

Health reform in England: update and commissioning framework

annex the commissioning framework

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Document Purpose	Policy
ROCR Ref:	Gateway Ref: 6865
Title	Health reform in England: update & comm framework
Author	Policy & Strategy Directorate, Department of Health
Publication Date	13 Jul 2006
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, GPs, Communications Leads
Circulation List	
Description	This document provides an update about health reform. It then focuses on commissioning NHS services, and in particular hospital services. It sets out a framework detailing key changes designed to strengthen commissioning and ensure commissioning drives health reform, improved health and healthcare, and improved financial health for the NHS.
Cross Ref	Health reform in England: update and next steps (Dec 05) The NHS in England: the operating framework for 2006/7 (Jan 06)
Superseded Docs	N/A
Action Required	This document includes some issues upon which feedback and responses are invited.
Timing	Any feedback or responses by 6 October 2006
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1. Introduction

- 1.1 This is an annex to *Health Reform in England: update and commissioning framework* and should be read in conjunction with that document.
- 1.2 The commissioning framework sets out an over-arching vision for the commissioning role of the Primary Care Trust (PCT). Every PCT is responsible for commissioning the full range of health services for its population, working in partnership with practices to promote practice-based commissioning (PBC). This publication deals primarily with commissioning arrangements for hospital services covered by Choice and Payment by Results (PbR).
- 1.3 The framework has been informed by the valuable work of the Third Sector Commissioning Task force,¹ which has highlighted the issues that need to be addressed to enable a full range of service providers, including those in the third sector, to participate in providing health and social care services.
- 1.4 Other aspects of commissioning, including commissioning for primary care services, children's and maternity services, health and wellbeing, long-term conditions and joint commissioning with local government, will be addressed in more detail in a second phase of the commissioning framework in December. This will strengthen partnerships with local authorities and other key local partners such as employment and training agencies, police, the probation service and the third sector
- 1.5 The document defines the goals of effective commissioning and describes how these goals will be achieved. It sets out a number of measures that should be implemented now, and poses a number of questions on which we would welcome views. The issues for consultation can be found in appendices C-E and cover:
 - > the approach to contracting for NHS care;
 - > the approach to public petitions; and
 - > practice-based commissioning (PBC) governance and accountability.

¹ *No excuses. Embrace partnership now. Step towards change!* Report of the Third Sector Commissioning Task Force, July 2006. Available at www.dh.gov.uk/stakeholders.

2. What is commissioning?

- 2.1 Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean:
- > the best possible health outcomes, including reduced health inequalities;
 - > the best possible healthcare;
 - > within the resources made available by the taxpayer.
- 2.2 Commissioning itself is not new, but stronger PCTs and the acceleration of practice-based commissioning (PBC), together with the incentives introduced by the health reforms, provide the opportunity for more effective commissioning that will benefit patients and taxpayers alike.
- 2.3 In delivering their commissioning responsibilities, PCTs and their practices have two roles as:
- > the advocate for patients; and
 - > the custodian of taxpayers' money.
- 2.4 Every PCT is responsible for commissioning the full range of health services for its population, working in partnership with practice-based commissioners. Most PCTs also directly provide many community health and other services and will continue to be free to do so, with appropriate governance arrangements which provide a proper distinction between their commissioning and providing functions.
- 2.5 At the heart of commissioning are the millions of individual decisions of patients and clinicians that lead to the provision of care and the commitment of resources. Behind these clinical decisions lies a range of separate but related processes that collectively make up commissioning, from needs assessment, through reviewing services and deciding priorities, through contracting and procurement, to seeking feedback on the services provided. Together these processes can be thought of as a commissioning cycle and are described in more detail in paragraphs 2.11 – 2.14.

Who is involved in commissioning?

- 2.6 As statutory bodies, **PCT boards** are responsible for securing the best possible services for their population, within their allocated budget. PCTs cannot hand over accountability for the commissioning functions to

others; but equally, they cannot achieve their goals without close partnership with others such as local authorities. PCTs will need to work closely and effectively with **primary care practices and other clinicians** (including dentists, pharmacists, opticians and other front-line staff), **patients and the public** and **local government**.

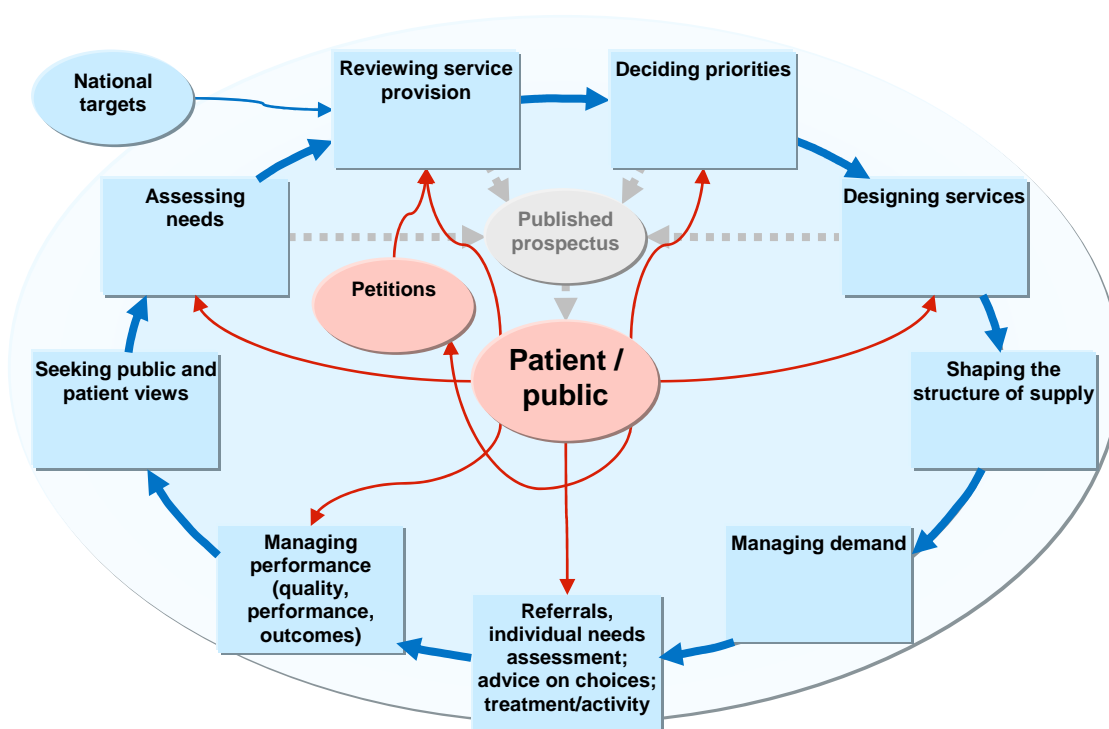
- 2.7 PBC will be critical in enabling PCTs to achieve the best value for patients. Through PBC, **practices** will have indicative budgets and the freedoms and incentives to exercise devolved responsibility for aspects of the commissioning and redesign of services. Many practices are already forming commissioning consortia to take advantage of PBC.
- 2.8 PCTs will support the development of PBC by providing information, budgets, public health needs assessment, analysis of cost-effectiveness of interventions and training and development for practices. Practices will develop, through their business plans, proposals for redesign of services and for releasing resources.
- 2.9 Effective commissioning means effective engagement of patients and local communities. **Patients**, through greater choice, will drive improvements in many services. For services where wide choice may not always be possible, the views of patients and **carers and families, groups of service users** and their **communities** should still substantially influence service provision. Other third sector organisations can often provide helpful insights into the needs of particular groups which may not be met adequately, or at all, by existing services.
- 2.10 Some patients require access to very specialised medical services provided in relatively few specialist units. The provision and co-ordination of such services will be strengthened through new, more consistent specialised services commissioning arrangements recommended by the Carter Review² (see appendix B).

² Review of Commissioning Arrangements for Specialised Services, May 2006 – an independent review requested by the Department of Health.

The commissioning cycle and effective commissioning

- 2.11 Effective commissioning makes the best use of allocated resources to achieve the following goals:
- > improve health and wellbeing and reduce health inequalities and social exclusion;
 - > secure access to a comprehensive range of services;
 - > improve the quality, effectiveness and efficiency of services; and
 - > increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs.
- 2.12 PCT performance will be assessed and managed against these outcomes by Strategic Health Authorities (SHAs), and the Healthcare Commission (HCC) will publish independent information on PCT commissioning to support public accountability.
- 2.13 Effective commissioning is about care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all sections of society. By redesigning care around the patient so that we reliably provide all the right care first time, we improve clinical quality, avoid costly readmissions, improve patient and staff satisfaction and thereby release savings that can be invested in other services. We see evidence of this not just in the NHS but in healthcare systems around the world. For example, the current 'Pay for Performance' experiment with 300 healthcare organisations working with Premier Inc. in the USA is demonstrating that reliable, high-quality clinical care, designed around the needs of patients, is lower in cost and leads to lower mortality rates and fewer hospital readmissions. Good commissioners constantly seek to reinforce a virtuous circle of service redesign around the patient.
- 2.14 Effective commissioning requires more than success on one element of commissioning. PCTs and their practices will need to work with their patients, local communities and local partners to ensure all the elements of commissioning described in figure 1 below are delivered effectively.

Figure 1: The commissioning cycle for health services



Assessing needs

This will increasingly be based on more rigorous analytical approaches involving population segmentation and risk stratification and will involve public health professionals, local authorities, GPs and patients and the local community.

Reviewing service provision

Practices will identify gaps and the potential for improvements in existing services. PCTs will use the aggregated intelligence of their practices and their local needs assessment to identify gaps or inadequacies in provision, as well as broader requirements for service development.

Deciding priorities

The PCT should produce a strategic plan for the health community based on data on needs assessment collated from practices and on the clear choices patients are making. Practices and PCTs should work collectively to reinvest resources that have been released through service redesign where these would achieve greater impact. PCTs should ensure patients and the local community, as well as local government and other partners, are properly involved in the process of deciding priorities.

Designing services

Practices will work individually, or in groups, to develop strategies and service models to improve healthcare services and address the priorities of the public.

PCT prospectus

The PCT prospectus will signal the strategic direction for local services, highlighting commissioning priorities, needs and opportunities to service providers, offering a focus for discussion with patients and local community and an opportunity to open dialogues with potential providers.

Shaping the structure of supply

PCTs will be clear about the services and service specifications they and their practices and patients want to see developed and will give strategic support to proposals where necessary. They will seek to develop new services and will work with NHS Trusts and Foundation Trusts, expanding GP practices, neighbouring PCTs and private and third sector providers to ensure the best services for local people.

Where appropriate, PCTs will encourage practices to offer services locally and also attract private sector and third sector providers to offer services in line with identified needs and priorities. Incentives and levers will be available to PCTs to stimulate the supply of services.

PCTs will agree contracts with local secondary care providers within a new national contracting framework, with the involvement of practice-based commissioners. For a few very specialised services, contracts will be held at national level. For other specialised services, PCTs will group together to set contracts.

Managing demand and ensuring appropriate access to care

Practices and PCTs will establish strategies for care and resource utilisation to ensure that patients receive the most appropriate care in the right setting, ensuring that healthcare resource is maximised.

Clinical decision making

Individual practices and clinicians undertake individual needs assessments, make referrals and advise patients on choices and the treatments available to them – each referral is effectively a micro commissioning decision. Practices will work with social services and other agencies where appropriate to assess the needs of their patients. It will be important to facilitate the opportunity for patients to make their choices with the benefit of good advice from their GP. PCTs and local authorities should work together to develop this environment in which integrated working between practices and social services is the norm.

Managing performance

Practices will seek to manage their indicative budget to maximise the benefits from the resources available to them. To help them, PCTs will provide a support programmes including training and development, and will develop systems to allow practices to monitor the services their patients receive through accurate, relevant and timely data. PCTs will be responsible for the aggregated financial position and for ensuring financial balance overall.

Patient and public feedback

PCTs will be responsible for measuring and reporting on patients' experience. Practices will also want to monitor patients' satisfaction. Robust mechanisms for collecting and understanding patients' views will need to be developed by PCTs and made available to practices. Throughout, PCTs will ensure that the public voice is heard in the development of priorities and shaping services.

- 2.15 PCTs and practices will achieve the goals of effective commissioning through:
- > information to support commissioners, including drawing on the skills of companies with particular expertise, for example in population risk assessment, social marketing, etc;
 - > better clinical engagement, for example through PBC;
 - > improved community engagement and stronger voice through a new Prospectus, patient and community petitions and the work of the proposed new Local Involvement Networks (LINKs);
 - > incentives and contracts for commissioners; and
 - > increased choice for patients.
- 2.16 **Table 1** summarises how the commissioning elements together can achieve the objectives and the box below gives an example of where this is happening now. The rest of this section then discusses the key issues.

Central Cornwall PCT has taken a whole system approach to the management of long-term conditions. Community matrons are working alongside GPs in the EPIC practices. The GPs and their teams have been able to access services rapidly via the community matron, who has a workstation within the practice and access to the patients' records. Practices report far greater co-ordination of care and access to services. They particularly value the monitoring role of their elderly patients.

Using a benefits realisation format, they have been able to demonstrate a reduction in emergency admissions of 457 across Cornwall, the facilitation of 84 early discharges, reduced GP visits in and out of hours and increased patient satisfaction, generating savings of £975,000.

Table 1: Delivering the objectives of effective commissioning

	Information	PBC	Prospectus	Community voice	Increased choice	Effective incentives and contracts
Improve health and wellbeing and reduce health inequalities	Good population-needs information from general practices, local authorities and public health data will enable services to be targeted at very specific local needs at neighbourhood level and be sensitive to the needs of excluded and disadvantaged groups.	Patient-level knowledge held in practices will enable very specific targeting of commissioning priorities. PBC facilitates redirecting resources towards health and wellbeing.	Prospectus is developed with engagement of local people, and PCT is accountable to them for contents, so highlights local issues. Prospectus informs providers of specific population needs to be met. Encourages new providers where specific needs are to be met..	Engagement of communities in needs assessment and service planning will highlight local inequality issues, issues of cultural diversity and health-gain priorities. Accountability to community ensures PCTs address local priorities. Involvement of PCTs in Local Area Agreements (LAAs) and Local Strategic Partnerships (LSPs)	Providers incentivised to tailor services to local needs and priorities or they risk losing potential patients.	Contract specifies health inequalities and health-gain initiatives to be addressed by provider.
Improve quality, effectiveness and efficiency	Outcome and patient experience data widely available to inform choice. National and international benchmarking information will help PCTs target services where they can make the most impact. PCTs and practices will be able to identify individual patients who experience multiple hospital admissions and provide more efficient and appropriate support.	GPs and practice-based commissioners act as the integrators of care for their local population. Clinical engagement of primary care and hospital clinicians to develop efficient care pathways and improve outcomes. Quality of clinical services enhanced by the clinical involvement in commissioning. PBC and Pbr incentivise development of community alternatives to hospital services.	Prospectus will identify services where quality, efficiency and productivity initiatives will be targeted. Encourage alternative providers where an incumbent performs poorly.	Engagement of patients and local people will result in measures of quality that matter to them. Public petition triggers formal review of poorly performing service.	Providers who provide high-quality, safe services with good outcomes and positive patient experience will be favoured above those who do not.	Potential quality criteria in contract (proposal subject to consultation). Potential bonuses or financial penalties for quality (proposal subject to consultation). 18-week total waiting time target included in contract. Incentives for greater productivity through PbR payment regime.

	Information	PBC	Prospectus	Community voice	Increased choice	Effective incentives and contracts
Increase choice and responsiveness	<p>Expectations of local people will be clearly set out to providers.</p> <p>PEXIS information summarises patient survey data for PCTs.</p> <p>Key quality, safety and performance indicators available to inform choice.</p>	<p>Practices incentivised to expand the range of services they provide.</p> <p>Patient-level knowledge of population enables more responsive commissioning.</p> <p>Partnership with local authorities to jointly commission health and social care will result in more integrated, responsive services.</p>	<p>Prospectus developed with community involvement signals how providers respond to local needs.</p> <p>Prospectus can encourage new providers in areas where choice is inadequate.</p>	<p>Patients and local people engaged in whole commissioning process.</p> <p>Communities can petition for review of specific services.</p> <p>PCTs accountable through Prospectus to LINKs/OSCs for plans.</p>	<p>Providers incentivised to respond to local population needs and wants to attract patients.</p>	<p>Contract specifies requirements for responsive services.</p> <p>PCTs have a responsibility to ensure and sustain choices for patients by contracting with a range of providers.</p>
Comprehensive services	<p>Information will be available for providers on what constitutes a comprehensive range of services to meet population needs.</p> <p>Commissioners and providers will use timely activity and financial information to alert them to the risk of a service becoming unviable.</p>	<p>PBC must support PCTs in ensuring a comprehensive range of services is available to meet population needs.</p>	<p>Range of services required to meet local need set out in prospectus.</p> <p>Community involvement in planning highlights service gaps.</p>	<p>Local people have the right to petition PCTs formally if a provider fails to respond to local needs.</p>	<p>PCT would fail in its duty to sustain real choices for patients without provision of a comprehensive range of services.</p>	<p>Potential for time-bound opportunity to incentivise for new providers to set up.</p> <p>Potential to contract for 'bundles' of services to mitigate financial risk to providers who may be unwilling to provide a service where costs exceed the tariff price.</p>
Achieving best value within available resources	<p>PCTs will require close to real-time financial and activity information to provide to practices to effectively manage within budget.</p>	<p>PBC will incentivise clinicians to redesign services to deliver appropriate care and eliminate unnecessary costs.</p> <p>Practices will manage and be accountable for indicative budgets.</p> <p>Commissioners will be able to secure appropriate care through referral and treatment protocols, referral management centres, prior approval and utilisation review.</p>	<p>Set out services to be delivered to meet needs of the population within available resources.</p> <p>Regular review of performance against plans by PCTs and providers.</p>	<p>Local people consulted on priorities.</p>	<p>PCTs need to ensure that cost-effective choices (eg non-surgical interventions, services transferred from hospital to community) are available.</p>	<p>Contracts will clearly set out the responsibilities of the commissioner and provider, including assumptions on activity profiles and an agreed approach to managing risk, including over-performance. (Detailed content of contracts for 07/08 subject to consultation.)</p>

Improve health and wellbeing and reduce health inequalities and social exclusion

- 2.17 The second phase of this commissioning framework, to be published in December, will address in greater depth how commissioning will contribute to health and wellbeing and deliver the commitments made in *Our health, our care, our say* and the outcomes in *Independence, Wellbeing and Choice*. In essence, social care commissioning, health commissioning and joint commissioning all contribute to improving health and wellbeing of children and adults. Early experience from joint commissioning in children's services is available to inform the development of this work. In addition, The Maternity Plan will be published in October, and will support commissioners to deliver the Government's commitments on choice and continuity of care, and the provision of services in community settings.
- 2.18 The characteristics of effective commissioning to improve health and wellbeing and reduce health inequalities are as follows:
- > It covers whole communities, not just current users of services, and is based on accurate, detailed assessment of local needs and characteristics, arrived at through partnership with local authorities, communities and other local partners. Directors of Adult Social Services (DASS), Directors of Children's Services (DCS) and Directors of Public Health (DPH) working across health and local government will carry out regular joint strategic needs assessments of their local populations.
 - > It is commissioned by working across systems and partnerships and at different levels, from specific services (such as smoking cessation support) to complex, whole-community initiatives managed and delivered across a range of public, private and third sector partnerships.
 - > It supports local partnership commissioners from local authorities, PCTs and PBCs in taking a whole-system approach to service transformation using the vehicle of Local Area Agreements (LAAs) to simplify and pool funding streams. Similarly, Local Strategic Partnerships (LSPs) will need to work closely with PCTs to develop Local Delivery Plans (LDPs) and PBC plans.

- > It can improve the effectiveness of prevention and early intervention services, so that users will be better served and demand for complex health and social care services reduced. Many prevention initiatives bring benefit in the long term, while some can realise benefits very quickly. Individual budget pilots enable people needing social care to determine the nature of the services and support they require.
- > It promotes the health and wellbeing of all population groups in the commissioning of health services, in ways that are fair and equitable to all sections of society. PCTs must be able to demonstrate progress in reducing health inequalities over time and ensure that in their commissioning decisions the opportunities for promoting equality (on grounds of gender, disability, ethnic or national origin, religion, age, sexual orientation and social class) have been considered. PCTs should undertake equality and diversity impact assessments on their commissioning plans, as required.

As we develop the second phase of the commissioning framework we will provide further guidance on this. In the meantime, PCTs should be aware of the procurement guidance on equality from the Commission for Racial Equality, available at www.cre.gov.uk/duty/procurement.html.

Secure access to a comprehensive range of services

- 2.19 PCTs will be expected to secure access to a range of high-quality healthcare services to meet local needs. This will include maintaining existing services, developing new services to deliver care closer to home and meeting patient expectations.

New services

- 2.20 The combination of patient choice and Payment by Results (PbR) provides real incentives to providers to develop responsive services which patients want to choose. PCTs will work with existing and potential providers to ensure that they understand the services required by the local population and the opportunities to develop new services, to meet unmet needs, or to improve the quality of service on offer.
- 2.21 We recognise that establishing new services (either as an existing provider or a new provider) can have additional costs or higher risks than

simply continuing to offer the established services. For this reason, a commissioning model based on patient choice and tariff alone may not be always be sufficient to secure the development of new services. PCTs may therefore need further mechanisms to support new services.

- 2.22 There are a number of approaches PCTs could choose to adopt to reduce the risk for providers and consequently make the provision of new services more attractive to existing providers or new entrants, including those from the third sector. The main options are outlined below. Whether or how these are applied could potentially have significant implications for whether there is a 'fair playing field' between providers. While the decision to use additional incentives is a matter for local discretion, we would expect PCTs to follow the following principles if offering an incentive:
- > The PCT must be able to demonstrate that the required service would not be provided if additional incentives were not made available.
 - > Any incentive must be strictly time limited.
 - > Decisions to apply an incentive must be transparent and auditable.
 - > Any incentive must produce specific and measurable benefits and must be supported by a robust business case.
 - > The process for awarding the incentive to a provider must be open to any willing provider, and proportional and transparent.
- 2.23 These principles are essential if we are to preserve the basic incentives for quality and productivity which are embedded in the national tariff. The use of additional incentives must be justified and not simply used as an excuse to support higher payments to providers who are struggling to meet the requirements of the national tariff.
- 2.24 To ensure that PCTs use the range of additional incentives appropriately, their use will have to be authorised by the SHA. Where PCTs develop a track record of effective development of local services and good financial performance, they can expect greater freedom in their decision making on the use of additional incentives.
- 2.25 Possible approaches include the following:

- > **Pay a supplement to the tariff.** In some scenarios it may be appropriate for PCTs to offer a start-up allowance or supplement to the tariff, such as the 'pass-through' payment allowable under PbR local flexibilities, to cover the set-up or development costs faced by a new provider. For services not covered by the tariff, PCTs will need to agree the price with the provider, sufficient to secure provision but while offering best value.
- > **Provide guarantees within the contract.** The level of risk for the provider could be reduced by extending the contract term and providing guarantees of the minimum income to be provided.
- > **Reduce the capital investment required from the provider.** Where a new service would require significant capital investment, the PCT could seek to lower the barriers for new providers by considering a variety of different ownership and service delivery models which reflect the range of services provided and the different funding sources available. These include:
 - public ownership: publicly owned assets and services run by either PCTs or acute providers;
 - not-for-profit ownership: assets owned and run by the third sector, for example charities, social enterprises and co-operative ventures;
 - independent sector ownership: assets owned and run by the independent sector; and
 - joint venture ownership: any combination of the above, for example privately owned assets with services run by the NHS or third sector.

Existing services

- 2.26 PCTs will also be concerned with maintaining the delivery of existing services where these deliver high-quality, cost-effective care. As patients are given more choice, providers more freedom and as the tariff is embedded, it is possible that some providers of hospital care may wish to withdraw from some services they have traditionally provided. In many cases, where this is part of local service realignment to deliver the *Our health, our care, our say* goals of shifting care, this is healthy. Equally, where alternatives already exist or can easily be developed, this may be appropriate. PCTs must also be able to ensure the continuity of essential

services, where these cannot easily be replaced. The measures required to provide such protection will be addressed in guidance on the management and regulation of the healthcare system, to be published later in the year.

- 2.27 NHS Foundation Trusts provide an example of one possible approach. They already have to provide a range of mandatory services as part of their terms of authorisation. We will consider whether similar approaches are required to secure the continued provision of essential services from all other healthcare providers. Commissioners will need to be closely involved in any process to determine mandatory services.

Improve the quality, effectiveness and efficiency of services

- 2.28 A key objective of commissioning is to improve the quality of services for patients, either by securing new or different services from a range of public, private and third sector providers or by securing quality and performance improvements in existing services.
- 2.29 Choice and PbR provide real incentives to improve quality in elective services, as high-quality services should attract more patients and resources. Where choice is limited, and for services not yet covered by the PbR regime, practices and their PCTs will need other approaches.
- 2.30 For all services, a minimum acceptable level of quality and patient safety will be ensured through the regulatory framework. Additional incentives could be targeted at driving improvements in clinical outcomes and patient satisfaction. Possible approaches are explored in appendix C. They include the following:
- > **Contractual standards.** These would require the delivery of specified levels of performance against clinical outcomes and patient experience measures. The contract would include sanction or incentive regimes to encourage delivery.
 - > **National or local quality bonus scheme.** A separate fund could be established to reward performance and quality improvement. The fund would be paid out on the basis of relative performance against a defined set of clinical outcome and patient satisfaction measures, with a sliding scale of payment depending on performance.

- 2.31 The White Paper *Our health, our care, our say* set out an expectation that, from 2007, PCTs will develop a systematic programme to review the services they commission on behalf of the local population, working with practice-based commissioners and other partners.
- 2.32 PCTs will be expected to ensure that providers of community health services accord with the direction set out in the White Paper on service equity, quality and value for money. Priority for review should be given to services where there is public or local authority Overview and Scrutiny Committee (OSC) concern, or where locally agreed business plans are not being met. PCTs will be expected to seek the views of patients and users and use benchmarking information to assess performance against good practice.
- 2.33 We expect PCTs to be robust in their management of services that do not meet the necessary quality. Where there are deficiencies in service quality, the PCT will be required to set out a clear improvement plan. This may include tendering for the service where standards fall below the expected standard, either immediately or where improvement goals are not delivered after one year.

Improving the quality of information for commissioning

- 2.34 The intelligent use of good information is crucial to effective commissioning and driving improvement in services.
- > The ability to obtain accurate referral, activity and financial information in a timely way – as close to real-time as possible - to analyse it effectively and predict trends (in patient flows and service viability) will be cornerstones of successfully managing local health economies.
 - > Working with partners and communities to gain real local intelligence is crucial for good needs assessment, to make use of available data sources and needs analysis tools which can drill down to neighbourhood level.

- > Use of national (and international) benchmarking information will help practices and PCTs focus attention where there are opportunities for making savings while sustaining or improving services. This should include information on length of stay, day-case rates, FFCEs per consultant and follow-up outpatient appointments.
- 2.35 PCT information requirements will be specified nationally in contracts and PCTs will make the information available to their practices.

Strategic information solutions

- 2.36 Connecting for Health has established the Secondary Uses Service (SUS) which, once fully developed, aims to provide timely patient-based data and information for all NHS-commissioned services through the National Care Records Service. Information on SUS can be found on the Connecting for Health website at www.connectingforhealth.nhs.uk/sus.

Information tools available now

- 2.37 National information solutions such as SUS will take time to develop. In the meantime, commissioners will need to make optimum use of information tools that are currently available. For example, one area where we know commissioning can be greatly improved is in stroke services, where there is considerable scope to improve the patient experience and to reduce mortality, disability and lengths of stay. We have developed a simple tool that can assist commissioners in comparing how their local services perform (available to download from www.dh.gov.uk/stroke).
- 2.38 A PBC information management template has been produced to assist with the requirements of PBC. It is available at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning.
- 2.39 In addition, we have evaluated similar tools that have been developed by local NHS organisations. We are publishing the conclusions of this exercise, alongside the template. Further details are available at the web address above.
- 2.40 In February 2006, the NHS Appointments Commission publication *The Intelligent Board* set out the information that NHS Trust boards require to discharge their responsibilities effectively. In itself, this provides a helpful checklist for measuring providers' performance and will be followed by a

second publication, *The Intelligent Commissioning Board*, aimed at SHA and PCT boards.

- 2.41 The NHS Institute for Innovation and Improvement has published useful information in *Delivering Quality and Value – focus on productivity and efficiency*, which enables PCTs to benchmark local services against a national picture in areas where there is greatest variation in practice and performance (and therefore opportunity for improvement).
- 2.42 The Department of Health PEXIS system enables an analysis of patient survey data by individual organisation.

Increase choice for patients and ensure greater responsiveness to people's needs

- 2.43 Through choice and increased voice, local people and patients will have a central role in influencing commissioning to ensure that health and social care services are matched to their needs and preferences.
- 2.44 Choice, individual social care budgets, PBC and PbR mean that commissioners already have the tools to support the delivery of patient-centred services.
- 2.45 To support active choice, information on health services should be presented to patients in clear and engaging formats. It will need to address all preferred methods of communication, including language and level of literacy.
- 2.46 In addition, commissioners will also need to ensure that patients and communities, including harder-to-reach groups, are involved throughout the commissioning cycle. Full consultation will help to achieve this, and many third sector organisations should be systematically involved, as they are able to provide valuable insights into users' views and unmet needs, as well as provide clear and well-grounded views on how best to achieve the outcomes service users want.

PCT prospectus

- 2.47 The PCT prospectus will be developed as a proactive method of communicating with patients and the public and could provide a focus for

debate on local needs, performance of local services and the priorities for improvement. In setting out the PCT's forecast requirements, the prospectus will also provide a signal to providers on the services they may wish to develop and the likely demand they can expect. Along with HCC-published information, it will provide an important vehicle for public accountability.

2.48 The PCT prospectus will:

- > set out the results of local health needs assessments;
- > publish patient satisfaction and patient experience ratings of services;
- > present areas for future investment and commissioning priorities, including the longer-term strategic direction and a forecast of future service needs;
- > stimulate service development by signalling commissioning priorities and opportunities to potential providers; and
- > provide direct public accountability for commissioning decisions and performance by explaining what and why particular commissioning decisions have been taken, such as why investment has been made in certain service areas and not others.

2.49 PCTs will also present a three-to-five-year forecast of future service needs and anticipated demand. Forecasts would describe plans to:

- > achieve LDP priorities; and
- > address specific local needs in addition to those covered by LDPs – for example extra diabetes provision in response to high local demand.

2.50 There are already many examples of good practice in this area, with a number of local areas making good use of the existing *Your guide to local health services*. This prospectus will develop from these existing foundations and will be distributed directly to local providers. It will also be published on PCT and local authority websites so that it is available to the public and to potential providers from outside the area. The

prospectus will need to be written in a format and terms that will be accessible to members of the public.

Strengthening the community voice

- 2.51 The proposed new Local Involvement Networks (LINKs) will have a key role to play in helping commissioners use people's knowledge and experience to improve the services they use. LINKs will gather and analyse information from a wide range of people and sources, identify and pass on trends and concerns, and make recommendations to providers and commissioners. Further information on LINKs is given in *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services*.
- 2.52 There is also scope for local authority OSCs to express concerns with regard to a specific service or area and for this to trigger a review by the PCT, as well as more broadly facilitating engagement and debate. Where an OSC makes criticisms, the PCT should respond and detail their plans, or transparently explain and justify their reasoning. LINKs will establish a specific relationships with OSCs and will have the power to refer matters to OSCs.
- 2.53 Section 11 of the Health and Social Care Act 2001 currently places a duty on all NHS organisations to make arrangements to involve and consult patients and the public in the development and planning of services and in how services operate. There are plans to extend the duty to involve and consult and to use the commissioning cycle to clarify what is expected of commissioners at each stage (see *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services*).
- 2.54 In circumstances where members of the public feel that services are unresponsive or resistant to their needs, there is an option to undertake a petition. Further details about this are provided in appendix E, Triggering Community Action.
- 2.55 The PCT will be expected to publish its response to petitions (as it will to concerns from regulatory bodies such as the HCC and the Commission for Social Care Inspection/CSCI) and should make improvements as soon as possible (within a maximum of 12 months). As set out in

paragraph 2.33, we expect PCTs to be robust in their management of services that do not meet the necessary quality.

Achieving best value within the resources provided

- 2.56 PCTs have a statutory duty to achieve financial balance. They are required to work within the resources made available to them by the taxpayer, delivering the best-quality care and securing the best value for money.

Milton Keynes admission avoidance/facilitated discharge

Milton Keynes PCT and Council are working together to provide joint health and social care intermediate care services, which offer a community-based 24/7 joint rapid response and a single point of contact. This has resulted in:

- > an average of 89 admissions avoided per month;
- > an average of 95 discharges speeded per month; and
- > a net return on investment of £33,500 per month.

- 2.57 The introduction of PbR provides real incentives to improve productivity and efficiency. Efficient providers will generate surpluses under PbR which can be used to fund service developments. For commissioners, PbR provides an incentive to fund more efficient community services to reduce their reliance on hospital-based treatments.
- 2.58 By focusing care around the patient, it is possible to improve outcomes and the patient experience while saving money:
- > **Prevention:** Some health prevention measures can show real benefits for patients and taxpayers quickly, for example stopping smoking can improve heart/respiratory conditions within 12 months.
 - > **Ensuring appropriate services are in place:** Reduction of emergency conditions, by better management of long-term conditions, can show results within 12 months. Provision of GP/nurse practitioner primary care at A&E provides more appropriate care and can lower hospitalisation rates.
 - > **Effective forecasting and planning:** This should be reinforced by the inclusion of planned activity levels in contracts and regular review of performance against plans by PCTs and providers.

- > **Practice-based commissioning:** PBC ensures that practices have real incentives to redesign services to deliver new community-based care and better value for money.
- > **Focusing on clinically-effective activities:** A considerable amount of the activity that the NHS undertakes has little or no evidence to support it. It may have been superseded by more effective treatments or tests, be duplicating other treatments or tests, or simply be without clinical evidence. PCTs should focus on reducing this expenditure before reducing activities that we know to be effective.
- > **Referral and treatment protocols:** For example, a musculo-skeletal triage service in Manchester now deals with 90% of orthopaedic referrals by a specialist physiotherapist as part of a multi-disciplinary team, with increased patient satisfaction. A further example from East Devon is highlighted below.

East Devon PCT specialist orthopaedic physiotherapist role

A whole system approach is used involving working with GPs, consultants, an extended scope physiotherapy practitioner and East Devon physiotherapists. A physiotherapist, specially trained in skeletal orthopaedics, is based in the community and co-ordinates a weekly triage facility at three East Devon localities through which GPs can refer patients who may benefit from alternative intervention to surgery for (initially) hips and knees. This has resulted in:

- > secondary care referral avoided for 74% of patients, who instead get conservative treatment and pain management close to home;
- > overall conversion of referrals from specialist orthopaedic physiotherapy to secondary care increasing to over 80%. Prior to this service being introduced, average conversion rate in the secondary care setting was 27%;
- > secondary care outpatient appointments being freed up; and
- > a net saving of over £16,000 in the first five months.

- > **Reducing unexplained variations in utilisation:** Referral rates, diagnostic testing rates, A&E attendance rates and surgical intervention rates vary hugely across the country between PCTs and between hospitals, with no correlation to need or outcome. PCTs should help their practices manage this through the provision of information, support and strong commissioning from their hospitals. The NHS Institute will support PCTs and hospitals with benchmarking data to identify the potential for savings.

Where improvements are slow to come and expenditure is being committed disproportionately to particular groups of patients or clinical conditions, PCTs may wish to implement more interventional approaches such as:

- Referral management centres (RMCs) that accept GP referrals and provide advice on the most appropriate next steps for the treatment of the patient. These are appropriate only where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice.
- Prior approval requires clinicians in secondary care to confirm the appropriateness of a proposed intervention or course of treatment with the referring GP (including for consultant-to-consultant referrals).
- Undertaking utilisation reviews to assess the appropriateness and setting of admissions, with the aim of reducing not only the level of inappropriate admissions, but also ensuring the patient is in the most appropriate setting at all times throughout their care.

When used appropriately in response to local circumstances, alongside the incentives and controls in the basic operating environment (PBC, PbR and choice), these strategies can provide a range of controls to manage NHS expenditure effectively over time and ensure that patients who need hospital care get seen quickly. Further information on these approaches is provided in appendix A.

Wakefield older people's mental health rapid access service

Inpatient assessment and treatment has been replaced with:

- > single point of contact for referrals, a rapid-access clinic providing one-stop assessment, care planning and delivery of care packages, with the aim of supporting people in their own homes and giving rapid access to medical, nursing and therapy staff;
- > intensive home treatment service for short-term specialised treatment;
- > day treatment or short-term treatment for people with functional mental health needs; and

- > a liaison service to general hospitals and care homes.

This has resulted in significant improvements in the quality of patient care and savings to the NHS:

- > Average wait time for initial assessment has been reduced to four days (two hours for urgent referrals).
- > Assessment and treatment are carried out at home wherever possible.
- > Packages of care are put in place immediately to prevent crisis escalation. Crises now rarely arise in the evening (when many older people feel more vulnerable).
- > In the first 12 months, of 865 referrals received, less than 5% resulted in inpatient admission.
- > Inpatient bed base has reduced, admission rates have reduced and bed occupancy has dropped from 102% (2003-04) to 88% (2005-06). Length of stay (LOS) and bed days have reduced due to the ability to support discharge with the home treatment team.

Interim measures

- 2.59 While practices need to implement these strategies now, it will take time for them to become fully effective. Interim controls may therefore be needed while the system matures, to enable PCTs to remain within budget. Each year the Department of Health will publish an operating framework that explicitly sets out the controls that can be appropriately applied, taking full account of the progress on embedding the health reform programme. In exceptional circumstances, an SHA may request permission from DH to introduce additional measures to dampen volatility in a particularly financially challenged community. Where this involves an NHS Foundation Trust, additional measures will only be implemented after seeking to agree them with Monitor.
- 2.60 Contracts offer the possibility of much more explicit agreements on the activity expected by the commissioner and the responsibilities and obligations of providers. For 2007/08, it is possible for contracts to play a more significant role in securing financial balance. Appendix C sets out proposals for consultation. The key issues relating to financial control are set out below.
- 2.61 The rules for this year were set out in the NHS operating framework in July. As set out in the operating framework,³ in exceptional circumstances an SHA may request permission from DH to introduce

³ *The NHS in England: the operating framework for 2006/07*, DH, January 2006, para. 6.9

additional measures to dampen financial volatility in a particularly financially challenged community.

- 2.62 Contracts must embody a clear understanding of the respective responsibilities of commissioners and providers. They must set out agreed assumptions on activity profiles, including the broad underlying assumptions on GP referrals, consultant-to-consultant referrals, conversion rates, emergency attendances and admissions, progress towards 18 weeks and achieving financial balance.
- 2.63 These activity profiles should reflect the need for practice-based commissioners and providers to innovate and improve local services - so such activity assumptions should be **ranges**, rather than fixed figures or crude activity caps. In particular, providers who attract additional patients through Choice by improving the quality of care must be free to receive the appropriate rewards under PbR. In signing such contracts, all parties are making a joint commitment to work together towards the local delivery of such activity profiles. In developing this contracting approach PCTs and providers will want to focus their efforts on those high volume, high value procedures where clear agreement will bring the most gain.
- 2.64 If activity exceeds the profiled levels by more than an agreed margin, a PCT should work through a checklist of questions with practices and service providers to determine where responsibility lies for any 'over-trading' that threatens local financial balance:
- > Has the expected volume of activity been realised?
 - > What is the distance from the agreed profile of activity?
 - > Has a clinical audit been undertaken?
 - > Are referrals on profile?
 - > Is the 'conversion rate' of outpatients to inpatients/day cases within the appropriate range?
 - > Are patients being treated according to clinical priority, fairly, and in line with agreed waiting-time reductions?
- 2.65 Where local financial balance is at risk, these questions should allow the PCT to be clear in identifying the root cause of any local problems.

Addressing these should always start with a process of negotiation and discussion between PCTs and others, to agree mutually the way ahead.

- 2.66 Where additional activity is the result of primary care-generated referrals, PCTs will be expected to pay providers for this activity. To address excess referral rates that put financial balance at risk, PCTs will need to work with practices and practice-based commissioners to change referral behaviour accordingly. If appropriate, they may have to reprioritise their budget. Actions might include, in order:
- > identifying the practices or the care pathways where referral rates are significantly above expectation;
 - > providing targeted benchmarking information to such practices or on such care pathways;
 - > selecting and monitoring more closely such referral patterns, and providing targeted support to the practices concerned; and
 - > establishing local peer review processes whereby local practices can discuss and address each other's performance.
- 2.67 Where additional activity puts financial balance at risk and is the result of provider decisions that go beyond the ranges of agreed activity and underlying assumptions (such as conversion rates and consultant-to-consultant referrals), then likewise the contract should enable appropriate action to be taken, such as the enhanced scrutiny, benchmarking and peer review mechanisms listed above. If this proves ineffective, then the contract will enable the PCT to make reduced payments for activity in excess of plan. Measures could include:
- > allowing PCTs to stipulate temporarily the maximum number of cases to be treated per annum and per quarter in the affected specialty; and
 - > paying a rate below tariff for activity exceeding the planned level;
- 2.68 Such approaches should be based on the number of referrals from primary care and expected conversion rates. Providers who attract additional patients from referrals from primary care providers must still be free to earn the appropriate rewards under PbR.

- 2.69 There is the potential for future contracts to set out an agreed mechanism for dispute arbitration, to tackle difficulties in reaching an agreed contract, or disputes over the application of the contract terms. This is one of the issues raised for consultation in annex C.

Assuring the validity of transactions

- 2.70 Accurate clinical coding is vital for ensuring the validity of claims and payments for acute services. In turn, accurate coding depends on accurate recording of patients' diagnoses and treatment. Therefore, it is right and proper that the PbR system should introduce incentives for providers to improve the quality of clinical data and we have put in place training and support for clinical coders through *NHS Connecting for Health*.
- 2.71 However, there is a risk that these incentives encourage providers to manipulate clinical data in order to maximise income. To maintain credibility we need to have appropriate checks and balances around the accuracy of claims and payments, which is an important role of commissioners and contract managers. In addition, we have asked the Audit Commission to develop proposals for an assurance framework for PbR, focused on provider data quality. During 2006/07, this work is being piloted in the former Strategic Health Authority areas of South Yorkshire and Avon, Gloucestershire & Wiltshire, comprising two main elements:
- > benchmarking of provider data; and
 - > clinical coding audit.

3. Roles and responsibilities for effective commissioning

- 3.1 This section briefly sets out the main roles and responsibilities for effective commissioning, starting with the Department of Health's (DH) role to provide fair funding to commissioners.

Fair funding for commissioning health services

- 3.2 Since 1997, the funding available to DH has increased very substantially. A growing proportion of the total funding has been devolved directly to Primary Care Trusts (PCTs), which now directly control around 80% of the NHS budget.
- 3.3 Changes have also been made to ensure that NHS funding is as fair as possible. There was a major review of the formula for the allocation of funding to PCTs in 2003/04, particularly to the element of the formula that directs funding to the most deprived areas. This found significant discrepancies, with some PCTs receiving over target and some under. Funding allocations will continue to reduce this inequality, ensuring that while all areas continue to receive substantial growth, those which need the most will get the biggest increases.
- 3.4 There may be concern that, with organisational changes, more deprived areas will lose out. Practice based commissioning (PBC) will enable new PCTs to allocate resources at GP practice level, thus targeting the health needs of neighbourhoods rather than at large population level. This will allow them to confront the inequalities where they truly exist at neighbourhood level. Strategic Health Authorities (SHAs) will monitor PCTs to ensure that they are correctly targeting areas of greatest health need.
- 3.5 Some PCTs continue to argue for a greater share of resources. We will keep the funding formula under review, but allocations made for 2006/07 and 2007/08 will not be changed. It is the responsibility of the PCT board to operate within the cash limit.
- 3.6 SHAs have been asked to establish a regional reserve that will support organisations while they return to balance. PCTs that have stayed within

their budget or delivered a surplus have been asked to contribute. However, that money will not be lost to those communities. It will be repaid, normally within the three-year allocations period; those areas with the greatest health needs should be repaid first.

Commissioning roles for PCTs and practices

- 3.7 Commissioning cannot be regarded as a set of activities carried out in isolation, rather there are a number of roles and responsibilities, which interact to ensure that effective health and social care services are commissioned at all levels. The key roles are set out in table 2 below.

Table 2: Roles and responsibilities for effective commissioning

	Information	PBC	Prospectus	Community voice	Increased choice	Effective incentives and contracts
Patients and the public	Give feedback on service quality and experience.	Give feedback on service quality and experience.	Engage in development, including: - identifying need; - assessing performance; -deciding priorities.	Views of the community and representative groups feed into commissioning.	Choose the provider that is best for the individual.	Give feedback on service quality and experience.
Practices	Help patients understand the information available about services and support choice.	Engage with community in drawing together PBC plans. Develop proposals for service and clinical pathway redesign.	Contribute to needs assessment. Represent patient views. Contribute to the development of priorities.	Engage with community in drawing together PBC plans.	Provide patients with information and advice about services.	Inform PCT about quality requirements for contracts with providers.

	Information	PBC	Prospectus	Community voice	Increased choice	Effective incentives and contracts
PCTs	<p>Ensure information on quality and patient experience is available to practices and the public.</p> <p>Develop data systems to monitor service quality and contracts.</p>	<p>Support practices through provision of indicative budgets, clinical and management information, analysis of population needs and comparative data.</p> <p>Provide governance for practices and report to SHA on all services developed in community.</p> <p>Agree PBC business plans.</p>	<p>Produce the prospectus.</p> <p>Manage the production process.</p> <p>Provide public health analysis.</p>	<p>Actively facilitate community engagement and debate.</p> <p>Obligated to formally respond to community petitions.</p> <p>Undertake review of services when asked to do so by Overview and Scrutiny Committees or a community petition.</p>	<p>Support practices in ensuring information is provided on services and choices.</p> <p>Ensure patients have a choice of providers for choice applicable services.</p>	<p>Agree and sign contracts with local providers.</p> <p>Enable the development of new services.</p> <p>Develop data systems to monitor service quality and contracts.</p> <p>Manage contracts with providers.</p> <p>Settle invoices from providers.</p>
SHAs	<p>Responsible for supporting and performance managing the implementation and operation of new commissioning arrangements.</p>	<p>Ensure that relationships between PCTs and GPs develop in accordance with PBC principles.</p> <p>Arbitrate where local agreement cannot be reached.</p>	<p>Ensure that PCTs produce their prospectus.</p>	<p>Ensure that the process for community engagement and responding to petitions and complaints is transparent and robust.</p>	<p>Ensure PCTs provide choices to patients where applicable.</p>	<p>Authorise PCT use of any additional incentives to attract providers.</p> <p>Ensure financial balance within region.</p>

Supporting practice based commissioning

- 3.8 PBC is a key element of the health reforms and will be critical in enabling PCTs to achieve the best value for patients. This section of the commissioning framework describes how PBC will be strengthened.

Local incentive schemes

- 3.9 PCTs are required to introduce an incentive scheme to engage practices in redesign. The Directed Enhanced Service (DES) incentive scheme described in earlier PBC guidance is the minimum requirement for such an incentive scheme. PCTs should consider offering additional local

incentive schemes, over and above the DES, that facilitate the provision of care in settings more convenient for patients, closer to home. Such schemes **must** be cash-releasing. They could be used, according to local circumstances, to:

- > encourage greater use by patients of primary care services rather than A&E where appropriate;
 - > encourage, where safe to do so, the management of patients in their homes, or in convenient community settings, particularly those with long-term conditions;
 - > introduce clinically-driven, protocol-based triage services;
 - > achieve reductions in follow-up outpatient appointments that do not enhance the care of patients;
 - > reduce inappropriate consultant-to-consultant referrals which could be managed in primary care;
 - > support the development of integrated care with social services and secondary care;
 - > support the development of self-care; and
 - > facilitate the achievement of the recommendations of the White Paper, *Our health, our care, our say*.
- 3.10 Incentive schemes must be clinically appropriate and supported locally and must be cash-releasing. The money made available to practices would be treated as direct income, rather than as savings, to be used as the practice chooses.

PBC – guidance on procurement

- 3.11 In January 2006 we published *Practice based commissioning: achieving universal coverage*, which provided guidance on the implementation of PBC. Since then we have been asked by PCTs and practices to clarify the approach they should take to the procurement and tendering of services.

Developing services within existing contractual arrangements

- 3.12 Existing primary care providers with General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider of Medical Services (APMS) contracts, and Specialist Provider Medical Services (SPMS) providers who hold a registered list, can develop services:
- > by extending the management of patients pre-referral, or actively discharging patients from outpatient follow-up back into practice (and the service becoming part of the 'essential' GP services); or
 - > under a Local Enhanced Service (LES) arrangement or within other GMS/PMS contractual arrangements.
- 3.13 Developments under any of the above arrangements should be assessed against criteria set by the PCT which should focus on local health need. The key minimum requirements should be that the service can provide value for money, taking into account the hospital-based tariff; that PCT approval is given for clinical governance arrangements; and that the development will assess the impact on health inequalities. The payment should be for items of service, to allow easy comparisons with the costs of tariff-based services.
- 3.14 Clinical governance arrangements should reflect the complexity of the service provided. A 'one size fits all' approach is not appropriate. Small, low risk service provision should not be required to meet standards for complex provision.
- 3.15 It should **not** be necessary to put proposed service developments supporting the achievement of national or local targets and standards out to tender for existing GMS and PMS providers (and APMS and SPMS providers holding a registered list). Approval can be given via the above approaches.

Assessing proposals to develop primary care services

- 3.16 There are two levels of primary care provision against which proposals for service developments should be considered: services for a single practice population and services provided to a wider population.

Level 1: Services for a single practice population

- > PCTs will be expected to approve PBC proposals to use resources released through service redesign in services if the proposals address a national or PCT priority, subject to appropriate clinical governance arrangements, which should be proportionate to the scale of the service.
- > Where practices wish to invest resources released through service redesign in areas that have not been identified as a priority, or wish to invest prospectively in order to achieve savings, they should obtain agreement from their PCT. If the PCT perceives a significant financial risk, it may ask for a business case.
- > Continuing funding of the service will be dependent on achievement of the assumptions in the business case, including on freeing-up resources.
- > The PCT must satisfy itself that appropriate propriety has been observed in letting contracts or employing staff.

Level 2: Services provided to a wider population

- > In addition to the requirements for level 1 full payment will be guaranteed to the provider practice for patients referred from other practices. Where the service to be provided is the same as an existing hospital service, and is within the PbR scheme, payment should be at tariff rate.
- 3.17 Contractual arrangements in both cases will be via the LES or within other GMS/PMS contractual arrangements agreed with the PCT. Short-term guarantees of activity of financial support could be agreed within a fiscal year.
- 3.18 Arrangements should be implemented so that PCTs are required to report to the SHA on all services developed in the community, providing details on price, activity levels, contractual arrangements and clinical governance arrangements.
- 3.19 Where start-up costs are proving a barrier to the development of new services for GMS and PMS providers and APMS and SPMS providers with a registered list, PCTs might consider providing pump-priming loans to start up a service by purchasing equipment or recruiting staff, having

assessed the proposal for affordability. Loans would only be available to develop services re-provided from secondary care settings, and not for core GMS services. Repayment of such loans should be factored into the price of the service. (Additional items of service payments need to be defined to offer simple, direct comparison of value for money with the Payment by Results tariff.)

- 3.20 Existing GMS and PMS providers and SPMS providers with a registered list are likely to have access to the new Expanding Practice Allowance (EPA) announced in *Our health, our care, our say*, which DH is developing in conjunction with NHS Employers. The EPA should not be confused with the new local incentive scheme announced here.
- 3.21 We know from the feedback we received in the consultation leading to the publication of *Our health, our care, our say* that patients would like more services to be provided in more convenient settings, particularly in services such as diagnostics and rehabilitation. Practice-based commissioners may develop business cases to redesign pathways to move part of the service into primary care, to meet these expectations. Policy on PbR provides the flexibility to unbundle the tariff to support this. Further national work on tariff unbundling will reinforce the expectation that local health communities will agree approaches to unbundling which facilitate care pathway redesign. Guidance will be issued shortly on this approach.

Practice based commissioning: early wins and top tips

In February 2006 DH, along with a wide range of stakeholders, including the Royal College of General Practitioners, the Royal College of Nursing, the National Association of Primary Care, the NHS Confederation, the National Primary Care Development Team (NPDT), NHS Alliance and the National Institute for Health and Clinical Excellence, published *Practice based commissioning: early wins and top tips*. This is a clinically focused document highlighting how PBC can be used to redesign care pathways and improve services for patients. It contains tips based on the experiences of individuals involved in setting up PBC, which can be used a series of prompts, as well as established examples from NPDT's experience of helping PCTs and practices redesign patient services. However, the over riding message is that patient involvement is key to ensuring success in PBC. The document can be found at www.dh.gov.uk/assetRoot/04/13/13/97/04131397.pdf.

Ensuring PCTs work together effectively

- 3.22 PCTs need to work together to share expertise, reduce bureaucracy and commission those specialised services that can only be effectively planned for a population larger than a single PCT.

Co-ordinating commissioners

- 3.23 We want to avoid creating a system in which providers need to hold separate contracts with each PCT whose residents choose to be treated there. This would be overly bureaucratic, time-consuming and expensive. We also need to avoid developing regional contracting arrangements that would be remote from practice-based commissioners and create barriers to individual relationships and dialogue between local commissioners and providers.
- 3.24 A new model for contracting, which will deliver benefits of reduced bureaucracy to PCTs without confusing governance and accountability, will be based on co-ordinating PCTs. Most providers will have a single contract, agreed directly with one PCT, usually the geographical 'host' PCT. This PCT will act on behalf of all other commissioners whose patients choose to use the provider. The contract will specify care pathways and standards that represent the requirements of all interested commissioners. The co-ordinating PCT will also ensure that providers receive co-ordinated plans of activity to help plan their services, as well as acting as a focus for service redesign.
- 3.25 In some areas, a number of PCTs may each be responsible for a significant proportion of a provider's activity. In these circumstances, the co-ordinating commissioner model will allow for SHAs to decide which PCTs should hold contracts with the provider, for example all PCTs who have traditionally been responsible for 20% or more of a provider's business. The requirements of all other commissioners will still be met through the co-ordinating PCT. This approach will maintain important local relationships while reducing the contracting burden for providers. Views on this approach are sought in Appendix C.

Shared commissioning business services

- 3.26 While the holding of contracts will be a PCT function, a range of commissioning and contracting support functions could be co-ordinated at a regional or supra-PCT level. These might include elements of needs assessment such as risk stratification, and functions like data collection and analysis. This would enable commissioners to share scarce skills and capabilities and reduce costs. PCTs, or groups of PCTs working together, will also want to consider how the private sector might be able

to support them with these functions. Arrangements for engaging private sector support are described at paragraph 4.7

Specialised services commissioning

- 3.27 Specialised services are those services provided in relatively few specialist centres to catchment populations of more than 1 million people.⁴ Specialised services are not provided by every hospital and tend to be found in larger hospitals based in big towns and cities. Specialised services are high-cost, low-volume interventions and treatments. The risk to an individual PCT of having to fund expensive, unpredictable activity is reduced by PCTs grouping together to commission such services collectively and share financial risk.
- 3.28 DH guidance on the commissioning arrangements for specialised services was last issued in March 2003. Since then, individual Local Specialised Commissioning Groups (LSCG) and Specialised Commissioning Groups (SCG) have had some notable commissioning successes. However, some concerns were expressed at the variability of commissioning arrangements across the country and the range of specialised services covered. As a result, Ministers commissioned an independent review of commissioning arrangements for specialised services. The Carter Review's report was published in May 2006, and is available at: www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/. Its recommendations were broadly accepted by Ministers and are addressed in this framework. The key commissioning requirements for specialised services are set out in more detail in Appendix B. More detailed guidance on these requirements will be issued in due course.

⁴ Statutory Instrument No. 2375, The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002, defines specialised services as those services with planning populations of more than 1 million people.

4. Building commissioning capacity and capability

- 4.1 Developing the capacity and capability of practices and PCTs to commission effectively will be critical to achieving the best value for patients and taxpayers. We are therefore introducing a range of development opportunities and capacity-building measures to support commissioners.

PCT development – building on Fitness for Purpose

- 4.2 The aim of the Fitness for Purpose programme is to ensure that all PCTs become excellent commissioners. PCTs will strengthen their commissioning function and demonstrate impact across the reform agenda, particularly *Choosing Health*, the *Our health, our care, our say* White Paper and the vision set out in *Creating a Patient-led NHS*. All PCTs will be required to design and agree a development plan, particularly focusing on board and senior level development.
- 4.3 The Department of Health is working with the NHS Institute for Innovation and Improvement and other stakeholders to prepare a focused national development programme. Key themes are likely to be:
- > board development, including integrated governance;
 - > organisational development and personal development for senior leaders;
 - > care and resource utilisation (building on the tools for care and resource utilisation highlighted in this framework);
 - > supply chain and relationship management;
 - > use of information for needs analysis, comparative performance and benchmarking as well as market segmentation;
 - > commissioning for quality and effectiveness across health and social care; and
 - > measuring and developing positive and constructive organisational cultures.

- 4.4 The programme will also identify good practice and support PCTs with networks and learning sets on clinical engagement, public involvement, partnership working and integrated commissioning, practice-based commissioning etc.

Developing an evidence base of effective commissioning

- 4.5 The NHS Integrated Service Improvement Programme (ISIP) has worked with the NHS in England to compile a database of commissioning and demand management initiatives, available through the NHS Networks website (www.networks.nhs.uk/commissioning). Work by all local health communities on the ISIP integrated planning process has provided PCTs with access to information about examples of good practice in particular fields which they can include in their own development plans.

Development of PBC

- 4.6 The Improvement Foundation (formerly the National Primary Care Development Team) is running a support programme for PBC which will involve all PCTs in England. It has three phases:
- > a preparatory phase, including a focus on budget setting and data collection;
 - > an assessment phase to review readiness for PBC using a diagnostic assessment framework; and
 - > a collaborative phase where clinical engagement and service redesign are the focus.

Further information is available at www.improvementfoundation.org.

Commissioning support services

- 4.7 Our vision for commissioning is challenging and will demand high levels of commissioning skills in PCTs and practices. The reconfiguration of PCTs will address some, but not necessarily all, gaps in capability and capacity. For many PCTs, buying in certain skills from companies with particular expertise in those areas could play a valuable role in strengthening commissioning. We are therefore undertaking a national procurement to support PCTs who wish to do so to 'call-off' a range of commissioning skills and services from the independent sector. Rather than undertaking many separate procurements, the NHS will achieve better value for money by DH procuring a single framework contract.
- 4.8 It is important that this procurement is seen in its correct context. PCTs have both a commissioning function for primary and secondary care and some responsibilities for directly providing primary care clinical services, particularly nursing and health visiting. This procurement relates **only** to the commissioning function and makes no assumptions about, nor does it have any implications for, the provider function. The commissioning function is and remains a statutory responsibility of the PCT board. The board remains accountable for the effective discharge of the function and cannot delegate this accountability to any other body.
- 4.9 PCTs will need excellent skills, for example in actuarial and population risk assessment, data harvesting and analysis, social marketing, opinion surveys, service evaluation and redesign and procurement. PCT boards may decide that these skills can best be bought in from companies with a particular expertise. This is a judgement for the boards to make.
- 4.10 The procurement will be structured in a way that will facilitate choice by PCTs – either of a particular service, a group of services, or a complete package. It will provide a menu of expert services to choose from, offering the best expertise at the best value to support them in improving the effectiveness of commissioning. For further information on the procurement go to: www.dh.gov.uk/ProcurementAndProposals/Tenders.

Appendices – further details

Appendix A Care and resource utilisation techniques

Appendix B Commissioning arrangements for specialised services

Appendix A

Care and resource utilisation techniques

A.1 This appendix describes some care and resource utilisation techniques which should be used to ensure that patients receive the most appropriate care in the right setting. A more detailed resource, *Identifying Priorities for Action*, is being developed and will be published on the DH website. This will draw on simple, nationally available data to begin a prioritisation exercise. In October we will publish a more detailed guide to care and resource utilisation and practical ‘toolkits’ covering the techniques set out below:

- > prior approval;
- > utilisation management; and
- > referral management centres.

A.2 The national model contract will set out the requirement for providers to co-operate with these techniques.

Prior approval

A.3 Prior approval (PA) requires clinicians in secondary care to confirm the appropriateness of a proposed intervention or course of treatment with the referring GP (including for consultant-to-consultant referrals). It can be a very powerful way to support best practice and to ensure the GP has a continuing oversight of the care given to his/her patient. But it can be time-consuming, so it is essential to ensure its use is appropriate and proportionate to the issue.

A.4 PA can be used in many areas. For example:

- > For consultant-to-consultant referrals in cases where local commissioners have established alternative services that can manage the patient as effectively, for example for diabetics. PA could also be used to specify enhancements to existing care, for example that joint clinics are required for cancer patients.
- > Where there is evidence of treatments being undertaken when more cost-effective interventions are available, for example tonsillectomy or diagnostic arthroscopy. A clear protocol is required when these interventions are clinically appropriate and when PA is needed.
- > For specific patients – those with complex co-morbidities often benefit from explicit co-ordination of care. This can ensure that tests are not repeated and that treatment plans are coherent.
- > When there is concern over ongoing treatments of marginal benefit, for example after a specified number of follow-on outpatient attendances.
- > To ensure better handovers between primary and secondary care, for example where decisions concerning treatment in hospital commit primary care to a particular pathway, such as pharmaceutical treatments initiated in hospital that must be continued.

A.5 PA can apply at two levels:

- > **Group level.** Commissioners and providers agree in advance how to manage patients or pathways. For example, this could include clear clinical protocols over when tonsillectomy or diagnostic arthroscopy are required. Under such arrangements, providers do not need to get PA on each individual patient; instead, they agree to treat all patients to the agreed protocol. Commissioners can retrospectively audit activity to ensure adherence to the agreement (with clear tolerances over non-adherence). Group-level PA could be applied to any of the examples in paragraph A.4.

- > **Individual level.** Providers must get agreement before initiating treatment on a specific patient. Clear agreement over where such PA is required and how clinicians should communicate with patients affected is required. This form of PA needs sensitive handling as it requires real-time interventions in patient treatment pathways. It is likely to be appropriate only in decision-making where there is a low volume of requests for PA, for example very high-cost, complex pathways.

A.6 Before applying PA:

- > commissioners must have evidence that there is an issue that needs to be resolved;
- > commissioners should discuss the issue with providers and relevant clinicians;
- > it must be agreed that PA is the most appropriate intervention and that there is a need to escalate the issue. For example, before incurring the expense of PA, commissioners should usually share with providers their cause for concern and identify the likely nature and target for PA that they are considering and introduce a trial period of prior notification; and
- > while group-level PA may appear an easier option, the information requirements to ensure that adherence can be identified will need to be clear and agreed.

Principles of PA

A.7 PA must conform to the principles underlying all care and resource utilisation. In particular this means:

- > The protocol or guideline being enforced must represent good clinical practice.

- > Unnecessary delays must not be introduced into patient pathways. For PA this clearly means that commissioners must respond to requests for approval in a timely manner. Required response times need to be specified in advance and failure to provide responses within this period can be taken by providers as permission to proceed. Where retrospective group-level PA has been established, commissioners must complete any audits within specified time periods (likely to be within the financial year treatment was undertaken).
- > Patients must be informed of the process clearly.
- > Commissioners should expect a proportion of patients to follow some pathways (for example consultant-to-consultant referral), and should monitor and intervene only if the proportion changes significantly.
- > The requirement to co-operate with PA will be placed in the model contract and commissioners will then need to identify the areas for PA. Failure to comply with PA will incur financial sanctions. These sanctions will apply only after a margin of tolerance identified in contracts has been breached.

Utilisation management

- A.8 Utilisation management (UM) involves assessing admitted patients for 'appropriateness'. This is a two-part process that assesses severity of illness and the appropriateness of the procedures undertaken.
- A.9 UM can be undertaken for every patient, but this would not be cost-effective. Instead, an approach developed in Greater Manchester and Cumbria & Lancashire Strategic Health Authorities is based on occasional reviews of providers. This involves trained nurses assessing patients for a test period. 'Inappropriateness' can take two forms:
- > inappropriate admissions, but only from a local health economy perspective. This group includes patients who were admitted because there were no primary/community services to manage them in other settings. This is an issue for commissioners to ensure the right services are in place; and

- > inappropriate admissions because the patient did not require hospitalisation, either because sufficient services were available elsewhere or because they did not need such intensive healthcare support.
- A.10 UM has two purposes. First, to help commissioners and providers understand the drivers and scale of ‘inappropriate’ admissions, and to save patients from unnecessary interventions. This includes where patients are registered, identifying the time and day of admission, who admitted them, their diagnosis, the interventions they received and whether admission was inevitable.
- A.11 Secondly, UM can be used to target reductions in admissions down to a threshold margin of tolerance, contracts will require providers to participate in UM.
- A.12 UM can also be used to help local health communities strategically plan the correct mix of patient settings, both in and out of hospital.

Referral management centres

- A.13 Referral management centres (RMCs) or clinical assessment services (CASs) fulfil a number of roles. RMCs must abide by the principles for care and resource utilisation. In particular, they:
- > must not lengthen the patient journey or create ‘hidden’ waiting times;
 - > must carry clinical support and abide by clear protocols that provide clinical benefits to patients;
 - > should provide feedback to practices on referrals, thus enabling GPs to review appropriateness of their referrals. This will include ensuring referral letters contain sufficient information to enable consultants to understand the reason for referral;
 - > should not preclude practices from the effective redesign of services under PBC where this might necessitate changes to the pathway(s) used by the RMC. (In certain circumstances, service redesign may necessitate the use of new pathways outside those normally used by the RMC); and

- > should not be imposed on practices without their agreement or used as a device to avoid constructive challenge of poor or inappropriate referral behaviour.
- A.14 These requirements mean that RMCs/CASs need to provide real diagnostic or treatment benefits directly to patients. Primary Care Trusts should review existing RMCs/CASs to ensure they create tangible benefits for patients.

Sources of information and experience

- A.15 Further details on applying these approaches will be provided in *Identifying Priorities for Action*, to be published in August. In the meantime, information and tools on developing care and resource utilisation strategies are available at the NHS Networks demand management page, www.networks.nhs.uk/168.php.

Appendix B

Commissioning arrangements for specialised services

- B.1 This appendix describes the approach to co-ordinating the commissioning of specialised services developed from the Carter Review. It will help to strengthen the commissioning and provision of these services, leading to more consistent and improved access for patients who require them.
- B.2 A National Specialised Services Commissioning Group (NSSCG) will be established to co-ordinate specialised services commissioning and make national decisions, where appropriate, across all Specialised Commissioning Groups (SCGs).
- B.3 The National Specialist Commissioning Advisory Group (NSCAG) will continue to commission services for extremely rare conditions or very unusual treatments nationally and to advise Ministers on national provider designation status, but it will move from the DH to the NHS and be constituted as a subgroup of the NSSCG. It will be hosted by a Strategic Health Authority (SHA) on behalf of all SHAs.
- B.4 High-security mental health services will be covered by national commissioning arrangements. Further guidance will be issued in due course.
- B.5 Performance management of the NSSCG and the NSCAG will be undertaken by one SHA acting on behalf of all SHAs.
- B.6 Each SHA will be responsible for ensuring that appropriate and effective collaborative commissioning arrangements for specialised services are in place for the PCTs in their area and will performance-manage such arrangements. In particular:
 - > Each SHA area will have an SCG responsible for the commissioning arrangements for all specialised services, including medium/low-security mental health services and screening services. Further guidance on the latter will be issued.

- > All PCTs are required to be a member of the SCG, and SCG decisions are binding on PCT members.⁵
- > SCGs will be supported by dedicated teams of commissioners with sufficient capacity and expertise to support the designation programme, develop contracts and ensure compliance.
- > SCGs will be funded from a budget pooled from PCT allocations to cover:
 - the cost of specialised services commissioned on behalf of its PCTs; and
 - the SCG commissioning team costs.
- > SCGs will formally designate specific providers to provide specified specialised services; designation will be based on an agreed set of criteria (eg patient-centred, clinical, service, quality, financial) and will be reassessed every five years.
- > SCGs will facilitate the delivery of integrated care by working closely with service/clinical networks to achieve commissioning and investment plans that support integrated care and will act as the co-ordinator where the service in question has a planning population covering several networks; PCTs will act as the focal point in ensuring a good fit between the priorities and commissioning plans of practices and those of the SCG so as to maintain and strengthen integrated care pathways.
- > SCGs will support the establishment of national/regional clinical databases and regular audit of specialised services to enable commissioners and providers to monitor clinical outcomes and performance against standards and compare performance between providers and over time.

⁵ As set out in *Commissioning Arrangements for Specialised Services*, (DH, March 2003). Each LSCG and SCG is formally established as a joint sub committee of its PCT Board. The Establishment Agreement gives delegated authority to the SCG, including the power of the SCG to make binding decisions.

- > SCGs will have a Patient and Public Involvement (PPI) strategy and ensure patient representation on relevant committees to strengthen patient and public input to the SCG designation process, to the SCG annual prioritisation process and to the SCG annual commissioning plans. (Further guidance will be issued on PPI and Overview and Scrutiny Committees with regard to specialised services.)
- > SCGs will publicise details of their commissioning arrangements, including contact details for the lead commissioner for each specialised service.

B.7 We will discuss with Monitor how SCG views might be taken into account in relation to:

- > the proposed mandatory services that are specialised services in the application processes for NHS Foundation Trusts; and
- > where an NHS Foundation Trust seeks to cease providing a mandatory service which is a specialised service and could damage patient access to key services.

Appendices for consultation

Appendix C Contracting for NHS care

Appendix D PBC governance and accountability framework

Appendix E Triggering community action

Appendix C

Contracting for NHS care

Purpose of the consultation

- C.1 This appendix sets out proposals for the approach to contracting for NHS care for consultation with the commissioners and providers of NHS-funded care, partner organisations and interested parties.
- C.2 The proposals in the appendix are for those services covered by Payment by Results (PbR), essentially hospital-based services. Later in the year, we will publish similar proposals for community-based services (excluding those services funded under primary care contracts).
- C.3 The Department of Health is seeking views on these proposals to inform the development of a 'national model contract'. The aim is to develop a model contract, which can be used to procure services from NHS Trusts, NHS Foundation Trusts, independent and third sector providers. While it is recognised that the legal status and enforcement procedures may be different for contracts with different types of provider, the Department believes the core content of the contract should be broadly similar to ensure fairness. The legal status of NHS contracts will not be affected by the proposals in this appendix.
- C.4 The Department of Health will discuss with Monitor the approach to contracting with NHS Foundation Trusts.
- C.5 The aim is to publish a model contract in autumn 2006, in time to be used in the 2007/08 contracting round. It will form part of the annual

‘operating framework’. Clearly, where existing contracts are in force, the move to the new model contract will follow as the established contract expires.

Why is this consultation important?

- C.6 Commissioners and providers both need to be clear on their responsibilities for improving care and access to care, the expectations that are placed on them and the freedoms they have to take their own operational decisions. Capturing these requirements in contracts will be important in ensuring that the organisations and staff involved in providing services to NHS patients have this clarity. As performance management in the NHS moves increasingly to management down the commissioning line, contracts will also become an increasingly important part of the accountability process.
- C.7 This is not to say that contracts will replace good relationships and communication between clinicians and their organisations party to the contracts. On the contrary, good relationships and communication will be crucial, both in developing and agreeing the contracts, and more importantly in ensuring patients receive the services they need to the quality they expect.
- C.8 The Department of Health believes that producing a standardised national model contract will avoid much of the unnecessary bureaucracy that might otherwise develop around contracting. The key requirement will be to include sufficient detail in the contract to ensure delivery, while avoiding unnecessary content, variation and specificity.

Role of contracts

- C.9 Contracts will be the key accountability mechanism between commissioners and providers of NHS services. Contracts define expectations, quality, controls, accountability, balance of risk, planning environment and durations. They clarify the relationships between commissioners and providers, and enforce more transparent and accountable working relationships.
- C.10 Contracts will work alongside the system-wide incentives of health reform (choice, PbR, PBC) to:

- > specify the services to be provided;
- > ensure the delivery of national quality and performance standards;
- > drive improved quality and responsiveness of care;
- > secure financial balance; and
- > provide an agreed dispute resolution process.

National model contract

- C.11 The Department of Health will introduce a national model contract, which all NHS commissioners and providers of services will be expected to adopt for services covered by PbR. Commissioners may then seek to include additional locally agreed content within their contracts. Failure to agree on additional local standards should not prevent the award of a contract to a provider who otherwise meets the range of national requirements (including those that require local specification, eg activity profiles).
- C.12 The rest of this appendix sets out the proposed content for a national model contract, in three sections:
- > standard mandatory requirements;
 - > mandatory requirements for local completion; and
 - > content for local agreement.

Standard mandatory requirements

- C.13 The national model contract will include some standard provisions that should apply to all services covered by PbR. These requirements will be the same across the country and every provider and commissioner will be expected to be bound by them. The proposed standard content is set out below.

National quality standards

- C.14 The DH national standards across the seven domains of safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health should be incorporated into the contract, and maintaining the standards a condition of the contract.

- C.15 Until the standards for NHS and non-NHS providers are fully aligned, slightly different approaches are likely to be required to establishing standards in contracts.

National performance standards

- C.16 The contracts will include the key national performance standards that form a key part of the NHS 'contract' with patients and the public. The joint agreement to the delivery of these standards will inform the agreements on the detailed activity levels within the contract.
- C.17 The performance standards will need to be updated on an annual basis to ensure they keep pace with the national agenda and changing public expectations.

PbR payment schedule

- C.18 The PbR tariff schedule would be included in the contract to establish the payment terms for activity carried out under the contract.

Information flows

- C.19 Mandatory information requirements to support patients, clinicians, commissioners and national oversight of the service would be included. The requirements will include data quality and timeliness as well as specifying the clinical and activity data required.

Contract agreement and dispute procedure

- C.20 Contracts should be in place ahead of the financial year to which they relate. The NHS has not always delivered this, with negotiations expanding well into the summer.
- C.21 The expectation is that contracts will in future be agreed on time. The Department of Health will talk to Monitor, the SHAs and other stakeholders about an appropriate process to secure agreement to contracts and arbitrate in any disputes.
- C.22 The main options for a dispute process are:
- > a voluntary arbitration process; or
 - > a binding adjudication process.
- C.23 In the first case, a specialist and independent arbitrator would attempt to provide a conciliation service. In the second case, parties to the contract

would submit to the binding decisions of an independent and specialist adjudicator.

Mandatory requirements for local completion

Activity profiles and 18 weeks

- C.24 The core of the contract will be an agreement to the services to be provided and the expected volumes of activity to be undertaken.
- C.25 Agreements on activity profiles will form the basis for planning to deliver 18 weeks and the delivery of financial duties. Given this central role for activity agreements, they will form a mandatory part of the national model contract. The actual profiles will of course be for local agreement, hence this section of the contract will be mandated nationally but will require local completion.
- C.26 Contracts must embody a clear understanding of the respective responsibilities of commissioners and providers. They must set out agreed assumptions on activity profiles, including the broad underlying assumptions on GP referrals, consultant-to-consultant referrals, conversion rates, emergency attendances and admissions, and progress towards 18 weeks.
- C.27 These activity profiles should reflect the need for practice-based commissioners and providers to innovate and improve local services - so such activity assumptions should be *ranges*, rather than fixed figures or crude activity caps. In particular, providers who attract additional patients through Choice by improving the quality of care must be free to receive the appropriate rewards under PbR. In signing such contracts, all parties are making a joint commitment to work together towards the local delivery of such activity profiles. In developing this contracting approach PCTs and providers will want to focus their efforts on those high volume, high value procedures where clear agreement will bring the most gain.
- C.28 If activity exceeds the profiled levels by more than an agreed margin, a PCT should work through a checklist of questions with practices and service providers to determine where responsibility lies for any 'over-trading' that threatens local financial balance:
 - > Has the expected volume of activity been realised?

- > What is the distance from the agreed profile of activity?
 - > Has a clinical audit been undertaken?
 - > Are referrals on profile?
 - > Is the conversion rate of outpatients to inpatients/day cases within the appropriate range?
 - > Are patients being treated according to clinical priority, fairly, and in line with agreed waiting-time reductions?
- C.29 Where local financial balance is at risk, these questions should allow the PCT to be clear in identifying the root cause of any local problems. Addressing these should always start with a process of negotiation and discussion between PCTs and others, to mutually agree the way ahead.
- C.30 Where additional activity is the result of primary care-generated referrals, PCTs will be expected to pay providers for this activity. To address excess referral rates that put financial balance at risk, PCTs will need to work with practices and practice-based commissioners to change referral behaviour accordingly. This might include, in order:
- > identifying the practices or the care pathways where referral rates are significantly above expectation;
 - > providing targeted benchmarking information to such practices or on such care pathways;
 - > selecting and monitoring more closely such referral patterns, and providing targeted support to the practices concerned; and
 - > establishing local peer review processes whereby local practices can discuss and address each other's performance.
- C.31 Where additional activity puts financial balance at risk, and is the result of provider decisions that go beyond the ranges of agreed activity and underlying assumptions (such as conversion rates and consultant to consultant referrals), then likewise the contract should enable appropriate action to be taken, such as the enhanced scrutiny, benchmarking and peer review mechanisms listed above. If such steps

prove ineffective then the contract will enable PCTs to make reduced payments for activity significantly in excess of plan. Measures could include:

- > allowing PCTs to stipulate temporarily the maximum number of cases to be treated per annum and per quarter; and
- > paying a rate below tariff for activity significantly exceeding the planned level.

C.32 Such approaches should be based on the number of referrals and expected conversion rates. Providers who attract additional patients from referrals from primary care providers must still be free to earn the appropriate rewards under PbR.

C.33 We will develop a similar approach based on agreed activity profiles, and that clear apportionment of responsibilities and risks, to ensure the delivery of 18 weeks.

C.34 Providers will also be expected to co-operate with PCTs where they wish to introduce specific care and resource utilisation tools. The Department of Health will develop national toolkits to support the development of prior approval and utilisation reviews (see appendix A). While these care and resource utilisation tools are potentially powerful, they need to be introduced carefully and only with clinical support.

C.35 We will talk to Monitor, the SHAs and other interested stakeholders to develop a final proposal which will form the basis of a model contract for 2007/08 and be endorsed in the operating framework for 2007/08.

Content for local agreement

C.36 Some elements of the contract between PCTs and providers will be for purely local agreement.

C.37 There are three areas where local agreement may be sought on inclusion in contracts:

- > **Specified pathways.** Detailed agreements on the pathways for specific treatments, including handover arrangements, and any non-standard approaches to reflect local circumstances.

- > **Local quality standards** to reflect preferences and expectations of local people and clinicians.
 - > **Additional incentives.** Where commissioners have been unable to secure access to services on the basis of PbR and choice, they may wish to offer additional incentives to encourage providers, key NHS Trusts, NHS Foundation Trusts, primary care providers, or independent or third sector providers, to offer the services the commissioner requires. These could include additional payments over and above the tariff or offering contractual guarantees on income, activity or extended contract length.
- C.38 While the local content will not be mandatory, PCTs will be able to negotiate on the basis of their understanding of the requirements of their local residents and clinicians, and to publicise which providers are willing and able to sign up to local quality enhancements. Providers should be ready to work with PCTs to meet identified local needs, as this will increase the likelihood of patients choosing them.

Penalties and incentives for quality

- C.39 Contracts could be used to set financial penalties or incentives for improved quality. At this stage, we believe that this would be an unnecessary additional requirement to add to the 2007/08 contract.
- C.40 There are a range of system drivers for quality already in place through:
- > clinical governance;
 - > Healthcare Commission (HCC) regulation;
 - > engagement of commissioners and providers in device redesign and improvement; and
 - > Choice and PbR, which should see higher quality providers attract greater numbers of patients.
- C.41 We would welcome views on whether or not these mechanisms should be supported by a national quality bonus. This would work by providing additional bonus payments to the highest performing providers. Bonuses

would be awarded on a sliding scale so that performance improvement at all levels is incentivised.

Co-ordinating contracting




- C.42 The negotiation and holding of contracts for secondary care services should be co-ordinated to minimise bureaucracy and transaction costs while strengthening the commissioning process.
- C.43 We want to avoid creating a system in which providers need to hold separate contracts with each PCT whose residents choose to be treated there. This would be overly bureaucratic, time-consuming and expensive.
- C.44 The new model for contracting will be based on ‘co-ordinating PCTs’. Most providers will have a single contract, agreed directly with one PCT, usually the geographical ‘host’ PCT. This PCT will act on behalf of all other commissioners whose patients choose to use the provider. The contract will specify care pathways and standards which represent the requirements of all interested commissioners. The co-ordinating PCT will also ensure that providers receive co-ordinated plans of activity to help plan their services as well as acting as a focus for service redesign.
- C.45 In some areas a number of PCTs may each be responsible for a significant proportion of a provider’s activity. In these circumstances the co-ordinating commissioner model will allow for SHAs to decide which PCTs hold contracts with a particular provider, for example all PCTs who have traditionally been responsible for 20% or more of a provider’s business. The requirements of all other commissioners will still be met through the co-ordinating PCT. This approach will maintain important local relationships while reducing the contracting burden for providers.

Questions for consultation

- C.46 To help us prepare an effective and deliverable national model contract comments are sought on the issues raised in this appendix. In particular we would welcome views on the following questions:

- > Overall Approach
 - Is the overall approach correct?



- Are we seeking to include appropriate controls and incentives in contracts?
 - Is the proposed balance between contracts and other mechanisms (eg choice, regulation) appropriate
- > National Model Contract 
 - Will a national model contract be useful?
 - Is the 3 level approach (standard mandatory requirements; mandatory requirements for local completion; and content for local agreement) appropriate?
- > Content of the Contract 
 - Have we identified the right content?
 - Are there other issues we should address?
 - Is the balance of risk between commissioner and provider appropriate?
 - How do we ensure the contract is deliverable?
 - How should we best promote and enhance quality?
 - Would a national quality bonus be an effective approach to promoting quality?
- > Mechanisms 
 - Do we need a dispute and arbitration scheme? If so how should it work?

Next steps

- C.47 Comments on the issues raised in this chapter and the specific questions posed are invited from the NHS, partner organisations and other interested parties. Comments should be sent to nhs.reform@dh.qsi.gov.uk by 6 October 2006.
- C.48 The Department of Health will work up a model contract for use in the 2007/08 contracting round. Comments on the principles outlined in this chapter will be invaluable in developing an effective model contract.

Appendix D

Practice-based commissioning governance and accountability framework

- D.1 This appendix sets out proposals for a governance and accountability framework for PBC. In January 2006 we published *Practice-based commissioning: achieving universal coverage*, which provided guidance on the implementation of PBC. The proposals here respond to feedback from Primary Care Trusts (PCTs) and practices indicating that further clarity would be welcomed, building on the January guidance. The proposals aim to balance public accountability for the effective use of taxpayers' funds with the freedom for clinicians to innovate to deliver real improvements for patients. The aim is enhanced quality for patients with minimum bureaucracy for practices and proper accountability for taxpayers' money.

Clinical and corporate governance arrangements within the PCT

Clinical governance

- D.2 There should be clear accountability to the Professional Executive Committee (PEC) and PCT board through a committee responsible for ensuring appropriate clinical governance arrangements for services moved from hospitals to more appropriate settings. Such arrangements should be proportionate with the complexity of the service. The role of this committee should be: to establish a clear local framework that incorporates national guidance; to provide guidance to providers on clinical governance requirements; and to approve the clinical governance aspects of business cases.

Corporate governance

- D.3 Business cases from practices should be treated on their merits, and in a manner that is timely and transparent and ensures probity. It is for PCTs to decide how to do this. Cases should usually be considered by an appropriate committee or sub-committee of the PCT, chaired by a non-executive director, that has clear, delegated powers to approve business

cases, although local arrangements might be agreed for the approval of small-scale business cases by an executive director.

- D.4 Contracts for the shift of services from hospitals to more appropriate settings should include quality criteria covering patient experience, quality and service standards. There should be regular sampling and the results should be easily available to patients.

Practice groups

- D.5 Locality groups and consortia of practices are not regarded as formal legal entities, unless there is a specific vehicle under which they operate (such as a limited company), or there is a sharing of profits from service provision.
- D.6 Plans within consortia for new services shifted from hospitals to more appropriate settings should demonstrate how plurality of provision will be secured across a geographical area, ensuring equity of access for patients.
- D.7 Where practices establish a new legal entity for redesigning and developing services, such as a limited company, the new body should be treated by the PCT in the same way as all other bodies of the same type for the purpose of procurement. (This should not affect General Medical Council (GMC) regulations about change in contractor status.)
- D.8 The PCT should create an environment in which practice groups lead (or, as a minimum, are represented in) partnership meetings between Trusts and the local authority and contract meetings between the PCT and providers.

The role of the Professional Executive Committee (PEC)

- D.9 A review of the role and composition of the PEC is currently taking place. We are seeking views prior to the establishment of new PCTs in October. The review addresses the principal role of the PEC in relation to PBC.

PBC accountability

- D.10 The aim of this accountability framework, or code of conduct, is to help practice-based commissioners and PCTs to work more effectively

together to address the key issues of health services improvement, and health and social inclusion.

- D.11 All parts of the NHS are expected to conform to the highest standards of honesty, integrity and probity, and to work in partnership in a patient-centred, inclusive way.
- D.12 Practice-based commissioners, in taking an indicative budget, take on additional responsibilities for managing those resources and redesigning services for patients. This means that they should play their full part in meeting national priorities and objectives.
- D.13 Practice-based commissioners should work in partnership with their PCT, primary care teams, secondary providers and local authority to develop and implement locally agreed health and service strategies. PCTs should involve GPs in this process in a way that is non-bureaucratic and sensitive to the needs and working practices of primary health teams.
- D.14 PCTs have statutory responsibility for leading the implementation of national policy at local level. This includes advising and informing practice-based commissioners of the wider implications of their proposed services redesign (such as impact on local hospitals) while respecting clinical and management decisions taken by GPs on behalf of their patients.
- D.15 PCTs have a role in ensuring that patients can choose from a diverse range of service providers. While PBC has not yet properly taken effect, PCTs should avoid agreeing new long-term contracts with service providers which would further cement monopoly provision arrangements and exclude practices from being able to propose service and care pathway redesigns.

Demonstrating accountability

- D.16 Practice-based commissioners are accountable to their PCT for achieving best value within their indicative budget effectively and delivering their PBC plan. The SHA will ensure that relationships between PCTs and GPs develop in accordance with the above principles. They will seek a solution in rare cases where local agreement cannot be reached (and attempt to avoid the need for any contractual

disagreements with a Directed Enhanced Service (DES) to be resolved by the NHS Litigation Authority or the courts).

- D.17 GPs are directly accountable to their patients and to the GMC for their standards of clinical practice. In addition, practice-based commissioners are responsible for maximising the health and service benefits from their indicative budgets through their proposals for service redesign.

Management accountability

- D.18 Practice-based commissioners are required to produce a practice-based commissioning plan. That plan should include the following:
- > How the practice intends to make its contribution to meeting national targets and priorities by redesigning services, and by identifying resources that could be released from the budget. The plan should be submitted to the PCT. It is the PCT's responsibility to confirm approval of those plans within eight weeks⁶ and to confirm that they are consistent with national priorities.
 - > As part of the PBC plan, the practice should identify those areas which it believes need a more collective approach to service redesign and improvement. The PCT then needs to establish a clear agreement of local priorities and a mechanism for ensuring their delivery, with practices engaged in this process.
 - > The practice-based commissioner should report progress on delivery of the plan to the PCT. The PCT should ensure that a developmental approach to performance management is used. Practices and PCTs should hold regular review meetings. There should be genuine dialogue between partners with the focus on identifying areas for development and sharing best practice.
- D.19 Clearly, practice-based commissioners who set themselves reasonable objectives within the national framework and deliver their objectives can expect to be monitored less closely than those who do not. Equally, practice-based commissioners can expect the information they provide to PCTs to be used to inform local strategic planning and receive regular

⁶ *Practice-based commissioning: achieving universal coverage*, DH, January 2006, paragraph 52.

feedback on this as well as on their own performance. Practice-based commissioners can expect to receive information from their PCT, as specified in the PBC guidance.⁷

Accountability to patients and the wider public

- D.20 Practice-based commissioners now have the ability to redesign services, and with that comes the responsibility to ensure that their plans involve their patients, and that their plans are available for public scrutiny by their practice population.
- D.21 PCTs need to ensure that the collective plans for all the practice-based commissioners are available for public scrutiny by the Overview and Scrutiny Committee of the local authority and also by the general public. PCTs also need to ensure practices have engaged their patients and Local Involvement Networks (LINKs) in service redesign.
- D.22 All NHS organisations are required to ensure they have effective complaints procedures in line with national guidelines. PCTs are required to ensure that any new arrangements for services meet national guidelines on complaints and patient advice and liaison services (PALS).

Financial accountability

- D.23 The PCT has a statutory responsibility to achieve financial balance. Practice-based commissioners have a responsibility to agree an indicative practice budget and then manage within that, as explained in the PBC guidance.⁸ Practice-based commissioners are required to have this expenditure and activity monitored on a monthly basis against the PBC plan. The PCT will discuss with the practice how to operate within this plan and should organise an audit or show best practice to help the practice manage expenditure and activity.
- D.24 The practice-based commissioner must have the agreement of the PCT for their proposed use of freed-up resources. Such agreement should be

⁷ *Practice-based commissioning: achieving universal coverage*, DH, January 2006, paragraphs 21-27.

⁸ *Practice-based commissioning: achieving universal coverage*, DH, January 2006; paragraphs 28-42.

in accordance with regulations benefiting patients and representing value for money. The PCT is required to reply to the practice within eight weeks.

- D.25 In circumstances where the PCT is working to restore financial balance, they must still provide a fair and realistic budget, based on historical usage. Equally, practices must use the 70% of any resources released through service redesign which they are entitled to retain to address national or local priorities. Practices and PCTs working effectively together will facilitate major redesigns which can release significant resources. Such redesigns should draw on evidence such as the NHS Modernisation Agency's High Impact Changes and on international evidence such as the Plexus work in the Netherlands on one-stop-shops, which achieved significant improvements in quality and reductions in waits.

Clinical and professional accountability

- D.26 All clinicians in the NHS have the responsibility to ensure that they provide care of the highest standards within available resources. The White Paper *Our health, our care, our say* said that the Department would be consulting with the Healthcare Commission and professional organisations on the options for assessing the quality of care given by primary care providers, so that patients can be reassured that all services are safe and of good quality and that information is available on those practices which achieve exceptionally high standards.
- D.27 In addition, practice-based commissioners who provide additional services are expected to ensure that their new services meet all national standards of clinical governance including those set out in *Standards for Better Health*. Practice-based commissioners should set out briefly their annual clinical audit plans for such new services.
- D.28 The PCT is responsible for ensuring that an effective system of clinical governance is in place to approve and monitor services with its health community in line with national guidance and the Healthcare Commission.
- D.29 While it is not a requirement for practice-based commissioners to include developments to the services they provide under their General Medical Services or Personal Medical Services contract in their business plans,

many will wish to do so. This has the advantage of offering a coherent view of all services to the PCT and its patients. Such practice may prove useful in helping practices and PCTs to work together on strategies for developing primary care.

- D.30 The framework for commissioning health and wellbeing, long-term conditions and joint commissioning, to be published in December 2006, will set out proposals (as promised in the White Paper)⁹ for aligning the health planning and budgeting cycle with the timetable for local government. As part of this, DH will need to consider the implications for the timetabling of financial allocations.

Question for Consultation

- D.31 Will the proposals in this appendix enhance quality for patients and ensure proper accountability for taxpayers' money while providing freedom for clinicians to innovate? Comments should be sent to nhs.reform@dh.gsi.gov.uk by 6th October 2006.



⁹ *Our health, our care, our say*, DH, January 2006 paragraph 2.75.









Appendix E

Triggering community action

- E.1 The proposals in this appendix relate to one of the ‘triggers’ to which the White Paper *Our health, our care, our say* envisaged that Primary Care Trusts (PCTs) would be expected to respond. **Public Petitions** (paragraph 7.21 of *Our health, our care, our say*) from members of the public in the area served by the PCT and/or users of the services commissioned by that PCT. MPs could also choose to raise petitions, whilst councillors will continue to be able to raise concerns through OSCs.
- E.2 The following principles would apply to the design of mechanisms for public petitions. Mechanisms should:
- > encourage genuine, not trivial or vexatious petitioners;
 - > take into account the need to balance the needs of different groups in the population and priorities;
 - > be consistent with the aims and values of the NHS and the roles of PCTs;
 - > be fair to providers and their staff, preventing victimisation;
 - > be transparent, credible and fair, promote accountability, and be simple and communicable. PCTs should be held to account for the process, which should be demonstrably independent, as well as the outcome;
 - > be properly resourced to ensure a thorough and rigorous approach;
 - > give PCTs a degree of discretion in how they respond; PCTs would, however, be required to set out publicly how they are responding to a petition, including rejection, against a transparent set of criteria that could be subject to independent scrutiny; and
 - > include a clear arbitration process laid out for when the originator of the petition appeals against the decision of the PCT.
- E.3 The scope of petitions would include demand for new services, dissatisfaction with existing providers and dissatisfaction with existing

provision. They could not be used to prolong debate on a proposed service reconfiguration following the outcome of a formal consultation exercise.

E.4 Further work is required to develop specific mechanisms and thresholds for public petitions. These will be subject to consultation later this year. It is important, however, that this work is informed by the views of patients, the public, providers, staff, and partner organisations. Views are therefore sought on:

- > Should petitions should cover only community and primary care services (including jointly commissioned services and primary care), or the whole of PCT-commissioned activity including acute services and (through the co-ordinating PCT) specialised services? 
- > Who can petition? 
- > How the voices of children and the vulnerable, disadvantaged and excluded members of society can be heard? 
- > The threshold number of signatories to require a formal response from the PCT. What level of threshold should induce a review, for example a response from 1% of the public served by a PCT or 10% of the users of a service? 
- > What should the process be for PCTs to respond to petitions? 
- > Which measures should be used to ensure a fair and robust process in all cases, but especially when the service to be reviewed is provided by the PCT and independence needs to be demonstrated? 
- > What are the rights of challenge to the PCT's decision? 
- > Who will arbitrate if the response of the PCT is challenged? 

Glossary

Acute care Care for a disease or illness with rapid onset, severe symptoms and brief duration.

Alternative Provider of Medical Services (APMS) contract A type of contract that Primary Care Trusts (PCTs) can have with primary care providers, particularly designed to bring in new types of provision, such as social enterprise and the voluntary sector.

Carter Review An independent review of NHS commissioning arrangements for specialised services in England. The Review Group, headed by Scotland's former Chief Medical Officer Professor Sir David Carter, made a number of proposals for improvement. Their report was published in May 2006.

Choice Since January 2006, patients are offered the choice of at least four hospitals and a booked appointment when they need a referral for elective care. By 2008, patients will be able to choose any healthcare provider that meets NHS standards and can provide care within the price the NHS is prepared to pay ('free choice').

Choose and Book An NHS initiative that allows people to make their first outpatient appointment, after discussion with their GP, at a time, date and place that suits them.

Clinical Assessment Service (CAS) A system whereby a patient is referred to a CAS, which will assess the patient and advise on the next course of treatment.

Commission for Social Care Inspection (CSCI) The single independent inspectorate for all social care services in England.

Commissioning The full set of activities that local authorities and Primary Care Trusts (PCTs) undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively.

Community care Care or support provided by social services departments and the NHS to assist people in day-to-day living.

Community hospitals Local hospitals serving relatively small populations (fewer than 100,000 people), providing a range of clinical services but not equipped to handle emergency admissions on a 24/7 basis.

Directed Enhanced Service (DES) Services that PCTs must provide for their populations, e.g. childhood immunisations.

Director of Adult Social Services (DASS) A statutory post in local government with responsibility for securing provision of social services to adults within the area.

Director of Public Health (DPH) An executive director post in SHAs and PCTs, the DPH leads on improving and protecting the health of the community and reducing health inequalities, health emergency planning, professional leadership, clinical quality and patient safety. PCTs are encouraged to make joint appointments with local authorities, and to work with the Directors of Adult Social Services and of Children's Services to promote the health and wellbeing of their local communities.

District general hospital (DGH) A hospital providing a range of clinical services sufficient to meet the needs of a defined population of about 150,000 or more for hospital care, but not necessarily including highly specialised services.

Elective care Planned care for a pre-existing illness or condition.

Expert Patient Programme (EPP) An NHS programme designed to spread good self-care and self-management skills to a wide range of people with long-term conditions. Using trained non-medical leaders as educators, it equips people with arthritis and other long-term conditions with the skills to manage their own conditions.

Framework contract A contract listing a range of suppliers who have demonstrated that they are able to provide specified goods or services. Once in place, organisations call upon one or more of the suppliers for goods or services as required.

General Medical Council (GMC) The statutory body responsible for licensing doctors to practise medicine in the UK. It protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine.

General Medical Services (GMS) This is one type of contract that PCTs can have with primary care providers. It is a nationally negotiated contract that sets out the core range of services provided by family doctors (GPs) and their staff.

General Practitioners with Special Interests (GPwSI) GPs who supplement their generalist role by delivering a clinical service beyond the normal scope of general practice. They may undertake advanced procedures or develop specific services. They do not offer a full consultant service.

Hard-to-reach groups Usually defined as groups or individuals who find it challenging to access appropriate health and social care services. Additionally they are unlikely to contribute to influencing health and social care services provided locally. Groups or individuals may be classed as hard to reach if they are minority groups, those who slip through the net or who are resistant to the service provided. Examples may be the homeless, substance misusers, street workers.

Healthcare Commission (HCC) The independent inspectorate in England and Wales that promotes improvement in the quality of the NHS and independent healthcare.

Healthcare Resource Groups (HRGs) These are standard groupings of clinically similar treatments, which use common levels of healthcare resource. They may be considered as standardised 'units of currency' within the Health Service, allowing for costings across services.

Independent sector (IS) An umbrella term for all non-NHS bodies delivering healthcare, including a wide range of private companies and voluntary organisations.

Independent sector treatment centre (ISTC) Treatment centres (TCs) provide safe, fast, pre-booked surgery and tests for patients. Additional TC services are being secured from the independent sector under a competitive tendering process in order to expand capacity within the NHS.

Integrated Service Improvement Programme (ISIP) An NHS programme that integrates the planning and delivery of benefits from the investment in workforce reform, Connecting for Health, and best practice from the Modernisation Agency and NHS Institute. The programme aims to drive delivery of efficiency through effective commissioning and integrated planning.

LIFT (Local Improvement Finance Trust) NHS LIFT is a public-private partnership scheme for improving and developing frontline primary and community care facilities. It allows PCTs to invest in new premises in new locations, not merely to reproduce existing types of service. It is providing patients with modern, integrated health services in high-quality, fit-for-purpose primary care premises.

Local Area Agreement (LAA) A three-year agreement setting out the priorities for a local area in certain policy fields as agreed between central government (represented by the Government Office), and a local area, represented by the local authority and Local Strategic Partnership (LSP) and other partners at the local level. The agreement is made up of outcomes, indicators and targets aimed at delivering a better quality of life for people through improving performance on a range of national and local priorities.

Local authority Democratically elected local body with responsibility for discharging a range of functions as set out in local government legislation.

Local Delivery Plan (LDP) A plan that every Primary Care Trust (PCT) prepares and agrees with its Strategic Health Authority (SHA) on how to invest its funds to meet its local and national targets, and improve services. It allows PCTs to plan and budget for the delivery of services over a three-year period.

Local Enhanced Service (LES) A locally developed service that PCTs have determined necessary to meet the needs of their population.

Local Involvement Networks (LINKs) Patient forums will be replaced by Local Involvement Networks. LINKs will be established for every local authority area with social services responsibilities. These networks will be able to provide flexible ways for communities to engage with health and social care organisations in ways that best suit the communities and the people in them.

Local Strategic Partnerships (LSPs) LSPs bring together representatives of all the different sectors (public, private, voluntary and community) and thematic partnerships. They have responsibility for developing and delivering the Sustainable Communities strategy and Local Area Agreement (LAA).

Long-term conditions (LTCs) Those conditions (for example, diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.

Mental health services A range of specialist clinical and therapeutic interventions in mental health and social care provision, integrated across organisational boundaries.

National Institute for Health and Clinical Excellence (NICE) An independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NHS Foundation Trusts (FTs) NHS hospitals controlled and run locally as independent, public benefit corporations. FTs have increased freedoms regarding their options for capital funding to invest in delivery of new services.

Our health, our care, our say White Paper published in January 2006 setting out a strategy to provide people with good quality social care and NHS services in the communities where they live.

Overview and Scrutiny Committee (OSC) A committee made up of local government councillors concerned with local NHS and social care matters.

Patient advice and liaison service (PALS) Provides information, advice and support to help patients, families and their carers.

Patients' Forums (or Patient and Public Involvement Forums) Patient-led organisations, established by the NHS Reform and Healthcare Professions Act 2002, for every Trust (including NHS FTs) and Primary Care Trusts (PCTs). Their functions include monitoring the quality of services and seeking the views of patients and carers about those services. Patients' Forums are set to be replaced by Local Involvement Networks (LINKs).

Payment by Results (PbR) A scheme that sets fixed prices (a tariff) for clinical procedures and activity in the NHS whereby all trusts are paid the same for equivalent work.

PCT Fitness for Purpose Programme *Commissioning a Patient-led NHS* saw the reconfiguration of PCTs as the first stage in delivering a robust infrastructure from which to strengthen their commissioning function. The second stage focuses on ensuring that PCTs are fit for purpose. This will be done through developing: a 'commissioning diagnostic tool' that allows PCTs to be benchmarked against best practice commissioning; an 'organisational assessment tool' similar to the NHS FT diagnostic; and a 'Chief Executive competency framework' that will underpin the PCT CE appointments process.

Personal Medical Services (PMS) contract A contract locally negotiated with practices between Primary Care Trusts (PCTs) and primary care providers.

Practice-based commissioning (PBC) PBC gives GPs direct responsibility for achieving best value within the funds that the Primary Care Trust (PCT) has to pay for hospital and other care for their practice's population.

Practitioner with Special Interests (PwSI) The term covering all primary care professionals working with an extended range of practice. A PwSI will specialise in a particular type of care in addition to their normal role, for example a PwSI in dermatology would see patients with more complex skin ailments.

Primary care The collective term for all services which are people's first point of contact with the NHS.

Primary Care Trusts (PCTs) Freestanding statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.

Prior approval (PA) A technique to help commissioners ensure that patients receive appropriate care and secure value for money. Prior approval from the PCT/practice is required before the proposed treatment can be provided. It requires clinicians in secondary care to confirm the appropriateness of a treatment with the referring GP (including for consultant-to-consultant referrals).

Provider A generic term for an organisation that delivers a healthcare or care service.

Referral management centre (RMC) A facility to help commissioners ensure that patients receive appropriate care and secure value for money. Referrals for treatment are routed through an RMC that assesses the clinical appropriateness of the referral before treatment goes ahead. RMCs should abide by clear protocols that benefit patients and provide education and feedback to the clinicians in order to drive up the quality of referrals.

Secondary care The collective term for services to which a person is referred after first point of contact. Usually this refers to hospitals in the NHS offering specialised medical services and care (outpatient and inpatient services).

Service level agreement (SLA) This is a formal written agreement made between a provider and the commissioner of a service. It specifies in detail how and what services will be provided, including the quality standards that the service should maintain.

Social enterprise Businesses with primarily social objectives. Their surpluses are reinvested principally in the business or the community.

Social exclusion Social exclusion occurs when people or areas suffer from a combination of linked problems including unemployment, poor skills, low incomes, poor housing, high-crime environments, bad health and family breakdown. It involves exclusion from essential services or aspects of everyday life that most others take for granted.

Specialised services Those services where the planning population is greater than 1 million; they range from bone marrow and kidney transplants to secure forensic mental health services.

Specialist Provider of Medical Services (SPMS) contract This is one type of contract that Primary Care Trusts (PCTs) can have with primary care providers. SPMS is a flexibility within Personal Medical Services (PMS) whereby patients do not have to be registered with the provider to receive specialist care. It is designed in particular to give PCTs and providers flexibility to deliver services to people whose needs may not be fully met by other primary medical services options.

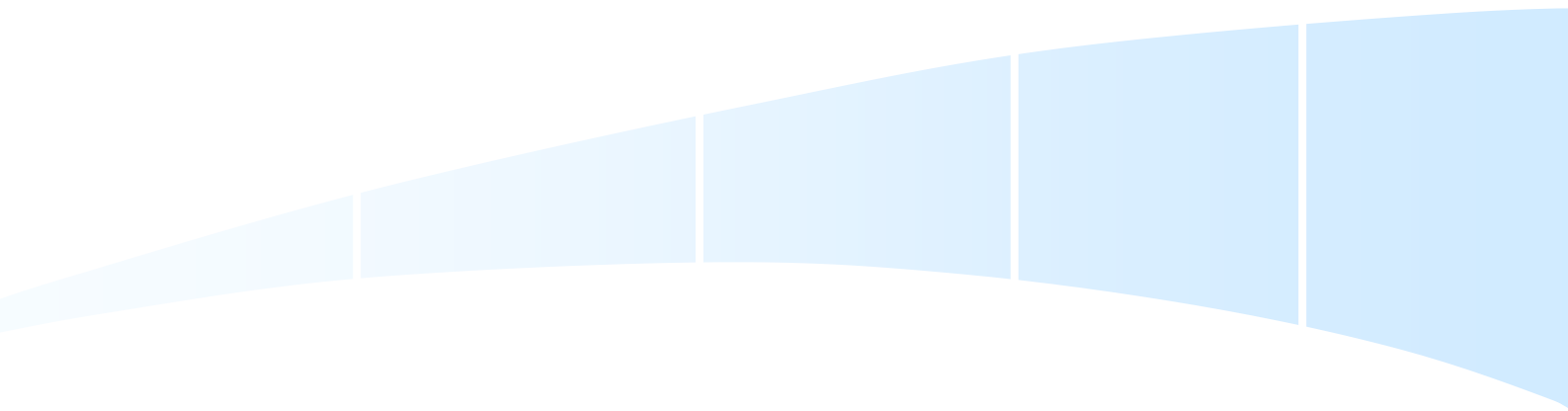
Strategic Health Authority (SHA) The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and for ensuring that Primary Care Trusts (PCTs) are performing well. They are the link between the Department of Health and the NHS.

Tariff A set price for each type of procedure carried out in the NHS, for example a hip replacement.

Third sector The full range of non-public, not-for-profit organisations that are non-governmental and 'value driven'; that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

Utilisation management (UM) A technique to help commissioners ensure that patients receive appropriate care and secure value for money. Utilisation management involves the assessment of the appropriateness of admissions, aiming at reducing the level of inappropriate admissions. Admissions could be classed as inappropriate on the grounds that the patient did not require a stay in hospital, for instance.

Voluntary and community sector An umbrella term referring to registered charities as well as non-charitable non-profit organisations, associations, self-help groups and community groups, for public or community benefit.



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Produced by COI for the Department of Health
275873 1 p 0.3k July 06