KINGS FUND COLLEGE

IDEAS IN DEBATE

PURCHASING PATIENT CENTRED CARE

Integrated Primary, Secondary and Community Health Services

Christopher Heginbotham

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Each is issued to stimulate debate on a topic of importance
but where either insufficient work has been done to justify
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or the idea is in a stage of germination and needs wider consideration.

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Acknowledgements

This paper is the result of a number of discussions held during 1992, in particular a seminar facilitated by the author for the NHS Management Executive as part of the dissemination of lessons from the Localities Project.

The author wishes to thank all those who attended the seminar, especially Adrian Dawson, Max Millet, Laura Noel and Martin Roberts, and Ian Carruthers, Tom Dean and Doug Harris for their helpful comments. Dick Stockford, Ivan Ellul, Kathy Tyler, Helen Coley and Maggie Evans gave useful feedback.

Although preparation of the report was supported by the NHS ME, the ideas contained in the report do not necessarily reflect national policy and are put forward to enhance and encourage debate. Any mistakes or omissions remain the responsibility of the author.

Executive Summary

1. Purchasing patient-centred health (and social) care requires a deliberate focus on the patient through:
   - patient centred care planning in the primary care setting
   - close collaboration between purchaser's, GPs and the primary health care team
   - integrated health care provision
   - detailed casemix outcome measures
2. Eight possible ways are suggested for analysing service requirements in order to develop effective purchasing plans. Of these:
   - population 'need', and
   - care processes

   are recommended as basic building blocks in combination with
   - location of care, and
   - outcomes at each location
3. A fundamental change is required of purchasers and providers who must recognise the importance of the GP role in care planning, make that role explicit and support its development. This is called **patient centred care planning**.

1. Introduction

The impetus for this publication came from a seminar which was set up on behalf of the NHS Management Executive to investigate the lessons learned for the development of integrated purchasing from the Localities Project. The lessons fell into three broad areas as shown in Box 1

BOX 1

LESSONS

- Outcomes for Patients
- Expectations of the purchasing process
- Implications for provider development

Briefly, these included the following concerns:

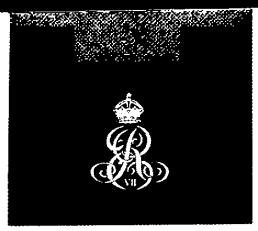
- **Outcomes for Patients**

  The core issue is how to achieve improved outcomes for patients from the health care they receive – or what is sometimes described as "health gain". As purchasing has gone beyond the initial stage of simple contracting, purchaser organisations are beginning to look critically at how to achieve improved outcomes for patients from the resources available for their health care provision.

  'Direct' health outcomes are already measured. These include screening results, especially breast and cervical cancer, immunisation rates and disease incidence, and chronic care outcomes such as in diabetes through improved detection and surveillance and thus prevention of blindness. Much more must be done, however, to provide detailed information to make commissioning effective.

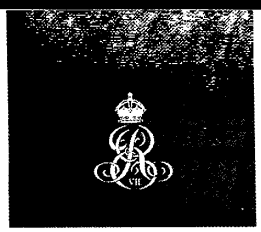
- **Expectations of the Purchasing Process**

  Achieving good outcomes requires a purchasing process which can identify marginal unmet need, translate need into workable service specifications, commission those services from appropriate providers with appropriate quality control and monitor the results. There is, therefore, considerable demand placed on the purchasing process if it is to be successful.



- **Implications for Provider Development**

  Effective purchasing requires both good relations with providers and provider development. Effective commissioning of services requires purchasers and providers to be responsive to changing needs with the development of new services and the continuation and possible closure of others. Many services will have to change in their orientation and approach to service users and develop an outcome oriented perspective. To do so will demand a new approach by providers to a user centred service.



2. What is 'integrated purchasing'?

Purchasing for integrated health care is less straightforward than it might seem at first sight.

A first difficulty is that the use of terms varies and agreed definitions must be found. Second, there is more than one dimension to the integration debate which should embrace all 'cross-care' issues. Third, the organisational, constitutional and cultural differences between health and social services create tensions; and the purchaser provider split, whilst encouraging creative thinking about service delivery can also be an obstacle to service development. However, the care management model is one which might profitably be borrowed from social care with suitable amendment.

Integrated purchasing requires a partnership approach between and within purchasers and providers and ideally across health and social care boundaries. Organisational obstacles must be minimised with a clear lead from RHAs through a "contract for action" process. Purchasing must also take place at the right geographical or community level and involve everyone who has a stake in the outcome. There is no short cut to explicit debate and no standard blueprint for local needs.

BOX 2

INTEGRATION REQUIRES:

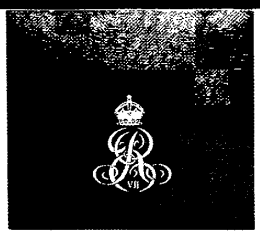
- Putting the patient at the centre of service delivery
- Making primary care the focus of health
- Shifting secondary care to primary care wherever possible
- Focusing on shared-care protocols

Principles for integration

Health care should be integrated around the patient and his or her needs; and thus effective purchasing must focus on the patient. This suggests that purchasing must place particular emphasis on primary care and the 'core' service with secondary care seen as an extension of primary care. This will require shared care protocols. To be successful it must also be based on a set of clear principles, of which the key points are set out in Box 3.

BOX 3

- Primary care should be the main focus of health care;
- Care and treatment should be provided in as local a community setting as possible;
- Individuals should take greater responsibility for their own health;
- Patients' own needs, not professional services or models, are the starting points;
- Secondary care exists to support primary care, not the reverse;
- A shared commitment to make every pound count for the local population is essential;
- Patient dependence must be minimised and autonomy and choice promoted;
- Integrated packages of care, across providers, and across social and health care, is the goal;
- Change for change's sake must be avoided;
- Specific initiatives must "make sense" in the wider context.



3. The Focus of Integrated Purchasing

Integrated purchasing requires a focus as close as possible to the patient. While integrated care does not mean only primary care, it suggests the need for an emphasis on primary care as the core of a health service, with secondary care as a support to primary care. This requires a focus on shared care protocols and a shift of care closer to the patient – from secondary into intermediate levels of care and into primary care, and within primary care from hospitals and general practice to home based services.

Many GPs will argue that primary care has always been the focus of health care, and the shift gives GPs a greater say in health service provision, and recognises their particular role (Box 4).

BOX 4

- Shifting secondary care towards primary care involves shifting focus of outcome to primary care.
- Quality and good outcomes must be maintained as this shift occurs.
- Outcomes obtained by services shifted to primary care may not necessarily be better but must be as good as those achieved in secondary care.
- Many outcomes are dependent upon shared care.
- It is important to build on what already exists.

Commissioning health care requires purchasing authorities to consider carefully the appropriate perspective to take. Box 5 shows eight approaches which might be adopted, ranging from the 'level of care' (i.e. primary, secondary or tertiary care), to the geographical configuration of provider units.

BOX 5

EIGHT WAYS TO FOCUS COMMISSIONING ACTIVITY

1. 'Level' of care
2. Provider/Service Configuration
3. Population
4. Care Groups
5. Care Processes
6. Providers Spatial Configuration
7. Specialties
8. Geography

Each of these approaches has its advantages and disadvantages and are set out in Annex 1. No one approach on its own is likely to be sufficient and two or three approaches in combination may produce the most appropriate process. The proposed arrangement which best suits the development of integrated purchasing is to link 3 and 5 (from Box 5) with the location at which specific care processes take place. A suggested process is shown in Diagram 1. This is as follows:

- **First** – Population need is described as appropriate to the locality by age, race and gender and by health care requirement, diagnosis or disease;
- **Second** – The location of care or the level (i.e. primary secondary, community) is described in conjunction with the care processes which go on at that location/level;
- **Third** – The outcomes are considered which are achieved by the care processes taking place at the particular location of care. Those outcomes are then matched to population need. This can be shown more clearly in Diagram 2. Need is translated through a matrix of location/care process. At each node of the matrix are outcomes which should meet the needs defined.

INTEGRATED HEALTH CARE

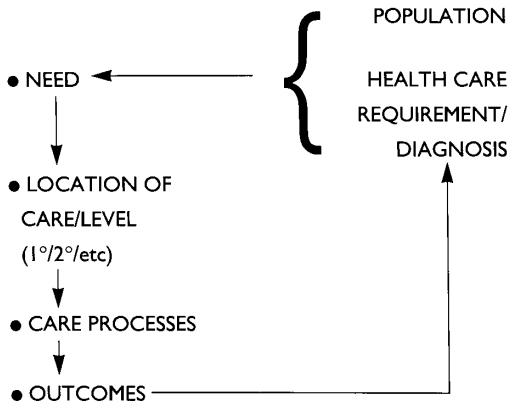
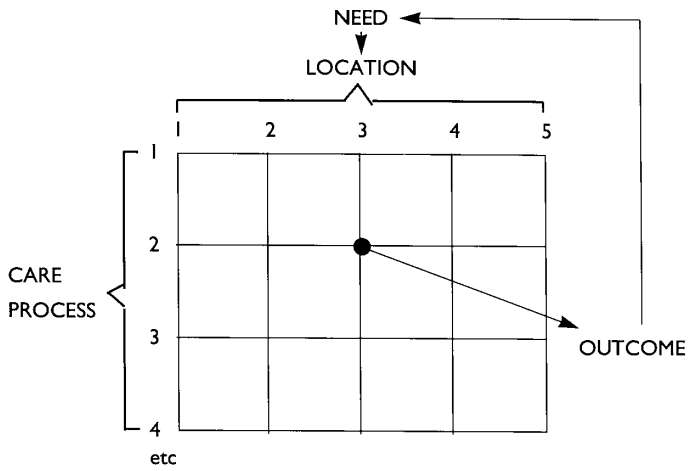


DIAGRAM 1



EACH NODE IS A CONJUNCTION OF 'LOCATION' AND 'CARE PROCESS' AND CREATES AN OUTCOME FOR THE PATIENT

DIAGRAM 2.

In this way, the various approaches to commissioning can be brought into a coherent process. Using this model, it can be seen that some of the approaches to commissioning are less useful than others. Provider/service configuration, care group designation, geography, specialties and providers' geographical configurations are less important than population need, care processes and location. Purchasing agencies will still have to take account of provider location and ensure that appropriate provision is made for care groups. The model suggests, however, that the main concerns are the care processes which go on to meet need associated with the outcomes achieved.

Purchasing agencies should thus focus on the processes of care which are required to deal with particular disease entities, disorders or health care requirements and find locations for those processes **as close to the patient as possible**. In other words, wherever possible those locations should be in a primary care setting. The constraints are obvious. The shift to primary care cannot be achieved where good outcomes cannot be guaranteed or where interventions cannot physically be undertaken in the primary care setting – for example, most forms of major elective surgery. However, the

model implies that the primary care focus becomes the point at which **patient requirements are managed**. Put another way, all interventions should be controlled and managed on behalf of the patient by the primary health care team under a process which might be called **patient centred care planning**.

The term care management has been widely used in relation to social and community care to be undertaken by local authorities. In this context, the term **patient centred care planning** relates to the provision of primary, community and secondary care, where the primary health care team acts as the health care manager, and in the case of fundholding GP practices is the purchaser of services for the patient during the time the patient requires care. Each episode is thus self-contained, but is managed throughout from the primary care setting (Box 6).

BOX 6

PATIENT CENTRED CARE PLANNING
STRENGTHS

- Similarity with care management in local authority community care (but must not be confused)
- Requires a sharing of objectives for patient care
- Places emphasis on the individual patient
- Supports the development of care profiling
- Generates a single document (patient held?) for communication between professionals
- Places GP/PHCT firmly in the role of patient advocate
- Links with patient focused systems being developed for secondary care
- Enables processes of care to be identified and provided at location which provides best outcomes/lowest cost

Patient centred care planning provides a route into integrated purchasing of primary, secondary and community health (and social) care. The challenge for purchasing agencies (including fundholding and non-fund holding GPs) is to find ways of commissioning health services via primary health care as a way of creating a managed package

of care for each patient episode. Implicitly this will provide leverage to push resources down to the primary care level, give a clear role to both fund holding and non-fund holding GPs and begin to define the relationship between GPs and district health authorities/family health service authorities.

Only an effective partnership between:

- the DHA (as secondary purchaser)
- the FHSA (as primary care purchaser – and ring holder for GPs), together with
- fundholding GPs as care managers with budgets, and
- non-fundholding GPs as major referral agents

working within the context established by the other parties, will a true primary care (and thus user/patient) centred approach be developed.

4. Making it happen

Developing integrated services demands a major cultural change – from a focus on specialty and professional, hospital based services, to one which places emphasis on the individual, the family, the home and work. Changing cultures is never easy even after the 'paradigm shift' of the NHS reforms. Some antagonistic attitudes have been created during the last three years, including:

- strong arm purchasers, alienating key providers
- NHS Trust and GP parochialism
- wasteful competition and duplication
- some superficial, short-term concerns

It is likely that only by developing a partnership approach, minimising organisation obstacles and developing a local framework will it be possible to create the right conditions for purchasing of integrated services to be successful. Those conditions are shown in Box 7:

BOX 7

- the creation and sustenance of a vision of local integrated services
- the establishment of realistic targets for change
- use of the contracting mechanism rigorously but strategically
- careful targetting of development monies
- development of clinical protocols with associated clinical audit.
- involvement of GPs/PHCT in the production of locality commissioning plans
- a careful balance of 'strategic commissioning' (DHAs/FHSAs) and 'operational purchasing' (FHGPs/PHCT) (see Diagrams 3 and 4)

DIAGRAM 3. Balance Strategic and Operational Purchasing

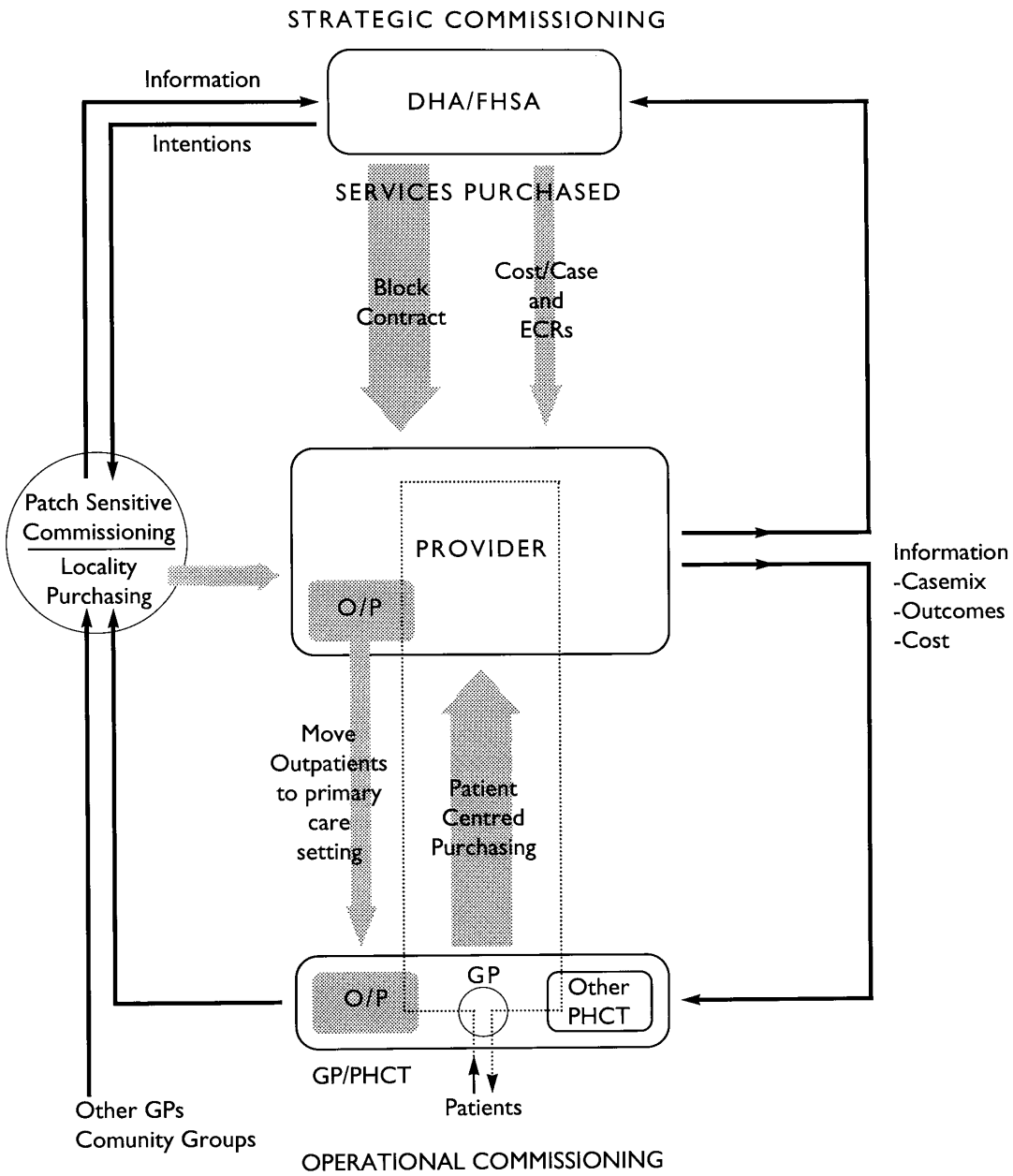

STRATEGIC COMMISSIONING
Information
Intentions
DHA/FHSA
SERVICES PURCHASED
Block Contract
Cost/Case and ECRs
Patch Sensitive Commissioning
Locality Purchasing
PROVIDER
O/P
Information
-Casemix
-Outcomes
-Cost
Move Outpatients to primary care setting
Patient Centred Purchasing
O/P
GP
Other PHCT
GP/PHCT
Patients
Other GPs
Comunity Groups
OPERATIONAL COMMISSIONING

DIAGRAM 4:

Purchasing authorities and fundholding GPs (together with other GP consortia) must work in tandem each supporting the other. GPs are crucially placed to obtain and provide essential complementary information to block or cost/volume contracts. In particular, GPs have a valuable combination of information as shown in Box 8.

BOX 8

GP INFORMATION AVAILABLE

- individual cost of treatment (including alternatives e.g. in the private sector)
- waiting times of different providers at the moment of needing treatment
- individual patient condition
- patient preferences for treatment/provider/location
- patient tolerance, including
  - quality of life prior to treatment
  - waiting time
- 'human scale' budget availability
- local political considerations

Integrated purchasing should thus result in organisations which are more capable of delivering focussed care (Box 9):

BOX 9

ORGANISATIONAL CAPABILITY

- better integrated and less compartmentalised
- susceptible to ideas from outside the health services
- have a wide local vision of services
- patient need focussed
- less professionally or clinically oriented

To be effective, purchasing should achieve a number of critical success factors (Box 10). In particular, purchasing should achieve some small but tangible improvements

and develop measurable outcome indicators which are used to target resources and monitor activity. Outcome measures must involve patient contributions and use simple quality of life measures relevant to patient lifestyles. **Patient responsive operational management** may be required, constantly obtaining feedback through reports and ratings of the care provided.

In particular, some form of **patient centred care planning** will be an essential component of a continuum of care. Fund holding GPs, especially, will have a crucial role to play in developing a primary health care team focus, assessing individual need, diagnosing illness and constructing and progressing a package of care to meet the patients' requirements.

BOX 10

CRITICAL SUCCESS FACTORS

What purchasing must be seen to have achieved in the medium term:

1. An evolving and dynamic *strategy* 'owned' by all local key players (by FHGPs, GPs, DHA, LA).
2. Development of the *primary health care team.*
3. An analytic approach with appropriate *evaluation* of care and cost effectiveness information.
4. Development of *protocols* for referral, admission and treatment agreed by key players.
5. Development of a number of *indicators* and targets for 'healthgain', starting with the 'givens' e.g. cataracts, hip replacements, CABGs etc.
6. Demonstrable *responsiveness* to patients and general public.
7. Development of a number of measurable quality standards linked to the *Charter.* Must involve GPs, be 'owned' and publicised.
8. Meet some *Health of the Nation* targets through an inter-sectoral approach.
9. Agreed procedures for *assessment and care management* for community care and ensure that clients are not in inappropriate settings.
10. Evidence of strategic *dis-investment,* with *re-investment* in new priority areas.
11. Agreement amongst major stakeholders that *purchasing/commissioning* is *valuable and viable.*

5. Conclusions and Suggestions

Integrated purchasing and patient centred care planning offer a radical challenge to traditional orthodoxy in patient management and provide a route forward for shifting the focus of care into the primary sector. However the proposals do require a number of fundamental issues to be addressed and resolved (Box 11); it is hoped that this paper will catalyse the necessary debate.

BOX 11

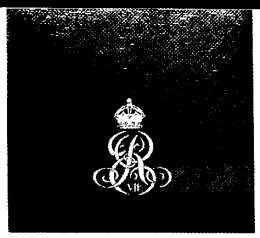
ISSUES IN PATIENT CENTRED CARE PLANNING

- How do purchasers specify the processes and the outcomes of care?
- How is 'success' measured from one case to another?
- Can and should GPs/PHCT take on the role of care co-ordinator/planner across primary, secondary and community health care?
- What further developments will be needed to establish this approach and will PCCP require education of patients and professionals?

Each of these issues demands innovation and levers to achieve change. Some of those levers may already be available to DHAs and FHAs; others may need to be negotiated. In this final section a number of suggestions are made for taking the issues forward.

5.1 Processes and outcomes of care

District Health Authorities and Family Health Service Authorities may need to place emphasis on process and outcome contracts. Work has already begun on cost/outcome contracts in some authorities. Particular emphasis is needed to specify the processes of care that will take place and to define those processes between different locations. Contracts will thus have to be negotiated jointly between GPs, other members of the primary health care team, community health service providers and secondary care hospitals. Simply tendering for elements of the care will not be sufficient. Development of agreed protocols between primary and secondary care will be an essential component from both a purchaser and



provider perspective. Purchasers require protocols to enable patient centred care management to be effective and to ensure that priorities are observed.

Effectiveness and outcome measures are being developed but are still little used for contract management. Utilisation review linked to resource allocation and outcomes achieved will be a challenge for the NHS in 1993 and beyond. Outcomes must be specified in relation to the processes of care and the location of that care (see Diagram 1 and Diagram 2). Integration of health care requires integrated purchasing activity and "integrated negotiation" whereby each provider in the network of providers can demonstrate:

- achievable outcomes for their component of the patient's care; and
- effective transition planning to enable smooth admission and discharge from one care component to another.

5.2 Success criteria

Recent developments in quality management and audit have demonstrated the importance of user and patient involvement in health service management. Purchasers and providers will continue to agree input and output measures such as waiting list and waiting time information. However, there is an increasing emphasis on patient responsive systems, such as the patient responsive management approach developed by Tom Delbanco and colleagues at Beth Israel Hospital in Boston, the patient focussed hospital developments exemplified by Central Middlesex and Kingston Hospitals in the UK, and consumer focussed quality audits such as that using the ENQUIRE approach (used extensively in Scotland and in a number of authorities in England and Wales). Each of these builds on consumer preferences and consumer reports of the service provided.

Auditing every individual case is impossible. Two approaches may therefore be needed:

- a proper sampling mechanism to ensure that individual cases are considered in some detail, usually through audit mechanisms;
- survey methodologies which ask all patients during a time period about their experience.

One effective way in which this is done is through a form of "priority search" in which a series of focus groups helps purchasers and/or providers to determine the most important questions with which consumers are concerned and then build those questions into a survey to be applied to a wider population of patients or service users. This approach has been used in North Derbyshire, in surveys undertaken by the purchaser health authority, and similarly is the basis of the patient responsive management questionnaire developed in Boston. That questionnaire is now being applied more widely in the UK by Prof. Nick Bosanquet and colleagues.

Consumers can also be involved in audit and quality assurance methods and form part of visiting or observational teams such as in the ENQUIRE process. In this approach, health service users become full members of a quality assurance team involved in ascertaining what is significant for patients about a service.

5.3 General practice and primary health care team roles

Developing **patient centred care planning** will place increasing importance on the role of the primary health care team and in particular on general practitioners. The benefits of **patient centred care planning** are that the GP will be able to follow the patient's pathway through the service. For GP fundholders, this will provide important information about the staging of a patient's care and the outcomes achieved at each point. The development of protocols incorporating flow charts and pathways will make explicit the care provided by different components of the service. GPS will come to be seen less as 'gatekeepers' to secondary care, and more as 'pathfinders' for appropriate care.

In areas where there are now, or are likely to be, few fundholders, it may be possible to develop consortia of GPs that will take on delegated commissioning budgets from District Health Authorities. The idea of 'managed commissioning' supported by DHAs or FHSAs but under the control of GP consortia is being developed in a number of Health Authorities (e.g Bath). Such consortia would have the same incentive to develop protocols and pathways as fundholding general practitioners.

Further incentives might be provided by DHAs and FHSAs to fundholders and

consortia by offering additional or enhanced direct access services such as physiotherapy, occupational therapy, psychology and audiology.

Extending the primary health care team and developing patch/locality commissioning offers an opportunity to provide a patient focused service. Additional management and administrative support may also be required, and in the longer term enhanced GP training and selection will be necessary.

5.4 Further Developments

A number of other developments may assist the establishment of patient centred care management. The Tomlinson Report on the future of London's health care puts great emphasis on the development of the primary health care team and proposes the establishment of "primary care development zones". These, together with GP consortia and locality commissioning, clearly provide a context in which patient focused services can be developed. Although nurse prescribing has been put on the back burner nationally for the time being, nurse prescribing pilots might be run in conjunction with primary care developments as a way of ensuring maximum flexibility within the primary health care team.

Effective purchasing is now firmly on the national agenda and a number of purchasing authorities are beginning to make significant strides. Some, such as Dorset, are developing highly innovative ways of moving resources to the primary care team. The more that resources are invested in primary care, the more it will be essential (rather than desirable) for GPs and the PHCT to take on a care management function. If secondary care is genuinely a support to primary care then the power and control traditionally exercised by the hospital must be diminished and that control handed to the primary health care team.

In summary, purchasers must address the key points shown in Box 12.

BOX 12

- Develop close and detailed working relationships with GPs, directly with fundholding practices and with consortia of smaller practices.
- Establish protocols between primary and secondary care to bring together:
  - casemix information
  - outcome measures
  - component processes of care
  - location nearest to patient
- Assist and support GPs and the PHCT in developing **patient centred care planning**.
- Encourge hospital consultants and GPs to develop improved communication mechanisms.

Annex

	STRENGTHS	WEAKNESSES
1. LEVELS OF CARE Prevention Primary Care Secondary Care Tertiary Care Palliative Care	• Works when matched with breakdown of population • Good for assessing need when matched with population • Useful for *analysis* across care groups or conditions • Links to policy areas, e.g. strengthening primary care	• Will inhibit looking at integration primary/ secondary care unless matched with population focus • Definition of primary, secondary, etc. are unclear

	STRENGTHS	WEAKNESSES
2. PROVIDER/ SERVICE CONFIGURATION (a) Primary Care (b) Priority Services (c) Acute Services	• Is simple and straightforward • Reflects current contracting arrangements • May be a forerunner for provider geographical configuration	• Will inhibit looking at integration • (b) can cover full spectrum of care whereas (a) and (c) do not • Does not match the developing policy agenda

	STRENGTHS	WEAKNESSES
3. POPULATION Children Adolescents Adult Men Adult Women Elderly People Ethnic Minorities	• Good for assessing need • Can be matched with *all* other sets • Helps to see the whole person • Good for looking at integration	• Ethnic minorities duplicates other groups but is a necessary focus

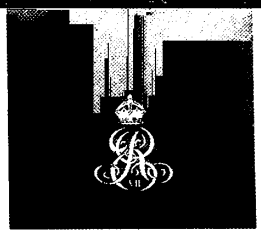
	STRENGTHS	WEAKNESSES
4. CARE GROUPS (a) Children (b) Women (c) Elderly (d) Physical Disability (e) Learning Difficulties (f) Mental Health	• Works if matched with care process and population • Good for integration across care groups • Need to see service plans across each care group, i.e. analysed by care process	• Where do adult men fit in? • Duplication between a/b/c and d/e/f • Tends to marginalise primary care • Confusing mixture of population groups and morbidity groups

	STRENGTHS	WEAKNESSES
5. CARE PROCESSES Prevention Diagnosis Treatment Rehabilitation Respite Continuing Care Palliative Care	• Can be matched to location of care (and possibly to level) • Works when matched with population • Good for assessing need when matched with population	• May inhibit looking at integration or primary/ secondary care unless matched with population focus • Insufficient on its own • Needs considerable analysis of care processes for sets of intervention

	STRENGTHS	WEAKNESSES
6. PROVIDERS / SPATIAL CONFIGURATION Locality (primary care) Internal Providers External Providers Localities could be a mixture of this and overall geography	• Good for provider development • Analysis essential to implement purchasing plan, i.e. service options and contracts • Can reflect actual 'competition', substitutes and options	• Not useful for needs assessment • Not particularly helpful except in large conurbations (e.g. London) • Insufficient detail for generating strategic shifts on service patterns

	STRENGTHS	WEAKNESSES
7. SPECIALTIES Medicine Surgery Obstetrics and Gynaecology Orthopaedics Elderly Paediatrics ENT Urology Psychiatry	• Can follow a condition over time and compare effectiveness of intervention, i.e. matched to kinds of care and care processes • May be effective if sets of *conditions* used instead	• Tend to see a condition rather than a personn • Emphasis on acute/medical model, i.e. how does disability fit in? • Emphasis on sickness and intervention rather than health promotion

	STRENGTHS	WEAKNESSES
8. GEOGRAPHY Locality Borough Agency Regional National	• Can be matched with Care Groups or population to inform contract configuration/ VFM • Use to identify effective levels of needs analysis • Localities suitable for high percentage of service specifications, i.e. non in-patient • Important in developing 'path sensitive' commissioning	• Good for *analysis* but not for organising job roles • Difference between localities usually swamped by 'givens', e.g. national targets



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