

Effective Patient Centred Commissioning in HIV Meeting, Thursday 16 January 2014, London

Feedback reports from BHIVA attendees

Report from Dr Victoria Johnston

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This meeting provided an overview of how HIV services will be commissioned within the new NHS structure, with four speakers focusing on different aspects of HIV commissioning.

1. **Commissioning HIV services and the role of NHS England¹**: *Clare Foreman* described how NHS England is responsible for the national commissioning of all specialized services. The aim being to ensure that there is equitable access to a consistent standard of specialist health care throughout the country. In the context of HIV, this includes commissioning care for adults and children living with HIV, specialist in-patient and out-patient care and HIV drugs. The first step has been to set service specifications which outline the essential components of an HIV service. All HIV services will be assessed to determine if they meet these specifications. Where gaps are identified a derogation process occurs, whereby a management plan and time-line are drawn up for delivery of these specifications, which will often involve reconfiguration of individual services into formal clinical networks. NHS England will also be responsible for policy development, QIPP, CQUIN, Quality dashboard, and defining outcome measures. Local Area Teams are 'local' offices of NHS England who are tasked with the actual commissioning of local HIV services. They will hold the contracts with the providers, ensure national policy is implemented, and monitor local services and feedback on any issues which arise from implementation.
2. **HIV service specification, its implications for service providers and the role of the clinical reference group²**: *Simon Barton* described how the CRG is the primary source of clinical advice for national commissioning. It comprises a group of specialist healthcare workers, patients, affiliate members and commissioners who work by consensus, engaging with key stakeholders in the field e.g. BHIVA. Tasked with advising on HIV service specifications the CRG reflected on the needs of HIV patients and the optimal HIV care management model required to meet these needs. The current patient population comprises a high volume of stable patients and a lower volume of more complex patients. The current model of providers in multiple clinics taking sole responsibility for ART prescribing, patient monitoring and in-patient management is no longer the optimal model. Reconfiguration of individual clinics into clinical networks will enable stable patients to access care locally, whilst those with complex needs (e.g. drug resistance, co-morbidities, in-patient care) can access specialised services via the network. Each network will need to be responsive to the needs of the patient population, take account of the available services and the competencies of the HIV providers. There is no 'blue print'; the specific structure of these networks is an evolving field. Clear care pathways for accessing services provided by co-dependencies need developed (e.g. sexual health). Also GPs have an important role in managing non HIV related conditions

to NICE / NSF standards; as a gateway for referrals; and from a financial perspective (budgets for non-specialised HIV care lie with CCGs and Local Authorities [LA]). Well-functioning networks aim to improve quality (e.g. centralised in-patient care ensures clinicians competencies are maintained hence optimising patient outcomes) and increase productivity (e.g. avoids duplication of complex care and a critical mass to allow efficient staffing/rotas); however there are potential 'perils'. Local cost-cutting may undermine service standards and if outcomes are not monitored may cause harm and incur great costs; tendering and commissioning entropy can fragment services resulting in inequitable care. Data on process and outcomes must be collected and used to drive up quality of care.

3. **'Creating the links – commissioning HIV prevention and testing and the role of Public Health England'**: Jane Anderson described the role of PHE, a new, integrated agency which incorporates many bodies e.g. HPA, national treatment agency for drugs. Its vision is to protect and improve patient health, address inequalities and work with all stakeholders who are interested in improving health. It ensures that public health policy, set by the department of health, is delivered in practice by the LA. However, it is not responsible for managing LAs. Key functions of PHE include: surveillance, knowledge and intelligence to support local policy and programme decision-making; provision of area-specific data on local epidemics, assets and interventions and cost-effectiveness data; and training and capacity building to accelerate translation and implementation. LAs have taken on responsible for sexual health commissioning, including HIV prevention, sexual health promotion, HIV testing programmes in sexual health, clinical and non-clinical settings and reducing late diagnosis. However, LAs are faced with a huge funding gap (cash cuts of >66% by Dec 2020). Inevitably service priorities and public service structures will be reviewed and services put out to tender; local providers must consider how to meet the service specifications and respond to these tenders.
4. **'Commissioning for Quality, outcomes and value in the NHS – what can providers do?'** Stephen Callaghan discussed the part providers can play in this process. Recommendations included (1) Identify your commissioner (2) understand what 'outreach when delivered as part of a provider network' means for your area (3) be the catalyst to ensure that the patient pathway (from prevention to end of life care is commissioned appropriately) (4) demonstrate that your service is achieving the outcome indicators which commissioners need to deliver on (see NHS outcomes framework) and (5) create evidence-based pathways for HIV that includes indicators, competencies etc.

The underlying theme of all of these talks was the need for providers and commissioners to embrace the current changes in commissioning. Understanding and respecting each other's roles, responsibilities, expertise and constraints for all those working across the HIV pathway will be critical for success. There are new opportunities as well as potential risks which will drive system transformation. Success will require leadership, partnership, transparency, communication evidence-informed decision-making, co-ordination of care and a commitment to evaluation and innovation.

Report from Dr Marc Lipman

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The half-day meeting, organised by MEDFASH, covered the new HIV commissioning landscape, and developing local links and collaborations. It brought together clinicians in HIV and Sexual Health, Public Health commissioners and service managers.

Following Brian Gazzard's introduction, Claire Foreman, Accountable Commissioner for HIV within NHS England, outlined where HIV services sit within the new NHS as part of Specialist Commissioning. She went on to discuss Service Specifications and the issues germane to HIV, including local implementation of the Service Specifications (and the potential for derogation if these are not met); delivering QUIPP; re-configuring networks and changing the model of care; data collection; the role of primary care and the pricing of services, including treatment costs.

A theme that emerged from her session was that the current relationship between Sexual Health services and HIV provision will alter. This was picked up in Simon Barton's presentation given as Chair of the HIV Clinical Reference Group, where he emphasised that the considerable success associated with treatment and care has now led to an expanding, medically stable patient population with needs in addition to those historically associated with HIV. Simon outlined future challenges for patients, providers and the NHS including the impact of an aging HIV population; integrated care; economies of scale and central management of drug and pathology costs; health improvement and disease prevention, e.g. management of STIs; and the need for a single patient record across the whole care pathway allied to an awareness of maintaining patient confidentiality despite the inevitable resultant increase in data sharing.

Questions from the audience focussed on avoiding service fragmentation; maintaining high quality local care in the face of the drive to centralise inpatient services; the impact on the specialised work-force and the relationship between Specialist Commissioning and Local Authorities.

Ruth Lowbury, Chief Executive of MEDFASH chaired the second session on developing local links and collaborations. She highlighted the key issues from the MEDFASH survey of providers of HIV services in England and Wales. This had also noted the risk of fragmentation through changes in commissioning and the loss of links between Sexual Health and HIV.

Jane Anderson, representing Public Health England, discussed changes that have resulted from its closer alignment to Local Authorities. Some of this reflects new ways of thinking: Local Authorities are interested in "people not germs"; and hence arguments are likely to be more convincing (and hence supported) if they focus on the person (and population) rather than the disease itself. Whilst encouraging, Jane emphasised that by 2019–2020 there will be a Local Authority funding gap of £16.5 billion. This represents almost one-third of their revenue; and means that Public Health, and therefore both Sexual Health and HIV services, are likely to be significantly affected.

The final speaker, Stephen Callaghan from EQE (Effectiveness, Quality and Economy) Health reviewed the mechanisms that can improve quality, outcomes and value in HIV. Clinical networks that meet the needs of their local and wider population were proposed as a possible solution. The question of who was responsible for co-ordination of care across a network, and how this might be monitored were debated.

The meeting left delegates in no doubt that the issues raised could not be ignored and that urgent involvement was needed if they wished to help in shaping future NHS HIV & Sexual Health services.