

Implementing care closer to home: Convenient quality care for patients

*Part 2: Step-by-step guide to commissioning services
using Practitioners with Special Interests (PwSIs)*

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*Part 2: Step-by-step guide to commissioning services
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This guide, Part 2: *Step-by-step guide to commissioning services using Practitioners with Special Interests (PwSIs)*, should be read (where appropriate) in conjunction with:

Part 1: *Introduction and overview*

Part 3: *The accreditation of GPs and Pharmacists with Special Interests*

Supporting Q&A

And with the relevant competency-based specialty-specific guidance currently being refreshed. These will be published on both the Department of Health and NHS Primary Care Contracting (PCC) websites.

With thanks to the following organisations:





Contents

1. Introduction	1
2. Sequencing of these steps	3
3. Step-by-step guide	5
3.1. Assess needs	5
3.2. Review the current service provision	5
3.3. Decide priorities	6
3.4. Design the service	6
3.5. Shape the structure of supply	6
3.6. Manage demand and ensure appropriate access to care	10
3.7. Clinical decision making	10
3.8. Managing performance (quality, performance, outcomes)	11
3.9. Patient and public feedback	11



1. Introduction

Health reform in England: update and commissioning framework (Department of Health, July 2006) set out the policy framework for commissioning within the wider context of the health reform programme.

The health reform programme is refocusing the NHS to meet the challenges of rising expectations, the demographic challenge, the revolution in medical technology, and continuing variations in the safety and quality of care. To address these challenges, we have a clear vision: to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare.

The new NHS will not be created in the old way through command and control. In the next stage of improvement and reform, we need a decisive shift from top-down to bottom-up as we develop a devolved and self-improving health service where the main drivers of change are patients, commissioners and clinicians, rather than national targets and performance management.

This revitalised, patient-led and locally-driven NHS is designed to achieve a central goal: improving dramatically the quality of patient care and the value we get from the public money spent on health services.

The commissioning framework set out a range of measures to strengthen commissioning. These included:

- stronger clinical leadership through practice-based commissioning;
- a stronger voice for people and local communities;
- better information to underpin commissioning decisions;
- new incentives available for commissioners to attract new service providers and improve service quality;
- more effective levers for commissioners to secure financial stability, including new model contracts; and
- measures to build commissioning capacity and capability.

The next phase of development for commissioning policy was introduced with the *Commissioning framework for health and well-being*, which was published for consultation in

March 2007. It provides guidance for health and local authorities in commissioning community healthcare, social care, public health, well-being, and primary care (with the exception of the nationally negotiated General Medical Services (GMS) contract), as well as other relevant services, support and interventions.

It signals a clear commitment to greater choice and innovation, delivered through new partnerships. Its key aims are to achieve:

- a shift towards services that are personal, sensitive to individual need and maintain the patient's independence and dignity;
- a strategic re-orientation towards promoting health and well-being, investing now to reduce future ill-health costs; and
- a stronger focus on commissioning those services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

Guidance for practice-based, PCT, joint and specialist commissioners has an important role in driving up the quality of care to patients and the public, but guidance is just that. The responsibility for taking decisions about the scope and range of services rests with local commissioners based upon their local needs assessment and evidence of how to maximise the health gain for their population.

This step-by-step guide aims to provide practical support and advice for the commissioning of more specialist care closer to home and to clarify the steps that commissioners will need to take. It builds on and reflects the commissioning cycle described within *Health reform in England: update and commissioning framework*.

Best practice for effective commissioning of more specialised services in community settings has identified the following key requirements:

- commitment from senior clinicians and managers;
- establishment of a dedicated commissioning group;
- identification of recurring/capital funds; and
- a lead time of between 3 and 18 months.

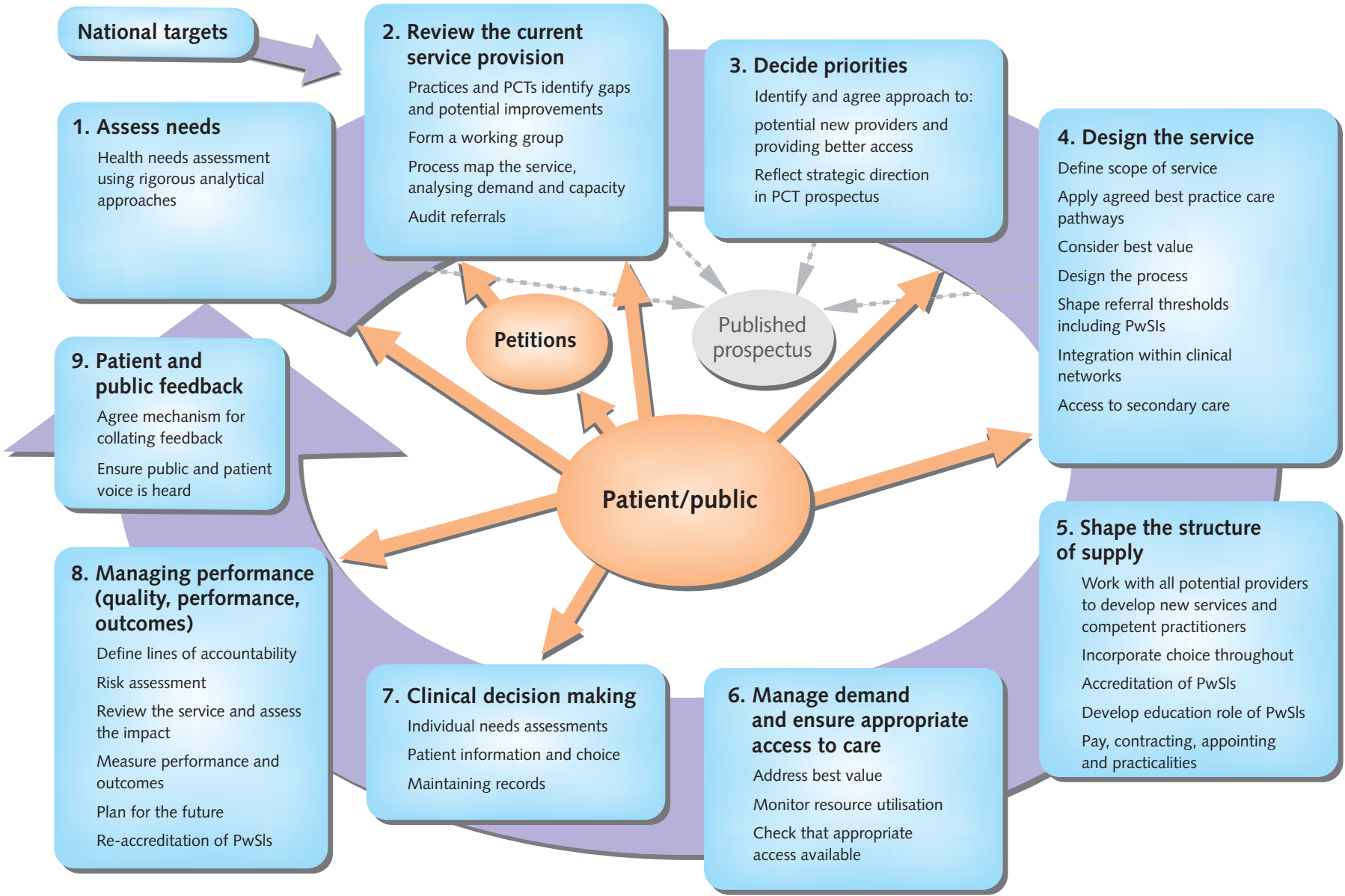


2. Sequencing of these steps

The timing of these steps may vary according to local circumstances. Work around service design may need to be completed before recruiting and training individual clinicians who will work in the new service, but there may be circumstances in which commissioners want to start proactively encouraging individuals to think about the possibility of extending their roles at an earlier stage in the process, for example if a particular qualification is likely to be required.

This step-by-step guide should be used within the overall context of current Department of Health (DH) commissioning frameworks. Appendix E of the *Commissioning framework for health and well-being* includes a comprehensive list of nationally developed commissioning toolkits and related resources, including NICE commissioning guides that support clinical service redesign. Links to these resources are available in *Part 1: Introduction and overview*, Annex 1B.

Figure 1: The commissioning cycle



3. Step-by-step guide

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
3.1. Assess needs	<i>Health needs assessment</i> <i>Patient and public views</i>	<p>A rigorous analysis of local needs to identify those areas in which PwSIs could make the largest impact is an essential first step. It is likely that a combination of health needs, patient and public views, and commissioning pressures from longer waiting times may be seen as priority areas. Practice-based commissioners, primary care trusts (PCTs), local authorities and patients should all play a full part in this step. (The Department of Health (DH) is consulting on proposals to introduce a statutory duty of partnership for PCTs and local authorities to work together to undertake a joint strategic needs assessment to a minimum standard.)</p>
3.2. Review the current service provision	<i>Identify gaps and potential improvements</i> <i>Formation of a working group</i> <i>Process mapping, analysing demand and capacity</i> <i>Audit referrals</i>	<p>Commissioners also need to clarify who will take overall responsibility for the steps set out in this guide, and many health communities have given responsibility for this to an identified clinical group. This approach brings together clinicians from across the patient pathway, and allows primary and secondary care clinicians to take joint ownership of the way in which this particular initiative will be taken forward.</p> <p>Commissioners, in conjunction with any working group, will need to process map current services, analyse capacity and demand, and audit referrals. Links to tools to assist with this process are available in Step 5.</p> <p>The active involvement of appropriate senior hospital clinicians is normally a precondition for the launch of a successful PwSI initiative. There may, however, be special circumstances in which a commissioner decides to go ahead without the support of the local consultants, by ensuring that the role that they would normally play (eg in accreditation) is provided by other suitably qualified and experienced clinicians</p> <p><i>Care and Resource utilisation: Ensuring appropriateness of care</i> (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063265) sets out for commissioners using practice-based commissioning (PBC) and PCTs some techniques to help identify areas where services can be redesigned, thereby freeing up resources to focus on clinically needy patients.</p>

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
<p>3.3. Decide priorities</p>	<p><i>Agree approach to: reducing inequalities, potential new providers and providing better access in line with PCT prospectus</i></p>	<p>PCTs should ensure that patients and the local community, as well as local government and other partners, are properly involved in the process of deciding priorities. Commissioners of more specialist care in community settings should consider how developing PwSI services may contribute to reducing inequalities, improve access to care, and increase choice through development of new providers. They will also wish to reflect the strategic direction for health and well-being as outlined in the PCT prospectus.</p>
<p>3.4. Design the service</p>	<p><i>Define scope of service</i></p> <p><i>Apply best practice care pathways</i></p> <p><i>Consider best value</i></p> <p><i>Design the process</i></p> <p><i>Shape potential referral thresholds</i></p> <p><i>Integration within clinical networks</i></p> <p><i>Access to secondary care</i></p>	<p>The role of the PwSI is not a generic one in the way that the role of a primary care GP, community pharmacist, nurse or a hospital consultant is. PwSIs are appointed to deliver a particular clinical service within a defined patient pathway, and clarity about the nature of that service is an essential precondition for successful accreditation.</p> <p>Therefore, detailed preliminary work will be required to identify:</p> <ul style="list-style-type: none"> • the particular clinical pathway within the specialty that will add greatest value for patients; products from care closer to home demonstrator sites and other work on moving services into community settings may include redesigned model care pathways (see Part 1: <i>Introduction and overview</i>, Annex 1B for link); • the particular clinical roles that PwSIs will play within that pathway, and thus the basis on which patients will be referred to them and the basis on which patients move along the care pathway between community and acute hospital settings, and between generalist and more specialist care; • the resources available to support the new service, and how these can be deployed to demonstrate best value in financial terms; • the volume and type of activity to be delivered by a PwSI; • the kinds of facility within which the service could be safely provided – eg community hospital, walk-in centre, community pharmacy – and whether this matches the locations proposed in the initial needs analysis; • the way in which the new service will comply with local clinical governance arrangements; and • the key indicators by which the quality of the service will be measured.
<p>3.5. Shape the structure of supply</p>	<p><i>Accreditation of services</i></p>	<p>The services within which PwSIs work should also be accredited. The Government's <i>Standards for Better Health</i> define the standards required within all providers of NHS and private healthcare in England, including reference to appropriate premises requirements, information technology (IT) etc.</p> <p>Commissioners are advised to refer to these standards during the development of new specialist services in community settings. This guide represents best practice, and may be used to support the Healthcare Commission's assessment of provider organisations.</p>

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
3.5. Shape the structure of supply (cont)	<i>Developing competencies of individuals prior to accreditation</i>	<p>Commissioners need to determine the kind of training individuals may need. Some GPs or pharmacists may have already developed an appropriate range of skills and competencies (perhaps by working as a clinical assistant in the local hospital, for example) but most will need to complete appropriate training before they will be in a position to apply to be accredited.</p> <p>Acquiring a new qualification may be part of that training, if it is relevant to and appropriate for the work that the GPwSI or PhwSI will be doing. Current best practice, however, shows that most GPwSIs acquired the skills and experience they needed by working alongside a senior colleague in the appropriate speciality, and this constitute a vital element in their training.</p> <p>That senior colleague may or may not be hospital based, but they will have sufficient appropriate specialist experience to be able to provide effective supervision during training and, ideally, continue to provide ongoing clinical support thereafter. Agreed pathways of care and specialty-specific guidance may advise local commissioners on the most appropriate way for this supervision to be put in place. So while the core role of the GPwSI or the PhwSI is a generalist one, the core role of the person who supervises them may be found in the speciality within which they plan to work.</p> <p>Commissioners also need to consider how they select individuals for training.</p> <p>Finally, commissioners need to ensure that there is proper remuneration for both those who deliver the training and those who receive it. In particular, the role of the senior clinician who works on a one-to-one basis with the potential GPwSI or PhwSI is crucial, and the impact of this commitment upon day-to-day workload will need to be recognised.</p> <p><i>The accreditation of individual practitioners as PwSIs</i></p> <p>Part 3: <i>The accreditation of GPs and Pharmacists with Special Interests</i> provides detailed information on how the accreditation process can be implemented.</p> <p>Overall responsibility for specifying in service level agreements (SLAs)/contracts every aspect of the quality of the service and, where necessary, the individuals who work within that service rests with the commissioners. Responsibility for delivery of those services in accordance with the SLA or contract rests with the provider organisation. PCTs will be expected to maintain an up-to-date and publicly accessible list of all accredited PwSIs providing NHS care in that health community, for example via their website.</p> <p>Practice-based commissioners may need to consider issues such as at what point 'generalist care' becomes 'specialist care', and also ensure that clinical governance arrangements are proportionate to the complexity of the service. The PBC section in Part 1: <i>Introduction and overview</i>, includes further information on the circumstances in which accreditation may not be necessary.</p>

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
<p>3.5. Shape the structure of supply (cont)</p>	<p><i>Practical issues: infrastructure, staff, logistics, appointment process and contracts</i></p>	<p>The fact that a GPwSI or PhwSI has been accredited in one part of the country does not, however, remove the obligation to re-accredit that individual should move elsewhere. The experience and competencies that they have already demonstrated may mean that they will be able to fulfil many of the requirements of a GPwSI or PhwSI working in the same clinical specialty in another part of the country, but each group of accreditors should satisfy themselves that the individual has the appropriate skills and experience to work in the service that they are accrediting.</p> <p>Accreditation across a wider area than that covered by a single PCT may achieve economies of scale and economies of skill, and enable consistent and auditable standards of training and transferable qualifications. At least one Deanery takes responsibility for accreditation across all but one of the PCTs in its area, and its skill and competence in discharging this role has developed in direct proportion to the larger numbers of individuals it has accredited.</p> <p>Infrastructure</p> <p>Suitability of the premises to be used for service delivery will form part of the accreditation process. It is important, therefore, that the facilities provide safe, secure and high quality environments for both patients and staff. As well as compliance with statutory requirements such as fire and building regulations, and the Disability Discrimination Act 1995, there are principles of good practice for the provision of modern, fit-for-purpose facilities. These include:</p> <ul style="list-style-type: none"> • identifying an appropriate location for the service that is convenient for patients and makes effective use of resources; • <i>Standards for Better Health</i> and guidance from HCC inspectors; • <i>Primary and Social Care Premises: Planning and Design Guidance</i> on the Primary Care Contracting (PCC) website (the Design section of the website will be replaced by a Health Building Note expected to be published in autumn 2007); • guidance on models for modern community hospitals – work on these is under way and a link will be included on the DH Estates & Facilities Directorate, Knowledge & Information Portal (see Part 1: <i>Introduction and overview</i>, Annex 1B); and • information relating to individual clinical services – this may be included within specialty-specific guidance. <p>There will also be a need to ensure premises and other overhead costs are agreed with the provider of the facilities. Similarly, consideration must be given to proposals for premises' alteration/improvement/replacement and agreement reached, as appropriate, about associated costs including equipment, IT and supplies, and appropriate access to the NHS care record system.</p>

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
3.5. Shape the structure of supply (cont)	<i>Practical issues: Infrastructure, staff, logistics, appointment process and contracts</i>	<p>Staff</p> <ul style="list-style-type: none"> • Ensure that the service is sustainable in terms of cover, staff sickness and turnover. For these reasons, the provision of a PwSI service should not rely on a single practitioner, and should be part of a wider local service. • Consider the need for Criminal Records Bureau checks. • Agree remuneration or fees for services. <p>Logistics</p> <ul style="list-style-type: none"> • Agree the arrangements for organising referrals and booking appointments. • Manage follow-ups and any subsequent programme of care. Ensure that the PwSI service has the necessary administrative and technological support. Promote public awareness of the service. • Ensure that prescribing costs are identified and that there is agreed access to a prescribing budget (if appropriate). For individuals who are qualified prescribers, this may include arranging for special coded prescription pads to be issued to the service by the Prescription Pricing Division of the NHS Business Services Authority, in order to monitor prescribing trends and costs. • Put in place arrangements for quality assurance of any equipment such as for anticoagulation. Ensure that this is considered fully in costings and that relevant guidelines are followed. <p>Appointment process and contracts</p> <ul style="list-style-type: none"> • Consider the options available for contracting routes. • <i>Primary Medical Services Contracts</i> (NHS PCC, 2006) includes detailed information on GMS, Personal Medical Services (PMS), Alternative Provider of Medical Services (APMS) and Specialist Provider of Medical Services (SPMS) contracts. • Guidance on contracting for specialised dental services is available at www.pcc.nhs.uk/161.php • Guidance on contracting for services using accredited PhwSIs is included in section 4.3.3 of <i>A national framework for Pharmacists with Special Interests</i> (DH, 2006). Available options include enhanced services within the community pharmacy contractual framework (ref). • Agree contracts with NHS Trusts and Foundation Trusts. • Agree contracts with other providers of NHS services. <p>Where relevant for GPwSIs, clarify issues relating to employee vs independent contractor scheme pension contributions.</p>

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
<p>3.6. <i>Manage demand and ensure appropriate access to care</i></p>	<p><i>Address best value</i> <i>Monitor resource utilisation</i></p>	<p>Commissioners will monitor demand and resource utilisation. Feedback from patients and practitioners may be used to check evidence that access to the service is as planned. Commissioners should also regularly review the new service to ensure that it continues to represent best value, in line with current commissioning guidance referred to in Part 1: <i>Introduction and overview</i>, Annex 1B. Learning from existing PwSI services has highlighted the importance of effective advertising and regular review.</p>
<p>3.7. <i>Clinical decision making</i></p>	<p><i>Professional indemnity insurance</i></p> <p><i>Information to support choice</i></p>	<p>Medical Defence Union (MDU) advice to members has not changed significantly since 2003, and states that:</p> <p><i>If the general practitioner is employed directly by the Primary Care Trust or Acute Trust, they will be covered by the Clinical Negligence Scheme for Trusts run by the NHS Litigation Authority. If the general practitioner is an independent contractor, then they will normally be covered by their professional indemnity provider. However, in all circumstances the general practitioner is advised to notify their medical defence organisation. GP and nurse members with specialist interests are advised to contact them to discuss the nature of the work they are undertaking to ensure they are adequately indemnified.</i></p> <p>Similar advice is given by organisations that provide indemnity for pharmacists, and this is referred to in the PhwSI national framework.</p> <p>Nurses providing specialist care in community settings should contact their professional organisation to confirm the conditions of their indemnity. This is important even when, as is likely, they are employed within an NHS trust that is part of the Clinical Negligence Scheme for Trusts (CNST). Nurses providing this specialist care who are self-employed or working outside the NHS may need to consider whether membership of a professional body confers sufficient indemnity, and may wish to seek alternative cover from a specialist organisation.</p> <p>Both commissioners and PwSIs should ensure that individuals are appropriately indemnified and are aware of any overall increases in the cost of indemnity insurance for individual PwSIs. Any clinician with independent contractor status who is a member of an accreditation panel will need to inform their indemnity insurers of this role. Reference to indemnity should be made during contract negotiations with independent sector providers.</p> <p>Commissioners will need to consider how, within the PwSI service, individual choices made by patients and practitioners can be supported by good information.</p>

Stage of commissioning cycle	Issues to consider	Questions to ask and practical information
3.8. Managing performance (quality, performance, outcomes)	<p><i>Review the service and assess impact</i></p> <p><i>Measure performance and outcomes</i></p> <p><i>Provide ongoing support to the service and to individual PwSIs</i></p>	<p>Commissioners</p> <ul style="list-style-type: none"> • New service will be commissioned through SLAs or employment contracts. <p>Patients</p> <ul style="list-style-type: none"> • Patient experience should be captured and fed into audit and review. • This may be undertaken through 'critical friend' groups. • Routine returns and outcome information should be monitored. <p>Accreditors</p> <ul style="list-style-type: none"> • The accreditation team will be available to support commissioners throughout, and act as source of expertise when required. • If at any time commissioners have serious concerns about the safety or quality of the service, they can ask the accreditors to make a further visit to assess fitness for purpose. • If a service is not fit for purpose, accreditors must advise on the steps that need to be taken. <p>Service providers and PwSIs</p> <ul style="list-style-type: none"> • Audit service provision and review.
3.9. Patient and public feedback	<p><i>Patient and user involvement</i></p> <p><i>Agree mechanisms for collating feedback</i></p> <p><i>Impact assessment screening</i></p>	<p>It is important to develop ways of enabling patients/users to play their proper role alongside clinicians and managers in the evolution of the service. People from the local community should be involved from the outset to ensure that the new service meets their needs in the way that the clinicians and managers intend. In the early months of a new service, credibility issues can arise, and may effectively be addressed through unambiguous evidence of patient involvement. Lay people who have been involved can often become some of the service's most effective advocates.</p> <p>One model that is being developed in general practice may be particularly suitable: 'critical friend' groups have been established, drawn from patients using the service who work alongside the clinicians and administrators to analyse the results of the patient surveys and to agree what action needs to be taken as a result.</p> <p>Commissioners are required by law to carry out impact assessment screening at an early stage in policy development. The outcome will determine whether or not a full impact analysis is required.</p>



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