Practice Based Commissioning
Engaging Practices in Commissioning

October 2004
Practice Based Commissioning

**Introduction**

1. There is nothing new in the concept of Practice Based Commissioning. The 1998 white paper, *The New NHS*, stated that, “over time, the Government expects that … PCTs will extend indicative budgets to individual practices for the full range of services”. In June of this year, *The NHS Improvement Plan* indicated, “from April 2005, GP practices that wish to do so will be given indicative commissioning budgets”. This paper represents our latest thinking on a concept that has developed over several years.

2. The right to hold a budget and our willingness to see it as a first step towards the development of a sophisticated range of ways in which practices are involved in commissioning, are entirely consistent with the principle of greater devolution. The Department recognises the important role that GP practices play in commissioning services for their patients and local populations. Further, there are changes in the NHS that means that Practice Based Commissioning will assume greater importance in the system overall. These include:
   - The importance of patient choice as a driver for quality and empowerment. Practices will be able to secure a wider range of services, more responsive to patient needs and from which patients can choose. From 2008 the impact of free choice for elective procedures will change the dynamic further. Practices could then use their commissioning abilities to identify alternative provision, including in primary care, to give patients greater choice.
   - Payment by Results. This will mean that where practices are able to provide or commission services locally, as patients choose to use these services, the funds will follow.
   - Increasing importance of supporting people with long term conditions. Practices will be able to direct funding into packages of care that best meet the needs of patients.

3. By promoting practice level budgets for commissioning the Department envisages a number of ways in which patients will benefit:
   - A greater variety of services
   - From a greater number of providers and
   - In settings that are closer to home and more convenient to patients.
Further, there are ways that the NHS as a whole, and hence, the public will benefit from:

- More efficient use of services and
- Greater involvement of front line doctors and nurses in commissioning decisions.

4. There is good reason to be confident in these expectations because of the evidence supporting Practice Based Commissioning. This was recently summarised in the report on Practice Based Commissioning published by the Kings Fund and endorsed by the NHS Alliance and National Association for Primary Care.¹ Further, professional bodies have also indicated the need to engage clinicians in the commissioning process.²

5. GP practices are one of the main determinants of health care utilisation. Furthermore, with their central co-ordinating function, often they have a major influence on what care a patient receives and how a patient exercises choice. At present, with the possible exception of prescribing, all this comes without any need for practices to consider how they are using health service resources and often without the financial ability to secure better and more innovative services for their patients.

6. The same is true, albeit to a lesser extent, of other clinicians working in primary care. Community nurses for example, could hold an indicative budget for the benefit of their patients. This is discussed in the section on “How do we anticipate Practice Based Commissioning will develop over time?”

7. In summary, Practice Based Commissioning is a key part of improving the NHS. PCTs should encourage their practices to take on budgets for commissioning, indeed many are already doing so; the expectation is that every PCT will do so, maximising the potential of this policy as far as possible.

**Scope of our current thoughts**

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

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

This paper covers:

1. What do we mean by the right to an indicative budget?
2. How do we anticipate Practice Based Commissioning will develop?
3. Further issues
4. What the Department plans to do to support Practice Based Commissioning
5. Arbitration

1. *What do we mean by the right to an indicative budget?*

10. First, every practice must receive annual feedback on their use of health services. This already occurs for prescribing, and the best PCTs already do this for other aspects of care including scheduled care, unscheduled care, and diagnostics. However, it is clear that not every PCT is currently doing this, sometimes for paucity of information. The engagement of and sharing of timely information with individual practices is essential for effective commissioning and management of demand. Experience of PCTs who do feedback utilisation with their practices demonstrates how useful it is, confirming the considerable evidence base. The expectation is that the Healthcare Commission will see this is a key factor in assessing PCT competence in commissioning.
11. The basic right of a practice or a group of practices to have an indicative budget from April 2005 goes beyond this. Practices who wish to do so will receive a firm indicative budget from the PCT that they would use to directly manage the delivery of services (secondary and/or primary care) for their patients. Using the indicative budget, the practice or group of practices, with support from their PCT, would identify the health needs of the local population and in conjunction with local stakeholders, identify the appropriate services to be provided. Commissioning decisions would need to be made within the context of the agreed Local Delivery Plan (LDP).

12. The timing of when to take up the right to an indicative budget is clearly going to be determined by the ability of practices to have resources in place. Therefore, practices may claim that right at any time in year from April 2005, negotiating timing with the PCT who should support practices to start as soon as practicably possible.

13. The PCT would continue to hold the actual budget and would be responsible for the contracts with the secondary care provider. However, the practice or group of practices would make the commissioning decisions and be able to retain 50% of any savings. The remainder can be charged against reasonable practice management costs with the balance going to the PCT.

14. Initial costs to provide 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 their share of savings. Once established as commissioners, practices can continue to deduct management costs from the PCT share of savings directly. The PEC will oversee the use of management costs and make recommendations to the Board to ensure they are reasonable.

15. Resources freed up in the form of savings may only be used for patient services (with the exception of management costs as outlined above). The Professional Executive Committee will recommend approval for the spending of savings and management costs to the Board. In the case of dispute, the arbitration process will apply (see 39).

16. The scope of this budget is for an individual practice or group of practices to determine in the first instance. We anticipate that some will choose to start with a limited range of
services; for example high volume elective care, a specific long-term condition, or community services; other practice will choose to cover the entire budget. The practice and the PEC must agree, in advance, a mechanism for resolution should there be an adverse impact on other service use or budgets. However, over a three year period practices will move towards holding budgets covering the entire scope of health care provision with the exception of a few highly specialised services. They can however ask the PCT to commission particular services on their behalf (“block back”), but would remain responsible for the utilisation of those services and hence for any over or under spends. The scope does not include specialised services (see 22).

17. Where a practice requests the right to an indicative budget in April 2005, that budget will be based on historical spend for the year 2003/4 with the appropriate uplift. A weighted capitation budget will be calculated using the national formula (to follow in technical guidance). Practices (or groups of practices) will then move from a historical budget to a weighted capitation budget over three years.

18. Because this is an indicative budget, overspends will be met by the PCT. However, a practice that has claimed the right to hold an indicative budget will be expected to balance that budget over a three-year cycle. In particular, overspends in any one year should be offset by savings in another. If they are unable to balance their budget over three years, then they will forfeit the right to hold an indicative budget except in exceptional circumstances. These might include an unusual problem with high cost cases, or the practice might demonstrate that they are approaching a balanced budget and have a robust recovery plan in place.

19. In exceptional circumstances, where practices have increasing over spends and are unable to either justify this on an unusual case mix, and/ or do not have a coherent strategy for recovery, then the PCT, on the advice of the PEC, may refer the practice or group of practices to arbitration to determine whether they should continue to hold an indicative budget.

20. Since overspends are being met by the PCT we are not planning a risk limitation scheme, but practices could pool risks with others as described below (see 32). This would be up to
the practice to organise with others. The PCT would play a key role in facilitating such scheme.

21. Summary of the rights a practice can expect

<table>
<thead>
<tr>
<th>What can practices that claim a right to hold an indicative budget expect?</th>
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<tbody>
<tr>
<td><strong>Savings</strong></td>
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<tr>
<td>% to be retained by practice</td>
</tr>
<tr>
<td><strong>Overspend</strong></td>
</tr>
<tr>
<td>If there is a an overspend over 3 years practice forfeits the right except in exceptional circumstances (unusual case mix) or if showing a definite trend towards budgetary balance with robust recovery plan</td>
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<tr>
<td><strong>Budget</strong></td>
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<tr>
<td><strong>Setting</strong></td>
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<tr>
<td><strong>Resource and Management Costs</strong></td>
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22. Commissioning for specialised services is not included in the scope of the practice’s indicative budget. These are services provided in relatively few specialist centres to catchment populations of more than a million people covering several PCTs. The issue was covered by Guidance on Commissioning Arrangements for Specialised Services issued in March 2003 and the conditions are listed in the Specialised Services National Definition Set. ³

2. How do we anticipate Practice Based Commissioning will develop over time?

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

³ http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/fs/en
range to include all aspects of health care. We would like to further emphasise, practices should not need to exercise their right because good PCTs will be promoting Practice Based Commissioning.

24. There are many compelling reasons for PCTs to encourage practices to come together in localities to commission as a group. This will allow division of labour between practices, the ability to commission services they might not otherwise be able to (e.g. employ a specialist nurse), and share risks. Experience has shown that the best size of commissioning unit depends on what is being commissioned. There is no one correct size for commissioning. Therefore, we anticipate that some services will be commissioned by individual practices (even quite small ones), some by groups of practices, and some may still be commissioned by the PCT, or increasingly by a group of PCTs. In the same way that we are encouraging a multitude of providers so this initiative will develop a multitude of commissioners.

25. One of the strengths of Practice Based Commissioning is that it brings the decision making process closer to communities. We would like to see practices explore ways to engage their patients and local communities in the commissioning process. We anticipate that PCTs will both encourage and support practices in this process. As these informal models of local patient and public involvement develop, the NHS as a whole can learn from them.

26. GP practices should be able to demonstrate that all relevant front-line staff have been involved in commissioning decisions and the use of savings where appropriate. This will be particularly relevant for community nursing teams with regard to long-term care.

27. We have already indicated that groups other than practices could hold indicative commissioning budgets. For instance, community based nursing teams could hold an indicative budget, perhaps for vulnerable adults or for other groups. The legal mechanism for this is through PMS contractual frameworks.

28. We cannot, and do not expect to have covered all the ways in which practices and PCTs will develop Practice Based Commissioning. Indeed, innovation would not be innovation
if it were known in advance! We plan to learn from how Practice Based Commissioning evolves over time and will feed the best examples back to the NHS.

29. As practice levels budgets develop there are only three areas we wish to reinforce. First, savings must be used for developing or providing services for patients. Practices should outline arrangements for what they intend savings to be used at the start of each financial period (depending on when the practice starts to hold a budget). The Professional Executive Committee should recommend for the use of savings to the Board. However, in the majority of cases where PCTs and practices are working collaboratively to develop Practice Based Commissioning we would like to see the development of locally appropriate mechanisms for deciding how savings are used. We believe that sharing provides incentives for both practice and PCT; what is certain is that savings must not be used for individual profit.

30. Second, we are quite clear that patients must still be able to exercise choice. This is especially so where practices are providing services themselves, patients should still be give a choice of other providers of that service and should not feel unduly pressurised to choose the practice as provider. PCTs should be responsible for performance managing this. We expect the SHA to keep an overview of this situation.

31. Finally, the quality of new services commissioned or provided by practices must be assured. Therefore, PCTs will have a role in ensuring that proper clinical governance procedures and appropriate standards in respect of the services provided or commissioned by their constituent practices are in place.

3. **Further issues**

There are a number of issues that practices and PCTs should need to be aware of and that will be covered in greater detail in technical guidance due out early in 2005. However, PCTs and practices could come to agreement now.

*Risk and overspend/underspend*

32. Smaller commissioners of care are more exposed to risk from random fluctuations in activity. This means they are more likely to overspend (or underspend) through no fault of their own. We suggest that practices work together, with support from their PCT, to create a risk pool that they would manage. Specific criteria for accessing the pool should be
agreed by the practices. At the end of the year, practices that have overspent and fall in the
agreed criteria, could access the pool. This would mean that overspending practices would
have to justify their budgetary problems to their peers. Other mechanisms for pooling risk
are likely to develop and we might learn from them.

Moving from a historical to a capitation based budget

33. There are many benefits of moving from a historical budget to a weighted capitation based
one. These include the ability to increase the equitable distribution of resources and to
increase incentives on practices to make best use of resources. Continuing with historic
based budgets also acts a disincentive to practices who are below capitation; the
opportunity for them to innovate or make savings may be limited. The speed at which
practices move from a historical budget to a weighted capitation based budget should be
agreed locally. Moving too fast will be a strong disincentive for those over capitation
budget, whilst moving slowly might be seen as unfair to those under capitation budget.
The practices and PCT need to agree on a fair rate of change, generally one that allows
scope for those over and under capitation to make savings each year. If agreement on the
pace of change cannot be found, then practices should move to a weighted capitation
budget over three years.

4. What the Department plans to do to support Practice Based Commissioning

IT support

34. Many PCTs have developed sophisticated software to support the flow and analysis of
utilisation data. Some PCTs have indicated to us that sharing this software would be
helpful to practices and PCTs. We will commission a piece of work nationally to provide
such software for all PCTs and practices which will be in place early in 2005 to allow
practices and PCTs to start to determine budgets.

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

Capability building

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

37. As we have already indicated, we shall commission a piece of work to determine formulae to help practices and PCTs set weighted capitation budgets for total and expected partial budgets. Except in the case of a practice exercising its right to an indicative budget where these formulae must be applied as outlined above, they are meant as a guide. Again, where locally determined budgets appear to be working well they will be shared with the NHS.

**Learning**

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

**Arbitration**

39. We do not want a complex and bureaucratic arbitration system. In the case of dispute, for instance if a practice or groups of practices feel that their PCT is delaying their ability to start holding an indicative budget (paragraph 12), there is disagreement about the use of savings (paragraph 15), or escalating overspends (paragraph 19), the SHA will be asked to arbitrate. The SHA arbitration system will be led by a GP, specifically appointed by the SHA. Ideally the GP will have previous experience or knowledge of health care commissioning.

**What next?**

40. There is little time to lose. Payment by Results is already a reality for Foundation Trusts and begins to cover other Acute Trusts from April 2005. Patient Choice is an increasing reality and record investment in the NHS means that the scope for innovation is enormous. We are road testing the thoughts contained in this paper with the NHS. PCTs and Practices should start a dialogue now. SHAs should be facilitating those discussions, helping sharing of best practice across the health authority area.