The King's Fund

Ideas that change health care

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PBC two years on
Moving forward and making a difference?

nhs alliance

Executive summary

Practice-based commissioning (PBC) has been a major strand of NHS policy since 2005. There continues to be a high level of commitment to the policy among GPs, but many still remain hesitant about its impact to date and unsure if its potential will be fulfilled.

In 2007, The King's Fund and NHS Alliance conducted a straw poll, which found that there was a long way to go in terms of putting the basics of budgets, data provision and support in place for PBC. At that point, more than 70 per cent of respondents felt that PBC had not improved the quality of patient care (Lewis *et al* 2007).

Now, two years on, how is PBC working? Has PBC moved forward and is it making a difference to patient care?

Our 2009 survey has found that commitment to PBC among respondents is high and has increased since 2007. Respondents largely felt positive about the potential for PBC to make a difference to patient services. In addition, progress has been made towards developing formal agreements and structures. However, alongside these positive changes remain some enduring problems. Many of the problems highlighted in this survey – for example, a confusion over roles, low engagement among clinicians and a lack of clarity over the purpose and vision for PBC at a local level – were also highlighted in the 2007 survey.

Although the Department of Health has gone some way towards developing and promoting a clear vision for PBC at a national level and reaffirming its place at the heart of commissioning, it is evident that the lack of vision and direction for PBC at a *local* level is still playing a major part in dampening

enthusiasm and engagement. Indeed, although commitment to the policy remains high, the 2009 survey found that more than half of clinicians who responded reported feeling 'not at all' or 'not very' engaged.

So, where now for PBC? There have been some positive shifts and some progress made since 2007 but it is apparent that certain issues still need urgently addressing. Whatever form PBC takes (be it as integrated care organisations or otherwise), it is clear that, as the NHS faces one of its most significant financial challenges yet, a productive and mutually beneficial partnership between primary care trusts (PCTs) and their clinicians will be critical to success as the service seeks to balance cost, quality and productivity.

Introduction

Practice-based commissioning (PBC) has been a major strand of NHS policy since 2005. The government's target to achieve 'universal coverage' was achieved by December 2006. More than three years on from the achievement of this target, although we are beginning to observe the beginnings of change, progress has been slow and significant issues remain.

The King's Fund and NHS Alliance carried out a straw poll of GPs and practice managers in April 2007 (Lewis *et al* 2007) in order to assess how much progress had been made towards implementing PBC and whether any impact was being felt. The report found that very minimal progress had been made and identified what was needed to speed up implementation. A further report from The King's Fund, published in late 2008, which looked in depth at the development of PBC in four PCTs, found that little progress had been made and that significant barriers still remained. However, the March 2009 wave of the quarterly practice survey commissioned by the Department of Health from Ipsos MORI in March 2009 suggested that progress is being made. Since the Ipsos MORI survey began in October 2007, support for the policy has been steadily increasing. The latest wave of the survey found that the number of services commissioned and provided by practice-based commissioners had increased, and the proportion of practices that felt PBC has improved patient care had risen (Department of Health 2009a).

Since The King's Fund/NHS Alliance survey of 2007, the Department of Health has sought to reinvigorate PBC through the NHS Next Stage Review (Department of Health 2008) and to reaffirm its vision for the policy (Department of Health 2009b).

In March 2009, the Department of Health made clear that successful PBC is a pre-requisite of successful world class commissioning (Department of Health 2007c). The vision clearly laid down the entitlements of practices/PBC clusters and the expectations on PCTs to support PBC. It:

- made it clear that if PCTs do not get behind PBC and deliver on the expectations they will not achieve level 2 of world class commissioning
- clarified that both PCTs and strategic health authorities (SHAs) will be held to account for delivery of successful PBC
- provided the opportunities for greater devolution of responsibility, with accountability, for PBCs that develop expertise and demonstrate effectiveness (including the possibility of 'hard budgets') (Department of Health 2009b).

The vision, however, did not provide any further practical guidance on how the barriers identified within The King's Fund's 2008 report should be overcome.

The King's Fund/NHS Alliance 2009 online survey of practices and PBC clusters across England aimed to assess whether PBC has moved forward since the straw poll of 2007. It asked whether attitudes towards PBC have changed and whether the Department of Health's reaffirmation of its national vision has provided the impetus needed to overcome the barriers.

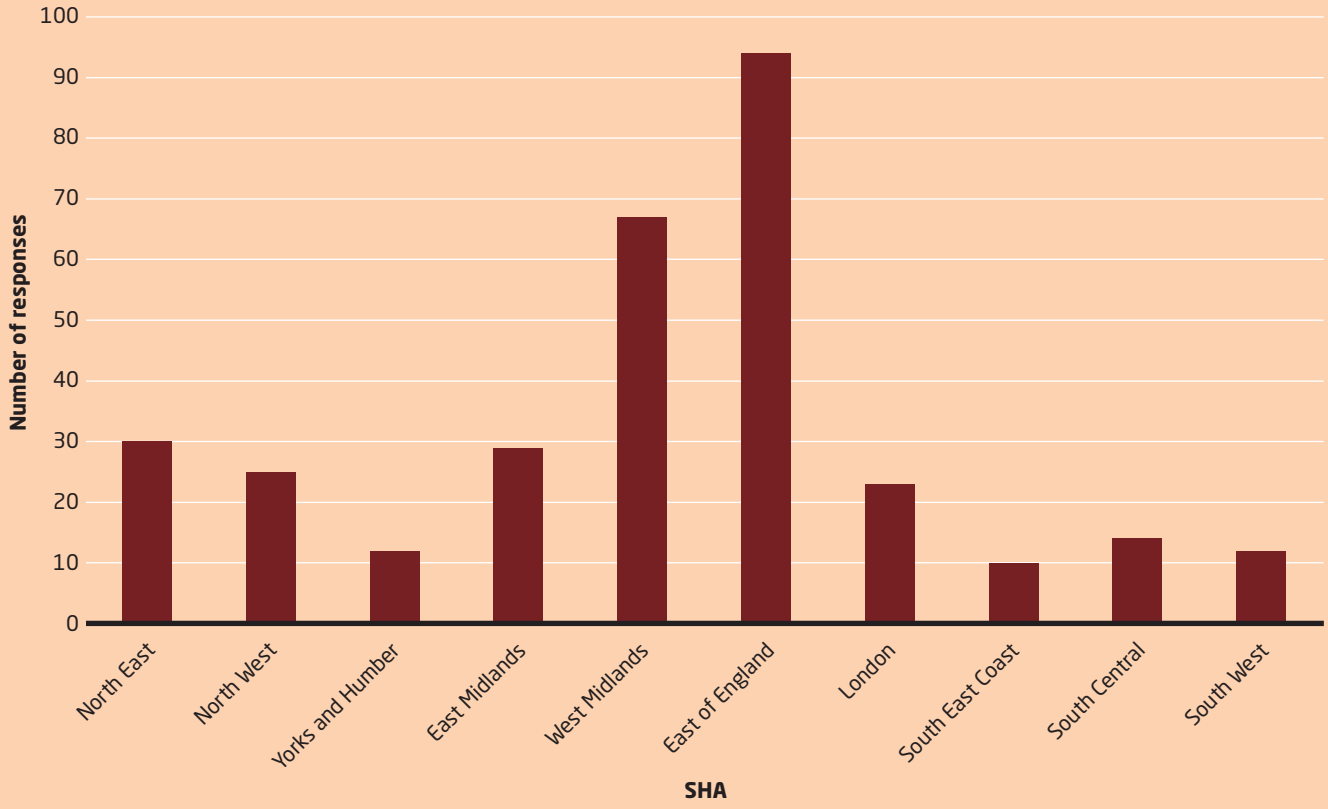
The state of PBC – our findings

Responses

The survey was sent out via email to the NHS Alliance members' network as well as to the PBC consortia/practices identified through NHS Networks' 'PBC connection'. A response was submitted by 321 people, which compares favourably with the 257 responses received in 2007. Recipients were encouraged to forward on the survey to colleagues so it is not possible to calculate an exact response rate. This survey could be described as a straw poll; it is not a representative sample and we do not claim that the results necessarily represent the views of the wider GP, practice manager and PCT community. However, we do believe that it provides a valuable insight into the views of those most closely involved with PBC.

In the sample, 95 different PCTs (63 per cent of all PCTs in England) were represented; respondents were from all SHAs, but the representation was rather unequal, with half being from the East of England or West Midlands SHAs.

Figure 1 Number of responses by SHA



The breakdown of respondents by professional group is shown in figure 2, overleaf, and cluster size in figure 3. Interestingly, 45 per cent of respondents were GPs. The remaining respondents came from a wide range of backgrounds – for example, practice managers, chief executives, PCT managers, information analysts, commissioning managers and business managers. Therefore, it should be noted that the opinions and views presented in this paper are not just those of GPs but of a broader range of professionals. Due to the small numbers in some of the groups, analysis by sub-group has not been undertaken except in a small number of instances.

The majority of respondents represented clusters with more than 10 practices and covered populations larger than 50,000.

Figure 2 Respondents by professional group

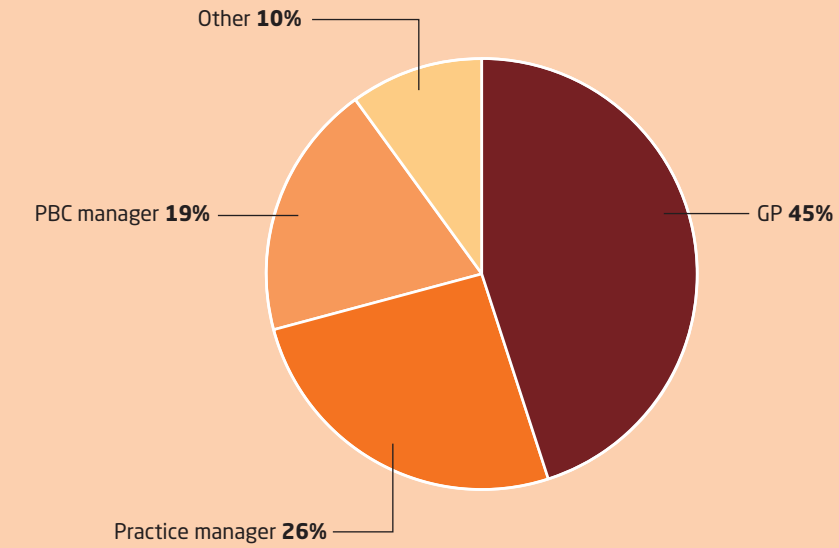
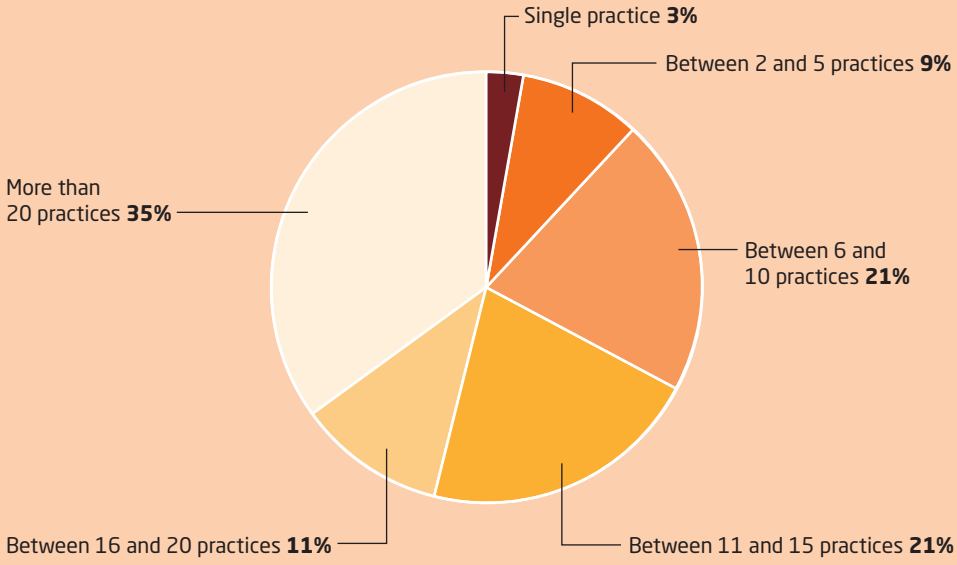


Figure 3 Cluster size



Commitment and engagement

Commitment to PBC among those at the front line is a key factor in its success. Results indicated that commitment to PBC had increased since 2007 (*see* figure 4, opposite).

- The percentage of respondents registering very high or high commitment to PBC increased from 73 per cent in 2007 to 78 per cent in 2009.
- The percentage of respondents registering low or very low commitment to PBC fell from 27 per cent in 2007 to 22 per cent in 2009.

When this data is examined by professional group, it shows that there is a very high commitment among PBC managers but a more variable picture amongst practice managers and GPs.

Figure 4 Commitment to PBC: 2009 compared with 2007

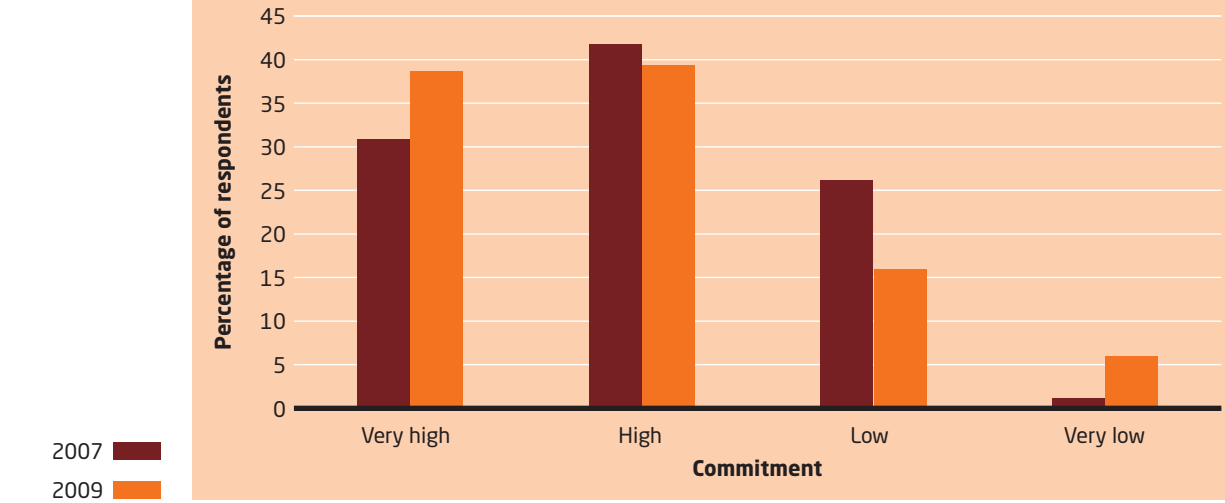
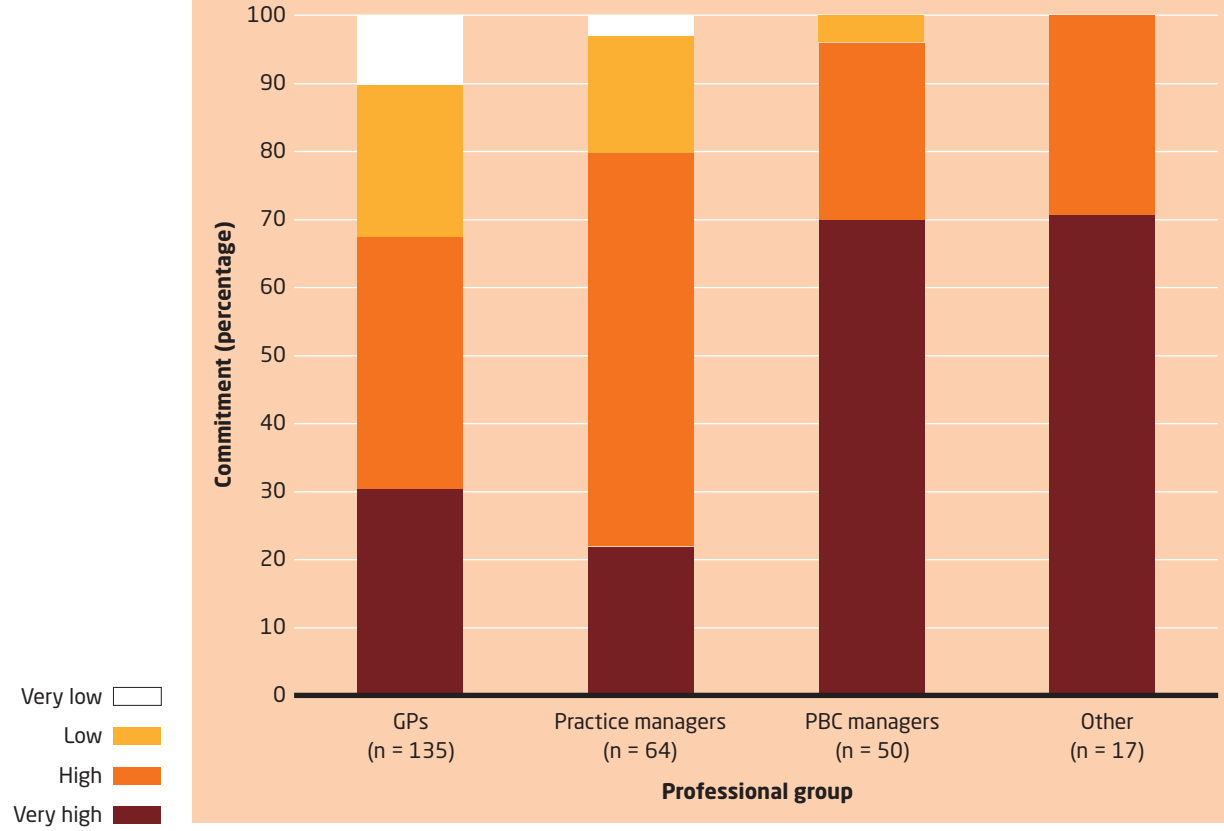


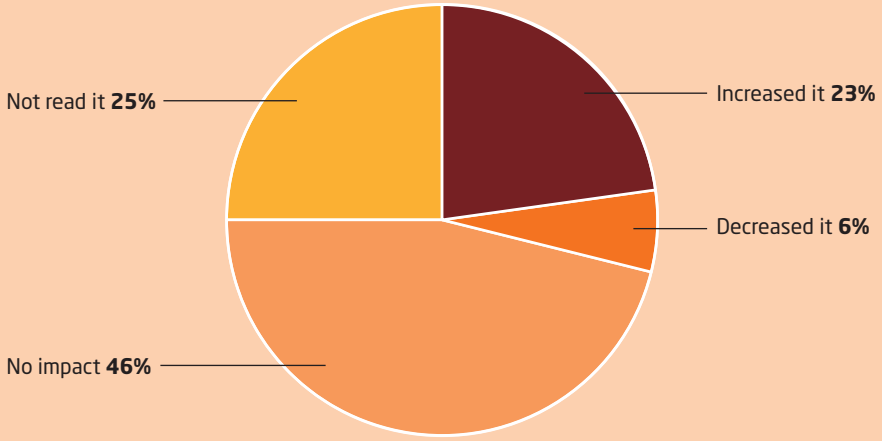
Figure 5 Commitment to PBC by professional group



Respondents were asked whether the Department of Health's recent document *Clinical Commissioning: Our vision for practice-based commissioning* (Department of Health 2009b) had had an impact on their commitment. As figure 6, overleaf, shows, 23 per cent of respondents said that it had increased their commitment.

The most frequently cited reason for increased commitment was that the document had confirmed that PBC is a national priority. Others who said it had increased their commitment said that it had provided a clearer indication of the vision for PBC and put clinicians firmly at the heart of commissioning. The majority of those who said the document had decreased their commitment said that it was all rhetoric with no specifics.

Figure 6 Impact of Department of Health's 'vision' document on respondents' commitment to PBC

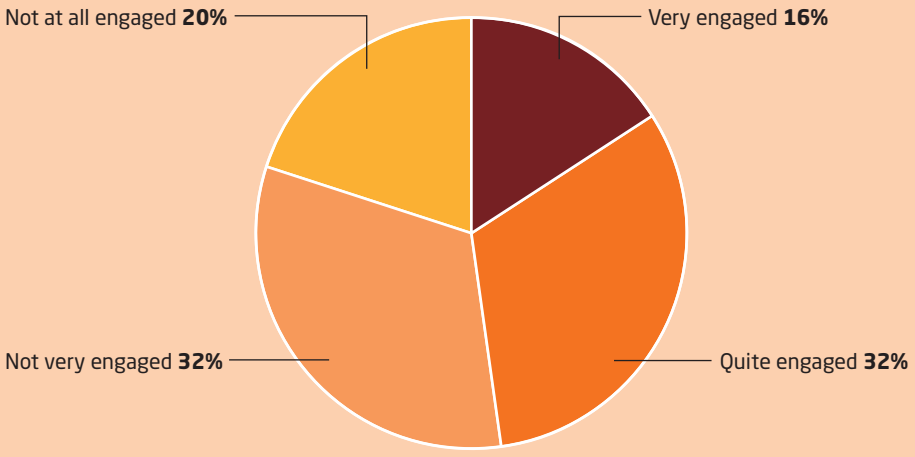


Clearly, PCTs have an important role to play in harnessing commitment and engagement. A key issue highlighted in The King's Fund report of 2008 (Curry *et al* 2008) was that primary care professionals felt that their PCT did not consider PBC to be a high priority. The results of this survey indicated that 22 per cent felt PBC was a very high priority for their PCT and a further 42 per cent thought it was a high priority. Only nine per cent thought it was a very low priority.

The Department of Health has set out PCTs' responsibility to foster clinician engagement and sees PBC as a key vehicle by which this will be achieved. One of the world class commissioning competencies states that PCTs must 'lead continuous and meaningful engagement with clinicians to inform strategy, and drive equality, service design and resource utilisation' (Department of Health 2007b).

Of the clinicians who responded, 52 per cent said they still do not feel very, or at all, engaged by their PCT at a local level (*see* figure 7, below) despite the high levels of commitment to the policy.

Figure 7 Level of engagement among clinicians



'Oiling the wheels of PBC' – having the basics in place

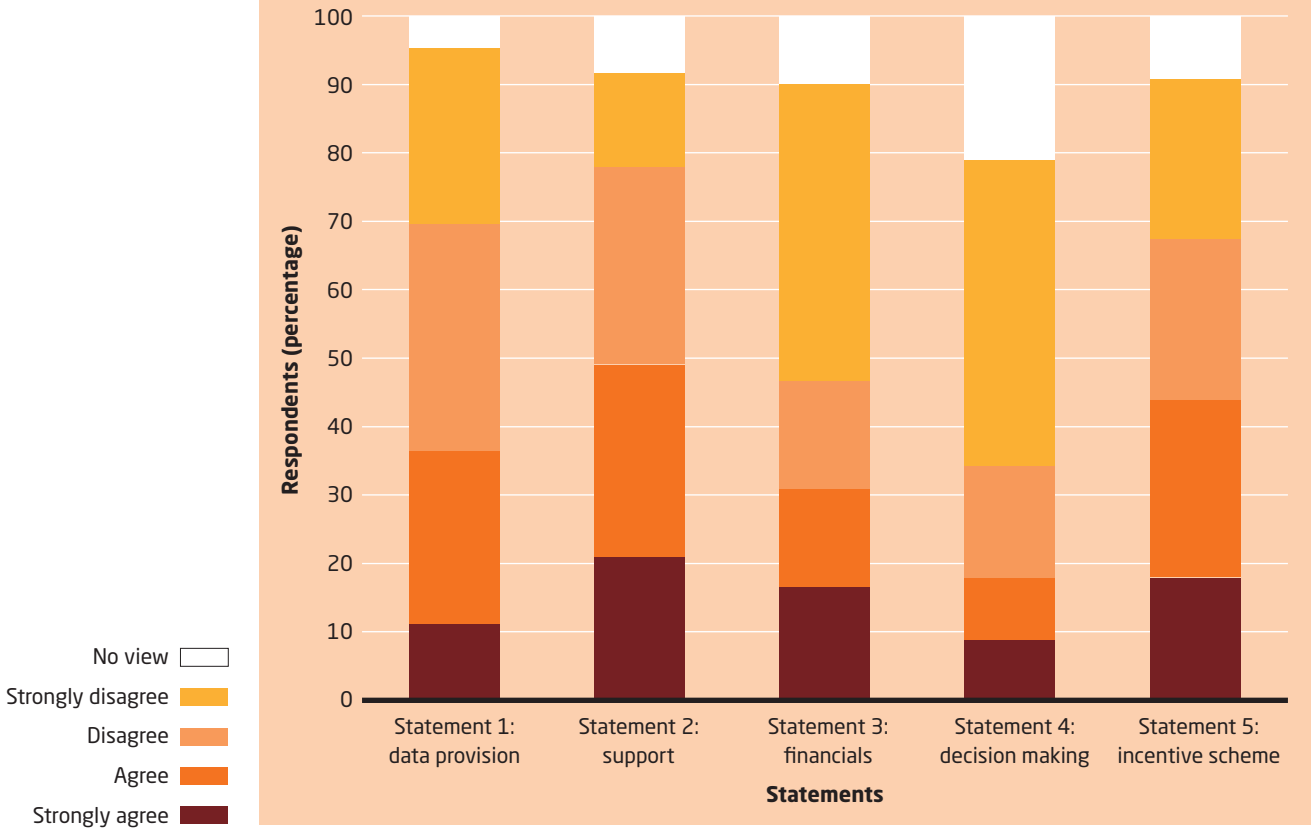
Previous research has indicated that there are basic components that need to be in place for PBC to operate effectively. These basics include such elements as budgets, information, and management support. The Department of Health document published in March 2009 (Department of Health 2009b) sets out a number of entitlements for practice-based commissioners which, in effect, form the basic building blocks of PBC.

Table 1 Explanation of the entitlements for PBC

Entitlements for practice-based commissioners*	
Statement 1	My PCT provides me with accurate, timely data and analysis, in particular on budgets, expenditure, referrals, prescribing, activity and, where possible, clinical performance.
Statement 2	My PCT provides a package of support that includes, as a minimum, a management allowance, designated support from PCT staff and/or external partners (eg, from the development framework), and a plan setting out how the PCT intends to support PBC development needs.
Statement 3	My practice received our indicative budget and had agreed our management and financial support with the PCT by 1 May 2009.
Statement 4	My PCT makes decisions on PBC plans and business cases within a maximum of eight weeks.
Statement 5	My PCT has agreed PBC incentive schemes that promote better health, better care and better value in specific areas.

* Adapted from DH guidance

Figure 8 Respondents' views on the extent to which their PCT was meeting the entitlements



Less than 50 per cent of respondents agreed or strongly agreed with each of the five statements, indicating that significant progress is still required if PCTs are to properly fulfil the entitlements. Statements around financial support and budgets and decision-making on business cases are rated particularly poorly with only 31 per cent agreeing

or strongly agreeing that they had received and agreed their indicative budget and their management and financial support by 1 May 2009. Only 18 per cent agreed or strongly agreed that their PCT makes decisions on PBC plans and business cases within a maximum of eight weeks.

In 2007, 33 per cent of respondents rated the support provided by their PCTs as 'poor'. Results for 2009 show that provision of support is still highly variable.

However, one positive signal was that, looking forward into 2009/10, almost two-thirds of respondents said that there was a management budget in place in their PCT to support PBC. Table 2 sets out the level of budget.

Table 2 Level of management budget for 2009/10

Amount	Number	%
Up to £1 per patient	46	28
Between £1 and £2 per patient	64	39
More than £2 per patient	15	9
Don't know	38	23

Budgets and incentives

Accurate budget setting is one of the key basic building blocks of PBC but continues to be an issue on which further progress needs to be made.

There have been some clear improvements, but there is still some way to go before 100 per cent of practice-based commissioners have a budget set by 1 May of the financial year as per the Department of Health guidance (Department of Health 2009b).

- 43 per cent of respondents had an agreed budget for 2009/10 by the time of this survey (mid-May 2009), which suggests this process needs to be accelerated in future years.
- 74 per cent had a budget agreed in 2008/9, representing a clear improvement from 2007 where only 30 per cent of respondents had a budget agreed.

According to Department of Health guidance, budget setting should be moving towards what it calls 'fair shares' (Department of Health 2007a), which is a method for calculating budgets based on the needs of the practice population, not just on historical spending and referral trends. When asked on what basis their budget had been set, it is evident that there has been some good progress towards using the fair shares methodology.

- 21 per cent of 2009/10 budgets were at fair shares compared with 7 per cent of 2008/9 budgets.
- There had been a corresponding reduction in the use of historical activity as the basis for budgets from 33 per cent in 2008/9 to only 12 per cent of 2009/10 budgets.

One of the key incentives for GPs to engage with PBC is the possibility of retaining a share of any budgetary surplus for reinvestment in patient services. In 2007, 14 per cent did not expect to underspend. In 2009, 49 per cent did not expect to underspend.

The Department of Health suggests that practice-based commissioners should retain 70 per cent of any underspend with 30 per cent being retained by the PCT. Results of the survey reveal that a greater proportion of practices expected to retain 70 per cent in 2009 compared with 2007 (42 per cent in 2009 and 16 per cent in 2007).

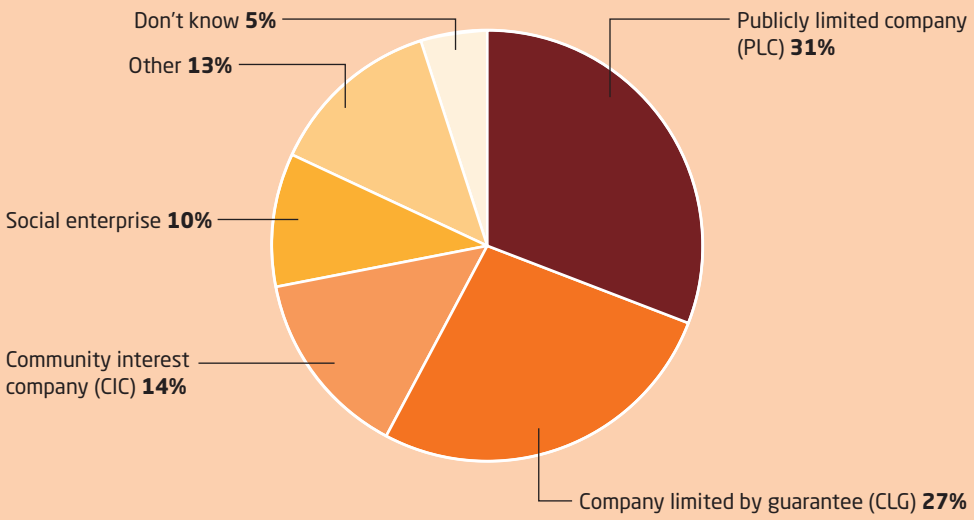
Governance, roles and accountability

Previous research has identified as barriers to progress a lack of appropriate governance, a lack of local PBC agreements about who does what, an absence of organisational architecture (whether formally constituted or not) and a lack of clarity around the purpose and vision for PBC.

The results of this survey suggest that a more formalised approach is being taken to PBC, with an emphasis on the cluster rather than the single practice as the key unit. Results show that:

- 48 per cent of respondents said there was a clear and articulated vision for PBC agreed between the PCT and the cluster
- 57 per cent of respondents said that their PBC budget was held at a cluster level rather than at their own practice
- 52 per cent said that their cluster had developed a constitution
- 60 per cent said there was an agreed governance framework between their cluster or practice and their PCT
- 40 per cent said there was an agreement in place in their PCT as to how conflicts of interest are to be managed
- 30 per cent of respondents said that their cluster had formed a formal organisation (constituted in a number of different ways – *see* figure 9, below).

Figure 9 Type of formal organisation formed by clusters



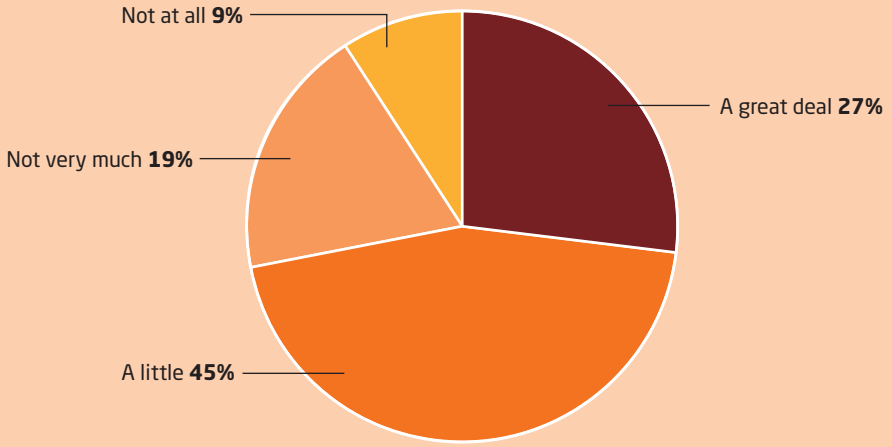
Although these results indicate the development of more formal structures, there appears to be a continued lack of clarity about the delineation of roles and responsibilities between the cluster/practice and the PCT despite the call for a clear 'rules of engagement' document to be produced at a local level (Department of Health 2009b). More than half of respondents (56 per cent) said that there was no clarity around roles.

Having an impact: being able to make a difference to health care services locally

The King's Fund's 2008 report (Curry *et al* 2008) found that most of the GPs who described themselves as highly committed to, and very engaged with, PBC said that the key motivation was the potential to improve health care for their patients. The most recent Ipsos/MORI survey stated that 'there is an increasing trend in the proportion of practices that agree PBC has improved patient care'. Our 2007 and 2009 surveys also reflect this positive shift.

- In 2007, only 19 per cent of respondents felt that PBC had had an impact on patient care and 54 per cent felt that it had not impacted on patient care at all.
- The 2009 results suggest a more positive attitude. When looking forward from 2009, 72 per cent of respondents said they felt PBC had the potential to impact upon patient care in the next two years.

Figure 10 Respondents' views on whether PBC would help to improve patient care over the next two years



Commissioning services

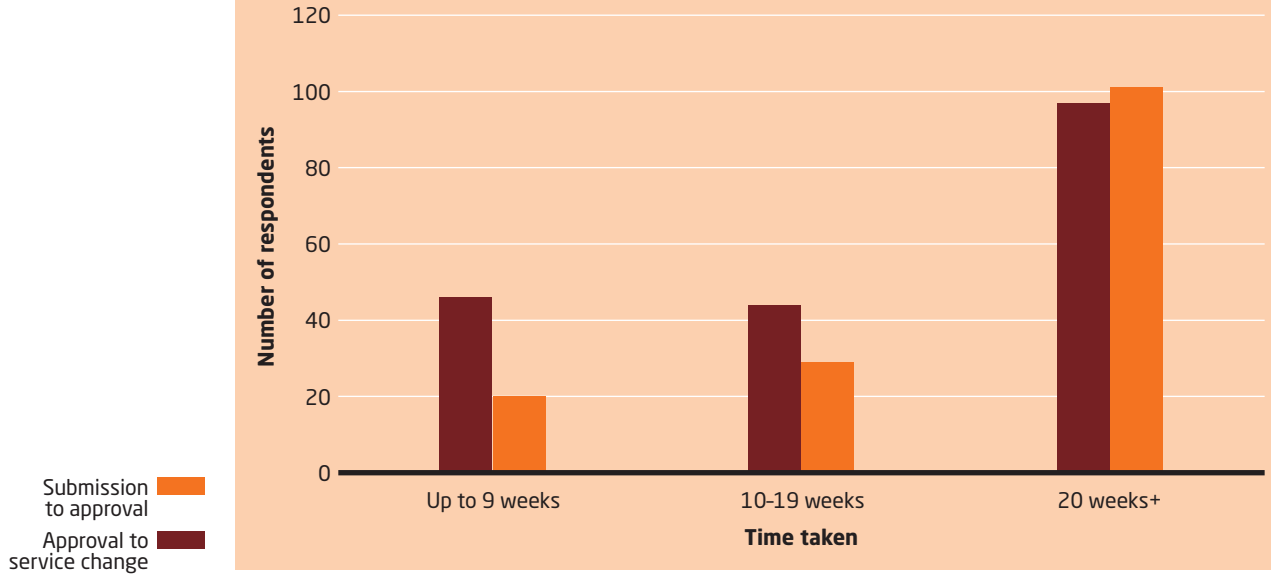
Department of Health guidance (Department of Health 2009b) specifies that a PCT should make a decision on a business case within eight weeks. The latest Ipsos MORI survey on PBC (Department of Health 2009a) found that an increasing number of services are being commissioned through PBC, but our survey revealed that turning a good idea into service change is still no easy or swift task. In particular, our results showed that (*see* figure 11, opposite):

- 29 per cent of respondents who had submitted a business case said that, on average, it takes 25 weeks or more for it to gain approval
- 35 per cent of respondents who had submitted a business case said that, on average, it take 25 weeks or more for service change to happen following approval of the business case
- in almost half of all cases, it takes almost a year for a business case to go from being submitted to service change taking place.

One of the issues highlighted in the 2008 report from The King's Fund (Curry *et al* 2008) was the lack of appropriate robust and proportionate governance processes in place at

PCT level. Whatever the reasons for the drawn out timeframes being reported in this survey, attention needs to be given locally to resolving this, not least as in this survey slow pace and too much bureaucracy remain two of the most often cited barriers (*see* table 3, p 13).

Figure 11 Time taken for PCT decision on business cases

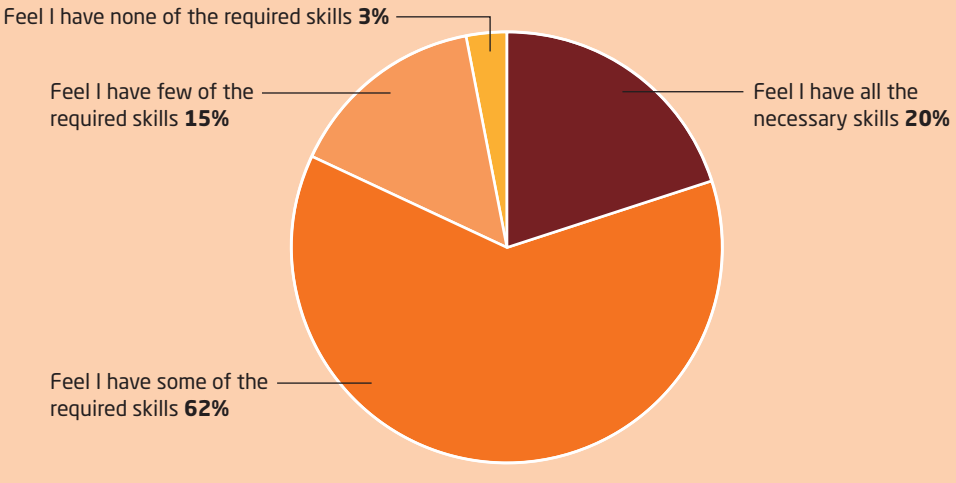


Skills

Other research (Curry *et al* 2008) has suggested that a range of factors could be contributing to the slow pace at which good ideas are turned into practice. One of those factors is a lack of appropriate skills at both cluster/practice and PCT level in developing robust business cases and having appropriate processes in place to consider them.

This survey asked respondents if they felt they had the skills necessary to undertake effective PBC. Only 20 per cent felt that they had all the necessary skills. Major skills that they felt they lacked included negotiation, financial aptitude, data analysis, management, influencing and commissioning.

Figure 12 Respondents' views on whether they had the skills required for PBC



Relationships

The survey also explored the impact PBC was having on working relationships. In a picture similar to that painted by the 2008 research (Curry *et al* 2008), this survey suggests that one of the more positive impacts of PBC has been an improvement in some working relations.

- 66 per cent thought PBC had had a positive impact on working relationships between GPs with 27 per cent reporting no impact and 7 per cent that it had worsened relationships.
- 45 per cent thought PBC had improved relationships between GPs and PCTs, with 21 per cent reporting worsened relationships.
- 32 per cent thought working relationships with their local trusts had improved; 23 per cent thought they had worsened.

Aspirations

Respondents were asked what they would like PBC to enable them to achieve in the near future. Of the 187 responses, only six suggested that PBC be abandoned entirely. Other responses were many and varied but the most popular included:

- bringing about better patient care (in terms of, for example, access or quality or in terms of a specific issue, for example, long-term conditions) and/or an improved patient experience
- better joint work with other GPs, PCTs and other stakeholders
- more autonomy for GPs to make decisions about day-to-day service delivery. Some of these respondents called for real budgets to underlie this and others called for a shift in power from secondary to primary care
- embedding clinical engagement in commissioning and for PBC to be seen as an integral part of commissioning, not set apart.

A lot of respondents said they 'just want to achieve something', which suggests that, as recommended in The King's Fund/NHS Alliance 2007 survey report (Lewis *et al* 2007), some quick wins are needed to retain engagement.

Barriers to 'doing the job'

Although the results set out above indicate that there have been some changes since 2007, what is disappointing is that many of the same barriers that emerged in that survey and in the 2008 report are cited again in this survey, only with a subtle reordering of frequency (*see* table 3, opposite).

The perceived lack of interest and priority at PCT level along with burdensome governance and information issues continue to hamper progress. Financial limitations were deemed to be an obstacle by fewer respondents in 2009 than in 2007, perhaps reflecting the harsh financial reality that many health economies faced in 2007. It is, therefore, likely that the looming financial challenges of the coming years are going to pose a significant challenge to the further development of PBC.

Another striking observation is that, despite the recent efforts put into clarifying the national vision and embedding clinical engagement in commissioning, lack of engagement among GPs was still cited by 8 per cent of respondents, and conflicting vision and purpose for PBC was cited by 9 per cent.

Table 3 Barriers to progress in PBC cited by respondents

Identified barrier	% of respondents (some respondents identified more than one barrier so does not total 100%)
Issues at PCT level (including slow pace, risk aversion, instability, disinterest)	27
Lack of time	24
Too much bureaucracy	11
Poor relationships	10
Data and information issues (eg, unavailability/poor quality)	10
Lack of autonomy and influence amongst PBCs	10
Conflicting vision and purpose for PBC	9
Lack of support (admin, managerial and analyst)	9
Financial limitations (PBC is not properly invested in)	8
Lack of engagement/disillusionment among GPs	8
Secondary care sector power	7
Lack of appropriate skills	5
Weak financial incentives	4

Discussion: so, have things moved on?

The results of this 2009 survey suggest that progress has been made in some aspects of PBC, but that there appear to be enduring issues that continue to frustrate the full implementation of PBC. Although some of the positive messages that are emerging from the Ipsos/MORI survey (Department of Health 2009a) are reflected in this survey, many of the key messages of The King's Fund 2008 research (Curry *et al* 2008) are confirmed here, suggesting that little has changed in the past 12 months.

It is evident from these results that commitment to the policy remains high and has even increased slightly since 2007, but it is concerning that, despite that high commitment, there is a lack of engagement of clinicians by PCTs at a local level. The positive impact on relationships that PBC has fostered in some areas might go some way to securing ongoing commitment and encouraging engagement among some, but it is evident that other barriers are preventing or discouraging others from getting behind it. Given that one of the key tests for world class commissioning competency is effective clinical engagement, and that clinical engagement in commissioning is confirmed by the Department of Health as essential for success, this will need further attention by local health communities.

One of the most striking results to emerge from the 2009 survey was the length of time it takes for business cases to pass through the system, suggesting that the issue of cumbersome bureaucracy –identified in previous research and in this survey as a key barrier – endures. The cause of lengthy business case approval processes was not explored in this survey, but the lack of appropriate skills (financial experience, negotiation and so on) among practice-based commissioners could be a contributory factor, as could the existence of disproportionate governance processes at PCT level – an issue identified by the Department of Health in its latest vision for clinical commissioning (Department of Health 2009b).

Although the business case approval process is bound to impact on enthusiasm, it was remarkable that one of the more positive messages to come out of this survey is the confidence that people have that PBC still has the potential to bring about service change for patients. Although the impact on services for patients in 2007 was largely non-existent, the majority of respondents to the 2009 survey felt that PBC still had the potential to bring about change for patients. Interestingly, very few respondents directly called for the policy to be abandoned.

Despite the continued confidence in its potential, it is clear that PCTs are still struggling to put in place the basic building blocks of PBC. While it is undeniable that significant progress has been made towards implementing fair shares budgets since 2007, the majority still do not have financial support, adequate information or clear incentive schemes in place. As the financial position of the NHS worsens, further financial incentives may not be realistic, so it is essential that other non-financial incentives are developed. The Department of Health's vision document has at least clarified exactly what entitlements practice-based commissioners have and it may be that that clarification might now enable PCTs and practice-based commissioners to work together to embed those basic building blocks.

One of the most interesting developments highlighted by this survey was that there appears to have been a shift towards a more formal approach to PBC. This might indicate the beginnings of progress towards the future vision set out in the latest Department of Health document where clinicians take on increasing levels of autonomy as they move towards a model of integrated care (Department of Health 2009b). The relatively large cluster sizes and the relatively large proportion of clusters that have developed formal organisations suggest that practice-based commissioners are beginning to see the strength in a more formalised approach. Whether that is more likely to bring about results is yet to be seen. In addition, the high number of respondents reporting the existence of constitutions, governance frameworks and policies for dealing with conflicts of interest that had been agreed with PCTs suggest that the need for robust and formal governance structures has been recognised. This more formal approach was called for in The King's Fund's 2008 report (Curry *et al*) which warned that, if PBC remained a voluntary partnership between practice-based commissioner and the PCT where accountability structures were unclear, the policy was unlikely to succeed.

The recent Department of Health documents have no doubt helped to direct wavering interest back to PBC and to reaffirm its position as a key national policy. The results of this survey suggest that this reaffirmation of PBC as a national priority has gone some way to pushing the agenda forward but what has become clear is that the operational details need to be addressed at a local level and that prescriptive national guidance is not going to be forthcoming. While the components of 'good' PBC have been explored and set out in previous papers (Wood 2009), what still remains unclear is how practice-based commissioners and PCTs achieve that. However, there are indications in this survey that there are some issues, particularly relating to performance management and governance, that could (and should) be addressed.

- While the national vision has been clarified, there is a need to translate this, and make it relevant, to the local context.
- As set out in Department of Health guidance, the development of local 'compacts' or 'rules of engagement', which outline clearly who will do what and what support can be expected, are essential in overcoming the confusion about where responsibility lies.
- Clear lines of accountability are critical to any effective governance process. Accountability structures need to operate at multiple levels: practice-based commissioners need to be held to account by PCTs; PCTs need to be held to account by SHAs; and, in turn, SHAs need to be accountable to the Department of Health for fostering the development of resilient partnerships.
- Business case approval processes remain cumbersome and need to be streamlined so as to be appropriate and proportionate while still being robust.

Where next for PBC?

Much speculation has taken place over the past year as to the direction in which PBC is heading. These results appear to indicate that there is little appetite for abandoning the policy but that progress continues to be hampered by recurring barriers. The recent reaffirmation of the policy as a national priority and the clarification of the national vision should go some way to harnessing what enthusiasm still remains for PBC. Whether that is enough to motivate real service change at a local level is yet to be seen.

What is clear is that, whatever form PBC takes (be it as integrated care organisations or some other model), as the NHS moves into a period of restricted financial resources where critical investment and disinvestment decisions will have to be made, it will become increasingly important for the PCT and clusters/practices to work closely alongside each other in an increasingly expert co-commissioning partnership. Bringing about this partnership will require real clinical engagement anchored by clear locally developed visions, structures and agreements (local 'compacts'), and lines of accountability.

References

Curry N, Goodwin N, Naylor C, Robertson R (2008). *Practice-based commissioning: Reinvigorate, replace or abandon?* London: The King's Fund.

Department of Health (2009a). *Practice based commissioning: GP Practice Survey: Wave 1–6*. London: Department of Health. Available at: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Practice-basedcommissioning/DH_076565 (accessed on 11 June 2009).

Department of Health (2009b). *Clinical Commissioning: our vision for practice based commissioning* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095692 (accessed on 17 June 2009).

Department of Health (2008). *High Quality Care for All: NHS Next Stage Review Final Report*. London: Department of Health.

Department of Health (2007a). *Practice Based Commissioning – Budget Setting Refinements and Clarification of Health Funding Flexibilities, Incentive Schemes and Governance*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081101 (accessed on 11 June 2009).

Department of Heath (2007b). *World Class Commissioning: Competencies*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080958 (accessed on 18 June 2009).

Department of Heath (2007c). *World Class Commissioning: Vision*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956 (accessed on 18 June 2009).

Lewis R, Curry N, Dixon M (2007). *Practice-Based Commissioning: From good idea to effective practice*. London: The King's Fund.

Wood J (2009). 'PBC: Why managers should still give it air time!' *Management in Practice*, vol 17.

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