

Practice-based commissioning

Practice-based commissioning (PBC) is a policy intended to give more decision-making power over NHS resources to general practitioners (GPs), and allow them to design and deliver completely new services or commission others to do so. It has a number of underlying policy objectives including delivering more cost effective and convenient forms of treatment outside hospital. Practice-based commissioning is a key strand of recent NHS reform policy in England alongside Payment by Results, patient choice and enhanced competition between providers. This briefing looks at the development of PBC in England, examines the pace of implementation and offers some analysis of the impact – current and future – on NHS services.

Origins of PBC policy

Before the introduction of practice-based commissioning in 2005, the bulk of NHS funding was allocated from the Department of Health to primary care trusts (PCTs) who then paid hospitals, GPs (and other health care providers) for the services delivered to their local populations. Under PBC, GPs are given an 'indicative' budget by their PCT, accompanied by data about the cost and volume of services patients from their practice are using in the local NHS (for instance by attending accident and emergency or hospital inpatient stays). This information should contain comparisons with other practices locally and nationally. Practice-based commissioning is designed to bring change on two levels.

- First, detailed financial and service usage data should equip GPs to make more informed decisions about how they care for their patients and where they refer them for tests or treatment.
- Second, PBC also aims to enable GPs themselves to commission new services, either provided within the practice or by new alternative providers.

The main incentive for GP practices is that they are allowed to keep a proportion of any 'efficiency gains' resulting from more cost-effective ways of treating patients, which can then be ploughed back into developing new services – full details are given below.

Giving GPs more power over resources used by their patients to deliver better care is not a new idea. Similar policies to PBC, including GP fundholding and total purchasing pilots, were implemented by the Conservative government in the 1990s. These gave GPs control over

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budgets (primarily for elective, non-urgent care services), the right to keep savings and the freedom to deliver new services, with the wider aim of creating more efficiency in primary care and creating some competitive pressure on hospital providers (a sector that has historically absorbed a large proportion of NHS resources). These practice-level initiatives were abolished by the new Labour government in 1997, partly due to their (initial) ideological hostility to the idea of using competitive pressure to drive change in the NHS, and partly due to a belief that fundholding had created extra bureaucracy and led to a two-tier service, benefiting some areas more than others leading to greater comparative inequality in access to care for patients (Department of Health 1997).

Even though fundholding was rejected by the new administration, it believed there was still some intrinsic merit in the idea of devolving commissioning decisions to GP practice level. A commitment to devolve the commissioning function to GPs was given a brief mention in the White Paper, *The New NHS: Modern, dependable* (Department of Health 1997). The bulk of the White Paper was concerned with winding up fundholding and setting up the new primary care groups (PCGs) – the forerunners of PCTs. However, the government acknowledged that the experience of GP fundholding had delivered some benefits to patients in some cases, for instance, by broadening the range of services available in GP surgeries. Even so, in the immediate future, commissioning power was to be exercised not by individual practices but by the new primary care groups (although in some areas a few GP-led groups did survive to advise the larger PCGs about local commissioning needs). The White Paper envisaged further devolution at some point: ‘Over time, the Government expects that Groups will extend indicative budgets to individual practices for the full range of services.’

In fact, it was a further six years before this policy was developed further, by which time there had been a change of overall emphasis in NHS reform policy, with the introduction of choice and competition as drivers of change. Details of the new ‘practice level commissioning’, as it was initially called, began to emerge in the autumn of 2004, following a pledge made in June 2004 by the government that PCTs would provide ‘indicative’ budgets to any GP practice that wanted them by April 2005 (Department of Health 2004d). In December 2004, the government began to set out some of the detail of how practice-based commissioning was designed to work and declared that ‘there are no targets: we simply have the aspiration that all practices will be involved in Practice Based Commissioning by 2008’ (Department of Health 2004c).

Policy objectives of PBC

Many of the subsequent government documents on PBC have been concerned with the detail of *how* PBC will function as a mechanism for change (*see below*), but it is worth documenting the stated objectives – *what* changes PBC is trying to achieve and *why*.

PBC is described as a key enabler for the policy of patient choice (Department of Health 2004b, 2004c) by allowing GPs to identify a variety of different providers for their patients; and, in the longer term, add to the choices on offer by directly providing or commissioning new services themselves.

PBC is also described as ‘pivotal’ to delivering another key government objective: ‘care closer to home’ (Department of Health 2006b). The White Paper, *Our Health, Our Care, Our Say*, made clear that ‘care closer to home’ means care delivered in a place that is not a large hospital. This shift is justified by government on the grounds of more convenience for patients (who, they argue, do not want to ‘plan their lives around multiple visits to large hectic sites’ (Department of Health 2006b) and better use of resources. Examples are cited from

abroad where a much larger proportion of 'outpatient' activity is provided in non-hospital settings. PBC is envisaged as playing an important role in finding innovative 'pathways' for patients, in which a range of diagnostic tests, minor procedures, consultations and follow-up appointments are delivered outside hospitals. More recent guidance refers to PBC being a tool to help PCTs deliver the 18-week 'referral to treatment' waiting time target (Department of Health 2006d) where service 'redesign' might involve finding quicker, non-hospital based diagnostic services.

PBC has also been held up as a means to secure longer-term savings by incentivising the delivery of better preventive care. The need for effective public health initiatives to avoid future costs was spelled out in the NHS Plan (Department of Health 2000) and subsequent White Paper, *Choosing Health* (Department of Health 2004a). The potential of PBC to contribute to this is flagged up in *Our Health, Our Care, Our Say*: 'PBC will give primary health care teams a real freedom and a real incentive to look after their population more effectively' (Department of Health 2006b). This idea is not developed further in relation to broad public health initiatives, such as preventing obesity, but focuses mainly on preventing 'unnecessary' hospital admissions, through better care of those already unwell with long-term conditions. Better and more proactive management of patients with long-term conditions had already been a focus of government policy, under a public service agreement target to reduce emergency bed days by 5 per cent by 2008 (Department of Health 2007e).

Finally, there is an objective to use practice-based commissioning to control, and ultimately reduce (where appropriate), the overall rate of GP referrals into the hospital sector. By 2004, the government was already concerned that achieving shorter waiting times could increase demand for hospital services and described commissioning by PCTs and practices as crucial to making sure that referrals to hospital were 'appropriate' (Department of Health 2004d). This theme of controlling hospital demand became even more urgent as Payment by Results was implemented, which contained potentially strong incentives for hospitals to increase their activity, at a time that coincided with the emergence of widespread financial deficits across the NHS in 2005–6. By 2006, the Department of Health had issued guidance to the PCTs with examples of the sort of initiatives that PBC 'redesign' could deliver (fewer emergency admissions by offering new primary care services or more community care), but made it clear that, 'Such schemes must be cash releasing' (Department of Health 2006a).

How is PBC intended to work?

From 2005, all PCTs have had to put in place certain structures to implement PBC: information for each GP practice on their clinical and financial activity compared with local and national indicators; an indicative budget covering an agreed scope of services and the offer of an incentive payment. PCTs are also expected to agree governance and accountability arrangements with practices (Department of Health 2006c). This situation, referred to as 'universal coverage', had to be achieved by December 2006.

Once a GP practice has an indicative budget agreed with their PCT, they are then able to submit business cases to the PCT proposing changes to commissioning or the establishment of new services.

In order to engage GPs in the scheme, there are several financial incentives on offer. First, there is a centrally funded incentive scheme, known as a DES – Direct Enhanced Service – payment, which was announced in 2005 and was available until the end of the 2007 financial year (NHS Employers 2005). It is split into two segments, each worth £0.95 per patient. The

first payment was payable when a GP initially signed up to PBC (in exchange for a brief plan setting out their aims and objectives for PBC). At the end of the financial year, 'if plans are achieved', GPs received another £0.95 per patient (Department of Health 2006d).

Second, GPs engaging in PBC are entitled to retain a proportion of the money 'saved' by the new activity at the end of the financial year (net of any administrative costs). The latest guidance recommends that practices can keep up to 70 per cent of savings, with the remainder available for the PCTs to use for other purposes (Department of Health 2006c). Crucially, the guidance states that PCTs are not able to top-slice savings to solve PCT deficits. Third, PBC empowers GPs not only to make commissioning decisions but also to develop their own service provision. In this scenario, if GPs are able to provide services that 'are the same as' those provided in acute trusts, they can attract the full cost for each episode of care under the Payment by Results system (Department of Health 2006d).

How are budgets set?

Unlike fundholding in the 1990s, budgets are not 'real' but indicative, and PCTs remain legally responsible for the money and its administration. To date, budgets have been based on past referral and hospital usage patterns. However, there are significant differences between GP practices in the number of people they refer to outpatient clinics that are not explained by underlying levels of illness; the government has argued that it is fairer and more transparent to base budgets primarily on calculations about patients' clinical needs. Therefore, from 2007 the government has started to introduce a 'fair shares' approach to determine a GP practice's commissioning budget. A national formula has been developed in order to calculate each practice's 'fair shares' budget, based on detailed information about the age of patients registered with the GP and data on average illness and deprivation levels in the local area. This has revealed that some GP practices are substantially over, and some under, the target of what they should be spending. In order to prevent any rapid changes in budgets and associated instability, the guidance dictates that movement towards 'fair shares' should be capped at 1 per cent per annum (Department of Health 2007d).

Unlike the fundholding experiments of the 1990s, the cost of the services that the budgets cover do not vary but are fixed according to the national tariff set as part of Payment by Results (Department of Health 2006e).

Practice-based commissioning budgets remain separate to the funds GP practices receive under the existing contracts they have for their core work (General Medical Services (GMS) and Personal Medical Services (PMS)). These arrangements will remain unchanged whether or not they hold their own commissioning budgets (Department of Health 2006c).

Progress with implementation of PBC

The Department of Health has been collecting data to measure the progress of implementation against two main indicators. The first indicator measures 'universal coverage' and the second measures uptake of DES payments. Universal coverage refers to a situation whereby every PCT has put in place the information and processes required for PBC to operate, as described above (Department of Health 2006e), and implementation has been monitored by Strategic Health Authorities (SHAs). The government's early guidance set a target for achieving universal coverage of practice-based commissioning in England by 2008, but this target was subsequently brought forward to the end of 2006 (Department of Health 2005a) This target was achieved and the Department of Health published data indicating

that all PCTs in England had put in place the required arrangements for PBC to operate (Department of Health 2007b).

The Department of Health also collects data about the uptake of incentive payments. The latest figures available on the Department of Health's website (2007b) indicate that 96 per cent of practices had taken up an incentive payment (although it is not made clear whether this includes both the first and second tranche of the payment). Universal coverage is a mandatory target for PCTs and was met by December 2006, but PBC for GPs remains voluntary.

Impact of PBC

The government has only just begun to commission formal evaluation of PBC. There are, to date, limited sources of information about what impact PBC has begun to have on the NHS.

The Department of Health has published examples of the sort of changes that can be made to services under PBC (Department of Health 2007c). These are implementation 'progress reports' for each SHA detailing the activities that have taken place in the name of PBC and, where possible, the impact they have had. Although many examples of service redesign are cited within these reports, there are relatively few quantified impacts – many simply state objectives or cite very high level estimates of impacts. However, the site does contain a file setting out all approved business cases for East of England SHA. Below are some broad examples of the types of initiatives emerging.

- Reducing avoidable emergency admissions through better management of people with chronic conditions. One example cited in the list of approved business cases in East of England is of a community diabetic service in Suffolk PCT with estimated shift in activity from secondary care of 30 per cent with potential savings of just under £4,000. A similar diabetic service has been set up in Kensington and Chelsea PCT and is estimated to have reduced new outpatient appointments by 750 and follow-up appointments by 1,800 (Department of Health 2007c). Other PCTs are trialling GP triage services where GPs act as the first point of contact for all patients entering the accident and emergency department. The GP assesses each individual and, where appropriate, redirects them to primary care.
- Referral management centres run by PBC groups. In order to control the number of elective referrals, many PCTs have been establishing referral management or assessment centres, often run by local PBC consortia, where each referral is scrutinised and, where deemed inappropriate, returned to the referring GP. There are examples of such centres that have brought about fairly dramatic results in terms of the percentage drop in referrals; for example, a Department of Health press release pointed to a 25 per cent drop in referrals to secondary care in Kingston PCT as a result of a referral management centre run by a PBC consortium (Department of Health 2007c).
- Setting up alternative sources of expertise. This builds on an existing initiative known as GPs with Special Interests, where GPs gain extra training and can take on some of the work that hospital consultants have done in the past. Examples provided by the Department of Health include GPs setting up dermatology clinics or GPs performing minor surgery in their offices. One example in the North East has found that the setting up of a dermatology service in primary care has reduced new referrals by 18 per cent. An approved business case from East of England SHA is for a musculoskeletal service in Bedfordshire that is predicted to shift 50 per cent of activity from secondary care with potential savings of

£26,000 (Department of Health 2007c).

- Purchasing new diagnostic equipment can also enable GPs to manage people in the community. For example, conditions such as congestive heart failure can be diagnosed using in-house echocardiography equipment. This can potentially mean that only those with a high probability of the illness are referred on to a hospital consultant, instead of being referred and then waiting for the tests to be done in hospital before a diagnosis (or not) is confirmed. An example of a business case in Peterborough is cited on the Department of Health website. This business case proposes setting up direct access echocardiogram in the community with the potential to take 73 per cent of activity out of secondary care but with no potential savings identified (Department of Health 2007c).
- Reducing follow-ups: one approach being taken by a number of GP clusters is the reduction of follow-up outpatient appointments at hospital (which are all charged for under Payment by Results). So, instead of a patient having to go back to secondary care for an appointment following a procedure, the GP takes on that responsibility, thus reducing the inconvenience to patients and the cost incurred by the PCT. Bedfordshire PCT has submitted a business case to reduce follow-ups for dermatology and trauma and orthopaedics by 10 per cent with potential savings of £38,000 (Department of Health 2007c).

While this evidence from the Department of Health builds a picture of a relatively rich mix of service redesign initiatives, it is clear that many are at an early stage of development (and it is not clear that all of them flow from PBC specifically rather than other initiatives already in place).

The impression of limited impact is supported by other evidence. The Department of Health has published a survey of 1,200 GP practices across England (Department of Health 2007a). According to the survey, even though nearly two-thirds of practices said they were 'supportive' of PBC as a policy, 60 per cent said they had not commissioned any new services as a result of PBC. Of those interviewed, 37 per cent believed that it was 'too early to tell' if PBC had improved patient care, 31 per cent 'disagreed' that PBC had made improvements and only 13 per cent felt that it had. In addition, a third of practices believed that information provided by the PCT was 'poor' and over half rated the quality of managerial support from PCTs as poor also.

This finding echoes earlier research about the quality and timeliness of information supplied to GPs (Lewis *et al* 2007; Audit Commission 2006), on which a great deal of PBC's effectiveness hinges. Many of these problems may be a function of time: PBC is still a very new policy, managed by organisations that have only recently emerged from extensive reorganisation (Department of Health 2005a, 2005b). Evidence from previous attempts at engaging GPs with commissioning suggests that the scheme will need time, resources and sustained management support to deliver quantifiable outcomes (Smith *et al* 2005).

Looking beyond the process of implementation, questions still remain about the overall direction of PBC and its likely impact on services, even if fully implemented. The Audit Commission's most recent report on PBC was based on case studies of 16 PCTs (Audit Commission 2007). In common with the other evidence, it found that engagement with GPs was incomplete and matters relating to implementation (such as data quality) were still pre-eminent concerns. More importantly, the Audit Commission examined the content of the minority of PBC service 'redesign' plans and found that they had not yet had a significant impact on services and many had not taken into account local health needs. The Audit

Commission provide some positive examples of service redesign, but note that, on the whole, GPs tended to be more interested in directly providing services on a small scale and in a few clinical areas than getting involved in commissioning. The Audit Commission also found that PCTs did not have well-developed arrangements for assessing the cost effectiveness of plans and that there is a 'tendency to assume that a primary-care based solution is more cost effective'. The Audit Commission estimates that at least £98 million has been spent on the implementation of PBC so far (Audit Commission 2007).

The Audit Commission's findings are similar to evidence emerging from a King's Fund research project, which is based on interviews with managers and doctors across several PCTs. Although uptake of incentive payments has been high, underlying interest amongst GPs varies considerably, with the least engaged regarding PBC as a managerial, top-down initiative of little relevance. Respondents also refer to a lack of clarity about PCTs' roles, particularly whether PCTs should be actively driving the content of PBC commissioning plans or simply facilitating a more bottom-up approach.

Future of PBC

Much of the evidence has focused on the practical challenges of implementing PBC and suggests that at a local level these have yet to be fully overcome. There is, nevertheless, 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.

Two uncertainties remain, however. The first concerns the degree to which it will be possible to transform the behaviour of the yet-to-be engaged majority of GPs (Stevens 2007; Lewis *et al* 2007). The lessons from the history of fundholding and total purchasing pilots – backed up in the recent Audit Commission report (2007) – would strongly suggest that there is a limited stock of entrepreneurial and managerial talent naturally occurring within the body of GPs and that active take-up was limited to a relatively small cadre of innovative individuals (Petchey 1995; Goodwin 1998). In order to overcome the inequities implicit in this, the government chose to make PBC 'universal' by using incentive payments to encourage GPs and targets for PCTs to support the policy. But it is not yet clear that the incentive payments will have been strong enough to deliver more than token involvement or that they have not been crowded out by the stronger incentives contained within the GMS contract. Much now hinges on the ability of PCTs to complete the implementation of PBC at a local level: most of the Audit Commission's recommendations are aimed at PCTs rather than practices. Yet PCTs have a very broad canvas of objectives – including achieving financial balance, reducing health inequalities, delivering the 18-week waiting-time target, ensuring patient choice and care closer to home – and PBC may not be seen by all PCTs as central to achieving their strategic goals.

The second uncertainty concerns the clarity of the underlying objectives of PBC. As discussed earlier in this briefing, there is a spectrum of policy objectives behind PBC, which are only now coming into focus as PBC emerges from the challenges of implementation. Increasing choice and convenience for patients, moving services outside hospital, saving money in the short and longer term and delivering services of higher clinical quality are not necessarily compatible objectives. The many PBC schemes currently being implemented may well fall under one of the above categories, but may also involve trade-offs: more convenience and services closer to home may actually mean fewer overall choices for patients. For example, an implicit incentive for GPs leading PBCs is to invest in and commission local services that they themselves provide. This creates a direct conflict of interest that will need careful handling if

effective patient choices at the point of referral are to be maintained. Another risk is that PBC will conflict with other policy objectives. As the Audit Commission points out, PBC creates an incentive for practices to reduce referrals into secondary care (and retain the 'savings'), but this might deepen health inequalities in areas where unmet health needs would suggest an *increase* in referrals might be needed.

As PBC increasingly moves from plan to reality, there will need to be greater clarity about its objectives and continuing scrutiny, both local and national, over its impact on services.

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