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Practice-based commissioning

INTRODUCTION

This article offers an introduction to practice-based commissioning (PBC) and its links to policy development.

It highlights the context for change, alongside a basic explanation of the mechanics of PBC and suggests some potential implications for the future.

CONTEXT FOR CHANGE

The publication of *Commissioning a Patient Led NHS (CPLNHS)* in July 2005 built upon the earlier publications of *Creating a Patient Led NHS* of March 2005 and *The NHS Improvement Plan* in June 2004.

At the heart of CPLNHS is the emphasis upon use of NHS resources to secure more efficient delivery of appropriate care for patients. PBC is seen as the route to this. GP practices were given the opportunity to manage indicative commissioning budgets from April 2005.

PRIMARY CARE COMMISSIONING

What's new?

GPs have for a long time been described as 'gatekeepers' to the NHS, given their role of making onward referrals of patients to secondary care for diagnosis or treatment.

In the early 1990s, the Conservative government introduced GP fundholding, to allow GPs to hold an agreed budget for a limited range of hospital, and later community (including mental health) services, with incentives to make cash savings within budgets that could go to practice partnership profits.

Later, total purchasing pilots (TPPs) were introduced, comprising one or a group of practices receiving a budget to purchase all of the hospital and community health services for their registered population.

In 1997 the new Labour government introduced GP commissioning pilots, to address wider population needs of around 100,000 patients.

These pilots heralded larger scale approaches to GP engagement in commissioning, such as primary care groups as subcommittees of health authorities.

Primary care trusts were introduced in 2001, allowing other primary care practitioners to become involved in decision-making and for more formal partnership working with social services.

Evaluations of TPPs and commissioning pilots indicated that there was inadequate information – such as formal assessment of population needs – when setting purchasing objectives.

Under all the commissioning models it is questionable to what extent primary care professionals have actually been able to influence and redesign health care, within a reportedly secondary care provider dominated model.

PbR

Payment by Results was introduced in 2004 as a new financing system for the NHS, which sets national tariffs for a range of hospital-based services such as emergency admissions and outpatients.

It has acted as catalyst for PCTs and practice-based commissioners to track resource utilisation and discuss how to redesign services. Shifting hospital care into the community and focusing on preventative care, particularly for long-term conditions such as chronic obstructive pulmonary disease, can improve patient access to care and prevent costly emergency admissions.

Non hospital-based care

The newly reconfigured PCTs are now separating the governance for their own internal provider services from commissioning.

Many are still in the process of defining clear measures of productivity for community provision to a similar level of refinement as that for acute care.

The non hospital-based services of a PCT include, in many areas, existing commitments to partnership-based services with social services, such as older people, intermediate care, mental health, children, learning disabilities, and substance misuse. Funding for such pooled or integrated services is estimated at around £4bn.

The total NHS spend for non acute care will be much higher than this figure, encompassing as it does

the whole range of community health-led nursing, therapy and specialist community medical services.

There is more imperative now within the new PCTs to understand these services and to 'commission' their contribution, with attention as great as that on acute care productivity. All PCTS are expected to have reviewed these services by the close of 2006/07.

COMMISSIONING AT PRACTICE LEVEL

Early guidance on PBC stated there was nothing new PCTs needed to do, which is arguably true if the point of PCTs was to engage clinicians in service design and system (budget) management with information to support that.

Within the context of a continuing journey of GP involvement since the 1990s in commissioning and use of NHS resources, there really is no change, at least not in the general policy imperative across political parties.

Achievement of universal coverage by December 2006

PCTs were required to ensure that all of their services were covered by PBC by December 2006, either by GPs undertaking PBC, or GPs 'blocking back' that responsibility for commissioning to the PCT.

The minimum measurement for achieving universal coverage was defined as a follows:

- All practices are receiving information that will allow them to understand their clinical and financial activity compared with local and national indicators.
- All practices to have received an indicative budget covering an agreed scope of services.
- All practices are receiving support from the PCT and the offer of an incentive payment (the Directed Enhanced Service [DES] or locally agreed payment) to support PBC.
- Governance and accountability arrangements for PBC are in place and agreed in partnership between the practice and the PCT.

The DES payment for 2006/07 was to be offered subject to submission of a plan to the PCT on what steps the practice would be taking to manage demand. The exact nature of this 'plan' subsequently varied within each PCT area.

DH data published last month indicates that all PCTs have achieved universal coverage and that practice 'take up' (the actual number of practices now participating in some way in the process, rather than total 'blocking back' of all budget) is at 93 per cent.

See: *www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4136758&chk=7ZBazh*

Modus operandi

PBC relies on PCTs providing information and indicative budgets to practices in order to facilitate commissioning advice and formulation of plans.

All practices should receive a budget that covers the total spend for their population. In addition a tool is available that helps move practice budgets to weighted populations i.e. 'fair shares' over a set period.

Membership of PBC is voluntary. GPs can decide whether to operate within a practice or as groups of practices across a locality in order to consider activity and commissioning needs. Both are possible for the commissioning of different services at say, practice population level e.g. extended access, specialist clinics, and new 'in house' services or within wider locality coverage e.g. mental health.

The aim is that the participating indicative budget holder will assess the information on their use of local NHS resources in order to decide if there are improvements that can be made. Referral patterns, patient health or patient behaviour are all areas for scrutiny that can help prevent inappropriate use of services. Practices may consider designing new services that deliver care more locally.

GPs also have available to them within their own practice, extensive data based upon the Quality and Outcomes Framework (QOF) of the national GP contract. This includes registers of patients with long-term conditions and payment-based rewards to the practice for designing and achieving plans for health improvement interventions for that population.

PBC-LED COMMISSIONING PLANS

All practices participating in PBC must mutually agree a commissioning plan with their PCT. The plan should be drawn up with those who will be affected or involved in its delivery, including consultants, nurses and social services.

Where practices form a commissioning consortium, a single plan may be generated.

The plans should be based upon:

- how the practice will respond to the particular need of their population and the patients' experience of healthcare;
- the practice's particular contribution to the 18-week target for hospital treatment;
- how they will contribute to redesign of services and the resources that could be released as a result;
- identifying areas where a collective approach with other practices within PBC would be beneficial.

The PCT will then aim to respond within four weeks to plans, ensuring they comply with national and local priorities, after which they should form the basis of the PCT's commissioning plan.

There will be regular reviews between a PCT and practices to monitor the delivery of plans along with monthly monitoring of spend and activity.

A risk pool for the whole PCT is to be managed using a share of all the indicative budgets.

RULES ON SAVINGS GENERATED UNDER PBC

Savings achieved by practices are subject to a 70/30 rule – 70 per cent for the practice and 30 per cent for PCT use.

Savings achieved but not anticipated in the original practice commissioning plan may still be used by the practice, subject to agreement of additional objectives.

Practices wishing to provide new services themselves from savings achieved under PBC may make a submission to the PCT board subcommittee, chaired by a non-executive director, on how the savings will be achieved and the service provided. Plans may be for services that span other providers as well.

PCTs in financial difficulty may not withhold practice PBC savings but in areas of special circumstance the practices will still need to agree use of savings in accord with national and any special local priorities for the PCT.

All new services provided by practices must comply with national clinical governance requirements.

DIVERSITY OF PROVISION (CHOICE) AND THE RIGHT TO PROVIDE

DH guidance emphasises that PCTs have a role in ensuring that patients can choose from a diverse range of providers.

Here it is stated that commissioners must not constrain free choice of provider for patients and the opportunity for any willing provider to offer services. This is the case for elective services provided in hospital or community settings.

This means that PCTs should offer a contract to any provider willing to provide such services so long as they meet national standards and requirements.

The contract is a not a contract to offer services up to specific volume or value – but is permission in fact to provide services, and only be paid if they are used.

This also means that no tendering is required for such services to operate and PCTs are specifically encouraged to promote a range of providers such as GP-led limited companies, third sector organisations that are values driven, as well as private companies.

This does not exclude PCT providers themselves from offering services.

Tendering will normally only be required when the intention is to create a monopoly by awarding a contract to a single provider, according to DH guidance.

PARTNERSHIP IN COMMISSIONING DESIGN AND MARKET ENABLEMENT

Two key strands of recent government policy must now be considered.

Our Health, Our Care, Our Say

The white paper, *Our Health, Our Care, Our Say* sets out expectations for integration. The focus is upon health and well-being and integration of design and delivery of care outside hospital.

The backdrop to this is in the demands placed through changing demographics for the nation as a whole e.g. a doubling of the numbers of people over 65 years old in the next 10 years who have long-term conditions (two per cent of this group in Evercare pilots accounted for 30 per cent of unplanned hospital admissions) and doubling within 14 years of those over 85 years with a need for residential-based provision.

Many other statistics for people with long-term conditions are available to show the demand that such groups place upon NHS resources and similarly, housing and social care.

See: *www.dh.gov.uk/assetRoot/04/07/52/13/04075213.pdf*

The white paper describes the requirement for NHS and local authorities to produce a plan for investment

in out-of-hospital care. This has been indicated as due for publication in 2007/08 and upon which approval of the PCT local delivery plan (LDP) is dependent. The plan is described as one that must be agreed between practice-based commissioners, the PCT and the local authority.

There is also an expectation of more innovative use of Health Act flexibilities by practice-based commissioners to move to the partnership arena with social care.

Strong and Prosperous Communities

More recently the new local government white paper *Strong and Prosperous Communities*, published in October 2006 sets out requirements for a 'statutory partnership for health and well-being' involving PCTs and local authorities within the scope of a common assessment framework, single budgets and delivery of joint targets.

New guidance will be issued as a part of the forthcoming health and well-being commissioning framework from the DH, requiring a joint strategic needs assessment to be undertaken by both social care directors (adults and children) and the director of public health.

The third sector is identified as key to participation in design and delivery of this, through a more enabled market of supply and stronger support for its engagement.

Subject to the Comprehensive Spending Review 2007 (CSRO7) there will also be a single set of about 200 indicators covering social care, public health, health protection, disease prevention and mental health.

This will be coupled with an annual risk assessment approach across partners as a basis for understanding risk to delivery of outcomes.

Cross-agency services and working will be examined for impact upon efficiency and to understand cost or efficiency transfers that can occur positively or perversely. This will also be used as a means of informing the best source for central investment.

The scope of Overview and Scrutiny Committees will be extended to include scrutiny of the response from both local authorities and PCTs to the reports of directors of public health on improving the health of the local population.

Finally the role of strategic health authorities and regional government offices in monitoring delivery will be aligned to enable more effective securement of joint outcomes.

Thus for issues that require joint working the partners will be bound to a set of shared targets for which they will be jointly responsible.

Commentary

An approach to working together within a shared accountability framework for health and well-being requires the engagement of general practice from the outset.

This means agreement of priorities, based upon sound and jointly agreed needs assessment for known segments of the population, with innovative strategies for change towards improving health, as well as system wide demand management.

The demographics are indisputable and now is the time for imaginative solutions to tackling need and inequality.

Early stages of PBC have focused upon NHS shift, practice-level needs and populations. These are in many respects, shared populations with a single set of needs for care spanning the NHS and local authorities. They present a joint challenge for commissioning.

A guide produced for local authorities on PBC sets out examples of how partners might work together within a partnership-based model of commissioning and delivery:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4139630&chk=XptTW4

Recent announcements of successful pathfinders for social enterprise spanning health and social care also demonstrate how joint approaches to services can be achieved.

See: *www.dh.gov.uk/assetRoot/04/14/23/41/04142341.pdf*

A new health and well-being framework might also demonstrate how PBC and social care can tackle the future agenda together. Although it may not be direction that is required, than perhaps encouragement which is needed.

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