King's Fund Briefing

Practice-based commissioning

What is practice-based commissioning?

Practice-based commissioning is a policy that aims to give more influence and control to GP practices in England over how money is spent on health care services. At the moment, the bulk of NHS money is allocated to primary care trusts (PCTs) who then commission and reimburse hospitals (and other health care providers) for the services used by their local populations, and pay GP practices for the services they deliver to patients.

Under practice-based commissioning, GP practices are to be given their own 'notional' budgets with which to 'buy' health services for their patients. The practices are accountable to their PCTs, who draft the contracts with hospitals and other providers in line with past GP referral decisions and remain legally responsible for the funds. The notional budgets reflect any NHS services their patients receive, including attendances at accident and emergency departments, all referrals to hospital for outpatient and inpatient treatments, and drugs.

The policy is partly designed to raise GP awareness of how the money is spent once a patient leaves their surgery. It is hoped that GPs will do more than passively scrutinise the information and will actively take responsibility for commissioning some of the services. The idea is that this 'active' commissioning will encourage practices (or groups of practices) to come up with new ways of using the money to design services that might be more cost effective and more convenient for patients.

Incentives are being built into practice-based commissioning in the form of payments to GPs who take up practice based commissioning and, more importantly, by allowing any 'surpluses' generated through better management of budgets to be available for practices to reinvest into patient care.

Why is practice-based commissioning being implemented?

Giving GPs more power over resources used by their patients is not a new idea. Similar policies, including GP Fundholding and Total Purchasing Pilots, were implemented by the Conservative government in the 1990s. These experiments were abolished by Labour when it came to power in 1997. Even though the specific form of fundholding was rejected by the new administration, a commitment to the principle of a primary care-led NHS remained, and Labour retained the Conservative idea of having a local 'purchaser' of services which is separate from the 'provider' of those services.

The initial form of purchaser was the 'primary care group', which evolved into PCTs. An early commitment to devolving the commissioning function even further towards the front line was first mentioned by the Labour government in its 1997 White Paper *The New NHS*[1]. In this document, the government pledged to give all GP practices commissioning budgets for a full range of services. However, the White Paper did not specify the date when this would be delivered.

The June 2004 *NHS Improvement Plan*[2] added more detail. It committed PCTs to providing commissioning budgets to any GP practice that wanted them by April 2005. Since the *NHS Improvement Plan* the Department of Health has provided an increasing volume of guidance to PCTs and GP practices on implementing PBC, the most recent issued in February 2006.[3]

Practice-based commissioning draws together a number of policy strands. One is the long-standing commitment (since the 1990s) to use the knowledge and potential power of family doctors to commission services. The logic behind this is that GPs know their individual patients much better than a larger institution such as a PCT.

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Practice-based commissioning also derives from a desire to correct the balance of health care spending, which had tipped towards the acute sector, partly because of the government's relentless pressure on hospitals to reduce waiting times from 1998. This need for correction has become rather more urgent since 2003, as the full implications of NHS 'system' reform have become clear. The new Payment by Results (PbR) hospital payment system needs strong commissioning – and the creation of non-hospital alternative treatments – to counteract the incentives on the hospital sector to do more work. In other words, the system required more effective ways of managing demand for services. For this demand management to work, GPs who remain the key gateway to a great deal of hospital base care needed to be engaged in the decisions about the use of those NHS resources.

Practice-based commissioning has also been designed to act as a mechanism to stimulate services to provide some of the 'preventive' care which aims to keep people healthier and offer better care for chronic conditions. The need for better prevention to avoid future costs was spelled out in the first Wanless Report and subsequent White Paper *Choosing Health*.[4]

That theme has been elaborated further in the most recent White Paper *Our health, our care, our say*,[5] which envisages practice-based commissioning as one of the solutions to delivering effective prevention and innovative locally based health care, as well as giving patients more choice within primary care.

A lot of the NHS system reform now hinges on the successful implementation of practice-based commissioning.

When is practice-based commissioning to be implemented?

GP practices have been able to hold a commissioning budget since April 2005. There do not appear to be any routinely collected figures about how many practices have signed up, or indeed what signing up means in practice. However, according to an unpublished survey of 30 PCTs conducted in June 2005 by the Department of Health, only 20 per cent of practices were said to have 'participated' in practice-based commissioning at the time, although the same survey estimated that the number would rise to 70 per cent by June 2006.

The government's early guidance set a target for achieving universal coverage of practice-based commissioning in England by 2008. *Commissioning a Patient-Led NHS*, published by the Department of Health in July 2005, brought forward the timetable of implementation. This document directed PCTs to 'make arrangement for 100 per cent coverage of practice-based commissioning by no later than the end of 2006.'[6]

Although universal coverage is a target, GP practices cannot be forced to take part: the scheme remains technically voluntary. 'Universal coverage' will be monitored by tracking how many GPs take up an incentive payment (worth 95 pence for each registered patient) in return for a plan on how they propose to reform or redesign some of their services. The plan must be developed in consultation with the PCT.

How does practice-based commissioning work?

All PCTs have to supply practices with a budget and a set of data (every month) to help them understand how patients are using other services including:

- elective activity – inpatient and day case
- non-elective admissions, including information on length of stay
- use of diagnostic tests and procedures
- consultant to consultant referrals
- prescribing
- community and mental health services
- primary care including essential and enhanced PMS and GMS services, and
- accident and emergency attendances.

Uptake of the incentive payment represents a minimum level of engagement with the scheme. If a GP practice then achieves the changes, another incentive payment is payable (again equivalent to 95 pence per patient). The biggest incentive is the possibility of keeping up to 100 per cent of funds 'saved' by better services to plough back into the practice. However, the latest guidance recommends that PCTs keep up to 30 per cent of savings (to distribute elsewhere in the PCT), leaving up to 70 per cent for practices, although this will vary by PCT. Crucially, PCTs have been given latitude under certain circumstances to retain the full 30 per cent to offset deficits.

It is clear from the latest guidance that there will be, in effect, very different degrees of involvement with practice-based commissioning, ranging from a minimum (being in receipt of information and creating a short plan which envisages changes to a few services) to a proactive and entrepreneurial level, where practices might create their own alternative services and contract with other practices to provide them.

How are budgets set?

Unlike GP fundholding, practices will not have to negotiate prices (which are fixed according to the national tariff) nor will they directly administer funds. The funds are held by PCTs which remain legally responsible for them.

In the short term, budgets are based on past referral and hospital usage patterns. However, there are big differences between GP practices in the number of people they refer to outpatient clinics. Not all these variations can be explained by patient need and historical spending patterns risks entrenching poor practice rather than correcting it.

Over the longer term, therefore, the government plans to use a 'fair shares' approach to determine a GP practice's commissioning budget. A national formula will be used to calculate each practice's 'fair shares' budget, based on detailed information about the age, deprivation and other variables of patients in the area.[7] The expectation is that some GP practices will be substantially over and some will be under the target of what they should be spending.

For the time being, practices will not be faced with abrupt changes to their budgets that might result from a rapid shift from a historic to a weighted capitation formula. It will be up to PCTs to determine the pace of this change over the next financial year, but no target has been set.[8]

Commissioning budgets are 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.[9]

What sort of changes to services are possible under practice-based commissioning?

There is a growing body of examples of the sort of changes that can be made to services, generated by the minority of practices, or groups of practices, that have already become involved with initiatives to improve primary care.

- Reducing avoidable emergency admissions through better management of people with chronic conditions. GPs are becoming aware that some of their patients with illnesses such as diabetes are experiencing emergency admissions when their symptoms temporarily worsen. Under practice-based commissioning, GPs have incentives to improve care in the community, in order to prevent clinical deterioration and emergency admissions. Savings made through prevented admissions can be used to fund better primary care services. The Department of Health has collected examples which show reductions in hospital admissions, in one case of 50 per cent.[10]

- 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.

- 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.

Innovative examples exist in a range of specialties, including mental health, orthopaedics, ophthalmology and urology. Savings can be substantial. Evidence provided to a recent workshop of over 800 participants (GPs and practice managers) included savings of over £110,000 in one GP practice in East Devon PCT which had adopted a form of practice-based commissioning two years ago. The underspend came from reducing emergency admissions of people with long term conditions by purchasing extra hours of nursing, social work and pharmacy care.[11]

Will practice-based commissioning work?

To make practice-based commissioning work, there are several practical challenges to be overcome, not least the provision of accurate and timely data about costs and hospital usage. The environment for rapid change is not altogether promising, with all PCTs being merged and a substantial minority in deficit. But the biggest challenge is the effective engagement of all GPs. It is not clear whether recent increases in GP salaries will be an incentive or disincentive to deliver change. PCT deficits – or top-slicing resources from PCTs in surplus, as is happening in London – may well act as a powerful disincentive for GPs to get embroiled in what they may perceive to be a debt-sharing scheme, especially as the latest guidance allows PCTs to use GP-generated 'profits' to offset their own deficits. On the other hand, GP engagement with the incentives contained in the 'Qualities and Outcomes Framework' (part of the GP contract) appears to have been high.

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[12]. The relatively tight timetable of achieving universal coverage by the end of 2006, the financial uncertainty and the re-organisation of PCTs make the delivery of practice-based commissioning very challenging in the short term.

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[1] See Department of Health (1998) *The New NHS*. London: The Stationery Office.
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[2] See Department of Health (2004) The *NHS Improvement Plan: Putting People at the Heart of Public Services*, p 68 to p 73
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[3] See Department of Health (2004) *Practice Based Commissioning: Engaging Practices in Commissioning* Department of Health (2004) *Practice Based Commissioning: Promoting Clinical Engagement.* London: The Stationery Office.
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[5] Department of Health (2006) *Our health, our care, our say: a new direction for community services* London: The Stationery Office.
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[6] Department of Health (2005) *Commissioning a Patient-Led NHS*, p 6.

[7] *Supporting practice-based commissioning in 2006/07 by determining weighted capitation shares at practice level.* Department of Health 2006.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127155&chk=f7Nx8B

[8] Department of Health (2006) *Practice-based commissioning: achieving universal coverage*, p 9.

[9] Department of Health (2006) *Practice-based commissioning: achieving universal coverage*, p 8.

[10] Department of Health (2006) *Practice-based commissioning: early wins and top tips*

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