

Practice Based Commissioning: GPC guidance for GPs and LMCs

March 2005

Practice based commissioning is currently an England-only initiative. However, some of the messages in this guidance note may have implications UK-wide.

1 Why practices should get involved

- 1.1 The GPC is aware that practice based commissioning (PBC), initially, may not hold sufficient appeal for many GPs to consider becoming involved. In addition to concerns about overstretched GP capacity, the recently published technical guidance has introduced a number of disincentives to the scheme. However, there remain many reasons why practices should seriously consider becoming commissioners.
- 1.2 The NHS is going through yet more radical change, largely as a result of the Government's introduction of market-based financial flows into the health service through Payment by Results (PbR), patient choice and the introduction of private sector providers. Alternative Provider Medical Services (APMS) is a significant threat to general practice. The political imperative for PCTs to develop APMS has the potential to result in patients being diverted to a multiplicity of private sector primary care providers. In order to help prevent the fragmentation of care, extra emphasis needs to be put on strategic local service planning. PBC has the ability to develop NHS general practice and move resources into primary care. Service redesign via effective commissioning, using freed up funding for the development of community and in-house services, can therefore go some way to address the issue of fragmentation. In essence, if a practice or groupings of practices become successful commissioners, they will have more control over the forces that otherwise would adversely affect their working environment. Furthermore, if GPs decide not to hold budgets then others, such as community matrons and/or district nurses or private providers, may be willing to do so.
- 1.3 The advantages for patients of a robust and multi-faceted primary care sector are numerous. Community services and the personal longitudinal care provided by general practice has demonstrable benefits to patients and is associated with higher patient satisfaction, healthier populations, reduced prescription of drugs, lower hospitalisation rates, reduced adverse effects of social inequality and lower overall health service expenditure.¹
- 1.4 PbR introduces perverse incentives to hospitals to carry out increased numbers of procedures within secondary care. PBC has the potential to introduce appropriate checks and balances into the system and maintain an appropriate level of accountability. It is also an opportunity to work with consultant colleagues to ensure that care pathways and service redesign are developed in the best interests of patients.

¹ Starfield B (1998) *Primary care: balancing health needs, services and technology*. New York: Oxford University Press.

- 1.5 Finally, if managed in an effective way, savings made from commissioning budgets can be used for investment into capital projects, including premises, staff and equipment.

2 Moving forward

- 2.1 The GPC's guidance on PBC in December 2004 urged LMCs to initiate discussions locally on the initiative, both with practices and PCTs. This guidance still stands, as does the list of specific issues to consider contained within it and can be found via the following website address:

www.bma.org.uk/ap.nsf/Content/pracbasedcomm1204?OpenDocument&Highlight=2,practice,based,commissioning

- 2.2 Following publication of the Department's technical guidance (23 February 2005), it is clear that much detail is still lacking on the initiative and that, as a result, it will be down to LMCs and practices to attempt to fill in the gaps through local negotiations with PCTs. We gather, however, that the technical guidance has been left vague intentionally in order not to constrain innovation. It should be noted that the Department has developed a support programme for PCTs and practices, details of which can be found at paragraph 51 of the technical guidance. The technical guidance should be read in conjunction with the Department's earlier guidance, published on 15 December 2004. Both documents can be accessed on the Department of Health's website, via the following addresses:

Making practice based commissioning a reality – technical guidance

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4104152&chk=/K4etf

Practice Based Commissioning: Promoting Clinical Engagement

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098564&chk=uBbP%2Bg

- 2.3 This GPC document aims to raise awareness of the main issues that will arise where practices wish to become involved in PBC and does not set out to be prescriptive. Although we are aware that many GPs will already be at a more advanced stage in their discussions, this guidance is targeted at what we imagine to be the majority of GPs, who may either be wary of getting involved or who have little or no previous, hands-on experience of fundholding, multi-funds and/or locality commissioning.

3 Budget setting

- 3.1 In 2005/06, Payment by Results (PbR – see appendix 1) will usually only cover elective inpatient and day-case care, except where secondary care providers are Foundation Trusts. These are the services which would be covered by a 'default' budget and for which practices have an absolute entitlement. In order for practices to take on a commissioning budget that includes services outside these areas (such as emergency, diagnostic, outpatient care and community services) PCTs will need to disaggregate existing local block contracts between other/different services and agree pricing for services without the formal application of the national tariff.

- 3.2 We would argue that expanding the scope of PBC to be wider than that of PbR in 2005/06 would put commissioners in a stronger position to be able to make savings and achieve service redesign. If the PCT is prepared to disaggregate block contracts, LMCs and practices will need to decide the best way to go about setting budgets in the absence of national guidelines. The technical guidance encourages PCTs to enable practices to take on a wider commissioning budget than the default contract (paragraph 17). The LMC may need to mediate, with possible SHA involvement, where a PCT is not supporting the development of PBC in keeping with practices' aspirations.
- 3.3 The default budget may be geared to deal with existing waiting lists and funding will be committed accordingly, making it more difficult for practices to achieve savings. As a result, if the PCT is not willing to disaggregate existing contracts, practices will need to consider whether there would be less risk involved if they were to delay taking on a commissioning role until 2006/07. In addition, 2005/06 default budgets will be based on referral data from 2003/04, meaning that practices with historically low referral rates will automatically be disadvantaged by the budget setting process. It should be noted however that from 2006/07, the 'intention' is to move to a capitation allocation, which should eliminate this problem but may, of course, create other problems of its own.
- 3.4 Whether practices take on a default or wider budget, they should ensure that the proposed sum is scrutinized and that they are content that it is accurate before agreeing the budget price. In addition and where recurring deficits exist, practices and LMCs should resist attempts by PCTs to set insufficient commissioning budgets in order to ration care.

4 Choose & Book (C&B)

- 4.1 GPs support real patient choice, but have serious concerns about the implications of the 'booking' element of this initiative. We maintain that patient choice is not synonymous with the present C&B system. However, the technical guidance states that practices will 'need to demonstrate that they intend to implement Choose and Book in accordance with the national guidance (paragraph 11)'.

Despite this, we do not believe that the fact of having to express an intention to implement C&B should necessarily constrain practices from getting involved in PBC. Practices can always reconsider their position when the final C&B guidance is available and decide whether they wish to continue operating PBC.

- 4.2 The GPC's position on C&B is clear and GPs should be aware of our guidance on this issue, which can be found on the BMA website at the following address: www.bma.org.uk/ap.nsf/Content/chooseandbook1104

In summary, we remain concerned over a number of unresolved issues relating to C&B, particularly the potential workload and resource implications for GPs. The GPC are working with the Department of Health and the National Programme for IT to resolve these issues and we will update the profession on developments via LMCs and the BMA website.

- 4.3 The Department of Health announced a new scheme on 19 January 2005, which offers financial incentives to PCTs in order to encourage the take-up of C&B. The press release can be found at the following website address:
www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4101642&chk=8Yq9ks

Further detail on this scheme has not been made available, but if it is of interest to GPs, LMCs should discuss with PCTs how this money might be distributed to practices and any agreement reached should be reflected in the PCT's Local Development Plan (LDP).

- 4.4 In order to fulfil their obligations under the choice agenda and in the context of PBC, practices should not coerce patients into choosing an in-house service.

5 Management costs, including adequate clinical time

- 5.1 The funding of adequate management costs by PCTs, from the outset, is essential to the success of PBC. Practices should be cautious of taking on the commissioning role if they feel that the management costs on offer are inappropriate and fail to reflect the real value of clinician involvement.
- 5.2 Practices will need to make a realistic cost estimate of GP, practice manager and administrative time that will be necessary to take on the commissioning role. This should include overheads, IT support and the incurred cost of clinicians taking time out of the practice. It could be argued that recompense for clinicians' time and input should represent the most part of the management costs budget, and this would ensure that funding goes directly to the practices involved.
- 5.3 When calculating the estimated costs, practices should consider the following factors which will affect the level of necessary management:
- the indicative budget figure
 - the service(s) that are intended to be commissioned
 - whether the practice is commissioning individually or as part of a 'locality'
 - the potential number of patients for whom commissioning will be carried out
 - the costs of any contract monitoring the practice(s) may decide to undertake
- 5.4 There may be benefit in developing a benchmark range of recommended practice management costs which will strengthen local negotiations with PCTs and minimise significant variation in management support between different PCT areas. Developing a benchmark range of management costs may be difficult, since there may be less apparent, non-financial resources offered to some practices, such as when a PCT provides seconded staff to a practice. Practices should bear in mind however that cash resources tend to be more reliable than support in kind, which may be re-routed at a later date.

6 PCT risk management

- 6.1 The financial risk involved in PCTs devolving budgets to practices must be duly considered by all parties concerned. Practices should ensure that the PCT's assessment of risk corresponds with the services that practices wish to

commission. It could be argued that areas of work that would entail significant risk are outside the remit of PBC at this present time. LMCs and practices should be fully aware of the implications of any risk management strategy that is applied.

- 6.2 LMCs should consider, with the PCT, whether or not there is a more appropriate PCT-level risk management mechanism than the one suggested by the Department – a ‘top-slice’ PCT-held contingency fund. If the top-slice method is adopted, LMCs should be instrumental in agreeing the percentage of the top-slice with the PCT. As is the case with the management costs estimate, there are a number of factors that will affect this figure which should be taken into consideration – see paragraph 5.3 above.

7 Savings or ‘efficiency gains’

- 7.1 We would argue that PCTs should agree, in advance, to allow practices to invest 100% of any savings made from the commissioning budget into patient services, and would hope that LMCs are able to influence this decision. [It should be noted that the up front management costs will be recouped from the savings before they are directed to practices.] This will act as a significant incentive to practices to take part in the initiative.
- 7.2 Practices and LMCs should be vigilant to the possibility that savings from PBC are seen by PCTs as an automatic mechanism from which to offset recurrent deficits.
- 7.3 Where practices have grouped together to form a locality, an agreement will need to be reached, in advance, on how savings will be distributed. It may be that using practice populations would be the fairest way of doing this. The funding of capital projects from savings and how these will benefit a population wider than that of the individual practice should also be discussed. Practices should be looking to achieve service redesign irrespective of the level of savings.
- 7.4 Practice based commissioners will need to agree how savings will be deployed in order that such proposals can be put to the PEC, at the beginning of the year, for its consideration and approval. LMCs should discuss with PCTs early on how they are to be involved in this process, to help ensure that no conflicts of interest arise regarding GP members of the PEC who have also taken on a commissioning budget.

8 Involving patients and ‘front-line staff’

- 8.1 The majority of patients have high levels of confidence in their GP. By involving patients in commissioning decisions, practices will be able to strengthen their position and highlight the importance of providing more services in the community. Local patient liaison groups should be consulted if and where appropriate and agreements on the level of patient involvement should be included in the LDP.
- 8.2 For the purposes of the PEC approving use of savings proposals, practices may need to demonstrate that front-line staff are also being involved in commissioning decisions. We would argue that, in order for PBC to succeed, engaging with the wider practice team will be crucial. It is likely therefore that consultation with the relevant parties will happen as a matter of course.

- 8.3 In addition, the Department of Health guidance states that practices need to commission within the context of the PCT's LDP. There may therefore be a need for a public health dimension in assisting practices to make commissioning decisions based on health priorities. One solution to this might be to discuss the possibility of PCT public health support being given to practices that have taken on the commissioning role.

9 Monitoring secondary care data

- 9.1 Although often inaccurate and incomplete, it will be a necessary part of PBC for practices to monitor secondary care data in order to pinpoint the areas where referral patterns need improvement. The recent NHS Alliance paper, *CAVEAT EMPTOR ('buyer beware'): payment by results and practice led commissioning*, highlighted the importance of validating the work that is carried out in hospitals. A link to this paper was included in the February edition of GPC News and can be found at the following website address:
www.bma.org.uk/ap.nsf/Content/nhsalliancecaveat

- 9.2 The aim however should be to minimise any bureaucracy. Practices will need to work with PCTs to ensure that all procedures carried out are appropriate and that the tariffs used are the correct ones. Clinical input into this process is imperative. LMCs/practices might consider using clinical leads across practices to do this work, properly funded from the agreed management costs.

10 Alternative Provider Medical Services (APMS) and PBC

- 10.1 We have mentioned the threat that APMS poses to general practice in paragraph 1.2 of this guidance note, which for the most part relates to the introduction of private sector provided essential services. The GPC also maintains that APMS holds an opportunity for GPs similar to that of PBC, one that can help maintain GPs' control over the changing environment of general practice.

Some background information on APMS was included in the December edition of GPC News and can be found at the following website address:
www.bma.org.uk/ap.nsf/Content/gpcnews171204#AlternativeProviderMedicalServ

- 10.2 One way to use APMS in the context of PBC is for GPs to tender to provide certain services as an APMS body. By commissioning from this body, practices would fulfil their obligation to commission a percentage of their budget from the private sector, without risking fragmentation of care.
- 10.3 Further information, a model contract and guidance on APMS will be published by the APMS Core Group, lead by the NHS Employers Organisation, in due course. The GPC will inform the profession of any developments on APMS and relevant documentation via LMCs accordingly.

11 Conclusion

- 11.1 We believe that there are compelling reasons why general practice should be involved in commissioning. The decision to take on the commissioning role, however, is one that should be based on practices having weighed up the relative merits of involvement versus the associated risks.
- 11.2 The Department of Health's technical guidance lacks detail on the precise arrangements so, where clinicians do wish to become commissioners, LMCs and practices will need to enter into negotiations to agree the terms locally. We hope that this GPC guidance will help facilitate these discussions, as will seeking advice from GP colleagues previously involved in fundholding, multi-funds and/or locality commissioning.
- 11.3 As PBC develops and models of good and successful practice emerge, many of the issues that we have identified, both here and in discussions with the Department of Health, will become less of a concern. However, the GPC will continue to keep abreast of these issues and endeavour to advise GPs and LMCs further, as and when necessary and possible. To this end, when good practice models emerge in your area, we would appreciate LMCs sharing details of these with the GPC secretariat.

For information we have attached guidance recently prepared by the Londonwide LMCs secretariat – see appendix 2.

Appendix 1

Payment by results

The NHS introduced the payment by results (PbR) system in April 2004, starting with a pilot scheme in foundation hospitals. PbR should be seen in the wider context of the introduction of market financial flows to the NHS through patient choice and the introduction of private sector providers.

Under PbR, providers are paid on the basis of case-mix adjusted activity, rather than by block contracts. In other words, providers are basically paid a fixed price for each case treated. Healthcare resource groups (HRGs), based on diagnoses and the complexity of treatment, are used to measure care provided. Each HRG commands a tariff based on the national average cost of treatment in England. PbR therefore removes prices from local negotiation. On the basis of national tariffs, PCTs or commissioning practices will commission, from a plurality of providers, the volume of activity required to deliver service priorities, adjusted for case-mix.

Details of the 2005/06 HRG tariffs can be found at:
www.dh.gov.uk/assetRoot/04/09/15/31/04091531.pdf

Tariffs for 2005/06 can be found here:
www.dh.gov.uk/assetRoot/04/09/15/32/04091532.xls

PbR has potential benefits including enhanced data collection and fairer distribution of resources. However, it is also associated with significant risks. There are concerns for example that hospitals with above average costs will face closure, that patients may be classified into more expensive HRGs, that hospitals will favour less expensive patients and that they may needlessly increase their activity; Evidence already shows a disproportionate rise in the number of short stay inpatients admitted through accident and emergency departments in foundation trusts.²

Planned implementation of PbR across all NHS trusts has been slowed. Although it will still be rolled out across the NHS from 2005, phasing in of PbR has been amended to include elective care only in 2005/06.³

² Rogers R, Williams S & Jarman B et al (2005) Dr Foster's case notes: "HRG drift" and payment by results. *BMJ*. **330**: 563.

³ Scope of payment by results for 2005/06: Important Announcement 10/01/2005. Department of Health. www.dh.gov.uk/assetRoot/04/10/09/34/04100934.pdf

Practice Based Commissioning Londonwide LMCs guidance

This guidance reflects our understanding of the present guidance from the DoH and our interpretation of the intentions behind this latest initiative.

All practices in the Londonwide LMCs area have had the opportunity or an invitation to attend seminars/workshops, either organised by your own LMC or in conjunction with your PCT. There will be other local events as the agenda develops.

This guidance note is being sent to all GPs, and an additional copy is going to all practice managers together with the latest technical guidance from the DoH (see www.lmc.org.uk).

What is practice based commissioning?

It is an opportunity for GPs and nurses to take *responsibility* for ensuring that all the health needs of a population are met.

An indicative budget is then negotiated to pay for those services.

With shared responsibility comes shared *accountability*, both for the health outcomes and the budget.

Should our practice be involved?

This is for you and the practice team to decide. It may help to answer some questions:

1. Do our patients receive the best possible hospital, community and mental health care?
2. Could we do it better ourselves?
3. With the tight cash limits on GMS and PMS budgets, how else can we obtain additional resources to invest in premises, equipment and the practice team?

If you do decide to become involved, there are a number of ground rules:

You will be expected to:

- develop a shared agreement with the PCT
- reflect some pre-existing commissioning arrangements made by your PCT
- involve patients and the local community in the decision making process
- ensure that patients must be able to exercise choice
- deliver key national targets
- deliver value for money
- implement Choose and Book when it is working properly (negotiations are in progress regarding this and any payment)

How do we do it?

You can choose to do it as a practice and/or as a group of practices and/or as a locality or neighbourhood.

Remember, your PCT cannot *impose* its locality structure on you.

You may find the following steps helpful:

1. Discuss the opportunities with other practices and with the PCT
2. Consider which services you wish to commission and see how those tie in with other practices
3. Prepare a cost estimate of GP, manager and administrative time, plus overheads and IT support

Remember, there could be economies of scale in grouping together with other practices.

Don't forget that the PCT, not practices, will be acting as the agent to procure and pay for the services you commission.

How will the budget be set?

- There are no national rules, although a 'default' mechanism is set out in the technical guidance
- Involvement is voluntary and the methodology is agreed locally
- Payment by Results (PbR) will be phased in for the year 2005-06, so the national tariff will apply to elective inpatients and daycases only
- Budgets for non-elective and outpatients have to be agreed locally
- If practices start with elective services only, the PCT will have to monitor other referral activity to ensure that there is no inappropriate transfer and that practices are preparing to hold a budget for more services in the future

What about the risks?

Although there are potential financial and clinical governance risks in becoming involved, there are arguably greater risks in *not* taking the opportunity. By becoming involved, practices reduce the risks of fragmentation and of alternative provision of primary medical services by the private sector and expansionist foundation trusts.

Financial risks can be managed at different levels, some at:

- practice level
- group or locality level
- PCT level or beyond

Remember that the risk management strategy will need to plan for the expansion of Payment by Results (PbR). Top-slicing devolved budgets to create a contingency fund to be retained by the PCT or group of practices is one approach.

Practices will need to ensure that there are robust clinical governance and referral arrangements to avoid any possible conflicts of interest.

What about management costs?

These are vital to success!

There are no set scales, but practices will need:

- payment for clinical and staff time
- funding for and/or secondment of managers to run the process
- costs of overheads and IT

Remember that you will need this funding even in any preparatory 'shadowing' stage.

These initial costs will be provided in advance by the PCT. The PCT will then recoup its costs from the savings made at the end of each financial year.

How can we use our savings?

Essentially for things which improve patient services. These may include:

- clinical and practice staff
- expansion of your premises or IT

Remember that you can keep *up to* 100% of any savings for purposes agreed *in advance* with the PEC. In turn the LMC will wish to ensure a transparent process with the PEC.