

Future commissioning of health services in Bristol



the care forum
voluntary sector service

2 November 2010

Attended:

Nik Attryde, NHS Bristol; Sue Bateman, Action For Blind People/RNIB; Joan Bayliss, Bristol LINK; Michelle Bradford, Surg User Group; Daphne Branchflower, Bristol City Council - Policy Performance And Equalities; Hazel Britton, Black Carers Project; Jan Cave, Bristol LINK; Andy Coombs, Bristol LINK; Joan Cox; Derek Dominey, Alzheimer's Society - Bristol Branch; Richard Drake, Brook Bristol; Hildegard Dumper, Bristol LINK; Frances Fox, The Bridge Foundation; Mike Hatch, Princess Royal Trust Carers Centre (Carers Development Project); Pam Hitchins, The Harbour; Melanie Iddon, Brook Bristol; Stephen Jones, Terrence Higgins Trust West; Faiza Khaliq, Avon & Wiltshire Mental Health Partnership NHS Trust (AWP); John Langley, Bristol LINK; Geoff Loydon, Bristol Patients Forum; Bob Maggs, Retired & Senior Volunteer Programme (RSVP); Michelle Mansfield, Brunelcare; Pauline Markovits, Bristol Survivors Network; Fiona Matthews, UWE; Gillian Maw, Bristol LINK; Kay McMahon, Bristol LINK; Lyn Mitchell, Bristol LINK; Frank Palma, South Glos LINK; Suzanne Pearson, Chair Of Bristol Mind And Freelance Trainer; Jayne Peters, Bristol Drugs Project (BDP); John Plumb, Bristol LINK; Jane Prior, Mencap Pathway; Leon Quinn, The Care Forum; Christina Rees, Brunelcare; Sarah Richardson, Age Concern - Bristol; Marjorie Ritchie, Bristol Oscar; Pat Roberts, Bristol Older People's Forum; Susan Rooke-Mathews, Bristol Survivors Network; Silvia Scalabrini, University Of Swansea; L Scales, British Red Cross; Gillian Seward, Bristol LINK; Paula Shears, Alzheimer's Society; Jill Shepherd, NHS Bristol; Pat Taylor, Princess Royal Trust Carers Centre (Carers Development Project); Peter Tiley, ICAS; Will Warin, NHS Bristol; Colleague of Laura Welti, Bristol Disability Equality Forum; Laura Welti, Bristol Disability Equality Forum; Erica Wildgoose, Bristol MDF The Bipolar Organisation; Mark Williams, Bristol Disability Forum; PA to Mark Williams, Bristol Disability Forum; Sarah Young, NHS Bristol; Liz Skelton; Jan Cave, Bristol LINK

Apologies:

Tim Douglas, Two Way Street; Debbie Fear, Princess Royal Trust - The Carers Centre; Meryl Gaskell, Living; Anne Green, Bristol LINK; Roy Hackett, Bristol West Indian Parents & Friends Association; Diane Jenkins, Bristol LINK; Sam Lane, Black Carers Project; Mandie Lewis, Bristol LINK; Glenn Townsend, NHS Bristol; Sue Walker, Hartcliffe Health & Environment Action Group

Presentation: Presentation by Jill Shepherd, Director of Strategic Projects, NHS Bristol and Will Warin, Professional Executive Committee Chair, NHS Bristol

http://www.thecareforum.org/publication_uploads/LINK%20.11.10%20Configuration%20of%20GP%20Commissioning%20Consortia%20Will%20revised%20diagram.pdf

Q: What does clinical engagement mean?

A: One of the important elements of the white paper is the involvement of every GP in commissioning.

Some of the points in the presentation were expanded as follows:

There will be a discussion at the Professional Executive Committee (PEC) on 11 November. The PEC is made up of GP representatives from the localities in Bristol, Bristol City Council representatives and officers of the PCT. The decision making process starts at the PEC. The

PEC makes its recommendation to the NHS Bristol Board. It is now likely that the Board will simply note the recommendation of the PEC. If it is Bristol wide, GPs will probably make that decision. If the decision is wider than Bristol, the discussions will need to be continued with North Somerset and South Glos GPs. It is a very complex and unusual exercise. The Secretary of State is very clear that it is a decision for GPs. GPs in Bristol are not organised in a way to make these decisions. When the PCTs are seen to be active in the role of the leading the discussion, they are slapped down by the Local Medical Council. These decisions are of vital importance and all GPs leaders with any mandate to promote these discussions are starting to come together in Bristol, North Somerset and South Glos. The working model derives from that group. The evidence from localities so far suggests that they create quite a good small context. There will be the need to commission robustly from big acute hospital trusts, therefore there needs to be a majority purchaser. BNSSG has partnership arrangements, but the partnership is not completely solid. Health promotion needs to be part of healthy and sustained communities. There is a need to be both big and small when working with the local authority. If there is one big organisation, it tends not to be very good at fostering a local feel. If six small organisations are working together in Partnership, the problem could be with the bureaucracy of statutory organisations such as Board and governance arrangements. I'd like to test the working model with you.

Q: Which are the GP consortia?

A: In my version, there will be three accountable organisations.

Q: We've only heard about one of the options.

A: There are five, as laid out in the paper. In my mind, you can reduce those to two broad options: a big organisation or a small organisation. The working model is derived from those discussions and is not formally one of those options. We've now reduced it to a set of arrangements with the most mileage.

Q: There is no detail around options or costings or how much will be saved in reducing admin costs.

A: We don't know the costs. It's very complicated and we are talking about a small part of the whole white paper. We are simply looking at the best configuration for a GP commissioning organisation for the future. We can't include anything about costs as we don't know how much funding there will be for GP consortia. We do know what is in the paper. The cost of NHS Bristol is £21 per head of population and that is an average amount. We also know that amounts being bandied about nationally are between £6 and £10. We don't know what the amount per head will be.

A: We need to test the five options, looking at getting support functions at the best price etc. We need to think about function not form.

Q: We don't have a view from the other PECs, so it's difficult to make a decision.

A: That point can be picked up in the discussion groups.

Group Discussions

Groups were formed to discuss the pros and cons of one of the five options and had the opportunity to ask Jill Shepherd and Will Warin questions about these options.

Option 1: "three organisations for the city of Bristol, covering the same geographical areas as the current localities"

Pros/cons

How would option 1 interact with acute services?

Postcode lottery: acute service dependent on where you live.

How will other services engage?

How will it influence patient experience?

Where do mental health services fit in the model?

What is the mechanism to relate to VCS?

Learn from mental health. AWP is not locally sensitive.

Three too many. Assumes 3 GP consortia will operate in partnership. Model more suitable for Option 2.

Don't know where VCS will sit in new model – need to look at Local authority etc context

How will ensure equality will be integrated? Concerned community care will become more medical than social model. Small VSOs will depend on good relations between localities and partnership.

Pro

Most local/small but economy of scale and city is a whole population. Flawed decision making process.

Problems about cross threshold replicated at whatever scale.

Option 5 – not supported

All others depend on communications across groups/levels/trusts. GPs don't know about a lot of the new remit.

A: Most GPs will not be involved in commissioning; others have got broader knowledge and experience working with commissioning managers

A: Mental health: GPs have useful view and experience not yet used enough. GPs don't see groups of mental health users – advocacy, homeless in social model. Need to build relationships with equality groups and small VSOs. PCT has been successful in this. GPs don't go in for these communities.

A: GP groups have huge development needs will need two years shadowing to do this.

A lot of valuable services provided in small pockets many mental health service users get more from small VSOs. Money has been eroded. Will this continue for all services outside acute services?

A: GPC not a panacea driven by need to do more for less but interesting opportunities.

Next steps?

A: Get an idea of key themes; test model; enough funding? In next 2 months

Q: How will we know what plans for shadow arrangements?

Q: How will you determine the relationship with public health when commissioning?

A: Public health not just one thing. Feel positive about opportunity to do better with GPC working with P/H. Don't know how rest will work.

Q: How will dental services fit in?

A: Outside scope of GPC – will be commissioned by National County Board – along with GP services and maternity services. This does not sound sensible – needs more local knowledge.

Option 2: “One organisation covering the city of Bristol, with three localities to ensure local clinical engagement”

Pros

- Less of a postcode lottery than other options
- Particularly for 'extra' services like drugs and alcohol treatments cost effective
- There should be one size fits all for Bristol
- Easier partnership working when there is a centralised option
- Could say there are no pros as we currently don't know what it will be like
- Removing large number of administrators could be argued of each option
- Part of GPs role? Already private businesses
- Should be part of their remit in terms of current wage.
- Less of a financial risk with this option

- Cannot see that this option will change the working of voluntary sector organisations. Will just have to build new relationships with GP consortia.

Cons

- Postcode lottery – how will decisions be made for each locality?
- Are services tied to the GP practice or based on where you live? Can you get a service in one area and another somewhere else?
- Do GPs have time to fulfil these new commissioning roles?
- Will patient care be affected? Will they have to think about cost when prescribing for patients?
- Will it become medical care by accountancy – private involvement?
- Consortia and patients outside Bristol will feel left out of some decisions – e.g. development of new Southmead Hospital. Postcode lottery for patients outside Bristol.
- This should all be about patient choice/experience not just financial considerations.
- Don't agree with working model as didn't have chance to comment on it.

People who voted for option 2 later on in the morning, also made the following comments:

- I am concerned how any other mental health services are going to be integrated with the health care plan.
- Concerned about how mental health commissioning will be done by GP Consortia – GP's are not mental health experts. Very much hope that GP's will start to be concerned more about patient experiences. Healthcare is a partnership between the Doctor and the patient, not Doctors dictating to patients (as in recovery approach for mental health services).
- Bristol is big and complex already. One organisation is more than appropriate to meet the needs of all the communities. Covering a larger area would not allow for BME issues to be looked at or ensure there is equality due to the differences in geographic demographics which is seen currently just in Bristol regardless of the limited work done by NHS Bristol or BME specific work.
- Commissioning or contracting services out to providers will be more complex and cannot ensure they meet the needs and smaller more appropriate organisations meeting needs of BME communities will be lost due to competition from bigger organisations. The larger board will never see or understand more local complex issues and hence be at the bottom of the pile.
- How much room for 'out the box' thinking in terms of commissioning? Would a GP consortium, for example, work in partnership with a service user/patient consortium.
- Build into the thinking early on how to develop relationships outside statutory sector including with marginalised groups.
- Early thinking and practice in communicating clearly – easy read documents, etc.
- Replicating the local implementation teams – they can work really effectively in bringing together users, carers and providers to steer development of a broad range of services.
- Most of all, listen!!
- Whichever section/model is considered it must be considered alongside other related structures (Education; Social Services; Voluntary Sector) that need to work alongside clinical providers to deliver a full, effective health service. (especially in relation to health education).

- General concern that this dismantling of current commissioning is being railroaded by the Government.
- Particular concern that GP Consortia do not have specialist knowledge of mental health services.
- Mental Health Commissioning: NHS Bristol currently works efficiently and well – do we have to lose this?
- I like the willingness to discuss the latest ideas.

Option 3: “One organisation covering the Bristol, North Somerset and South Gloucestershire areas, with localities to ensure clinical engagement”.

Questions to Will – concerns raised over how the AWP mental health trust would operate and how the acute trusts would operate. A lead commissioner would be needed, as would need a powerful commissioner to be the majority purchaser.

How will the three areas agree? GPs from the three areas are meeting together; there is in fact already a lot of agreement for the proposed working model. At some stage a referendum may be needed across the GPs.

How would the money be shared out? If Bristol currently has the most money because it has the highest number of patients then it will be a brave move to share resources and have pooled budgets.

Will GPs commission and provide services? Is this ethical? They will not commission their own services, but the commissioning arrangements used to commission GPs’ services will indeed sharpen up what they offer.

Who will commission services from charities? How will GP consortia know about the voluntary and community sector?

Who will do the administrative functions of commissioning?

A single organisation would be a good thing as it would remove anomalies across areas. But if the localities don’t have accountability and power, how will they ensure that their local knowledge is taken account of?

Large organisation would have cost savings, agree this could be a good thing so long as is not at the expense of detailed local knowledge which can only come from smaller organisations/groupings.

Role of the VCS is to be innovative and do different things – how will this happen if the funding is simply to provide public services. Will there be a two tier voluntary sector? Will those who are not funded by GP consortia be a loose canon?

How will commissioning decisions be informed by the VCS?

Will GPs be responsible for commissioning social care?

Difficulties could be conflict of interest for GPs and a lack of communication. Who will sit on the commissioning boards and how will they hear about the VCS and the patient voice?

All seems a bit vague and the VCS needs to have proper influence and opportunity to shape decisions rather than just hear about them.

People who voted for option 3 later on in the morning also made the following comments:

- It will be useful to have a simple description of how existing NHS Functions will be organised in the future when GP Commissioning will take over many functions. E.g., which functions are outside the GP remit?

- Great problem of local authorities working together. Problem of size of North Somerset and South Gloucestershire if they “go it alone”.
- I have voted for option 3 because a larger organisation could have better clout/purchasing power primarily because of the need to purchase from acute services. However my concern is how social care, which is Bristol-based and people would like to see run locally fit into this. This will be a local authority responsibility – how will this fit into a wider than Bristol geographical area?

Option 4: “One organisation covering Bristol and other areas that refer mainly to the Bristol acute trusts (i.e. South Gloucestershire and the Woodspring locality of NHS North Somerset) with localities”

Pros

- South Glos and North Somerset can't manage on own
- Not sensible for South Glos to look North
- Commissioning outside area will still happen
- Having one would solve cross boundary issues

Cons

- Bristol could manage on own
- Geography even more confusing as not recognised
- What opportunities to access other services in other areas
- Could lose specialist areas
- How fit with choice?
- Track record of three local authorities is poor in working together
- Differences within Bristol of needs is already huge so to add South Glos and North Somerset as well could cause minority need to suffer
- People want to take ownership of own areas
- Have to be careful Bristol doesn't dominate

Notes/points raised in discussion

- In the early days, I read that the consortia couldn't cover themselves for insurance etc unless there is a population of 500,000. North Somerset and South Glos couldn't cope on their own
- Difference between 3+4? Only Woodspring in option 4
- Option 4 isn't an area we can refer to in geographical terms
- What would be the opportunities to access other specialist services in other areas?
- Could be too many differences in care – could lose out on other services possible
- I don't think so, as it would be up to the GPs to commission services
- Nowhere do I see anything about patient choice. There is an opportunity here for people to feed in and we're not being asked
- We're lucky to have the opportunity to discuss this
- Presumably, we could still choose a GP
- How do we ensure that there are GPs with the right skills to commission specialist services e.g. mental health and sickle cell
- Mind/Rethink has expressed grave doubts. At the moment, Bristol is good at commissioning mental health services. How do we ensure, with whatever model, that GPs and other specialists know what is going on? There needs to be input from patients.
- At the sickle cell and thalassaemia centre, we are the only organisation providing genetic counselling. It is very specialist. GPs know so little. We get queries from GPs in

Taunton. We can't refuse them even though they are out of area and the SLA is with Bristol. There is an increase in clients who are carriers.

- Specialist things in bigger city areas may lose out. We would need to make links with GP consortia outside Bristol and we don't have time to do those negotiations.
- At the Alzheimer's Society, we have found it very difficult to constantly engage small groups of people; therefore it might be better to go to a bigger group.
- Will GPs have time to put to this if a lot of organisations are coming to them?
- Welfare of majority could reduce need for specialist services if working in a large area
- Difficult for small organisations to make links etc and costs of time to large number of consortia
- Concerned public health will be lost in the bureaucracy of local government. Public health and prevention are very important. Would the three local authorities get together?
- On page 13, it mentions that Bristol Community Health is to become a social enterprise. I don't know what would happen in North Somerset and South Glos.

[Jill and Nick now in group to respond to some of issues]

- Q: Will the councils be joining together for health promotion?
- A: Whether the councils would join together is a difficult question as there are political reasons that might stop them. There will probably be three Health and Well Being Partnership Boards (HWPB).
- A: There has been a discussion about there being a supra HWPB above the others. Each local authority acknowledges that there will be certain situations where they need to come together to make decisions. Public health issues are wider than just Bristol. Each local authority is grappling with how the HWPBs might work. A public health white paper is due out in December.
- Q: The local authority has published a JSNA. The differences in South Glos and North Somerset must be huge. I am concerned that in a large group, these differences would cause problems for minority groups.
- A: Whatever the configuration, it is very important to keep a local focus.
- Q: Will the localities be powerful enough?
- A: We will need to make sure the right arrangements are in place.
- Q: Will pooling of budgets make better use of resources, so that, for example, expensive cancer drugs can be provided in North Somerset and provision made for the city centre of Bristol?
- A: I'd like to think that both would happen and pockets of deprivation get the services they need. Care pathways will be commissioned so that people will have access to the same treatments whether in Bristol, North Somerset or South Glos.
- Q: Can North Somerset and South Glos manage on their own and is a critical mass of population needed
- A: North Somerset and South Glos could do it on their own. Evidence suggests that 500,000 is a good number for commissioning, but the government says they will leave it to GPs to decide. There will always be boundary issues, but I think that the working model is the most popular with GPs.
- Q: Other areas want to take ownership because of border issues and they don't want Bristol to own what they've got. Smaller organisations setting themselves up may want to use Bristol's resources. My concern is about conflict building up if Bristol is running the four areas.
- A: In Will's model, each organisation is separate and the three organisations are telling support services what they want them to do. The three organisations would have their own budgets.
- Q: If Bristol were to put in a larger amount of funding, would that sway what is being requested?

- A: No more so than happens at the moment. The three PCTs work together to commission services at the moment and agree similar care pathways for other areas. GPs may choose to do it differently.
- Q: How many GPs contribute currently to the consortia in Bristol?
- A: All GPs are members. They can put themselves forward to go on the Board and are voted on. There are approximately three to six GPs on each locality Board. It is slightly different in each locality, but there are approximately 12 GPs on the Board at the moment.

Option 5: “One organisation covering the “Avon” area, to include Bristol, South Gloucestershire, North Somerset and Bath and North East Somerset, with localities”.

Pros

- Potential simplification
- Economies of scale
- May help with cost pressures
- How will GWAS be commissioned? Through national commissioning board?
- Greater numbers of consortia = more clout
- Is this a chance to reconfigure commissioning for the benefit of the patient?

Cons

- Large scale
- Will economies of scale materialise?
- BNSSG not suited to partnership that includes B&NES
- General move away from regional structures
- Sheer variation of problems
- Would be less cost efficient than BNSSG as configuration doesn't exist

A person who voted for option 5 later on in the morning made the following comment

- The key issue for me is how the “partnership” interacts with the localities – how effectively the localities can engage with their communities and who will assist GP's to do this.

Rachel Robinson thanked everyone for giving up their time and bearing with the structure of the meeting. She hoped that people felt that they had been given the chance to give their views and reminded the meeting that this is the beginning of a long process.

Will said that they had enjoyed the discussions and had got a different perspective which would be very useful. They hope to have a shadow arrangement in place by 1 April 2011 and commissioning by GPs will begin on 1 April 2013. Will added that this is the opposite of a tick box exercise as it is very much an evolving story and ideas are developing and fluid. He hoped that people would take the opportunity to influence the debate.

Rachel Robinson thanked Gill Shepherd and Will Warin again and all participants at the meeting.

Q: Before this meeting, were you aware that a researcher is using this meeting as part of her research?

A: (Silvia Scalabrini) The PHD is based at Swansea University; I have ethical approval from my department and authority from Bristol LINK. I am interviewing people in the PPI arena. No names or identities are disclosed in my studies.

Kate Oliver: Perhaps you could take up the issue with the LINK management committee.

Evaluation:

What was the most significant outcome of the event for you?

- Opportunity to hear from lead professionals involved in GP consortium planning and hopefully opportunity to express views and be listened to
- Hearing the variety of views
- Having a better understanding of/ information about the process commissioning of health services and GP Consortia, possible options and the background
- A realisation that this event was a bit of a farce - at least NHS Bristol have jumped through the patient view hoop - a bit tokenistic
- The arguments and reluctance to stick to the points to be discussed
- Frustration - a briefing paper would have been enough. Structuring meaningful engagement in this forum was challenging
- Left me wondering about more than answering questions
- Presentation of model by GP. Explanation of how it might be made to work by Jill Shepherd when in small groups
- Seeing the attitudes of those present. Hearing about the present ideas and weighing up the pros and cons with people's input
- Need to know a lot more before making any decisions/offering opinions. Financial info backup
- That we are at least starting to engage with the complex uncertainties

Are there any other comments you would like to make?

- Prior to the event, it should have been clear what the voting options were and that these would be part of the activity. Maybe some pointers to background reading, prior, summary etc. Also some sense of what will happen next as a conclusion to the event
- Print outs were unreadable because of the bright paper and slides were hard to read
- There was not enough information from the presenters and not enough time to discuss in depth the implications of all the options
- Very useful information from speakers - thank you
- No opportunity to feed back from discussions of single options. The meeting was programmed to end at 12.30. It ended at 12.05. How do you make a judgment on the options when there were no discussions of the pros and cons of all options?
- Attendance list not available
- I think that the event was difficult to manage because of the current vagaries of the issues
- Feels like the beginning of a process
- Thank you for organising the event - it was worth coming to
- A better understanding of the future structure of commissioning health services
- Rather disorganised. Could have said where the groups were based in the main session. Didn't have enough facilitators
- Thanks for putting this on.
- Not sure the way the meeting was structured was the best way forward. More chance for questions before going into workshops would have been helpful. I am concerned that carers issues are picked up when planning in the functions of the new localities however these are configured
- Start earlier - say 9.45/10 to provide more time for discussion. Facilitators cut short people who wanted to speak too often

Content	Average mark (out of 5)
Understanding of subject at start	2.6
Understanding of subject at end	3.5
Sessions	
Speakers	3.8
Other elements	3.4
Organisation	
Pre-event information	2.9
Facilitation	3.4
Organisation on day	3.4
Venue	
Access	4.4
Refreshments	4.2
Standard of room	4.3

Future of Commissioning of Health Services in Bristol – Voting Results

29 people returned ballot forms.

Of these, 1 person voted for option 1: “three organisations for the city of Bristol, covering the same geographical areas as the current localities”

11 people voted for option 2: “One organisation covering the city of Bristol, with three localities to ensure local clinical engagement”

11 people voted for option 3: “One organisation covering the Bristol, North Somerset and South Gloucestershire areas, with localities to ensure clinical engagement”.

2 people voted for option 4: “One organisation covering Bristol and other areas that refer mainly to the Bristol acute trusts (i.e. South Gloucestershire and the Woodspring locality of NHS North Somerset) with localities”.

3 people voted for option 5: “One organisation covering the “Avon” area, to include Bristol, South Gloucestershire, North Somerset and Bath and North East Somerset, with localities”.

1 person abstained.

Here are the results in a pie chart.

