Primary Care Trust Network

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discussion paper

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Practice-based commissioning

Delivering the vision

When practice-based commissioning (PbC) was first introduced the objective of the policy was to increase the involvement of primary care clinicians in identifying the needs of their local communities, designing services best suited to meet those needs, and managing the resources available to secure those services. There is evidence that since PbC was put on a formal footing in April 2005, some practice-based commissioners have made progress in redesigning services to improve access, efficiency and local service delivery. Overall, however, there is a sense that PbC has largely failed to capture the imagination of clinicians, NHS managers and the general public. Recently, both World Class Commissioning and the NHS Next Stage Review have put the purpose and potential of practice-based commissioning back under the spotlight. It is therefore a good time to look again at the strengths and weaknesses of existing practice-based commissioning arrangements and to explore how the policy can be re-invigorated.

Key points

- PbC was intended to increase the involvement of primary care clinicians in commissioning in order to improve local health services and health outcomes.
- The response to the PbC policy has been lukewarm. It has "not been a failure, but not a big bang".
- In a mature system, PbC would not be a separate policy area. Instead integrated clinical commissioning would be a core part of both PCT and practice business.
- To achieve this, debate around PbC needs to refocus on the outcomes it is intended to achieve.
- A set of principles for developing integrated clinical commissioning may help PCTs and practice-based commissioners work together to deliver the vision for PbC.

The NHS Confederation held a seminar in July 2008 with a range of primary care trust (PCT) commissioners and professional executive committee (PEC) chairs, both GPs and from other professions. This *discussion paper* sets out the summary of our discussions, and introduces the vision for integrated clinical commissioning that emerged from the event. It forms part of our ongoing work programme to support commissioning policy development and implementation. Rather than being a final position statement, it is intended to stimulate wider discussion. Please email elizabeth.wade@nhsconfed.org with your comments and feedback.

Practice-based commissioning and the current policy agenda

Original policy objectives

The Department of Health's (DH) first formal guidance on the policy (Practice-based commissioning – promoting clinical engagement [1]) made it clear that PbC was intended to increase the involvement of primary care clinicians in all aspects of the commissioning process. Although the act of devolving indicative budgets to practices was set out as one of the mechanisms for encouraging this engagement, it was not proposed as an end in its own right. Rather it was intended to be "a first step towards the development of a sophisticated range of ways in which clinicians are involved in commissioning".

Early policy also made clear that, while more decision-making was to take place at a practice level under PbC, the initiative was not simply an invitation to individual practices to develop their own services and special interests in isolation. One of the key stated principles of PbC was: "Practices and PCTs must work in genuine partnership and should aim to create meaningful strategic clinical change using practice-based commissioning as one of their tools." [2]

More recently, both World Class Commissioning and the Next Stage Review have re-emphasised the central role of clinicians in effective strategic commissioning.

World Class Commissioning

The DH launched the World Class Commissioning (WCC) programme in December 2007. Its vision was to transform the commissioning of health and healthcare services, using a set of 11 competencies and an assurance framework to underpin the organisational development of PCTs.

WCC policy contains a clear message that effective clinical engagement is crucial to achieving World Class Commissioning standards. Indeed, one of the competencies that PCTs must demonstrate in order to achieve 'world-class' status is the ability to collaborate with local clinicians. Linking this explicitly to PbC, the WCC guidance states:

"Although PCTs are the budget holders and have overall accountability for healthcare commissioning, PbC has a key role to play at all stages of the commissioning process. In particular, practice-based commissioners, working closely with PCTs and secondary care clinicians, will lead the work on deciding clinical outcomes. They also play a key supporting role to PCTs by assessing local needs, helping to decide local priorities, designing care and providing valuable feedback on provider performance." [3]

NHS Next Stage Review

The NHS Next Stage Review again restated the purpose of PbC as being to "empower family doctors and community clinicians to assemble high-quality care around the needs of patients. It should put clinical engagement at the heart of the commissioning process". [4] However, the review acknowledged that to date PbC had not delivered this ambition, and so set out to re-invigorate it.

The review advocates greater support for PbC with incentives for a broader range of clinicians to get involved, bringing family doctors, community clinicians and specialists in hospitals together to develop more integrated care for patients. It also proposes establishing different levels of engagement with PbC, with increasing earned autonomy for groups that show they are willing and able to take on more responsibility for the design of services and the management of resources. PCTs would need to hold their practice-based commissioners to account for the way in which they discharge these increased responsibilities, and the outcomes they achieve. In turn, however, PCTs would be fully held to account for the quality of their own support for PbC, including the management and information resources they provide.

The NHS Next Stage Review also said: "Pilots will test ways of PCTs commissioning integrated care organisations, multi-professional groups based around groups of GP practices, to manage the healthcare resources for their local populations and decide how best to use these resources to shape services around individuals and promote healthy lives." The DH has recently issued the prospectus for these pilots.

[1] *Practice-based commissioning - promoting clinical engagement*. DH, 15 December 2004.
[2] *Making Practice-based commissioning a reality – technical guidance*. DH, 23 February 2005.
[3] *World Class Commissioning – Frequently Asked Questions*. DH, 28 July 2008.
[4] *NHS Next Stage Review: Our vision for primary and community care*. DH, 30 June 2008.

It is clear then that current health policy sees primary-care-based, clinically-led commissioning playing a continuing, and increasingly important, role in efforts to strengthen the demand-side of the NHS in England over the next few years. But in practice, feedback about the uptake and impact of PbC suggests there is some way to go if this vision is to become a reality.

Progress of practice-based commissioning

Uptake and impact

Formal monitoring of the uptake and impact of PbC has been fairly limited to date. Although uptake of the PbC directed enhanced service (DES) (introduced into the GMS contract to incentivise practices to participate and to produce PbC plans in 2006/07) suggests 100 per cent participation, real levels of active engagement are less clear.

For example, the Audit Commission's review of progress on the implementation of PbC in 16 PCTs during 2006 reported only modest progress. Despite the universal uptake of the DES, involvement of GPs was not uniform, and there were still significant concerns regarding factors impacting on implementation such as data quality. The Audit Commission's review of the content of some of the PbC service redesign plans found that these initiatives had not had a significant impact on services, and many had not taken into account local health needs. PCTs did not have well-developed arrangements for assessing the cost effectiveness of PbC plans and there was a "tendency to assume that a primary-care based solution is more cost effective." [5]

Early analysis of the policy from the King's Fund was slightly more positive, suggesting that despite the practical problems of implementation, there is "clear evidence of a minority of entrepreneurial and innovative GP practices across England, whose ideas have shown that PbC, as a policy, has considerable potential to improve services in some form." [6]

However, in their evaluation of PbC implementation in four PCT areas during 2007/8, King's Fund researchers found that "very few PbC-led initiatives have been established and there seems to have been little impact in terms of better services for patients or more efficient use of resources"… [Although] "PbC has been partially successful in encouraging GPs to become more engaged in commissioning and budgetary decision-making… this has generally been limited to a small group of enthusiastic GPs in each PCT." [7]

The National Primary Care Research and Development Centre's [8] ongoing evaluation of PbC appears to be generating similar findings. One element of the research has involved studying five PbC consortia in three PCTs, all of which were pre-defined as 'early adopters'. By early 2007 they had made discernible progress in establishing at least the forms and governance arrangements for PbC. In these sites, researchers found that PbC was becoming established and that some changes in service organisation were beginning to have an impact. GPs were engaging with the process and small groups of highly motivated GPs were taking the lead in most consortia. They found little active opposition to PbC but there was some scepticism about whether or not PbC as a policy will stand the test of time, and some respondents were disillusioned with the slow pace of change.

Specific seminar findings

Our seminar participants reinforced the picture of PbC portrayed in these various reports and surveys. Specifically, they characterised PbC as "not a failure, but not a big bang." The first year of implementation was felt to have had limited impact. In particular, although the Payment by Results (PbR) tariff system is now improving as it is refined, PbC had not initially acted as an effective counterbalance to PbR as originally intended. Participants agreed that PCTs are in a better financial position now, in part because of the money recouped through PbC, but were clear that frustrations about community budgets and pricing are hampering

Implementing PbC

The most up-to-date information on implementing PbC comes from the DH quarterly practice survey on GPs' perceptions of the initiative. The figures published in December 2008 [9] showed that support for the policy is not universal across general practices and that progress in delivering change remains slow. Specifically:

- **62 per cent of GPs were supportive of PbC**
- **56 per cent of practices said that they had commissioned one or more new service**
- **66 per cent of GPs felt that indicative budgets had not yet made any significant difference to the way their practice operates.**

5 *Putting Commissioning into Practice: Implementing practice-based commissioning through good financial management.* Audit Commission, 2007.
6 *Practice-based commissioning: briefing.* The King's Fund, November 2007.
7 *Practice-based commissioning: reinvigorate, replace or abandon?* The King's Fund, 2008.
8 *Practice-based commissioning in the National Health Service: interim report of a qualitative study.* National Primary Care Research and Development Centre, University of Manchester, 2008.
9 *Practice-based commissioning GP practice survey.* DH, 5th December 2008.

progress. The group noted that PbC is only one part of the dialogue between practice and PCT and there was some debate about how much devolved budgets drive or actually get in the way of redesigning services. National policies and initiatives can also sometimes skew innovation because they might not include the areas that practices would choose to concentrate on. These top-down 'must dos' are seen as confusing, and as lessening the potential of PbC.

Our seminar participants also recognised concerns about the potential challenge to decision-making by practice-based commissioners. With increasing plurality of provision and greater awareness of competition rules, decision-making by PbC groups is likely to be increasingly scrutinised by other providers. PCTs are developing ways of managing conflicts of interest, but these will require greater clarity on the respective roles and responsibilities of PCTs and practice-based commissioners.

Our participants made the important point that the lack of robust and consistent PbC monitoring makes it difficult to know how best to proceed to resolve these issues. In particular, they did not feel that the existing quarterly survey questions enable PCTs to understand what they need to know about uptake and support for PbC. They believe that, in order to get a more concrete idea of the current situation, more sophisticated information-gathering on practice activity is needed.

In summary

We know that some proactive and innovative GP practices are using PbC as a vehicle for service improvement. But it seems that in many areas implementation has become focused on questions of governance and process, while a clear sense of actual or potential benefits, and the means of achieving them on an industrial scale, remain somewhat obscure. It is therefore not surprising that, anecdotally, PbC has raised far less passion in clinicians, and indeed managers, than the former GP fund-holding policy.

Despite this rather luke-warm evaluation, seminar participants were clear that amending and relaunching PbC was not the solution to improving uptake and engagement. Rather, they believe stability for both PCTs and the PbC policy is important to enable organisations to take stock, develop existing thinking, and continue to embed PbC in the commissioning system.

The group felt that refocusing debate on the desired end-point, namely a system in which primary care professionals are actively and constructively involved in health service commissioning, and contributing to improving local health services and health outcomes as a result, would be helpful.

A picture of successful PbC

We asked our seminar participants what they felt success would look like in a high-performing PbC system. Their vision was very clear. In a mature system, PbC is no longer a separate policy area but, instead, integrated clinical commissioning is a core part of both PCT and practice business. In a successful health economy, therefore, a common forum would exist for all commissioning, based on trust between clinicians and managers working to a common purpose: to improve the care, health and well-being of the local population.

Participants agreed that integrated clinical commissioning would not have to take the same form in every PCT, but they were clear that any successful model would have the following critical features in common:

- All local clinicians have the opportunity to input to the commissioning process, although this will often be led by a smaller number of local clinical leaders with explicit responsibility for providing the clinical expertise required.
- The model encompasses clinical input from all primary care professionals, not just GPs, and from specialist secondary care clinicians as appropriate. Clinical common interest groups and networks with secondary care clinicians are seen as a core part of service innovation and monitoring.
- All clinical staff are expected to take a role in adopting the care pathways developed through the commissioning process, and to provide feedback on how well they work.
- The importance of strong clinical leadership of commissioning is recognised, and career opportunities and training and development programmes are in place for clinicians, including for specialist commissioning and/or commissioning areas such as planning.

Along with these shared features, our delegates also agreed that successful integrated systems would have the following outcomes in common (see box).

Outcomes of successful integrated commissioning systems

For patients

- Care and health is better.

For the practice

- The working lives of GPs and their colleagues and staff are easier
- Practices feel confident about their role in and contribution to the local health economy
- GPs are linked to other GPs and clinical colleagues and reinvigorated by discussion of clinical issues (e.g. through federated models of working).

For the PCT

- PbC supports the overall agenda of improving health and services to patients
- There is a convergence of PCT and GP views
- PbC manages its own clinical performance through locally agreed mechanisms.

Indicators for successful PbC

- Commissioning decisions have a single platform.
- Patients receive the same level and quality of services, whichever practice they are registered with.
- Identified clusters or groupings of practices provide clinical leadership on behalf of their colleagues in specialist areas of commissioning.
- Data capture and utilisation is well developed.
- PbC has a structure for clinical leadership and development programmes.
- Dedicated time and resources are available to GPs and other primary care staff to promote engagement in PbC.
- The governance arrangements for PbC are clear and transparent.
- PCTs have a system to pick up intelligence about what engages innovative GPs, and how effective upstream commissioning initiatives could be identified and accelerated.

Practice-based commissioning and personalisation

Proposals in the NHS Next Stage Review for increasing personalisation through, for example, individual budgets for healthcare, did not feature prominently in the discussion during the seminar. It could therefore be argued that while the emerging vision for successful PbC progresses the debate, it reflects a rather traditional model of primary care practice – one in which professionals continue to make decisions on behalf of patients and communities.

This suggests there is a risk that thinking on PbC is developing in parallel to, rather than in concert with, that on personalisation when in fact the two things are inextricably linked. It seems very clear, for example, that developing more individualised services will initially depend on the attitudes and actions of primary care professionals, and their approach to coordinating local services in a way that allows choice and flexibility.

For this reason, it is important to emphasise that PbC includes micro- as well as macro-level commissioning activity. There will always be services that cannot be efficiently and safely planned at an individual level, for example urgent care or screening services – those which, arguably, are not amenable to a tailored approach, and those which individual service users may not be willing or able to specify. It makes sense for the planning and monitoring of such services to take place at a PCT or consortia level, with primary care professionals coming together to agree how the market for such provision should be developed. However, as individuals are given greater control over the resources available to fund their long-term care and support, the role of commissioners will gradually change. In this environment, practice-based commissioners may be advocates, facilitators and advisers, but will not necessarily be the decision-makers, planners or procurers of services. Of course, many GPs and their colleagues would argue that this is simply a re-statement of their core responsibility as primary care professionals. But perhaps this is a responsibility not sufficiently

emphasised in current debates over the governance, financing and organisation of PbC. If this is recognised as part of the definition of PbC, it further strengthens the argument that PbC is not a policy or initiative, but rather a description of what primary care professionals do to deliver clinically integrated, patient-centred care.

Delivering the vision

Delivering the vision depends on:

- PbC being core business instead of a minority pastime
- robust governance arrangements being in place
- participation in PbC operating on a continuum
- having the right tools and incentives available
- practices and consortia having good access to public health expertise
- PbC decisions being linked to patient outcomes
- PbC that covers all services
- support for PbC within wider health system reform
- collaboration with providers
- PCTs having strong clinical leadership systems
- evolution not revolution
- recognition that PbC is not just about budget holding.

Principles to help deliver this vision

Having articulated a vision for PbC, the principles underpinning the strengthening of both the PbC and PCT input into the system also become clearer.

PbC is core business, not a minority pastime

While some aspects of PbC, for instance strategic planning, can be seen as specialist functions, PbC in its widest sense is core business for both PCTs and practices. Seminar participants felt that use of a term such as 'clincally-based commissioning' (rather than PbC) would better reflect this integrated model. However, it was recognised that because policy stability and continuity is important, a formal re-naming of the initiative would not necessarily be constructive at the current time.

Robust governance arrangements are essential

Strong governance arrangements are essential if the focus of local PbC implementation is to shift from structure and process to action and outcomes. Decision-making and monitoring arrangements must be robust to ensure the potential conflicts of interest facing both practices and PCTs are managed appropriately. However, they must also be clear and proportionate, so they do not create unnecessary barriers to progress.

PbC is a continuum

Although our participants were clear that involvement in commissioning should be a core activity, and not optional, if that engagement is to be genuine it will inevitably vary in form between practices and between individual primary care professionals. The escalator concept set out in recent policy implies that practices will want to move up the escalator as their skills improve. Our seminar participants felt this need not necessarily be the case. Our integrated clinical commissioning model accepts that different practices and different clinicians can legitimately have different levels of involvement in the commissioning process. Some clinicians may wish to continue to develop their expertise without taking on greater levels of budgetary responsibility and this should not be seen as a failure of PbC.

The right tools and incentives should be available to support PbC

Adopting PbC as part of the day-to-day work of primary care teams will depend on the right tools being available and accessible to support its delivery. These will include publishing good practice advice, and promoting practical examples of business cases and governance models. Structural support from the local PCT is also necessary, including investment in leadership development and change management activities, as well as deploying management resource which can support individual practices or consortia. It is crucial that information and IT requirements are met so that practices have good intelligence about local health needs, can understand and manage demand, and can assess service quality and effectiveness. Mechanisms and resources designed to help primary and secondary care clinicians come together in the commissioning dialogue will also be critical.

Practices and consortia should have good access to public health input

One of the most important resources that must be made available to practice-based commissioners is public health expertise. An inherent tension in PbC policy is the extent to which it potentially impacts on health inequalities by allowing, and to some extent promoting, differences between the services commissioned

for particular local communities. For example, the innovation by individual practices or consortia of practices that is encouraged by PbC could lead to a widening of health inequalities if certain basic principles relating to equity of outcome are not strongly reinforced. The extent to which public health expertise is available for practices is key to ensuring that PbC decision-making is based in the context of the Joint Strategic Needs Assessment, and on evidence linked to national guidance produced through NICE. Public health experts have a significant role to play in bridging the gap between strategic commissioning functions delivered by the PCT, and the patient and community-based decisions which are the strength of PbC.

PbC decisions must link to patient outcomes

If PbC is to contribute to public health improvements, it is clear that commissioning strategies must be developed with particular patient and population-level outcomes in mind, and should not focus entirely on matters of structure and process. While demand management has been a large part of PbC up to now, the quality of interventions and the development of patient quality and outcome measures are also of great importance. Increasingly, PbC will have to include outcome measures, reported by both clinicians and patients. Support from the PCT to develop patient, public and community involvement mechanisms will be necessary to ensure that decisions have local legitimacy.

PbC should cover all services

While early service redesign or innovation can be achieved in some services, other areas are more complex and run the risk of being ignored by PbC. PbC should not be restricted to services that general practice can provide. High-performing PbC will be able to work collaboratively between practices or consortia to look in more detail at some of these contentious or difficult areas and so improve the way in which they are commissioned.

Wider health system reform should support PbC

National policy needs to take the needs of practice-based commissioners and PCTs into account to ensure there are no perverse incentives that could make the coordination of strategic, community and individual commissioning decisions more complex. The introduction of PbR has helped to generate interest in the management of demand into secondary care as a way of improving quality and efficiency of local services. Any changes to the PbR system must continue to support PbC, particularly in the development of community pricing and quality incentives such as Commissioning for Quality and Innovation (CQUIN). Similarly, as the concept of personalised health budgets is developed and policy emerges, it must take account of the role and responsibilities of practice-based commissioners.

Collaborations with providers are essential

There is a need to build understanding between PbC and local service providers and particularly with senior secondary care clinicians. Indeed, the use of common interest groups and established clinical networks is a key part of the vision of the NHS following the NHS Next Stage Review. Collaborations of practice-based commissioners with providers are therefore essential, albeit with PbC in the guise of commissioner and with strong PCT support. This should enhance the service specifications, improve understanding of the impact of commissioning decisions and enable the market to be developed to deliver the best service fit for patients.

PbC should be supported by strong clinical leadership systems within the PCT

As the clinical advisory group of the PCT, the professional executive committee sits at the heart of the organisation, giving support to clinical leaders. It also guides the PCT commissioning machinery, enabling skills development and mediating to ensure that PbC delivers the strategic vision of the PCT both individually and as part of the wider Local Area Agreement.

Evolution not revolution

The system must be given time to develop in its present form. The shared vision developed in our seminar needs to be adapted to meet different local circumstances. Support for PbC is therefore not only technical but includes the development of relationships between the PCT and practice or consortium which enhance decision-making and improve the evidence base on which decisions are made. If PbC is to succeed in the long term and lead to lasting change in the way services are commissioned, a period of stability will be needed so it can develop and be refined.

PbC is not just about budget holding

While transferring budgets, either indicative or actual, is one way of engaging primary care clinicians in commissioning, it is not the only way. We should judge the policy by the degree to which commissioning is genuinely clinically-led and to which clinicians feel ownership and comply with commissioning outcomes, rather than the number that hold budgets. This is not to say that budget holding

is not a legitimate means of achieving this engagement. However it is important that it is seen as a means rather than an end, and that other means of involving clinicians in commissioning are also promoted and valued.

Looking ahead

The principles set out in this paper are designed to improve the capacity of PbC within PCTs and to address some of the perceived engagement and relationship issues between clinicians and PCT commissioners. However, it is important to note that changes elsewhere in the system will impact on PbC in ways that are, as yet, unclear. The extent to which the developing market in community services changes the landscape of providers available to PbC is still difficult to gauge, as is the long-term impact of personalisation, particularly in the area of personal budgeting. Alongside this, further refinements to PbR and the development of 'year of care' approaches may alter the relationship between practice-based commissioner and the recipient of care. Finally, the development of integrated care organisations may change the dynamic between the commissioning role and practice-based provision functions which are likely to be linked in the integrated care organisation model.

The principles we have outlined should improve the ability of the PCT and its PbC practices and consortia to develop and adapt to these changing conditions, but PbC as a policy will need to be reviewed regularly to ensure its objectives are being met.

Our seminar participants were agreed that PbC will only be deemed successful once it is so closely embedded within local commission arrangements that it is no longer a separate policy area. In the meantime, support from PCTs for PbC is vital to ensure that it continues to develop.

Further information

This paper is designed to stimulate discussion and is not intended to be our final position statement on practice-based commissioning.

We would welcome your views on the vision and principles we have outlined. Do you agree it is the right way to go? Is there anything we have missed? Please send your comments and feedback to **elizabeth.wade@nhsconfed.org**

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs.

We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

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