Early lessons in implementing practice based commissioning

Key areas to focus on for success and key questions for primary care trusts’ boards to consider
Practice based commissioning is a key reform for the National Health Service (NHS). It is an important focus of the Audit Commission’s local audit work and our national work on financial management in the NHS. This booklet is the first in a series of products that the Audit Commission intends to produce on practice based commissioning to support and monitor implementation. Drawing on evidence from those primary care trusts (PCTs) which are furthest ahead, it identifies the key areas that PCTs and practices should be focusing on in the early stages of implementation and sets the scene for a fuller national report on practice based commissioning, to be published in early 2007.
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Introduction

Practice based commissioning

1. The introduction of practice based commissioning in the NHS heralds a major change in the commissioning landscape, one which is critical to the NHS reform programme.

2. Practice based commissioning entitles practices and other groups of primary care clinicians to hold an indicative budget for commissioning health services on behalf of their patients. It is similar in concept to the General Practice (GP) Fundholding and Total Purchasing Pilots initiatives in 1990s, which sought to devolve commissioning decisions to the front line. Primary care trusts

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I This includes secondary care (elective and non-elective admissions, day cases, outpatient contacts, diagnostic tests and procedures), prescribing, community and mental health services, and other primary care.

Early lessons in implementing practice based commissioning
(PCTs) continue to be legally responsible for finances and contracting with providers, for the overall commissioning strategy and for implementation of practice based commissioning. However, GP practices and other groups of primary care professionals will be incentivised to commission services on behalf of their patients; to manage referrals; and to redesign services locally in a way that is more cost-effective and convenient for patients.

3 Savings that are generated, for example by reducing hospital admissions through effective chronic disease management, can be reinvested by practices. This might involve expanding the range of services provided in primary care to deliver higher-quality or more convenient services at a lower cost. It is a counterweight to payment by results which encourages hospitals to increase their activity (as well as their efficiency).

4 Practice based commissioning provides the primary care sector with an important opportunity to drive through significant
improvements in the commissioning of secondary care services for patients, and develop a truly primary care led service. It is also an opportunity to make better use of resources. Practices account for more than 80 per cent of NHS patient contacts and, directly or indirectly, commit the bulk of NHS resources by prescribing, treating and referring patients to other clinicians.¹

Challenges

Practice based commissioning presents many opportunities but implementation brings significant challenges. It will not be easy to engage practices, establish the necessary infrastructure including information and financial management systems, and to redesign services in a way that is cost-effective and leads to positive and real change. In addition, not all PCTs or practices necessarily have the capacity to operate in this environment. PCT reconfiguration and

the financial difficulties that many PCTs are facing further add to the challenge this year.

6 There are also risks associated with the move to practice based commissioning, if it is not managed well. These include:

- Exacerbating **financial pressure** at PCT level – for example, through increasing management costs or ongoing difficulties managing demand for acute sector services.

- **Widening inequalities** of provision and access between areas, as well as fragmentation in service provision, where some commissioners are more successful than others.

- **Delivering poor value for money overall** if practices are not successful in managing demand and reducing hospital activity and if new services developed in primary care settings are not cost-effective.
• Potential **conflicts of interest** with practices acting as both commissioners and providers of services, which may impact negatively on both financial and quality outcomes.

7 Practices play a central role in overcoming these challenges and managing the risks. However, as the organisations responsible for implementation and strategic commissioning, it is PCTs, with the support of their strategic health authorities (SHAs), that need to ensure that practice based commissioning is implemented and managed effectively.
Implementing practice based commissioning

8 Practice based commissioning is a primary care led initiative. Its success rests on the engagement and participation of practices. However PCTs are expected to make arrangements for all practices in England to take part in practice based commissioning by December 2006 (15 months earlier than originally envisaged). This requires that all practices are receiving information on their clinical and financial activity, have an indicative budget covering an agreed scope of services, and are receiving support from the PCT, including the offer of an incentive payment, either locally agreed or through the Directed Enhanced Service (DES) scheme. Governance and accountability arrangements also need to be agreed and in place. The main way the Department of Health (DH)

1 Department of Health, July 2005, Commissioning a Patient-led NHS.
will measure take-up of practice based commissioning is through the uptake of incentive payments. This may skew the national picture if not interpreted carefully, as the initial payment is made on the basis of the practice signing up, whereas genuine engagement requires practices to be actively managing indicative budgets.

9 Practices have been entitled to an indicative commissioning budget since April 2005, but there has been considerable variation in approaches to implementation and levels of take-up. A few areas have already achieved 100 per cent take-up across their practices, while others have made little progress. Early estimates from the DH, based on data submitted in April 2006 by SHAs, suggest that around 20 per cent of PCTs are already achieving universal coverage. Trajectories indicate that they will achieve universal

1 The DH is also measuring the progress of the commitment for PCTs to put in place arrangements for practice based commissioning. This is measured by SHAs and records the number of PCTs achieving four criteria (set out in guidance issued in January 2006) to achieve universal coverage.
coverage of practice based commissioning by December this year.

10 However, PCTs in many areas have had difficulty engaging practices; this highlights the importance of incentivising practices. Anecdotal evidence suggests the majority of practices which have engaged to date were previously GP fundholders – that is practices already experienced and interested in performing a commissioning role. Greater effort will be required from now on to bring other practices on board.

11 PCTs and practices have adopted different approaches to implementation, which may also have influenced take-up. In some areas it is largely practice driven, while in others the PCT is leading the work or an SHA-wide approach has been adopted. Regardless of the approach, PCTs have a key role in change management and implementation, but the extent to which they are fulfilling it varies.

12 Overall, few PCTs have been able to look beyond the initial mechanics of engaging clinicians, giving practices the information
they need and setting budgets. There is a long way to go before practices are actively involved in strategic commissioning and more comprehensive service redesign and prevention.

13 The PCTs which are further ahead with the implementation of practice based commissioning tend to be those that:

- had developed local approaches similar to practice based commissioning prior to the introduction of the policy, recognising the importance of engaging clinicians in managing referrals and local service redesign to support effective commissioning;
- have a history of engagement and partnership working with primary care professionals who drive the agenda;
- are operating in comparatively simple commissioning environments, often rural-based with a smaller number of practices; and
- have a comparatively healthy financial position, without the added challenge of implementing practice based commissioning while trying to recover a budget deficit.
Priority areas

14 We visited four sites that have been relatively successful at implementing practice based commissioning (Craven, Harrogate and Rural District (CHRD) PCT, North Bradford and Airedale PCTs Partnership, South Hams and West Devon PCT and West Berkshire PCT) to explore the priority areas that PCTs and practices should focus on over the year. These PCTs all achieved high levels of take-up (from 70-100 per cent) relatively early on and are moving beyond the initial mechanics.

15 Drawing on findings from these sites, as well as local audit work on practice based commissioning, there are six key areas that PCTs in particular should be focusing on: strategy, clinical engagement, managing the finances, information, supporting practices and governance.

1 The approach implemented at North Bradford and Airedale PCTs Partnership was developed in North Bradford prior to its partnership working with Airedale PCT. The findings largely relate to North Bradford, although the approach has since been extended across the two PCTs.
Strategy

16 Having a clear strategy for the implementation of practice based commissioning is an obvious starting point. Critical elements include:

- a dedicated strategy and implementation plan for practice based commissioning jointly developed by practices and the PCT(s);
- a shared vision for practice based commissioning, underpinned by a common understanding of what it means;
- clear roles, responsibilities and expectations between the different parties;
- alignment of practice based commissioning initiatives with the overall commissioning strategy and the local delivery plan; and
- robust monitoring of progress against the plan to the professional executive committee (PEC) and the board.

17 How strategies are developed and used varies. Some PCTs have established a dedicated project team to manage implementation, others have integrated it into their overall
commissioning approach. In South Hams and West Devon PCT, for example, the strategy and supporting implementation plan was developed by a dedicated implementation team, operating as a subgroup of the PCT’s strategic commissioning group, answering directly to the PEC. Our audit work to date indicates that several PCTs follow this approach. The NHS Confederation and the National Association of Primary Care have developed an agreement for PCTs and practices to use, which covers the main aspects of implementation that need to be jointly addressed and resolved.

Elsewhere, objectives and approaches related to practice based commissioning are incorporated into the PCT’s overall commissioning strategy. While this supports an integrated approach, unless there is a clear implementation plan, there are likely to be difficulties in ensuring a clear and consistent understanding of practice based commissioning and in monitoring progress.

The agreement is available on the websites of both the NHS Confederation and the National Association of Primary Care.
19 Even in the most successful areas, there are still differences in understanding about what practice based commissioning means in practice – and in particular, suspicion among practices about the PCT’s agenda. Openness and transparency about respective agendas is critical in overcoming this.

20 Most importantly, the vision, implementation plan and supporting infrastructure should be jointly developed and owned by both PCTs, PECs and practices, and overseen by the PCT board. Approaches to achieving this include having GPs and practice managers proactively involved in the implementation team, and full engagement of the PEC.

21 Once the strategy and implementation plan are in place, PCTs need to establish robust arrangements for monitoring and measuring progress. It is relatively straightforward to monitor implementation against plan, tracking progress by each practice and regular reporting to the PEC and the board. However less progress has been made in monitoring outcomes, for example from service redesign. Few PCTs
are systematically assessing service redesign initiatives to ensure they are cost-effective, then measuring the outcomes of these initiatives to inform future planning. There is a tendency to assume that a primary care-based solution is more cost effective, which will not always be the case. For example, in some cases treating a patient in a practice or primary care setting will be more expensive than sending them to hospital. It is important that PCTs and practices properly assess the costs and benefits of new initiatives prior to implementation. Focusing on patients at high risk of avoidable hospitalisation, which is the approach taken in most areas, is obviously important. However, effective cost benefit analysis and monitoring of outcomes needs to become a priority if the benefits of practice based commissioning are to be realised. Involvement of patients and the public in discussions about clinical pathways, as well as genuine engagement of secondary care clinicians, help support this.
Clinical engagement

22 Practice based commissioning cannot work without the engagement of clinicians and yet this has proven a challenge in many parts of the NHS. Even the most advanced sites pointed to instances where practices had refused to engage in practice based commissioning. Three key factors are involved:

- **Incentives.** PCTs that have achieved high levels of take-up have set up early incentives schemes that ensure GPs are recompensed for their involvement. The introduction of the DES should go some way to addressing concerns about the lack of incentives in the short term, although where existing arrangements are already in place, these should be combined with DES payment, rather than replaced. In addition, agreeing arrangements for sharing savings with practices will be critical. Ensuring practices are appropriately incentivised needs to be an ongoing priority. Early consideration needs to be given to harmonising incentives following reconfiguration.
• **Scepticism** about PCT motives and practice based commissioning making a difference, often due to historically poor relations or financial difficulties at PCT level. Practice based commissioning may help address local financial difficulties, but this should not be the primary driver. PCTs should be clear and transparent about their financial position and work to engage practices in the issues and establish joint ownership of the solutions.

• **PCT leadership style.** It is difficult to achieve strong and supportive PCT leadership without either being overly controlling or too removed, particularly for PCTs that do not have a history of engaging effectively with primary care clinicians. The PCTs that have been more successful at engaging clinicians have tended to adopt a flexible leadership style – guiding, facilitating and supporting practices. They have also been looking ahead to how the approach they have developed locally will fit within the new PCT configuration and the steps that will need to be taken to harmonise the approaches.
Managing the finances

Practice based commissioning gives practices the opportunity to influence how resources are being used for their patients through devolving budgets to practice level. Setting and managing budgets and the associated financial risk at both practice and PCT level are both critical and challenging. PCTs should be focusing on the following key issues.

- **Coverage.** Although PCTs can help to identify priority areas (for example where referral rates and emergency admissions are high), the scope of indicative budgets is for practices to determine. Even among the leading implementers, practices were only interested in managing the budget for a limited range of services at this point. PCTs need to have a clear strategy in place now to meet the DH’s requirement that practice budgets cover the entire scope of health services over a three-year period.

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1 Excludes core General Medical Services/Personal Medical Services and specialised services commissioned regionally.
• **Budget setting methodology.** PCTs have a responsibility to ensure that resources are distributed to practices in a fair and transparent manner, which is understood by and acceptable to practices. Budgets are set largely on the basis of historical activity. But this approach favours high referrers and penalises GP practices that manage their referral and admission activity. PCTs have also found it problematic due to the reliability and availability of activity data and the affordability of secondary care activity in particular, which is priced on the basis of the national tariff under Payment by Results. Over time, PCTs and practices are expected to move to a ‘fair shares’ approach, based on population need. This is recognised on the ground as essential if the objectives of practice based commissioning are to be met. However, it will necessarily create winners and losers and getting all practices to buy into the new methodology and the pace of

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change will be a major challenge, particularly as early evidence points to some fairly substantial shifts in funding between practices. The fair shares approach is not yet in use among the leading implementers we visited and most had not set a timetable for implementation. The resource allocation formula issued by the DH is reported by early implementer PCTs to be difficult to implement. North Bradford and Airedale PCTs Partnership have explored a number of alternative approaches, using various indices including deprivation, and have decided to adopt a simple approach based on the number of patients on practice lists. Critically, PCTs need to maintain an open dialogue with practices about the new methodology and jointly agree a realistic approach. They should assess the implications of the new methodology as soon as possible, and engage practices in a discussion about likely budget variations, the reasons for this, and the validity of the methodology. We also recommend introducing a shadow ‘fair shares’ system, as South Hams and West Devon PCT has done.
Financial risk. All practices face considerable financial risk from, for example, unexpected activity volatility or high-cost patients – this is particularly true for smaller practices. This in turn creates risks for PCTs and their bottom line. To make this risk more manageable, PCTs can exclude high-cost patients and procedures from practices’ indicative budgets to limit overspends. They should also establish contingency pools to cover, for example, instances where practices fail to manage demand or experience a significant change in their list size. There are different ways to manage this reserve and incentivise practices to manage their own budgets. CHRD PCT considers those calls upon the reserve deemed avoidable as debts to the fund, with first call upon any freed up resources in the future. Penalties can be imposed on practices if avoidable overspends persist. Should any of the contingency fund remain at the end of the year, and the PCT’s financial situation allows, this is then passed on to practices. CHRD PCT has also adopted brokerage rules deployed by the SHA, whereby savings in-year from one practice
may be used to offset overspends elsewhere and are then made available in the following year. However, PCTs considering this approach need to take care that this does not act as a disincentive to practice engagement. In addition, PCTs need to have robust financial and information systems in place which enable them to monitor practice budgets. Trigger points to initiate discussions about significant variations against plan, particularly referral activity, and any action required to ensure that practices remain within budget, should be agreed with practices. In most PCTs, if a practice overspends within a given year they are required to plan how this will be recouped in the following year.

- **Savings.** The opportunity to use funds freed up through practice based commissioning (for example, through better referral management) to develop new services is an important incentive for practices, both to engage in practice based commissioning and to underspend. DH guidance states that practices should be entitled to at least 70 per cent of any freed
PCTs need to be clear how they intend to meet practice expectations in this area – a particular challenge for PCTs who may be faced with a choice between releasing savings to practices in line with guidance or the statutory duty of breaking even. At North Bradford and Airedale PCTs Partnership, practices are entitled to retain up to 70 per cent of savings that have been made via implementing seven high impact tasks, identified through performance against defined indicators and the level and extent of activities that practices have engaged in.


II (1) Providing services closer to patients – in house service development; (2) Improving the quality of referrals; (3) Improving outpatient follow-ups; (4) Case management of patients with complex/high needs; (5) Improving the quality of patient care through better use of pathology; (6) Monthly reviews of activity and cost; (7) Validation of activity/clinical information.
Information

24 For practice based commissioning to work, practices need timely and accurate information on patient activity and finances, particularly for secondary care services, to monitor and manage their budgets. PCTs have a responsibility to provide this information. Earlier this year the DH made an information template available to assist PCTs and to ensure that all practices receive information in a consistent format. There are a number of limitations with existing information systems at PCT level that can make this difficult. Not all PCTs receive timely and accurate information from secondary care providers, or have the requisite information systems to analyse it at
practice level. The introduction of the new Secondary User Service\(^I\) (originally due to be implemented in April 2006) is expected to address some of these issues, but this has been delayed.

25 The more advanced sites:

- Identified the arrangements for the provision and validation of secondary care activity data as a priority area early on and are continuing to invest in their information infrastructure. CHRD PCT, for example, has implemented the MIDAS\(^\text{II}\) information system from

\(^I\) The Secondary User Service (SUS) is part of the NHS Care Records initiative. It will provide pseudonymised patient-based data and information for purposes other than direct clinical care, including planning, commissioning and performance improvement. It is expected to address existing limitations around data quality and improve the reliability and consistency of data flows and reporting.

\(^\text{II}\) Middlesbrough PCT Information, Data and Statistics (MIDAS) – a browser-based statistical reporting system for practice based commissioning developed by Middlesbrough PCT.
the beginning of May 2006 to give practice based commissioners more in-depth information to support commissioning.

- Closely involved practices in the development of activity reporting formats to ensure that their requirements were met. While most use spreadsheet-based reports, many are developing their own, or purchasing, new IT systems to provide practices with online budgetary and activity information.

- Devoted staff resources to ensuring that secondary care activity data is reliable and robust, and credible to practices.

- Use information systematically to monitor referrals as part of demand management initiatives; help practices identify patients at high risk of admission in the forthcoming year so as to design appropriate support for these patients; and facilitate peer challenge at practice, locality and PCT level. North Bradford and Airedale PCTs Partnership and CHRD PCT are planning to take this one step further and incorporate national benchmarks of
referral activity in the activity data they provide to practices. Both also plan to provide comparative data on prevalence of particular conditions.

- Engage practices in validating secondary care activity data, for example, through checking data against their own records and participation in sample audits, to ensure accuracy of payments, to improve data quality and guard against potential gaming by secondary care providers to increase their income.

26 Even at the more advanced sites, information is still a challenge. Practices are concerned about the reliability of activity data, and have reservations about extending the scope of their indicative budgets while this is the case. They are further frustrated by the timeliness and quality of discharge summaries which are received from acute trusts, which affect their ability to monitor their patients and validate payments. Validation itself can be time-consuming, and it is important to adopt a cost-effective approach, supported by rigorous and automated monitoring by the PCT. In North Bradford
and Airedale PCTs Partnership, practice validation of activity is
carried out on an exception basis, where the data looks anomalous.

27 Information systems and arrangements to monitor data quality will
require particular attention during PCT reorganisation. Integrating
information systems is a difficult and time-consuming process and
PCTs should recognise the impact this may have on their ability to
provide data to practices, and develop contingency plans accordingly.

Supporting practices

28 PCTs have a vital role to play in supporting practices that have
engaged in practice based commissioning, through:

• helping to build capacity in practices, ensuring that they have
  the information and expertise they need;
• facilitating peer challenge of referral activity between practices;
• working with practices to redesign clinical pathways and secure
  the services that are required locally; and
• transferring local innovation into other areas.
Equally, PCTs need to provide alternative forms of challenge and support to practices that are unwilling or unable to adopt practice based commissioning.

29 To support practices effectively, PCTs must build capacity to manage and monitor implementation, devolve and monitor practice-level budgets and produce timely and accurate information for practices. Existing commissioning, finance and information functions need to be adjusted to this end. In addition, PCTs will also need to consider how support arrangements developed locally will fit within any new PCT configuration.

30 In more advanced PCTs:

- a priority has been developing budget monitoring information for practices, working closely with practices to ensure it is provided in a format that they understand;

- practices have been given support to build their capacity through, for example, workshops on budgets, activity
monitoring and writing practice plans. PCT-based staff had been nominated to work closely with practices, each having responsibility for specific geographical areas; and

- a form of management allowance had been agreed to provide financial support to practices from an early stage.

31 The majority of practices that had taken up an indicative budget were working together as localities or consortia for commissioning purposes. The benefits of working in this way and pooling expertise are starting to be realised in the form of relatively small, local pathway redesign projects and better demand management and activity monitoring. Groupings are likely to be most successful where they evolve organically to address local priorities and developments, with facilitation from the PCT. PCTs need to be prepared to manage and support this flexibly.

32 In addition to these support mechanisms, we have already highlighted the importance of covering management costs in
incentivising practices to take part in practice based commissioning. North Bradford and Airdale PCTs Partnership introduced a practice allowance early on to cover attendance at workshops, analysis of management information and protected time to plan and develop services. This was an important factor behind the 100 per cent take-up achieved by the PCT. South Hams and West Devon provided non-recurrent funding during 2005/06, but in the following year practice management costs will have first call on any savings realised by practices.

**Governance arrangements**

Practice based commissioning presents risks for both PCTs and practices. It adds complexity to the commissioning environment and requires sound governance and accountability arrangements. Arrangements should cover:

- the approval of practice plans (redesign, reinvestment of savings);
- managing the rules for and calls on contingency pools;
• identifying and utilising efficiency gains (savings); and
• conflict of interest, where practices hold both provider and commissioner roles.

34 The more advanced implementers have developed arrangements in conjunction with practices, on the basis of guidelines set by the DH. They have established an important role for the PEC, which considers all service modernisation and commissioning decisions before making recommendations to the board for approval. The board ensures that practice plans, including plans for using efficiency gains, align with the PCT’s strategic framework and contribute to national and local targets.

35 Separation of duties, clear specification of quality standards and transparent pricing are recognised by the early implementer PCTs as particularly important in managing the potential conflict of interest between provider/commissioner roles at practice level. However, not all had developed and formalised specific processes
to address this risk. North Bradford and Airedale PCTs Partnership permits practices to extend their role as providers and move funds to match new patient pathways. A main principle being to develop services locally that are safe and cost effective. Through a service level agreement between the PCT and practices, the purchase of any services (either directly provided by the practice or commissioned via an alternative provider) would be required to demonstrate value for money and meet robust clinical governance measures. These measures are currently in development.
Questions for PCT board members

Strategy

• Do we have a dedicated strategy, setting out our vision and the benefits we plan to achieve at both PCT and practice level, and an implementation plan for practice based commissioning? Has this been developed jointly with practices?

• Have we set out clearly the respective roles, responsibilities and expectations of the PCT, PEC and practices in implementing practice based commissioning and communicated these?

• Do we have arrangements in place to ensure that practice based commissioning initiatives align with the PCT’s overall commissioning strategy and the local delivery plan?
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- Have we established how we will monitor practice based commissioning, including outcomes, and demonstrate value for money?
- Is progress against our plan being regularly reported to the PEC and the board?
- Have we identified the impact of PCT reorganisation on the implementation of practice based commissioning and identified actions which need to be taken?

Clinical engagement

- Have we ensured that practices are appropriately incentivised to achieve a high level of take-up?
- If we are planning to combine the new Directed Enhanced Service with our own pre-existing local arrangements, does this result in a reduced incentive and will this have a discouraging effect on practices?
• How are we engaging practices in the PCT agenda (including financial position) to establish jointly owned strategies and solutions?

• Have we established an appropriate leadership style for the implementation of practice based commissioning?

Managing the finances

• Do we have plans in place to ensure that practice budgets will cover the entire scope of health care services (with the exception of core GMS/PMS services and specialised services commissioned regionally) within three years?

• Do we have arrangements in place to devolve indicative budgets?

• Do we have a budget setting methodology that is understood by and acceptable to practices?
• Do we have a robust plan and timetable to achieve ‘fair shares’ budgets by 2008, and are we successfully managing the expectations of practices regarding the achievement of this?
• Are we successfully managing the expectations of practices regarding the achievement of ‘fair shares’ budgets and retaining savings?
• Have we agreed trigger points, such as referral ceiling and floors, to support budget monitoring and demand management?
• Have we established systems for shared accountability for overspend across the PCT and practices?
• Have we established a risk pool/contingency fund? If we have, have criteria for its utilisation been agreed?
• Have we made robust arrangements for identifying and utilising efficiency gains?
Information

• Have we put arrangements in place to ensure data quality and are we engaging practices in validating data?

• Are we ensuring that accurate data and information is being provided to practices on a regular and timely basis to operate practice based commissioning efficiently and effectively?

• Has the format of the activity information that we provide been developed with and agreed by practices? Does it suit their needs?

• Are we meeting the information requirements set out in *Practice Based Commissioning: Achieving Universal Coverage*?

• Are we encouraging practices to monitor services for which budgets are not devolved to guard against perverse incentives?

• Have we incorporated into the information we provide to practices national benchmarks of referral activity and comparative data on prevalence of particular conditions?
• Have we considered the impact of reorganisation on information systems and data quality and developed a contingency plan to cover any disruption?

Supporting practices

• Have we assessed the potential need for structural change and organisational development to support implementation of practice based commissioning?

• Have we carried out work to ensure that the right infrastructure and skills are in place at practice and PCT level to effectively commission, including clear guidance and relevant support where practices require it?

• Have we engaged with GPs to determine the appropriate population clusters or localities for commissioning various services?

• Are we providing the necessary support to facilitate peer challenge of referral activity between practices?
• Are we supporting practices with the redesign of clinical pathways and to secure services that are required locally?
• How are we facilitating the transfer of local innovation across areas?
• Are we providing challenge and support to practices that are unwilling or unable to adopt practice based commissioning?

Governance arrangements
• Do we have robust arrangements in place to govern the approval of practice plans?
• Are we ensuring that new care pathway schemes are going to enable practices and localities to comply with national and local initiatives and targets?
• Have we established arrangements to safeguard against potential conflicts of interest for practices holding both provider and commissioner roles?
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