

Practice Based Commissioning – opportunity or threat ?

Having debated PBC at length in LMC and having considered the issues from both our perspectives as a practicing GP and management consultant working in Primary Care, the following sets out a brief statement of our position.

Introduction

It seems to us that other papers on the subject suffer from one or more of the following flaws:

- They consider the policy in isolation.
- They do not consider the policy from the perspective of the practices.
- They persist in comparing this policy with that of General Practice Fundholding, ignoring the considerable change which has taken place in the Health Economy since the death of that initiative.

Contextualising PBC seems to be the right first step before we move on.

Context

Recent initiatives mean that the landscape within which PBC is placed is radically different than that which met Fundholding. This both means that it has a greater likelihood of success and that it is more likely to offer the power and responsibility to the practices which we have long believed would make a real difference to our roles and the wider system in which we sit. Patients and GPs are the force for good in the health economy and through the changes which are taking place around us, PBC becomes the tip of an iceberg of initiatives which mean that we will be able to exercise the power to make the difference. For example:

Payment by Results and Foundation Trust Status

Payment by results means that payments to hospitals will be fixed by a national price list, on a cost per case basis. The primary care trust will be allowed to negotiate maximum and minimum numbers of referrals. It is expected that providers will then compete on quality, efficiency and convenience. Contracts with Foundation trusts will be legally binding, and not subject to controlled amounts. These two initiatives together create an environment where every patient contact with a hospital means a bill for the PCT at a fixed price.

These are, from the perspective of General Practice, large bills. For example two no stay attendances (e.g. Assessment for a patient with COPD who is sent straight home) would pay for all the QoF points for COPD for an average practice with £1000 to spare.

The above scenario paints a picture where the secondary care sector consumes every penny within the NHS. No change there then, but there are other initiatives which, if correctly deployed, will counter this danger.

Patient Choice

Patient choice has not been welcomed by those GPs who rightly fear the administrative burden, but patient choice implies that the patient chooses where they get their care, and patients will turn to their most trusted advisor, the family Doctor. Rather than fear the administration, we wonder whether we should welcome the empowerment potential of this initiative.

The new General Practice Contracts; Specialist PMS; Alternative Provider Medical Services

There are now limits to what a practice can be expected to deliver for a flat fee. All the talk has been of GMS2 and PMS2, but the new contracts of relevance here are SPMS and APMS. SPMS means that teams can come together from differing practices, or even primary and secondary sectors to deliver care. Patient choice means that funding must follow the patient, and payment by results means a flat financial playing field. So far so good, but another player has been invited onto the field in the shape of APMS.

This means that no longer do the practices hold a monopoly on community services. The commissioners have a duty to ensure best value for money. It is possible that these community services could be created under a locally enhanced service, but all enhanced services are voluntary. Therefore to ensure equality of access (clearly essential under patient choice) then either all practices would need to partake or some practices would need to provide services for others. It would need to be decided locally which contracting method was most appropriate.

Practice Based Commissioning

It is only against this context that we can understand the potential of practice based commissioning.

Payment by results means a fixed cost, patient choice means options for patients, SPMS & APMS mean that services can be provided in the community. Practice based commissioning is the framework by which clinicians and managers come together to create a contractual framework to deliver the services that the practices and the patients want as opposed to what is on offer as we have to deal with it now.

But it is not all good news. Under PBC the practices will be offered a budget that they will be expected to live with. Detailed guidance is currently awaited from the DoH concerning this, and of course there will be a significant amount of devil in the detail.

Practices will be expected to spend this money wisely on behalf of their patients. Wisely will include:

- Quality: The practices know which services suit which patient. They also know where there is no service that suits patients.
- Responsiveness: Some patients will choose short waiting times, others local services.
- Effectiveness: Are outpatient attendances to see an SHO to be told "Go and see your doctor for a sicknote" best use of taxpayers money ?
- Efficiency: This means that when it is better to provide services in the community that is what should happen.
- Responsibly: Practices will be expected to plan and to be accountable for use of taxpayer money.

In conclusion

Practice based commissioning offers massive potential for the practices, but if not handled correctly some hazards. Successful implementation requires a quantum jump of management capability in a group that is already undergoing massive change in the new contracts and are already fatigued by the increasing commercialisation which is required of them. Quite simply, some of us didn't go into medicine to be anything other than first class clinicians and requiring us to be managerial is not the same as making us managers. And yet, PBC does represent the opportunity to combine power and responsibility in the system to deliver the clinical outcomes which we seek. In the light of that, acquiring the managerial capability to operate effectively in this new world seems a small price to pay for the freedom to do the right thing.

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