

Health

National report

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Putting commissioning into practice

Implementing practice based commissioning through good financial management

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Summary

Practice based commissioning (PBC) is a policy that enables primary care trusts (PCTs) to manage their financial risk better. Importantly, it also encourages the creation of better services for patients through service redesign, better clinical engagement and better use of resources. Under PBC, clinical and financial responsibility is being aligned. PCTs continue to be legally responsible for finances and contracting with providers, the overall commissioning strategy and for the implementation of PBC. But, by devolving indicative budgets to practices that treat and refer patients, GPs and other primary care professionals are being encouraged to manage referrals and to commission and redesign services in a way that is more cost-effective and convenient for patients.

Good financial management is critical to the success of PBC. The Commission's report *World Class Financial Management (Ref. 1)* identified a number of factors that are important to achieving excellence in financial management. Engagement with, and of, budget holders; clear understanding of the financial consequences of individual actions; the alignment of resources with strategic objectives; and the provision of timely and relevant information are all critical. These are no less relevant to PBC. In short, PCTs need to foster a culture in which there is individual and collective responsibility for the effective stewardship and use of resources.

The Audit Commission visited 16 PCTs and found that some progress in implementing PBC has been made in all of them. The combination of an incentive payment to practices, together with the requirement on PCTs to provide a supporting infrastructure, has helped to introduce and implement PBC. During 2006/07 nearly all practices received incentive payments totalling an estimated £98 million. About half of this was associated with signing up to PBC and accepting an indicative budget. The remainder was conditional on practices achieving their PBC plans. Many practices had either formally or informally organised themselves into consortia or locality groups in order to share capacity and resources. We found that they were beginning to understand the financial consequences of the clinical decisions that they make, and that they were making progress in managing inpatient referrals, and new and follow-up outpatient appointments.

However, we also found that engagement of practices was variable. PBC is largely being led locally by enthusiastic practices working with supportive PCTs. The quality of the underpinning financial infrastructure was also variable, with many practices unclear how their budgets had been set, or how financial risk was to be managed. They were also

critical of the information available to them and of the support provided by PCTs to help them properly manage their budget and get the best out of the resources available. These findings are echoed in the Department of Health's latest GP practice survey (**Ref. 2**). PBC will not work without robust budgets and sound information. Arrangements for sharing and using any savings, which are important incentives for many practices, were also still theoretical, unclear or criticised, particularly where savings would be retained by a PCT to cover any overspend.

The redesign of services and their transfer from secondary to primary care had yet to gather pace. However, it was clear that many practices were more interested in using their budgets for the direct provision of new services rather than to commission others. In both cases there needs to be more consistent provision and proper assessment of sound business cases to ensure best use of the funds available. There also needs to be strong governance arrangements to overcome any potential conflicts of interest. We found that PCTs' approach to business cases were generally underdeveloped, as were arrangements for monitoring the impact of any changes. All PCTs had put in place recommended governance arrangements, but in many cases these had yet to be properly tested.

Good financial management requires that resources are properly aligned with an organisation's strategic objectives. PCTs are increasingly working with local authorities to commission services, improve health and well-being and address health inequalities. However, we found little evidence that practices were engaging with public health staff or with local authorities. Without such engagement, resources are unlikely to be matched to PCTs' strategic objectives.

2006/07 was only the second year of operation for PBC. Progress was significantly affected in those PCTs subject to reconfiguration. Most PCTs and practices we visited saw PBC as an important vehicle for improving care and making the best use of resources, and were keen to develop it further. But we saw few signs of the scale of service change envisaged by the Department of Health (DH), or any real contribution to more effective management of PCTs' financial risks. To achieve these, PCTs will have to improve the level of engagement of practices and shared ownership of objectives, but also address key points about the infrastructure for PBC. Practices will need to develop an outward looking approach, engaging with other practices; the PCT (including on public health issues); and local authorities. This will take time. But it may then be possible for PBC to deliver the scale of service change envisaged by the DH and also effectively manage PCTs' financial risks.

1

Introduction

Background

- 1 PCTs are financially responsible for clinical decisions taken by general practitioners (GPs). This division of responsibilities creates obvious financial risks, as PCTs cannot directly control one of the main elements that drives their expenditure, and the decisions taken by GPs may not always result in the best use of resources, as these decisions lack a financial component. PBC attempts to manage these financial risks by aligning clinical and financial responsibility.
- 2 PBC is intended to give practices direct financial control of the way that healthcare is organised and provided. PCTs remain legally responsible for managing finances; negotiating and managing all provider contracts; the overall commissioning strategy; and the implementation of PBC. However, under PBC, practices¹ are entitled to hold an indicative budget, on behalf of their patients, within which they are expected to operate. Using these budgets, practices commission services from, and manage patient referrals to, secondary and tertiary care providers and are engaged in redesigning services to make them more cost effective.
- 3 Indicative PBC budgets are set by the PCTs and are typically made up of a number of specific areas of NHS activity (**Table 1**). PCTs may not refuse to provide an indicative budget to a practice unless there are clear reasons why it is unsuitable. For example, where a practice fails to balance its budget the PCT can remove the practice's right to hold a budget.
- 4 Under PBC, if practices make savings through effective budget management and/or service reform, for example by reducing hospital admissions through providing better care, they are able to receive and spend a portion of the indicative surplus to support the development of local services. This is an important incentive for engaging practices and encouraging the best use of resources.

¹ For the purposes of this report, we have used the term practices to refer to GP practices and other allied healthcare professionals who have accepted and are managing an indicative budget as practice based commissioners.

- 5 PBC may be undertaken by a single GP practice, but is usually undertaken by a consortium, or cluster, of practices or by localities, normally based on a group of practices covering a specific geographic area. PCTs' responsibilities in implementing PBC include ensuring that all practices (**Ref. 3**):
- receive information that enables them to understand their clinical and financial activity compared with local and national indicators;
 - receive an indicative budget covering an agreed scope of services;
 - receive support from the PCT and an offer of an incentive payment (for 2006/07 this was the national Directed Enhanced Service (DES) payment or a locally determined alternative); and
 - have appropriate governance and accountability arrangements for PBC in place, agreed in partnership between the practice and the PCT.

Table 1
Key elements of an indicative budget

Element	Description
Secondary care <ul style="list-style-type: none"> • Elective • Non-elective • Outpatient 	This budget relates to expenditure for: <ul style="list-style-type: none"> • Planned hospital treatments/procedures (eligible for payments at the national tariff). There are particular specialist treatments such as in vitro fertilization and chemotherapy which are not eligible for payments at the national tariff. • Unplanned hospital treatments/procedures (eligible for payments at the national tariff). • Consultation with a healthcare professional which does not require admission (eligible for payments at the national tariff).
Prescribing	This budget relates to expenditure on prescription drugs in primary care.
Community and mental health services	This budget relates to expenditure for mental health services and those provided in community settings (ineligible for payments at the national tariff).

Source: Audit Commission

- 6 PBC is one of the central planks of the current NHS reform programme. It was first referred to in the 1998 white paper, *The New NHS* (Ref. 4), which stated that ‘over time the government expected PCTs to extend indicative budgets to individual practices’. PBC follows the principles set out in the *NHS Plan* (Ref. 5), supporting the concept that commissioning should take place as close to the patient as possible, that is, at GP level. Since April 2005, practices that wished to participate in PBC have been entitled to an indicative budget (Ref. 6). The Department of Health (DH) envisaged that by 2008 most or all practices would be engaged.
- 7 The NHS has implemented a number of different approaches to commissioning during the last 17 years¹, which have all sought to devolve commissioning decisions to GPs (Table 2).

Table 2
Commissioning timeline

1990-96	GP fundholding; total purchasing pilots; GP-led commissioning with health authority purchasing
1996/97	Locality commissioning pilots
1998	Primary care groups
2000	Primary care trusts
2004	First PBC guidance issued

Source: Audit Commission

- 8 PBC is a hybrid approach to primary care-led commissioning, seeking to achieve all the benefits of the preceding commissioning models while avoiding their disadvantages. PBC is not the same as GP fundholding (GPFH) as some have suggested. While they share some similarities, there are also some differences. For example, there is no national framework and implementation has largely been left to local discretion. In addition PBC differs in that it is not governed by legislation; there are no direct financial incentives; PCTs remain responsible for contracting; and there are no dedicated and prescribed management resources.

¹ Since the 1990 NHS and Social Care Act which introduced the purchaser provider split in the NHS.

Expected benefits of PBC

- 9 PBC is, of course, not only a way of managing financial risk. Its primary aims and potential advantages for patients, which are not considered in this report, include:
 - a greater choice of treatments;
 - an increased range of services provided locally;
 - more services provided in the patient's home;
 - alternatives to hospital admission;
 - seamless care between providers; and
 - reduced inequalities of outcome.
- 10 PBC provides a number of potential advantages for PCTs, including:
 - better commissioning and services through clinical involvement;
 - better management of referral of patients to hospital by GPs; and
 - better information on which GPs base their decisions.
- 11 There is real potential for PBC to transfer both funds and services from secondary to primary care. Practices can develop clinics; employ nurses; GPs; or even consultants, and fund them from their budgets to provide accessible, high-quality services at a lower cost.

Early lessons from implementing PBC

- 12 In 2006 the Audit Commission published *Early Lessons in Implementing Practice Based Commissioning* (**Ref. 7**), which drew on evidence from a small number of PCTs that were early implementers of PBC. The main findings were that:
 - Many PCTs were experiencing difficulties with engaging practices. Those practices that had engaged were already experienced and interested in commissioning. We therefore highlighted the importance of incentivising practices and the need for increased effort to bring other practices on board.

- Several different approaches to implementation had been adopted. In some areas it was largely practice driven; in others, PCTs were leading the work, or a strategic health authority (SHA)-wide approach had been adopted. We identified that PCTs had a key role in change management and implementation, although the extent to which they were fulfilling it varied, regardless of the approach taken.
- Few PCTs had been able to look beyond the initial mechanics of engaging clinicians, giving practices the information they needed and setting budgets.
- There was some way to go before practices would be actively involved in strategic commissioning and more comprehensive service redesign and prevention.

13 *Early Lessons in Implementing Practice Based Commissioning* identified six key areas on which PCTs and practices in the early stages of implementation should focus on, namely strategy, clinical engagement, managing finances, information, supporting practices, and governance.

Study scope

- 14 This study set out to determine whether PBC is working from a financial management perspective. For the purposes of this research, we defined working as ‘the financial incentive of devolving budgets to GPs is enabling PCTs to manage their financial resources better’. The research questions that we set are listed in **Appendix 1**.
- 15 In this study, we focused on the following areas:
- indicative budgets, including the methodologies for setting them; the scope of health services that they covered; and the arrangements for moving practices to fair shares¹;
 - incentives and rewards offered to practices to engage in and implement PBC;
 - arrangements for managing financial risk;
 - information arrangements to support budget setting and budget and activity monitoring and management;

¹ Fair shares is where practices receive budgets to provide services, based on the number of patients registered and adjusted for factors such as deprivation. This is discussed in further detail in Chapter four.

- PCT support arrangements for PBC; and
- governance arrangements.

16 The methodologies used were:

- Semi-structured interviews conducted at 16 PCTs (**Appendix 2**), including 3 PCTs that participated in the previous research we undertook for *Early Lessons in Implementing Practice Based Commissioning*, to examine local PBC arrangements, identify obstacles to implementation and to collect notable practice. These were undertaken during January and April 2007.
- A survey of general practices, targeted at a sample of practices at each of the 16 PCTs to get a practice perspective on policy and implementation. The survey was sent to 623 practices and we achieved a 20 per cent response rate (122 returns) from GPs and practice managers. While the sample is not representative of the GP population of England, we have used this evidence to help us validate and interpret what we learned from the interviews we conducted. The National Association of Primary Care and the NHS Alliance provided assistance to encourage practices to respond.
- Desk based research which included analysis of relevant PBC documents provided by the 16 PCTs, analysis of national and local datasets relating to PBC and a review of findings from local audit work on PBC (**Appendix 3**).

Report overview

- 17** The remainder of this report is divided into five chapters. Chapter two outlines the key findings of the study. Chapters three to five explore the barriers to effective implementation of PBC in more detail, with case study examples of solutions and notable practice. Chapter six makes recommendations for DH, PCTs and practices and discusses prospects for the future.

2

Key findings

- 18 This chapter outlines our key findings. The Commission's report *World Class Financial Management* (Ref. 1) identified a number of factors that are important to achieving excellence in financial management. Engagement with, and of, budget holders; clear understanding of the financial consequences of individual actions; the alignment of resources with strategic objectives; and the provision of timely and relevant information are all critical. These are no less relevant to PBC and we have considered the progress being made in PBC through this framework.
- 19 Since the publication of *Early Lessons in Implementing Practice Based Commissioning* we have identified areas where PBC is beginning to make progress. These include:
- providing GPs with an understanding of the financial consequences of their decision making; and, particularly through this
 - engaging GPs in the management of secondary care usage.
- 20 The areas that we found needed further development include:
- PCT, practice and other stakeholders' ownership of PBC;
 - PCT support to practices;
 - incentives and arrangements for sharing savings, as both are crucial to practice engagement;
 - budget setting, including the move to fair shares¹; and
 - provision and quality of data and information.
- 21 Furthermore, we identified that PBC had led to only modest steps in service redesign and that practices were more interested in increasing their own provision rather than commissioning from others. Both these points raise important issues in relation to:
- the development of sound business cases which properly assess costs and benefits; and
 - governance arrangements, including the management of potential conflicts of interest.

¹ Fair shares is where practices receive indicative budgets to provide services based on the number of patients registered and adjusted for factors such as deprivation, rather than on the basis of historical usage. This is discussed in further detail in chapter four.

Finally, in many cases PCT reconfiguration had significantly affected progress in implementing PBC.

Effective aspects of PBC

- 22 One area of obvious success for practices was gaining a better understanding of the financial consequences of their actions. Where PCTs have provided an indicative budget at the start of the year, and regular budget and activity statements thereafter, practices had been given an indication of the financial impact of their activities. This helped to inform the behaviour and decisions of practices in a number of ways. For example, it influenced the way in which they managed their patients and the types of treatments for which they were referred. In some places PCTs and practices had started to focus particularly on managing patients with long-term conditions, with a view to providing cost-effective treatments without recourse to an admission to hospital.
- 23 Through the use of Payment by Results (PbR), transparency of funding for hospital activity has also helped practices to understand the financial implications of their clinical decision making. Under PbR, tariffs have been provided for approximately 80 per cent of acute hospital activity. Therefore practices can easily identify the cost of procedures or services for their patients.
- 24 Where financial recovery was a key local objective, PBC was seen as central to encouraging practices to use resources more effectively. Two of the PCTs we visited, who were part of the national Turnaround Programme and had financial turnaround plans^I in place, viewed PBC as an important lever to financial recovery. **Case study 1** describes the emphasis Leicester PCT placed on PBC in their financial turnaround plan.

Case study 1

Leicester PCT's financial turnaround plan

Leicester PCT's turnaround plan placed clinical engagement at the heart of PCT activity. Two out of three of their plan's main aims related to managing secondary care usage, specifically reducing the impact of non-scheduled care and managing elective care through redesign of patient pathways.

^I The Department of Health established the national Turnaround Programme in 2005/06 to address PCTs and NHS trusts with significant financial problems. The aims of the programme were to identify and challenge organisations that were experiencing financial difficulties.

The PCT took a radical approach to the scope of indicative budgets, given its financial recovery position. Some of the services included are difficult for practices to manage directly, but the decision was taken by the PCT and Professional Executive Committee that their inclusion would focus practices on demand management, allow them to develop a keen understanding of health community commissioning arrangements and have some collective influence on the key aim of provision locally.

Source: Audit Commission

- 25 We also identified early improvements in practices' management of demand for acute services, particularly inpatient referrals, outpatient and follow-up appointments (elective activity) and to a lesser extent emergency admissions. Indeed, PBC was increasingly seen as synonymous with demand management, also sometimes referred to as care and resource utilisation, by both PCTs and practices.
- 26 Practices were being encouraged to control referral activity via demand management^I objectives in practice plans. Our interviews with PCTs and practices confirmed that PBC was starting to have a positive impact on elective referral patterns. Fifty-five per cent reported that there had been a positive impact on referrals and almost all had worked to reduce referral activity (**Table 3**). Our analysis of activity data on GP referrals to secondary care confirmed that there had been some reductions for specific specialities, particularly those relating to musculo-skeletal and dermatology services. This was not solely due to PBC as it works hand in hand with other initiatives, particularly PbR which also encourages PCTs to manage usage of secondary care better.

Table 3

Comments made by GPs and practice managers about the impact on referrals to secondary care since PBC was introduced

Has there been any impact on referrals to secondary care since PBC was introduced?

'Reduced follow up rates in secondary care'

'We have monitored referrals actively and critically in our practice resulting in the lowest referral rates in our PBC group'

^I Also referred to as care and resource utilisation.

‘Approximately 17 per cent reduction in referrals over the period January 2006 to December 2006’

‘Reduction in referrals for some specialities, notably paediatrics and gynaecology. Also, use of new musculo-skeletal triage service to deal with more cases within primary care’

‘Reduction in unscheduled and scheduled inpatient activity. Increase in day patient and outpatient activity’

‘Local PBC incentive scheme resulted in drop of referral rate by 20 per cent’

‘We have lowered the number of referrals to secondary care who would have needed dermatology appointments’

‘Pathways for referral discussed to ensure that the same procedures are followed by all GPs’

Source: Audit Commission Practice based commissioning survey 2007

- 27 All the PCTs that we visited viewed practices as central to the management of secondary care usage. The GPs and practice managers that we interviewed acknowledged that they were in a position to influence secondary care use directly. We found that practices were focusing on areas of routine referral activity, such as inpatient referrals, and new and follow-up outpatient appointments, that had been identified locally by clinicians as high volume and cost.
- 28 Some PCTs were regularly providing their practices with information on their most costly patients, for both elective and emergency activity. This encouraged them to review how they were caring for, and supporting, their patients. Some practices were reviewing frequent attendees at accident and emergency (A&E) departments, to investigate the reasons for each attendance; review current access levels in general practice; and examine the impact that increased access to primary care would have on A&E attendance rates. Practices were also working to set up clinical assessment units that would assess patients and decide on the most appropriate setting for treatment.

- 29 Peer to peer challenge of referral activity by practices was an important driver for demand management. Regularly provided financial and activity information underpinned this, both in terms of managing secondary care usage and, to a lesser extent, in informing practice thinking on redesigning care pathways. In many areas practices used the national PBC Directed Enhanced Service (DES)¹ payment to fund their participation in referral peer review processes.
- 30 Peer review of referrals took place at a variety of levels and involved sharing activity data to raise questions about secondary care usage. In its simplest form, it involved GPs within a practice comparing, and where appropriate, querying their respective referral rates. At one consortium we visited, monitoring took place at consortium level and a nominated lead GP visited each practice to discuss and challenge referral rates. As a result, elective activity referrals began to reduce across their practices. Many practices were comparing their referral rates with the PCT average, resulting in the development of practice- or consortia-wide referral protocols to promote the adoption of a consistent approach.
- 31 Practices also told us that they were drawing on their experience of budgets and associated incentives to support better prescribing. They recognised that a number of characteristics of that policy should be transferred to PBC, such as clearly understood budgets, the provision of good quality information, and incentives for practices to help them to deliver savings and remain within their budgets.

Aspects for further development

- 32 We found that a strong sense of ownership of PBC had been developed in and between many practices, particularly where there had been a prior history of working together. However, a shared sense of ownership and agendas between practices and PCTs, including links with secondary care and between practices and PCTs' public health functions, was often less well developed. Our study found that a genuine partnership approach, alongside good leadership from the PCT and sound PBC infrastructure, were key to implementing PBC. Partnerships with secondary care and local authorities were generally in the early stages of development or non-existent.

¹ The Directed Enhanced Service was a payment offered by PCTs to practices during 2006/07 (Ref. 8). It was designed to accelerate GP engagement in and delivery of PBC. This is discussed in further detail in chapter three.

- 33 Practices need to be engaged in PBC to help PCTs to achieve better use of resources. There was significant variation in how and whether practices were engaged in PBC. Our research found that PBC tended to be led locally by a small number of enthusiastic GPs, and that financial incentives alone were not sufficient to engage other practices.
- 34 Arrangements for monitoring and measuring the performance of PBC were generally weak. Only limited elements of a risk management approach had been implemented by PCTs, and in particular there were no early warning arrangements to alert them to significant variation in performance against plans. We also found that practices had a limited understanding of risk management arrangements.
- 35 PCTs experienced considerable difficulty in setting indicative budgets and providing these to practices in a timely way, and in planning the move to fair shares budgets. Practices tended to have a limited understanding of both the budget setting methodology and the timetable for moving to fair shares.
- 36 There were significant problems with the provision of secondary care activity information to practices to support PBC. Practices were particularly concerned about the quality of data that they had access to. In addition, we found that few PCTs had implemented data capture arrangements to monitor service redesign initiatives that were implemented in primary care and community settings.
- 37 In April 2007 the DH published figures indicating that all PCTs had achieved universal coverage¹ by December 2006. Their figures, based on data collected from SHAs, were designed to give an indication of PCTs' progress towards putting in place the arrangements to support PBC. While this data claims that universal coverage had been achieved, our findings about practice budgets and information do not support this. We found that many of the PCTs we visited were not adequately satisfying all of these requirements.

¹ Universal coverage is about PCTs putting in place the arrangements to support PBC. These include providing practices with the budgets, information, incentives and accountability and governance arrangements to take on PBC.

38 The scale of service redesign achieved through PBC has been modest so far. Where service redesign had occurred, it was small-scale and localised and was sometimes attributable to previous primary care led initiatives that predated PBC. Practices had a preference for developing and providing new services, rather than for commissioning them. Service redesign and direct provision of service, that is where the practice effectively commissions itself to provide the service, both raise important financial management questions relating to the soundness of business cases and of the governance arrangements that apply to PBC. We found that arrangements for assessing the cost effectiveness of business cases and new services were underdeveloped. In addition, while many PCTs had implemented reasonable governance arrangements, processes to mitigate potential conflicts of interest were largely untested.

PCT reconfiguration

- 39 We visited nine PCTs that were reconfigured from 1 October 2006 and found that implementation of PBC had effectively stalled in these new bodies in the period immediately following reorganisation, but was now being reinvigorated. Two of the trailblazing PCTs we visited for our *Early Lessons in Implementing Practice Based Commissioning* report and again for this report, had subsequently become part of reconfigured bodies and were effectively starting from scratch.
- 40 Organisational developments, and staff changes in particular, often resulted in an inability to make decisions and impeded progress. The main difficulties that both PCTs and practices reported were indicative budget setting, the often considerable delays experienced in providing budgets to practices, and the provision of monitoring information on a regular and timely basis. This was primarily because the new bodies were in the process of either unifying or implementing new budget setting and information arrangements. Practices also indicated that they were experiencing delays with the approval of practice plans and business cases, largely because some relevant key posts remained unfilled and therefore decisions could not be taken.

- 41 When we visited these newly formed bodies, we found that PCTs and their constituent practices were in the process of developing, agreeing and embedding a common approach to take PBC forward. In some cases, this involved drawing on tried and tested approaches from one of their predecessor organisations. However, this sometimes created local tensions that required negotiation. In developing a common framework, the major obstacles that these new organisations faced included aligning and agreeing on:
- the overall framework of rules and procedures within which PBC is implemented, including local incentive, management allowance and governance arrangements;
 - different budget setting methodologies;
 - practice budget and activity monitoring report formats, including the provision of benchmarking data;
 - arrangements for IT systems to support PBC; and
 - the support being offered to practices by the PCT.
- 42 The following chapters concentrate on those areas that need further development.

3

Ownership, support and incentives

- 43 Getting the proper engagement of budget holders is fundamental to successful financial management. Fostering an organisational culture, in which there is individual and collective responsibility for the stewardship and use of resources, is essential for good financial management (**Ref. 1**). These points are no less true for PBC. To do this:
- shared ownership needs to be fostered between practices, PCTs, secondary care and local authorities, along with adequate PCT support; and
 - appropriate incentive and savings arrangements need to be in place.

Ownership

- 44 For PBC to function effectively, shared ownership and agendas need to be developed between PCTs and practices. In addition, PCTs need to provide adequate support to practices. Strong ownership needs to be developed at a number of levels, especially between:
- practices, particularly those organised into groups or consortia;
 - PCTs and practices, including the PCTs' public health functions;
 - PCTs, practices and secondary care; and
 - PCTs, practices and local authorities.
- 45 In most of the PCTs we visited, the majority of practices had joined into groups often referred to locally as clusters, consortia or localities. Practices felt, first, that they would have more influence over PBC developments as a group rather than as a single entity; and, secondly, that collectively they would have greater capacity for implementation. Ninety-five per cent of respondents to our PBC survey indicated that their group of practices had decided among themselves to join together (**Case study 2**).

Case study 2

Walsall PCT's approach to engaging GPs

At Walsall PCT, four clusters emerged that were based on similar geographical networks as the former primary care groups. Importantly, no cluster leads were identified, as practices felt that it was important for all GPs to have an equal say and be actively involved. All practices are working to a generic PBC business plan, with demand management a key priority for action to prioritise outpatients and emergency admissions for service redesign, thus helping to achieve shared goals agreed with the PCT.

Source: Audit Commission

- 46 One of the benefits of groups and consortia is that resources can be pooled. This approach was taken by consortia in Bristol PCT which pooled their DES payment in 2006/07, allowing them to fund management costs and other activities such as the audit of referral activity data. **Case study 3** further demonstrates the benefits of pooled resources.

Case study 3

Sutton and Merton PCT's approach to DES pooling

In Sutton and Merton PCT, which was part of the national Turnaround Programme, practices had organised themselves into four consortia. Each consortium not only pooled their DES payments, but also the additional management costs they received from the PCT. This enabled them to fund the recruitment of a full-time senior manager to provide leadership for PBC, administrative support, and a data analyst to work on the provision of accurate activity information.

Source: Audit Commission

- 47 The relationship between PCTs and their practices is fundamental to the successful implementation of PBC. In particular, key areas of joint working include:
- developing practice plans and business cases;
 - developing and agreeing an incentive framework;
 - developing and agreeing indicative budgets;
 - working with PCT public health functions to understand health needs so resources can be deployed most effectively; and

- providing support to practices.

- 48 The DH's June 2007 GP practice survey revealed that 7 per cent of practices rated their relationship with their PCT as very poor and 18 per cent as fairly poor (**Ref. 2**). Throughout our interviews with PCTs and practices, we found that implementation was helped by a history of joint working, both between PCTs and practices and between practices themselves. Indeed, many of the clusters or consortia were identical or close to former primary care group structures precisely because practices had previously developed professional relationships and collaborative experience. They could, therefore, more easily progress the development of their overall approach to PBC and the development of PBC plans. We noted that, where PBC was being implemented successfully, there was alignment of and strong involvement from PCT finance, commissioning and information departments. We also observed that, at the more advanced sites, PBC was being led or significantly overseen by the PCT director of finance or commissioning. This demonstrated that PBC is more easily implemented where senior members of staff show their support and engagement.
- 49 Ownership of the PBC agenda is an important determinant of genuine GP engagement. In *Early Lessons in Implementing Practice Based Commissioning* we reported that PCTs that have been more successful at engaging clinicians have tended to adopt a flexible leadership style – guiding, facilitating and supporting practices (**Ref. 7**). Where PCTs were perceived to be controlling or imposing the local approach, practices tended to be less enthusiastic or even reluctant to be involved. Many believed that PCTs were unwilling to relinquish control, and were stifling practice enthusiasm for PBC and innovation in service redesign. Although this feeling was common across all the PCTs we visited, it was particularly strong among practices where their local PCT was facing financial difficulties. In addition, some practices reported tensions between the PCT responsibility for meeting the needs of the wider local population and practices' focus on their patients' needs.
- 50 However, there are good reasons why certain functions and systems are based at PCT level, not least because it would be inefficient for individual practices to duplicate these systems. PCTs and practices need to work together to identify which tasks are most efficiently done at each level.

- 51 PCTs have a statutory responsibility to achieve financial balance and practices that accept an indicative budget have a responsibility to manage within it over the course of the financial year. As a result, both need to work together throughout the year to ensure that resources are properly monitored and controlled; that freed-up resources are effectively deployed to benefit patients locally; and that PCTs achieve financial balance. This is discussed in more detail in chapter four.
- 52 The role of public health and public health data is critical if practices are to deploy their resources effectively and if allocation of funds is to match the strategic objectives that the PCT has set for addressing health inequalities. PCTs therefore need to make public health data and support available to practices to inform their delivery plans. Delivery plans and business cases also need to be assessed against their capacity to reduce health inequalities.
- 53 Almost one-half of respondents to our PBC survey indicated that they were using public health data to inform how they used their resources. However, the evidence from our fieldwork visits indicated that the provision of practice level public health information was very limited. Although most of the practices we interviewed were aware of their PCTs' public health work, we found few instances where there was a systematic link between practices and public health specialists. There is a risk that resources will not be aligned with strategic objectives and priorities unless there are good links between public health specialists and PBC. We came across one example where this is taking place at North East Lincolnshire PCT (**Case study 4**).

Case study 4

North East Lincolnshire PCT's approach to providing public health advice to practices

North East Lincolnshire PCT has sought to integrate public health advice into each of its primary care health teams (consortia of practices) by attaching public health advisors to each team. The advisors take a proactive approach to working with local practices to inform them of the health needs of the population they serve.

More recently the PCT's public health department has become part of the local authority and this allows public health advice to also incorporate other areas related to health and well-being such as local housing policy, the local environment and links with law and order.

Source: Audit Commission

- 54 Similar points arise in respect of PBC and local authorities. DH policies, set out for example in *Our Health, Our Care, Our Say* (Ref. 9) have increasingly emphasised the importance of PCTs and local authorities working in partnership to commission services, promote health and well-being and address health inequalities. The Local Government White Paper, *Strong and Prosperous Communities* (Ref. 10), reaffirmed this. Unless practices properly engage, the resources that they control will not be used to support wider strategic priorities set by the PCT and local authority on the basis of their Joint Strategic Needs Assessment¹. Moreover, opportunities to pool funds and jointly commission services more effectively will be lost.
- 55 In our interviews with practices, very few indicated that they were working with local authorities to plan and deliver services. This view was supported by our survey findings, with 78 per cent of respondents also indicating that they were not working with local authorities to deliver services under PBC. However, we came across one example in the early stages of development at Leicester PCT (Case study 5).

Case study 5

Leicester PCT's approach to working with a local authority

Leicester City PCT was in the early stages of implementing an integrated approach to intensive case management for patients with a high risk of admission. They were working towards fostering links between practices and the local authority, and had set up a steering group comprising:

- GP representatives from each of the PBC consortia;
- a senior manager from Leicester City Council;
- a community nurse manager;
- a district nurse;
- a community matron; and
- the PCT's assistant director of service redesign.

¹ The Commissioning Framework for Health and Well-being proposed to establish a duty on PCTs and local authorities to produce a joint strategic needs assessment. A good strategic needs assessment should be based on a joint analysis of current and predicted health and well-being outcomes, an account of what people in the local community want from their services, and a view of the future, predicting and anticipating potential new or unmet need.

The group was in the process of developing a business case for piloting the ‘Unique Care’ approach¹. It seeks to assist primarily older people with complex health and social care needs who are often admitted to hospital as emergency cases because the necessary coordinated support to help them in their homes and communities is not available.

The steering group’s business case will include an estimate of the reduced level of admissions and therefore the expected level of financial savings. They were collecting data on patients identified as high risk, and simultaneously determining the level of health and social resources required and how that support would be made available to patients in the community.

The approach is based on the Castlefields approach to case management, and has been developed by the Improvement Foundation working with PCTs, acute trusts, practices and local authorities across the UK. There are currently 35 active sites across England, at different stages of implementation. Sites range from a whole PCT and local authority working together through to single practices working with one social worker.

The approach involves introducing new ways of working that:

- ensure local health and social services work side by side to effectively coordinate care;
- establish communications between GPs, community nurses and social workers;
- establish in-reach systems in hospitals to ensure patients return home as soon as they possibly can; and
- constantly adapt to respond to the individual needs of patients and support people to live at home.

Impact achieved at sites ranges from 15 to 25 per cent reductions in unplanned admissions and 20 to 40 per cent reductions in bed days.

Source: Audit Commission and Improvement Foundation

¹ This approach brings together social services and healthcare in order to jointly respond to the needs of individual patients. The aim is to bring together person-centred, cost-effective care closer to home. Further details are available at www.improvementfoundation.org.uk.

Support

- 56 Local PBC frameworks, developed jointly by PCTs and practices, set out exactly the types of support that the practices should expect to receive from PCTs. Where such frameworks existed, PCTs typically offered support on budget matters; information provision and analysis; the development of practice plans; and business cases.
- 57 We examined the level and types of support being offered by PCTs. The PCTs we visited had already given consideration to restructuring existing staffing roles and structures to support practices. Others, particularly newly reconfigured organisations, were in the process of doing so. The types of support that practices most wanted included funding to support time away from patient appointments, to allow them to be involved in demand management and care pathway work, and for pump-priming or invest-to-save schemes to support service redesign. Practices also indicated that they required additional analytical capacity to provide meaningful activity analyses and assistance with data validation. Furthermore, many, particularly those who had organised themselves into consortia, indicated a preference to obtain funding to make their own arrangements.
- 58 Two thirds of practices in our survey reported that their PCTs were offering them support to implement PBC. Some PCTs had redirected existing, or had appointed new, staff as dedicated managers to support individual practices or groups of practices on all aspects of PBC, often covering certain geographical areas or specific groups of practices. Others had allocated existing staff, particularly from their finance, information and commissioning departments to support practices. **Case study 6** describes Bradford and Airedale Teaching PCT's approach to supporting practices.

Case study 6

Bradford and Airedale Teaching PCT's support to practices

Bradford and Airedale Teaching PCT has provided substantial support to its four PBC Alliances (consortia) and their constituent practices. The PCT has established a budget to fund Alliance general managers and their teams. Additionally, the PCT is funding support for each of the Alliance's GP leads on the basis of three clinical sessions per week for each, to support the leadership and development of the Alliances.

Source: Audit Commission

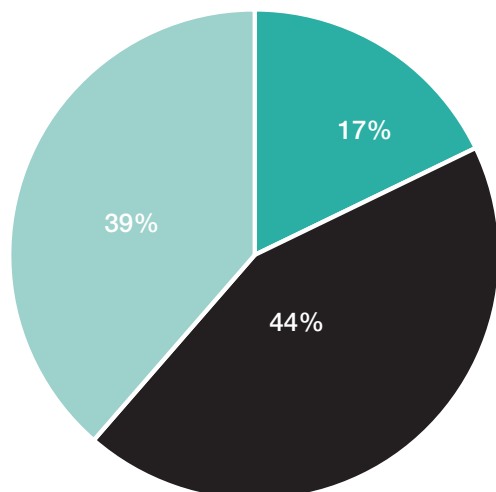
However, many of the practices we interviewed felt that the PCT support being offered to their practice or group of practices was inadequate. This was corroborated through our survey where over three quarters of respondents made similar points.

- 59 The majority of practices we interviewed reported a lack of resources and time to implement PBC. This view was supported by the responses in our PBC survey. Less than one fifth of practices reported that they had sufficient capacity both to manage an indicative budget and to monitor activity (**Figure 1**). Where progress had been made, the main reason for this was that practices were motivated by a genuine desire to improve services for patients. However, they also indicated that this largely relied on their goodwill and enthusiasm.

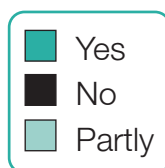
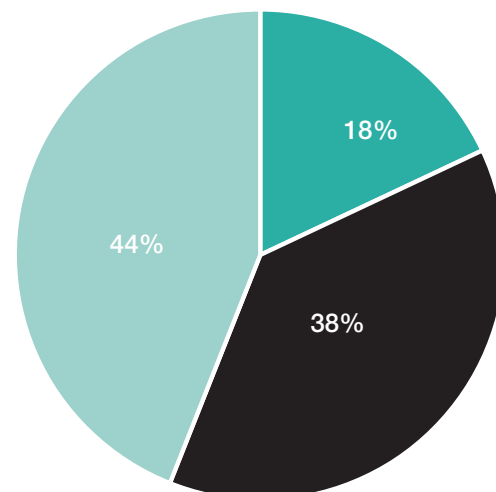
Figure 1

Practices' views on whether they had sufficient capacity to manage an indicative budget and to monitor activity

To manage an indicative budget



To monitor activity



Source: Practice based commissioning survey 2007, Audit Commission

60 Nearly three quarters of practices reported that their PCTs were not supporting them to build capacity to implement PBC. While few of the PCTs we visited had formally identified training needs around PBC, almost all had organised training workshops to fill knowledge gaps. These shared learning events offered the opportunity to bring PCT staff and practices together to develop a shared understanding of the importance of the commissioning changes being introduced through PBC. For example, North East Lincolnshire PCT provided training to local practices to improve their understanding of PbR, and specific sessions on how to use the information that they received on emergency admissions and on patients who were frequently admitted to hospital.

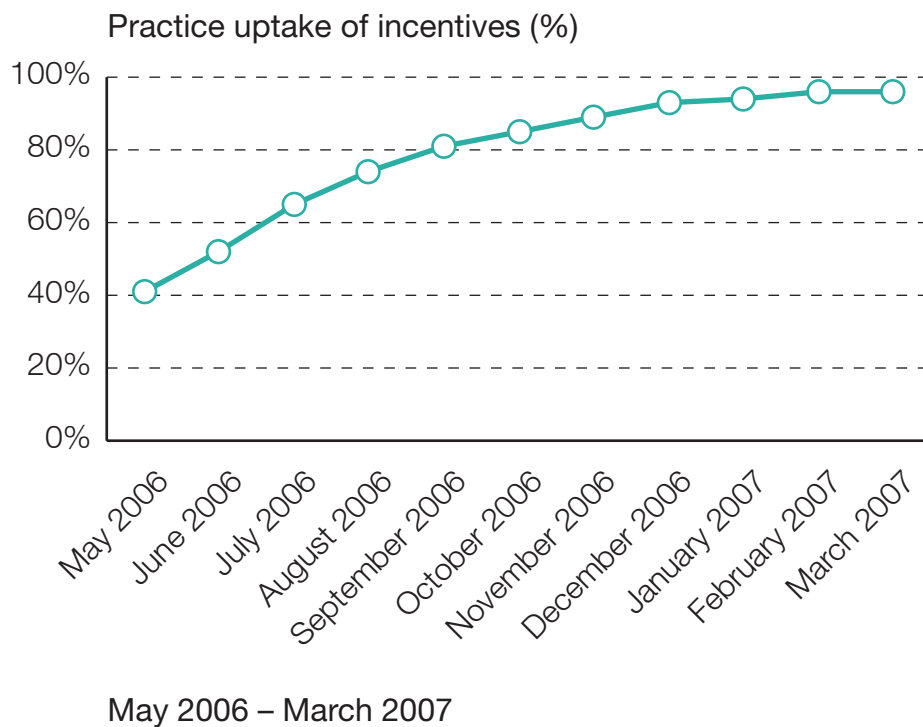
Incentives

- 61 In our previous report (**Ref. 7**) we indicated that national take up of PBC by practices was patchy in its first year of implementation during 2005/06. Our research indicates that, in most places, implementation of PBC only developed momentum during 2006/07. This was in part due to a previous lack of incentives to encourage practices to take up PBC.
- 62 To prevent this trend continuing, the PBC DES scheme was offered to practices by PCTs in 2006/07. The DES was made up of two components payable separately. The first component entitled practices to 95 pence per registered patient in recognition of the need to support them with the development and implementation of locally agreed plans. If, through a process of review, PCTs determined that practices had delivered the objectives set out in the plan, they were entitled to component two. Component two was a minimum of 95 pence per registered patient, which had to be reinvested in practice activity for the benefit of patients locally.
- 63 Using the uptake of DES as a proxy measure to indicate practice level engagement, figures published by the DH (**Figure 2**) indicate that in April 2007, 96 per cent uptake of PBC was achieved across England. However, this figure must be interpreted carefully, as the initial DES payment is made on the basis of practices signing up to PBC. Genuine engagement, however, requires practices to be actively managing indicative budgets.

- 64 The DH have estimated a minimum total cost of £49 million for component one. The actual total cost may, however, be higher as this value does not include additional local incentives arrangements provided by PCTs^I. An estimate of the total cost of component two payments is in a similar range^{II}. Therefore, a conservative estimate of the total cost of engaging practices and incentivising them to deliver the objectives of their plans amounts to approximately £98 million.

Figure 2

Practice uptake of Directed Enhanced Service for PBC



Source: Department of Health: Departmental Report 2007

- ^I At a minimum, local incentive payments had to be of equivalent value to the DES, so can be counted as part of a minimum estimated cost. However these arrangements vary as they are subject to local determination and the costs are unknown.
- ^{II} Practices are entitled to retain, for reinvestment in patient care or other practice activity which supports the continued delivery of objectives, a minimum of 95 pence per patient from the resources their plan has released, (and therefore is cost neutral). Component two payments are designed to incentivise GPs but are for reinvestment in patient care for the benefit of the practice population rather than being direct income for the practice, like component one.

- 65 From our fieldwork, we identified significant variation in whether and how practices engaged in PBC. In our PBC survey, we asked practices to rate their level of engagement in PBC. While almost two thirds of respondents indicated that they were either totally or significantly engaged in implementing PBC, one-third indicated that they had a minor level of involvement and the remainder (4 per cent) said they were disengaged. We found that where there was a history of good relationships between PCTs and practices, there were higher levels of engagement. Typically PBC was being led locally by small cadres of enthusiasts, working with like-minded PCTs. Former GP fundholders or those previously involved in Locality Commissioning tended to be among the greatest enthusiasts, whereas single-handed practices were generally less willing to participate.
- 66 There were a number of reasons why GPs were, or were not, involved in PBC. The main reason for involvement according to GPs and practice managers was the opportunity to make a difference for their patients by freeing up resources to reinvest in primary care services. However, other factors also played a part, including the provision of the DES and local financial incentives; the potential threat of new entrants into primary care from the private sector; and the opportunity to regain some control and/or influence over commissioning from PCTs.
- 67 Practices that were enthusiastic about taking up new opportunities or were innovative in their approach tended to be those that were leading implementation locally, either as single entities or within consortia. They also tended to have more capacity to manage implementation, and were often multi-partner rather than single-handed practices.
- 68 The second component of the DES was conditional on the delivery of practice plan objectives. However, despite this, one PCT paid both components to practices in-year, even though these payments were linked to the delivery of specific objectives and targets relating to performance across the entire financial year. More commonly, PCTs had set up performance review arrangements to assess practices' eligibility for delivery related incentive payments at the year-end.
- 69 Most PCTs had used the PBC DES as a stand alone incentive, rather than combining it with their own local arrangements to fully or significantly fund the time and resources required by practices to engage in and develop PBC plans.

70 Fifty per cent of practices reported that their PCT had provided a local incentive scheme in addition to the PBC DES for 2006/07. These incentives varied greatly, with 37 per cent of practices indicating they were in the form of management costs; 17 per cent responding that their incentive was in the form of reinvestment of savings; and 13 per cent saying that they were in the form of a combination of both. However, 28 per cent of practices indicated that they received an incentive that was neither in the form of management costs or reinvestment of savings, but instead was payment to fund specific aspects of PBC such as GP attendance at relevant meetings (to provide cover in practices) or to engage in demand management¹. When we asked practices if they were sufficiently incentivised to engage in PBC, more than two thirds said they were not. The reasons for this are shown in **Table 4**.

Table 4

Comments made by GPs and practice managers about why they were not sufficiently incentivised to engage in PBC

If you think your practice was not sufficiently incentivised, please indicate why?

‘Current levels of support do not provide enough to recognise GPs’ time and expertise. Most important is the fact that this takes away clinicians’ time in caring for patients’

‘Incentives would come from a feeling of improving services, and making savings’

‘The PCT is unwilling to divulge any PBC savings to the practices that made savings’

‘There is a huge amount of work for the doctors/practice managers, papers to read are excessive. It takes us away from clinical care. The management allowance won’t even cover the time to read the paperwork let alone do anything!’

‘No time and no funds to look into new pathways or manage budget’

‘The current programme will cost this practice more than twice what will be received in payment through the incentive. Ideally the service redesign should make up the shortfall but the incentive is not slanted towards achievement of service redesign; it feels more like paper pushing and data gathering’

Source: Practice based commissioning survey 2007, Audit Commission

¹ The remaining 6 per cent is accounted for by practices stating their local incentives comprised the following categories: management costs and other; return on savings and other; and a combination of all three.

- 71 There are currently other, stronger, incentives in primary care to motivate GPs, and therefore detract attention from PBC. A number of GPs and practice managers specifically cited the new General Medical Services (nGMS) contract as their main incentive. The Quality and Outcomes Framework (QOF) under nGMS provides direct financial incentives for nGMS practices to meet specified quality standards and GPs can increase their practice income through the achievement of high scores. PCTs and practices need to have a clear understanding about the linkages between nGMS, local prescribing schemes and PBC.
- 72 The biggest threat to the long-term success of PBC was from potential disengagement of practices. There were three main aspects to this. The first related to PCTs' inability to demonstrate the impact of PBC, both in terms of clinical outcomes and financial performance.

'There is minimal active engagement in PBC at grass roots level with practices going through the motions collecting what money is available, but without being actively engaged in the process which is largely being dragged along by enthusiasts and the PCT.'

Senior partner at general practice

Source: Audit Commission Practice based commissioning survey 2007

- 73 Secondly there was concern among some practices that there would be a policy change if PBC was seen as failing to achieve its objectives, and therefore that any time and effort invested in implementing PBC may be wasted. This point was also echoed by some respondents to our PBC survey.

'The future of PBC lies in the balance at the moment; there is very little enthusiasm for the process, but an acceptance that GPs are being forced down this road. Without tangible benefits, achieved within the next three to six months and a commitment from the DH to fund the work required and return savings to practices as agreed, the process will break down. I write this as an executive member of the local PBC consortium and an enthusiast for what I see as a potentially very beneficial system. I do have many colleagues though with grave misgivings and "the stick" alone will not support PBC for very much longer.'

Principal GP, PBC lead

Source: Audit Commission Practice based commissioning survey 2007

Both these points can be addressed through clear leadership and commitment from the DH and PCTs, as well as the achievement of service improvements as the system beds in.

- 74 The third point concerns savings. An important incentive for practices is the opportunity to use any savings to develop new services. DH guidance states that savings through PBC may only be reinvested for patients services (**Ref. 11**)¹. It is left up to PCTs and practices to locally determine exactly what they can be used for. However, in our survey 74 per cent of practices reported that there were no clear guidelines from PCTs for identifying and sharing savings, a finding supported by our interviews. Initial guidance from the DH on the sharing of savings between PCTs and practices was considered unclear, creating conflict and uncertainty. PCTs and practices themselves could determine the amount of savings that could be distributed and the areas where these could subsequently be spent (**Ref. 11**). However, more recent guidance (**Ref. 12**) states that practices are entitled to at least 70 per cent of any resources released for reinvestment in patient care. The remaining 30 per cent (or less) can be used by the PCT at its discretion. Unplanned efficiency savings are also subject to these rules, and in these circumstances the practice must agree with the PCT which additional objectives will be met with the funds.
- 75 The guidance further states that it is unacceptable for PCTs to withhold these savings and that indicative budgets should not be top-sliced to resolve PCT overspends (**Ref. 12**). Therefore, in applying the guidance, some PCTs may have to resolve financial difficulties while simultaneously handing back savings to practices. However, in PCTs that are subject to special circumstances, PCTs and practices have a shared responsibility to achieve financial balance (**Ref. 12**).
- 76 As part of our follow-up work at the end of 2006/07, we found that only three PCTs had actually identified and planned to share savings achieved through PBC. Practices were very aware of their entitlement to savings, in line with DH guidance, and this created particular tensions between PCTs and practices where the local health economy was in financial difficulty. In these circumstances, there was real uncertainty among practices as to whether the PCT would actually share savings if they arose. For this reason many of the practices we interviewed told us they could not see the benefit for their patients of participating in PBC.

¹ This does not preclude the use of resources for capital development where such a development would enable a wider range of services to be provided than is currently the case, and to a wider than practice population (**Ref. 10**).

- 77 We found that PCT arrangements for identifying and agreeing savings were underdeveloped and largely untested. This was partly because most of the PCTs we visited were in their first year of implementing PBC. We identified that there were several difficulties in measuring savings generated through PBC, particularly those achieved through demand management, as it was often difficult to prove that changes in secondary care usage directly relate to the actions of practices.
- 78 However, this was less problematic where changes were directly linked to the objectives set out in PBC or local service improvement plans. At one site there was a disagreement between the PCT and practices about the extent to which practices had contributed to savings achieved through reduced outpatient activity. The PCT challenged practices to provide evidence that they had made the savings, because in its view savings had more likely been the result of service changes at the local acute provider. Unless PCTs and practices have clear arrangements in place for identifying and agreeing savings, including how to deal with areas where it is not possible to attribute changes to PBC, confusion about sharing savings is likely to persist. An example of a good policy on the sharing of savings is described in **Case study 7**.

Case study 7

North East Lincolnshire PCTs' policy on sharing savings

North East Lincolnshire PCT has set out its approach to the identification and sharing of savings in its handbook for practices. It has identified two categories of 'resources freed up' (RFU) within practice-held commissioning budgets:

- resources not used within budgets at year-end (under-spend); and
- planned RFU forecast through service improvement plans.

For both categories, PCT sets out clearly to practices exactly how and when it will determine the level of RFU achieved, the proportion that will be shared and lists the priorities for investment that these may be used for, which also applies to the PCT's share of RFU.

Source: Audit Commission

Summary

- **Ownership and support** – genuine PCT/practices partnerships are needed, with PCT leadership and provision of a sound infrastructure, as incentives alone are not sufficient to engage practices. Practices need to develop an outward looking approach, engaging with other practices, the PCT including on public health issues, secondary care and local authorities.
- **Incentives** – measuring and monitoring the impact of PBC needs to be improved, a clear understanding of the linkages between the nGMS contract, local prescribing schemes and PBC should be developed, and PCTs should have a clear policy on sharing savings with practices.

4

Budgets, plans and information

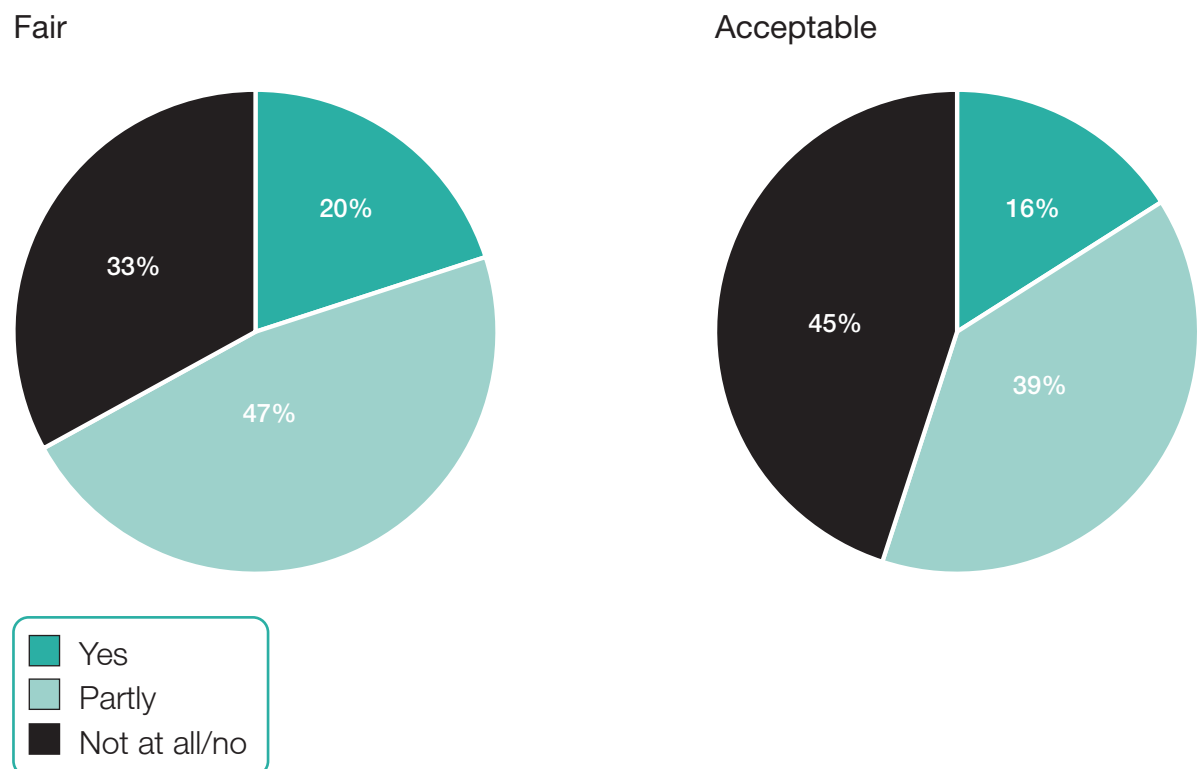
- 79 The basic ingredients of good financial management include: engagement with and of budget holders; clear understanding of the financial consequences of individual actions; and provision of timely and relevant information. For PBC this means that practices:
- should be provided with indicative budgets and understand how they have been derived;
 - should ensure that their plans and business cases are robust, aligned with strategic priorities, and reviewed on a timely basis to encourage the development of innovative, high-quality services; and
 - are provided with timely and accurate information on patient activity and finances.

Budgets

- 80 Under PBC, PCTs are required to provide practices with indicative budgets at the beginning of the financial year (**Ref. 13**). These should be set on an individual practice basis, and not consortia level (this is because practices are the recognised legal entity). Indicative budget statements should also provide practices with information on their share of the PCT's overall resources.
- 81 Practices and PCTs are expected to work together throughout the year for a number of purposes. These include ensuring that resources are properly monitored and controlled, and that any savings generated are effectively redeployed to benefit patients locally. Initial guidance from the DH required practices to balance their indicative budgets over three years, with PCTs able to remove their right to hold a budget if they failed to do so (**Ref. 11**). This was seen by many as being incompatible with PCTs' statutory duty to stay within annual revenue resource limits. More recent guidance has sought to resolve this issue by requiring that PCTs and practices work in partnership throughout the year to ensure that resources are properly controlled and so that PCTs achieve financial balance (**Ref. 12**).
- 82 In the past, budgets have been set largely on the basis of historical activity. However, this approach favoured those with high referral rates and penalised practices that managed their referral and admission activity. Under PBC, PCTs have a responsibility to ensure that resources are distributed to practices in a fair and transparent manner, using a method which is understood by and acceptable to practices.

83 During our research concerns were raised both by PCTs and practices about the derivation and complexity of the budget setting methodology. Only 17 per cent of practices indicated that they understood the method used, with 48 per cent having a partial understanding and the remaining 36 per cent none at all. Many practices reported that their PCTs had not explained the methodology used. In addition, 45 per cent of practices felt that the methodology was not acceptable and 33 per cent thought it was not fair (Figure 3). The reasons given for this often related to the relative position of the practice in relation to its peers and whether it traditionally made less use of secondary care or had made savings earlier (Table 5).

Figure 3
Practices' views on the acceptability and fairness of the indicative budget setting methodology used by PCTs



Source: Practice based commissioning survey 2007, Audit Commission

Table 5
Comments made by GPs and practice managers about the acceptability and fairness of the methodology used to determine practice budgets
If you think the methodology used to determine practice budgets was not acceptable and/or fair, please state why?

‘My practice is being penalised as we were low spenders before PBC came in so indicative budgets are low’

‘Those like us who did engage in PBC in its first year and made savings lost out in the following year as budgets were based too highly on historic data; benefiting the poor/unengaged practices’

‘It is based on historical spend so favours high referring practices. The playing field will be levelled when budgets are based on weighted capitation’

‘This area has been under-resourced historically, and, because of its rurality, we have been doing much more in-house anyway, and so we have spent less. We must get a fair shares budget otherwise we will be penalised for having been good. This we have not had’

‘Budgets were purely based on historical activity, with no relation to prevalence of disease, demography etc’

Source: Practice based commissioning survey 2007, Audit Commission

- 84 The DH has issued detailed guidance on setting indicative budgets. However, PCTs cited a number of difficulties following the DH methodology, including:
- the recommend base year for calculating activity data was not considered to be an accurate reflection of usage;
 - adopting the approach precisely resulted in unaffordable budgets;
 - the accuracy and/or unavailability of the necessary supporting activity information created problems for budget setting;
 - the prescribed period of historical activity was not an accurate reflection of usage; and
 - uncertainty about the future of the methodology.

Because of these difficulties, PCTs chose to adopt elements of the guidance rather than the entire approach. A few PCTs approached and obtained approval from their SHAs to deviate from the methodology.

- 85 The majority of practices we interviewed indicated that they had received an indicative budget for 2006/07, though two PCTs told us that they were operating PBC budgets informally during 2006/07. However, almost one third of practices that responded to our survey indicated that they had not received an indicative budget. When asked why they had not received one, many reported that they had asked for their budget, sometimes repeatedly, but were unclear as to why it had not been provided.
- 86 Clearly PBC cannot operate if budgets have not been provided. Some practices reported that they did not receive their indicative budget until part way through the financial year, owing to difficulties that their PCT was having in determining it. Practices were therefore unable to manage and take responsibility for their indicative budgets until this point. This not only dampened practice enthusiasm, it potentially also limited their ability to manage demand and generate savings.
- 87 Our research has identified that PCTs with effective processes in place to support the system for devolving indicative budgets had:
- made the budget setting methodology explicit in their accountability agreements with practices and had undertaken this process in consultation with them to ensure transparency;
 - set out their intentions regarding the introduction of weighted capitation budgets (fair shares) and the arrangements for the intervening period, for example, rolling forward existing budgets and adjusting for inflation and changes to list sizes; and
 - set out other elements such as pathology, radiology and community services, or accident and emergency attendances, that would be added to the PBC budget in future with the consent of practices.
- 88 The approach Redbridge PCT has adopted to setting indicative budgets promotes transparency (**Case study 8**). It is important that practices understand how budgets are set to ensure that they are engaged in PBC.

Case study 8

Redbridge PCT's PBC budget setting approach

At Redbridge PCT, its PBC clusters had been provided with indicative budgets for 2006/07 from April 2006. The model and process of budget setting and reporting was described fully in the Accountability Agreement between the PCT and its clusters. For 2006/07, budget setting was informed by historical activity levels. Historical activity was averaged over two years to dampen the effect of variability at practice level between years. The activity was weighted using the 2006/07 tariff structure to derive a case mix adjusted weighted activity share.

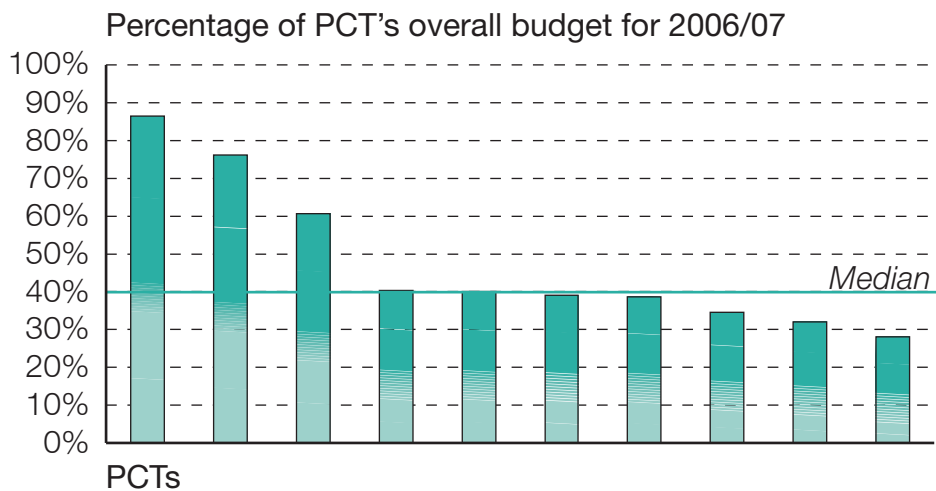
The PCT also undertook a robust exercise to make adjustments for changes in practice list size when setting the budgets on a historical basis. Before the final budgets were set for 2006/07, a separate exercise was undertaken to compare Hospital and Community Health Services weighted list size of each practice. Data was then used to generate an index that was applied to the historical activity based budget to reflect changes in list size and demographics.

Source: Audit Commission

- 89 Early DH guidance (**Ref. 11**) allowed PCTs and practices to determine the scope of indicative budgets. Subsequent guidance (**Ref. 3**) suggested that, as a minimum, all hospital based care, prescribing, community services and mental health costs should be included. Throughout our visits, we found that most PCTs had largely followed the spirit of the national guidance on indicative budgets, by excluding elements such as core General Medical Services^I and Personal Medical Service^{II} budgets. However, there was wide variation in the overall proportion of PCTs' total commissioning budgets for 2006/07 devolved to practices in the form of indicative budgets (**Figure 4**).

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- I General Medical Services are those services provided under the new general medical services contract. All local primary healthcare providers are required to provide essential services, as defined in the contract, as well as additional and enhanced services.
 - II Personal Medical Services are those services provided under personal medical services contracts. They aim to encourage innovation in service improvement among primary care professionals, to meet local needs better and address inequalities in healthcare provision.

Figure 4
Scope of PBC indicative budgets



Source: Audit Commission

- 90 We asked practices whether their indicative budgets covered the entire scope of health services that could be included. Sixty nine per cent of respondents in our survey reported that they did not. Mental health, continuing care and community services were the most common areas of activity that were not covered. Seventy-four per cent also reported that they did not have a role in determining the scope of health services included in the indicative budget. One of the PCTs that we visited had atypically excluded A&E and prescribing. Over time, as practices develop more confidence in budget management, we would expect PCTs to ensure that all these elements are included.
- 91 In 2005 the DH set a timetable for PCTs to move their indicative budgets towards a fair shares approach by 2008. Fair shares is where practices receive budgets to provide services, based on the number of patients registered and adjusted for factors such as deprivation. Actual usage of services is not a factor in setting the budget, thereby resolving tensions between high and low referring practices. Practices should be provided with information on their target fair share of the PCT's resources, so that they can see whether they are receiving the appropriate level of resources for their registered population.

- 92 The DH is currently evaluating and reviewing options for a fair share budget setting methodology for 2008/09.^I In the interim it has developed a toolkit for PCTs to use.^{II} While some PCTs had carried out financial modelling of the implications of moving practice budgets to fair shares, many had yet to do this analysis and therefore had not considered setting and agreeing a timetable with their practices. Eighty-three per cent of practices that responded to our survey indicated that they did not know what their practice's budget allocation would be under fair shares. In addition, the absence of an established methodology created uncertainty for PCTs, with many deciding not to proceed until further guidance was issued.
- 93 Inevitably there will be winners and losers in moving practices to fair shares budgets. Of those who had been notified of their fair shares budget, 26 per cent understood that their budgets would be unchanged, while 37 per cent expected to gain and the remaining 37 per cent expected to lose funding. PCTs that had undertaken analyses were concerned about the period of transition required to move their practices' budgets to fair shares. Some of the analyses we were shown indicated variations against the target budget in excess of plus or minus 30 per cent – very much greater than the difference between PCT budgets and target allocations which has taken many years to resolve. In contrast with the previous DH guidance, the most recent version allows PCTs to move practices with significant variances towards fair shares budgets over a longer period of time (**Ref. 12**).
- 94 We asked practices if a timetable had been set for moving their budgets to fair shares and just over half (55 per cent) reported that one had not been set. Arrangements at North East Lincolnshire PCT illustrate a sound approach to moving to fair shares (**Case study 9**).

I The DH is currently exploring the possibility of introducing a person-specific element to capitation-based funding; a new way of allocating resources down to PBC level, based on actual patient characteristics to take greater account of the needs of people registered with particular practices and to deliver fairer shares. Such approaches are well established in health systems such as in the Netherlands where the state provides additional, risk-adjusted, funding for health insurers to mitigate the risk of cherry picking and ensure a consistent premium for everybody, regardless of their healthcare needs.

II The DH's toolkit and guidance for determining weighted capitation shares at practice level can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127155.

Case study 9

North East Lincolnshire PCT's approach to moving to fair shares budgets

Budgets for practices were set from historical activity, re-costed to the payment by results tariff price for 2006/07. This historic spend was then compared with a weighted capitation share, using the national formula, to give a distance from target for each practice.

National guidance allowed a 10 per cent variance from target, but adopting this threshold would have perpetuated some marked differentials between practices and the PCT chose to move more quickly. The finance department assessed the risk entailed in giving practices under the weighted capitation threshold a greater share of resources and considered that 5 per cent would be a reasonable compromise between:

- the risk of moving practices to weighted capitation target quickly; and
- the concerns of under-capitation practices denied their fair share of funding.

Source: Audit Commission

Plans and business cases

95 All practices must mutually agree a PBC plan with their PCT, which sets out what practices intend to achieve through PBC. There is no standard national format, although the latest PBC guidance (Ref 1) requires practices to include:

- how they will respond to the needs of the local practice population;
- how they will contribute to the achievement of national priorities; and
- areas in which the practice believes a more collective approach is required.

A plan which covers a consortium of practices can be submitted where these have formed.

- 96 All plans should be linked to the organisation's strategic and corporate planning processes. This was highlighted in *World Class Financial Management* in relation to financial planning, but the same holds true for all planning in the NHS (**Ref. 1**). Throughout our fieldwork, PCTs' arrangements for the development and approval of PBC plans were generally sound. While PCTs had worked closely with practices and consortia to ensure that their PBC plans linked with local delivery plan (LDP) objectives, particularly with PCTs' key demand management objectives, the process was often largely top-down. PBC project groups played an important role in developing and reviewing plans before these were considered by the Professional Executive Committee (PEC) and PCT Board. However, further work will be required by PCTs and practices in order to achieve a shared sense of ownership of plans.
- 97 Our survey supported the general view that practice plan approval processes were generally robust. Seventy-one per cent of practices indicated that their plans had gone through an approval process. However, in some cases, finalisation of plans had not actually occurred until part way through 2006/07. This was sometimes because overall PBC implementation arrangements were still in the process of being agreed and formalised. Time was often taken up with the process of aligning PCTs' objectives and practices' plans. To ensure PBC plans are in place at the beginning of the year, PCTs will need to ensure that, as part of the annual cycle of PBC activities, the development of annual PBC plans is reconciled with the development of any medium term plans. **Case study 10** outlines the approach that PBC clusters at Westminster PCT have taken.

Case study 10

The composition of PBC cluster plans at Westminster PCT

At Westminster PCT plans developed by PBC clusters identified practice level resources and budgets, and their savings plans identified outcomes that the clusters intended to realise. Plans also included local and national priorities, key local priorities and information technology and workforce information. The PCT's new commissioning strategy incorporated the PBC plans.

Source: Audit Commission

- 98 Based on the objectives in the plan, separate PBC business cases are required to support service redesign proposals. These must be approved by the PCT. Many PCTs reported that they had received few business case submissions from practices. GPs felt that this was due to a lack of practice expertise and poor support from the PCT. Many GPs were also frustrated by delays with the process for approving business cases for service redesign. **Case study 11** describes the business case template developed by Greenwich PCT.

Case study 11

Greenwich PCT's business case template and assessment criteria

Greenwich PCT has developed a business case template which supports practices to link explicitly their plans with the key demand management objectives of the PCT. The template also prompts the practices to consider the local needs of the population and the reduction of health inequalities. Practices are encouraged to undertake systematic needs assessments of their practice population.

The PCT has clearly set out the criteria against which business cases to redesign services will be assessed. They are:

- Do the plans assist in the delivery of the PCT's strategic intent and key priorities?
- Do the plans meet assessed local health needs?
- Do the plans describe how the views of patients and public have been or will be sought and acted on?
- Do the plans identify appropriate patient safety and clinical governance arrangements?
- Do the plans draw on clinically effective and good practice guidelines, for example Healthcare Commission standards, National Institute for Health and Clinical Excellence guidelines and National Service Frameworks, and the national policy context for the service in question?
- Do plans demonstrate how relevant stakeholders have been or will be involved in the development (for example, nurses, health visitors, pharmacists, dentists and optometrists)?
- Do the plans demonstrate value for money?
- Do the plans demonstrate affordability, that is, that they are not likely to create a cost pressure for either the PBC practice, cluster or PCT, and consideration of options for expenditure reduction?

- Do the plans describe how activity and financial information will be managed and used?
- Do the plans identify key risks and plans to minimise them?
- Can the progression of the plans be taken forward by the PBC practice or cluster without destabilising services still required for the patients of other PBC practices or clusters?
- Is there evidence from the plans and current performance that the practice or cluster has, with the support of the PCT, the capacity to deliver the scheme?

Source: Audit Commission

- 99** The latest guidance (**Ref. 12**) from the DH states that PCTs should aim to approve PBC plans and business cases within four weeks and no later than eight weeks. While in some PCTs the approval deadline had slipped by only a matter of a week or two, in others it was delayed by months. This not only dampened enthusiasm among practices, but it also created the perception that PCTs were blocking proposals or that they were unwilling to allow PBC to be led by practices.
- 100** In some cases the delay was attributable to the fact that the PCT approval process had not been developed and/or formalised. Some practices suggested that their PCTs were stifling enthusiasm for PBC and innovation. However, in some, PCTs raised concerns about the implications of business case proposals on the equity of provision.
- 101** In the majority of sites we visited, both PCTs and practices indicated that PBC was not yet having a significant impact on services. Where new services or cost-effective alternative pathways had been developed, they tended to be small scale and highly localised and many were the result of initiatives in place before PBC. However, PBC had stimulated the development of ideas for alternative approaches to service provision and 39 per cent of practices indicated that they had recently redesigned clinical services through PBC.

- 102** PBC aims to secure the engagement of GPs in the commissioning of hospital treatment. In a few places, practices were being engaged in the contracting process and were in a position to influence provider agreements, although we found little evidence of significant changes to commissioning practices. PCT staff that we interviewed highlighted that practice plans and business cases did not typically include any consideration of the health needs of the population concerned. We also found that there was an additional tendency for the most engaged practices to be more interested in the provision opportunities that PBC creates.
- 103** We identified many examples of local, small-scale service developments, such as GPs undertaking minor surgery, that were being provided in a practice or community setting. However, we found no examples of the large scale level of change that the DH is anticipating. The development of local services often related to treatments involving the following clinical specialties:
- dermatology;
 - orthopaedics, particularly deep vein thrombosis;
 - urology;
 - endocrinology, particularly diabetes; and
 - respiratory conditions, particularly chronic obstructive pulmonary disease.

Many of these examples were in the early stages of implementation. Our findings are consistent with those of the DH's June 2007 GP practice survey, which revealed that 60 per cent of practices had commissioned no new services as a result of PBC and 23 per cent had commissioned only one or two new services (**Ref. 2**). However, there were a few examples that had been in operation for some time and were in a position to demonstrate benefits, such as in Bradford and Airedale Teaching PCT where a reduction in the number of endoscopies was achieved through the introduction of breath testing at practices.

Case study 12 provides a further example of service redesign at Bath and North Somerset PCT.

Case study 12

Using PBC to achieve effective service redesign at Bath and North East Somerset PCT

The lower gastrointestinal scopes project at Bath and North East Somerset PCT is a good example of engaging GPs and secondary care to address a capacity problem and redesign a pathway. The PCT has reduced the waiting list from more than 800 patients waiting for more than 9 months to around 70 over 6 weeks. This has been achieved in seven months with considerable support from GPs, practices and secondary care. To address a significant backlog for colonoscopies at the Royal United Hospital in Bath, the PCT included service redesign and clinical validation in the PBC plan for 2006/07. GPs worked closely with secondary care consultants, supported by PCT commissioning managers, to develop a clinical validation process and redesign the pathway for referral into secondary care.

The validation work done at practice level was secured as part of the local incentive scheme set up for PBC. While primary care and secondary care engagement was provided on the basis of goodwill, there were some opportunity costs for both. GP involvement was funded via sessional payments paid to those on the PBC executive group and commissioning manager input costs were born by the PCT. The PCT estimated annual savings made during 2006/07 in reduced colonoscopies and adoption of the new pathway was in the region of £160,000.

Taking a whole system approach to a significant problem affecting the entire health community produced other benefits. The PCT found that being able to give examples of service changes achieved through joint working was helpful in subsequent negotiations with secondary care.

Source: Audit Commission

- 104 However, local redesign initiatives were often coordinated by the PCT and not initiated directly through PBC, creating a situation where practices did not own the redesign agenda and felt that new solutions were being imposed on them. Where this did occur, practices often questioned if PBC was, or would ever be, practice led. To help create a sense of shared ownership, as discussed in the previous chapter, PCTs need to manage the annual cycle of PBC activities to ensure the timely production and approval of practices' business plans.

- 105** Many service redesign proposals were initiated by GPs with special interests (GPwSIs)¹. This is perhaps unsurprising, as GPwSIs generally have experience of providing an extended range of clinical services or procedures in their practices. They also have experience of working with colleagues to redesign pathways so as to raise the standards of clinical care for patients with a specific chronic disease.
- 106** As service redesign gathers pace, PCTs need to ensure they have the appropriate structures in place to consider business cases and ensure that they are robust if best use is to be made of the resources available.
- 107** Arrangements for assessing cost-effectiveness were often underdeveloped. Few PCTs were systematically assessing service redesign initiatives to ensure they were cost-effective, and none had considered measuring the outcomes of these initiatives to inform future planning. This reflects the relatively slow progress made by PCTs in relation to service redesign. Most bodies were in the process of developing systems and criteria for their assessment processes. In the few examples we came across, PCTs were mainly using national tariffs as benchmarks against which to judge proposals for developing new services. However, to secure best value, PCTs need to assess whether a small improvement on the tariff is enough or if further savings could be made.
- 108** If the full benefits of PBC are to be realised, effective cost benefit analysis of business cases and ongoing monitoring of outcomes and costs is a priority for PCTs and practices. This will require the development of systems to capture information about new services that are being provided in primary care. The unbundling of national tariffs will assist in the development of community and local tariffs, but PCTs and practices will also need to develop their own local cost benchmarking information. Engagement with secondary care clinicians in discussions about clinical pathways, could also involve obtaining cost information from providers.
- 109** PCTs should also help by producing clear guidance on defining benefits and ensuring that it is consistently applied in practices' business cases. Practices need to ensure that they have a thorough understanding of the financial implications of current and potential alternative activities as highlighted in *World Class Financial Management (Ref. 1)*. While benefits will accrue from different areas of commissioned activity in different ways, the process for defining, identifying and assessing them should be consistent and robust. Although there may be a number of strands to defining benefits, PCTs should provide clear guidance on how they expect to see benefits expressed in practices' business cases.

¹ These are GPs who supplement their generalist role by delivering a high-quality, improved access service to meet the needs of a single PCT or group of PCTs, often in areas where there are access problems. They may deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services.

- 110** There is a tendency to assume that a primary care-based solution is more cost-effective. This may not always be the case. In certain instances treating a patient in a practice or primary care setting will be more expensive than treating them in hospital (**Ref. 14**). Costs may arise, for example, where services are simultaneously provided both in practice settings and secondary care, as new redesign initiatives develop. It is important that PCTs assess the costs and benefits of new initiatives prior to implementation. Our 2004 report, *Quicker Treatment Closer to Home* (**Ref. 15**), found that there were considerable weaknesses in PCTs' approaches to business cases that supported transfers of services from secondary to primary care; a finding that has been supported by this study. It is clear that most PCTs have not implemented robust systems to capture data on and monitor new services initiated through service redesign and to monitor the results.

Information

- 111** PCTs and practices must have access to good financial information and activity data provided in an appropriate format and at the required level of detail, to enable them to make informed decisions about how to commission services. The provision of timely, reliable information is critical to support practice monitoring and the management of indicative budgets. It also reinforces PCT oversight of practice PBC performance.
- 112** In *Practice Based Commissioning: Practical Implementation*, the DH set out the recommended types of clinical activity and financial information that PCTs should be making available to practices. This included information on elective and non-elective activity; diagnostic tests; prescribing and primary care; as well as benchmarking data on referral rates, admission rates, first outpatient attendances, and follow-up rates.
- 113** As previously mentioned in chapter two, the DH published figures indicating that all PCTs had achieved universal coverage of PBC by December 2006. However, in reality, many of the PCTs we visited were not adequately satisfying the national requirement relating to the provision of information. Indeed, most were experiencing difficulties with the regular provision of budgetary and activity information to practices.

- 114** The overall impression on information provision gained from our visits to PCTs and practices was negative. Almost two-thirds of survey respondents reported that information on patient activity, which was key to monitoring and managing the budget, was not provided on a timely basis. Few had access to data on a real-time basis. In our interviews with practices, almost all commented on the variability and infrequency of data provision. Furthermore, where it was provided, it was often out of date. These findings are broadly consistent with those in the DH's June 2007 GP practice survey (**Ref. 2**). PBC will not work without the provision of prompt and accurate information to practices. This is a critical area for improvement.
- 115** The principal reason given by both PCTs and practices for the lack of timely data was that PCTs' systems were based on information derived from the Secondary Uses Service¹ (SUS) and they regularly experienced significant delays in obtaining data from this source. It is possible that these problems arose because the system was, at the time, relatively new. PCTs and practices both reported that quarterly hospital activity data were typically provided by the SUS three months after the end of each period.
- 116** Although some PCTs had worked closely with practices to establish reporting formats and to identify the types of analyses required, many practices reported difficulties. In our survey, 69 per cent indicated that they did not find the information they received useful for budget management purposes. In many of the PCTs we visited, practices had not been involved in developing reporting formats. This view was confirmed in our survey, with over three-quarters of practices indicating that they had not been involved in the development of activity reporting formats. PCTs' information teams need to work closely with practices to ensure that monitoring reports are meaningful and useful. Consequently, it may also be necessary to adapt information management systems and invest in data analyst capacity, software and/or hardware.

1 The Secondary Uses Service is the single repository of person and care event level data relating to the NHS care of patients, which is used for management and clinical purposes other than direct patient care. These secondary uses include healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance. The data currently managed within SUS is derived from the commissioning datasets, which providers of NHS care must submit and make available to commissioners.

- 117 A small number of PCTs had implemented sound information technology infrastructures to provide practices with timely and reliable information. Many had adapted their information management systems or purchased off-the-shelf solutions to capture and analyse referral data. Some PCTs have also invested in data analyst capacity to help PBC to operate more effectively. Improving the quality and timeliness of information is also likely to satisfy other demands on PCTs, for example to meet PbR requirements. **Case study 13** describes the range of information that North East Lincolnshire PCT provides to its practices.

Case study 13

North East Lincolnshire PCT's information provision to practices

At North East Lincolnshire PCT, all practices are provided with raw patient activity data on elective, non-elective, referral and outpatient activity. In addition, information showing the overall cost of activity and the top ten high cost cases at an individual practice level is also supplied. Benchmarked activity, comparing one practice with others, is provided at a Primary Healthcare Team and PCT level. Feedback from practices led to the development of a more comprehensive information pack providing raw data as well as some trend analysis. While the provision of data did not have a vast impact on referrals patterns during 2006/07, savings of £140,000 were achieved through PBC service improvement plans from diversionary schemes applied in-year.

Source: Audit Commission

- 118 There were many approaches to disseminating information to practices. Some PCTs were distributing reports in hard copy formats, others electronically. Three of the PCTs we visited had implemented web-based systems which provided access to activity information, including patient level details, that practices could access securely via local intranets.
- 119 Confidence in secondary care activity data was often low among practices. A particular issue was the incorrect attribution of patients to practices which may affect indicative budgets. Our survey supported this view, with 73 per cent of respondents indicating that the information they were provided with to manage their indicative budgets and monitor activity was inaccurate. Few PCTs that we visited routinely involved practices in validating secondary care activity data. Those practices that were former Total Purchasing Pilots

and fundholders and keen to draw on their experience, were among the most enthusiastic to be involved in the validation of secondary care referral data. However, many PCT staff that we interviewed raised concerns about practices returning to the approach typically found with GPFH, of validating every referral made, often against a discharge notice or summary.

- 120 Some PCTs and practices had resorted to using data either directly sourced from acute providers or referral data recorded by practices themselves (see Case studies 14 and 15). A few PCTs were working with and incentivising practices to undertake sample-based validation of secondary care activity data. Activity was also being mapped to Healthcare Resource Groups (HRGs), thus making the link between referrals and costs, and between PBC and PbR.

Case study 14

Work undertaken by PBC consortia to improve the provision of secondary care data

The Sutton Horizon Commissioning Group, a consortium of practices in Sutton and Merton PCT, decided to gather their own activity information because of local issues with data timeliness. A data analyst was employed by the group to work closely with practices to produce monthly reports for the group, to assist with resolving any activity queries arising and to ensure that monthly reports were tailored to the needs of individual practices within the consortium.

Sutton Horizon and two other consortia have been collecting data on referrals directly from practices throughout 2006/07. This helped them to monitor the impact of their demand and referral management initiatives every month. Information was presented to practices every month to show the progress that was being made. As these data are available just after the end of the month, it was available before the data provided by secondary care providers. The three consortia maintain that sharing information in this way helped with referral management initiatives. For example, the Nelson Commissioning Group reduced overall GP referrals by 8 per cent. The information also allowed them to target the specialties they needed to focus on.

Source: Audit Commission

Case study 15

North East Lincolnshire PCT's data quality arrangements

North East Lincolnshire PCT undertakes data reliability audits and typically found 90 per cent accuracy. Drawing on a good working relationship with a local acute hospital, they have worked closely to resolve issues with data quality. Data are routinely cleansed, and this includes practice coding checks against the Exeter system^I. Practices are encouraged to refer any queries they identify to the information systems hotline and significant issues can lead to the withholding of payments until the issues are resolved. While no payments were withheld during 2006/07, it enabled the PCT to add clauses relating to financial penalties attached to delayed discharge letters in its provider contracts for 2007/08.

Source: Audit Commission

- 121 Systems for capturing data on community services were often weak and there needs to be a focus on improving these, particularly as new services are developed in primary care settings.
- 122 A few PCTs were providing practices with local benchmarking data. However, none of them was able to offer national comparative data. This information was particularly useful for peer challenge of referral activity. The NHS Information Centre^{II} has developed a PBC comparators website^{III} that is available to all GP practices, PCTs, SHAs, and others. For PCTs and SHAs, the website allows them to benchmark performance and to assess the impact of PBC by comparing data that may have been affected by PBC activity. For practices, it provides comparable information on current health service usage and enables them to understand how resources are used and to identify areas that will benefit from redesign.

I The Exeter computer system is a comprehensive database of all patients registered with an NHS GP in the UK.

II <http://www.ic.nhs.uk>.

III <https://www.nhscomparators.nhs.uk/NHSComparators>.

Summary

- **Budgets** – PCTs should calculate practice level indicative budgets and provide them to practices by the start of the financial year. Indicative budgets should cover the entire scope of health services that can be included. They should discuss the methodology with practices and clearly explain the final result to them. They should also work with practices to develop the timetable for moving to fair shares.
- **Plans and business cases** – PCTs should review the structures they have in place to ensure that PBC business cases are robust and are reviewed on a timely basis. Attention to assessing the cost and benefits of any changes is particularly important.
- **Information** – This is a critical area. DH must resolve the problems with SUS. PCT information teams must work closely with practices to ensure that the information provided is relevant, timely and in an accessible format, to meet both demand management needs and to inform service redesign. PCTs also need to implement data capture arrangements to monitor new services developed in primary care and community settings.

5

Performance and financial risk management and governance

123 PBC is a way of helping PCTs to manage better their financial risk. *World Class Financial Management* highlights three factors that are applicable to PBC (**Ref. 1**). PCTs and practices need to:

- monitor financial and non-financial performance;
- have a thorough understanding of the financial implications of current and potential alternative activities; and
- foster a culture in which there is individual and collective responsibility for the effective stewardship and use of resources.

Performance management

124 To achieve good financial management, activity and finance should be monitored and managed together. Monitoring one or the other in isolation will not enable a complete picture to emerge of how resources are being deployed; whether they are having the intended effect; whether and why financial pressures are arising; and whether funds can safely be moved from areas which are apparently underspending.

125 PCTs had set out their arrangements for monitoring activity and financial performance in their overarching PBC frameworks, but we found that approaches varied. In addition, arrangements had yet to be fully tested as these processes were often in their first year of implementation. In our survey of practices, almost two-thirds reported that their practice plans were monitored, in terms of activity performance and finance, by the PCT. However, one-third of practices were unclear exactly what the process of monitoring involved.

126 Activity and budget monitoring processes were often PCT-led by staff charged with supporting and performance managing practices. In some places monitoring was undertaken at consortia level, with PCTs taking a light touch approach. We found that tracking the progress of each practice and reporting to PECs was irregular, often because of shortcomings in the provision of monitoring information. Case studies 16 and 17 describe two approaches to the performance management of PBC.

- 127** Arrangements for reporting the overall implementation and impact of PBC varied among PCTs. They tended to focus on reporting progress on practice uptake and the development of arrangements and processes to underpin PBC implementation, and not on actual performance. This information was typically reported to the Board by the PEC chair or PCT PBC lead.
- 128** To run organisations effectively, senior management needs up-to-date financial and non-financial information (**Ref. 1**). In most cases, reporting to PCT boards was mainly restricted to reporting the PCT's overall financial position. We found few instances where information on practices' indicative budget performance was conveyed. The more advanced PCTs had developed systematic arrangements for formal monitoring, where they met practices individually to discuss budget performance at predetermined intervals during the course of 2006/07.

Case study 16:

Croydon PCT's approach to performance managing practices

Croydon PCT has implemented robust arrangements for performance management of PBC. Progress on the PCT's integrated change programmes (the four work streams into which PBC feeds) and on national and local targets is monitored monthly at Board level. Under the PCT's governance arrangements for PBC, there are monthly reviews of data, with investigation of significant variance. Variances are then discussed with practices, to identify whether referrals should have been managed within the practice or referred to the acute provider. Practices can benchmark themselves against their PBC group's average referrals for each speciality.

There is comprehensive contract monitoring of service level agreements with trusts, reviewing activity levels and performance against budgets. The Board receives detailed reports on this through the monthly activity and finance reports, helping it to discharge its governance duties.

Source: Audit Commission

Case study 17

North East Lincolnshire PCT's performance framework for PBC

North East Lincolnshire PCT has developed an overarching performance framework for practices that incorporates the QOF of the nGMS contract, Personal Medical Services contract and PBC. Core indicators have been developed by the PCT and practices which enable both to form a view on performance of practices. They are first assessed at month 6 (September) and then reviewed at month 12 (March). Initially, the PCT staff met with all practices on a three-monthly basis. However, the frequency was reviewed according to the assessment of performance.

The overall results of the performance review processes were very encouraging. A number of practices achieved a higher number of indicators which enabled them to move to a higher band practice. One practice remained at a level 1 and this was a single handed GMS practice. The majority of practices produced an excellent informative report prior to the meeting which discussed all the indicators in the performance framework.

Source: Audit Commission

- 129** PCTs should discuss with practices how they can operate within their plans and actively work with them to achieve this. This process should operate at either individual practice or at consortia level and should be integrated with arrangements for assessing practices' eligibility for delivery-related incentive payments at the year-end. Other mechanisms that PCTs should consider to assist practices to manage their budgetary performance include sharing best practice or organising a review of the arrangements of other practices.

Financial risk management

- 130** Small practices in particular face financial risk from unexpected volatility in activity, or from high-cost patients. This is an inherent risk for PCTs and their financial standing. PCTs therefore need to have robust arrangements in place to manage unplanned in-year variations in activity and cost. To protect practices' indicative budgets from high-cost patients and procedures, many of the PCTs we visited were operating arrangements which largely followed DH guidance and were similar to those which applied in GPFH. These included:

- Responsibility for particular high-cost, low-volume treatments, for example, specialised services commissioning, was removed from the scope of indicative budgets, to leave resources and decisions with the PCT or group of PCTs.
- A PBC specific contingency fund, typically of between 3 to 5 per cent of a practice's indicative budget, was set aside. PCTs in financial difficulty used a general corporate risk pool of funding from which to draw on. In both instances, a threshold value for treatments was set, typically between £10,000-20,000 per patient, and costs which exceeded this threshold were funded by the contingency fund.

131 The majority of PCTs we visited had established arrangements for managing the financial risk of overspending practices in their accountability and governance frameworks. Where PBC consortia had formed, we found that they had been given the responsibility for ensuring that there was financial balance across the group of practices. Financial frameworks also set out that, in PBC consortia where an overspend occurred, a coherent strategy for recovery would subsequently be put in place. We found that arrangements for managing overspends were not yet embedded in some PCTs.

132 Risk pooling was a common feature of PBC financial risk management arrangements. Most risk or contingency pools were operated by PCTs, although we also found that where a consortium of practices had formed they expected to operate a collective risk pool themselves during 2007/08. Only a few PCTs had implemented early warning type arrangements, such as trigger points, to alert either the PCT or PBC consortia to significant variations in practices' performance against plan. These were used to initiate discussions and identify any action required, particularly managing referrals, to ensure that they remained within budget. There may also be financial risk from use of savings if these are not recurrent. **Case study 18** exemplifies one PCT's approach to this.

Case study 18

Bradford and Airedale Teaching PCT's approach to managing risk from savings

In consultation with its PBC alliances, Bradford and Airedale Teaching PCT recognised that savings achieved in 2006/07 cannot necessarily be regarded as recurrent, as they might result from unexpected fluctuations and can only be relied upon once a trend has been established. It was agreed that there would need to be a level of certainty before savings could be committed for practice use. To mitigate this risk, the PCT requires that first year savings would be used primarily for non-recurring

expenditure only. As the PCT was mindful of the possibility that this might restrict opportunities for service development through the use of savings, they do consider business cases that require recurrent funding. These must meet criteria that the PCT has set and agreed with the alliances.

Source: Audit Commission

- 133** One critical point, however, is that budget holders must both know and sign up to whatever risk management arrangements are in place. Many practices told us that they had not signed up to any arrangements to manage financial risk, and this view was supported by 86 per cent of respondents in our survey. Of the few who said they had, the majority indicated that they had agreed to the operation of a centrally held risk or contingency pool which could be used for high cost patients or treatments.
- 134** We found that knowledge of risk management arrangements was limited at individual practice level. Sixty-eight per cent of survey respondents indicated that a risk pool or contingency fund for PBC had not been developed. Of those who were aware of such arrangements, just over half (53 per cent) reported that clear guidelines for calls on the fund had not been developed and formalised. Fifty eight per cent also indicated that these were not developed and agreed with practices. To create the conditions for individual and collective responsibility under PBC, PCTs need to work closely with practices to ensure that they understand and have signed up to the financial management risk arrangements.

Governance

- 135** The overall aim of governance and accountability, in relation to PBC, is to balance accountability for the effective use of taxpayers' funds with minimum bureaucracy for practices and maximum freedom for clinicians to deliver real improvements for patients.
- 136** While PCTs remain accountable for the PBC implementation process, there are a number of key stakeholders who also have important roles and responsibilities. Most PCTs we visited had developed good governance arrangements to support PBC. However, at a few PCTs, the respective roles and responsibilities of the PCT Board, PEC and practices had to be reconsidered and revised and made more transparent to avoid confusion and to be consistent with the latest DH guidance.

- 137** All PCTs had established project groups, comprising PCT and GP representatives, to oversee implementation and the annual cycle of PBC activities. These groups were crucial to supporting the PCT Board and PEC and to steering the implementation of PBC. Typically their roles included:
- developing and recommending to the PEC, and subsequently to the PCT board, an overarching PBC framework under which practices the PEC and the PCT would operate;
 - monitoring and overseeing PBC implementation and developments in conjunction with the PEC; and
 - recommending practices' business case applications to the PEC and/or PCT Board on a regular basis.
- 138** Conflicts of interest can arise, for example, where an individual practice or consortium is both the commissioner and also the provider of the service. PCTs need to ensure that there are clear systems in place to recognise potential conflicts and address them. In the most recent PBC guidance, the DH clarified and strengthened its position on governance and accountability arrangements relating to this particular area (**Ref. 12**). However, although there are some principles for resolving conflicts of interest, there is currently no universally agreed system.
- 139** From our research, safeguards to mitigate potential conflicts of interest had either been put in place or were in the process of being developed. But they remain largely untested where practices held both provider and commissioner roles. Both PCTs and practices indicated that there had been few instances where situations of this kind had actually arisen. However, this was an area that both parties were concerned about, as they expected that it would become a growing issue in the future. The majority of PCTs had already adapted, or were thinking about adapting, their existing governance processes to avoid conflicts arising in the re-provision of services. They had done so in a number of ways:
- By setting up a sub-committee of the PCT, chaired by a non-executive director and with membership from the PCT board and PEC, with responsibility for the approval of business cases submitted by practices.
 - By requiring practices to exclude themselves from the assessment or decision-making process relating to any PBC business cases in which they have an interest or with which they are associated.

There must also be full transparency in decision making, not only for practices, which have an obvious interest in this, but also for the benefit of the taxpayer.

- 140** PBC has also introduced some potential tensions in the role of GPs. For example, a practice may have an incentive to reduce the demand for external services, such as those provided by an acute trust, because savings will be available for reinvestment in the practice. Equally if a practice or group of practices invests in a community facility, they will want to ensure the facility is fully utilised. However, patients rely on practices to act in their best interests. Both PCTs and practices need to be open about this tension and develop local arrangements to manage this type of conflict of interest. **Case study 19** outlines the approach City and Hackney PCT has taken to mitigate this risk.

Case study 19

City and Hackney PCT's arrangements for countering under referring
 City and Hackney Teaching PCT's PBC framework includes arrangements to counter-balance any perverse incentive to misuse PBC by under-referring. The PCT has raised awareness of this issue with practices and is introducing plans to mitigate the potential health inequalities arising from poorly performing practices. The PCT is using data and information that would enable it to identify practices that may be under-referring. In addition, the PBC framework refers to the PCT's primary care performance framework, which includes specific referral thresholds and checks. The performance framework also indicates that access to PBC savings uses satisfactory performance against the performance framework as qualifying criteria.

Source: Audit Commission

Summary

- **Performance management** – PCTs need to implement robust arrangements for monitoring and measuring the performance of practices.
- **Financial risk management** – PCTs should work closely with practices to ensure that they understand and have signed up to arrangements for managing financial risk.
- **Governance** – PCTs need to review periodically their governance arrangements to mitigate potential conflicts of interest.

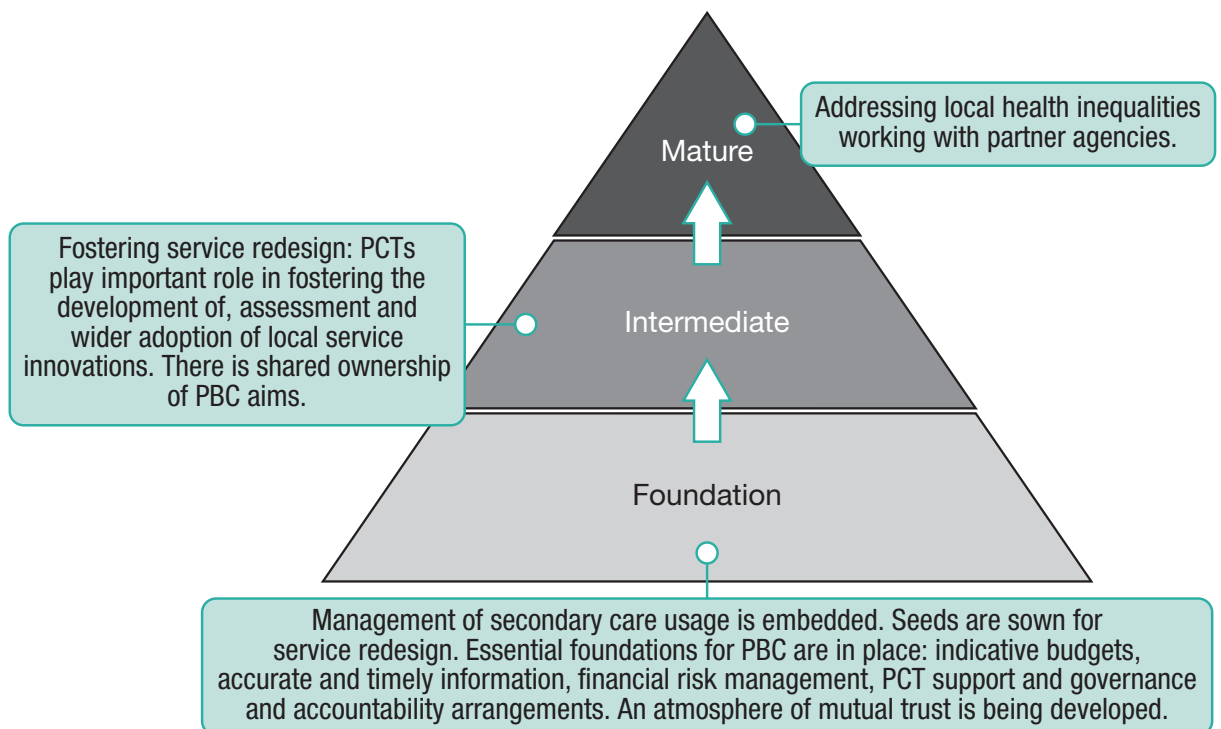
6

Conclusion and recommendations

141 This chapter sets out our conclusions and makes recommendations for the DH, SHAs, PCTs and practices.

142 **Figure 5** illustrates the way in which the implementation of PBC is evolving. At the first level, the essential foundations are built on which PBC can potentially flourish. Practices are engaged, indicative budgets are devolved, accurate and timely information is provided, financial risk management, governance and accountability arrangements are developed, agreed and implemented and PCT support to practices is cemented. With these elements in place, the management of secondary care usage is embedded and the conditions are set for the development of cost-effective alternative services locally.

Figure 5
Evolutionary stages of PBC development



Source: Audit Commission

- 143** The majority of PCTs that we visited were at the first level, particularly those that had reconfigured, as most appeared to have only really started to implement PBC during 2006/07. Progress had been made in all 16 PCTs that we visited, although this generally related to the organisational development aspects of PBC – engaging GPs and developing PBC specific policies and processes. The critical financial management aspects which underpin PBC and which are outlined above were still evolving. While PCTs were using PBC as a tool for demand management with varying success, there were some early signs of cost-effective service redesign coming to fruition or being implemented. However, these were all small scale and highly localised.
- 144** Few of the PCTs we looked at had reached the intermediate level of **Figure 5**. To move PCTs and practices to this level:
- PBC infrastructure needs to have been developed and tested;
 - PCTs, practices and other relevant partners, such as acute provider clinicians and local government, need to have fostered a shared sense of ownership of PBC, both in terms of challenging current care pathways and to advance local service innovations;
 - practices will need to have developed strong service redesign proposals and PCTs will need to assess these promptly; and
 - PCTs will also need to ensure that they have sound arrangements for mitigating potential conflicts of interest.
- 145** The third level will require expanding the sense of ownership and engagement. It will require strong links between practices and the public health workforce and between practices and local authorities. Indicative budgets and plans will need to be aligned with PCTs', and their partner local authorities' strategic objectives, if resources are to be properly deployed to meet them. This should also involve greater adoption of pooled or aligned budgets between PCTs and local authorities.

The future of PBC

- 146** PBC is seen by the government as a key policy vehicle for achieving service improvements and greater efficiency in the use of resources, particularly now the annual growth rate of NHS funding will slow in the coming years.

- 147 The experience of GPFH shows that it took several years for arrangements to become embedded before it made a demonstrable impact (**Ref. 16**). Implementing PBC has been a substantial organisational development project for primary care, both in terms of adapting cultures and creating new systems and processes. Given that there is still much more to be done, particularly by late adopters, PBC arrangements across the country will need more time to develop if further progress is to be made.
- 148 The cultivation and maintenance of a strong sense of ownership, principally among PCTs and practices but with other stakeholders as well, will be central to successful implementation. Future prospects will also hinge on PCTs' ability to maintain practices' engagement in implementation. As our research has found, the availability of financial incentives to practices is not the only way to engage them. Many are genuinely motivated by a desire to use PBC to improve the care offered to patients.
- 149 However, a greater level of engagement of GPs and other allied healthcare professionals will be required than currently exists if PBC is to really flourish in the future. Increased levels of engagement would provide the means to secure further improvements in the management of secondary care usage, and also to increase the scale of production of cost-effective alternative services in primary and community settings.
- 150 Without the foundations in place as set out in **Figure 5**, it is unlikely that PBC will be able to deliver the scale of service change envisaged by the DH.

Recommendations

Recommendation	DH	SHAs	PCT	Practices
Ownership and support				
1			✓	✓
2			✓	✓
3				✓
4	✓	✓		
Incentives				
5	✓			
6			✓	
7	✓	✓		
8	✓		✓	✓
9			✓	✓
Budgets				
10	✓	✓		
11			✓	
12			✓	✓
Plans and business cases				
13			✓	✓
14			✓	

Recommendation	DH	SHAs	PCT	Practices
Data and information				
15 Review the adequacy and timeliness of the Secondary Uses Service's ability to provide activity data for PBC.	✓			
16 Work closely with practices to ensure that the information provided is relevant and timely to meet both demand management needs and to inform service redesign. Engage practices in data validation processes.			✓	✓
17 Provide benchmarking data to practices, drawing on national as well as local performance.			✓	
18 Implement data capture systems to monitor cost effectiveness of new services developed in primary care and community settings.	✓		✓	✓
Performance and financial risk management				
19 Implement robust local arrangements for monitoring and reporting PBC performance, particularly to Boards.			✓	✓
20 Develop clear policy on budget overspends.			✓	
21 Develop and share guidelines, tools and good practice on managing budget overspends and risk sharing.	✓	✓		
22 Develop arrangements for monitoring contracts with secondary care providers for PBC purposes.			✓	
23 Work closely with practices to ensure that they understand and have signed up to the financial risk management arrangements.			✓	✓
Governance and accountability				
24 Regularly review governance arrangements to mitigate potential conflicts of interest.		✓	✓	

Appendix 1: Study questions and research methodology

Study questions

- How well it is working (specifically in terms of the mechanics of PBC)?
- Is PBC being effectively tied into other financial management processes (particularly Payment by Results (PbR))?
- Are probity and governance risks being adequately addressed?
- What other PBC risks have emerged in practice?
- How can PBC be made to work better?

Research methodology

- **Fieldwork visits** were conducted at 16 PCTs, between January and April 2007, to examine local PBC arrangements, to identify obstacles to implementation and to collect notable practice. This work involved semi-structured interviews with PBC leads, directors of finance, directors of information, PEC chairs, information managers and some GPs and/or practice managers. Site selection took into account a number of characteristics, including population served, rural/urban location, geographic distribution, financial standing and Auditors' Local Evaluation scores. The sample also included some early implementer PCTs that were involved in the research undertaken for the *Early Lessons in Implementing Practice Based Commissioning* report.
- A **survey of practices** was undertaken to get a practice perspective on policy and implementation. It was targeted at a sample of practices at each of the 16 fieldwork sites. The survey specifically covered the incentives arrangements for engaging practices in implementing PBC, the financial management aspects of implementation (including indicative budgets, arrangements for managing financial risk and sharing savings), information about the support practices receive to implement PBC, and governance arrangements, risks that have arisen, the extent to which the expected benefits are being realised and the barriers to implementing PBC effectively.

- **Desk based research included:**
 - analysis of relevant documentation provided by the 16 fieldwork sites;
 - analysis of national and local datasets relating to PBC, including referral patterns and emergency admissions; and
 - a review of findings from local audit work on PBC.

Appendix 2: Fieldwork sites

No.	PCT	SHA area	Population	Reconfigured from 1 October 2006	Total number of GP practices	Under/(over) spend against Revenue Resource Limit 2005/06 (£000)	Overall ALE/Use of Resources score 2005/06
1	Liverpool	North West	444,000	Yes	105	Merged	Merged
2	Walsall Teaching	West Midlands	253,000	No	61	3,618	2
3	North East Lincolnshire ¹	Yorkshire and the Humber	159,000	No	46	0	2
4	Warwickshire	West Midlands	525,000	Yes	102	Merged	Merged
5	Stockport	North West	282,000	No	60	51	3
6	West Sussex Teaching	South East Coast	762,000	Yes	142		
7	Nottingham City	East Midlands	275,000	No	70	342	2
8	Berkshire West	South Central	441,000	Yes	78	Merged	Merged
9	Leicester City Teaching	East Midlands	285,000	Yes	44	Merged	Merged
10	Bradford and Airedale Teaching	Yorkshire and the Humber	481,000	Yes	112	Merged	Merged
11	Bristol Teaching	South West	394,000	Yes	70	Merged	Merged
12	Central Lancashire	North West	449,000	Yes	92	Merged	Merged
13	Tameside and Glossop	North West	247,000	No	44	107	3
14	County Durham	North East	497,000	Yes	133	Merged	Merged
15	North Yorkshire and York	Yorkshire and the Humber	765,000	Yes	194	Merged	Merged
16	Sutton and Merton	London	370,000	No	65	-6,708	1

¹ North East Lincolnshire PCT became a Care Trust Plus on 1 October 2007.

Appendix 3: 2006/07 Audit Commission practice based commissioning audits of PCTs and acute trusts

PCTs

Bexley Care Trust
Brighton and Hove PCT
City and Hackney PCT
Croydon PCT
Dudley PCT
Enfield PCT
Eastern Birmingham PCT
Greenwich Teaching PCT
Havering PCT
Heart of Birmingham Teaching PCT
Kingston PCT
Isle of Wight NHS PCT
Lambeth PCT
Leicester City PCT
Portsmouth City Teaching PCT
Redbridge PCT
Richmond and Twickenham PCT
Southampton City PCT
Southwark PCT

Stoke on Trent PCT
Telford and Wrekin PCT
Westminster PCT
Walsall PCT
Hillingdon PCT

Acute trusts

Bromley Hospitals NHS Trust
Epsom & St Helier NHS Trust
Kingston Hospital NHS Trust
Newham University Hospital NHS Trust
Royal Free Hampstead NHS Trust

Appendix 4: Glossary of key terms used in the report

Commissioning

This is the process whereby PCTs assess the health and social care needs of their local population, set relevant priorities and allocate resources accordingly, and negotiate agreements with providers (NHS, private and voluntary) to deliver services to meet these needs.

Demand management

This is where PCTs, practices and acute trusts work, either individually but more often collectively, to monitor and manage demand for acute services (outpatient appointments, inpatient referrals and some emergency admissions). It is used to ensure the appropriateness of referrals, to drive service efficiency and improve the patient experience. It is also sometimes referred to as care and resource utilisation.

Fair shares budgets

Fair shares is where practices are provided with indicative budgets to provide services for their patients, based on the number of patients registered in their practice and adjusted for factors such as deprivation. In this way, indicative budgets should reflect local need. Historically, budgets were set on the basis of usage of health services, which created tensions between high and low referring practices.

Financial management

This is defined by the Chartered Institute of Public Finance and Accountancy as ‘the system by which the financial aspects of a public body’s business are directed and controlled to support the delivery of the organisation’s goals’ (**Ref. 1**).

The New General Medical Services Contract (nGMS)

This is a framework for providing individual funding to GP practices which came into effect on 1 April 2006. It provides for a basic payment for every practice and further payments for specified clinical and organisational quality measures and outcomes (see also Quality and Outcomes Framework).

General Practice Fundholding (GPFH) and Fundholders

General Practice Fundholding was introduced in the early 1990s. Fundholders were GPs whose practice managed a budget for their staff that enabled them to purchase some hospital and community care for their patients, and cover drugs and management costs.

Indicative budgets

Under PBC, practices are provided with an indicative, rather than an actual cash, budget, which they monitor and manage. Legal responsibility for performance against this budget remains with the PCT.

Payment by Results (PbR)

This funding system was designed to ensure that NHS finances are deployed directly in line with patient treatment. It requires PCTs to pay NHS providers of acute services a nationally set tariff for clinical activity undertaken. This replaces the previous system of fixed-price block contracts.

PBC Directed Enhanced Service (DES)

An incentive payment offered by PCTs in 2006/07 to encourage GP practices and other allied healthcare professionals to participate in PBC. The Directed Enhanced Service was made up of two components. The first component entitled practices to 95 pence per registered patient in recognition of the need to support them with the development and implementation of locally agreed plans. If, through a process of review, PCTs determined that practices had delivered the objectives set out in the plan, they were entitled to component two. Component two was a minimum of 95 pence per registered patient, which had to be reinvested in practice activity for the benefit of patients locally.

Primary care and primary care trusts (PCTs)

Primary care covers the health services provided by GPs, community dentists, opticians, pharmacists, community nurses and allied healthcare professionals. PCTs are the bodies responsible for assessing the need for local healthcare provision, planning and commissioning health services and improving health. There are currently 152 PCTs.

Professional Executive Committee (PEC)

Each PCT has a professional executive committee made up of key clinicians in the local community. Their main role is to provide clinical leadership, maximise the role of clinicians and support the commissioning relationship between primary and secondary care.

Quality and Outcomes Framework (QOF)

A system of standards, assessment and incentives relating to the quality of care delivered to patients by GPs. The framework measures practice achievement against a range of clinical-based evidence indicators and against a range of indicators covering practice organisation and management. Practices score points according to their level of achievement against these indicators, and practice payments are calculated from points achieved.

Strategic health authorities (SHAs)

SHAs are regional bodies that are responsible for strategic leadership, organisational and workforce development and ensuring local health bodies (PCTs and NHS trusts) operate effectively and deliver improved performance. There are currently 10 SHAs.

Secondary care and NHS trusts

NHS trusts are the organisations responsible for running hospitals and providing secondary care. Patients must first be referred into secondary care by a primary care provider, such as a GP.

Service redesign

This is where health service managers and clinicians across primary and secondary care, including hospital doctors and general practitioners, look at how patients currently receive healthcare and, if appropriate, reorganise services to improve the patient experience and cost effectiveness.

Universal Coverage

PCTs were charged with putting in place the arrangements for universal coverage of PBC by December 2006. To achieve this, PCTs had to ensure that practices were provided with budgets, information, incentives and accountability and governance arrangements to implement PBC.

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