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Federation of Practice Based Commissioning Practices

newsletter – issue 10

THE LONG HELLO

First of all please accept my apologies for a short summer break for the newsletter when, as usual, little was happening in the NHS. However summer is now slipping away and activity with PBC is increasing again.

First of all the DH has clarified what Universal coverage of PBC means in a useful interpretation on its website

- **Misperception** - Achieving universal coverage for practice based commissioning is based on the number of practices involved.
  Fact - The target for achieving universal coverage is not based on the number of practices involved, rather PCTs. A PCT that is meeting the four criteria is said to be achieving universal coverage for PBC.
- **Misperception** – There are targets for practices to engage in practice based commissioning.
  Fact - There are no "targets" for practices, practice based commissioning is voluntary, however the Department aspires to most practices getting involved due to the benefits: a greater range of services, more services provided closer to home, increased clinical involvement in commissioning, and an investment in primary care to better meet the needs of patients.

So no targets and universal coverage does not mean the number of practices involved, but the latest monitoring figures show that 69% of PCTs are hitting the target for offering the four elements for PBC and 74% of practices have signed up to the first part of the “Towards PBC” DES.

In truth this appears “spin” to meet the targets but please note carefully the national tenders advertised in July for private companies to support PCTs with commissioining – this must be the Plan B for PBC if practices don’t bite and enagge in the process..

If we don’t do it – commissioning functions could be contracted out to third party (and often private sector) providers!

So the “Long Hello” of PBC continues yet many practices still report that this picture masks a paucity of timely accurate data to support PBC and also the fact that quite often practices still have not received an indicative budget though this is improving every day.

Tariffs and Tenders?

New PCTs are now established and appointments to these are being made, so hopefully the planning blight caused by NHS re-organisation will end and PCTs will really focus on supporting the development of PBC.

Consultation on the commissioning framework has now ended and NHS Alliance has been very high profile in demanding the end to the clause that any services moved from hospitals to the community that are identical should be charged at tariff price (as reported in the last newsletter). DH have been heard to report that this is to stop competition on simple price and see very few circumstances where it would be enforced, but we have received many complaints from both our practice and PBC members that this reduces the drive to move services from hopsitals and removes the incentives for practices to refer to such services. Many PBC clusters and PCTs were planning to charge these services at under tariff and have business plans ready to go on this – hence our vociferous calls to DH to change this.

Why was it included? –we do not know for sure but suspect powerful lobbying from the private sector or foundation trust network to ensure they can compete.

Patricia Hewitt was quoted in Public Finance magazine that this was not intended to apply to community services after all but this was then retracted by the DH press office so all is not clear! Lets wait and see what the final position on this is.

The other key issue in the commissioning framework that still remains poorly understood but yet seems very clear is the statement that PMS GMS APMS and SPMS providers who hold a local list will not need to automatically tender to provide new services.

The key issue here is the registered list so new GP companies are not exempt from this and also even those with a list may sometimes be asked to tender where a local monopoly might be seen to emerging. This clause though gives a powerful advantage for practices and local PBC clusters should be able to use this clause to their advantage – using local practices (who hold a list) to lead on new provider developments across areas or clusters.

On all of this there is a chance things should change but we expect more movement on the tariff issue than the tender one! Good communications between local PCTs and practices will help, and if the tariff issue remains unchanged when the final commissioning framework is announced, some careful “reshaping” of services so they don’t look exactly identical to hospital services (e.g. build in a specialist nurse or GPSI element) should mean these services can be charged below tariff. Remember anything that helps address overall financial balance is likely to be supported this year!

NHS ALLIANCE NINTH ANNUAL CONFERENCE

Bournemouth International Conference Centre
23rd/24th November, 2006

If you have not already booked please sign up for our annual conference in Bournemouth on November 23rd-24th. This is a great opportunity to network, share the best ideas and hear the latest on the everchanging world of the NHS.

Take advantage of our special offer – GPs bring along your Practice Manager for free!
Why not persuade your local PCT to come along especially if they are newly configured.

Full programme and booking form at www.nhsalliance2006.co.uk

NHS Alliance Acorn Awards 2006

Many, many, thanks to all those who have taken the time to submit outlines of their projects making this a record year for entries to this year’s NHS Alliance Acorn Awards.

All entries have now been sent to the judges for consideration and we hope to be able to contact the shortlisted entrants in each category shortly. Of course, at the same time we will also send our commiserations to those who were unsuccessful on this occasion.

We are delighted that Rt Hon Patricia Hewitt MP, Secretary of State for Health has agreed to present the awards at the NHS Alliance Annual Conference (November 23/24, Bournemouth International Conference Centre) where the winners and runners up will be announced.

To tender or not to tender?

The requirements for tendering for services are a difficult area but basically commissioners need to take account of two issues:

1. Their PCT standing Orders and Standing Financial Instructions
2. European requirements.

The PCT SOs and SFIs are the basic rules of governance for the PCT and all those who act on its behalf. There are national model rules which can be found at http://195.33.102.76/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4139133&chk=6lMLLW. Be careful with these – they are only models and your PCT may have adopted them with variations but basically they spell out when services need to be tendered.

Historically, there have been three sets of UK regulations implementing EU directives on public procurement. From 31st January 2006, these separate regulations were replaced by the **Public Contracts Regulations 2006** which implements the new EU Public Sector Directive. This divides services into Part A contracts and Part B contracts with Part B being technically exempt from tendering and thankfully, health and social care services are part B. even then Under Regulation 4 of the Public Contracts Regulations 2006, PCTs have an obligation to treat economic operators (i.e. those tender for contracts) equally and non-discriminatorily and to act in a transparent way. At present, it is unclear how far this 'transparency obligation' extends and what it entails.

Apart from the technical issues, probably the most important issue about tendering is to make sure that the specification of services is comprehensive and well defined. Many public (and private sector) contracts have come a cropper when a service is poorly defined.

The best advice at the moment for Practice Based Commissioners is to seek the advice of the PCT re tendering and stick to it. It may be possible to avoid tendering and indeed the Commissioning Framework makes it clear that tendering is not required in all circumstances. But even when it is not required – remember the transparency obligation and make sure your contracts are let in an even handed way… in some instances this may only be achieved by actually tendering or at least advertising an intent to let a contract.

Budget pressures

As practices get their budgets and regular updates they are likely to note some specific pressures, particularly on their budgets from elective care. Budgets should have been set on last years activity at this years prices, but PCTs and hospitals have to be reducing waits for elective outpatients and operations, so in fact will need to increase their activity to do this even with stable referral patterns. PCTs have been given c 9% budget increases to help acheive this, but practices have rarely had these levels of increase so control of new elective referrals will be vital to stop overspends on elective care.

Data validation remains a crucial issue. In our practice we continue to do this but due to agreements between the PCT and local foundation trust and delays to data streams, we often have less than a week from recieving data to raise any queries with the trust.

Do work with your PCT to ensure these agreements are built into trust contracts ready for next year, as otherwise your ability to challenge any mistakes are curtailed. The most common errors are for patients no longer registered with you, and DNAs (and they are easy to prove),but challenges to diagnosis and charging codes are much more difficult.

Non elective admissions and A&E attendances remain the most important risk to budgets and often seem out of the control of individual practices as they occur out of hours, but many practices and PCTs are looking at urgent care schemes alongside local A&E departments.

Maidstone Emergency Care Centre is a good example of this and is highlighted in the latest DH consultation on urgent care services available at: http://www.dh.gov.uk/Consultations/LiveConsultations/LiveConsultationsArticle/fs/en?CONTENT_ID=4139428&chk=SvcEBc.

This document says little for sure, but does ask many questions and clearly suggests that, in future, standards for response for urgent requests for care will be extended to in hours services as well. Practices will need to consider the implications of this and PBC plans will need to address commissioing out of hours, and in hours, urgent care, where up to 70% of PBC budgets are spent.

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Improvement Foundation (Incorporating the NPDT) PBC Development Programme September Update

The 28 sites on the national wave 1 have had their second learning workshop in September. This focussed on many of the sites presenting on progress on service redesign so far as well as looking at key issues for PBC including the role of practice managers, patient involvement in redesign and working in challenged health economies.

Over 140 teams have now started work on wave 2 of the PBC development programme with the teams having completed their preparation training and commencing the collaborative phase of the programme. Sites on wave 3 are also commencing the first phase of their training shortly.

It is still possible to join the programme and further details are available from the local Improvement Foundation Centre or visit the IF website PBC homepage www.improvementfoundation.org click on Practice Based Commissioning programme (under topics) and then on the 'How to Participate' icon.

The Improvement Foundation has also published more materials on its website including a series of "at a glance" guides, as well as resources from around the country in the following areas: business planning tools; interpreting PBC information; working together - consortia and PCT/practice agreements, understanding contracts, governance arrangements

Practices are also being invited to local learning exchanges being run around the country. These have focussed on displaying local examples of service re-design, looking at data and looking at key issues relating to PBC and commissioning. The regional Improvement Foundation centres will have further details of these.