Practice-based commissioning and GPSIs: Time to stop practising

Brian Karet

Brian Karet is a GP at Leylands Medical Centre, Bradford and a GPSI in Diabetes.

Practice-based commissioning (PBC) has been evolving in the mind of the Department of Health (DoH) for many years as a way of really engaging the people who direct the provision of care (GPs and primary health care teams) in the commissioning of care. Definitive guidance (DoH, 2004) was issued in December 2004 with the stated aim that PBC would:

- provide close-to-home and convenient care for people with diabetes
- increase the variety and scope of providers
- develop new services by collaboration between clinicians.

And it's not just the old fundholding revisited. That was an attempt to bring market forces to health care. PBC allows PCTs to improve the scope of commissioning while still maintaining control and ensuring services are provided within an overall strategy. The other big fear is that PBC will destabilise hospitals that are shackled by payment-by-results (PbR) tariffs. The reality is that without constraint on referral patterns brought about by PBC, any system of PbR would quickly bankrupt PCTs as hospitals would work hard to increase referral rates. So, PBC and PbR are two sides of the same coin.

The really important thing about PBC is that it inexorably shifts the balance of power to the individual with diabetes and their carer in the community, and this fits in almost seamlessly with the aims of the highly influential Our Health, Our Care, Our Say White Paper published in 2006 (DoH, 2006a). The core message of this 'must-do' white paper was to redesign services around the person with diabetes rather than shoehorn them into existing historical, often hospital-based, services with an emphasis on education, early intervention, supported self care and community engagement. These ideas didn't come out of thin air but were the result of extensive public consultation, which is why they carry such weight.

Recent developments

Services are now being developed in the community by involving all service users in care pathway redesign. This ultimately involves looking at other ways that people with chronic condition such as diabetes, can be cared for outside of the traditional hospital setting. Care provided in this way should not only be cheaper and more timely but more convenient for the individuals receiving it. In addition, any potential savings can be reinvested in care. PCTs are also pleased to involve primary care teams in financial management and budget setting, which it is hoped will lead to lower care costs and service development by reinvestment of savings made. Indeed, the only part of fundholding that was wholeheartedly successful was the devolvement of drug budgets to practices with huge efficiency savings in the early years.

This need for alternative sources of expertise outside of hospitals has led to the further development of the GPSI-led services originally born out of the NHS Plan 7 years ago (DoH, 2000). Services are already being run in many specialities; however, concerns remain about training, clinical governance and integration with secondary care.

Getting involved in practice-based commissioning

So, how can those of us who care about how people with diabetes are looked after get engaged in this process? Fortunately, there is a wealth of information to help, contained in a publication

called the *Diabetes Commissioning Toolkit* (DoH, 2006b). This 2006 publication was a joint venture between the DoH, Diabetes UK, the Association of British Clinical Diabetologists (ABCD), and the Primary Care Diabetes Society who led the process. It is the first disease-specific commissioning guidance available and was driven by Azhar Farooqi, OBE, a GP in Leicester. It won't come as a surprise to know that the first thing any commissioning body ought to do when considering a service redesign is to ask the users: the patients and healthcare professionals. In order to be of value, however, this is best done when an effective health needs assessment of the current and future diabetes population has been undertaken.

It is amazing how many health organisations make seismic changes to the way care is delivered on the basis of poor and inadequate data. Good-quality information is crucial when new models of care are being discussed since diabetes is complex and care involves a large number of interventions. It is important that any model of care proposed is robust enough to cope with the demography while keeping the person with diabetes at the centre of its focus.

Given the complexity of good diabetes care and the almost exponential increase in the variety of treatments and interventions available, it is all too easy to tinker at the edges of the existing service with a new retinal camera here and an education programme there. Although all valuable components, this approach would be a betrayal of the spirit of the Our Health, Our Care, Our Say document. Around the country, a large proportion of diabetes care is delivered in the community by trained and accredited GPSIs working with and alongside diabetes specialist nurses, podiatrists and dietitians. However, even this falls short of giving each individual the best care available if there is no engagement from our consultant colleagues who have a dual role in this process. They act first as mentors and supporters of community-based services; and, second, as part of the accreditation process that has been recently and explicitly spelt out in part 3 of the 2007 DoH Implementing Care Closer to Home document (DoH, 2007), which makes it clear that the accreditation process for GPSIs must also look at the design and structure of the service in which the GPSI is working.

The required support

One further component is essential to a successful PBC service redesign and that is top-class managerial and financial support. It is very clear that any community-based diabetes service must support and facilitate GPs and their teams to look after people with diabetes using more developed skills. Skill acquisition and maintenance in primary care needs incentivising and this can most easily be done by diverting directly enhanced services funds. This, along with the quality, clinical governance, health and safety, IT and reporting aspects of any service, needs comprehensive costing and contract construction. Seamless care needs seamless management. PBC is not just about commissioning but about changing where and how care is delivered. If *we* don't do it, the private sector *is* ready and willing to step in!

Conclusion

Therefore, rather than being something to be wary of, PBC presents GPs and GPSIs with a unique opportunity to actively redesign the service in their locality in collaboration with their PCT. Leadership and ownership of any service are crucial for success but there are many different models around the country. Stephen Lawrence is a leader and innovator (as well as a concert pianist!) and in the following article (pages 168–170), describes his experience and shows how most obstacles can be overcome. Read it, digest it, do it! ■

DoH (2000) *The NHS Plan: a plan for investment, a plan for reform.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960 (accessed 25.06.07)

DoH (2004) *Practice Based Commissioning: Promoting Clinical Engagement.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4098564 (accessed 25.06.07)

DoH (2006a) *Our health, our care, our say. A New Direction for Community Services.* http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/index.htm (accessed 25.06.07)

DoH (2006b) *Diabetes Commissioning Toolkit.* http://www.diabetes.nhs.uk/downloads/commissioning_toolkit_diabetes.pdf (accessed 25.06.07)

DoH (2007) *Implementing care closer to home: Convenient quality care for patients Part 3: The accreditation of GPs and Pharmacists with Special Interests.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074430 (accessed 25.06.07)

Page points

1. The first thing any commissioning body ought to do when considering a service redesign is to ask the users; patients and professionals.
2. In order to be of value, however, this is best done when an effective health needs assessment of the current and future diabetes population has been undertaken.
3. It is important that any model of care proposed is robust enough to cope with the demography whilst keeping the person with diabetes at the centre of its focus.
4. Top-class managerial and financial support is essential to a successful PBC service redesign.
5. Rather than being something to be wary of, PBC presents GPs and GPSIs with a unique opportunity to actively redesign the service in their locality in collaboration with their PCT.