

THE NHS's STRATEGIC POLICY FRAMEWORK

A SUPPLEMENT TO

Effective Information for Managing Medicines – A Strategy for the UK Medicines Information Network in a Patient-led NHS

Prepared by Dr. Patricia Oakley
Director, Practices made Perfect Ltd.
for the UK Medicines Information Service

Practices made Perfect Ltd.
Alpha House
100 Borough High Street
London, SE1 1LB
Tel: 0870 241 9937
www.practices.co.uk
email: office@practices.co.uk

Foreword and Acknowledgements

Since the late 60s the NHS's UK Medicines Information (UKMI) Service has established a strong culture of collegiate excellence and innovation which readily embraces technology-led new ways of working. This approach has also built a robust infrastructure of collective knowledge and skills which has helped to make the NHS safer for patients through better prescribing practices and medicines management. Looking to the future, the NHS exists in a world which is rapidly changing because of the internet, people's expectations of public services and their relative health and wealth compared to previous generations. In recognition of these pressures, the UK Medicines Information Service is developing a strategy so that it can develop a service which is fit for purpose in an NHS which itself is changing in response to the combined pressures of devolution, "market" forces and operating within its financial allocation.

To support the development of its strategy, the UKMI Service commissioned Practices made Perfect Ltd. to research and prepare a Supplement to that Strategy which describes and explains the NHS's policy framework. This has not been straightforward because there have been, and continue to be, a number of major policy initiatives launched since the spring of 2005. In addition, NHS policies are increasingly divergent across the UK as each country develops its unique government's priorities and policies for the NHS within its jurisdiction.

I have tried my best to find a course through this evolving situation which itself is framed increasingly by the changing European laws and regulations. I have been helped by the UKMI Service's network of lead officers, all impressive senior and experienced medicines information pharmacists, who have provided advice and guidance on a continuing basis over the last 18 months. I would particularly like to acknowledge the help of Peter Golightly from the Leicester Centre and David Erskine from the London – St. Thomas's and Guy's Centre. They have been kind enough to give me very detailed information and advice which has made this Supplement a better foundation to support the UKMI Service's Development Strategy. As a former junior hospital pharmacist at the (now closed) Westminster Hospital in the mid-1970s where we helped to develop the NHS's original "Drug Information" Service, and subsequently, as a former Chief Pharmacist at what is now called the Chelsea and Westminster NHS Trust, where we helped to develop the original clinical pharmacy service in the early 1980's, I have been, and continue to be, very impressed by what hospital pharmacists achieve even in the face of very difficult financial problems.

Dr. Patricia Oakley
Practices made Perfect.
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THE NHS's STRATEGIC POLICY FRAMEWORK

EXECUTIVE SUMMARY

1. The Public has become increasingly aware of, and sensitive to, the nature of the risks, including prescribing and medication errors, that they and their families face when they are admitted to hospitals. As a result, the NHS has started to develop a culture of continuous service improvement through individual and organisational learning and practice reviews. The UK Medicines Information Service has played an important role in this emerging culture of learning through providing both proactive and reactive medicines information; education and training support for prescribers; and specialist inputs to local and national policy developments.
2. The NHS's complex legal and regulatory structure is changing in the light of the Post-Shipman Review which will create a more robust process to ensure all healthcare professional staff, including doctors, are fit to practice for the whole of their working lives across the UK. This, coupled with recently aired concerns about some doctors' competence to prescribe safely and the NHS's relatively high error rates, places the UKMI Service potentially in a central position to support the development of safer prescribing practices.
3. The UK Government is committed to devolving its powers and to this end, it has set-up the Scottish Parliament, the Welsh Assembly Government, the Northern Ireland Assembly (which is currently suspended) and the London Regional Government Assembly. As the devolution policy matures, it is the Government's intention to enhance the powers for the Welsh and London Governments, and in time, to possibly set-up Regional Government structures and processes in England. This creates a divergence in policy development for the NHS as each Government gives priority to the issues which address the concerns of its Citizens. The UKMI Service, in trying to develop a coherent strategy within this context, needs to identify the key binding forces which are strong enough to hold the medicines information network together while being sensitive to each Government's policy developments and priorities. There is more commonality in the approaches of the NHS in Scotland, Northern Ireland and to some extent Wales, with the biggest policy changes occurring in England in both service provision and service commissioning.
4. The broad "generic" policy objectives are to improve access to good quality care; to increase the NHS's efficiency and performance levels by improving the organisation and management of clinical care; to develop new ways of working to reduce bureaucracy, duplication and hold-ups; to shift the NHS's cost structure from the current fixed cost system to one which is more flexible and variable; and to embed quality assurance and risk management within the service's design and ways of working. However, in England, this also incorporates a move to develop a more eclectic range of service providers including charities, social enterprises and the private sector in what is collectively called the "third sector".
5. Each Government is committed to developing care outside hospitals and in England in particular, the Government is going to commission 50 new "community hospitals" under the aegis of its recently published White Paper "Our health, Our care, Our say: A new Direction for Community Services". This is mirrored, in part, in Wales under "Designed for Life" and in Scotland under "Delivering for Health". Similarly, each Government is developing its own form of multi-agency public service networks particularly for children's services, care of the elderly and care of the mentally ill services. These developments pose a serious challenge to the UKMI Service.

6. At the moment, the publicly-funded UK Medicines Information Service, under the aegis of the NHS, provides specialist support to NHS Trusts, Public Foundation Trusts, and GP Partnerships. However, given the broadening range of service providers, especially in England, it will need to consider both the future boundaries of the UK Medicines Information Service, and its principles regarding future funding arrangements and charging for its services.
7. The White Paper's proposals to develop the new community-based hospitals in England does not mention whether pharmacy and medicines management services will be provided directly or by some form of franchising or sub-contracting, but it would seem reasonable to assume that as these new local community-based hospitals will provide support for, in the main, elderly patients with long-term conditions, and that this group of patients do draw upon, and benefit greatly from, the specialist services of pharmacists, that this major service development will require the support of pharmacy services – both dispensing and medicine management. Consequently, this proposal will require the support of the Medicines Information Service. It is also likely that the Medicines Information Service in England will be required to support directly the staff who are based at, or work from, such community hospitals as they will be working with, and caring for, the majority of patients who have complex needs arising from their multiple pathologies and polypharmacy requirements. In particular, the White Paper mentions the use of "friendly helpers". We do not yet know the specification for this role, or the minimum training and accreditation requirements, but given the relative vulnerability of this group of patients, and their carers, it is likely that this staff group will also require direct support from the Medicines Information Service.
8. In addition, there is a need to recognise the requirement for an underpinning Medicines Information Service to support specialists working in the networks. This is an under-recognised need in the planning and financial system and the consequent under-resourcing of the UK Medicines Information Service places its staff in the potentially invidious position of having to make choices about whether to support the Networks.
9. In summary, the implications of these developments for the UK Medicines Information Service are that it will need to:
 - maintain its networked ways of working;
 - increase its scope of activity in areas where it has not traditionally covered;
 - develop depth in the knowledge and skills of the staff working in the network's medicines information service;
 - agree its ways of working and funding with the multiplicity of future service providers;
 - develop a quality assurance framework for the service and its stakeholders to ensure it meets the standards and offers value for money.
10. Given the potential centrality of the UKMI Service in the NHS's Knowledge Management Strategy to make the NHS safer for patients, there are a number of strategic planning issues to be addressed including:
 - i) **Funding**
 - how will the Service's network of local hospital informatics and IT, which have been built-up over many years, be integrated and further developed as the National Programme for IT and Knowledge Management becomes established?;

- how will the Service be funded in the future in the context of devolution and the different approaches that are emerging for allocating capital funds?;
- how will the Service address, and possibly work with, the potential competing organisations, eg. the National Electronic Library for Health, the BMJ's Clinical Evidence on-line Service, the various GP support services eg. GP Notebook?

The funding options for the Service within the increasingly divergent funding systems in the four countries are to:

- make a case for direct funding from the four national central budgets;
- make a case for direct funding from the local or regional service commissioners;
- embed the costs of the service and support packages within the organisation's strategic plan and investment bids;
- embed the overall costs of the service in the financial allocation or tariff (in England);
- charge the costs for each item of service on the basis of an agreed UKMI Service tariff.

The UK Medicines Information Service will need to be sensitive to, and work with, the new and different funding schemes as they begin to take shape across the four countries.

ii) **Quality Assurance**

Given the possible changes in the legal and regulatory framework and the importance of ensuring staff are fit to practice, all staff working in the UKMI Service will be subject to the new regulatory requirements. Given the potential for developing a more consistent approach to clinical practice across the UK driven by the new UK-wide bodies, it would seem sensible for the UKMI Service to build on its work to develop a Medicines Information Service's Knowledge and Skills Competency Framework, and to ensure that this is used to underpin local staff appraisal processes and their submissions, in time, to the Regulator to be re-registered. This will require development funding in addition to the funds required for providing the service and upgrading the equipment as discussed above.

iii) **Succession Planning**

Given that this area of pharmacy practice takes some time to master before individual pharmacists can feel confident in their role, succession planning is an important issue. The NHS's current staff complement servicing the UKMI Service may not be adequate for the new agenda. The Service therefore needs to analyse the future demands for its specialist pharmacists and technicians in the light of the proposed legal and regulatory changes, and it needs to examine the nature of its future supply to ensure there is an adequate match. At the same time, it needs to take account of the fact that its staff will have to divert some of their working hours into updating and maintaining their own knowledge and skills and that this call on specialists' time will deplete the current resources so its impact will also need to be taken into account.

11. Finally, to take this forward, the UKMI Service needs to develop effective leadership which can form the Service's "intellectual fountainhead" and create the momentum required to make its strategy "live" locally in the form of an effective Medicines Information Service.

THE NHS's STRATEGIC POLICY FRAMEWORK

1. Introduction

1.1 Risk Management – Patients', Prescribers' and Managers' Needs

The public has become increasingly aware of, and sensitive to, the nature of the risks that they and their families are exposed to when they are admitted to hospitals. This is due in part to a combination of factors that have eroded the public's confidence in the NHS in the recent past including:

- the publication of major Inquiry Reports following failures in infection control¹;
- the public debate concerning medication errors and poor prescribing practices²;
- the failure of some NHS organisations to address the problems of clinical negligence and poor medical practice³.

As a result, patients', prescribers' and managers' needs converge around their collective requirement for the NHS to ensure that it delivers a safe and effective prescribing, dispensing and medicines management service which reduces medication error risks, and readmission and complication rates.

1.2 Knowledge Management – The Role of the UK Medicines Information Service

An emerging theme from the Public Inquiries, service reviews and inspections, and the wide body of research on managing and reducing clinical risks is the need to develop a culture of continuous service improvement through individual and organisational

¹ See for example: The Healthcare Commission's Report: A snapshot of hospital cleanliness in England, Dec. 2005; the Joint Reports of the Healthcare Commission and Health Protection Agency: Management, prevention & surveillance of *Clostridium difficile* – Interim findings from a national survey of NHS acute Trusts in England, Dec. 2005, and Investigation into outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, July 2006; The Healthcare Commission's Annual Healthcheck through assessment of Care Standard 4a & assessment against the new national target for the reduction of MRSA.

² See for example: the Healthcare Commission's Report on its performance review of prescribing and dispensing medicines practices to improve the management of medicines, August 2006; the National Patient Safety Agency's (NPSA) National Reporting and Learning System data that shows 41,220 or 9% of all incidents reported from the acute sector in England and Wales (1.7.2005-1.7.2006) were related to medication – report to be published in late 2006; the Sufferers of Iatrogenic Neglect's Submission to the Bristol Royal Infirmary Inquiry (refer to www.sin-medicalmistakes.org/Publications3.html) which refers to a pilot study to quantify medical error in the UK led by Charles Vincent, head of the clinical risk unit at University College, London, whose preliminary estimates are consistent with the findings of the NPSA; the Royal College of Physicians' (London) Conference Abstract on the Problems and Perils of Prescription Medicines, May 2003, and its Learning to Manage Health Information – A Theme for Clinical Education – Avoiding Prescribing Errors (refer to www.rcplondon.ac.uk/general/college/layingthefoundations); the Ergonomics and Safety Research Institute's Applied Vision Medication Errors website and links which refer to useful publications in this subject domain (refer to www.lboro.ac.uk/research/esri/applied-vision/projects/med_errors/index.htm).

³ See for example: the NHS's Litigation Authority's Key Facts concerning clinical negligence in 2005-2006 (refer to www.nhsa.com/home.htm); the Shipman Inquiry's six reports published between July 2002 – January 2005 (refer to www.the-shipman-inquiry.org.uk/reports); the Report of the Royal Liverpool Children's Inquiry – January 2001 (refer to www.rlcinquiry.org.uk); the Bristol Royal Infirmary Inquiry – July 2001 (refer to www.bristol-inquiry.org.uk/final_report); the Rodney Ledward and Richard Neale Inquiry Reports – June 2000 and September 2004 (refer to www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance).

learning and practice reviews. To this end, the NHS has developed a set of collective goals to support the development of:

- the organisational context which is aware of the risks associated with medicines;
- a culture of learning and practice improvement through the use of evidence;
- a culture of respect for medicines and their use through effective policy development⁴.

To complicate the situation, the prescribing decision-making system is increasingly complex with many more influencing forces, some of which are of dubious quality, trying to have an impact on a growing number of prescribers, some of whom are not very experienced. This, coupled with the fact that medicines are increasingly more potent, increases the propensity for mistakes to happen and for the risk profile to grow. Therefore, it is reasonable to propose that the UKMI Service, by providing both proactive and reactive tailored information support to prescribers, education and training for prescribers, and specialist inputs to local policy developments, which are all important locally in reducing risk, is critically important to the NHS's Knowledge Management Strategy⁵.

1.3 The Changing Legal and Regulatory Context – Protecting Patients

The NHS's legal and regulatory structure, which is very complicated at the best of times, is changing rapidly to meet the more rigorous and modern requirements arising from the developments outlined above. In particular, there are currently three key driving forces:

- the Post-Shipman Review and the proposed changes to the regulatory framework governing doctors working in the UK⁶;
- the parallel developments and proposals for a new regulatory approach for other healthcare professionals⁷;

⁴ See for example: The General Medical Council's Good Medical Practice, 3rd edn. London: GMC, 2001; the Federation of Royal Colleges of Physicians's Good Medical Practice for Physicians, Federation of RCPs, 2001; the DH Publications: An Organisation with a Memory – June 2000, and Pharmacy in the future: Implementing the NHS Plan – Sept. 2000.

⁵ The idea of Knowledge Management (the facilitation of the acquisition, sharing, storage, retrieval and utilisation of knowledge) has arrived relatively recently – for an excellent overview of the subject refer to Mark Easterby-Smith's and Marjorie Lyles's Introduction in the Handbook of Organisational Learning and Knowledge Management, Oxford: Blackwells, 2003; the NHS has located its National Knowledge Service within the National Library for Health's Knowledge Process and Safety (KPS) work stream (refer to fuller discussion in section 4 and www.connectingforhealth.nhs.uk/delivery/serviceimplementation/kps/im2010/documents/kps_business_plan.pdf).

^{6&7} The Secretary of State for Health is consulting on a UK-wide basis on the proposals set out in the consultation documents: Good Doctors, Safer Patients, and The Regulation of the non-medical healthcare professions: A Review by the Department of Health – July 2006 and the related web links (refer to www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAnd...). Among the key themes raised by the proposals are changes to the governance and accountability of the professional regulators; the importance of operationalised standards against which to regulate; the appropriate legal standard of proof; the introduction of an independent adjudicator; a spectrum of revalidation across all clinical professions; and devolution of some regulatory powers to the local level.

- the strengthening of, and the proposed changes to, our criminal and civil laws to increase citizens' rights with regard to their protection and safety within the context of European law⁸.

While these developments are designed to make prescribing, dispensing and medicines management safer, a number of other policy and practice developments are taking place which potentially exacerbate the problem of patient safety:

- the need to increase prescribers' training in basic pharmacology and prescribing⁹;
- the pressure to develop more potent (and riskier) medicines and thus bring the ED₅₀ and LD₅₀ closer together¹⁰;
- the rapid transfer of care for patients with multiple pathologies and complex therapeutics from the acute service to the community where the medicines management safety net and interventions are less well developed compared to those within acute hospitals¹¹.

This confirms the NHS's critical need for the UKMI Service.

1.4 The Challenges for the UKMI Service – The Consequences of Devolution

The UK Medicines Information Service has developed since the late 1960s to the present multi-centred networked service which is organised across the four countries of the UK. The Service is well-developed with specialists who serve and support their local health communities, and their work has been underpinned historically with investments in technology and skills so that the medicines information service that they provide is

⁸ The Government proposes a new offence of Corporate Manslaughter (Corporate Homicide in Scotland) (refer to www.commonleader.gov.uk/output/page979); under new proposals to hold organisations to account, the Bill outlines if the way organisation's activities are managed or organised by senior managers a) causes a person's death and b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased, that organisation is liable. A person is a "senior manager" of an organisation if s/he plays a significant role in the making of decisions about how the whole or a substantial part of its activities is to be managed or organised; or the actual manager or organiser of the whole or a substantial part of those activities (refer to discussion by Tim Randles – Regulatory Compliance Lawyer & Laytons Solicitors – set out on the BBC News: <http://news.bbc.co.uk/1/hi/business/4537053.stm>, 16.5.2005); see also the Crown Prosecution Service's definition and case law summaries (refer to www.cps.gov.uk/legal/section5).

⁹ See "Concerns over medics' drug skills": Professor Sir Mike Rawlins, professor of pharmacology at Newcastle University and Chairman of the National Institute for Health and Clinical Excellence said: "A great deal of mis-prescribing is because of a lack of knowledge. About 80% of adverse drug reactions are avoidable", and "students need to be told about what drugs to prescribe, in what proportions and how they interact and then they need to be examined on it" (refer to the BBC News: <http://news.bbc.co.uk/1/hi/health/519237>).

¹⁰ See "Applied Toxicology-Module 1: Background and Principles of Toxicology – Doses and Units of Doses, developed from Toxicology Tutorials at the National Library of Medicine (refer to http://aquatispath.umd.edu/applied_tox/module1-dose.html); and the Centre for Non Proliferation Studies' research programme: The Moscow Theatre Hostage Crisis: Incapacitants & Chemical Warfare – a study of fentanyl-based compounds comparing the ED₅₀ and LD₅₀ doses (refer to <http://cns.mii.edu/pubs/week/02110b.htm>).

¹¹ See the Medical Defence Union's summary of claims against GPs over the last 11 years: 51% - failed/delayed diagnosis; 23% medication errors; 7.5% - minor surgical procedures; 4.5% failed/delayed referral; 2% unsatisfactory patient management (refer to www.the-mdu.com/gp/casehistories/index).

both timely and accurate. Local centres, and commissioners, are supported by designated regional centres in England in the following cities:

- Birmingham
- Bristol
- Ipswich
- Leeds
- Leicester
- Liverpool
- London - @ Guy's Hospital
- London - @ Northwick Park Hospital
- Newcastle
- Southampton

In Scotland, there are designated regional centres in the following cities:

- Aberdeen
- Dundee
- Edinburgh
- Glasgow

In Wales and Northern Ireland, the designated national centres are located in the capital cities of Cardiff and Belfast.

The Medicines Information Service has successfully developed as an adjunct to the ward and subsequent clinical pharmacy service in NHS hospitals, and more recently, it has developed a complementary service for colleagues working in the primary and community care services. In addition, since the mid-1990s, it has developed a portfolio of specialised information support services for the emerging Clinical Networks and the various NHS agency services that have been commissioned to improve patient care and access, for example by providing a service to NHS Direct/NHS24; and it has helped to identify and reduce risks for patients, for example by working with the National Patient Safety Agency. The Medicines Information Service has also helped to improve safety and the quality of prescribing through providing support to non-medical prescribers.

However, devolution is creating an NHS with increasingly different governance structures and ways of working. This shift in power, building on the success of the Scottish Parliament, and the resultant policy divergence, will be driven further and faster by the recent legal developments for the Welsh Assembly Government and London Regional Assembly Government, and the proposals to develop and strengthen the English Regional Government structures and powers of attorney¹². As a result, this changes, across the UK, how service providers will develop in the NHS with the English reforms showing potentially a rapid broadening of the types of organisations involved. In addition, there are changes to how the service will be commissioned and how cash will flow to Trusts, particularly in England.

In the light of these major policy developments, the principle of maintaining and developing a UK-wide Medicines Information Service will need careful consideration.

¹² See the Department for Communities and Local Government's proposals to grant additional powers and responsibilities, including health policy, for the Mayor and Assembly of the Greater London Authority – July 2006 (refer to www.communities.gov.uk/index.asp?id=1500896); and its proposals to reform the structure of local government in the English Regions under the Future of Local Government – Developing a 10-year Vision (refer to website above: id=1137789). Also, see the Government of Wales Bill which will enhance the Assembly's powers and reform its structure and electoral system to create a more transparent and accountable body (refer to www.wales.gov.uk/keypubmrsaca/content/legislation.htm#Wales). The Scottish Parliament's website shows the scope of its devolved powers (refer to www.scottish.parliament.uk/corporate/powers/index/htm, and www.opsi.gov.uk/legislation/scotland/s-acts.htm). The situation in Northern Ireland is complicated as the Assembly is suspended and it is ruled directly from Whitehall (refer to www.opsi.gov.uk/legislation.northernireland/ni_legislation.htm).

1.5 The Strategic Policy Framework – Providers, Commissioners and the UKMI Service

This supplement complements the UKMI Service's Strategy: Effective Information for Managing Medicines – A Strategy for the UK Medicines Information Network in a Patient-led NHS; and it seeks to outline the Government's Strategic policy framework for the NHS. To this end, the discussion below sets out how:

- service provision will be developed across the four countries over the next 3-5 years;
- the Post-Shipman Review's proposals might be introduced across the UK;
- the investments in clinical informatics and IT across the UK will help to develop local Knowledge Management strategies to embed organisational learning;
- service commissioning will be developed to manage cash flow and accountability within the context of devolution over the next 3-5 years.

Finally, the supplement concludes with a discussion on the key issues that will inform the UKMI Service's strategic development agenda.

2. Developing Service Providers

2.1 The Policy's Strategic Development Objectives

There are many challenges facing the NHS in the 21st century. In addition to the need to reduce the risks that patients potentially face, as discussed above, the NHS will need to address the following issues within the context of devolution:

- the pressure on service budgets as the Government seeks to reduce the size of the underlying deficits and increase the service's efficiency levels and effectiveness, especially concerning the purchase and use of new drugs;
- the requirement to build systemic quality assurance procedures into the clinical protocols that form the care pathway, especially concerning easy access to, and the best use of, information about the appropriate use and review of medicines;
- the requirement to develop effective multidisciplinary team working and shared responsibility for decision-making;
- the pressure to address patients' (and their carers') choices, especially in England;¹³
- the requirement to implement in some parts of the UK a new payment/cash allocation system, eg. the Payment by Results Tariff in England.¹⁴

The next wave of NHS and Social Care reforms, building on previous changes within the context of devolution, have the following key policy objectives:

- to improve access to good quality acute and primary care services by reducing waiting times and building more patient-focussed evidence-based programmes of care;
- to increase the service's efficiency and performance levels by improving the organisation and management of clinical care;
- to develop new ways of working to reduce bureaucracy, duplication and hold-ups in providing clinical services;
- to shift the NHS's cost structure from the current fixed cost system to one which is more flexible and variable;
- to embed quality assurance and risk management within the service's design and ways of working.

¹³ See the Secretary of State for Health's (England) speech given at the King's Fund, London, 14.6.2006 – Patient Choice the key to NHS future – (refer to www.labour.org.uk/index.php?id=news2005); the New Local Government Network's think-tank piece – Making Choices: How Can Choice Improve Public Services? (refer to www.nlgn.org.uk); the Labour Party's 2005 Manifesto – Chapter 4/Section: Empowering patients: choosing not waiting (refer to www.labour.org.uk/fileadmin/manifesto); the "Bedfordshire" Ruling on a patient's choice (refer to <http://news.bbc.co.uk/1/hi/england/beds/bucks/herts/3156838.stm>).

¹⁴ See "Payment by Results" Overview, Progress & Work Schedule Reports & cross web-links for the NHS (England) (refer to www.dh.gov.uk/PolicyAndGuidance/OrganisationalPolicy/FinanceandPlanning/NHSFinancialReforms/fs/en).

In addition, the recently published White Paper proposes for England¹⁵ the development of more integrated health and social care services provided outside hospitals and nearer to, or in, patients' own homes. It places emphasis on involving patients with long term conditions, and their carers, in planning and providing for their own care through:

- learning about how to manage and live with their condition through the "Expert" Patient Programme;
- purchasing "packages" of care directly from local approved suppliers using public funds allocated under the direct and co-payments scheme which was successfully piloted in England during the last Government;
- having access to specialists locally, particularly for diagnostic tests and investigations, some procedures, and clinical services including surgery, gynaecology, ear, nose and throat, cancer care, some general medicine, urology and dermatology.

2.2 Developing a Plurality of Providers

To support the expansion and development of long-term care provision in the community, particularly in England, the Government has made available the following five legal formulations to underpin potential service providers so that they may be considered and included on the public procurement list for service commissioners:

- Public Foundation Trusts, eg. the Royal Devon and Exeter NHS Foundation Trust;
- Public Limited Companies, eg. Boots, and Clinovia's and Baxter's Home Care Services;
- Registered Charities, eg. the Marie Curie Foundation and the MacMillan Nursing Service;
- Registered Partnerships, eg. local GP practices;
- Social Enterprises, eg. Greenwich Leisure and Daily Bread.

The details of these legal formulations are given in Appendix 1.

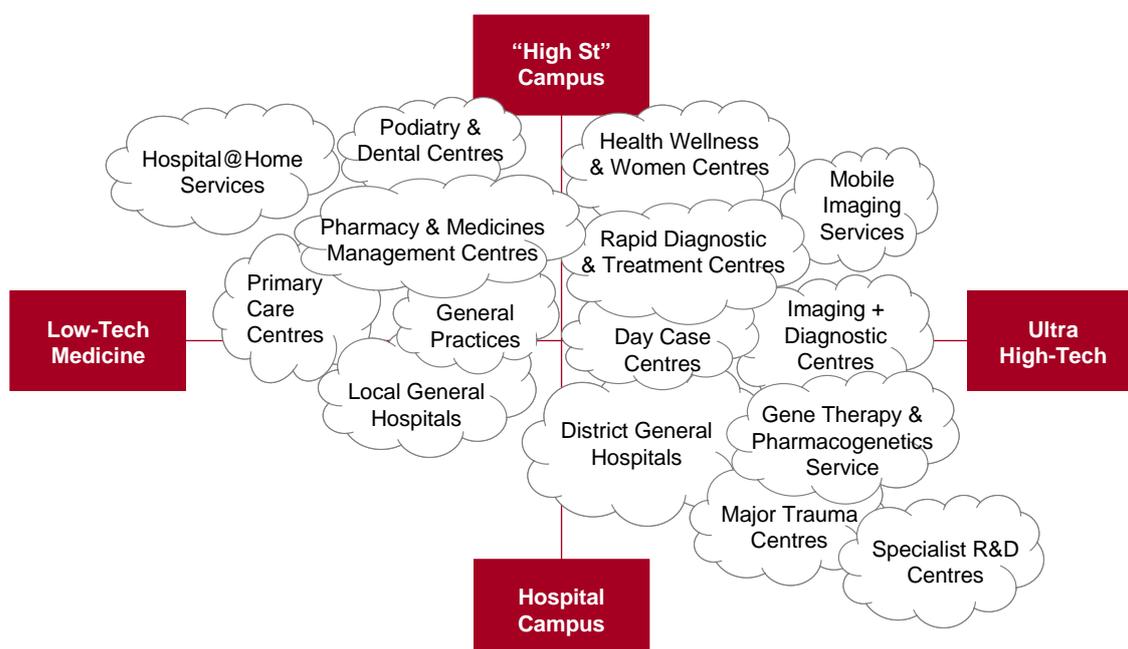
2.3 Developing Care Outside Hospitals

To support these proposed developments, the Government intends to commission for England at least 50 new community-based hospitals which might include diagnostic centres as well as consultation and treatment rooms and facilities for providing rehabilitation and therapy services.

Looking to the future, it is likely, especially in England, that the expanded service provider map will be much more plural in nature. This is summarised in the diagram below which distinguishes on the one hand the location of future services in the "high

¹⁵ See "Our health, Our care, Our say: A New Direction for Community Services" – January 2006 (refer to www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAMpGBrowsableDocument/fs/en?CONTENT).

street” and the “hospital” campuses, and on the other, services which are supported by low-technology or ultra high-technology:



These major developments in the provision of community-based care in England are being mirrored by complementary developments in the devolved administrations, eg. in Wales, under “Designed for Life”, which builds on the recommendations of the Wanless Report for Wales;¹⁶ and in Scotland, NHS Scotland seeks to address its major Public Health Agenda (tobacco, cancer, food and health, sexual health, physical activity, mental health, drug misuse, alcohol problems, health inequalities) by community-based policy developments within each of its 15 Boards working with their Local Authorities, to achieve the objectives set out in “Delivering for Health”.¹⁷ Clearly, each administration will develop its own policies and ways of working to meet the challenges it faces but the broad direction of travel seems to be based on the following generic policies:

- the development of some GP-Practices into providing more specialised services under the aegis of the General Medical Services contract and the Quality and Outcomes Framework;
- the development of community pharmacy services under the Medicines Management initiative and the new General Pharmacy Services Contract;
- the development of community nursing services under the “Community Matrons” initiative and the strategy for advanced nursing practice development;

¹⁶ See “Designed For Life” – May 2005 (refer to www.wales.nhs.uk/sites3/page.cfm?orgid=452&pid=11608) and the Welsh Assembly Government’s Health Minister Dr. Brian Gibbons’s interview with BBC Wales News – 19.5.2005 (refer to <http://news.bbc.co.uk/1/hi/wales/4560653.stm>).

¹⁷ See the Scottish Executive’s Health & Community Care Programme and NHS Health Scotland’s Programme of Work (refer to <http://www.scotland.gov.uk/topics/health> and <http://www.healthscotland.com>).

- the development of the Ambulance Trusts' paramedical services and the upgrading of the paramedics' "first responder" skills and ways of working;
- the development of accredited prescribers who can both initiate, in some cases, and maintain therapies under the aegis of a medical practitioner.

2.4 Developing Multi-Agency Clinical Networks

In a parallel set of policy developments, the Government and the devolved administrations, building on earlier policies to encourage partnership working between providers in public agencies, has encouraged the development of managerial and financial convergence in such partnerships. Under a lead chief officer, who is accountable to a number of public bodies that form the multi-agency network, the three key services that are affected by this policy are:

- Children's Care Services;
- Mental Health Care Services;
- Care of the Elderly Services.

This pattern of networking several organisations and bringing together their planning and financial standing orders to form a coherent virtual "whole" organisation fixed on a care group has been replicated with varying degrees of success in the following clinical services:

- Cancer and Cardiology Networks;
- Surgical and Intensive Care Networks;
- Emergency Services Networks.

The longer term success of this bridging device between NHS organisations which provide either primary or secondary care services is not known but the Department of Health for England has commissioned a major review of the clinical networking programme, and the pilot multi-agency partnerships, to assess if they will be substantiated beyond 2008 when the current support funding finishes. Clearly this has implications for the organisation and delivery of the pharmacy service as the call on both the dispensing and the Medicines Management Services is great in all these areas.

A summary of the management challenges facing the NHS concerning maintaining the spread of its Accident & Emergency Departments, and all its specialist back-up services, in the face of the pressure on its staffing levels and costs arising from the new regulations and "Agenda for Change", is given in Appendix 2.

2.5 Implication for the UKMI Service

With the likely expansion of care provided outside hospitals across the UK, and the development of more community-based medicine and prescribing, the collective impact of the policies outlined above on the Medicines Management Service will place increasing demands on the UKMI Service.

At the moment, the publicly-funded UK Medicines Information Service, under the aegis of the NHS, provides specialist support to NHS Trusts, Public Foundation Trusts, and GP Partnerships. However, given the broadening range of service providers, especially in England, it will need to consider both the future boundaries of the UK Medicines Information Service, and its principles regarding future funding arrangements and charging for its services.

The White Paper's proposals to develop the new community-based hospitals in England does not mention whether pharmacy and medicines management services will be provided directly or by some form of franchising or sub-contracting, but it would seem reasonable to assume that as these new local community-based hospitals will provide support for, in the main, elderly patients with long-term conditions, and that this group of patients do draw upon, and benefit greatly from, the specialist services of pharmacists, that this major service development will require the support of pharmacy services – both dispensing and medicine management. Consequently, this proposal will require the support of the Medicines Information Service. It is also likely that the Medicines Information Service in England will be required to support directly the staff who are based at, or work from, such community hospitals as they will be working with, and caring for, the majority of patients who have complex needs arising from their multiple pathologies and polypharmacy requirements. In particular, the White Paper mentions the use of “friendly helpers”. We do not yet know the specification for this role, or the minimum training and accreditation requirements, but given the relative vulnerability of this group of patients, and their carers, it is likely that this staff group will also require direct support from the Medicines Information Service.

In addition, there is a need to recognise the requirement for an underpinning Medicines Information Service to support specialists working in the networks. This is an under-recognised need in the planning and financial system and the consequent under-resourcing of the UK Medicines Information Service places its staff in the potentially invidious position of having to make choices about whether to support the Networks.

In summary, the implications of these developments for the UK Medicines Information Service are that it will need to:

- maintain its networked ways of working;
- increase its scope of activity in areas where it has not traditionally covered;
- develop depth in the knowledge and skills of the staff working in the network's medicines information service;
- agree its ways of working and funding with the multiplicity of future service providers;
- develop a quality assurance framework for the service and its stakeholders to ensure it meets the standards and offers value for money.

3. The Post-Shipman Review and Protecting Patients

3.1 “Good Doctors, Safer Patients” – The Regulation of Doctors

The Chairman of the Shipman Inquiry, Dame Janet Smith, made serious criticisms of the current medical regulation system and the General Medical Council (GMC) and she made recommendations to update them with the objective of protecting patients and improving their safety¹⁸. The Chief Medical Officer (CMO) for England, working with the CMOs for Northern Ireland, Scotland and Wales, has undertaken a broad review and he has submitted detailed recommendations in a report: Good doctors, safer patients. This report proposes measures to strengthen the arrangements for the protection of patients including devolving some of the powers of the GMC to local (employer) level, changing its structure and function, and creating a new framework for doctors’ revalidation¹⁹.

Sir Donald Irvine, the former President of the GMC, has highlighted the key issues²⁰ which are summarised below:

- defining what a good doctor is and the standards of professional practice for achieving that;
- embedding these standards into the medical registration and licensure, certification for specialist and general practice, medical education and doctors’ contracts of employment;
- standardising the entry to the profession through a new national examination for all doctors applying for registration with the GMC for the first time;
- ensuring doctors are competent to practice on a continuing basis through revalidation embracing relicensure and recertification;
- locating the regulation of doctors within the wider set of systems for improving and quality assuring modern practice;
- establishing a more robust management and fairer process when there are concerns about a doctors’ practice by placing greater emphasis on retraining and rehabilitation, having access to a workplace GMC affiliate and separating the investigation and adjudications in fitness to practice cases;
- adopting a civil rather than a criminal standard of proof in fitness to practice cases.

The Royal Colleges and specialist societies are to take lead responsibility for delivering the key recertification element of revalidation for their members thus spearheading the development of a strong professional and competent workforce²¹. In addition, the proposal is to bring together and consolidate responsibility for both undergraduate and postgraduate medical education on the (to be renamed) Postgraduate Medical

¹⁸ See The Shipman Inquiry Safeguarding Patients: Lessons from the Past, Proposals for the future (Chairman Dame Janet Smith). London: Stationary Office, 2004.

¹⁹ See Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients, July 2006 (refer to www.dh.gov.uk/PublicationsAndStatistics/Publications, and related websites).

²⁰ See Donald Irvine’s excellent editorial in the Journal of the Royal Society of Medicine, vol 99, September 2006, which is also available at www.rsm.ac.uk/media/pr209.htm.

²¹ See for example, the infrastructure of evidence-based performance metrics developed for cardiac surgeons by the Society for Cardiothoracic Surgery in Great Britain and Ireland, and the Healthcare Commission (refer to <http://heartsurgery.healthcarecommission.org.uk>).

Education and Training Board (PMETB) thus creating a continuum of education across the UK²².

3.2 Fitness to Practice and Prescribing Risk Management

To underpin the proposed major changes above, NHS employers will have an important role in ensuring that their doctors' appraisal processes are sufficiently rigorous and consistent across the UK. The six key functions which might be expected in reviewing individual doctors and their practices include:

- ensuring that practice is safe;
- ensuring that practice is of a good standard;
- taking opportunities to improve practice;
- reviewing performance in relation to service goals, objectives and targets;
- identifying and meeting professional development and training needs;
- checking that conduct is honest and ethical, and that the individual behaves with integrity²³.

The current system of medical appraisal in the NHS varies from a "cosy chat with a sympathetic colleague" to a more rigorous form of assessment. For the proposed new process of revalidation to be effective, the system needs to be upgraded. It will need to be based on a valid and reliable assessment of a doctor's everyday standard of practice so as to enable a judgement to be made about how good that doctor is, about the safety of their practice, and about the extent to which quality is embedded in their everyday work²⁴. The issue of embedding the notion of "fairness" in the appraisal process as directed by employment law will mean that NHS employers will have to place greater emphasis on providing all doctors with the necessary support in the form of retraining and rehabilitation.

Given the earlier discussion about poor prescribing practices and the inadequacies of doctors' training in this key area of competence, the discussion above confirms the proposition made earlier about the potential role of the UKMI Service in providing both the proactive and reactive tailored information support to prescribers; education and training for prescribers; and specialist inputs to local policy developments. These are all important activities locally in reducing risks for patients and they confirm the UKMI Service's organisational role in the NHS's Knowledge Management Strategy²⁵.

3.3 The Regulation of the Non-Medical Healthcare Professions

In a parallel development, the Department for Health for England, working under the government's reserve powers with colleagues in Northern Ireland, Scotland and Wales, has proposed a set of complementary reforms for the regulation of the non-medical healthcare professions, including pharmacists²⁶. The recommendations are summarised below:

- the regulation of the professions should form one integrated and consistent framework across the different professions, and should link up better with the measures employers take to satisfy themselves that their staff are working safely;

²² The undergraduate curriculum is currently located with the GMC and its four country structure; if it is consolidated with PMETB, a UK-wide body, this policy creates a unifying force for training and development across the UK (refer to www.pmetb.org.uk).

²³ See paras. 57-62 of "Good doctors, safer patients" cited in footnote 19 above.

²⁴ See paras. 67 *ibid*.

²⁵ Refer to discussion in section 1 above.

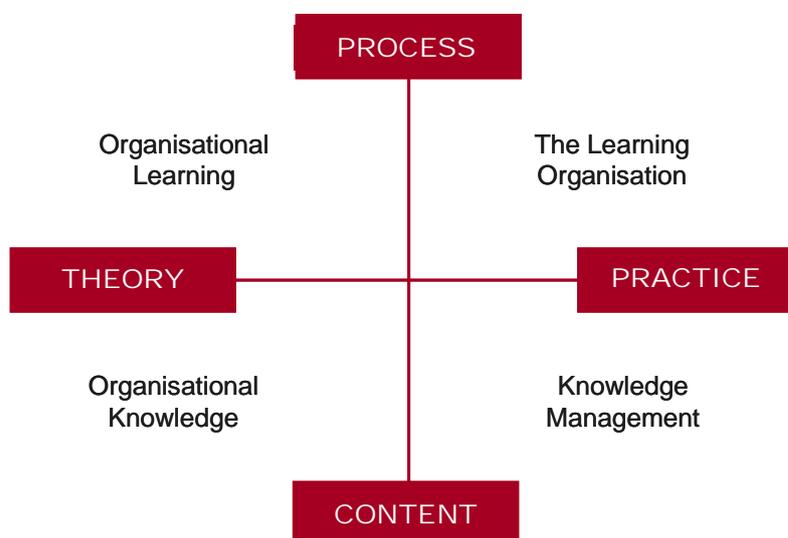
²⁶ See "The regulation of the non-medical healthcare professions: a review by the Department of Health", July 2006 (refer to www.dh.gov.uk/PublicationsAndStatistics/Publications).

- the creation of a more independent adjudication process about cases where someone's fitness to practice causes concern;
- the need to provide objective and robust assurance that individual professionals remain fit to practice by standardising the content and enhancing the value of work place appraisal;
- every registered professional will need to revalidate, but the amount of detail they need to provide will vary depending on how much risk to patients their work creates;
- a major employer role in revalidation, with a system to check that employers fulfil this duty with parallel arrangements where there is no employer.

The proposals also include that the revalidation system should be both formative (an aid to development) and summative (a check that a required standard is met). Within the NHS, information gathered under the Knowledge and Skills Framework (KSF) should be the basis of revalidation. Within this context, the issue of identifying common educational standards such as the knowledge needed to underpin safe prescribing has been flagged for the attention of the regulators and the Council for Healthcare Regulatory Excellence. This resonates with the themes discussed earlier and further emphasises the potential role of the UKMI Service in the provision of specialist support not just for doctors but also for non-medical professionals, especially those who are prescribers.

3.4 Knowledge Management and IT Developments

The concept of Knowledge Management (the facilitation of the acquisition, sharing, storage, retrieval and utilisation of knowledge) was introduced earlier²⁷. Although a relatively new field of study, Easterby-Smith and Lyles have distinguished several research domains which are summarised below and set within the two intersecting dichotomies of theory and practice, and process and content²⁸:



Given the proposed changes to the regulations and appraisal processes discussed above, the NHS will have to develop more robust approaches to supporting individual

²⁷ See section 1.2 above.

²⁸ See Mark Easterby-Smith's and Marjonie A. Lyles's Introduction: Watersheds of Organisational Learning and Knowledge Management in the Handbook of Organisational Learning and Knowledge Management, Oxford: Blackwells, 2003.

doctors' and professional staff's education and training needs through developing a Knowledge Management Strategy for prescribers.

Easterby-Smith and Lyles point out that Knowledge Management also has to sit within the context of the organisation's social architecture of knowledge exchange. This is potentially an important issue in the NHS and it has been embraced by the NHS's major investment programme in clinical informatics and IT²⁹.

To illustrate the depth of these developments for example, in England, two work streams are focussing on the National Knowledge Service and the Clinical Practice and Process; the key elements include:

The National Knowledge Service	The Clinical Practice & Process
<ul style="list-style-type: none"> ▪ Best Current Knowledge Service ▪ The National Library for Health ▪ The Nursing Knowledge Toolbox ▪ National Decision Support Service ▪ The Map of Medicine ▪ NHS Search Engine ▪ Integrated Child Health Knowledge 	<ul style="list-style-type: none"> ▪ Better Prescribing ▪ Risk Minimisation ▪ Clinician Professional Development ▪ Do Once and Share ▪ The Busy Clinician ▪ National Clinical Toolbox ▪ The Connected Patient

A summary of the developments incorporating extracts from the Knowledge, Process and Safety Business Plan are given in Appendix 3.

3.5 Implications for Developing the UKMI Service

Given the potential centrality of the UKMI Service in the NHS's Knowledge Management Strategy to make the NHS safer for patients, there are a number of strategic planning issues to be addressed including:

iv) Funding

- how will its network of local hospital informatics and IT, which have been built-up over many years, be integrated and further developed as the National Programme for IT and Knowledge Management becomes established?;
- how will the UKMI Service be funded in the future in the context of devolution and the different approaches that are emerging for allocating capital funds?;
- how will the Service address, and possibly work with, the potential competing organisations, eg. the National Electronic Library for Health, the BMJ's Clinical Evidence on-line Service, the various GP support services eg. GP Notebook?

²⁹ See for example for England, Connecting for Health's Strategy for Knowledge, Process and Safety, Better Prescribing, Risk Minimisation, Clinical Professional Development, Clinician Professional Development, the Constant and Connected Patient, the Busy Clinician, Clinical Knowledge Management, and The Electronic Prescription Service which incorporates the Electronic Transmission of Prescriptions Programme (refer to www.connectingforhealth.nhs.uk/delivery/serviceimplementation/kps).

The funding options for the UKMI Service within the increasingly divergent funding systems in the four countries are to:

- make a case for direct funding from the four national central budgets;
- make a case for direct funding from the local or regional service commissioners;
- embed the costs of the service and support packages within the organisation's strategic plan and investment bids;
- embed the overall costs of the service in the financial allocation or tariff (in England);
- charge the costs for each item of service on the basis of an agreed UKMI Service tariff.

The UK Medicines Information Service will need to be sensitive to, and work with, the new and different funding schemes as they begin to take shape across the four countries.

v) Quality Assurance

Given the possible changes in the legal and regulatory framework and the importance of ensuring staff are fit to practice, all staff working in the UKMI Service will be subject to the new regulatory requirements. Given the potential for developing a more consistent approach to clinical practice across the UK driven by the new UK-wide bodies, it would seem sensible for the UKMI Service to build on its work to develop a Medicines Information Service Knowledge and Skills Competency Framework, and to ensure that this is used to underpin local staff appraisal processes and their submissions, in time, to the Regulator to be re-registered. This will require development funding in addition to the funds required for providing the service and upgrading the equipment as discussed above.

vi) Succession Planning

Given that this area of pharmacy practice takes some time to master before individual pharmacists can feel confident in their role, succession planning is an important issue. The NHS's current staff complement servicing the UKMI Service may not be adequate for the new agenda. The Service therefore needs to analyse the future demands for its specialist pharmacists and technicians in the light of the proposed legal and regulatory changes, and it needs to examine the nature of its future supply to ensure there is an adequate match. At the same time, it needs to take account of the fact that its staff will have to divert some of their working hours into updating and maintaining their own knowledge and skills and that this call on specialists' time will deplete the current resources so its impact will also need to be taken into account.

4. Developing Service Commissioning and Accountability

4.1 Strengthening Financial Governance and Accountability

The Government raises taxes from the British public and allocates the resources against the many claims on the fund after Parliament has approved the government's budget. Part of this fund is then allocated to the Scottish Parliament, Welsh Assembly Government and the Northern Ireland Office (as the Assembly is currently suspended), and their First Ministers, elected members and lead officers decide how much of their fund will be spent on the NHS within their jurisdiction.

In England, the fund for the NHS is allocated to the Department of Health which then administers it through the Strategic (Regional) Health Authorities.

As it is public money, it has to be accounted for to Parliament where the Comptroller and Auditor General reports on the value for money achieved and the efficiency of the public service. Similar arrangements apply in the devolved administrations. As a result of this strong financial governance framework, the NHS has to publicly allocate, and account for, its resources according to the rules laid out in the Standing Financial Orders, Standing Financial Instructions and the Scheme of Reservations and Delegations³⁰.

Two important developments will affect how the financial governance and reporting framework will operate in the NHS in the future:

- i) The "Enron" disaster and the Higgs Commission – as a result of the "Enron" financial disaster and subsequent Inquiries in the US, the UK government (via the H.M. Treasury and the Department for Trade and Industry) commissioned a review of the likelihood that such a disaster could happen in the UK. The resulting Higgs Report has highlighted potential weaknesses particularly in the way Boards work in their scrutiny role and has made recommendations to strengthen this area. These recommendations inform how public bodies need to strengthen their financial governance arrangements³¹.
- ii) The "Arm's Length Bodies" Review – to ensure that the bulk of taxpayers money is spent on public services rather than on an infrastructure of bureaucracy, the Government has started a review of all the "Arm's Length Bodies" with a view to reducing their numbers and size, and to streamlining the costs of administering public services. As a result, many inspection and advisory bodies, and public funding bodies, are being merged, or disbanded, and their running costs severely capped³².

³⁰ See for example Model Standing Orders, Model Standing Financial Instructions and Model Reservation and Delegation Orders for NHS Boards in England, March 2006 (refer to www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance).

³¹ See The Higgs Review and the Institute of Directors' Response to the Higgs Commission (refer to www.dti.gov.uk/bbf/corp-governance/higgs-tyson/page23342.html and www.iod.com/intershoproof/ecs/store/en/pdfs/Higgsresponse.pdf); and the BBC news and FT special report on the Enron disaster (refer to <http://news.bbc.co.uk/1/hi/business/1780075.stm> and [2096445.stm](http://news.bbc.co.uk/1/hi/business/2096445.stm), and <http://specials.ft.com/enron>).

³² See for example the Arm's Length Bodies Review in the NHS and Social Care system for England (refer to: www.dh.gov.uk/AboutUs/DeliveringHealthAndSocialCare/OrganisationsThatWorkWithDH/ArmslengthBodies/fs/en).

This set of developments create the context within which NHS service commissioning will develop over the next 3-5 years.

4.2 NHS Commissioning and Accountability Arrangements Across the UK

A recent review of the effectiveness of primary-care led commissioning and its place in the NHS from the Health Foundation has shown that from 1991-1997, commissioning policy was largely consistent across the four countries of the UK. Since 1997 however, the approach has varied, and the authors have summarised this as follows³³:

- England - the purchaser-provider split has been largely retained and Primary Care Trusts have become the main local commissioning body and they are charged with developing new forms of devolved practice-led commissioning.
- Northern Ireland - local health and social groups have been created as a method of developing effective clinical and public engagement in the commissioning process. The groups have however struggled to secure GP involvement.
- Scotland - The quasi-market was abolished and the funding system was returned to the directly managed – central allocation system where commissioning and providing roles are effectively integrated. Community Health Partnerships are viewed as key forums for determining local health and social care priorities and plans.
- Wales - the purchaser-provider split has been retained with a strong emphasis on forming local partnerships with local government and local communities focused on 22 Local Health Boards.

In the light of the discussion above, and the pressure on reducing administration costs while increasing the rigour of financial governance, there are a number of changes to the structures and processes of NHS commissioning across the UK:

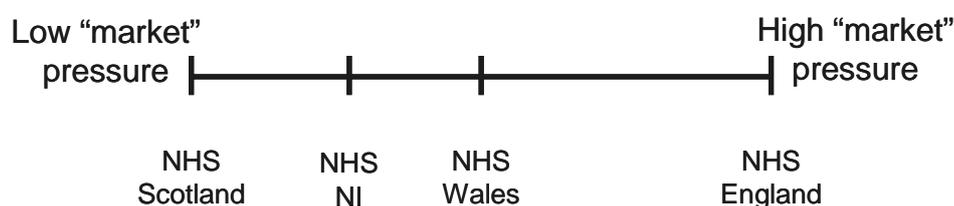
- England - the number of Strategic Health Authorities and Primary Care Trusts has been dramatically reduced and their respective roles and responsibilities are being redefined to focus them on developing more effective service commissioning and accountability. As a result, Primary Care Trusts (PCTs) now cover a larger geographical area and they are supported by a number of administrative back-up services which are organised at a regional level to achieve economies of scale savings. PCTs have a specific duty to develop GP Practice-based Commissioning and as a result, they will lose, in time, their service provider duties.
- Northern Ireland - the number of Health and Social Service Boards and their constituent health and social care Trusts has been dramatically reduced so that there is now one “Board” for Northern Ireland which will commission and work with five “super” health and social care provider organisations.

It is unclear how GP involvement will be taken forward.

³³ See The Health Foundation’s Report “A review of the Effectiveness of Primary Care-led Commissioning and Its Place in the NHS”, October 2004 (refer to <http://www.health.org.uk/mediaroom/pressreleases/index.cfm?id=58forasummary>).

- Scotland - the number of Health Boards and their functions are under review and the development of service commissioning and performance management within the context of the local Community Health Partnerships depends on how the Scottish Parliament wants to develop its governance and accountability structures and processes, including involving GPs.
- Wales - the number of Local Health Boards, working with their Local Authority Partners, is under review but many have already developed shared commissioning duties and responsibilities across three regional networks which are also supported by a national commissioning group.

Clearly, service commissioning across the UK is developing according to each country's culture and requirements and may be seen on a conceptual continuum of the level of "market" forces applied to create performance pressures in the providers:



4.3 NHS Commissioning and Accountability Arrangements in England

The NHS in England is rapidly developing its commissioning model in a different direction compared to the policies for Northern Ireland, Scotland and Wales. Given the proposed changes to the structure of the English Regional and Local Government system, modelled in part on the London Regional Assembly Government, the UKMI Service needs to be able to work with the different systems of strategic planning and financial allocation across the UK. As the English system is the newest and most complicated model, a brief overview is set-out below and a summary is given in Appendix 4.

To develop service commissioning, accountability and performance management using the "market" lever, the Department for Health for England has introduced five key policy instruments for the reformed PCTs and Strategic Health Authorities to enact:

- Contestability and Foundation Trusts – to establish the mechanisms of the "market" so that the reformed PCTs, under the aegis of their reformed Strategic Health Authority, allow a wider range of service providers to enter the "market" (see earlier discussion in section 2.2), including NHS Foundation Trusts, which have much stricter operational and financial controls applied to them under the aegis of the "market's" Regulator (called Monitor).
- The Tariff and Contract Currencies – to underpin the "market" and service commissioning with an information base that defines a "programme" or "episode" of care and its price. Experience in the US and Germany shows that it takes about 10-15 years for this type of funding system to bed in. The Tariff is established in surgery and work is in hand to introduce the necessary information for service commissioners in the domains of long term conditions and mental health services in late 2006-2007. Financial Controllers have the power locally to vary the Tariff according to the Standing Orders given to them under the "Payment by Results" rules.

- “Choice” and Administration Costs – to establish the twin goals of introducing “choice” for patients in the light of the Government’s policy and the “Bedfordshire” ruling, and the successful pilots conducted in the last Parliament (see earlier discussion in section 2.1); and capping administrative costs to deliver the required savings targets (see earlier discussion in section 4.1).
- Commissioning and Contracting Services – to distinguish commissioning from the administrative functions that service commissioning, eg. the contractual paperwork and the purchasing financing systems³⁴.

It is likely that with this important distinction, the administrative functions could be organised in a different way, possibly in a shared-service agency held at a regional level to achieve the necessary economies of scale, and in some cases, they may even be tendered out to a third party to provide on behalf of the NHS in England.

- Contract Compliance, Market Regulation and Service Inspection – to build-up the framework of public protection requirements and to hold the service commissioners and providers to account on behalf of the taxpayers and patients; the Offices of the Healthcare Commission and the Regulator (known as the Monitor) are now well-established but their roles overlap in some areas causing confusion so there is a review in train which will clarify each Body’s jurisdiction. The roles of the (reformed) Strategic Health Authorities and PCTs in ensuring Contract Compliance has still to be clarified.

4.4 Strengthening Public Protection

Service Commissioners across the UK commission the services that are required by their local populations as defined by the local Public Health Strategies which are based on careful local audits and research. Where possible, the commissioning plans are underpinned by evidence-based practices and much of these are informed by the standards laid down by the various august bodies such as the medical Royal Colleges and the National Standards Boards working across the UK. This discipline helps to create a consistency in service provision across the NHS. To check progress and to ensure this more rigorous evidence-based approach informs commissioning development, each country has an Inspectorate: the Healthcare Commission for England, which is based in London, Nottingham, Leeds, Bristol and Manchester; the Healthcare Inspectorate Wales which accounts to the National Assembly for Wales; the NHS Quality Improvement Scotland which accounts to the Scottish Parliament; and the Health and Personal Social Services Regulation and Improvement Authority for Northern Ireland which accounts to the Northern Ireland Office in the absence of the Assembly (which is currently suspended).

This emerging Quality Assurance system gives the third leg of the UK’s 4 Governments’ triangulated approach to ensuring public protection and safety:

- Financial Governance and Controls Assurance;
- Clinical Governance and Staff’s Revalidation and Certification;
- Commissioning Governance and Evidence-based Commissioning.

³⁴ See the University of Birmingham’s Health Service Management Centre’s comprehensive and excellent review of PCT commissioning in “Commissioning in the reformed NHS: policy and practice” by Elizabeth Wade, Judith Smith, Edward Peck and Tim Freeman, March 2006.

4.5 Implications for Funding the UKMI Service

With the changes to service commissioning and performance management, and therefore cashflow, especially in England, the funding of the UKMI Service is potentially at risk. Funding for the Medicines Information Centres, and their constituent networks of local hospital centres, in Belfast and Cardiff are probably the most straightforward in that they are both well-embedded in the local capital-based Teaching Hospitals' funding systems along with the local allocations to their partner hospitals. The funding issues for NHS Wales and NHS Northern Ireland is how they maintain their current allocations in the face of great pressures locally to make savings, and at the same time, obtain new funding to support the development of their Medicines Information Services to meet the Knowledge Management requirements discussed earlier.

Similarly, the four major centres in Scotland in Aberdeen, Dundee, Edinburgh and Glasgow are located within Scotland's four University Teaching Hospitals and Medical Schools and their funding is in effect rolled-up within the Local Health Boards' cash allocation to those hospitals. This would be unlikely to change in the event of the current 15 Boards being amalgamated into a smaller number of larger Boards. However, the funding issue for NHS Scotland is how the Service obtains new funding to support the proposed role expansion discussed above.

The situation for maintaining and expanding the Service in the NHS in England is far more complicated. Not only has the English part of the UKMI Service got to address the stricter operational and financial control requirements of Foundation Trusts as they clear their underlying deficits while introducing the new cash allocation and accounting procedures as set out in "Payment by Results," it also has to cope with the rapid introduction of new (non-public sector) providers and the possible restructuring of Regional and Local Government along the lines of London's Regional Assembly Government. The alternatives seem to include:

- each (Foundation) Trust seeks funding for its service from the local reformed PCT, including the Centres;
- develop local bundled funding arrangements with the reformed PCTs and Strategic Health Authorities to support the Centres and their constituent network of local hospital partners;
- be reclassified as a Specialist Network within the Regional structure and be commissioned as a Specialist Service under the Super-Trust regional commissioning arrangements;
- be reclassified as a National Specialist Service and be commissioned (as a National Service) by the National Specialised Services Commissioning Group (this is the arrangement for tertiary paediatric and orthopaedic services and the medium to low security mental health services);
- each Service, be it at Trust or regional level, develops a Tariff for its Services and charges for them on a zero-based budgeting system.

The implications for developing the UKMI Service are potentially great and the question arises – what is the UKMI Service in the 21st Century NHS?

5. The Strategic Development Agenda for the UKMI Service

5.1 A Good Track Record

The current arrangement of designed MI Centres supporting their local networks of hospitals has developed, over the last 50 years, a strong culture of collegiate excellence and innovation which readily embraces technology-led new ways of working. This approach has also built a robust infrastructure of collective knowledge and skills which inform the training and development of future MI specialists. These developments, driven by dedicated individuals across the UK, have helped to build a safer NHS and protect patients. Building on this foundation, the issue the Service now faces is how can the current UK-wide MI Service develop in a way which is robust enough to withstand the pressures arising from:

- the devolution policy which will create different priorities and pressures across the UK;
- the strengthening of the local management teams to focus on their Financial Control Assurance and Performance;
- the increasing rate of transferring complex acute-based clinical services to the community.

5.2 Facing the Future

The discussion above has outlined a future where the NHS will focus more on ensuring patients are safe through better risk management underpinned by legislation, involving:

- implementing the new more rigorous regulatory requirements concerning medical and professional staff's fitness to practice;
- developing local Knowledge Management Strategies to support staff's Continuous Professional and Practice Development;
- developing local prescribing and medicines management support infrastructures to help prescribers to maintain safe clinical practices.

In addition, there are two further developments which will need to be addressed, especially in England:

- i) The potential impact of the private sector – the move by the European Commission to free up access to scientific journals and research, and developments in internet publishing, will change what information is available and how it is accessed and used, eg. Google Scholar and Reed's Scirus which collate academic material and research, and publish it on the web for free. Microsoft Windows Live Academic Research is another such offering in an increasingly competitive market. To develop information businesses, major companies are increasingly diversifying and offering more specialised services, eg. Reed Elsevier's acquisition of an online drugs database for about £30m. Reed's healthcare information unit is expected to grow fast with the movement to online training and databases for doctors and pharmacists to complement its healthcare publishing business³⁵.
- ii) The potential impact of the multi-agency public service partnerships – the application of the Children Act in England is rapidly developing a more meaningful and productive local partnership approach involving social services,

³⁵ See Dan Milmo's excellent article in the Media business section of the Guardian, April 19th 2006 (refer to www.mediaquardian.co.uk).

health, education, police, probation, the voluntary sector, and other organisations, to set an overarching vision, direction and culture for looking after children and supporting their families. As these complex organisations mature under the duty to cooperate, they will develop robust decision-making arrangements as the new children's trusts which will account for up to two-thirds of a Local Authority's budget. The goal of such networks is to coordinate the myriad of complex services into a coherent and accountable "whole" service. If they succeed, they form the template for Local Authorities to develop similar approaches in care of the elderly and care for those who are mentally ill.

As a result, the UKMI Service's strategy needs to build on its strong foundations and ensure that it is well-placed to support the NHS's future risk management needs, within the reality of devolution. It also needs to ensure that it can work with commercial providers and Local Authorities, especially in England, as the provision of public services develops and changes over the coming 3-5 years.

5.3 The Unifying Forces to Support the UKMI Service

In the light of the above, there are a number of important unifying forces that potentially could bind the UKMI Service and keep it as a coherent networked specialist service. They include:

- the need for common and explicit standards of Medicines Information Service practice that local Chief Officers, Inspectorates and Auditors can use to assess a service's "fitness for purpose" and "value for money";
- the need for common technical specifications to ensure that the local medicines information systems can communicate with each other;
- the need for common accredited education and training programmes to support the continuous development of competent medicines information specialists.

In addition, to underpin these policy proposals, the UKMI Service needs two further developments to consolidate and underpin the unifying forces:

- the development of a workforce strategy to ensure it has enough qualified Medicines Information Service staff to support the NHS's future expanding requirements while at the same time there is a loss of expertise from the Service as specialists retire, leave the Service or critically, reduce their working hours, a relatively common phenomenon associated with female pharmacists who seem to be increasingly opting for an employment pattern known as "multiple job holding"³⁶.
- the development of effective leadership which can form the Service's "intellectual fountainhead" and create the momentum required to make its strategy "live" locally in the form of an effective Medicines Information Service.

PAO/PmP – 5th draft
20.8.2006

³⁶ See Professor David Guest's, Dr. Sarah Battersby's and Dr. Patricia Oakley's Pharmacy Workforce Report: "Future Pharmacy Workforce Requirements; Workforce Modelling and Policy Recommendations" 2004, Commissioned by the Royal Pharmaceutical Society of Great Britain and Guest, D.E., Oakley, P. A., Clinton, M, and Budjanovcanin, A (2006). Free or precarious? A comparison of the attitudes of workers in flexible and traditional employment contracts. Human Resource Management Review, vol 16, issue 2, June, p.107–p.124.

Developing a Plurality of Providers

Public Foundation Trusts are in their infancy in England but it seems likely that all NHS providers will be expected to meet the stricter financial and operational control requirements of such status by 2008, hence we may assume that all NHS provider organisations will have achieved Foundation Trust status by 2008/2009. At the moment, this applies to secondary care but the NHS's regulator for England is currently considering how this status might be applied to the community services provided currently under the aegis of Primary Care Trusts.

Public Limited Companies are registered under the Companies Act and they have to meet the strict financial reporting requirements of this Act which may be enhanced soon in the light of the "Enron" disaster in the United States, and the subsequent Higgs Commission of Inquiry in the UK which has assessed the current potential risks of such financial impropriety occurring in UK-registered companies. Much of the expanded health and social service provision in England over the last 10 years has been provided by registered companies, and this trend seems set to continue in the future.

Registered Charities are registered under the Charities Act and they have to meet the strict financial reporting requirements of the Act which has been enhanced recently following a review of its fitness for purpose in the 21st century. Registered charities range from being very small local groups of individuals who are united around a heart-felt cause, eg. providing educational support against the use of drugs in memory of a loved one who has died, to major multi-national complex organisations which provide specialised services, eg. the Marie Curie Foundation and the MacMillan Nursing Service. Many of these charities enjoy high levels of recognition and respect amongst the public and their increasingly expanded role in providing specialist health and social care services locally is expected to continue in the future.

Registered Partnerships are owned by its founders who are called Partners, and their organisations are registered under the Partnership Act which has been strengthened in the recent past to offer a form of limited liability following several major court cases brought against world-class accountancy firms. It is used as the legal formulation of choice to support the establishment of traditional General Practitioner Services and this historical pattern is set to continue for the foreseeable future. However, the long-term trend analysis indicates that this model of service provision might start to see a gradual decline as the current owners of registered GP practices retire and their successors use other legal formulations to support their health and social care enterprises.

Social Enterprises are workers' cooperatives or mutual organisations set-up under a new legal form called the Community Interest Company. In its re-election Manifesto of May 2005, the government made its commitment to such organisations clear by stating that it believed these organisations "have an important role to play in the provision of local services, from health to education, from leisure to care of the vulnerable ... its potential for service delivery should be considered on equal terms". Although early days, there have been several successful initiatives under this development in Northern Ireland and England. While such initiatives tend to be small at the moment, in England, consideration is being given to commissioning a proposed pilot scheme to provide Community-based nursing and therapy service involving nearly 800 staff from such a workers' cooperative. We do not know if the idea will stand the pressures associated with scale but given the Government's commitment in its manifesto, these types of organisation could increasingly provide community-based services.

Developing a Network of Emergency and Unplanned Care Services

Emergency and Unplanned Care Services

The network bridging device is an effective inter-organisational development tool to support the changes required in three key interrelated services:

- Emergency Care Networks;
- Surgical Service Networks;
- Intensivist Service Networks.

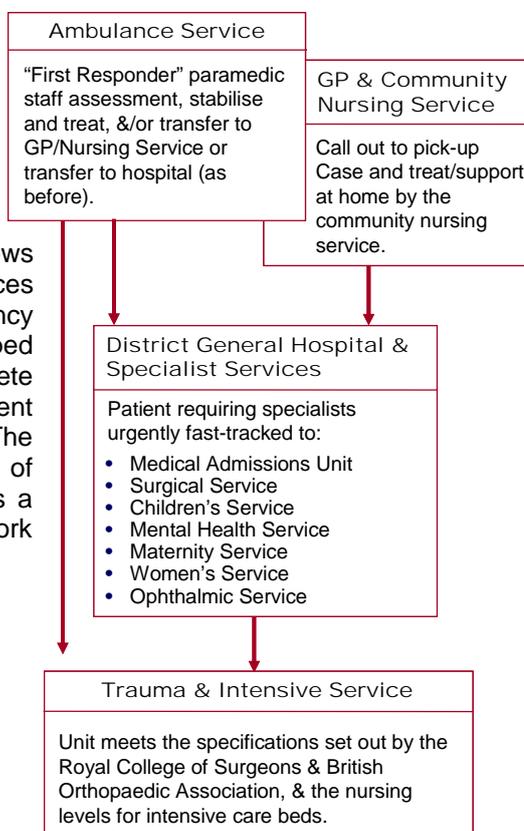
Currently, these services are organised in relatively discrete pockets within the District General Hospitals and the major Teaching Hospitals. They are supported by the GP out-of-hours service and the Ambulance Trusts. There are unique pressures in each of these highly specialised services which when taken together give the rationale for reforming and reorganising emergency and unplanned care services.

Emergency Care Networks

Accident and Emergency Departments are well-recognised and used by the public as a safe port of call for most of their problems especially when the other statutory agencies are shut. As a result, over the years, these Departments have built-up their services and “know-how” in three distinct areas:

- trauma services which can form about 1-2% of the work for most Departments;
- minor injuries which can form about two-thirds of the workload;
- major injuries which can form the balance of the work.

Staffing such specialist services with accredited competent individuals around the clock in rota and shift patterns that comply with the increasingly tight regulations is getting more difficult. Therefore, local health communities are looking at ways of reorganising the work flows and making better use of the resources available. As a result, local emergency care networks are being developed which seek to integrate the discrete components into a more coherent “whole” multi-agency service. The resulting more focused deployment of skills and clarified relationships gives a potential 4-level organisational network structure for the service:



Service objectives:

- treat and see locally and reduce patient flow to A & E Departments;
- fast-track urgent cases to specialists for assessment and intervention without delays;
- fast-track trauma cases to specialists without delay.

Surgical Services Networks

At the same time, surgical services are becoming increasingly specialised and some surgeons' and anaesthetists' ability to cross-cover in other more general areas is becoming more difficult as they will need to be accredited as competent in those areas in the future as the regulations become tighter. This creates pressure on the smaller and mid-sized District General Hospitals in particular as their "pool" of accredited staff is relatively smaller so that ultimately they cannot meet the new rota and shifts for the accident and emergency departments as they might have done in the past. This pressure is exacerbated by the historical shifts that have been taking place over the last 20 years and the current trends to:

- concentrate specialist surgical services in centres of excellence, eg. neurosurgery, cardiology, urology, cancer, ophthalmology, paediatrics;
- concentrate elective surgery in centres of excellence eg. orthopaedics, and transfer some cases to private sector units in England;
- increase the proportion of day case surgery including the transfer of some cases to private sector units in England.

The net result is that patients and their GPs and community nurses will need access to a range of hospitals and specialist services, and this may mean that for some specialist services, patients (and their carers) may have to travel further afield.

Intensivist Care Networks

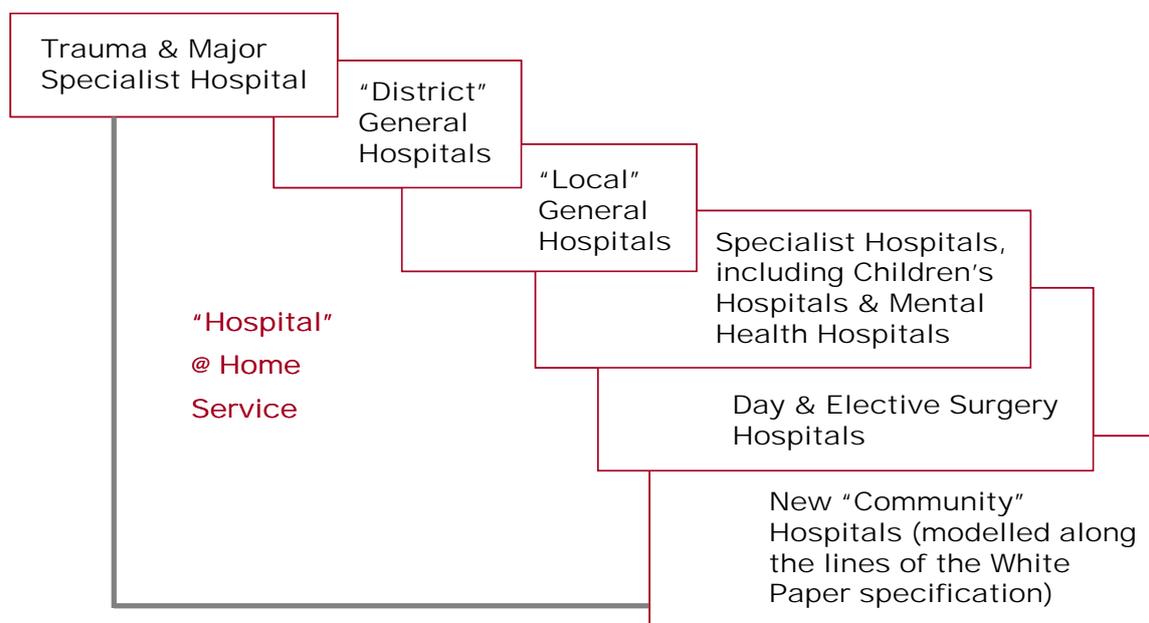
To complement the developments outlined above, the intensivist care networks are increasingly forming around the patient's level of critical illness in a 4-level system:



This local networking creates a supportive environment for potentially isolated services. In some cases however, as the staffing levels are very high eg. in intensive care units, at least six qualified intensivist nurses are required for each bed, maintaining the provision of such services is increasingly difficult in some local general hospitals. Without this crucial back-up service, local accident and emergency departments and surgical services cannot be maintained.

A Multiplicity of “Hospitals”

The challenge of this collective pressure is forcing Trusts to work together to find an acceptable resolution to these complex issues. It will mean that in the future, local health communities will be more inter-dependent as specialist services are concentrated in a smaller number of hospitals which will be complemented by an increase in locally provided services. This multiplicity of “hospitals” working in a networked inter-dependent system is summarised below:



- Refer to:**
- The Royal College of Surgeons of England and The British Orthopaedic Association’s Report “Better Care for the Severely Injured” (2000).
 - The Royal College of Surgeons of England’s Reconfiguration Working Party Report “Delivering High-quality Surgical Services for the Future” (2006).
 - The Royal College of Surgeons of England’s National Collaborating Centre for Acute Care’s National Clinical Guidelines on “Head Injury: Triage, assessment, investigation & early management of head injuries in infants, children & adults” (2003).
 - The Royal College of Surgeons of England’s Professional Standards & Regulations: “Developing a Modern Surgical Workforce” (2005).
 - The NHS Modernisation Agency’s hosted Critical Care Networks for the English Trusts’ Networks and Contacts (refer to www.modern.nhs.uk/scripts/default.asp?siteid=20&id=7117) and the Neuroscience Critical Care Report – Progress in Developing Services (August 2004) available on this site along with all the Official Guidelines.
 - The Healthcare Commission’s Report “Acute hospital portfolio – Accident & Emergency (A&E) 2004 (refer to www.healthcarecommission.org.uk/serviceproviderinformation/reviews&inspections).
 - The Department of Health for England’s Report on Modernising Emergency Care & the Ambulance Service, June 2006 (refer to www.dh.gov.uk/AdvancedSearch).

Appendix 3

Key Extracts from the Knowledge, Process and Safety Business Plan

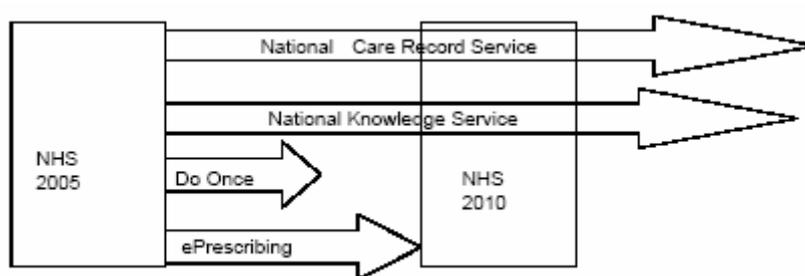
Whilst proposed for the NHS in England, in principle, the themes summarised below are generic for all 4 countries. For details refer to:
http://www.connectingforhealth.nhs.uk/delivery/serviceimplementation/kps/im2010/documents/kps_business_plan.pdf.

The Clinical Knowledge, Process and Safety

The work stream aims to:

- ensure that the National Programme for IT (NPFIT) NPfIT evolves taking into account developments in clinical practice and care
- facilitate the transformation of clinical practice and pathways that the NPfIT will necessitate and enable
- ensure that all decision can be based not only on best current knowledge but also on the needs and preferences of the individual patient.

Proposed Timescale:



The National Knowledge Service

The purpose of the programme is to ensure that every decision made by a patient or healthcare professional can be supported by the knowledge base. A specific requirement will be to ensure that where certainty exists, the knowledge used by the patient and healthcare professionals is derived from the same sources and is consistent.

To improve access to this information the National Knowledge Service (NKS) will create a one-stop shop that provide the navigation and links to all the government procured sources of health and social care knowledge.

Within five years all 2 million consultations a day will have IT support that provides access to knowledge sources that provide useful information in the context of an individual patient's care.

Within five years all 10 million clinical decisions will be supported by knowledge.

Patients will have access to and be encouraged to use knowledge sources before, during and after contact with healthcare services so that they can exercise choice and make well informed decisions about their treatment preferences.

(**Source:** Delivering Benefit from the National Programme for Information Technology).

The National Knowledge Service will achieve its objective by:

- procuring best current knowledge;
- organising it through the National Library Health;
- mobilising it;
- localising it;
- promoting its utilisation.

The objective of the National Knowledge Service is to ensure that all decisions can be based not only on best current knowledge but also on the needs and preferences of the individual patient. The scope of this programme includes:

- Best Current Knowledge Service
- National Library for Health
- National Question Answering Service
- National Decision Support Service
- Map of Medicine
- NHS search engine.

These five services will be developed through a number of projects. Some are already funded and operational. Listed below are those still at the planning stage but which will commence and deliver in 2005/2006.

Better Prescribing

The Prescribing Project aims to improve safety, effectiveness and cost-effectiveness by using the potential of the National Programme for IT to help people who prescribe, dispense, manage, and consume medication combine best current knowledge and practice with the clinical needs and values of the individual patient. These work streams will allow clinicians to learn as they prescribe.

This work will include the creation of a single source of best current knowledge – the National Library of Medicines. In addition, work will be done to help clinicians given prescribing powers for the first time, principally nurses, to prescribe safely and appropriately. This will be part of the National Library for Health and will conform to the procurement principles of the National Library for Health:

- improving the quality of the knowledge procured;
- ensuring its currency;
- preventing unknowing and unnecessary duplication of effort and waste of resources.

<p>Deliverables in 2005-2006</p>	<p>By the end of 2005-2006</p> <p>A National Library of Medicines, a single source of knowledge about medicines will be in operation</p> <p>All the contracts for knowledge about medicines will be with the Directorate</p> <p>A safer prescribing project will be launched with NPSA.</p>
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Busy Clinician

The new system will deliver for doctors, nurses and allied healthcare professionals:

- reduced time to access knowledge required on medicines, best practice and other treatments;
- ease of referrals to other services and sharing information in the clinical record;
- easier ordering of tests and rapid return of results, e. g. time walking to get x-rays;
- easier prescribing and ordering of other interventions.

Useable systems are intuitive, familiar, easy to navigate, and preserve the context of all the information used to make decisions. The systems should also easily integrate into normal working practice when they are first deployed.

The Constant Patient

The changes from NPfIT will give benefits to patients by increasing convenience and giving a more personal service for each patient:

- access to their own health records to enable them to participate as fully as they wish in health decisions;
- access to information on the treatment alternatives supporting individual choice and empowering individuals via a web and digital TV one-stop shop;
- safer care by providing alerts to allergies, contra-indications and interactions;
- care tailored to individual needs by providing prompts to good practice based on individual patient problems and concerns;
- access to information on service location, availability and quality via the same one-stop shop, providing ease of use;
- streamlined referral and convenient appointment bookings;
- safer prescribing and more convenient access to prescriptions.

(**Source:** Delivering Benefit from the National Programme for Information Technology).

The NHS Reforms in England

Summary Notes

Based on the 2006/7 Policy Masterclass Programme delivered by
Dr. Patricia Oakley, Director, Practices made Perfect Ltd.



The NHS in the Future
How are the Customers' Lives Changing?

- The Changing NHS and Environmental Pressures.
- Service Commissioning and Quality Assurance.
- Provider Development and Changing Customer Base.
- The Prescribing Decision-Making System.
- The Implications for Service Development and Change.

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Prepared by Dr. Patricia Oakley, Director, Practices made Perfect Ltd., Alpha House, 100 Borough High Street, London SE1 1LB. Tel: 020 241 9937 web: www.practices.co.uk email: office@practices.co.uk

1. This talk will give an update on the government's third term reform agenda for the NHS locating it within the wider policy context of reforming the UK's public services. To this end, the NHS's environmental pressures will be examined to explain the underpinning reasons for the current emerging policies concerning public service commissioning.
2. Commissioning NHS services in practice differs across Scotland, Wales, Northern Ireland and England because of the devolution of power and authority from the UK parliament to the Devolved Administrations. As a result, the approach to strategic financial planning, service development, cash allocation and reconciliation, Controls and Quality Assurance in the NHS varies.
3. Similarly, the policy on developing service providers varies with England showing in particular a more eclectic mix involving in addition to the traditional public sector, the private sector, charities and a number of other legal entities known collectively as the "third sector." This policy underpinned by contrasting (and controversial) philosophies concerning whether a "market" for health care provision should exist or not, and if it should, how this can be effected.
4. This policy is being driven in large part by the increasing consumerist attitude to health care by certain parts of the population and this force is also apparent in driving the subtle changes to the prescribing decision-making system. Increasingly, the influencers are changing and this shift is being underpinned over time by major policy developments and acquisitions in the form of the Electronic Transfer of Prescriptions IT Programme (ETP).
5. It will take some time for this complex system to be implemented and embedded across primary, secondary and tertiary care but as it makes progress, one of the key effects will be to streamline and rationalise prescribing through controlling the drugs lists that prescribers can access. This potentially has major implications for how pharmaceutical companies organise, detail and reward their sales forces, and how marketing strategies and campaigns are developed.



The Changing NHS and Environmental Pressures (The Blair III Reforms)

- “Small” Government and Public Service Reforms.
- “Choice” and Direct and Co-Payments.
- Commissioning & Quality Assuring Public Services.
- Developing a Plurality of Providers.
- Shifting from Fixed to Variable Costs.

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1. The government's third term reform agenda builds on the progress made in its previous two terms. In taking this forward, the government now seeks to reduce the size and cost of its central administration by the loss of up to 80,000 civil service posts while reforming and refocusing the work of the great offices of the state. The implications for policy development in the NHS are that it needs a more streamlined, accountable and effective service commissioning structure and process, and that service expansion does not necessarily mean an expansion in public service jobs.
2. The issue of giving taxpayers more “choice” to satisfy their increasing consumerist culture in respect of public services is reflected in the NHS in the government’s incremental approach to offering patients in England a choice of up to five places where they might have a surgical procedure. This will be opened-up in 2008 to a fuller menu of procedures and places, and this development will be supported over time by making available carefully constructed multi-factored information on clinical performance. At the same time, the government proposes to implement in England a system of “direct payments” for social care programmes following a successful pilot in its second term. The current White Paper for England includes proposals in this respect and in addition, proposes a convergence in the health and social care planning and financial systems. As a result, the issue of “co-payments” will need to be addressed as currently, the social care programmes in England are means-tested (in effect an indirect taxation), and health care provision is not.
3. Commissioning and Quality Assurance in the NHS are relatively underdeveloped but there has been much progress since its first manifestation in the form of GP-Fund holding in the early ‘90s. The current White Paper proposals for England (which may also be applied to the reforms taking place in Wales and Northern Ireland) will require these fundings to be upgraded and even professionalised through further education and training development programmes. In England, the reforms will centre on merging Primary Care Trusts and Strategic Health Authorities and upgrading the service planning, commissioning and contracting processes. At the same time, the government’s main triangulated inspectorate and scrutiny system in the form of the Health and Social Care Commission, the Health Protection Agency and the Local Overview and Scrutiny Committees, is starting to develop into a really potent and collective force for change.
4. The government’s proposals (for England only) to develop a plurality of service providers is both controversial and difficult. There are many parties with vested interests on both sides of the very public argument that result in this being an exquisitely sensitive policy to implement locally. In addition, there are some high barriers to market entry and exit which will potentially put off many good players. As a result, the government has sought to off-set these forces by setting up a national procurement and long term investment programme.
5. The net effect is that the NHS, particularly in England, will need to develop more flexible and business-like approaches to its employment practices and staff deployment patterns, i.e., move from a fixed to a variable cost accounting procedure in respect of its staff costs (which form about 70%-75% of the NHS expenditure).

Public Service Reforms Developing Commissioning & Providing

- Social Services and Local Authority.
- Schools and Local Education Authority.
- Health Services and Primary Care Trusts.
- Universities and Funding Bodies.
- HM Prison and Probation Services and the National Offender Management Services.

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1. To illustrate the extent of the public service reform agenda, and the emphasis on bifurcating service commissioning from its provision, the government has presented a complementary set of proposals to parliament so that it may be granted the legal powers to take forward its manifesto commitments. For example, in social services, which has in effect operated this policy for many years, the current White Paper, for England, seeks to further integrate health and social care provision, and to develop more integrated service commissioning for care of the elderly and for those with long-term conditions.
2. The government's proposed reform of the provision of secondary schools in England has been passed by parliament (with much heartache and difficulty) and this will result in the Local Education Authorities becoming in time commissioners of secondary education for their Local Constituents' children, and secondary schools developing in a more independent and plural way driven by local demands.
3. The NHS reforms outlined above, and discussed in more detail below, follow this pattern of public service bifurcation.
4. As a result of the government's reforms in tertiary education in the last parliament, the Universities have already been reformed along these lines. As a result, Universities compete in very competitive ways for undergraduate and post-graduate students to fill their courses. They also have to bid for research funds from the very astute and well-developed Research Funding Bodies which act as research commissioners on behalf of the state e.g., the MRC and ESRC.
5. The government proposes a major reform of its prison and probation services (for England and Wales) following the Carter Review. This in effect follows the pattern above but requires new and complex legal powers to develop "Correctional Services" Commissioning, through a new body called the National Offender Management Service, and a more integrated prison and probation service which focuses on providing prisoners with bespoke rehabilitation and treatment programmes so that their resettlement in the community is likely to be more successful. The current rate shows up to 60% of discharged prisoners reoffend and return to prison within 1-2 years of their discharge date. Critically, much of the rehabilitation and treatment programmes required consist of education and skills-building, and mental health and detoxification programmes.

In addition, in respect of the "Lifers" and those detained indefinitely in the specialist psychiatric prisons, the government proposes a programme of support as these prisoners mainly men, become old and infirm, and suffer from the normal process of ageing including senile dementia. Because the reform programme is so complex and sensitive, it will take a number of years to implement but clearly, there are overlaps between the programme commissioners for the prisoners and the emerging commissioning roles for education and health and social care provision.

Health & Social Care Reforms The “Choice” Agenda

- “DORA” factor } “choice”
- “EDNA” factor }
- Long Term Conditions and Pathways to Work.
- Direct and Co-Payments and the Bank Savings Ratio.
- Integrated Programmes of Support & Care @ Home.



Dora



Edna

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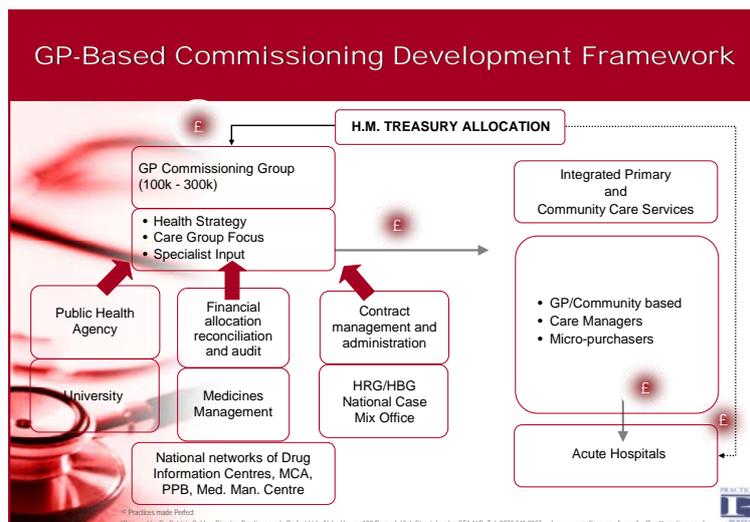
1. To explore the underlying “choice” agenda a bit further, the government is sensitive to the fact that the attitudes to public service provision are changing, especially in England. This is particularly illustrated by two contrasting populations of mature and elderly women. On the one hand, you have a group of women born after WWII – the “baby boomers” who are relatively more and well educated, especially as a result of the education reforms that took effect in the mid-late 60s, and who have had jobs resulting in pension contributions and savings over a long working life. This cohort forms the next generation of women pensioners who are in effect “healthier, stealthier and wealthier”. They have different attitudes to public service provision which they have contributed to for all their working lives and they are educated and well-informed “consumers” who have the potential to exercise choice. This is the “DORA” factor – Demanding of Regular Attention.
2. In contrast, there is a group of women pensioners who have experienced the horrors and deprivations of life before and during WWII; they saw the birth of the NHS and its universal ‘free’ service. They are not particularly muscular in asserting their rights. This is the “EDNA” factor – Entirely Demanding Nothing At all. In policy terms, the government seeks to satisfy both groups to prevent a 2-tier service emerging, and at the same time, it seeks to support the “EDNA” group so that these women become more informed and articulate about what they want from the service. For brevity, this is a gross simplification of the social group mixes as the story is indeed much more complex. However, this brief explanation underpins, in part, the government’s proposals to develop under the aegis of the White Paper, the “Expert Patient” Programme, focusing on Long Term Conditions e.g., diabetes, mental health, cardiac problems.
3. With an emphasis on looking after yourself and your family, mature and elderly women form the backbone of the UK’s carer “workforce”, and they are critical to the well-being of not just themselves but also of their men. As a result, the “Expert Patient” Programme has been set up as a Social Enterprise with a budget of £26m to help to educate and support both the “EDNAs” and the “DORAs”, in England, and to create a force for change in the provision of health and social care. In addition, there are about 4m people in the UK in receipt of disability benefits. The government seeks to mobilise a proportion of these people back into the workplace. As a result, they will require support for their Long Term Conditions, particularly mental health problems.
4. The Standing Financial Instructions (SFIs) to underpin the proposals to introduce Direct, and possibly Co-Payments, in England, are not available yet but currently social services provision is supported by the taxpayer if the individual is “poor”, defined here as having a pot of savings limited to a ceiling of £20,000. The SFIs, when they are available, will give the details of how the means-test rules will be applied in the future in England.
5. With the growth in the proportion of the elderly in the UK, and the commensurate pressure on the tax-funded health and social care service, and an increasingly tax-averse public, the policy bundle described above needs to be supported by an expanded service but not necessarily a hospital-based service. As a result the White Paper proposes the development of 50 local “community” hospitals (polyclinics) to support an expanded “hospital@home” service, for England.

Developing Public Service Commissioning

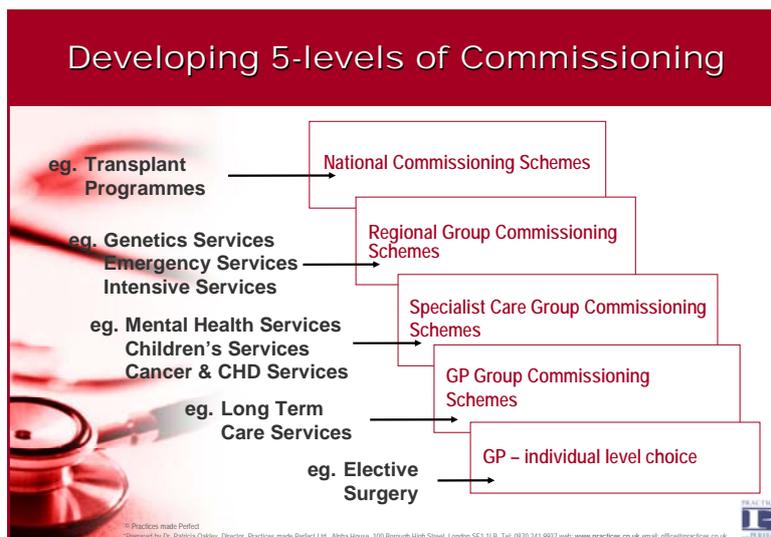
- Contestability and Foundation Trusts.
- The Tariff and Contract Currencies.
- “Choice” and Administration Costs.
- Commissioning and Contracting Services.
- Contract Compliance, Market Regulation & Service Inspection.

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1. To take forward the proposed service commissioning reforms summarised above in health and social care, the government has developed a number of policy instruments to underpin the proposed “market” system which will operate in England. Two central developments are the framework of “rules” to make the “market” work which is known as the “contestability” process. This is subject to the European Community’s rules of how “markets” for public services work as a signatory to the Treaty of Rome and its successor regulations. In addition, the government has set-up legislation in the form of “Public Interest Corporations” where NHS Trusts (and other public service providers) can apply for “Foundation” status. If they meet the strict financial performance criteria, they are granted such status which in effect loosens them up from central control making them a little more “independent”, but accountable to the public service commissioner.
2. To support the “market”, the government has developed a set of tables which state the “programme” of care and its “tariff”. At the moment, it covers, in England only, mainly the surgical procedures but there are plans to bring out similar tables for “programmes” of Long Term Conditions and Mental Health Services in 2006-07. Once the glitches have been resolved, and the proposed contract currencies validated, this will allow the “market” to operate from about 2008. It is based on the American “DRG” system developed by Yale’s Professor Fetter in the early-mid 80s. It is complicated work and it is estimated that it will take 10-15 years to bed down in the NHS.
3. As the government implements its “choice” agenda, in England, and cuts the number of ‘administrative’ jobs in the NHS (a manifesto commitment), the NHS cannot incur extra costs to support the new administrative infrastructure required to support the implementation of “choice”. Therefore, the NHS has to be inventive in how it reconciles these two competing pressures. As a result, there are likely to be economies-of-scale applied to the administrative activities in the “back office” functions to meet the probable expenditure limit of no more than 4%-5% of the revenue base spent on the administrative infrastructure.
4. It is important to distinguish service commissioning from the “contracting” activities which underpin the strategic planning decisions made by commissioners. This “contracting” activity can itself be further differentiated into the underpinning financial and legal aspects of the work. Both would seem to benefit from organising them as scaled activities particularly in the light of the NHS’s skills shortages in these areas, let alone their costs.
5. Finally, to develop the “market, the government needs to protect the taxpayer and patients. To this end, it has set up a “Market Regulator” (known in the NHS as the Monitor) who has legal powers of entry to Foundation Trusts if they deviate from their financial tolerance levels when it can issue painful course correction notices; an “Inspector” (known as the Health Commissioner) who has legal power of entry to the whole Service on a rolling basis of inspection when it can issue censure notices and recommendations for change; and a “Contract Compliance Officer” who can ensure the performance of the contracts issued by the Service Commissioner. In practice, these roles have some degree of overlap and following a review, the government will seek to clarify the future domains of authority in the autumn of 2006.



1. Although the SFI are not yet available, it is possible to propose a likely cash flow model and management informatics framework based on the way GP Fundholding worked in the NHS of the early-mid 90s. Broadly, a cash allocation from Her Majesty's Treasury via the statutory bodies in the reformed NHS in England (merged Strategic Health Authorities and the merged Primary Care Trusts) could be set against the "local" service and clinical strategy for each major care group which is built-up in the 3 year rolling planning process. This should involve GPs and hospital specialists as set out in the planning guidelines that underpin the "LDP" process in England.
2. This plan needs to meet the needs of the 'local' population and the agreed priorities both of which are set out in the Local Public Health Reports. Clearly, they must meet to requirements of the National Standards Boards, as defined in the National Service Frameworks, and of NICE. The location and role of Public Health Specialists in the reformed NHS in England is not yet clear but it is likely that they will form a cornerstone of the new Commissioning Agencies' work but they may possibly be organised on a regional basis with close links to, and even embedded in, a major local University's Public Health Department.
3. Similarly, the finance function is a critical underpinning speciality and it may also be organised on a pan-commissioning agency, or regional, basis. More controversially, it may even be subcontracted to a specialist company for the service. An important component within this domain is the strategic management of the financial pressures associated with the drugs budgets. To this end, the hospital pharmacy service has a small number of specialist pharmacists, normally organised on a regional basis, who work on a triangulated agenda to control the introduction of new drugs; to suppress the underlying inflation rate of the drugs budgets; and to negotiate and purchase on a collectivised and bulk basis drugs which are in routine use by the NHS's hospital service.
4. The current rather informal "contracting" arrangements in the NHS in the form of "Service Level Agreements" is not robust enough when non-public sector bodies become service providers under the new arrangements. It is likely therefore that a set of standard contracts and possibly regionally organised contracting units are set up to introduce a more legally-grounded contracting system. As the NHS has no real legal capacity, this is likely to be subcontracted to a set of legal firms.
5. The net effect of these nitty-gritty work programmes is to create a costed clinical strategy and indicative budgets to manage its components' performance. GP Practice-based Commissioning is being developed but the SFIs are not yet available to see exactly how they will work. However, the situation will be clarified as a matter of urgency since the local service commissioner in Derbyshire (the current PCT) has awarded in principle a contract for primary and community care services to a major American Multinational Company, United Health Care. This is uncharted and controversial territory but the net effect is to create real cash flow problems for the NHS hospitals as the "market" bites. This may create great political pressure and unpalatable decisions regarding the potential closure of local hospital services. Politicians say they will support local managers' decisions but they might take fright so taking a prudent line, a financial contingency reserve may be set-up to support local hospitals which find themselves in difficulty as a result of the "market".



1. Service Commissioning needs to be organised where possible on a scaled basis to ensure the administrative costs do not breach the possible limit of 4%–5% of the revenue base as discussed above. Therefore, where it is possible and sensible to do so, some services will be commissioned and quality assured on a national basis through the National Specialised Services Commissioning Group. For example, the transplant programmes, specialists children's orthopaedic services, and the medium-long term secure mental health units, are all likely to be commissioned nationally.
2. Some services are already organised quite sensibly on a regional basis eg., the intensivist and emergency services so they will probably be commissioned and quality assured on a regional (or even pan-regional basis).
3. Similarly, there are a number of clinical networks which have the necessary expertise to commission and quality assure their services, for example in cancer and cardiology, so they might reasonably be brigaded to form specialist commissioning groups.
4. GPs, working in consortia of practices, possibly organised on a locality basis, would seem to be a sensible place to locate the commissioning of long term care services. As GPs are also providers of care, and subjected to the service agreements and bonuses set out in the new GMS contract, the legal and financial details of GPs' role as both commissioners and providers of the same service will need to be clarified and separated to avoid accusations of conflicts of interest, and potentially risks to patients.
5. Elective surgery is the most straightforward to commission as the "programmes" are quite well-defined, the accuracy of the tariffs are getting better, and the list of accredited providers who meet the quality criteria is known to GPs, and increasingly to patients. Therefore, it is likely that a form of "bundled" block contracts might be set-up from which local GPs can call down their "spot" purchase. A close inspection of the SFIs and legal details will confirm the arrangements.