Practice-based commissioning: implications for secondary care

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ABSTRACT – General practitioner (GP) practice-based commissioning (PBC) is a much debated politically driven NHS innovation at a time of ongoing change. Unlike GP fundholding it is envisaged that PBC will involve all GP practices by 2008. A possible outcome is that some current secondary care services may be commissioned in primary care in the form of local enhanced services or intermediate clinics and run by GPs with special interests. Examples where this has occurred are diabetes and anticoagulation. Similarly, private providers may be commissioned. Inevitably there will be an impact on hospital services through a possible reduction in funding and consultants being subcontracted to provide services in primary care. Issues such as clinical governance and cost-effectiveness, however, require evaluation to determine the potential effect on the working relationships and so the interface between generalists and specialists.

KEY WORDS: commissioning, enhanced services, fundholding, primary care, referrals

Background

Practice-based commissioning (PBC) is not a new concept and is not about new money. This initiative, first described in a 1997 white paper, sees primary care organisations (PCOs) extending indicative budgets to general practitioner (GP) practices for services.[1] The precedent for PBC came about in the early 1990s with NHS reforms, the creation of the purchaser–provider split and GP fundholding. Practice-based commissioning is different from GP fundholding as it involves the whole budget of a PCO and the services commissioned with that budget. Fundholding covered a proportion, approximately 25%, of secondary care services, did not involve all GP practices (all patients), there were different levels of fundholding and therefore inequities. Perhaps the greatest inequity was where the PCOs (then called health authorities or health boards) commissioned services for GP practices who did not wish to fundhold or were too small to do so.

Fundholding was abolished in 1998 and the 2004 *NHS improvement plan* stated that GP practices would be able to have an indicative budget from April 2005 to commission if they wished.[2] Fundholding was about referring patients to the cheapest provider but PBC, in theory, offers providers of the same quality with differing waiting times and locations and so, with the necessary patient information, will permit an informed choice of provider. Quality is to be ensured by guidelines such as National Service Frameworks[3] and those published by the National Institute for Health and Clinical Excellence.

Practice-based commissioning

In the late 1990s the concept of a purchaser–provider divide was no longer emphasised in an attempt to remove the idea of a competitive internal market. As a result, 'commissioners' replaced 'purchasers' and PCOs became the legal commissioning bodies. In an attempt to define PBC the Department of Health (DH) stated:

> *PBC is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions. PBC will lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want.*[4]

Theoretically, PBC is about GPs commissioning health services for their patients and ensuring that the needs of the local population are met in a cost effective and efficient way.

The gestation of PBC has been long and Julian Neal believes this is the result of the considerable overspends of strategic health authorities (SHAs) and a mismatch between expenditure and outcomes.[5] Similarly, the reported disparity between the patient experience and that of NHS managers has aggravated the issue. There is a belief by politicians that primary care will be able to commission reconfigured services and so control secondary care expenditure. Whether savings can be generated to the ultimate benefit of patients is unknown.

It might be said that the enthusiasm for PBC has been minimal in some areas, but with the

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Clin Med 2008;8:61–64

reconfiguration of SHAs and PCOs, the government recommended that PCOs must have arrangements to support PBC in place by the end of December 2006. General practitioners have had to sign complicated legal agreements with their PCOs stating their obligations before they take on PBC. Figures vary, but it is thought that up to 50% of GP practices were involved in the voluntary process of PBC by the middle of 2006. The figure is now thought to be as high as 95%, but a lesser percentage are thought to have received an indicative budget.

Local developments

Practice-based commissioning started in April 2005 with groups or consortia of GP practices analysing the budget held by a PCO for services currently commissioned with secondary care. One vision is that all services will be commissioned by these consortia, but to begin with they will choose two or three services to take on a budget and examine the choice available to provide that service. A current example is anticoagulation services. General practitioners will be directly involved in the process and so practices within consortia will need to work more closely to develop a collaborative and 'corporate' approach which will be a new ethos in primary care. Fundholding involved individual GP practices where profits could be used within the organisation. Practice-based commissioning has been referred to as 'ethical fundholding' because there are no personal profits for GP practices and underspends will go back into the service to fund management costs, and will be reinvested in patient care. In addition, there will be no competition between individual practices as a standard tariff for services will be negotiated according to its quality and defined parameters. These new services relocated in primary care are referred to as local enhanced services (LESs).

The success of PBC will depend on practices and organised consortia working in partnership with PCOs and engaging with patients to ascertain local needs. Inevitably, PBC will involve change for GP practices, PCOs and secondary care services and it will work in parallel with, not isolation from, other change, such as the directed enhanced service (DES), Choose and Book. The priorities will be patient choice and identified patient need and the success of PBC will involve engagement of all stakeholders. The change will be an opportunity to refocus and redesign services and it could be the framework by which doctors and managers work together on their contractual arrangements to deliver patient care.

Piloting

The initial process will be the piloting of agreed pathways in areas of care such as diabetes, dermatology and orthopaedics. Practice consortia and PCOs will be driven by two basic questions:

- Which services require 'enhancing'?
- What budget is currently available to support these services and can it be used more effectively?

Choose and Book will be a pathway to facilitate choice and will direct patients to particular services. It has received considerable opposition, however, not least because of the time pressure it places on GPs in already congested consultations by adding a further tier of administration. Practice-based commissioning is a potential catalyst for Choose and Book. Any negotiated budgets will remain the legal responsibility of the PCO, which will also meet any overspends, and so the process is 'risk free' for GP practices. As with all new government initiatives there are targets; PBC should have been made available to all GP practices in 2006 and all practices should be involved by 2008.[6]

There are many questions regarding the potential savings of PBC. Under commissioning rules, at least 70% of the savings can be reinvested into GP practice patient services, management costs and, possibly, premises. The final details of this, however, are being negotiated and GPs are worried that any savings may be used to make up for PCO deficits in other areas. Until this is negotiated many feel that incentives for PBC are poor and there are risks. Primary care organisations would retain the remaining 30% savings. Some localities are setting up referral management centres to monitor and divert referrals and in some cases clinical assessment, treatment and support services with investigations such as X-rays and treatment to implement alternative primary care services that could address the majority of referrals in particular areas, eg orthopaedics, dermatology or diabetes. The British Medical Association's General Practitioners Committee has negotiated a DES for 2006–7 for practices to agree a PBC plan with PCOs and thus a financial incentive for the staff time and work that will be generated to oversee the process. Given the deficits in PCOs budgets there has been little available for these pump-priming funds and a potential £1.90 per patient, to encourage GP practices to initiate PBC, has been the average national incentive.

Healthcare in community setting

A 2006 white paper, *Our health, our care, our say: a new direction for community services,* advocates healthcare to be increasingly provided in community settings.[7] This has been seen by government as an opportunity to counteract the system of Payment by Results (PbR) where a cash price is put on different items of secondary care work. The aim of PbR is to provide a transparent, rules-based system for paying NHS trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix. Importantly, this system should ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Some have argued that PbR has the potential to compromise the current NHS funding arrangements within the first decade of the millennium unless the risk of over activity is balanced against the development of more services outside a hospital setting, appropriate referrals, and an audit of current hospital data and activity.[8] It is anticipated that PBC will give GP practices more choice over where this work is performed, eg in primary or secondary care.

Practice-based commissioning could therefore be used to move patients through different pathways or primary care services to achieve the implementation framework laid out by the DH in May 2006.[9] The framework sets out how NHS organisations will deliver a maximum wait of 18 weeks for patients, from referral to specialist treatment, by December 2008. For this to be successful GPs will need evidence of the gain to their patients and that they will not be forced to deal with further paperwork and bureaucracy. The success of PBC therefore depends on a healthy partnership between PCOs and GP practices.

As a result the nature of health organisations will change and, depending on the commissioned services, it is likely that there will be a further growth of the independent sector as well as a number of new partnership arrangements.[10]

Implications for secondary care

The implications for secondary care are important as PBC examines alternative pathways to provide both diagnostic and treatment services. This may mean services alternative to those currently utilised in secondary care being commissioned. In terms of treatment, this could be the development of LESs called intermediate clinics run by PCOs and staffed by GPs with special interests (GPwSIs) and possibly consultants who are subcontracted to provide their specialist input in these clinics. Intermediate clinics are rapidly developing and are a real concept.[11] One GP has written that the most important issue is integrating specialist and generalist care where conflicting incentives in the current environment are 'currently pulling the two apart'.[12] The impact of PbR, for example, encourages acute hospitals to treat and admit increasing numbers of patients while the incentives for PBC are to reduce the demand for hospital services, frequently purported as being more expensive, and extend the scope and provision of this care in a primary setting.

Possible areas to save money are the triage of outpatient referrals, reduction of follow-up appointments, the use of intermediate clinics run by GPwSIs, the interception of consultant-to-consultant referrals, and consultants establishing clinics, again in GP surgeries, as was the case during GP fundholding. To reduce hospital workload, primary care triage is required at hospital accident and emergency departments and rapid response services should be introduced in the community to manage those with exacerbations of chronic illness. Furthermore, the use of community matrons should ensure optimal control of chronic conditions, such as chronic obstructive pulmonary disease and heart failure, and keeping such patient groups stable. There is no doubt that visiting the way GPs and their practices refer, prescribe and use hospital beds that alternative care pathways could be considered if they are to reduce NHS expenditure without compromising patient care. In these ways, PBC will inevitably impact on hospital services.

Clinical governance

The clinical governance arrangements for community specialist clinics need to be robust with adequate training, accreditation, ongoing continuing professional development, appraisal and supervision of GPwSIs. Audit is required to ensure that the new services are high quality and cost effective and that excellent care is provided to patients if they are to be an alternative to current secondary care services. A concern is the increasing competition between general practice, hospitals and independent providers. Will this plurality of providers lead to improved efficiency or a path to further privatisation and de-unification of the NHS? Ideally this may be combated by the formation of clusters of commissioning practices and so development of consortia for provision of specialist sessions and careful discussion and decision making with secondary care colleagues.

If PCOs franchise out services to intermediate clinics or private providers there is a threat to secondary care budgets, staffing, a defined patient workload and, as a result, training. It can be argued, however, that secondary care may take little notice as the GP practice budgets are indicative. Nevertheless, there is a potential threat that NHS trusts could lose part of their budget to fund PBC. This can only be justified if it can be proven that there is a significant reduction in expenditure through primary care intermediate clinics and provision of equal or better quality of care. Ultimately, shifting resources means disinvestment.

Ideally, there should be the potential through PBC to be able to focus both medical and social services on the needs of the local population and really begin to meet their needs. Practice-based commissioning should be called patient-based commissioning. A 'good commissioner is someone who knows the needs of the local population and is a good housekeeper' and ensures there are leftovers in the budget to meet the unexpected or to be creative.[13]

Political implications

Some politicians view PBC as the central pillar of the current NHS reform encouraging the progression of the market economy by using a plurality of providers and facilitating the transfer of more care from secondary to primary care settings through greater GP control of commissioning. The result could be GPs and consultants becoming opponents in a bidding war, rather than colleagues with different areas of competence who currently cooperate in the management of patients. This threatens the precious relationship that has served the NHS so well. Disintegrating secondary care services with a threat of private firms ultimately has a similar impact on primary care services. The role of the GP as the 'gatekeeper' will be lost to specialist services which could, ironically and potentially, escalate costs.[14] General practitioners will no longer have first refusal on provision of these services. Potential service redesign needs to be debated by PCOs, trusts, patient groups and GPs and this is being increasingly recognised by politicians.[15]

Conclusions

Practice-based commissioning should proceed with caution and be continually revisited as to its cost-effectiveness and quality of care. Commissioning practices may be viewed as care

entrepreneurs, providing new services for their local communities through their ability to reinvest surpluses in improving patient care. They may not, however, have adequate time and space to plan and create new services.[11] Similarly, there is need for improvements in the training, supervision and audit of commissioners.[12] Although PBC may have the potential to reduce emergency hospital admissions, lessen waiting times for non-emergency treatment, improve coordination of primary, intermediate, and secondary support services, and appropriately involve clinicians in the commissioning process, this has yet to be evaluated and proved. In addition, there are drawbacks which may include patient dissatisfaction, further management of healthcare and associated transaction costs, potential inequities of access to clinically indicated secondary care specialists and may culminate in the destabilising of secondary care.[16]

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