

Patient perspective

In search of quality in practice-based commissioning

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ABSTRACT

Practice-based commissioning is the mechanism whereby groups or clusters of practices in England are given indicative budgets to purchase health care for the needs of their patient populations. This article describes people-based commissioning, to be distinguished from the more technical and short-term approach characterised as pocket book commissioning, and argues that people-based commissioning

should be the preferred approach, which needs to address public health and mental health needs of the community, be based on a clear ethical framework and seek political support through real engagement with the public.

Keywords: ethics, health economics, practice-based commissioning, user involvement

How this fits in with quality in primary care

What do we know?

Practice-based commissioning is the mechanism whereby groups or clusters of practices in England are given indicative budgets to purchase health care for the needs of their patient populations.

What does this paper add?

This article distinguishes between pocket book (the current technical approach) and people-based commissioning, and argues that the latter preferred approach needs to address public health and mental health needs of the community, be a process that is informed by public health analyses, and be strong enough to listen to pressure groups and provide decisions about healthcare priorities in an ethical and evidence-based fashion.

Introduction

It is striking just how much is expected of practice-based commissioning, the system whereby practices have been given indicative budgets for the care of their patients. The National Audit Office asserts that ‘the introduction of practice based commissioning in the NHS heralds a major change in the commissioning landscape, one which is critical to the NHS reform programme’.¹ It is seen by the Department of Health as the key to greater clinical engagement and the more efficient use of resources, as a critical counterbalance to a payment by results system that might otherwise lead to over supply of secondary care, as a mechanism to deliver greater plurality of provision, and as a driver for the provision of care closer to home.² Collectively,

they represent an extraordinarily challenging mission, and this article questions whether the necessary structures and approaches are in place to achieve these objectives successfully.

Pocket book commissioning and people-based commissioning

I begin by contrasting two potential models for practice-based commissioning. The first is ‘pocket book commissioning’. On this account, short-term financial

considerations are of paramount importance and commissioners will focus on areas where savings can be made in fairly quick time. Most of the successes to date seem to come under this heading (see for example the case studies on the Improvement Foundation website³) and they include multi-agency working to prevent avoidable admissions, reductions in unnecessary referrals to secondary care, and the introduction of outreach community clinics in areas such as dermatology, gynaecology and minor surgery.

Many of the changes that are currently flagged up as good practice were, in fact, already happening elsewhere in the country without the need for practice-based commissioning. For example, we have known for some time that older people are often admitted unnecessarily to hospital through lack of support in the community, and that some general practitioners (GPs) have idiosyncratic referral patterns that lead to inefficient use of resources. So while it is encouraging if pocket book commissioning has encouraged the resolution of these issues, it is hardly the radical step forward that the system's proponents are envisaging.

The second, largely competing, model that I wish to introduce is called 'people-based commissioning'. This takes a far wider view of commissioning decisions. It is not against delivering quick savings but is also willing to invest for the future, it takes health inequalities extremely seriously and it is undertaken in partnership with the community, rather than on the community's behalf. It has a great deal in common with the Department of Health's own understanding of practice-based commissioning which I quote at length below:

Commissioning is the process by which the health needs of a population are assessed, the responsibility is taken for ensuring that appropriate services are available which meet these needs (including delivery of national and local NHS planning framework targets) and the accountability for the associated health outcomes is established. Practice Based Commissioning transfers these responsibilities, along with the associated budget from the Primary Care Trust (PCT) to primary care clinicians, including nurses. They will determine the range of services to be provided for their population with the PCT acting as their agent to undertake any required procurements and to carry out the administrative tasks to underpin those processes.⁴

This is a powerful statement and implies that practice-based commissioning is about far more than shifting the balance between primary and secondary care or encouraging GPs (in particular) to take greater interest in, and responsibility for, their referral patterns and broader clinical care. It is, instead, about health needs assessment, redefinition of available services and, furthermore, it comes with accountability for the outcomes. What needs to be in place, then, if people-based commissioning is to be delivered successfully?

The public health and mental health components

The differing roles of public health and mental health are important in distinguishing pocket book from people-based commissioning. The pocket book variant is piecemeal in nature and focused on improvements that can be made *to the system*. I do not suggest that it does bad things, but rather that it risks prioritising poorly as it rarely starts from the broader needs of the communities that it serves. People-based commissioning, on the other hand, is based on a deep understanding of the major health inequalities and health needs and how they might be tackled.

This requires a strong public health and mental health presence within the commissioning clusters that are taking decisions on behalf of their communities. This would advise on how the areas with lowest life expectancies might be targeted. The public health perspective should also offer local guidance on investment strategies that deliver important longer-term health gains, in areas such as falls prevention.⁵ In the mental health field, the Sainsbury Centre for Mental Health has expressed its concern that practice-based commissioners may focus on common mental health problems, such as short-term depression, rather than on patients with severe and enduring illness.⁶

The ethical component

The issue raised by the Sainsbury Centre leads to consideration of how commissioners will decide which treatments should be given priority. My suggestion is that it should be strongly influenced by public health considerations, but this is not the only perspective. Ideally, people-based commissioners will recognise the ethical implications of their decisions and take them extremely seriously.

An example of how this might operate is provided by a Didcot practice (Dr Couldrick and partners) who published in the *British Medical Journal* their policy document on the values that underpinned their use of fundholding.⁷ They had spent some time considering which of three ethical theories they found most attractive (quality-adjusted life years, fairness and a lottery account).

The practice dedicated some 20 meetings over an 18-month period to reaching agreement on contentious issues. They acknowledged, as many of those leading on practice-based commissioning do not, that the act of commissioning (as defined by the Department of Health) inevitably involves ethical choices.

Many of the dilemmas that they confronted will have to be addressed under the new arrangements.

The point can be illustrated with a fairly recent example from the world of primary care commissioning. In November 2005, three Suffolk PCTs ruled that their GPs should not refer patients with a body mass index of 30 or more for hip and knee replacements. This was defended openly as a cost-saving measure, yet the decision is ethically questionable (as well as medically – there is research that contradicts the view that the severity and incidence of complications are worse for obese than non-obese patients^{8,9}), and was taken in the absence of any broad framework that might justify it. Furthermore, it is far from clear that it *will* save money when all of the implications are taken into account.

The political component and accountability

Any commissioning process will generate winners and losers. What is striking about pocket book commissioning (and indeed many other aspects of healthcare decision making) is that it seems to be addressed in a purely technical fashion, largely ignoring these deeply political considerations. Nowhere is this more evident than in the superficial way that public engagement, a potential source of political legitimacy, is addressed.

Through their management of indicative budgets, people-based commissioners will be responsible for spending major amounts of public money. This inevitably means that some will do better than others as difficult choices are made about priorities, pathway redesign and the investment of any savings that are realised. It is therefore important that an effective accountability framework is in place. Not only will this add credibility to the decisions that are made, it will also minimise the number of challenges that may be made to the commissioners' authority by disaffected interests.

At present, the accountability framework is largely upwards facing. 'Practice based commissioners are accountable to their PCT for achieving best value' and they are also expected to 'play their full part in meeting national priorities and objectives'.¹⁰ PCTs will hold commissioners to account for their clinical and corporate governance arrangements and the PCT also has to give its agreement for any proposed uses of freed-up resources.

Moving in the other direction, national guidance also speaks of the relationships with patients and the wider public. Practice-based commissioners are to ensure that their plans 'involve their patients', 'are available for public scrutiny' (including by the local

authority overview and scrutiny committee), and that they have 'engaged their patients and Local Involvement Networks in service redesign'.¹¹

Although it appears as a section heading, it is noteworthy that the language of accountability is otherwise absent when the relationship between commissioners and the wider public is laid out by the Department of Health. It would seem that practice-based commissioners are *accountable* to the PCTs, but that they merely *involve* patients and the wider public and work in a way that is *open to public scrutiny*.

This is an important weakness (not least because the democratic accountability of PCTs is so questionable) and people-based commissioners should address it by operating *as if* they are accountable to the wider community. This means that they should think of themselves as accountable and put in place mechanisms by which they can be held *de facto* accountable, even if they are not *de jure* accountable. They need to move away from decisions taken in secret in smoke-free rooms to far more transparent ways of working.

The first stage of *as if* accountability must be to report on the current position by producing the first in a series of annual reports. The reports should come in two variants. First, a straightforward, highly readable version and, second, a more detailed account produced with the more interested individuals and groups in mind.

These annual reports should cover the following ground and should be hosted on the PCT website and displayed in every practice:

- summary of decisions made by the practice-based commissioning group
- the process by which those decisions were made, together with the mechanisms by which they will be evaluated
- the reasoning behind those decisions, including anticipated health and financial gains
- the decisions taken on reinvesting any savings, together with the process by which those decisions were taken
- a statement on how members of the public can contribute to the decision-making process in future
- a statement that explains any financial implications for the commissioning practices of the decisions that have been made.

This report could then be presented at a specially called annual meeting for the commissioning cluster, and those present would have the opportunity to raise issues and put forward their own proposals for future action. The meeting should be widely publicised and specific invitations should be sent to, at the very least, the following:

- the local involvement network (subject to legislation currently going through Parliament)

- the overview and scrutiny committee membership
- the patient participation groups within the practices concerned
- the local MP
- all local health trusts and social care providers
- the overarching body for the voluntary sector in the area
- local public-health and health-promotion specialists.

The annual meeting should be a legal requirement and would be an opportunity for those present to highlight their priorities and to discuss how patients and members of the public will be able to contribute to decisions over the coming year. Naturally, over time, the meeting will serve to assess whether the changes have brought about the desired outcomes.

This process would help to deliver both 'upwards'- and 'downwards'-facing accountability, building accountability to communities into a system that currently only stresses formal accountability to the NHS hierarchy. It would give commissioners greater confidence that they are effectively working to meet local needs and improve local health. It would also allow patients and the public influence over a key area of public spending, holding directly to account those who are making decisions on their behalf.

But this approach will only seem attractive to those who accept that greater patient and public involvement will be worth the effort involved. This is a contentious area but one would hope that the NHS Centre for Involvement can, over time, produce a coherent evidence base in this area. But even in the absence of *that kind* of evidence, it is clear that the health service has to find new ways of getting us more engaged in our health as a whole. Practice-based commissioners who behave *as if* they are accountable are likely to make a positive contribution in this respect.

It is important to remember that fundholding delivered numerous improvements for patients at fundholding practices, but it also led to significant reductions in patient satisfaction. GPs may have been distracted by the extra management responsibilities and patients may have resented the inequities in access that it generated.¹² Patients may also have started to 'blame' practices when things did not go well, believing that fundholding offered practices the power to move mountains. If that story repeats itself, practice-based commissioners may find themselves held to account by patients whether they like it or not.

Conclusions

It is of course very early to be making judgements, but the current activities of pocket book commissioning are likely to deliver only at the margins of our current £90 billion annual spend on health. Apart from the

concerns raised by the National Audit Office (it has raised concerns about increasing financial pressures, greater fragmentation, potential conflicts of interest and delivering poor value for money overall. Based on case studies in four of the more advanced PCTs, the National Audit Office recommends that PCTs focus on strategy, clinical engagement, managing the finances, information, supporting practices and governance¹³), there is little evidence that it will significantly reduce current health inequalities or encourage communities to become far more engaged in their own health. There are also doubts about the depth of clinical engagement that it will deliver, as the British Medical Association argues that insufficient resources have been provided to free up GPs to undertake this work.¹⁴ It argues that the current payment system:

will enable GP practices to choose a few clinical areas on which to reflect and monitor referral patterns, conduct peer-review within the practice where necessary and carry-out some audit and analysis in order to ensure more rational referral behaviour across the practice. It is unlikely to facilitate major service redesign, which would require a far higher level of clinical engagement and workload than the available resources will enable.¹⁴

If practice-based commissioning is to have a major impact, its approach needs to correspond to that defined by the Department of Health, which I have called people-based commissioning. In which case, the ethics and politics of practice-based commissioning need to be addressed in a far more serious manner than has hitherto been the case. We need structures of public engagement that help to confer legitimacy on the decisions that are taken and that can ensure that the voices of all interests within the community are heard. And we need a process that is informed by public health analyses, is strong enough to listen to pressure groups, and able to make decisions in an ethical and evidence-based fashion.

In 1988, Ian Kennedy (now Sir Ian) wrote that 'it is not for professionals to set the moral agenda for their relationship with those they serve. They have only extra duties, not privileges'.¹⁵ Yet this agenda setting is precisely what may result from pocket book commissioning arrangements as they are currently framed. This will not best serve the interests of patients. Nor will it serve the interests of professionals if their decisions are perceived as lacking in legitimacy. (The legitimacy may be at its most fragile as practices move away from the partnership model and where PCT boards approve reinvestment of savings to develop premises that are owned by practices.) Greater clinical engagement and more responsive commissioning is certainly desirable, but the technical expertise is only part of what is needed to get things right. The ethical insights must be sourced more widely and the politics cannot be ignored.

As is so often true in health care, practice-based commissioning will work best when it is the result of a genuine partnership between the public, patients and professionals.

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