Practice-based commissioning:
are there lessons from fundholding?

Responding to practice-based commissioning (PBC), enhanced service bids, and alternative provider medical services (APMS) is proving difficult. This should be no surprise — their design and implementation is ad hoc as they undergo frequent revisions and reinterpretation. In this article, we use our practice's experience to highlight difficulties and propose change.

PBC is a misnomer — it is not practice based but locality based, and is of the same size or larger than the recently deceased primary care trusts (PCTs). It, therefore, runs the risks of inheriting all the PCT foibles and weaknesses that contributed to their demise; principally limited clinical involvement, weak leadership and decision making and poor financial management relative to usual commercial practice.[1] Not a promising starting point for improving clinical care and achieving financial stability.

Our practice is approved as an investigator-led research centre by the RCGP. We, like others, hoped that enhanced services would bring new levels of clinical competence to primary care, improving the experience of illness via smoother patient pathways and financial stability. Unhappily this is proving illusory. The practice had prepared, and won, an enhanced service bid to deliver heart failure diagnostics and non-obstetric ultrasound, intended to run simultaneously as a service to patients across the whole PCT area, as well as a research project evaluating patient pathways and clinical outcomes. The success was short-lived: it was withdrawn after the PCT deemed it unaffordable. A close look at the facts shows that their reasoning was flawed. Proposed costs covered both labour and equipment, including depreciation over the proposed tenure. By contrast, hospital trust contracts have often excluded equipment costs, as these capital costs have come from protected monies outside core trust funding. Primary care enjoys no similar funding,[2] so if enhanced services are to evolve, let alone prosper, costing must make allowances for equipment purchase or rental. An invitation to provide a further, and different enhanced service for digital diabetic retinopathy screening again foundered on capital costs, despite running successfully in our practice for 2 years,[3] and being considered as an alternative to a failed hospital-based service. The recurrent theme is that enhanced services with the potential to make a difference are unaffordable without new money. With new money going to primary care, local trusts will be pushed further into debt in the short term. Without proper investment into primary care-based services there will be no choice but to maintain the inexorable rise in referrals to secondary care, perpetuating its long-term debt. The rational solution for this dilemma for both primary and secondary care is to jointly invest and work in ways that exploit each other's potential.

Collaborative working has, however, also proved a noble concept that often fails to crystallise in practice. An APMS bid for heart failure diagnostics and non-obstetric ultrasound fared no better. The preparation was meticulous: a company was set up and a consortium formed to give commercial credibility beyond that expected of primary care. Yet after a perfunctory review it was rejected on an allegedly weak presentation of the non-obstetric ultrasound service, for which no secondary care commitment could be determined by the time of submission. A meeting with the hospital trust's chief executive, clinical director and the service development lead resulted in a statement of their full support, but this did not suffice. The fact that hospital consultants sitting on APMS assessment boards would probably have concerns about a primary care-based solution that has, in their view, a weak secondary care presence, loomed large in our thinking. Keeping an open mind, this outcome was discussed with a radiology colleague in a different trust, who felt our interpretation of events quite reasonable and unsurprising. According to him, many consultant colleagues never accept that primary care can deliver high quality solutions. His own experience was rather different; he established community-based services for radiology and non-obstetric ultrasound, and indeed this partly influenced our proposed model. Both services were run by his trust, were well received, and he was saddened when, predictably, they were the first to go when the trust's cutbacks arrived.

During times of significant change clinicians are understandably anxious about their roles, let alone their jobs. Yet the complaint that primary care imposes unnecessary workload on hospitals rings hollow when solutions offered by primary care are undermined. Innovation within primary care and attempts to bridge the primary–secondary interface by collaborative working is rejected because of protocols, quality measures and standards, yet hospital practice has an imperfect record in implementing best practice.[4]

A further impediment is often generated within general practice — the pursuit of equality as the Holy Grail. Good, innovative primary care that is able to embrace new ways of working is frequently regarded as irrelevant — the maverick exception that proves the rule. But this approach is both wrong and unsafe. The rising burden of chronic disease generated by an ageing and diverse population is the greatest challenge to health care in the UK and comparable countries.[5] Hospital services must provide technologically advanced diagnostic and therapeutic facilities, but cannot expect to increase capacity in this area while continuing all they do now. Consequently, there has to be a growth in primary care capacity — doctors, nurses and allied professionals — to free hospital practice from large areas of its current workload. Indeed, primary care has a fine track record in this respect, having absorbed the majority of care of asthma, hypertension and diabetes in recent years. However, without new, appropriately funded services within primary care facilitating further such shifts, the pressure upon hospital capacity will grow, with predictable damage to service quality and staff morale. Investing in new,

separate commercial 'players' within primary care is unlikely to work well or be rolled out elsewhere if they remain independent and separate from mainstream care. Establishing integrated healthcare teams in primary care remains difficult, but with yet another separate provider, the chances of success recede further.

Fundholding, despite its inherent inequality, supported massive change and innovation in many practices that were willing to grasp the opportunity. It accelerated the secondary to primary shift, and having treatment within primary care saved many hospital referrals.[6] Fundholding was also conceptually more robust and had clearer rules of engagement than PBC, which suffers by comparison because budgets are indicative and not real, and there is a lack of clarity over key issues such as management funding, risk apportionment between practices and the range of services commissioned.[7]

Unless there is support for further change in ways of working in primary care and an acceptance of both risk and necessity of investment through commissioning, there is little chance of a clinically effective and financially balanced health service. Less well performing practices deserve attention, but to do so at the expense of innovative practices able to provide tangible solutions to the challenges facing healthcare would be a folly that leaves us all poorer.

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Self-inflicted injury ...

It's a Sunday afternoon in August. The sun is shining but I'm holed-up in a rural English A&E department treating people who have injured themselves 'having fun in the Dales'. Bikers with broken legs, paragliders picked off pylons, horse riders who have gone head-over-heels, concussed climbers: they all get the treatment that they need. Inwardly, however, I'm resentful and have an inner dialogue along the lines of 'What do you expect if you choose to do such foolish things?'

That was 6 years ago when I was fairly fresh out of medical school. Cut forward now to my recent summer holiday in north Cornwall. 'Let's buy some wetsuits and body boards before we go — the surf's meant to be great!', suggests my holiday companion. This sounds a splendid idea. Thus, on our first day in Cornwall (a Sunday afternoon, as it happens) you find us striding confidently towards the rocky beach, sporting crisp new wetsuits with shiny body boards tucked under one arm. Not put off by the ominous grey skies and strong gusting wind we venture forth towards the looming waves. We don't actually stop to wonder why no one else is out in the surf, or falter at our own inexperience. 'No fear' is our mantra as we struggle to penetrate the wind-whipped breakers pounding the rocky shoreline at high tide. Once in the sea my spirit lifts as I catch a whopper and rise heavenwards on its crest. My elation turns to panic as I twist and tumble in its force, and am slammed back down onto the rocks. Unable to get up, I need carrying out of the pounding surf by four bystanders who have been watching our progress with interest and alarm. Spine-board, then helicopter to the not-so-local hospital and I'm starting to castigate myself for my foolishness.

'Oh mate, I've done the same thing', a paramedic sympathises as he loads me into the helicopter. 'Is the surf any good today', someone else asks while they're unloading me at the other end. Inwardly I'm still wagging an accusatory finger at myself: 'What do you expect if you will indulge in such stupidity?'. However, I don't sense any criticism from the staff in A&E. Not even a whiff of judgmentalism. Far from it in fact, some treat me as a fellow surf comrade while others cluck and brood in a motherly tone.

Now, thankfully, my back is fine and the hole through my lip has been stitched-up perfectly. However, when I feel the scar and I remember my day of reckless fun-turned-nightmare, I am humbled. I am reminded not to judge, but to care for the injured, no matter how self inflicted their plight. After all, to err is human and to be a bit crazy sometimes is part of the joy of being alive.

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