

Practice Based Commissioning

Promoting clinical engagement

Practice Based Commissioning – Promoting clinical engagement

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Practice Based Commissioning – Promoting clinical engagement

Introduction

- 1 There is nothing new in the concept of Practice Based Commissioning. The 1998 white paper, *The New NHS*, stated that, “over time, the Government expects that ... PCTs will extend indicative budgets to individual practices for the full range of services”. In June of this year, *The NHS Improvement Plan* indicated, “from April 2005, GP practices that wish to do so will be given indicative commissioning budgets”.
- 2 The right to hold a budget and our willingness to see it as a first step towards the development of a sophisticated range of ways in which clinicians are involved in commissioning, are entirely consistent with the principle of greater devolution. The Department recognises the important role that practices can play in commissioning services for their patients and local populations. Furthermore, there are changes in the NHS that mean that Practice Based Commissioning will assume greater importance in the system overall. These include:
 - The importance of patient choice as a driver for quality and empowerment. Practices or localities will be able to secure a wide range of services, responsive to patient needs, from which patients can choose. From 2008 the impact of free choice for elective procedures will change the dynamic further. Practices and localities could then use their commissioning abilities to identify alternative provision, including in primary care, to give patients greater choice.
 - Payment by Results. This will mean that where practices or localities are able to provide or commission services locally, as patients choose to use these services, the funds will follow.
 - The increasing importance of supporting people with long term conditions. Practices or localities will be able to direct funding into packages of care that best support patients with long term conditions.

- 3 By promoting practice level budgets for commissioning the Department envisages a number of ways in which patients will benefit:
 - A greater variety of services
 - From a greater number of providers and
 - In settings that are closer to home and more convenient to patients.In addition, there are ways that the NHS as a whole, and hence the public, will benefit from:
 - More efficient use of services and
 - Greater involvement of front line doctors and nurses in commissioning decisions.
- 4 There is good reason to be confident in these expectations because of the evidence supporting Practice Based Commissioning. This was recently summarised in the report on Practice Based Commissioning published by the Kings Fund (endorsed by the NHS Alliance and National Association for Primary Care) and more recently by a Health Foundation report¹. Further, professional bodies have also indicated the need to engage clinicians in the commissioning process².
- 5 Practices are one of the main determinants of health care utilisation. Furthermore, with their central co-ordinating function, they often have a major influence on what care a patient receives and how a patient exercises choice. At present, with the possible exception of prescribing, all this comes without any need for practices to consider how they are using health service resources and often without the financial ability to secure better and more innovative services for their patients.
- 6 The same is true, albeit to a lesser extent, of other clinicians working in primary care. Community nurses for example, could hold an indicative budget for the benefit of their patients. This is discussed in the section *Making Practice Based Commissioning a reality*.

¹ Lewis R, *Practice-led Commissioning: Harnessing the power of the primary care frontline*, Kings Fund, 2004 available at www.kingsfund.org.uk/pdf/practiceledcommissioning.pdf; *A review of the effectiveness of primary care-led commissioning and its place in the NHS*, by Judith Smith, Nicholas Mays, Jennifer Dixon, Nick Goodwin, Richard Lewis, Siobhan McClelland, Hugh McLeod, Sally Wyke, Health Foundation, September 2004. See www.health.org.uk

² “Clinicians, services and commissioning in chronic disease management in the NHS.” *Report of a joint working party of the Royal College of Physicians of London, the Royal College of General Practitioners and the NHS Alliance 2004*. Available at www.rcgp.org.uk/corporate/position/chronic_disease_nhs.pdf

7 In summary, Practice Based Commissioning is a key part of improving the NHS. PCTs should encourage their practices or localities to take on budgets for commissioning, indeed some are already doing so; in publishing this guidance the Department is indicating the expectation that every PCT will do so, maximising the potential of this policy as far as possible. There are no targets; we simply have the aspiration that all practices will be involved in Practice Based Commissioning by 2008.

8 With the exception of explaining the right of practices to hold an indicative budget from April 2005, this paper outlines very little that the NHS must do. We want PCTs and practices to work together to ensure that Practice Based Commissioning works best for their population. This may mean, if there is local agreement, going well beyond the basic right of a practice to an indicative budget. In giving practices the right, we have signalled our determination to see Practice Based Commissioning happen. We anticipate that PCTs will use this policy as an opportunity to enhance the effective procurement of services for their population.

9 The remainder of this paper is a discussion of the issues associated with Practice Based Commissioning indicating how PCTs and practices can further develop Practice Based Commissioning to improve the NHS.

This paper covers:

- A practice's right to an indicative budget
- Making Practice Based Commissioning reality
- Risk sharing, budget setting and arbitration
- What the Department plans to do to support Practice Based Commissioning
- Departmental support for Practice Based Commissioning
- Next steps

A practice's right to an indicative budget

10 Firstly, every practice must receive annual feedback on their use of health services. This already occurs for prescribing, and the best

PCTs already do this for other aspects of care including scheduled care, unscheduled care, and diagnostics. However, it is clear that not every PCT is currently doing this. Yet the engagement of and sharing of timely information with individual practices is essential for effective commissioning and management of demand. Experience of PCTs who do feedback utilisation with their practices demonstrates how useful it is. The view of the Department is that this is a key factor in assessing PCT competence in commissioning.

11 The basic right of a practice or locality to have an indicative budget from April 2005 goes beyond this. Practices or localities who wish to do so will receive a firm indicative budget from the PCT that they will use to directly manage the delivery of services for their patients (subject to paragraph 22). Where a practice or locality is unable to meet the conditions outlined in paragraph 22, the PCT will agree a development programme to allow the practice or locality to take up a budget in the future. Using the indicative budget, the practice or locality, with support from their PCT, would identify the health needs of the local population and, in conjunction with local stakeholders, identify the appropriate services to be provided. Practices or localities should be encouraged to develop their own local delivery plans. In turn, these local delivery plans, will feed into the PCT's Local Delivery Plan (LDP). Where PCTs have pre-existing contractual agreements these should be reflected in the practice and locality plans.

12 The timing of when to take up the right to an indicative budget will be determined by the ability of practices or localities to have the necessary time and resources to effectively commission. Therefore, practices or localities may claim that right at any time in year from April 2005, negotiating timing with their PCT who should support practices or localities to start as soon as practicably possible.

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- 13 The PCT would continue to hold the actual budget and would be responsible for the service level agreements with the secondary care provider, including monitoring and invoicing functions. However, the practice or localities would make the commissioning decisions and be able to reallocate resources freed up through cost effective commissioning to new patient services. They can also charge reasonable management costs associated with Practice Based Commissioning against resources freed up through effective commissioning.
- 14 Initial costs, in terms of necessary resources and management support for Practice Based Commissioning, will be provided in advance by the PCT. The PCT can then recoup this outlay from resources subsequently freed up. Once established as commissioners, practices or localities can continue to deduct management costs from resources freed up. The Professional Executive Committee (PEC) will oversee the use of management costs and make recommendations to the PCT board to ensure they are reasonable³.
- 15 Resources freed up from effective commissioning may only be used for patient services (with the exception of management costs as outlined above). It is our expectation that this reinvestment will be used to improve clinical services in a substantive way. The PEC will recommend approval for the use of resources freed up through effective commissioning and management costs to the PCT board. In the case of dispute, the arbitration process will apply (see paragraph 35). To aid practices, localities and PCTs, we shall give further information in the technical guidance; ideally we would like to see local agreements developed between practices, localities and PCTs which best meet the needs of their patients.
- 16 The scope of this budget is for an individual practice or locality to determine, after consultation with the PCT. We anticipate that some practices and localities will choose to start with a limited range of services; for example high volume elective care, a specific long-term condition, or community services; other practices or localities will choose to cover the entire budget. The practice and the PEC must agree, in advance, a mechanism for resolution should there be an adverse impact on other service use or budgets. However, to avoid cherry picking, over a three year period, practices or localities will move towards holding budgets covering the entire scope of health care provision with the exception of a few highly specialised services. They can, however, ask the PCT to commission particular services on their behalf ("block back"), but would remain responsible for the utilisation of those services and hence for any over or under spends.
- 17 Commissioning for specialised services, services that are commissioned nationally and national screening programmes, are not included in the scope of the practice's indicative budget. These are services provided in relatively few specialist centres to catchment populations of more than a million people covering several PCTs. This issue was covered by *Guidance on Commissioning Arrangements for Specialised Services* issued in March 2003 and the conditions are listed in the Specialised Services National Definition Set⁴. Similarly, commissioning for general and personal medical services will continue to be the PCT's responsibility with the exception of enhanced and PMS+ services.
- 18 Where a practice requests the right to an indicative budget in April 2005, that budget will be based on historical spend for the year 2003/4 with the appropriate uplift. Over a

³More details on what we expect reasonable costs to be will be issued with the technical guidance. However, it will recognise the cost of clinical time, not just simple replacement costs, and minimal administrative support.

period of time they will be expected to move to a fair shares based division of the PCT allocation. This will be based on the national formula (to follow in technical guidance).

- 19 Because this is an indicative budget, overspends will be met by the PCT. However, a practice that has claimed the right to hold an indicative budget will be expected to balance that budget over a three-year cycle. In particular, overspends in any one year should be offset by underspends in another. If they are unable to balance their budget over three years they forfeit the right to hold an indicative budget for three years. At times the PCT may wish to waive this rule, for instance if there were unusual problems with high cost cases, or the practice might demonstrate that they are approaching a balanced budget and have a robust recovery plan in place.
- 20 In exceptional circumstances, where practices or localities have large and increasing over spends and are unable to either justify this on an unusual case mix, and/or do not have a coherent strategy for recovery, or are not meeting the agreements with their PCTs referred to in paragraph 22, then the PCT, on the advice of the PEC, may step in and request remedial action. This ultimately could result in the removal of some or all of the practice's or locality's budget. The practice or locality has the right to go to arbitration to determine whether it can continue to hold an indicative budget (see paragraph 35).
- 21 With the introduction of Payment by Results and activity sensitive contracts, PCTs will be exposed if there are large rises in activity. Evidence shows that encouraging practices to hold indicative budgets will mitigate against this⁵. However, PCTs will also want to develop a contingency plan to ensure they meet their

statutory responsibilities to break even on an annual basis. To that end, the PCT may top slice a small proportion of the practice or locality's budget to hold in a ring fenced withholding fund, for all participating practices. Further details will be outlined in the technical guidance. Monies that are not used by practice or locality overspends will be distributed proportionately to those practices that have balanced their budget or underspent at the end of the year, for use on patient services. The PCT may not use this withholding fund to manage overspends from other parts of their budget, including by non Practice Based Commissioning practices.

- 22 Like PCTs, practices or localities who hold an indicative budget also have a duty to use the money responsibly. Therefore:
 - Patients must be able to exercise choice. This is particularly the case where practices are providing services themselves. Patients should still be given a choice of other providers of that service and should not feel unduly pressured into choosing the practice as their provider. To facilitate patient choice we expect that practices and localities will make full use of electronic booking systems. PCTs are responsible for ensuring that patients are able to exercise choice and we expect the SHA to keep an overview of this situation.
 - Practices or localities should agree in advance with their PCT how all national and locally agreed targets that relate to the budgets they hold will be delivered. This will include access and clinical targets relating to the practice or locality's role as a provider of health care (including general and personal medical services, and enhanced and PMS+ services) as well as those stemming from the new commissioning role. In year, we will expect PCTs to provide appropriate support to

⁴ www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en

⁵ Dusheiko, M, Gravelle, H, Jacobs, R, and Smith, P. *The effects of budget on doctor behaviour: evidence from a natural experiment*. 2003. Centre for Health Economics, University of York, TP 26.

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Summary of the rights a practice can claim from April 2005

23	What can practices that claim a right to hold an indicative budget expect?	
	Use of reinvestment of 100% of resources released through cost effective commissioning	Development and provision of patient services only; agreed by PEC and approved by the PCT board
	Overspend	If practices or localities fail to break even over a three year period the practice/locality forfeits the right to hold a budget for three years
	Budget – Scope – Setting	Initially by agreement, in longer term to cover all health costs except those listed in paragraph 17 Initially on a historical activity basis and moving over a period of time to a fair shares based division of the PCT's allocation
	Resource and management costs	Reasonable resource requirements funded from the resources released through the clinical changes plan (PEC to oversee)

practices or localities to meet this agreement.

- Practices or localities must ensure that any clinical changes do not adversely affect health inequalities within the PCT, and take due account of the recently published white paper on public health titled *Choosing Health*

Making Practice Based Commissioning a Reality

- 24 We see the basic right of a practice or locality to hold an indicative budget as the first starting point. If a practice has elected to hold an indicative budget for only a limited range of services, we would like to see PCTs encouraging

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East Devon PCT already has six of its 13 practices fully signed up to Practice Based Commissioning, with another two in the pipeline.

This represents a strong start, not least because the PCT's approach has been to develop a flexible scheme where practices are free to take control of their budgets at a time and level that feels right for them.

According to Beverly Stretton-Brown, Project Manager for Devolved Budgets at the PCT, developing the scheme has been about recognising that each practice was coming to this with different levels of expertise and enthusiasm.

"Some practices have previously been involved with secondary care commissioning and managing budgets and it's given practices a head start – mainly in terms of confidence and recognising the potential benefits of managing budgets at practice level," Beverly explains.

"Some practices will be natural leaders on Practice Based Commissioning, but others will be more

practices or localities to broaden that range to include all aspects of health care.

- 25 There are many compelling reasons for PCTs to encourage practices to come together in localities to commission as a group. This will allow division of labour between practices, the ability to commission services they might not otherwise be able to (employing a specialist nurse, for instance), and share risks. Experience has shown that the best size of commissioning unit depends on what is being commissioned. There is no one correct size for commissioning. Therefore, we anticipate that some services will be commissioned by individual practices (even quite small ones), some by groups of practices, and some may still be commissioned by the PCT, or increasingly by a group of PCTs. In the same way that we are encouraging a multitude of providers so this initiative will develop a multitude of commissioners.
- 26 One of the strengths of Practice Based Commissioning is that it brings the decision making process closer to communities. We

would like to see practices explore ways to engage their patients and local communities in the commissioning process. We anticipate that PCTs will both encourage and support practices in this process. As these informal models of local patient and public involvement develop, the NHS as a whole can learn from them.

- 27 Where appropriate, practices should be able to demonstrate that all relevant front-line staff have been involved in commissioning decisions and in the use of resources that have been freed up. This will be particularly relevant for community nursing teams with regard to long-term care.
- 28 We have already indicated that groups other than practices could hold indicative commissioning budgets. For instance, community based nursing teams could hold an indicative budget, perhaps for vulnerable adults or for other groups. The legal mechanism for this is through PMS contractual frameworks.

focused on the new primary care contracts and want to get to grips with these first.”

While the flexibility of the scheme is designed to accommodate a staggered uptake of Practice Based Commissioning, the strong push towards more community-based services in East Devon means devolved budgets are clearly the way forward for this rural PCT. “Geographically we are a wide-spread PCT with one main acute provider for a population of 116,000. For the last three years we have had a big drive towards improving access for patients through developing more local services closer to where people live,” says Beverly.

Other factors have also strengthened the case for moving toward Practice Based Commissioning, including a growth trend in secondary care activity and the newly acquired foundation trust status of the acute hospital - meaning Payment by Results has been operating in full since April 2004.

“Payment by Results does create a more appropriate environment for practice-based commissioning because funding will follow the patient,” adds Beverly.

“But at the same time this means it’s more important than ever for practices and the PCT to understand what secondary care services we are

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- 29 We cannot, and do not expect to have covered all the ways in which practices and PCTs will develop Practice Based Commissioning. Indeed, innovation would not be innovation if it were known in advance! We plan to learn from how Practice Based Commissioning evolves over time and we will feed the best examples back to the NHS.
- 30 As practice levels budgets develop there are only two areas we wish to reinforce. Firstly, resources freed up from effective commissioning must be used for developing or providing services for patients. At the start of each financial period, practices or localities should make a plan for how they intend to spend resources freed up as a result of effective commissioning (depending on when the practice starts to hold a budget). The PEC should make a recommendation on this plan to the PCT Board.
- 31 In the majority of cases where PCTs and practices are working collaboratively to develop Practice Based Commissioning we would like to see the development of locally appropriate mechanisms for deciding how freed up resources are used. We would encourage practices to consider pooling resources to invest in projects that will benefit all the PCT's population and not just their own patients; what is certain is that these freed up resources must not be used for individual profit.
- 32 Secondly, as with existing services, the quality of new services commissioned or provided by practices must be assured. Therefore, PCTs will have a role in ensuring that proper clinical governance procedures and appropriate standards in respect of the services provided or commissioned by their constituent practices are in place.
- Risk-sharing, budget-setting and arbitration**
Risk and overspend/underspend
- 33 Smaller commissioners of care are more exposed to risk from random fluctuations in activity. This means they are more likely to overspend (or underspend) through no fault of their own. We suggest that practices work

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using and what these are costing us.

"GPs are in the best position to know what services their patients need. Practice Based Commissioning is about enabling, empowering and providing incentives for them to think more about referral patterns, understand the underlying cost implications and use this data to explore how things can be done differently to benefit the patient."

The PCT has taken a phased approach to setting up the new scheme. Year one (2003-04) was a foundation year where the PCT paid practices a small amount to carry out validation work on referral data. At this stage practices were

encouraged to think about how they recorded referrals so the data was accessible for validation at a later date.

This year, the focus has been on setting indicative budgets for each practice - based on their highest spend over the previous three years - and setting up mechanisms to provide practices with monthly budget statements as well as detailed secondary care activity data at patient level.

"Successful practice-based commissioning depends heavily on the information coming down to practices – so we've invested time and resources in this area," adds Beverly. Supported by an existing

together, with support from their PCT, to create a risk pool that they would manage. Specific criteria for accessing the pool should be agreed by the practices. At the end of the year, practices that have overspent and fall within the agreed criteria, could access the pool. This would mean that overspending practices would have to justify their budgetary problems to their peers. Other mechanisms for pooling risk are likely to develop and we might learn from them.

Moving from a historical to a fair shares based budget

- 34 There are many benefits of moving from a historical budget to a fair shares based division of the PCT allocation. These include the ability to increase the equitable distribution of resources and to increase incentives for practices to make the best use of resources. Continuing with historic based budgets also acts as a disincentive to practices who are below target; the opportunity for them to innovate or release resources may be limited. The speed at which practices move from a historical budget

to a fair shares based division of the PCT allocation should be agreed locally. Moving too fast will be a strong disincentive for those over target, whilst moving slowly might be seen as unfair to those under target. The practices and PCT need to agree on a fair rate of change, generally one that allows scope for those over and under target to release resources each year.

Arbitration

- 35 If at all possible, we do not wish to see the arbitration process used. Most disputes should be managed and resolved locally. However there are two cases where arbitration might be invoked if local resolution has failed:
- in the case of continued disagreement about the reinvestment of budget resources released through cost effective commissioning and
 - where a PCT has removed the right to hold an indicative budget and the practice or locality feels this is incorrect.
- The arbitration panel should use as its reference any existing locally agreed arrangements (referred to in paragraphs 15 and 22).

Information service, shared between PCTs in the area, East Devon has established a system to convert existing data feeds from the NHS-Wide Clearing System (NWCS) into monthly budgetary statements for each practice.

These are sent to every practice alongside a more detailed file showing each charge for inpatient and day case elective activity and inpatient non-elective activity that has been attributed to the practice budget. This can be analysed at patient level, enabling GPs to validate data against their own knowledge and records of each patient's pathway.

Although indicative budgets and regular

budgetary information are provided to all 13 practices – only those who are formally signed up to Practice Based Commissioning will benefit from the financial incentives enabling them to use 50 per cent of any savings for reinvestment in patient services. The other 50 per cent will be retained by the PCT to cover overspends and further service development activities.

GPs have recognised that investment and resources are needed at practice level to manage practice-based budgets. As well as support from Beverly and a devolved budgets facilitator, GPs have also asked for resources that will allow them to

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- 36 There will be one arbitration group per SHA area. The group will be chaired by a GP, working with a second GP, a Practice Manager, and a PCT Finance Director. They will be appointed by the SHA. The arbitration process will be on a so-called pendulum basis; that is decisions will be either/or and not a compromise. This is to reduce the risk of either party asking for arbitration on the basis that they would expect some gain.
- 37 Arbitration should normally be resolved within one month of notification.

Departmental support for Practice Based Commissioning

IT support

- 38 Many PCTs have developed sophisticated software to support the flow and analysis of utilisation data. Some PCTs have indicated to us that sharing this software would be helpful to practices, localities and PCTs. We will commission a piece of work nationally to provide such software for all PCTs and practices

or localities from spring 2005 to allow practices or localities and PCTs to start to determine budgets.

- 39 The Department will support the installation and application of the IT schemes needed to support Practice Based Commissioning.

Capability building

- 40 Practice capacity and capability to commission effectively is crucial. To this end we are linking this work with a development programme for Practice Management. Part of this programme will be to ensure that practices or localities have the requisite commissioning skills needed for Practice Based Commissioning.

Budget calculations, management resources and contingency funds

- 41 Technical guidance will be issued in January, which will cover budget setting, reasonable management costs and PCT contingency funds. In addition, where locally determined budgets appear to be working well they will be shared with the NHS.

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dedicate extra time to managing the system.

As a result the PCT is working with practices to develop a set of cost management activities, including clinical review of referral activity and data validation – the latter currently representing the biggest expense for most practices.

An important feature of the East Devon model is that the management costs incurred by practices to run the scheme will be offset against the total savings *before* they are split between the practice and the PCT.

“This means both the PCT and the practice are investing in management resource from the

secondary care budget,” explains Beverly.

Dr Phil Taylor, GP at Axminster Medical Practice, one of the practices already signed up to Practice Based Commissioning, stresses that while validation will be critical to the process of service redesign under Practice Based Commissioning, it must not become a black hole for time and resources.

“We need to ensure we are not losing ridiculous amounts of time checking what we have been charged against what we have used. This is time that we need to be investing in developing new and better services for patients.

“But our early validation activities are showing

Learning

- 42 In the interest of learning from and spreading best practice we shall ask Strategic Health Authorities to produce an annual report of the state of Practice Based Commissioning in their area. These will be collated and fed back to the NHS.

Next steps

- 43 Payment by Results is already a reality for Foundation Trusts and begins to cover other Acute Trusts from April 2005. Patient Choice is increasing and record investment in the NHS means that the scope for innovation is enormous. PCTs and practices should start a dialogue now. SHAs should be facilitating those discussions, helping the sharing of best practice across the health authority area.

some discrepancies and the immediate challenge are to ensure that Payment by Results and the tariffs and coding it uses are sophisticated enough to support Practice Based Commissioning."

Dr Taylor can however see clear benefits for patients on the horizon – especially in bringing down some of the traditional barriers between primary and secondary care and promoting closer collaboration between GPs and acute specialists based on shared values and "enlightened self interest".

"This early work has already led to the development of a locally-based fracture clinic within

this locality," he says.

"And cardiology is another example where things could really change. We are keen to look at new models that enable many of the diagnostics to be done in community settings. The consultant will only need to get involved at the point where their specialist skills are really needed.

"Overall, devolved budgets will mean we are no longer working within the confines of traditional practice budgets. They will give us the freedom and the potential savings we need to make real changes for our own patients in our own communities."



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