

Practice Based Commissioning

Technical Guidance

Introduction

1. The Department of Health published guidance on Practice Based Commissioning entitled *Practice Based Commissioning: Promoting Clinical Engagement* on 15 December 2004. This followed the road testing of our initial thoughts in October 2004. *Practice Based Commissioning: Promoting Clinical Engagement* indicated that Technical Guidance would be produced covering :

- Budget setting and risk management (referred to in the original document as contingency funds)
- Management costs
- Use of efficiency gains

We have also addressed the issue of governance and set out the values that underpin successful commissioning.

2. Please read this document in conjunction with *Practice Based Commissioning: Promoting Clinical Engagement*.

What is Practice Based Commissioning?

3. Commissioning is the process by which the health needs of a population are assessed, the responsibility is taken for ensuring that appropriate services are available which meet these needs (including delivery of national and local NHS planning framework targets) and the accountability for the associated health outcomes is established. Practice Based Commissioning transfers these responsibilities, along with the associated budget from the PCT to primary care clinicians, including nurses. They will determine the range of services to be provided for their population with the PCT acting as their agent to undertake any required procurements and to carry out the administrative tasks to underpin these processes.

Values, governance and principles

4. Practices and PCTs must work in genuine partnership and should aim to create meaningful strategic clinical change using Practice Based Commissioning as one of their tools.
5. Practices may choose to work in groups or networks (referred to as localities) to improve efficiency, recognise economies of scale and to work together in areas of service redesign. The utilisation of these localities for Practice Based Commissioning cannot be imposed on practices.
6. Other clinicians, for example nurses, should, if they wish, expect to hold a budget under Practice Based Commissioning. This approach could be particularly valuable in providing community matrons with a budget for the management of long term conditions.
7. It is expected that practices or localities will develop a shared agreement with the PCT that will clarify the obligations for each party in operating Practice Based Commissioning. The exact nature of the shared agreement will be for local partnerships to decide, but it is expected that this agreement will detail how all national and local planning framework targets that relate to the budgets they hold will be delivered by the delegation of the budget to the practice or locality. This includes access and clinical targets relating to the practice's or locality's role as a provider of health care, as well as those stemming from any new Practice Based Commissioning role.
8. Practices or localities will agree in advance with their PCT how the PCT's right to intervene will be exercised if it is apparent that the delivery of a key target is threatened by Practice Based Commissioning. Additionally, target delivery and appropriate movement towards prospective key national targets will be a prerequisite for continued commissioning.
9. Practices or localities will be able to specify, in agreement with the PCT, the range and timeliness of the Practice Based Commissioning support that will be provided to the practice or locality by the PCT.
10. With the increasing transfer of responsibility for commissioning to practices under Practice Based Commissioning, and the introduction of greater patient choice, it will be vital that patients are referred to the right practitioner at the right time. Practices and PCTs

are strongly encouraged to review their approaches to referral management as part of Practice Based Commissioning. There are a number of emerging models with potential, including referral to Practitioners with a Special Interest, the use of rapid access diagnostics and clinical assessment centres. The Department will share models of good practice later in the year.

11. Choice and the use of the National Choose and Book system are key elements of any referral process. Practices involved in Practice Based Commissioning will therefore need to demonstrate that they intend to implement Choose and Book in accordance with the national guidance.
12. Where PCTs have pre-existing agreements, such as those with an Independent Sector Treatment Centre or a Foundation Trust, or where partnership arrangements exist such as the integration of children's services, Children's Trusts or section 31 agreements, these should be reflected in the decisions taken by practices.
13. Like PCTs, practices or localities that hold an indicative budget also have a duty to obtain good value for money from the public purse. If practices or localities are both a provider and a commissioner of services, it is very important that there are no actual or perceived conflicts of interest. In order to protect the integrity of the local health system and to check developing thinking against the views of patients and local communities:
 - We expect that patients and local communities are involved in the planning of Practice Based Commissioning and in the decision making process for the use of the budget. It should be noted that PCTs retain responsibility for ensuring that section 11 of the Health and Social Care Act 2001, the duty to involve and consult patients, is carried out in the Practice Based Commissioning context.
 - Patients must be able to exercise choice. Patients should still be given a choice of other providers of that service and should not feel pressured to choose the practice as provider.

Budget Setting

14. *Practice Based Commissioning: Promoting Clinical Engagement* advocated the development of local solutions to practice based budgeting, in which the budget setting methodology is agreed locally and involvement is voluntary. However, in situations where the practice feels insufficiently engaged in commissioning activity they can 'claim' the right to a commissioning budget, covering the full range of patient care. We believe that in the large majority of cases it will not be necessary for this right to be claimed. What follows is a methodology for setting a 'default' budget. PCTs may also use this methodology as a guide for establishing local budgets.
15. Some practices and PCTs already have fully costed activity by practice or localities for all or part of 2004-05, or have already found meaningful ways of identifying changes to activity as a result of work on clinical pathways and it would be more effective for these communities to continue using their locally agreed methodologies.
16. In 2005-06, the 'default' budget will relate to elective inpatient and daycase activity only. This is because for 2005-06 the national tariff will apply to elective inpatients and daycases and commissioning arrangements for other services (such as non-electives or outpatients) will be determined locally. Given that these commissioning arrangements will vary, it is not possible to provide central guidance on how practice level budgets should be set for these services.
17. Practices or localities are still encouraged to hold budgets for the full range of patient care, not just elective care. However, budgets for these services will need to be agreed locally. If practices hold budgets for elective care only, PCTs still need to monitor practice or locality referral activity on other services to ensure that they are well-prepared for practices to hold a budget for more services in the future. This will also enable PCTs to ensure that there is no inappropriate transfer of activity from categories that are part of the agreed budget to those which have been agreed to be excluded.
18. Hospital Episode Statistics data for 2003-04 is an appropriate baseline for setting default budgets for most practices. We will assist the local budget setting process by calculating the distribution of tariff-weighted activity by practice within each PCT using HES data,

and making this available to PCTs as soon as possible.¹ PCTs should email pbcc@dh.gsi.gov.uk to indicate an e-mail address they would like this data to be sent to. The HES data can be aggregated locally to groupings of practices if practices and PCTs have agreed that this is the preferred way forward. PCTs should use this information as a basis for determining the indicative relative share of the commissioning budget to which each practice or locality is entitled. The overall size of the commissioning budget for a given service should be determined locally, with reference to the historic level of activity in that area, the tariff price, and the PCTs financial allocation. The locally agreed approach to risk management (see following section) will also have an influence on the size of the budget devolved to practices.

19. The 'default' budget for 2005-06 will be based on 2003-04 referral data, uplifted for increased demand and adjusted for changes in the practice list composition. The budget may be subject to local adjustment if there have been changes to patient pathways, by moving services from secondary to primary care.
20. Setting budgets based on historical referral activity brings to bear the positive incentives associated with practice based budgeting, but does not redistribute funds between practices on a needs basis. Practices that have been historically high referrers will therefore benefit from this approach. The intention is that from 2006-07 a fair shares approach will be used to calculate practice budgets, and over time, practices will move from their historic baseline to a fair share allocation.
21. The quality of HES data does vary considerably between providers. A view will need to be taken by the PCT and its practices about the quality of clinical coding and attribution of activity to practices. Validation of activity data at practice level is vital. Initial evidence is that:
 - Overall, 1.2% of elective HES activity (by value) has a missing or invalid practice code.
 - There are two PCTs where more than 5% of activity cannot be attributed to one of their practices, and a further 31 PCTs where 2-5% of activity cannot be attributed to a practice.

¹ 2003/4 elective HES data multiplied by the 2005/6 national tariff for each practice and HRGs, and then summed across all HRGs.

- Practices that have merged, reconfigured, opened or closed during 2003/4, or which had large increases or decreases in their list during 2003/4, will need to be assessed on an individual basis.

Non-elective and outpatient services

22. On a similar basis to elective services, we will calculate tariff-weighted activity by practice to aid local budget setting for those areas that wish to devolve indicative budgets for a wider range of services. However, as the national tariff will not apply for these services in 2005-06, PCTs will need to disaggregate local contracts between different services.

Uplifting 2003-04 Activity to 2005-06 levels

23. The baseline 2003-04 activity should be uplifted to reflect changes in activity between 2003-04 and 2005-06.² The recommended way to do this is to use SHA level uplifts based on the Local Delivery Plans (LDPs). As part of the annual LDP process, SHAs provide information on the activity they plan for their population. This is split between electives, outpatients and non-electives. These planned activity growth rates could form a benchmark for uplifting the baseline activity. An advantage of the LDP information is that activity growth for electives can be separately identified. In most cases this data will have been built up from PCT level, and where this is the case PCTs may choose to use their own activity growth rather than the SHA aggregate.
24. In cases where the electives budget is claimed by the practice, the 'default' methodology is to use the LDP activity uplifts for electives, where possible at PCT level.

Methodology for Adjusting Commissioning Budget for List Changes

25. Budgets are determined by baseline activity in 2003-04. The budget will need to be adjusted to reflect changes in practice list composition between the baseline year and 2005-06. A step-by-step methodology for calculating this is set out in Annex A.

² Activity covered by PbR in 2005-06 does not need to be uplifted for price inflation as the tariff is in 2005-06 prices.

26. This methodology determines a practice share of the budget for list changes up to April 2005. As part of the in-year monitoring arrangements, PCTs and practices should monitor changes in the practice list within the 2005-06 financial year, and major list expansion or reduction may lead to a revision of the indicative budget.

Risk Management

27. As part of Practice Based Commissioning, practices, localities and PCTs will need to consider the balance between incentivising clinicians to engage with Practice Based Commissioning and the potential financial risk they will each have to bear and consequently develop robust risk management arrangements. It is also appropriate to consider that different types of services may need different types of risk management, some at practice level, some at locality level, some at PCT level and some beyond this. There does not necessarily need to be a large risk pool, and the levels at which risk is managed should be for local determination. The risk management strategy should be considered in conjunction with plans to manage the risk associated with the expansion of services covered under Payment by Results (PbR). Practice Based Commissioning should help manage any risk introduced through PbR.

28. In 2005-06, PbR only applies to elective activity, and therefore the risk to which PCTs are exposed should be lower than that in subsequent years. This provides an opportunity for clinicians to develop alternatives to hospital attendance – indeed practices, localities and PCTs should use this year to consider and to develop their clinical and risk management arrangements in preparation for the further expansion of PbR in 2006-07.

29. As local circumstances will vary, risk management arrangements should be developed locally, but health communities may wish to consider the following method.

A PCT held Contingency Fund

30. Under this approach, a top-slice of the devolved budgets is retained by the PCT (or group of practices or PCTs) as a contingency. A call on the contingency fund may result from a significant change in list size or from a failure to manage underlying demand. PCTs and practices will need to assess contingency fund usage according to a locally agreed set of criteria. Such a process may best be instituted in collaboration with other PCTs or the local LMC.

31. Calls upon the reserve that were deemed avoidable could be considered as debts owed to the fund – and first calls upon any future freed-up resources. In some cases penalties in terms of reduced rights to hold budgets could be imposed should avoidable overspends persist.
32. The contingency fund may be treated either as a recurring annual expense or as a non-recurrent fund. In the former case, if the contingency fund is not exhausted at the end of the year, the PCT should pass on this underspend to practices, in proportion to their budgets. Any allocations to practices should be offset by avoidable overspends. These funds would be used for service development.
33. Alternatively, if the fund is treated as a non-recurrent fund, its level could be reviewed quarterly, with reallocation of any surplus if the fund exceeds maximum likely calls on the fund in the succeeding quarter. Again, any allocations to practices of surpluses would be net of avoidable overspends.
34. The top slicing to create a contingency fund means that in effect, all practices will be under-funded against their baseline. Practices will therefore need to redesign services cost effectively and PCTs will need to support practices in achieving this goal.
35. The size of the fund is therefore subject to local discretion and the appropriate level of contingency fund will vary across PCTs, depending upon:
 - *The services that are being commissioned at practice level.* Some services are likely to be subject to greater random variation than others.
 - *The total value of the services as a proportion of the PCT's budget.* The contingency will need to be in proportion to the size of the delegated budget.
 - *The size of the practice as commissioner.* Smaller commissioners may be subject to proportionately greater random fluctuation than larger ones. For this reason, PCTs and practices should consider the option of groups of practices acting as commissioner for some services.

36. The Department of Health will carry out analysis of fluctuation in activity rates across PCTs and practices over recent years using Hospital Episode Statistics (HES). This information will be made available to PCTs who may use it to inform their Risk management strategy.
37. We anticipate that other methods of risk management will be developed locally. It is important that we learn from this innovation. In particular, SHAs will have a role in ensuring that best practice is shared across the health authority area.

Monitoring and Trigger Points

38. PCTs will regularly and pro-actively monitor referral activity against baseline. Referral ceilings and floors should be agreed only to act as trigger points to ensure that discussions take place to ascertain the underlying causes of significant variations in referral activity. This monitoring should also cover services for which practice budgets are not devolved – to guard against perverse incentives, and allow practices and PCTs to consider the expanded range of services that may be included in budgets in 2006-07.

Management Costs

39. Adequate levels of management support are vital to the success of commissioning. Research has shown that schemes with higher levels of support have more effective outcomes.³
40. “Management Costs” should include payment for the clinical time that is needed to achieve effective service redesign.
41. Management costs will vary depending on local circumstances, for example the scope of the budgets that are devolved.
42. 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 at the end of each financial year.

³A review of the effectiveness of primary care led commissioning and its place in the NHS, Judith Smith et al, The Health Foundation

43. It is good practice to ensure that all parties clearly understand how such management costs are being funded locally.
44. Practices and PCTs are encouraged to make full utilisation of existing experienced commissioning staff who may currently be based within a practice or PCT, and to review how funded clinical time is currently being utilised.
45. It is appropriate for practices and PCTs to explore fully shared commissioning management arrangements, particularly with regard to public health, finance and IM&T.
46. The Professional Executive Committee (PEC) will oversee the use of management costs and make recommendations to the PCT Board to ensure they are reasonable.

Use of Efficiency Gains

47. Resources freed up from effective commissioning may only be used for patient services (with the exception of management costs as outlined previously). This does not preclude the use of resources for capital developments where such a development would enable a wider range of services to be provided than is currently the case, and to a wider than practice population.
48. At the start of each financial period, practices or localities should draw up an agreement for how they intend to use any efficiency gains. The PEC will make a recommendation on this proposal to the PCT Board. In the case of dispute, the arbitration process will apply.
49. In order to avoid any conflict of interest, it is expected that the PEC will itself ensure total transparency in making recommendations to the Board, and must be able to clearly justify their decision to the practice or locality involved. PEC members are reminded that they should be vigilant about declaring an interest on all relevant occasions. PECs may wish to agree with representative bodies locally how to ensure they achieve this transparency. The PCT board has a role in ensuring all PEC decisions comply with PCT governance arrangements.
50. The PEC will wish to see that the following issues are being taken into account when recommending proposals to the PCT Board for approval:

- The contribution the proposed service changes make to demand management, key NHS Planning Framework targets, the implementation of the white paper on public health and the overall financial position of the PCT.
- The benefits to patients
- The extent to which the proposals demonstrate a whole system solution
- The management of risk without stifling innovation
- The anticipated health gains
- Proposals providing appropriate and effective care
- Value for money
- That practices have the agreement of community matrons, district nurses, health visitors, allied health professionals and school nurses when making any commissioning decisions for patients who are the responsibility of other primary care practitioners
- Front-line staff has been involved in commissioning decisions and in the use of resources that have been freed up. This will be particularly relevant for nursing teams, therapists and integrated care teams with regard to long-term care, end of life care and public health nursing services.

Capability building and sharing learning

51. Practice capacity and capability to commission effectively is crucial. Therefore, we have developed a support programme aimed at PCTs and Practices to ensure that each partner has the requisite commissioning skills needed for Practice Based Commissioning. The programme will include:

- regional roadshows and workshops for PCTs and Practices
- a web based toolkit for PCTs
- a support pack for PEC and PCT Boards
- a practical “fundamentals of PBC” booklet for PCTs and Practices.

52. In the interest of learning from and spreading best practice, we shall ask Strategic Health Authorities to report annually on the state of Practice Based Commissioning in their area and disseminate best practice locally.

Annex A

Step 1:

Determine practice list size at April 2003 and April 2004, broken into the following age bands:

0-4 5-14 15-44 45-64 65-74 75-84 85+

Step 2:

Calculate the average list size by age band for 2003-04, by taking the average of the April 03 and April 04 lists.

Step 3:

Calculate the age cost weighted list for 03-04 by applying the following weights to the average list.

0-4	5-14	15-44	45-64	65-74	75-84	85+
542.04	269.01	525.78	655.41	1,245.37	1,976.50	2,799.22

Step 4:

Determine populations in the above age bands for Quarter 1 2005 and calculate the age cost weighted list for April 2005.

Step 5:

Calculate the ratio of the April 2005 cost weighted list to the 2003-04 average cost weighted list is then used to uplift or deflate the 2003-04 budget.