NHS

Primary care contracting

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Practice Based Commissioning

A Preliminary Toolkit for PCTs

April 2005

Contents

Acknowledgements

This preliminary 'Toolkit' has been developed in conjunction with PCTs predominantly in the East Midlands and Yorkshire areas during the first part of 2005.

The Primary Care Contracting Team wishes to thank all those PCTs that have contributed in some way to this toolkit, especially the 'early adopters' who have already begun the journey towards Practice Based Commissioning.

Also thanks go to the Toolkit Project Team of Sean Fenelon (Primary Care Contracting Team) and Jeff Anderson (Gedling PCT and *Primary Care Unlimited*) as well as the Project Steering Group and those who have commented on the Toolkit draft.

Chapter 1 Introduction

1.1 The development of this preliminary toolkit for PCTs took place at the same time as the release of the recent Practice Based Commissioning (PbC) guidance issued by the Department of Health[1]:

Practice Based Commissioning: Engaging Practices in Commissioning (October 2004 Consultation Document)

Practice Based Commissioning: Promoting Clinical Engagement (December 2004)

Practice Based Commissioning: Technical Guidance (February 2005)

1.2 Whilst the DH guidance can be interpreted in a variety of ways, this toolkit does not attempt to clarify the detail of the guidance except where reference to it is necessary. It is therefore important for PCT personnel to familiarise themselves with the guidance and use it in conjunction with this toolkit.

1.3 **The aim of the toolkit is to assist PCTs in the early planning and implementation process of PbC in a local context.**

How to use the toolkit

1.4 The content has been developed by a small project team drawing on evidence gathered at learning workshops, site visits, via a questionnaire, as well as feedback from individual PCTs. The resources and ideas are already in use as part of implementation processes at PCT level. In these early stages of PbC, some 'tools' are untested and some are embedded in early forms of PbC or in other related areas of PCT work.

1.5 It is important that PCTs use the toolkit as they see fit. A number of the areas covered are set out as simple **'checklists'** designed to get PCTs started quickly and efficiently. Some PCTs will want to use all the tools and checklists, some will want to select different parts depending on their specific needs and stage of development.

1.6 The Project Team has not changed the purpose of the resources and ideas it has received and been able to collate. All the 'tools' included are considered to be of value to PCTs although some PCTs may find it relatively basic in both scope and detail. **The Project Team accepts the number of PCT tools available is limited at this stage and recognises this is a 'first attempt'.**

[1] http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/fs/en

1.7 To this end, the toolkit is by no means the answer to implementing PbC. It is hoped that as PbC develops this will inevitably provide a richer knowledge base at PCT level and offer up more practical examples. Indeed, an expansion of this toolkit is already planned by the Primary Care Contracting Team during the first six months of 2005-06. This will be informed by future planned PCT focused events during May and June 2005.

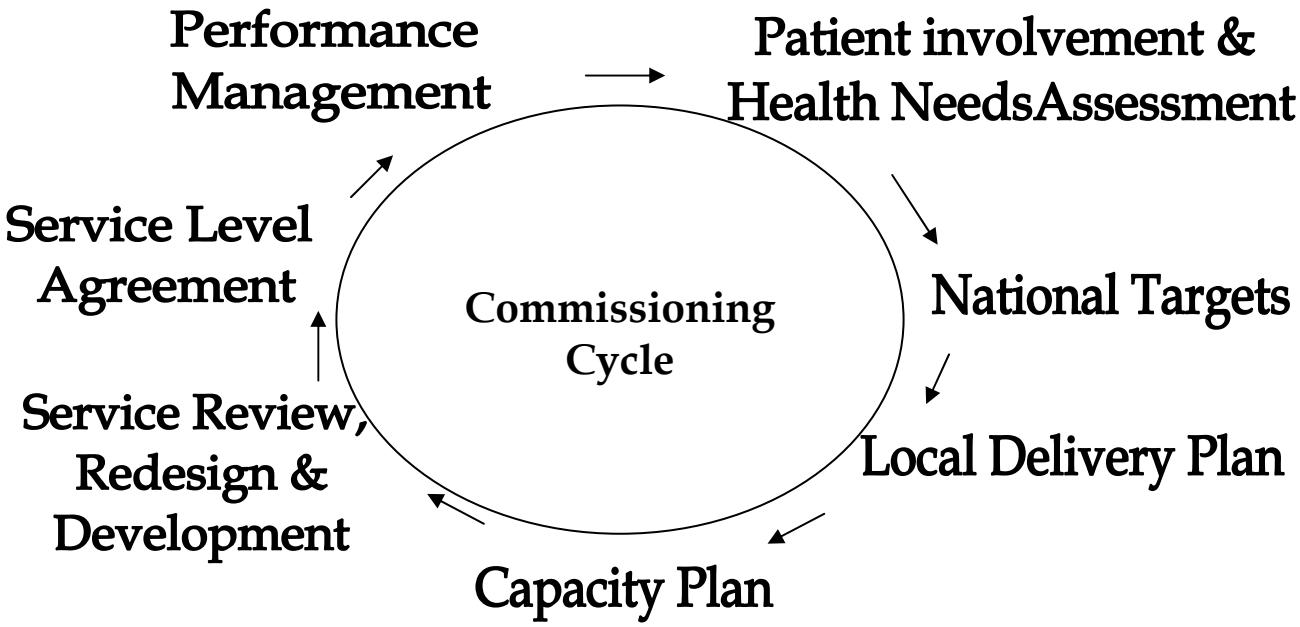
1. Introduction - Summary Key Points

- This toolkit should be read in conjunction with the recent Department of Health national guidance.
- The toolkit is a first attempt as it is still early in the design and implementation process of PbC. Specific examples of successful tools remain limited but will develop over time.
- Where appropriate, tools have been provided to get PCTs started quickly and efficiently.

Chapter 2 Practice Based Commissioning in Context

The Commissioning Cycle

2.1 For those PCT personnel new to the commissioning process, **Leicester City West PCT** have proposed a useful diagram to describe the key elements of the cycle. Many PCTs have also used NatPaCTs 'Commissioning Friend'[2] to help them address local commissioning implementation in the past.



Overview

2.2 In the autumn of 2003 the Department of Health, when consulting on technical aspects of the new "payment by results" funding system being introduced in England, identified four principle policy directions that the new funding system was intended to underpin.

2.3 The first of these was devolution. Important decisions should be taken as close as possible to the patient, within a national framework of standards and accountability. Aspects of this policy direction include:

- PCTs receiving three year funding allocations and having more freedom to shape strategy for their local health economies;
- delegation to foundation trusts, within a locally-focused governance structure and a national regulatory regime;
- the "shifting the balance of power" initiative;
- National Service Frameworks.

2.4 PbC, which gives GP practices direct financial control of the way health care is organised and provided, is part of this policy. It is designed to ensure that

[2] www.natpact.nhs.uk and click on 'Commissioning & Practice Based Commissioning' from the menu

general practitioners, and other clinical professions in primary care, are able to steer the strategic direction of their health communities.

2.5 The other three key policy directions listed in 2003 were:

- *Patient choice* - patients should, wherever possible, be empowered to take key decisions about the care they receive from the NHS. Thus far most national patient choice initiatives, such as "choose and book", have focused on the location of treatment. From December 2005 patients are to be given a choice of at least four or five hospitals for elective procedures.

- *Plurality* - a "mixed economy" of public and private sector healthcare provision. The last two years have seen rapid growth in independent sector hospital provision in England, mainly through the creation of treatment centres. Foundation trusts, which are required to operate as if they were free-standing businesses, can also be seen as part of this transition to a mixed economy, and there are suggestions that plurality may soon be extended into primary care.

- *Investment* - the substantial financial growth that the NHS has enjoyed in recent years comes with a condition that the money must be spent wisely and efficiently. The national tariff is not only the new basis of funding for the NHS; it also provides a series of benchmarks against which we can measure our relative costs.

2.6 PbC supports each of these directions. It facilitates the development of genuinely personalised care, making choice of provider "real" for patients. It is seen by many as a route to a wider configuration of providers and a greater variety in styles of care provision, unlocking innovation at provider level. And involving GPs in financial decisions is also, arguably, the key to ensuring that NHS resources are used wisely and efficiently. Certainly it is hard to imagine effective demand management without extensive GP involvement.

2.7 Two more recent pressures have also made practice-based commissioning seem attractive:

- a shift in policy emphasis during 2004 towards chronic disease and other long term conditions. Successful management of long term illness relies heavily on effective personalised care

- concern that, according to a 2004 Audit Commission report, only some 28 per cent of GPs feel engaged in the commissioning of hospital treatment. The PCT structures that had been explicitly designed to engage GPs would seem not to be working well. PbC is one way of addressing that deficit.

Historical and Physical factors

2.8 This section details a number of key factors for successful implementation of PbC. These are based on historical and physical factors and will determine the potential for any local approach.

Historical factors

2.9 *The number of ex-GPFH or Total Purchasing Pilot (TPP) practices* - It is highly likely that the number of former TPP or GPFH Practices a PCT has will have a direct impact on initial take up rates for PbC. Moreover, PCTs would be wise not only to determine these numbers but also to actively ascertain previous levels of involvement at both a management and clinical level. This is not to suggest that PCTs should seek to resurrect specific aspects of previous schemes but more to harness the implied untapped resource which was potentially afforded through these historical schemes and any resultant locality commissioning arrangements.

2.10 *PMS coverage* - The breadth, depth and nature of PMS coverage will have significance in the context of PbC. For example on a purely superficial level PMS will have resulted in the development of an ongoing monitoring process which could be augmented to a PCT's approach to PbC.

2.11 *Development of Practitioners with Specialist Interests (PwSI*) - Factors including previous use of Health Service Circular 96/31 to support the movement of services from secondary to primary and any work carried out to support the development of specialist interests should be taken into consideration. Further to this a number of the "action on" programmes utilised GPs as a means of boosting the availability of clinical resources from a secondary care perspective.

Physical factors

2.12 *Existence of neutral or non-general practice facilities* - Evidence from existing models of PbC such as **East Devon** and **Craven Harrogate and Rural District PCTs** indicates that the existence of neutral facilities such as community hospitals can support the development of specialist interests. This can be extended to include both diagnostic and treatment centres and LIFT sites.

2.13 *Natural geography fitting the model you choose* - PCTs need to consider their choice of model carefully. For example where natural clusters of practices exist it makes sense to at least investigate possible locality models such as those in place in **East Devon** and **Harrogate**.

2.14 *Staffing capacity and expertise* - It is important that PCTs provide adequate management resource to support the development of PbC. As a minimum strong involvement from finance; information; commissioning and contracting and primary care will be required. PCTs should also strongly consider involving their public health and patient and public involvement arms at an early stage.

Key features for PCT consideration

2.15 A range of areas relating to both an individual PCT's local environment and the overall national context should be considered carefully. These, including historical commissioning arrangements, will determine the local model to a large extent. PCTs should consider the following:

- links to and impact of other commissioning and primary care planning policies including
  - Status of local acute trust(s) – Foundation Trust (FT) or otherwise;
  - Patient choice and Choose & Book;
  - NPfIT roll out;
  - Payment by Results implementation programme;
  - Choosing Health White Paper – local implementation;
- current and future local service planning (LDPs; SSDPs) in relation to local health need;
- current and predicted financial position of the PCT and local health economy;
- local culture of PCT/Practice engagement and development;
- PCT and practices capacity and capability to take on this agenda;
- effectiveness of cross-PCT working including taking into account existing or planned shared procurement arrangements. PCTs should consider how PbC will integrate into such a system and what the rules of engagement/functionality at different levels will be;
- effectiveness of inter-practice working;
- current and predicted service pressures or area in need of change;
- local incentives to innovate and initiate change.

2.16 Potential barriers to PCT implementation include:

- management/clinician capacity and capability as well as local managerial ethos;
- risk sharing arrangements;
- GP focus on QOF;
- availability of good quality information to PCTs and to practices;
- Local Commissioning – PbC inevitably adds to the structures and generates potential mixed models of commissioning on different levels;
- PCTs ability to handle multi-commissioning models;
- PCTs need to ensure that they do not lose sight of targets in respect of health promotion and the wider public health agenda;
- practice engagement and the adoption or creation of 'neutral ground'.

2.17 PCTs need to be mindful that a strong "top down" approach which strictly determines the size, scope and timing of PbC may result in practices perceiving PbC as a threat rather than an opportunity.

2.18 Local arrangements will not be perfect in the first instance. As a result it is crucial that PCTs build-in opportunities for continual review and utilise the concept of pilots where necessary.

The General Practice perspective

2.19 It is important that practices understand that commissioning now has to be part of a whole systems approach. If primary care is to develop practices will need to be involved in commissioning. Admittedly the PCT and its LDP will operate like a "golden share" whereby national priorities take overall precedence but this is inevitable given that it involves the public purse. However, this need not be seen as too great a negative factor, especially where a PCT sees PbC as an opportunity to get GPs involved. PCTs must see that some areas in PbC may not be major wins for them.

2.20 PbC allows practices an opportunity to influence resourcing decisions in a different way. Input at an early stage would allow a practice(s) to offer an alternative to secondary care at the same time as they make their business case.

2.21 Furthermore whilst it is important not to overplay the potential for savings they do offer a route to fund primary care development, at a time when other primary care funding routes are either specifically earmarked (for example, QOF) or as a by-product of other efficiencies in line with on-going service reviews.

2.22 Practices will need clear guidance on how adequate and appropriate funding will be made available for practice input. The cost of clinician backfill could quickly deter interest. This is a major risk for both PCTs and practices.

PbC v GP Fundholding

2.23 PbC has been perceived by many to represent a return to GP Fundholding (GPFH). However, there are a number of reasons why this is not and will not become the case. The following table highlights key differences.

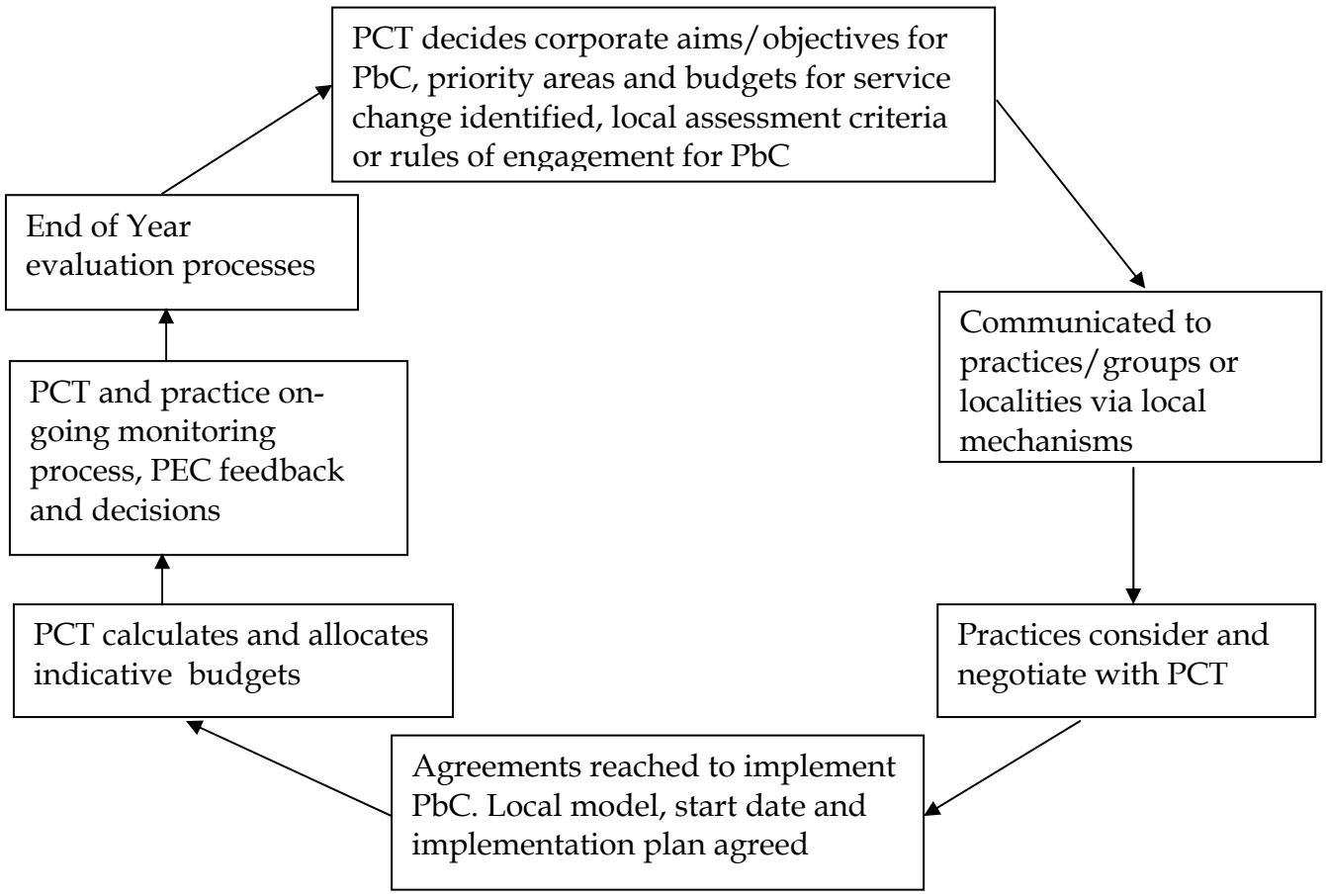
Area	GPFH	PbC
Scope of commissioning	Set list of goods and services which could be purchased by Practices	No centrally directed "menu". Practices and PCTs able to determine range
Budgetary coverage	Prescribing and community nursing a mandatory requirement	Practices and PCTs not obligated to include either prescribing or community nursing budgets
Contracting and monitoring	Direct contracts between practices and secondary care. Monitored at practice level	Responsibility of the PCT, based on need as identified in conjunction with practices. Negotiated and monitored at PCT level to minimise financial risks and administrative bureaucracy

Management costs	Fixed amounts set at a national level with maximum thresholds for clinical time	PCTs and Practices able to agree appropriate levels of resource
Currency	No fixed price for secondary care services	Under Payment by Results (PbR) there is a common currency and fixed price for secondary care
Use and treatment of savings	Centrally directed.	Central guidance emphasises that any resources freed must be reinvested in patient care
Political context	Supported by national legislation and central incentive funding eg. computing reimbursement	Independent of national legislation with no central incentive funding attached
IT and software	Nationally defined "bolt on" software	In the short term PCTs will provide Practices with information as required with the DH driving forward an integrated solution in the future.

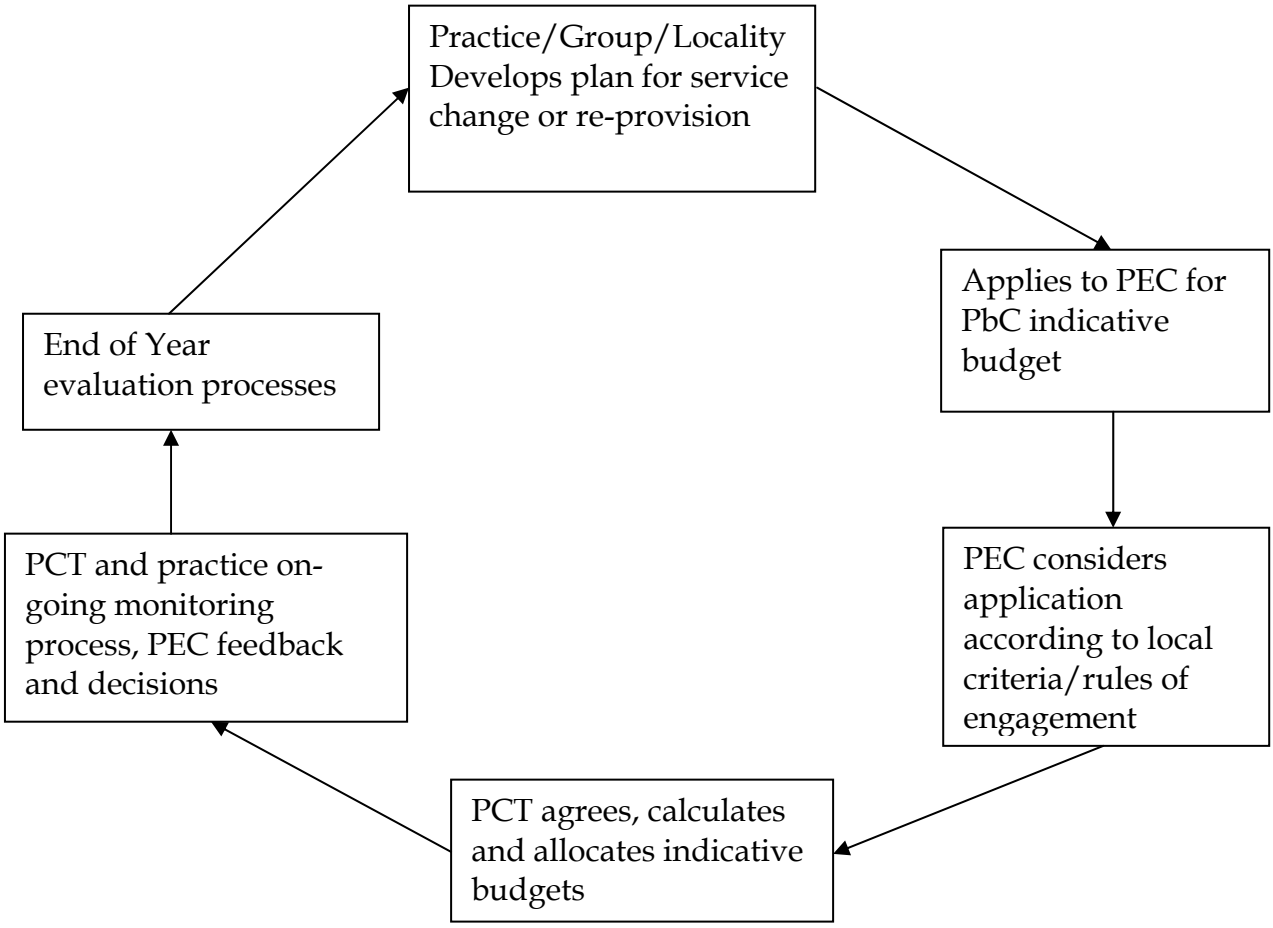
2.24 PCT approaches – Top down or Bottom up?

PbC can be described on the basis of a continuum of approach. The following diagrams describe options for PCTs. However, this should not be considered as an either/or scenario and PCTs should take into account what is likely to be most effective in their environment.

Top-Down



Bottom-Up



2. Practice Based Commissioning in Context - Summary Key Points

- PbC can follow the commissioning cycle closely and support those other key policy directions that offer patient choice, plurality of provision, and increased investment in primary care.
- A number of powerful historical and physical factors will determine the potential of any local approach.
- PCTs will have other local considerations when implementing new policy initiatives, which may be complementary or competing, and will significantly influence the change process. PCTs and practices accept that a perfect solution may not be possible first time.
- As with patients, practices must be integrally involved in the commissioning process and influence resourcing decisions. To achieve this, funding will be needed to cover practice backfill.
- Major differences highlight that PbC is not a return to GP Fundholding although experience of fundholding should be utilised.

Chapter 3 Accountability

3.1 It is clear the permissive guidance documentation has been the catalyst for PCTs to put PbC to the top of their local agenda. There are inevitably both opportunities and threats to progressing PbC implementation locally, especially financially within the context of PbR or operating alongside Foundation Trusts. Early examples of PbC (perhaps by another name) are now being developed further, new ideas are gathering momentum and PCT management structures are being revisited. Similarly, further work on clinical engagement has begun, key individuals are being tasked with leading the process, and discussions are continuing as to the impact on local health services as well as the PCT financial context.

Roles and responsibilities of PCTs

3.2 PCTs are accountable for the whole implementation process and a number of key stakeholders have important roles and responsibilities within the wider context of PbC. To this end, PCTs have a key 'change management' role to play in PbC by:

- finding ways to engage and develop local clinicians in the wider commissioning agenda and the specific local plans for PbC;
- engaging other staff and other local stakeholders, at different levels, in the commissioning process and the redesign and reprovision of local services;
- developing local processes and ensuring successful and high quality services are provided across primary and secondary care.

3.3 Early examples have shown differing degrees of PCT preparedness and opportunism to **re-structure** existing staffing roles and structures in order to take on the implementation of PbC. For example, moving staff out into distinct locality management and support roles at practice level in line with the a locality commissioning model for PbC. Others have taken a more global view, retaining staff in roles to support central commissioning functions at PCT level. There are examples of PCTs whose decisions on staff re-structuring lie somewhere in the middle.

3.4 **Craven, Harrogate and Rural District PCT** has begun to define its role in relation to practices by providing as a minimum:

- referral, health needs and activity information by practice;
- budget and contract monitoring support;
- contracting support – negotiation, documentation, monitoring;
- expertise on national requirements and targets;
- training (where identified and appropriate).

3.5 Many PCTs have established a **PbC Project Group** to support the PEC and to develop plans for implementation. This group may also serve to assist the PEC

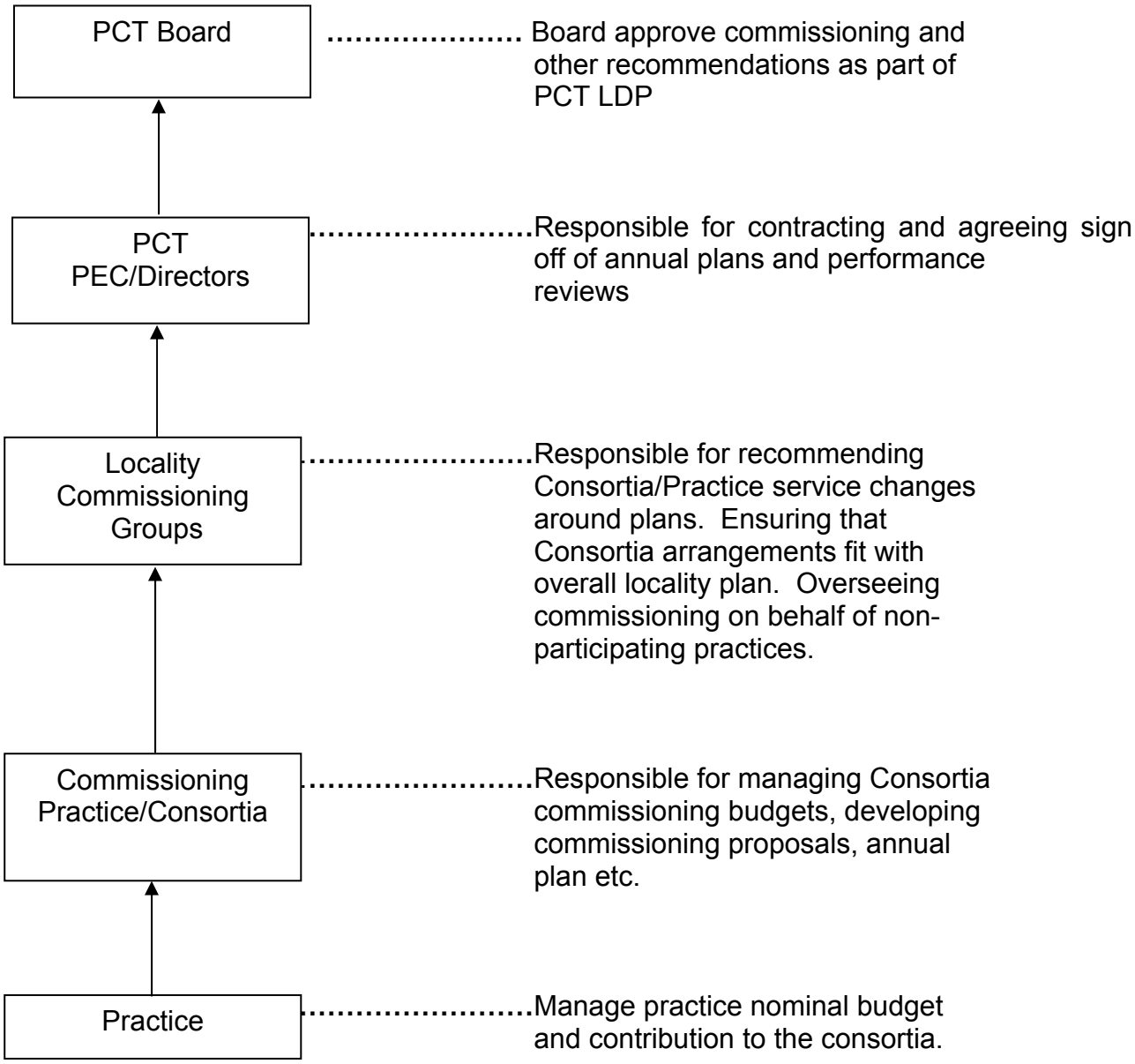
by recommending a framework under which both practices and the PEC operate and by recommending practice applications to the PEC on a regular basis.

3.6 The **PEC role** is fundamental to any PbC local system and is clearly described within the guidance documentation. In summary, the PEC should:

- set the general direction for PbC development;
- help devise clinical pathways of care;
- oversee the use of management costs and make recommendations to the PCT Board on the reasonable use of any freed up resources;
- ensure local agreements are in place;
- ensure transparency throughout the local process (including through corporate governance of its own members in declaring interests);
- monitor the levels of activity and spend under PbC;
- ensure the following are being taken into account when recommending proposals to the Board:
    - the contribution any proposed service changes make to demand management and key policies;
    - the benefits to patients;
    - the wider public health gains;
    - the demonstration of whole-system solutions;
    - value for money;
    - the provision of appropriate and effective care;
    - key stakeholder support;
    - the involvement of patients and front-line staff.

3.7 The **PCT Board** also has a key role as it will consider recommendations from the PEC and sign off any statutory processes necessary. They may also wish to consider and agree on the impact of local PbC arrangements on the wider opportunities for changes to health services on a population basis or any local partnership agreements. The Board must be assured that potential conflicts of interest are addressed when, for example, there are circumstances where the practice commissioner is also the provider of the service. Furthermore, the Board plays a crucial part in ensuring that patients and the public are integrally involved in the commissioning decisions made under PbC.

3.8 An example of a PCT accountability framework might include:



(Adapted from **Craven, Harrogate and Rural District PCT**)

Roles and Responsibilities of Practices

3.9 When Practices are ready to take on PbC, they (be it individual, or within groups, clusters or localities) will hope to maximise the opportunities of any local approach. These may include the ability to develop existing and new services as well as managing demand for secondary care. Practices have a key role to play in providing clinical input into this development.

3.10 Practices have a critical role in determining the success of PbC. In order to achieve this they do have important responsibilities which they should fulfil.

PCTs developing their relationship with practices will wish to reinforce these at various times and **Gedling PCT** has proposed that practices:

- ensure they develop a broader understanding of the wider commissioning agenda alongside the PCT;
- agree individually, or among their neighbours, a realistic timeframe to begin any key PbC process;
- be flexible to any local implementation approach and open to new ideas;
- ensure practice or locality applications to the PCT are thorough, realistic to implement and achieve the desired outcomes;
- recognise the risks that PbC generates for all key stakeholders;
- provide a clear commitment to work with the PCT on the early implementation processes.

3.11 Practices also have a responsibility (indeed they may be in the best position) to ensure patients and the public are integrally involved in local commissioning decisions. **North Kirklees PCT** has suggested this may be achieved by:

- establishing /enhancing patient dialogue on services through patient councils and patient surveys (perhaps as part of the QOF process);
- working with the local PPI Forum (though these are to be reconfigured from April 2006);
- using practice meetings to discuss anecdotal patient feedback;
- ensuring links with local authority area forums or committees.

Role of LMC

3.12 Practices and the PCTs should consider the LMC as a valuable resource to drawn upon in these early stages of implementation. This is particularly important where:

- the level of practice engagement as a whole is not at an optimum level;
- practices need points of clarification on key aspects of local processes or local shared agreements;
- PCTs need further influence at individual practice level;
- support may be necessary in the event of local appeals.

Role of the Strategic Health Authority

3.13 The guidance documentation is clear on the role and responsibility of the SHA which is asked to

- report annually on local PbC performance within an area;
- support learning and sharing of best practice;
- ensure any arbitration role is clear with the development of a specific arbitration group in each SHA.

3.14 The following table describes some key questions for use in a potential arbitration exercise resulting from rejected PbC applications. As this aspect of PbC remains untested at SHA level, more specific questions will be generated once experience and intelligence has been gathered.

On the PCT side:
On what basis has the PCT rejected the PbC proposal? Has the PCT developed a strategy in respect of PbC that has been discussed at PEC or Board level (or both)? If so, what were the outcomes and/or recommendations? Can the PCT demonstrate a commitment to involving or having involved General Practice (or other PbC proposer) in the development of its LDP? Does the PCT have an SSDP and/or Primary Care strategy in place and, if so, how was General Practice engaged? Does the PCT have a GP forum or other mechanism for including and/or involving General Practice in overall development (of Primary Care or otherwise)?
On the Practice side:
Does the PbC proposal strategically fit and how does it satisfy PCT objectives and improve patient outcomes? What is the scope of the commissioning budget requested (i.e. full range, default, other)? Number of Practices involved and why? What redesign (if any) is being proposed? What management and clinical capacity is in place to support the proposal?

3.15 SHAs may also want to consider setting local targets for PbC and to ensure PbC is developed whilst retaining patient choice and other key national policy requirements and national standards.

3. Accountability - Summary Key Points

- PCTs must apply a robust governance and accountability framework to PbC which is complementary to statutory processes.
- PCTs have a key role in change management and the engagement of clinicians and other stakeholders in the commissioning agenda. Structures may need to be reviewed as a way to catalyse this change.
- The role of the PEC and Board is specific under PbC and includes strategic planning, development, decision-making and monitoring.
- Practices have key responsibilities which should be made clear from the outset including ensuring their patients are involved in local commissioning decisions.
- Other local partner organisations have specific and helpful roles to play such as the LMC and SHA.

Chapter 4 Building Capacity

Engaging Practices

4.1 Despite good working relationships in many PCTs, there are often difficulties in engaging practices fully in major policy developments for a variety of reasons. This is also the case when PCTs require additional clinical input in primary care planning or commissioning processes. It is fundamental that PCTs are able to gain significant buy-in from local clinicians and their respective practices. PbC offers a further opportunity to develop this and practices have the ability to make a real difference locally.

4.2 The following describes some of the successful approaches used by PCTs to engage practices in the past and during this early stage of PbC development. On the whole, practices want:

a) permission – to develop local ideas and begin implementation;
b) information – however basic, which is accurate, up-to-date, and useful;
c) support – for clinical backfill, day-to-day practice and to gain greater understanding.

4.3 PCTs will not wish to raise practice expectations too high about what can be achieved or what incentives there may be for practices under PbC. Yet at the same time, PCTs must ensure they do not temper individual or practice enthusiasm for clinical engagement in the commissioning process.

4.4 Experiences from PMS have shown that clinical engagement can be improved by communicating **straightforward information** to practices. This will help practices gain a broader understanding of the any local processes, and to enable them to potentially draw up their own PbC applications. **Amber Valley PCT** has proposed that PCTs should make clear:

- what the PCT and practices can and can't do under local PbC arrangements and ensuring these messages are consistent;
- national and local aims/objectives any scheme will have;
- where the funding for PbC initiatives comes from. This is particularly important in relation to discussions relating to the requirement on PCTs to spend up to their Enhanced Services Floor[3];
- how payments under PbC are made to practices such as in-year incentives or payments on account;
- what criteria will be used for inclusion in PbC and what will be the expected outcomes;
- what financial consequences there may be to practices and any plans for handling risk at PCT, practices, group, or locality level;

[3] However, the Enhanced Services Floor might be revisited by practices and the PCT in respect of inclusion of any PbC management costs specific to practices or potential secondary care savings made if redeployed and contestable to GP practices with agreement from the LMC.

- specific budget information and any criteria for use of any savings;
- expected timeframes and milestones the PCT wishes to work towards;
- next steps for practices in the local process.

4.5 **Local decision-making mechanisms** will also be essential if PbC is to work properly. Any local structures must be current and active. Many PCTs have established a local GP group and in some instances have extended this to other contractors or clinical stakeholders such as community pharmacists, dentists and community nurses.

4.6 Making use of, and supporting the growth of, **local clinical leaders** or champions as important change agents within each PCT or locality will also be important.

4.7 Of course, **PCT managerial support** to practices in this process is a fundamental part of PbC. PCTs will need to determine how this support can and should be provided in the first stages of a PbC process and throughout implementation. Key factors that will need to be addressed at the earliest opportunity will be time commitments of practices and PCT officers, costs and value-for-money for practices and the management support available to implement and monitor progress. In particular, PCT support for clinical involvement in strategic service development and change will be necessary ensuring links are made with any LDP or SSDP.

4.8 Some PCTs have already identified initial primary and secondary care service priorities as **quick wins** for themselves and their constituent practices or localities. These areas can be loosely defined as those that

- practices seem most keen to explore;
- would be beneficial to practices on a day-to-day basis;
- make good use of limited managerial capacity by working closely with those practices;
- give the greatest patient outcome and financial saving as early as possible recognising the opportunities under Payment by Results.

4.9 The following table gives details of where PCTs have begun to focus on service priorities which suit their own particular set of circumstances:

Craven, Harrogate & Rural District PCT	General Surgery Orthopaedics Urology Oral Surgery Ophthalmology ENT Elderly care medicine
N. Kirklees PCT	Mental health Teenage pregnancy
Newark & Sherwood PCT	Minor surgery Outpatients /therapy areas Long term conditions and end of life care
Gedling PCT	Dermatology ENT Orthopaedics Ophthalmology Geriatrics Non-elective services eg suspected DVT
East Devon PCT	Specialist Orthopaedic Physiotherapist Dermatology Vasectomy ENT Gynaecology Mixed Fracture/Minor Surgery Community DVT Community Echo
High potential impact specialities	Care of the elderly Accident and emergency Paediatrics Psychiatry Diabetologists Chest medicine

4.10 It has been shown on numerous occasions through local and national schemes that practices optimise their performance, their engagement and their willingness to improve on day-to-day practice if this is linked to **incentive arrangements**. PCTs should decide early if there is scope, however limited, to explore and implement local innovative incentive schemes for practices or localities under PbC.

4.11 Whilst practices will engage in the commissioning process when circumstances are right for them to do so, PCTs should recognise the significant change practices have undergone over recent years. This in itself may dampen practice enthusiasm to become involved. It will be up to PCTs to **continually reinforce** the advantages of PbC over a period of time through appropriate local mechanisms before any significant shift in implementation is made.

4.12 Finally, PCTs should be clear in their plans and ensure that **communication to practices** is accurate and in good time. These plans should state the practical next steps for practices with realistic and achievable timescales.

How ready for PbC is the PCT?

4.13 So far, the following key factors seem to determine the state of PCT readiness in planning and successful implementation of PbC. They are not presented in any priority order. A corresponding 'traffic light' **self-assessment template** can be found in **Annex 1.**

4.14 *Relationship between the PCT and local practices* – Determined by the degree of understanding and collaboration, the degree and effectiveness of clinical engagement with the PCT, what natural structure or geography is available (clusters/localities or individual practices)

4.15 *Level of commissioning and management competency of practices, clusters or localities* – more details can be found below

4.16 *Level of commissioning and management competence and capacity of PCTs* – Dedicated resources identified in respect of both staff and project budget. Defined leadership with clear linkages to planning, provision and commissioning strategies and the LDP.

4.17 *Clarity of focus for PbC in the PCT* – Clearly defined aims and objectives of PbC within the PCT and how these can be achieved. Which key service priorities will be targeted, what scale and scope will these take and within what implementation timetable? Clarity of links with other local and national targets contained within the LDP.

4.18 *Transparent and accurate resource mapping* - Clear budgets identified and financial regimes organised including processes for moving to weighted capitation budgets, agreed criteria for use for savings, and key financial risks explained and the extent to which these can be reduced.

4.19 *Robust governance arrangements* - Accountability framework in place and key roles and responsibilities for key stakeholders identified. Financial, service and data contingencies described clearly. Local decision-making mechanisms in place including assessment panels for PbC applications and assessment of savings re-investment at practice level. Contractual agreements between all parties.

4.20 *Data quality available to practices and the PCT* - Identification and use of quality data and the abilities of key personnel to analyse and use data. Defined scope and sophistication of local IT infrastructure and solutions.

4.21 *Defined management structures and support available* - Clear leadership with preferably local clinical champions. Dedicated financial and management support offered to practices to at least initiate practice input to the process. Clear

links between PbC and other management areas including wider PCT commissioning processes and performance management agenda.

4.22 *Extensive communications strategy* - Details of plans, monitoring and outcomes shared both internally and externally to the PCT. Wider publicity to appropriate health community partners eg Acute Trusts, Social Services, Voluntary Sector.

4.23 *In-built evaluation processes* - Defining interim milestones for PbC in conjunction with robust monitoring arrangements. Having the confidence and flexibility to change course if necessary, to penalise practices and to implement contingencies.

Practice Competencies

4.24 Whilst it may be difficult to define exactly which practices will be keen to explore PbC and which will be more successful than others, **North Kirklees PCT** have proposed a useful set of key factors which may be used as a preliminary framework to assess practice competencies for delivering PbC. PCTs should seek evidence from practices or localities to reassure themselves that:

- they have sound local delivery plans in place;
- they can influence local decision-making, service re-design and delivery and a recognition of what they can't do at this stage;
- they have a good understanding of the PCT commissioning agenda, LDP priorities and key policy drivers;
- they cover a minimum list size which would be effective in any local model. The administrative cost of dealing with very small lists could make commissioning at this level prohibitive, plus a small practice will be more exposed to annual fluctuations in demand;
- they have a good record of data quality – eg high use of NHS numbers, sound information systems, no critical audit reports, no outstanding list validation issues and the level of QMAS data is sufficient;
- they have recognised high quality practice performance as determined by, for example, QOF or practice achievement awards;
- they have stable IT systems and processes in place;
- they have no outstanding disputes or issues with the PCT, eg PMS/GMS contract, large debts outstanding, high number of patient complaints;
- they would be able to actively manage PbC in a systematic way;
- they are can demonstrate a commitment to patient and public involvement;

- they have or are developing systems for offering patient choice;
- they have good systems for clinical governance and risk assurance;
- they are able to enter into unambiguous agreements with the PCT and other local practices.

Timetable for Implementation

4.25 According to the guidance documentation, from 1st April 2005 all practices have a right to request an indicative budget from their PCT. However, PCTs should ensure all practices are offered a clear opportunity to operate PbC by 2008.

4.26 Essentially, any timetable for implementation will be linked to the local PCT model or approach. Apart from some early implementer examples, the majority of PCTs seem to be adopting a pragmatic approach to setting out their timeframes within project plans. Implementation during 2005/06 appears to run in line with local Payment by Results timescales but there are no hard and fast rules to this. A relatively cautious approach looks likely to be adopted with at least the first half of 2005/06 being a **'shadow' period** for PCTs and practices, allowing time for clarity of focus, building of clinical engagement and capacity and data validation. This will also allow for more widespread learning and sharing of experience as PbC develops.

4. Building Capacity - Summary Key Points

- There are a variety of mechanisms to engage local practices in PbC. At an early stage, PCTs should concentrate on providing permission, information and support to practices and should communicate details about the local approach and any targeted service areas.
- PCTs need to assess their own preparedness for PbC as well as practice competencies to deliver key objectives.
- Timetables for implementation should be realistic yet challenging in order to realise the opportunities of PbC as early as possible. Many PCTs have opted to run PbC in 'shadow' form during 2005-06.

Chapter 5 PbC Processes

Assessment of Practice / Locality applications

5.1 Depending on the local approach, PCTs may wish to invite practices to submit PbC applications within the overall implementation plan. **Annex 2** offers a basic **Practice Application Assessment Template** for PCTs to assess these applications and could be adapted locally, making more defined links to practice competencies as necessary.

5.2 This tool may also have a number of possible uses such as:

- to distribute to practices in advance of the application process;
- an assessment tool for any applications sent to the PCT;
- a planning tool for PCT management teams to determine size, scope and impact of local approach.

5.3 It might therefore be used, as appropriate, by:

- practices in developing their applications to the PCT;
- the PEC or delegated PCT decision-making group;
- PCT management teams or PbC project groups.

Contracting and Shared Agreements

5.4 The following section provides a template of **minimum requirements** for consideration when designing local PbC shared agreements between practices and the PCT. As this is only a guide to the key areas, it may be necessary for PCTs and practices to seek legal advice before signing and implementing local agreements.

5.5 It is also worth noting that further national approaches to contract management have recently been proposed by the Department of Health[4] which may influence PCT and practice decisions around interim contractual arrangements locally.

Section 1 – Aims and Objectives of the agreement

- Aim of PbC locally (national aims and specific local focus as appropriate)
- Specific; Measurable; Achievable; Realistic and Timely (SMART) Objectives

Section 2 – Parties to the agreement

- PCT (or PCTs)
- Locality or Group (if formally structured)
- Individual named practices

[4] Creating a Patient-led NHS: Delivering the NHS Improvement Plan – March 2005

- Local service providers (as necessary)

Section 3 – Key Services

- Those commissioned under local scheme
- Those provided under local scheme

Section 4 – Accountability and Governance arrangements

- Description of any PCT statutory processes applicable to PbC
- Named lead personnel
- Systems of governance – service and financial
- Links to other agreements eg PMS
- Review, notice and termination

Section 5 – Data transparency, quality and use

- Level and nature of data to be shared
- Systems of data quality or validation
- Data confidentiality
- Description of how data will be used for incentives, budget setting, or savings

Section 6 – Performance management

- Locally agreed quality indicators
- Performance management framework and timeframes
- Rules in respect of over and underperformance

Section 7 – Contract monitoring and reporting

- Systems for contract monitoring and timescales
- Key personnel involved
- Specific process for reporting through PEC

Section 8 – Financial management

- Calculation of budgets and contract values
- Criteria for use of savings
- Systems for dealing with overspends and financial recovery
- Risk management processes and agreed contingencies
- Review periods

Section 9 – PCT and Practice roles and responsibilities

- PCT agrees to …
- Practice agrees to …
- Locality agrees to …

- PCT and practice collaborative working and management arrangements

Section 10 – Inter-practice agreements

- System of accountability and lead personnel
- Description of collaborative working and management arrangements
- Shared financial agreements.

5. PbC Processes - Summary Key Points

- A PCT process of assessing practice applications under PbC should be in place as part of the local PCT accountability and decision-making framework.
- There may be a need to design and develop local shared agreements, which include minimum requirements. Agreements should be seen in the context of the wider commissioning cycle and be checked thoroughly.

Chapter 6 Finance and Monitoring

Setting indicative budgets for 2005-06

6.1 There is strong Department of Health support for the local determination of approaches to practice based budgeting. The *technical guidance* allows a considerable degree of local flexibility and outlines a methodology for setting what it terms a "default" budget. This is to be used where practices wish to claim the right to a commissioning budget for the full range of patient care. For 2005-06 the guidance specifies that such a budget will apply to elective in-patient and day case treatment only, as these are the only categories of care for which the national tariff will apply.

6.2 However, first wave Foundation Trusts will also use the tariff in 2005-06 for non-elective in-patient treatment, for outpatient attendances and for accident and emergency attendances.

6.3 The specified methodology for setting this default budget:

- takes 2003-04 actual referrals as a baseline, using Hospital Episode Statistics (HES) data aggregated locally to groups of practices. This establishes the share of the overall commissioning budget to be allocated to each practice or locality;

- uplifts this baseline to 2005-06 levels, by taking into account increased levels of demand and changes in practice list composition. The recommended way to do this is through the use of SHA level uplifts, which form the basis of agreed Local Delivery Plans;

- accommodates local adjustments to care pathways arising from services moving from secondary to primary care.

6.4 The *technical guidance* also includes a step-by-step methodology for adjusting for changes in practice list composition. The following practical routes through some of the potential problem areas are also suggested:

- There are known weaknesses in the 2003-04 HES data. These are acknowledged in the technical guidance, which accepts that 1.2 per cent of elective HES activity has a missing or invalid practice code. PCTs should not disregard these complexities, which may well prove material at practice level.

- The uplift from 2003-04 actual to 2005-06 plan needs to take account of the 2004-05 forecast outturn level of activity, and the extent to which the local delivery plan accommodates this growth (or shrinkage). This is significant. 2004-05 has seen many first wave Foundation Trusts achieving activity levels

well in excess of plan, in the expectation that they will be funded under the Payment by Results regime.

- The uplift also needs to allow for growth, reductions and service changes that have been built into the 2005-06 LDP. These will not simply consist of transfers from secondary to primary care. They will also include, in many cases, the implementation of recovery plans and the achievement of planned efficiency savings.

- In terms of timing, there may be a mismatch if practices are seeking indicative budgets but the local delivery plan for 2005-06 has still to be finalised. It has not been uncommon in some areas for LDP negotiations to last well into the new financial year. In this circumstance PCTs may need to make provisional estimates of the final LDP content.

- The practical freedom of GPs to commission and organise services differently in 2005-06 may in reality be constrained by LDP agreements with providers. In this instance, practices should be made aware of the constraints upon their short-term freedom to commission differently.

"Fair shares"

6.5 The budget-setting methodology outlined above is based upon historic referral patterns. There may well be accusations, from an early stage, that some practices – and hence their catchment populations - are not receiving their "fair share" of NHS resources.

6.6 The DH technical guidance states that "from 2006-07, a fair shares approach will be used to calculate practice budgets". This may well raise expectations of early resource redistribution so it may be important for PCTs to:

- dispel any illusion that this transition will happen overnight, and begin a dialogue with all practices about what would be an acceptable "pace of change". Experience of aligning PCTs with their own "fair shares" of the overall NHS budget shows that this is a sensitive issue, and one that is best handled through the differential allocation of growth funding than by destabilising cuts in funding, which "rob Peter to pay Paul";

- consider whether any practices deserve special treatment because of specific local population issues. For instance, a practice serving a number of care homes may incur additional costs that will not be reflected in high-level population statistics.

Management costs

6.7 There needs to be an explicit agreement with practices about the amount of funding that will be made available to support the management costs of PbC. It is suggested that resources could help to free up time for clinical input. Whilst it may not be preferable that clinician time is swallowed up in data validation, some paid time to give clinicians confidence in data for PbC use might be a beneficial investment for some PCTs.

6.8 There are real risks in building new management structures to support PbC within practices, on the assumption that they will in time be proved to be self-financing through as yet unspecified savings. It is not realistic to assume, explicitly or implicitly, that PbC carries no additional cost at practice level. This will be the crux of successful implementation as PCTs begin further engagement of practices at a local level.

Incentives for practices

6.9 Balanced incentives are required if PbC is to function. As a result PCTs should consider what incentives, over and above the requirement to provide management costs, they need to put into place. It is wholly possible and arguably desirable for a PCT considering establishing a model of PbC which incorporates a referral management element to provide a greater financial incentive in those areas which offer most pressure.

Managing risk and contingency funding

6.10 There are 2 principle approaches to risk management. The first, which is outlined in detail in the technical guidance, involves the use of a top slice whereby the budget that a Practice or locality is given has been reduced so as to create a central risk pool. This model by definition is financially focused. The second model which was used sporadically during the GPFH period is activity based and involves the creation of a risk pool based on stripping out high cost low volume and/or highly volatile activity from any budgets established.

IT and data support

6.11 This section has been developed in parallel to the work undertaken by a sub-group of the PbC team at the DH, focusing on IT solutions to assist implementation.

6.12 PbC requires new and revised processes in SHAs, PCTs, localities/practices, trusts and certain central functions.

6.13 Existing IT solutions may be of value, either as models for approaches to support PBC, or as systems (or platforms) which could be modified to provide direct support.

6.14 Whilst developing their local approaches, PCTs may wish to keep in mind individual, or a combination of, potential IT and data solutions including:

- NPfIT's NHS Care Records and Secondary Uses Services systems should collect and collate all treatment activity data;
- modifications to support Payment by Results should support pricing by national tariff (where applicable);
- Choose and Book should become the route for all referrals and, hence, a point at which referral data could be captured for PBC reporting;
- the discontinued OSCAR system provided costed comparative activity information;
- NHSIA's Performance Investigator system provides activity and cost information;
- the PPA's national prescription pricing systems collect, collate and process all prescriptions, feeding cost and comparative data back to practitioners;
- the QMAS system provides all practitioners with a database to manage QOF information;
- reporting tools are being investigated to support QOF analysis at practice level and might also be used to extract activity information from practices' clinical data.

6.15 DH has been aware of several PCTs and related organisations which have pathfinder PbC IT solutions of their own design which may be useful to other PCTs. During early 2005, a small number of these pre-existing IT systems, tools and templates have been identified and evaluated. The following is a list of these resources.

- **Durham Dales PCT**
- **Thames Valley SHA**
- **NHSIA Tools: HRG Toolkit & Performance Investigator**
- **North Bradford PCT**
- **South Hams & West Devon PCT**
- **East Devon PCT**
- **Eastern Birmingham PCT**
- **Craven, Harrogate and Rural District PCT**
- **Cambridgeshire SHA**

6.17 Further details of these resources will be made available during April 2005 on a the Primary Care Contracting Team website

www.primarycarecontracting.nhs.uk

This facility is likely will develop in line with full national IT support.

6.18 Realistic timings for the mainstream IT development cannot be ascertained in advance of the assessment work, but the aspirational target is to have those systems and data used in the preparation of budgets and annual commissioning available by January 2006 so that they can be used to prepare for full operation of PbC in April 2006.

6.19 For those PCTs wishing to develop local solutions of their own in the interim, it may be worth keeping in mind the following specific questions as a check against some of the basics which should be included within the local design. These are:

- How are practices and localities informed of their budgets?
- How is their budget broken down?
- How often does the PCT provide reports of costed treatment activity data to localities and/or practices?
- Where does that the costed treatment activity data come from?
- How is it priced?
- What quality is the data (and is that good enough for the purpose)?
- What specific problems are there with data?
- Is treatment in a primary care setting captured so that it can be included in reports (if so how)?
- How do localities and/or practices participate in the commissioning of services, eg do they electronically manipulate numbers locally at the practice or do they simply talk to the PCT?
- How is data transferred to and from the practice?
- Does the practice link the PbC data with its practice management or clinical systems? If so which systems, what data, how and why?
- Do the practices actually issue commissioning requests which the PCT acts upon or is it more a question of informing referral decisions by the practitioners?
- What does the PCT do to collect together and act upon the commissioning requirements from the localities and/or practices?

- What kind of performance reporting does the PCT generate for practices and localities – eg costed activity or referrals vs commissioning budget?

6. Finance and Monitoring - Summary Key Points

- Flexibility does exist in how PCTs set their PbC budgets and the use of the 'default' budget can also be developed.
- A "fair shares" approach to budget setting in complicated and will not happen without adopting a realistic pace of change locally. Specific practice circumstances may determine the need for PCTs to treat practices differently and local agreement may need to be reached.
- Management costs, incentive arrangements and contingency funding are critical factors determining early success of PbC, particularly in engaging practices and other stakeholders such as neighbouring PCTs.
- Whilst national IT solutions are being developed through NPfIT which should be complimentary to primary care system supplier development and implementation, local solutions may be adapted or developed to suit local circumstances. Several examples will be available in April 2005 at www.primarycarecontracting.nhs.uk

Chapter 7 Further Support for PCTs

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Useful resource material can be found at:

PCC website – all aspects via
www.primarycarecontracting.nhs.uk

Department of Health website – guidance via
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/fs/en

NHS Alliance via www.nhsalliance.org

National Association of Primary Care via www.primarycare.co.uk

National Primary Care Development Team Primary Care Contracting Collaborative via
www.npdt.org

Annex 1 - PCT State of Readiness Self-Assessment Template *(to be adapted locally)*

Specific PbC area to address	Evidence of progress or achievement	State of Readiness			Further Actions Required
		Red	Amber	Green	
PCT – Practice Relationships					
Collaborative working					
Clinical Engagement					
Natural commissioning units identified					
Practice Competency					
Commissioning competency					
Management competency					
Other					
PCT Competency					
Staff resources identified					
Budget resources identified					
Commissioning linkages made					
Clarity of Focus					
Aims/Objectives clear					
Outcomes clear					
Key services identified					
2′ Care SLAs for PbC identified					
Scale/scope of implementation planned					
Finance					
2003/04 budgets clearly identified					
Process for moving to weighted capitation budget planned					

Specific PbC area to address	Evidence of progress or achievement	State of Readiness			Further Actions Required
		Red	Amber	Green	
PbR resources identified for key PbC areas					
Set up costs for practices identified					
Continuing management costs identified					
Resources for PCT support identified					
Arrangements for Managing Risk					
Contingency arrangements agreed					
Clear criteria for level and use of savings					
Governance					
Accountability clear					
Local PbC quality standards agreed					
Monitoring arrangements established					
Practice/PCT shared agreement					
Patient Choice assurance					
Key roles identified					
Decision-making mechanism clear					
IT and data					
Possible IT solutions explored					
Identification of quality data and key practice data to be fed back to fit purpose					
Process for using quality data clear					
Support personnel identified and trained					
Develop monitoring tools as necessary					
PCT Management					
PCT Leadership clear					
Local clinical champions engaged					

Specific PbC area to address	Evidence of progress or achievement	State of Readiness			Further Actions Required
		Red	Amber	Green	
Dedicated management support in place and offered to practices					
Clear linkages between PbC and other management areas					
PEC responsibilities clear					
Risk assessment of individual practice competencies and locality models Criteria for assessing PbC applications					
Criteria for in-year decision making and any documentation					
Documentation for reporting to PCT Board					
Local processes for dispute resolution (before arbitration)					
Staff training needs analysis					
Processes for implementing behaviour change					
Practice implementation timetables					
Communication					
Inform practices of LDP					
Inform practices of key PbC focus areas and plans for implementation and support					
PCT Stakeholder event					
Communication to key 2'care and other stakeholders					
Communicate internally in PCT					
Evaluation and review of local PbC					
Process for evaluating local PbC implementation					
Process for monitoring impact of PbC					

Annex 2 – Practice Application Assessment Template *(to be adapted locally)*

Criteria for Assessment	Yes	No	Comments or further adaptations required
A. Strategic Fit Satisfy key local aims and objectives of PbC as defined locally?: 1) 2) 3) Key outcomes delivered?: a) b)			
B. Accountability – for example Practice/PCT shared agreement in place? Locality agreement in place? Leadership and management structures clear? Management capacity clear and sustainable? Choice offered? Evidence of PPI?			
C. Financial – for example Level of management cost required? (Please provide indicative level only – Final costs to be agreed) Potential overall savings? Greater than **£a,000** Greater than **£b,000** Greater than **£c,000** Financial risks to practice/locality assessed? Confident that this level of service/funding can be sustained? Priorities for re-investment have been stated? IT in place or data validation taken place?			
D. Service Provision – for example Maintains local stability of services and equity across practices/locality? Assessment of current service undertaken? Numbers of patients benefiting determined? Satisfied with balance between numbers of patients benefiting compared to whole PCT population? (If not whole PCT) Possibility of roll out to wider PCT area if successful?			
E. Timeframes – for example New arrangements proposed start date: 2005/6 2006/7 2007/8			