Commissioning a Patient-led NHS

Issue 2 - October 2005

Practice Based Commissioning

An LMC view on PBC across London

Welcome to the second in our series of current issues around Commissioning a Patient-led NHS. This briefing has been produced in response to numerous enquiries for information on what is happening with PBC across London.

Key message

- GP practices will face increased competition from alternative providers
- PBC is a vehicle for helping practices to work closely together to meet the challenges and opportunities of the competition agenda
- PCTs will have different roles and responsibilities and may be "merged"
- Community services will in due course no longer be provided by PCTs
- Practices in poor premises or with inadequate staff or working in isolation will face major challenges

Did you answer yes to these questions in our first issue?

- Do we want our patients to receive the best possible hospital, community and mental health care?
- Could we do it better ourselves?
- Do we want to try and gain additional resources to invest in premises, equipment and the practice team?

If so, then you should be actively engaging in PBC.

What will you be expected to do?

- Develop a shared agreement with the PCT
- Reflect some pre-existing commissioning arrangements made by your PCT
- Involve patients and the local community in the decision making process
- Ensure that patients must be able to exercise choice
- Deliver key national targets
- Deliver value for money
- Implement Choose and Book when it is working properly (negotiations are in progress regarding this and any payment)

By now many of you will have formed tentative groups or consortia, but those of you who have not should think very carefully about the impact the current changes will have on your practice.

Key message:

PCTs will not have growth funds in future. The savings from PBC, by managing the demand for expensive hospital services and by undertaking more work in primary care, are likely to be the main source of any additional investment for practices.

Tensions

It is fair to say that even when groups have been formed, no matter what their shape or structure, there are some very real tensions which have been recognised that will need to be overcome before PBC can really work.

- **Lack of incentives for GPs** - GPs have been very cautious about the uptake of PBC, mainly due to the lack of incentives and the need to concentrate on maximising QOF achievement.
- **Pace of change** - If PBC moves too slowly for some, the project becomes tiresome and frustrating and motivation is lost, but if it goes too fast others will become disengaged and threatened by the sense of lack of control. So it's essential that each PBC group agrees its own plan with the PCT rather than being forced into a PCT-dictated "one size fits all" model.
- **Constructive tension** - There is particular tension between the PBC consortia and the acute sector. The hospital is looking to *generate more activity* because more activity, using payments by results, means more money and therefore income for the hospital. A good example is consultant to consultant referrals. On the other hand, PBC consortia will be seeking efficiency gains (savings) from *reducing activity* and referrals. Clearly the two parties have two different objectives and at times these will appear to be in conflict. Such tension is an expected part of the process and, if applied skillfully, can be a key driver in delivering the desired redesign of local services which has been so elusive to PCTs and their predecessors who have for some time been consumed with managing deficits.
- **Financial deficits** - PCTs with deficits are finding it very hard to develop a methodology that fairly devolves budgets to practices. Budgets which include historic deficits are met with resentment and scepticism by practices, and the tension lies in finding a mutually agreed way forward.
- **Management costs** - PCTs are tasked with achieving financial balance but have not been given any extra financial resource. PBC consortia, supported by their LMC, are therefore finding it difficult to get PCTs to release sufficient funds.

Key message:

Although GPs have been said to have a degree of apathy towards PBC and a sense of 'implementation fatigue' GPs have now got to drive the PBC agenda.

We believe that you, the GPs, with the power and backing of your group, should ensure that continued pressure is applied to the PCTs to locally resolve these issues.

What's happening across London?

It is interesting to see that often common features have emerged in these early stages of implementation in the more advanced consortia - noticeably key principles and infrastructure.

1. **Principles** – Know and understand the rules of the game. Each consortium needs to establish, with the PCT, a common set of principles that can be put into a shared agreement. This provides the framework within which both the PCT and the

consortium can work. The expectations of both parties will be contained and each will know what is allowed and what is not.

It is equally important to establish some ground rules between all the practices in the consortium. Whilst these agreements would not be legally or contractually binding, they would lay down some jointly agreed terms of reference or engagement. Taking time to establish these terms at the beginning of the scheme will help things to run more smoothly as the project takes off, but don't spend so much time deciding what they should be and forget to move on to the next stage!

Some agreements are already in place across London. We are compiling current examples of such agreements and hope to make them available at our autumn roadshows and on the website.

2. **Process** - Establish a steering group and identify key workstreams. If this kind of infrastructure is not set up with the appropriate feedback and communication links in place, the project will move very slowly indeed. However, avoid creating bureaucracy at all times. Decide what it is that needs doing and get on and do it. Look for people with those specialist skills, eg IM&T or commissioning, and pull like-minded stakeholders together. Use the skill mix of the people around you both from the practices and the resources on offer from the PCTs to get these workstream groups up and running.

3. **Skills** - Capture people who have a track record of success and motivation. Resist being landed with people without those characteristics. Put old 'emnities' to one side. Work with those who seek to turn PBC into something that avoids fragmentation of good quality general practices, delivers a redesign of local services in a practice-supportive way, and who are prepared to support practices to meet the competition agenda.

4. **Engagement** – Communication with practices is crucial if practices are to feel involved. Clarity of understanding at individual practice level of the key messages on service redesign opportunitities and competition are crucial if PBC is to deliver its objectives.

We have conducted and made our own assessment of PBC progress across London and the details are attached.
Information was correct at time of printing.

Key LMC message

PBC groups need to:

- Balance GP autonomy with a pragmatic approach which manages any risks against a pace of implementation and financial gains
- Work with a simple, but not yet perfect scheme or system, in order to understand and effect some changes which may give some quick and immediate financial benefits
- Aim for local schemes which are low in bureacracy, even recognising them as evolving 'pilots' for a fixed period of time, with built in flexibility, wherever possible

Practical assistance

At a time when NHS structures are changing yet again with major upheavals to the roles, responsibilities and configurations of London Strategic Health Authorities and PCTs, primary care may well suffer from a lack of practical support. We will do our best to help with as much information as we can muster.

We shall do this by

- Sharing models of good practice
- Encouraging GPC to publish updated national guidance
- Strengthening LMC involvement in PBC steering groups
- Running roadshows through November and December – watch out for details in your local LMC mailings

Remember:

Support - Your LMC will continue to lend its support and expertise, wherever possible, to help any proposals taking these initiatives. Our Directors of Primary Care Strategy and Executive Director of GP Support Services are available for advice and contact details can be found below.

Practical tools - If you have any suggestions or requests as to what would be of practical use and help for you either at practice or practice based commissiong group level, then email (see below) and we will see if we can help.

Further information - We will of course take every opportunity to keep you informed of any further developments and all relevant guidance which can always be found on our website at www.lmc.org.uk.

LMC contact support details:

Directors of Primary Care Strategy		
Andy Michaels	North West	amichaels@lmc.org.uk
Gill Rogers	North West	grogers@lmc.org.uk
Julie Freeman	South East / South West	jfreeman@lmc.org.uk
Mazzie Sharp	North East / North Central	msharp@lmc.org.uk
Executive Director of GP Support Services		
Jean Hassell	Londonwide LMC	jhassell@lmc.org.uk