



Practice based commissioning: early wins and top tips



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Message from David Colin-Thomé



GPs and other primary care professionals are in prime position to redesign services that best meet patients needs and deliver what local people want. Practice based commissioning is the best vehicle for ensuring clinical leadership from all those professionals; a leadership essential for redesigning services for patients to better meet their health care needs and the wider health and public health needs of the local population.

By providing GPs and NHS professionals with information about the budgets that are available for their practice (indicative budgets) and financial and activity data that allows them to compare themselves with neighbouring practices as well as with the national average, they will be better equipped to make changes to the way services are provided locally.

The White Paper, *Our health, our care, our say: a new direction for community services* sets out some key objectives for how services are to be provided in the future. In summary, we expect:

- more services to be provided in a community setting;
- more services to be provided by practices;
- longer opening hours for practices;
- greater use of a wide range of providers;
- more convenient services for patients; and
- more integration between health and social care.

With relevant information, appropriate governance arrangements and support from PCTs, practice based commissioning is already helping primary care professionals deliver these objectives. None of this is possible without NHS professionals across the whole of the NHS working together and for many of our patients, with colleagues in social care, education, housing and leisure.

Practice based commissioning: early wins and top tips

Practice based commissioning is also a chance for practices to provide more services themselves or in partnership with other practices. Delivering the recommendations in the White Paper by using practice based commissioning represents an exciting, influencing and fulfilling opportunity for all of us in primary care.

A good example of how practice based commissioning could be used to challenge our clinical thinking is around out-patient follow up appointments. This example also has the advantage that it can be developed in stages, as practices become more familiar with practice based commissioning.

- Consider whether patients really need to go back to out-patients for follow up appointments for which there is a tariff and carry out the follow up treatment locally instead.
- Invest resources that would otherwise be spent on out-patient tariffs on redesigning services, by for example employing a specialist nurse or working with a physiotherapist, providing direct access to diagnostics for those patients that would previously have been referred to out-patients.
- Over time as more resources accrue because of reduced out-patient referrals, invest these freed up resources in a case manager or community matron for people with a long-term condition. Such case management has been proven to reduce the need for hospital treatment, again freeing up further resources to spend on community services.

By the end of 2006 the Government expects every PCT to have put in place the arrangements necessary to enable practices to carry out practice based commissioning. To help meet this target the National Primary Care Development Team is providing a programme of support to PCTs and practices to help them implement practice based commissioning locally.

This document is not guidance. Detailed guidance is available at www.dh.gov.uk/practicebasedcommissioning and at the back of this document you will find details of where to find out more information about practice based commissioning. What follows are examples of how practice based commissioning is already making a difference – these examples are intended to provide you with practical help and hopefully engage and stimulate you to set you on the road to practice based commissioning.



David Colin-Thomé
National Clinical Director for Primary Care

Top tips to support practice based commissioning within and between primary care providers

The following tips are based on the practical experience of those involved in setting up practice based commissioning. No doubt there will be others as more practices and other professionals develop expertise. Nonetheless they are likely to be a useful “first base” checklist. There is no expectation that you do everything in this list of tips, rather they are meant to act as a series of prompts.

Overriding all of them is one clear imperative: involving patients is crucial to maximising success in practice based commissioning. It is essential that those involved in using various service elements are consulted and can help create solutions and redesign.

Experience with the Healthy Communities Collaborative and others demonstrate powerfully how much added value, in terms of the debate and the outcome, systematic involvement of community members can create. It is therefore important that as you implement practice based commissioning, consideration is given as to how to involve patients meaningfully in all that you do.

TOP TIPS

- 1 Set up monthly internal meetings between clinicians and other practice staff to discuss and review referral activity, as well as A&E attendances and emergency admissions. Ensure that comparative data per clinician is available.**
- 2 Set up a skills directory of individual clinicians and other health professionals within a practice, other practices and local providers, to facilitate appropriate primary to primary referrals.**
- 3 Put in place protocols and clinical governance audit mechanisms for internal referrals for services such as dermatology and musculoskeletal services. These can be part of internal triage pathways for referrals in specific conditions.**

continued...

TOP TIPS

- 4** Self-management plans are increasingly accepted as improving clinical outcomes and helping to manage demand. Proactively and sequentially creating them for the most common long-term conditions has a significant impact.
- 5** Improved patient information to help patients to help themselves also assists demand management. A big impact can be made by providing information on musculoskeletal problems and back pain for example. Use a variety of media and signpost patients to existing information such as relevant websites.
- 6** Ensure that systems are created in practices (or commissioning consortia) to share and receive timely and systematic feedback on activity data to inform discussions and monitoring. The data should not just focus on referrals but also follow-ups (with aim at reduction) and length of stay (to ensure no tariff gaming – many tariffs specify an expected length of stay, stays beyond that attract a per diem rate). And seek opportunities for economies of scale for triage systems.
- 7** Protocols for triage systems between practices and primary to primary referrals need to be established where such pathway changes are put in place. For most of the large volume conditions, protocols are likely to be available from other areas that you can adapt.
- 8** Establish scoring systems for secondary care referrals e.g. New Zealand score for hips and knees.
- 9** Other professionals such as nurses and physiotherapists, have a vital role to play in assisting the redesign and commissioning of services. The structure, especially in commissioning consortia, needs to enable this input to be made. Ensure that there is a clear understanding of the local opportunities for partnership working – particularly with colleagues in social care. There should be an awareness of priorities in local action plans such as the Community Strategy and Local Area Agreements agreed with local partners.
- 10** Communicate about practice based commissioning to patients, staff and also other members of the primary care teams and how they might contribute. Use multiple media are such as websites, lunchtime meetings and leaflets.

Ideas for pathway redesign to use with practice based commissioning

Introduction

Practice based commissioning is fundamentally about improving services, improving patients' experiences and enhancing health outcomes. This involves redesigning existing service provision.

The following are established examples from the National Primary Care Development Team's experience of helping PCTs and practices redesign patient services. All of them are relatively easy to implement and not only improve patients' experiences and outcomes, but are beneficial to the local health economy as a whole.

"Many GPs I speak to wish more could be done to redesign services. As a practising GP I know that there is real need to develop better local services for patients. A lot of my time is taken up dealing with problems that my patients have encountered in their journey in the wider health and social care system. So, I welcome the initiative of practice based commissioning which presents a significant opportunity to deliver a wider range of local services to meet the needs of the local population. This useful document gives examples of some of the possibilities including service redesign. Practice based commissioning – with standards and user involvement – gives a real opportunity for primary care to be in the driving seat. Sometimes primary health care teams are so busy with their day to day work that they cannot step back and think of the bigger picture. But that is precisely what we have to do! After all primary care is one of the most innovative sectors in the NHS. I would urge primary health care teams to be creative and ambitious about practice based commissioning – this will require strong clinician-manager partnerships to improve patient care even further."

Dr. Mayur Lakhani , Chair of the Royal College of GPs

Practice based commissioning: early wins and top tips

It may well be that within your area similar schemes are already operational, but others may not be. These examples are here to prompt thought and local discussion and are not in any sense presented as an exclusive or exhaustive list. However, they are changes that, using practice based commissioning, can make a rapid difference to patients and develop the role of primary care providers.

The examples cover the following areas. They are in alphabetical order in the next pages to ease navigation of this section.

- Chronic obstructive pulmonary disease
- Dermatology
- Heart failure
- Long-term conditions
- Mental health
- Ophthalmology
- Orthopaedics
- Podiatry
- Urology

For more information about any of these examples contact
national.team@npdt.nhs.uk

"This booklet is very helpful for those practices which are engaging in commissioning for the first time. It sets the scene of the early stages of practice based commissioning and identifies the potential for future developments and achievements. There are good examples of how practices might extend patient delivery outside of hospitals and into the community. There is opportunity to pursue local initiatives in partnership with PCTs. NAPC is supportive of the Department of Health in the continued expansion of local service re-design, using practice based commissioning as the vehicle. Practices now have a marvellous opportunity to be as ambitious as they wish in developing and providing quality patient focused, locally accessible services."

Dr James Kingsland, Chair of the National Association of Primary Care (NAPC)

Chronic Obstructive Pulmonary Disease (COPD)

Developing practice based COPD services

Approach

A primary care COPD service can move both the diagnosis and management of COPD into primary care, leaving secondary care to manage severe acute exacerbations and provide very specialised clinics and advice. Alongside the shift of diagnosis and management at a later stage, additional services such as assisted discharge and pulmonary rehabilitation could also be provided. These services can be initiated and supported by practices.

Likely results

- Acute hospital admissions for exacerbation of COPD could fall by around 14 – 20 per cent.



Case study

Spilsby Surgery started by establishing an accurate register of patients with COPD through a thorough spirometry screening programme. They have established formal COPD clinics which include self management and advice and in conjunction with their PCT, have set up both assisted discharge and pulmonary rehabilitation services that they and other practices can access.

Dr Noel O’Kelly, a GP with a Special Interest in respiratory medicine, says “We have made immense progress with our management of patients with COPD. We diagnose better, treat better and have better systems in place for when patients get discharged from hospital.”

Case study

In 18 months a practice within the Forest of Dean has achieved a reduction in hospital admissions of 50 per cent (real figures 37 down to 17). The practice has ensured that it has an accurate register of COPD patients.

The practice has introduced a regime of treating patients who report the first signs of an exacerbation by treating with steroids and antibiotics. Patients are also given an emergency supply to take at home if needed and agree a self-management plan.

“Practice based commissioning provides general practice with a unique opportunity to lead the development and improvement of local services and health and to have a major impact on the lives of our patients outside the consulting room. The question for practices, GPs and other primary care professionals today is simple. “ Do we want to be led by others – such as traditional NHS management hierarchies, the acute sector or even private corporates – or do we want to lead the change ourselves and take a central role both as commissioners and providers of local services?” There is only one right decision for general practice today and this document provides an excellent and pithy starting place for practice based commissioners with some useful examples of what can be done in various clinical areas. We must hit the ground running and show that we are up to the task of leading NHS change. This piece of work will help all of us to do just that.”

Dr Michael Dixon, chair of the NHS Alliance

Dermatology

Use of a GP with a Special Interest (GPwSI) in dermatology across a group of practices or PCT or use of GPs with greater dermatology skills in individual practices

Approach

Establish a GPwSI and develop a referral protocol between primary and secondary care. Undertake secondary care referral casemix analysis and implement nurse-led care and adopt nurse-led protocols to remove the pharmacy step in the pathway.

Likely results

- Reduction in out-patient appointments and waiting times of up to 30-40 per cent.

Case study

Practices within Sheffield PCT employed GPwSIs and nurse specialists as part of a service redesign exercise. This led to a 37 per cent reduction in waiting times for routine out-patient appointments. Analysis of secondary care referrals led to a further 10 per cent of the waiting list moving to the GPwSIs. This enabled patients to be seen and treated in one visit thus removing an unnecessary step from their journey.

Nurse-led protocols adopted for a number of conditions are also enabling nurses to issue treatments. Community phototherapy clinics with nurse-led protocols are enabling nurses to discharge patients without the need for them to attend secondary care and see a consultant.

“Understanding and operating practice based commissioning well will make a real difference to our patients, and our communities. Furthermore it will enable organisations and individual professionals to grow and develop skills and abilities to make them more effective. This will serve them and their patients well as primary care moves into a new pluralistic environment. Practice based commissioning is an opportunity we should not miss”

Sir John Oldham, chair of the National Primary Care Development Team

Community-based children's eczema clinic across a group of practices

Approach

Setting up a community-based children's eczema clinic run by specialist children's nurses with skills in dermatology will remove the need for referrals into secondary care dermatology out-patient clinics.

Likely results

- You can expect to see up to a 40 per cent reduction in referrals to secondary care.

Case study

Community services in Sheffield for children aged up to five years are run jointly between specialist nurses and health visitors. 60 per cent of conditions are being managed in the clinics and do not require referral to secondary care.



Heart failure

Diagnosis of congestive heart failure (CHF) in primary care

Approach

Congestive heart failure diagnosis has traditionally been challenging in a primary care setting. However some practices have taken an innovative approach to diagnosing CHF, in the knowledge that improved diagnosis could mean that more patients will be diagnosed more quickly. There are two approaches being used; the use of B-type natriuretic peptide (BNP) testing to remove the need for onward referral and an in house testing echocardiography (Echo) service.

Likely results

- BNP testing should lead to a reduction in waiting times for the secondary care provided Echo service.
- In-house Echo services can, in addition, remove the need for secondary care involvement completely.

Case study

Markfield Medical Centre started BNP testing in September 2005 following a six-month design period. They selected the most appropriate test in conjunction with secondary care cardiologists and developed a clear patient pathway. Only those with abnormal ECGs receive BNP testing and patients with raised levels of BNP are referred on for Echo. All GP partners attended protected learning sessions and are on board with the process.

GP Dr Chris Trzcinski says "It's really been no bother to us. It's a simple blood test that all my partners are comfortable performing, we get the results back within a week and have open access to Echo for those patients who need it, which is terrific. I'm confident that it has improved the standard of care in our practice significantly".

Case study

The Adam Practice in Dorset developed a primary care Echo service with cross-PCT coverage in the Poole area covering a population of over 170,000. A GPwSI runs the service with support from a qualified medical technical officer and a service manager/clerk. Each Echo costs about a quarter of the cost of a secondary care referral, which offsets the initial start-up cost fairly rapidly.

GP Dr Liddiard, who runs the scheme with a clinical assistant in cardiology, says "There are some real benefits for patients in running a primary care Echo service, with more patients having Echos and more people needing treatment being found. Treatment can be changed appropriately and cardiologist time can be saved for patients with more severe morbidity."



Long-term conditions

Identifying at risk patients

Approach

Identify patients with multiple long-term conditions to enable targeted interventions by, for example, using the new predictive case finding tool available at www.networks.nhs.uk¹

Likely results

- You can expect a reduction in unplanned admissions and reductions in the length of stay for patients.

Case study

Castlefields Health Centre in Runcorn focused on high risk elderly patients with multiple long term conditions. The initial aim was to identify these patients and develop case management plans for them.

Initially 48 patients were identified amounting to 4% of the over 65 year olds. They were identified as high risk using the following criteria:

- four or more active chronic diagnoses;
- two or more unplanned admissions in the last 12 months;
- two or more emergency department attendances over the last 12 months;
- four or more medications for more than six months; and
- significant difficulties in daily living as measured by questionnaire.

¹ Predicting those most at risk of emergency admission is a complex task. To address this, a package of predictive case finding software algorithms has been developed and is available free of charge within the NHS.

Community matron focusing on people with highly complex long-term conditions

Approach

Use the pathway approach linked to a range of community services such as rapid response, step down, intermediate care services and social care and work closely with individual practices. Allow community matron and other case managers to access and update practice records and hold regular case updates with practice team

Likely results

- You can expect a reduction in both the number of referrals to secondary care and unplanned admissions.
- You can expect to reduce the number of GP visits both in and out of hours.

“Practice-based commissioning gives the potential to deliver local services in new and innovative ways. But it will need a strong commitment from both PCTs and GP practices to work in partnership on its development and implementation. A clear framework of responsibilities will enable good working relationships to be developed to the benefit of local patients.”

Dr Gill Morgan, Chief Executive of the NHS Confederation

Case study

Central Cornwall PCT has taken a whole system approach to the management of long-term conditions. Community matrons are working alongside GPs in the EPIC practices. The GPs and their teams have been able to rapidly access services via the community matron who has a workstation within the practice and access to the patient records. Practices report far greater coordination of care and access to services. They particularly value the monitoring role of their elderly patients.

Using a benefits realisation format they have been able to demonstrate a reduction in emergency admissions of 457 across Cornwall, the facilitation of 84 early discharges, reduced GP visits in and out of hours, and increased patient satisfaction, generating initial savings of £975,000.

Practice based nurse focusing on housebound patients with long-term conditions

Suggested actions

A nurse practitioner focuses on housebound patients with long-term conditions to ensure adequate management and follow up. This co-exists as part of case management strategy within the practice.

Likely results

- Improvements in clinical measures for the various disease entities.
- A significant reduction in acute hospital admission rates and A&E attendances.

Case study

The Shama practice near Grimsby had a high proportion of housebound patients on its chronic disease register. A nurse practitioner has the role of visiting and monitoring these conditions and may also undertake acute visits for the same cohort of patients. The nurse has also developed relationships with colleagues in community nursing and social services. Direct access for the nurse to step up care has been negotiated operating alongside a rigorous system of examining data on emergency admissions. This allows targeted and focused intervention on those frequently admitted. For COPD the patient admission rates have been cut by 87 per cent, with none of those patients being admitted through A&E.

“Practice based commissioning provides the means to achieve accessible, patient-focused care. Using NICE guidance to underpin commissioning decisions will ensure new initiatives – and decisions about existing services – are based on the best available evidence of clinical effectiveness and can provide value for money.”

Professor Sir Michael Rawlins, Chair of NICE

Mental health

Primary care based provision for mental health users to access treatment and brief psychological therapies

Approach

Set up a primary care team within a practice that includes GPs and other practitioners with a special interest in mental health, as well as a mental health co-ordinator with a community psychiatric nurse background. Train practice nurses and receptionists in using the Hospital Anxiety and Depression scale (HAD) so they can direct patients properly when they first contact the surgery.

Likely results

- You can expect to see a reduction of up to 70-80 per cent in referrals to Community Mental Health Teams (CMHTs) or secondary care and a reduction of around 20 per cent in GP consultations.

Case study

Dr Richard Edwards at the Eastleigh Surgery in West Wiltshire began this work as part of the National Primary Care Collaborative four years ago. The surgery has developed an electronic list of patients, broken it down into severity categories and devised protocols of care accordingly. This practice uses the Vision clinical system. The mental health coordinator works closely with the practice nurses and the receptionists so that an initial screen for suitability for brief psychological interventions by the coordinator is undertaken by the practice nurses and the receptionists on first contact using the HAD assessment scale. This has led to an 84 per cent reduction in referrals to the CMHT and a 25 per cent drop in GP consultations by mental health patients.

“Patient centred care is at the heart of nursing practice and these case studies provide excellent examples of how nurses, working with the whole healthcare team, have been at the forefront of developing new services. Why is this so important? Because it is delivering real improvements in both services and outcomes for patients”.

Beverly Malone
RCN General
Secretary

Mental health provision across a group of practices or all practices within a PCT

Approach

Set up a multidisciplinary primary care mental health team and a care pathway that requires all referrals to go through that team.

Likely results

- The majority of the patients can be dealt with within the team without the need for onward referral.
- You can expect to achieve a reduction in referrals to CMHT or secondary care of up to 80 per cent.



Case study

Practices in Oldham PCT have a single point of entry into their tier 2 link workers in primary care. As a result of this service the wait time for adult psychiatry services dropped from 13 weeks to two weeks, a reduction of 4.6 per cent. They also have community matrons and active case management for common mental health disorders.

Case study

Practices in Wakefield and Pontefract have a team which consists of community mental health nurses, cognitive behavioural therapists, counselling psychologists and counsellors.

The service provides a single point of entry for referrals and of the referrals 62 per cent are either dealt with by the team in treatment or discharged after receiving advice. Of the 38 per cent referred onto other services only four per cent are to consultant psychiatrists and one per cent to CMHTs. The team managed to achieve a reduction in DNA rates from 33 per cent to 17 per cent. The team now also accepts referrals from the secondary care community mental health care team.

Case study

Practices in Great Yarmouth and Waveney PCTs have formed a primary care mental health service based at Northgate Hospital in Great Yarmouth PCT. Their patient-centred approach was to redesign a holistic care pathway that enabled a seamless service between primary and secondary care. The aim was for a truly integrated service approach to care delivery across the statutory health and social care services, voluntary service and private providers.

Using a single point of referral and an integrated team approach by all the teams in the patient pathway, they have seen substantial reductions in onward referral to secondary care mental health services of up to 85 per cent. The admission rate reduced by 40 per cent as a result of this approach.

Ophthalmology

Locality based intermediate assessment of ophthalmology patients.

Approach

Set up a locally based ophthalmology service to reduce secondary care referrals. This service can then act as an intermediate assessment point.

Likely results

- You can expect to see up to a 60-70 per cent reduction in referrals to secondary care and in out-patient waiting times.

Case study

Shiplely Ophthalmic Assessment Programme (SOAP) was set up to increase capacity in primary care and reduce demand on secondary care. It has achieved a 64 per cent reduction in referrals to out-patient departments.

The service developed protocols for cataracts, raised intra ocular pressures, floaters and flashers, age related macular degeneration (ARMD) and pigmentary changes in fundus.

Only 36 per cent of patients seen by the service are referred on to secondary care. Waiting times for patients to initial appointment also decreased to a two week maximum and a saving of 32 per cent was made compared to the previous service pathway.

The service is used and rated highly by the local GPs.

² Pilots testing model pathways for glaucoma, age related macular degeneration (AMD) and low vision are currently under way and will be evaluated later in the year.

Orthopaedics

Referral triage systems

Approach

Multi-professional interface clinics and systems provide a filter for primary care joint pain referrals to determine who might benefit from surgery. Consultant allied health professionals, extended scope physiotherapists, GPwSIs and nurse practitioners can be involved. Care pathways and protocols are agreed with orthopaedic surgery and rheumatology teams. Specialist assessment and clinical management in primary care where possible, and/or screening prior to surgery reduces referrals to hospitals.

Likely results

- Up to 50 per cent reduction in referrals to orthopaedic team

Case study

In Warrington a multi-professional referral team was set up with a physiotherapist and GPwSI. It has access to podiatrists and pain management specialists. They screened all referrals and gave advice and physiotherapy where relevant. Half the referrals were managed in this way.

Case study

In Somerset Coast a GPwSI runs an interface clinic for orthopaedic referrals. They organise investigations and treat the patient with physiotherapy, occupational therapy, podiatry and injection management. Case studies of patients who need to be referred to an orthopaedic specialist are discussed with the specialist which can result in direct in-patient listing, thereby avoiding a further out-patients appointment.

Primary care specialist

Approach

Refer orthopaedic cases to primary care specialists in orthopaedics who can work with the physiotherapists, surgical podiatrists and consultant pharmacists to manage them. Put in place protocols for direct access to a range of diagnostic investigations such as MRI scans.

Likely results

- Up to 50-60 per cent reduction in referrals to hospital orthopaedic teams.

³ Work is underway on a musculoskeletal services framework – good practice guidance on reshaping services for people with musculoskeletal conditions such as arthritis.

Podiatry

Developing practice based diabetic podiatry

Approach

A practice based diabetic podiatry service moves the responsibility for service provision from secondary care to primary care. Trained practice nurses, evaluated by the podiatrist, can then carry out podiatry services as part of the routine diabetic review or on request for patients that present with acute symptoms. The practice nurses should have a direct referral route to the podiatrist for those patients with particularly complex needs.

Likely results

- A practice can expect to make fewer secondary care referrals which will increase capacity in secondary care.
- This leads in turn to a reduction in waiting time for diabetology services and a focus on more appropriate referrals – in short the diabetologists see patients with greater need more quickly.
- Practice based podiatry services offer a much shorter waiting time for patients.
- Additionally, patients seen in primary care have an allocated appointment time rather than waiting in a first-come first-served clinic.

Case study

The secondary care podiatry team trained the two practice nurses at the Lane End Surgery in Newcastle upon Tyne. Both nurses went through a rigorous training programme, both theoretical and practical, and were subsequently evaluated before commencing the practice podiatry service.

Podiatry takes place as part of the twenty minute diabetic review, allowing education to be given at the same time in a much more meaningful manner. The practice has protected appointments with allocated times, meaning that patients don't have to turn up and wait as they previously did at out-patient clinics.

Marie Pearson, clinical quality lead for the practice, says "We really enjoy it. As nurses it is always nice to develop the range of skills you have, but what is particularly rewarding is being able to offer a holistic package to our patients with diabetes. In addition we now have a direct route of referral to the podiatrist for those patients we have concerns about".

Urology

Implementation of a pathway for haematuria

Approach

GPs agree to work with urology consultants to establish a high-level pathway for patients presenting in general practice with haematuria. GPs or other practitioners with special interests can then order all the diagnostic tests specified in the protocol at the same time. And local arrangements are put in place to ensure that all tests can be completed quickly and with minimum visits for the patient. The pathway specifies the process for reviewing the results and taking the appropriate action.

Likely results

- Up to a 50 per cent reduction in diagnosis time for patients with haematuria leading to quicker surgery for patients found to have cancer and speedier reassurances for those who do not.

Case study

Bradford urology consultants have worked with five GPwSIs in urology to agree a haematuria protocol that has been implemented city-wide. There is an agreement that GPwSI can directly refer for surgery if cancer is detected.

A booklet for patients has been developed to explain the investigations required. If the results show that the patient does not have cancer the patient is informed by letter but is given the option to attend an appointment with the consultant if they want to do so.

The average time from patients presenting at the GP to having bladder surgery has been reduced from 14 weeks to six weeks. Bradford has progressed to having a single electronic record accessible from hospital and community, but the pathway changes can be made without this.

Where to find more information about practice based commissioning

The latest Department of Health guidance on practice based commissioning is available on the Department of Health website www.dh.gov.uk/practicebasedcommissioning

On the DH page you will also find previous guidance, PBC case studies and links to the web pages below.

The National Primary Care Development Team is supporting PCTs and practices to help them become practice based commissioners in a national programme that will be available to all PCTs including an early series of webcasts and simulation events open to all. NPDT has created with strategic health authorities and PCTs a practice based commissioning assessment framework and is to be recommended. Further details of the programme and the assessment framework are available www.npdt.org

The National Association of Primary Care is operating a practice based commissioning helpline and web page resource. It is also collecting and will be disseminating best practice. It will be running further conferences on practice based commissioning and NHS Foundation Trusts throughout 2006. For more information contact Maggie Marum on 0207 636 7228 or maggie@napc.co.uk and www.napc.co.uk

The NHS Alliance supports and represents current and aspiring practice based commissioners through the NHS Alliance Federation for Practice Based Commissioning, which provides information, advice, a comprehensive database and monthly newsletters for member practices and practice clusters/localities. There will be 15 regional practice based commissioning conferences this spring and the launch of a practice based commissioning 'flying squad' for practices and PCTs. Practice managers, PCT commissioning managers, PEC chairs, specialists, nurses and allied health professionals can also directly access help with practice based commissioning through six national networks created specifically for these clinician/manger groups. For more information contact Kaye Locke on 01777 869080 or office@nhsalliance.org or visit www.nhsalliance.org

Practice based commissioning: early wins and top tips

The Primary Care Contracting Team has produced a practice based commissioning toolkit and is producing briefing sheets on specific subject areas. It can also provide details of your local primary care contracting advisor who can provide local expert knowledge and support. For more information contact sean.fenelon@pcc.nhs.uk and rebecca.thornley@pcc.nhs.uk or alternatively visit www.primarycarecontracting.nhs.uk

The General Practitioners Committee (GPC) of the BMA continues to offer advice on practice based commissioning to Local Medical Committees (LMCs) and individual GP practices. It has produced guidance for LMCs and GPs on the initiative and plans to issue further guidance following publication of this document. For more information contact Sally Al-Zaidy at sal-zaidy@bma.org.uk or alternatively visit www.bma.org.uk/ap.nsf/Content/Hubpracticebasedcommissioning

The NHS Confederation has produced briefings which will assist commissioners to understand the design principles that could be used to develop practice based commissioning organisations that are fit for purpose. The series of papers '*Shaping the Future of Community Health and Care for Patients*' provides commissioners at PCT and practice level with service design principles and covers key issues which will support the planning of services. For further information visit the website on www.nhsconfed.org or contact Jo Webber, Deputy Policy Director at jo.webber@nhsconfed.org

The Royal College of Nursing is running a series of masterclasses throughout 2006 for senior nurses and workshops for all clinicians who wish to further develop their commissioning knowledge. These high quality events are free to RCN members and can be accessed via the RCN Regional Office. Further work will be taking place to support senior nurses who will have commissioning roles to enable them to share and learn from each other and build their commissioning capability. The RCN primary care and public health web site contains specific guidance on commissioning and supporting nurses through changing roles. For more information contact Lynn Young on 0207 647 3740, email lynn.young@rcn.org.uk Alternatively visit www.rcn.org.uk/pcph

The National Institute for Health and Clinical Excellence (NICE) produces guidance for the NHS based on the best available evidence of clinical and cost-effectiveness. Using NICE guidance to underpin commissioning decisions will therefore ensure any resultant business case meets the PCTs' criteria that new services are based on evidence of clinical effectiveness and value for money. To provide practical support for the commissioning process, NICE also produces detailed information on the costs and savings associated with any change in current practice, and provides advice for commissioners on the steps needed to put guidance into practice. For more information visit the NICE website www.nice.org.uk



