Practice-based commissioning: Is it helping to reconfigure diabetes services?

Azhar Farooqi

Practice-based commissioning has been a major feature at meetings and on conference programmes for the past few years. In this article the author considers whether or not practice-based commissioning has aided the reconfiguration of diabetes services, what has changed due to the commissioning process and where commissioning is headed.

The NHS Plan published in 2000 by the Department of Health (DoH) set out a 10-year programme to reform the NHS. This strategic document outlines the vision of an NHS with an increased choice of service providers; and by using the mechanism of 'money following the patient,' increased sensitivity to customer needs. The use of this type of market philosophy to improve the efficiency of health care provision is not new to the NHS. There have been three attempts within the last two decades to use internal market mechanisms as a means to achieve the 'holy grail' of a cost-effective but high-quality health service. The first such scheme was GP fund holding which, while not universally adopted (and eventually dropped for political reasons), did demonstrate the potential to constrain both prescribing and referral costs (Gosden and Torgerson, 1997). The emergence of PCTs as the new and sole champions of commissioning (DoH, 2000) was the second attempt and is generally accepted (in the face of the large and complex remit of PCTs) to have failed to engage clinicians, control NHS expenditure or meet patient expectations. Hence the arrival of attempt three – practice-based commissioning (DoH, 2004).

Article points

1. Practice-based commissioning is a mechanism whereby commissioners are free to acquire services which they feel are appropriate for their population.
2. well-organised primary care can deliver good diabetes services.
3. Arguably, the QOF and the continuous upskilling of primary care practitioners have probably had a greater impact on delivery of diabetes services than practice-based commissioning.
4. World-class commissioning can provide the means to make practice-based commissioning work for the NHS.

Key words

- Practice-based commissioning
- Diabetes services
- World-class commissioning

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1. Practice-based commissioning is a mechanism whereby commissioners are free to acquire services which they feel are appropriate for their population.
2. Arguably, diabetes is an ideal condition to be managed almost exclusively outside of the hospital environment.
3. Many practices already achieve maximum QOF points for diabetes, and the primary care workforce is becoming increasingly more skilled in diabetes care.
4. As well as GPs there are other potential providers who could contribute to reconfigured service provision.

Practice-based commissioning

Practice-based commissioning is a mechanism whereby commissioners are free to acquire services which they feel are appropriate for their population. The practice-based commissioning cycle consists of identifying needs, developing service specifications, and tendering and monitoring of service provision. The commissioners under the present NHS structures (in England and Wales) are ultimately PCTs; however elements of the commissioning cycle can be delegated to others, such as single GP practices or local consortia of practices. What is clear is that practice-based commissioning must deliver services that are 'good for tax payers' (DoH, 2006a). Commissioners must therefore work within defined budgets and encourage innovation and reorganisation of services based on business planning principles, including promotion of an increased choice of service providers.

Practice-based commissioning and diabetes

Diabetes is an ideal condition for practice-based commissioners who must regard it as 'low hanging fruit' for reconfiguring services so they are more cost-effective and accessible. Arguably, diabetes is an ideal condition to be managed almost exclusively outside of the hospital environment. We know that well-organised primary care can deliver good diabetes services (Griffin, 1998; Khunti et al, 2001; Williams and Farrar, 2001). Indeed, a number of service developments (for example, Bradford and parts of Birmingham) have already demonstrated that diabetes care does not have to be delivered in the hospital setting. Many practices already achieve maximum QOF points for diabetes, and the primary care workforce is becoming increasingly more skilled in diabetes care – through both more involvement in diabetes surveillance and further training. The DoH offer examples of good ideas for practice-based commissioning, stating that day-to-day care for diabetes could be provided at practice level (DoH, 2007a) and that commissioners may wish to 'develop plans to deal with insulin dependence within the community, by GPs taking on more responsibility' (DoH, 2007b). As well as GPs there are other potential providers who could contribute to reconfigured service provision. This could include the expansion of the role of specialists (particularly into community provision of services), involvement of the voluntary sector (perhaps in patient education), or even a role for private industry – for example by pharmaceutical companies (who already employ a significant specialist nurse workforce in support of the NHS).

What has changed?

The potential of practice-based commissioning is clear; however the mechanism by which it could change services has now been available for 2 years – so what has really changed? The reality is that while there have

been some initiatives to reconfigure diabetes services using practice-based commissioning, in general it has yet to emerge as a tool that has significantly changed the diabetes care landscape in terms of either service provision or quality improvement. Arguably, the QOF and the continuous upskilling (over the last 20 years) of primary care practitioners have probably had a greater impact on delivery of diabetes services than practice-based commissioning. Why has this been the case? The answer, I suspect, is known to the Department of Health, and is recognised in their latest initiative regarding practice-based commissioning known as 'world-class commissioning' (DoH, 2007c). This initiative has been put at the very top of the agenda of PCTs and tacitly accepts that practice-based commissioning thus far has been disappointing.

World-class commissioning

The world-class commissioning process recognises that more skills, resources and rigour are needed to make commissioning an effective tool for improvement of health care, and requires PCTs to address a series of specific competencies for commissioners (DoH, 2007c). The 11 defined competencies require that commissioners:

- Are recognised as the local leader of the NHS.
- Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.
- Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health.
- Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation.
- Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements.
- Prioritise investment according to local needs, service requirements and the values of the NHS.
- Effectively stimulate the market to meet demand and secure required clinical, and health and well being outcomes.
- Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration.
- Secure procurement skills that ensure robust and viable contracts.
- Effectively manage systems and work in partnership with providers to ensure contract adherence and continuous improvements in quality and outcomes.
- Make sound financial investments to ensure sustainable development and value for money.

It is important to note that the above competencies are often not the

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1. Where the diabetes commissioning toolkit has been piloted thus far it is lack of the above competences (for example, prioritising investment or presence of effective procurement skills) which have prevented effective implementation.
2. World-class commissioning can provide the means to make practice-based commissioning work for the NHS and sets a challenging agenda.
3. It remains to be seen whether PCTs possess the leadership and political guidance to meet this challenge.

core skills that practicing clinicians possess, it is therefore important that health-service managers acquire and provide these skills in the commissioning process. This is not easy to achieve and requires increased resources in training, information systems, financial control and market development. Many of these competencies are essential for the effective implementation of the diabetes commissioning toolkit (DoH, 2006b), Indeed, where the toolkit has been piloted thus far it is lack of the above competences (for example, prioritising investment or presence of effective procurement skills) which have prevented effective implementation.

Concluding remarks

World-class commissioning can provide the means to make practice-based commissioning work for the NHS and sets a challenging agenda. Getting the balance right between management and clinical input, between stimulating markets and managing the existing health system, and in meeting consumer needs or wants will be difficult to get right. It remains to be seen whether PCTs possess the leadership and political guidance to meet this challenge. If they fail to do so then practice-based commissioning will remain just another failed initiative in introducing market principles to the NHS. ■

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