

Editorial

Commissioning for quality

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Practice-based commissioning (PBC) is no longer the new kid on the block of NHS reform. A direct descendant of the purchaser-provider split conceived by Margaret Thatcher and Alan Enthoven as part of the market reforms of the 1990s, referred to in earlier policy documents^{1,2} and developed in the White Paper on community care, *Our health, our Care, our Say*³ it is nevertheless a move towards greater partnership and patient centredness in health care.⁴ Whereas general practice (GP) fundholding encouraged individual entrepreneurialism which subsequent primary care groups and trusts were never able to match, PBC, by working directly at the coalface of primary care, does have the potential to lead to rapid transformation more widely.⁵

I am grateful to Steve Gillam for guest editing this special section of *Quality in Primary Care* and attracting a stellar cast of contributors devoted to exploring where PBC has come from and how it might deliver the quality of care that the recent investments in health have promised. David Colin-Thomé, the Primary Care Czar, explains how general practice is uniquely and ideally placed for comprehensive care, for decisions about whether and what to purchase and for the extension of primary care to provide a greater range of services, neatly summed up as 'make or buy'. Martin McShane and John McIvor, argue that PBC can square the circle of an individual focus with a population approach and how this will require more refined systems and processes for quality improvement. Mike Dixon of the NHS Alliance discusses where PBC has come from, how it has the potential to harness the energy of primary care for transformational change and what the consequences might be if this policy experiment does not succeed. Finally Richard Lewis and Steve Gillam argue that for PBC to succeed we need to increase professional engagement, provide timely and valid information and support the commissioning process with responsive management systems.

Indeed, information and management systems, in their broadest sense should be at the heart of PBC. Ben Skinner provides an overview on the increasing amount of information about tools and techniques for quality improvement. Currently, many of the models for improvement are not an integral part of PBC, but

commissioning groups do have the potential to support and measure the effects of change. Indeed commissioning clusters and primary care trusts will need to improve the quantity and quality of information available on patients' health needs and outcomes for patient choice to become a reality. Of course, there is already a vast amount of data on conditions that are common and important, or that lead to significant disease, disability, death and cost. However, what is considered important has traditionally been determined by providers of health services whether they be doctors, drug companies or the government. Involving patients and understanding their views on health needs and outcomes will inevitably become a greater priority for providers and commissioners of services. Information on providers can also reveal important gaps in care through excessive variation or adverse events. There is a sense that in any process where there is a large variation there must be a problem with the processes for delivering that care but we do not define what acceptable and unacceptable variations are and have not yet developed satisfactory mechanisms for doing this. Failure to implement evidence is often organisational and PBC clusters will need to become more sophisticated in their approach to implementation. In the past it has been the provider or the organisation that determines where the needs, gaps and failures are and what should be done about them and this is an approach that has led to huge wastes of money. The overtreatment of glue ear and increasing use of drugs for social conditions are examples of this.

The early phase of 'experimental implementation' in PBC is rapidly being superseded in 'early adopter' sites by more focused approaches in primary care. Despite the evidence that there is clinical engagement,⁶ the problem is that real evidence of the effect of the new policy is lacking and research, whether to inform or to understand the effect of change, is often not high on the agenda of commissioners who are working hard and fast to develop new models of service. Whether the model is of federations of practices, polyclinics or another paradigm, the need to integrate, improve and commission high-quality primary care will remain. Norman Weir and colleagues

have looked at how increasing choice through the recently implemented system of 'Choose and Book' has supported or hindered patients' decision making.

Together these articles show what possibilities may arise from PBC. While the debate about whether the new policy will work still continues,^{7,8} the articles here highlight the dearth of empirical research that exists on PBC, and perhaps because of its complexity this is not surprising. I hope this special section encourages and stimulates new avenues of research and exploration into how PBC is being implemented and the effect it is having.

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