Practice based commissioning: challenge or opportunity?

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We think we need a clear vision from the Department of Health of what PBC can achieve, and an explanation of its distinct benefits.

There is currently no clear vision for PBC or an explanation of its distinct contribution to health commissioning

- Process almost as a means in itself – we're not focusing on the ends
- Emphasis so far has been on getting GPs to sign up to the process, rather than on winning their hearts and minds – nearly £100 million in incentives payments so far
- But exactly what is DH's vision for what PBC might achieve? Have GPs (and PCTs) been sufficiently inspired to fully take part?

A distinct vision of what PBC could achieve?

Helping hold the NHS machine to account

Personalisation

Primary and secondary prevention, and palliation

A distinct vision of what PBC could achieve?

Helping hold the NHS machine to account:

Managing referrals into secondary NHS care
Holding providers to account for what they provide and how they provide it
Encouraging GPs to see themselves as part of a broader 'system', and to
Understand the systemic implications of their actions
Challenging the dominance and power of the local hospitals

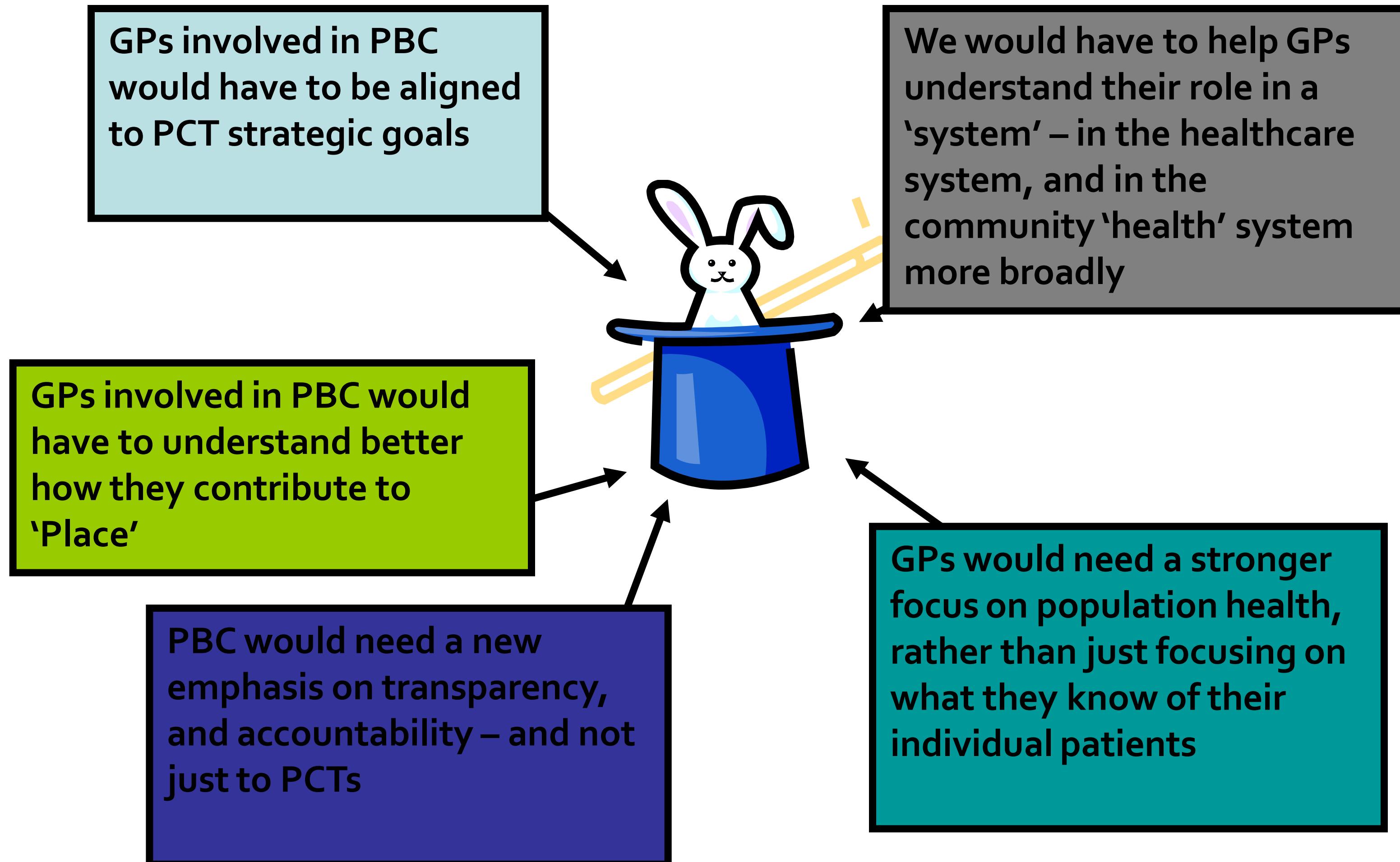
Personalisation:

GPs are often patients first port of call and are naturally well placed to
understand what individual patients need, and to tailor care that meets those
Individual needs in a commissioning role

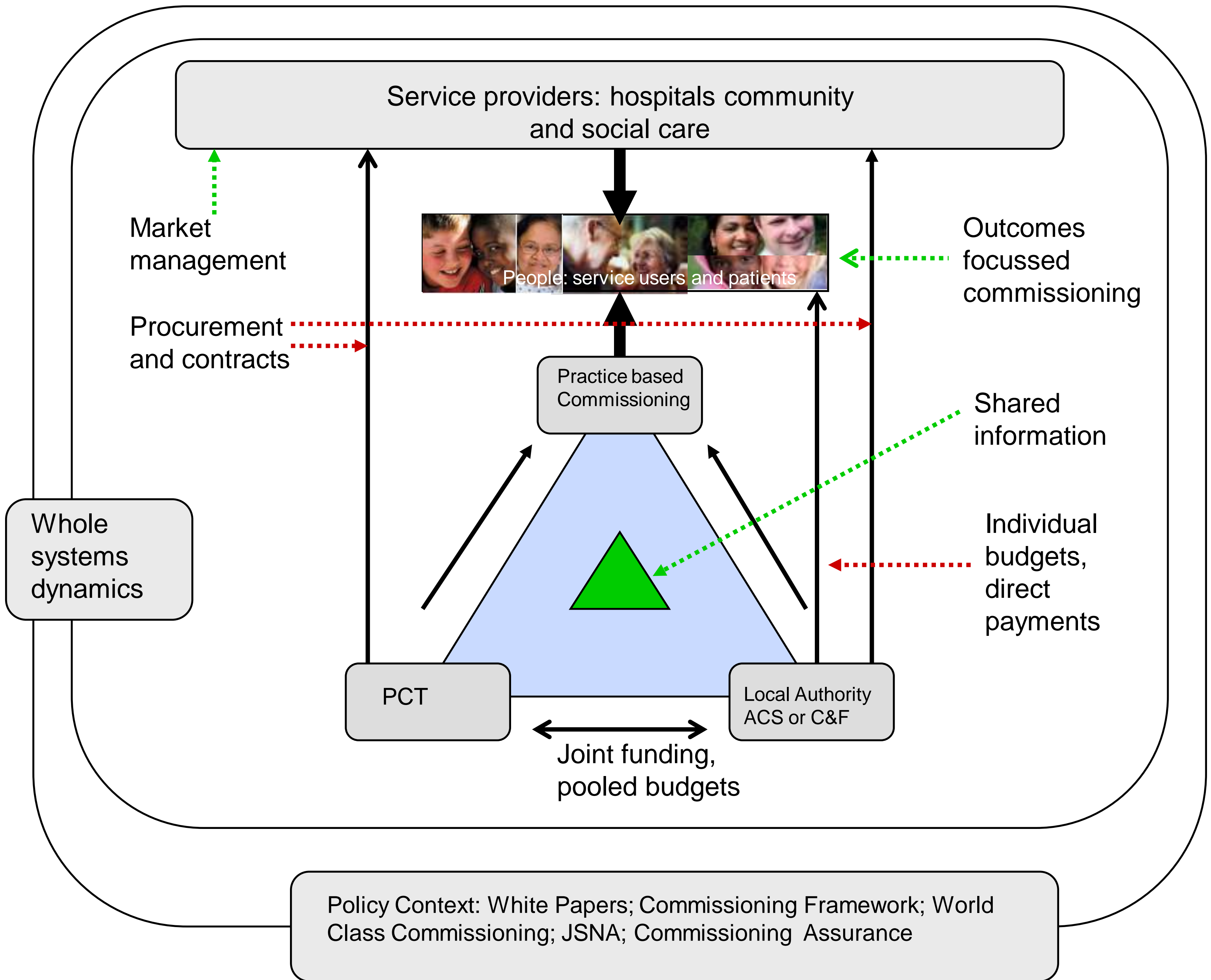
Primary and secondary prevention, and palliation:

PCT strategic plans have mostly identified preventative/upstream
Priorities; this has been priority for Local Government for some time
What is the PBC role in enabling prevention – supporting behavioural and lifestyle change?
Locality-based commissioning across whole system, depending on strengths of that system
And depending on our insights into what will motivate people to change their behaviours?

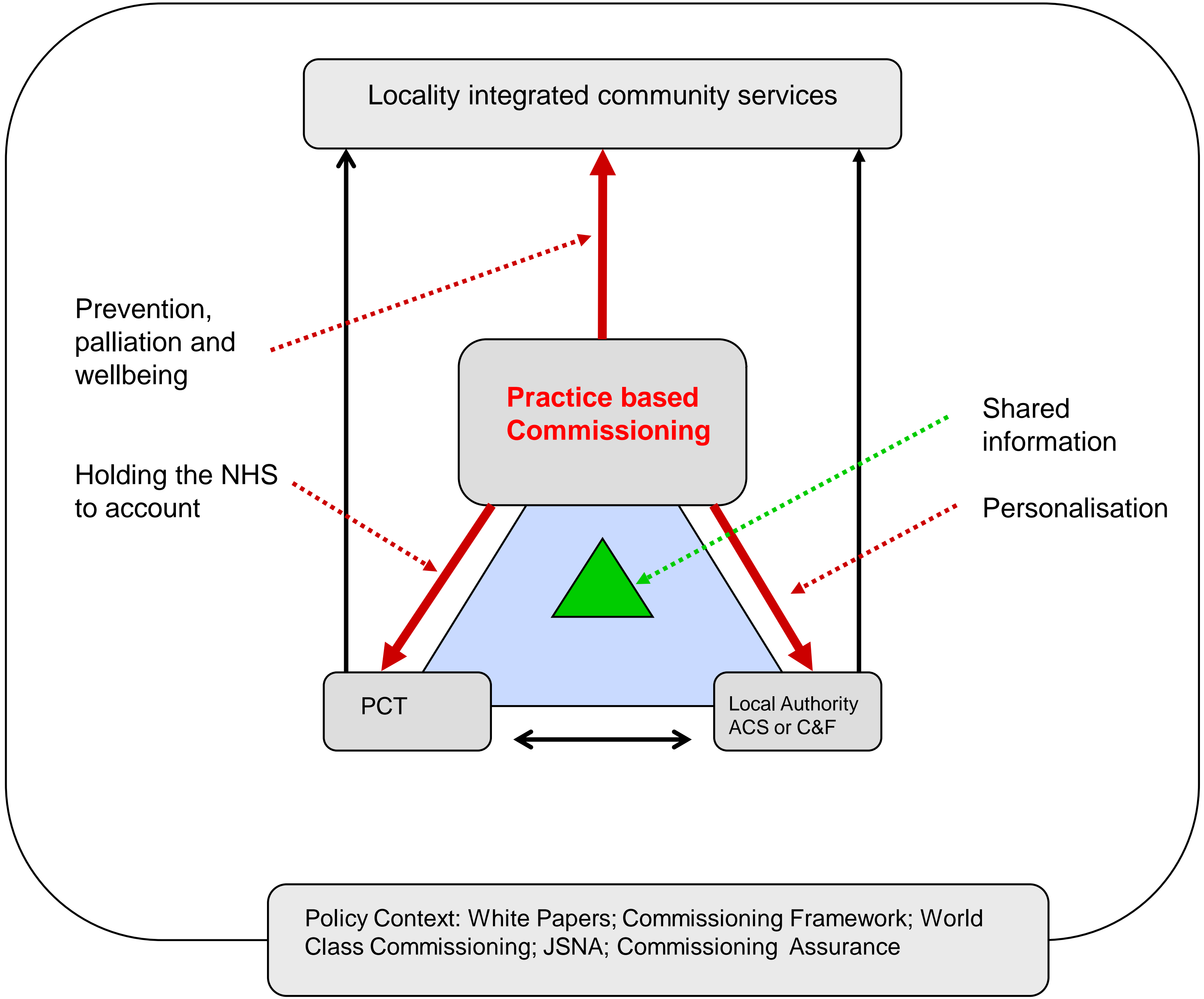
This model would only work with some 'magic' ingredients



We need a model for PBC that shows how it fits with the other levels of commissioning



Service providers: hospitals community and social care
Market management
People: service users and patients
Outcomes focussed commissioning
Procurement and contracts
Practice based Commissioning
Shared information
Whole systems dynamics
Individual budgets, direct payments
PCT
Local Authority ACS or C&F
Joint funding, pooled budgets
Policy Context: White Papers; Commissioning Framework; World Class Commissioning; JSNA; Commissioning Assurance



Locality integrated community services
Prevention, palliation and wellbeing
Practice based Commissioning
Shared information
Holding the NHS to account
Personalisation
PCT
Local Authority ACS or C&F
Policy Context: White Papers; Commissioning Framework; World Class Commissioning; JSNA; Commissioning Assurance

Even CIPFA had different models in mind 2 years ago

- Facilitating individual patient purchasing
- Commissioning by individual or group practices on behalf of their patients
- Locality or cluster commissioning
- Joint commissioning – with PCTs and /or Local authorities
- Lead for PCTs on behalf of PCTs rather than separately

Let's be smarter about the commissioning function and how best to structure it.

We need to develop a more sophisticated understanding of what's best done at:

- practice level, through **PBC**
- **at PCT level**
- **across a number of PCTs, even regionally**

Across PCTs- *in cases where bigger is best*

- Developing joint commissioning strategies where a wider
- footprint makes sense; supporting commissioning as a
- business cycle, 'better buying' from large NHS providers through economies of scale
- e.g. service specifications, performance management, contracting, admin support; systems and
- Information support; procurement expertise.
- Collaboration and learning between PCTs because it makes good business sense.
- Collaborative commissioning when PCT footprint is too small and inherently limiting, e.g. specialised
- Commissioning, some mental health commissioning

PCT level – *strategic commissioning for population*

- Needs assessment; providing information and intelligence to support PBC,
- Including information about referrals, performance of existing services;
- Ensuring contestability and transparent decision making re. PBC (managing
- Conflicts of interest that arise through GP as commissioner and provider);
- Create Prospectus/ strategic development framework
- Inc definition of strategic priorities, service outcomes and quality standards

Practice level- *for when being at the 'front line' is an advantage*

- Through PBC and clinical engagement, defining resilient, optimum care pathways
- Aligning patient experience/choice with clinical decision-making
- Demand management, ensuring patients only enter an acute NHS setting when they need to.
- Using GPs and clinical leaders to hold hospitals to account
- Using PBC to hold GPs to account

Have we got the incentives right?

Incentives are particularly important when looking to change GP behaviour!

- Opportunity cost to an entrepreneurial GP of spending time on commissioning? Far more money to be made by income-maximising practice in QOF, or in providing intermediate care services.
- Is it still more of an incentive to use PBC for provision rather than for commissioning?
- Even if a GP is keen to take part have we got the right infrastructure in place (at both PCT and Las) to enable him to do this well?
- Is there an ethical question about the use of resources to maximise patient benefit? Indeed GPs may well respond positively if patient benefit can be shown clearly
- And have we won their hearts as well as their pockets??

Has DH learnt sufficiently from experience of GP fund holding?

If nothing else....

- The Audit Commission with CQC is developing Comprehensive Area Assessment
- Next year 2009-10 there will be vocal, visible criticism of the lack of local progress and the potential waste of resources
- Engaging GPs in PbC is one route to more effective localised focussed resource management.