COMMISSIONING A COMMUNITY COPD SERVICE: LESSONS FOR THE NHS
Based on a case study in Somerset PCT by IMPRESS[1]

Summary

This case study is written for clinicians, service managers and commissioners to illustrate the complexities in commissioning and procuring a new service for people with long term conditions if existing services do not address patients' needs. It is accompanied by a set of suggested "dos and don'ts" on the last page. One of the most important of these is to recommend to colleagues that a continuous programme of improvement, which actively engages patients, led by clinicians from primary and secondary care with managerial support, is a simpler, potentially more sustainable approach. However, if a competitive process is chosen, it offers guidance for bidders on how to make a successful bid and for commissioners on how to develop the market.

Introduction

At the end of February 2008, Somerset PCT launched a new community COPD service for the residents of the county of Somerset. This was achieved following a competitive procurement process won by a private sector provider in partnership with local primary care clinicians. The award of a core clinical service for people with a long term condition to a non-NHS provider is a new development in commissioning. Therefore IMPRESS, a joint initiative between the British Thoracic Society (BTS) and the General Practice Airways Group (GPIAG) for improving and integrating respiratory services in the NHS, judged it to be worthy of further exploration and understanding. In February, two of the IMPRESS team attended the Somerset COPD Forum, a meeting for patients and carers and local clinicians to learn more about the new service and to offer feedback. The PCT has used the commissioning process to engage significant numbers of patients: there were probably 60-70 patients and carers at the meeting. During this a video of the patient's perspective was shown that captures what the consultation process had learnt: http://www.somersetpct.nhs.uk/how%5Fwe%5Fdo%5Fthings/Urgent%20Care%20Reform%20Programme/copd.asp In late March 2008 IMPRESS met with a range of stakeholders including Somerset PCT commissioners, the practice-based commissioning (PbC) lead, the successful provider, and one of the unsuccessful NHS bidders. The purpose of this second visit was to understand the process by which the PCT had decided to invest in a new community-based COPD service, to use a competitive process, and subsequently to award the contract to a new private provider. Our intention was to draw lessons from this to share with our networks. This paper is a result of these visits, and debate at IMPRESS.

[1] Improving and Integrating RESpiratory Services in the NHS. A joint initiative between the BTS and GPIAG (http://www.impressresp.com Also at NHS networks http://www.networks.nhs.uk/networks/page/942). IMPRESS represents both primary and secondary care clinicians with an interest in respiratory disease. Our core beliefs are that integration of services along care pathways that stretch across primary and secondary care are necessary for high quality care, and that current policies endanger this integration. We also believe that patients need to be offered generalist and specialist care and that policies must acknowledge the value of both; provided at the right time in the right place.

Relevance
This paper tells a story about the complexity of implementing World Class Commissioning (http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm). It illustrates clinical and patient/public engagement; delivering knowledge management; setting five year health outcomes and shaping and reforming the market. For providers less familiar with World Class Commissioning, there are eleven stretching competences that commissioners are expected to demonstrate. Three of particular relevance here are:

- Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation (Competence 4)
- Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration (Competence 8)
- Proactively seek and build continuous meaningful engagement with the public and patients, to shape services and improve health (Competence 3).

Background
Somerset has relatively advanced commissioning arrangements. There is one PCT covering the county of Somerset, with a countywide practice-based commissioning (PbC) group, Wyvernhealth.com, representing 71/75 practices, with another three on the point of signing up. There are also active locality PbC groups. There are two district general hospitals one in Taunton (west) that, at the time of the bidding was preparing to be a foundation trust, and one in Yeovil (east), already a foundation trust; 13 community hospitals and one PCT provider arm. Somerset is a mainly a rural area with poor transport links but with sizeable communities in Taunton and Yeovil. The lead clinician in Taunton has a national reputation amongst peers for COPD in relation to the development of services; service re-design and national audit and peer review.

A respiratory network had been in existence for many years, which had put forward ideas for service development that were not matched by investment until the decision by Wyvernhealth.com to prioritise the development of community-based COPD care. This was part of the commissioners' strategic aim to reduce avoidable admissions and to improve the provision of urgent care. Its particular aim for COPD care was the introduction of community-based services requested by patients. These would ensure that the advantages and attributes of the hospital-led early discharge service that supported people with COPD living near Taunton Hospital were available across the county, but "reframed" as community services that prevented admission, rather than an early discharge service from hospital, and optimisation of treatment and care. The commissioners were consciously rebalancing their attention and investment away from elective care, driven by achievement of the 18-week wait target, towards unscheduled care. This was driven partly by recognition of inequity in COPD service provision across the county, non-compliance with NICE and BTS guidance on oxygen therapy and very limited provision of pulmonary rehabilitation.

The PbC commissioners developed 6 areas of action to improve community services and reduce avoidable emergency admission to hospital. The PCT identified that the service developments required different models of commissioning, including the option of competitive procurement. The health community was open to the idea of third sector provision; for example it had a history of this with renal dialysis and elective surgery. It therefore decided that the COPD service should be competitively tendered. So, it developed a service specification with the support of local clinicians, including Wyvernhealth.com's COPD service GP lead, and advice from respiratory specialists employed by the acute trusts. It also commissioned a patient survey and a needs assessment, that both influenced the final specification. There was a very tight timescale, with the service specification published in early August and the formal time from issue of tender documentation to submission deadline (1 October 2007) of three weeks. Whilst the NHS

clinicians who had been involved in the specification process knew that a competitive process was in the offing, and had sight of the specification for 7 weeks, it seems it was particularly difficult for them all to muster the resources necessary to develop the bid in the three weeks, due to clinical commitments, booked annual leave and the involvement of senior management of one hospital in another major piece of work - applying for Foundation Trust status.

The PCT built in the option to bid for the whole of Somerset or for just the "West", or just the "North and East".

The acute trusts chose to make separate bids to the PCT, each in collaboration with the PCT provider arm. A third provider, Clinovia, a home-health company, part of the BUPA group, in partnership with Avanuala, a new company led by 2 local GPs, was the third shortlisted provider. It was this provider, Clinovia, in partnership with Avanuala, that won the contract for the whole of Somerset. It was awarded a three year contract, starting in February 2008, with the opportunity to extend year by year for two further years.

The COPD specification: objectives, incentives

The specified service required: (*Para 2.5 of Service Specification 7 September 2007*)

- A multidisciplinary community based service to improve the care of people with COPD;
- A pulmonary rehabilitation Service that supports and promotes optimal self-care;
- An oxygen assessment Service and ongoing support for people on long term oxygen;
- A nebuliser service;
- Effective links to the existing community and specialist palliative care services for people with COPD requiring care at the end of their lives;

The commissioner would financially reward the service provider if they achieved a number of specified targets: (*pages 11-12 of the invitation to tender document 7 September 2007*).

1. Reduction in the cost of COPD admissions
"The Somerset Primary Care Trust will reward the Provider of the service with £50,000 in each year of the contract that the overall cost of COPD admissions has reduced by more than the target specified below"

West Somerset: 15% reduction in acute admissions for COPD, expressed as a financial target:

	Value of COPD emergency Admissions (2006/07) £
Taunton and Somerset NHS Trust	609,285
Weston Area Healthcare NHS Trust	101,181
TOTAL	**710,466**

North and East Somerset: 20% reduction in acute admissions for COPD, expressed as a financial target (more scope as did not have a community service in place, whereas Taunton had an early discharge service in place):

	Value of COPD emergency Admissions (2006/07) £

Yeovil District Hospital NHS Foundation Trust	364,511
Royal United Hospital Bath NHS Trust	106,831
	471 342

2. Reduction in the cost of oxygen therapy
"Somerset Primary Care Trust has made significant investment in the budget for oxygen therapy. The annual budget is £1.3 million across Somerset. The current forecast expenditure in 2007/08 is £1.6 million (excluding VAT which is reclaimed).

The Contract with the [oxygen provider] is due to be renegotiated in April 2008, with the expectation that there will be an overall price reduction.

The Primary Care Trust wishes to reward the selected Provider for putting in place a service that will effectively assess patients' ongoing needs for long term oxygen and ensure that they are in receipt of the most appropriate provision. It will therefore agree an incentive framework with the Provider based on the following outline format:

Year One – measured at the 31 March 2008	50% shares of any under spend against the PCT budget of £1.3 million (adjusted for outcome of the oxygen tender)
Year Two - measured at the 31 March 2009	25 % shares of any under spend against the PCT budget of £1.3 million .(adjusted for outcome of the oxygen tender
Year Three - measured at the 31 March 2010	25% shares of any under spend against the PCT budget of £1.3 million (adjusted for outcome of the oxygen tender. "

Lessons for the NHS

The following paragraphs summarise what IMPRESS concluded from its viewing of the documents, its meeting with patients, and its conversations with some of the stakeholders. It is not a formal evaluation, but rather a paper that captures, as soon as it can, some of the lessons that seem important for commissioners and clinicians in the run-up to the publication of the National Service Framework (NSF) for COPD and the anticipated increasing numbers of tenders for COPD services.

Needs assessment

- Somerset PCT undertook a thorough needs assessment. This is a crucial step in service specification, and should not be short-circuited, for example by replicating another PCT's work, although standard methodologies and advice on data sets would be welcome. It would be helpful if there was a lead public health observatory for respiratory disease, like there is for many other conditions.

- The reason for each PCT undertaking its own assessment is because as well as public health data, it should take into account local provision, geography, preferences and trends. Furthermore, if local patients, clinicians, and managers are involved it will also ensure local ownership of any resultant service.

- It is important to validate the coding used in any baseline assessment so that an accurate picture of trends is available. An understanding of the underlying trend is essential for any evaluation of service impact. For example, are admissions increasing for COPD year-on-year, or has this already been stabilised? Are there post-code or ward differences? Are lengths of stay already changing? Is the severity of disease of those people admitted to hospital changing?

- An important issue in needs assessment is health inequality. The baseline assessment should review access to care and outcome by locality, ethnic group, GP practice and age. The service should aim to reduce inequalities; this might require positive action in certain localities. Recent work by the British Lung Foundation (BLF) http://www.lunguk.org/media-and-campaigning/special-reports/InvisibleLivesKeyFindingsASummary.htm and the East of England Public Health Observatory http://www.apho.org.uk/resource/item.aspx?RID=47926 has shown significant variation in prevalence rates.

- One of the elements of the needs assessment process that was not included in the service specification in Somerset, but which might be an important element of a service for people with long term conditions elsewhere, is case-finding. Campaigns such as that by the BLF as well as epidemiological studies demonstrate that there are likely to be many people with COPD undiagnosed. How to case-find for people with COPD is an important topic for local engagement.

Service specification

- PCTs such as Somerset are to be applauded for working hard to take patients' views into account in the design and delivery of a new service. Bidders should take note that the patient voice is becoming stronger. As commissioners become more skilled at listening to patients and patients become more confident at expressing their views, they might hear information not previously known to the system, so it is important for clinicians and service managers not to make assumptions about knowing what patients want. A key message from Somerset is that patients with COPD frequently feel frustrated that they are admitted to hospital when they feel that with more preventative care and support in the community an admission could be avoided. There was a strong sense that health professionals fail to provide sufficient information and do not recognise the patient as being the expert in their condition.

- We advocate the use of clinical networks to provide to commissioners with clinical knowledge that is evidence-based and local. These clinical networks tend to operate on the principle of colleagues freely sharing their knowledge and expertise for the good of patients and services. These networks are unlikely to involve commercial providers. However, at the point when the commissioning cycle moves from needs assessment and service specification to procurement, the intellectual property that has been shared between NHS colleagues becomes available to potential bidders, including commercial providers. It could be argued that this is unfair and even exploitative. Ways to counter this might be to pay the NHS for its expertise; or to ensure that the intellectual property of the commercial sector is also shared (such as its skill at bid preparation, customer focus and modelling). This requires high level policy development and advice to commissioners.

- In some areas where networks or good relationships across organisations already exist, it will be important that everyone is clear about what roles people have now, after recent

reorganisations. For example, is the PCT manager with whom you were working a commissioner or are they now a PCT provider arm manager?

- In the Somerset specification there was no early discharge service specified despite recommendations from the network to include it, due to its grade A evidence of effectiveness and its support in a NICE commissioning guide. The reason is that whilst the commissioner agreed with the evidence, and saw early discharge as beneficial for patients, the commissioner already pays for each hospital spell through the national tariff. There is no financial incentive for the commissioner to invest in services to reduce length of stay unless these reduce the stay to less than 48 hours (two "midnight crosses"). Therefore any activity to reduce the length of stay (and therefore free up the bed for a new patient attracting a new full tariff) should be paid for by the acute trust from its tariff income. Therefore if clinicians and patients believe that quality of care and patient experience would improve with an early discharge scheme, it will be incumbent upon the acute trust managers and clinicians to agree to set this up as part of ongoing work to improve the hospital's services. Clinicians may need to develop a business case with their hospital trust management that not only describes how it would improve the patient's experience but also shows how reducing lengths of stay through investment in an early discharge team is both financially and clinically possible. This may not require new investment, but different ways of working and linking with existing resources, such as community nurse teams.

  For information: There are currently several bids being presented to Connecting for Health (CfH) for new codes which will offer the potential for greater definition of activity and this would include bundled packages of care such as Programmed Pulmonary Rehabilitation. Assisted early discharge/Hospital at Home will require a new discharge code to identify this pathway and is currently under consideration by the Information Standards Board. The evolution of HRG 4 and OPCS 4 codes will offer greater potential to identify activity which is currently 'invisible'. Health professionals and coders will need to familiarise themselves with these developments and ensure that they are using these codes routinely so that when reference costing is applied it is based on full national data and the derived tariffs will be more reflective of true costs. Some of this more recently defined activity may well be better costed by taking a patient-level costing approach, particularly where there is a well defined package of care which is supported by a nationally agreed integrated pathway.

- Terms in specifications such as "specialist" and "integrated" may need definition if the bids are to compared fairly, and the service evaluated appropriately, as they are open to wide interpretation. Does "specialist" relate to certain competences, or to a qualification or accreditation or to experience? This is an issue of quality control and patient safety. How would you know a service was "integrated"?

- One of the hardest challenges in commissioning is recognising and planning for interdependencies; not only between different disease areas for patients with comorbidities, but also between different services within an acute trust. The Somerset specification takes one pathway and aims to streamline it, and improve its equitable application. However, it is important to bear in mind when agreeing the scope of a specification, that many people with COPD have comorbidities, and depending on what services are included in the specification, there will be "knock-on" effects on other services. In terms of market management, one of the issues will be at what point does implementation of a care closer to home policy take away so much of hospital services that the hospital is no longer sustainable. There will, inevitably, need to be trade-offs between providing a full range of care and where that care is delivered.

Procurement and bidding

- If there is a good, effective and integrated, patient-centred service, then there is no particular reason why a commissioner would choose to use a competitive process to improve care. A recent BMJ article by Chris Ham (Ham C (2008) Competition and Integration in the English National Health Service, BMJ, 336: 805-807 http://www.hsmc.bham.ac.uk/staff/staffdetails/hamc.htm) reminds us of the transaction costs of such processes. Certainly, the IMPRESS team felt overwhelmed by the paperwork created by such activity, and was aware of a significant number of person-hours spent by the commissioners and bidders. The cost (financial and emotional) to the NHS of preparing two bids, for no gain and some loss, was substantial. Efficiency gains are usually possible applying a range of improvement methodologies as long as the managers and clinicians are receptive to change. Therefore there is a clear message to NHS providers to check that they do provide a good, effective, integrated and patient-centred service.

- However, European Union (EU) procurement and competition regulations and current NHS commissioning guidance (World Class Commissioning) may require PCTs to undertake competitive procurement for new investments over a defined financial threshold or to provide a strong legally defensible reason why not. PCTs will have to weigh up the time and cost of competitive procurement and decide what is manageable. For example, Somerset PCT would suggest that three per year is probably the limit. There is a new guide to procurement for PCTs that will need to be followed, published in May 2008: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084778

- The standard time for EU tenders is six weeks, and so NHS providers will need to have bid processes in place to cope with this. It would also be helpful if commissioners could either avoid periods when many will be away on pre-planned holidays or perhaps build in an extra week or so. Somerset PCT chose to issue the specification early, as part of the Memorandum of Information (MOI) stage in recognition of the tight timescale and time of year.

- If patients are involved in a substantial way in determining how a service should be provided, the solutions may not be those familiar to the NHS. The NHS is often locked into the use of assets and staffing that does not allow the flexibility patients require. See Clinic to go as an example: http://www.institute.nhs.uk/care_outside_hospital/care/clinic_to_go.html

- Patients with COPD, when asked, do not always express satisfaction at their care in hospital, particularly if they are not seen by a respiratory specialist team. As an example, see the patient video from Somerset. Therefore acute sector bidders may have to work extra hard to both demonstrate their commitment to listening to patients and carers and to actually hearing what they say. It may be worth drawing this to the attention of the secondary care community through programme streams at meetings such as the British Thoracic Society winter meeting.

- NHS providers do not have the levels of support in bid preparation that the commercial sector does. Bid preparation requires financial modelling and marketing, but also in thinking "outside the box". A commercial provider works up a bid from a zero-base: it may not have local fixed assets like buildings or equipment that it has to use; it has no staff in post (although there will be TUPE rules to consider if the same job is offered). This can allow for significant creativity in providing a service, and encourages thinking based on "where are the patients?" rather than, "where are we?". For example, concerns about standards of equipment can sometimes hold back creative thinking but the Evercare example (http://www.erpho.org.uk/viewResource.aspx?id=13212) showed how community matrons and diagnostic services could become more mobile and go to the patients.

- Three to five years is a short period in the life of either a practising clinician or a patient with a long term condition. Therefore service contracts for this period can seem insufficient. It is too early to say in this case. However, if a contract is won by a new provider that means an existing NHS provider has to divest itself of staff and resources, then three to five years is sufficient time for the NHS provider to have lost the capability to bid again when the contract is renewed. This may be less true for the private sector that may have a central resources to draw on for bid development and recruitment.

- Technology tends to improve to match demand. Normally, this is a gradual process of evolution and can be anticipated and described in a bidding process. However, there is also the concept of "disruptive technology" that is a potential feature of whole systems change where unproven technology may be introduced that radically alters how things are done. Typically it is introduced by new small players, and ignored by big organisations.

- A basic, but crucial point. The commissioner wants the service it has specified which may have involved judgements not just about the evidence, but also about feasibility and acceptability to patients and the local community. This may have involved compromise. Therefore the bid needs to demonstrate how it will meet or exceed the specification. This is different from describing the ideal COPD service or the service that exists now. If a provider does not agree with the specification they need to consider whether they should bid at all – does it fit with their organisation's strategy? The only occasion when it might be appropriate to suggest a change to the specification is if you have grounds to believe there is a patient safety issue or a potential for increasing rather than reducing inequalities.

- A second crucial point. Answer all the questions and address all the requirements of the service specification; take note of any weighting in how much detail is provided and do not assume any prior knowledge. The Commissioner can only evaluate bidders on the basis of the information provided.

- A third crucial point. Develop and sustain a productive relationship between commissioners and providers throughout the year not just between January and March when negotiations for service agreements occur.

- When a service specification is developed, the overall aim may well be couched in a management target-driven language that is off-putting for some clinicians. This commissioner language, of outcome-based commissioning, quality targets and incentives will be an increasingly frequent element of service requirements and contracts, which is core business for PCTs and PbCs. Therefore it will be important for providers – both clinicians and managers – to become familiar with the language. However, it is normally possible to align ambitions of both managers and clinicians and of commissioners and providers.

- IMPRESS wrestled with the question from where does a PCT recruit external reviewers to adjudicate bids? In the Somerset example, the PCT was able to find external primary care input, but not secondary care.

Unintended consequences of system change

- In a whole system, any change will create consequences, some may not be foreseen or intended. If the commissioner initiates that change it will need to model consequences in advance; that is, it needs to imagine the "what ifs". As the NHS gains experience in different procurement models, so it will become easier to anticipate a full range of consequences. In the meantime, it will be important to capture, record and disseminate those findings for the benefit of both NHS commissioners and providers. IMPRESS is contributing to that process,

but it requires a wider NHS effort.

- The guardian of NHS funds is the commissioner. Plurality of providers means that some NHS money will be spent on non-NHS providers for the public good. However, there are some opportunity costs that should be considered. For example, if there is a financial incentive to reach targets eg for reducing prescribing costs or reducing avoidable emergency admissions or follow-up outpatients, and the provider achieves that, then the financial reward will use NHS money but will not necessarily be channelled back into providing services. This is in contrast to PbC rules that learnt the lessons from GP Fundholding and restrict the use of savings. Although, it could be argued, that GPs, as independent contractors to the NHS, are already "outside" the NHS.

- A plurality of providers means there is also the potential for fragmentation of the service because of lack of trust between the providers of the services. The procurement process may make this worse. This may need active management.

- Some NHS services such as the provision of informal training and mentoring and research are often not documented or costed, and there is a risk that the NHS will stop providing these if the provider management does not draw attention to them and to their value and the commissioner does not demonstrate that it values them by including them in service specifications. It is incumbent on the NHS to "surface" the social and intellectual capital and contribution to the development of the evidence-base if its value is to be understood and, where appropriate, sustained.

Teamwork

- A successful bid and a successful service will require input from managers and clinicians in both primary and secondary care (a forthcoming NHS Service Development and Organisation (SDO) research report by Hilary Pinnock will confirm this). Who leads it is less important than having these different perspectives and their respective skill-sets and experience represented.

- There is the possibility that more than one NHS trust might compete for a local contract. These organisations need to ensure that they do not focus attention on this competition, but instead, look to collaborate and so strengthen their bid. Otherwise there is the prospect of an competitor taking advantage of the loss of focus. Hopefully the development of a shared vision across a locality, and common pathways will encourage collaboration that could be developed further through networks or regular communication. The network will not necessarily be a provider (indeed, some policy-makers might regard networks as anti-competitive if they also provided services) but it should at least encourage integration rather than fragmentation and ensure the NHS puts in the best possible bid.

- Bidders also need to understand the patterns of influence locally. A key player is likely to be now or in the future, one or more commissioning groups of GPs. Therefore it will be important for NHS acute and community providers to develop relationships and understanding with primary care, and to view primary care as a customer rather than a referrer.

- In reality, the role of GPs is increasingly complex as they can play a role both as provider and commissioner, and there are, therefore, potential conflicts of interest. It will be important for national policy direction on how to manage this to ensure transparency.

- If part of a clinical service for people with a long term condition that requires different inputs over a person's life-time is provided separately, then there is the risk of loss of teamwork unless all players are motivated to work together. Culturally, many NHS staff feel uncomfortable working with non-NHS providers, particularly those that have to generate share dividends. So what is in it for the NHS staff to work with a new provider? What messages do managers and clinicians need to spread to colleagues? What do commissioners need to model in their scenario planning? Firstly, there is a professional responsibility to do the best for patients. In addition, there is an opportunity to share skills and alternative ways of delivering care. Third sector providers may be more flexible than NHS providers as they may have established different employment packages and job roles.

Evaluation

- The major impact of procurement from the private sector on local services and resources may well require qualitative not just quantitative evaluation. Our hypothesis is that national guidelines and consensus is not available for every situation or may not be easily sourced by commissioners, and therefore local clinician engagement is necessary to support local needs assessment, service specification and pathway development. Therefore there is the potential for a loss of intellectual property, expertise and goodwill from the NHS if this is not acknowledged and respected.

- IMPRESS advocates integration, and the challenge is to define measures of integration that could be used to evaluate the impact of the new service. We suggest that continuity of personal care is a key positive marker; perhaps assessed by a random selection of patients' histories. Another, negative marker might be the number of hand-offs. That is, will the new service lead to more or fewer steps in the care pathway?

- Commissioners have a responsibility to commission sustainable services that will support people over their lifetime of chronic illness. It is hard to see how a 3-5 year contract can achieve this and suggests that such a procurement process is problematic for long term care.

- One of the invisible attributes of an NHS service, particularly a specialist one, may be intellectual advancement. That is, keeping up with the evidence and contributing to it through audit and research. If that is not in the specification, then it is unfair to ask the provider to demonstrate this. However, evaluation of the impact of awarding the contract to a locally untested provider ought to capture whether there is active engagement in research and development, since the NHS requires there to be an active R&D programme. It should be noted that this will require the cooperation of all agencies, as no single organisation will have all the necessary data.

- In the Somerset example, responsibility for case finding was not part of the specification. However, in order to populate the service, the provider is visiting practices to support GPs in identifying and referring patients suitable for the scheme, working to agreed referral criteria. The question is, how does the commissioner ensure that they are the patients who most need the scheme, not the easiest to manage? That is, that health inequalities are reduced.

- At present, many NHS organisations are naïve about the procurement process. The question is, do they learn from the process and share it with others? What we can expect is that a new provider, particularly from the commercial sector, is likely to have excellent processes to develop its organisational memory to enable it to win further bids. Therefore there is an important role for the NHS to share its learning with colleagues. Should this be evaluated locally by commissioners with their World Class Commissioning focus on market management?

- If the conclusion of a market testing exercise is to remove investment from a local acute trust, or not to make an additional investment, then what happens to the residual costs of providing an acute medicine service and therefore the total costs of the system? Evaluation needs to capture this.

The next page summarises some of these views in a series of dos and don'ts.

IMPRESS's dos and don'ts of procurement of community services for people with COPD

Commissioners

- Support, if in existence, or establish, a clinical network to guide the development of a needs assessment, service specification and care pathways
- Involve local patients actively and continuously
- Consider if a competitive procurement process is the most cost-effective and sustainable way of improving care or if a continuous improvement programme could be developed
- If it is, consider the readiness of the local NHS to enter a fair competition and discuss locally what support might be available if needed
- Consider the impact on integration and on NHS sustainability if the contract is won by a non-NHS provider
- Ensure you have expert primary and secondary care advice for adjudication of bidders
- Ensure that responsibility for keeping the service up-to-date with best practice is built into the specification
- Consider whether you wish bidders to bid for the provision of audit, research, education and training of primary and community care professionals
- Consider inclusion of incentives to reward best practice
- Have benchmark data for evaluation and some manageable but important evaluation criteria such as continuity of care for patients, equity of access across practices and localities, hospital utilisation, unscheduled care.
- Make it clear to clinicians who the commissioners are – there is potential for confusion if the same people who were employed by the PCT are no longer commissioners but on the PCT provider side, or if GPs who were in one role are now leading practice-based commissioning.

NHS clinicians

- Get involved in any local clinical network and actively work together with colleagues across primary and secondary care to consider how care could be improved. Use resources such as the BTS referral criteria to assist in these conversations.
- Plan for how you and your colleagues will listen to patients and engage them in not just self-management but also in service design, information provision and service evaluation
- Campaign for investment in respiratory care, demonstrating how it can meet commissioners' aims such as reduction in avoidable hospital admissions, shorter lengths of stay and care closer to patients' homes.
- Maintain relationships with colleagues but be sure you know what their role is now, and who the decision-makers: who is a PCT commissioner, who is in the PCT provider organisation, who is a practice-based commissioner and who is a GP with an interest in providing services (and note that it is possible to be both a practice-based commissioner and a GP provider).

Bidders

- Familiarise yourselves with the process, particularly the scoring system, timelines and adjudication process.
- Get help early from people who have the appropriate skills sets in budgeting, data analysis, scenario planning, social marketing, presentations, and make connections with key stakeholders
- Having read the specification, decide whether it is appropriate to bid – does it fit with your organisation's strategy? Do you have the resources to bid? What are the risks of not bidding, or not winning? Do you have the resources to deliver the service?
- If you bid, respond to the specification as it is written in the final documents; seek clarification using the formal processes
- Try to start by thinking "out of the box", without being restricted by knowing how things are done now or the implications for the use of NHS assets.

- Think about not just the written submission but any other adjudication processes such as an interview. Who should attend? For what reason? Imagine what your competitors might do.
- Consider any unintended consequences such as what happens to the residual costs of providing an acute medicine service and therefore the total costs of the system if investment is removed from a local trust.

Siân Williams and Tony Davison, with input from the IMPRESS team. 24 June 2008