MAY 2007

Practices' entitlements and PCTs' responsibilities in respect of practice based commissioning in 2007-08

Model letter to a PCT from the LMC and/or GP practices

BACKGROUND

The latest Department of Health (DH) guidance 'Practice based commissioning: Practical Implementation' published in November 2006 sets out a number of new or reinforced entitlements for practices and responsibilities for PCTs, of which both parties should be aware. The General Practitioners Committee (GPC) has already produced a detailed analysis of the DH guidance, as well as a shorter 'key issues' summary; both documents are available here: http://www.bma.org.uk/ap.nsf/Content/Hubpracticebasedcommissioning

In order for PBC to develop in 2007-08, practices should fully understand the terms of their engagement in the initiative as well as those of PCTs. Not only should practices be well informed, but they should also feel empowered. To date, this has not been the case and although the latest DH guidance appears to try to address this fact, in many areas, an extra push to ensure that PCTs are fully signed up to making PBC work will be necessary. To this end, the GPC has produced the following model letter, which highlights practices entitlements and which those LMCs and/or GP practices who are concerned that their PCT is not following the national guidelines, may wish to send to their PCT.

Where PCTs are not fulfilling these requirements, LMCs should inform the GPC secretariat, via their usual LMC Liaison Officer. This will enable the GPC to maintain an accurate picture of local implementation of PBC in 2007-08, which will prove useful for communications with the national DH PBC implementation team.

Dear [insert name of PCT chief executive]

As you will be aware, practices in [insert PCT area] wish to continue engaging in PBC in 2007-08. We are keen that local implementation of the scheme in our area follows closely the national guidelines as set out in the Department of Health's (DH) guidance 'Practice based commissioning: Practical Implementation' published in November 2006.

This year, practices have a number of new and/or reinforced entitlements, which we believe will help GPs develop in their role as commissioners and facilitate a more constructive working relationship with the PCT whilst doing so. This letter sets out these entitlements and we would expect to see local implementation of PBC in 2007-08 be delivered accordingly.

Governance

- The PCT should form a committee/subcommittee with accountability to the Board, which will be responsible for assessing practices' plans for commissioning and service provision. Furthermore, "Clinicians must exclude themselves from decisions on any PBC business cases in which they have an interest or with which they are associated". [See paragraphs 2.3-2.8 of DH guidance].

Commissioning plans

- All practices engaging in PBC must agree a practice based commissioning plan with the PCT. There is no standard national format and the level of detail in the plan is to be kept to a minimum.

- PCTs should aim to approve practices' commissioning or PBC plans within 4 weeks, and in no more than 8 weeks.

Management support and resources

- All aspects of the PCT budget should be devolved indicatively to practices, who will hand back elements of this notional, whole practice allocation to PCTs as appropriate based upon their PBC plan. This will include funding for the PCT's central management team, which should be clearly identified (paragraph 3.14) and PCTs are to set out what practices can expect in return for this funding.

  If the PCT does not deliver on its commitment, there is provision for practices to negotiate a budget from the PCT to procure these services independently (paragraph 4.4).

Local incentive schemes

- PCTs should operate local incentive schemes to engage practices in PBC (paragraphs 4.10- 4.13). These incentive schemes should as a minimum encompass the provisions of the 'Towards practice based commissioning (PBC) DES' arrangements (paragraph 4.11).

- Local incentive scheme payments are to be regarded as practice income.

Freed up resources

- The DH guidance states that "...it is imperative that practices are allowed to use a minimum of 70% of any FURs for reinvestment in primary care". This is "…irrespective of whether these were included in practice business plans or not" (paragraph 3.24).

- PCTs should aim to approve practices' proposals for use of FUR within 4 weeks, but no later than 8 weeks (paragraph 2.38).

- Freed up resources made in the previous year should not be deducted from future indicative budget allocations (paragraph 3.9).

Business cases to provide new services

- The mechanism for practices/consortia to develop their provider services through PBC is via submission of a business case to the PCT, for approval (paragraphs 2.16-2.20). The business case should include the management resources required to deliver the service and the up-front costs required for the proposals and their recovery period.

- PCTs should aim to approve practices' business cases within 4 weeks, and in no more than 8 weeks.

Procurement of services and tendering

- The DH guidance introduces a new 'any willing provider' model which promotes the principle of there being both multiple and a range of providers for routine elective or extended primary care services delivered in the community (paragraph 3.35). PCTs' contracts with providers for such new services will not set any level of guaranteed income/payment or activity/volume. Under these arrangements, tendering is not required on the understanding that 'any willing provider' is content to provide the service.

- Payments for such services, for the most part, fall outside Payment by Results (PbR) and will be made via an informal local tariff system, which will be informed through benchmarking of price bands at PCT, SHA and national level. These prices should be activity-based, published in an open and transparent way and made available to PBC commissioners.

- The DH expects PCTs to "…avoid agreeing new long-term contracts with service providers that would further cement monopoly provision arrangements and exclude practices form being able to propose service and care pathway redesigns" (paragraph 2.31).

- Tendering is only required when a contract is going to be awarded to a single provider, which would then create a service monopoly e.g. where a whole service is moved from a local hospital with no alternative equivalent being in place within the PCT boundary. This should only happen in 'exceptional circumstances' (paragraph 3.43).

Information

- Information must be timely and digestible and there are minimum requirements on PCTs regarding the information to be provided to practices/consortia (see chapter 5 of the DH guidance).

National guidance also sets outs a dual role for SHAs in relation to PBC comprising arbitration and PCT performance-management. We have therefore cc-ed this letter to [insert name and title of SHA Chief Executive].

If there are reasons why you believe that the PCT will not be able to deliver on any of the requirements detailed in this letter, please let us know as soon as possible.

We look forward to working with you and making PBC a success in 2007-08.

Yours sincerely
[insert name of LMC or PBC consortium]

cc. [insert name and title of SHA Chief Executive]