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Guest editorial

Improving the quality of care through practice-based commissioning

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Improving the quality of care must continue to underpin any health service reform. Practice-based commissioning (PBC) is a key component of reform and it offers a chance for general practice with its registered population of patients to fulfil still more of its potential. How can PBC raise quality of care?

Essentially, the main benefits of previous schemes such as fundholding were to enhance the provision of primary care and I expect the same focus from PBC – certainly from the early innovators. What aspects of primary care provision are we building on?

We know that first-contact primary care, and specifically general practice, has much to offer a healthcare system.[1] An almost unique feature of UK general practices is their lists of registered patients. This helps to deliver better care to patients who have a chronic disease, and addresses public health priorities among the population, but also enables the allocation of budgets to cover the healthcare needs of these patients.

Such a population approach enables a systematic and hence better care of people with chronic disease (or 'long-term conditions'). Systematic care entails the registration, recall and review of such patients. General practices can offer preventive services for their patients including a search for the undiagnosed and recall of those lost to follow-up. Health services have a huge responsibility for such care as 'personal health services' have a relatively greater impact on severity of clinical conditions (including death) than on incidence. As inequities in severity of health problems (including disability, death, and co-morbidity) are even greater than are inequities in incidence of health problems, appropriate health services have a major role to play in reducing inequities in health.[2] And as the practice is the local resource for its community of patients, it carries that responsibility. The Quality and Outcomes Framework of the GP contract has already improved the care of patients with such conditions and is narrowing the gap in health inequalities. Care can be further improved through the use of resources released through PBC.

In the near future, an increasing proportion of health care will be provided locally, reflecting international best practice, advances in technology and the public's preference. Furthermore, the Wanless review reported that unless we radically extend primary care, 'co-produce' care with our patients and address prevention, then the healthcare systems may become unsustainable.[3]

Of course, if general practice wishes to deliver these gains, many questions are raised. By whom and how will the practice manage these enhanced roles and responsibilities? How does general practice maintain its 'localness' and yet function as a micro-strategic organisation for its population? Certainly, senior experienced managers with broad-based experience and qualifications are required, not least in clinical management. The support of locality or primary care trust (PCT) management is crucial. While we should encourage locality groups of practices or consortia working, the practice remains the building block of PBC and it is through their practice that clinicians will chiefly be engaged. Localities have a different role, for example in providing a mechanism for practices to work together, for benchmarking data on practices and other healthcare organisations, and in commissioning for the services that a single practice may be too small to influence. The relationship between the PCT and the practice should be a 'meeting of experts', and the same relationship must also exist between the practice and the locality consortia of practices.

So general practice will have three key roles, at least in the short term – principally provision and referral or – to use health economics parlance – 'make or buy'. They also will be advising PCTs what services to procure. There is early evidence that PBC is enabling the provision of extended services, the scope of which were described in my Department of Health report this year *Keeping it Personal*.[4] This described how we can build on the best of traditional general practice.

The Improvement Foundation support programme for PBC has already demonstrated a lessening of the need of some hospital services. Such release of resources

can be invested in primary care services and/or in underdeveloped but essential hospital services. As practice-based commissioners develop confidence, and with the active support of public health specialists, they may invest resources in addressing some of the wider social determinants of health.[5]

Future extension of healthcare services driven by entrepreneurial practices and aided by high-quality managers will be extensive. This could create multi-specialty organisations serving the broad health needs of registered populations and employing generalists and specialists from a range of local NHS employers.

Through good husbandry of its budget and by recognising that efficient care often costs less, PBC can be a key driver of such a comprehensive future. If a vital priority has to be 'to live within available resources' then clinicians hold the key, as it is estimated that 80% of NHS resources are spent as a consequence of clinical decisions. The word 'rationing' is often overused to defend current practice however inappropriate and ineffective. An excellent definition of rationing is 'the delay or denial of appropriate and effective interventions' and its corollary 'frequently what clinicians offer is neither appropriate nor effective'. I cite many aspects of such care, e.g. much outpatient care, variation in lengths of hospital stay and day case rates, inexperienced clinicians admitting patients and wide variation in the quality of primary care.[6,7] Questioning these activities is much in vogue, but evidence of a systematic widespread addressing of them is much less apparent. A further clinical imperative is to enquire of the evidence base for clinical interventions. David Eddy and Jack Wennberg's work in the US amply demonstrates that much care is not evidenced based and is often subject to large variations.[8,9] I also subscribe to Professor Al Mulley's dictum that 'variations can be either warranted (patient preferences) or unwarranted'.[10] Primary care clinicians with knowledge of their patients' needs, budgetary controls and the evidence base are particularly well placed to ensure optimal use of resources.

In conclusion, PBC can take English general practice to a higher level as a local quality-driven and accountable organisation. It can drive quality as well as cost-effectiveness by ensuring clinical governance across the extended primary care team and through its commissioning advice. The more we give of ourselves, the more influence we will achieve.

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