vegetables are all highest in our most deprived Wards. Smoking and alcohol consumption are therefore areas, which require strong preventative healthcare interventions, together with exercise and healthy eating programmes.

There are marked disparities between deprivation scores (both IMD and Child Poverty) in our Wards, which range from 8 in the least deprived Wards to over 64 in the worst. This has serious implications for incapacity and life expectancy for our residents who are living in the most deprived areas.

Perinatal mortality rates are also higher in our PCT than for England & Wales, and within some of our Wards, still birth, perinatal and infant death rates are higher than in

Birmingham as a whole. It is clear that children within the PCT face a number of stark health inequalities. These are most marked in Washwood Heath and Kingstanding Wards, which also happen to be the Wards with the highest number of children under 18. The need to act to reduce these inequalities is therefore more vital than ever.

Teenage conception rates appear to be rising in some Wards, though areas, which have received the most preventative activities, appear to be stabilising or falling. With regard to sexual health, Chlamydia infections are particularly high in Tyburn, Hodge Hill and Perry Barr, while other STIs are generally highest in our most deprived Wards.

Alongside the above, short stay unplanned admissions to local acute hospitals continue to be challenging, in particular for nineteen ambulatory sensitive care conditions that the Department of Health have identified that could be managed effectively in Primary Care. Also there continues to be evidence that some procedures and outpatient attendances, due to changes in treatments and technological advances, are no longer required and there is a need to reduce the level of secondary care interventions to shift resources to the issues highlighted through the Director of Health Improvement's public health report.

Clearly Birmingham East and North PCT's Commissioning strategy should reflect the above and ensure that Local Commissioning Delivery Plans (LCDPs) produced by each PBC Locality focus on interventions, which address some of the major causes of morbidity and mortality whilst commissioning services that focus on reducing the inequalities within our populations and do the right thing for local people. Many of the new interventions commissioned will be aimed at segmenting populations and using risk stratification tools to identify patients with particular conditions or the potential to develop a particular condition. All these individuals will have a higher than average risk of unplanned interventions either in the short or long term.

An increasing proportion of commissioning will be in partnership with the Local Authority (Social Services, Housing and the Children's Trust). The commissioning agenda will reflect interventions that target, with our partners the well-being of our populations as envisaged within the White Paper "Our health, Our care, Our say" and the recently published local government white paper. Targets will increasingly become the joint responsibility of Health and Social Care and this will increase the need for Joint Commissioning arrangements which are truly joint including a significant extension of pooled budgets as part of formal Section 75 Agreements.

The PCT is not however starting from a zero base as a number of initiatives aimed at ill-health prevention and promoting health and well-being have been developed and implemented in line with our approach to systematic patient segmentation and risk stratification. Examples of these include: -

- **Systematic Approaches to Health Improvement**

Use of Population based information to target and make decisions on appropriate and relevant interventions for individuals. This includes work commissioned by the Health and Well Being Partnership to support the increase of Male Life Expectance screening programmes which supports early intervention.

- **Assertive Case Managers (ACMs)**

We have recruited 23 ACMs (Community Matrons) to work with patients with long term conditions to support them in living at home and to avoid unnecessary hospital admissions. They each now coordinate care for up to 200 patients with district nursing teams at any one time.

- **Smoking Cessation**

We have used of social marketing techniques to target support to reduce the number of smokers.

- **Redressing the Balance Project**

Initially designed to redress health inequity and inequitable resource distribution in our children's services it has also allowed us to redeploy resources, introduce radical workforce redesign and provided a framework for integrated care pathways.

- **Birmingham Own Health**

BOH is providing a telephone-based, proactive care management service to people with heart failure, coronary heart disease (CHD) and diabetes initially targeted at the two most deprived localities. It presently provides a service to 2000 BENPCT residents. This service will be extended to 27,000 residents by 2012.

- **Intermediate care**

We have a range of Intermediate care beds and community outreach services providing rehabilitation therapies in the patients own home. These services have been extended to provide a third community rehabilitation team and day rehabilitation service.

- **IV Therapy in the Community**

We have trained nurses to undertake IV Therapy in the community to support patients in their own home, to avoid unnecessary hospital admissions and to support earlier discharges from hospital,

- **Orthopaedic Triage**

All new referrals for orthopaedic services are first triaged by our enhanced physiotherapy team, which will identify the most effective treatment option including faster access to physiotherapy services. This service has now been extended to provide back pain services to members of the population, supporting early intervention which reduces periods away from work for individuals with back problems.

- **Mental Health**

We have established a network of Mental Health workers (Gateway & Primary Care Workers) attached to each GP practice across BEN PCT to provide foster assessment and easier access to a range of psychological therapies. Further community based support services have also been developed.

- **Dermatology Service**

In the North of the PCT, a service which provides access for patients to be seen and treated for Dermatological conditions within two weeks at multiple locations has been developed.

- **Continence Service**

A community based continence service is now in place to support many members of the population, particularly women who have found it difficult to access a service to resolve a problem which for many has blighted their lives for years.

- **Care Co-ordination**

In undertaking segmentation care co-ordination and navigation through is becoming increasingly important. Through commissioned services, e.g. OwnHealth, the PCT has demonstrated how important this type of service will be to individuals and communities in the future.

- **Incentives**

Testing sample population groups as to whether the use of incentives influences their approach to adopting a healthier lifestyle

- **Technologies**

Exploiting the use of new technologies to support the prevention of accidents, increasing self care and independent living

## **5 Commissioning Vision**

All BEN PCT's commissioning is governed by its core purpose and big goals. Commissioning will be undertaken at a variety of levels which range from Practice Based Commissioning, PCT Commissioning, Specialised Commissioning and Joint Commissioning with the Local Authority. For all services the PCT commissions whether individually or with partners its commissioning vision is to: -

- Improve health outcomes and reduce inequalities and social exclusion through partner based commissioning
- Secure access to a comprehensive range of services
- Improve the safety, quality, effectiveness and efficiency of services
- Increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs; and
- Achieve best value with taxpayers resources.

This is in line with national requirements but needs further translation to ensure locally that the commissioning is understood by all through practical examples. An example of this local translation is shown below: -

### **Birmingham Own Health**

Birmingham Own Health was commissioned to provide a telephone based care management service for patients identified with a specific long-term condition. The service was aimed at patients who were deemed "hard to reach" by their General Practitioners.

This was in relation to the individuals understanding and self-management of their long-term condition. The scheme has been designed to be relevant to the populations targeted and responsive to individual needs of people with long-term conditions. It is also aimed at reducing the number of unplanned interventions / admissions to hospital. The service is radically different as it aims to motivate and empower people to take control of their condition and their lives whilst reducing the risks factors associated with their long-term condition.

This example is just one of many initiatives which demonstrate the PCT's commitment to its population using commissioning as a driver for radical change and how through redesigned or newly commissioned services the PCT will deliver changes using the "BRISK" approach and which support the achievement of the overall goals of the PCT. However, the challenge for the PCT with its partners is to commission services, which are universally accessible to its population; it therefore needs to scale up developments from the small-scale (artisan) initiatives to large (industrial) scale level.

## **6 National Commissioning Drivers**

There have been a number of key policies and initiatives, which have shaped the direction for PCTs in relation to commissioning. The current drivers are:

### **1. World Class Commissioning**

On the 3<sup>rd</sup> December 2007 the Department of Health launched its vision for World Class Commissioning (WCC) across the National Health Service through its one hundred and fifty two Primary Care Trusts (PCTs). This vision is built on the premise that healthcare commissioning is underdeveloped world wide but that the National Health Service has the best possible chance to achieve excellence in commissioning which will have a direct impact on the health and well-being of the population. Ultimately the Department of Health sees WCC delivering better health and well-being for all, better care for all and better value for all. The strap line for this is "adding years to life and life to years".

All PCTs will aspire and have an ambition to be world class commissioners but in attempting to become world class PCTs need to have a design which enables innovation but also pay attention to improvement in "getting the basics right". The WCC programme will help PCTs become more systematic in the way they commission so that services are available and accessible to all members of the PCT's population and also ask organisations to become ready to lead transformational change. The Department of Health have been clear that WCC is not an end in itself but a vehicle for increasing commissioning impact previously unseen in the NHS.

**2. White Paper, Our Health, Our Care, Our Say' where the key expected outcomes are:**

- ❖ Change the way community services are provided in communities and make them as flexible as possible
- ❖ Provide a more personal service that is tailored to the specific health or social care needs of individuals
- ❖ Give patients and service users more control over the treatment they receive
- ❖ Work with health and social care professionals and services to get the most appropriate treatment or care for their needs

**3. The Department of Health's Operating Framework for 2008/09 highlighted the requirement for PCTs to ensure they have appropriate strategies in place for the commissioning of: -**

- ❖ Improving cleanliness and reducing Healthcare Acquired Infections (HCAs)
- ❖ Improving access through achievement of the 18 Week referral to treatment target and improving access to GP Services
- ❖ Keeping up Adults and Children well, improving their health and reducing health inequalities
- ❖ Improving patient experience, staff satisfaction and engagement
- ❖ Ensuring that all our services (whether directly provided or commissioned) are robust for Major Incidents including Flu Pandemic, CBRN and terrorism and have business continuity plans in place.

#### **4. The NHS Next Stage Review (Darzi Review)**

The Darzi Review has been under consultation with the service clinicians. There are now eight national agreed clinical pathways for the following areas:

- ❖ Staying Healthy
- ❖ Children's Services
- ❖ Planned Care
- ❖ Acute Care (Unplanned)
- ❖ End of Life Care
- ❖ Long Term Conditions
- ❖ Mental Health
- ❖ Maternity & Newborn

In the West Midlands a ninth pathway for the treatment of Dementia has been developed. These care pathways are increasingly important and the PCT will be using the pathway work to inform commissioning strategies and plans in these key areas.

#### **5. PCTs and Practice Based Commissioners are also expected to:**

- ❖ Secure access to a range of high quality healthcare services to meet local needs
- ❖ Where necessary stimulate new services including possible use of incentives
- ❖ Continue a systematic programme to review all services commissioned
- ❖ Improve use of information including local intelligence
- ❖ Develop approaches to procurement through a supplier strategy
- ❖ Ensure plans to support the aspiration to deliver World Class Commissioning are in place

## **7 Local Commissioning Drivers**

As outlined earlier the PCT has articulated four big goals, which provide the framework for PCT activities. The PCT has pioneered collaborative working with partner agencies in particular working with Heart of England Foundation Trust and Solihull Care Trust in a programme entitled *Working Together for Health*. This is based on an integrated approach to care using the principles adopted from collaboration with Kaiser Permanente. This has led to nationally recognised work in commissioning services formerly provided in secondary care being shifted into primary care. This did include for example the development of intermediate Diabetes Care, Orthopaedic triage and Heart Failure self care and education programme. The Working Together for Health strategy now covers the whole of the BENPCT area. Revisions to the programme arrangements have been agreed to support future commissioning developments to ensure full engagement of clinicians across the patch in service development and redesign.

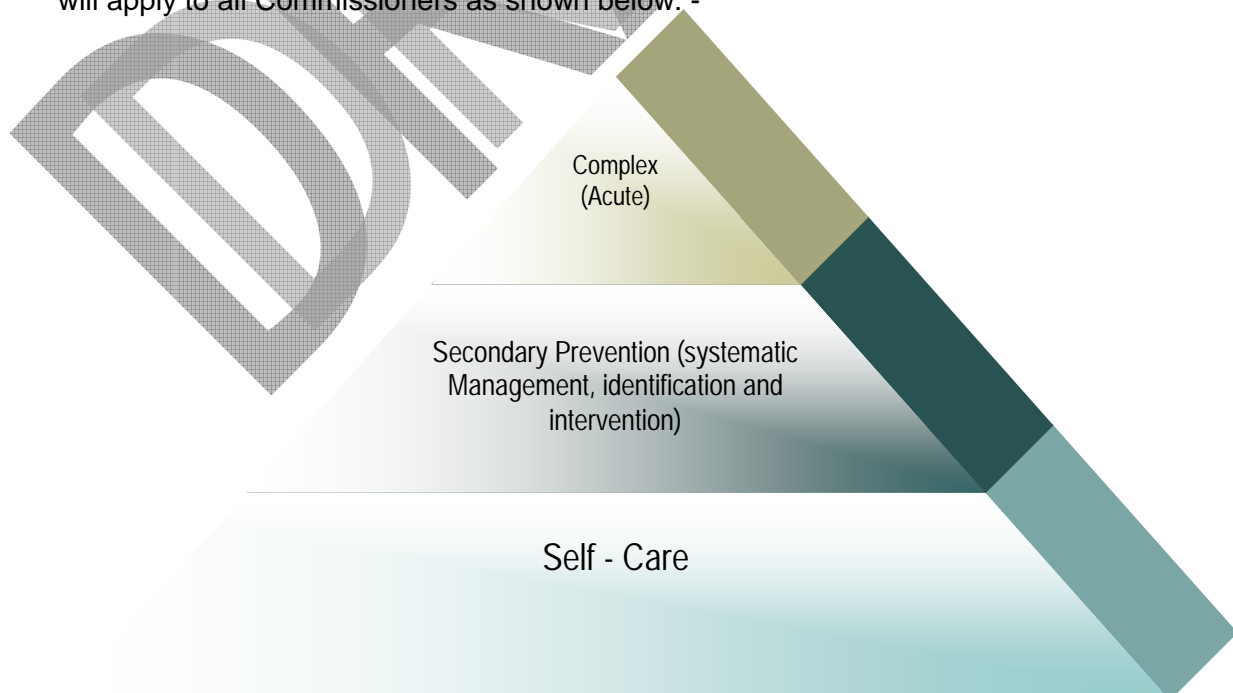
The PCT has worked with hospital clinicians and other stakeholders to develop a strategic approach to redesign through WtFH. The following principles describe the elements required in redesigning current patterns of service provision to deliver both improved health outcomes and best value.

- An integrated approach to education of patients and public, maximising self care
- Best practice in Long-Term Conditions management
- Range of community 'at home' and flexible support
- Access to diagnostics
- Maximum efficiency and appropriateness in use of hospital beds
- Integrated workforce planning and development

The local framework for all commissioning and service redesign uses a model of patient segmentation and risk stratification underpinned by robust Public Health data and a needs analysis approach based on health equity as social marketing; this will also reflect health and social care data based on where people live which ensures that services are appropriately commissioned, designed and delivered based on need with a clear set of agreed outcomes which promote health, well being, independence and reduce inequalities. These commissioning arrangements set out to remove all unplanned interventions from the health system and describe any unplanned interventions as a system failure requiring a critical incident review to understand why the commissioning arrangements failed and what changes may need to be made to commissioning arrangements in the future.

<b>Commissioning Levels</b>
Individual patient based commissioning through personalised budgets
Practice based Commissioning (e.g. Acute Care, Community Services etc)
Primary Care Commissioning (e.g. GMS, PMS, GPs)
PCT based Commissioning (e.g. Specialist Mental Health, Learning Disabilities, Complex Care)
Specialised Services Commissioning (e.g. Cardiac, Cancer Care, Neo-natal etc)
Partnership Commissioning (e.g. Children's services, Older People, Mental Health, Learning Disabilities, Sexual Health, Drug and Alcohol Services, Physical Disability)
National commissioning

Commissioning in the future will be diverse and undertaken at different levels as shown above. However the principles of Commissioning being needs led through effective use of Public health and other data and sound clinical evidence whilst listening to users will apply to commissioning at whatever level. The principles of segmentation and risk stratification will apply to all Commissioners as shown below: -



National Standards have introduced targets that cut across primary and secondary care and social care. Local Area Agreements are now the vehicle by which joint commissioning will be undertaken. Delivering of Commissioning across systems will require whole system service redesign. The PCTs approach to commissioning needs to reflect these changes. The PCTs early adoption of the Kaiser Permanente principles combined with our developing Local Health Economy vision and plan puts the PCT and its partners in a strong position to make real and significant improvements to how health care is commissioned and will create a solid baseline from which to deliver World Class Commissioning. The PCT will progress the Practice Based Commissioning (PBC) agenda with primary care clinicians through each of its six localities. Each Locality has produced its own LCDP setting out what the Locality wishes to commission for its population over the next planning period and within the framework set by this and related overarching strategic plans. These plans will build on and take cognisance of a number of commissioning developments that have and will continue to be a key feature of the PCTs strategic commissioning arrangements.

Commissioning decisions will continue to need to be evidenced based using the full range of guidance and intelligence available on what works. Challenges to these commissioning decisions will be provided individually through the PCT's Service Development Appraisal and Approval process known as the "Gateway Process" and eventually through its procurement of a specialist partner to support the development of a new relationship with patients, public and staff.

A key local driver in developing the PCTs commissioning role is to take a number of its present initiatives that are focused on commissioning for prevention and health and well-being and scale up these developments to a level where larger segments of the population are able to access these services as part of mainstream commissioning and delivery. These strategic developments that will be the subject of scaling up will include: -

#### **Quality Safe Services**

- Reducing Healthcare Acquired Infections
- Developing systematic approaches to the promotion of high quality evidence based healthcare
- Ensuring consistently high quality service provision within both established and newly commissioned services through the development of quality based service specifications and robust monitoring arrangements.
- Implementation of NICE Clinical Guidance

#### **Staying Healthy**

- Increasing the numbers of individuals involved in Birmingham Own Health, Expert Patient Programme, Heart Failure Education Sessions, Healthy Eating programmes and development and implementation of the Assisted Technology project. This will increase access to services for example in Birmingham Own Health to 11,000 in 2009 and 27,000 by 2012.
- Increase the number of males taking part in active management of their own health through the jointly commissioned Male Life Expectancy project. Commissioning of increased screening and intervention for high risk males.

- Joint commissioning in line with the White Paper objectives to support Health and Well-being of the population and reduce health inequalities through the Local Area Agreement and increased number of health act flexibilities, increasing the number of pooled budget arrangements

### **Children's Services**

- Commissioning services to target the growing problem of Obesity particularly in Children
- Developing CAMHS Services to promote Early Intervention and improve its coverage of Children and Young People

### **Planned Care**

- Further market testing to secure pathways that are more appropriate for patients providing quicker access and treatment in a Primary Care setting
- Commissioning a range of high quality services having reviewed both the care given and the resources utilised. This will mean a continued commissioning focus on reducing unnecessary Consultant to Consultant referrals, follow up outpatient attendances and reducing short stay unplanned admissions for ambulatory sensitive care conditions where services are or will be available in Primary Care
- Development of diagnostic provision through a range of providers, where appropriate
- Commissioning of Vertical Integrated planned care services which creates a single point of access in Primary Care
- Specialised Commissioning for low volume, high cost interventions where collaborative commissioning will ensure the best possible care for the patients served
- Increased collaborative commissioning to ensure effectiveness and good use of resources across a range of services and areas.

### **Acute Care (Unplanned)**

- The development of Urgent care services with the following key objectives:
  - Developing and supporting self –care where appropriate
  - Developing an integrated model across primary and secondary care providers and other partners with clear tiers of services and pathways
  - Providing simple access and choice in quality urgent care for patients and managing demand.
  - Supporting clinical leadership across the urgent care system

- Developing capacity across the urgent care system to deliver new integrated models of care.
- The benefits and outcomes of a more integrated urgent care system will be more consistency in urgent care pathways, less waiting and more local services for patients.
- Co-ordinated caseload management Out of Hours and eventually 24 hours a day and seven days a week
- Commissioning of planned system for urgent care where incentive schemes are devised to support Providers in developing services which encourage patients to attend the most appropriate service for their needs

### **End of Life Care**

- Commissioning of an integrated supportive care service for people in the last year of life, which increases choice for individuals in their last year of life and ensures effective use of facilities both in hospital and community settings
- Coordination of End of Life Care Out of Hours
- Commissioning of a managed Provider Network

### **Long Term Conditions**

- Extending the use of health monitoring technology to support people not only at home but whilst mobile
- Further population segmentation linked to Case and Care Managers to enable people with long-term conditions to understand how and when to access services to help them in times of need
- Commissioning of increased integration of services including extension of intermediate care services in the community
- Commissioning of further services to support individuals with Diabetes, COPD, Heart Failure and CHD through use of Quality and Outcomes Framework information
- Development of integrated Musculo-skeletal system of care
- Increased integration of health and social care commissioning through the increased use of joint commissioning arrangements and the use of Section 75 agreements
- Pilot commissioning to support individual budgets and direct payments for members of the public

### **Mental Health**

- Commissioning of a range of Psychological Therapies for people with mild to moderate mental health problems

### **Maternity & Newborn**

- Integrated approach to commissioning of services for children with the emerging Local Authority Children's Trust as well as focusing on commissioning effective healthcare services for Children to reduce perinatal mortality. This will bring together under a joint arrangement commissioning for children which has in the past suffered from fragmentation

All the above set the focus on our outward looking approach to Commissioning which sets out the strategic intention of the PCT to ensure more resources are available for commissioning Primary, Community and Social Care and a stable resource for Secondary Care. All developments will be subject to rigorous evaluation of their benefits and effectiveness prior to further commissioning decisions being taken on extending the services. The use of the OSCAR (Organisational, Satisfactory, Clinical, Activity, Resource) (See Appendix 1) outcomes framework will be key in measuring service effectiveness.

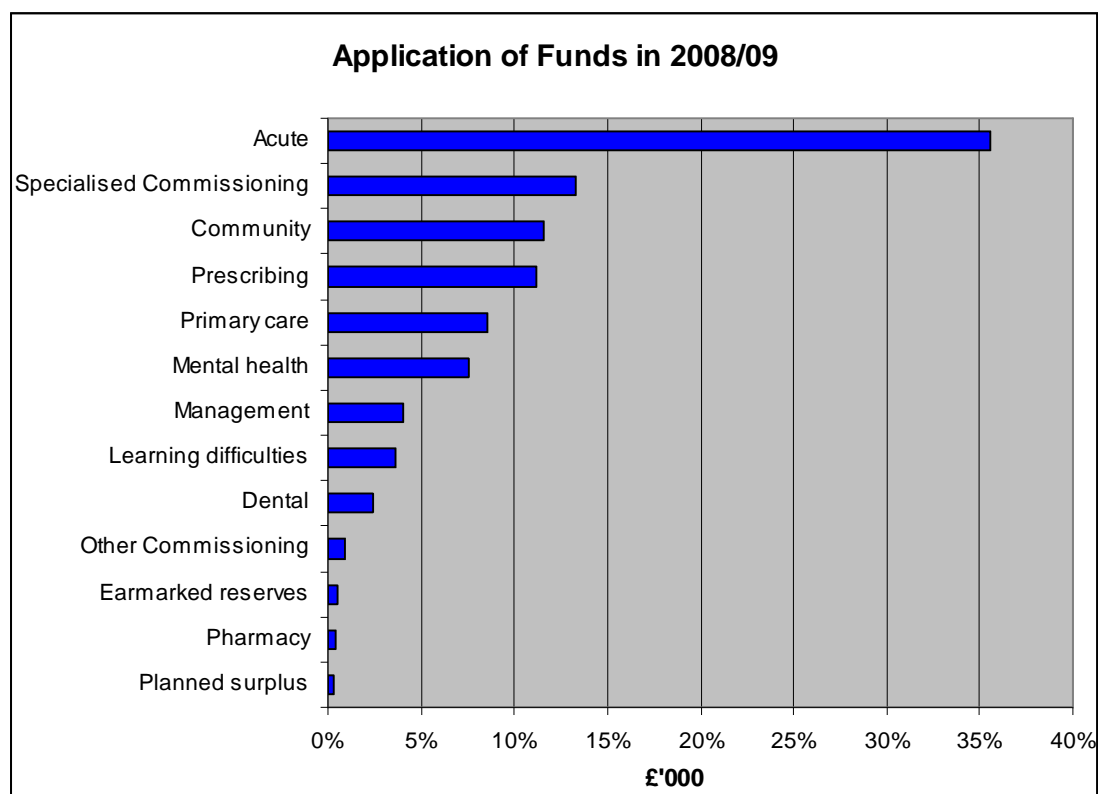
Practice Based Commissioning (PBC) will continue to be a feature on the development of commissioning in that PBC will increasingly be responsible for local planning of services. The PCT will play a significant role in the procurement and performance management of commissioned services and will need to set out clearly its own local supplier strategy to ensure fairness and equity is demonstrated and delivers patient's choice. PBC planning arrangements will therefore continue to develop through the devolution of commissioning responsibility. The challenge will be not to lose sight of the PCT strategic goals when locally based commissioning is the norm rather than the exception. Each Locality will deliver a three year Local Commissioning Delivery Plan which sets out how it proposes to develop and deliver effective commissioning in its locality.

A key local driver will be the ability of commissioners to involve patients and the public in the design, development and introduction of new services and ensure that the services meet the needs of the populations served. This can only be achieved by a different approach to gaining the views of the population and will require the PCT to have a clear public, patient and staff involvement strategy, which uses the mechanisms and levers for engagement in a proactive and innovative way. This will involve continuing to "take the story to the people" in a manner which is open, transparent and honest about the decisions the PCT has to take and how the public, patients and staff can be involved in that decision making process. For PBC this will be critical and they will need to articulate in LCDPs how they have or will test their plans with local populations and patient groups. This will only be achieved through developing a different relationship with the patients, public and staff. The systematic partnership between BEN PCT and the provider processes to support these new relationships will be important in delivering the above.

## 8 Financial Profile

The PCT has a revenue resource limit of £633 million, which is used to commission a broad range of health services on behalf of the population of the 440,000 people living in north and east Birmingham.

The planned application of this funding in 2008/09 is shown below:-



The PCT has been working hard to reach sustained and robust financial health. In the financial year 2006/07, the PCT was set a savings target of £25.8 million. This was narrowly missed and the PCT delivered a £0.95 million deficit. In 2007/08, the PCT planned for, and achieved, a £3.2 million surplus. This was partly achieved due to the recurrent savings made through actions taken in 2006/07.

In 2008/09, PCTs have been given lower levels of growth funding than in recent years. However, the PCT has a medium-term plan to remain financial healthy by delivering a recurrent surplus of £1.9 million, whilst at the same time continuing to invest in new services; bringing more choice for patients and more services closer to home. This investment in improving services will be sustained through the period of lower levels of growth funding by increasing productivity and diverting activity away from traditional hospital-based settings to more appropriate community-based sites.

The PCT is planning to invest £18 million in new services and service developments in 2008/09. The PCT continues to invest only in service which demonstrate, through business planning, both value for money and return on investment. This is to ensure that the PCT makes the best use of its limited resources, whilst being responsive to the needs of the population on whose behalf services are commissioned.

## **9 Local Commissioning Delivery Approach**

This Commissioning strategy proposes an approach, which promotes active involvement of a range of stakeholders in assessing the need for commissioner developments. This approach shifts Commissioning towards being a needs based activity built around the goals of the organisation and linked directly to public health issues, local needs and embodied in local service strategies. Commissioners will then lead the process of procurement which involves redesign of present services or market development and /or testing to ensure the services proposed meet the specific needs of populations and are in line with the goals, principles and “BRISK” processes within the PCT. Providers will be requested to demonstrate how any service proposal meets the PCT’s key goals, as well as showing how new developments will be measured in terms of outcomes.

With the establishment of PBC though the six localities, there is a need to address both national and local requirements whilst addressing the engagement of wider stakeholder interests which will include the Local Authority and the Voluntary Sector. Commissioners will be faced with a wide range of competing interests and priorities and therefore will need to work collaboratively with partners to ensure that collective commissioning power is used to bring about substantial change in service provision.

In line with this, future investment decisions will only be considered where providers can demonstrate best use of present resources, evidence of service redesign, how short-term pump priming can be used to deliver change or if further investment is required, how this increases capacity and meets national and /or local targets and outcomes.

Section nine sets out a number of broad areas of commissioning, which the PCT would wish to address in the period 2008-2013. It is also proposed that PBC, patient interest groups and other stakeholders in relation to the detailed LCDPs adopt the broad areas subject to review, comment and revision.

Once priorities are agreed it would be a matter for Commissioners to review investment proposals and where appropriate provider service plans that meet population need. Any proposals will need to define as a minimum a return on investment and a set of outcomes using the OSCAR outcomes framework, which can be monitored.

This process will support the delivery of World Class Commissioning.

## **10 Local Commissioning Delivery Plans**

Critically important to the delivery of world class commissioning is the development of clear service strategies and the development of the role of Practice Based Commissioners and how their commissioning plans drive local service development and redesign.

The need to create an integrated planning process will be key to enabling commissioning to be effective. There is a danger as Commissioning is further devolved that it becomes fragmented and that commissioning plans are so locally focused that they do not reflect the strategic framework of the PCT or national requirements.

The Local Commissioning Delivery Plans (LCDPs) will provide a framework for all commissioners to set out their plans, describe how they propose to deliver those plans as well as demonstrating the link to strategic PCT objectives and national requirements. The plans will also set out the anticipated benefits and will reflect the “BRISK” processes.

These documents will be the driving force behind commissioning decision-making and will be significant in future planning and development. All Practice Based Commissioners will need by June 2008 to have produced their three year LCDPs for sign off.

### **Commissioning Intentions**

The key areas where commissioners will be concentrating their efforts over the next five years will be as follows: -

#### **Staying Healthy**

- Increasing the numbers of individuals involved in Birmingham Own Health, Expert Patient Programme, Heart Failure Education Sessions, Healthy Eating programmes and development and implementation of the Assisted Technology project. This will increase access to services for example in Birmingham Own Health to 11,000 in 2009 and 27,000 by 2012.
- Increase the number of males taking part in active management of their own health through the jointly commissioned Male Life Expectancy project. Commissioning of increased screening and intervention for high risk males.
- Joint commissioning in line with the White Paper objectives to support Health and Well-being of the population and reduce health inequalities through the Local Area Agreement and increased number of health act flexibilities, increasing the number of pooled budget arrangements
- Promoting increased self-care and more systematic care across patient pathways
- Increase the number of individuals who are taking responsibility for the own care
- To improve the health and well-being of the population by developing approaches to social marketing which aids the development of interventions which improve health and in particular life expectancy and builds a new relationship with patient, public and staff.
- Using social marketing approaches to target specific and general services to key populations
- Testing the use of incentives with key groups, including pregnant women and teenagers
- Increased access to sexual health services in Primary Care and third sector
- Developing an integrated approach to Sexual Health and Contraception

#### **Children's Services**

- To develop joint commissioning with the Children's Trust to address health inequalities within the area.
- Apply workforce management approaches to target investment and future activity

### **Planned Care**

- Development of community based services based on clinical integrated models of care
- Movement of outpatient services into community settings where appropriate and feasible
- Provision of community based Peri-operative Care
- Increased use of the Prior Approval and Utilisation Management techniques
- Increased use Clinical Assessment Centres (Triage) driven by appropriate clinical pathway development
- Reductions in use of interventions with limited clinical value
- Application of the long-term conditions model whatever the condition
- A review of Commissioning of enhanced services to ensure they are in line with the "BRISK" strategy
- Review by commissioners of all Community Based Services to ensure they offer best value and performance identifying alternatives as necessary.

### **Acute Services (Unplanned)**

- Reductions in unnecessary hospital interventions and the increasing focus on diagnostic access and assessment in Primary and Community Care, to reduce the level of 85% of patients ending up with no further action in Secondary Care.
- Reductions in unplanned admissions by increasing the number of people receiving systematic care

### **Long-Term Conditions**

- Ensure general Practitioners identify people early in their disease career and apply effective early chronic disease management interventions
- Ensure people are supported at the right level in the system and fully supported in taking control of their condition
- Scaling up Commissioning where appropriate in key disease areas where prevalence is high for example Heart Failure, Respiratory Disease, Diabetes and CHD.
- Develop performance management plans for management of long-term conditions
- Further development models of intermediate care in conjunction with the Adults and Communities Directorate including the expansion of Section 75 arrangements

- Improving service provision e.g. Stroke care to improve patient recovery and rehabilitation and provide interventions to prevent stroke
- Develop a range of services and support mechanism to enable people to keep them well and make best use of scarce resources
- Continued development of local market to allow more local commissioning of complex care packages with different contractual arrangements to get best return on the investment required
- Commissioning of all Complex Care through Joint Commissioning teams
- Support specialised commissioning through Local Collaborative Commissioning Groups
- Further development of models of intermediate care in conjunction with the Adults and Communities Directorate including the expansion of Section 75 arrangements
- Improving service provision e.g. Stroke care to improve patient recovery and rehabilitation and provide interventions to prevent stroke
- Develop a range of services and support mechanisms to enable people to keep them well and make best use of scarce resources
- Ensure General Practitioners identify people early in their disease career and apply effective early chronic disease management interventions
- Ensure people are supported at the right level in the system and fully supported in taking control of their condition
- Scaling up Commissioning where appropriate in key disease areas where prevalence is high for example Heart Failure, Respiratory Disease, Diabetes and CHD.
- Commissioning which supports increased self-care and more systematic care across patient pathways
- Increase the number of individuals who are taking responsibility for their own care
- Increasing commissioning of services for people with learning disabilities to promote independence
- Review of service provision for people with learning disabilities to create an expanded market, diversity and attract new providers
- Development of Section 75 pooled budget arrangements to support increased Joint Commissioning of services for people with learning disabilities

### **Mental Health**

- Development of dedicated strategy through workshop events for future health interventions in mental health

- Increased capacity to support self-care and “locus of control” achieved through CBT and other psychotherapeutic interventions and shifting care from secondary to primary care
- A focus on co morbidities and the determinants of and interplay between mental and physical ill health
- Provide treatment and care at times and places which are convenient for people through fully integrated teams organised around the needs and wants of people.
- Provides treatment and care in ordinary environments through a range of providers
- Increase choice in every aspect of treatment and care including patient directed care and an increasing use of direct payments and individual budgets.
- .
- Culturally sensitive and culturally competent services
- Increased focus on age-free services in Mental Health
- Increased joint commissioning of service provision with Local Authorities to ensure the links to housing, employment and social care
- Increased development of the market for Mental Health services including use of the third sector.
- Development of pooled budget arrangements under Section 75 which increases the effectiveness of joint commissioning
- Redesigning mental health services for older people including joint working with the Local Authority on provision of services

#### **End of Life Care**

- Develop training and support in identification of patients in final year of life and ensure supportive End of Life Care Planning is available for patients
- Commissioning an increased range of services for people in their last year of life and as described in the End of Life Care Commissioning Strategy
- Extension of Palliative Care to Non Cancer conditions

#### **Maternity and Newborn**

- Develop citywide specification of maternity services to tackle infant mortality
- National guidance has emphasised the need for early booking to ensure women are provided the best possible care and therefore reduce perinatal and infant mortality through early intervention and support for the mother, therefore 75% of women will have an appointment booked within 12 weeks of gestation to enable early intervention and access to services for these women.

- A standardised risk stratification model, which will set out the services (health and social) that women in the four risk categories, will be provided by agencies, therefore enabling resources to be targeted to those in most need.
- The PCT will commission the provision of Nurse Family Partnership Scheme to target the most vulnerable families to enable intensive and multi-disciplinary interventions at an early stage, therefore reducing the risk of future problems for the child and family.

## **11 Patient, Public and Staff Involvement**

In revising this Commissioning Strategy, BEN PCT continues to be fully committed to finding innovative and effective ways of engaging with patients, the public and its staff in the process of development and implementation of this Strategy.

Birmingham East and North Primary Care Trust have entered into a three year partnership with Dr Foster Intelligence to design and deliver a Programme for Relationships and Intelligence Metrics and Equality (PRIME). The programme will develop new relationships to tackle health inequalities with public, patients and partners, based on the creative use of healthcare intelligence generated by a range of innovative approaches. Most importantly for us at BEN, the Programme will build on our established commitment to Patient and Public Involvement (PPI) and together with Dr Foster's strong record in public health innovation will provide an exciting platform for us to reach out and engage with our community. PRIME will support and take forward our ambition to tackle health inequalities through World Class Commissioning and particularly allow us to progress our goal of 'most informed and empowered community' and 'ten more years of healthy life'.

BEN PCT is keen to ensure that it tests out this Commissioning Strategy with all interested stakeholders to ensure that the strategy reflects real population needs and preferences. Effective patient, public and staff involvement will support commissioners in delivering greater choice, continuity of care and provision of services in community settings. The procurement of an external partner to develop new relationships with the public, patients and staff will be key to this.

BEN PCT therefore fully embraces the increased focus on appropriate and real dialogue with its communities and is committed through its procurement of a strategic partner to demonstrate delivery in this area. This will not only deliver on our statutory obligations but will embed ongoing consultation and dialogue at different levels in commissioning from specific services to whole community initiatives managed and delivered across a range of public, private and voluntary sector partnerships. Therefore the PCT is committed to the following principles around the future commissioning of services: -

- Patients, through greater choice, will drive improvements in many services
- Clear notice to all interested parties through its strategy and future planning rounds on the potential proposed changes it is considering in relation to the commissioning of health services
- A commitment to enter into a dialogue with relevant individuals, organisations and other stakeholders prior to decisions being made on any potential changes

- The publishing of a clear process whereby meaningful advance dialogue and consultation can occur
- An open approach to requests for information to help patients and the public take part in discussions and debate about the commissioning of future health services
- A proactive stance on communication on key health issues which affect the PCT's population. The views of patients, carers, families, local interest groups and their communities will be sought through a range of mechanisms so that they can influence service provision and improve the patient experience
- The commissioning and locality teams will work closely with the PPI team to ensure that patient and public feedback has a direct impact on commissioning and service redesign
- This impact will be documented and reported back to patients, the public and local communities. An ongoing systematic approach to engagement with communities which exploits the use of the technology to understand individual needs

As with many things this approach will require time to develop and become embedded across the organisation and will need to continue to be reinforced and revisited to ensure the approach is having the desired outcomes.

## **12. Workforce Planning and Development**

Many of the intentions outlined within this strategy are based on assumptions about having available people with the right skills and experiences to undertake the delivery of healthcare to BEN PCT's population. The introduction of new services alongside developments in technology and clinical practice suggests the need for a workforce across health and social care, which is increasingly integrated with more generic roles, which cut across professional boundaries.

Commissioners have a responsibility to set out clearly the specification for the service but also need to facilitate with providers the introduction of new roles, which enable the new types of service to be introduced. This approach creates challenges to many professionals and the PCT is committed to working with providers on this approach.

The PCT is also committed to ensuring its workforce planning based on this strategy is robust and that it is, with providers, forward planning workforce requirements over the next three to five years. This will be achieved through the development of enhanced roles in non-medical practitioners and increased competence in relation to specialist interest of GPs and other clinicians.

## **13. Market Development and Management**

The PCT is committed to supporting an increasing plurality of provision in appropriate circumstances this includes working with the third sector. All providers will be expected to set out their credentials to demonstrate they have the appropriate track record and skills to provide the relevant services. Commissioners are aware however that the development of a range of providers will require commissioners to provide support to providers who may not yet have the infrastructure to compete on an equal footing in the NHS market place but yet have the skills to deliver the requirements of commissioners. It is with this in mind that

commissioners will not only use the market testing route for finding appropriate providers but will in advance of any development invite potential providers to enter dialogue with the PCT on what that provider could offer. The PCT will also encourage providers to come together in confederations to put forward proposals, which covers the whole pathway of the service. It is the intention of the PCT to create a vibrant provider market, which increases commissioner options and enables new providers including the third sector to enter the provider healthcare market. This will build on early market development in diagnostics through the independent sector, Learning Disabilities, Mental Health and the voluntary sector. Key to this approach will be the development of a supplier strategy for the appropriate procurement of services in line with the principles and rules for co-operation and competition.

## 14 Performance Management

The NHS Commissioning Framework requires PCTs to improve the safety, quality, effectiveness and efficiency of services. Part of the approach to monitoring the outcomes of any services commissioned will include regular review of progress against the following five outcome/output metrics:

- Financial )Outputs
- Activity )
- Satisfaction (Patients / Clinicians))
- Clinical Outcomes ) Outcomes
- Organisational Outcomes )

Clearly the outputs and outcome metrics in service areas may be different and significant partnership working between Commissioners and Providers will need to be undertaken to ensure that the output and outcome metrics are measurable, challenging and improve significantly the patient outcomes experience of services. Providers will need to commit to three key output and outcome metrics in each of the above.

The PCT is also developing a systematic approach to satisfaction and clinical outcomes particular in relation to secondary care both acute and mental health providers in the next five years.

## 15. Strategy Implementation

### Structure for delivery

Across the health economy, the PCT is re-designing the interface between organisations, the people who work within them and the processes, which guide the patient through the system. The PCT as the strategic commissioner has a responsibility for ensuring commissioning works across the increasing number of organisations and individuals involved in Commissioning.

The PCT is currently reviewing its committee structure and it will be important that there is a clear line of accountability in overseeing the implementation of this strategy whilst also ensuring that there is close engagement with all clinical interests, patients and the wider public

## 16. Action Plan

Work streams	Actions	Timescales	Lead	Progress
<b>Governance</b>	<ol style="list-style-type: none"> <li>1. Agree Programme Board</li> <li>2. Agree membership</li> <li>3. Develop work programme and agree leads</li> </ol>	<p>Immediate</p> <p>Immediate</p> <p>May 2008</p>	Executive Directors	
<b>World Class Commissioning</b>  <b>Commissioning Service Strategy Development</b>	<ol style="list-style-type: none"> <li>1. Ensure fit of Strategy to World Class Commissioning</li> <li>2. Consider how strategy demonstrates meeting competencies and provider assurance.</li> </ol>	<p>Immediate</p> <p>Immediate</p>	Executive Directors	
<b>Performance Management</b>	<ol style="list-style-type: none"> <li>1. Embedding of five key output and outcome metrics</li> <li>2. Agree performance arrangements for all commissioned services</li> <li>3. Ensure systematic Clinical and Medical performance management</li> </ol>	<p>June 2008</p> <p>Ongoing</p> <p>Ongoing</p>	<p>Louise Pritchard</p> <p>Commissioning Managers</p> <p>Doug Wulff &amp; Richard Mendelsohn</p>	
<b>Procurement</b>	<ol style="list-style-type: none"> <li>1. Agree an overarching procurement strategy which creates a range of options for procuring new services over and above formal market testing</li> </ol>	3 <sup>rd</sup> July 2008	Jonathan Tringham	
<b>Market Development</b>	<ol style="list-style-type: none"> <li>1. Develop supplier strategy approach</li> </ol>	May 2008 onwards	Andrew Donald	
<b>Darzi Themed Areas</b> <ul style="list-style-type: none"> <li>• Staying Healthy</li> <li>• Children's Services</li> <li>• Planned Care</li> <li>• Acute Care (Unplanned)</li> <li>• End of Life Care</li> <li>• Long Term Conditions</li> <li>• Mental Health</li> <li>• Maternity &amp; Newborn</li> </ul>	<ol style="list-style-type: none"> <li>1. Development of service strategies and detailed individual commissioning intentions and service specifications</li> </ol>	May 2008 onward	Andrew Donald	
<b>Communication</b>	<ol style="list-style-type: none"> <li>1. Communication plan</li> <li>2. Develop and agree communication messages</li> <li>3. Run programme of communication events etc</li> </ol>	<p>June 2008</p> <p>June 2008</p> <p>June 2008 Onwards</p>	Louise Pritchard	

## 17. Conclusion

This is the revised Commissioning Strategy for BENPCT; over the coming months and years there will be the development of specific strategies for key areas of service which will inform commissioner priorities and decisions in those areas. In 2008/09, this will include Planned Care, Urgent Care, Long-term Conditions and Children's Services

This strategy has been written to clearly set commissioning in the context of the PCTs audacious goals, strategies and commissioning principles. It spends some time outlining the National and Local Drivers and suggests an approach to commissioning which is inclusive rather than exclusive. Increasingly more detailed plans will develop on Commissioners views based on feedback from partners, patients and the public.

DRAFT

**Appendix One**

# OSCAR Framework

## **O**rganisational

- Organisational and individual learning
- Skills development
- Network enlargement
- Working in partnership with other organisations

## **S**atisfaction

- Staff satisfaction (and satisfaction surrogates such as turn over rate with new model)
- Staff reported outcomes:
  - ❖ Job satisfaction
  - ❖ Patient satisfaction
  - ❖ Career progression
- Clinician satisfaction
- Patient reported outcomes:
  - ❖ Satisfaction
  - ❖ Preferences
  - ❖ Health related quality of life
- Client satisfaction

## **C**linical

- Clinical outcomes
- Health outcomes
- Generic and disease specific outcomes

## **A**ctivity

- Number of patients shifted from secondary / acute care to primary care /the community/the home
- Percentages of patients retained in the community and the percentage referred to secondary care
- Number of patients who didn't need to visit hospital.
- Number of clients accessing a new service

## **R**esources – Financial or Economic

- Cost models should be kept clear and understandable
- Clear, simple analysis of costs and savings are more meaningful
- Costs and savings should be included in the cost model
- Projects involving shifts in care typically entail increased resources at one point in the care path, and decreased resources elsewhere. All direct costs and savings to the NHS need to be considered. When finalising the cost models the emphasis will be on modelling the most significant costs.