

Principles underpinning the process and considerations within a SWOT analysis

1 Introduction

The following paper provides an opportunity to consider practice based commissioning (PBC) within a SWOT analysis – strengths, weaknesses, opportunities and threats. It should be read in conjunction with the following documents:

Making practice based commissioning a reality – technical guidance

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4104152&chk=/K4etf

Practice based commissioning: promoting clinical engagement

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098564&chk=uBbP%2Bg

Practice based commissioning: GPC guidance for GPs and local medical committees, March 2005

<http://www.bma.org.uk/ap.nsf/Content/pracbasecomm0305?OpenDocument&Highlight=2,abc>

Why practice based commissioning?

The General Practitioners Committee (GPC) is aware that practice based commissioning (PBC) may not initially hold sufficient appeal for many GPs to consider becoming involved. In addition to concerns about overstretched GP capacity, the recently published technical guidance has introduced a number of disincentives to the scheme. However, there remain many reasons why practices should seriously consider becoming commissioners.

Since the NHS is going through radical change GP's may need to consider PBC. The radical changes are largely due to:

- Payment by results (PbR).
- Patient choice.
- Private sector providers.

2 Strengths of PBC

As with many of these types of developments, the strengths are initially the driving force for implementation. Some of the factors that are thought to be the strengths of PBC are:

- Effective PBC can lead to more control by practitioners.

- GPs playing a role in commissioning services for their patients and local population, being more responsive to patient needs.
- PBC will over time be of great importance in the NHS system overall, for example system changes such as patient choice driving quality improvements and empowerment.
- Ability to direct funds where needed and so able to support patients with long term conditions.
- Better services for patients from a range of providers and in community settings closer to home.
- Use of Doctors and nurses in commissioning decisions.
- Use of patients in commissioning decisions.

3 Weaknesses

For PBC to be of success there will be many aspects within the system that will need to be '*ironed*' out, such as:

- Indicative budgets – clear data/information on what health services the practices are using. PCTs already provide information on prescribing and some PCTs already provide information on scheduled and unscheduled care and diagnostics.
- Timely, accurate information will be essential for effective commissioning and management of demand.
- GPs to be clear on funds required to manage PBC – management and administration costs, as well as any overheads, IT support and time given by clinicians.
- Lack of clarity from DOH guidance (Feb 2005) – will need to be agreed between LMC, GPs and local negotiations with PCTs.
- Budgets will be set on historical referral data i.e. 2003/4 and if historically practices had low referral rates, they may be automatically disadvantaged in the setting of their budgets.
- Ensure insufficient commissioning budgets are not set, where PCTs have financial deficits and PBC is seen as a means of tackling this problem, which could result in rationing of services.
- When agreeing costs for implementing PBC with the PCTs, it is important to recognise that non-financial resources offered to the practices, such as PCT owned staff support or PCT staff seconded to a practice may not necessarily be as reliable as cash resources.

4 Opportunities

There will be various aspects of PBC that will present opportunities to general practice such as:

- The biggest focus in all this is *'more and better services for the patient'*.
- To prevent fragmentation that could be caused from alternative provider medical services (APMS).
- Commissioning decisions between the practices and PCT's to be based in the context of the local delivery plans (LDP) and commissioning of services based on health priorities.
- PBC to also consider health needs assessment of local population with guidance from public health.
- Utilisation of PBC to move resources into primary care.
- Service re-design through effective commissioning, using money freed up to develop better in-house services for instance.
- Develop a detailed picture of which services GPs are referring to and what's happening to the patient at each stage of their treatment pathway.
- Open up a closer dialogue between GPs and PCTs.
- Practices to be able to retain savings and plough these savings into other service areas.
- Hospitals may increase number of procedures due to PbR but PBC can monitor this and ensure accountability.
- Develop care pathways and service re-design are in the best interests of patients.
- Vagueness of the technical guidance could allow for innovation!
- Although alternative provider medicals services (APMS) may be seen as a threat, it is also an opportunity for GPs to tender to provide services as an APMS body.
- PBC should improve the inclusiveness of hard to reach populations, address their needs accordingly and reduce health inequalities.

5 Threats

There are some threats that general practice needs to consider:

- Alternative Provider Medical Services (APMS). The imperative for PCTs to develop APMS has the potential for patients to be diverted to numerous private sector primary care providers.
- If GPs decide not to hold their own budgets then others such as community matrons, district nurses or private providers may be willing to do so.

- Risks involved in PCTs devolving budgets to practices, especially if budgets are not calculated correctly or there's a shortfall.

6 Overall factors to consider

There are various aspects that need to be considered when implementing PBC, these are presented in the sections below.

6.1 Choose and Book (C&B)

Choose and Book (C&B) is not necessarily synonymous with patient choice and there are further concerns on resource implications on GPs to implement C&B. In order for the GPs to fulfil their obligations under the choice agenda and within PBC, it is important that they do not coerce patients into choosing in-house services.

6.2 Calculating costs

When calculating costs, practices should consider:

- The indicative budget figure.
- The services that are to be commissioned.
- Potential number of patients for whom services will be commissioned.
- Costs for any contract monitoring that the practices may decide to do themselves.
- Management and administration costs
- Any overhead costs.
- IT support.
- Cost implications of time given by clinicians.

6.3 Risk management

The financial risks involved in PCTs devolving budgets to practices must be considered by all involved in PBC. Practices should ensure that the PCTs risk assessment corresponds with the services that practices wish to commission. The LMC and GPs would also need to be clear on the risk management strategy adopted by the PCT.

6.4 Efficiency gains

A 100% investment of savings made from PBC would be agreed with the PCT from the outset. The management costs should be recouped from these savings and any surplus ploughed into service improvement.

Practices who have grouped together for the purpose of PBC should agree in advance how cost savings will be distributed. A suggestion for distribution is by practice populations. The funding of capital budgets

should be taken holistically for the benefit of the patient population of all the practices involved in PBC. The whole aim should be service redesign irrespective of the level of savings.

Practice based commissioners will need to agree how savings will be deployed and put to the PEC for approval. LMCs should be discussing with PCTs early on, on how it is to engage in this process, ensuring no conflict of interest arise regarding GP members of the PEC, who may also be involve in PBC within their own practices.

6.5 Involving patients and frontline staff

Practices involved in PBC should consider involving patients in their commissioning decisions. By linking in with the local patient liaison groups, practices could strengthen their relationships with their patients and highlight the importance of providing more services in a community setting. The local deliver plan (LDP) should also be very clear on how patients will be involved.

For PBC to be successful, engagement of front line staff is crucial, ensuring the wider practice team are involved, not just the GPs.

6.6 Local Delivery Plan and health priorities

An important aspect to consider is that PBC is within the context of the PCTs LDP, with a clear understanding of the public health dimensions. Decisions made by practices should be based on health priorities. Practices may wish to consider support from the PCTs public health department.

6.7 Governance and Values

Some governance and values that need to be considered by the whole health community embarking on PBC are:

- Practices free to choose if they work with other practices or not.
- Partnership between PCT and practices.
- Agreement between practices and PCTs on achieving targets.
- Support for the practice by the LMC and PCT.
- Practices must seek to obtain good value for money.

7 Conclusion

Overwhelmingly, it is demonstrated by some of the arguments stated above that practices should seriously consider taking on the commissioner role. Taking into consideration the pro's and cons, in particular associated risks of not getting involved. With all this in mind PBC offers practices some degree of control for the provision of health

services for their local patient population. If practices ensure their PBC plans are in context with the local delivery plan (LDP) of the PCTs, as well as inclusive of the health needs assessment as guided by the PCTs public health department, the benefits outweigh the 'teething' problems of implementing PBC.

The DOH technical guidance is a little lacking in detail and the LMC, general practitioners and PCTs will need to agree the terms locally. Some examples of PBC in other parts of the country are included in **Appendix 1.**

APPENDIX 1

**Summary of Good Practice' examples, with
web addresses.**

This section contains a range of files relevant to the implementation of PBC in an alphabetical listing by organisation. The examples, which are in differing file formats, cover a variety of topics and have been made available to PCTs for adaptation purposes.

Location: Norfolk, Suffolk and Cambridgeshire (NSC) SHA

This implementation example is a relatively complex spreadsheet that gives age standardised data for a practice example. It can be adapted for the purpose of both budget setting and contract monitoring. The model can also be cannibalised and used to support the development of arrangements for risk management.

In order to be, adapted macros will need to be reset. As a result it is recommended for use by information and/or finance specialists.

http://www.primarycarecontracting.nhs.uk/uploads/pbc_files/Cambridgeshire%20SHA%20Practice%20budget%20example.xls

Location: Craven, Harrogate and Rural District PCT

This is an overview document which describes the approach taken by CHaRD PCT. Section 6 will be of particular interest to PCTs wishing to consider a possible cluster or locality approach.

It gives brief detail on their approach to budget setting and contract monitoring. Risk management arrangements are covered as part of their locality structure.

Management costs are detailed in paragraph 5.2.2 on page 5.

http://www.primarycarecontracting.nhs.uk/uploads/pbc_files/CHaRD_PCT_Framework.doc

Location: Dorset and Somerset SHA

This is an overview document that is heavily focused on the budgetary mechanics of PbC. Pages 2 to 7 cover budget setting but are heavily based on DH guidance. The document does provide a simple methodology in para 5.7 on page 5.

http://www.primarycarecontracting.nhs.uk/uploads/pbc_files/Dorset%20and%20Somerset%20financial%20framework%20f.doc

Location: Durham Dales PCT

This is an Excel tool which covers all specialities for outpatients and both elective and non-elective work including spells information. It could be developed as a contract monitoring tool and includes useful graphical representation. The spreadsheet also includes a weighted capitation element which could be used to support risk management arrangements.

http://www.primarycarecontracting.nhs.uk/uploads/abc_files/Durham%20Dales%20Practice%20budget%20example.xls

Location: Eastern Birmingham PCT

Overview information which gives an outline for their proposed model and brief detail on the framework and associated methodology.

http://www.primarycarecontracting.nhs.uk/uploads/abc_files/Eastern%20Birmingham%20consultation%20paper.doc

Location: NHSIA Tools:

This web link provides some useful tools which could support PCTs in developing activity profiles to support the calculation of Practice budgets. The full pack includes an HRG grouper and spells converter. It could also be developed so as to support both contract monitoring and risk management.

<http://www.icservices.nhs.uk/casemix/pages/tools.asp>

Location: North Bradford PCT

The presentation details both the history of the North Bradford Model and options for integration within the PbC environment. Slides 7 and 8 detail the history and 19 and 20 future options. A basic overview of their approach to budget setting is given on slide 10 and slides 12 and 22 cover management costs. A number of graphs which relate to contract monitoring are included on slides 11, 15 and 16 but this is headline information only and cannot therefore of itself be adapted.

http://www.primarycarecontracting.nhs.uk/uploads/abc_files/North%20Bradford%20model.ppt

Location: South Hams & West Devon PCT

This PEC paper gives an overview of their approach. A basic description in respect of budget setting is described on page 2 and page 3 gives brief detail of their incentive scheme which is an extension of the QOF. Page 4 provides headline information on the coverage of their contract monitoring processes.

http://www.primarycarecontracting.nhs.uk/uploads/abc_files/South%20Hams%20and%20West%20Devon%20PCT%20PEC%20Paper.doc