CIMA response to Practice Based Commissioning

The Department of Health published Practice Based Commissioning on 6 October 2004 and invited comments by the end of October. CIMA is not commenting on general NHS policy issues, but rather on fundamental finance and accounting issues. There are several important financial implications in making the proposals work. CIMA’s comments, prepared by its NHS projects working group, cover these financial issues.

For a short paper (10 pages) Practice Based Commissioning (called PBC hereafter) is surprisingly specific on what is proposed and on the timescales which will apply. It is a lot less specific on the detail required to make it all work, especially financially. CIMA’s response in these areas covers:

- Clarity on “commissioning”
- Information needs
- Compatibility of what is proposed with the PCT financial regime
- Financial risks, and how they might be minimised.

1 Clarity on “commissioning”

1.1 As the Kings Fund point out (Practice-led Commissioning, June 2004), “Commissioning is a term used liberally and variably within the NHS”. The Kings Fund list five elements, some of which (e.g. “planning the coherent delivery of services”) may only be possible above practice level. PBC sometimes uses commissioning and holding a budget as meaning much the same thing: they don’t, and more clarity is needed.

2 Information needs

2.1. CIMA agrees entirely that, as a minimum, every practice should receive annual feedback on its use of health services. Plainly much more information than that is needed if a practice is going to manage an indicative budget. This places a big burden on acute hospital trusts (some of which struggle to provide PCT-level information at present) or PCTs (if they have to sub-analyse information provided by hospital trusts). A particular problem is the proposal in para 16 of PBC to let each practice select the services for which it will have an indicative budget. This could mean that each practice requires different information from the same provider (e.g. one might require all that provider’s activity, one might want elective activity only, one might want most activity but with certain high-cost procedures excluded, one might only want outpatients and diagnostics, etc). It is all do-able, but at a cost; and it greatly increases the complexity for the PCT of managing all the budgets which practices don’t choose to manage. Hence, CIMA thinks more standardisation would be more efficient.

2.2 A further complication arises from the way the NHS is implementing Payment by Results (PbR), in two ways. Firstly, PbR has become more complicated, with separate
tariffs for short and long stays etc. Having more, smaller commissioners under PBC doesn’t help. Secondly, PbR assumes that there is an agreed contract activity, with most variations in-year valued at marginal cost. It would be very laborious to agree contract activity down to individual practices in the level of detail PbR requires. An alternative is to say that all activity at practice level is paid for at full cost, so that it no longer matters financially what the contract value or activity might be: this is simpler, but creates financial risks (see below).

2.3 On a point of detail, para 17 of PBC says that practice budgets will be based on historical spend for the year 2003/4. Presumably, for any services covered by PbR, this actually means 2003/4 activity valued at 2004/5 national tariffs?

2.4 The proposal in para 24 for group commissioning, whilst sensible in principle, may further complicate the information needed, if the experience of PCT consortia is anything to go by.

2.5 Finally, CIMA supports in principle the proposal to move practices to a weighted capitation budget, but has concerns about obtaining the information needed to do this – especially if practices only hold budgets for selected services.

3 Compatibility with the PCT financial regime

3.1 The proposal in para 17 of PBC is to move all practices to weighted capitation funding over three years. The NHS has never, so far, been able to move health authorities or PCTs to weighted capitation funding over three years: there just isn’t enough uncommitted growth money to give to the commissioners who need more, unless money is actually taken away from those more generously funded. Is the NHS really intending to move PCTs to capitation over three years? If it isn’t, how can PCTs afford to move individual practices to capitation?

3.2 The PCT has to meet any overspends (PBC para 18). Practices only have to balance their budgets over three years (and if they don’t, the PCT can remove the budget but is left with the overspend). This is not compatible with the current statutory financial duty of a PCT to break even every year: either the PCT has to rely on an underspend somewhere else to offset any practice overspends, or it risks overspending in total and so failing a statutory duty. Will the financial regime for PCTs be revised?

4 Financial risks

4.1 Any optional system creates financial risk (those practices which might make savings are quick to sign up, those likely to overspend leave the problem with the PCT). Practices are likely to ask for indicative budgets if they: a) Are well run and want to take more control (the aim of PBC) b) Had a lot of activity in 2003/4 (e.g. to reduce waiting lists), so will inherit a generously funded until it moves to capitation.

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c) Are spending below capitation, so can expect substantial growth money. Practices which happened to have low activity in 2003/4, or are above capitation, will be less enthusiastic. Hence, the risk of an overspend for the PCT as a whole may increase: the practices which were likely to underspend will reinvest their savings, and the other practices will have no direct incentive not to overspend. *PBC* envisages this position continuing for up to three years, until all practices have capitation-based budgets for most/all services. There is substantial financial risk until then.

4.2 In 2.2 above, we argue that it is not really practical for each practice to have its own contract activity in the detail needed by PbR, and that it may be simpler if all practices pay for actual activity at tariff. However, if this is what provider trusts actually receive, it creates a more financially risky environment than was envisaged under PbR. Alternatively, perhaps, PCTs could actually pay for variations at marginal cost, but charge practices at full cost: however, if practices then start re-investing a saving calculated at full cost, when the PCT has only saved marginal cost, total PCT expenditure will increase. It is simply not clear from *PBC* how this is all expected to work.

**Conclusions**

CIMA considers that a great deal of work will be needed to turn this paper into something that can be introduced locally from April 2005. We appreciate that the scheme has to be flexible enough to be attractive, but are unsure how it can really work locally if each practice holds budgets for different services. We are concerned about the inconsistencies with the PCT financial regime and with Payment by Results. We also have concerns about the financial risk created, especially during the intended three year period until all practices hold their own indicative budgets.

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