



Practice Based Commissioning (PBC) Agreement between Practices and Primary Care Trusts

An Approach to Implementing Practice Based Commissioning
Developed by

NHS Confederation
National Association for Primary Care


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The following document has been developed by the NHS Confederation and the National Association of Primary Care to help construct an agreement that can be used by practice based commissioners and their Primary Care Trusts (PCTs). This should be used as a guide to the main issues that need to be addressed and resolved before the commissioning process begins.

Models of Practice Based Commissioning

The Department of Health (DH) technical guidance confirms that Practice Based Commissioners should have an indicative budget from the beginning of their commitment to this way of working that details all of the resources available to them. The concept is to devolve the PCT's total unified indicative budget to the practice. The key areas of discussion between PCT and practice will be to then decide how much of this budget is used to commission services by the practice and how much is blocked back to the PCT to commission on the practice's behalf locally. Models are being developed that use a tiered approach to engaging the practices in these discussions. Such models vary but may cover;

- A basic level where all of the budget is blocked back but the practice  gives information on their commissioning activity and compares this to their indicative budget
- One or more intermediate levels where some of the budget remains devolved to practice or PBC group for the commissioning of specific services, and the remainder blocked back to the PCT. Intermediate levels may include some differentiation between tariff and non tariff activity and this will require discussion with the PCT about indicative funding levels.
- An advanced level where all services are commissioned at practice or PBC group apart from those excluded by the guidance i.e. those subject to specialist commissioning arrangements, nationally prescribed.

 It is for local negotiation between the Professional Executive Committee, PCT senior management and local practices to agree a model which is flexible and suits local circumstances.

However, there needs to be an underlying set of arrangements and commitments that should be in place prior to any commissioning commencing. These have been structured in a four-element model.

The Elements of the Agreement

1. Principles

The basis of any agreement is a set of shared principles which must be agreed prior to any further discussions about the detail of practice commissioning arrangements. These include;

- 1.1 Partnership and a joint commitment to the principles of devolved responsibility for commissioning decisions across the clinical community within the PCT.
- 1.2 A mutually agreed direction and vision for what can be achieved through practice based commissioning. This includes learning together and jointly developing systems for ensuring that patients benefit from this model of commissioning.
- 1.3 Support for a variety and diversity of approaches to practice based commissioning, allowing for single practice approaches but also for practices that work together, particularly in localities, to improve efficiency and value
- 1.5 The encouragement of innovation by enabling practices and localities to be ambitious in creating changes.
- 1.6 A collaborative approach between the practice / locality and the PCT in securing the new services for patients that commissioners want to redesign and create, bearing in mind the underlying principle of equity of service provision responsive to local health needs.

2. Framework

The agreed principles then need to be set in the context of PCT and practice responsibilities. It will therefore be necessary to consider together;

- 2.1 Constraints and pre-commitments and their impact on the local commissioning decisions that can be made e.g. are there ISTC or Foundation trust contracts that are binding and how will the practices enable these pre-commitments to be honoured through their commissioning activities? Similarly, account must be taken of those elements of service which will be commissioned through

partnership arrangements e.g. Children's Trust or (virtual) Care Trust arrangements or specialist commissioning agreements.

- 2.2 Fit with Local Delivery Plan targets and priorities and PCT commissioning strategies or strategic frameworks including how the PCT can use practice based commissioning to develop a bottom up approach to LDP priority setting.
- 2.3 Fit with NHS plan and PSA targets and other national priorities including "Choose and Book".
- 2.4 Clinical governance arrangements and the degree of risk that both PCT and practice will take in the particular level of commissioning activity proposed.
- 2.5 Corporate governance arrangements and the degree of risk that both PCT and practice will take in the particular level of commissioning activity proposed.
- 2.6 How management and support costs will be quantified and apportioned.
- 2.7 How consultation with the public and other stakeholders will be undertaken and the relative responsibilities between practice and PCT for delivering this engagement.

3. Commitments and Responsibilities

3.1 Practice commitments and responsibilities

3.1.1 A clear rationale of their reasons for commissioning at their chosen level and the outcomes expected.

3.1.2 A commitment to;

- *mutual accountability* for the degree of success of their commissioning decisions. (For practices, this will mean ensuring proper internal governance/accountability structures, evidencing of decisions and involvement in decision making, taking into account consequences and conflicts of interest etc)
- *extend the range of commissioned services* as appropriate over a three-year period and, where agreed, to a total devolved budget for services.

- *engage in wider planning activities* with the PCT so that their commissioning activity is consistent with overall priorities.

3.1.3 A responsibility to;

- *clearly articulate* their aspirations and objectives.

• *engage* in regular, locally agreed review with the PCT.

- *identify* the use to which any efficiency gains will be put prior to engaging in commissioning. (This is not inclusive of opportunistic savings that may occur in year where agreement as to their use may need to be made quickly).
- *ensure* that there is no cost shifting from incentivised to non-incentivised areas of service and to proactively manage the risks associated with decisions.
- *gauge* patient satisfaction as part of annual patient surveys.
- *ensure* that any practice group commissioning planned to develop PBC coherently seeks to ensure that it enhances efficiency and effectiveness.
- *ensure* that practice based commissioning decisions do not adversely affect the levels of health inequalities across the PCT.

3.2 PCT commitments and responsibilities

3.2.1 A clear vision for health improvement and service delivery in order to support PBC for at least a three year rolling period.

3.2.2 A commitment to;

- *mutual accountability* for the degree of success of practice commissioning decisions. (For the PCT, this includes a responsibility to guide and support commissioners in establishing and maintaining their

commissioning mechanisms and the provision of data that informs their decision making).

- *describe the level and type of support available* to practices to extend their range of commissioning over a three-year period and, as appropriate, to the total commissioning of all services. This will include management and administrative costs, service development and investment in change with clear processes for accessing funds.
- *manage the risk of savings plans* with investment including the development of contingency funding mechanisms up front as necessary.
- *ensure* that local planning processes support the development of practice based commissioning activity.

3.2.3 A responsibility to;

- *look at* the wider public health agenda and judge the impacts of PBC, communicating this to the practices regularly.
- *support* commissioning practices with training, IT and possibly administrative or managerial support.
- *manage* risks over the wider PCT system.
- *ensure* that PBC groups are structured to provide consistent and needs driven services for a local population and enable co-ordinated commissioning activity to be undertaken; but supporting different self determined group development when appropriate and advantageous.
- *undertake* regular reviews with the practices.
- *ensure* that practice based commissioning decisions to not adversely affect the levels of health inequalities across the PCT.

4. Audit and Evaluation



The performance management, audit and evaluation of the impact of practice based commissioning is vital to ensuring that both practice and PCT are confident in discharging their commitments and responsibilities outlined above. PCT boards and PECs will hold the overall accountability for the implementation of PBC. Arrangements therefore should be made prior to the commencement of a formal agreement on:

- 4.1 Review arrangements, their frequency, structure and content. These will need to be consistent with Healthcare Commission and other regulatory body monitoring processes.
- 4.2 Whether such reviews form part of a wider audit, quality monitoring and/or evaluation programme for commissioning within the PCT.
- 4.3 The role of patient and public involvement in the processes and how this and patient satisfaction will be monitored as the range of commissioning activity increases.
- 4.4 The mechanisms for and outcomes of a mutually agreed remediation process.