

Development and policy

Practice-based commissioning and future mental health services

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Please fasten your safety belts for an express tour of practice-based commissioning. And though I shall try to be as politically incorrect as Nigel Edwards, my end vision model is slightly different from the one that he described.

If practice-based commissioning is going to work we're going to need the man behind this gravestone. I came across it in the Isle of Wight earlier in the summer. His name was Colonel William Moss Robinson and his gravestone says, 'One who never turned his back, but marched breast forward, never doubted clouds would break'. Nothing can still this man's optimism, even at the bottom it reads, 'He sleeps in order to wake'. This is a man who can't be beaten, and that is precisely the sort of thinking we are going to need to make practice-based commissioning work. Against the odds, against practices who frankly are more concerned at the moment about the Quality and Outcomes Framework (QOF) and a number of other things. And primary care trusts (PCTs), who currently have more than enough on their plates with reconfiguration and other priorities. So it is going to be quite a job to get things moving.

What is practice-based commissioning? Well these are the bones of it, rather bare bones. It's about practices or groups having a budget to improve local services. They don't actually have the budget themselves, and the contracting is done by the PCT. Interestingly, it is something that could have occurred three or four years ago, and indeed did in places like Bradford and East Devon. It is more a sort of sequence of thought really than a new initiative or a new policy. The NHS giving permission if you like – 'Well if you feel your commissioning has got slightly ethereal why not bring it down to earth and do practice-based commissioning?'. In a sense, that, and the guidance that follows it is nothing more. But you will have read in *Commissioning a Patient-led*

NHS that the aim is to have all practices in the net by the end of next year. The question is to what extent will they be in the net?

You can take a horse to water but can you make it drink. You can give a practice a budget but will it be something that actually makes any difference?

Why do we want practice-based commissioning in the first place? It's not just about purchasing or commissioning secondary care. It's really about a whole range of things. First of all the Government doesn't think that PCTs, like health authorities before them, have commissioned effectively. And I think in some cases it's a fair comment. Certainly a lot have failed to engage their clinicians. In fact we're continuing to do that with *Commissioning a Patient-led NHS* and the current reconfiguration of PCTs. Forty per cent of PEC chairs say that the strategic health authority hasn't even approached them yet.

So once again we are going headlong into NHS change and forgetting the clinicians. And that can't be right because you need the clinicians, not only in the sense that maybe we can add something to what could be commissioned and give you some commissioning edge in that, but also because we're the ones that will be advising our patients 80% of the time what sort of service to use. And more than anything because we've got the cheque book. In my day-to-day general practice, I am the one that has the NHS cheque book in the sense of prescribing, referrals and diagnostics. So if I'm not included in the system it gets extremely dislocated, which it really has. Certainly, commissioning meetings I went to eight or nine years ago were all clinicians. Nowadays they're all managers. We need to get back to a stage where it's half and half.

Many of us are trying to bring services more locally, and practice-based commissioning being a very local form of commissioning would hopefully do that. And in particular we've got this crisis in

emergency admissions with them going up 5% or 10% per year. And unless we get front-line clinicians somehow geared into this as a problem that they own, it's certainly not going to change. The most urgent reason though is around the previous creation of Foundation Trusts and the introduction of Payment by Results. In my own area where we have a primary Foundation Trust, we also now have Payment by Results. Every time a patient goes to outpatients it's £150. Every time they go through the hospital doors as an inpatient it's a minimum of £600 and an average of over £1000. So we're talking about the tills clicking the whole time, and hence the NHS debt and all the PCTs saying – except for Bradford where the acute trust went bust rather than the PCT – that they're short of cash. So it's a real emergency and one that PCTs throughout the country are now getting their head round very quickly.

How do you go about practice-based commissioning? It is probably boring to go into some of the detail, but as I'm a practice now with a budget of £4 million, the actual detail is really crucial, because otherwise nothing happens. And this is possibly why commissioning has been such a flop to date. Because first of all you've got to actually know what services you're using. What are my referrals compared to those of my partner? And do the patients need to be referred? Is there an alternative? So first of all we've got to have that information. And going round the country it seems to me that almost about 40% or 50% of practices are getting some information. We've asked them whether they're getting the right information. Very few say that they're getting information that's very useful. And probably at this stage it has to be generated by the practices themselves, because at least that's dead accurate data based upon the referrals that they've made. Someone else can analyse them and hand them back.

But then you've got to have headroom for the clinicians to actually look through those referrals and compare them with each other, and decide how they might improve the system. In our own particular case we're doing all this as an enhanced local service. We're paying all practices to generate their own data to analyse them and make an action plan. But then you need to get the partners together and start deciding what you're going to do. Are you going to mentor each other's referrals? Are you going to have a referrals meeting each week? Are you going to start creating new services either within the practice or in the locality? You've got to actually change things, and that takes time. And very, very few practices either have budgets at the moment or are getting into this sort of detail. But until we start doing that nothing's going to happen. In our own practice, interestingly, the first thing

we've gone for is a modern matron. So we've created a business plan that shows a £30 000 saving, and we've created a post for that. And even if you're into the, if you like, the nitty gritty of how you're using resources, changing their use, either deciding when you don't need to refer or when you can refer elsewhere, or when you can change the service, all requires a bit of savvy. Because one thing we've found locally is that 20% of the bills that come in are wrong and you've got to challenge them. That takes a bit of time, and it's not really the best use of clinician's time or anyone's time for that case. But it's going to be a year or two before we've got a national system for that. In the meantime any practice-based commissioner that wants to do the job is going to have to be checking bills, because otherwise you can do all the work but find that you're a million pounds out simply because the bills are wrong.

Some of the categories are ludicrous. If you have something called a Baker's cyst in the back of your knee, which is totally harmless, the inpatient cost of that is about £3000. If you have a deep vein thrombosis that is investigated that is harmful the cost is a little under £1000. So you've got enormous anomalies that do need checking out. For the moment you probably need some clinicians involved in that checking, rather than the 'pointy heads' that invented them to begin with.

So, how are we getting on? We've just done five regional conferences to see what the state of play is nationally in practice-based commissioning, and it's really at first base still. Perhaps it's not surprising. Where anything is happening it's happening because of really good strong leadership, and two sorts. Either the PCT is putting in locality managers who are going round really enabling, supporting, and making things happen. Or you've got practices that are being very proactive, going to their PCT saying, 'We know how we're going to do it. Give us a bit of management costs. Give us a budget, etcetera, and we will get on with it'. But these are rarities still. Just a few PCTs and just a few practices. Most practices are struggling with the QOF and most PCTs are struggling to cope with change in their patch – empty posts, new priorities and all the rest of it. So it is variable at the moment and likely to be so for a while.

Now what about commissioning mental health in particular. For my own practice, mental health, that was one of our main reasons for becoming a practice-based commissioner. Here I'm probably going to make some extremely politically incorrect comments. If I've noticed anything happening in mental health and primary care over the last few years it has been this sort of going off into the distance. We used to have community psychiatric nurses that we

saw on a daily basis and related to. We used to have much closer contact with the services. Now it seems people wait longer, they go off, they get an assessment, and then they go off and see somebody else. And the whole thing has become hopelessly drawn out and disintegrated. And I don't feel that we're either giving our best or the services that were commissioned. So for me the real reason for going to practice-based commissioning when it comes to mental health services is to bring primary care mental health back into the community, closer to the surgery, and to make more of it available.

Now there's no tariff in mental health at the moment, so that could be a mixed blessing. On the one hand it doesn't create the divisiveness that Nigel Edwards referred to. It means you can create integrated plans without there being all sorts of goings on either side of the primary/secondary divide as to how you do that. On the other hand the disadvantage of having no tariff is that you can't easily devolve services and money into the community and then put them into mental health services that you as a practice, or group of practices, might want. So it does create a degree of inflexibility in the short term. This may be appropriate when we're talking about practice-based commissioning in individual practices. And I'll say what I mean by that shortly. But with savings, we can potentially create incremental improvement in mental health services. And certainly with our savings that's probably where our money is going to go – into counselling, cognitive-behavioural therapy (CBT), and extra community psychiatric nurses (CPNs) for the surgery. And in time, as practices start working together, I think that they'll move from this very narrow idea of practice-based commissioning, which is having a budget, how you use your savings, being if you like 'a cost container', into a much more radical area of re-designing all the services locally and making them more appropriate.

Coming up in the White Paper may be some ideas about using money for health, either having a health budget for each practice, or maybe having each category of service needing to spend so much money in health. And I think that could radically change things, because I think as practices we've been very bad at looking at health seriously. And I think this could concentrate our minds and make sure that health takes a bigger profile than it has previously.

So the question is, how do we move on from here to something that's a little bit more inclusive and a bit less like practices taking over the world and then making everyone march to their agenda? We did a paper with the Small Practices Association, published last week, which I hope gives some idea of where this might all go. And we called it, *Squaring the Circle*. So it's squaring the circle of, if you like, small

practices providing personal care but also providing comprehensive care locally that fits together. I want to tell you a little bit about this model finally because I believe this is the way things perhaps ought to go rather than some of the models that Nigel described.

First of all, within that model, we saw practices working together as practice-based commissioners. I mean, clearly a small practice is not going to be large enough to be a commissioner for all the reasons Nigel said. It won't know enough in terms of commissioning. It won't be able to provide the specialist personnel and needs to make it happen. So first of all we need practices working together, either virtually or in one centre. And we also need to start looking at all the services we're providing, rather than just a budget and what we can do in terms of overspend and the rest of it. So a radical redesign. And involving all the community staff, not just general practitioners (GPs) going off into a corner. And involving local people. This to me seems to be the most important aspect that's not been looked into very much. We need to have practice participation groups. We need to have commissioning participating groups, so that the decisions that we make as commissioners are the ones that the patients are going to make when individually they want to access a particular service. If the two are disconnected, then commissioning means nothing, because we've got to make sure that we are reflecting patient choices in what we do. And then I think if you have practices working together as commissioners, increasingly I think they'll move into providing mode as a sort of, if you like, a generalised American health maintenance organisation (HMO) rather than the specialised HMO that Nigel suggested.

That is more or less what we're doing in my own practice where we're moving into a private finance initiative (PFI) integrated centre for health in about a year's time, and in there we're going to have social services, mental health, voluntary services, even complementary health and the like. And a bit like those Surrey nurses, I see us eventually creating a provider model that puts everything under the same roof. And that would be really quite exciting, because that would not only be an integrated service but it would also be an empowered service, led and owned by the front-line. And it would also create this paradox, which is, in the one sense we're all concerned that the market will lead to fragmentation and different people doing different things, over capacity and over provision. But the paradox is if we at the front-line are just a little bit more proactive and start putting these models together while PCTs are being told to devolve the provider functions, we could actually create an integrated service out of the market. But that would require us to be fairly bold.

The problem Nigel raised is that all bids or proposals would have to go in the official journal of the European Union. I think this is the big debate at the moment. And I'm told by those at the Department of Health that there may be means of facilitating this sort of development without us all having to bid against Tesco, Virgin or other large corporates. But whether that will happen we shall see.

Whatever happens I think that practice-based commissioning is only going to work if there is real synchrony between the practice, the locality and the PCT. And I see the locality actually as probably being the central spot here, although it won't be the statutory organisation. That will remain with the PCT. I think the locality will be the central glue between making sure that what individual patients, population and practices are wanting to offer is not filtered out. At the same time it will be making sure that there's a bit of an overview, a bit of strategic planning, and that things don't become completely fragmented.

Alliance is providing considerable support for this process. We're very keen to support not only practice-based commissioners but also the new army of

primary care providers that I believe will come from this. We are creating an 'ethical provider's' organisation but members said that was a bit pompous, so we're calling it a provider's organisation for providers who subscribe to the NHS ethos.

My final slide is my father in a Swordfish, about to go off and bomb the Bismarck in 1942. And I think this is an analogy with where we're at in trying to commission mental health. There he is in something that looks like a sort of World War I aeroplane, in 50-foot waves, gales, and off he and the squadron went. And they sank the most modern battleship of all time. So I think it can be done. I think we can commission mental health successfully against all the odds but we shan't do it except through great resolve and determination.

Thank you.

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