

# Section 1

## Getting to grips with NHS commissioning

**A drive for 'best value' healthcare services, reduced inequalities and a sharpened allocation of resources on the basis of patient need lies at the heart of strategic commissioning. So what might this mean for the physiotherapy profession?**

**This section gives a 'helicopter view' of commissioning, highlights some key developments and trends to watch, and suggests some key messages for physiotherapists looking to seize the opportunities that commissioning presents.**

Increasingly, commissioning agencies across the UK will expect physiotherapy managers to be able to demonstrate that they provide a cost-effective, quality response to patient needs that integrates seamlessly with other services to meet a range of wider health targets.

Understanding how to respond positively to the demands this presents will be critical to the future of the physiotherapy profession.

# understanding the commissioning process

NHS commissioning has been defined by the Department of Health (DH) as follows:

***'Commissioning is the means by which we secure the best value for patients and taxpayers. By "best value" we mean:***

- ***the best possible health outcomes, including reduced health inequalities***
- ***the best possible healthcare***
- ***within the resources made available by the taxpayer.'***

*Department of Health, 2006a*

By now, the concept of commissioning will be familiar to all NHS managers. It has been at the core of NHS structures since the arrival of the purchaser-provider split that defined the internal market of the 1990s, superseding the planning processes of an older, centrally directed NHS. Yet there remains a gap between rhetoric and reality.

Implicit in the DH definition is some kind of rational process, based on measurement and comparison, by which commissioners can choose between the many different possibilities for spending their budget. For instance, no one would question part of the total NHS resource being spent on the care of those with cardiac disease, but how much? Commissioners have the sometimes unenviable task of deciding:

- the share of the overall resource devoted to cardiac care
- within this share, the relative proportions used to fund surgery, drug regimes and prevention
- the balance between primary and secondary care provision.

## The contracting timetable in England

The annual NHS operating framework defines the contracting timetable in which commissioning preferences are translated into firm and binding agreements with NHS providers within the context of a local delivery plan (often known as an LDP). The key dates for each year are set out below.

### **December**

The DH issues the operating framework for the coming financial year (for example, the 2008/09 operating framework is published in December 2007), plus guidance on priorities and details of the payment by results tariff.

### **January**

SHAs submit preliminary risk assessment to the DH.

### **February**

PCTs agree contracts with providers, subject to them being signed off by SHAs. SHAs conduct detailed assurance of PCTs' plans, including reconciliation with provider assumptions.

### **March**

PCTs' contracts with providers signed off by the end of March.

However, it is not unknown for contract disputes to go unresolved well into the spring, and sometimes longer.

Figure 1: The commissioning cycle



PCTs are statutorily responsible for commissioning health services for their population. In practice, however, they cannot work well unless they are in close partnership with local GP and primary care practices, local government, patients and the public.

The commissioning process is often described as a cycle. A diagram of the commissioning process is shown at Figure 1; note that it does not necessarily describe an annual cycle.

In the past, NHS commissioning was often dominated by funds flowing directly to local providers under block contracts. This is changing rapidly. Improved information is steadily turning the aspiration of a rational commissioning process, based on an assessment of health needs, into a reality.

# key developments in England

Three developments are of particular significance to NHS commissioning in England.

## Practice-based commissioning

This is essentially a process for devolving key commissioning decisions, and budgets, to GP practices. It is based on the belief that this devolution is the most effective way of exerting real financial control and inspiring innovation.

DH guidance issued in November 2006 states that in 2007/08:

- practices will receive clear budgets and information flows
- all aspects of PCT budgets will be 'indicatively devolved', with the elements that need to be returned to the PCT clearly identified
- practices will receive regular referral and financial information, including benchmarking data
- a locally agreed incentive scheme will be developed and offered to all practices.

However, this may prove to be ambitious, given the continuing weakness of some information systems, the degree of dislocation resulting from the 2006/07 PCT reconfiguration and some GPs' lack of enthusiasm for taking on responsibility for commissioning.

Note that at a formal level PCTs will still do the commissioning work on behalf of GPs.

## New healthcare providers

A second development is the growing interest of large-scale commercial providers in building businesses in primary care, and the DH's explicit support for their entry into the market. Their ambition encompasses both primary care provision and systems (often using insurance expertise) to support commissioning. For example, in 2005/06 the former Thames Valley SHA proposed the outsourcing of much of its commissioning.

In addition to commercial organisations, social enterprises and voluntary bodies are also taking their place in an increasingly diverse landscape of healthcare providers. It will also offer new ways for the physiotherapy profession's many thriving independent businesses to engage with the NHS.

This will require physiotherapy managers to get used to tendering to provide their services. It will be a new experience for many, and one that calls for, in particular, high-quality information. But tendering also provides scope for growth. Why not extend an excellent service into neighbouring geographical districts?

## New ways of managing demand

As commissioners have come under increasing pressure to balance their books, they are trying a variety of developments under the broad heading of demand management. These include administrative and peer review processes for validating referrals to hospital, and care pathways that require triage (and often treatment for many patients) in community settings as an alternative to hospital admission. Commonly these are led by GPs and make significant use of therapists.

# reading the NHS landscape

## Priorities for England

The operational priorities for the NHS in England are issued each year in the form of an operating framework document. It is the key document for anyone wishing to understand the framework within which NHS commissioners are working.

*The NHS in England: Operating Framework for 2007/08* (Department of Health, 2006b) is relatively short and is accessible from the DH website. In his foreword David Nicholson, NHS chief executive, writes:

***'The operating framework for 2007/08 provides consistency of purpose for the NHS, setting out the key targets that our staff need to***

***focus on in order to improve patient experience, reduce health inequalities and achieve financial health.'***

The operating framework sets four development priorities for 2007/08:

- achieving a maximum wait of 18 weeks from GP referral to start of treatment of patients
- reducing rates of MRSA and other healthcare associated infections
- reducing health inequalities and promoting health and well-being
- achieving financial health.

Because the priorities are national and non-negotiable, service plans couched in terms of achieving these

## Key targets for the NHS in England

### **Priority one: 18 weeks maximum wait**

*'The key milestones to be achieved as a minimum by all PCTs and all providers by the end of March 2008 are:*

- *85 per cent of pathways where patients are admitted for hospital treatment should be completed within 18 weeks*
- *90 per cent of pathways that do not end in an admission should be completed within 18 weeks.'*

**Priority two: Reducing rates of MRSA and other healthcare associated infections**

*'PCTs and providers have signed up to local targets for year-on-year reductions in MRSA infections... we expect PCTs and providers to engage with clinicians and agree local targets for a significant reduction in Clostridium difficile infections.'*

### **Priority three: Reducing health inequalities and promoting health and well-being**

*'For 2007/08, PCTs need to focus on the interventions that evidence shows can have the biggest impact on reducing health inequalities. This builds on the recommendations*

*in a review of the life expectancy target.'*

### **Priority four: Financial health**

*'By the end of this financial year we expect the NHS to return to net financial balance. 2007/08 will be a further year of financial recovery and we will require the NHS to make a net surplus of at least £250 million across NHS trusts, PCTs and SHAs. We are also planning on the basis of a 2.5 per cent efficiency improvement across the NHS.'*

Source: Department of Health, (2006). *The NHS in England: Operating Framework for 2007/8*

priorities are far more likely to win favour with commissioners than plans that focus on other areas.

This is a challenging message for physiotherapists committed to providing an excellent service in areas such as long-term care, paediatric care and mental health care. Nevertheless, the practical reality is that commissioners must demonstrate progress in relation to national priorities, while at the same time sharpening their response to the specific needs of their local populations. Harnessing the knowledge of practitioners will be critical both to translating policy into practice and finding the right ways of fine-tuning it.

In reality, physiotherapists can do a great deal to help achieve the 18-week maximum wait target. They can support this priority directly by becoming part of (and, indeed, leading the transition to) care pathways redesigned to reduce delays. They can also support it indirectly through interventions that encourage earlier discharge from hospital beds and thereby release capacity.

Physiotherapists can help with many pathways, particularly in the initial stages, and almost any contribution to achieving this target is likely to be attractive. A particular opportunity lies in emergency bed pressures in the acute sector and consequent problems in admitting elective patients to hospital (as illustrated by the work of the Cardiff and Vale NHS Trust to reduce patients' length through seven-day working, as described in Section 2).

Physiotherapists can also offer considerable help towards regaining financial balance. The four examples of effective services in Section 2 point to the potential of physiotherapy to generate whole systems financial savings, typically through reducing or avoiding another cost.

When an organisation is in deficit, it is increasingly hard for its management to concentrate on anything other than getting back into the black. So of all the arguments for physiotherapy, those based on cost efficiency (rather than, say, the quality of patient experience) are likely to prove the most persuasive. However, this is not to underestimate the importance of understanding commissioners' perspectives and priorities and tailoring bids to reflect these, as highlighted in Sections 3 and 4.

## Developments in Northern Ireland, Scotland and Wales

Health policy, structures and priorities differ across the UK, although the need for physiotherapists to demonstrate the impact and value of their interventions remains constant. Moreover, there are common strands running through policy developments in all the four countries' various health systems, driven by the same desire to improve value for money and the patient experience.

In Northern Ireland, for example, major changes in the commissioning process are already under way, with new structures in operation from April 2007. In Wales the *Designed for Life* health strategy (Welsh Assembly Government, 2005) incorporates a target for access to seven-day-a-week therapy services for older people by March 2008. And in Scotland the report *Building a Health Service Fit for the Future* (known as the Kerr report) (Scottish Executive, 2005) has prompted a set of reforms collectively known as *Delivering for Health*, with access and efficiency as key components.

## some trends to watch

Although there has been a significant volume of change in the NHS in recent years, four environmental issues are of immense significance for the future of NHS physiotherapy.

### New models of service delivery

A genuine freedom to change the way that care is delivered is emerging for commissioners and managers. This new-found freedom is the combined effect of several recent reforms, in particular:

- pay reform (including the government's Agenda for Change programme covering pay for all directly employed NHS staff excluding doctors, dentists and senior managers) has placed more emphasis on practical skills than on qualifications and professional allegiances

- the payment by results funding system, with its built-in incentive to reduce the cost of care provision while still being funded at average cost level
- the service improvement ('modernisation') movement that has swept through healthcare.

For physiotherapists this represents both a threat and an opportunity. It allows commissioners to challenge established working practices and staffing structures, and permits a transition to a diluted skill mix or even to withdrawal from whole areas of care provision. But it also allows physiotherapy to extend its remit into areas that have traditionally been dominated by other professions, for precisely the same reasons.

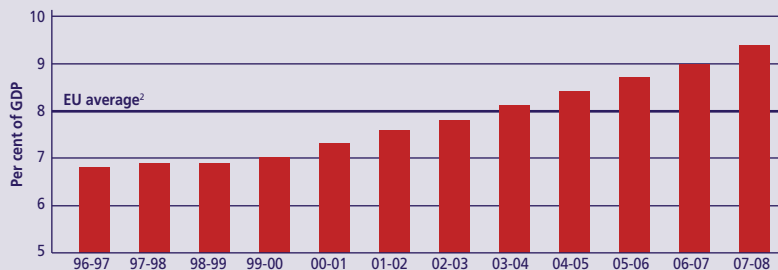
### Changes to PCT provider arms

The future of physiotherapy and other care services in the past directly managed by PCT 'provider arms' is not yet clear. A range of possible future locations – extending from incorporation within foundation trusts to new social enterprise models – is being explored. Some therapy managers are actively pursuing the potential of these different possibilities.

### A reduction in NHS growth

A major reduction in the annual funding growth of the NHS is now imminent. Since 2003, government spending on the NHS in England has grown by almost 10 per cent each year. Not all of this has gone directly to NHS providers; a significant amount has been used to build up private sector alternatives, notably in the

**Figure 2: UK health spending<sup>1</sup>**



<sup>1</sup> Total UK health spending as a percentage of GDP. Source: HM Treasury

<sup>2</sup> EU health spending as a percentage of GDP (unweighted average) in 2000, the latest year for which data is available. Source: OECD (2002) Health Data

form of the independent sector treatment centres that now undertake over 10 per cent of all NHS elective surgery. Nevertheless, the NHS has become accustomed to funding settlements well in excess of general inflation.

Looking ahead, in 2008 it is almost certain that the funding tap will be turned off. The central spending review process (CSR 2007) for deciding how much government money will go to healthcare over the following three years is not yet complete, but many suggest the NHS will have to get used to annual funding increases of only two or three per cent in the future.

As with the modernisation reforms, reduced annual growth represents both a threat and an opportunity for the physiotherapy profession. Commissioners, under increased pressure to eliminate any unproductive expenditure, or anything they categorise as a luxury, may be ruthless in cutting therapies that are not demonstrably evidence based. But where physiotherapists can present a coherent business case for their interventions, showing the proven impact of what they do, they may well be gainers.

One early impact may well be scarcity of 'pump priming' funding for initiatives. Projects that require up-front funds, on the promise of savings released later, may find commissioners are simply unable to identify cash for this type of investment.

However, physiotherapy services that are directly managed by PCTs may find themselves exposed. The payment by results system, combined with the rigorous business culture within which the new foundation trusts operate, has restricted (some say perversely) the amount of short-term control

that commissioners can exert over rising hospital admissions. Many PCTs have therefore looked first to their directly managed services for an undue share of savings.

## **New roles and ways of working**

There is a fourth environmental issue of particular significance for physiotherapy. The years since 2000 have seen massive NHS investment in training which has led to more doctors, more nurses – and more therapists. It has been apparent for some time that, at the level at which newly qualified physiotherapists enter clinical practice, there are now many more applicants than jobs.

For the individuals concerned, this has often been demoralising, but for an NHS capable of redesigning care pathways and the skill mix more freely than ever before, it represents a golden opportunity. Why not use this new flexibility to stretch the boundaries of what physiotherapy can offer? Opportunities to work differently may well form the basis of career openings for the allied health professional consultants of the future.

This guide is aimed specifically at physiotherapy managers. However, many physiotherapists work within a wider, often complex, framework of integrated care provision. Commissioners are often attracted to packages of care that include physiotherapy alongside other health professionals; physiotherapists often find themselves in teams led by other therapists. Increasingly they need to be familiar with, and explain, a 'big picture' that extends well beyond the physiotherapy intervention.

# key messages for physiotherapists

There are three key messages for all physiotherapists:

- **Get to know your local commissioners.**  
Physiotherapy managers need to be very clear about how PCTs are working to commission health services for their populations. This includes knowledge of who will be in charge and how decisions will be taken, and the role of GPs. Local priorities may prove to be as important as national ones.
- **Make a clear business case for your services.**  
As commissioning skills becomes sharper and the financial environment more stressful, the notion of a physiotherapy budget that simply rolls forward from one year to another – give or take a few marginal changes and some haggling about efficiency savings – may soon become an anachronism.

Commissioners are beginning to look not just at incremental change but at the impact of entire services. What's more, they are required to do this within a national framework of priorities. If the 2007/08 priorities do not explicitly include some of the things that physiotherapists traditionally do, they equally offer numerous opportunities for physiotherapy to have a real and visible impact on high-profile targets.

If physiotherapists can make a convincing business case for their services, and express this in terms of progress towards overall financial gain and other national priorities, commissioners may well be persuaded to invest in them.

- **Show how physiotherapy adds value.**  
The commissioning process presents huge opportunities to define the value of physiotherapy's contribution to

wider healthcare in new ways, and to broadcast this widely. Physiotherapists may not always have been the pushiest of professionals when it comes to publicising their achievements – but a glance at the impacts of the four innovative physiotherapy services described in Section 2 give a sense for what can be achieved.

Physiotherapy can and should demonstrate its real impact in improving not just the quality of care and the patient experience, but also its contribution to how the NHS performs against demanding access and financial targets.

For physiotherapy managers, there are two further important messages:

- **Deploy information and data tactically.** It is not enough to have data; physiotherapists also need to understand enough about the commissioning cycle to use it persuasively. They also need to collect data that demonstrates clearly the benefits that physiotherapy can bring to the total patient journey and packages of care, through integrated condition management and service delivery.
- **Show physiotherapy's wider impacts.** While there is much evidence for the clinical effectiveness of physiotherapy practice, plenty more remains uncovered in terms of the impact of physiotherapy on wider service delivery. It will be important to collect persuasive data across a wide range of specialties, settings and services, and show clearly how this points to physiotherapy's contribution.

The remaining sections of this guide focus on how physiotherapists can respond to these messages and the rapidly changing context in which they work.

