

Practice-based commissioning: the jury is still out on many issues

The reorganisation of primary care trusts and the advent of practice-based commissioning was the background to discussions on the future of prescribing advice in the NHS at this one-day seminar. Dawn Connelly reports

The jury is out on whether primary care trusts are truly making progress towards achieving universal coverage of practice-based commissioning, according to Sandy Briddon, project director for what was the Thames Valley primary care trusts. The Department of Health has specified that universal coverage will be achieved when all PCTs are providing practices with information on clinical and financial activity, indicative budgets and incentive payments, and governance arrangements are in place.

Although Department of Health figures showed that by August 2006, 69 per cent of PCTs had arrangements in place and 74 per cent of practices were receiving incentive payments, Ms Briddon says that in reality there are wide variations nationally in the level of engagement by PCTs and GPs.

In a number of areas PCTs are not providing GPs with indicative budgets or hospital activity information.

"How can practices participate... without having that type of information," she asked.



Sandy Briddon: engagement with practice-based commissioning patchy

Ms Briddon told participants that a lot of PCTs are in financial deficit and are therefore setting lower budgets for their practices,

which is a huge challenge for these new commissioners.

The few governance arrangements that are in place are being challenged by PBC consortia and lawyers working with groups of practices, said Ms Briddon. There is also little involvement of nurses, pharmacists and social care in PBC.

"If we do not start to gel this together then PBC will not meet the aims the [department] hoped it would," she said. She questioned why GPs are working in large consortia. "Is it the fear factor that if they do not now work together somebody in the private sector may come and do this for them? Or do they genuinely want to improve care locally? I think the jury, again, is out on that," she added.

In summary, she concluded that PBC is the tool for delivering service reform. The message from the Government is that there is no more big money for the NHS so we need to improve access and quality of care within the resources that we have, she told participants.

Joint management of pharmacy across the interface

Although most of the medicines-related savings under PBC will be made in primary care, secondary care needs to be involved, said Ian Bourns, director of medicines management and pharmacy at East Sussex Hospitals NHS Trust, in his presentation on joined-up thinking between hospitals and PCTs in the drug budgets.

Mr Bourns explained that, because the influence of secondary care is significant, it needs to be involved in PBC otherwise large savings will not be made and less money will be available to commission services from secondary care. He mentioned several areas in which hospital pharmacists could be involved, such as improved communication across the interface.

Mr Bourns then presented some of his own thoughts about future scenarios in terms of funding of the NHS. He said that joint drug budgets are often mooted as a way of addressing interface funding issues. But, he said, while there are multiple organisations he cannot see that working. However, he added: "Where we have got care pathways coming along, we may be able to identify the expenditure for given diseases and, if we can, there is a lot of opportunity for changing how we work."

Mr Bourns also floated the idea of joint management of pharmacy services across pri-

mary and secondary care. He believes that it is possible but pointed out that strategic advice would still be needed to individual organisations, which might have slightly different aims.

"I suspect we will see greater integration in the majority of health economies between primary and secondary care, a lot of which will be focused around care pathways. But in some areas we will see a joint management approach to pharmacy," he said.

Finally, he argued that to address the NHS financial problems radical changes are needed and these changes will affect pharmacy. Pharmacy staff across boundaries will need to share information and develop joint information sources. They will also need to resist internal pressures from their organisations to be protective and parochial.

Jonathan Cooke, director of research and development, and clinical director of pharmacy and medicines management at South Manchester University Hospitals NHS Trust, told participants about a medicines management outreach project in South Manchester, where hospital pharmacists were funded to work with GP practices to support effective prescribing in line with the PCT and trust medicines management strategy. The project

actively improved communications on medicines issues across the primary/secondary care interface.

Professor Cooke explained that a number of budding consultant pharmacists in the areas of respiratory medicine, cardiology, palliative care, psychiatry, surgery, pain control and oncology were involved. A three-month review of the project, which spanned five GP practices, demonstrated that it was financially viable and the interventions made were similar to those made by hospital pharmacists in admissions wards. This type of service might help to reduce admissions to hospital as well as improving pharmaceutical care to patients.

Professor Cooke also raised the possibility of vertical integration of the pharmacy workforce. "Why do we not look at rotating our pharmacy staff through the different sectors to get the confidence, knowledge and skills to deliver some of [the new contract] quality initiatives," he said.

"The future for prescribing advice in the NHS" national seminar was organised by **Pharmacy Management** and took place at the Radisson SAS Hotel, Manchester Airport, on 18 October.

Groups of pharmacists could take over GP practices

Some practice-based commissioning consortia may be predatory and be looking to take over both provision of pharmaceutical advice and community pharmacy services, said Peter James, one of the founding and lead GPs in the East Berkshire GP Consortia. But, equally, he said, he could not see why groups of pharmacists cannot be predatory and start to take over some of the underperforming GP practices.

Dr James's advice to pharmacists is not to wait for PCTs or GP consortia to involve them in PBC. "Given that PCTs were not very effective as commissioners, I am a little

bit wary about whether they are going to involve you very quickly and very efficiently and effectively in the near future." Pharmacists need to be proactive in coming forward and telling PCTs what they can contribute, he added. They should also market their benefits to consortia, he suggested.

He believes that pharmacists can play both a strategic and operational role in PBC. "The consortia need people to work with all practices but also with individual practices within the consortia that are perhaps not working in the same way or to the same level as other practices," said Dr James. He also mentioned

increasing access, chronic disease monitoring, medicines compliance and wastage, and uptake of immunisations as areas in which pharmacists could help practices.

Dr James highlighted that PBC consortia will be using peer pressure to target overspending GPs. "This is better at achieving compliance with the norm than anything else you can do, including prescribing incentive schemes," he said. He recommended that prescribing advisers who benchmark GPs should hand that information over to PBC consortia, which will then challenge their colleagues about their prescribing habits.

Pharmaceutical advisers and commissioners share many skills

A lot of prescribing advisers in PCTs are taking on practice-based commissioning roles since many of the skills that they have developed in their advisory roles are transferable to commissioning, said Jonathan Mason, head of prescribing and pharmacy at City and Hackney PCT.

For example, prescribing advisers have developed influencing and negotiating skills, which can be used to help change GPs' referral behaviour. They are also accomplished at gathering a plethora of data together and presenting it in a useable format, which will be a valuable skill for PBC consortia in terms of analysing referral and activity data, said Mr Mason. Pharmacists have an appreciation of where medicines and pharmaceutical care is needed in care pathways, and are able to integrate PBC data and messages into their routine prescribing visits and practice support activities, he added.

An important part of Mr Mason's role is liaising between commissioners and contractors around what sort of services consortia want to commission. He believes that there are a number of areas in the new community pharmacy contract that will be important for practice-based commissioners. The essential

services provided by pharmacists, for example, will ultimately improve the population's health and reduce the impact they have on other local health care services. The same applies to advanced services; the benefits of medicines use reviews, such as improved concordance and savings from unwanted medicines, are a good argument for investing in pharmacy services, said Mr Mason. "Talk to the PBC consortia and practices and ask them who you should be targeting for MURs — it will not cost the consortia anything and it is really good public relations," he advised.

Mr Mason acknowledged that enhanced services is where the real impact will be for both patients and consortia. Services such as minor ailments schemes, smoking cessation, obesity management, substance misuse, immunisation and emergency hormonal contraception will all ultimately lead to improved access for patients and reduce accident and emergency and walk-in centre attendances, he said.

Mr Mason's presentation also addressed the opportunities that PBC presents for hospital pharmacists. "If you can get proper [discharge] planning to make sure that patients are not readmitted, that is a good bargaining tool with PBC consortia." Hospital pharma-



Jonathan Mason: new contract will be of interest to commissioning consortia

cists can also conduct medication reviews during inpatient stays, get involved with care pathway design and shared care issues and look at supplementary prescribing and where that fits in with management of long-term conditions, he suggested.

Prescribing budgets need to be embedded in care pathways

Shailen Rao, head of medicines management and diabetes lead at Hillingdon PCT and chairman of the Primary Care Pharmacists' Association, told participants that in his area there are three localities with one PBC board led by GPs. The clusters are currently developing their commissioning intentions but have not yet taken on any budgets.

At the moment, says Mr Rao, many GPs see PBC as being about the services they can provide not about taking on the prescribing budget. He has been trying to convince commissioners that the prescribing budget is an area where savings can be made quickly. This is because lots of data are available on pre-

scribing, it is a large budget that is mostly managed by the GPs themselves, and it does not require any workforce development.

He believes that PBC has the potential to turn the tables in terms of the prescribing budget since it will incentivise GPs in much more effective ways than prescribing incentive schemes did. He believes that, instead of pharmacists wondering how they can get GPs to do what they want them to do, GPs will be asking how can they get help to do what they want to do.

Mr Rao said that much of the work that pharmacists have done around guidelines is a precursor to care pathways and what has been

missing is the environment within which those guidelines can flourish. "I think that, particularly around chronic disease management, PBC will give us that opportunity," he said. However, he warned that in all this change and positive enthusiasm to create care pathways, prescribing budgets should not be forgotten. "Prescribing budgets need to be part of the whole commissioning process."

A key issue is raising this with commissioning groups. Medicines management teams are already well placed and experienced to provide the momentum to get prescribing budgets embedded in care pathways, he said.