Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance

Department of Health

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
Document purpose	Action
Gateway reference	9203
Title	Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance
Author	DH/P&SD/Demand Side Reform
Publication date	14 Dec 2007
Target audience	PCT CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, Directors of Finance, Allied Health Professionals, GPs, Directors of Children's SSs, Practice Managers, Directors of Commissioning
Circulation list	
Description	Provides details for PCTs and practices for implementing practice based commissioning, namely budget setting refinements, clarification of health funding flexibilities, PBC incentive schemes and governance
Cross-reference	The NHS in England: The operating framework for 2008/9
Superseded documents	n/a
Action required	n/a
Timing	n/a
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Executive Summary

Practice based commissioning – Budget setting refinements and clarification of health funding flexibilities, incentive schemes & governance

The direction of travel for Practice Based Commissioning remains unchanged. This document follows up the commitment made in *Practice based commissioning: practical implementation* to refine the budget setting methodology, and responds to requests received through the *Commissioning Framework for Health & Well-being* consultation for clarification on the flexible use of NHS funds, governance arrangements and incentive schemes.

The direction of travel for Practice Based Commissioning (PBC) remains unchanged. It is central to world-class commissioning and here to stay.

This document follows up the commitment made in *Practice based commissioning: practical implementation* to refine the budget setting methodology, and responds to requests received through the *Commissioning Framework for Health & Well-being* consultation for clarification on the flexible use of NHS funds, governance arrangements and incentive schemes.

It is up to PCTs to make sure that PBC succeeds – by making sure that their practices have their 'fair share' of the budget, and accurate and timely information on referrals and budgets. PCTs should also ensure that the governance around PBC fits within their overall PCT governance framework and is proportionate to the individual circumstances.

PCTs are expected to support PBCs in using their financial flexibilities to make the simple changes that make things better for patients – such as arranging for a carer so that an elderly person does not end up in hospital when their carer has a routine operation.

Introduction

1. PBC is central to world class commissioning and is our most powerful way of reaching in to local communities. It is a crucial method through which PCTs and practices can work together to improve health outcomes and reduce inequalities.

Flexible use of NHS resources through practice based commissioning to improve health and well-being

2. The *NHS Next Stage Review Interim report*[1] encouraged practice based commissioners to use the existing powers to use NHS funds much more flexibly to secure alternatives to traditional NHS provision. To encourage PCTs and practice based commissioners to use these powers, we consulted on a support framework, in *The Commissioning Framework for Health and Well-being*.[2] The consultation responses told us that this approach was welcomed, but that further clarity was needed.

Using NHS Funding Flexibly

3. PCTs should agree with practice based commissioners a menu of local flexibilities, to support their achievement of local and national priorities (informed by needs assessments, reflecting priorities in Local Area Agreements). In doing so, PCTs are encouraged to seek the views of Local Authority partners to ensure there is an appropriate fit with the overall local commissioning strategy. Practice based commissioners can expect PCTs to put in place a framework which allows them to spend funding on the locally agreed menu, including ensuring cost effective options for delivering the options on the agreed menu. Where practice based commissioners wish to use interventions on the local menu, they should submit a light touch business case. As a starting point, PCTs should consider the menu of interventions below, which is not exhaustive.

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079077

2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Possible 'Menu' of Flexibilities

Staying Healthy	**Supporting healthy lifestyles** – through provision of dietary advice and access to weight reduction and exercise programmes through GP practices. Where this exists, this should include evidence based programmes that support behaviour change (NICE guidance).
	Provision of Citizens Advice, other advocacy, parenting, benefits, debt and return to work advisor sessions at practices – Patients with situational disturbance often seek medical advice, and sometimes inappropriately receive medical treatment, when their need is through social interventions.
	Developing social and practical support for isolated older people to build community capacity to support isolated older people to maintain their independence. This could include activities to provide care, support and advice, such as accompanying people to doctor appointments, and assisting the carers of these older people.
Mental Health	**Developing multi-disciplinary mental health resources in community settings** to improve the quality of care for people with mental health problems and their carers through occupational therapists, community psychiatric nurses, approved social workers, and other services such as pharmacy, clinical psychology and counselling. This could also include evidence based psycological therapies as recommended by NICE.
Children's health and well-being	**Purchasing of programmes to promote positive parenting and improve the social and emotional development of children** which could include behaviour management programmes, and anger management support for children and young people. This could also include services which supplement the universal Child Health Promotion Programme, such as extra antenatal early intervention and prevention, additional breast feeding support and intensive programmes for the most at risk children.
	Support to parents – This could include community support such as information, advice and signposting to other services, parenting programmes (formal interventions designed to support the parent-child relationship, including practitioner training). It could also include employment of a breast feeding counsellor and support for young carers such as access to leisure opportunities to encourage young carers to be children and young people first.
Long-term conditions	**Supporting greater independence for people with long-term conditions** – which could include provision of self-monitoring equipment and self-care educational programmes.
	Purchase of respite care – to allow carers to take a break, e.g. families of children with a disability, or when patients with a terminal illness need more intensive nursing for a fixed period of time.
	Crisis avoidance and intervention – This could include urgent aids or adaptations such as installing grab rails, equipment to help with mobility, sensory impairment or daily living activities (eg walking, bathing or reaching aids, telecare), or equipment to prevent deterioration (eg special seating or standing aids).
End-of-life care	**Supporting people who are approaching the end of their lives** and those who care for them, to remain at home, if that is their wish. This could include rapid access to pharmacy and equipment services, emergency respite care, or help with personal care.

4. Where practice based commissioners wish to spend funding on interventions that are not on the locally agreed menu, they should submit a business case to their PCT. PCTs should ensure that no unplanned shift of resources occurs.

Governance

5. Building on arrangements in *Practice based commissioning: practical implementation*,[3] PCTs should ensure clear governance and accountability to manage transparently any potential conflicts of interest of GPs working within a PCT and on the PEC or other decision making boards. Any arrangements should be proportionate and must be in accordance with the *Department's Principles and Rules for Co-operation and Competition*.[4]

A conflict of interest, *in relation to PBC*, as a minimum could be if the clinician:

- is a director of, has ownership of or part-ownership of, or is in the employment of, the body submitting the business case (including non-executive directorships),
- he is a partner of, or is in the employment of, or is a close relative of, a person who is a director of the body submitting the business case, or
- where the body is a practice, he is a close relative of a member of the practice, or
- he is a close relative of a person in the employment of the body submitting the business case, or
- he has a beneficial interest in the securities of the body submitting the business case, or
- he provides or has provided any services to that body submitting the business case.

PBC Local Incentive Scheme for 2008/09

6. PBC incentive schemes in 2008/09 should include incentivising practice based commissioners to reduce people's lifestyle risks. However, PCTs should ensure that this does not involve 'double paying' – i.e. over-rewarding activities that are already financially incentivised through other means such as the Quality and Outcomes Framework. Also, incentive schemes should be cash releasing, and funded from savings made from PBC. Further examples on how PBC can ensure savings are set out in Care and Resource Utilisation: ensuring appropriateness of care.[5]

3 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703

4 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

5 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063265

Practice Budget Setting

Introduction: PBC Budget Setting in 2008/09

7. PCTs are responsible for ensuring that practices receive an indicative budget that reflects the needs of their population as accurately as possible. This allows a practice to access a 'fair share' of the resources available to the whole of the PCT for its patients.

8. In *Practice based commissioning: practical implementation* the Department of Health committed to reviewing options for practice budget setting in 2008/09. The Department and academics have carried out research on the existing budget setting toolkit. The Department also conducted fieldwork with practices and PCTs on the application of the current guidance and how it could be improved.

9. In light of this work, this document sets out:

   a. The mechanism for calculating the 'fair share' for practices

   b. Appropriate rate of change for 08/09

   c. Additional information to help PCTs and practices determine need.

The mechanism for calculating the 'fair share' for practices.

10. The current formulae for the 'fair shares' toolkit will be maintained. The formula remains the best estimate of relative resource need, although care is needed in interpreting it at a practice level . We have reviewed the different methodologies currently available and concluded that any changes in the estimation of need would not justify the turbulence caused. The toolkit for calculating the fair shares tool can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127155

11. Practice 'fair share' budgets are calculated using the above toolkit, to cover the acute activity listed in *Practice Based Commissioning: Practical Implementation*. In addition, PCTs should use weighted capitation to allocate resources for Community and Mental Health services.

12. The toolkit requires populating with practice population data, as well as the matching needs indicators for those practices. The linked population and needs variables can be requested from the PBC mailbox, pbc@dh.gsi.gov.uk

13. The Department remains committed to improving the methodology of budget setting. To support this it has commissioned research into the feasibility of person based resource allocation as a basis for setting practice budgets.

14. PCTs are responsible for ensuring that practices receive an indicative budget that reflects the needs of their population as accurately as possible. This allows a practice to access a 'fair share' of the available resources to commission services for its patients. The 'fair share' practice budget supports the principles of equal resource for equal need.

15. PCTs should set indicative budgets for practices, rather than groups of practices or PBC consortia, because practices are the recognised legal entity. Supporting information should also be provided at practice level. Where local consortia exist, and with the agreement of the local member practices, budgets and information can be aggregated in addition to being provided at practice level.

16. SHAs should ensure that practices are receiving indicative budgets from PCTs. They should ensure that PCTs are delivering indicative budgets to practices.

Pace of Change

17. To facilitate a smooth transition to fair share practice budgets PCTs should follow the rules set out below:

- Where the last available twelve months costed activity (at 2008/09 prices) and the fair share target budget are within 10% of each other the PCT does not have to carry out any pace of change movement.

- Where the last twelve months costed activity and 'fair share' budget target differ by more than 10% that difference should be reduced. The minimum reduction is expected to be 1% point. But, where activity, prevalence or exceptional circumstances provide strong evidence against that movement, PCTs should not impose the minimum reduction.

- The maximum movement will be left to PCT discretion but should be informed by a triangulation of 'fair share', activity, and prevalence and deprivation information for the practice in question. Further information is given in Annex A.

Additional information to help PCTs and practices determine need

18. While the 'fair shares' allocation toolkit remains the best estimate of relative resource need, it is not completely accurate at the level of a practice and so it should not be applied too mechanistically. So in 2008/09 PCTs are encouraged to use additional local information to inform the fair share budget setting process. This could include activity and prevalence data. This additional data will be added to the NHS comparators website,[6] and provides interpretations for PCTs and Practice Based Commissioners to help tailor the 'fair share' target to local circumstances.

Best Practice Budget Setting

19. Building on *Practice based commissioning: practical implementation* we have set out a recommended process that practices can expect PCTs to follow in determining the move towards 'fair shares'.

Interpreting the 'Fair Share' Allocation

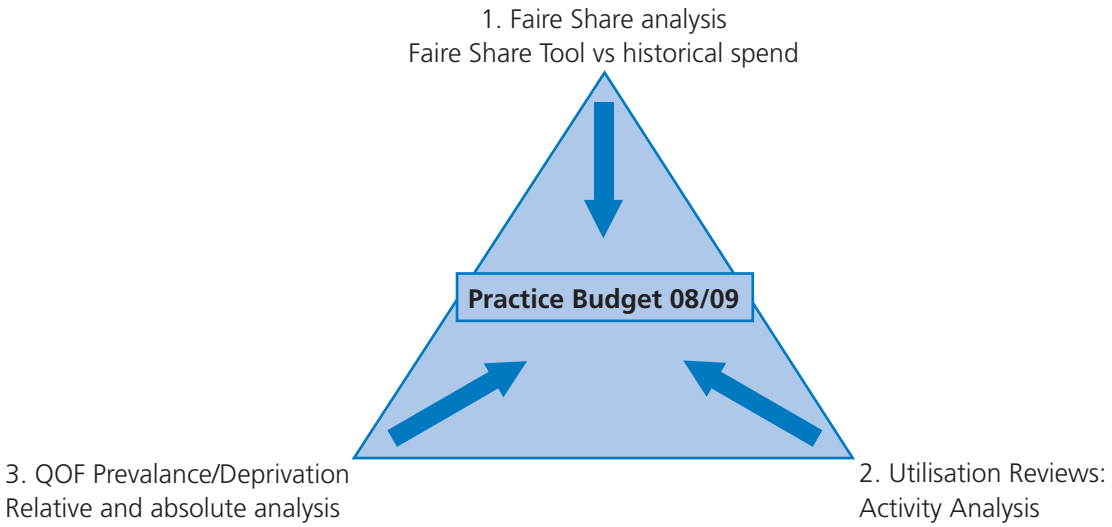
20. To account the 'fair share' allocation toolkit not being completely accurate in all circumstances, the Department has set out best practice for PCTs to follow and use local discretion to influence the final indicative budget.

21. PCTs must first calculate the fair-share allocation for all of their practices using the 'fair share' toolkit. Once the PCT has used the 'fair share' toolkit to calculate a 'fair share' budget, the next step is to compare these results to the historical spend of practices. This provides the start of three areas of analysis.

22. The three areas of analysis are:

6 https://nww.nhscomparators.nhs.uk/NHSComparators

- The fair-share allocation
- QOF prevalence/deprivation data
- Secondary Care Utilisation review



23. The 'Triangulation analysis' aims to provide insights into the questions:

    a. Does the fair share reflect the disease prevalence of the population and/or deprivation?

    b. Are there activity patterns that explain why practices are spending outside the 10% accuracy range?

    c. Can a more/less progressive pace of change be justified?

24. In addition to activity and prevalence information, PCTs may want to use deprivation information, which is an important factor influencing health need and inequalities. There are several sources of deprivation data that can be used. The indices of multiple deprivation can be found on the Department for Communities and Local Government website and will be suitable in most areas:
    www.communities.gov.uk/archived/general-content/communities/indicesofdeprivation/216309

Budget Setting Interpretation Indicators

25. To support the analysis of practice budgets the Department is working with Connecting for Health to provide a budget setting interpretation function available on the PBC Comparators website. The site can be accessed via the following NHS link:
    https://nww.nhscomparators.nhs.uk/NHSComparators

26. The site will compile a list of indicators so that PCTs can conduct an assessment of both need and resource use as depicted in the triangulation analysis diagram. These indicators are likely to include:

    Indicators of NEED for resources

    - **Reported QOF prevalence** across **16 disease groups**
    - **Expected QOF prevalence** for those disease groups where expected formulae exist
    - **Admissions** per 100 population
    - **Costs of admissions** for six QOF disease groups: CHD, diabetes, COPD, asthma, cancer and atrial fibrillation

    Indicators of Secondary Care ACTIVITY:

    - **Elective inpatient admissions:** by HRG and specialty
    - **Elective daycase admissions:** by HRG and specialty
    - **Non-elective admissions:** by HRG and specialty
    - **Outpatient activity:** attendance by referrer and specialty group

27. Where relevant, practice data should be compared to PCT and national averages to provide benchmark comparisons.

28. Where significant differences between the practice and the PCT average occur, a list of possible interpretations will be provided by the NHS comparator tool to aid judgements. Furthermore, users can drill-down into the data to benchmark practice indicators at a more detailed level. Further detail of these data is provided in **Annex A**.

29. While these additional data can support the setting of fair shares budgets, PCTs need to be careful not to follow too mechanistic an approach and need to ensure that local intelligence is also reflected in setting budgets.

Annex A

30. This annex sets out some of the methods PCTs can use to explore the relative need of their practices.

Assessment of Health Need

31. PCTs need to form the most likely interpretation about the need of a practice's population. The four indicators listed in this section can help them do this.

32. These indicators can be enriched by reviewing additional local deprivation data. In addition, detailed data on specific QOF disease groups will help identify those areas where differences from the PCT average are most significant. In the NHS Comparator tool, this detailed data can be accessed through drill-down menus.

33. QOF prevalence data is useful for acquiring a better understanding of health need. The disease register counts measure practice prevalence across 16 disease groups. Carefully interpreted, these variations can provide insights into practice need.

34. **Needs Indicator 1 – Practice Reported Prevalence per capita:** This indicator helps understand the extent to which a practice has identified patients who have an existing disease as categorised by QOF.

35. Where reported prevalence per capita is greater than the PCT average, one explanation is that the practice has higher underlying need than the PCT as a whole. The age and sex profile of the practice population may explain this. Alternatively, the cause could be differences between the primary care activity of the practice and that of its peers. For example, the proficiency of casefinding or effectiveness of disease prevention will affect the reported prevalence numbers.

36. PCTs should identify those QOF disease groups where reported prevalence differs most from the PCT average. For the QOF disease groups with the biggest differences from the PCT average, the PCT needs to consider what the secondary care cost implications of these differences might be to assess the relative weight to be attached to this indicator.

37. **Needs Indicator 2 – Practice Reported Prevalence Versus Expected Prevalence for QOF Conditions:** Reported prevalence should reflect the age, sex and ethnicity characteristics of the practice population. Expected prevalence calculations based on age, sex and ethnicity provide an estimate for the number of cases a practice is expected to find given its population characteristics. However, these calculations do not take into account exceptional practice populations that are not represented at a national level. For some of the QOF diseases the NHS Comparator tool compares the ratio of the practice's reported to expected prevalence and provides the PCT average reported to expected prevalence ratio.

38. Where the practice reported prevalence exceeds expected prevalence, the PCT should try and understand the possible causes. If the practice reported to expected ratio is greater than the overall PCT ratio this will provide information relative to other practices. The higher reported counts could be because of higher underlying need than accounted for in the expected calculation. For example, where a practice provides a specialist service. PCTs should also consider casefinding proficiency in relation to the PCT as a whole.

39. **Needs indicator 3 – Admissions per 100 patients on QOF disease register:** This ratio indicates the intensity with which secondary care services are used in relation to those patients identified with a QOF disease by the practice. Prevalence data alone does not indicate the severity of a disease in the practice population. However, comparing results across several indicators provides an indication of severity.

40. If a practice has a higher rate of admission per 100 prevalence than the PCT average this means that for a given prevalence more patients are admitted from the practice compared to its peers. This could be caused by a higher morbidity. However, the PCT should evaluate the practice's referral patterns to assess the balance between primary and secondary care use relative to the rest of the PCT. The primary care activity of the practice will affect this ratio. Effective casefinding, primary care prevention and case management, will determine the extent that patients in the later stages of their illness require more admissions.

41. **Needs indicator 4 – Average cost per QOF admission:** The average cost of an admission related to a QOF disease indicates the cost of the case-mix admitted to secondary care. It is the average cost of admissions associated with diagnoses from particular QOF groups. The indicator compares the average cost per QOF admission for the practice to the PCT and national average.

42. A high cost per admission relative to the PCT average, indicates the case mix of admissions is more expensive than the average of the PCT. This might be because of higher morbidity. Alternatively, the referral patterns and primary care activity will also affect the cost, because low case finding and/or prevention will mean later disease identification requiring more complex procedures.

Relationship between need and primary and secondary care spending

43. Practices assessed with lower relative need compared to the PCT average are, other things being equal, expected to have lower secondary care costs. However, PCTs need to be aware of wider practice costs, in particular the practice's primary care costs. A practice may be effective at managing risk factors to prevent incidence, subsequently its prevalence might be relatively low. In order to achieve this, the practice may have invested resources on an extensive risk assessment programme.

44. Therefore, when setting budgets for secondary care spending, PCTs need to be aware of the wider spending profile of the practice. In particular, PCTs should consider whether practices have spent effectively in primary care to reduce their secondary care burden. Where the primary care payment to a practice has traditionally been high relative to other practices this should also be taken into account in redistribution of secondary care resources.

Practice Needs Assessment

45. PCTs should use the above indicators and the associated results summarised in Table A in the assessment of the practice need in relation to the 'fair share' tool.

Table A: NHS Comparator & Local data providing needs assessment

	Higher Relative Need	Lower Relative Need
Indicator 1. QOF Prevalence per capita	Reported prevalence greater than PCT average for majority of QOF diseases	Reported prevalence below PCT average for majority of QOF diseases
Indicator 2. Reported vs Expected Prevalence	Reported prevalence generally above expected prevalence; ratio above PCT average	Reported prevalence generally below expected prevalence; ratio above PCT average
Indicator 3. Admissions per QOF Prevalence	High admissions per prevalence (not explained by primary care activity or relative high referrals for QOF diseases)	Low admissions per prevalence (not explained by primary care activity or effective referrals for QOF diseases)
Indicator 4. Average cost per admission related to QOF disease	High average cost per QOF admission (not explained by primary care activity or effective referral management). If both indicators 3 & 4 are high, then implies high severity	Low average cost per QOF admission (not explained by primary care activity or ineffective referrals for QOF diseases). If both indicators 3 & 4 are low, then implies low severity
Local Deprivation Data	Deprivation data indicates practice has higher deprivation than others in PCT	Deprivation data indicates practice has lower deprivation than others in PCT
Local Intelligence	For example, practice located close to a high concentration of elderly care homes	For example, practice located close to university accommodation

Assessment of Secondary Care Resource Activity

46. PCTs need to understand whether a practice's activity reflects an appropriate use of resources given the needs of the population. PCTs should assess the use of secondary care resources by practices that have costed historic activity greater than 10% above or below their fair-share budget.

47. PCTs need to form the most likely interpretation of a practice's use of secondary care resources by using the four indicators below. This can be combined with local data sources. The four high-level secondary care activity indicators are standardised by the age and sex profile of the practice population. The NHS Comparator tool can compare secondary care activity rates for patients from a particular practice against the overall PCT average activity rate. In addition, further detailed information is available on specific breakdowns of secondary care activity.

48. The PCT average can be used as an activity benchmark. The tool provides benchmarking against the national average, which can act as a sense-check for the appropriateness of the PCT average.

49. **Activity Indicator 1 – Emergency Admissions:** The volume of emergency admissions (per 1,000 age-sex standardised population) provides an insight into areas that the practices have less control in the short term. Depending on the source, the emergency admission rate can be a reflection of unavoidable morbidity, preventable morbidity or the pattern of service use by patients.

50. A lower than average admission rate should reflect a practice with lower morbidity, and good management of the morbidity that is identified. However, given that the activity is weighted by the population a PCT needs to decide whether the lower admissions are compensated by extra activity elsewhere, or the weighting of the population is inaccurate. In the case of a higher than average admission rate the converse of the above could be true, or the extra activity could be explained by a patient preference for using the hospital as the primary point of access to health care.

51. **Activity Indicator 2 – Elective inpatient admissions:** PCTs can improve their understanding of a practice's use of secondary care resource by comparing its elective admission rates to the PCT average. The data presented on the NHS comparators website is the elective admissions per age-sex standardised population.

52. A higher elective inpatient admission rate than the PCT average could be generated through a high volume of referrals given the need of its population. This explanation is linked to the treatment pathway and primary care activity preferred by the practice. The PCT needs to assess the effectiveness of casefinding, prevention and pathways for those areas that differ significantly from the PCT average. Finally, it is also possible that the age-sex standardisation fails to fully adjust for the need of the practice population, and, if the true need of the population was used the practice would be comparable to its peers.

53. PCTs must decide which of the possible interpretations is most likely. Local data sources on referral patterns may help to supplement the high level indicators; as will drilling down into the data to investigate those HRGs where admissions differ most from the PCT average. Any local intelligence that the PCT has about the primary care activity of the practice will also be useful in understanding the importance of primary care activity as an explanation.

54. **Activity indictor 3 – Day-case admissions:** Similar interpretations to elective inpatient admissions can be applied to day-case admission rates that are higher than PCT averages. However, since day-case admissions are usually only available to less severe cases, any underestimation of severity due to standardisation is less likely to affect the day-case admission rate.

55. **Activity indicator 4 – First outpatient attendances:** The number of first outpatient attendances per 1,000 standardised population is a measure of a practice's tendency to refer compared to the PCT average.

56. A higher number of first outpatient attendances than the PCT average can indicate a preference for a particular treatment pathway given the adjusted population. However, the practice may not be the only source of referrals. The primary care activity of the practice is also a possible explanation for high referrals. For example, specialisation by a GP may increase the number of patients treated with a particular disease.

57. Alternatively, low casefinding rates can increase the number of cases that require referral. A further possibility is that the age-sex standardisation fails to fully adjust for the need of the practice population. The need of the practice population could be higher than adjusted for meaning that more referrals are likely to be required.

58. As before, using local knowledge about primary care activity and drilling down to compare specialties will help to put in context any conclusions about the practice's tendency to refer.

Practice Secondary Care Resource Needs Assessment

59. PCTs should use the above indicators and the associated results summarised in Table B to assess the practice secondary care resource use in relation to the 'fair share' tool.

Table B: NHS Comparator & Local data providing secondary care resources assessment

	High Need Activity Relative to PCT Average	**Low Need Activity Close to PCT Average, or Low Relative to PCT Average**
Indicator 1. Emergency admissions	Higher emergency admissions than PCT average because of poor health status (not explained by primary care activity or access issues)	Lower emergency admissions than PCT average because of good health status (not explained by primary care management)
Indicator 2 & 3. Elective and Day Care Rates	Total elective inpatient admission rate above the PCT average (not explained by primary care activity of practice or standardisation accuracy). Total elective day care rate above PCT average (not explained by primary care activity of practice, provider admission thresholds or standardisation accuracy)	Total elective inpatient admission rate similar or below the PCT average (not explained by primary care activity of practice or standardisation accuracy). Total elective day care rate similar or below PCT average (not explained by primary care activity of practice, provider admission thresholds or standardisation accuracy)
Indicator 4. First Outpatient Attendance Rate	First outpatient attendance ratio above the PCT average (not explained by primary care activity of practice or standardisation accuracy)	First outpatient attendance ratio similar or below the PCT average (not explained by primary care activity of practice or standardisation accuracy)
Local Data	Referral patterns of practice found to be high by locally used software packages	Referral patterns of practice found to be similar or less than PCT average by locally used software packages
Local Intelligence	Practice known to have high referring GPs	Practice known to have appropriate or low referring GPs

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