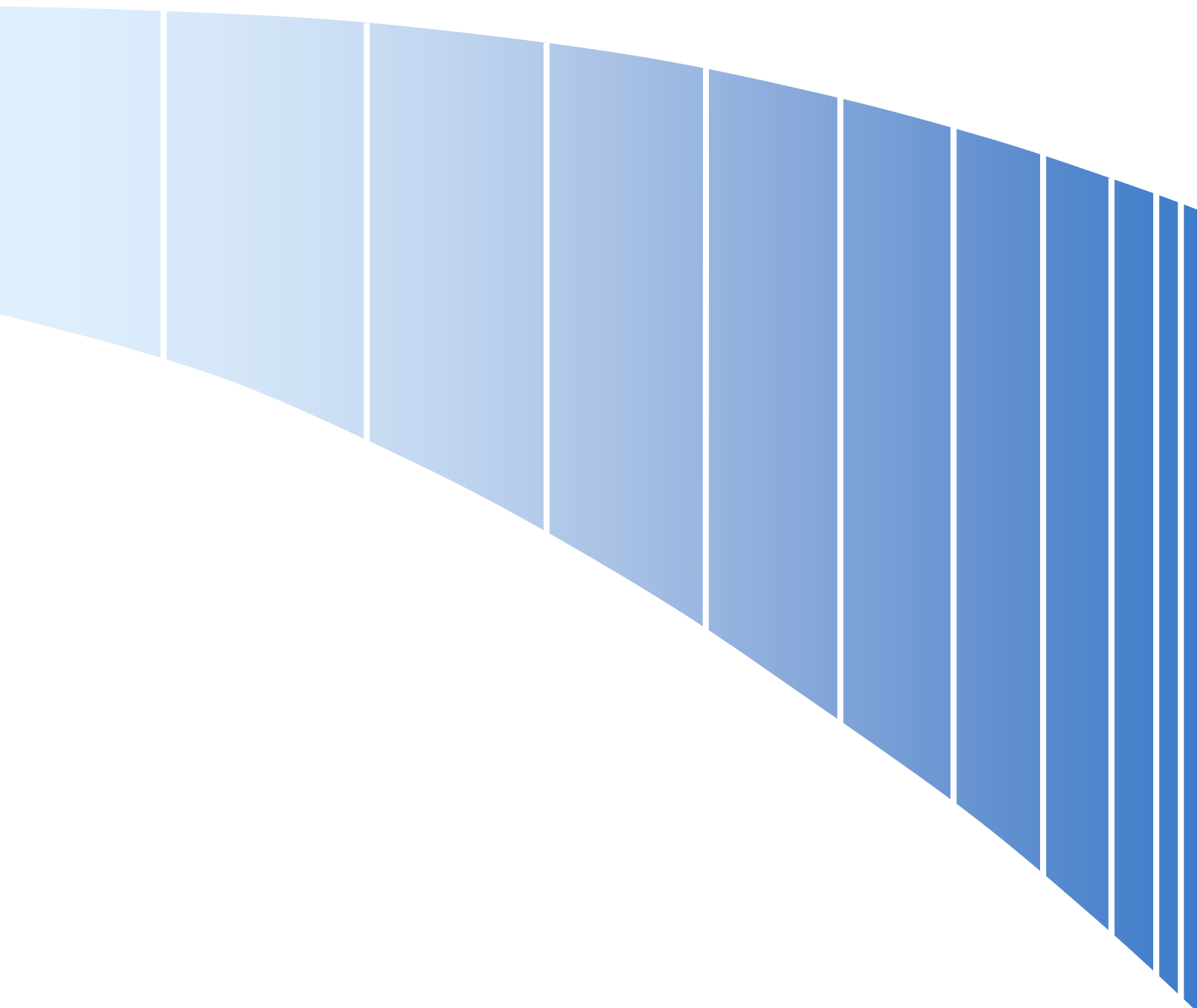


Practice based commissioning: practical implementation



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1. Introduction

- 1.1 Practice based commissioning (PBC) continues to play a vital role in health reform. It places primary care professionals including GPs, nurses and practice teams, working alongside secondary care clinicians and other primary and allied health professionals, at the heart of decision making to commission services for their local population.
- 1.2 We are nearing the end of this year's commitment to have in place the arrangements to support practice based commissioning. Efforts have focused on putting in place the environmental building blocks for PBC and good progress has been made. Work in 2007/08 must build on that has been done so far, by delivering practical implementation of PBC that makes a difference to people's lives.
- 1.3 This year's guidance on practice based commissioning replaces *Practice based commissioning: achieving universal coverage* (January 2006). It should be read in conjunction with the *NHS in England: the operating framework* for 2007/08, published in December 2006.
- 1.4 The direction of travel for PBC remains unchanged but we hope this guidance clarifies a number of challenging issues. Key points include:
 - > clarification and strengthening of governance and accountability arrangements to avoid potential conflicts of interest between the commissioner and provider roles within PBC,
 - > a methodology for setting indicative practice budgets for 2007/08, including new guidance on the pace of change and the use of resources freed up,
 - > clarification of the procurement rules for services commissioned through practice based commissioning and the need for tendering, along with the scope for local tariff flexibility.
- 1.5 Our primary audience for this document is the new Primary Care Trusts (PCTs) who are charged with ensuring that PBC continues to flourish.

The following are the key expectations placed on PCTs.

- > A locally agreed incentive scheme will be developed and offered to all practices.
 - > The scope, timeliness and access by practices to activity and financial information relating to their practice will be addressed in line with practice preferences.
 - > PCTs to provide practices with the tools and support they need to effectively discharge their commissioning responsibilities, either directly or through agreed alternative arrangements.
 - > A combination of indicators to help take a balanced view about progress towards implementation and the impact that PBC is having across the local health economy will be reported for 2007/08.
- 1.6 This latest guidance has been produced following extensive consultation and with help from the BMA's General Practitioner Committee, the NHS Confederation, the NHS Alliance, the National Association of Primary Care (NAPC), the Royal College of GPs, the Royal College of Nursing, the NHS Primary Care Contracting Team (PCCT) and the Improvement Foundation. We hope that all primary care professionals will wish to read this guidance but a shorter version, *PBC: Practical implementation – what does this mean for practices?* is also available at www.dh.gov.uk/practicebasedcommissioning.
- 1.7 Practice based commissioning provides many opportunities for primary care professionals to engage, influence and take action to innovate and challenge current practice. Working in partnership with PCTs and local government, this guidance supports the Government's overarching goal to provide high quality care for patients while making the best use of public health service resources.

2. PBC governance and accountability

- 2.1 In July 2006 we published *Health reform in England: update and commissioning framework*, which set out for consultation further guidance on governance and accountability arrangements for PBC. The following governance and accountability framework for PBC represents the final version of the proposals set out in July, having been shaped by the consultation responses.
- 2.2 The overall aim of governance and accountability, as it relates to PBC, is to balance public accountability for the effective use of taxpayers' funds with the minimum bureaucracy for practices and maximum freedom for clinicians to innovate to deliver real improvements for patients.

Clinical and corporate governance arrangements within the PCT

- 2.3 PCTs regularly draw upon clinical expertise to help shape and steer plans to improve the health of local communities. This means that there may be a potential conflict of interest for clinicians such as GPs who are involved in the assessment of PBC business cases in which they may have a direct interest.
- 2.4 To avoid conflicts of interest in the re-provision of services through PBC, there should be clear accountability to the PCT Board through a committee or sub-committee of the PCT. This will be responsible for:
 - > clinical governance arrangements for services moved from hospitals to more convenient settings for patients arrangements should be proportionate to the complexity of the service,
 - > establishing a clear local framework that incorporates national guidance,
 - > providers guidance to on clinical governance requirements.

- > approving PBC business cases submitted by practices, and
- 2.5 The committee should be chaired by a non-executive director with membership drawn from the PCT Board and professional executive committee (PEC). It should have clear, delegated powers to approve business cases, although local arrangements might be agreed for the approval of small-scale business cases by an executive director. It may need to meet frequently when a high number of PBC plans are predicted to be referred to it for decisions.
- 2.6 Clinicians must exclude themselves from decisions on any PBC business cases in which they have an interest or with which they are associated.
- 2.7 A review of the role and composition of the PEC is currently taking place. The review addresses the principal role of the PEC in relation to PBC.
- 2.8 There are two broad types of activity that practices engaged in PBC can undertake:
 - > acting purely as a commissioner and re-designer of services (remodelling pathways and/or reducing waste, for example); or
 - > developing and offering services themselves as an extended primary care provider.

Practice based commissioning plans

- 2.9 All practices engaging in PBC must mutually agree a practice based commissioning plan with their PCT. This will set out what the practice wishes to achieve through PBC, ie its commissioning objectives. As a principle, to avoid burdening practice based commissioners with bureaucracy, the level of detail in plans should be kept to minimum.
- 2.10 Whilst no standard national format is prescribed for such plans, there are a number of good practice examples available from stakeholders. Details are available at paragraph 4.7 onwards.
- 2.11 In developing their PBC plans, practices (in conjunction with other relevant clinical professionals, including district nurses, community pharmacists and health visitors) need to establish an understanding of the needs of their populations. Where PBC plans impact on secondary

care, practices should seek the involvement of consultants and wider secondary care clinical teams.

2.12 Plans should cover the following.

- > How the practice will respond to the particular needs of their practice population and their experience of local healthcare.
- > How the practice intends to make its contribution to meeting national priorities (including delivery of the 18 weeks target and supporting health improvement) by redesigning services, and by identifying resources that could be released from the indicative budget.
- > An indication of areas where the practice believes that a more collective approach to service redesign and improvement is needed. The PCT will then establish a clear agreement of local priorities and a mechanism for ensuring their delivery, with practices engaged in this process.

2.13 Where practices have grouped together into formal PBC consortia, a single plan may be submitted on behalf of the group rather than requiring individual practices within the consortium to do so. Any collective plan should also include details of PBC activity that individual practices are engaged in, which is additional to that undertaken across the group.

2.14 PCTs should aim to approve PBC plans and business cases within four weeks and no later than eight weeks, confirming that they are consistent with national and local priorities. PBC plans should form the basis of overall PCT commissioning plans. Practices and PCTs should hold regular review meetings to discuss progress against the plan. This should be a genuine dialogue, focusing on identifying further areas for development and sharing best practice.

2.15 Clearly, practice based commissioners who set themselves reasonable objectives within the national framework and deliver their objectives can expect to be monitored less closely than those who do not. Equally, practice based commissioners can expect the information they provide to PCTs to be used to inform local strategic planning and receive regular feedback on this as well as on their own performance. Practice based

commissioners can expect to receive information from their PCT, as specified in the section 5 on information requirements.

PBC business cases

- 2.16 Practices who wish to develop and provide a service through PBC must submit a business case to their PCT for approval.
- 2.17 Business cases from practices should be treated on their merits, and in a manner that is timely and transparent and ensures probity. It is for PCTs to decide how to do this. The PCT is expected to clearly identify its reasons for not supporting a business case and the actions that would resolve this.
- 2.18 In summary, business cases are expected to cover the:
- > service to be provided;
 - > benefits for patients;
 - > expected improvements in efficiency and effectiveness;
 - > management resources required; and
 - > costs of the proposals and their recovery period.
- 2.19 The criteria for assessing business cases will include:
- > Evidence-based clinical effectiveness;
 - > clinical safety, quality and governance;
 - > a contribution to offering care closer to home and delivery of the national 18 weeks priority;
 - > whether the specific needs of population groups such as disabled people (including those with learning difficulties or mental health needs), people from Black Minority Ethnic communities (BME), the differing needs of men and women and of the diverse age groups, different faiths and sexual orientation of individuals and groups accessing services have been taken into account;

- > patient and stakeholder support;
 - > justification/evidence that resources can be released through the substitution of care;
 - > affordability within the current and projected indicative budgets;
 - > consideration of whether formal tendering is required, which it is envisaged will be infrequent;
 - > assessment of the risks of the development;
 - > the procurement route (see paragraph 3.31 onwards); and
 - > value for money, including using benchmarked costs to determine a reasonable price range for services.
- 2.20 Contracts for the transfer of services from hospitals to more appropriate settings should include quality criteria covering patient experience, quality and service standards. There should be regular sampling and the results should be easily available to patients.

Practice groups

- 2.21 Locality groups and consortia of practices are not regarded as formal legal entities, unless there is a specific vehicle under which they operate (such as a limited company).
- 2.22 Plans within consortia for new services transferred from hospitals to more appropriate settings should demonstrate how a range of provision will be secured across a geographical area, ensuring equity of access and choice for patients.
- 2.23 Where practices establish a new legal entity for redesigning and developing services, such as a limited company, the new body should be treated by the PCT in the same way as all other bodies of the same type for the purpose of procurement (this should not affect general medical services regulations about change in contractor status).

- 2.24 The PCT should create an environment in which practice groups lead (or, as a minimum, are represented in) partnership meetings between trusts and the local authority and contract meetings between the PCT and providers.
- 2.25 A best practice guide to assist practices in establishing an effective PBC consortium will be published early in 2007, covering issues such as inter-practice agreements. We will be looking to key stakeholder organisations to develop this.

PBC accountability

- 2.26 The aim of this accountability framework, or code of conduct, is to help practice based commissioners and PCTs to work more effectively together to address the key issues of health services improvement, and health and social inclusion.
- 2.27 All parts of the NHS are expected to conform to the highest standards of honesty, integrity and probity, and to work in partnership in a patient-centred, inclusive way.
- 2.28 Practice based commissioners, in accepting an indicative budget, take on additional responsibilities for managing those resources and redesigning services for patients. This means that they should play their full part in meeting national and local priorities.
- 2.29 Practice based commissioners should work in partnership with their PCT, primary care teams, community nurses and health visitors, secondary providers and local authority to develop and implement locally agreed health and service strategies. PCTs should involve practices in this process in a way that is non-bureaucratic and sensitive to the needs and working practices of primary care health teams.
- 2.30 PCTs are responsible for leading the implementation of national policy at local level. This includes advising, co-ordinating and informing practice based commissioners of the wider implications of their proposed services redesign (such as the impact on local hospitals) while respecting clinical and management decisions taken by practice teams on behalf of their patients.
- 2.31 PCTs have a role in ensuring that patients can choose from a diverse range of service providers. While PBC is in its early stages, PCTs should

avoid agreeing new long-term contracts with service providers that would further cement monopoly provision arrangements and exclude practices from being able to propose service and care pathway redesigns.

Demonstrating accountability

- 2.32 Practice based commissioners are accountable to their PCT for achieving best value within their indicative budget and for delivering their PBC plan. The Strategic Health Authority (SHA) will ensure that relationships between PCTs and practice based commissioners develop in accordance with the principles set out in this guidance. In rare cases where local agreement cannot be reached, the SHA will arbitrate as set out later in the guidance (paragraph 2.44-2.45).
- 2.33 Professionals are directly accountable to their patients and to their regulatory body (such as the GMC or Nursing and Midwifery Council) and PCT (under the terms of their contract) for their standards of clinical practice. In addition, practice based commissioners are responsible for maximising the health and service benefits to patients from their indicative budgets through their proposals for service redesign.

Accountability to patients and the wider public

- 2.34 Practice based commissioners now have the ability to redesign services, and with that comes a responsibility to ensure they involve their patients in developing their plans. Practices should make their plans available for public scrutiny by their practice population and should be included in the annual PCT prospectus.
- 2.35 PCTs need to ensure that the collective plans for all the practice based commissioners are available for scrutiny by the Overview and Scrutiny Committee of the local authority and also by the general public. PCTs also need to ensure practices have engaged their patients in service redesign.
- 2.36 All NHS organisations are required to ensure they have effective complaints procedures in line with national regulations. PCTs are required to ensure that any new arrangements for services meet national guidelines on complaints and patient advice and liaison services (PALS).

Financial accountability

- 2.37 The PCT has a statutory responsibility to achieve financial balance. Practice based commissioners have a responsibility to agree an indicative practice budget and then manage within that, as explained in the section on PBC finance arrangements in this guidance. The PCT should monitor practice expenditure and activity on a monthly basis against the PBC plan. The PCT will discuss with the practice how to operate within this plan and should organise an audit or share best practice to help the practice manage expenditure and activity.
- 2.38 The practice based commissioner must have the agreement of the PCT for their proposed use of freed-up resources. The PCT should aim to respond to the practice within four weeks and no later than eight weeks.
- 2.39 PCTs that are subject to special circumstances, should still provide a fair and realistic indicative budget, based on the approach described in this document at paragraph 3.3 onwards. Equally, practices should use the 70 percent of any resources released through service redesign that they are entitled to retain to address national or local priorities. Practices and PCTs working effectively together will facilitate major redesigns that can release significant resources. Such redesigns should draw on evidence such as the NHS Modernisation Agency's Ten High Impact Changes¹ and on international evidence such as the Plexus work in the Netherlands on one-stop shops, which achieved significant improvements in quality, reductions in waits and more efficient use of resources.

Clinical and professional accountability

- 2.40 All clinicians in the NHS have the responsibility to provide care of the highest standards within available resources. The White Paper *Our health, our care, our say* said that the Department would be consulting with the Healthcare Commission and professional organisations on the options for assessing the quality of care given by primary care providers, so that patients can be reassured that all services are safe and of good quality.

¹ www.wise.nhs.uk/cmswise/HIC/HIC+Intro.htm

- 2.41 In addition, practice based commissioners who provide additional services are expected to ensure that their new services meet all national standards of clinical governance including those set out in *Standards for Better Health*. Practice based commissioners should set out briefly their annual clinical audit plans for such new services.
- 2.42 The PCT is responsible for ensuring that an effective system of clinical governance is in place to approve and monitor services with its health community in line with national guidance and the Healthcare Commission.
- 2.43 While it is not a requirement for practice based commissioners to include developments to the services they provide under their GMS or Personal Medical Services (PMS) contract in their business plans, many will wish to do so. This has the advantage of offering a coherent view of all services to the PCT and its patients. Such practice may prove useful in helping practices and PCTs to work together on strategies for developing primary care.

Arbitration

- 2.44 It is expected that practices and PCTs will agree on a local application of this guidance. If practices and PCTs cannot agree local interpretation, the issue will be referred to the SHA.
- 2.45 SHAs will be expected to establish one or more arbitration groups, depending on demand, and to ensure independence. The group(s) should include practitioner, financial and management representation and will be appointed by the SHA. PCTs will be expected to follow the decision of the arbitration group.

3. PBC financial guidance

- 3.1 In July 2006 we published *Health reform in England: update and commissioning framework*. It presents further guidance on developing practice based commissioning including proposals for a governance and accountability framework.
- 3.2 The following builds on this and sets out guidance on:
 - > the approach to setting indicative practice budgets for 2007/8;
 - > procurement arrangements, specifically addressing tendering requirements and 'like for like' services;
 - > the use of resources released for reinvestment in patient care; and
 - > risk management.

Setting indicative practice budgets

- 3.3 PCTs are responsible for ensuring that practices receive an indicative budget that reflects the needs of their population as accurately as possible. This allows a practice to access a 'fair share' of the resources available to the whole PCT area. Moving from an indicative budget based on historical usage towards a 'fair share' budget will enable the needs of neighbourhoods and practice populations to be more accurately addressed and health inequalities tackled.
- 3.4 To achieve this, PCTs will need to adopt a more sophisticated approach to indicative budget setting than previously, one which is sensitive enough to take into account the increased fluctuation and inherent volatility that occur when dealing with smaller population sizes at practice level. The Department of Health is evaluating and reviewing options for a 'fair share' budget setting methodology for 2008/09.
- 3.5 The following sets out interim arrangements for 2007/08 that will consolidate existing indicative budget setting processes while paving the way for introducing 'fair share' practice budgets in the following year.

Interim arrangements for 2007/08

- 3.6 The indicative budget setting approach in 2007/08 will be guided by the following set of principles:
- > The methodology used by PCTs must be consistent, fair and transparent.
 - > It must be compatible with budget setting plans for 08/09 onwards.
 - > Any pace of change should not adversely affect PCT financial stability.
 - > It must be kept simple.
- 3.7 *Practice based commissioning: achieving universal coverage* established the approach PCTs should take in setting indicative budgets for 2006/07. These arrangements will be used as the basis for setting indicative budgets for 2007/08 as set out in this guidance. This will allow local indicative budget setting processes and the supporting data to be robustly developed, enabling indicative practice budgets to be calculated with greater accuracy.
- 3.8 In summary, for 2007/08, PCTs should calculate indicative budgets on the basis of:
- > actual activity for the last six months of 2005/06 and the first six months of 2006/07, converted into 2007/08 prices.
 - > current formulae for prescribing including the appropriate inflationary uplift; and
 - > weighted capitation for any services within the agreed scope for which no historic activity data are available.
- 3.9 Resources released through PBC activity in the previous year should not be deducted from future indicative budget allocations.
- 3.10 The indicative budget should include community services and mental health, if only on a whole time equivalent (WTE) or per capita population basis, bearing in mind existing utilisation rates where available. This will allow practices, in partnership with their PCT, to assess their spending in

these areas relative to other practices and the impact on their practice population.

- 3.11 It is important that practices can see how indicative budgets are calculated. They should feel that the process is fair and that their patients will receive an adequate share of resources without disadvantaging other patients or practices.
- 3.12 PCTs should set indicative budgets for practices, rather than groups of practices or PBC consortia. This is because practices are the recognised legal entity. Practices that have formed groups can subsequently aggregate their indicative budgets in pursuit of a common PBC plan.
- 3.13 For greater transparency, all aspects of the PCT budget should be devolved indicatively to practices with those elements that need to be returned to the PCT, such as funding for the central management team, clearly identified. This will allow practice based commissioners to see exactly how the final indicative practice budget has been calculated. The elements of the indicative budget that practices will hand back to PCTs will be determined by the agreed scope of their PBC plan.
- 3.14 However, the minimum scope for indicative PBC budget responsibility should include all hospital-based care, Payment by Results (PbR), prescribing, community services and mental health costs.

Pace of change from historical to 'fair share' budgets

- 3.15 To support progress towards 'fair share' budgets, the Department of Health has developed a tool that allows the use of the national resource allocation formula to calculate indicative weighted capitation budgets at practice level. The tool and guidance on its use can be found at www.dh.gov.uk/practicebasedcommissioning.
- 3.16 The volatile nature of population data below PCT level means that the tool is limited to a +/-10 percent degree of accuracy when calculating a 'fair share' practice budget. A recent survey of PCT budget setting approaches indicates that around 70 percent of indicative practice budgets would fall within this 10 percent accuracy range of a notional 'fair share' budget. This means, however, that the remaining 30 percent of practices are likely to be receiving indicative budgets that are significantly higher or lower than their 'fair share'.

- 3.17 To facilitate a smoother transition to notional 'fair share' practice budgets, it is appropriate that progress is made in 2007/08 to move those indicative practice budgets where the DH tool indicates that it is more than 10 percent greater or less than its historic spend, towards this 10 percent target range. However, any pace of change measures should not be overly aggressive.
- 3.18 PCTs will take the following approach.
- > Where the 2006/07 indicative practice budget is more or less than 10 percent from the target range, the PCT will undertake a simple utilisation review with the practice, based on data for disease prevalence and present usage of hospital services. The intention is to have a reasonable dialogue and develop a greater understanding as to why a particular practice is spending more or less than its potential 'fair share' budget. It would also be an opportunity for practices to make sure their prevalence data are sufficiently robust. Prevalence data are important to ensure that all unmet need has been identified by the practice and the intention is for such data to be used in future 'fair share' budget methodology.
 - > Any percentage adjustments to bring the 2007/08 indicative budget closer to the 'fair share' budget target range would be for local discretion based on the utilisation review results, up to a maximum shift of 1 percent of the indicative practice budget available for use by practice based commissioners to commission care for their patients (see paragraph 3.13).
 - > Once indicative budgets have been set, PCTs will continue to support practices in identifying opportunities for service redesign and release resources.
- 3.19 The amount by which the overall PCT budget has grown will include elements such as prescribing, which the DH tool would not factor in when calculating indicative practice budgets. Any uplift to indicative practice budgets based on PCT growth rate will need to be adjusted to take out prescribing increases (but must be reapplied to the prescribing budget).
- 3.20 PCTs should review indicative practice budgets on a quarterly basis. This will enable timely adjustments to take into account changes in

practice populations. To assist this, the DH tool will be updated to allow data to be extracted on a more frequent basis.

Use of freed-up resources and management of risk

- 3.21 The use of freed up resources and the management of risk are inseparable. PCTs and practices will need to work together in partnership both to understand both the issues and to agree their management.
- 3.22 One of the main benefits of PBC is that, through innovative redesign of services, it enables substantial resources to be released for reinvestment in patient care. At present, PBC is operating within an environment where some PCTs are working to recover deficits and restore financial balance. PBC can make a contribution to this through freeing up resources and producing savings.
- 3.23 However, for PBC to be successful and continue to make this contribution, it is imperative that practices are allowed to use a minimum of 70 percent of any freed-up resources for reinvestment in patient care. The remaining 30 percent is for the PCT to use at their discretion. The ability to use, innovatively, unlocked resources for the benefit of patients is a fundamental attraction of the scheme for many clinicians and should not be undermined.
- 3.24 With this context in mind, practices will be entitled to use at least 70 percent of resources released for reinvestment in patient care, irrespective of whether these were included in practice business plans or not. Where resources are freed up that were not planned, the practice will agree with the PCT which additional objectives will be met.
- 3.25 Where the PCT is working to restore financial balance, it is not acceptable to withhold freed-up resources and practices must still be provided with fair and realistic indicative budgets. Indicative budgets should not be allocated with elements top-sliced to resolve PCT deficits.
- 3.26 Equally, practices in PCT areas subject to special circumstances, must use the 70 percent of any resources released through service redesign, to address specific national (such as 18 weeks) or local priorities as determined through mutual agreement between the practice and PCT.

- 3.27 In PCTs that are subject to special circumstances, PCTs and practices have a shared responsibility to achieve financial balance. Financial balance can be achieved only by close co-operative working between the PCT and practice based commissioners. A particular focus should be on identifying the causes of the financial difficulty and agree a joint strategy for resolving deficits. PBC plans should reflect the contribution from practice based commissioners to the PCT recovery plan.
- 3.28 When a health economy is in special circumstances, PCTs and practices will be expected to agreeing how financial balance should be achieved.
- 3.29 Exceptionally, where local agreement cannot be reached, the SHA will have the option to put a request to the Department of Health asking permission to modify locally the PBC guidance relating to indicative budget setting and the use of freed-up resources.
- 3.30 No patient or practice should be disadvantaged because of high cost individual care. PCTs, therefore, will need to have robust arrangements in place to manage unplanned in-year variations in activity and cost.
- 3.31 This, and other contingency requirements, can be met through use of a risk pool, held by the PCT, to which it is suggested that practices would contribute between 3 and 5 percent of their indicative budget. PCTs may wish to set access thresholds based around specific high-cost but relatively uncommon treatments as indicated by Payment by Results Health Resource Group (HRG) data. Such treatments would then be funded from the risk pool rather than individual indicative practice budgets.
- 3.32 Specific rules on operating the risk pool and procedures for accessing funds should be transparent, fair and locally agreed.
- 3.33 Transparency of the risk pool can be achieved through PCTs devolving indicatively the whole practice budget allocation and then asking practices to hand back a certain proportion for the risk pool. This would reassure practices that risk pool contributions are fair and proportionate. With seven out of ten practices² now forming PBC groups, this should facilitate groups of practices holding their own risk pools for certain contingencies as agreed with their PCT.

² Data from the Improvement Foundation

Procuring services through practice based commissioning

- 3.34 *Health reform in England: update and commissioning framework*³ provided guidance on procurement arrangements for services developed through PBC. The following provides further clarification.

Any willing provider of elective services

- 3.35 For routine elective services, the principles of free choice of provider for patients and the opportunity for any willing provider to supply services (if they are licensed to do so) should not be constrained by commissioners. This holds true for elective services provided in community settings through PBC.
- 3.36 Within this 'any willing provider' model, there are no guarantees of volume or payment in any contract given. PCTs, through contracts, give permission for the provider to supply services to their population without any promises regarding income. PCTs should give such contracts only to providers who can demonstrate that they meet national minimum quality criteria (as set out by the Healthcare Commission) and agree for the service to be placed on local choice menus where appropriate. It is, in effect, a local approval process for providers with the intention that competition is encouraged within a range of services rather than for them.
- 3.37 This means that for providers looking to supply a routine elective service, including those developed through PBC, tendering is not required.
- 3.38 The same approach of fostering, not limiting, choice should be extended to the development of enhanced primary care services through PBC. PCTs should seek to establish a range of providers (such as GP limited companies, third sector organisations that are 'values-driven', community pharmacies and private companies) from which patients can choose, driving up quality through contestability. This does not preclude PCTs who act as providers. As with elective services, a prospective provider will need to satisfy the PCT of its ability to deliver the service and compliance with quality standards, before a contract or agreement (where the provider holds a GMS, PMS or Alternative Medical Services

³ *Health reform in England: update and commissioning framework* (DH, Jul 2006) paragraphs 3.11 - 3.15

APMS contract) is awarded. As described at paragraph 3.36, such a contract would have no guarantees of volume or income.

- 3.39 In July 2006 we published *Health reform in England: update and commissioning framework*. This established that PCTs have the option of developing services through extending existing GMS, PMS, APMS contracts including under local enhanced service (LES) arrangements.

Ensuring value for money

- 3.40 PCTs and practices have a responsibility to ensure that value for money is secured from the services they commission. However, tendering is not the only method for achieving this. Value for money can also be ensured through the following measures.
- For those services encompassing patient choice, the PCT should facilitate the development of alternative additional providers so that contestability can be driven, at least in part, by patient choice. The approach should be to develop a market and a range of providers rather than the award of a contract to one provider after competitive tender.
 - Benchmarking of costs & prices at PCT, SHA and national level and will allow price bands for services outside the scope of Payment by Results to be set locally and used as a value for money measure.
 - These should be open and transparent publication of prices, making them available to all PBC commissioners, together with the production of a choice menu for practices and patients for this sector.
 - Contracts between the PCT and the provider-practice's limited company should include clear profiling, referral, conversion rates and expenditure ceilings, but no income guarantees.
- 3.41 Generating choice and contestability, underpinned by robust contracting and benchmarking of costs, will provide a mechanism for ensuring value for money. PCTs should use data from benchmarking of costs to set the right prices for local services outside the scope of Payment by Results and to use as a yardstick for determining whether a proposed service would provide best value.

- 3.42 EU Procurement Directives are incorporated into UK law and set out the procedures to be followed by purchasers in the public sector, which includes healthcare (listed as 'Part B' services). However, where the PCT is granting permission for any willing provider to operate in their area rather than purchasing an exclusive service from a single or limited number of providers, then these regulations do not apply and tendering is not required.

When tendering is required

- 3.43 For services developed through PBC, tendering will normally only be required when the intention is to create a monopoly by awarding a contract to a single provider rather than to grant approval to providers who reach the required standard (see paragraph 3.36 onwards), i.e. where an unavoidable service monopoly would be created. This would be, for example, where the proposal seeks to move a whole service out of a local hospital without an alternative equivalent service available within the PCT boundary. PCTs should only award a contract to a single provider in exceptional circumstances as this inhibits patient choice and contestability.

Payment for services provided to a wider population than that of a single practice

- 3.44 *Health reform in England: update and commissioning framework*⁴ established a principle that where the service to be provided is the same as an existing hospital service, and is within the scope of PbR, payment should be at tariff rate.
- 3.45 We have been asked by practices and PCTs to clarify the circumstances in which a service provided in a community setting can be deemed 'the same as' an existing hospital service.
- 3.46 As PbR is an activity-based, casemix adjusted payment system, the new service would need to satisfy the relevant HRG and/or OPCS definitions. A service should be regarded as being 'the same as' an existing hospital service and therefore attract payment at tariff rate, if it directly fits these definitions and does not meet one or more of the following criteria:

⁴ paragraph 3.16

- > the service could be delivered through any contractual option to provide GP services including GMS, PMS or APMS contracts,
- > the service is provided in a community facility and performed by a GP any health care professional employed by or on secondment to a GP, or community nursing teams or allied health professionals contracted to work in primary care,
- > the service is provided within a facility receiving notional or cost rent reimbursement or equivalent benefit (Local Improvement Finance Trust (LIFT) schemes, for example),
- > the service is an outpatient service. This is an interim measure pending further progress on unbundling the outpatient tariffs for diagnostics (as, without large numbers of patients, the cost of diagnostics is a prohibitive risk). In these cases the PCT is free to negotiate a local price for the service.

Services outside the scope of Payment by Results (PbR)

- 3.47 The scope of PbR is set out in *Payment by Results: Implementation Support Guide (Technical Guidance)* and broadly extends to acute hospital services commissioned directly from NHS Trusts and Foundation Trusts. Funding for local services outside the scope of PbR must be negotiated through the contracting process and should be activity-based where appropriate to support choice and contestability (i.e. money should follow the patient).

4. Support for practices and incentive schemes

- 4.1 The Department expects PCTs to facilitate practices' engagement in practice-based commissioning by addressing potential barriers.

Local support for practice based commissioners

- 4.2 For practice based commissioning to flourish, PCTs should give practices the necessary tools and support. The Directed Enhanced Service (DES) incentive scheme (and its local successors) goes part of the way towards funding the time and resources expended by practice based commissioners in engaging and developing PBC plans.
- 4.3 A significant part of the traditional PCT role in commissioning is now being undertaken by practice based commissioners. It is important that practices are properly supported to do this work through access to good quality analytical HR and IT support. Dudley Beacon and Castle PCT for example, provides practices with its data together with a dedicated analyst to support the practice to interpret and use the information effectively in identifying trends and opportunities for service redesign.
- 4.4 PCTs will notionally allocate the full budget to practices. Funding to cover central management and support overheads will then be returned to the PCT. As part of this blocking back, the PCT will set out in broad terms what services and support the practices can expect from the PCT. Practices can normally expect PCTs to provide this support directly. If these services are not provided as promised, or not to the correct standard, or not in a timely way, practices will be able negotiate a budget to procure these services for themselves. It is expected that such negotiations will be resolved locally, with cases referred to the SHA if agreement not is reached. The budget would be proportionate to the scope of the practice's PBC plan and, if applicable, the size of the practice consortium. The budget itself will be held and controlled by the PCT with practices arranging for invoices for agreed management support to be submitted to the PCT for payment. 'Adequate support' is

that which meets the standards defined in this guidance. Minimum information requirements are outlined from paragraph 5.1 onwards.

- 4.5 It is important that PCTs provide the necessary support functions to practice based commissioners and that negotiations for a management support budget are exceptional.
- 4.6 In order to ensure a level playing field, management costs associated with the provision of services to patients by practices through PBC should be included as part of the locally agreed price for the service.

National support for practice based commissioners

- 4.7 The Department of Health-sponsored PBC development programme provided by the Improvement Foundation is the main DH vehicle for PBC development. This programme brings together local health economy partners to help create the infrastructure for PBC and facilitate the redesign of clinical pathways. There are many examples of pathway redesign for scheduled and unscheduled care being created. These and other resources (including webcasts on key topics) are available on www.improvementfoundation.org. The programme is in its spread phase where tailored help through the Improvement Foundation's regional centres is being facilitated through local learning exchanges and workshops.
- 4.8 At the request of the Department of Health, the Improvement Foundation is co-ordinating other DH-sponsored activity supporting PBC from key partners, the NHS Alliance, the NAPC and the PCCT. These activities, often in joint partnership, are targeted at particular groups (e.g. practice managers, PCT managers) or issues (e.g. developing consortia, developing as a provider). Details can be found on:

www.nhsalliance.org
www.napc.co.uk
www.primarycarecontracting.nhs.uk
www.improvementfoundation.org
- 4.9 In addition, other organisations such as the Royal College of GPs, the Royal College of Nursing, the NHS Confederation, the BMA General Practitioners Committee and local medical committees (LMCs) all provide support to practices and PCTs. Details can be found on:

www.rcgp.org.uk
www.rcn.org.uk
www.nhsconfed.org
www.bma.org.uk

Incentive schemes

- 4.10 *Health reform in England: update and commissioning framework*⁵ states that PCTs should operate an incentive scheme to engage practices in service redesign. At a minimum this was the DES, with encouragement to develop additional local incentive schemes.
- 4.11 With the DES incentive scheme ending at the end of March 2007, PCTs should now focus on the locally agreed incentive schemes. The provisions within the DES arrangement represent the minimum requirements for local incentive schemes as set out in *Practice based commissioning: achieving universal coverage*.
- 4.12 Local incentive schemes must be clinically appropriate, affordable and cash releasing. In order for schemes to be cash releasing, PCTs should consider focusing local incentive schemes on encouraging activity that supports delivery of the national 18 weeks priority and the ten High Impact Changes identified by the NHS Modernisation Agency.
- 4.13 Any incentive scheme payment should be regarded by practices as income. The size of payments would be for local determination, with proper regard to PCT affordability and with any award dependent on practices not overspending their indicative budgets.

⁵ paragraph 3.9

5. Information for PBC

- 5.1 Information for practice based commissioning is crucial to facilitating service change and improvement and to enable practice based commissioners to support delivery of the 18 weeks target. Information on a practice's utilisation of health service resources (including benchmarking) as well as local intelligence on needs assessment must be made available to practices for effective PBC.

Access and presentation requirements

- 5.2 PCTs are responsible for ensuring that the information needs of practices are met. In particular, we expect PCTs to offer information to their practices that is timely and in a form that practices find most helpful. This might involve direct access by practices to computer desktops (eg. the MIDAS⁶) or information that has already been filtered and analysed by the PCT.

Tools and support

- 5.3 PCTs need to offer to support practices with analysis and interpretation of management information to help with commissioning/service redesign decisions. PCTs may choose to develop skills in-house or make use of the forthcoming national framework for commissioning support services from the independent sector⁷.
- 5.4 The Department of Health is continuing to work with Connecting for Health on driving up the quality and timeliness of data available from the Secondary Uses Service (SUS) and to develop analytical tools e.g. the calculation of patient pathways, as well as to expanding access to a wide range of users including SHAs, PCTs and practices.

⁶Middlesborough PCT Information data and statistics (MIDAS) Tool PCT developed by Middlesborough PCT

⁷<http://www.dh.gov.uk/ProcurementAndProposals/Tenders/RecentlyAwardedAndExistingTenders/RecentlyAwardedExistingTendersArticle/fs/en>

Data requirements

- 5.5 PCTs are required to share information with their practices on financial and clinical activity.
- 5.6 The minimum requirement is information on:
- > elective activity;
 - > inpatient and day cases;
 - > non-elective admissions, including length of stay;
 - > first outpatient appointments and follow-up appointments;
 - > consultant-to-consultant referrals;
 - > A&E attendances;
 - > use of diagnostic tests and procedures;
 - > prescribing;
 - > community and mental health services; and
 - > primary care, including essential and enhanced PMS and GMS services.
- 5.7 Benchmarked data on:
- > referral rates;
 - > admission rates;
 - > first outpatient attendances; and
 - > follow-up rates.
- 5.8 We recognise that these requirements are challenging but we expect PCTs to continue to develop the data needed to support PBC or to contract with others to achieve that objective.

6. Indicators for PBC

- 6.1 In order to better understand the implementation and effectiveness of PBC, there is widespread agreement that new and different indicators are needed for 2007/08. These should enable PCTs to understand their own performance, including feedback from practices; allow SHAs to track progress and have meaningful discussions with PCTs; and the Department to present a national picture to account to Parliament and to influence future policy direction.
- 6.2 The PBC indicators will enable PCTs, SHAs and the Department to build an informed view of PBC progress using information from a variety of sources. Considered in isolation, each indicator has limitations however, when combined, they provide a tool to assess the effectiveness of the implementation of PBC in delivering clinical engagement, service redesign and financial awareness. The indicators have been developed around a three-pronged approach to answer the following questions:
- > **Is the PBC framework enabling?** Do PCTs provide practices with the information, indicative budget and support that enables them to use PBC?
 - > **Are practices engaging with PBC?** Are practices developing and implementing plans for new pathways through PBC, and do they feel clinically and financially engaged?
 - > **Are there new pathways and what is their impact on outcomes?** Does PBC result in new pathways for patients and users, and do these improve health outcomes?

Is the PBC framework enabling?

- 6.3 By the end of December 2006, all PCTs will have put in place the arrangements to support practice based commissioning. The minimum framework for practices to take on PBC will therefore be in place, and so, in 2007/08, the next step will be to improve the quality of this framework to facilitate practice engagement and service redesign.

SHA assurance and practice plans

- 6.4 SHAs will be expected to assure themselves that there is a quality framework in place to support PBC. Minimum national standards relating to the framework are set out in this document, although it is expected

that locally determined standards may exceed these. A good practice PBC plan is at the heart of successful PBC. Practices developing high quality PBC plans which are agreed with their PCT will help SHAs assess whether the PBC framework is enabling. SHAs will wish to assess the quality of the local framework through analysis of a random sample of practice plans that have been approved by the PCT.

Fitness for purpose and PCT development plans

- 6.5 SHAs and PCTs will be able to make use of the results from the fitness for purpose exercise to assess PCT commitment and capability in commissioning, including the additional components on PBC included in wave three. PCT development plans will also provide useful information enabling PCTs to understand their own performance, and SHAs to monitor ambition and progress.

Are practices engaging with PBC?

Practice survey

- 6.6 As part of the three-pronged approach to understanding PBC implementation, the practices' perspective is vital. The Department will commission an independent quarterly practice survey, covering a sample of practices from each PCT, to assess practice engagement and the practices' perception of the support offered by their PCT. The survey will include questions to assess availability of an indicative budget and a local incentive scheme, practice satisfaction with the quality of information and support provided by the PCT, and a measure of the practices' perspective on their own clinical and financial engagement with PBC.

Are there new pathways and what is the impact on outcomes?

- 6.7 In addition to information about whether there is a quality framework for PBC and whether practices feel clinically and financially engaged, it is important that the indicators for PBC implementation give a picture of whether PBC is resulting in any change to services and outcomes. This information on service redesign will also be important for the delivery of the 18 weeks target.

SHA annual report

- 6.8 SHAs will be required to submit an annual report to the Department in June, providing examples of service redesign in their area. These reports will serve to collect and share success stories, good and innovative practice and track activity changes. They will serve as a useful summary both across each SHA area and nationally. They will be published by the Department on the PBC website, with links where appropriate. We will discuss with our stakeholders how this good practice will best be spread.
- 6.9 The annual report should provide five case study examples of service redesign commissioned by practice based commissioners, including financial information about resources invested as detailed in the business cases submitted by the practices. The report should include summary activity trends indicating the range of specialties in which service redesign has taken place across the SHA area, and the number of patients accessing these new services. There should be a summary of financial information across the SHA, aggregated from PCT-approved business cases, detailing total resources freed up and total resources reinvested. The report should also include the total number of business cases submitted to PCTs compared with the total number of business cases approved.

Scorecard of impact indicators

- 6.10 In order to assess service redesign and provide an indication of impact on outcomes, the Department will develop a quarterly scorecard from existing central data collections. This will be made publicly available and will allow practices, PCTs, SHAs and the Department to assess the impact of PBC and the variation of its impact across these key outcomes. There is a need to use this scorecard with a degree of caution as there will be no way of directly linking PBC to changes that may occur. There are no national targets linked to the scorecard and it is intended as a benchmarking tool only. The basket of indicators that make up the scorecard will include:
- > admission rates for five procedures with evidence of overuse;
 - > emergency admissions for 19 ambulatory care sensitive conditions;

- > outpatient referral rates, aggregate and for six specialties identified for care outside hospitals;
- > first-to-follow-up ratios;
- > average length of stay; and
- > emergency-bed days, including 0-1 day admissions.

Using the indicators

6.11 SHAs will utilise the indicators to assess PCT progress on the implementation of PBC. Ahead of the start of the next financial year, SHAs will work together to design a single common national system to assess PCT progress against the three key criteria:

- > enabling;
- > engagement; and
- > impact.

Progress will be assessed by SHAs on a quarterly basis. The Department will receive the feedback on all 152 PCTs and will use this information to influence the PCT development programme and future policy frameworks.

6.12 These indicators form the core that will provide practices, PCTs, SHAs and the Department with the information to build a picture of the success of PBC implementation. For their future development, SHAs, PCTs and practices might also wish to consider progress against the ten High Impact Changes for practice teams developed by the Improvement Foundation and the NHS Institute for Innovation and Improvement. These can be found at www.improvementfoundation.org or www.institute.nhs.uk.

