



Practice Based Commissioning Policy Into Practice

LINDA MARKS & DAVID J HUNTER

A report based on feedback from five regional
workshops held in September and October 2005



commissioned by



“ Practice Based Commissioning is the door to the future for general practice and better patient care. For GPs and frontline primary care professionals it is a question of lead or be led. Indeed it provides the best hope for the future of the NHS and all of us ”

Dr Michael Dixon
Chair, NHS Alliance

The Authors

Linda Marks
Senior Research Fellow

David J Hunter
Professor of Health Policy and Management

Centre for Public Policy and Health
School for Health
Wolfson Research Institute
Durham University

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Foreword by Rt. Hon. Patricia Hewitt MP, Secretary of State for Health

The NHS Alliance has done us all a great service by publishing this report on practice-based commissioning. By drawing on the experience and views of over 800 seminar participants, in five regions of the country, this report shows us the challenges, and importantly the huge opportunities ahead. It is significant that over half the participants were GPs or practice managers – the people who will need to embrace the opportunities of practice-based commissioning for it to fulfil its potential.

Practice-based commissioning, as part of our wider reforms towards a patient-led NHS, has the potential to improve patient access, create innovative services, and make every penny of the extra investment in the NHS work for the patient. It will help to make GP practices, working with Primary Care Trusts, both the champions of the patient and the guardians of the public's money. It will devolve decision-making and service design closer to the front-line.

This report makes clear that potential benefits for patients and the public should be the guiding principle for reform, and crucially that 'the impact on local health economies will partly be determined by the actions of those operating within them.' This basic truth – that even the most complex of systems depend on real people doing real jobs – should never be lost from the debate.

I look forward to continuing the dialogue with the NHS Alliance and its members, and commend this report Practice based Commissioning: policy into practice to you.

Rt. Hon. Patricia Hewitt MP
Secretary of State for Health

Executive Summary

Clinicians and managers are grappling with a range of policies designed to reshape the NHS, diversify the provision of health care and increase the capacity of the NHS to provide choice. These policies are being implemented against a backdrop of significant organisational reconfiguration and a reduction in management costs.

Practice-based commissioning (PbC) and payment by results (PbR) are key elements of this redesign. PbC can encourage primary care to extend into a wide range of services at the interface of primary and secondary care, further reduce the demand for secondary care through managing referrals and reducing unscheduled admissions, and encourage financial stewardship through the regular monitoring of practice budgets. As a cost per case system, it is argued that PbR will increase productivity, reward efficiency and increase patient choice. It will also allow for increased investment in primary care services, if demand for acute care is managed.

Although the report is principally concerned with PbC, this particular policy initiative should not be viewed in isolation from the many other initiatives being implemented simultaneously. They will interact in various and often unforeseen ways.

A national feedback report

This national feedback report draws on five regional workshops (New world, new levers - putting practice-based commissioning, payment by results and service redesign into action), carried out in September and October 2005, and attended by over 860 delegates, of whom over half were GPs or practice managers. The workshops encouraged managers and practitioners to put forward their views on PbC and PbR in facilitated syndicate groups. Case studies were also presented which showed how services could be successfully redesigned.

The report provides a snapshot of policies and of practitioner views at a time of rapid and possibly uncertain change for the NHS. Inevitably, it is framed by the disciplines and interests of those taking part in the workshops and by the speed of, and sudden shifts in policy. Debates were largely concentrated on health care services for patients (rather than on identifying local health needs) and on activity data, contracts, budgets and models for providing health care services.

Engagement is urgent

PbC highlights long-recognised problems in the balance of services across primary and secondary care, the inappropriate use of hospitals and the vagaries of hospital coding practices. Initiatives currently being discussed under the broad umbrella of PbC are already being implemented within existing frameworks such as the 'Locally Enhanced Services' element of the Quality and Outcomes Framework, Personal Medical

Services, PMS plus, Specialist Provider Medical Services and Alternative Provider Medical Services.

However, speakers emphasised the urgency of engaging with PbC, an urgency now reinforced by the new deadline for implementation. A failure to do so could mean that PbR, through incentivising hospital activity, would suck resources out of primary care and into secondary care and that general practice would be less able to compete with other providers of primary care services. Effective management of the demand for hospital services needed to be in place given the expiry, in 2008, of the current financial settlement and significant new investment for the NHS. There were many models for providing services, including limited companies, public interest companies, mutuals, cooperatives and community ownership initiatives.

Practice-based commissioning in action

Case studies illustrated how practices could be engaged in meaningful dialogue about PbC and how critical analyses of practice-based data, hospital activity information and financial data could stimulate plans to redesign services and manage demand. There were examples of how incentive programmes and new organisational arrangements could support innovation. However, there were different views over the extent of services that could be commissioned by practice-based commissioners, the degree of consensus that practices had to reach over their commissioning arrangements, and the extent to which commissioning plans shaped or simply reflected Local Development Plans.

Views from the field

Some are enthused

Many workshop participants thought that PbC would encourage critical and comparative approaches to existing services, and foster innovative service design, different ways of working, clinical mentoring, including peer review of referral practices, and improved patient access. PbC was a lever for providing responsive services and influencing contracts, not on the basis of price, as that was determined by the national tariff, but in terms of quality and access. It was stressed that PbC was more about the quality and redesign of services than about financial savings. However, the possibility of extricating money from the acute sector, which could then be ploughed back into developing primary care services or used to improve premises, was a clear incentive. This had proved almost impossible in the past, with only marginal costs being transferred to primary care.

PbC would promote awareness of the financial consequences of decision-making in primary care and encourage financial stewardship. As well as understanding how the overall budget

was constructed and apportioned, this could involve reviewing which groups engendered the greatest hospital costs and why; modelling projected costs and benefits of different ways of delivering services; and comparing referral patterns and costs across practices. In particular, attention would be directed to accessing, validating and reconciling information from Trusts, in order to identify any miscoding, over-recording or duplication. It would encourage regular audits of the quality of discharge information and of emergency admissions.

Others are less enthused

However, others were not enthused by the prospect of PbC. The incentives for engaging with it were not clear to them, given that services could be redesigned through existing mechanisms. Some were unconvinced of the sustainability of the initiative, especially in the light of perceived contradictions with 'Choose and Book': others felt that a market in healthcare would eventually make practice-based commissioning irrelevant. Initially, the existence of a market might increase the number of providers, but over time the number of competitors could be reduced. Participants were not convinced that SHAs and PCTs would be allowed to destabilise the system or that GPs would support this. Many felt they were being asked to take on extra work, without any additional payment, and that rewards should be better aligned with effort.

More support needed at local level

The lack of detailed national guidance was often replicated by a lack of support at a local level. Many PCTs were criticised for not providing strategic direction, for failing to provide practices with the activity data and financial information that they needed, for constantly revising indicative budgets, or even failing to contact practices about PbC or the likely impact of reconfiguration. Given that PCTs needed to approve commissioning plans and bore the financial risk, tensions were likely to emerge over different approaches. There were also examples of PCTs and practices at cross purposes over how to approach PbC; the choice of geographical clusters or consortia of practices was one example of this. The change management process was therefore variable and sometimes haphazard.

The nature of practice budgets, how differences between PCTs and practices would be resolved, and how underspends and overspends would be apportioned, were all sources of confusion. In particular, there was concern over the impact on practice budgets (and the fate of practice savings) where PCTs were already in deficit. There were other parts of the budget such as mental health and joint commissioning arrangements which were yet to be resolved.

Leadership was provided in some areas by GPs, particularly those with a track record in commissioning or fundholding, and in others by PCT managers. However, many participants described a lack of local leadership.

Moving forward

Many participants saw benefits in PbC. Some argued that practices should start with 'quick wins', with services they

wanted to redesign and the elements of the budget they wished to manage, focusing on what was clinically beneficial, useful and manageable. However, others focused on areas where most savings could be achieved, and this was of particular importance where PCTs were already in deficit. For example, practices needed to identify patients at high risk of repeated unscheduled admissions to hospital, clarify the reasons for these admissions, and develop care pathways and alternative models of care. Many areas were ripe for service redesign, although better management of chronic obstructive pulmonary disease was cited as one key priority. It was important to model the cost of such alternatives, however, and help was needed for this.

In order for practitioners and managers to engage with these substantial changes, financial and practical issues needed to be addressed. They included clarity over contracts; issues of corporate and clinical governance; the thorny issue of how the need for incentives was to be gauged against the responsibility of PCTs to manage risk; recognition of the management costs and clinical time involved in making these changes; and better dissemination of good practice, toolkits and templates. Given the enormity of the change management agenda, new skills and competencies were required.

Last, but not least, the gap between experienced commissioners and those currently operating without indicative budgets, commissioning networks or adequate PCT support needed to be recognised. A more systematic approach was required in order to engage practices and to provide the appropriate financial and management support.

Collaboration or competition?

The question of whether PbC and PbR fostered collaboration or competition was echoed throughout the workshops and formalised via a debate held in each workshop between representatives from primary care and from NHS or Foundation Trusts, followed by a vote. The view that PbC would lead to competition, and not collaboration, was held by either a large majority, or unanimously. It was difficult to encourage clinical engagement across primary and secondary care when PbC and PbR were 'pulling in completely different directions'. Many participants reported already working in 'low trust' environments which would further encourage competition between providers. The climate was now more competitive, and this could make it more difficult for those without a track record in commissioning to compete. The various employment models available could give providers a competitive edge, and reduce their financial risk, in what was perceived as a market system.

Others saw both collaborative and competitive models as possible, depending on local circumstances. Partnerships arising from the vertical integration of a Foundation Trust and networks of GPs could foster clinical integration and develop pathways of care, but would also serve as an alliance of interests competing with other Foundation Trusts or the private sector. In any event, the organisational landscape of the NHS would look very different and become more diversified and complex.

The push and pull of different incentives

PbC forms part of a wider policy canvas and participants reflected different perspectives on the push and pull of various incentives. Although there were incentives to collaborate across the health economy, as well as to compete within it, almost all the participants were concerned that PbC and PbR would lead to increased competition. It was argued that if full patient choice were implemented through 'Choose and Book', it would be difficult to guarantee future patterns of service use. In the same way, it was unclear how triaging referrals through referral management centres to try and control demand would square with patient choice.

Neither was it clear to participants how potential conflicts of interests in GPs playing both commissioner and provider roles would be resolved. The question was raised whether the introduction of a market in health care would, over time, serve to reduce competition between providers and eventually drive up costs. Participants anticipated a more competitive environment for primary care providers, the development of different models of provision, and the eventual separation of commissioner and provider roles.

The motivation to engage in PbC as a key element of the NHS reforms was partly determined by how participants viewed the other reforms and their likely outcomes in the longer term.

Key issues

In this section we have synthesised the various key issues which arose from the workshops. They are grouped according to the key stakeholders - PCTs, practices and national government, including SHAs. We have included SHAs since, as agents of the government, they will exercise an important market management role. However, SHAs were barely mentioned in the workshops.

For PCTs

- PCTs need a clear strategy for communicating with all their practices about PbC and how best to develop it. They can facilitate PbC through systematically visiting practices, running seminars and forums and encouraging practices to work together.
- PCTs can identify the elements of PbC which could be carried out at a practice level and explain the benefits of wider commissioning groupings, where larger populations were needed.
- They can support practices already working together and help them develop commissioning skills and construct business cases for service redesign.
- PCTs should provide for each practice: budgets and monthly budget monitoring reports; analysis of out-patient activity (first attendance and follow up); analysis of elective and non-elective activity and length of stay, by provider and for each specialty; and estimated 'fair shares' measures. Information could be web-based.
- PCTs can distribute PCT staff to practices to provide management support.

- PCTs can offer clinical reviews of referrals through referral management centres.
- PCTs can provide a central contract management and administration unit.
- PCTs can establish a programme of incentives, which could include pump priming service redesign where based on a business case, management funding, incentives linked to performance and meeting LDP priorities, and the reinvestment of efficiency gains in improving patient care.
- PCTs can put in place systems for effective corporate and clinical governance across the range of potential primary care providers.
- PCTs can establish a communications strategy, ensuring that information on commissioning is made available to the public.
- Commissioning spans a spectrum of activities and many stakeholders can become commissioners. PCTs should ensure that PbC is not considered in isolation from other aspects such as health needs assessment, commissioning for health improvement and reducing inequalities in health, and joint commissioning arrangements with local authorities.

For practices

- Practices need urgently to engage with the implications of PbR and PbC, in order to prevent money seeping from primary to acute care, to ensure the sustainability of the local health economy, and safeguard their traditional role in an increasingly competitive healthcare market.
- Practices can form groups and networks, based on locality or like-mindedness. They can form federations, consortia or companies, creating clusters that will provide economies of scale.
- Practices need to engage with the acute sector as well as with other practices.
- Practices doing PbC need to understand the tariff system and the 'gaming' that can be carried out within the acute sector in order to maximise income, including 'HRG creep', upcoding, unbundling care (for example, two spells instead of one) and unnecessary admissions.
- Practices doing PbC need to assess their practice budget, understand how it is constructed and apportioned, and review groups of patients which have the highest hospital costs, identifying reasons for this.
- Practices need to direct attention to accessing, validating and reconciling information from Trusts, in order to identify any miscoding, over-recording or duplication.
- PbC, in tandem with PbR, offers practices the opportunity to redesign and expand their services, bringing services closer to patients and minimising admissions. These include rapid access clinics; running community hospitals; avoiding hospital admissions through employing professionals specialising in care of people with long-term conditions; practitioners with special interests; triage services, for example in orthopaedics; and 'modern matrons'.

- Practices need to develop business plans and model costs and benefits of redesigning services.
- PbC is a means for influencing contracts in terms of quality and access, for example, in relation to discharge summaries.
- Practices can set up patient involvement steering groups. Patients should be involved in the design of local services, as part of improving choice, and encouraged in self care, as part of health improvement and demand management. Some new consortia have already set up patient consultation groups. Commissioning groups can also be set up.
- Some practices may wish to place themselves at a competitive advantage in what many see as an increasingly competitive environment for providing primary care services. There are a range of models available for providing interface and other services such as Specialist Personal Medical Services and Alternative Provider Medical Services.

For national government

- There are currently few incentives for practices to engage with PbC. There should be financial recognition of the management and clinical time involved which is not contingent on the financial health or otherwise of PCTs.
- There are wide disparities across the country in the readiness or capacity of PCTs and practices to engage with PbC. PCTs are in turmoil, given the imminent reconfiguration and many are in deficit. Many practices are unconvinced by and uninvolved in PbC. Substantial support is required to ensure PCTs and practices have access to the right skills and competencies for this significant change. This could form part of the role of the new NHS Institute for Innovation and Improvement. There is also a role here for SHAs especially as they will have a regional focus from April 2006.
- Many primary care practitioners are enthused by the prospect of service redesign, but more research and guidance on the costs and benefits of different models of service delivery are urgently needed.
- Practices welcomed information on the experiences of others and models for developing PbC. These could include starter packs, case studies, toolkits, flow charts and templates.
- A central data bank of care pathways and information on specific redesign initiatives, for example in managing COPD, should be made more widely available.
- Costs and benefits of alternative employment models should be identified and disseminated.
- Mental health and joint commissioning arrangements need to be resolved.
- While contracts will not be negotiated over price, given the national tariff, they can be used to improve access and quality. However, clarity is needed about how contracts are to be enforced with SHAs having a clear oversight role.
- The vast majority of participants in these workshops considered that the combination of PbC and PbR would lead to increased competition between providers both across and within primary and secondary care. This may lead to 'cherry picking' of services in both sectors. Mechanisms are therefore needed to monitor unintended consequences of the reforms and ensure that adequate market management and regulatory safeguards are built in from the outset. SHAs will have a prominent role in these discussions.
- Policies are not working in tandem which makes it difficult to offer staff a coherent narrative about their purpose and value. 'Choose and Book' is difficult to reconcile with PbC and with referral management centres, which triage referrals to control demand; commissioning and provider roles are merged within general practice, leading to potential conflicts of interest; the exercise of choice by commissioners when contracting with providers may conflict with the exercise of choice by individuals; PbR risks reinforcing a hospital-centred care model at a time when the emphasis in policy is on keeping people out of hospital who do not require to be there.
- Participants foresaw the separation of commissioning and provision in the NHS, and a more competitive environment for providers of primary care. The existence of a market raised questions about how the regulation of this market would be achieved and how clinical governance would be assured across a range of diverse providers.
- Motivation to engage with PbC is influenced by views on its sustainability given the overall policy context in which this initiative is being implemented. Will it be irrelevant within an increasingly competitive health care market? Will destabilisation of the acute sector be allowed?

Conclusion

How these reforms will work in practice is largely unpredictable. This means that the impact on local health economies will partly be determined by the actions of those operating within them. There is a danger that 'battling over the patient' in a competitive market will obscure potential benefits for patients and the public which should be the lodestone for service redesign and commissioning priorities. It may also, in the longer term, increase costs. It is in this wider context of potential gains and risks that decisions are being taken over how to approach PbC and develop new alliances of interest.

The workshops on which this report is based demonstrated a wide range of views concerning the potential impact of PbC – some of it positive, and some of it less so. But participants generally agreed on one thing, namely, that if PbC is to succeed across England then more needs to be done at all levels to prepare the ground, equip practitioners with the requisite skills, and ensure that the raft of policies being implemented simultaneously mutually reinforce each other rather than push and pull in different directions which could prove counter-productive and destabilise services.

The changes taken together are significant in their scope and complexity and will leave no part of the NHS untouched. Being alert both to the opportunities PbC and the other changes offer and the risks they carry would seem prudent if the changes are to succeed. For they amount to a major transformation in the way the NHS will in future conduct its business.

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Copies of the full report are available from www.medman.co.uk

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Centre for Public Policy and Health
School for Health
Wolfston Research Institute
University Boulevard
Thornaby
Stockton on Tees TS17 6BH



Goodbody's Mill
Albert Road
Retford
Notts DN22 6JD

Tel: 01777 869080
www.nhsalliance.org



Horizon Place
600 Capability Green
Luton
Bedfordshire LU1 3LU

Tel: 01582 836000
www.astrazeneca.com



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