

# Practice based commissioning in 2007-08: detailed analysis of policy and guidelines

GPC guidance for LMCS and GPs  
(England only)



# CONTENTS

<b>1</b>	<b>Introduction</b>	<b>page 3</b>
<b>2</b>	<b>Governance</b>	<b>page 4</b>
2.1	Clinical and corporate governance arrangements within the PCT	
2.2	Practice/consortium commissioning plans (or PBC plans)	
2.3	Practice groups/consortia	
<b>3</b>	<b>Accountability</b>	<b>page 5</b>
3.1	General	
3.2	Patients and the wider public	
3.3	Financial	
3.4	Clinical and professional	
<b>4</b>	<b>Arbitration</b>	<b>page 7</b>
<b>5</b>	<b>Financial guidance</b>	<b>page 7</b>
5.1	Setting indicative practice budgets for 2007-08	
5.2	From historical to 'fair share' budgets	
5.3	Use of freed up resources	
5.4	Risk management	
<b>6</b>	<b>Provision and procurement of services through PBC</b>	<b>page 10</b>
6.1	Practice/consortium business cases as providers	
6.2	Elective services delivered in the community by 'any willing provider'	
6.3	Extended primary care services delivered by 'any willing provider'	
6.4	Tendering	
6.5	Payment by results and local tariffs for services	
<b>7</b>	<b>Support for practices and incentive schemes</b>	<b>page 13</b>
7.1	PCT management support for practice based commissioners	
7.2	Incentive schemes	
7.3	National support for practice based commissioners	
<b>8</b>	<b>Information for PBC</b>	<b>page 15</b>
8.1	Tools and support	
8.2	Data requirements	
<b>9</b>	<b>Monitoring development of PBC</b>	<b>page 16</b>
<b>Appendix 1</b>	<b>Summary of new policy for 2007-08</b>	<b>page 17</b>

# 1 INTRODUCTION

The Department of Health (DH) published '*Practice based commissioning: practical implementation*' in November 2006. This latest DH guidance applies to the 2007-08 financial year and can be found online at the following address:

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_062703](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703)

Apart from certain sections, it replaces the 2006-07 guidance '*Practice based commissioning: achieving universal coverage*' published in January 2006. In addition, it builds upon the DH publication '*Health reform in England: update and commissioning framework*' issued in July 2006. This GPC guidance is based on the latest DH guidance and gives a detailed analysis of policy and guidelines for PBC and the rules around service provision and procurement for 2007-08. The GPC has also produced a shorter 'key issues' guidance note for those GPs who are less heavily involved in PBC; which is available online via the following address: [www.bma.org.uk/ap.nsf/Content/Hubpracticebasedcommissioning](http://www.bma.org.uk/ap.nsf/Content/Hubpracticebasedcommissioning)

There are a few significant policy changes for GP practices to be aware of in 2007-08, but for the most part, PBC will continue along the same lines as it has to date. Possibly the most relevant change to note is that the one-year 'towards practice based commissioning' directed enhanced service (TPBC DES) will end on 31 March 2007 and there will be no successor. A summary of changes in DH policy can be found at appendix 1 to this paper.

A large part of the GPC guidance produced in respect of the 2006-07 year will still be relevant, especially that on 'consortium working'. All GPC guidance notes on PBC can be accessed online at the BMA website address above (some documents require log-in).

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## Other relevant developments

**\*New\*** DH guidance '*Care and resource utilisation: ensuring appropriateness of care*', December 2006. This includes guidance on utilisation management, prior approval, clinical assessment services and referral management and risk profiling.

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4141316&chk=iJxRrx](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4141316&chk=iJxRrx)

**\*New\*** DH publication '*The NHS in England: operating framework for 2007-08*', December 2006

[www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/HealthReform/HealthReformArticle/fs/en?CONTENT\\_ID=4141082&chk=Zzujni](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/HealthReform/HealthReformArticle/fs/en?CONTENT_ID=4141082&chk=Zzujni)

**\*New\*** NHS model contracts for use between PCTs and providers of acute hospital based care, January 2007

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4141197&chk=FcbsGj](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4141197&chk=FcbsGj)

**\*New\*** ability for PCTs to subcontract out some of their commissioning responsibilities to the private sector

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4143055&chk=y3WUAY](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4143055&chk=y3WUAY)

**\*New\*** DH publication '*Commissioning framework for health and well-being*', March 2007

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_072604](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604)

## 2 GOVERNANCE

### 2.1 *Clinical and corporate governance arrangements within the PCT*

**GPC comment: The DH guidance attempts to put in place an accountability framework to address concerns regarding conflicts of interest arising from professional executive committee (PEC) direct involvement in PBC.**

- PCT to set up committee or subcommittee with accountability to the PCT Board (paragraphs 2.3-2.8).

**GPC comment: This is new policy.**

#### Responsibilities of the committee/subcommittee

1. *Clinical governance*; put in place arrangements for services moved from hospitals into the community; these should be proportionate to the complexity of the service.
2. *Establish a local framework*; incorporating national guidance.
3. *Approve PBC business cases* submitted by practices (see paragraph 2.4).

#### Make-up of the committee/subcommittee (paragraph 2.5)

1. Chair; non-executive director.
2. Members; from PCT Board and PEC.

#### Avoiding conflicts of interest (paragraph 2.6)

- Clinicians should exclude themselves from decisions on PBC business cases in which they have an interest or association.

### 2.2 *Practice/consortium commissioning plans (or PBC plans)*

#### Principles (2.9-2.11)

1. Must be agreed with the PCT.
2. Where plans impact on secondary care services, practices should 'seek the involvement' of consultants and wider secondary care clinical teams.
3. Only one plan necessary on behalf of PBC consortium; any individual practice activity to be included in collective plan (2.13).
4. 'Regular' review meetings to be held between practice(s) and PCT to discuss progress against the plan; level of monitoring depends on practice performance/outcomes.

#### Contents

1. No standard national format.
2. Level of detail in the plan to be kept to a minimum.
3. Should address/respond to practice population needs.
4. Contribute to meeting national priorities (including 18 weeks target) by redesigning services and identifying resources that can be released from the budget.
5. Include an indication of areas where collective approach to service redesign needed.

6. For new services transferred from hospitals, ‘...demonstrate how a range of provision will be secured across a geographical area, ensuring equity of access and choice for patients’.

#### Approval of plans (paragraph 2.14)

1. PCT to aim to approve within 4 weeks, and in no more than 8 weeks.

**GPC comment: This is new policy.**

2. Approval to include confirmation that plans and business cases are consistent with national and local priorities.

### **2.3 Practice groups/consortia**

- Consortia are not regarded as legal entities unless specifically working under a company structure. If doing so, this would not affect their individual contractor status and PCTs should treat the company in the same way as other bodies of the same type in terms of procurement.
- The Department of Health intends to produce further guidance to assist the development of PBC consortia.

**GPC comment: The Department of Health has confirmed that the GPC will be part of this process.**

- PCT to ensure that consortia either lead or as a minimum are represented in partnership meetings between Acute/Foundation Trusts and the local authority and contract meetings between PCT and providers (paragraph 2.24).

**GPC comment: Appropriate remuneration and/or expenses reimbursement should be provided for GPs involved in these meetings.**

## **3 ACCOUNTABILITY**

**GPC comment: This section proposes a two-way accountability between PCTs and practices (see paragraphs 2.28-2.30).**

### **3.1 General**

#### PCT responsibilities

- Advise practices of the implications of their plans for service redesign, whilst respecting clinical and management decisions taken by consortia.
- “...avoid agreeing new long-term contracts with service providers that would further cement monopoly provision arrangements and exclude practices from being able to propose service and care pathway redesigns” (paragraph 2.31).

**GPC comment: We would expect this to apply equally to service providers from the private sector.**

### **3.2 Patients and the wider public**

#### PCT responsibilities

- Make all PBC commissioning plans available for scrutiny by Overview and Scrutiny Committee of the local authority and by general public via the annual PCT prospectus.

***GPC comment: This is new policy and further information can be found in the new DH publication 'Commissioning framework for health and well-being'.***

- Ensure that practices have engaged their patients' views on service redesign.

#### Practice responsibility

- Make commissioning plans available for public scrutiny by their practice population.

***GPC comment: This is new policy.***

### **3.3 Financial**

#### PCT responsibilities

- Monitor practice expenditure and activity on monthly basis against commissioning plan.
- Provide practice with a fair and realistic indicative budget, even if under special circumstances
- Aim to approve practices' proposals for use of freed up resources (FUR) within 4 weeks, but no later than 8 weeks.

***GPC comment: Practices should make use of this provision and ensure that PCTs make decisions within this timeframe.***

#### Practice responsibilities

- Use 70% of FUR to address national or local priorities.

### **3.4 Clinical and professional**

- Additional services provided by practice based commissioners must meet all national standards of clinical governance including those set out in *Standards for Better Health*, which can be found at the following website address:  
[www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf](http://www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf)

***GPC comment: This will mean that practices' business cases for extended provision of services will need to be cognisant of these standards.***

- Practice based commissioners to set out 'briefly' their plans for annual clinical audit of new services.

***GPC comment: Practices need to factor the costs arising from the workload associated with the above into their bid/business case to provide services.***

## 4 ARBITRATION

- Practices and PCTs to agree local application of national Department of Health guidance. Where no agreement is reached, the issue will be referred to the SHA.

***GPC comment: Although there is no mention of LMCs, practices may wish to seek the involvement of the LMC where necessary.***

- SHAs to set up one or more arbitration group; should include practitioner, financial and management representation; appointed by the SHA.

***GPC comment: It would be appropriate for the practitioner member of the arbitration group to be taken from the LMC.***

- PCTs to following decision of arbitration group.

## 5 FINANCIAL GUIDANCE

### 5.1 *Setting indicative practice budgets for 2007-08*

- PCTs are responsible for giving practices budgets that reflect the needs of the population as accurately as possible.

***GPC comment: However, in deficit PCTs, practices will receive less than their share of actual historical spend; this is an unavoidable reality and one about which the DH continues to be less than open.***

- Methodology should be consistent, fair and transparent and compatible with budget setting plans for 2008-09 onwards
- Budgets should be calculated at individual practice level and not consortia level as practices are the recognised legal entity. The methodology is very similar to that of 2006-07 and is as follows:
  - ❖ Actual activity for last 6 months 2005-06 (October 2005 - March 2006) and first 6 months 2006-07 (April - September 2006) converted to 2007-08 prices
  - ❖ Current formulae for prescribing including appropriate inflationary uplift
  - ❖ Weighted capitation for any services within agreed scope for which no historic activity data are available
- Any freed up resources from the previous year should not be deducted from future indicative budget allocations (paragraph 3.9).

***GPC comment: This is an important point and one which practices should be aware of in particular.***

- All aspects of the PCT budget should be devolved indicatively to practices. Practices will hand back elements of this notional, whole practice allocation to PCTs as determined by the scope of commissioning agreed in the PBC plan; such elements should be clearly identified.

- The minimum scope for the indicative budget includes:
  - ❖ All hospital-based care;
  - ❖ Payment by Results (PbR);
  - ❖ Prescribing;
  - ❖ Community services; and
  - ❖ Mental health costs.

***GPC comment: The minimum scope of services for 2007-08 is wider than it was in 2006-07.***

- It is intended that including community services and mental health in the indicative budget will allow practices to assess their spending in these areas relative to other practices.

***GPC comment: Community services and mental health are not covered by PbR and therefore the risk associated with these services being included in the indicative budget is not high. Their inclusion in the indicative budget may give GPs a say in the planning of such services if they so wish.***

- PCTs in financial deficit must not resort to top-slicing in order to address the deficit (paragraph 3.25).

## **5.2 From historical to 'fair share' budgets**

- The Department of Health is evaluating options for a 'fair share' budget setting methodology for 2008-09.
- The Department of Health has made a tool available to calculate 'fair share' or indicative weighted capitation budgets at practice level in 2007-08. This tool is limited to +/-10% degree of accuracy.
- Recent survey showed that 70% of practices were receiving indicative budgets based on historic spend which were within this 10% margin. However 30% are receiving indicative budgets based on historic spend which are significantly higher or lower than their 'fair share'.
- If according to the tool indicative budgets based on historic spend are more than 10% greater or less than the 'fair share' budget, then progress should be made to the 10% range. This should not be overly aggressive and should happen as follows:
  - ❖ PCT to undertake simple utilisation review with the practice, based on data for disease prevalence and present usage of hospital services.
  - ❖ Whether or not to make adjustments to bring the 2007-08 indicative budget closer to 'fair share' is for local discretion; any adjustments should be up to 1% maximum of the part of the budget practices are managing.
- PCTs to review indicative budgets quarterly.

- Note that the tool does not take into account elements such as prescribing – refer to paragraph 3.19 for further detail on how to work around this.

### **5.3 Use of freed up resources**

- Imperative that practices use a minimum of 70% of freed up resources (FUR) for reinvestment in patient care, whether or not this was included in practice PBC plans. Where FUR were not planned, PCT and practice should agree on how this funding will be reinvested into patient care.

***GPC comment: As this new guidance does not give a definition of ‘patient care’ the definition given in the previous Department of Health guidance (‘Achieving universal coverage’ paragraph 44) could be used as follows:***

***“Resources freed up must be used to fund services for the benefit of patients locally. Resources freed up may be spent on equipment, training, clinical and non-clinical staff. They may also be spent on premises development with specific PCT board approval...”***

***Certainly we see using FUR to fund estate development to enable an extended range of services to be delivered in a primary care setting as being a reinvestment in patient care.***

- PCTs should aim to approve practices’ proposals for use of freed up resources (FUR) within 4 weeks, but no later than 8 weeks.
- Remaining portion (maximum of 30%) is for PCT to use at its discretion.
- It is not acceptable for PCTs to withhold FUR (paragraph 3.25)
- In PCT areas which are ‘subject to special circumstances’ (i.e. formal turnaround arrangements), the following apply:
  - ❖ Practices must use 70% of FUR to address specific national or local priorities, as agreed between practice and PCT;
  - ❖ The PCT and practices have a shared responsibility to achieve financial balance and should agree joint strategy; and
  - ❖ Where a joint strategy cannot be reached, the SHA can request permission from the Department of Health to modify the national PBC guidance relating to indicative budget setting and use of FUR.

### **5.4 Risk management**

- Practices to contribute 3-5% (suggested proportion) of the indicative budget towards a PCT-held risk pool. Alternatively, practices can hand back to the PCT a proportion of the notional, whole practice allocation for a risk pool.
- Some high-cost, uncommon treatments could be funded solely from the risk pool.
- Rules around use of the risk pool should be transparent, fair and locally agreed.
- PBC consortia may hold their own risk pools for certain contingencies as agree with the PCT.

## 6 PROVISION AND PROCUREMENT OF SERVICES THROUGH PBC

### 6.1 Practice/consortium business cases as providers (or PBC business cases)

***GPC comment: The DH guidance gives provision for practices to develop their provider services through PBC via submission of a business case to the PCT. This will be an important tool for practices and for many will be the primary reason for becoming involved in PBC.***

#### Principles

1. Must be agreed with the PCT
2. PCTs to decide how to assess business cases; must be treated on their merits, timely, transparent and ensure probity
3. PCT to set out reasons for not supporting business case and how it could be amended accordingly

#### Contents

1. service to be provided;
2. benefits for patients;
3. expected improvements in efficiency and effectiveness;
4. management resources required;
5. costs of the proposals and their recovery period; and

***GPC comment: Presumably these costs (and any management resources – see point 4 above) will be funded up-front and later recouped from savings made. In addition, this may mean that it will be possible to extend the recovery period beyond the end of the financial year concerned. These are important negotiating points for practices to bear in mind.***

6. though not a requirement, practices can include details of the enhanced services they currently provide through GMS/PMS.

#### Criteria for assessment of business cases

1. Evidence-based clinical effectiveness;
2. clinical safety, quality and governance;
3. a contribution to offering care closer to home and delivery of the national 18 weeks priority;
4. whether the specific needs of population groups such as disabled people (including those with learning difficulties or mental health needs), people from Black Minority Ethnic communities (BME), the differing needs of men and women and of the diverse age groups, different faiths and sexual orientation of individuals and groups accessing services have been taken into account
5. patient and stakeholder support;
6. justification/evidence that resources can be released through the substitution of care;
7. affordability within the current and projected indicative budgets;

8. consideration of whether formal tendering is required, which it is envisaged will be infrequent;
9. assessment of the risks of the development;
10. the procurement route (see paragraph 3.31 onwards); and
11. value for money, including using benchmarked costs to determine a reasonable price range for services.

#### Services transferred from hospitals

1. Contracts need to include quality criteria covering patients' experience, quality and service standards.
2. Regular sampling with results being made easily available to patients.

#### Approval of business cases

1. PCT to aim to approve within 4 weeks, and in no more than 8 weeks
2. Approval to include confirmation that plans and business cases are consistent with national and local priorities

### **6.2 Elective services delivered in the community by 'any willing provider'**

- The latest DH guidance gives clarification on and builds upon the guidelines set out in 'Health reform in England: update and commissioning framework', July 2006.
- For routine elective services delivered in community settings, a new 'any willing provider' model encourages there being both multiple and a range of providers for the same procedures between which patients can choose.

#### ***GPC comment: GP practices are considered 'willing providers'.***

- PCTs' contracts with providers will not set any level of guaranteed income/payment or activity/volume.
- PCTs should only award such contracts to providers who demonstrate that they meet national minimum quality criteria as set by Healthcare Commission.
- These services should be added to the local choice menus where appropriate.
- There is no need for tendering under these arrangements.

#### ***GPC comment: This is an important point and should facilitate a more streamlined process for practices who wish to offer extended primary care services.***

### **6.3 Extended primary care services delivered by 'any willing provider'**

- As with elective services, PCTs are to establish a range of providers of extended primary care services via a new 'any willing provider' model, between which patients can choose. These might include GP limited companies, third sector organisations that are 'values-driven', community pharmacies, private companies and PCT provider services.
- Prospective providers should satisfy the PCT that it can comply with quality standards.

- Contracts/agreements should not include guaranteed volume or income.
- PCTs can use LES route for these services where the provider already holds a GMS, PMS and/or APMS contract.

***GPC comment: Using the LES route should be seen as a payment mechanism for extended primary care services delivered by contractors already holding a GMS, PMS or APMS contract. These services should be paid for with funding over and above the enhanced services floor as they represent a secondary to primary care shift. Although provision of such services may be exclusive to a few practices in the PCT area, presumably, under the 'any willing provider' concept, if other practices within the area also wish to provide the service, then upon approval from the PCT on a business case, they will be able to do so. There is likely to be a need for a joined-up approach across PBC groups in the area to avoid conflicting plans for service development and to enable a sharing of ideas for service redesign.***

***For further guidance on the interface between PBC and enhanced services refer to the GPC's guidance note 'Enhanced services and floors from April 2007' which is available online via the following website address: [www.bma.org.uk/ap.nsf/Content/Hubenhancedservices](http://www.bma.org.uk/ap.nsf/Content/Hubenhancedservices)***

- Contracts between PCTs and GP provider limited companies should include:
  - ❖ Clear profiling;
  - ❖ Referral;
  - ❖ Conversation rates; and
  - ❖ Expenditure ceilings.

***GPC comment: The DH guidance only refers to limited companies here, but this is inconsistent as you do not need to be a limited company in order to bid to provide extended services. We would interpret this therefore as applying to all practices holding a GMS, PMS or APMS contract.***

#### **6.4 Tendering**

- By moving away from the PCT purchasing an exclusive service from a single provider and instead allowing 'any willing provider', legal requirements for tendering do not apply (paragraph 3.42).

***GPC comment: Although we welcome the fact that tendering need not be an obstacle in the development of new services by practices in primary care, the financial risk of setting up a service, within a competitive arena and with no guaranteed volume of activity needs to be understood.***

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

### **6.5 Payment by results (PbR) and local tariffs for services**

- Where a service is provided in a community setting that is not the same as an existing hospital service, it is outside the national tariff/PbR. Price bands for such services are to be set locally with help of benchmarking of costs and prices at PCT, SHA and national level. These prices should be activity-based and published in an open and transparent way and made available to PBC commissioners.
- Where a service is provided in a community setting that is the same as an existing hospital service, it is within PbR and the national tariff rate applies.
- The Department of Health has provided clarification on the definition of 'the same' in this context. If one of the following criteria applies, then a service **is not** regarded as 'the same' and the PCT is free to negotiate a local price for the service:
  - ❖ the service is delivered through any contractual option to provide GP services including GMS, PMS or APMS contracts;
  - ❖ the service is provided in a community facility and performed by a GP, any health care professional employed by or on secondment to a GP, community nursing teams and/or allied health professionals contracted to work in primary care;
  - ❖ the service is provided within a facility receiving notional or cost rent reimbursement or equivalent benefit (Local Improvement Finance Trust (LIFT) schemes, for example); and/or
  - ❖ the service is an outpatient service. This is an interim measure pending further progress on unbundling<sup>1</sup> the outpatient tariffs for diagnostics (as, without large numbers of patients, the cost of diagnostics is a prohibitive risk).

## **7 SUPPORT FOR PRACTICES AND INCENTIVE SCHEMES**

### **7.1 PCT management support for practice based commissioners**

- Recognition that the 'Towards practice based commissioning' directed enhanced service (TPBC DES) only went part of the way to funding PBC activity.

***GPC comment: This is an important point and practices should remind PCTs of this accordingly.***

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<sup>1</sup> **Unbundling** Current PbR tariffs include several stages of a procedure, for example the follow-up outpatient appointments after an operation as well as the operation itself. Unbundling breaks the tariff down to cover these constituent parts.

- As stated previously, all aspects of the PCT budget should be devolved indicatively to practices. Practices will hand back elements of this notional, whole practice allocation to PCTs, including clearly identified funding for a central (PCT) management team.

***GPC comment: By virtue of the process of handing back funding for central management to the PCT, practices have legitimate authority over how these resources are used. This offers a greater element of control and the output of the central management team should meet the needs of practices. There was no such entitlement in the past and this should empower practices and provides a shift in mind-set for PCTs.***

***Practices should be aware of the new ability for PCTs to subcontract out some of their commissioning responsibilities to the private sector via the framework for procuring external support for commissioners (FESC). The BMA will be producing a briefing and position statement on the FESC in due course. This will be available online via the following website address: [www.bma.org.uk/ap.nsf/Content/Hubcommissioningserviceprovision](http://www.bma.org.uk/ap.nsf/Content/Hubcommissioningserviceprovision)***

***We would advise that where PCTs wish to use part of the central management funding to buy in services from the FESC, the agreement of practices should be sought accordingly.***

- PCT to set out what practices can expect in return, but if these services are not delivered or are delivered, but not to a good enough standard, practices will negotiate a budget from the PCT to procure these services independently. Where local agreement cannot be reached on the arrangements, the case should be referred to the SHA.
- This budget should be proportionate to the scope of commissioning agreed in the PBC plan and size of consortium.
- Budget to be held by the PCT and practices to send invoices to the PCT for payment.
- The Department of Health hopes that adopting such measures will be the exception.

## **7.2 Incentive schemes**

- Following the end of the TPBC DES in March 2007 PCTs are to put in place local incentive schemes where ‘... the provisions within the DES arrangement represent the minimum requirements for local incentive schemes...’ (paragraph 4.11).

***GPC comment: The lack of a DES could potentially result in inequitable local resourcing of PBC, as well as incurring disproportionate time on local negotiation.***

- Guidelines on local incentive schemes outlined in the Department of Health guidance ‘Health reform in England: update and commissioning framework’, July 2006 still apply for the most part. Three key points are that local incentive schemes are clinically appropriate, affordable and cash-releasing.

***GPC comment: We previously commented<sup>2</sup> that the 'local incentive scheme' appears to be different from the original concept of a management resource that would be recouped from freed up resources. The additional proviso here appears to be that in order to access a local incentive scheme, the proposal must demonstrate that it will free up resources.***

- To achieve the cash-releasing requirement, the Department of Health recommends a focus on the national 18 weeks priority (GP referral to start of treatment) and the ten High Impact Changes identified by the NHS Modernisation Agency, details of which can be found here: [www.wise.nhs.uk/cmsWISE/HIC/HIC+Intro.htm](http://www.wise.nhs.uk/cmsWISE/HIC/HIC+Intro.htm)
- Incentives scheme payment to be regarded as practice income.

***GPC comment: The definition of these payments as practice income is a welcome change from the criteria placed on the DES payments.***

- Pricing of incentive schemes is for local determination and payment of any awards is dependent on practices not overspending against the indicative budget.

***GPC comment: We would reiterate the importance of practices being adequately remunerated for their involvement in commissioning activity and we consider the TPBC DES pricing as the bare minimum acceptable.***

### **7.3 National support for practice based commissioners**

- The Department of Health-sponsored PBC development programme is provided by the Improvement Foundation [www.improvementfoundation.org](http://www.improvementfoundation.org)

## **8 INFORMATION FOR PBC**

- PCTs must provide practices with the following:
  - ❖ Information on practices' use of health service resources;
  - ❖ Local intelligence on needs assessment; and
  - ❖ Information on financial and clinical activity.
- Information must be timely and digestible.

### **8.1 Tools and support**

- PCTs to support practices with analysis and interpretation of management information, either by developing the skills in-house or by using commissioning support services from the independent sector.

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<sup>2</sup> See GPC guidance *Health reform in England: update and commissioning framework*: GPC summary/analysis of new policy developments in relation to practice based commissioning, August 2006

## 8.2 Data requirements

- The minimum requirements for information are as follows:
  - ❖ Elective activity;
  - ❖ Inpatient and day cases;
  - ❖ Non-elective admissions, including length of stay;
  - ❖ First outpatient appointments and follow-up appointments;
  - ❖ Consultant-to-consultant referrals;
  - ❖ A&E attendances;
  - ❖ Use of diagnostic tests and procedures;
  - ❖ Prescribing;
  - ❖ Community and mental health services; and
  - ❖ Primary care, including essential and enhanced PMS and GMS services.
- Benchmarked data should be provided as follows:
  - ❖ Referral rates;
  - ❖ Admission rates;
  - ❖ First outpatient attendances; and
  - ❖ Follow-up rates.

## 9 MONITORING DEVELOPMENT OF PBC

- New approach for 2007-08 based on three indicators; enabling; engagement and impact.
- *Is the PBC framework enabling?* SHA to analyse random sample of practice plans approved by PCTs, predominantly in order to assess quality of the local commissioning framework and PCT capability.
- *Are practices engaging with PBC?* The Department of Health will commission independent quarterly survey covering a sample of practices in each PCT. The questions will include availability of indicative budgets and local incentive schemes, satisfaction with the provision of information and PCT support.
- *Are there new pathways and what is their impact on outcomes?* SHAs to include in their annual reports (June 2007) five detailed case studies of good practice and service redesign in the area. This will be published online by the Department of Health. In addition, The Department of Health will also develop a quarterly 'scorecard of impact', which will be publicly available – for more detail see paragraph 6.10.

***GPC comment: This implies that the Department of Health will be performance managing PCTs via a practice survey, which is encouraging. This offers practices the ability to give a vote of confidence or no confidence in their PCT, which is better than the current arrangements and methodology for measuring engagement. However, we would seek to ensure that a proper survey is produced that represents the views of all practices.***

## SUMMARY OF NEW POLICY FOR 2007-08

### PCTs to...

1. Aim to approve practices (a) commissioning plans (b) proposals for use of freed up resources and (c) business cases for providing services within 4 weeks, and in no more than 8 weeks.
2. Set up a specific PBC committee or subcommittee with accountability to the PCT Board.
3. Ensure that consortia either lead or as a minimum are represented in partnership meetings between Acute/Foundation Trusts and the local authority and contract meetings between PCT and providers (paragraph 2.24).
4. "...avoid agreeing new long-term contracts with service providers that would further cement monopoly provision arrangements and exclude practices from being able to propose service and care pathway redesigns" (paragraph 2.31).
5. Make all PBC commissioning plans available for scrutiny by Overview and Scrutiny Committee of the local authority and by the general public via the annual PCT prospectus.
6. Make a minimum of 70% of freed up resources (FUR) available to practices for reinvestment in patient care, *whether or not this was included in practice PBC commissioning plans.*

### Practices to...

7. Make commissioning plans available for public scrutiny by their practice populations.

### Budget setting

8. The methodology for setting the indicative budget is the same as in 2006-07, except for the period for which actual activity is taken (last 6 months 2005-06 and first 6 months 2006-07 converted to 2007-08 prices).
9. Freed up resources made in the previous year should not be deducted from future indicative budget allocations (paragraph 3.9).
10. The minimum scope of services included in the indicative budget has been extended to include 'all hospital-based care', community services and mental health costs (in addition to payment by results (PbR) and prescribing).
11. There is a more specific instruction regarding the move towards 'fair shares' budgets in 2007-08. The DH has developed a tool for calculating a crude indicative weighted capitation budget, which has an accuracy deviation of +/- 10%. If a practice's indicative budget, based on historic spend, is found to be higher or lower than the 'fair share' (estimated at 30% of practices), PCTs to consider making an adjustment of up to 1% maximum of the part of the budget practices are managing.
12. All aspects of the PCT budget should be devolved indicatively to practices. Practices will hand back elements of this notional, whole practice allocation to PCTs.

### Provision and procurement

13. The criteria used by PCTs to assess GP practices' business cases for providing services have been amended.
14. A new 'any willing provider' model encourages there being multiple providers for the same routine elective procedures and extended primary care services delivered in community settings.
15. PCTs are to establish a range of providers such as GP limited companies, third sector organisations that are 'values-driven', community pharmacies and private companies, PCT provider services between which patients can choose.
16. PCTs should only award such contracts to providers who demonstrate that they meet national minimum quality criteria as set by Healthcare Commission and all national standards of clinical governance including those set out in *Standards for Better Health*.
17. PCTs' contracts with providers (including GP practices) will not set any level of guaranteed income/payment or activity/volume.
18. There is no need for tendering under these/the above arrangements.
19. Tendering is only required when a contract is going to be awarded to a single provider, which would then create a service monopoly e.g. where a whole service is moved from a local hospital with no alternative equivalent being in place within the PCT boundary. This should only happen in 'exceptional circumstances' (paragraph 3.43).

### Payment by results and local tariffs

20. Clarification is given on for what kinds of services a local price can be agreed, thus making them outside the national tariff/payment by results (PbR).
21. Price bands for these services are to be set locally with the help of benchmarking of costs and prices at PCT, SHA and national level. These prices should be activity-based and published in an open and transparent way and made available to PBC commissioners.

### Support for practices

22. Practices will hand back elements of the notional, whole practice allocation to PCTs, including clearly identified funding for a central (PCT) management team. PCTs are to set out what practices can expect in return for this funding. If the PCT does not deliver on its commitment, there is provision for practices to negotiate a budget from the PCT to procure these services independently.
23. PCTs are to put in place local incentive schemes where '... the provisions within the DES arrangement represent the minimum requirements for local incentive schemes...' (as per of Health guidance 'Health reform in England: update and commissioning framework', July 2006).
24. Local incentive schemes should be clinically appropriate, affordable and cash-releasing. Payments are to be regarded as practice income (as per of Health guidance 'Health reform in England: update and commissioning framework', July 2006).
25. The pricing of incentive schemes is for local determination and payment of any awards is dependent on practices not overspending against the indicative budget.