

Practice-based commissioning: Friend or foe?



Debbie Hicks

I was recently visited by the commissioning lead of the National Diabetes Support Team; he wanted to discuss the process behind the redesign of our diabetes service that we commenced in Enfield 18 months ago. After the visit, I began to reflect on the last 12 months – the first year of practice-based commissioning (PBC). How this further NHS reform has, and will, impact on nurses working in diabetes was at the forefront of my mind.

You may not yet have been involved in PBC, in which case: watch out! It's coming! To begin with, you should be asking yourself what exactly you understand by PBC. In short, commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean:

- the best possible health outcomes, including reduced health inequalities
- the best possible healthcare
- an option within the resources made available by the taxpayer.

When PBC was first brought to the attention of healthcare professionals, it was seen by some as a 'carrot' and by others as a 'stick'. Certainly in the specialty of diabetes, it was viewed with great nervousness, especially by those working in acute services.

Department of Health guidance

Commissioning is not the responsibility of a single organisation in a patient-led NHS. Rather, it should be a partnership between PCTs, general practice and local government.

Many of the current changes taking place in the NHS are dependent on a strong commissioning function. Service redesign is, in many cases, dependent on effective commissioning. Therefore, it is vital that commissioners have access to tools and expertise that will help them to commission high-quality care.

Several documents have laid out the specifics of PBC. *Commissioning a Patient-Led NHS* stated that the NHS should be moving from a provider-driven service to a commissioning-

driven one (DoH, 2005a). The document set out the importance of expert and imaginative commissioning in order to achieve the aim of a patient-led NHS. Later that year, *Health reform in England: update and next steps* was published and described the different reforms being made to the healthcare system. It also explained how these reforms are expected to interact (DoH, 2005b). The document reinforced the importance of good commissioning in achieving services that meet the needs of the local population while also obtaining value for money.

The White Paper on community services – *Our health, our care, our say: a new direction for community services* – emphasised the importance of good commissioning in providing integrated services, building on good local partnerships (DoH, 2006a). It stated that commissioners should commission for 'health and wellbeing' to ensure that health improvement is at the heart of the commissioning process.

Next to advise was *Health reform in England: update and commissioning framework*, published in July 2006. This provides a detailed framework for commissioning. The framework includes policy and implementation guidance on commissioning and PBC; plus expectations of how PCTs, GPs and health and social care commissioners will work together (DoH, 2006b).

The diabetes commissioning toolkit

Commissioning diabetes care should be a strategic process involving a wide range of different people, including individuals with the condition, carers and clinicians. It should also take into account the local vision for health and social care in the whole community. Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes – particularly with regard to type 2 diabetes. Commissioners should use the commissioning process to address these variations in care (DoH, 2006c).

How could GPs know what a diabetes service

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should look like? How would GPs know what constitutes a 'good' diabetes service and include all the important elements? I was involved in the early development of the *Diabetes Commissioning Toolkit*, the tool now used to address these questions (DoH, 2006c).

The toolkit is aimed predominately at NHS commissioners of diabetes care, at both PCT and practice level. The toolkit should support commissioners in a number of ways, including the following.

- Providing advice on how to carry out a healthcare needs assessment for a local diabetes population in order to understand their specific needs.
- Providing a generic specification for diabetes care, setting out the core elements of quality care and signposting best practice quality markers (such as NSF Standards and NICE guidelines).
- Providing suggestions for indicators that commissioners can use to monitor the quality of their current local service and identify improvements that need to be made.
- Providing key outcomes that a commissioner can specify when commissioning diabetes care.

In addition, the toolkit may be useful for providers of diabetes services by highlighting quality markers and encouraging local audit. Finally, the toolkit can be used by diabetes networks by providing a framework to look at service improvement and development of models of care.

Progress to date

Even a year on, there are still some PCTs that are only just embarking on this journey, probably because it is complex, time consuming and a new process for many involved in it.

As mentioned earlier, the whole process is about providing 'the most appropriate diabetes care in the most appropriate location' for the individual with diabetes by 'the appropriately skilled and competent healthcare professional.' However, this is all required to take place within available current resources. The *Diabetes Commissioning Toolkit* is a guidance document and will certainly help but it is not mandatory. Through PBC, any

service can now be contracted out to a provider, public or private sector, which is working in a free and open market. Any financial savings from commissioning a cheaper service can then be used by the commissioner to spend on other services.

On a final note, I have a worry that many practice nurses are paid less than a DSN. It is possible that a practice nurse could be expected to provide care at the same level as a DSN but without the equivalent pay, training and support. This situation would only serve to undermine the quality of care available to the ever-increasing number of people with diabetes. It is crucial that education programmes for the person with diabetes and their carers are included in all commissioned services to underpin self-care management. To ensure that the workforce caring for people with diabetes is 'fit for purpose', education programmes for healthcare professionals are also required to be included in these new commissioned diabetes services. ■

DoH (2005a) *Commissioning a patient-led NHS*. Available at: www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=20618&Rendition=Web (accessed 10.09.2007)

DoH (2005b) *Health reform in England: Update and next steps*. Available at: www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=8715&Rendition=Web (accessed 10.09.2007)

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DoH (2006c) *Diabetes commissioning toolkit*. Available at: www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=24270&Rendition=Web (accessed 10.09.2007)

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