

Practice Based Commissioning



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In October 2004 the Department of Health published a paper entitled "*Practice based Commissioning: Engaging practices in commissioning*" (1) the purpose of which was to outline on how the Department of Health means to support the Minister of State's stated aim "*To extend to all patients the benefits, but not the disadvantages of GP fund holding*". (2)

The questions begged by the paper are around the implications of this are for front line primary care trust managers and anything approaching a definition of Practice Based Commissioning might represent.

In thinking about these questions, we have identified a number of key elements to gaining an understanding of at least some of the implications of this new direction.

Context

The Minister refers to general practice fund holding. This was one of the manifestations of the purchaser-provider split that was introduced into the National Health Service in 1991. In its time it was revolutionary and here have been many studies assessing the impact of this organisational change. They are reviewed by Smith et al (4) who observe that these changes in structures were not isolated events and it is therefore difficult to allocate changes in outcome to one individual change in system. With those caveats however they observed that there were studies that implied:

- Faster admissions (5)
- Reduced pharmaceutical spending (6)

Which resulted in an unequal access to secondary care (7). It should be noted that the improvements in access of the authors own patients provided a significant part of the evidence of this Audit Commission report.

With the inclusion of emergency care and the further blurring of the primary secondary care divide the introduction of primary care led commissioning has more in common with total purchasing pilots than with general practice fund holding. It is when reviewing this data that Mays demonstrated the link between an organisations ability to achieve its commissioning objectives, and its per capita management costs (8).

The evidence from the past cannot be imported to the future without due consideration of the changes in the health service management environment, not turning now but during the time frame during which Practice based Commissioning is to be implemented.

The combination of "foundation trusts" and "payment by results" places the PCT finance departments responsible for funding clinical activity without the protection of contractual floors and ceilings (9). The financial regime of Practice based Commissioning does not reduce this risk, the risk of overspend is left with the Primary Care Trust and the benefit of under spend is shared fifty-fifty with the practice. The operational regime of Practice Based Commissioning reduces this risk significantly by providing information to those individuals who are responsible for instigating passages of care feedback on the consequence of those actions. Clinicians are interested in getting the most number of patients the maximum amount of benefit.

Commissioning

Commissioning is a term that has arisen out of the use of the word "purchasing". Purchasing was the coinage of the late 1980s to describe the process of securing the provision of clinical services that satisfied quality and value for money criteria. "Commissioning" is used to describe a more sophisticated derivation of "purchasing", implying an assessment of the

health needs of the population, and the purchasing of services to meet those needs, as part of a strategic effort to promote health. (3)

Smith et al (4) bypass this problem of definition to create a new definition of 'primary care led commissioning':

"Commissioning led by primary health care clinicians, particularly GPs, using their accumulated knowledge of their patients' needs and of the performance of services, together with their experience as agents for their patients and control over resources, to direct the health needs assessment, service specification and quality standard setting stages in the commissioning process in order to improve the quality and efficiency of health services used by their patients".

So we are left with the conclusion that commissioning represents the empowerment and liberation of the tacit knowledge base vested in GPs for the benefit of patients.

Empowerment

The initial stage of empowerment is to provide the practice with information and comparison with their peer group. This will provide the self motivated and well organised practice with the impetus for reflection and change, but it may not provide the necessary organisational power to achieve the whole system changes that are required to improve the patient experience.

By granting clinical staff authority over resource allocation, their ability to manage and lead change will be greatly enhanced. The Department of Health plans to do this by directing the Primary Care Trusts to provide a firm indicative budget for the practice that *"they would use to directly manage the delivery of services (secondary and/or primary care) for their patients"*.

Liberation

The departmental guidance is clear in that *"the scope of this a budget is for an individual practice or a group of practices to determine"*. This implies that in the initial stages of developing Practice Based Commissioning the practices are free to target their resources at changing the health care system where it most needs the change. It is expected that after 3 years practices will take over budgets that cover *"the entire scope of health care provision with the exception of a few highly specialised services"*.

Implications

The evidence is that involving clinical staff in commissioning produces enhanced outcomes for patients. How can this best be achieved ?

In simplistic terms the provision of an indicative budget meets the guidance from the Department of Health. This alone may be all that well organised practices with highly internal levels of management capability may need.

It is clear, however, that not all practices have this capability and it is the vision of the Minister to roll out improved systems for all patients.

There is an assumption that clinicians will step forward to take on these extra burdens. This should not be viewed as guaranteed. The practices are engaged with the massive changes required to implement nGMS/nPMS and may not have the capacity. The NHS Confederation has made the observation that the aspirations of Practice Based Commissioning are similar to the aspirations of primary care trusts. Care should therefore be taken not to replicate the conditions which have inhibited the trusts in the Practice Based Commissioning models (10).

There will be some practices that will need to develop more than others to embrace this challenge. These practices will need to be incentivised and supported in all that those verbs mean, not just in financial terms. Practitioners waste time due to inefficiencies within the health care system; they are exposed to professional risk by systems that expose their patients to clinical risk and they are de-motivated by a system that fails to acknowledge their

expertise (11). Practice Based Commissioning has the potential to move away from this and motivate practitioners by:

- Increasing the ability of the system to respond to the needs of the patient rather than the provision of this system.
- Improving integration of patient care, reducing the risks of transition from primary to secondary care.
- Empowering practitioners to make the multiple small improvements that are the hallmark of continuous quality improvement (12).

It is true that delivery of these incentives will require financial resources. It is not true that the delivery of financial resources will provide these incentives.

Therefore NHS managers must provide the resources for system change. The Department of Health paper is direct about the requirement to develop the skills of practice management. This is not the same as developing practice managers, but requires development of the practice team as a whole. Most of the practices are owned by medical staff and it these medical staff that provide the leadership within the practice. For these leaders to enable and manage change effectively they need time, space, development and managerial support in a way which is unparalleled in this environment.

Conclusion

Practice based Commissioning is a management initiative designed to increase the ability of key primary care clinicians to commission services for their patients. Unlike previous initiatives the government wishes to roll out these benefits to the patients of all practices no matter the practices current capacity to deliver. This is an ambitious target.

Evidence supports the premise that there are benefits from enhanced clinical involvement for the patient and the Health Community as a whole and the challenge for NHS managers is to make it happen.

This is a further change for practices that are already involved in massive change. Many at work on those practices now view their core mission as responding to those who are, or who feel that they may be unwell. The skills required to commission health care are different, new and challenging. The default setting for all human beings in such circumstances is resistance.

This places a responsibility upon the primary care trusts to lead the development of the practices such that the decision-making process is brought as close to the patient as is possible. This development programme will need to include transactional elements such as budgeting, business planning, and service monitoring but more sophisticated solutions than management education for those who do not feel motivated to manage must be found. Doing what has been done before will bring the same outcomes as those initiatives which have gone before and if the benefits of Practice Based Commissioning are to be felt by the patients and the Health Economy then a new way must be found to engage the practices in the changes and leadership demands which are going to be placed on them.

References

1. Department of Health (2004) *“Practice Based Commissioning: Engaging the Practices in Commissioning”* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4090357&chk=p7UCbg Accessed 25 November 2004
2. John Hutton, Minister of State for Health. *Hansard HC* 11 Nov 2004 col. 958.
3. Ovretveit, J., (1995) *Purchasing for health: a multi-disciplinary introduction to the theory and practice of purchasing* Open University Press, Buckingham
4. Smith J, Mays N, Dixon J, Goodwin N, Lewis R, McClelland S, McLeod H, Wyke S. *A review of the effectiveness of primary care-led commissioning and its place in the NHS.* www.health.org. Accessed 18 Nov 2004
5. Propper C., Croxon B., Shearer A (2002). *Waiting times for hospital admissions: the impact of GP fund holding.* Journal of Health Economics. 21 227-252
6. Baines D, Tolley K, Whynes D. (1997) *Prescribing budgets and fundholding in general practice* London. Office of Health Economics
7. Audit Commission (1996) *What the Doctor Ordered, a study of GP Fundholders in England and Wales.* London HMSO.
8. Mays N, Wyke S., Malbon G, Goodwin N. (2001) (eds.) *The Purchasing of Health Care by Primary Care Organisations; An evaluation and guide to future policy.* Buckingham, Open University Press.
9. National Primary and Care Trust Development Program *“The Finance Friend For PCT’s”* http://www.natpact.nhs.uk/uploads/finance_friend.pdf Accessed 23 Nov 2004
10. The NHS Confederation. *Practice Based Commissioning; Comments on the Guidance* http://www.natpact.nhs.uk/uploads/2004_Nov/NHS%20Confed%20PBCommissioning.doc. Accessed 25 Nov 04
11. Smith, R., (2001) “Why are Doctors so unhappy?” *British Medical Journal* 322 pp1073-4
12. Slack N, Chambers S, Johnston R, (2001) *Operations Management* Pearson Education, Harlow.