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Discussion paper

Practice-based commissioning: our hope for the future

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ABSTRACT

This paper looks at where practice-based commissioning (PBC) has come from and explains why the author considers it an unmissable chance to improve the quality of services. It describes the why, what and how of PBC, its short-term and long-term future and what needs to happen for it to succeed. It shows how PBC provides an opportunity for general practitioners to revisit their purpose and core values and make a real difference in terms of improving patient services and health.

Keywords: cost effectiveness, general practice, health, local services, practice based commissioning, primary care trust, service improvement

How this fits in with quality in primary care

What do we know?
Most patients wish to make clinical choices with their general practitioner. These decisions determine the majority of health service spending. Practice-based commissioning is the system whereby practices are encouraged to work together to commission improved health and services with indicative budgets.

What does this paper add?
Practice-based commissioning provides an opportunity for general practitioners to revisit their purpose and core values and make a real difference in terms of improving patient services and health.

Introduction

The question is simple: how in an NHS less dominated by national targets and central control do we improve local services and health, increase cost-effectiveness and re-engage frontline clinicians in the process? The answer: practice-based commissioning (PBC) is radical though still (in spite of at least two false starts) largely untested. Yet there is every reason to believe that PBC can succeed where other initiatives have failed. That is because it represents a natural evolution of health policy since the early 1990s and because there are good theoretical reasons why it should work.

A natural evolution

Practice-based commissioning represents a hybrid of fundholding, introduced by the Conservative government at the beginning of the 1990s, and the general practitioner (GP) commissioning movement (spontaneously initiated by non-fundholders). The latter advocated GP practices commissioning local services in partnership with each other and with their local health authority, and arose as a response to the perceived inequities of fundholding. Even before the Labour election victory of 1997, these previously opposed factions were on a convergent path. Indeed, at the time of that election, there were 112 GP commissioning groups nationwide and half of their member practices were fundholders.

Thus ten years ago, the scene was set for practices working together to commission improved health and services with real or indicative budgets. The locality commissioning pilots during the first two years of the new Labour government seemed to be a fulfilment of that vision. The following year saw the wholesale move of all GP practices into primary care groups (PCGs). These were welcomed by many, though others thought they lacked the quick-footedness of locality commissioning, which they felt should have been allowed to develop more organically. Within a year or two, and against the wishes of most of the original GP commissioners and fundholders, all PCGs (which were solely commissioners) had become primary care trusts (PCTs) (which were also providers of local community services). This centrally imposed change was based upon the argument that PCTs as commissioners and providers could better integrate primary care provision.

In PCTs, the accountable officer (the PCT chief executive) was a manager; this was in contrast to the accountable officer of the PCG, who was a clinician (the PCG chair). Thus, commissioning, which had been previously led by clinicians and supported by managers, metamorphosed into a process led by managers with the variable involvement of clinicians. The growing perception in government circles that PCT commissioning was weak led to the decision to reintroduce commissioning led by frontline clinicians in the form of PBC.

Originally conceived by the Department of Health as an individual practice activity, PBC has spontaneously evolved (just as in the 1990s) to be a collective process. Today, nine out of ten GPs belong to practice collectives. These average between five and ten practices, covering a population of between 50 000 and 100 000 patients. Currently, the government is encouraging PCTs to divest themselves of provider functions so that they can improve their commissioning function and better support PBC.[1]

This story echoes the 'Grand old Duke of York', but the similarity between today's practice commissioning collective and yesterday's locality commissioning group or PCG is reassuring. With each reorganisation of the past 15 years, the NHS frontline has edged towards this model of commissioning: led by grassroots primary care clinicians, working in partnership with managers, and covering a given geographical area with the primary aim of improving services and health for local patients.

Practice-based commissioning: why?

There are also good theoretical reasons why the NHS needs PBC. Eighty percent of patients (according to two recent MORI surveys) want to make their clinical choices with their GP.[2,3] Logically, therefore, making the GP or practice the commissioner will ensure that the potential choices of patients are more likely to be met. Furthermore, NHS spending is largely predicated on the short- and long-term consequences of GP decisions whether they be on prescribing, diagnostics or specialist referral. If GPs wash their hands of commissioning and disclaim responsibility for NHS spending, then there is no way that the PCT or anyone else can contain NHS expenditure, and deficits become inevitable. PBC is thus the answer to how we make commissioning more patient sensitive and to how we make the NHS more cost-effective.

Local GPs, who are often in harness for 20–30 years, are also in a good position to know what their patients and local population want and need. In daily contact with the raw edge of patient experience, they can add an urgency to commissioning, where it is currently failing patients. Experience suggests that, when frontline primary care clinicians meet their secondary care counterparts, logical solutions that improve care rapidly emerge and the clinicians are better able to get peer ownership of those solutions, and thus more effective implementation.

Practice-based commissioning: what?

It is easy to give a mechanistic explanation of PBC. Practices or collectives are given a budget, and if they underspend within that budget then 70% of savings can be used on patient services. What we want to achieve from PBC is more complex.

One answer, represented by the more enthusiastic practice commissioners, is that PBC represents the emancipation of frontline practitioners (working with patients) to redesign local services and health and thus to create radically different patterns of local services and health. Frequently, this will result in a move of services from secondary to primary care and an emphasis on self-care and personal health.

Another answer is that PBC is only about saving money and represents a means of performance managing GPs to keep within budget. Current NHS rhetoric supports the former position, but if the implementation of policy veers towards the latter, there is a danger that GPs and their patients will walk away from a policy that appears to restrict rather than liberate.

Practice-based commissioning: how?

Previous incarnations of frontline commissioning had the flaw that whenever a new service was set up in the

community, the commissioner frequently had to continue paying for the old service in the hospital – whether it was used or not. The new national tariff (called 'Payment by results' though it is really payment by activity) now provides frontline commissioners with an 'opportunity cost'. If you do not refer a patient to outpatients, for instance, then £150 is saved and this can go towards a cheaper locality service for that patient or even a prolonged general practice consultation that might obviate the need for referral altogether. PBC thus hands frontline clinicians (and hopefully their fully involved patients) the keys to commissioning and an opportunity to decide exactly where and how the money is spent in a way never previously possible. For it to function effectively, there is an urgent need to tighten up the payment system, currently favouring provider over commissioner, and to make payment by results fairer. Nevertheless, the scene is now set for commissioning to become far more effective than was ever possible in the past.

The move of services from secondary to primary care is likely to be accelerated by the self-interest of frontline clinicians and practices, who will often themselves be the providers of services commissioned outside hospital, as well as the means of generating underspends to pay for them. That is desirable, but the creation of complacent local monopoly providers might not be. The new world will require fleet-footed PCT commissioners, who can ensure that the patient gets value for money and that there is contestability, where necessary. It will also call for sophisticated relationships between a PCT and its practices, who may be commissioners and providers almost within the same breath.

Practice-based commissioning: progress to date

The NHS Alliance/King's Fund report (May 2007) revealed that PBC was still at an early stage although most GP practices in England are now, officially at any rate, practice commissioners.[6] Few practice commissioners thought they had done anything substantial so far, but an increasing number of GPs and practice managers were positive about the potential of PBC and thought that it would deliver over the next year. Nevertheless, they felt hampered by lack of information, which if available was rarely in a useable form, and most felt they were getting insufficient support in terms of manpower and resource from their PCT. Most felt restricted in their role as commissioners rather than being part of a wider health and service redesign agenda. For instance, only 3% had been involved in their local development plan. The level of trust was not very high either, with a minority thinking that they would be able to keep 70% of their underspends although this was official government policy. It appeared that the reorganisation of around 50% of PCTs had left many without the necessary resource and manpower to support PBC. In a minority of PCTs and strategic health authorities there was neither the will nor the way.

The future: short term

Over the last year PBC has gained further momentum. The new ministerial team has confirmed that it is 'the only game in town'. A Department of Health survey of practices this autumn which asked them about the support provided by their PCTs for PBC, has provided a further spur for PCTs and practices to deliver faster. With over 800 practice collectives now in operation, many are beginning to show solid progress. They are having to do so against a headwind of criticism, managerial inertia and frontline apathy.

Some NHS commentators say that there are insufficient GPs either interested in commissioning or competent to do it. Commissioning, they contend, is far too complicated to leave in the hands of clinician amateurs. Their arguments are misleading because effective commissioning requires only one or two leaders in every locality. Far from being complicated, commissioning is what every frontline clinician does every day in helping patients to access the right treatment or service. Such criticism can, however, have an erosive effect at a vulnerable stage in the development of PBC.

Traditional 'NHS think' and ingrained conservatism also stand in the way of practice commissioners. This sees the practice commissioner as bottom of a commissioning hierarchy extending from Department of Health to strategic health authority to PCT and thence to practices. Fortunately, an increasing number of PCTs are beginning to see that their own commissioning plans should be based upon practice commissioning plans (rather than vice versa) and that their main function is to support PBC. Elsewhere, the most proactive and determined practice commissioners are seen as troublemakers simply because they challenge the complacency to be found in the NHS tiers above them.

Sometimes, GPs and practices are their own worst enemies. Some GPs say they just want to be patient advocates and not population advocates as well. Others, who may want to take on a role in improving health and services, are saying that the incentives are too small for them to make any significant effort. Generally, however, there is a growing consensus in

general practice that PBC does present an unequalled opportunity and a realisation that primary care will not be given a second chance if it fails.

The future: long term

Credible PBC needs to be a joint operation between frontline clinicians and managers and their local population. The wiser practices and practice collectives are already creating patient participation groups, citizen's juries, locality patient liaison officers and the like, so that they can demonstrate that they reflect the needs and wishes of the local population.[4]

As practices come together as commissioners within one corporate organisation, many (often the same practices) are also coming together as providers of primary care services but under a different corporate hat.

In some cases, they are literally coming together on a purpose-built site ('polyclinic') with facilities for diagnostics, secondary-type services, social services, voluntary services and others. Other practices are coming together as virtual provider units with some provider services provided within individual practices and others from a central locality diagnostic and treatment centre. Specialists and a wide range of practitioners and therapists will increasingly work within these 'nested' or virtual provider units.

Where these commissioning and providing practice collectives cover the same population, they may, in time, merge within one corporate identity. Such practice collectives will then cover a population of registered patients within a given geographical area and, where patients cannot be looked after within its own local provider unit, the collective will use its available budget to commission secondary and tertiary services elsewhere.

Though these 'USA style Health Maintenance organisation' organisations may compete for patients on their borders, some will advocate that they should lose their geographical base in the interests of more competition and patients should be able to register with the organisation of their choice. The arguments for such practice collectives having a geographical population base in terms of improved health, health inequalities and integrated care will probably trump these calls for greater competition unless there are unacceptable differences in the quality of health and care provided between them. Current calls for PCT boards to be democratically elected may, in time, also be reflected in similar calls for elected leaders within practice collectives. Some collectives may be taken over by large corporations with an eye to increasing profits and creating monopolies rather than guarding the NHS interest. It would be an irony if PBC became the Trojan horse for private companies, and the NHS thus lost its unique family doctor service based upon small self-employed providers balancing professional vocation with running a small business.

Keeping the baby and the bathwater will be the prime responsibility of PCT commissioners. They will need to create the right level of contestability but also to ensure that their practice collectives take commissioning every bit as seriously as provision. PCTs of the future, with fewer staff, will be needed in the role of 'commissioning guardian', but an increasing number of current PCT functions may, in future, be undertaken by organisations that represent several local practice collectives.

Conclusion

PBC represents a unique solution which is possible in the NHS because primary care and general practice are strong. If frontline clinicians and managers prove to be neither up for it nor up to it, then market solutions involving large corporate providers will be all that remain to a government that will feel that it has been let down by its GPs and practices. GPs and practices are beginning to understand this, and fear of this happening may prove to be the strongest incentive for PBC to succeed.

The quality of general practice is variable, but GPs have generally shown themselves able to balance personal profit and public service. This was evident with the old 'Red Book' payment system, which usually delivered good general practice although the financial incentive was to register a large number of patients and do a minimum for them. General practice has also shown itself to be innovative during the fundholding and commissioning years and to be able to adapt and deliver fast within the new GP contract and Quality and Outcomes Framework.

National targets, centrally driven initiatives and the almost exclusive use of financial rewards as an incentive have led to wealthier but less-happy and less-engaged GPs and practices.[5] PBC now enables them to revisit their purpose and core values and make a difference in terms of improving local patient services and health. Well handled, it could encourage frontline practitioners to take on a wider NHS role in addition to their current advocacy of the individual patient and also improve their professional self-esteem and reduce the current level of clinical alienation. All of these will be as important in making PBC a success as they are today in determining the quality of the individual patient consultation.

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