

SHIFTING THE BALANCE OF HEALTH CARE TO LOCAL SETTINGS

The SeeSaw report

Sarah Harvey and Laurie McMahon

King's Fund



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First published 2008 by the King's Fund

Charity registration number: 207401

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ISBN 978 1 85717 572 1

A catalogue record for this publication is available from the British Library

Available from:
King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801

Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Typeset by Andrew Haig & Associates
Printed in the UK by PWP FS Print & Design

This report was commissioned by the Department of Health's Shifting Care Closer to Home policy team.

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Introduction

SeeSaw is the name given to a simulation-based project led by the King's Fund in partnership with Loop2, and commissioned by the Department of Health's Shifting Care Closer to Home policy team. Its purpose was to better understand how a shift in care from hospital to community settings could be achieved. The title SeeSaw was chosen to reflect the fact that increasing the level of care in community settings will require a reduction in the volume of care undertaken in hospitals.

Over the past decade a consistent strand of health policy has been to encourage a greater range and volume of care to be delivered outside the walls of the traditional district general hospital. In 2003, *Keeping the NHS Local: A new direction of travel* described how innovation in technology made it increasingly possible for people to be diagnosed and treated at home or in local primary and community facilities (Department of Health 2003). In 2006, the government issued the White Paper *Our Health, Our Care, Our Say*, which was packed with proposals, care models and case studies of care closer to home (Department of Health 2006). Around that time the Department also piloted new approaches to delivering care closer to home (Sibbald *et al* 2007). The evaluation of these pilots showed that community-based services could provide the same quality of care as a hospital environment but at a lower cost – although the evidence base seemed relatively weak.

Over the past year or so 'care closer to home' has been joined by the new mantra of 'out-of-hospital care', reaching its most explicit form in Lord Darzi's *Healthcare for London: A framework for action*, which is being used as a 'soft' blueprint for service redesign not just in the capital but up and down the country (Darzi 2007).

When we began to design SeeSaw we talked to people across the health and social care system to ascertain their views about this highly consistent and enduring strand of government health policy. We asked three questions: *Why* is ‘out-of-hospital care’ and ‘care closer to home’ being pursued? *Who* is going to provide these local services? And *where* will they be provided?

In response to the first question – why is this policy being pursued? – a number of interrelated ‘benefits’ were cited.

- It can prevent people from having to attend hospital unnecessarily.
- It will reduce the burden on acute hospitals and shorten waiting times by providing parts of the care pathway, such as outpatient appointments or diagnostic tests, in community settings.
- Following on from this, it will help to deliver the 18-week targets.
- It responds to the growing demands of patients to get more local access to services.
- It helps to reduce costs by providing care in cheaper settings.
- It is a way of enabling providers to disinvest in the buildings and workforce on hospital sites.
- It is possible to improve the quality of clinical care by avoiding the risk of going into hospital.
- It stimulates new ways of working and allows a remodelling of the workforce.
- It exploits a wide range of new clinical and technological developments.
- It encourages people to be more independent and prevents illness and injury.

In response to the second question – who is going to provide these services? – there were fewer answers.

- Many saw this as a primary care development and thought that out-of-hospital care would be provided by GPs working in large practices or by the new entrants into the primary care market. It was interesting that there was an unanswered subsidiary question about the level of specialist doctors required and where they would be sourced.

- Some still saw the most likely provider of out-of-hospital care as being the acute hospital that had built satellite ‘hubs’ to its main operation.
- Others thought that the independent and private sectors would be sufficiently nimble to develop services in local settings – especially those experienced in providing modular and mobile diagnostic and clinical services.
- It was often suggested that the extended care pathways involved in providing care closer to home would require a multiplicity of providers working together in integrated supply chains that would include social and domiciliary care providers.
- Most people felt that no matter what kind of organisation was the lead provider, care closer to home would soon require or stimulate the growth of a very different workforce with an accent on multi-disciplinary teams with generic and flexible competencies and with a much-reduced dependency on ‘full’ professionals. In the case of long-term conditions, patients became part of the supply chain through innovations in self-care.

With regard to the third question – where might these services be provided? – the responses were similar to those for the second question.

- Many thought that community hospitals would fulfil this role, as they were often said to be in the right place but with the wrong care model.
- Some thought that the most likely location would be the larger GP practices and health centres.
- The idea that acute and diagnostic services would be provided in mobile facilities that drew up alongside community hospitals and health centres was quite common.
- Others suggested that we could expect to see services provided wherever people congregate, at stations, shopping centres and schools.
- It is not surprising perhaps – given the amount of publicity the idea has generated – that ‘polyclinics’ were most frequently cited as being the ‘place’ where care closer to home would be provided.

- Few mentioned care being provided in patients' homes, which was surprising given the recent upsurge in interest in assistive technology.

What remains the more puzzling policy question is why – given that out-of-hospital care/care closer to home has been a consistent policy direction for the past five years – has the scale and pace of the changes been so tentative? The reasons for this are not entirely clear, but many cited provider interests – with hospitals not wanting to lose work and revenue to local providers and GPs, despite what they espouse, and not really wanting to take on the bigger responsibilities of moving care closer to home on a large scale. The lack of conviction among commissioners who either did not understand what was required or were too timid to disturb the status quo was felt to be equally important. As part of that, it was felt that the public reaction to care closer to home – or more accurately the effect it might have on reducing the levels of care in hospitals – made implementing the policy particularly unattractive.

Whatever the reasons for this ambivalent and relaxed attitude to moving care out of hospital and closer to home, the situation could not continue, especially as the work of Lord Darzi has brought the whole policy into sharp focus. SeeSaw was commissioned and designed specifically to see how to make the system really accelerate services.

SeeSaw did *not* set out to determine whether or not shifting care closer to home makes good clinical or economic sense. Others inside and outside government will develop the evidence for this through much more rigorous evaluation. We started with the policy as a given and the assumption that because making the change was so complex and 'whole system', nobody knew who had to do what to make it happen. The aim of SeeSaw was to help policy-makers, managers and clinicians answer two key questions:

- How can shifts in care closer to home be achieved on a larger scale and in a consistent way using the current range of resources, incentives and information in the system?
- What changes in policy, incentives and information would help the health and social care system make shifts that would provide a better patient experience and more productive use of resources?

This report is divided into three parts. Part 1 gives some background on behavioural simulations and explains why this approach was used for the SeeSaw project. Part 2 details what we learnt from SeeSaw, together with proposals about what should happen if we are to secure the productivity gains and improvements in patient outcomes that can be achieved from a shift in the pattern of health and social care. Part 3 describes the simulation itself and what happened in each of the two rounds.

It is worth pointing out that what actually happened during the simulation exercise itself – although highly realistic – was less important than the shared understandings that are derived from it. The majority of this report therefore focuses on the learning that emerged during the event and in all the subsequent discussions on the implications for policy-makers, managers and professionals working in the NHS, in social care, and in the independent sector. We have further refined the simulation messages and recommendations contained in this report through structured discussions with a group of leading practitioners, managers and policy-makers who did not take part in the event itself. Their insights, as well as those of the participants themselves, have been invaluable.

Part 1: Learning from simulations – the SeeSaw design

Why use a behavioural simulation?

The orthodox approach for planners to predict the future is to use historical, quantitative data and – with varying degrees of sophistication – to extrapolate from the current point A to a point B on the distant horizon. This may work well for concrete issues in relatively stable environments; however, such an approach offers much less predictive value in circumstances where we are trying to understand the future of complex social systems in more chaotic environments. In these circumstances there are usually so many forces and drivers at work, and so many powerful stakeholders involved, that the sum of all their interaction is impossible to model satisfactorily. In these situations it is more helpful to use ‘soft’ or qualitative futures, which draw directly on the experience and judgement of people who are involved in the system we want to understand. One of the most powerful of these processes is behavioural or ‘open’ simulations.

Open simulations are based on the premise that what happens in complex social systems is the product of formal and informal negotiation and bargaining between large numbers of stakeholders representing national, professional, institutional and personal interests. To replicate this negotiating process two key ingredients are needed: a set of participants representative of those in the real world and a fictional but realistic operating environment for them to work in. There is no role-play, having to imagine how someone might think or react; participants are asked to take a position in the simulation that mirrors their own so that their behaviour is accurately informed by their real-life insights and experience. As in real life, open simulations allow conventions, structures and rules to be challenged and renegotiated, and the only rules that apply are those that already govern the players

in their everyday work, such as legal obligations or the regulations relating to organisational or professional conduct. Participants bring into the simulation their own understanding and interpretation of the evidence base for their decisions.

Open simulations are like a giant version of the flight simulators used to train pilots: they offer a highly realistic but safe learning environment for the ‘crew’ (in our case, approximately 70 players). What happens in the simulation is less important than the insights and learning that participants and moderators generate together after the experience. It provides one of the most robust ways of understanding how complex social systems respond to large-scale and rapid change and was therefore the perfect tool for helping to understand how the NHS might respond to the strategic imperative to shift care closer to home.

The SeeSaw simulation design

The SeeSaw simulation explored two time periods. The first round covered the financial year 2008/9, while the second round covered 2012/13. The two-year gap gave us the opportunity to refocus the play both with the ‘rules’ and issues drawn from the first round and with some new hypothetical changes introduced to explore wider developments that might impact on the health and social care field.

Underpinning the simulation design was a set of questions that we wanted to explore about the various levers and incentives for change and their effectiveness in either supporting or hindering the development of more responsive care for patients. The challenges and opportunities that we brought into the simulation design were based on real-life challenges and questions that have been raised in different parts of the country. These included, for example:

- the role of new technologies in enabling people to be cared for at home

- the tensions for primary care trusts (PCTs) in being both commissioners and providers of services
- the cost pressures of private finance initiative (PFI) developments and the extent to which they might impact on efforts to shift care outside hospitals
- the power of practice-based commissioning
- the development of integrated services between health and social care
- the role of public, patient and political opinion in shaping service reconfiguration
- foundation trust surpluses and how these might be reinvested in patient care
- the role of social enterprises, independent and third sector providers in developing new models of care
- the changing role of ambulance services.

The SeeSaw ‘patch’

The SeeSaw simulation was set in a hypothetical but realistic context that had been specifically designed for the event – the mythical county of Taitshire located in the Greater Catt Strategic Health Authority (SHA). SeeSaw involved two of the PCTs in the Greater Catt SHA: the larger Taitshire County PCT, and Georgetown PCT, which shared its boundaries with the unitary authority, Georgetown City Council.

In Taitshire, the three practice-based commissioning groups were active and enthusiastic but pursuing a disparate set of commissioning and providing interests. In Georgetown, practice-based commissioning was patchy, as was the quality and accessibility of primary care. Both PCTs continued to run in-house community health services although they had made efforts to manage them at arms length.

Acute care in the county was provided by Gomersall Hospitals NHS Foundation Trust in the north and Georgetown Hospitals NHS Foundation Trust in the south. Across the county there were also a

number of community hospitals and health centres. Ambulance and paramedic services were delivered by the Greater Catt Ambulance and Paramedic Trust, and mental health services were provided by the Moody Mental Health Trust. Both were working towards achieving foundation trust status. Three independent sector providers were included: Vango Healthcare, which provided GP out-of-hours care and mobile diagnostic and surgical services; Ashton International, a provider of home care monitoring and personal care services; and Farrell Community Hospital, run by a community-led social enterprise. Patient and public interests were represented by a small panel whose interests covered both Georgetown and Taitshire. Taitshire County Council representatives included both adult care commissioners and the overview and scrutiny committee. In addition to these local players, two national regulatory bodies were included in the play – Monitor and the Healthcare Commission (which became the Care Quality Commission in the second round).

The data supporting the descriptions of the organisations was drawn from actual NHS organisations but the names were changed to encourage participants to think laterally rather than be constrained by any knowledge of a real health system.

In parallel to the behavioural simulation we tested out a relatively new quantitative tool developed by the NHS Institute for Innovation and Improvement – the scenario generator model. This enabled us to model some of the consequences of proposed shifts in care pathways negotiated in the first round to help participants gain a more informed picture of the impact of their decisions on the whole health economy. We were interested in exploring the tipping points that might trigger organisations to rethink their strategies, strengthen their resolve or address the downsides of their decisions.

Part 2: The learning and the messages

In this section of the report we draw out the main learning points that emerged from the discussions with participants both during and after the simulation and from the structured debates with a wider range of commentators in the meetings that followed. These latter discussions were extremely useful in helping us move from observations about the SeeSaw simulation to ‘what should happen next’ to support shifts in the pattern of health care that are expected to deliver benefits to patients and improved use of resources.

We identified eight key messages from SeeSaw that point the way to securing a faster and more consistent shift in the pattern of health care that will deliver the intended benefits for patients and productivity. These are summarised below, then discussed in more detail.

Communicating the rationale for service change More attention needs to be given to communicating the rationale for shifting care closer to home, in terms of access, convenience and service quality. Primary care trusts (PCTs) need to address public concerns that changes are purely financially driven, that they will add to the burden of informal carers, or that the necessary staffing skills will not be available.

There are some examples where large-scale service changes have been managed smoothly, without major public opposition, and delivered better patient care. A more typical experience in the NHS, however, is that dialogue with the public is partial and defensive, the rationale for changes in the pattern of care is poorly explained, and the precise impacts on and benefits for patients and carers are not

clearly stated. There needs to be a shift to more timely, mature and deliberative debate about changes that will improve patient care.

Making better use of technology innovations There is a growing range of technology solutions that allow patients to be monitored and cared for at home. But the take-up of these approaches is patchy and they tend to be added on to existing service models rather than enabling large-scale shifts in the way patients are treated. Far more attention has been given to expanding the delivery of primary and community services in new and improved primary care premises and polyclinics than to what can be safely and effectively undertaken in patients' homes. Both commissioners and providers have a role in securing better use of technological innovations.

Reshaping primary care Decentralising hospital care can be achieved through a variety of methods. It does not have to be delivered by the centralisation of primary care into large polyclinics or community hospitals. Greater diversity in the provision of primary care is needed to enhance the benefits of local access for patients and allow a wider range of services to be provided locally. Commissioners need to focus on services and outcomes and not become preoccupied with buildings.

Better commissioning Commissioners need a more sophisticated grasp of the change levers they can use and of the risks and consequences of alternative health care options. Setting a future vision and direction is an area that most commissioners have mastered. The real challenge for PCTs in demonstrating world class commissioning performance is in translating that 'big picture' into real change on the ground through programme planning, clarity about how the different forms of commissioning will be used, effective procurement and sensitive risk management. PCTs need to develop stronger governance arrangements to handle the inherent

conflicts of interest in practice-based commissioning. They should also learn from local authorities about their experiences of market management and commissioning, which in itself might support more integrated working.

Integrated working between health, social care and housing

Despite the progress made in service integration and joint commissioning, the health and social care sectors still have difficulty in understanding each other's context, culture and constraints. Removing these barriers would be one of the most effective ways to improve outcomes for people needing care and reduce unproductive use of resources. Strong working partnerships are needed to provide clarity about the respective responsibilities of health and social care. Individualised budgets could open up significant opportunities to provide more integrated approaches to providing health and social care support at home and make better use of health and social care resources. The health sector could build on the experience of micro-commissioning in social care.

Managing health and social care supply chains Shifting the pattern of health care at the same time as increasing contestability and plurality of supply will need more effective relationship management and better use of supply chain integration. New care pathways require integrated service delivery from a range of suppliers working in new forms of partnership, underpinned by appropriate accountability and clinical governance processes.

Levers and incentives Current levers and incentives in the health care system are not sufficient to enable large-scale changes in the way care is delivered. Some of the levers that have been introduced in the latest round of health system reforms need refinement. For commissioners, the real and/or perceived risks of service destabilisation and change remain the most powerful influences over their approaches. The changes that are needed include: clearer

political leadership on the direction of change; greater emphasis on and specification of health outcomes; the introduction of tariff and productivity measures for community services; incentives for innovation; and financial headroom and flexibility to manage financial surplus and deficit over longer timescales.

Workforce and organisational development The scale of workforce development, organisational development and education and training needed to underpin new ways of working should not be underestimated. There are real risks that the current clinical workforce and the way in which it is regulated could act as a constraint rather than an enabler of improvements to patient care. The Department of Health and strategic health authorities (SHAs) need to work with local health care systems to scope out the organisational, information and communication technology (ICT) and workforce development agenda associated with shifting the pattern of health care delivery.

Communicating the rationale for service change

The issues

- ‘Care closer to home’ sounds like a simple goal but the reality is more complex, as we suggested in the introduction. At one end of the spectrum it can mean the same care delivered by the same workforce in different places. At the other end it is shorthand for a radically different approach to diagnosis, treatment and ongoing care delivered by a different workforce mix and supported by greater use of technology developments. While there has been a consistent emphasis that shifts in care closer to home are ‘a good thing’, each specific change will need to be analysed on its own merits with clarity about the objectives and expected outcomes.
- To convince the public that more care closer to home is better requires clarity about what it means for their local services and hospitals and the specific benefits for access, convenience and

quality. Productivity and financial benefits are also important but not enough on their own to convince a sceptical public. Public reactions to proposals for changes to their local health services tend to be conservative. Perceptions of risk lie at the heart of the matter. The public are unlikely to shift their views without clear communication of the benefits from authentic and trusted leaders and an explanation of how care will be delivered, and by whom.

- There are some examples where large-scale service changes have been managed smoothly, without major public opposition, and delivered better patient care. A more typical experience in the NHS, however, is that dialogue with the public is partial and defensive, the rationale for changes in the pattern of care is poorly explained, and the precise impacts on and benefits for patients and carers are not clearly stated. The recent large-scale deliberative approaches to public engagement as part of the *Our NHS, Our Future* review (Department of Health 2007) have shown that where the public are fully engaged in mature dialogue, and where the evidence about the rationale for change is properly presented and discussed, they will not only support changes to local health services but will, in fact, demand that they are made. Too often, however, consultation proposals have been triggered by financial pressures or are justified in economic terms, which fuels public perceptions that the changes will result in poorer services. Even if financial pressures are not the primary reason for local changes, the historic media coverage of the financial difficulties faced by the NHS leaves a legacy that feeds public speculation. Now that the NHS overall is in a position of surplus, there is an opportunity to reclaim and reposition the debate about the benefits of care closer to home.
- While most people would prefer to receive their health care as close to their home as possible, care *within* the home provokes more mixed reactions. One of the concerns that the health sector needs to recognise is a fear of the burden that might fall on informal carers or that the workforce to deliver home care will not be available. The public and their representatives want to know that managers

and clinicians will handle any changes to the pattern of health care smoothly and effectively. They will want assurance that the risks of the changes have been fully analysed and can be managed and that they as patients will experience better care as a result. History has shown that major changes in service delivery are not always handled well. The public and key stakeholders are not always kept sufficiently well informed about the details of implementing service changes, and this can fuel their anxieties.

What needs to be done?

Apart from observing the basic principles of effective public engagement and communication, an important message for commissioners and health care providers to get across to patients and the public is that shifting care closer to home is not a blanket concept – the only shifts that will be made are those that are safe and cost-effective, and bring tangible benefits in the quality of care for patients.

- The Department of Health should consider developing a more positive brand and identity for local and home-based care. This should include the use of consistent terms to describe accurately what is meant by care outside hospitals or closer to home and how these services relate to those offered in specialist hospital facilities. The concept of local care also needs to be more effectively marketed and communicated, both nationally and locally by each PCT.
- PCTs, in promoting a shift in the pattern of health care, need to ensure that they listen and respond to the concerns of patients and their families and are not simply selling the message of new and better models of health care.
- PCTs and health care providers planning major changes to the delivery of care need to find ways to reassure patients and their families that: a) sufficient detailed planning of the implementation process has been undertaken; b) the appropriate workforce will be available to provide the care they need; and c) unnecessary clinical risks are not being taken. Communication about these points locally will be important given historic media coverage of shortages in

medical and nursing staff; it would be most effective if undertaken on a joint basis between health and local government.

- Linked to the above points, patient/carer champions need to be identified at both national and local levels to promote positive personal experiences of getting care closer to home. Greater publicity of examples where shifts in the pattern of care have been handled smoothly and delivered a better system of care would also be helpful.

Making better use of technology innovations

The issues

- There are many innovative ideas and technologies that could make a bigger impact if they were properly harnessed and commissioned as part of an integrated system. Assistive technologies, remote monitoring and telecare have not yet fulfilled their full potential but the reasons for this are not entirely clear. For example, home-care monitoring equipment provides considerable opportunities to support patients with long-term conditions and reduce the risks of unnecessary hospital care, yet it is relatively under-utilised.
- Commissioners and providers may not always be fully aware of all the opportunities available or how best to procure them. Managers and commissioners may also be wary of championing particular technology innovations if they are not fully endorsed by the clinicians who need to deploy them. A further factor may be lack of analytical skills to understand or predict the risks that technology solutions may present to the existing pattern of current provision.
- Many of the new developments that can support more community and home-based care have been introduced as small-scale pilots or used alongside an existing way of working. While this may be appropriate in testing whether the approaches are suitable for application to all patients, there seems to be no mechanism for systematically rolling out these developments once their impact has been proven.

- A further issue for suppliers in this field is that it is not always clear who they should approach to fund their services – PCTs, social services or a combination of the two.

What needs to be done?

- There needs to be a systematic way of scaling up the development and implementation of clinical pathways. There is also a need for methods that enable commissioners to analyse and understand the risks involved in alternative clinical pathways (such as those that include technology solutions). For providers, planning tools would be helpful to assess clinical pathway effectiveness and the degree of flexibility that should be tolerated in responding to the needs of individual patients. Tools such as the NHS Institute’s scenario generator model may offer one method for commissioners and providers to test out new pathways ahead of implementation, and they could enable faster decision-making. Behavioural simulations can also play a role in ‘benchtesting’ new ways of working.
- Producers of technological developments that could support home-based care may need to provide better information to help commissioners and providers to: a) see how the innovation fits within existing care pathways – do the developments offer complementary or substitutable approaches, for example; and b) enable the potential risks of implementation and the transition process to be understood and addressed.
- PCTs and local authorities need to build technology solutions that would support enhanced health and social care into their joint commissioning plans and where necessary pool budgets to simplify the procurement of these services.
- PCTs and health care providers need to get better at learning from the experience of other parts of the country in testing new technologies. SHAs need to ensure that PCTs and providers are aware of the skills and resources offered by the innovation and adoption hubs, which are part of the NHS Institute.

Reshaping primary care

The issues

- The decentralisation of services from hospital locations can be achieved through a number of methods. Yet SeeSaw showed that there might be a risk that too much emphasis is placed on care being delivered in bigger primary care centres or polyclinics, formed from centralising local surgeries and clinics.
- There is a need for significant improvements in the quality of primary care estates and premises, and some larger facilities do need to be developed to enable a wider range of diagnostic and treatment options to be provided locally and outside a hospital environment. However, the majority of patients needing primary care consultations progress no further than basic reassurance and perhaps short-term medication. For them, immediate and local access may be far more important than having an extended range of specialist services under one roof.
- There is no single model of polyclinics or community hospitals/ resource centres that will be applicable to all circumstances. A failure to communicate this has led to widespread opposition to the concept from a range of health professionals. There are five variables to consider:
 - the range of services to be provided, including the scale of inter-sectoral working
 - the management responsibility for providing the range of services in the facility
 - the governance arrangements that link the various providers together
 - the way in which the services link to the local primary care and pharmacy outlets
 - the ownership of the building/asset.
- Where there is a multitude of providers and complex shared-governance arrangements, the risks that the polyclinic model will not deliver its intended benefits for patients and productivity are likely

to be greater unless there is powerful and detailed commissioning. One of the easiest models to envisage is where these facilities are managed by a single lead contractor, who can then subcontract the delivery of different elements of care to other providers. SeeSaw showed that while there are many different providers who can take on this role – large GP practices, social enterprises, independent sector providers and even acute foundation trusts – they will bring quite different philosophies of care to the way these services operate. This should be given as much attention in the commissioning process as their management ability.

- In many rural areas the population sizes needed to support a polyclinic or primary care resource centre would be scattered over a large geographical area. Large primary care centres may not offer a much better solution for patients than travelling to their nearest general hospital. Mobile services – ‘visiting health centres or hospitals’ – provide the flexibility to bring services closer to patients and have the advantage of being a quicker response than redevelopment or new builds.

What needs to be done?

- PCTs need to ensure that they commission services and outcomes, not buildings. In considering the locations where services should be provided the starting point should be what can be safely and cost-effectively delivered to patients at home rather than assuming that primary care premises are the first port of call.
- Greater diversity in the provision of primary care is needed to both preserve and enhance the benefits of local access for patients and allow a wider range of services to be provided locally. While some patients with complex and long-term medical conditions may prefer the continuity and familiarity of remaining with a registered practice, others may be happy with a more episodic pattern of consultation at places convenient to where they work or undertake other activities.

- There is a need for honest debate with the public about the extent to which it is possible to provide continuity of care from their known GP *and* extended opening hours.
- PCTs covering rural areas or considering the redevelopment of community hospitals need to think about the benefits that mobile or ‘visiting’ services could offer before investing in fixed assets. Not only do these approaches provide flexibility in what services are provided where and when, but they may also be quicker to procure and do not need access to large capital investment.
- Where they are developing larger primary and community health centres or polyclinics, PCTs need to ensure that they consider the strengths and weaknesses of the different delivery, governance and integration models that will be appropriate in their location. There is no single solution that will fit every local circumstance. Opportunities for service linkages, if not co-location with other public services, should also be explored – housing and benefits advice, leisure and library facilities may all offer benefits for clients not only in terms of access but also through the links that may be made between these services. However, this may be less easy to achieve in areas where a polyclinic/community health centre serves residents of more than one local authority.

Better commissioning

The issues

- Setting a future vision and direction about a new pattern of health care is something that most commissioners can master. However, they may need support to develop the skills to realise that vision through a detailed implementation programme.
- PCTs face a classic dilemma – they want the space and autonomy to be able to set their own direction, yet they are anxious that their chosen approach will be undermined by guidance or instruction from above. Bold and ambitious moves to bring about large-scale shifts in the pattern of care are unlikely to happen without more

clarity from SHAs about the scope and scale of the changes they or the centre expects. PCTs will still have to set their own specific course and be judged on the outcomes.

- PCTs lack the information systems and analytical capacity to help them understand some of the ‘what if’ aspects of alternative options and decisions. This lack of analytical power is a contributory factor in commissioners’ reluctance to challenge the current pattern of health care.
- A further issue here is the balance between the different forms of commissioning – including specialist and lead commissioning, PCT commissioning, joint commissioning and practice-based commissioning – and how these are combined to take forward the vision of care closer to home. These different forms of commissioning could be seen as a set of ‘Russian dolls’ working at increasingly fine levels of detail. However, in reality they do not always work in such a harmonious way. For example, some practice-based commissioning groups may be covering too small a population to exert real leverage over acute care providers. Different levels of commissioning aggregation may be appropriate for different services or providers.
- Practice-based commissioning can be a really strong lever for limiting unnecessary hospital treatment but there are risks of conflicts of interest where the commissioning lever is used to promote the practice’s own service provision without fair and open competition.
- There are pressures from some groups of GPs to be given real population-based budgets as they believe this would give them more commissioning ‘muscle’. While this may offer some benefits in terms of incentivising gatekeepers to refer appropriately, reduce admissions to hospitals and invest in health promotion, any move in this direction raises big issues about accountability and governance arrangements for use of public money and the varying competence of GPs to manage risk. This approach might also open up the risk of patient selection, should practices choose not to register individuals

perceived to have higher risks or care costs. The current arrangements for sharing savings between PCTs and practice-based commissioners would also come under far greater scrutiny given the sums likely to be involved.

- Open competitive tendering is just one possible approach to securing large-scale shifts in care and needs to be used carefully, consistently and appropriately. Commissioners are still relative novices at using tendering as a means of procurement and there are real risks of legal challenge and delay if the process is not undertaken in a fair and transparent manner. Tendering processes also bring risks of delivering unintended consequences, particularly if financial factors are given too much weight as evaluation criteria.
- Commissioners and providers need effective quality measures and outcome indicators if they are to use the lever of competition to deliver the improvements in care that matter to patients.
- Commissioners do not always have the right level of clinical advice and expertise in-house to develop effective specifications. While the expertise of local clinicians can be invaluable, there will be occasions when more impartial advice is needed, particularly if commissioners are seeking a rather different pattern of service delivery than is currently on offer from local providers.
- There is a tendency for commissioners to focus on commissioning increasingly detailed care pathways. Not only are they time-consuming to develop but they also negate some of the creativity and innovation that service providers can bring. A focus on outcomes rather than inputs and outputs would be preferable.
- Complex procurement processes can act as a disincentive to third sector providers, small businesses (including GP practices and pharmacies) and some social enterprises that might be interested in providing services to a local health system. This could limit the choice available to commissioners and the scope for introducing innovation. PCTs need to ensure that the procurement process they adopt is tailored to the nature and scale of the services being secured, to the speed with which they want improvements to be

made and to the degree of diversity of provision they wish to develop locally.

‘Tendering and contestability is important but the timing needs to be right. When you are trying to take a change programme forward you are more likely to get sign-up and commitment of the players if they know they have two to three years to get the new ways of working in place before they will be expected to go into contestability processes. I would hope there is a way of allowing flexibility for appropriate development periods where complex change programmes are being taken forward.’

What needs to be done?

- Quantitative models such as the NHS Institute’s Scenario Generator can help commissioners understand the potential effects of alternative health care options on patient outcomes, inequalities, the sustainability of local provider services and affordability. There is also a need for commissioners to develop better indicators to monitor the effects of current services on patient outcomes and experience. PCTs may need to work together in order to create the critical mass of analytical and modelling skills they need to be effective commissioners. An assessment of the analytical skills that are routinely needed and what specialist analysis might be needed on a more ad hoc basis – which could be bought in – might be helpful.
- PCTs cannot discharge their responsibilities as commissioners, though they can decide to delegate commissioning functions upwards to a supra-PCT level, sideways (through joint commissioning) or downwards to practice-based commissioning groups. As well as being clear about which approach to commissioning is appropriate in which circumstance or for which population, boards need to maintain a clear picture of the

governance arrangements and information flows to support commissioning at these different levels.

- PCTs should develop the appropriate performance management and governance processes to ensure that practice-based commissioning groups work in an impartial way and to minimise any conflicts of interest that may arise in developing community-based alternatives to hospital services. This may mean separating the development of new service specifications and procurement processes from decisions about how new contracts are awarded. PCTs still technically hold the commissioning purse strings and current rules allow them to waive the need for formal tendering if ‘any willing provider’ can offer services. PCTs need to consider whether this is a sufficient safeguard to avoid conflicts of interest in situations where practice-based commissioning groups want to award contracts to their own provider arm for expanded service provision without testing the local market.
- PCTs know that few practice-based commissioning groups are capable of or interested in handling a full commissioning budget for their patients. However, they need to be confident that their practice-based commissioning groups have sufficient scale and leverage to be able to effect changes in the areas that they select to work on. PCTs should give consideration to concentrating practice-based commissioning decisions into the hands of fewer, larger groups that have the necessary ambition, vision and analytical and negotiation skills to be able to commission effectively.
- PCTs and practice-based commissioning groups need to learn from the experiences of local authorities in commissioning social care. There are potential lessons about how best to shape a local provider market by encouraging appropriate bidders, how best to support smaller providers such as voluntary/third sector organisations to contribute to service delivery, and how to develop mature relationships with providers. There may also be lessons from social care about commissioning from ‘in-house’ services that may be of

relevance to PCTs, given that few have fully externalised their provider services.

- The alignment of PCTs and local authorities, the increase in joint appointments, and the stronger push towards integration through joint strategic needs assessment, joint commissioning and common area assessments provide helpful opportunities for understanding local authorities' experiences in commissioning, provided the health sector is open to learning from other public bodies.

Integrated working between health, social care and housing

The issues

- Despite the progress made in service integration and joint commissioning, the health and social care sectors still have difficulty in understanding each other's context, culture and constraints. While at a local level a range of methods have evolved to secure greater integration in joint service delivery, planning, commissioning and funding, they remain inefficient and many will not stand the test of the resource constraints that seem to be affecting local government.
- The closer that care providers get to delivering care to patients in their homes, the more they cannot escape engaging with the individual's social circumstances and their whole range of care needs. Many of the people who need hospital care will also have social care needs, even if their needs and circumstances, as judged by the interpretation of the Fair Access to Care criteria, do not warrant actual support from social services.
- While not explicitly addressed in SeeSaw, an issue raised in the subsequent discussions was the poor quality of clinical support to clients in residential and nursing homes. There are two issues here: basic personal and nursing care and the lack of consistency in primary care support. Improvements in these areas could help limit

unnecessary use of hospital services, yet they have received far less attention than other aspects of demand management.

- Care closer to home requires a range of housing options catering for people with differing levels of dependence and different preferences for how they want to live. In many areas this spectrum is simply not available.
- As technology and care solutions allow more people with increasing dependency and mobility needs to be supported at home, the health sector will need to take far more account of the suitability of the housing stock. For people with increasing levels of dependency, there are few options between being supported at home at one end of the spectrum and intensive support in a residential care or nursing home at the other. The availability of suitable equipment is a further issue.
- The NHS, on both the commissioner and provider front, is ill prepared to support patients and their families with more self-care. Examples such as the expert patient and expert carer programmes have worked well but the current arrangements make micro-level commissioning of care packages around individual patient needs complex, with the exception perhaps of continuing care. This is in stark contrast with social care, where care packages are typically more tailored and bespoke to individuals due to the system being based around assessed need rather than general entitlement. The health sector could do more to mirror the approach to micro-commissioning used in social care as a means of developing personalised care for patients.
- Local authorities are in the process of introducing a major change in the way that resources are allocated to support client needs. Self-directed support, with a range of options that allow service users various degrees of control over what services they get to meet their assessed needs, is likely to introduce a wholesale change in both commissioning and the landscape of social care provision. At present, individualised budgets for health services are not allowed. SeeSaw showed that individualised budgets for specific conditions

and tightly defined needs could provide the right conditions for delivering more integrated approaches to providing health and social care support at home and better use of health and social care resources.

- As social service budgets are stretched and with rising demands from residents, many councils are restricting support to users whose needs put them in the ‘critical’ or ‘substantial’ band. Not only is it confusing for clients having these two different regimes – one that is free and one for which they are expected to pay – it is also increasingly likely to raise dilemmas for PCT commissioners. At issue here is the role that commissioners may need to play in supporting the social care needs of those either in the earlier and preventable stages of dependency or where social care support is an enabling mechanism to allow the individual to be cared for at home.
- There are two key areas where agreements about health and social care responsibilities and resourcing are essential. The first is in supporting clients who have crisis situations where a fast response would prevent the need for hospital admission. There are some examples of good, joined-up solutions that provide instant support where charges are waived for a defined period of time, but these are not consistently available. The second is in securing a speedy initial assessment of client needs. Again, there are areas where single assessment has worked well and others where duplication, bureaucracy and lack of professional trust remain rife.

‘There is a real disconnect between charging for social care, based on eligibility criteria, and the provision of health care based on need. This will become an increasing issue as more people are provided with health care in their own homes and cannot be simply ignored as it is at the moment.’

What needs to be done?

- The Department of Health should give careful consideration to the introduction of individualised budgets for people with defined clinical conditions where it is likely that they would have both health and social care needs. In designing these options care must be taken to ensure that the systems are completely compatible with individualised budgets in social care and would allow clients to combine these sources of support for their needs. Examples might include people with multiple sclerosis and some mental health conditions.
- There is a need for a national debate about the range of housing options necessary to support an ageing population that will have varying levels of dependency and to provide the opportunity to have a wider range of care and support at home. This is an area that needs long-term investment both to provide a wider spectrum of options for people to choose from and mechanisms that allow people in old age to unlock their capital assets and make the transition to different forms of housing and care.
- PCTs need to extend their working partnerships with local authorities beyond social care to include housing and leisure services, particularly in planning care for older people and people with disabilities. Looking to the longer term, housing developers need to ensure that new housing designs take account of this shifting agenda and the potential for technology solutions to support people at home.
- Health and social care commissioners need to ensure that they consider the implications of moving care closer to home on demands for community equipment and home aids and adaptations. Unless adequate resources are invested in these forms of support there are risks that transfers of care from hospital will be delayed, patients will have to be admitted to a hospital bed unnecessarily or will be prevented from having their choice of end-of-life care at home. This requires a joint response from health and social care partners.

- Some parts of the country have already made improvements in equipment availability and access through the integration of health and community resources to form common stores with a single point of access. The recent pilots to introduce retail models in which service users can access equipment from approved retail providers and top up their vouchers may demonstrate that this is an effective approach. However, neither of these approaches will be sufficient if investment levels are inadequate or projections of need for particular types of equipment are inaccurate.
- PCT commissioners and health care providers need to be explicit about the limits to their contribution to social care and housing. Health sector organisations need to differentiate between those services that fall firmly within their own areas of responsibility, and which would benefit from joint initiatives with the social care and housing sector, and those where they can be most effective in acting as an advocate, encouraging other bodies to shift their investment priorities or improve their current approaches.
- For some care groups – frail older people, and those with certain long-term conditions, for example – PCTs, community health providers and potentially practice-based commissioners need to be encouraged to set up micro-commissioning arrangements co-ordinated by case managers drawing off macro-contracts negotiated by PCTs. This would enable people with a complex mix of needs to have packages of care tailored to their individual needs and circumstances.
- PCTs need to pay attention to the quality of medical and nursing support to residential and nursing homes and the quality of clinical care available in these settings. Contracts that provide homes with the full support of a single, consistent, multi-disciplinary, round-the-clock primary care team might be more effective than the disparate arrangements that are typical in many places.

Managing health and social care supply chains

The issues

SeeSaw highlighted the complexity of implementing care closer to home at the same time as attempts to increase contestability and plurality of supply. It is far easier to see shifts in care taking place where a single, large provider can lead the process and be incentivised to secure some of the benefits of handling the change process. If PCTs are to make these types of shifts at the same time as encouraging new providers into the market, they will need to pay greater attention to brokering relationships between different partners in the supply chain and/or structuring contracts with effective incentives.

'In the late 1950s/early 1960s it became clear we needed to close the asylums – but little happened until there was a formal closure programme in the 1990s and a financial and workforce framework was in place to support the transfer of resources (both money and people) from the institutions to community-based care. This was comparatively easy because there were identifiable patients to link to the shift of resources. In acute care it is not that simple. We are unsure exactly how much capacity we will be able to take out of the system, and what we need to put in place to deliver that. For every acute bed, what is the equivalent community resource we need to put in its place?'

What needs to be done?

- In planning shifts in the pattern of care, commissioners need to think about how they can secure integrated service delivery along the supply chain and the governance model that would best promote this.
- As partnerships become an increasingly popular way of working, not only between NHS bodies but also with and between independent and third sector providers, health care organisations need to ensure

that there is clarity about who is responsible for patients at different points on the care pathways, that there are agreements about the deliverables and receivables by each party, and that performance measures are in place that allow each organisation to hold the other partners to account for their contribution to the care process. Systems and processes to support the fast development of supply chain relationships would also help minimise the risks of care pathways being fragmented by multiple providers.

Levers and incentives

In 2007 Lord Darzi published his ambitious blueprint for health care in the capital, *Healthcare for London* (Darzi 2007). It sets out a highly ambitious shift in the pattern of health care that would see around half of all current major hospital activity undertaken in polyclinics, minor hospitals or patients' own homes. While detailed work remains to be done to map out precisely how this shift will be implemented, *Healthcare for London* outlines the scale of what could be achieved were there to be sufficient will, commitment, funding, levers and workforce available. The big question that hangs over this ambitious vision is whether it is genuinely achievable and whether this type of approach would work in other parts of the country, including mixed rural and urban counties such as the patch that we explored in SeeSaw.

The issues

A number of the current levers for change available to providers and commissioners work only partially and need to be refined if they are to be helpful in securing a shift in the overall pattern of health care delivery.

- The tariff system and Payment by Results (PbR) are perceived by commissioners to be an improvement on the previous system of financial flows. But SeeSaw highlighted several difficulties in the incentives that these offer to provider behaviour. On the one hand the tariff system and PbR allow commissioners to unpack the

resources that historically would have been tied up in a block contract. On the other hand it can be difficult for commissioners to shift more care to community settings when the reward arrangements for acute providers are so strongly aligned with activity.

- PbR was intended to remove competition on price and, together with the levers of patient choice and commissioning, encourage a greater focus on quality. As currently operated, however, the emphasis is more on the payment and less on the results (the benefits and outcomes for patients). The immaturity of the market and the commissioning process, coupled with the lack of consistently applied and monitored quality indicators, inhibit the effectiveness of the PbR regime.
- We have started to see attempts by providers and practice-based commissioners to bend tariff prices (effectively price competition by another name). Examples range from negotiations focused on outright price reductions for specific or guaranteed service volumes to bundling ‘soft’ services into care pathways in order to increase the attractiveness of the service to patients and commissioners. PbR is still regarded by acute care providers as a payment for activity that incentivises them to do or control more and reduce costs in order to generate surplus or profit. The incentives for acute providers to invest in service quality that does not lead to extra activity are weak.
- SeeSaw demonstrated the risks of using the tariff system to incentivise shifts in the volume of care provided in community settings. A lower tariff for provision of care outside hospital *could* act as an incentive for commissioners to secure more care in local settings, provided it is safe and effective. However, this would bring reduced income for activity to health care providers so they would be unlikely on their own initiative to plan shifts in care closer to home. As the health care system awaits the maturation of commissioning, incentives that operate at the provider level continue to be an important influence on the pattern of care and the extent to which it delivers benefits for patients.

- Another issue with PbR that is highly relevant for moving care closer to home is that tariffs have yet to be developed for primary and community services. This is in part due to the under-development of pricing and costing for these services. The extent to which PCTs can genuinely commission community health services and encourage greater contestability and plurality into the system is limited by the lack of robust measures of activity, quality and price.
- There are some targets for commissioners and providers that have stimulated service redesign and significantly reduced waiting times for patients. The 18-week target, for example, has helped to catalyse pathway redesign and has also facilitated some shifts in care closer to home. But these changes take time to plan. While pressures in the system create the need to do things differently, the demands on hospital clinicians to deliver increased activity, the greater demands on GP time for both clinical work and commissioning, and the tighter specification and management of consultant job plans have conspired to give clinical leaders less flexibility in their working days and less time for them to work together to plan new ways of delivering care.
- Performance incentives in the current system may also be inhibiting shifts in the pattern of health care. Some acute trusts are struggling to reconcile their strategy for decentralisation with Monitor's stringent requirements around foundation trust status. In other cases, trusts find themselves compromised by long-term private finance initiative (PFI) deals. The pressures created by holding assets and the need to continue to draw in activity to support the PFI debt both militate against a strong push to localisation of health care.
- For commissioners, disincentives are currently more powerful motivators for change than incentives. Willingness to secure shifts in the pattern of care that could bring greater benefits to patients is dampened by perceptions of factors such as recognition for achievement, the degree to which the SHA is encouraging service reconfiguration, the scale of public and political opposition and the perceived risks of destabilising the current pattern of care. The

health system remains a relatively unforgiving environment for leaders who are portrayed as making mistakes or whose plans receive hostile media coverage. Commissioners who appreciate the complexity of the task in achieving a large-scale shift in the pattern of care may understandably be reticent to push ahead if they perceive the balance of support and recognition as favouring the status quo.

- The financial position on both the commissioner and provider side is an important enabler of shifts in care closer to home and may go some way to explain why the expected changes have not happened faster and more consistently. While it may be true that in the longer term a shift from a pattern of care dominated by large volumes of care delivered in hospitals to a more distributed pattern of care in patients' homes and primary and community settings will secure lower costs, the transition will require a period of double running. Providers and commissioners that lack the necessary financial headroom will find it harder to achieve the changes than those who are in a healthier financial position.

What needs to be done?

- Ministers need to give a clearer lead to commissioners and health care providers about what they expect, and the degree of political 'cover' they will provide. True or imagined, the institutional memory in the health service is that there is insufficient 'cover' when large-scale change is contemplated and that local political opposition to change prevails over the evidence of benefits to patients.
- The transition to a new pattern of care has to be underpinned by a financial investment plan in which there is a period of double running or tapering to allow new primary and community services to be put in place before any hospital-based services are fully withdrawn. The national strategy to create greater financial headroom is right but the rationale for surplus needs to be better communicated to the public and patients.

- While many have an intuitive belief that provision of care closer to home could offer financial gains, particularly where there is the opportunity to close part- or full-acute hospital sites, detailed economic modelling and analysis has to be undertaken on a case-by-case basis. Hospitals that are based on the old ‘tower block’ model, for example, are likely to face tighter constraints on realising the financial gains from decentralisation than those with a more sprawling estate.
- The Department of Health and/or SHAs need to develop stronger incentives for PCT performance with greater emphasis on the achievement of improved health outcomes, recognition of innovation and new approaches, and flexibility to manage surplus and deficits over a longer timescale.
- The tariff system needs to be extended to cover primary and community services, and the development of measures of community service activity and quality must be accelerated.
- PCTs need to explore the application of alternative incentives for provider performance that encourage the delivery of better quality and outcomes. The ‘payment for performance’ pilot led by NHS North West is an example of how this might be done. Risk-sharing agreements to share financial gains and losses or tapering payments that enable providers to adjust income losses may also be helpful. Vertical integration of acute and community services may be a further option, though care would need to be taken to ensure that the community services elements remain properly funded and supported.
- PCTs should secure the advice of independent clinical panels on commissioning decisions and service redesign if they are to avoid the risks of conflicts of interest that may arise in advice from local primary and secondary care clinicians. This is something that SHAs could help to co-ordinate.

‘We need PCTs to identify much larger sums to pump prime the big shifts in care – for the development of new primary care facilities, for example. It is important that the surpluses being generated in the NHS are used for development funding, not simply continuing with existing ways of working.’

Workforce and organisational development

The issues

- It could be argued that tendering for new patterns of health care is a relatively simple, if technical, exercise. But the point at which a contract is awarded is only the start of the process of service development. Arguably, the next phase of the process is more important and is typically given less attention than the early part, procurement.
- Where contracts are awarded to new providers there may be issues around staff changes and transfers, the significant task of securing new relationships with other providers in the supply chain, and a good deal of learning about running the service in practice, which may be somewhat different to that envisaged in the response to the tender documentation.
- Commissioners and SHAs may also need to consider how they manage the impacts of decisions on local providers who are unsuccessful in winning a contract yet continue to provide other elements of patient care.
- Knowledge of the workforce constraints and opportunities that limit or enable a shift to care closer to home is under-developed. Modelling and planning for the skills and competencies required to deliver new models of care is crucial, particularly given the significant differences between providing care in people’s homes and providing the same type of care in a hospital setting.
- In the current state of play in the NHS it is far from clear where workforce planning and the commissioning of education and

training should sit, yet they are both critical functions in enabling shifts in the pattern of care. On the one hand it could be argued that workforce supply is a provider responsibility and that the way they choose to do this is part of their intellectual capital. On the other hand commissioners have a duty to ensure that within the market, workforce investment is in line with the pattern of care they want to see delivered in the future. Currently the commissioning of education and training rests in the hands of the SHAs that performance manage commissioners, yet increasingly they have little to do with the providers that have foundation status.

- One of the key constraints in delivering care closer to home is the impact that changes in medical education will have for future generations of GPs. The emerging trends in policy and practice require GPs who are prepared to take on a wider range of clinical work, to work in partnership with other health and social care providers who deliver other parts of care pathways, to lead larger teams of multi-professional staff, to embrace the opportunities of practice-based commissioning and to potentially develop specialist interests. GPs have themselves suggested that the new cohort of GPs in training are far less willing and capable than their predecessors to take on this range of work and work as autonomous partners immediately after completing their vocational training.

Professional bodies have tremendous power to restrict or enable workforce change and influence the pattern of health care. There are concerns that the way the professional bodies currently word their guidance to provide an effective environment for medical education tends to require greater concentration of health services in larger centres. This does not always offer the best model for patients, yet these guidelines tend to be given considerable weight by commissioners and providers in planning and service redesign.

What needs to be done?

- SHAs need to work with local health care systems to scope out the organisational, ICT and workforce development programmes to support a shift in the pattern of health care delivery.
- The current structure of workforce planning and the commissioning of education and training is clumsy and needs to be remodelled to fit with the current dynamics of commissioning and provision of health care. This needs to be led by SHAs in conjunction with their constituent PCTs, trusts and independent care providers. With increasing integration of aspects of health and social care, these trends also need to be considered in any future arrangements.
- PCTs need to ensure that they put as much effort into the post-contract negotiations and the monitoring of transition where they have tendered new services, new providers or service relocations.
- Providers of pre- and post-registration education and training need to be actively engaged in understanding the proposed shifts in care and encouraged to design education programmes that prepare people for new models of service delivery.
- Providers of community-based services need to ensure that health professionals are properly supported with the appropriate information and communication systems, clinical supervision and support to equip them to work effectively in non-institutional settings and feel confidence in their practice.

Some final observations

The SeeSaw simulation started with the question of how to overcome the apparent reluctance of the health and social care system to take care out of hospitals and closer to people's homes. The answers that emerged are as complex as the health and social care system itself – often partial, frequently interdependent and sometimes contradictory. However, looking through all the material that was generated during the simulation and in subsequent discussions, there appear to be four main barriers.

The first two barriers concern the power of commissioning. With all NHS trusts set to acquire foundation status in the next few years and PCTs externalising their provider functions, we are moving to a situation where most – if not all – care providers to the NHS will be beyond direct control by the Department of Health or their SHAs. This leaves commissioning as the biggest and most important driver of service design, yet it is widely recognised that the NHS has some way to go in developing the cadre of informed and stalwart commissioners required to do the job.

There are serious doubts about the analytical power of PCTs and the level of resources they have available for the analytical task. It will require sophisticated economic, epidemiological, activity and cost modelling to be able to determine with sufficient certainty what services need to be commissioned over which periods of time and in which settings. It needs sophisticated programme and project management skills and well-developed procurement and evaluation capacity. Without this, services will change only incrementally – if at all – and any imagined benefits for patients or costs will not be realised.

SeeSaw showed the sheer complexity of commissioning care closer to home. There is a need for SHAs, PCTs and regulators to work together to understand: how best to commission and procure new patterns of care; how to structure contracts and accountabilities across multiple providers contributing different elements of the care pathway; and how clinical governance can reflect the reality of care pathways, not simply organisational boundaries. SeeSaw also highlighted the fact that procurement is only the start of the change process. The world-class commissioning movement *has* to succeed not just in developing the competencies of commissioning organisations but also in ensuring that the right organisational delivery and performance management mechanisms are in place to encourage and enforce their rapid adoption.

Being informed is important but commissioners must also be brave – and this represents the second barrier to shifting care closer to home. To make these big changes happen, commissioners will have to deal with the reaction of the professional and provider institutions, the public and patients who tend to resist any reduction in care in hospitals, as well as local politicians nervous about the impact of change on the voting behaviour of their constituents. Winning the hearts and minds of these people is about more than mass communication of a future vision or the ‘case for change’ – they need tangible examples of the benefits to them on the ground. They need to understand that new services will be in place before traditional patterns are dismantled and they have to feel confident that clinical leaders and managers are up to the task of managing the transition smoothly and effectively with no detriment to patient care.

Local autonomy does not mean a lack of direction from the top. Political leadership – showing the public why the service needs to change and what they should expect locally – would provide support to the actions of local commissioners. It would help commissioners be more confident about disturbing the status quo and give them confidence that if they do stir up the hornets’ nest of major service configuration, then the centre will not intervene on political grounds against what is in the best interests of patients. Setting out clear expectations of commissioners and giving them full support for making the right changes happen would remove a powerful disincentive for commissioners to be brave. This does not mean that PCTs can abrogate their responsibilities for managing relationships with local politicians, stakeholders and the public but it would give them ‘permission’ to take the difficult decisions.

The third barrier is the challenge that moving care closer to home presents to the boundaries and working relationships between health, social care and housing. Many of the clients who could be safely and effectively treated at home or in primary care settings instead of hospital are elderly, and many have social as well as health care needs.

However, as we have learnt, different cultures, funding and charging regimes, different terms and conditions for staff and differing mindsets of the professionals involved all conspire to make this joint working difficult. Our discussions with both health and social care leaders highlighted the fact that if we are to move care for a significantly larger group of patients into community settings then the joint plans and funding arrangements, the joint commissioning and joint appointments, and all the pragmatic accommodations and understandings will be stressed to breaking point. What has evolved to support greater integration so far may not bear the strain of significant amounts of care moving out into the community domain.

The big issue for politicians to consider is removing the boundary between health and social care completely. If this is a step too far, there needs to be urgent attention paid to unlocking the funding and accountability constraints to service improvement.

The fourth barrier is the incentives that the current pattern of financial flows presents to both acute and primary care providers. With commissioning still evolving, the power of acute providers in particular remains strong and to all but the most perceptive of boards there appears to be little incentive for acute trusts to move their services out into community settings. They see bringing activity into the hospital as a way of covering their fixed costs – especially in a PFI building. The evidence about whether out-of-hospital care is cheaper is equivocal and will depend on the specific assets that are involved. By keeping things as they are, acute trusts avoid having to persuade their clinical community that leaving the ‘safety’ of the building has merit.

For primary care, the incentives work in a rather different way. Practice-based commissioning has opened up the world of greater practice-based provision and for many this has great financial as well as service attractions. But the amounts of money involved make the inherent conflict of interest difficult to side step. There are also issues about

clinical governance, the accreditation of GPs with special interests and the cost-effectiveness of some of these models that need further scrutiny. PCTs certainly need to strengthen the performance management of practice-based commissioning. They also need to manage the overall health care market through more sophisticated and sensitive financial incentives that reward quality, outcomes and an improved patient experience. This could be the key to securing support from all parties for patterns of distributed health care that work in the interests of patients rather than organisations.

Part 3: What happened in SeeSaw

This part of the report outlines some of the specific developments that took place during the SeeSaw simulation.

The following organisations were represented in the SeeSaw health system.

- **Monitor** – the foundation trust regulator. In round one, Monitor continued with its role in supporting the establishment of foundation trusts. In round two, it continued as the regulator of all NHS trusts and had a wider role in providing loans.
- **The Healthcare Commission** – in round two, the Commission became the Care Quality Commission following its integration with the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission. Its challenges were clarifying the interfaces between its role and that of Monitor and the strategic health authority (SHA), and how best to take forward integrated assessments of health and social care.
- **Greater Catt Strategic Health Authority** – it had set its primary care trusts (PCTs) the challenge of demonstrating world-class commissioning. The SHA was also considering how it should behave as market manager.
- **Taitshire Primary Care Trust** – a large and relatively high-performing PCT, with active if maverick practice-based commissioning groups and major health inequalities.
- **Three practice-based commissioning groups in Taitshire:**
 - **Gomersall group**
 - **Taitshire South group**
 - **Taitshire West group.**
- **Georgetown Primary Care Trust** – shared its boundaries with the unitary authority, Georgetown Borough Council. Georgetown PCT was coping with rather apathetic practice-based commissioning groups, a

small provider arm and major difficulties with the quality of primary care,

- **Georgetown Federation of practice-based commissioning groups.**
- **Georgetown Hospital NHS Foundation Trust** – this large trust had recently taken over a new private finance initiative (PFI) hospital and was experiencing financial pressures in covering the costs of the new facility. The trust had still to resolve the future of the old infirmary site in the city centre, which it had recently vacated.
- **Gomersall Hospitals NHS Foundation Trust** – a trust with two main sites: Gomersall and Sheringdon hospitals. A programme of reconfiguration had been largely completed, concentrating emergency care at Gomersall and elective work at Sheringdon.
- **Farrell Community Hospital** – a social enterprise run by residents of the village of Farrell.
- **Moody Mental Health NHS Trust** – expenditure on mental health in the county was higher than in benchmark PCTs but there continued to be areas of demand that were not being met. We were interested in how this trust would react to the care closer to home agenda.
- **Greater Catt Ambulance and Paramedic Service** – an ambitious organisation keen to see its range of services extended.
- **Vango Healthcare** – part of a major national charity providing hospital care and well-being services. Vango provided out-of-hours primary care in Taitshire and was a leading provider of mobile diagnostic and theatre services.
- **Ashton International** – a provider of home-care monitoring equipment and personalised care. The company had yet to secure any contracts in Taitshire.
- **Patients’ Panel** – an active and assertive group of patient representatives.
- **Taitshire County Council** – a progressive council represented by the overview and scrutiny committee (OSC) and adult social services.

Round one: SeeSaw 2008/9

The first round of the simulation took place in 2008/9 with a policy trajectory similar to that in real life. Overall, we saw many of the operational constraints that appear to get in the way of major service change played out with great realism – financial difficulties, a focus on short-term performance and misunderstandings of the role and contribution of different organisations and stakeholder groups.

Patient and public engagement

- The patient and public representatives sensed a great willingness to engage them in debate throughout the year. Both commissioners and providers had sought their views. The SHA too was taking greater interest in feedback from patients about the quality of their health care experiences.
- However, as the debate moved from general principles to more specific proposals, these players appeared to shift the approach from consulting to selling, and at this point they encountered more public resistance to change. To some extent this may be inevitable as it is far easier to gain support for general points until the precise implications become clear. Illustrative examples may help to bridge the divide.
- Despite this, the public felt frustrated by the lack of consistent messages they were getting from commissioners and providers about what was happening to their health services and why. While phrases such as ‘care closer to home’ or ‘shifting services into the community’ were often heard, patient representatives found the language confusing and the rationale for the changes appeared to be muddled.

Community health services

Taithshire PCT had inherited a mixed bag of services, with community hospitals and health centre estate. They ranged from the state-of-the-art Dellaglio Hospital to the small and costly St Jonny’s Hospital. While the

PCT's provider arm, in its bid for community foundation trust status, had assumed that these assets would be an integral part of its inheritance from the PCT, the commissioning side of the organisation had other ideas and opted to keep these assets under its control. The rationale here was that by retaining these facilities the commissioners would have greater freedom to invite other players to provide services on the community hospital sites than if they were wholly owned by the putative community foundation trust. The PCT also saw these assets as a key lever in its ability to reprofile services and deliver reductions in urgent care and meet the 18-week target.

Farrell Community Hospital attracted a good deal of interest when other parties began to see its potential to support their own interests. The social enterprise, admitting that it felt somewhat naïve in its negotiations with some of the better established organisations, found a natural ally in Gomersall Foundation Trust, which saw the potential for the site as part of its strategy to decentralise services yet made no moves to take over the organisation. It began to offer outpatient appointments and bed-based care of older people on the Farrell site. The social enterprise also had expressions of interest from the Taitshire practice-based commissioning groups and from Taitshire provider services but these discussions did not lead to firm agreements.

The future of the Georgetown community facility was a legacy from the PFI development. With part of the site sold for commercial development, the remainder had been retained at the behest of the overview and scrutiny committee for health care development. Georgetown PCT had an option on its future use but rather than make an immediate decision it agreed with the practice-based commissioning federation to undertake a formal option appraisal on a health economy-wide basis. Given the diversity of interests in the health and social care community it would have been interesting to see if a true consensus emerged from this process. It appeared that the PCT was looking to establish consensus between all health care providers

about the ‘least worst’ option rather than make a decision as an impartial commissioner focusing on the best interests of patients.

Commissioning

Taitshire PCT made an active commitment to secure more community-based care early in the year and there were indications that they were genuinely interested in supporting plurality of provision in which ‘any willing provider’ would be given an opportunity to provide health care to patients in the county. The PCT signalled its intention to tender the provision of an urgent care network although this was not followed through to its logical conclusion. As a commissioner, however, one of its big decisions was how best to handle its community hospitals. At the end of the year the PCT decided that these assets were part of its leverage as a commissioner and refused to transfer them to its provider arm when it became a community foundation trust.

Georgetown PCT similarly made early progress in developing a set of commissioning intentions that worked in the best interests of patients. The PCT put great emphasis on building strong relationships and alliances across the range of organisations in its patch to get buy-in for the ‘big picture’ strategy. Its commissioning priorities were designed to address health inequalities, the rise in long-term conditions and alternative approaches to urgent care. But faced with increasing pressure from the SHA to address its financial deficit, the PCT found it had to compromise, if not park, its strategic commitments around shifting care closer to home. The impression given was that the PCT saw its strategy of shifting to a new pattern of community-based care as a separate strand of activity to reaching financial balance or achieving the 18-week target rather than as a means of achieving both of these goals. Significantly, the PCT had also made a commitment to repatriate some of its acute work, which had been going out of county, back to Georgetown Hospitals to assist them with their activity and financial challenges. Whatever happened to patient choice?

Joint commissioning

Joint commissioning proved to be one of the more successful outcomes from round one, with two areas being explored – joint commissioning of bed-based intermediate and continuing care and integrated health/social care support for people with long-term conditions. The latter was acknowledged to be a complex field as local authorities do not typically plan for the care of this client group and it would take time to get the specification right.

The negotiations between the local authority and PCT took place with the complete exclusion of the practice-based commissioning groups. There were two explanations as to why this had happened. Either the local authorities did not fully understand the role and power of practice-based commissioning groups or they did, but had chosen not to negotiate with these groups and negotiate instead with the PCT, which actually held the power and the purse strings as commissioner.

The joint commissioning agreements exposed some interesting differences between the health and social care sectors. First, there was a lack of appreciation by the health sector players that local authority adult social care departments are primarily commissioning bodies, having outsourced the majority of their in-house provision. Second, the social care players were far more inclined to move to a tendering solution than their health sector colleagues, whose natural inclination was to work through influence over current providers. While this was in part a reflection of the different stages of commissioning sophistication, it was also felt to be a necessary approach while the PCT's provider services were in the process of being externalised.

Practice-based commissioning

The practice-based commissioning groups in the fictitious county of Taitshire were far larger than is typically the case in the real world. Nevertheless, they still felt too small, underpowered and overawed by the muscle of the foundation trusts. Despite their initial objectives and

intentions, one of the practice-based commissioning groups acknowledged that they had opted to further their own practice interests, giving priority to financial gains rather than quality improvements. Others felt frustrated at their achievements and the protectionist stance taken by the foundation trusts.

The Taitshire practice-based commissioning groups started to negotiate around the tariff. It was unclear whether this was because of their previous experience of fundholding or genuine frustrations at the rigidity of the tariff system.

Handling patient and public opinion was experienced by some of the practice-based commissioning groups as an onerous task. In the real world most PCTs provide cover for practice-based commissioning groups by undertaking much of the engagement work with the public, leaving the groups to handle patient opinion. In the simulation, however, the practice-based commissioning group began to see some of the political difficulties in working with patient and public activists who ‘want it all’ – a service that is customised and responsive to their needs but also consistent across the county, with no practice-based commissioning postcode lottery.

Health inequalities proved a strong focus for the Gomersall practice-based commissioning group. Their main efforts, however, were invested in lobbying for fair share allocations of resources.

In Georgetown, the practice-based commissioning group started with strong intentions to be a lead commissioner, not led by the PCT. Very quickly, however, it was corralled by the PCT to support an organisation-wide commissioning plan formulated by the PCT. The group’s relationship with the PCT proved sufficiently strong for it to support the PCT’s efforts to address the short-term financial difficulties in preference to the longer-term objectives to which they had all signed up. The group had been committed to the redevelopment of the community

facility in the city centre as a polyclinic. As this development was pushed off the agenda, the group entered into discussions with the foundation trust to use spare capacity on their site for a polyclinic development. With the concentration of health problems and population in the city centre and the existing difficulties in accessing the hospital, this move appeared to signal a triumph of opportunism over clarity of purpose.

The future of PCT provider services

In Taitshire PCT, which had a very large provider services arm, establishing a degree of separation from commissioning responsibilities proved relatively easy. In Georgetown, where the PCT's provider services role was far smaller, an arms-length relationship proved much harder as control over community services was one of the few strong levers for change available to the PCT.

The Georgetown community health services initially found it difficult to engage with practice-based commissioning groups that were far more interested in the gains they could make from negotiations with acute trusts. Once they had secured the PBC group's interest their interest focused on direct employment of community health service staff rather than joint ventures or having a commissioning relationship with their community service counterparts. The integration of community health services and practice-based commissioning appeared to make intuitive sense and both parties found lots of opportunities to work together. However, the governance arrangements and nature of the partnership proved a more significant challenge.

One of the interesting issues for the larger Taitshire PCT provider services was in differentiating commissioning and providing activities. At times their discussions sounded as if they were commissioning care from other players – for example, in securing contributions to reduce health inequalities – or was this simply subcontracting or an attempt at differentiating the supply chain?

Responding to shifts in care – the reaction of acute trusts

The two acute trusts in the SeeSaw simulation faced contrasting pressures. Georgetown was performing well but was faced with falling income and activity now that the 18-week target had been reached. With more capacity than it needed and financial pressures, it had little incentive to shift any care outside the trust and indeed had developed a range of tactics to attract additional work. Gomersall Hospitals NHS Foundation Trust, by contrast, had a strategy to disperse its services to more community locations but was frustrated by the lack of consistent provision of primary care and failure of the practice-based commissioning groups to deliver on their commissioning intentions. As a consequence it was failing to achieve the 18-week target.

Gomersall Foundation Trust went all-out for income generation by boosting its private work. With a healthy surplus already built up, it invested some of that money in a state-of-the-art IT system that would provide up-to-the minute information on patient referrals and progress through care pathways. Linked to a financial package, it believed this would provide a more sophisticated information system to support the unbundling of tariffs. It secured agreements with practice-based commissioning groups to shift diabetes and chronic obstructive pulmonary disease (COPD) services into community settings so that the trust could concentrate on higher value activities. While the trust had problems in meeting the 18-week target, overall it continued to push for shorter waiting times for first outpatient appointments, recognising that patient choice was an important lever that it should not ignore. The trust established a partnership with Vango Healthcare to take some of the elective work to local hospitals. This secured patient flows, supported the achievement of the 18-week target by providing a temporary increase in capacity and brought care closer to the patient.

Agreements were forged between acute and primary care players, between acute trusts and the ambulance service and also with the independent sector. Commissioners did not appear to be entirely in the loop with some

of these arrangements. Similarly, the two acute trusts, recognising the pressures on these services across the county, moved to differentiate services and functions across sites, with the tertiary work, including the majority of cancer care, concentrated on the Georgetown site.

‘Acute providers continued to plan their own direction irrespective of commissioners’ views.’

For Georgetown Hospital, as a teaching hospital and with the constraints of the PFI development, the prospect of losing tertiary and secondary care was a real threat. Gomersall Hospitals Foundation Trust, by contrast, demonstrated its greater flexibility and nimbleness by looking at opportunities to decentralise and reduce its overall bed base. Its philosophy was that decentralisation was likely to happen anyway and that it was better to be an active player, securing at least some of the income, than a resistor where the potential losses were far greater.

Urgent care

Urgent care was the area where greatest innovation in thinking and planning was shown, although the actual pattern of care had changed little by the end of the year.

Gomersall Hospitals NHS Foundation Trust made an agreement with the ambulance trust to secure a 30 per cent reduction in category C calls that would be brought to the hospital. This would be achieved through the ambulance trust working with staff from the acute trust to secure treatment for patients at the site of their illness rather than transporting them to hospital. The ambulance trust also started working with Taitshire PCT to establish a single point of access for unscheduled care.

The ambulance trust was delighted at the opportunity to diversify and develop into a full mobile clinical service. Its overall aim was to be the

‘glue’ between home- and hospital-based services. In reality, however, the ambulance trust noted that most acute trusts have only an embryonic understanding of the role of ambulance and paramedic services in transforming urgent care services.

Georgetown practice-based commissioning group similarly decided to focus its attention on reversing the trends in demand for urgent care by identifying patients described as ‘frequent fliers’ and those who might have been admitted to hospital unnecessarily. An incentive scheme to reward practices for reducing the number of cases passing through to hospital was introduced.

Independent sector provision

The independent sector providers started out with a natural scepticism about whether they really were playing in a market that offered a fair competitive environment. With many players interested in exploring potential opportunities, the independent sector providers quickly established some rigour, focusing only on those proposals that offered the greatest potential for success in their core business. The provision of mobile diagnostic services and health care proved an attractive option for securing the dispersal of services on to community facilities, for both NHS and private work. Gomersall Hospitals Foundation Trust worked with Vango Healthcare to strengthen its private diagnostics and wellness services at Sheringdon Hospital and bring some of its acute surgical work out to Jason and Dellaglio hospitals.

The two independent providers in the simulation agreed to work together as partners, forming the VangAshton group. Their complementary offers, they claimed, made them far more effective as collaborators than competitors. Key to the success of the Vango and Ashton partnership was the flexibility that came from having limited fixed assets in the form of property. It enabled them to be open to a range of potential offers and relationships without having specific territory to defend.

Improving mental health care

Moody Mental Health NHS Trust fixed its sights firmly on core business and made little attempt to diversify or stitch mental health services into acute care pathways. Its primary focus was on improving care for patients through integrating mental health and social care, repatriating mental health work that had been commissioned with out-of-county providers, and expanding the provision of psychological care in primary care settings.

On the integration of mental health and social care, Moody found a willing supporter in Taitshire County Council, but this discussion turned out to be a conversation about integrated commissioning rather than service delivery. As its service strategy rested on this development, the trust decided that it should defer its foundation trust application and concentrate on the things that would make a difference to patients.

Innovation in supporting care closer to home

A creative approach from Farrell social enterprise to Moody Mental Health NHS Foundation Trust and the county council attracted some interest. Farrell was proposing to establish a new local insurance scheme that would provide patients and carers with up to one week's non-acute stay for rehabilitation or respite should they need it. While it might be tempting to conclude that this was too new and innovative to gain support, perhaps one of the real challenges for this type of initiative is the confusion among patients and carers about what level of support they could expect if they or their relative became frail and in need of intensive home-care support or rehabilitation.

Relationships between PCTs and local authorities

While Taitshire County Council indicated that it had a broad interest in health and well-being and early intervention, its main focus in round one proved to be on the interface between health and adult social care. Its passion for delivering more personalised care for service users was tempered by significant financial pressures that it had to address.

Regulation of care quality

The Healthcare Commission realised that the future pattern of care would be far more complicated to oversee than the present system and that the licensing and regulation task for the Care Quality Commission would be a significant one. Not only would there be more players but there would also be more partnerships and diversity in care pathways, which would be a challenge to its current way of working.

Monitor identified the early signs of financial difficulties at Georgetown Hospital Foundation Trust and encouraged it to take the situation more seriously. Monitor realised that it had to pay far more attention to commissioner views in its assessment process and wanted to see evidence that foundation trusts were doing the same.

The SHA appeared to give mixed messages to its PCTs. On the one hand it expressed disappointment that so little had been achieved. It also found it difficult to keep abreast with the spectrum of commissioning and provider activities, being effectively ‘blind’ to foundation trust performance, this role being performed by Monitor. However, on the other hand, despite insisting that its role was to support commissioners in making difficult decisions, the SHA intervened in PCT plans to secure short-term financial balance.

Conclusions

At the end of 2008/9, despite good intentions, few agreements had been reached that would have led to a significant amount of care and funding out of hospital. Clinicians and managers in both commissioning and provider roles appeared to be preoccupied with relatively small-scale improvements in clinical pathways and negotiations about who was best placed to provide care to people with long-term conditions.

The 2008/9 round was dominated by providers and their interests. Commissioners started to make an impact but for the most part the two

acute trusts ploughed their own furrow. There was a sense that the foundation trusts believed that the commissioners were either not sufficiently committed or able to secure a dramatic shift in the pattern of care.

Many of the provider-led discussions about shifting the pattern of care did not start from the question of why more care should be provided outside hospitals – that is, the potential benefits for patients. As a consequence, ‘care closer to home’ appeared to be cited as an accepted and unquestioned mantra and used to further organisational interests. Partnerships that began to form across primary and secondary care equally appeared to serve sectional interests and were embarked upon as a way of sharing and reducing risks.

Commissioners assumed they could move money and contracts between acute providers without consideration of patient choice. This stood in stark contrast to discussions about social care where the impression given was that clients would have expanded choices as a result of the new system of personalised budgets being put into place. While this might have been a signal to health care providers to explore new opportunities in the social care field, none of the SeeSaw providers saw this as territory they were willing to enter.

The risk of destabilising the health care system appeared to be a key influence on commissioners’ thinking. They were concerned about the implications of taking a more assertive approach to shifting the pattern of health care not just for continuity of care for patients but also for their own reputation.

Round two: SeeSaw 2012/13

With the challenges, successes and disappointments from 2008/9 still relatively fresh in their minds, SeeSaw participants faced some new challenges in 2012/13.

- A new government was elected, with a much-reduced majority. The government's programme of public service reform placed great emphasis on personalised, responsive care and choice.
- A tight financial settlement and continuing expectations on the delivery of productivity improvements.
- Despite Olympic fever hitting the country there had been no significant downturn in obesity although the rate of increase had slowed, with inevitable consequences in demand for health care.
- Health inequalities were widening as previous attempts to improve health and well-being had disproportionately benefited the wealthier segments of the population.
- All trusts had become foundation trusts with greater freedoms on access to capital and vertical integration.
- PCTs had become entirely commissioning organisations.
- The two PCTs in Taitshire were merged to form a single organisation but the two provider services had remained separate, forming a community foundation trust in Taitshire and in Georgetown a social enterprise comprising the Georgetown community health services and the practice-based commissioning group.
- Tariffs for community services were introduced and a new 'best-practice tariff' was introduced to incentivise commissioners to support more cost-effective care closer to home.
- Personalised budgets for patients with long-term conditions had been introduced and practice-based commissioning groups had the option of taking on the risks of real budgets, which could be used to support the holistic care needs of patients.
- The NHS Choices website had been revamped along the lines of the TripAdvisor model, with patients providing personal comments on the quality of care they received.
- Taitshire PCT announced intentions to commission a number of community health resource centres offering a wide range of services and invited interested parties and partnerships to submit bids.

A second set of assumptions was fed through from the NHS Institute's scenario generator model. The original intention was to model specific pathway shifts agreed by participants at the end of the first round. As these proved a little lacking in detail we fed through some modified assumptions about shifts in the volume of care to community settings based on those contained in the *Healthcare for London* report (Darzi 2007). The report's author, Lord Darzi, now the Health Minister, has always been at pains to stress that the blueprint for London would be unlikely to fit the requirements in other parts of the country; some have questioned whether the scale of the changes envisaged can be achieved in practice and within the timescales envisaged. In SeeSaw we therefore made some minor tweaks to the assumptions and presented the modelling as one source of evidence for Taitshire PCT to consider, leaving it to decide how best to interpret its relevance and applicability.

At the end of round two we saw more radical shifts in the pattern of health and social care and more effective thinking about the impact of these developments on patients and their families. The process of commissioning through tendering was the trigger for what would have been a seismic shift in the health and social care landscape. Two things appeared to have underpinned this movement: pressure and support from the SHA and a harder evidence base to inform PCT decisions.

Commissioning

Having externalised its provider arm, the new Taitshire PCT felt it was far easier for it to operate as an impartial commissioner. The PCT's plan to commission a range of services from community health resource centres was quite radical. The PCT also had some insight into the likely impact for the two acute foundation trusts, having had the performance figures modelled by the NHS Institute's scenario generator model. It was clear that one of these institutions would no longer be viable. The plan was signed off by the SHA early on in the year and this support strengthened the PCT's resolve to move ahead. The political 'cover' provided by the

SHA proved quite important in handling the consequences of the developments with the public and with patients. That said, the SHA made it clear that the PCT still had responsibility for handling local political, public and patient engagement.

Practice-based commissioning all but disappeared, with the commissioning groups' energy being diverted into putting together bids for the new services. The PCT understood this role and was clear that practice-based commissioning representatives could not be involved in the bid evaluation process.

Bidding for community health resource centres

Four contrasting bids were submitted. While the simulation timescale did not allow for these to be fully formulated, they were sufficiently developed to demonstrate different philosophies and styles of working. Common to all the bids was that, while the PCT had signalled that it wanted to develop up to seven community health resource centres, the bid partners felt that this underestimated the technological developments that would enable a larger volume of care to be delivered to patients at home. The advice from the providers was that the PCT needed to commission services, not buildings, and start from the principle of care in the home, using primary and community facilities and specialist hospitals to deliver those elements that it would not be safe or cost-effective to undertake in a domestic environment.

A second common theme was that bid players provided few details about links between the community health resource 'hubs' and the rest of the primary care facilities in the path (the 'spokes') despite this being an important element of the bid criteria. By contrast, all bidders had considered the vertical links with acute services.

Below we summarise the four models that emerged from the bidders and consortia.

Model one: the one-stop shop chain – a single major contractor

Led by a consortium comprising Gomersall Hospitals NHS Foundation Trust, the Taitshire Community Foundation Trust and primary care provider services from one of the practice-based commissioning groups, this was an ambitious bid. The main contractor would be Gomersall Foundation Trust. The bid combined the concept of a ‘one-stop shop’ with some flexible outreach services provided within mobile facilities. The proposed resource centres would each offer a similar range of services and, being run by a single provider, would offer the PCT and Taitshire residents consistent standards, a common brand and the ability to offer good access to local services through mobile facilities. As well as housing primary care GP services, the centres would offer specialist clinics – for example, for people with long-term conditions – diagnostics and well-being services, access to social care, urgent care and step-up and step-down beds, a hub for telemedicine monitoring of patients cared for at home, leisure services linked to health and primary care mental health services. They would not have a pharmacy on site but would provide links to local chemists and advice on medicines management.

Overall, this model appeared to offer a ‘mini-hospital’ with additional well-being and social care access components bolted on. The initial comment from the PCT was that, while it was superficially attractive to have a wide range of services under the same roof, this bid failed to demonstrate an understanding of how community-based services are delivered and the impact that this would have on patients and on primary care. It remained a very ‘bed-based’ solution.

The bid partners explained that not all practices could benefit from being located in the resource centres. However, they would try to establish a formal partnership with other practices that would be involved in some of the service provision within the centres. This was intended to offer the practices an incentive to refer their patients to use the services. The partnership also made it clear that services provided within the resource centres would need to be funded at tariff prices.

Model two: primary care plus – the primary care collaborative

The Georgetown social enterprise – an alliance between the practice-based commissioning group, the former Georgetown PCT provider services and the VangAshton group – produced a different model. The inclusion of the independent sector provider was sought to improve the quality of systems and processes so that the facilities could operate in a cost-effective way. However, this bid was very much a collaborative enterprise and offered both commissioning and service provision functions. The proposal included four modest resource centres of differing sizes that would largely replace the current outmoded primary care premises. The first, based on the old infirmary site, would be an inner-city facility serving around 60,000 patients. As well as primary care, diagnostics, outpatients, primary mental health care and a single point of contact for out-of-hours urgent care, there would be a range of healthy living initiatives.

One of the main differences from the first model was the inclusion of ‘micro-commissioning’ – care package co-ordinators who would help patients get the best from the range of services on offer both in the centre and in other locations. The co-ordinators would also offer advice to patients who opted to take up personalised budgets. A second difference was that the bid offered a more flexible approach with different types of facilities being offered in different locations and greater sensitivity to the existing pattern of primary care provision. One of the facilities planned, however, was to be based on the Georgetown Foundation Trust site. It was presented as a pragmatic move given the spare capacity that would be available by this point and with the advantage of being able to access on-site diagnostics, but its location was not in line with what was best for patients. Two smaller facilities were proposed for the east and west of town.

The PCT’s overall comment was that the bid had much to recommend it but had been developed without sufficient public and patient

engagement. The bid appeared to be driven by the interests of the GP practices and heavy influence from the Georgetown Foundation Trust rather than what was best for patients. The flagship development proposed for the city centre site, however, did appear to be in tune with local needs.

Model three: social enterprise

The Farrell Community Hospital social enterprise used the tender to launch a proposal that would redevelop the Farrell site and other community hospitals. Its bid used these hospitals as hubs supporting home-care monitoring and support, offering a well-being and independence support service in collaboration with the county council commissioners. One of the more innovative aspects of the bid was that it included transport services to bring patients to the centres.

The PCT was supportive of the bid for the redevelopment of Farrell Community Hospital as there was a track record of local support and there were well-established plans for that site. The concern was whether the social enterprise was overstretching its management capacity in expanding its horizons.

Model four: integrated services – the community development approach

This was a late bid that the PCT accepted following local pressure from the Gomersall community. The Gomersall practice-based commissioning group claimed that addressing health inequalities and engaging local residents takes time and this does not always sit well with the tight timescales specified in formal procurement processes.

The Gomersall bid was based on recognition that simply developing new forms of service in areas of deprivation is no guarantee that they will be appropriately used. There needs to be intensive effort invested in engaging the local community to develop their support and interest in

health and well-being and these elements have to be linked in with activities that address the wider determinants of health.

The innovative Gomersall bid was for three very local resource centres based in natural communities and supported by public transport networks. The bid recognised that across health and local government there are numerous initiatives that involve the development of local centres, including polyclinics, jobs and benefits centres and children's centres. It proposed establishing local community centres that would combine all of these functions in one location. They would house information, advice and resources, support for people with housing and benefits needs and would work with local 'spoke' networks into schools, supermarkets and workplaces. The proposal would make maximum use of Health Act flexibilities through pooling resources.

The health care components would include a strong emphasis on health and well-being, directly addressing local health needs and providing a first port of call for urgent care. Ambulance staff based at the centres would contribute to urgent care, provide a transport service for those patients who could not be managed in the local centres and would also offer mobile monitoring of patients cared for at home. People with long-term conditions would be supported by specialist community teams and specialist consultants undertaking outreach appointments. Diagnostic services would be enhanced by using mobile facilities provided by the VangAshton group.

The PCT was interested in the community development approach as it appeared to offer a direct means of tackling health inequalities. The novelty of the proposals, however, and the complexity of the decision-making processes that would be required to deliver them would mean a long lead time before the benefits, in terms of reduced health inequalities, would be seen. There were some doubts that the governance arrangements proposed – a partnership board comprising representatives from all of the stakeholder interests from primary care

to housing to local residents – would be sufficiently strong to drive through the proposals.

Acute service reconfiguration – handling organisational failure

The combination of PCT and practice-based commissioning intentions proved catastrophic for the two acute trusts and it quickly became apparent that both organisations could not survive if they lost such a significant volume of activity. Recognising that the commissioners were serious about their proposals, neither trust challenged the direction of travel. Their only option was to look for a solution through joint working. These discussions proved time-consuming and ultimately fruitless – they had divergent interests, which meant an informal partnership would not be a sustainable solution. In the face of financial meltdown the discussions focused on service reconfiguration between the north and south of the county. None of this had involved the commissioners, who remained focused on their big tendering exercise for community health resource centres. Monitor and the SHA watched as this took place but felt duty-bound to trigger a resolution. Patient forum representatives were actively consulted about the proposals by all parties. The situation was resolved by Gomersall Foundation Trust (perceived by Monitor as having the stronger management team and fewer financial pressures) offering a nominal sum to take over Georgetown Foundation Trust, its assets and debts. This was actively supported and encouraged by the SHA and Monitor.

The joint work between the SHA and Monitor proved to be a productive partnership and secured a quicker result than the two bodies working independently would have achieved.

Independent sector involvement

With its parent companies' experience in the NHS acute market being a less than positive one, the merged VangAshton group chose to focus its

efforts on the richer possibilities in the social care field both for the self-pay market and for clients with direct payments. Its assessment was that the significant financial pressures faced by social care would have the net effect of increasing the potential pool of people having to explore self-pay solutions. The lower tariff for community-based services also proved a disincentive for it to seek any further deals with PCTs. An early decision not to bid for the community health resource centres was met with surprise by NHS providers, but the group was reluctant to enter into any deals that involved capital investment and risk.

Mental health care

With freedom to explore vertical integration with acute and primary care, the mental health trust decided to focus on its core business. Mental health services continued to operate in a separate, almost parallel sphere to the rest of the health and social care system. Having sold off the parts of its estate it no longer needed – a faster option than waiting to see if the PCT would consider it suitable for new primary care facilities – the trust concentrated on winning business from commissioners in neighbouring areas. From a business perspective this may have been a sensible approach but it left unresolved some of the opportunities for normalisation of mental health or for addressing some of the mental health aspects of caring for people with long-term conditions. Commissioning of mental health services was virtually non-existent.

Regulating the quality of care

The Care Quality Commission found the revamped NHS Choices website to be a new source of information for triggering quality investigations and reviews. The new requirements for registration also kept the organisation busy as new partnerships had to re-register before bidding for service contracts. This raised questions about whether prospective or retrospective registration was the right approach.

Handling the politics of change

Both local politicians and the public continued to be confused about the potential benefits and risks of the proposed changes to health care in Taitshire. The local MP, who had a far less detailed grasp of the changes than the commissioners and health care providers, focused almost entirely on the process of public and patient engagement, ensuring that this had been undertaken in a legal and correct manner.

Concluding observations

In round two we saw a more dramatic shift in care outside hospitals, with the PCT stronger in its resolve and armed with national evidence about the potential scale of shifts that could offer clinical safety and cost-effective approaches. The backing from the SHA to push ahead with its localisation strategy had a galvanic effect but the tool ultimately used by the commissioner to secure the strategic shift – an open tender process – was a blunt one. The specification had been developed without provider input. In the procurement process the PCT was vulnerable on two counts. First, it would have been difficult to undertake a fair and transparent evaluation of the quite diverse offerings. Second, changes to the timescale midway through the bidding process, albeit for sound social reasons, would have exposed the PCT to potential legal challenges from bidders who might have felt disadvantaged by the process.

While the PCT had acted impartially, it had failed to realise the consequences and risks of the tendering activity and left its key providers to handle the consequences internally. The consequences for acute providers were poorly managed; there was a sense that in an effort to demonstrate impartiality, the PCT had acted indifferently.

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