Practice-based commissioning: should cardiologists fear it?

Stewart Findlay

Author

Stewart Findlay
PBC Chair, Durham Dales Locality

Bishopsgate Medical Centre, 178 Newgate Street, Bishop Auckland, County Durham, DL14 7EJ

Correspondence to: Dr S Findlay **(stewart.findlay@nhs.net)**

Key words

department of health, payment by results, practice-based commissioning, referral

Br J Cardiol 2008;**15**:121–2

Practice-based commissioning (PBC) achieved universal coverage by the end of 2006 according to the Department of Health (DoH).[1] So here we are well in to 2008 and I doubt if many cardiologists have seen any impact from PBC, and the latest DoH survey on PBC would suggest that the majority of general practitioners (GPs) feel that the scheme has yet to get off the ground. Having said that, 36% of practices say they have commissioned at least one new service through PBC.[2]

So will it die a natural death, or will it really make a difference to the way healthcare is commissioned? The DoH are saying that PBC remains central to world class commissioning, and the Conservative party are saying that, if they get in to power, they will give GPs real budgets. If we are to have payment by results, in a cash-limited service, we must have the balance of PBC. PBC aligns clinical and financial responsibility at the point of referral. It should also allow GPs to find new ways to deliver care closer to the patient, offer them real choice and drive up the quality of the care their patients receive. I cannot, therefore, see a future without some form of PBC and so it would make sense to come to terms with it and to make it work.

Patient choice

The other driver for PBC is that from the 1 April 2008, patients have a choice of any approved provider either from within the traditional National Health Service (NHS) or from the private sector. This bypasses any agreement the primary care trust (PCT) may have with a local provider and could potentially de-stabilise a secondary-care service if the GPs or their patients felt it was not giving them the level of care they might expect. We are witnessing the creation of a real market in the NHS!

On the face of it, this might be seen as driving a wedge between primary and secondary care, but it does not need to be that way. Enterprising Foundation Trusts should view this as an opportunity to market their services directly to GPs, and our colleagues in secondary care should see this as an opportunity to work more closely with primary care. If we work together we can use PBC and patient choice to make sure we have integrated care, better quality referrals from GPs and a greater understanding of each other's needs. We could even use it, working through our PCTs of course, to set up new services where both GPs and cardiologists have identified a specific need in their local population.

Room for improvement

We must also remember that in most cases secondary care services are provided to a very high standard and the majority of patients and GPs are happy with their local services. But there is always scope to improve and I will suggest a few areas that one might wish to look at.

Access to investigations is a problem in some areas and there is no reason why GPs could not use PBC to free up resources to allow them direct access to echocardiography, 24-hour electrocardiograms (ECGs) and B-type natriuretic peptide (BNP). Ideally the pathway of care should be agreed between GPs and their local Trust.

New clinics could be set up, such as 'one stop' heart failure clinics or arrhythmia clinics. We might see GPs taking more responsibility for follow-up care, allowing consultants to concentrate more on patients with new problems. We may also see a growth in cardiologists working in the community alongside GP commissioners.

GPs with a specialist interest (GPSI) in some areas are being used to screen GP referrals. The idea

being that many patients do not need to see a consultant. This does not have the support of DoH guidance,[3] as it affects patient choice, attempts to put in place a monopoly service, and can now be bypassed by patients taking advantage of their unrestricted choice of provider. I think it also encourages GPs to refer indiscriminately and it is surely better to educate GPs to use local services appropriately. PBC and the possibility of re-investing savings for patient benefit, should give them the incentive to do just that.

GPSIs could also compete with Trusts to provide some services, and, as they are working in the community, could easily undercut the hospital tariff. While GPSIs can provide safe high-quality services in many areas, they will still need a cardiologist mentor and will continue to depend on good relationships with their local department.

Accreditation is also becoming more difficult and perhaps some GPSIs might find it easier and more rewarding to work within their Acute Trust rather than against it.

Finally, we might want to look at some form of compact (i.e. a formal agreement between two or more organisations) between primary and secondary care that could include a contract to follow agreed pathways. It could describe what should be done by GPs before referral and the information our referral letters should contain. In return, we could agree secondary care standards for waiting times, timeliness of discharge summaries and clinic letters. We could agree how much information we need from secondary care and whether or not we can get that information via secure email.

In summary, PBC gives clinicians a unique opportunity to take the lead on service development. Using PBC as a lever to enlist management support we can work together to make our services fit for the 21st century

Conflict of interest

SF is PBC Chair, Durham Dales PBC Group, and NHS Alliance PBC Lead for the North East Region.

References

1. Department of Health. *Practice-based commissioning: achieving universal coverage.* London: DoH, 2006.

2. Department of Health. *Practice-based commissioning GP practice survey.* London: DoH, 2007.

3. Department of Health. *Health reform in England: update and commissioning framework.* Gateway ref. 6865. London: DoH, 2006.