Focus on the Towards Practice based commissioning Directed Enhanced Service (England only)

February 2006

1 Background

This guidance note should be read in conjunction with the following documents:

- 'Towards practice based commissioning' Directed Enhanced Service specification (20 February 2006) www.bma.org.uk/ap.nsf/Content/revisionnGMSFeb20062~annex6PBCDES

- Chapter 9 of the Joint GPC-NHS Employers guidance, 'Revisions to the GMS contract, 2006-07: delivering investment in general practice' (20 February 2006) www.bma.org.uk/ap.nsf/Content/revisionnGMSFeb20062

- Department of Health guidance, 'Practice based commissioning: achieving universal coverage' (26 January 2006). www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127125&chk=pAds%2BV

The GPC is supportive of the principles of PBC and the opportunities it presents to improve services to patients. However, we remain concerned about the potential barriers to the successful implementation of the initiative, one example being inadequate management resources available to support the work involved. The recent Department of Health guidance 'Practice based commissioning: achieving universal coverage' we believe has introduced some new disincentives for GPs which may prove to hinder the development of PBC further. A short GPC analysis of the Department of Health guidance can be found at appendix 1 and serves to highlight some of these latest concerns.

Practices should be fully aware of the arrangements pertaining to and implications arising from their involvement in commissioning at any level.

2 Introduction

The 'Towards practice based commissioning' (TPBC) Directed Enhanced Service (DES) will be offered to all GMS and PMS practices from April 2006, for one year only. It is a low level, introductory scheme, principally intended to incentivise practices to start engaging with the PCT on the approach to service redesign from their practice point of view, in order to inform and prepare them for greater involvement in commissioning at a later date. It '… provides a set of incentives around the key areas that will be important to focus on initially' (paragraph 4) and *is not intended to resource any additional management costs associated with operating PBC*. Practices should not undertake any level of activity under the DES that the associated funding does not adequately resource.

The level of practice sign-up to the DES – measured first in April 2006 and then January 2007 – will be used to monitor coverage of PBC across England (see analysis of Department of Health guidance).

3 How the DES works and what it covers

3.1 Component 1 (C1): 'Planning and redesigning patient flows'

- The first component – which amounts to 95p per registered patient based on the practice list size as at 1 April 2006 (see paragraph 9.2 of the joint GPC-NHS Employers guidance) – is payable upon agreement of a plan between the practice and the PCT.

- A template plan has been included with the DES specification, details of which can be found below:
  - Practice name and details and if joint plan with other practices;
  - Agreed scope of services covered by indicative budget. *[Note that the Department of Health guidance 'Practice based commissioning: achieving universal coverage' states that PCTs are expected to provide all practices with an indicative budget by April 2006 (see paragraph 28)].* Description of specialties and nature of service (acute/elective) which practice is to redesign in order to improve services to patients and/or the nature of activity/planning to be undertaken by practice to achieve more appropriate hospital usage;
  - Method by which quality of the redesigned services will be assured/demonstrated;
  - Agreed baseline of referrals and/or admissions by speciality for 2005/06;
  - Agreed threshold for meeting the objectives in this DES plan to trigger the award of component 2. *[Note that the practice objectives should be 'reasonable and achievable … [and] relevant to the practice's existing circumstances' (see paragraph 14 of the DES specification)]*;
  - Agreed information and monitoring requirements by PCT and practice.

- The DES specification suggests a few further inclusions for the practice plan:
  - Details of practice clinical engagement, including identifying a clinical lead;
  - How the practice plan links to the PCT's strategic plan and local priorities;

- Although practices can take up the DES at any time in-year, there is an expectation that they will do so by the end of April 2006 and that plans will be agreed, and C1 payments made, by the end of June 2006.

- Practices can produce a composite DES plan with other practices in the area and still be eligible for payment of C1. However individual practices will still be accountable for achieving the specific objectives set out in the plan. *[Note that practices should avoid the temptation to pool C1 payments to fund any additional management costs associated with operating PBC, or to pass individual payments on to the PCT for a similar purpose.]*

- C1 funding is intended to resource the practice time needed to develop and implement the DES practice plan. *[Note that it is for practices to decide how to utilise these payments.]*

3.2 Component 2 (C2): 'Demonstrating success'

- The second component – which amounts to a further 95p per registered patient based on the practice list size as at 1 April 2007 (see paragraph 9.4 of the joint GPC-NHS Employers guidance) – will be payable upon achievement of the objectives set in the plan.

- If implementation of the plan frees up resources from the indicative budget and these are equal to or greater than the equivalent of C2, then the practice will be able to access as a minimum the equivalent of C2 from these resources, but will not receive a C2 payment in addition. *[Note that the arrangements relating to access to freed up resources that are greater than the equivalent of C2 is not covered by the DES; see paragraph 4.1 below]*.

- Where the freed up resources are less than the equivalent of C2 and the practice has achieved its objectives, the difference will be met by the PCT. *[Note that the arrangements relating to access to these freed up resources is not covered by the DES; see paragraph 4.1 below]*.

- C2 payments will be paid to practices, where possible, by the end of April 2007 and at the latest, by the end of June 2007. *[Note that this will be laid out in the Statement of Financial Entitlements 2006/07 and the DES Directions]*. Practices are only eligible for C2 however if they have completed C1.

- C2 (or equivalent) is intended to go towards practice activity designed at continuing achievement against the DES objectives, which are to be delivered during 2006-07.

3.3 PCT support for practices

The DES sets out various areas where practices should receive support from the PCT, they include:

- A minimum package of information relating to practices' use of health services as detailed in paragraph 12 of the DES specification. *[Note that the Department of Health guidance 'Practice based commissioning: achieving universal coverage' states that such information should be provided by the PCT on a monthly basis (see paragraphs 21-27)]*. Where practices believe that the data provided is inaccurate, PCTs are expected to work with the practice to ensure the data's accuracy;

- A summary of the PCT's strategic and local priorities so that practices can be aware of these when developing their plans (see paragraph 12 of the DES specification);

- Clinical reviews of appropriateness of provider activity and emergency admissions (see paragraph 18 of the DES specification).

- The delivery of national priorities (see paragraph 18 of the DES specification).

3.4 Wider context of PBC proper

- The TPBC DES is intended to promote engagement in PBC and not, by way of its minimum pricing, to be an obstacle to the development of PBC locally. Hence the continuation of existing local arrangements for engagement with PBC are not precluded by it, nor are the establishment of alternative or additional schemes following introduction of the DES (see paragraph 7 of the specification).

- Where existing local arrangements have not been resourced as a minimum to the level of the DES, from April 2006 practices will be entitled to seek that the equivalent funding is provided for their continued activity (see paragraph 7 of the specification).

- Already agreed resource for commissioning activity that exceeds the level of the DES funding should be honoured (see paragraph 7 of the specification).

- Where PCTs and practices agree additional workload to that covered by the DES, additional resource to the DES should be made available (see paragraphs 4 and 9 of the specification).

4 What the DES does not cover

The specification does not cover all areas concerning involvement in the TPBC DES; these relate to issues on which it is not the place of the DES specification to dictate. As a result, practices and PCTs will need to refer to the Department of Health guidance 'Practice based commissioning: achieving universal coverage' and agree some local arrangements to complete the national scheme outlined in the DES specification.

4.1 Access to and use of freed-up resources

We would advise practices to obtain precise and clear written agreement in advance – ideally in the DES practice plan – to cover the scenarios below (see also section 9 of the sample plan at appendix 2).

- The event of resources freed up through activity under the DES being less than or equal to the equivalent value of C2 and the practice not having achieved its objectives

    - Practices should be able to access these monies and reinvest them in the same way as they would have been able to do upon achieving their objectives i.e. for practice activity designed at continuing achievement against the TPBC DES objectives. At the very least, practices should be able to access a significant proportion of these resources, in line with paragraph 47 of the Department of Health guidance 'Practice based commissioning: achieving universal coverage' which recommends a 70:30 practice:PCT split.

- The event of resources freed up through activity under the DES being greater than the equivalent of C2, whether or not the practice has achieved its objectives

    - Practices should be able to access a significant proportion of these resources, in line with paragraph 47 of the Department of Health guidance 'Practice based commissioning: achieving universal coverage' which recommends a 70:30 practice:PCT split. As for how these resources should be used, the GPC would advise that they go either towards practice activity designed at continuing achievement against the TPBC DES objectives – which is a stipulated use of C2 DES monies – or reinvestment in 'services for the benefit of patients locally' (see paragraph 44 of the Department of Health guidance).

- Timing of PCTs releasing freed up resources to practices

    - We would expect these payments to be made to practices in line with the arrangements relating to C2 payments, so where possible by the end of April 2007 and at the latest, by the end of June 2007.

4.2 Indicative budget

The scope of services to be included in indicative budgets and how to calculate the practice budget is covered in the Department of Health guidance 'Practice based commissioning: achieving universal coverage'.

As noted earlier in this document, the Department's guidance states that by April 2006, PCTs are expected to provide practices with an indicative budget and we would recommend that practices start discussing this with their PCT at the earliest opportunity. The Department's guidance also set a minimum scope for the indicative budget which covers all services under Payment by Results (PbR) in 2006/07 and prescribing (see paragraph 32). PbR in 2006/07 will be extended to cover electives, non-electives, A&E and outpatients in all hospitals; it will not cover critical care or mental health. Exclusions from the indicative budget include core GMS/PMS services, specialised services, services commissioned regionally and nationally and national screening programmes (see paragraphs 34-35). Under both the TPBC DES and separate, greater PBC activity, practices do not have to actively manage/commission the full scope of services included in their budget, however, any activity they do undertake and subsequent freed up resources they make will be measured against the total indicative budget. This thereby allows flexibility of involvement, though no flexibility of budgetary responsibility. As a result, it may be more difficult for those practices who take on a low level of activity to fre up resources than those who decide to take on a greater level of activity.

This should not put practices off from doing the TPBC DES since payment of C2 resources is guaranteed if they achieve their DES plan objectives. It should also be noted that DES resources are protected from PCT overspends as where practices achieve their objectives they will receive as a minimum, resources to the equivalent value of 95p/patient for both components 1 and 2.

That said, nothing in the DES specification dictates that the associated budget must cover the minimum scope of services as outlined in the Department of Health guidance above. Practices may therefore wish to discuss with the PCT the possibility of agreeing an indicative budget which covers just the range of services included in the DES plan.

Either way, it is important for at least one budget to be in place for practices to be able to effectively monitor their achievement against the objectives, the level of freed up resources made/not made and to inform the possibilities for service redesign.

For more detail on the budget setting process, refer to paragraphs 28-37 of the Department's guidance.

5 Appropriate levels of activity under the TPBC DES

The sample plan in appendix 2 provides practices with examples which they may wish to include in their own DES plans. The plan also reflects recommendations made in this guidance note that are not covered by the DES specification, for example in relation to arrangements around freed up resources. The GPC's sample plan goes into a level of detail above that which the template plan requires; however the intention is that it covers a range of situations that may arise from practices' discussions with PCTs. It therefore follows that practices' DES plans do not need to be as detailed as the GPC's sample plan, though practices may still wish to use it as a model from which to develop their own, practice-specific plans.

For the most part, the DES will enable GP practices to choose a few clinical areas on which to reflect upon and monitor referral patterns, conduct peer-review within the practice where necessary and carry-out some audit and analysis in order to ensure more rational referral behaviour across the practice. It is unlikely to facilitate major service redesign, which would

require a far higher level of clinical engagement and workload than the available resources (i.e. C1) will enable. Practices should however be prepared to consider using alternatives to hospital services, if such services are acceptable to the patient being referred and are available locally. In this way practices can demonstrate support for service redesign.

Practices should work within the resources available and not exceed them; work under the DES should only amount to what is possible for 95p/patient. For example, for an average practice of c. 5,800 patients and 3 full-time GPs and at current market rates, component 1 would fund about 1 locum session (of half a day) every fortnight. [Note that this does not take into account any practice managerial or secretarial time].

Any commissioning activity above and beyond the agreed scope of the TPBC DES should be properly resourced in addition to the DES monies. In order to achieve the long-term vision of effective service redesign and expansion of the range of services available in the community, significant and dedicated clinician engagement will be required. PCTs' failure to recognise the very real costs involved in commissioning will undermine the value and potential success of PBC.

6 Taking on commissioning activity greater than the scope of the DES

Paragraph 17 of the Department of Health guidance 'Practice based commissioning: achieving universal coverage' states that PBC is still voluntary for practices (see paragraph 17). Provision of the TPBC DES is also optional for practices. Furthermore, where practices do undertake the DES, there is no obligation on them to take on greater, commissioning activity in addition to what is agreed in the DES plan.

Where practices do wish to take on a wider range of commissioning activity than the DES funding allows, then they should discuss this and the resources available in order to do so, with their PCT. Upon reaching agreement with the PCT on this approach, practices may consider producing a practice plan and also an 'enhanced commissioning activity' plan, which builds upon the objectives that have been set in the DES plan.

7 Working jointly with other practices

As stated earlier in this document, practices can produce a joint DES plan with other practices in the area. PCTs are able to make agreements with groups of practices or consortia, rather than just with individual practices however each practice will still be accountable for achieving the set objectives in order to trigger payment of component 2. Practices which choose to pool some or all of their C1 incentive payments should draw up an inter-practice agreement defining the joint working and financial arrangements and agree a mechanism for receiving the C1 incentive payments with the PCT.

8 Enhanced services and PBC

The TPBC DES is not a specification for the provision of patient services, nor for enhanced GMS care and therefore, strictly speaking, should not be classed as an enhanced service. However, a DES offers the most appropriate payment mechanism for the following reasons: PCTs are legally obliged to commission DESs and pay for them at the nationally-set pricing; DES specifications (and payments) are laid down in statute (in the DES Directions) and practices can chose whether or not they wish to provide them. All the new 2006-07 DESs will be funded from monies over and above the 2006/07 enhanced service floor (which has been frozen at 2005/06 levels) and therefore there should be no confusion as to the correct use of use of floor monies. Furthermore, the joint GPC-NHS Employers guidance says the following:

"5.23 The established criteria according to which a service can be funded from the enhanced services floor, for example that it directly provides patient services, remains unchanged…"

9 Role of LMCs

There are several areas where LMCs' involvement in local negotiations on the TPBC DES would be of great value to their GP constituents. Depending on the LMC's capacity, they might include working towards ensuring the following:

- PCTs offer the TPBC DES to all practices in the area, whether PMS or GMS (see paragraph 6 of the DES specification)
- The level of activity outlined in practice plans is reasonable in light of the resource available and relatively consistent across the PCT area
- Practices' objectives are reasonable and relatively consistent across the PCT area (see paragraph 14, 2nd bullet point of the DES specification)
- PCTs apply a fair, transparent and consistent budget setting process and practices are provided with an indicative budget by the end of March 2006
- Agreement is reached across the PCT area on the division of freed up resources and in line with the Department of Health's recommendation that practices can redirect 70% as a minimum
- The relevant information relating to practices' use of health services is supplied to practices in a consistent and clear format
- Where this data is inaccurate, PCTs are willing to work with practices to resolve this (see paragraph 12, 1st bullet point of the DES specification)
- PCTs develop a system for carrying out clinical reviews of appropriateness of provider activity and emergency admissions (see paragraph 18, 1st bullet point of the DES specification)
- Existing PBC agreements are not undermined or unpicked, especially where they offer a higher funding level than the DES (see paragraph 7 of the DES specification)
- Where alternative schemes to the DES would better suit the local situation, that meaningful discussion between PCTs and practices takes place accordingly
- PCTs give due consideration to funding practice commissioning activity above and beyond the scope of the TPBC DES (see paragraphs 4 and 9 of the DES specification)
- PCTs make clear their strategic and local priorities in order to aid practices in putting together their DES plans (see paragraph 12, 3rd bullet point of the DES specification)
- Spend on the TPBC DES is not counted against the 2006-07 enhanced services floor.

The GPC's Commissioning and Service Development subcommittee will be producing further guidance on PBC in due course.

APPENDIX 1

PRACTICE BASED COMMISSIONING (PBC)
GPC ANALYSIS OF LATEST DEPARTMENT OF HEALTH (DH) POLICY

Context

- New DH guidance published on 26 January 2006, 'PBC: achieving universal coverage'

- 'Replaces detail' of the DH's 'Making PBC a reality: technical guidance' document (February 2005) although states principles are still relevant

  GPC comment:
  There is no clarity regarding which aspects of the technical guidance are replaced and which are still valid, which could lead to varying and selective interpretation of this statement.

- Principles of 'PBC: promoting clinical engagement' (December 2004) also still relevant

- Should be read in conjunction with the 'NHS in England: the operating framework for 2006/07' document (January 2006)

- Should also be read in conjunction with the White Paper, 'Our health, our care, our say: a new direction for community services' (January 2006)

- Some further clarification on the latest DH guidance can be found in a specific question and answer (Q&A) document. A more generalised Q&A document also exists.

For details of the website addresses for these documents, see annex 1.

Achieving universal coverage

- Universal coverage is defined (paragraph 15) in terms of providing practices with information on their clinical and financial activity, with an indicative budget and an offer to take-up an incentive payment (DES).

- PBC is still voluntary for practices (paragraph 17).

  GPC comment:
  In view of acceptance that PBC is 'voluntary', there is no information regarding what action PCTs will take if practices choose not to participate (in the DES). However the suggestion is that all practices will be involved passively by receiving monthly practice level information from the PCT and an indicative budget.

- PCTs will be performance managed by SHAs on the basis of uptake of the DES or equivalent incentive schemes by practices. PCTs to provide this information to SHAs in April 2006 and January 2007 (paragraphs 16, 18 and 19).

Information to practices

- A minimum and standardised package of information to be provided by PCTs to practices has been outlined (paragraphs 21-27). This information will be benchmarked to enable comparison with other practices in the PCT area and the national average (paragraphs 21-25).

GPC comment:
This does not mention accounting for practice level variations in case-mix, morbidity and needs. Such crude comparisons between practices are unlikely to be valid and will result in a misleading league table approach.

Budget setting and financial management

- PCTs are expected to provide all practices with an indicative budget by April 2006 (paragraph 28).

- A minimum scope for the indicative budget has been set to cover:
  - all services covered by the national tariff under Payment by Results (PbR) in2006/07 &
  - prescribing (paragraph 32).

- The practice is free to determine the range of clinical re-design it engages in, however any freed up resources will be measured upon expenditure against a total indicative budget (paragraphs 31-32).

  GPC comment:
  This allows flexibility of involvement, though no flexibility of budgetary responsibility, presumably to avoid 'cherry-picking'. Our interpretation is that the DES funding would cover in itself a minimal level of involvement.

- Exclusions from the indicative budget include core GMS/PMS services, specialised services, services commissioned regionally and nationally and national screening programmes (paragraphs 34-35).

- Budget setting based on:

- Actual 2005/06 activity (where available) converted to 2006/07 prices, in terms of the practice's share of the PCT allocation
- Current formulae for prescribing budgets
- Weighted capitation for any services for which no historic activity data is available
- An uplift to meet agreed additional activity over 2005/06 is stated, but is not guaranteed and will depend upon practices use of resources compared to target fair share and overall financial position of the PCT. (paragraph 36)

  GPC comment:
  Note the indicative budget will be the practice's share of the PCT allocation. This may mean that practices will inherit their share of PCT deficits where applicable.

- Fair share allocations 'over time' mentioned but no timescale stated (paragraph 37).

  GPC comment:
  Though there is mention of an on-line 'toolkit' for calculating weighted capitation budgets, this is untried and untested and notoriously unreliable at practice level, given the relatively small size of the practice unit and in-year variation.

- Requirement that PCT and practices will work together to ensure the PCT achieves financial balance, or runs a small surplus (paragraph 39).

GPC comment:
Reference to practices having a 3-year timescale to achieve financial balance (as in technical guidance) has been removed.

However, the DH Q&A document on their guidance includes the following:

'Do practices still have the right to balance their books over a three-year period? *Where a practice puts forward a plan to spend more in one year to free up resources in future years, PCTs must consider this as part of their wider financial responsibilities. In some cases, there may be the flexibility to do so, but for some PCTs in financial difficulties, the first priority must be to ensure balance at year-end.'*

- Risk management strategies suggested in paragraph 41. One is a top-slice from indicative budgets for a contingency fund to be held at PCT level; suggested 3-5%. Another is practices working in groups. Any unspent contingency to be returned to practices at year end (paragraph 42).

Resources freed up

- The terms 'savings' and 'efficiency gains' have been replaced by 'freed up resources' (FUR). '…practices are entitled to make recommendations about how to reallocate resources freed up from their indicative budget made from service redesign and more cost effective treatments' (paragraph 43).

- FUR can be used to 'fund services for the benefit of patients locally'. This includes equipment, training, clinical and non-clinical staff, premises development (with PCT Board approval) (paragraph 44).

- It is recommended that practices can redirect at least 70% of FUR and 30% is to go to PCTs (paragraph 47).

  GPC comment:
  This replaces the technical guidance's suggestion of up to 100% of 'efficiency gains' or 'savings' to be retained for practice control. However, the minimum of 70% of FUR for practices to redirect may be a useful lower limit.

- However, paragraph 48 allows 'these resources' to go towards covering PCT overspend or deficit 'as a last resort'. This arrangement will be reviewed in 2007/08. The PCT Board will oversee the use of FUR (paragraph 49).

  GPC comment:
  The DH has confirmed that paragraph 48 only applies to the PCT's 30% share of FUR. The DH Q&A document on their guidance includes the following:

  'What proportion of the freed up resources can the PCT retain to cover PCT overspends? *The guidance states that for 2006/7 practices should be entitled to access and redirect at least 70% of any freed up resources. The remaining up to 30% can be used by the PCT. The intention is that this 30% should be used by the PCT to meet a wider need across the whole PCT area, however as a last resort, this 30% may be used to cover PCT overspends.'*

  If PCTs disregard the DH guidance and redirect more than 30% of any FUR to their overspend this is highly likely to result in disengagement from PBC of practices in areas where PCT overspends or deficits are likely as it could amount to there being no guarantee of any FUR in spite of practice level effort in achieving efficiency gains. In turn, this could also result in discord between practices in an overspending PCT where some practices achieve FUR and others do not, with all practices being penalised by losing out on FURs.

  The GPC recommends that this risk is minimised through a formal agreement between the practice/PBC group and the PCT.

Note that either way and under the TPBC DES, upon achievement of the plan's objectives, practices will still be guaranteed payment of component 2.

- Provision for practices to receive upfront investment in order to deliver savings; practices will need to apply with a business plan, for PCT Board consideration and a decision on the business case application within 8 weeks (paragraphs 50-52).

  GPC comment:
  This offers practices the ability to receive up front investment for new services, equipment and staff which will translate into service re-design and freed up resources.

Supporting practices

- Guidance states support in kind will be offered by PCTs directly, as well as peer support by more experienced practices and a national programme of support by the National Primary Care Development Team (paragraphs 56-59).

- Financial support to be provided through the DES at 95p per registered patient '…in recognition of the engagement required … of practice staff in developing and implementing a locally agreed plan…' (paragraph 60).

  GPC comment:
  This is a description of component 1 of the DES and there is no detail here regarding the scope of objectives to be agreed as part of component 1. We have suggested a sample plan as part of the 'Focus on the Towards Practice Based Commissioning DES' guidance, which should be commensurate to the funding of component 1.

  Also note that there is no mention of any resource for work over and above the remit of the DES. However, the DES specification does make mention of additional resource for additional workload to DES activity (see paragraphs 4 and 9 of the specification).

- Upon achieving the objectives set in the DES plan, practices are guaranteed access to resources of 95p per registered patient as a minimum – taken from resources released from DES activity – even in PCTs with financial difficulties that might otherwise absorb that resource (paragraph 61).

  GPC comment:
  Paragraph 61 is inaccurate as it implies that practices will not have access to a payment unless they free up resources from the budget; this is not the case. Where practices do not make FUR, but do achieve their objectives, component 2 will be paid from funding already included in PCTs' 2006/07 allocations. This money is guaranteed. Please note that the DH Q&A document is also slightly inaccurate in its description of arrangements around component 2 of the DES.

- Following achievement of the DES plan objectives, the resources released are intended for reinvestment in '…patient care or other practice activity which supports the continued delivery of objectives' (paragraph 61).

  GPC comment:
  There is no mention of these resources being payable for clinician or practice staff time involved in commissioning and we would interpret the wording of paragraph 61 flexibly to allow for this.

Accountability and Governance

- There is an expectation for practices to involve and consult patients and the public for both provision of new services, as well as decisions about re-design and reallocation of freed up resources (paragraph 66).

- There is also an expectation of practices to consider all stakeholders when making decisions around service re-design (paragraph 67).

  GPC comment:
  Much of this involvement would involve time and effort beyond the funding available through component 1 of the DES.

Performance

- Clear statement that some practices will be more closely performance managed, while others demonstrating '… a track record of delivering change which is effective and releases resources', will receive earned autonomy and expect a 'lighter touch' from the PCT (paragraphs 69-71).

Arbitration

- Where practices and PCTs cannot agree '… local application of the national framework', the case will be referred to the SHA (paragraph 72). Groups will be set up on demand to include GP, financial and management representation, as appointed by the SHA (paragraph 73).

  GPC comment:
  There is no mention of involvement of LMCs. Throughout the document, there is also no mention of the PEC, but of PCTs and PCT Boards.

ANNEX 1

- ‘Practice based commissioning: achieving universal coverage’ (26 January 2006)
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127125&chk=pAds%2BV

- Detailed question and answer on ‘Practice based commissioning: achieving universal coverage’ (24 February 2006)
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4130515&chk=CEl9q0

- General question and answer on practice based commissioning (24 February 2006)
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4130497&chk=1Wee0P

- ‘Making PBC a reality: technical guidance’, February 2005
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4104152&chk=/K4etf

- ‘Practice based commissioning: promoting clinical engagement’, December 2004
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4098564&chk=uBbP%2Bg

- ‘NHS in England: the operating framework for 2006/07’, January 2006
www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4127249&chk=%2BnBex5

- The White Paper, ‘Our health, our care, our say: a new directions for community services’, January 2006
www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXIecj

APPENDIX 2

TOWARDS PRACTICE BASED COMMISSIONING DES

SAMPLE PRACTICE PLAN

Practices should read this in conjunction with the 'Focus on the Towards practice based commissioning DES' guidance note and in particular, section 5, which sets the context for the sample plan.

1 This document sets out **High Hill Surgery's practice plan** for implementing the 'Towards practice based commissioning' (TPBC) DES in 2006-07. [This is a joint plan with 2 other local practices, Lower and Middle Hill Surgeries.]

2 The **clinical lead** for this TPBC DES plan is Dr Khiani and administrative/management support will be provided by Mrs Redwood, practice manger. [The practice clinical leads in Lower and Middle Hill Surgeries are Drs James and Chou respectively].

3 The **scope of activity** to be undertaken [by each practice] is as follows:

3.i Referral analysis:

The practice will keep a record of referrals at a practice and GP-specific level for analysis and audit. A spreadsheet of individual GP specific referral rates will be circulated to all GPs on a monthly basis.

Validating reported hospital activity via random sampling or by targeting high cost interventions. The level of this will be limited via the resource limit of the DES, although the practice will be prepared to increase the level of validation if funded to do so.

The GPs in the practice will meet on a quarterly basis to discuss referral patterns at practice and GP-specific level. Areas of educational need for individual GPs will be identified, endeavouring to address this via individual professional development.

3.ii Where acceptable to the patient being referred and deemed clinically appropriate by the referring GP, the practice will partake in the various PCT-led service-redesign and demand-management initiatives in place, and those in development, including the various GPwSI services, adopting the PCT care pathways and prescribing guidelines.

3.iii The practice will focus on two specialties in 2006/07:

<u>Dermatology</u>

- To analyse and monitor both practice and GP-specific referral patterns regarding secondary care dermatology services with a view to ensuring that all such referrals are appropriate
- To manage (where appropriate) patients in primary care and specifically, by using the GPwSI service available
- To identify areas where new and effective care pathways could be developed in partnership with other practices and/or locality arrangements

The **agreed baseline** of referrals for dermatology is **X/month**.

[The agreed baseline of referrals for dermatology in Lower and Middle Hill surgeries is Y/month and Z/month respectively].

Ophthalmology

- To analyse and monitor both practice and GP-specific referral patterns regarding secondary care ophthalmology services with a view to ensuring that all such referrals are appropriate
- To manage (where appropriate) patients in primary care through existing services, specifically, by using the GPwSI service available
- To identify areas where new and effective care pathways could be developed in partnership with other practices and/or locality arrangements

The **agreed baseline** of referrals for ophthalmology is **A/month**.

[The agreed baseline of referrals for ophthalmology in Lower and Middle Hill surgeries is B/month and C/month respectively].

4 The **practice's objectives**, achievement of which will trigger payment of component 2 of the DES, are as follows:

4.i Demonstrating the practice's involvement in its stated objectives, in the form of ongoing written feedback to the PCT on a quarterly basis, and an annual summary.

4.ii An audit of the referral patterns to Dermatology and Ophthalmology, both at practice and practitioner level, with the expectation of a 2% reduction in referral from 2005/06 levels, or if not achieved, an explanation of the reasons why.

5 Details of practice engagement in undertaking DES activity

The practice will engage within the limit of the DES funding in the following ways:

Dr Khiani [, Dr James and Dr Chou] will aim to analyse the relevant practice information as appropriate, with a view to keeping all GPs and practice staff up to date with progress in the course of set/regular practice meetings. Mrs Redwood will support the work of Dr Khiani in so far as other, existing practice duties will allow. [Dr Khiani, Dr James and Dr Chou will aim to meet as appropriate.]

In order to enable Dr Khiani [, Dr James and Dr Chou] to carry out this work, it may be necessary to employ a locum from time to time and this will be funded with the DES monies.

6 Method by which quality of the redesigned services will be assured/demonstrated

Practices will need to discuss these arrangements with the PCT, but the method for quality assurance of practice-provided services should be no more onerous than the method for quality assurance of non-practice-provided services.

7 Information and monitoring requirements by PCT and practice

7.i The PCT will provide the [each] practice with the information detailed in paragraph 12 of the TPBC DES specification on a monthly basis.

7.ii The practice[s] will keep the PCT up to date on its [their] progress towards the agreed objectives on a quarterly basis. Where extra support is required in achieving the objectives, the practice[s] will inform and discuss its [their] needs with the PCT.

7.iii Peer-review within the practice[s] will take place on an informal basis as and when necessary.

8 General principles

High Hill [, Lower and Middle Hill] Surgery [Surgeries] is [are] committed to working towards improving the quality of care for its patients and where possible and appropriate, managing their care differently for the benefit of patients. The practice[s] is [are] willing to engage in and promote primary and community services by using service alternatives to those provided by secondary care where these are clinically appropriate and if such services are available locally. The relevant services that are currently available locally are as follows:
[insert examples]

The practice[s] is [are] also willing to engage with the PCT, providers and locality arrangements in planning and redesigning care pathways. In doing so, the practice will work with other relevant local stakeholders, especially community staff and social services in the development and implementation of their plans. Such involvement and input is above the remit of the DES and the practice or individual GPs will be expect commensurate remuneration for this additional workload.

The practice's aims through the TPBC DES will be consistent with and cognisant of the PCT's Local Delivery Plan.

9 Payment of DES funding

9.i. Component 1

Upon agreement between High [, Lower and Middle] Hill Surgery [Surgeries] and the PCT on this practice plan, payment of component 1 of the DES will be made to the [each] practice of 95p per registered patient based on the practice list size as at 1 April 2006.

9.ii. Component 2

[The arrangements below will apply to all practices involved in this joint plan. However achievement against the agreed objectives will be measured on an individual practice basis. Where one of the practices does not meet the objectives, this will not affect the other practices' entitlement to payment of component 2 where they have achieved the objectives.]

Where the practice **achieves its objectives, but does not free up resources** from the indicative budget, it will be paid component 2 (C2) of the DES (as per paragraphs 5, 7 and 20 of the DES specification) which amounts to 95p per registered patient based on the practice list size as at 1 April 2007.

Where practice activity results in **freed up resources** and these are **less than the equivalent of C2 and the practice has achieved its objectives**, the difference will be met by the PCT (as per paragraph 22 of the DES specification).

Where practice activity results in **freed up resources** and these are **less than the equivalent of C2 and the practice has not achieved its objectives**, the practice will be able to retain control of use of this resource.

Where practice activity results in **freed up resources** and these are **equal to the equivalent of C2**, whether or not the practice has achieved its objectives, the practice will be able to retain control of use of this resource.

Where practice activity results in **freed up resources** and these **exceed the equivalent value of C2**, the equivalent of C2 will be retained by the practice as a minimum. Regarding the freed up resource in excess of the equivalent of C2, 70% will be retained by the practice

either to go towards practice activity to ensure continuing achievement against the objectives set in the plan or for reinvestment in 'services for the benefit of patients locally' (as per Department of Health guidance). The PCT will retain the remaining 30%.

The PCT will release the agreed level of freed up resources to the practice in line with C2 arrangements so where possible by the end of April 2007 and at the latest, by the end of June 2007.

Any resource received by the practice up to and including the equivalent value of component 2 will be spent on practice activity to ensure continuing achievement against the objectives set in the plan (using the already agreed baseline of referrals and reduction threshold).

10 Indicative budget

The agreed indicative practice budget for High Hill Surgery for 2006-07 £Q, 000.

[The agreed indicative practice budget for Lower and Middle Hill Surgeries for 2006-07 is £R, 000 and £S, 000 respectively].

In order to calculate the level of freed up resources made/not made against this budget in 2006/07, the year end practice spend will be validated and agreed by both the practice and PCT.

11 Arbitration

In the event of any subsequent disagreement between the practice[s] and the PCT, the SHA will be requested to appoint a group to oversee and rule on the disagreement.