PCT COMMISSIONING UNDER PATIENT CHOICE:

Implications for Bedford Hospital

Susan Lang
Charles Wainwright
Kamal Sehdev

September 2004

HMRG
Healthcare Management
Research Group

PCT COMMISSIONING UNDER PATIENT CHOICE

Susan Lang
Charles Wainwright
Kamal Sehdev

Healthcare Management Research Group
Enterprise Integration
Cranfield University

September 2004

PCT COMMISSIONING UNDER PATIENT CHOICE

Published by
Cranfield University
Cranfield
Bedford MK43 0AL
United Kingdom

ISBN: 1 861941 12 9

Acknowledgements

The authors wish to acknowledge the contribution of the following researchers in the development of this report:

Nicolas Clement
Thomas Daflidis-Kotsis
Sabena Isroliwala
Harry Misginna
Kevin Windell

Contents

Introduction

By December 2005 National Health Service (NHS) patients who may require elective surgery will be offered a choice of four to five hospitals at the referral stage, as part of the government's vision for a responsive, patient-centric health service. The Healthcare Management Research Group of Cranfield Postgraduate Medical School has been working with Bedford Hospital NHS Trust to evaluate the possible implications of patient choice.

During February and March 2004 a number of meetings were held with key NHS stakeholders, including Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and General Practitioners (GPs) in Bedfordshire, Hertfordshire, Cambridgeshire, Huntingdonshire and Northamptonshire, and also the Department of Health in London. Conclusions from these interviews were supported by a literature review of academic papers, news articles, books, government guidelines and patient surveys. In particular, the process by which PCTs commission secondary care providers is assessed and the nine pilot schemes were evaluated. The purpose of this document is to explain changes to the commissioning process under choice and the effect these might have on trusts.

Primary Care Trusts (PCTs) are responsible for commissioning secondary care for their local population, thus when patient choice comes into effect in December 2005 they will play a key role in choice by defining the four or five providers offered to GPs and patients for elective surgery. A broader overview on commissioning can be found in Cranfield University's report '*A Review of Patient Choice in the NHS'* and the

purpose of this document is to examine in more detail the criteria PCTs may use to select hospitals and to consider the implications for Bedford Hospital.

Department of Health guidelines have only been issued for choice at six months so most PCTs are concentrating on meeting the six month target and have not yet formulated a plan for choice at referral. A dominant theme that emerged was therefore one of uncertainty, hence PCTs' predictions for how they will run choice form the basis of this paper rather than definitive policies.

Methodology

The map in Figure 1 shows the boundary of each PCT area, with the different colours representing the different Strategic Health Authorities (SHAs) they fall under.

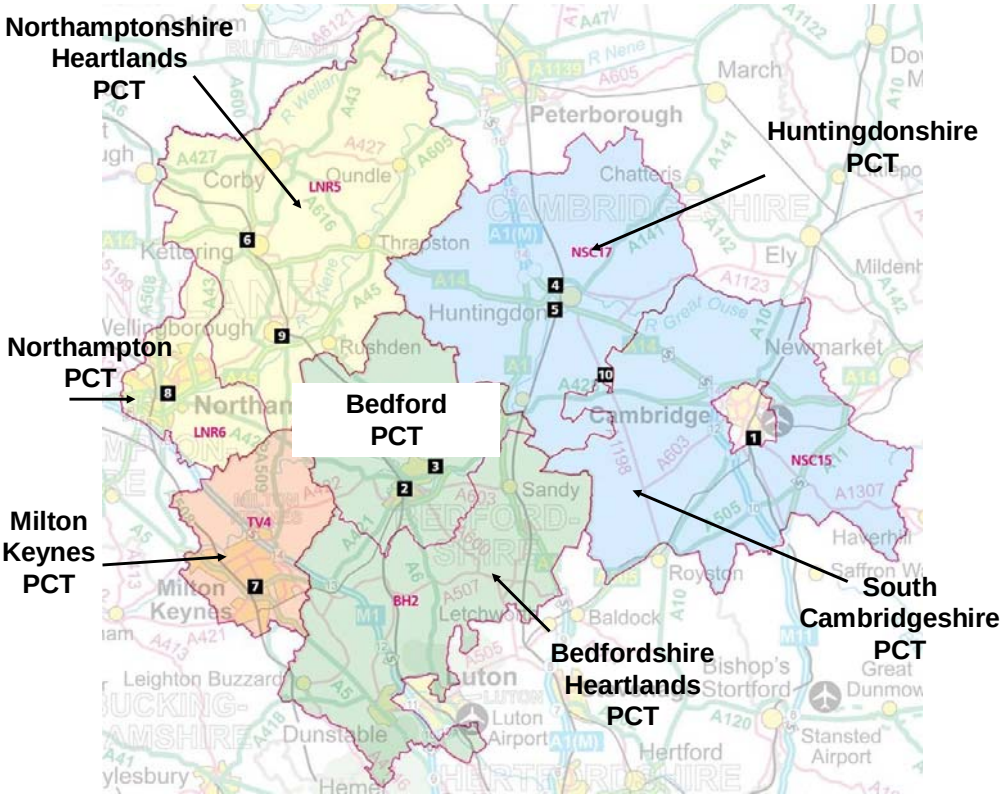

Figure 1: NHS organisations around Bedfordshire

The report is based on interviews with six local PCTs: Bedford, Bedfordshire Heartlands, Northampton, Northampton Heartlands, Milton Keynes and Huntingdonshire. These PCTs were selected as they are either in Bedfordshire or bordering counties, and therefore are possible users of Bedford Hospital. South Cambridgeshire PCT was eliminated from the study as it was finalising work on choice at six months.

Bedfordshire and Hertfordshire SHA was also interviewed to provide a higher level view of the commissioning process. Additional interviews were held at North Hertfordshire and Stevenage PCT, Trent PCT, Norfolk, Suffolk and Cambridgeshire SHA and Thames Valley SHA due to their involvement in choice pilot schemes, but their comments on the commissioning process are included. The final stage was a visit to the Department of Health to clarify some of the points raised in the course of these visits.

It was decided to use a qualitative approach to data collection with open ended questions to enable respondents to expand on their answers. A list of questions was devised to elicit the appropriate information from the interviewees and provide a structure to each meeting. The format for presenting the findings is qualitative.

Overview

None of the PCTs interviewed have decided on a list of four to five providers for patient choice, but they do not expect to make any radical changes to the commissioning process. If anything, PCTs see this as an opportunity to reduce their portfolio and reorganise local services more effectively. A key issue for PCTs is that local services have grown up over time and according to demand, so are essentially reactive and based on historical data. With changing demographics, notably population increases in certain areas, the needs of local populations have altered and PCTs are now struggling to align supply and demand.

Bedford PCT, for example, plans to try and reduce the number of providers they use, inherited from the days of GP fundholding and including some in London. Choice is also seen by Bedford Heartlands as an opportunity to formalise the existing system and exercise greater control through the menu, while they are unlikely to change providers as they use a number of hospitals already. Bedford Heartlands is a relatively unique PCT as there is no main NHS Trust, which will be an advantage for the PCT once choice has been implemented as it is not the lead commissioner in any Service Level Agreement (SLA), so has more flexibility. There may be a wider geographic scope and the inclusion of a private sector hospital, but this will be determined by specialty and depends on the quality of the additional providers.
Volume variances in the future could well be an issue and adequate capacity will be fundamental. There is great pressure at the moment to reach waiting list targets so any spare capacity would be welcomed by Northampton PCT. Huntingdonshire PCT is taking a very pragmatic stance towards adopting choice; for example, to meet

choice at six months, patients are going to be offered one choice only, based solely on capacity. The PCT also confirmed that if Bedford Hospital were to let PCTs know as soon as possible about their capacity for choice at six months then this could be hugely beneficial to them and they could well be written into contracts for the future. At the moment trusts are not lining up to offer capacity for choice at six months due to the risks of this promise; if the patient accepts the other offer then the receiving trust must provide a TCI (to come in) date by the end of month seven (i.e. within 4 weeks). Milton Keynes PCT is likely to be very interested if capacity is available at Bedford Hospital to free up space in Milton Keynes. When asked about commissioning under choice Northamptonshire Heartlands said that if a particular specialty, such as gynaecology, had the capacity then they would certainly consider it.

Bedford Hospital has traditionally been used by Huntingdonshire PCT for oral surgery and ophthalmology as well as dermatology in the new laser unit (all patients are currently referred to Bedford Hospital for this treatment), and there is no reason why the PCT will not continue to use these specialties.

The Department of Health has specified that there must be four of five choices for each specialty. Obviously there will be a few exceptions to this but in most cases it will be feasible. Around two thirds of PCTs already use three providers anyway, so it should not be too difficult for them to extend this to four or five.

There has been confusion over how trusts will enter details of each specialty onto the Electronic Booking System (EBS). The Department of Health has said that this is up to the trust and some will enter a pool of specialties, some will put each consultant's name. However, Norfolk, Suffolk and Cambridgeshire SHA disagrees and believes that as the patient receives a booked appointment it therefore follows that this must be with a particular consultant. The GP has to be able to access the correct information on each consultant's special interests, so that the appointment is booked with someone in the department who can perform the necessary operation, for example, or to meet surgeons' preferences for case mix. This will entail a huge amount of work for trusts and is something they must think about now. Early adopters in London and the South East have been selected for piloting the EBS and this will go live with the first bookings in June or July. However the pilot schemes have demonstrated that choice can work well without the EBS, using a simple model

with GP referral letters as happened before. Another issue that Norfolk, Suffolk and Cambridgeshire SHA feels must be addressed by trusts is that medical secretaries who traditionally deal with consultants' waiting lists may well feel threatened as the EBS is taking away this role.

Payment by Results

Payment by Results will have advantages and disadvantages according to Bedford Heartlands. Tariffs will make it easier when negotiating with trusts to avoid months of arguing over percentage costs for each operation and instead the focus will be on the patient. A problem will be that when paying for additional activity it will be more expensive as there is one fixed cost. Under the present system of block contracts the PCT can negotiate extra activity at a much lower rate, generally around 30%, as they have already invested in the hospital through the bulk of activity purchased. Northampton PCT also discussed the fact that at the moment they pay a marginal price for extra activity, whereas under payment by results PCTs will have to pay the full amount so just one extra patient will be expensive.

Northampton PCT feels that there are better grounds to refuse out-of-area treatments (OATs) under choice, as the patient is already being offered alternatives. Northamptonshire Heartlands believes that patients treated out of the area want to get home sooner than if treated at their local hospital, which can lead to a premature release from the receiving hospital and adds to concerns with aftercare. Medical complications can follow an early release and the patient ends up needing to be admitted to their local A&E. So an alternative trust may be willing to treat a patient and receive payment but will be less concerned with the less profitable (but necessary) aftercare, since the patient will return home and becomes the responsibility of their local trust. Milton Keynes PCT admits that transportation costs to other areas are a major consideration and currently, unless patients have special requirements, transportation is not covered in the cost of patient treatment. It is

therefore unlikely to encourage patients to travel out of the area as the PCT will be responsible for the travel arrangements under choice.

Quality

There will be no dramatic change to monitoring under patient choice, and the idea that PCTs will keep track of quality and change providers as necessary seems unlikely. If choice is supposed to drive up quality, then Huntingdonshire PCT is unsure how this is defined and measured. If there is so much up-to-date information available on readmission rates, infection etc then the PCT would find it extremely useful in contracting decisions, but doesn't believe it exists. There are enough problems finding accurate waiting list figures.

However, Bedford Heartlands mentioned that at the moment GPs could shift all their referrals from one trust to another if they weren't satisfied, and unless they told the PCT then it would take a while for anyone to find out. Once patient choice has been implemented this would be highlighted immediately so if there was a problem with a hospital then the PCT can try and improve it. Bedford PCT mentioned that in the future monitoring will be more dynamic as it will happen more frequently and if a trust is not meeting capacity or quality then the commissioner can put pressure on them or change providers. There are quality standards in each SLA (clinical governance, such as training and reporting, cleanliness, single sex wards, facilities etc) but these are quite crude, blunt tools. The aim is to move towards outcome measurements and comparison between consultants, the view of Bedford PCT.

Northamptonshire Heartlands is concerned with efficient local services and population requirements, so these are more important to them than providing choice. Milton Keynes PCT also mentioned several times the importance of longer-term

relationships with providers and Huntingdonshire stated the need to invest in hospitals and not just send them patients now and again. If Bedford Hospital can deliver good waiting times and avoid issues, such as the scandal at Bristol or any clinical governance problems, then Northampton PCT feels that there should not be any adverse reaction under choice. If a local trust is bad at something then the PCT could use a provider further afield; however this is still unlikely as there would be plans in place for the trust to improve and the PCT is more interested in long term relationships so would stick with the trust.

Bedfordshire is under their capitation funding, since local services have grown up over time according to demand and based on historical data, and this will only get worse with the huge population growth in the area. This means that Bedford PCT has a major problem with investment, and next year they will only be able to afford existing commitments, so are locked in a cycle whereby they find it harder to meet targets and improve local services. For this reason, it is probable that the PCT would rather keep sending patient to local hospitals to maximise the investment in local services.

The Department of Health aims to assess trusts using a combination of the best of current data with better indicators, a different system to star ratings. Two out of the four criteria for star ratings are patient experience and quality so these will continue to be used. Waiting time is less important once the EBS is implemented as patients already know when their appointment will be. The NHS website, www.nhs.uk, will be available in surgeries and it is up to practices how they provide access to this, whether they will issue print outs or availability on-line.

Competition and Marketing

PCTs locally have agreed that hospitals will have to publicise their spare capacity in particular, as well as any core strengths. Milton Keynes believes that competition among health providers is inevitable, as does North Hertfordshire and Stevenage, who suggested that trusts should produce marketing literature and advertise for patients. Northampton PCT recommended marketing to individual GPs if offering specialties, as GPs could then put pressure on the PCT to add the trust to their list. Norfolk, Suffolk and Cambridgeshire SHA supported the idea of trusts marketing themselves, and they are considering holding open days so that GPs can meet consultants from hospitals further away for important face-to-face contact. They warned against sending out brochures, as trusts overselling themselves will have a negative effect as they will be seen to be wasting money.

Northamptonshire Heartlands spoke about the fact that Bedford Hospital gynaecology and neo-natal departments are sought after within an area of approximately a 40 mile radius of Bedford Hospital. This is because there are two female consultants within the gynaecology department and the department itself has a good reputation. The department conducts a large number of day care and overnight stays, meaning that patient throughput is high as is capacity. Also, gynaecology has shorter waiting lists (around 3 months compared with approximately 7 months at Kettering). Therefore the PCT believes that it would be a very good idea for Bedford Hospital to market this specialty and attract patients away from trusts with longer waiting lists, with the female consultants and the overall reputation of the

department being used as an added enticement. The gynaecology department should not have to do a great deal of self-promotion as its reputation precedes it.

Northampton PCT thinks that if an aggressive trust starts marketing itself, through community work or bringing people to the area by bus, choice could be to their advantage. The private sector is likely to be more competitive than anticipated and may be able to meet tariffs. They can offer added value over and above waiting time, such as a private room, so trusts may be forced to compete. Norfolk, Suffolk and Cambridgeshire SHA supports this view, and says that choice will force prices down in the private sector, which will be beneficial.

The Department of Health does not think marketing will be an issue for trusts, as they already promote good news stories in the press and can use their forums for good representation. GPs will be the key and it is the job of PCTs to persuade GPs to refer to all the hospitals on the list.

Support for Patients

Patient Care Advisors (PCAs) have proved indispensable in the pilot schemes, but whether they will be retained under choice at the point of referral, or amalgamated into call centres, is likely to depend on each PCT. Two PCAs have been appointed to manage choice at six months for all patients waiting at North East Hertfordshire Trust, and the PCT anticipates that they will continue to be employed for choice at GP referral.

Bedford PCT plans to buy into the call centre, and possibly also have PCAs in GP surgeries in addition, but it has not been decided yet. Bedford Heartlands PCT is also using the call centre and has opted out of providing PCAs. A choice representative is starting in the modernisation department at Huntingdonshire PCT to look at implementing choice and the necessary support services. Milton Keynes PCT suggested that a call centre system seems to be a good solution for booking management as a single point for managing referrals. North Hertfordshire and Stevenage PCT spoke to the London choice pilot to determine if the PCAs should be clinically trained or administrative, and was persuaded that their role is purely administrative.

The view of Norfolk, Suffolk and Cambridgeshire SHA is that GPs are not committing to choice as they feel there is no demand for it among patients and they have little confidence in the IT being in place on time. Therefore choice in its present form is limited to allow for the necessary cultural change. Choice at six months was important for this to persuade consultants to relinquish some of the control of their

waiting lists and create a more accepting environment to promote choice at the referral stage.

Impact of Choice

Although under payment by results, the idea is that commissioning will be more dynamic, GPs will essentially be independent. A problem raised by North Hertfordshire and Stevenage PCT will be persuading any GPs to refer to hospitals that lie outside the traditional pathway. Bedford PCT believes most patients will follow their GP's advice and want to go to the local hospital, so once they have sorted out the six month wait then there shouldn't be too many problems. North Hertfordshire and Stevenage PCT agrees that in reality most people will take their GP's word. People want good local services and hearsay will be important in patient choice, with word-of-mouth among friends, family and neighbours about particular consultants and hospitals.

Bedford Heartlands also thinks it likely there will be an initial flurry of patients exercising choice but then it will die down. If the waiting times and standard of surgeons are reasonable then people will stay near their home. Norfolk, Suffolk and Cambridgeshire SHA thinks that at first the young, Guardian-reading, educated patients will benefit and take advantage of choice, but movement of patients will be limited. Local people will always want to go to their local hospital, and especially as around 65-70% of electives are for people aged 65-70 years old, according to Huntingdonshire PCT. Few people actually left their local area under fund holding so it could be the same today as there are some similarities between the two systems. This implies that Bedford Hospital is unlikely to suffer from patients leaving the area; conversely, it may also be difficult to attract patients from outside the local population.

One SHA was critical of the Dr Foster pilot report on choice at GP referral and feels that some of the published findings are inaccurate. In particular, stating that the length of time for GPs' consultations will not increase is extremely risky as the evidence for this was apparently not conclusive and the consultations will take significantly longer. A significant deterrent in the uptake of choice was that patients were not guaranteed faster treatment if they moved to another hospital as the website was six months out of date. The reasons patients gave that influenced them in their choice are more likely to be the GPs' concerns, raised in the consultation and passed on to patients. The SHA feels that patients generally assume the standard of care in the NHS is good, and are more uneasy about private hospitals due to the higher level of overseas staff.

Bedford Heartlands feels that the major impact of choice will be once it is extended beyond elective surgery and into chronic conditions, such as asthma and cancer. At the moment these patients are locked into the local system, maybe with a consultant whose views they don't share, but with the increase in more demanding 'expert patients' and greater choice there will be scope for more radical treatment options and different services. Some of these will be provided in the local area and others elsewhere. Norfolk, Suffolk and Cambridgeshire SHA supports this view, and feels that once SHAs and PCTs have worked harder at addressing equity issues then there is more potential to expand choice to more of the population (the SHA mentioned partnerships with voluntary organisations, such as RNIB, to help this). Bedford Heartlands PCT has also suggested that the main problem will be choice at six months, and once this is implemented choice at the point of referral should be relatively straightforward.

Conclusion

There should be no radical change to the providers PCTs commission from under choice. On the whole PCTs felt that choice at six months is the biggest problem for them, and in comparison choice at the referral stage should be relatively straightforward. The extension of choice into chronic conditions is likely to be the main challenge. Patients with chronic conditions require regular treatment and the most convenient location is their local hospital; resources should therefore be funnelled into the care pathway for these conditions, supported by better integration of primary and secondary care.

There is some potential for Bedford Hospital to benefit from choice through notifying PCTs of spare capacity, particularly in the short-term to meet targets for choice at six months, and to promote themselves through marketing and open days. It is the responsibility of PCTs to persuade GPs to make use of all the providers on the list, but trusts must play a role in this by providing accurate information on consultants. One consideration for Bedford Hospital is to plan the data requirements for the EBS, as this will require a fair amount of detail on each consultant and will be a time-consuming process.

By linking the choices patients make to the resources hospitals receive, the Government had hoped to force hospitals to improve. In reality, however, PCTs will be unwilling for money to leave the local health economy. The PCTs around Bedfordshire have indicated that their first priority is the local NHS trust, building a strong long-term relationship and investing in local facilities: the Department of

Health itself has defined their role as one of forging local partnerships. If for any reason a hospital is underperforming then measures will be put in place and the PCT will support the hospital until it improves. Therefore it seems unlikely that, even if a trust is performing poorly, it will lose a significant number of patients. So long as Bedford Hospital maintains a high standard and keeps waits short then PCTs will continue to commission services from the trust and patients will continue to go there, so there will be no adverse effects under choice.

HMRG
Healthcare Management
Research Group

Cranfield University, Department of Enterprise Integration, Cranfield, Bedfordshire MK43 0AL
Telephone: 01234 754073 Fax: 01234 750852
Internet: http://www.cranfield.ac.uk/cpms

ISBN: 1 861941 12 9