Purchasing Innovations

* Advancing the process of purchasing locally
* Improving health and health services
* Enabling others to progress

IMPROVING HEALTH THROUGH LOCALITY COMMISSIONING

Notes from a National Workshop in the
Purchasing Innovations Series, 14th June 1994,
National Motorcycle Museum, Birmingham

Contents

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KINGS FUND

MAPPING ISSUES IN THE DEVELOPMENT OF LOCALITY COMMISSIONING

David Towell/Richard Poxton

'Locality Commissioning' is an idea in good currency, in the sense that a significant proportion of health authorities are actively engaged in exploring different routes to achieving decentralisation in commissioning, understood in its broadest sense. This trend is partly driven by the need to adapt to the growth of GP fundholding but also reflects the wider aspiration to develop health services which are more responsive to the needs of small populations in a period when the overall size of health authorities has grown considerably.

As these points suggest, locality commissioning is a 'means', not an end in itself. A crucial starting point for the development of locality commissioning needs to be careful articulation of the aims which these processes are designed to achieve.

Such aims include:

* Improving NHS responsiveness, i.e. services which are more appropriate and effective in meeting needs, more efficiently provided and more easily accessed by users.

* Providing a vehicle for listening to local voices.

* Developing more sensitive ways of identifying and promoting the potential contribution of providers (particularly small agencies).

* Establishing ways of linking directly to local authority commissioning (especially Social Services care management arrangements) so as to permit collaborative commissioning of 'packages of care' designed for individuals.

* Enabling closer collaboration with general practices (whether or not, fundholding) so as to link health authority and practice contributions to commissioning for the practice population.

Clarification of aims is just the most basic of several elements in the strategies required to develop effective locality commissioning, the most important of which are represented schematically in the figure.

Interest in this idea brought thirty managers from DHAs and FHSAs across the U.K. to the first workshop in the current King's Fund "Purchasing Innovations" series. All were actively involved in developing locality commissioning in their authorities and several had relatively new posts with 'locality' in the title.

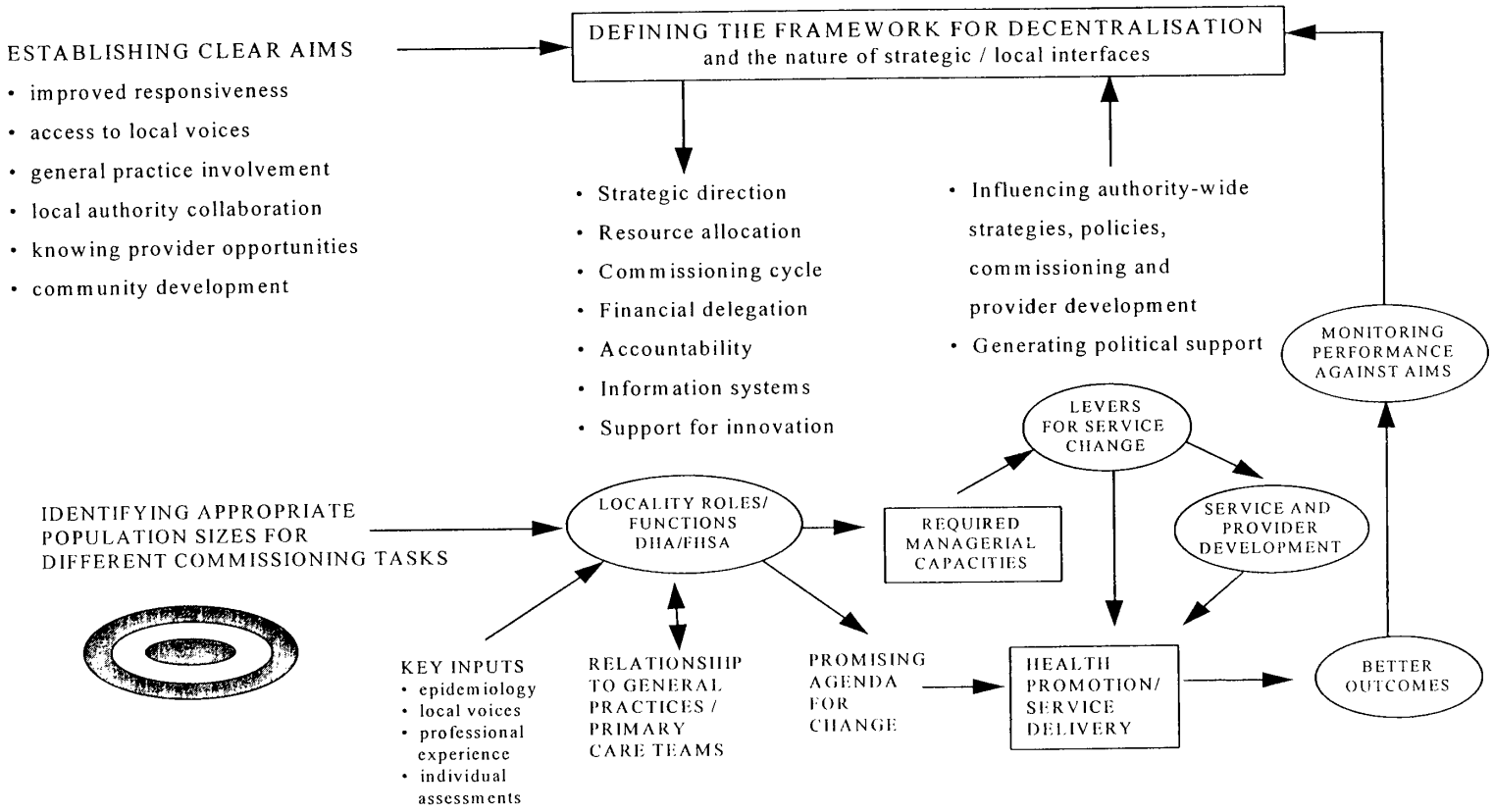
From the discussion it was clear that all faced significant challenges and choices in translating the rhetoric of 'locality commissioning' into meaningful practice. Indeed perhaps the most general conclusion from the day is that, as with commissioning more broadly, most of us are at a fairly early point on the developmental trajectories required to build effective working models, which will need to evolve both in scope and sophistication over a period of years.

The workshop heard from three main contributors on experience to date in their authorities.

Samantha Ward described how in County Durham a long history of social and economic change in the traditional mining villages, which with the 1960s new town of Peterlee make up Easington District, has produced a breakdown in communities and poor general health, all of which suggested the importance of a more participative and holistic approach to meeting local needs. Responding to this challenge, the NHS has decentralised total commissioning budgets to the local level and joined forces with the other public authorities including the county and district councils to develop collaborative commissioning across this broad agenda for health and well-being.

IMPROVING HEALTH THROUGH LOCALITY COMMISSIONING

Making choices and integrating key elements in an evolutionary strategy for successful model building



Mark Charny, from the Health Commission for Wiltshire and Bath, argued the merits of a different approach which takes as its starting point the centrality which general practices as both an administrative unit and a core service to a defined population already have in the local NHS. 'Practice-based commissioning' exploits this centrality by seeking to make primary care teams the focus for contracting services to the practice population while the Health Commission establishes contracts for health with these teams.

Adding to this sense of different starting points, Alan Talbot described how in Birmingham the trigger of some 'new money' for primary care development has been used to stimulate joint approaches to commissioning at the level of parliamentary constituencies, within a clear strategic framework which spells out criteria for assessing success.

'Overheads' from these three contributors are attached as an 'aide memoire' for workshop participants (although it needs to be confessed that, separated from the eloquence of these speakers, they may communicate rather less to readers of these notes who were not present).

One crucial - and unresolved - debate arising from these contributions focused on the question of how far general practices could become the linchpin of decentralised commissioning, some participants following Mark Charny in suggesting both the relative simplicity and efficiency of this approach while others drew attention to the variable orientations and organisational characteristics of different practices, cautioning therefore against putting all the commissioning 'eggs' in the G.P. 'basket'.

The workshop split into smaller groups for more detailed discussion of local experience, starting from three different elements in the figure (preceding):

* Defining the strategic (including financial) framework for decentralisation

* Identifying the job functions and managerial capacities required of leadership at the locality level

* Drawing lessons about effective ways of working with general practices

Reporting back on these discussions, a number of pointers emerged about what is involved in making local progress. These include:

i) It is essential to recognise that successful implementation of decentralised commissioning represents a substantial medium - term challenge in the current state of the NHS: it is important therefore to plan for an evolutionary process; recognise the barriers to progress and create realistic expectations in the short run.

ii). Not withstanding ' commissioning theory' (ie. start from population needs and work through to new patterns of services) it is probably wise in most situations not to start from a 'zero base' but rather to look for promising agendas and useful menus in the light of wider experience which might permit some useful gains (ie. defined by better health outcomes) early. (For example, the King's Fund joint commissioning project on services to elderly people and their carers is identifying a range of specific innovations which meet known gaps and weaknesses in existing services).

iii) At the same time it is also clearly essential that as locality commissioning evolves, appropriate methodologies are introduced both to establish shared 'visions' of the optimum patterns of support to local people and to ground commissioning in small population epidemiology (for example, using the Community Oriented Primary Care approach)

iv) The development of locality commissioning requires both a strategic framework (see figure) , without being 'top down', and local creativity, without being 'bottom up'. The 'top down' model risks damage to local

innovation through the inappropriate intervention of 'high level' management; the 'bottom up' model risks a lack of focus or sustainability. Instead experience suggests a 'negotiating' model of development in which strategic authorities seek to promote local innovation within conditions and parameters which are jointly agreed between 'centre' and 'periphery'.

v) In this context, both the 'centre' (ie. authority level) and periphery need to address concerns about public accountability and ensure that 'members' are involved appropriately.

vi) Developing locality commissioning in conjunction with local authorities (particularly perhaps the care management arrangements in Social Services) adds considerably to the complexity but also to the potential gains: the key question here is the breadth of the agenda which decentralisation is designed to address (witness the Durham example), and the scheduling which will enable complex issues to be addressed incrementally.

vii) Whatever the local stance on the main debate identified above, winning as far as possible the interest and active involvement of both general practices and wider primary care teams is an essential stimulus to effective locally-sensitive commissioning.

viii) All this requires significant managerial capacity to be exercised at the locality level ie. in involving relevant stakeholders, developing needs assessment, defining new service patterns, influencing providers, monitoring progress, enhancing the capacity to do these things and relating all this to strategic intent.

ix) Success is only likely in this context if we can engage with the reality of local development (rather than the rhetoric) and learn from our own and other people's experiences of taking this agenda seriously.

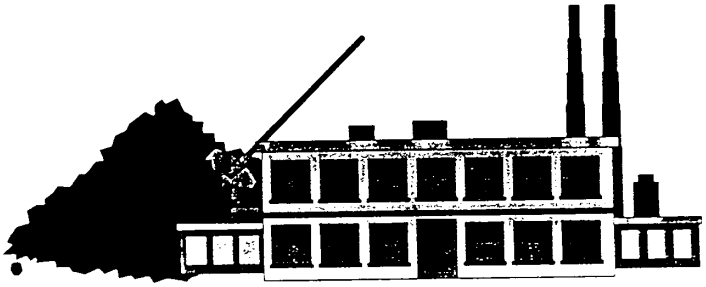
With this last point in mind, the King's Fund College agreed to organise a follow-up event (scheduled for 24 November) to review progress with workshop participants and others engaged in developing locality commissioning, and to help facilitate smaller mutual aid networks of managers who would like to meet with colleagues more regularly to share different local experiences.

PURCHASING INNOVATIONS WORKSHOP
KINGS FUND COLLEGE

SAMANTHA WARD
LOCALITY DIRECTOR - EASINGTON
COUNTY DURHAM HEALTH COMMISSION

WHAT ARE WE DOING IN EASINGTON?

- County Durham Health Commission: creating **LOCALITY** teams
- Established the Easington Joint Commissioning Board
- Reflecting the local environment, health and lifestyles
- Working on the patch
- Listening to local voices - planning the golden future



WHY ARE WE DOING IT IN EASINGTON?

SOCIAL NEEDS

- Economic degeneration
- Breakdown of local communities
- Loss of social structure
- Geographically remote
- Poor infrastructure
- Lack of enterprise

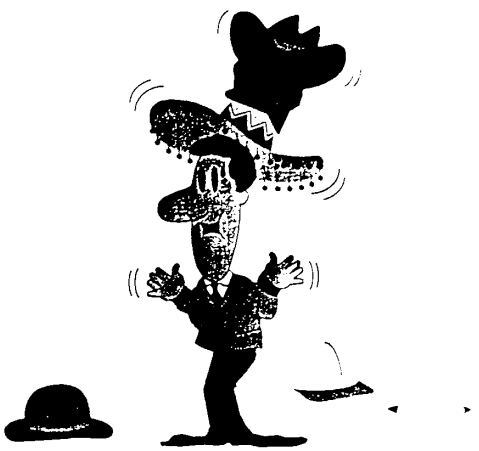
HEALTH NEEDS

- Poor health awareness
- Health Authority pass-the-parcel
- Increasing elderly population
- Increasing < 5 population
- Drugs & Sexual Awareness
- Mental health problems
- Supporting the carers

HOW ARE WE DOING IT IN EASINGTON?

LOCALITY TEAM

- Locality Director, Deputy & PA
- Responsibilities across all aspects of healthcare - GMS & HCS
- Budgetary responsibilities
- Planning & Commissioning
- Focus on the patch
- Managing the balance between locality & centre
- Challenge of joint commissioning



HOW ARE WE DOING IT IN EASINGTON?

ENGAGING THE LOCAL PEOPLE

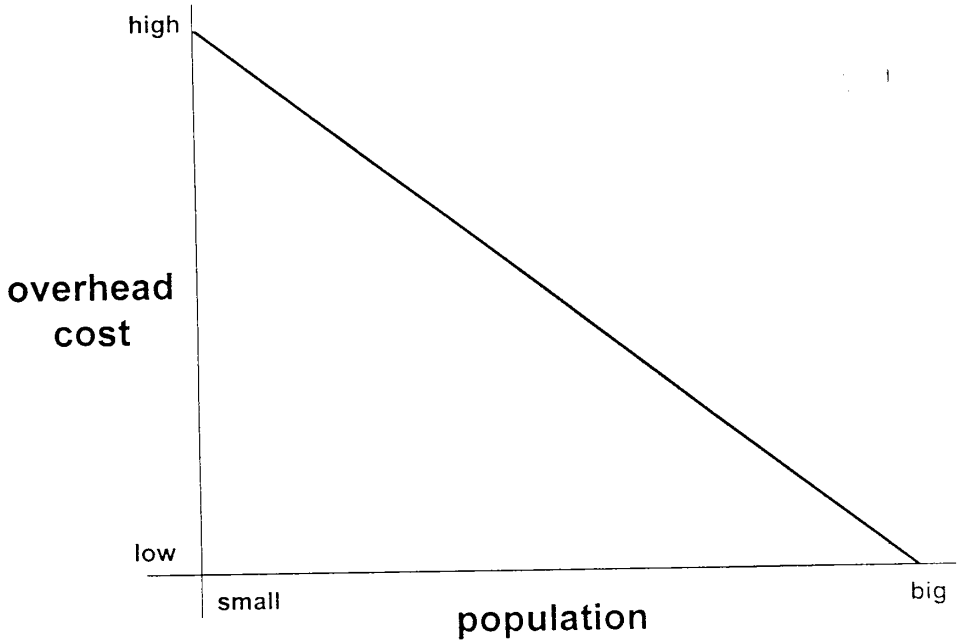
- Using the JCB
- Creation of 8 Local Planning Groups
- Multi-agency membership
- Local experts NOT representatives
- Search conference, public consultation and surveys
- Complementing local knowledge

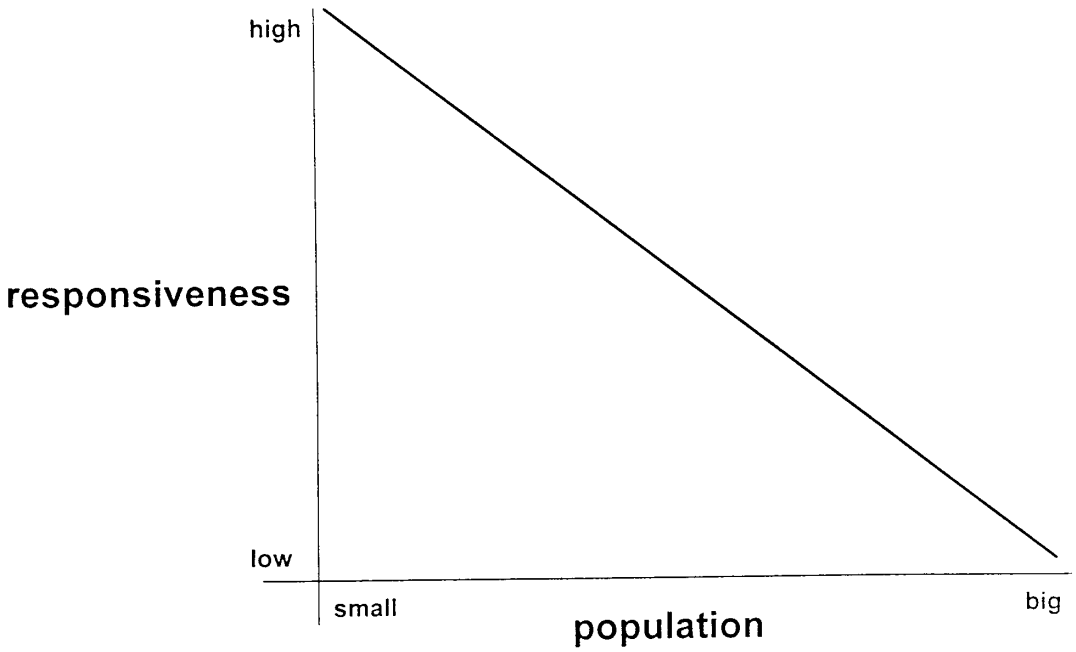
EASINGTON - THE STORY SO FAR

- Centre of attention
- Created expectation - maintaining the momentum
- Some successes - expenditure directed through LPG's
- Highlighting tensions and frustrations
- Hard work and ever increasing agenda
- Keeping the level of detail right
- Working relationships being worked at

PURCHASING INNOVATIONS WORKSHOP
KINGS FUND COLLEGE

MARK CHARNY
DIRECTOR OF PUBLIC HEALTH
WILTSHIRE HEALTH COMMISSION


high
overhead cost
low
small
big
population


high
responsiveness
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small
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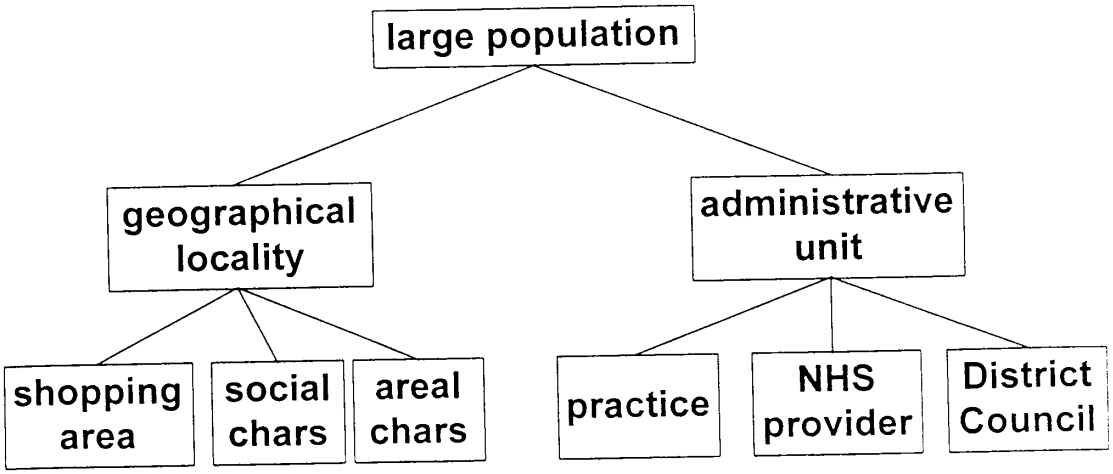
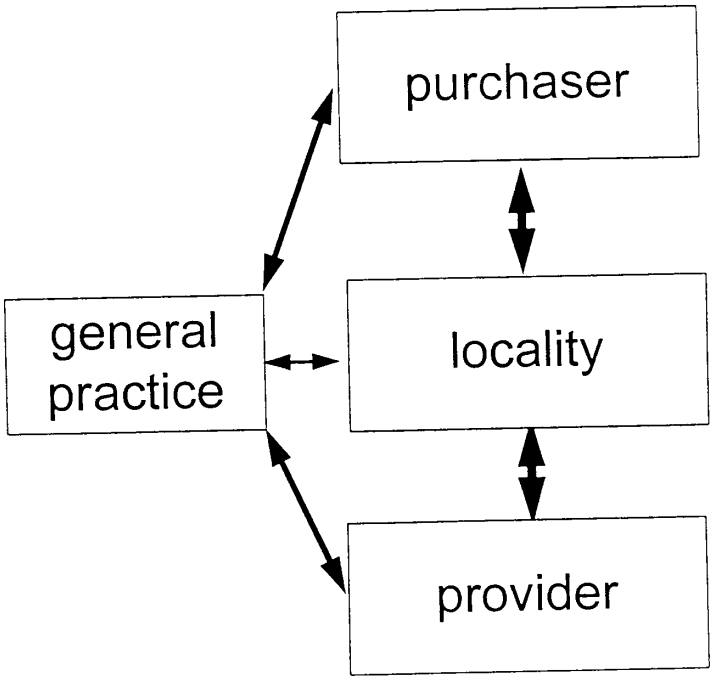
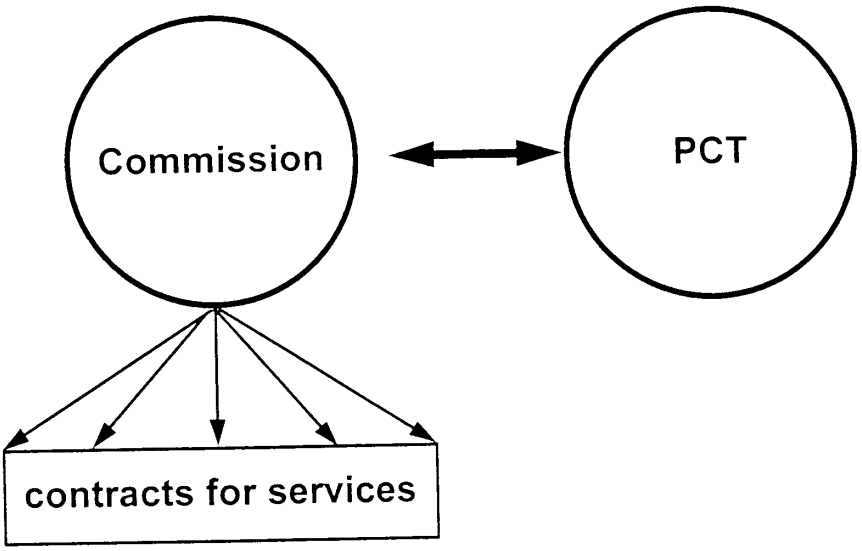
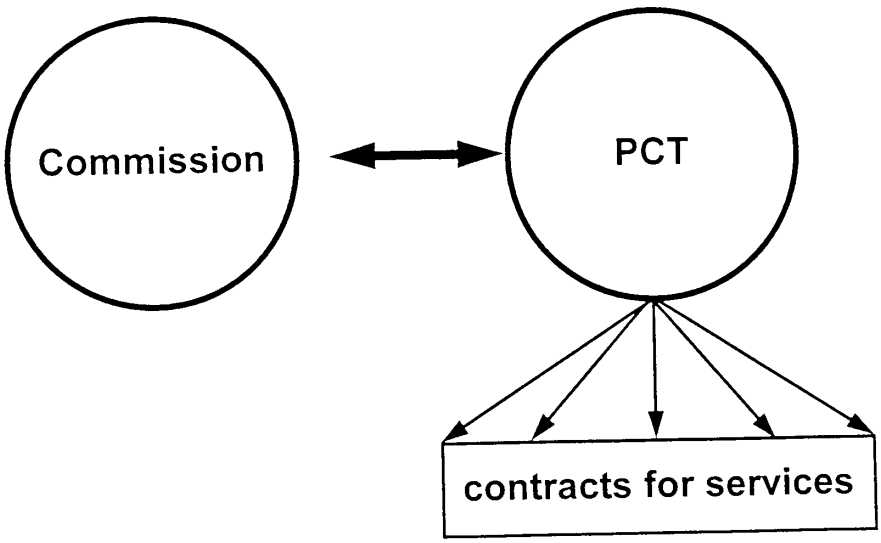
population

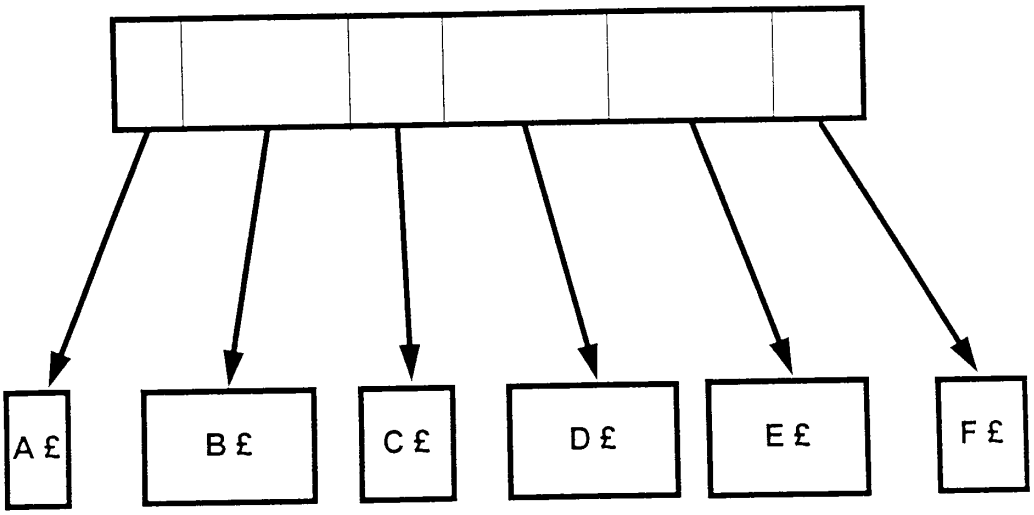

large population
geographical locality
administrative unit
shopping area
social chars
areal chars
practice
NHS provider
District Council


purchaser
general practice
locality
provider


Commission
PCT
contracts for services

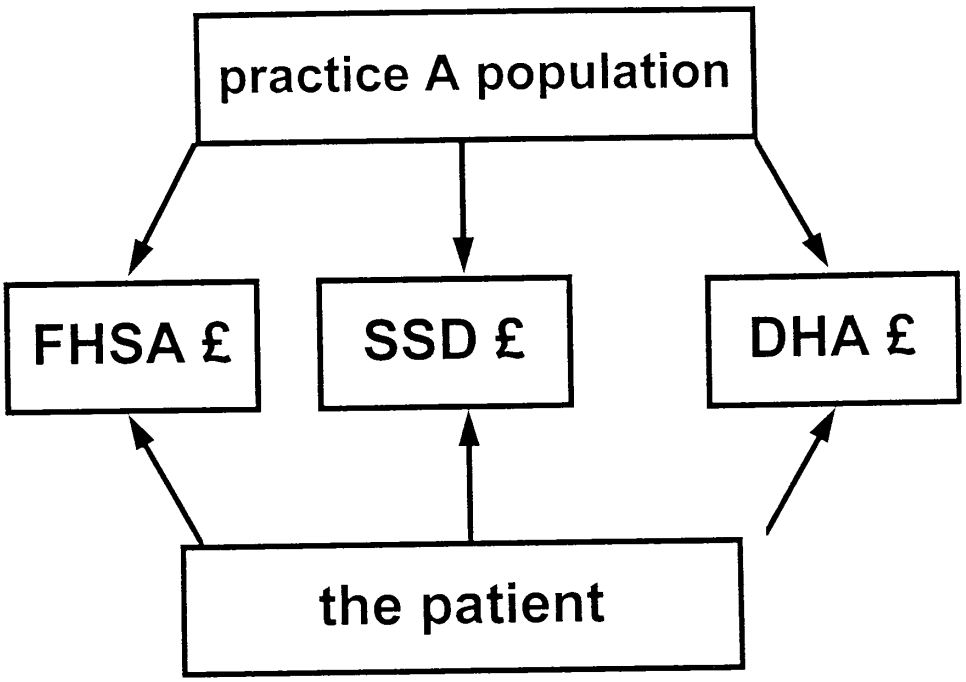

Commission
PCT
contracts for services

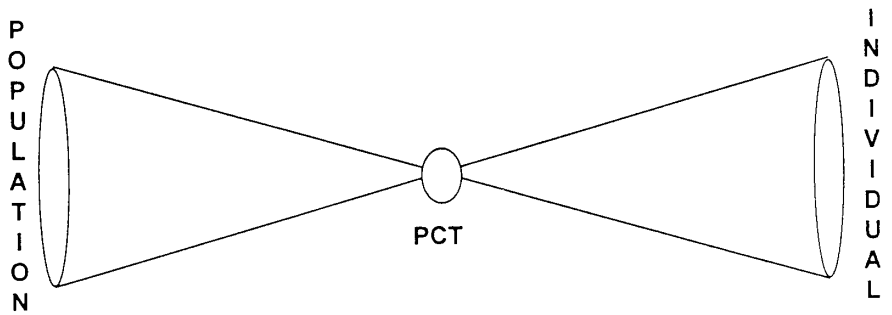
commissioning resources

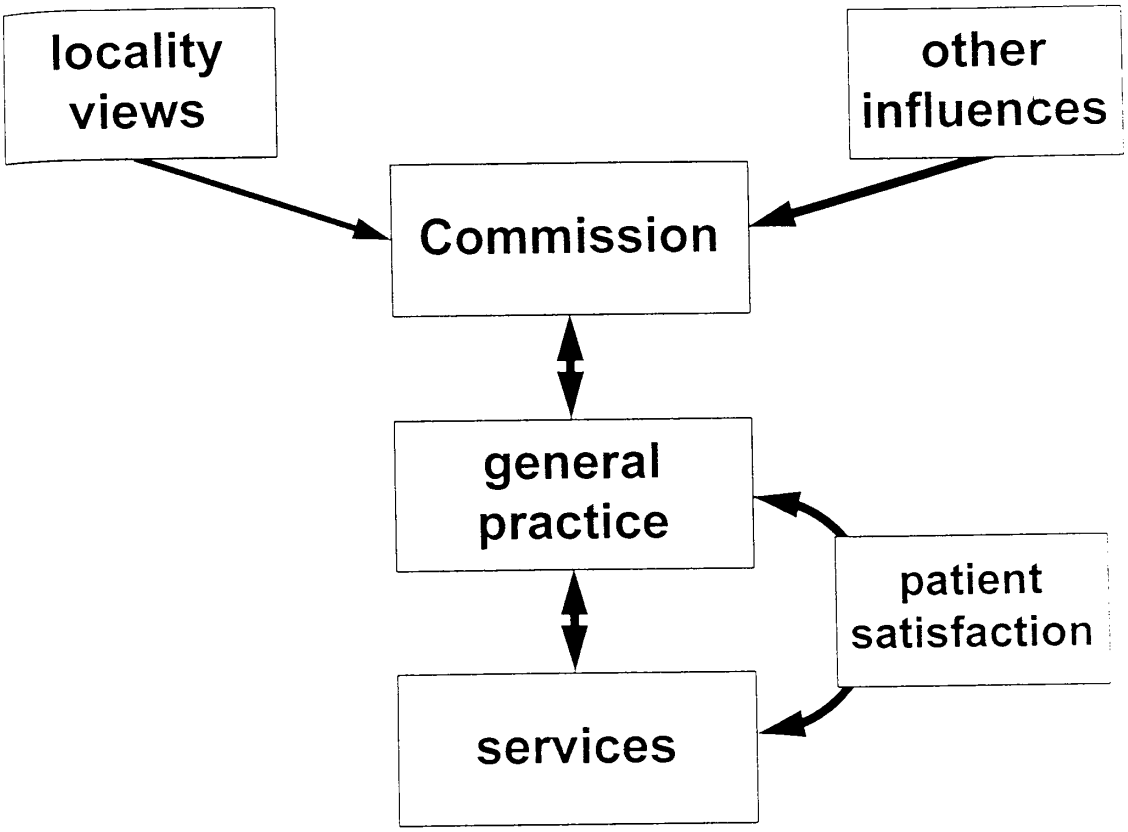


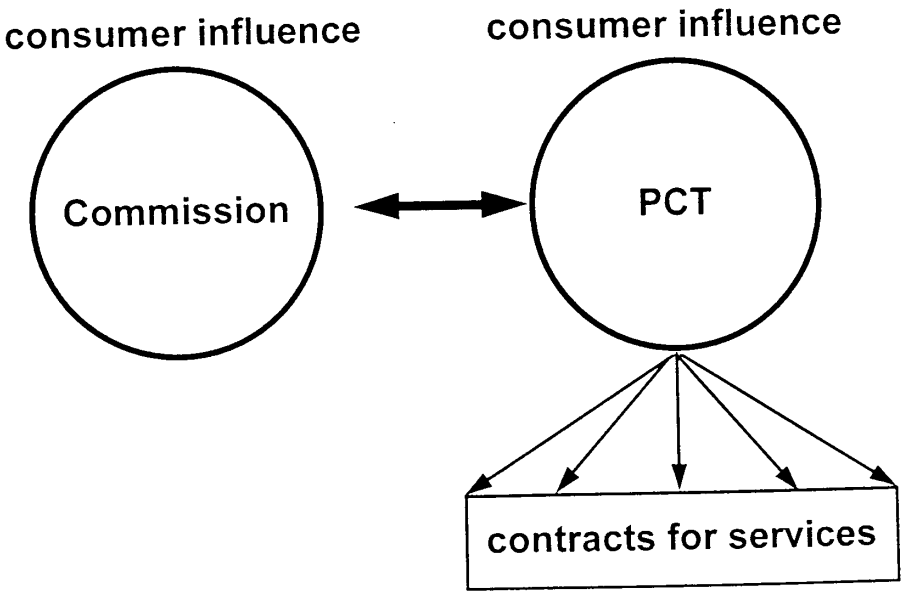
the PCT is an obvious choice

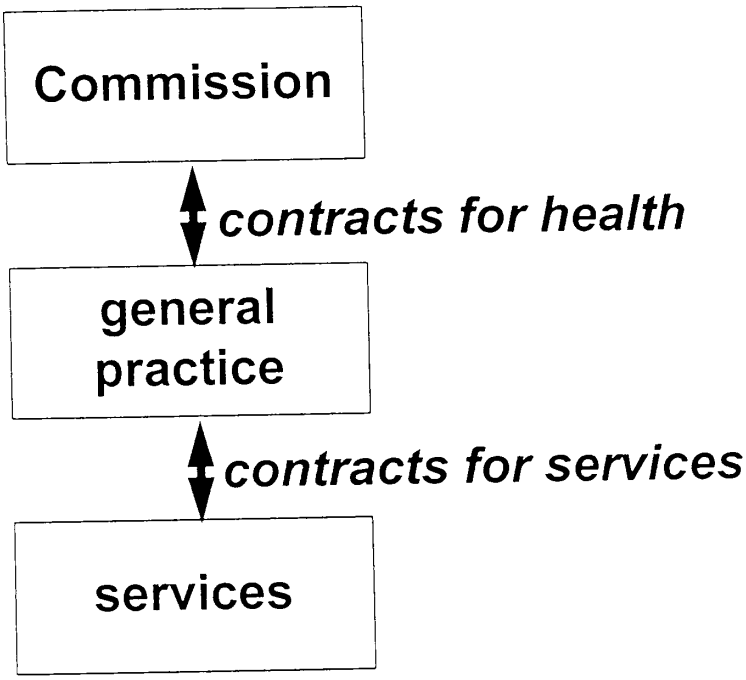
- gatekeeper role
- agent for secondary care
- knows the individual
- knows the social circumstances
- knows local opportunities
- knows local problems
- knows available skills

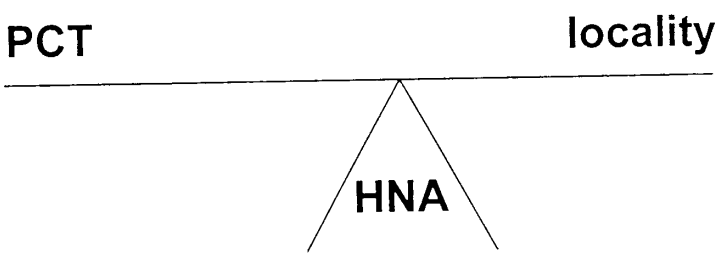

practice A population
FHSA £
SSD £
DHA £
the patient


POPULATION
PCT
INDIVIDUAL

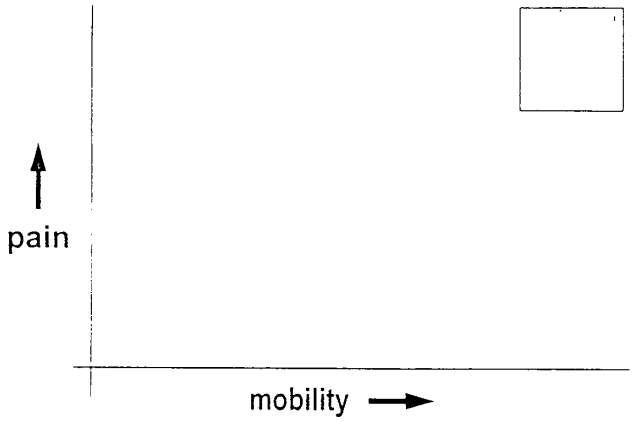

locality views
other influences
Commission
general practice
patient satisfaction
services


consumer influence
consumer influence
Commission
PCT
contracts for services

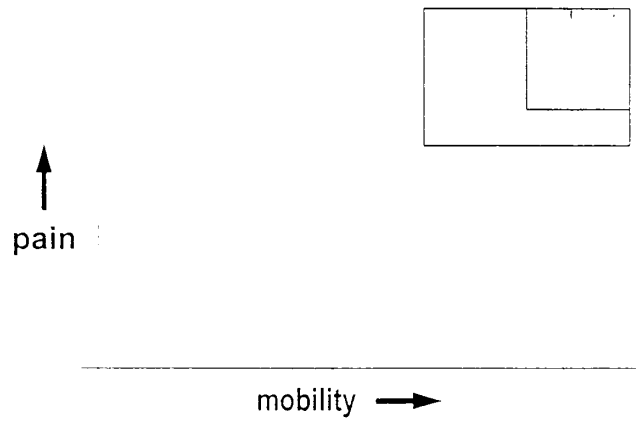

Commission
contracts for health
general practice
contracts for services
services


PCT
locality
HNA

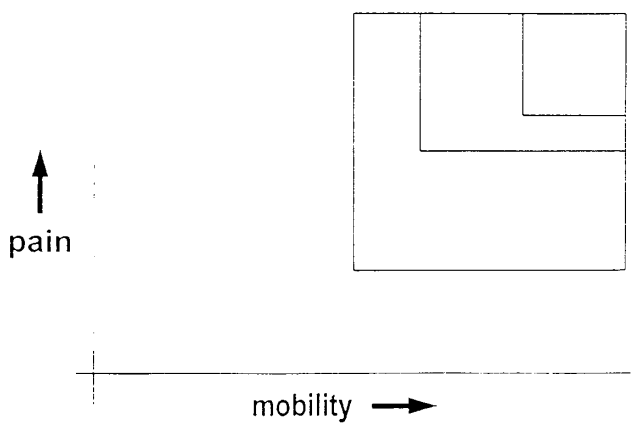
How many hip replacements?

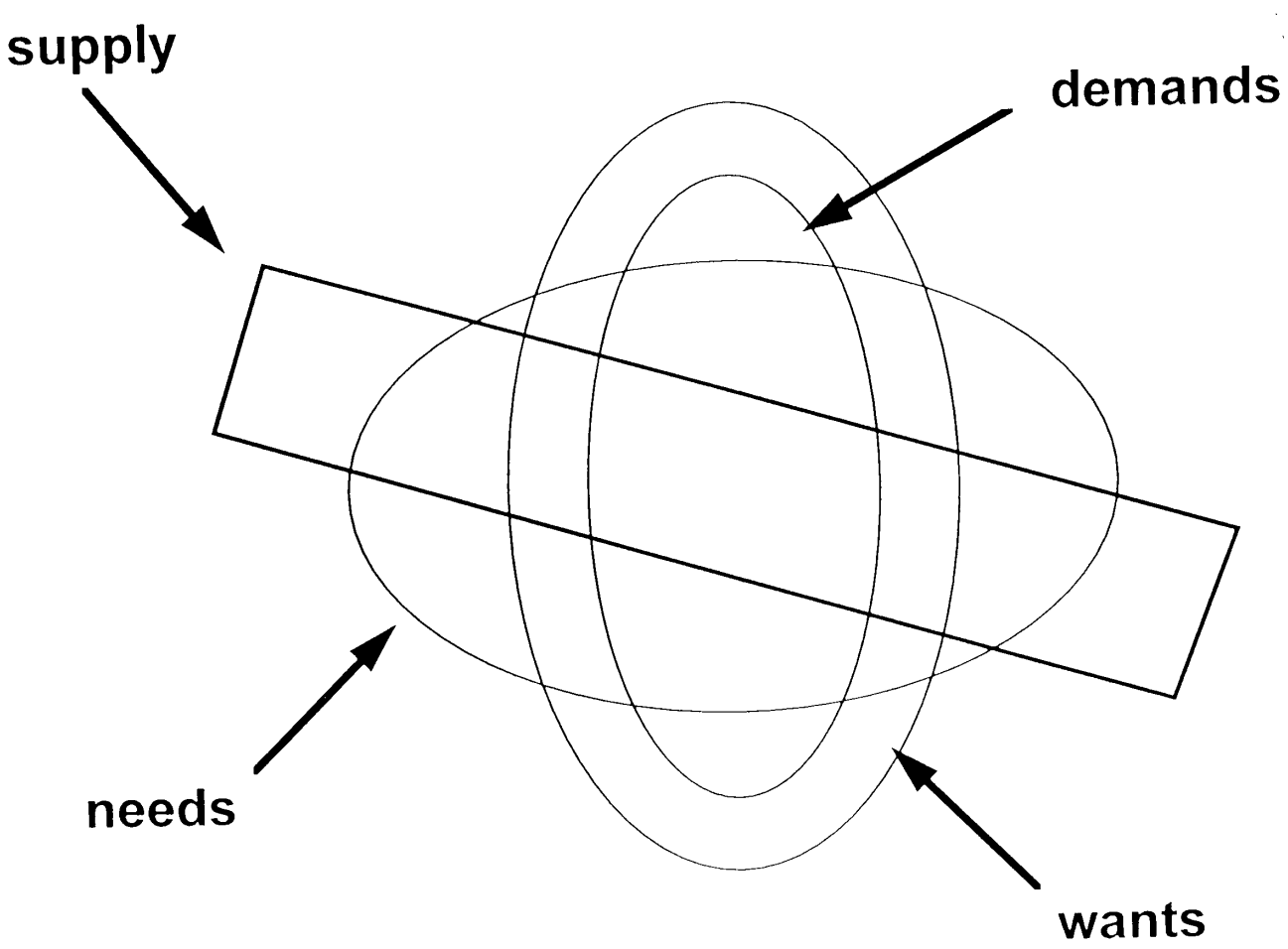


How many hip replacements?



How many hip replacements?




supply
demands
needs
wants

PURCHASING INNOVATIONS WORKSHOP
KINGS FUND COLLEGE

ALAN TALBOT
CHIEF EXECUTIVE
BIRMINGHAM FAMILY HEALTH SERVICES AUTHORITY

Birmingham Context

- Differential and increasing health needs
- Traditional hospital focus
- Joint agency approach to primary care
- Joint commissioning of primary health care
- GP and GPFH development
- Configuration of Trusts
- Primary care investment

Birmingham
family Health services

Developing Primary Care in Birmingham - a Locality Approach

- Birmingham context
- Constituencies
- CATs
- Involving local people
- Top-down/bottom-up
- Achieving change
- Measuring success

Birmingham
family Health services

CATs

- Local representatives of agencies and patient representation
- Power to get things done
- Forum for local dialogue, including HA and LA networks
- Strong desire to get on!
- Use of 'small grants' budget

Birmingham
family Health services

Constituencies

- Consensus of all agencies
- DHA purchaser development?
- Capacity to track health needs and changes
- Area for purchasing services as well as managing provision

Birmingham
family Health services

Top-down/bottom-up

- Strategy versus local action
- Equity of investment in each constituency
- "Purchaser" versus "provider" local knowledge
- Investment - speed versus quality

Birmingham
family Health services

Involving local people

- CHC input to CATs
- Each project to be tested
- CATs managing local community demands and interests
- CATs facing agency priorities against local perceptions of needs

Birmingham
family Health services

Measuring success

- Results
  - health change
  - cost effective
  - local priority needs
  - equity
  - sustainable
- Behaviour change
  - clinical practice
  - consistency and continuity
  - public and professional attitudes to primary care
- Agency contributions
  - re-orientation of investment
  - illness prevention
  - LA contribution as important as Health
- GP involvement
  - clinical changes
  - needs of local areas
  - working together
  - working with others

Birmingham
family **Health** *services*

Achieving change

- Investment in additional services
- Investment to re-orientate services
- Product champions
- Piloting/evaluating/generalising
- Range of investments (£ few → £1m +)
- Changing practice
- Purchaser and provider commitment

Birmingham
family **Health** *services*

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Chief Executive, Birmingham Family Health Services Authority

SAMANTHA WARD
Locality Manager, County Durham Health Commission

DR. DAVID TOWELL
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Facilitating throughout the day were:

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Fellow and Director of Purchasing Innovations Project, King's Fund College

STEVE MANNING
Fellow, King's Fund College

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Purchasing Innovations Network Co-ordinator, King's Fund College

PURCHASING INNOVATIONS
DATABASE

Entries relating to:

LOCALITY COMMISSIONING

Listing only

(abstracts will be available at the workshop)

May 1994

LIST OF DATABASE EXTRACTS
LOCALITY

Abstracts will be available at the workshop

TITLE OF INITIATIVE	HA / FHSA
Aldershot Locality Purchasing Consortium	North & Mid Hampshire Health Commission
A31 Locality Purchasing Group	North & Mid Hampshire Health Commission
Development of GP Locality Groups	Lothian Health Board
Localities Project	Walsall Health Authority
Locality Commissioning	Portsmouth & SE Hampshire Health Commission
Locality Liaison	Shropshire Health Authority
Locality Link Offices	North Nottinghamshire Health Authority
Locality Links	North Derbyshire Health Authority
Locality Sensitive Purchasing	Dudley Health
Locality Sensitive Purchasing	Walsall Health Authority
Open Access Physiotherapy Scheme for Southend Locality Physiotherapy	South Essex Health Authority
Practice Sensitive Locality Purchasing (PSLP)	East Surrey Health Authority
Local Voices	East & North Hertfordshire Health Authority
Charnwood Pilot Project	Leicestershire Health

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Turner, Mr Kevin	Lincolnshire Health	Principal Asst. Director of Finance (Purchasing)	Cross O'Cliff, Bracebridge Heath, Lincoln. LN4 2HN	0522-513 355
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Wakefield, Rachel	Berkshire FHSA	GPFH & Budget Manager	Pendragon House, 59 Bath Road, Reading. RG3 2BA	0734-503094 x 283
Williams, Deborah	County Durham Health Commission	Deputy Locality Director - Dales	Appleton House, Lanchester Road, Durham. DH1 5XZ	091-386 4911 x 3249
Wills, Tony	North Nottinghamshire HA	Deputy Director of Finance	Ransom Hospital, Southwell Road West, Rainworth. Notts. NG20 0ER	0623 22515 x 4502