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in partnership with **DH-N**

# NHS Reform

Practice based Commissioning



## Introduction

This briefing was written by Alyson Morley, Policy Officer at the Democratic Health Network, as part of the DHN's support to the CfPS Expert Advisory Team.

Practice based Commissioning (PbC) is one of the major drivers for change within the NHS. This briefing draws out the key issues for OSCs in policy guidance published by the Department of Health (DH) earlier in 2006. The documents are:

- *Practice based Commissioning: achieving universal coverage*
- *Practice based Commissioning: early wins and top tips*

Copies of the documents can be downloaded from the web link given below. In addition the NHS Chief Executive Bulletin, published weekly by the DH, regularly has information about the implementation of PbC. All information relating to PbC is available at: [www.dh.gov.uk/practicebasedcommissioning](http://www.dh.gov.uk/practicebasedcommissioning).

## Practice based Commissioning: achieving universal coverage

The document, published in January 2006, provides details for PCTs and practices on how to put in place arrangements for universal coverage by the end of 2006. It builds upon previous guidance *Practice based Commissioning: promoting clinical engagement* and supersedes *Making Practice based Commissioning a reality: technical guidance*. PbC is also a central plank of the DH *Operating framework for 2006/07* and the White Paper *Our health, Our care, Our say*. In his foreword to the document, Minister of State for Reform Lord Warner states that:

"Practice based commissioning gives primary care professionals [not just GPs but practice and community nurses, midwives, dentists, pharmacists and optometrists] more freedom to innovate and to reshape the boundaries between primary and secondary care. It allows them to look critically at all of the care pathways that patients and users follow."

The guidance identifies how PCTs and practices should work together to implement PbC and seeks to answer five questions:

- What does universal coverage mean?
- What information is needed to make PbC work?
- How will budget setting and financial management work?
- What is the governance and accountability framework for PbC?
- What support will be available to practices and PCTs to ensure that patients benefit?

### **Achieving universal coverage**

The aim of a full rollout of PbC by the end of 2006 is ambitious and, some would say, highly improbable given the sheer number of other key changes to the policy framework within which primary care operates. The emphasis is on PCTs to ensure that all practices fully understand how they perform both clinically and financially in comparison with national and local indicators. All practices will receive an indicative budget for an agreed range of services but the money will continue to be held by the PCT. PCTs will also take the bureaucratic and administrative burden so that practices are free to focus on patient care and the redesign of services and care pathways.

In order to encourage the uptake of PbC, practices will receive financial incentives either in the form of the Directed Enhanced Service payment (more of which later) or locally agreed incentive schemes. The extent of implementation of PbC will be a key performance indicator for PCTs and will be measured by SHAs through the uptake of incentive payments. Although PbC remains voluntary, there is a clear expectation that all practices will be operating PbC by the end of 2006.

The guidance recognises that rate of uptake is a crude measure, that does not necessarily translate into improvements in the range and quality of services available to patient. So far, though, no specific performance or outcome indicators have been developed to identify benefits to the patient.

### **Provision of information**

PCTs will provide practices with benchmarking, financial and activity information so that they can "understand the implications of their clinical decisions" on a regular basis. A national template will be developed to allow practices to have clear information on the following areas

- elective activity - both inpatient and day care
- non elective admissions - with information on length of stay
- first outpatient appointments and follow up appointments
- use of diagnostic tests and procedures
- referrals between consultants
- prescribing
- community and mental health services
- primary care services
- accident and emergency attendances.

Some information - on referral rates, admission rates, outpatient attendances and follow up rates - will be benchmarked locally and nationally. Independent and private providers of care commissioned by PCTs will also be required to provide accurate and up to date information.

Information on local needs and demographics - for example, annual child health mapping data - will be available to assist practices in aligning their spending with local health needs.

## **Budget setting and financial management**

All PCTs will provide all practices with indicative budgets by April 2006. Furthermore, PCTs will provide practices with information about their share of the overall indicative budget for all practices in the PCT area. A toolkit, developed by the DH, will assist PCTs in using the national resource allocation formula to calculate budgets at practice level.

Individual practices will need to decide which elements of health care they wish to include in the indicative budget. They will base this on their own commissioning plans, which will include the practice's proposals for improving services and reallocating freed up resources. Practices will not have an entirely free hand in deciding which services they can include in the commissioning plan: they will be required to include all services covered by Payment by Results (PbR) and the national tariff and all prescribing. Practices are also encouraged to consider including community and mental health services - especially where there are plans to shift these from secondary to primary care - and any budgets that are pooled under the Health Act 'flexibilities' in the indicative budget. Specialist services that are commissioned regionally or national are specifically excluded from indicative budgets.

The guidance outlines the approach which should be followed by PCTs in setting indicative budgets. The PCT should calculate the indicative budget on the basis of

- actual 2005/06 activity with an adjustment to 2006/07 prices
- the current formulae for prescribing including an uplift to reflect inflation
- weighted capitation for all the services in the agreed scope of the indicative budget for which there is no available activity data
- any uplift to meet agreed additional activity over 2005/06.

**Risk management** will be a major issue both for PCTs and practices and the guidance stresses that patients and/or practices should not be disadvantaged because of high cost individual care. PCTs need to actively manage risk in a number of ways: creating a PCT-held contingency amounting to no more than three to five per cent of the total indicative budgets; any treatment costs exceeding a pre-set threshold cost would be met from the contingency fund; the removal of high cost, low volume treatments from the indicative budget; support practices to working in clusters to collectively redesign services. All of these options need to be discussed and agreed with all practices. Any unspent contingency must be returned to practices' indicative budgets.

**Freed up resources** arising from service redesign and from using more cost-effective treatment must be spent for the benefit of patients and can be spent on equipment, training, clinical and non-clinical staff. Practices can only spend resources on premises development with the approval of the PCT.

All practices will develop PBC plans to identify: what services will be commissioned as part of the indicative budget; how the changes will free up resources; and how the resources will be used. The plans will be agreed with the PCT and other practices to encourage partnership working and ensure that plans are in line with national and local targets for performance and health improvement outlined in the Local Delivery Plan and in Local Area Agreements.

In the first year, the DH recommends that individual practices have access to at least 70 per cent of freed up resources with the remainder used to meet needs across the whole PCT area.

If, in 2006/07 deficits occur that cannot be covered by the contingency fund or recovery plan arrangements, these can be met from freed up resources.

PCTs are expected to keep bureaucracy to a minimum if practices propose small changes to services but they will have a major role in determining larger-scale proposals. Practices will be expected to put forward a thorough business case which outlines: what services will be provided; who will benefit; expected improvements in efficiency and effectiveness; management support required; costs; and specific timelines for recovering the initial financial outlay. PCTs will be expected to come to a decision, based on clear and agreed criteria, within eight weeks of receiving the business case.

**Contracting** PCTs will remain responsible for all aspects of contracts for new services but increasingly they will do so on the basis of advice from their local practices.

### *Support for practices*

PCTs and peer networks at local level, and the Primary Care Development Team at national level will support practices. Further information is available from [www.npdt.org](http://www.npdt.org). A key aspect of national support (or to the cynical eye, incentivisation) is the **Directed Enhanced Service (DES)** payment. DES entitles all practices which develop locally agreed PbC plans to 95p per registered patient per year. Some areas already have local incentive schemes and the DES will not override such schemes. More information on the DES is available at [www.dh.gov.uk/practicebasedcommissioning](http://www.dh.gov.uk/practicebasedcommissioning).

### *Accountability and governance*

PCTs will remain accountable for all the funds allocated to them and for ensuring fair access to good quality services for local people. They are also responsible for ensuring that local services meet national and local quality standards, especially with regard to patient safety. They remain accountable to the Secretary of State via SHAs.

PCTs also have a duty to consult local people and other key stakeholders (including local authorities and children's trusts) in the development of new services and in delivering their commissioning responsibilities. The guidance also states that: "practices are encouraged to ensure that patients, as the users of services, are engaged in decisions about the redesign and reallocation of freed up resources".

The guidance stresses the importance of clear governance arrangements for PbC which include

- dissemination of information to support practice based commissioning
- budget setting and financial management arrangements
- support for practices, including incentives

- a process to agree PBC plans
- a process for approving business cases for reallocation of freed up resources
- criteria for reaching decisions.

Performance the principle of “light touch” performance management will be applied to practices which demonstrate that they are delivering change and reallocating freed up resources according to local need. Support should be focussed on practices that are having difficulty in making cost savings and service improvements.

The DH expects that all practices and PCTs will come to a local agreement on how the national strategy for the roll out of PbC will be implemented. The SHA will consider referrals in cases where local agreement is not reached. The SHA will set up arbitration groups comprising practitioner, financial and management representatives to make decisions about disputed local PbC plans.

### ***Comment***

The government intends that the implementation of PbC will be a major driver for improving the cost effectiveness, quality and range of healthcare services. It also sees PbC as a major originator of new, more community based services. The implementation of PbC is ambitious, given that many practices are either unenthusiastic or downright sceptical about its supposed benefits. The guidance is welcome in that it outlines the support that practices will need from PCTs and from national organisations. However, it is not clear whether this support will result in better and more appropriate services rather than just a greater administrative burden for practices (which are not renowned for their ability to deal with bureaucracy).

Effective PbC depends upon accurate and timely data about finances and treatment activity being passed from practices to PCTs and back again. Without such information it will be difficult to develop feasible PbC plans. With some exceptions, the collection, analysis and dissemination of accurate and timely financial and activity data is not one of the strengths of the NHS. PCTs and SHAs will need to devote time and resources to ensure that data collection and dissemination is improved.

The guidance does, however, establish a clear division of labour between practices, PCTs and SHAs with regard to the implementation of PbC and, as such, is to be welcomed. We also welcome emphasis on involving patients and other local stakeholders in developing proposals for new services - although this represents a major culture change for PCTs and individual practices.

### **Practice based Commissioning: early wins and top tips**

This document follows on from *Practice based Commissioning: achieving universal coverage* and provides examples of best practice to illustrate how PbC can be used to redesign care pathways. It also provides a list of ‘top tips’ as a useful checklist for practices implementing PbC. They include the following suggestions.

- Set up monthly meetings with clinicians and practice staff to discuss and review referral activity.
- Set up a local skills directory to facilitate primary-to-primary referral.
- Agree protocols and clinical governance audit mechanisms for internal services.
- Begin to create self-management plans for the most common long-term conditions in order to manage demand and improve clinical outcomes.
- Provide patients with self-management information, including signposts to further information and support, on common conditions such as back pain.
- Practices or commissioning consortia should create data collection systems which include data on referrals and follow-ups and length of stay of inpatient treatment and identify opportunities for reducing costs.
- Establish protocols for “triage systems” and other ways of prioritisation cases between practices for new and existing care pathways.
- Establish “scoring systems” and other means for determining whether patients would benefit from secondary care referrals
- All practice based professionals should be involved in the redesign and commissioning of services. Social care professionals should also be involved in the design of new pathways and new services.
- Use a variety of different media to support and encourage all staff and patients to contribute to PbC.

The document then identifies good practice in the redesign of pathways for particular treatments and specialties. This briefing does not give a comprehensive summary of all the examples of good practice, however you are advised to look at the guidance that provides useful information about possible service improvements around the following specialties:

- Chronic obstructive pulmonary disease
- Dermatology
- Heart failure
- Long-term conditions
- Mental health
- Ophthalmology
- Orthopaedics
- Podiatry
- Urology

The examples of good practice identify reductions in some or all of the following areas: acute hospital admissions; out-patient appointments and the length of wait for outpatients appointments; referral to secondary care (including community mental health teams); unplanned admissions and length of stay in hospital; visits to GPs, both in and out of hours; diagnosis time leading to quicker referral to surgery. A copy of the full document is available at: [www.dh.gov.uk/practicebasedcommissioning](http://www.dh.gov.uk/practicebasedcommissioning).

## *Comment*

The primary audience for the guidance is primary care practitioners and the document contains terms and jargon that non-medical professionals may find difficult. The document is admirably brief and simply provides a number of case studies which practices can draw on for improving commissioning.

Reductions in waiting times, referrals, inpatient episodes etc. may improve the patient experience and health outcomes, but the case studies appear to be primarily concerned with identifying ways of reducing costs. This is no bad thing if the savings are reallocated to new and improved services specifically designed to meet local needs but there is little regard in the document to how patients will benefit.

## *Implications of PbC for OSCs*

It is important that OSCs have a clear understanding of PbC and its effects on the development of new services. The guidance states that proposals for new services or variations to existing services should be consistent with national and local standards and priorities, and should have particular regard to the priorities outlined in Local Delivery Plans (LDP) and Local Area Agreements (LAAs). OSCs need to be assured that all new services are in line with priorities of community strategies and LAAs, as well as the LDP. OSCs may find the following checklist useful in ensuring that they are fully aware of the effects of PbC on local health services.

- Do you know the range of services and treatments covered by local PbC plans?
- Have your PCT/s and practices consulted you on the scope of PbC plans?
- Are local PbC plans consistent with the priorities of the LDP, the community strategy and LAA? If they are not consistent, is there good reason for this?
- Is the OSC aware of new services and care pathways that are being considered by the PCT? Has the OSC been consulted by the PCT about new services and new care pathways?
- To what extent have patients, the public and other key stakeholders been involved in the development of PbC plans? Can the OSC assist practices and PCTs in providing information (drawn from previous OSC reviews, for example) on local health needs?
- To what extent are practices and PCTs working with colleagues in social care to develop integration between health and social care?
- Do PbC plans advance the aims of *Our health, our care, our say* to move health and social care away from hospitals into the community? Do such proposals link into the local development plans of the Council?
- Has the implementation of PbC led to better services and better health outcomes for local people? If not, why not?

Undoubtedly, there will be many more questions that OSCs need to ask about the local implementation of PbC. It may be advisable for OSCs to seek an informal meeting with the PCT's lead on PbC to discuss the progress of local implementation and its likely effects on local health and social care services as well as information on local implementation milestones.