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The Implications of "Practice Based Commissioning: Technical Guidance"

Introduction

This guidance document was long awaited. The initial thoughts around practice based commissioning had excited many organisations and individuals. The realisation of the power of this policy in context also aroused fears for the stability of the established structures of the health service. Many were expecting a revelation of processes and procedures that would ameliorate these fears. These individuals have been disappointed.

This has lead to a reduction in enthusiasm for the policy as a whole. This is short sighted. The potential for levering change is still vast. This change was never going to happen overnight. The publication of this guidance should be viewed as setting the scene for first steps. It is for these first steps that we examine the document.

The greatest danger to the policy is the linkage to "Choose and Book". If the perception of the practices is that "Choose and Book" is undesirable, and that "Choose and Book" is compulsory, then they will not engage. The benefits to patients will not then be realised.

Clarifications

<u>Localities</u>

Para 5

The guidance makes it quite clear that the formation of localities is neither compulsory nor geographical. This is welcome. There is not a shared history of co-operation among the practices in many localities. The removal of any possibility of compulsion will reduce the level of anxiety among the practices and paradoxically encourage co-operation. The realisation that these practices do not have to be related by geography will allow the formation of localities based around common aims, objectives, values and culture. These teams will be resilient.

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Choose and Book

Para 11

The guidance that teams need to "*demonstrate that they intend to implement "Choose and Book"* is interesting. If the interpretation is that implementation is not required merely a plan then that would diminish the moral authority of the guidance. If on the other hand the plan could include an commencement date for "Choose and Book" that was dependent on the policy and IT having proven its value to patient care, then that would be good management. It is this second interpretation that we at Xytal shall advocate.

Budget Setting

Para 14 on

This is both more and less clear. It is positive that there is one clear methodology. It is even more positive that this methodology can be varied to suit local conditions. But it is this very flexibility that has diminished clarity.

On the face of it there is a massive amount of work for Trusts (who are currently stretched) and practices (who are frequently financially naïve) to complete in order to agree a process. For teams that feel that way Xytal would advocate adoption of the default budget, until service planning and delivery reveals an anomaly that could be solved in a better way. This provides the focus of effort on where it belongs: patient care.

At this stage we should accept that the phrase "Fair Shares" means nothing in accounting terms. This is a river that will have to be crossed later.

Budget Deficits

The inevitable consequence of top slicing budgets for risk management, pre-commitments, and any devolved nursing budgets is a narrowing margin. There is no substitution for a hard look at an offered budget and walking away if necessary.

Central Planning

Para 7

The requirement that there will be an agreement between practices and PCT's on how all national and local targets will be delivered is a danger to the policy. This was identified in the NHS Confederation's response to the initial Department of Health Proposal:

> *"Practice Based commissioning undoubtedly will bring commissioning closer to front line clinicians and this is an important objective.*

However, this was the intention behind the creation of PCTs and if the authors of this guidance believe that this has not happened as much as was desired it might be worth asking whether this is a function of structures or of some other aspects of policy. It could be that clinical disengagement has other causes such as the multiple functions of PCTs, the requirement to meet targets, a lack of local discretion or other features of the current system. If this is the case then the development of practice based commissioning whilst desirable for other reasons may not actually solve this problem and other measures will be required in parallel. If the same constraints are to be put on practices as have been placed on PCTs then the policy may well fail to attract support"

Only time will tell how this issue plays out.

<u>Risk Management</u>

Para 27

The requirement for risk management is clear, and is shared with many industries. The two issues here are size and scope of this pool.

The required size of the risk management pool can be calculated by an analysis based on the normal distribution of clinical activity. Standard deviations can be calculated, and odds ratio's established. This would allow a PCT director of finance to assure their board that they will be protected from an overspend due to random fluctuation be it 95% of the time or 97% of the time or whatever figure is chosen.

However the complexity is to distinguish not only random from planned variation but also random variation from failure to achieve planned change. It will be this issue that will cause discord from practices who feel that they have achieved beneficial change and have been financially penalised to support those practices who have failed to deliver.

The only way to avoid this is to agree in advance across every budget holder the rules concerning the deployment, and consequences of deployment of the risk pool. No mean task.

Efficiency Savings

Para 48 on

This section is important. There is still a myth among the practices that practice based commissioning is like fund holding, and that practice income can be enhanced. This guidance clearly places conditions for the use of taxpayer's money, be it money offered in an initial budget offering, or as a result of a budgetary under spend. Those practices that wish to enhance income will have to demonstrate value for money to their local professional executive committee.

Management Costs

Para 42 on

The guidance has firmed up the status of initial costs. Initially the implication was that start up costs were a gift from the PCT to the practice. The technical guidance makes explicit that start up costs are part of project costs, and for the project to be attractive to the taxpayer the total costs must be decreased. *Paras 44 and 45* make clear that the practices do not exist in isolation, and that unnecessary duplication of effort/staff by the practices and the PCT wastes money. This is not unreasonable, however it should not be used as a rationale for protecting the status quo.

Conclusion

There has been criticism of this publication, "neither technical nor guidance". Detailed analysis shows that it does provide clarity in many areas. Importantly it is also explicit that there are some issues that require local work up and resolution.

We can offer seminars and workshops that will deliver action plans that are owned by both the PCT and the practices. These plans will be specific for the issues unique to your locality and your patients.

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