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PRACTICE-BASED COMMISSIONING

From good idea to effective practice

Practice-based commissioning (PBC) receives widespread support among the main political parties and important NHS stakeholder groups. Given this consensus, why has implementation of this apparently popular policy been such a struggle? Although the NHS now boasts 'universal coverage' of PBC, in practice this means the creation of an environment in which PBC *could* flourish rather than one in which it *is* flourishing. As yet, active commissioning by general practice teams is not widespread. Given that PBC was first mentioned in the 1998 White Paper, *The New NHS* (Department of Health 1998), and that it is now nearly three years since the first dedicated guidance on PBC was launched (Department of Health 2004a), it is fair to say that implementation has not been rapid.

Of course, it is possible to advance many reasons why this is the case. Primary care trusts (PCTs) have been in the throes of reorganisation since the summer of 2005. They have had other pressing issues to deal with, not least of which is ensuring financial balance on top of meeting other national targets such as the achievement of a maximum wait between referral and treatment of 18 weeks. Although these may all be 'good' reasons, they hide a disappointing truth: many PCTs currently see PBC as 'something else that needs to be done' alongside a wide range of other targets. In fact, PBC should be the vehicle through which these important objectives are delivered.

This paper considers the current state of PBC implementation and how it might be driven forward within the NHS. It is informed by the results of a 'straw poll' of GPs and practice managers designed to gauge opinion on the front line. From this we have distilled a course of action that the NHS could adopt to move PBC from good idea to effective practice. The ideas in this report have been tested with a group of GPs and practice managers but ultimately are the responsibility of the authors alone.

About practice-based commissioning (PBC)

What is PBC intended to do?

PBC is the devolution of commissioning roles from primary care trusts (PCTs) to general practice teams, together with financial accountability for 'indicative budgets' (although practices manage their use of resources, formal financial accountability remains with the PCTs). The Department of Health (2004b) has identified a number of objectives to be delivered through PBC:

- a greater variety of services
- services delivered by a greater number of providers and in settings that are closer to home and more convenient to patients
- more efficient use of services
- greater involvement of front-line doctors and nurses in commissioning decisions.

Perhaps more importantly, however, PBC is intended to strengthen the power of commissioning, relative to providers. The lack of commissioner bargaining power is widely regarded as a key weakness in the current market-based reforms of the NHS; indeed, it has been considered a weakness since the first purchaser-provider split in 1990.

This weakness is fast becoming ever more significant as other elements of NHS reform mature – in particular, Payment by Results (PbR), patient choice, and the liberalisation of market entry for both public and private providers. In this context, PBC is an important component of an overall 'demand management' strategy – controlling the growth in demand for elective services that may be brought about by a combination of better access and incentives for providers to increase activity (under PbR, hospitals are paid for each procedure or hospital stay provided).

For emergency care and long-term conditions, PBC is intended to shift the emphasis of care from reactive treatment to proactive prevention and health promotion. It is expected that PBC will lead to better 'upstream' management of patients, reducing episodes of ill health and their associated costs.

To engage primary care providers in PBC, they are given an indicative budget with which to commission care for their patients from the providers of their choice. Under national guidelines, primary care providers are able to keep 70 per cent of any underspend that they accrue to reinvest in patient services.

PCTs still have important commissioning roles to play: they must agree an overall strategic commissioning framework; agree and monitor contracts with providers (putting into effect the commissioning decisions

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of PBC); and, crucially, support the development of PBC and hold it to account. This support should include the provision of indicative budgets, information about finance and activity, managerial and analytical support and incentive schemes to encourage engagement with PBC within general practice.

Will PBC work?

PBC involves the deployment of a range of financial and non-financial incentives (see Table 1, below). These incentives can be ‘direct’ (that is, a payment to undertake a task) or ‘indirect’ (a benefit that may be implicit in or a by-product of the primary task). PBC applies potentially powerful non-financial incentives and, by delegating commissioning power to GPs, professional autonomy is increased. The ability to improve the patient experience through commissioning may likewise be an important indirect non-financial incentive.

Of course, PBC also applies financial incentives. The most obvious of these was the national, and now local, incentive payment in return for participation in the initiative. However, indirect financial incentives may also apply: practice-based commissioners may commission services from themselves, receiving payments as providers; they may also use budget surpluses to improve in-house services in which they have an interest (for example, by off-setting costs that previously they had to bear themselves).

Whether or not these incentives are sufficient to achieve the aims of PBC remains to be seen, however. Likewise, it is not yet clear whether the right balance between financial and non-financial incentives has been reached. The economic literature suggests that financial incentives can ‘crowd out’ non-financial incentives (Marshall and Smith 2003), as we discuss later.

TABLE 1: INCENTIVES FOR GPs TO ADOPT PBC

	Direct incentives	Indirect incentives
Financial incentives	National/local payment for undertaking PBC	Use of budgetary surpluses Opportunities to act as providers
Non-financial incentives	Higher levels of autonomy	Potential for improving patient care

There may be doubts as to whether the theoretical financial incentives will work in practice. For example, where PCTs are overspent, there seems little realistic prospect that surpluses at the level of an individual practice will be made available for local use, despite reassurances from the Department of Health. After all, PCTs have a statutory duty to break even in any given year.

It is also not clear whether recent increases in GP remuneration will dampen the effect of financial incentives. (Do GPs effectively have a 'target income' that they have already reached?) However, the positive response among GPs to the Qualities and Outcomes Framework (part of the GP contract (Department of Health 2005)) at least indicates that financial incentives linked to service quality have a powerful effect.

Notwithstanding these questions, there is reason to be optimistic that PBC will deliver at least some of the benefits anticipated by the government. Reviews of evidence of earlier initiatives of practice-centred commissioning (GP fundholding (GPFH), total purchase pilots (TPPs) and GP commissioning pilots) conclude that primary care-led commissioning has resulted in lower rates of hospital admission, lower prescribing costs and innovative primary and intermediate care (Lewis 2004; Smith *et al* 2004).

To translate these gains into a PBC context, however, there are a number of practical challenges to overcome. First, for PBC to be effective, GPs require accurate and timely data about costs and hospital usage. At present, data-sharing procedures within PCTs are not well developed and there are issues with data quality that must be overcome. Second, previous research suggests that organisational stability is required for effective primary care commissioning. Recent PCT reorganisation has led to instability and, although new PCTs are now in place, there is a continuing period of flux while new arrangements are embedded.

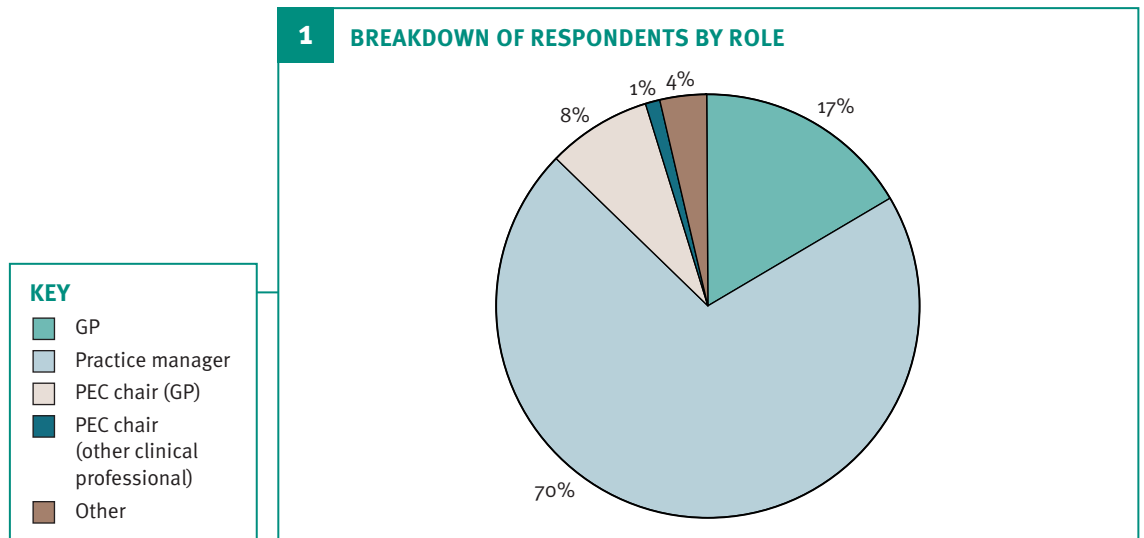
A bigger challenge, however, is likely to be the effective engagement of all GPs. In part, this will rely on the right blend of incentives as discussed above. However, it is also likely to be affected by the willingness and capacity of PCTs to provide support and to 'let go'.

It is likely that PCTs will use a variety of approaches to PBC development, piloting different models within their own area. In the absence of a single model sponsored by the Department of Health, an organic growth in this new phenomenon can be expected, with PCTs and practices implementing PBC in a variety of ways. There is the potential for mixed results and there are important lessons to be learnt and shared across the NHS.

What is happening on the ‘front line’?

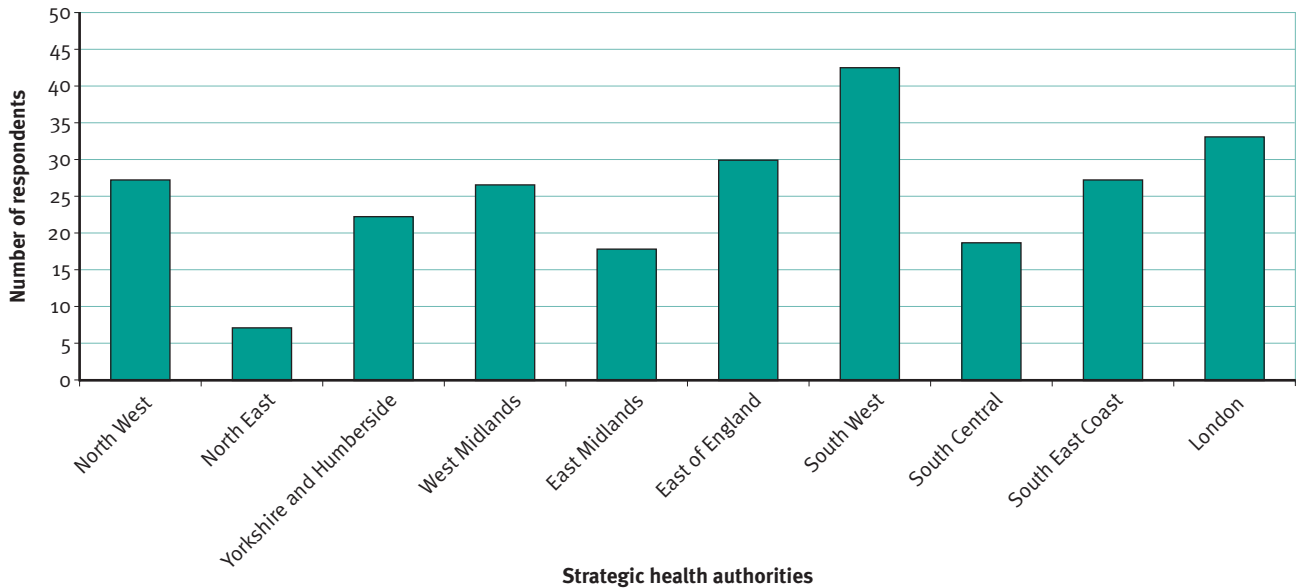
A brief questionnaire was emailed to more than 600 members of PBC and practice management networks run by the NHS Alliance (the questionnaire was forwarded to other networks, so the total number of people receiving the survey is unknown). We received 257 responses. We describe this questionnaire as a ‘straw poll’; it is not a representative sample and we do not claim that the results necessarily represent the views of the wider GP and practice manager community. However, we do believe that they give a valuable insight into the views of the general practice ‘front line’.

Of those who responded, 70 per cent were practice managers and 25 per cent were GPs (see Figure 1, below).



All of the strategic health authorities (SHAs) were represented in the answers, although respondents were not evenly spread: the highest number of respondents came from the South West SHA (43) and the lowest number from the North East SHA (7) (see Figure 2, overleaf). As a result of the relatively low numbers involved, no SHA-level analysis has been attempted.

2 NUMBER OF RESPONDENTS BY STRATEGIC HEALTH AUTHORITY



Support from PCTs

The results of the survey revealed some interesting details about the current state of PBC implementation.

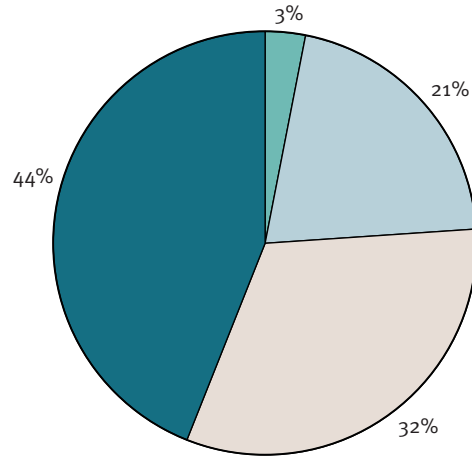
Respondents were asked about the information that they receive. Of the 164 people who responded to the question about secondary care activity data:

- 89 per cent reported that they are receiving information about secondary care activity
- 55 per cent of those who receive information about secondary care said that they find it 'quite useful' or 'very useful'.

When asked about PCT support, responsiveness and involvement in planning (see Figures 3–5, opposite), most respondents offered negative responses:

- only 3 per cent said that they felt their PCT involves them in strategic planning to 'a great extent' and 21 per cent 'to some extent'
- 30 per cent of respondents consider the support given by their PCT 'quite good' or 'very good' with 33 per cent rating it 'poor'
- 4 per cent find their PCT to be 'very responsive' and 28 per cent 'quite responsive' but 19 per cent find their PCT to be 'not at all responsive' to issues raised by them.

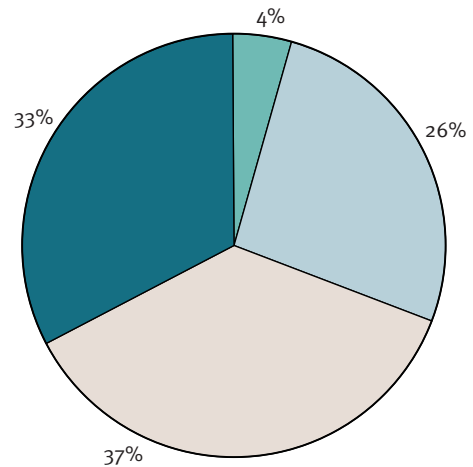
3 EXTENT TO WHICH RESPONDENTS FEEL INVOLVED BY PCTS



KEY

- To a great extent
- To some extent
- Not very much
- Not at all

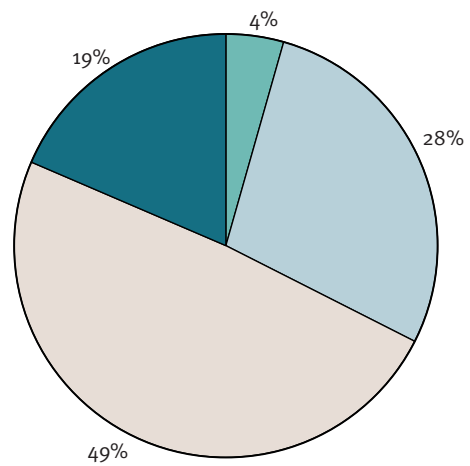
4 RESPONDENTS' PERCEPTIONS OF THE QUALITY OF SUPPORT OFFERED BY PCTS



KEY

- Very good
- Quite good
- Not very good
- Poor

5 RESPONDENTS' PERCEPTIONS OF THE RESPONSIVENESS OF PCTS



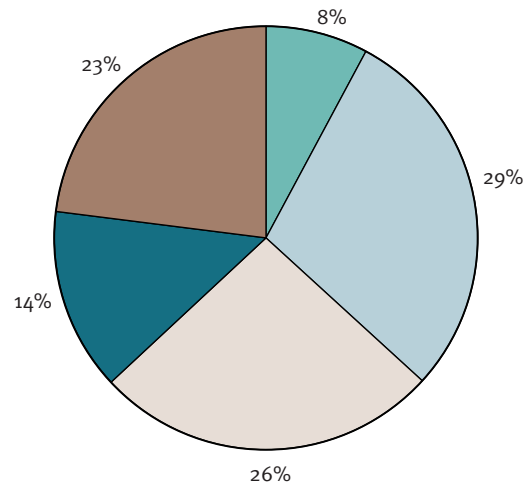
KEY

- Very responsive
- Quite responsive
- Not very responsive
- Not at all responsive

Budgets and financial incentives

- Almost a quarter said that they are not receiving budgetary or financial information. Of those who are receiving it, 40 per cent reported finding it 'not very useful' or 'not at all useful' (see Figure 6, below).
- Seventy per cent of respondents said that they do not have a budget agreed with their PCT for 2006–7.
- Of those who do have a budget, 37 per cent do not fully understand how it has been set (see Figure 7, below).

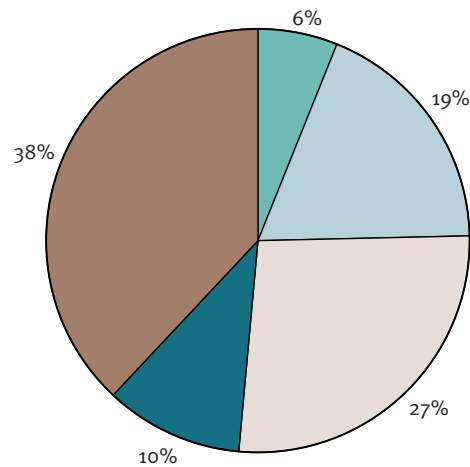
6 RESPONDENTS' VIEWS OF THE USEFULNESS OF THE BUDGETARY/ FINANCIAL INFORMATION THEY RECEIVE



KEY

- Very useful
- Quite useful
- Not very useful
- Not at all useful
- Not receiving this

7 RESPONDENTS' LEVEL OF UNDERSTANDING OF HOW THE BUDGET WAS SET



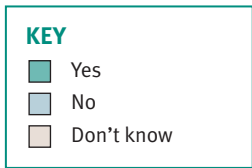
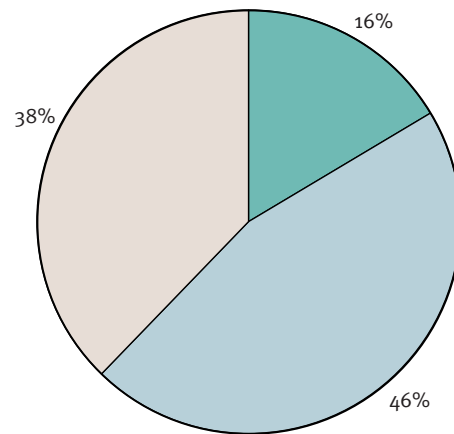
KEY

- Very well
- Quite well
- Not very well
- Not at all
- Not applicable

Respondents were asked whether they expect to underspend this year and, if so, whether they expect to be able to keep 70 per cent of the surplus, as set out in the Department of Health guidance:

- Fourteen per cent of respondents (35 of those who answered this question) do not expect to underspend this year.
- Of those who expect to underspend, 16 per cent (35 respondents) expect to be able to keep 70 per cent, 46 per cent do not expect to keep 70 per cent and 38 per cent do not know (see Figure 8, below).

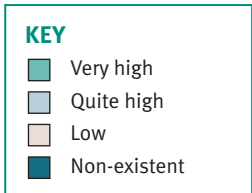
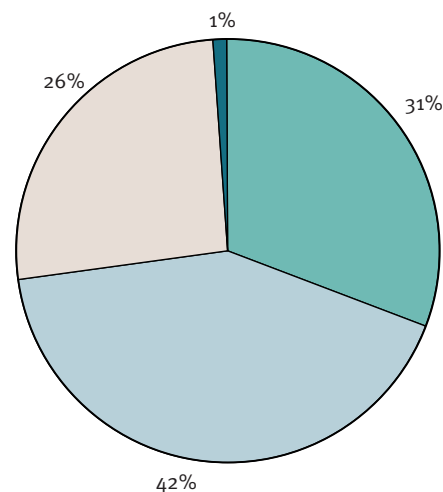
8 RESPONDENTS' EXPECTATIONS OF KEEPING 70 PER CENT OF UNDERSPEND



Commitment to PBC

The majority (73 per cent) of respondents reported a 'very high' (31 per cent) or 'quite high' (42 per cent) commitment to PBC (see Figure 9, below).

9 RESPONDENTS' LEVEL OF COMMITMENT TO PBC

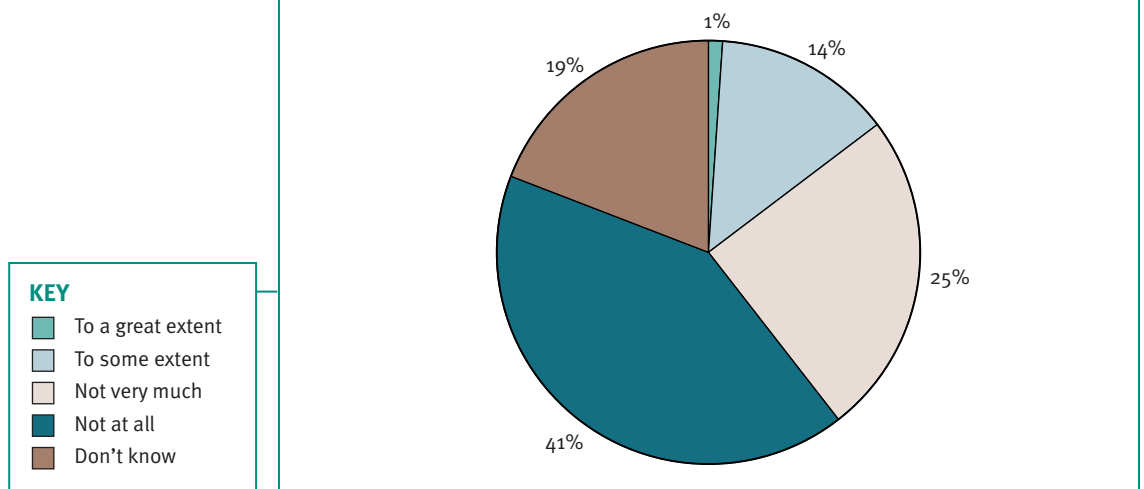


Is commissioning working?

Responses were relatively mixed about the impact of PCT-negotiated contracts on the quality of patient care (see Figure 10, below):

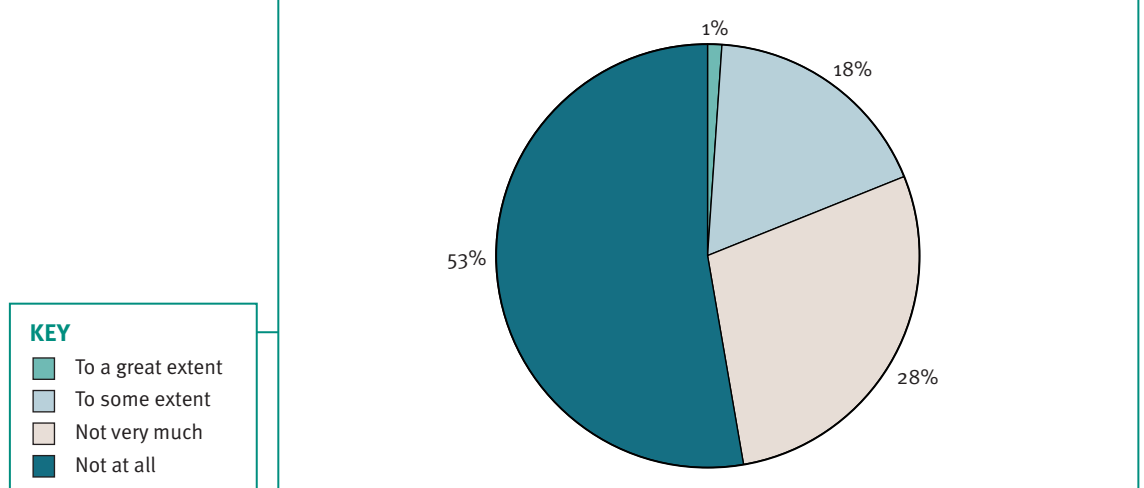
- Fifteen per cent felt that contracts had improved care, but almost a fifth of respondents did not know and 41 per cent thought that contracts had not improved quality at all.

10 RESPONDENTS' VIEWS ON THE EXTENT TO WHICH PCT-NEGOTIATED CONTRACTS HAVE IMPROVED THE QUALITY OF PATIENT CARE



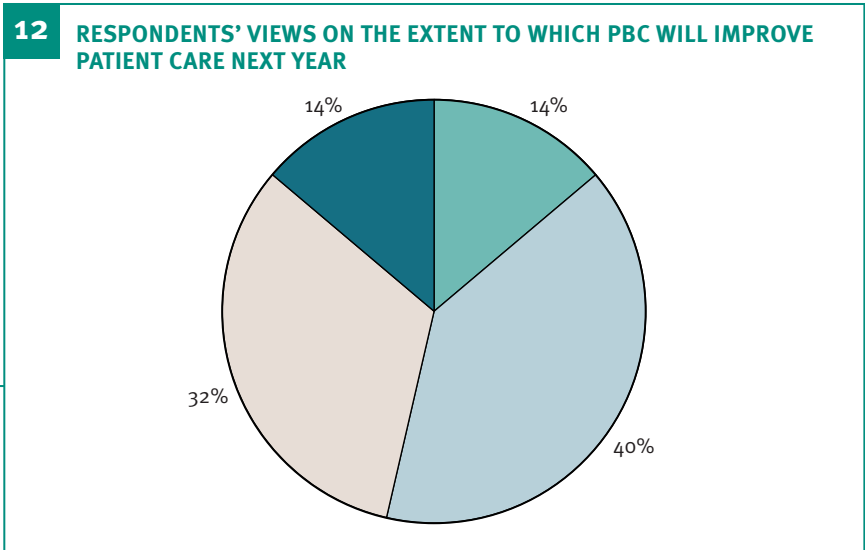
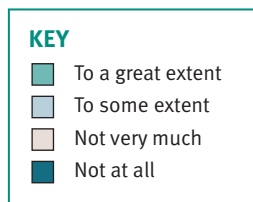
When asked about the impact of PBC on patient care, 53 per cent of respondents reported that, to date, PBC has had no impact on improving care (see Figure 11, below). However, responses are markedly more positive to the question of whether PBC will improve the quality of care in future (see Figure 12, opposite).

11 RESPONDENTS' VIEWS ON THE EXTENT TO WHICH PBC HAS IMPROVED THE QUALITY OF PATIENT CARE TO DATE



12

RESPONDENTS' VIEWS ON THE EXTENT TO WHICH PBC WILL IMPROVE PATIENT CARE NEXT YEAR



Barriers to effective PBC

Respondents were asked whether there were any barriers that could prevent them from becoming effective practice-based commissioners. Of the respondents, 186 (72 per cent) indicated that they thought there were barriers. A summary of these barriers, as perceived by respondents, is presented in Table 2, below. As Table 2 indicates, almost 40 per cent of

TABLE 2: BARRIERS CITED BY RESPONDENTS TO THEM BECOMING EFFECTIVE PRACTICE-BASED COMMISSIONERS

Barriers	Number of respondents*	Percentage of total number of respondents (186)
Lack of PCT support/excessive bureaucracy/PCT turmoil	73	39%
Financial constraints/short-termism	42	23%
Lack of information/poor-quality information/poor IT	30	16%
Lack of time	20	11%
Lack of GP engagement/low morale/GPs lack of power/GPs lack of knowledge	15	8%
Insufficient incentives	8	4%
Lack of co-ordination/lack of communication	8	4%
Other	8	4%
Impact of Payment by Results/unhelpful attitudes of secondary care professionals	6	3%
Lack of space/poor-quality facilities	4	2%

* Some people provided more than one response, so the numbers do not add up to 186.

those who responded to this question cited the PCT as a barrier to effective PBC. Respondents felt that the lack of PCT support, PCT reorganisation and high levels of bureaucracy were to blame. The second most frequently cited reason was financial constraints – many felt that their PCT's financial situation and short-term financial solutions were having a negative impact on PBC. Many respondents said that they do not receive sufficient, or sufficiently good-quality, information from their PCT and 20 felt constrained by a lack of time. Several reported that GPs in their area are apathetic or not engaged and that PBC consortia lack the requisite power to make real decisions. Others feel that the pull of PbR and, in some cases, the hostile attitude of secondary care staff are creating barriers to effective PBC.

What needs to be done to speed up implementation?

Our 'straw poll' underlines the challenge that lies ahead for the NHS. PCTs have not had sufficient time to develop their capacity to support PBC. GPs and practice managers have reported that there are serious issues with data quality and the time lag involved in receiving data. Many GPs and practice managers perceive PCTs as unsupportive and lacking in strategic direction.

In many cases, the lack of an enabling environment is a reflection of organisational turmoil within some PCTs, rather than a lack of commitment among managers. New senior teams are only just in place in many PCTs and they need some space and time to steady their ships and ready their crews.

However, the current lack of progress has been exacerbated by tensions between practice-based commissioners and PCTs over the evolution of commissioning roles. Commissioning relationships need to be defined at different levels:

- across several PCTs
- between health and local authorities
- at the level of the single PCT
- at the level of PBC.

How these relationships will be defined will depend on local context. For example, in London (with 31 relatively small PCTs) collective arrangements across PCTs to discharge some commissioning functions are emerging.

Yet it is important for all PCTs to understand that PBC should not diminish but strengthen them. PCTs can and should set the overall strategic framework within which PBC must operate. This is a key role for them and their strategy should be founded on a dialogue with their community and other stakeholders (including practice-based

commissioners). The Professional Executive Committee (PEC) will support the PCT board and ensure that such a strategy is clinically informed. For their part, practice-based commissioners are well placed to design services and respond rapidly to patients' needs, while giving due regard to the strategic boundaries. In this way, PBC and PCTs can create a powerful commissioning synergy – they should not be fighting for the same air-space.

The very nature of commissioning remains elusive for many, although the Department of Health (2006a) has made some progress here with recent guidance. As 'patient choice' becomes ever more pervasive, the role of the commissioner shifts from one of directing patients to services, to one where the right 'menu' of service options is created (Smith *et al* 2006). This shift implies that new commissioning skills will be needed at both the PCT and the PBC level.

If PBC implementation is lacklustre, to what extent does the answer lie with further incentives aimed at GPs? It may be tempting to see a hardening of financial incentives as the easy answer here. After all, have financial incentives not seen a rapid improvement in chronic care through the GP contract's Quality and Outcomes Framework? However, caution is required. First, it is likely that new direct financial incentives will have diminishing marginal returns, particularly as GP incomes have risen rapidly. Further, there is evidence that financial incentives will substitute for, rather than add to, non-financial incentives (Marshall and Smith 2003). In other words, by making PBC all about money, we may drive out equally powerful professional motivations for using PBC to improve patient care. Perhaps the most powerful incentive for practice-based commissioners is to ensure that their initiatives and innovations are acted on quickly by PCTs and turned into real improvement for patients. PCTs need to harness the professional competitiveness of GPs and to foster a sense of pride among them for their PCT. Getting the right balance between financial and non-financial incentives is therefore crucial.

A large proportion of GPs are committed to the concept of PBC, but it appears that some are cautious about engaging in it. Many GPs who have actively engaged in earlier forms of practice-level commissioning fear that PBC, like GP fundholding and primary care groups, might be short-lived. These fears will hold back implementation, although recent public commitments to PBC by ministers should begin to create more confidence in its future (indeed, PBC looks likely to survive any change of government).

However, even low levels of active engagement among GPs does not necessarily mean that PBC is doomed to fail. In reality, effective PBC does not require all GPs to play a major role in it. Rather, it depends upon a relatively small number being prepared to lead and, crucially, being able to engage with their peers. The pacing of implementation and the

support given to GP leaders is critical. PBC leaders need a point of contact at the PCT who is senior enough and sufficiently skilled to make change happen. Sufficient local momentum behind PBC is needed to embed it; however, early expectations of GPs should not be so daunting that they feel that it is too much too soon.

To achieve any level of engagement among GPs, ‘quick wins’ are needed. These will vary locally (although there are many instances of PBC-led initiatives available to be shared nationally, for example, by the Improvement Foundation). Early successes will create confidence that PBC can deliver but will require focused support from PCTs: management support, good information, rapid assessment and approval of PBC business plans. All these elements, our ‘straw poll’ suggests, are currently deficient.

PCTs that legally have to break even every year also face financial incentives to engage with PBC. However, at times these incentives may feel perverse. The over-riding need to deliver annual financial balance – even a surplus – may force them to favour short-term projects over those that will take longer to pay their way. They may also become very risk averse, with a consequent stifling of innovation.

In this climate, PCT interest is likely to focus on ‘demand management’ (in particular, reducing inappropriate referrals to or admissions by those who use secondary care). This activity is valuable, but is only one element of PBC. Where practice-based commissioners want to embark on a radical redesign of services, significant up-front financial investment may be required with returns delivered only later. The most substantial innovations may see investments required in one financial year and savings made in another – a difficult pill to swallow for cash-strapped PCTs. If PBC is to unleash the creativity hoped for and not be confined to the margins, PCTs will need to hold their nerve and be prepared to back schemes that look like promising outsiders.

The government has rightly signalled that NHS performance in commissioning must improve. More work is needed to ensure that progress in this regard can be measured and commissioners held to account. So far, the NHS has been measuring things of dubious value, such as the uptake of incentive schemes, although new ‘metrics’ for PBC developed by the Department of Health (2006b) are a promising improvement. More emphasis is needed on ensuring that the building blocks of PBC are in place (such as good-quality information and robust budgets). But, ultimately, commissioners should be judged on whether or not patient services and patients’ health are improving. SHAs need to monitor progress on PBC closely and ‘get their hands dirty’ by really testing out the quality of support offered by PCTs. This also means that SHAs may need to give more priority to their work in primary care, given the pervasive perception that they devote more energy to issues involving acute hospitals.

Recommendations

Not all of the recommendations listed below are new; part of the recipe for effective PBC is already well known and has been set out in guidance issued by the Department of Health. However, the challenge is to ensure that these actions are implemented consistently across the NHS.



Putting the foundations in place

- PCTs and practices should ensure without delay that each practice has:
 - a mutually agreed budget
 - the right information presented in a useful way and a clear plan of how to use it
 - support to carry out PBC in terms of people, resources and protected time for clinicians
 - an incentive scheme, which encourages maximum input from its practice-based commissioners.
- PCTs and practice-based commissioners (with support from the Department of Health) should identify the core competencies required for PBC and construct a programme to develop those skills locally.



Getting the relationships right

- Practice-based commissioners and front-line clinicians need to be more involved in strategic commissioning as co-authors of the Local Development Plan (LDP). The LDP should be seen as an evolving process and should not become fossilised into an annual document. This will allow PBCs to deepen their engagement with strategic commissioning and to create a joint vision and shared priorities.
- PCTs should assign one or more senior officers to act as a key point of contact with practice-based commissioners, with the responsibility for facilitating two-way communication, decision-making and action.



Being held to account for PBC development

- PCTs together with practice-based commissioners should produce an annual report that itemises the changes to patient care or local health that have come about as a direct result of PBC during that year. To ensure that momentum is not lost, both PCTs and practices should aim for quick and visible wins, which will demonstrate the value of PBC and keep front-line clinicians engaged.

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Improvement and Commissioning Network

Julie Wood, Director of the NHS Alliance
PCT Chief Executive Network and of the
NHS Alliance Practice-based
Commissioning Federation



Fostering innovation

- PCTs should consider establishing an 'innovation risk fund', which can be called upon to underwrite the risk of innovative PBC plans that might otherwise be put on hold in a risk-averse environment. Where PCTs face acute financial challenges, resources for this fund might be made available by the SHA as part of a recovery plan for the PCT.
- In the longer term, the Department of Health should explore whether PCTs might be allowed a three-year financial cycle within which they must break even, offering greater flexibility to 'invest to save' and bringing them more into line with the approach adopted for foundation trusts. Giving PCTs more scope to exercise financial responsibility is consistent with the idea that commissioning is 'growing up'.



Promoting the vision

- Ministers, the Department of Health and SHAs must all continue to articulate the importance of PBC and ensure that it is seen as the heart of the NHS commissioning function. More work is needed to provide a clear vision of how commissioning will drive improvement as the NHS market evolves.



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