

Copyright

The content, layout, design, data and graphics contained in this document are protected by UK and international copyright laws.

MAY 2006

GPC

General Practitioners
Committee

Practice Based Commissioning: The Commissioning Plan and an Agreement with the PCT

Guidance for GPs

BMA 

BACKGROUND

This document is the second in a new series of guidance notes from the General Practitioners Committee (GPC) on practice based commissioning (PBC). The first section, on 'Consortium working', was published on 13 April 2006 and is available online at the following address:

www.bma.org.uk/ap.nsf/Content/pbcconsort0406

Another GPC guidance note was published on 26 April 2006, 'Division of freed up resources', which can be accessed via the following website link:

www.bma.org.uk/ap.nsf/Content/PBCfreedup

For the most part, the series is aimed at practices who intend to take on a level of commissioning activity wider than the scope of the 'Towards practice based commissioning' Directed Enhanced Service (TPBC DES). Despite this, a large part of the guidance will still be relevant to practices undertaking the DES.

Before reading this and other guidance in the PBC series, practices should have an understanding of the aims of the TPBC DES – a low level, introductory scheme – and how it fits in with higher level commissioning activity. The GPC has already produced detailed guidance on the DES (February 2006), which can be accessed here:

www.bma.org.uk/ap.nsf/Content/focustpbcdes

Whatever level of commissioning practices take on, they should be aware of three overriding messages:

1. Practices are not obliged to undertake any commissioning activity if they do not wish, or are not being adequately resourced, to do so;
2. Practices should be fully aware of the arrangements pertaining to and implications arising from their involvement in commissioning. This applies equally to practices who choose not to be involved in the initiative; and
3. Clear and precise, written agreements must be in place, both between the PCT and practice(s) and between practices within a consortium, setting out the terms of engagement, particularly in relation to any financial matters.

The various Department of Health documents referred to in this guidance can be accessed online via the PBC homepage at the following address:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/fs/en

This guidance has been structured as follows:

1	Introduction	Page 2
2	Core components of the commissioning plan and the agreement with the PCT	Page 2
3	Scope of commissioning and service redesign	Page 4
4	Use of freed up resources	Page 5
5	Up-front investment in order to free up resources	Page 6
6	Indicative budget	Page 7
7	Financial and risk management	Page 8
8	Data verification	Page 9

1 INTRODUCTION

The commissioning plan will form the basis of a practice/consortium's PBC agreement with the PCT. It is likely to be subject to continual development as the commissioning role progresses. Any major changes or divergence from the original, agreed plan however will need to be approved by the PCT. It is advisable to discuss any commissioning ideas with the PCT as they develop and in advance of submitting them formally through the plan. If necessary, when drawing up the plan, practices/consortia should seek support from the LMC or other practices/consortia in the area.

In addition to this, the GPC would advise practices/consortia to put in place a formal arrangement with the PCT in the form of a written and signed contract before taking on the commissioning role. If the agreed commissioning plan covers the relevant issues in detail, the contract need not be a lengthy document, providing it specifically commits to adhering to the arrangements included in the plan. In practice, both plan and contract may be contained within one document. If not, where the contract refers to other documents, plans or correspondence, these should be appended to the contract accordingly. The principles and details of the partnership with the PCT must be clearly defined with both parties being aware of their respective obligations.

As there is a degree of cross-over between what should be included in the consortium agreement (where applicable, see earlier GPC guidance on 'Consortium working'), the commissioning plan and the contract with the PCT, practices/consortia should try to avoid duplication of work and/or putting in place any conflicting arrangements.

2 CORE COMPONENTS OF THE COMMISSIONING PLAN AND THE AGREEMENT WITH THE PCT

The content of the commissioning plan is likely to develop alongside the more specific agreements contained within the contract with the PCT, which are likely to be subject to more precise negotiation than the content of the plan. The content of the commissioning plan will focus more on the practice/consortium's intentions whereas the contract will focus on the corresponding agreements with the PCT; the latter have been highlighted below in italics.

- Details of practice/consortium, including identifying clinical and administrative practice leads;
- Details of proposed management structure and costed clinical engagement allowance (see earlier GPC guidance on 'consortium working');

Agreement on provision of and arrangements for above management costs, including relating to claw-back in the event of no freed up resources being made; state clearly what management costs comprise of, for example are they expenses, a fee/salary or reimbursement for time spent; clarify when are they paid etc.;

- Overarching commissioning aims and principles;
- The scope of commissioning activity and detail of planned service redesign (see section 3 below), including where this requires upfront investment (see section 5 below); clarification on the commissioning objectives already covered by the TPBC DES (where applicable).
- Projected expenditure taking into account service redesign and development of services in primary and community settings;

The agreed indicative budget, including the method for its calculation and any subsequent revision(s) (see section 6 below);

Arrangements in the event of the practice/consortium exceeding the indicative budget;

- Intended use of freed up resources (see section 4 below);

How freed up resources are to be calculated and shared between the PCT and practice/consortium (see GPC's earlier guidance on 'Division of freed up resources');

- Risk sharing arrangements between practices should the expenditure show signs that it is moving away from planned and predicted trends (also to be included in the consortium agreement as per GPC's earlier guidance on 'Consortium working');

Arrangements for financial risk management; where this is a PCT-held contingency fund, it should state whether it is PCT-wide, or solely consortium-wide and detail the circumstances under which the PCT and/or the practice can call upon this fund (see section 7 below);

- How the plan links to the PCT's Local Delivery Plan (LDP), local priorities and the national public health agenda and national imperatives such as patient choice, addressing health inequalities, access and existing contracts with providers;
- How the views of patients and the public have been taken into account in development of the commissioning plan;
- Governance arrangements;
- Mechanisms for data verification (see section 8 below), reporting, audit and evaluation;
- Identification and development of information sources and systems, including communications within the consortium.

Respective responsibilities of the parties (including the PCT Board and SHA) to the agreement such as provision of information by PCT (see section 9 of below);

- *Arrangements for dispute and arbitration;*
- *Liability, recommend should be restricted and/or capped with regard to the consortium;*
- *Duration; and*
- *Termination.*

The Department of Health published a model/template PBC plan in March 2006, which can be found at the following website address:

www.dh.gov.uk/assetRoot/04/13/10/27/04131027.doc

This Department of Health plan attempts to cover both the TPBC DES and more extensive commissioning activity together, which is confusing. In addition, it makes no mention of the TPBC DES template plan that was agreed between the GPC and NHS Employers as part of the DES specification. Practices and PCTs do not have to agree a plan based on the Department of Health model/template in order to trigger payment of component 1 of the DES. Despite that, practices who are taking on a level of commissioning above and beyond the scope of the DES may wish to refer to the Department's template.

3 SCOPE OF COMMISSIONING AND SERVICE REDESIGN

Commissioning plans should focus on achievable and specific areas and this process should not be dictated by the PCT. From data verification exercises (see paragraph 8 below) and experience of the local health system, practices will already have an idea of the areas both where service redesign could result in significant freeing up of resources and those more complex, high risk areas that would benefit from a more considered approach.

Service redesign will usually be most efficiently developed via a consortium approach and serving a wider than practice population. Lead GPs and clinicians with an interest and expertise in specific areas can develop such redesign and the time for such clinician involvement will need to be costed and included in the PBC management allowance. When deciding what scope of commissioning to take on, practices should refer to the PCT Local Development Plan (LDP) and speak to neighbouring practices/consortia about their plans.

In deciding the scope of commissioning to undertake, practices/consortia may wish to target areas that have historically been problematic or where particular health needs and services gaps have been identified. Other considerations in this process include:

- Extent of available skills and experience of GPs (and other allied health professionals) and the potential to develop these skills in order to expand provision of primary care and community services;
- Market factors such as whether an Independent Sector Treatment Centre (ISTC) or a major block contract exists in the area and the implications of this on proposed service redesign;
- Arrangements currently in force between PCTs and secondary care providers, including how long they have yet to run, their capacity and nature, funding that has been allocated to them (and especially whether any of this is independent of work done);
- Effect on commissioning aims of variance between individual practices within a consortium in terms of resource utilisation and patient case-mix;
- Whether or not there is a need to build into the commissioning plan a demand management system in order to provide some control over any inappropriate activity taking place within NHS/Foundations Trusts;
- Level of resources available to support clinical engagement in order to develop and implement the commissioning plan.

Practices may wish to refer to the Department of Health's guidance 'Practice based commissioning: early wins and top tips' (February 2006) and a variety of case studies from across England where PBC is already underway, both of which are available online via the following website address:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/fs/en

Also for reference, the Royal College of General Practitioners (RCGP) has produced a toolkit 'Quality assuring patient pathways in practice based commissioning' (11 May 2006) which can be accessed via the following website address:
www.rcgp.org.uk/default.aspx?page=3170

4 USE OF FREED UP RESOURCES

The calculation and division of freed up resources between practice/consortium and PCT was covered in an earlier GPC guidance note, 'Division of freed up resources', which can be accessed via the following website link:
www.bma.org.uk/ap.nsf/Content/PBCfreedup

Paragraph 44 of the Department of Health's guidance 'Practice based commissioning: achieving universal coverage' states the following:

"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. PCTs are expected to agree a local process to ensure sensible and upfront distribution of resources freed up."

Practices may choose to pool some or all of their freed up resources for reinvestment in patient services on a wider scale. If this is the route that the consortium wishes to go down, practices should discuss future arrangements relating to any shared equipment or communal premises/clinics in the event of the make-up of the consortium changing.

Alternatively, the consortium's freed up resources could be apportioned to individual practices. This could be calculated in a number of ways including by practice population or according to the level of commissioning taken on by individual practices. The most important thing is to reach agreement on any such calculation at the start of the year and include this in the consortium agreement.

Practices may wish to present two possible options for use of freed up resources, one relating to pooling and the other to apportioning, or a combination of both, so that the consortium can make its final decision at the end of the commissioning year.

It may also be helpful to construct a priority-weighted list of developments to be initiated depending on the resources available. For example, if the consortium makes a saving of £X amount, then it will invest in options A to C, if it gains two times £X, it will invest in options A to E.

Where practices' plans for use of freed up resources have minimum implications for existing contractual arrangements, it is expected that these will be agreed '...with a minimum of bureaucracy by the PCT' (see paragraph 49 of the Department of Health's 'Practice based commissioning: achieving universal coverage' guidance). This might include the consortium directly employing a practice nurse or GP with a special interest (GPwSI) to provide a particular service to the combined patient population.

However where recommendations for use of freed up resources are more extensive and/or costly, practices/consortia will be expected to submit a business case to the PCT, which the PCT Board will assess in accordance with paragraphs 50-53 of the Department of Health's 'Practice based commissioning: achieving universal coverage' guidance. Under the Departmental guidance, a decision from the PCT Board on the business case should be made within 8 weeks.

Paragraph 51 of the Department's guidance sets out the areas that the business case should cover, these are:

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

The Department of Health has produced two business case templates for this purpose, use of which is optional, one relating to the plans of a single practice and the second relating to a group of practices. These documents can be accessed via the following website address: www.dh.gov.uk/assetRoot/04/13/10/29/04131029.doc

In areas where major PCT reconfiguration results in decisions on practice/consortium business cases being made by a distant PCT Board with little local knowledge, it would be advisable for a mechanism to be put in place for personnel from within the consortium and possibly representatives from the LMC to be involved in this process.

Current legislation does not allow practices to contract directly with providers for new services and so for the most part, where new providers are commissioned as a result of recommendations made under PBC, contracts will be established between PCT and provider, rather than consortium and provider. Practices may wish however to discuss in more general terms the contractual terms and arrangements that PCTs put in place with these providers.

It is likely that practices/consortia plans for use of freed up resources will include recommendations for the provision of new services which members of the practices/consortium will themselves provide. If this is the case, there should be discussion and agreement with the PCT on such arrangements, for example, it may be necessary to put in place procedures to counter any resulting conflict of interest and to ensure that contestability and choice are maintained within this process.

Plans for freed up resources should have agreed exclusions, including national guidance, and should be based on a set of agreed criteria. Practices should also discuss arrangements to deal with differential levels of freed up resources made between practices, especially where some practices overspend and others under-spend against the indicative budget. For example, consideration will need to be given to whether or not individual practices that have under-spent against their budget will hold on to their savings if the consortium has a net overspend.

5 UP-FRONT INVESTMENT IN ORDER TO FREE UP RESOURCES

The same process outlined in section 4 above, relating to practices submitting a business case to the PCT where planned use of freed up resources is extensive and/or costly, also applies to practices who wish to request upfront investment from the PCT in order to be able to deliver freed up resources by the end of the year. It would follow that this should also apply in-year.

The Department of Health guidance therefore introduces a mechanism for practices/consortium to receive the funding required for implementing their service redesign plans before the end of the financial year and the calculation and allocation of freed up resources has taken place.

6 INDICATIVE BUDGET

Under the Department of Health's guidance 'Practice based commissioning: achieving universal coverage', PCTs are expected to provide all practices with an indicative budget by April 2006. This should not necessarily be a one-way transaction and calculation of and agreement on an accurate indicative budget will ensure that practices/consortia begin the commissioning process, at least financially, from a fairer starting point.

The scope of services to be included in indicative budgets and how to calculate the practice budget is covered in paragraphs 31-37 of the Department of Health guidance. A minimum scope for the indicative budget has been set and includes:

- all services under the national tariff or Payment by Results (PbR) in 2006/07; and
- prescribing.

Exclusions from the indicative budget include:

- core GMS/PMS services (e.g. essential and additional services, QOF);
- specialised services;
- services commissioned regionally and nationally; and
- national screening programmes.

Practices have the option of including community services and mental health within their indicative budget.

In 2005-06, PbR only applied to a small range of services, namely elective in-patient and day-case care. This year (2006/07), it has been extended to cover electives, non-electives, A&E and outpatients in all hospitals; it will not cover critical care or mental health. [Note however that PbR covers a much wider range of services within Foundation Hospitals.] Practices should understand that, for the same volume of care, the costings under PbR may not equate to historic expenditure under former locally negotiated block contracts.

In 2006-07, budgets will be calculated by using the following information:

- actual 2005-06 activity (where available) converted to 2006-07 prices, in terms of the practice's share of the PCT allocation;
- current formulae for prescribing budgets including appropriate inflationary uplift;
- Weighted capitation for any services within the agreed scope for which no historic activity data is available; and
- an uplift to meet agreed additional activity over 2005-06 (though this will depend upon practices' use of resources compared to a target fair share and overall financial position of the PCT and so is not guaranteed).

The Department of Health wishes to see PCTs moving towards fair share allocations at practice level 'over time' via use of a weighted capitation based formula (see paragraph 30 and 37); it is unlikely however that such a formula will be fully introduced for PBC before 2008-09. In 2006-07, PCTs will decide the pace of transition and the Department of Health has produced an on-line 'toolkit' and guidance for calculating weighted capitation budgets at practice level, which can be accessed via the following website address:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127155&chk=f7Nx8B

Until the move to full, weighted capitation budgets takes place, the total of PBC indicative budgets within a PCT cannot be greater than the total PCT budget. Inevitably therefore, budgets will reflect the state of the local health economy and allocations made to PCTs, which may mean that practices will inherit indicative budgets with their share of PCT deficits/overspend where applicable. [Note that this is likely to continue to apply to a certain degree when capitation budgets come into existence.]

Departmental policy allows for practices not to have to actively manage/commission the full scope of services included in their budget, however, any activity they do undertake and subsequent freed up resources they make will be measured against the total indicative budget. This thereby allows flexibility of involvement, though no flexibility of budgetary responsibility. As a result, it may be more difficult for those practices who take on a low level of activity to free up resources than those who decide to take on a greater level of activity.

7 FINANCIAL AND RISK MANAGEMENT

For the most part, practices and PCTs will be expected to balance their budgets in-year. Paragraph 39 of the Department of Health's guidance 'Practice based commissioning: achieving universal coverage' says:

'The PCT will retain its accountability for its allocation, and its statutory financial duty to break even. The PCT and practices will have to work together to ensure the PCT achieves financial balance, or runs a small surplus.'

However, the Department of Health's detailed Question and Answer (Q&A) document on 'Practice based commissioning: achieving universal coverage' states the following:

'Do practices still have the right to balance their books over a three-year period?'

Where a practice puts forward a plan to spend more in one year to free up resources in future years, PCTs must consider this as part of their wider financial responsibilities. In some cases, there may be the flexibility to do so, but for some PCTs in financial difficulties, the first priority must be to ensure balance at year-end.'

In some areas, where there is a large PCT deficit, it may be unrealistic to expect this to be cleared within one year as a result of PBC. Practices/consortia in such areas may well not achieve financial balance in-year, particularly where inadequate reimbursement for clinical engagement hinders their achieving more extensive service redesign. Consortia should however aim to demonstrate that they have realistic commissioning plans in place and that they have worked in accordance with these plans. The Department of Health's current guidance makes no mention of sanctions for practices that over spend against their indicative budget. [Note that the previous guidance, 'Making practice based commissioning a reality: technical guidance' (February 2005), the detail of which has now been replaced, gave as a sanction the removal of the right to commission.]

The Department of Health's guidance 'Practice based commissioning: achieving universal coverage' guidance suggests four risk strategies for PCTs in paragraph 41, as follows:

- PCT-held contingency fund derived from a small indicative budget top-slice;
- setting a threshold value for treatments, above which costs are taken from the contingency fund;
- removing responsibility for particularly high cost, low volume treatments from the scope of an indicative budget; or

- encouraging practices to work in groupings/consortia.

The top-slice contingency fund is recommended to range between 3-5% and is likely to be the most common method for PCT risk management. Practices should ensure that the methodology for calculating the percentage of the top-slice is understood and agreed by both parties, with LMC consultation if necessary. In addition, this methodology should be applied consistently across PBC groups across the PCT area. Depending on the risk associated with the scope of services taken on by practices and the size of the aggregated patient population, the contingency top-slice would probably only need to be around 3%.

Some PCTs may seek to establish a contingency fund PCT-wide, which would mean that the aggregated risk associated with the activity of all the PBC groupings within one area would be managed from a central pot of money. There are the obvious advantages and disadvantages of this approach and consortia should not feel pressurised into agreeing any risk management arrangements if they feel they are going to be significantly disadvantaged as a result. If a PCT-wide contingency fund is the favoured route, then there is a greater need for individual PBC groups to communicate with each other and reinforce the shared commitment to achieving service redesign in order to effectively manage the budget.

If the contingency fund is not exhausted by the end of the year, paragraph 42 of the Department of Health's guidance 'Practice based commissioning: achieving universal coverage' guidance states that this money should be returned to practices, at year end.

Practices should be aware that the Department's guidance makes no mention of any penalty for practices that make a call on the contingency fund, but practices within a consortium may wish to discuss and agree a set of criteria against which a reasonable call on the contingency fund can be made in order to avoid any future disagreements.

8 DATA VERIFICATION

Departmental guidance states that '... PCTs have a responsibility to ensure that the data are accurate and up-to-date' (paragraph 27). Despite this, the GPC believes that practices will still need to sample and validate the PCT information that they receive at some level and this work should be adequately resourced. This will include checking the hospital coding against the actual treatment received by the patient following GP referral. In some cases, practices may need assistance understanding hospital codes, which the PCT should be able to provide.

Individual practices, or consortia may wish to consider employing an individual specifically to carry-out this work.

Data validation is vital for the following reasons:

- To ensure that the indicative PBC budget, which will be calculated based on historic activity, is fair and correct;
- To identify areas where modifying the existing patient pathway will be most effective, thus to understand which areas of commissioning are most viable in order to make freed up resources or 'quick wins';
- To be able to identify where inaccurate coding or inappropriate activity has taken/takes place and address the situation accordingly;
- To highlight where clinical behaviour within practices can be improved upon;

- To understand the volume of hospital episodes to be paid for under the national tariff or PbR, that can be carried-out within (historic) budgets, thus to identify which areas are either unviable for commissioning or where service redesign is essential.

Practices should seek support from the PCT on clinical reviews of appropriateness of provider activity, as well as emergency admissions. Paragraph 27 of the Department guidance states the following:

‘Where the PCT is commissioning services from non-NHS providers, contracts require these providers to supply this information to the PCT.’

9 INFORMATION FROM THE PCT

The Department of Health guidance ‘Practice based commissioning: achieving universal coverage’ sets out a minimum and standardised package of information to be provided by PCTs to practices monthly, from April 2006 (see paragraphs 21-27). This information will be benchmarked to enable comparison with other practices in the PCT area and the national average. [Note that paragraph 12 of the TPBC DES specification also sets out a minimum set of information that PCTs should provide practices with.]

The Department has produced a ‘management information tool’ and accompanying guidance to aid PCTs with providing the required financial and activity information. This can be found via the following website address:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4130981&chk=YKXRWE