



# **10 Steps To Practice Based Commissioning**

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## **10 Steps To Practice Based Commissioning**

### **Introduction**

This booklet has been written to aid practices in the processes of Practice Based Commissioning (PBC) in its first year of a national roll-out. It does not purport to be a comprehensive guide, but is rather a framework to signpost the steps in the process and provide some suggestions for conduct of business based on best practice.

### **About Practice Based Commissioning**

PBC stems from an acknowledgement that by virtue of their clinical practice - making referrals, prescribing drugs, managing chronic diseases and improving self-care - GPs and nurses influence important areas of healthcare expenditure. Their closeness to patients means they are uniquely placed to act as commissioners and educators of their patients, helping them to make informed choices; to become expert patients in the face of chronic disease and to manage episodes of self-limiting illness themselves. They are also well placed to identify service gaps; manage avoidable delays or complications in care pathways (including reducing emergency admissions).

PBC aims to make clinicians aware of the financial consequences of clinical decisions, as well as provide them with an incentive to consider alternative and sometimes innovative forms of service delivery.

The benefits for patients can be:

- A closer and more personalised focus on individual needs across the spectrum of healthcare.
- Better quality services, with increased responsiveness on the part of providers
- More effective healthcare, with greater emphasis on evidenced based medicine.
- Development of services nearer to patients
- Improved efficiency and more appropriate patient pathways.

Benefits for a practice can be:

- Funding for new ways of working in practices
- Satisfaction for delivering timely and effective services
- Development of in-house expertise and increased skill levels
- Closer professional relationship with clinicians in secondary care

Benefits for Primary Care Trusts (PCTs) include:

- The opportunity to engage clinicians in budget management
- Reduced patient care costs
- Reinvestment of efficiency savings in developing services locally
- PBC works within the tariff framework established through Payment by Results (PBR). The Government has understood that PBR, without PBC, could result in serious problems for the entire economy of the NHS.

Practices have a right to hold an indicative budget. The government sees the process as a step towards the development of a sophisticated range of ways in which practices and localities are involved in clinical change through commissioning. PCTs continue to hold the actual budget and be responsible for the day to day negotiation of the contracts with local providers.

### **Getting Started**

#### **Step 1 - Scope Of Services To Be Commissioned**

Individual practices who wish to take part in PBC from 1 April 2005 should be clear about their reasons for so doing. They should consider the scope of the services they wish to commission; whether the full primary health care team and patients are signed up to the development and/or, with other practices and the support of the PCT, whether they have the skills and capacity to deliver improved service outcomes for patients. For some, the capacity already exists. For others, through working with other practices, the necessary capacity would become available. One size will not fit all, and much will depend on the scope of the services to be commissioned in the first year.

As soon as the scope of preferred services to be commissioned is clear, discussions should take place with the PCT and the range of the commissioning portfolio should be agreed through the PEC.

PCTs are not expected to apply unnecessary and inappropriate restrictions on the scope of services included in PBC. Practices for their part should assess and plan for any real or potential adverse affects on other services, preferably in discussion with the PCT and taking account of both PCT provided and commissioned services.

Some practices will choose to start with a limited range of services and others will choose to cover the entire budget, although, initially, this is unlikely to be

common, particularly as Outpatients and Emergency Admissions are outside the scope of PBR in 2005/6.

## **Managing PBC**

### **Step 2 - Developing A Business Plan**

PBC requires practices to have robust organisational arrangements. In so doing they will become better prepared to undertake a range of tasks involved in commissioning, which lead to patient and service benefits.

A well-written plan formulated on an assessment of needs and priorities of the practice population within the context of the joint PCT and Practice's local delivery plan (LDP) enables both staff and patients to be clear about commissioning objectives. It is a key planning and accountability document and forms the platform from which further action proceeds.

The new Public Health White Paper, PBC, combined with Choose and Book, point to the importance of engaging with practice populations and wider communities to bring about their improved health status and service improvements.

The business plan should identify the health needs of practice patients, and key areas to address through the commissioning process, based on local development plans and national frameworks, as well as any current problems in service provision.

A structured approach is useful in developing a plan. There are many management and financial handbooks which provide information on business planning. One is commended at the end of this booklet.

### **Step 3 – Negotiating A Pre- Agreement With Your PCT**

The National Association of Primary Care (NAPC) and the NHS Confederation have produced a document to help construct an agreement, which can be used by PBCs and PCTs. It is useful as a guide to the main issues to be addressed and resolved before the commissioning process begins. Details are on their respective websites, addresses for which are available at the end of this booklet.

To avoid the process becoming over-bureaucratic, it is open to PCTs and practices to consider whether the pre-agreement should be extended to cover the range of services practices will include in PBC; what service changes are

proposed and other relevant (commissioning) details. The following may be helpful in discussions to take this option forward.

### 1. Principles

The basis of any agreement is a set of shared principles which should be agreed prior to any further discussions about the detail of PBC.

### 2. Framework, Commitments and Responsibilities

The agreed principles then need to be set in the context of respective responsibilities of practices and PCTs, who together should identify what the parameters of the framework are and what their respective commitments and responsibilities include. Arrangements for the management of risk should be clearly identified, including the development of contingency funding mechanisms in the event of any practices overspends. These will also address the use to which any efficiency gains will be put prior to engaging in commissioning.

### 3. Audit and Evaluation

The performance management, audit and evaluation of the impact of PBC is vital to ensure that both practices and PCTS are confident in discharging their commitments and responsibilities identified earlier. Arrangements therefore should be made prior to the start of a formal agreement how these will operate.

Further information is contained in the joint NHS Confederation and NAPC model pre-agreement and is available on their respective websites

## **Step 4 - Identifying Management Costs – Issues To Consider**

Adequate levels of management support are critical to the success of commissioning. Initial costs to provide necessary resources and management support for PBC are negotiated in advance of the process and charged against expected efficiency gains resulting from the agreed clinical change programme. One of the keys to practice/practices achieving a wide range of benefits for patients is investment in quality management. Management costs will vary depending on local circumstances, for example, the scope of budgets devolved. The PEC is charged with overseeing management cost levels and making recommendations to the Board to ensure they are reasonable.

The PCT can recoup the outlay for management costs from resources subsequently freed up at the end of each financial year. All parties should be clear how such management costs are being funded locally.

Both practices and PCTs may wish to explore fully shared commissioning management arrangements, particularly around public health, finance and IM&T.

When considering/anticipating management costs the following items are areas to consider:

- Locum costs for clinical management time
- Data management costs
- Training, including workshops and conferences and support from membership organisations
- Specialist advice
- Weighted capitation position/or equivalent.
- IT capital costs. Any capital items purchased must relate to the administration of commissioning arrangements
- Cost of developing services, including relevant research.

Practices and PCTs, in considering management costs, are encouraged to make full utilisation of existing experienced commissioning staff.

In the first year of PBC, some PCTs have agreed with their practices not to top slice management costs from practices' overall budgets, particularly in cases where the PCT or practices are in a negative financial position, as a result of total equity budgets. As the scheme evolves, such PCTs expect practices to fund their management costs from their efficiency gains.

### **Step 5 - Agreeing The Indicative Budget**

'Practice Based Commissioning: Promoting Clinical Engagement' advocates the development of local solutions to practice based budgeting in which the budget setting methodology is agreed locally and involvement is voluntary. However, in a situation where a practice feels insufficiently engaged in commissioning activity, it can claim the right to a commissioning budget, covering the full range of patient care. The technical guidance sets out a methodology for setting a 'default' budget. It is also open to PCTs and practices to await the availability of 2004/5 data to determine provisional budgets for 2005/6 and indicative budgets for 2006/7.

Practices and localities are encouraged to hold a budget for the full range of patient care, not only services which are covered by the national tariff. Some principles for budget setting and the monitoring of contracts might include:

- Transparency and consistency within the strategic objectives of the health economy
- Based on historic activity, must be affordable and not exceed PCT financial envelope
- Simplicity, particularly in year one, given limited management resources at provider, PCT and practice/locality levels. As the scope and development of PBC increases over subsequent years, these are likely to increase.
- Reflection of practice/locality share of existing funded activity, as set out in the LDP at national tariff rates for 2005/6, where possible, with agreed adjustments as appropriate.
- Supports the choice agenda, avoids health inequalities and maintains the achievement of targets ie access and clinical targets including those for primary care, enhanced services and commissioning
- Addresses contingency planning and incorporates risk management arrangements

Budgets should incentivise practices and at the same time incorporate the above principles. They should be set in a ways in which practices are able to make efficiency gains through the local innovation, service redesign, commissioning effectiveness and changes in clinical behaviour.

Budgets are influenced by list size data, so arrangements should be put in place, which reflect list size changes at an agreed point(s) during the financial year.

Given that not all services are included in the national tariff, only a proportion of the budget can be calculated with any precision, if using historical activity as a basis. It is therefore recommended that budgets are divided into those which can be calculated using the national tariff or attributed on a capitation share of the budget and those that cannot. The remaining non-tariff services (eg midwifery, mental health inpatients, specialist commissioning, high dependency units/chronic dependency units etc) can be locally agreed and might, in the first year, be blocked back to the PCT to manage the risk.

The setting of practice budgets is complex and one size will not fit all circumstances. PCTs will need to make adjustments to the final budget allocation for a number of reasons, which should be easy to understand,

transparent and auditable. The total sum of practice based budgets should not exceed the total PCT allocation.

### **Step 6 – Developing Information Systems**

PCTs and practices should agree and develop systems for data collection that are robust. There can be significant variability between data produced at provider and that at practice level. Arrangements should be negotiated which encourage and support the capture of accurate information on the part of providers. Validation of activity data at practice level is essential at this stage, but over time PBR should remove the need for some of the current information problems

Some PCTs have developed software to support the flow and analysis of utilisation data and will share it with practices. The Department is identifying the information requirements for PCTs, practices and localities to support PBC. Accurate information is vital for efficient budget setting, contract negotiations and monitoring.

The Healthcare Commission in the future is likely to regard the provision of information to practices as a key factor in assessing aspects of a PCT's competence. Currently, every practice should receive annual feedback from their PCT on their use of all health services. For effective commissioning, PCTs and practices will need to develop information systems which provide timely data on a very regular basis, for effective and early clinical change. They will need access to sophisticated tools to profile patient risk, target cost-effective upstream care, manage demand, track appropriateness of treatment and influence clinical practice patterns. Such tools will play a very important part over time in successful commissioning. Practices and PCTs should discuss as a matter of urgency how to develop them.

Practices will also need to understand and validate all patient activity (referrals - elective, outpatients, as well as private referrals and emergency care). Interrogation of their own clinical systems will form an important aspect in the establishment and management of budgets.

For further information, please see IT tools on [www.primarycarecontracting.nhs.uk](http://www.primarycarecontracting.nhs.uk)

Looking to the future, Dr Foster is working on an information system for practices and PCTs, which will allow them to track hospital activity for their patients in NHS hospital trusts and Intermediate Treatment Centres. Further developments will include an analysis of primary care activity.

## **Step 7 - Agreeing Use Of Efficiency Gains**

Practices are able to use 100% of resources released through cost effective commissioning, which, with the exception of management costs, can only be used for the development and implementation of patient services. These have to be agreed in advance by the PEC and approved by the PCT board.

This reinvestment will be used to modernise and improve services in a very significant way. With the transfer of resources to practices under PBC and the arrival of greater patient choice, practices and PCTs are encouraged to review their traditional referral management patterns to ensure that patients are seen timeously by the most appropriate practitioner. There should be potential to extend the range of services and skill mix within primary care through PBC. Practices may wish to discuss with their practice populations and secondary care colleagues the redesign of care pathways, including ways in which services can be delivered nearer to patients and made more sensitive to their needs. For example, contracting with secondary care clinicians to run appropriate clinics, which are traditionally in the domain of secondary care, has been found in some parts of the country to be an effective and efficient way of providing care. Redesigning services through modernised clinical skill mix can also be a more effective way of delivering care. DH will be sharing emerging models of good practice.

The data and information gathered routinely through the monitoring of SLAs provide the basis for sensitive and rational service re-design, at the heart of which is patient involvement.

The DH envisages a number of ways in which patients will benefit from PBC including a greater range of services from a greater number of providers in settings more convenient to them.

Reasonable resource and management costs are also to be funded from resources released through clinical change plans, which again the PEC oversees and makes recommendations to the PCT board to ensure they are reasonable. Initial funding to support PBC will be provided in advance by the PCT, who will then be able to recoup this funding from subsequent efficiency gains. Importantly, as practices become established as commissioners, they will continue to be able to deduct management costs from released resources.

Because some PCTs are in a negative financial position, which impacts on practices ability to make early efficiency gains, incentive schemes have been agreed, which reward not only positive budgetary positions, but also improvements on budgets over the previous year. In this way, practices,

which cannot make efficiency gains in the first years, are encouraged to improve their performance.

One such scheme in South Hams and West Devon PCT has negotiated with its practices to introduce an incentive scheme using the principles of the new GMS contract. The PCT is offering an additional 100 points to each practice for effective commissioning. It is anticipated that the scheme will evolve over future years providing greater rewards to practices, patients and the PCT. Any monies the practices derive from the incentive scheme must be used for patient services.

### **Step 8 - Preparing To Commission and Redesign Services**

The purpose of commissioning through SLAs is to provide new services in line with clinical need and to change clinical practice in established services to those of best practice. Service changes and redesign should, where appropriate, be discussed with clinicians in secondary care and practice populations.

The commissioning cycle, which is a continuous yearly cycle related to the allocation of funds, largely centres on the NHS contracting process for acute and non-acute care.

Each of the stages of the cycle apply to the NHS and the private sector, although there are differences in the information available.

The key elements of the commissioning cycle are:

- April – September: planning/modelling, including an assessment of health needs of practice(s) population and the identification of service requirements
- September – November: commissioning intentions and service specifications, including clinician to clinician dialogue about service provision and redesign
- December – February: contract negotiations
- Monthly and Quarterly: contract monitoring
- Annually: evaluation of services

### **Planning and Modelling**

These require commissioners to evaluate current patterns of healthcare and identify the need and options for change. Key processes to achieve this

are: the assessment of health needs and planning for improvements to health, which address service gaps and the need for better local provision.

Health Needs Assessment (HNA) and planning require information obtained typically through survey and analyses of practice populations used in conjunction with:

- Epidemiological data
- Comparative data across the PCT
- Local knowledge

Practices will need to address the following questions:

- Are the practice or group of practices and their patients content with the current service;
- Which areas of service do not need changing, either because of low cost and/or high quality and good access;
- Are there particular areas of concern where change is desired in cost, quality or access;
- How much change is it realistic to expect for this year of contracting;
- What are the practice's or group's long term objectives for the provision of hospital services;
- How much flexibility should be retained in terms of referral options and patient choice.

## **Commissioning Intentions and Service Requirements**

### **Setting Priorities**

Having assessed the potential courses of action, the practice or group will need to discuss with the PCT its priorities and service requirements for the forthcoming year within the context of the LDP to which practices should contribute. To facilitate patient choice, there will need to be adequate flexibility built into commissioning arrangements.

Practices will also need to recognise that providers will not be able to meet a raft of different service specifications and be aware of the importance of the role of the PCT in brokering agreements with providers.

In determining priorities, practices will have to take on board a number of key influences:

- National frameworks and guidance
- PCT LDPs
- Views of patients
- Resources available
- Local provider delivery plans in acute and non-acute sectors
- Choose and Book
- Public Health requirements
- Clinical governance arrangements

Practices working in collaboration can share and ease the burden of this task.

Practices are expected to fulfil PCTs' key objectives in year. These objectives relate to the LDP, which in turn is driven by the document: 'National Standards, Local Action: Health and Social Care Standards'. For practices in South Hams and West Devon PCT the key objectives include:

- Choose and Book ( implementation to meet December 2005 targets)
- Use of private sector in relation to the PCTs capacity plans
- Acceptance of PCT data (unless proven inaccurate by all practices)
- Use of GPs with Special Interests or other local schemes set up in year (these will improve practices' budget performance)
- Proactive management of patients with long term conditions.

For 2006/7 practices within South Hams and West Devon PCT will take a more proactive role in the process for drawing up the LDP to drive forward their commissioning aspirations.

### **Step 9 - Managing The Budget And Activity**

Practice(s) should ensure that the indicative budget is managed efficiently and effectively. Poor management may lead to a reduction in the quality of patient care or an overspend, which could result in the withdrawal of commissioning status.

Good budget management depends on many factors, including:

- Sound planning
- Efficient administration
- Good quality monitoring information
- Effective operation of SLAs

- Sound risk management
- Effective communications with patients, staff, other practices, PCT and clinical colleagues

Financial flexibility and minimisation of risk are crucial factors for successful budgetary control, for example:

- committing only a percentage of the part of the budget for hospital services;
- identifying and dealing with patients treated without prior approval, self referrals, temporary and expensive patients
- overspending – caused by exceptional circumstances (increases in list size; numbers of high cost patients)
- provision for inflation
- ensuring accuracy of the baseline data
- identifying services which impact on other areas of the budget

Arrangements should be agreed between practices and PCTs on how maximum flexibility can be achieved in the first year to facilitate patient choice and at the same time minimise risk. For example, agreement should be reached on how changes to list sizes in year and expensive patients will be handled. Some PCTs and practices have adopted an insurance scheme for expensive patients, where practices accept responsibility up to a certain level for their patients, after which the PCTs, through a local insurance scheme, pick up the costs over and above the agreed amount.

South Hams and West Devon PCT has negotiated an incentive scheme, as part of its performance management of practices, which asks practices to sign up to quality markers. These include the acceptance of advisers and audit arrangements to identify high intensity users; the reduction in the number of unnecessary emergency admissions; innovation in primary care, use of professionals with special interest schemes (to reduce secondary care referrals). Other markers include performance against budget.

### **Monitoring Arrangements**

The monitoring of SLAs is responsibility of both the practice and the PCT and will include:

- Activity
- Quality measurements
- Financial commitments

The information used to monitor SLAs' performance comes from a variety of sources. It is important that this is identified at the same time as the SLA is negotiated, together with any constraints on the availability of information.

The following are examples of information required to monitor performance:

- Inputs and outputs as specified in SLA
- Quality and outcome-related measures
- Conditions of payment
- Other information the two parties agree should be exchanged periodically.

### **Inputs**

Inputs in SLAs include the availability of services or staff and are usually used when 'outputs' are difficult to measure eg community services.

### **Outputs**

Outputs relate mainly to activity levels that have been specified in the SLAs as the currency for the SLAs eg FCEs; SPELLs, outpatient attendances.

Outputs are currently the key monitoring elements within SLAs, where there are no outcome measures.

### **Quality and Outcome Measures**

Currently, quality and outcome measures within SLAs are the least well developed.

Direct contact between GP/nurse and patient provides an excellent opportunity to assess quality and to feed back directly to the provider on what was satisfactory or unsatisfactory about the service received. Such contact is invaluable in bringing about improved service redesign and quality improvements.

Over time, practices and PCTs will need not only to use routine data produced by hospital episode statistics on readmission rates and mortality; they may also seek to augment the information with data on infection rates and variability of consultant practice and outcomes.

### **National Framework for Assessing Performance**

The monitoring of a SLA is only a part of the wider context of performance assessment which has been introduced across the NHS. The National Framework is one within which both quality and activity are assessed.

The Framework looks at the following aspects:

- Health improvement
- Fair access
- Effective delivery of appropriate healthcare
- Efficiency
- Patient/carer experience
- Health outcomes

The essential components of any monitoring mechanism are agreed budgets and standards of service. Any standards set within SLAs should be designed from the outset to be measured and assessed.

### **Payment By Results**

Terms of payment should be clearly identified within the SLAs and should be dependent on the provision of appropriate data (eg minimum data sets and clinical letters) and the timing of the issue of invoices. Such an approach forms an important part of robust commissioning arrangements.

PCTs and practices should agree prior to the start of each year the nature and formats of reports required from external providers and those to be prepared in-house to monitor services delivered by the practice.

It is important that, as part of the monitoring arrangements, provider data should be reconciled with the practices' own records, at least until data is known to be robust.

The external monitoring process is normally undertaken by both the practice(s) and the providers, together with an overall monitoring role by the PCT. The processes will include:

- Preparation and review of monitoring reports
- Quality audit visits
- Questionnaires and surveys
- Regular review meetings

Financial monitoring involves comparing actual spend with budgeted spending to identify any variance. Such monitoring is mechanical and routine. Monthly management accounts are useful in highlighting areas of concern. The aspect which is more difficult is to assess the cause of any variation.

Monitoring is a mechanical process while performance assessment requires the exercise of professional and clinical judgement.

### **Step 10 – Managing Disputes**

In cases of dispute between practices and the PCT, every effort should be made to reach local resolution. In exceptional circumstances, where agreement is not reached, arrangements for arbitration are set out in 'Practice Based Commissioning, Promoting Clinical Engagement' which was first published in December 2004.

There are only two scenarios in which arbitration will be used, where local resolution has failed:

- Disputes about use of efficiency savings
- Removal of the right to hold an indicative budget

Each strategic health authority has appointed an arbitration group of two GPs, one of whom is chairman, a practice manager and a PCT finance director. Decisions, which normally will be made within one month of notification of the dispute, will be made on an either/or basis and will not be a compromise.

### **Best Practice**

In the interest of best practice strategic health authorities have been asked to produce an annual report of the state of PBC in their areas. These will be collated and fed back to the NHS.

### **Useful Information**

To support practices and PCTs in the roll-out of PBC, the Department is working in partnership with a number of organisations to deliver the following:

- A web-based toolkit which can be found at: [www.primarycarecontracting.nhs.uk](http://www.primarycarecontracting.nhs.uk)
- A pre-agreement checklist which can be found at: [www.nhs.confed.org.uk](http://www.nhs.confed.org.uk) and [www.napc.co.uk](http://www.napc.co.uk)

- A checklist for PEC Chairs which will be available at: [www.nhsalliance.org](http://www.nhsalliance.org)
- The National Primary Care Development Programme is aimed at primary care and practice managers. Further information can be found at : [www.npdt.org](http://www.npdt.org)
- PCTs and practices are invited to participate in action learning events. These are 3 part events which provide expert and practical support for taking forward PBC. Please contact [Marion.Pullen@modern.nhs.uk](mailto:Marion.Pullen@modern.nhs.uk)
- Details of the PBC pre-agreement can be located on [www.napc.co.uk](http://www.napc.co.uk) and [www.nhsconfed.org.uk](http://www.nhsconfed.org.uk)
- Ten Steps to Practice Based Commissioning has been produced jointly by NAPC and NHS Confederation are available at; [www.napc.co.uk](http://www.napc.co.uk) and [www.nhsconfed.org.uk](http://www.nhsconfed.org.uk)

Suggested handbook on business planning is: Business Planning for Healthcare Management by Carolyn Semple Piggott (Open University Press).

This booklet has been sponsored by a grant from the Department of Health.

### Budget Setting Methodology

Service Element	Base Budget Measurement	Adjustment 1	Adjustment 2	Adjustment 3	Final Budget
		Pro Rata	Pro Rata	Pro Rata	
Planned Inpatient/Day Cases	HES 2003/04	e.g. ISTC Add funded activity 2004/05 and onwards	Less Choice activity 2003/04 and low priorities		Adjusted HES x National Tariff
Outpatient First	HES 2003/04	e.g. ITSC + funded changes	Less Choice activity 2003/04	Target Reductions	Adjusted HES x National Tariff
Outpatient follow ups	HES 2003/04	+ Funded changes	Less Choice 2003/04	Target Reductions	Adjusted HES x National Tariff

Emergency Admissions	HES 2003/04	Less planned reduction 2004/05		Target Reductions 2005/06	Adjusted HES x National Tariff
CDU Activity	-	2004/05 Baseline			2004/05 baseline x Local Tariff
Prescribing Budgets		Reduced by 5% for new contract			Adjusted budget
Doctor Urgents/PTS	2004/05 Activity				2004/05 x Local Price
Provider/PMS /GMS					Current Budget
Walk-in A&E	2004/05 Local			Target Savings	2004/05 x Local Tariff
Regular Attenders	HES 2003/04	e.g. ISTC Add funded activity 2004/05 and onwards	Less Choice activity 2003/04 and low priorities	Target Reductions	Adjusted HES x Indicative Budget
Enhanced Services	Business Case				Business Case
AHPs	Activity Data 2003/04	Add funded activity 2004/05	Less any reductions 2004/05		Current budget
Diagnostics	2004/05 activity				2004/05 activity x local tariff

**NB** – some services may be at Indicative Tariffs