# The Secretariat of Wessex LMCs

# LMC Briefing Paper (BP5/06)

## Practice Based Commissioning (PBC[1])
## A Simple Guide!

*Introduction*

PBC is a concept that has been around for nearly 2 years and yet when the LMC talks to various groups of GPs, Practice Managers and PCT staff, there seems to be much confusion about various aspects of this initiative. I thought it helpful to de-mystify and clarify the main issues that seem to be causing confusion, including providing a summary of the background leading to the introduction of PBC, the terminology used and the practicalities of engaging and implementing PBC schemes – thus "A Simple Guide to PBC" follows.

*Background*

When Labour were elected into Government in 1997, they identified early in the parliamentary cycle that the NHS had suffered years of underinvestment. The Government committed itself to 'increase spending year on year', but did not commit itself to any specific figures. In 2000, the Prime Minister announced that by 2008 the investment in the NHS, in terms of Gross Domestic Product[2] (GDP), would be 9.4% and exceed the European average of 9%.

**UK Spend on the NHS**

| | % of GDP | Actual investment | Investment per person |
|---|---|---|---|
| 1997 | 5.7% | £46 billion | £783 |
| 2006 | 8.4% | £94 billion | £1700 |
| 2008 | 9.4% | | |

The Prime Minister stated that over a 10 year period annual growth in NHS spending would be 7 – 9%. Most other Government Departments would have to settle, during the same period, for 3 – 4% growth. The Prime Minister also confirmed that from 2008 onwards NHS growth would return to 3 – 4 % growth per year.

The Government agreed to this unprecedented investment with the intention of improving the quality of the health service, decreasing waiting times and generally introducing a programme of "modernisation".

The question that has since been asked by many is why, with this increased investment, was the NHS deficit over £400m in 2004/5 and nearly £800m in 2006/7?

The media have been quick to blame the deficit on increases in pay for Consultants and GPs; the truth is far more complex.

The NHS employs over 1,000,000 people and therefore any pay settlement will have a significant impact on finances. In 2000 the Government introduced the NHS Plan, a 10 year blue-print of major reform for the NHS. Reform is not cost neutral. In addition to a small rise in the number of GPs, there has been a significant rise in other sectors such as Nurses, Consultants and Managers.

***So what are the causes of the increased costs?***

- Service improvement
    - *Reduced waiting times*
        - *Out patient appointments reduced from 26 to 13 weeks*
        - *Elective operations reduced from 18 to 6 months*
    - *New technologies (e.g. Down's screening)*
    - *Advances in drug treatments e.g. Statins for CHD,*
    - *Increased numbers of Consultants, Nurses & GPs*
- Increasing elderly population
- Cost of new drugs (and NICE[3] Guidelines)
- Technology costs
    - *IM&T – a 10 year programme of development in both primary and secondary care*
    - *Diagnostic equipment, such as CT and MRI scanners*
- Increased investment in staff
    - *Consultants contract*
    - *GP Contract*
    - *Agenda for change*
- Competition and capacity
    - *Independent Sector Treatment Centres[4] (ISTCs)*
- Reorganisations
    - *The NHS has had a significant number of reorganisations in the last 20 years. The rationale is to provide more efficient structures and often to reduce cost. The reorganisations have rarely saved any money and any efficiencies that have been gained are negated by the stagnation that occurs during the process.*

In essence the problem is that, despite significant increases in funding, the NHS budget is insufficient to meet new demands placed upon it. The challenge that the NHS faces now is to try to achieve financial balance before the annual growth in funding is reduced to 3 – 4%. This could be achieved by a number of different routes, for example:

- Reduce demand
- Reduce the number of people working in NHS
- Reduce work done by hospitals that can be done at a lower cost in the community
- Provide services in a different way (e.g. move work from in-patient to day-case)

The Government decided that it would tackle these problems through a number of routes, hence the heralding of PBC



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### *1. Commissioning*

Despite PCTs' best efforts, the commissioning of patient care services has not been seen to be a great success. This is for many reasons but one important factor identified is the lack of clinical accountability. Commissioners have largely failed to engage in a meaningful dialogue with GPs and Consultants to make the most effective use of resources in designing appropriate patient care pathways.

To enable commissioning to be more effective the NHS must allow managers to manage. Currently the managers have only been allowed to administer the PCT's contract rather than truly commission patient services.

Clinicians need to engage with other clinicians but will only effect change if there is true leadership and working in partnership with senior managers.

### *2. Clinical accountability*

Clinicians are largely responsible for the consumption of NHS resources. Clinicians prescribe, refer, investigate and admit patients to hospital. GPs will argue that we are the patient's advocate and therefore should not be placed in the position of deciding between treating a patient or not, on the grounds of cost. Fundholding placed a similar challenge to GPs and, by becoming knowledgeable in understanding the true cost of many investigations and procedures carried out, they changed clinical behaviour in ways which were not detrimental to patient care.

Clinicians should understand the costs incurred on behalf of their patient populations and be able to justify this if challenged. Clinical accountability must not be a "witch-hunt" with which to blame clinicians for differing practise, based solely on account of activity and cost.

### *3. **White Paper: "Our Care, Our Health, Our Say"** – A New Direction for Community Services*

This clearly looks to increase investment in Primary, Community and Preventative Care and to decrease the percentage of the total NHS budget spent in Secondary Care. The current spend in primary care is 27% of the total NHS budget and by 2011 it is expected to rise to 33% (which is the current OECD[5] average).

The White Paper states that care should be provided as close to a patient's home as possible and identifies at least six clinical areas that could be moved from hospitals into the community.

As with most things it is much easier to talk about how you would do something rather than find practical solutions and make them work. The "only game in town" with which to shift the balance of power and influence to GPs, to regain financial balance, achieve more clinical accountability and redesign services, is Practice Based Commissioning.

## Practice Based Commissioning

The concept of PBC was initially introduced in 1990 when there was a split between the purchaser (Health Authorities) and the providers (Hospitals). Practices were allocated a budget to commission care from alternative providers and looked to make best use of the funds by a system of "demand management" and skill-mix.
Fundholding certainly changed the way services were provided and also made hospitals more responsive to the demands of Fundholding Practices. Inevitably this led to what has been

commonly referred to as the `post-code lottery'. A big problem was that savings were out-stripped by the costs. This was largely due to the 'high transactional costs' incurred. [King's Fund analysis]

***How should PBC work?***

To make PBC work all GPs in the practice have to work together and be prepared to work differently. Practices need to work within a well defined locality to ensure they are addressing patient population needs. Localities need to be actively engaged with the Commissioners of Patient Care within the PCT.

- ***Demand Management***

The first stage of PBC is demand management. It has been identified that in many areas the number of GP referrals has not increased over the last couple of years but the number of emergency admissions has increased significantly, as have Consultant to Consultant referrals.

- ***Payment by Results***

PBC is the counter-balance to Payment by Results (PbR). PbR is a national tariff used by all Hospital Trusts (and Foundation Trusts) as a method by which each area of activity, whether a first Consultant out-patient attendance or follow up, elective procedure (day case or in-patient), attendance at A&E, or emergency admission has a specific price. The only slight variation is an adjustment for the cost of staff (more expensive in London than Scotland).

PbR should mean that a patient who requires treatment can choose the hospital they want to go to with the cost to the PCT (or, under PBC, to the practice) being the same. This assumes that the procedure is "coded" the same in each hospital. Sadly, early evidence shows this not to be the case due to the different employment of coding staff in hospitals and therefore, as with Fundholding, verification of high cost procedures and significant anomalies in billed activity is essential. Unfortunately this verification largely has to be clinical and performed by the person who knows the patient history best - i.e. the GP.

The NHS budget for 2005/6 was approximately £84 billion, and the deficit at the end of the year will be between £809 million and £1 billion; this is approximately 1% of the total budget. The deficit appears greater in some parts of the NHS because of the uneven distribution of financial problems (called 'lumpy' distribution).

**Ask yourselves the following questions:**

***Are there referrals we currently make, that on reflection are unnecessary?***

Practices have found it useful to collect all referrals made to an agreed specialty over a period of a month and then discuss them in a constructive and supportive environment. Practices have reported that this has identified variations which are significant and can be addressed simply and in a non threatening manner. For example, a part-time partner had effectively become de-skilled in a particular area of medicine and referred patients to hospital rather than discussed alternative routes of treatment within the practice (this is not a dig at part-timers - I am a part-time GP and recognise these issues personally). There are also issues in training practices where they have GPs Registrars and referral rates to hospitals often increase.

It is far better to discuss these issues internally and to support each other, rather than a PCT publishing lists of high referrers and taking inappropriate action.

***Are there referrals we make that could be managed in a different way?***

Referral to a consultant used to account for 90% of all referrals. Can these be managed in a more appropriate and cost effective way? Many PCTs are working with practices to introduce alternative pathways via other practitioners, GPs with a Special Interest (GPwSI) or Community-Based Consultants.

***What is happening regarding Consultant to Consultant referrals?***

Many areas nationally have identified little in the way of increase in GP referrals to Consultants, but have noticed a significant increase in Consultant to Consultant referrals (in some cases up to 600%). Appropriate inter-Consultant referrals should be allowed without referral back to originating GPs, but a significant number are being referred from Consultant to Consultant when the problem could be managed better in General Practice. This is one of the inevitable consequence of increasing specialisation of secondary care clinicians.

***Are you aware of the cost of referrals?***

Did you know that some Foundation Trusts are charging for each piece of telephone advice or advisory letter that does not result in an out-patient appointment? Or that a five minute appointment with an SHO in surgery can cost £150 (see Annex 1). This knowledge can have two consequences:

- Does the person need to be seen? If not - a saving of £150.
- Can the work be done outside a hospital at a cheaper rate? If so, how much can be saved?

***Are you aware of the number of acute admissions of patients registered at your practice?***

The most significant rise in costs has been that associated with unscheduled care (emergency admissions). The majority of the increase recorded has either been via A&E or during the Out of Hours (OoHs) period.

Control of who needs to be admitted to hospital is a key issue that requires addressing. Practices can start by looking at their own admissions but can also work in localities and with the PCT to reduce OOHs admissions and those via A&E.

***Are you aware of the cost of an emergency admission under PbR? (See Annex 1 for further information)***

Community Matrons[6] (CM's) are supposed to be in post shortly and they will be tasked with carrying a caseload of approximately 50 patients who have the most serious long term conditions and are therefore the patients who are most frequently admitted to hospital. Pilot studies have shown that when CMs work closely with practices, acute admissions in this group are reduced and quality of life is improved for the patient. It would be best to ensure that Community Matrons are part of the Practice Nursing Team and not a group who work independently of GPs and practices.

So we have identified all the above, discussed it within the practice and pulled the information together within the locality - what next?

The PCT are required to allocate indicative budgets to practices and also provide monthly data to include acute admissions, A&E attendances, elective admissions (day case and in- patient)

and out patient referrals from 1st April 2006. This will be benchmarked against your locality, PCT data and against national statistics.

Focused discussion, using this information, and work carried out within the practice will hopefully not only be useful but potentially will also identify improved ways of managing certain patients.

These six questions are really the core of ***demand management.*** Improved management of patients resulting in a reduction in costs can be achieved without compromising patient care.

***Commissioning***

The first stage of PBC is for the practice and locality to work with PCT Commissioners to determine how the issues raised above can be addressed. This will almost certainly mean that patient care pathways will be different and, as a result, contracts for activity purchased from hospitals will be different in the future.

Remember that the PCT does the contract negotiating and can take advice from the practice but they are ultimately the responsible Authority.

As a result of discussions, it may be identified that work currently carried out in hospital can be provided more effectively in General Practice (see Annex 2 for examples). Alternatively there may be work that could be moved from hospitals into the community, although not all practices would wish to provide this. In these cases, a new service could be commissioned from an alternative provider (again, see Annex 2 for examples).

Some practices are assuming that because they come up with an idea and persuade the PCT that the new service could be provided by the locality, this can occur without challenge. This may not be the case. Remember - PBC is about commissioning the services that are required and where the need is evidence-based.

The **provider** needs to be considered separately. For some contracts, the PCT will offer the new service specification for competitive tender and ask for business cases to be submitted. The PCT will then have to award the contract to the provider who meets the defined criteria in a process that must be robust and transparent. The locality, if it has set up a Provider organisation, may be in a strong position to tender for and win the contract, but it is not something that is an automatic right.

The latest guidance marks a significant shift in emphasis for PBC and it is now clear that PCTs will remain accountable for their allocation of resources and their statutory functions and will retian responsibility for contracting and ensuring quality compliance.

**So, what are the roles within PBC?**

**General Practice or groups of practices forming localities** – Practices/Locality Groups have the right to undertake the planning and prioritisation of services required and also to procure the purchase and provision of these services. PBC is the aligning of practices' clinical and financial responsibililties, whilst delivering innovation, choice and contestability to primary care.

**The Contractor –** The PCT will be the contractor. They will place contracts with providers on behalf of the practices/localities who are assessed as being the most appropriate in terms of meeting the requirements of the service to be delivered. The PCT will also monitor and manage the contracts.



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**Commissioner –** The PCT will commission services required on behalf of the Practice/Locality Groups. They will also performance manage these services

**Provider –** Those who provide the services. This can be GMS, PMS, PMS+, APMS, SPMS and external private companies

**What does it all mean?**

***General medical services[7] (GMS)***

GPs under contract with the PCT, through either nGMS, PMS or APMS Contracts, provide what used to be called "core services" - now called "essential services".

***Defining health care according to population needs***

This task, under PBC, should be undertaken by the practice and the locality, with involvement of the PCT. PCTs will then use this information as the basis to form their priorities for the forthcoming year. This and national priorities will establish the general strategic plans and, more specifically, the PCTs' Local Delivery Plans (LDPs[8]).

***Demand management***

As described earlier.

***Commissioning***

This is the work involved in incorporating the practice and locality identified needs of the population into the strategic priorities that are set both locally and nationally and then transformed into a contract.

In reality the national priorities are so demanding that the 'headroom' for 'local' initiatives is very limited.

Although the PCT will be the Commissioners, practices and localities will play an important role but are not the commissioners in the true sense. Some practices and localities believe, mistakenly, that when they receive a devolved indicative budget they will commission services on behalf of their patients. It is important to remember that the budget is an indicative budget only and the purpose of this is to enable accountability without proceeding to the old Fundholding position of real budgets with full purchasing powers.

**PBC Directed Enhanced Service[9] (DES)**

This DES was introduced in April 2006 and is initially for one year only. It has caused more debate and confusion than any other Enhanced Service.

The DES for PBC has to be offered by the PCT to all practices between 01/04/06 – 31/03/07. It is up to each practice to decide whether it wishes to engage or not – either as an individual practice or within a locality.

Demand management and redesign of patient care pathways are core factors of the DES and aimed at engaging all clinicians. The principle is that to change clinical behaviour clinical engagement is essential.

Some PCTs seem to think that by getting practices involved, they can become less involved than before; nothing could be further from the truth. PCTs **MUST** work closely with practices and localities to enable real change.

Practices are therefore required to name a PBC Lead within the practice, and produce a Practice Plan that sets "reasonable and achievable targets". The Practice Plan must then be agreed with the PCT and can be individual to each practice or produced as a locality plan.

The Practice Plan is expected to focus on three aspects of healthcare:

1. Demand management
2. Redesign of patient pathways
3. Verification of invoices

(A flow diagram is included in Annex 3 to show how the Practice Plan fits and links into the bigger picture in terms of service planning and commissioning.)

As hospitals will be paid by the activity they claim to have performed, verification of invoices by the practice will be essential. Fundholding showed that by looking at high cost invoices, costs could often be reduced simply by correcting the incorrect hospital clinical coding. The NHS budget for the year 2005/6 was approx. £800m (or 1%) in deficit and First Wave Foundation Trusts were found to have errors in clinical coding of approx. 30%, with most being in their favour.

Practices will be funded at 95p per patient to carry out the work agreed above. Some practices have already contacted the LMC complaining that the expectation of PCTs, both in terms of what is achievable and the work involved, are out of balance with the funding available.

Firstly the practice or locality need to look at the funding available, work out how much manager or doctor time this will equate to and then agree with the PCT what can be done for this funding.

If the practice or locality achieve the targets set in the plan, or show significant movement towards the target, then a further payment of 95p per patient is available at the end of the year. This 95p per patient is expected to fund continuation of the on-going work involved in PBC and is not "profit" for practices.

There has been much discussion about what happens to any savings or freed-up resources that are made, especially when a PCT is in deficit.

A PCT can only allocate an indicative budget based on the resources it has available. This will be after a sum is top-sliced to fund those elements of commissioning not covered under PBC and also a contingency fund or "risk pool". If a PCT has a budget of £100m but is £5m in deficit, it can only allocate £95m and therefore you are starting out with a budget that has been set to take account of the deficit. The budget it devolves will be insufficient to purchase care for patients if the pathways of care and clinical behaviour remain as they are at present.



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**Savings**[10]

Savings can be made either by:

1. providing the service in the same way but at a lower price; or

2. by changing clinical behaviour and care pathways to provide the service differently and at a lower price.

It has been agreed nationally that any savings made will be divided between the PCT (30%) and the practice or locality (70%). Remember that savings can only be used on projects agreed with the PCT and in areas identified in the PCT's LDP.

Whichever way savings are made, it is unlikely that there will be savings on total indicative budgets within the first one or two years because, as discussed above, budgets during this period will reflect existing deficits.

Because of this, some PCTs are objecting to the 30/70 split, saying that all savings must be retained by the PCT while there is a deficit. The LMC view is that PCTs who take this view are wrong and short-sighted as, in the absence of realistic incentives practices and localities will not produce any savings for them at all. The Department of Health has also confirmed that PCTs cannot do this.

All savings, whether or not they are against the total indicative budget, should be reinvested in further improvements in patient care.

**Conclusion**

The NHS is in financial crisis and times are likely to get worse before they get better. Working as a GP in the current financial environment presents a number of challenges and threats to professional independence.

An added frustration currently is the reconfiguration of PCTs, which may prevent or slow down reform. The Strategic Health Authorities say that this will not be allowed to happen. The only problem is that they are being reduced in number from 27 to 10!

There are two clear options ahead for all GPs:

***Option 1-*** "Not our fault Gov!" – practices could inform patients that the financial crisis is not of their making and refuse to engage in reform. The result would be political spin (as we are already seeing) with the Government blaming the crisis on pay rises for GPs and Consultants, without acknowledging all the other important factors. Pay would be squeezed and working environments challenging.

***Option 2-*** We can drive some of the reform and ensure that it does not damage patient care, or our working environment. We may need to work in a different way - but let us influence and define this, rather than have it imposed by others who have little idea of general practice.

Wessex LMCs would endorse Option 2 and encourage GPs to become engaged. To do nothing is not an option if we wish to maintain and sustain the cornerstone of healthcare - general practice

The private sector is being dangled as a potential challenge to traditional general practice. We should take this threat seriously because it is a reality and not just a concept. The recent White Paper ("Our Care, Our Health, Our Say") which focused on care outside hospital is explicit that the Government wants 10 – 15% of general practice to be in the hands of the private sector within the next ten years. An additional challenge to general practice is that, if we are not responsive to the agenda set by the Department of Health, further competition will be introduced.

Practice Based Commissioning **can** deliver the Government's agenda of making the most effective use of limited resources in the NHS **but** only if delivered by independent small units working together with like-minded colleagues who have patients' best interests at heart. This is clearly traditional general practice. PBC may be a way of defending our practices from the private sector and other competition.

*[This document is best considered in conjunction with the GPC's document "Practice Based Commissioning: Consortium Working, April 2006"]*

**Annex 1**

| | PbR Tariff price | |
|---|---|---|
| **IN PATIENT** | | |
| **Medical** | | |
| Chest pain | £1,000 | |
| Management of skin ulcer | £3,800 | |
| **Surgical** | | |
| Inguinal hernia repair | £1,200 | |
| Appendicectomy | £2,500 | |
| Cholecystectomy | £2,000 | |
| Knee replacement | £5,500 | |
| Hip replacement | £5,000 | |
| Repair to fracture neck of femur | £5,000 | |
| Mastectomy | £2,500 | |
| TURP | £1,800 | |
| | | |
| **OUT PATIENT** | | |
| **Consultations** | **New** | **Follow up** |
| General surgery | £150 | £75 |
| Trauma and orthopaedics | £144 | £71 |
| Diabetic medicine | £240 | £88 |
| Rheumatology | £219 | £97 |
| Cardiology | £151 | £80 |
| General medicine | £215 | £92 |
| **Procedures** | | |
| Flexible sigmoidoscopy | £297 | |
| Subcutaneous injection/injection into skin | £176 | |
| | | |
| **A & E ATTENDANCES** | | |
| Minor injury | £54 | |
| Simple A&E | £71 | |
| Complex A&E | £99 | |



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**Annex 2**

## Example of work that might be transferred from hospitals into the community

### Minor Injuries

Each minor injury attendance at A/E costs between £51 and £75. It is clearly better value for money to look after these patients in general practice where appropriate. In addition, it may reduce unnecessary admissions which are even more expensive.

### Echocardiograms

In some parts of Wessex the waiting times for echocardiograms is in excess of 12 months. Patients are being referred to Cardiologists to get around the wait. With the new heart failure requirements of the 2006 Quality and Outcome Framework[11] (QoF), GPs require open access to echocardiograms.

### Rectal bleeding

Patients with rectal bleeding are, in many areas, referred to surgical outpatients and the cost of being reviewed and having a flexible sigmoidoscopy is in excess of £500 per patient. A community-based service, offering direct access flexible sigmoidoscopy, may not only free up access in surgical outpatients but it would also save money.

### Dermatology outpatients

Many GP referrals to Dermatology OPD are for the purpose of establishing a diagnosis and providing treatment recommendations. Community-based services can be re-configured to make better use of secondary care resources and provide a service which is more cost effective in the community.

### Minor surgery

Various minor procedures in General Surgery, Orthopaedics, Urology and Gynaecology could be commissioned as community-based services.

### Acute admissions

A child admitted with a pyrexia, who is given simple treatment to reduce their temperature and discharged 6 hours later, can cost ain excess of £1,500. Only clinically necessary admissions should end up in hospital. There needs to be greater investment in alternatives to prevent these admissions.

OOHs and inexperienced doctors in A/E are also identified as key areas that can increase unnecessary admissions.



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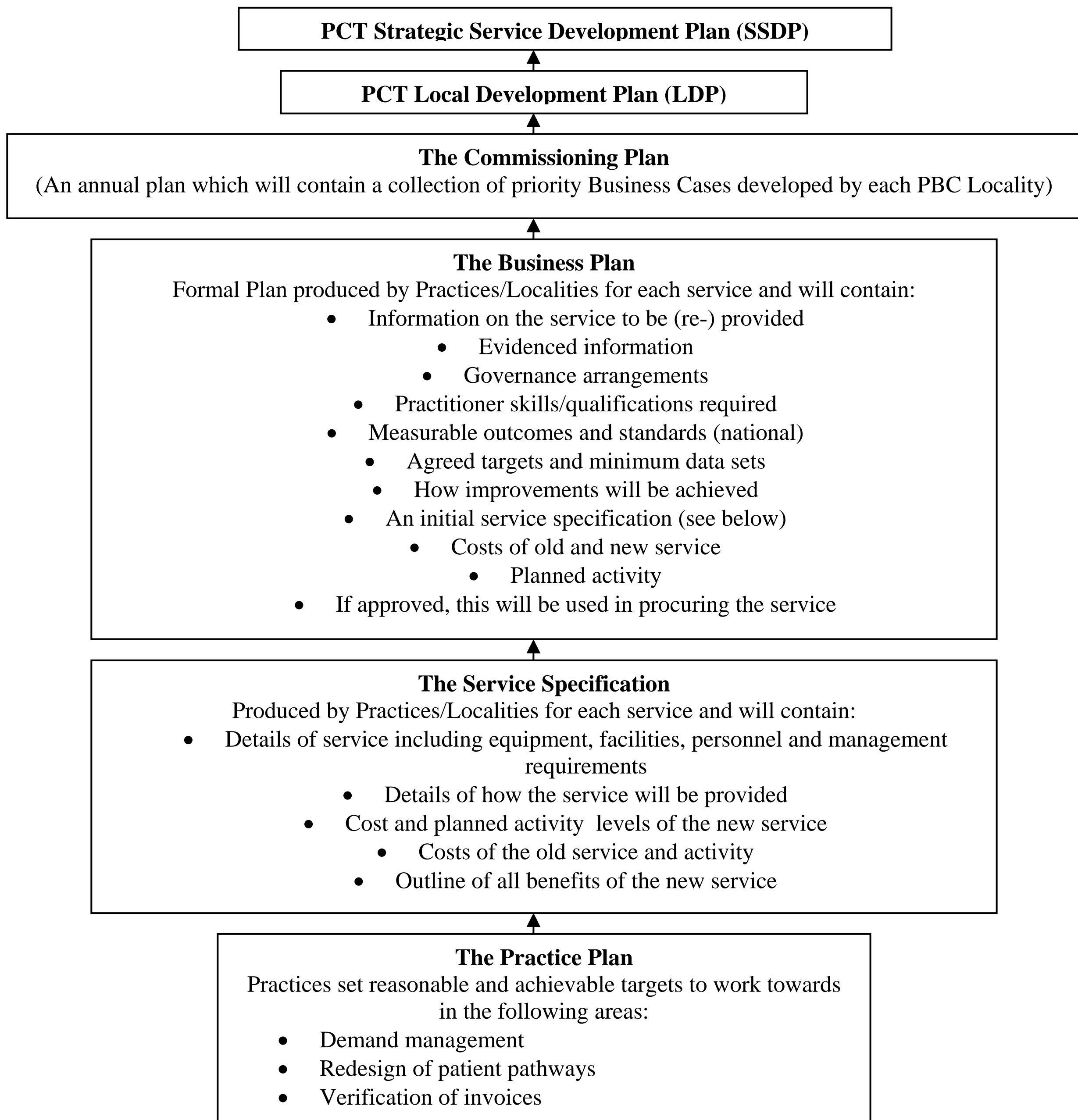
## Annex 3



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**Glossary of Terms**

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[1] PBC Practice Based Commissioning

[2] GDP The Gross Domestic Product - defined as the market value of all final goods and services produced within a country in a given period of time.

$$GDP = \text{consumption} + \text{investment} + \text{government spending} + (\text{exports} - \text{imports})$$

[3] NICE National Institute of Clinical Health and Excellence

[4] ISTCs Independent Sector Treatment Centres, these were set up to provide elective, uncomplicated surgical work. The ISTCs were given a guaranteed 5 year contract, being funded an estimated 20% above NHS costs, in an attempt to drive up quality and productivity in NHS hospitals who were considered monopoly providers.

[5] OECD Organisation for Economic Co-operation and Development

[6] CM Community Matrons, announced in 2004/5 but as yet few in place in Wessex. They are supposed to carry a case load of about 50 patients. These will be the most vulnerable patients (approx 25 per average practice). The CM's intervention is expected to decrease the number of acute hospital admissions in these patients.

[7] GMS General Medical Services – this is core (essential services) provided within general practice

[8] LDP Local Delivery Plan – an annual plan produced by all PCTs.
This plan is agreed with the Strategic Health Authority and details the PCTs budget and how it will be used during the financial year.

[9] DES Directed Enhanced Service – an enhanced service as defined in the 2004 nGMS Contract. Specification is defined and costed nationally.

[10] Savings Funding achieved by re-providing a service in a different way

[11] PbR Payment by Results (Secondary Care national tariffs)

[12] QoF Quality and Outcomes Framework

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