Practice based commissioning in 2007-08: key issues

GPC guidance for LMCS and GPs (England only)

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1. INTRODUCTION

The one-year 'towards practice based commissioning' directed enhanced service (TPBC DES) will end on 31 March 2007. Practices, where eligible, will receive payment for component 2 (C2) of the DES in early 2007-08. The GPC has produced a brief guidance note on C2 payments, which can be found online at the following address: www.bma.org.uk/ap.nsf/Content/comp2tpbcdes

Although there will be no PBC DES for 2007/08, the Department of Health (DH) published '*Practice based commissioning: practical implementation*' in November 2006, which specifies arrangements for local implementation of PBC for 2007/08, including incentive payments to practices to enable their involvement. This latest DH guidance applies to the 2007-08 financial year, forms the basis of this GPC paper (including the paragraph references) and can be found online at the following address:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703

This GPC paper summarises some key issues in the DH guidance, which LMCs and GP practices should be aware of in their local negations on PBC implementation.

The GPC has produced a more detailed analysis of the DH guidance which is available online via the following address: www.bma.org.uk/ap.nsf/Content/Hubpracticebasedcommissioning

2. PCT GOVERNANCE

The DH guidance highlights the need to prevent conflicts of interest for clinicians such as GPs who may advise PCTs in assessing PBC business cases at the same time as being involved in the production of such business cases. It proposes that PCT governance arrangements in the form of a PCT committee/subcommittee with accountability to the PCT Board should be put in place in order to assess practices' plans for commissioning and service provision (paragraphs 2.3-2.8). It further states:

> "Clinicians must exclude themselves from decisions on any PBC business cases in which they have an interest or with which they are associated" (paragraph 2.6).

Such arrangements will need to be put in the context of the DH's Professional Executive Committee (PEC) review proposals for April 2007 onwards.

3. PBC COMMISSIONING PLANS

All practices engaging in PBC must agree a practice based commissioning plan with the PCT. There is no standard national format and the level of detail in the plan is to be kept to a minimum. Where practices have formed PBC consortia, a single plan can be produced on behalf of the group rather than expecting individual member practices to do so. PCTs should aim to approve commissioning plans within 4 weeks, and in no more than 8 weeks

The plan will need to specify commissioning and service redesign proposals, including a contribution towards achievement of national priorities (including delivery of the 18 week target) (paragraph 2.12).

4. DEVELOPING NEW SERVICES/PBC BUSINESS CASES

The guidance specifies that the mechanism for practices/consortia to develop their provider services through PBC is via submission of a **business case** to the PCT, for approval

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(paragraphs 2.16-2.20).

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The business case should include the management resources required to deliver the service and the up-front costs required for the proposals and their recovery period; these are important negotiating points for GP practices. The GPC's understanding is that such upfront costs will need to be recovered from future savings.

PCTs should aim to approve business cases within 4 weeks, and in no more than 8 weeks.

5. **PBC ACCOUNTABILITY** (paragraphs 2.26-2.36)

The DH guidance specifies the accountability arrangements under PBC with regards to the responsibilities of PCTs and practice based commissioners, having accepted an indicative budget.

- **PCT accountability**: one requirement is for PCTs to "…avoid agreeing new long-term contracts with service providers that would further cement monopoly provision arrangements and exclude practices form being able to propose service and care pathway redesigns" (paragraph 2.31);

- **Accountability to patients and the wider public**: practices are required to engage patients in service redesign and to make their plans available for scrutiny by their practice population. PCTs should 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.

- **Financial accountability**: PCTs have a statutory duty to achieve financial balance and practice based commissioners have a responsibility to manage within their indicative budget.

- **Clinical and professional accountability**: new, extended services via PBC need to meet national standards of clinical governance including those set out in *Standards for Better Health.*

6. **PBC INDICATIVE BUDGET**

There is a commitment to a 'fair shares' methodology for setting the indicative budget from 2008-09, which the DH is currently developing. Meanwhile, the interim arrangement for setting practice level indicative budgets in 2007-08 remains largely the same as in 2006-07, based on the following:

(i) 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;

(ii) current formulae for prescribing including appropriate inflationary uplift; and

(iii) weighted capitation for any services within agreed scope for which no historic activity data is available.

In addition to the above methodology, there is a 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%. It is expected that for 30% of practices, the indicative budget based on historic spend will be

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higher or lower than their 'fair share', outside of the 10% margin. The guidance considers this to be a significant variation and where this is the case, PCTs should undertake a utilisation review with the practice and consider making an adjustment of a maximum of 1% to the 2007-08 indicative budget accordingly (paragraph 3.18).

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) (paragraph 3.10).

All aspects of the PCT budget should be devolved indicatively to practices, including funding for the PCT's central management team, clearly identified (paragraph 3.14). Practices will hand back elements of this notional, whole practice allocation to PCTs as appropriate based upon their PBC plan.

7. FREED UP RESOURCES

On the issue of FUR, the latest DH guidance is more strongly worded than previous guidance and practices should be aware of the following entitlements.

The guidance is emphatic regarding the 70:30 split in use of freed up resources (FUR) as stated in paragraph 3.23 "...it is imperative that practices are allowed to use a minimum of 70% of any FURs for reinvestment in primary care". This 70% use by practices is "…irrespective if whether these were included in practice business plans or not" (paragraph 3.24).

PCTs should aim to approve practices' proposals for use of FUR within 4 weeks, but no later than 8 weeks (paragraph 2.38).

Freed up resources made in the previous year should not be deducted from future indicative budget allocations (paragraph 3.9).

8. PROCURING SERVICES THROUGH PBC (paragraphs 3.34-3.47)

The guidance promotes the principle of there being both multiple and a range of providers for routine elective or extended primary care services delivered in the community, via a new '**any willing provider**' model (paragraph 3.35). PCTs' contracts with providers for such new services will not set any level of guaranteed income/payment or activity/volume.

Under these arrangements, **tendering is not required** on the understanding that 'any willing provider' is content to provide the service, which will need to meet national quality criteria (as set out by the Healthcare Commission). Although the GPC welcomes 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.

Payment for such services, for the most part, fall outside Payment by Results (PbR) and will be made via an informal local tariff system, which will be informed through benchmarking of price bands at PCT, SHA and national level. These prices should be activity-based, published in an open and transparent way and made available to PBC commissioners.

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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).

9. SUPPORT FOR PRACTICES AND INCENTIVE SCHEMES

The TPBC DES ends in 2006/07. For 2007-08, the DH guidance proposes that PCTs should operate local incentive schemes to engage practices in PBC (paragraphs 4.10- 4.13). These incentive schemes should as a minimum encompass the provisions of the TPBC DES arrangement (paragraph 4.11). Local incentive schemes should be 'clinically appropriate, affordable and cash-releasing' and payments are to be regarded as practice income (paragraph 4.13). Pricing is for local determination and payment of any awards is dependent on practices not overspending against the indicative budget.

The guidance also highlights the need for adequate PCT support to practices. It stipulates that all aspects of the PCT budget should be notionally allocated to practices, and practices will subsequently block back elements of this 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 (paragraph 4.4). In theory this provides practices with control over the management and support resource for PBC held at PCT level.

10. INFORMATION FOR PBC

There is a minimum requirement on PCTs regarding the information to be provided to practices/consortia (see chapter 5).

11. ROLE OF THE SHA AND ARBITRATION

Practices/consortia and PCTs should aim to agree local application of national DH guidance. Where no agreement is reached, the issue will be referred to the SHA-appointed, SHA arbitration group(s), which should include practitioner, financial and management representation. PCTs should follow the decision of the arbitration group.

12. INDICATORS AND MONITORING DEVELOPMENT OF PBC

SHAs will performance-manage PCTs on their implementation of PBC. One criterion will be the level of engagement by practices (paragraph 6.2)

It is proposed that the DH will commission an independent, quarterly practice survey, covering a sample of practices from each PCT, to assess practice engagement and their perception of the support offered by their PCT (paragraph 6.6). Provided the survey is of random practices in each PCT, the GPC hopes that this will highlight areas where there is poor support by PCTs and low engagement of practices.

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