

NPCRDC Briefing:

Practice-based Commissioning: theory, implementation and outcomes.

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National Primary
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BACKGROUND

Practice-based Commissioning (PBC) was gradually introduced to the English National Health Service (NHS) from 2004 to generate front-line clinical engagement with the commissioning process. It was officially seen as a complement to patient choice of provider, payment by results of provider, and the roll-out of foundation trusts. The essence of PBC is that general medical practices are provided with an 'indicative budget' to commission services for their patients. It was expected that practices, or groups of practices (consortia), would seek to redesign services to provide better experiences for patients as well as save money. Money saved was to be available for practices to invest in improved patient services. PBC was not officially specified in detail so implementation varied locally.

The aim of this research was to describe and analyse the rationale for, and implementation and outcomes of, PBC in the English NHS over a period of 27 months (2007-2009). The research was split into 3 phases:

- Interviews with civil servants and close reading of documentation to look at the rationale for PBC (2007);
- A questionnaire survey of Primary Care Trusts – PCTs 2007;
- Case studies of 'early adopters' implementation (2007), followed by further case studies on the impact of PBC (2008-2009).

See www.npcrdc.ac.uk/r5.82 for further details.

THEORY OF PBC

The initial examination of documents associated with PBC and interviews with civil servants identified two 'programme theories' as to how PBC could operate:

- Theory A suggested that the prime mechanism would be via the redesign of services by PBC groups;
- Theory B suggested that the prime mechanism would be the use of a wider range of providers.

In practice we found that programme Theory A (redesigning services) was a better descriptor of what was present on the ground, with little apparent appetite amongst our sites for extending the range of providers.

IMPLEMENTATION

PBC was in a fluid state, with organisational forms not yet finalised, and much ongoing effort in relation to developing patient pathways, PBC budgets, incentive arrangements and governance structures.

- The 'consortium' approach (groups of practices) was by far the most frequent arrangement for the operation of PBC.
- By 2007, about one-third of consortia had been given indicative budgets of the scope suggested in official guidance (Department of Health 2006), with two thirds of consortia allocated budgets that covered a narrower range of responsibilities.
- The large majority of PCTs had either developed, or were in the process of developing, local incentive schemes for PBC.

OUR MAIN FINDINGS AND THEIR IMPLICATIONS FOR POLICY ARE SUMMARISED IN THE FOLLOWING TABLE:

IMPORTANT FACTORS IN THE DEVELOPMENT OF PBC AND THEIR POLICY IMPLICATIONS

OUR FINDINGS	POLICY IMPLICATIONS
<p>Clinical engagement and legitimacy</p> <ul style="list-style-type: none"> • The relationship between PBC groups and their PCT was the single most important factor affecting GP engagement. • Many GPs across all sites saw the overall PBC project and the actions taken in its name as legitimate. • The degree of engagement in the day-to-day activities of PBC varied from participation in PBC governance, through communication of PBC decisions and services to colleagues, to practice-level action such as internally reviewing referral decisions and utilising new patient pathways and services resulting from PBC. • Legitimacy was helped in our study sites by: formal sign up arrangements; a sense amongst ‘rank and file’ GPs that they were being kept fully informed about PBC and its processes; systems that ensured that GPs were aware of and able to use any new services or pathways that had been developed; a financial incentive scheme perceived to reward work appropriately; and perceptions that progress was being made. • Factors that undermined the perceived legitimacy included: concern that national policy might substantially alter or abolish PBC at any time; and perceived excessively tight control by PCTs, with overly bureaucratic processes or a failure to support innovation. 	<ul style="list-style-type: none"> • There are no simple procedural or structural templates for good relationships. • It is not likely to be necessary (or desirable) for all GPs to be involved in governance and planning activities for PBC. • The most important factor in ensuring clinical engagement with PBC (at both consortium and practice level) is that the local PBC project should be seen as legitimate by the mass of GPs. • Formal sign-up arrangements to consortia enhance both legitimacy and clarity surrounding PBC. • Communication strategies seemed to be most successful if they both ensured that GPs felt fully informed and also provided easy to use information about available new services and pathways.
<p>Service developments</p> <ul style="list-style-type: none"> • Many new services and some patient pathways had been established in the name of PBC, ranging from small-scale practice-level innovations to much larger schemes. • There was a great deal of co-operation between consortia and local secondary care providers with the view to developing area-wide services. • All our PBC groups were also keen to provide services themselves. Some had established or were planning a formal ‘provider arm’ as a social enterprise or other type of company. This generated some disquiet amongst many PCT officers, concerned about potential conflicts of interest. Not all of these new arrangements were established solely as the result of PBC, but PBC provided a convenient vehicle for their ongoing development, management, governance and financing. In many cases the provision of services by GPs seemed successful, utilising existing premises and expertise, and providing services that integrated well with existing practice services. 	<ul style="list-style-type: none"> • Communication strategies in relation to service developments seemed to be most successful if they ensured that GPs felt fully informed and also provided easy to use information about available new services and pathways. • If provider competition intensifies the level of engagement necessary to underpin co-operation between PBC clinicians, secondary care colleagues and PCT contracting staff involved in effective PBC might be at risk.
<p>Budgets, savings and incentives</p> <ul style="list-style-type: none"> • Many of the PBC consortia had made savings, but budget setting and the calculation and use of savings were often a source of contention. • In general we found an appetite in PBC consortia for greater access to community and/or mental health budgets, as these are areas that have a very direct impact on the work of GPs. • Transparency about budget setting processes was important to participants. • The absence in some sites of consensus about how savings should be calculated, or whether or not it was meaningful to regard savings as ‘planned’ or ‘unplanned’ led to uncertainty and contention about the possibilities of reinvestment. • Sites which had set up formal agreements in advance about how savings were to be calculated and used were less likely to report conflict. Incentive schemes are most likely to be successful if they are simple to implement and if they act to align PBC activity with wider objectives. 	<ul style="list-style-type: none"> • Clarity about budgets and how savings will be calculated, allocated and used is vital, and formal ‘sign-up’ arrangements both within PBC consortia and between the consortia and the PCT may facilitate this. • The scope of the budget devolved enables or constrains the action possible through PBC, so that possible developments in community or mental health may remain constrained by PCT views about the difficulty of devising indicative budgets for such services.

Demand management

- All our study sites had developed or were planning systems to reduce overall demand for hospital services. These included peer-review of referrals and detailed auditing of specific service areas. These arrangements were more likely to be implemented at practice level if GPs accepted the overall legitimacy of PBC. Attempts by PCTs to impose tight control undermined this.

- Tight control of PBC by PCTs risks undermining the legitimacy of PBC.
- An approach that is flexible and supportive of innovation, whilst incorporating adequate governance safeguards, is most likely to be successful.

Management and information support

- Adequate management resources were important in all our sites. We found a variety of models, including seconded staff, directly employed staff and the employment of external consultants.
- PBC consortia often complained that they had insufficient support in analysing and responding to detailed hospital activity statistics. However, GPs were also often unclear as to exactly what they wanted from their data analysts.
- None of these models of management support was in itself clearly associated with better or worse outcomes for PBC.
- Precise contractual arrangements for managerial support were less important than the provision of adequate managerial time, with a clear remit and lines of responsibility.

- Hiring external consultants is not of itself a shortcut to success and important factors in the PBC process include:
 - ◊ Clarity over roles and responsibilities;
 - ◊ Willingness by GPs to engage in organisational development and to think in greater detail about information requirements;
 - ◊ A belief by GPs that associated managers were working on their behalf.

Health inequalities

- We found no agreed definition of 'health inequalities' or agreement about which social groups should be of concern in this respect.
- We also found little consensus about how any inequalities might be addressed by PBC and some concern that PBC might exacerbate inequalities if some consortia developed better services for their own patients.
- In a small number of our sites there were some plans to use PBC to invest extra resources in practices in areas of deprivation. This was more likely to occur in areas where the PBC project as a whole was seen as legitimate and successful.

- The perceived impact of PBC in 'tackling inequalities' depends upon how these 'inequalities' are defined.
- PBC could increase some forms of inequality whilst simultaneously reducing others.
- Greater clarity about official aspirations in this regard is required before any judgement can be made.

Unintended consequences – peer surveillance

- We found a new willingness by GPs to engage in peer-review and performance management of each others' work, although some preferred to talk about this as 'levelling up' general practice or 'education'.
- Mechanisms observed included: practice visits to discuss performance against budgets; publication of named performance data; open discussion of such performance data in meetings; and the use of PBC as a mechanism to implement an unrelated performance assessment framework.

- Peer review of performance under PBC is a significant positive outcome.
- There is a danger that the legitimacy of PBC will be undermined if this is not done sensitively or if external performance regimes are attached to PBC without GPs' agreement.

PBC and the wider health agenda

- Integration of PBC with the wider commissioning agenda of the PCT was variable between sites.
- We found some evidence of engagement with Local Authorities (LA), but this is much more difficult in areas where PBC boundaries do not coincide with LA boundaries.
- Patient and public involvement was rudimentary in most of our sites, although some had begun to establish mechanisms. There was no consistent pattern in the form or timing of such involvement.
- Integration of PBC with the wider commissioning agenda of the PCT was most likely to be successful where structures existed to enact integration on the ground, and GPs were engaged with both PCT priority-setting processes and with local public health specialists.
- Integration is easier to achieve if there are a smaller number of groups undertaking PBC in an area.

- GPs are most likely to accept the PCT's wider commissioning and health/wellbeing agenda where there is local respect for the ambitions of PBC.
- Successful involvement of patients and the public is more likely to be achieved via 'bottom up' approaches.
- PCTs and PBC groups may need to adopt different mechanisms for involvement for different areas of service development, and performance regimes should be flexible enough to allow a degree of local diversity to exist.

SUMMARY

Our study demonstrated that the initial objectives and aspirations for PBC were neither clear nor unambiguous. In our report we have refrained from making explicit judgements about whether or not PBC either locally or nationally should be judged a 'success' or a 'failure', preferring to describe what we found and point out the factors that seem to have influenced the actions and effects that we observed. Overall, our results suggest that the potential longer term impact of PBC in affecting the pattern and delivery of local services depends upon the extent to which PBC becomes integrated with the wider commissioning agenda of the PCT. This is not an easy thing to achieve, as it requires PCT managers to be prepared to cede some control, and GPs to engage beyond their traditional comfort zones, addressing wider population health needs and taking managerial responsibility. Furthermore, it will require significant managerial resources and commitment from individuals, and it is not clear from our study how far it will ultimately be achieved. However, tackling these difficult questions could bring significant rewards, including, for example: a general raising of standards in general practice using peer-surveillance and the spread of good practice; better informed commissioning, as GP practices provide ground-level intelligence that can be used in negotiations with powerful hospital trusts; and a general improvement in service planning and integration, as those with first-hand knowledge of patient experiences engage alongside PCT managers and hospital colleagues to develop better clinical pathways.

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FOR FURTHER INFORMATION REFER TO: NPCRDC website: www.npcrdc.ac.uk/r5.82

ABOUT NPCRDC

NPCRDC is a multidisciplinary centre, established in 1995 to carry out policy related research into primary care. Our centre is a collaboration between the Universities of Manchester and York, with our main base at the University of Manchester. We are committed to excellence in primary care research and dissemination.

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