



## PRACTICE BASED COMMISSIONING FRAMEWORK

2009/10

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## PBC FRAMEWORK 2009/10

### CONTENTS

Section		Page
1	GUIDING PRINCIPLES FOR 2009/10	4
2	PRACTICE BASED COMMISSIONING LOCAL ENHANCED SERVICE	5
	• LES1	5
	• LES2	6
	• FREED UP RESOURCES	7
3	BUDGET SETTING AND FINANCIAL MANAGEMENT FOR 2009/10	7
	• SCOPE OF PBC BUDGETS	7
	• BUDGET SETTING METHODOLOGY	7
	• RISK POOL – HIGH COST PROCEDURES	9
	• FREED UP RESOURCE	10
4	PROVISION OF INFORMATION	12
5	GOVERNANCE	13
	• CLINICAL AND CORPORATE GOVERNANCE WITHIN SOMERSET PRIMARY CARE TRUST	13
	• PBC COMMISSIONING PLANS	14
	• CRITERIA FOR ASSESSING COMMISSIONING PLANS	15
6	PROCUREMENT GUIDELINES	16
	• ANY WILLING PROVIDER OF ELECTIVE SERVICES	16
	• ENSURING VALUE FOR MONEY	16
	• WHEN TENDERING IS REQUIRED	17
	• PAYMENT FOR SERVICES PROVIDED TO A WIDER POPULATION THAN THAT OF A SINGLE PRACTICE	17
	• SERVICES OUTSIDE THE SCOPE OF PAYMENT BY RESULTS	18
7	CARE PATHWAY MANAGEMENT	19
8	PBC ACCOUNTABILITY FRAMEWORK	20
	• RESPONSIBILITIES UNDER PBC	20
	• DEMONSTRATING ACCOUNTABILITY	20
	• ACCOUNTABILITY TO PATIENTS AND THE WIDER PUBLIC	21
	• FINANCIAL ACCOUNTABILITY	21
	• CLINICAL AND PROFESSIONAL ACCOUNTABILITY	21

	• ARBITRATION	22
9	PARTNERSHIP WORKING	23
10	PBC INDICATORS	24
11	EQUALITY AND DIVERSITY	25
APPENDIX A	PRACTICE PBC PLAN TEMPLATE	26
APPENDIX B	ALLOCATION OF FREED UP RESOURCES TO PRACTICES	27
APPENDIX C	COMMISSIONING PLANS	28

# SOMERSET PRIMARY CARE TRUST

## PBC FRAMEWORK 2009/10

### 1 GUIDING PRINCIPLES FOR 2009/10

- 1.1 Practice based commissioning (PBC) continues to be an integral part of Health Reform in Somerset. Since 2006/07 progress has been made in creating the environment and infrastructure to take forward the future development of PBC. It is proposed that PBC will focus on six key priorities during 2009/10.
- 1.2 This framework provides the operating guidelines for PBC within Somerset for 2009/10 and is based on the latest Department of Health Guidance issued in March 2009 and in December 2007. The delivery of PBC in Somerset is closely linked to the NHS Somerset becoming a 'World Class Commissioner'.
- 1.3 NHS Somerset is committed to the continued development of PBC and supporting primary care clinicians to deliver improved patient care through implementing local commissioning plans.
- 1.4 It is proposed that PBC will focus on the following priorities during 2009/10:
  - unscheduled care and avoiding emergency admissions
    - \* using a practice based approach to identify and manage patients at high risk of emergency admissions that links effectively with Community Nursing and social care teams in an integrated approach
    - \* implementation of plans developed and agreed during 2007/08 to improve patient care and provide the financial headroom to develop more local services.
  - managing prescribing to ensure clinical and cost effectiveness
  - planned care and reviewing referrals to outpatients
  - supporting the implementation of the model of care for adults with diabetes
  - developing Mental Health Services particularly in Primary Care for people with complex but not necessarily severe and enduring, mental health problems and for people leaving specialist mental health services
  - Developing commissioning plans for implementation at a local level which meet the needs of the practice population.
- 1.5 This document has been developed jointly by NHS Somerset and WyvernHealth.Com (WH.C) in consultation with the LMC.

## 2 PRACTICE BASED COMMISSIONING LOCAL ENHANCED SERVICE

2.1 To encourage practices to continue to engage in PBC, NHS Somerset will offer a Local Enhanced Service (LES) for PBC in 2009/10. In line with other GP payments paid in advance the LES will be subject to post payment verification.

### 2.2 LES1

This will involve a payment to practices equivalent to £0.82 per registered patient, as at 1 April 2009 with an additional 41p per patient paid in July 2010. The payment of £1.23 per patient payment is to provide resource for the practice (and WH.C) to implement the key areas of the Local Enhanced Service.

- Avoiding emergency admissions and reviewing elective activity
- Implementing the adult diabetes pathways and supporting the implementation of the EH&WB Service
- Develop local action plans to implement commissioning plans locally
- Managing prescribing to ensure clinical and cost effectiveness

This will be divided into three equal components of 41p:

- Engagement in PBC – this will require practices to sign up to WH.C. Practices are expected to send a representative to attend at least three WH.C meetings during 2009/10 and nominate a named individual in the practice to be the PBC Lead. By the practice committing to be a member of WH.C there is an expectation that the practice would support changes to care pathways and engage in a small amount of data validation.
- Development of PBC practice plans – this payment is to recognise the work that practices need to do to implement changes in working practices to support the new care pathways developed as part of practice based commissioning. Practices will be provided with a template which will be adapted to local circumstances. Each practice and their PBC Lead will be supported by WH.C in the preparation of plans to implement PBC schemes including prescribing (template plan at Appendix A).
- Incentive payment – this is a payment to practices for successfully achieving improvements in the delivery of care to their patients by using the PBC schemes and delivering their PBC plan and thus the PBC priorities. This payment is split into two components; up to 21p for achievement in three priority areas of the practice plan and a further 20p for demonstrating improved utilisation of emergency avoidance schemes.
- All schemes are and will be in line with the guidance that ‘GPs must only refer patients to the service that they, in their professional opinion, believe is most appropriate for that patient’s condition, whether that be secondary care or other ‘care closer to home’ and / or ‘in house’ services<sup>1</sup>.

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<sup>1</sup> Paragraphs 74 & 75 of the GMC guidelines ‘Good Medical Practice’ 2006

### 2.3 **LES2**

The NHS Somerset recognises that there is still considerable uncertainty amongst practices about the extent to which freed up resources can be measured. Therefore the NHS Somerset is offering freed up resources equivalent to 75p per patient dependent on achieving the objectives within the Local Enhanced Service. This is invested by the practice in patient services in accordance with 3.23 below.

### 2.4 The proposed objectives to be used in assessing achievement of paying LES2 are:-

- emergency admission avoidance (25p per patient)
  - \* using Somerset Primary Link for over 75% of appropriate GP urgent daytime (8am to 6.30pm) admissions
  - \* demonstrating use of the RISC tool to identify 'at risk' patients and working with community teams to develop patient management plans.
- effective management of elective care (25p per patient)
  - \* demonstrate that practices are reviewing elective referrals using PBC information tools
  - \* undertake case note reviews of referrals to two specific specialties identified by the practice and to propose action plans
- To work to improve safe, clinical and cost effective prescribing (25 per patient).
  - \* Practices will be encouraged and facilitated to review all areas of prescribing and medicines management as this will lead to release of freed up prescribing resources for reinvestment.
  - \* Practices will be monitored on all quality markers (see below) but payments will be made based on performance of their 'best five' quality markers at the year end.
  - \* Payment of 5p per patient will be made for achievement of each target achieved up to a maximum of five (ie total max payment of 25p per patient). There will be no 'staged' payments for performance achieved below targets.
  - \* End of year (09/10) performance will be assessed by calculating the monthly average from the Quarter 4 (Jan 2010 – Mar 2010) data unless otherwise specified.

#### **1. Generic Simvastatin + Pravastatin as % of all statins – target 80% or**

- For practices with end March 2009 level between 70% – 77.4%:  
an improvement (increase) of 2.5% **or**
- For practices with end March 2009 level <70%:  
an improvement (increase) of 5%.

#### **2. Generic Alendronic acid 70mg as % of bisphosphonates + strontium – target 80% or**

- For practices with end March 2009 level between 70% – 77.4%

an improvement (increase) of 2.5% **or**  
➤ For practices with a March 2009 % level <70%:  
an improvement (increase) of 5% .

**3. ACEIs as % ACEIs + ARBs - target 80% or**

➤ For practices with end March 2009 level 70% – 77.4%:  
an improvement (increase) of 2.5% **or**  
➤ For practices with end March 2009 level <70%:  
an improvement (increase) of 5%.

**4. % Generic savings - target 0.3% or below or**

➤ For practices with Jan 2009 – Mar 2009 level > 0.3%:  
an improvement (decrease) of 0.25%.

**5. High dose formulary PPIs as % of Total PPIs - target < 20% or**

➤ For practices with end March 2009 level 22.4% – 30%:  
an improvement (decrease) of 2.5% **or**  
➤ For practices with end March 2009 level >30%:  
an improvement (decrease) of 5%

(for the purposes of this marker, high dose formulary PPIs = lansoprazole 30mg and omeprazole 40mg)

**6. Hypnotics (BNF 4.1.1) (excludes anxiolytics eg diazepam)**

Target = ADQ / STAR-PU <2.0

**7. Co-proxamol**

➤ Measured as No increase in co-proxamol items (Q4 09/10) compared to (Q4 08/09)

(practices are reminded that for every patient prescribed co-proxamol there should be a minimum of an annual recorded medication review which includes discussion to a licensed analgesic)

**8. Approved repeat dispensing (using batch prescriptions)**

Target = 2% of all prescriptions as batch prescriptions by April 2010

(For dispensing practices this will be 2% of their eligible non dispensing patients prescriptions)

2.5 Calculations to finalise the position in respect of the LES2 will be made in July 2010.

### **3 BUDGET SETTING AND FINANCIAL MANAGEMENT FOR 2009/10**

- 3.1 Indicative budgets will be calculated at practice level and be provided to practices by the end of May 2009.

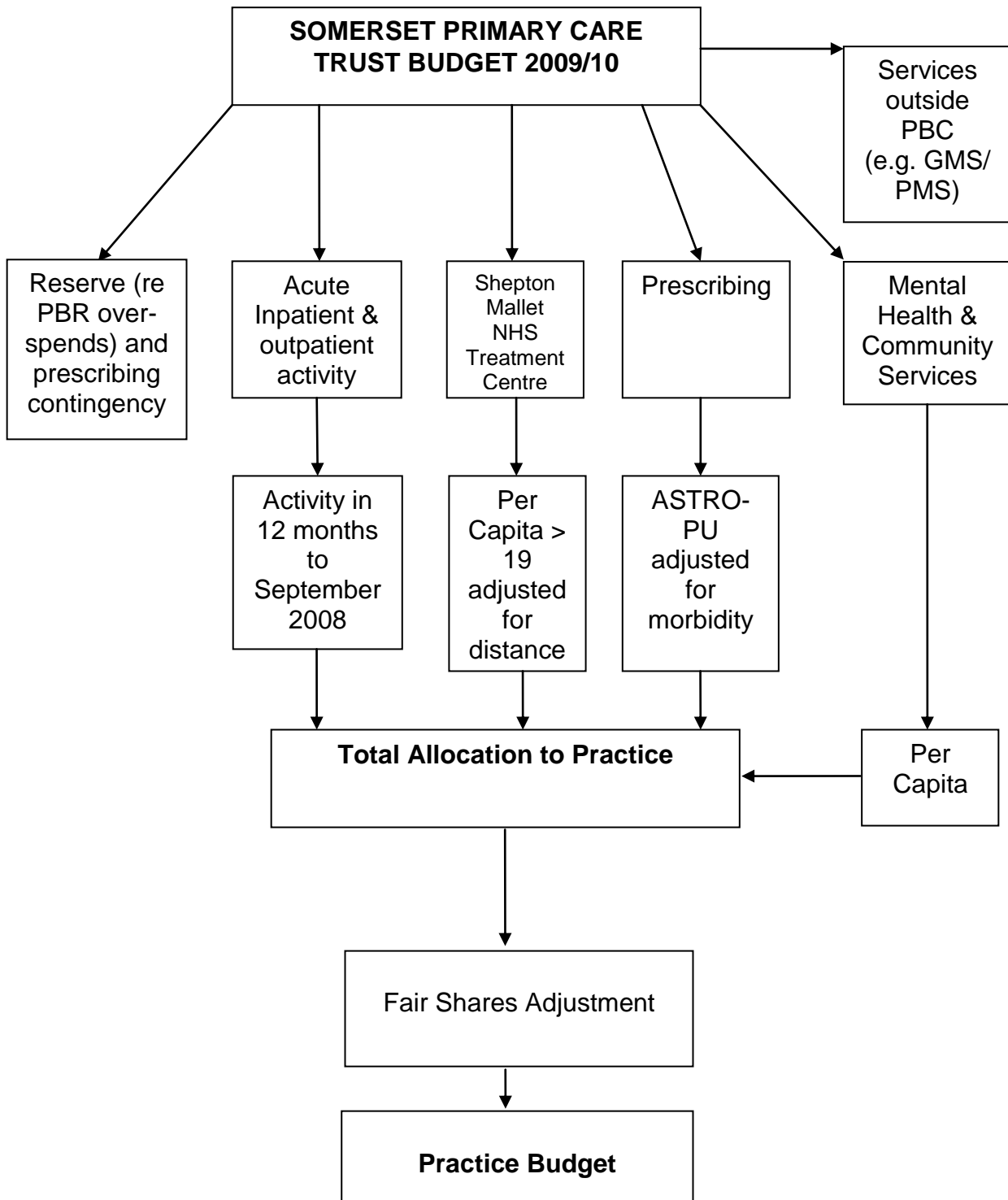
#### **Scope of PBC Budgets**

- 3.2 PBC indicative budgets will cover, as a minimum all services, subject to the Payment by Results (PbR) tariff, Shepton Mallet NHS Treatment Centre, community hospital outpatient activity and prescribing.
- 3.3 Payment by results covers inpatient activity (day cases, elective and emergency inpatients), outpatients and A&E activity within secondary care. The value of Practice Based Commissioning budgets will be based upon the national Payment by Results rules and will not use any financial envelopes that the NHS Somerset may agree with individual Trusts. The NHS Somerset does not yet receive robust data on A&E activity and so this area of activity has not been included in the PBC budgets.
- 3.4 During 2009/10 the NHS Somerset will work with practices to provide further information on mental health and community services. The starting point will be the total cost of these services attributed between practices on a per capita basis. More refined information will be developed during 2009/10.
- 3.5 National exclusions from PBC include national screening programmes, specialised services, services commissioned regionally and nationally and core GMS/PMS services (including GP out of hours services).

#### **Budget Setting Methodology**

- 3.6 The budget setting methodology will be developed jointly with practices through the PBC LIT, Somerset LMC and WyvernHealth.Com. The key elements of this process are set out on the following page:

**METHODOLOGY FOR SETTING PRACTICE BASED COMMISSIONING BUDGETS 2009/10**



- 3.7 The NHS Somerset will calculate a Fair Shares budget using the Department of Health toolkit issued in March 2009 using the same elements as the indicative budget. This information will be shared with practices. Further national work is being undertaken on the formula and it is not anticipated that any practice would be moved more than 1% towards a fair share – and for most practices within 10% of the Fair Share no adjustment will be made. A review undertaken for the NHS Somerset by United Health UK in November 2008 of the allocation to practices concluded no need to change the current arrangements.
- 3.8 The Payment by Results activity within the budgets will be costed using the national rules.
- 3.9 The Shepton Mallet NHS Treatment Centre component of the budget will be a block charge for activity up to the practice share. Over and above the practice share of the contract activity will remain free of charge until the overall Somerset contract is fully utilised – at which point practices using more than their share of the total contract will be charged a share of the additional cost. This share of the additional cost will not exceed the value of activity under the Payment by Results rules.

#### **Risk Pool – High Cost Procedures**

- 3.10 As part of the budget setting processes a risk pool for high cost procedures will be formed. It will be available to share the cost of procedures or hospital episodes in excess of £20,000.
- 3.11 The excess cost over £20,000 for any procedure or hospital stay may be charged to the risk pool; however, practices are expected to still retain commissioning responsibilities for these patients. Practices cannot aggregate different procedures on the same patient to reach the financial threshold.
- 3.12 The NHS Somerset will continue to hold a High Cost, Low Volume reserve for procedures costing over £40,000.
- 3.13 The under or over spend on the risk pool for high cost procedures will be distributed amongst practices at the year end. In-year monitoring information will be provided to practices.

## **Freed Up Resources (FUR)**

- 3.14 For 2009/10 the practice budgets for prescribing and PBR are managed separately and any underspends on these budgets are accounted for differently as outlined below and in Appendix B.
- 3.15 For 2009/10, if a practice achieves a prescribing underspend, and irrespective of whether the practice's PBC budget is under or overspent it will be eligible to receive the prescribing underspend up to a maximum of £2 / patient, on the condition that if it has made a PBR overspend its PBC Practice Plan for 2010/11 focuses on the actions the practice will take to manage the PBR budget.
- 3.16 For those practices that achieved a prescribing underspend which is in excess of £2 / patient they will receive as a minimum the £2 / patient. If there was an overspend on the PBR budget the remaining prescribing underspend would be used to offset this. Any net underspend will then be subject to the PBC rules: that the practices' proportion of PBC management costs, pump priming of PBC schemes and LES2 payments will be deducted from the remaining underspend. This will then be split 70:30 between WH.C and the NHS Somerset.
- 3.17 For the practice PBR budget if there is an underspend this may be used, firstly to offset any prescribing overspend and then to fund a proportion of the PBC management costs, pump priming of PBC schemes and LES2 payments. The net underspend is then split 70:30 between WH.C and the NHS Somerset.
- 3.18 Beyond 2009/10 it is proposed that FUR are derived from the practices' underspend on their payment by results budget and their prescribing budget. The calculation of freed up resources will be undertaken by the NHS Somerset at a practice level. In the event of one of these budgets overspending, this is netted off against any underspend. If both budgets are overspent, this is carried forward by the practice who will need to prepare a plan to break even within three years. This will be implemented when there is agreement that the budget setting arrangements are satisfactory and that practices are confident in the information to manage the PBR budget.
- 3.19 The first call on freed up resources will be any management costs agreed by the NHS Somerset in addition to the local enhanced service and any prescribing incentive payments. NHS Somerset investment to pump prime PBC schemes will also be deducted from freed up resources. The remaining freed up resources will then be allocated between practices and the NHS Somerset, as set out below.
- 3.20 Freed up resources on the total practice budget will be attributed 70% to the practice to be used for reinvestment in patient care in accordance with agreed plans. The balance of 30% is attributed to the NHS Somerset to cover either overspends in other budgets or for reinvestment in patient care improvements.
- 3.21 The final budget position each year is either carried forward as an overspend or for underspends converted into Freed up Resources. This means that any freed up resources can be used the following year but similarly any overspend will be taken forward as a debt.
- 3.22 Practices that have recorded an overspend will be expected to return to financial balance over a maximum period of three years – including the repayment of any support provided.

- 3.23 Freed up resources are intended for further investment in patient care or other practice activity which supports the continued delivery of PBC and is not income to the practice. Practices would need to obtain NHS Somerset approval for plans to use freed up resources by submission of proposals to the NHS Somerset for consideration by the PBC Approvals Committee in accordance with national guidance.
- 3.24 Any additional management support to individual practices or WH.C over and above the LES will need to be agreed separately with the NHS Somerset. All commissioning plans need, under PBC guidance, to be in line with the NHS Somerset strategic commissioning plan.

## 4 PROVISION OF INFORMATION

- 4.1 In accordance with *Practice based commissioning: Practical Implementation* (Department of Health, November 2006), the NHS Somerset is responsible for delivering the required information for PBC in a timely and appropriate format. The NHS Somerset was a pilot for the DH project on information for PBC. This was able to support the NHS Somerset in progressing the information agenda significantly by providing assurances on the quality of the data available and on providing a tool for practices to assess the risk of patients being admitted to hospital.
- 4.2 The Ardentia web based software has been procured by the NHS Somerset specifically to allow easy access to PBC information. Currently this system holds data about acute hospital activity that is covered by Payment by Results. It is envisaged that the system will be further developed to include access to the wider range of information that is required under PBC. The NHS Somerset will provide refresh training where required.
- 4.3 Practices are expected to take up access to Ardentia as this will be the principal method of providing PBC information to practices. This has been further developed by the development of a PBC dashboard for practices which provides a range of management information to inform the commissioning process.
- 4.4 The NHS Somerset will produce quarterly information packs which will be available on the PBC dashboard showing information in a graphical format and the relative position of each practice in Somerset.
- 4.5 The NHS Somerset has made available daily information on emergency admissions across the acute providers and community hospitals in Somerset. This can be e-mailed to practices every working day. In order to receive this the practice needs to request this from either the NHS Somerset or WyvernHealth.Com.
- 4.6 The NHS Somerset will produce a public health information pack on an annual basis. This will also be accessed via the PBC dashboard.
- 4.7 Validation of data supplied by providers is an integral part of commissioning. It is proposed that as far as possible this is undertaken by the NHS Somerset on behalf of practices. Under payments by results the key determinants of the charge against the budget:-
- identification of patient GP practice;
  - coding of diagnosis and/or procedure that determine the HRG;
  - length of stay.

The NHS Somerset will validate the data on a monthly basis looking for exceptional items and/or underlying trends. Practices will be asked to assist in reviewing exceptional items identified from this data analysis. Practices will not be asked to validate more than an average of 10 patients per month (for an average size practice in Somerset of 7,000 patients). Additional validation work above this would be subject to further discussion about appropriate resources.

## 5 GOVERNANCE

### Clinical and Corporate Governance Arrangements within NHS Somerset

- 5.1 In line with Department of Health guidance, NHS Somerset has created a sub-committee of the Board to ensure clear accountability to the NHS Somerset Board for governance around the provision of services through PBC. This Committee will be responsible for ensuring that:
- the local Practice Based Commissioning framework incorporates national guidance
  - the commissioning business cases are considered for approval against an agreed set of criteria including real improvements in services for patients that are safe and provide value for money
  - appropriate clinical governance arrangements are in place for services developed under practice based commissioning plans. Arrangements should be proportionate to the complexity of the service and clear guidance on requirements should be produced for providers.
- 5.2 The sub-committee is chaired by a non-executive director with membership drawn from the NHS Somerset Board and PEC. It has clear delegated powers to approve commissioning plans and business cases.
- 5.3 Clinicians must exclude themselves from any procurement decisions on any PBC commissioning plan or business cases in which they may have an interest or with which they may be associated and should declare an interest if there is the potential risk of a conflict of interest.
- 5.4 There are two broad types of activity that practices engaged in PBC can undertake:
- acting purely as a commissioner and re-designer of services
  - acting as a commissioner and re-designer of services but in addition developing and offering services themselves as an extended primary care provider
- 5.5 DH guidance *Practice based commissioning – budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance* issued in December 2007 outlined that NHS Somersets should agree with practice based commissioners a menu of local flexibilities, to support their achievement of local and national priorities (informed by needs assessments, reflecting priorities in Local Area Agreements). The NHS Somerset in 2009/10 will put in place a framework which allows WH.C to spend funding on a locally agreed menu, including ensuring cost effective options for delivering the options on the agreed menu. Where practices wish to use interventions on the local menu, they should submit a light touch commissioning plan. This will be prepared in accordance with the DH guidance.

## **PBC Commissioning Plans**

- 5.6 Practices who wish to develop and/or provide a service through PBC must submit a business case to the NHS Somerset for approval. For practices that are members of WyvernHealth.Com this is normally submitted to the NHS Somerset through the consortium.
- 5.7 Practices may discuss the development of commissioning plans with an Implementation Manager at WyvernHealth.Com in the first place who will support or advise as necessary on completing the commissioning plan or strengthening it.
- 5.8 Once complete the final commissioning plan will be considered by the Professional Executive Committee and be submitted for approval to the Practice Based Commissioning Approvals Committee.
- 5.9 Where business cases are not approved, the NHS Somerset will identify the reasons and any actions that would resolve this.
- 5.10 Commissioning plans must cover, as a minimum:
- service to be provided
  - benefits for patients including outcome measures
  - Clinical Governance/ Quality Standards
  - Expected improvements in efficiency and effectiveness
  - management resources required
  - costs of the proposals and their recovery period
- 5.11 A commissioning plan template is shown in Appendix C that is not mandatory but indicates the areas that will need to be covered.

## **Criteria for Assessing Commissioning Plans**

- 5.12 The criteria for assessing business cases will include:
- whether or not the proposed service addresses a high priority within the agreed statement of local health needs
  - evidence based clinical effectiveness
  - clinical safety, quality and governance
  - provider credibility and track record whether the specific needs of population groups such as disabled people, people from minority ethnic groups, the differing needs of men and women and of diverse age groups, different faiths and sexual orientation of individuals and groups accessing services have been taken into account

- patient and stakeholder support
- evidence that resources can be released through the substitution of care
- affordability within the current and projected indicative budgets
- consideration of whether formal tendering is required (this is generally only required when a guaranteed level of income is required regardless of referral levels)
- assessment of the risks
- value for money, including benchmarked costs to determine a reasonable price range for services

5.13 Contracts for the transfer of services from hospitals to local settings should include quality criteria covering patient experience, quality and service standards. There should be regular sampling and the results should be readily available to patients.

5.14 Plans within a consortium for new services transferred from hospitals to local settings should demonstrate how a range of provision will be secured across all practices involved, ensuring equity of access and choice for patients.

## 6 PROCUREMENT GUIDELINES

### **Any Willing Provider of Elective Services**

- 6.1 The NHS Somerset needs to have clear frameworks for procurement of new services (in line with the *Principle and Rules for Cooperation and Competition* and the *PCT Procurement Guide*), including arrangements for delivering and documenting interests and protecting against real or perceived conflicts. It is also essential to ensure that any service is governed by a clear contractual relationship and there is clear clinical accountability for the service.
- 6.2 For routine elective services, the principles of free choice of provider for patients and the opportunity for any willing provider to supply services (if they are licensed to do so) should not be constrained by commissioners. This holds true for elective services provided in community settings through PBC.
- 6.3 Within this 'any willing provider' model, there are no guarantees of volume or payment in any contract given. NHS Somerset, through contracts, gives permission for the provider to supply services to the Somerset population without any promises regarding income. NHS Somerset will give such contracts only to providers who can demonstrate that they meet national minimum quality criteria (as set out by the Healthcare Commission) and agree for the service to be placed on local choice menus where appropriate. It is, in effect a local approval process for providers with the intention that competition is encouraged within a range of services rather than for them.
- 6.4 This means that for providers looking to supply a routine elective service, including those developed through PBC, tendering is not required.
- 6.5 The same approach of fostering, not limiting, choice will be extended to the development of enhanced primary care services through PBC. NHS Somerset will seek to establish a range of providers from which patients can choose, driving up quality through contestability. As with elective services, a prospective provider will need to satisfy NHS Somerset of its ability to deliver the service and compliance with quality standards, before a contract or agreement is awarded. Such a contract would have no guarantees of volume or income.

### **Ensuring Value for Money**

- 6.6 NHS Somerset and practices have a responsibility to ensure that value for money is secured from the services they commission. However tendering is not the only method for achieving this. Value for money can also be ensured through the following measures.
  - for those services encompassing patient choice, NHS Somerset will facilitate the development of alternative additional providers so that contestability can be driven, at least in part by patient choice. The approach will be to develop a market and a range of providers rather than the award of a contract to one provider after competitive tender
  - benchmarking of costs at NHS Somerset, Strategic Health Authority and national level will allow price bands for services outside the scope of Payment by Results to be set locally and used as a value for money measure

- there will be open and transparent publication of prices, making them available to all PBC commissioners, together with the production of a choice menu for practices and patients for this sector
- contracts between NHS Somerset and the provider, practice or limited company will include clear profiling, referral conversion rates and expenditure ceilings, but no income guarantees

6.7 Generating choice and contestability, underpinned by robust contracting and benchmarking of costs, will provide a mechanism for ensuring value for money. NHS Somerset will use data from benchmarking of costs to set the right prices for local services outside the scope of Payment by Results and to use as a yardstick for determining whether a proposed service would provide best value.

6.8 European Union Procurement Directives are incorporated into UK law and set out in the procedures to be followed by purchasers in the public sector – specifically when public services have to be put out to tender. However where NHS Somerset is granting permission for any willing provider to operate in their area rather than purchasing an exclusive service from a single or limited number of providers, then these regulations do not apply and tendering is not required.

#### **When Tendering is Required**

6.9 For services developed through PBC, tendering will normally only be required when the intention to create a monopoly by awarding a contract to a single provider rather than grant approval to providers who reach the required quality standard. This would be, for example, where the proposal seeks to move a whole service out of a local hospital without an alternative equivalent service available within the NHS Somerset boundary.

#### **Payment for Services Provided to a Wider Population than that of a Single Practice**

6.10 *Health Reform in England: update and commissioning framework* established a principle that where the service to be provided is the same as an existing hospital service (see definition in 6.10), and is within the scope of PbR, payment should be at tariff rate.

6.11 As PbR is an activity based, casemix adjusted payment system, the new service would need to satisfy the relevant HRG and / or OPCS definitions. A service should be regarded as being ‘the same as’ an existing hospital service and therefore attract payment at tariff rate, if it directly fits these definitions and does not meet one or more of the following criteria:

- the service could be delivered through any contractual option to provide GP services including GMS, PMS, SPMS or APMS contracts
- the service is provided in a community facility and performed by a GP, any healthcare professional employed by or on secondment to a GP, or community nursing teams or allied health professionals contracted to work in primary care
- the service is provided within a facility receiving notional or cost rent reimbursement

- the service is an outpatient service. This is an interim measure pending further progress on unbundling the outpatients tariffs for diagnostics. In these cases the NHS Somerset is free to negotiate a local price for the service.

### **Services Outside the Scope of Payment by Results**

- 6.12 The scope of PbR is set out in *Payment by Results: Implementation Support Guide (Technical Guidance)* and broadly extends to Acute hospital services commissioned directly from National Health Service Trusts and Foundation Trusts. Funding for local services outside the scope of PbR must be negotiated through the contracting process and should be activity based where appropriate to support choice and contestability (such as money should follow the patient).

## **7 CARE PATHWAY MANAGEMENT**

- 7.1 It is clear that redesigning patient care pathways is a complex area. It is expected that proposals for new pathways will be initiated by WH.C and member practices.
- 7.2 It will be the responsibility of WH.C with member practices to produce outline care pathways.
- 7.3 WH.C will then need to work with all stakeholders (including the NHS Somerset and providers) to ensure that proposed new pathways are worked up in full. WH.C have established an Advisory Group comprising a wide range of stakeholders to make comments and suggestions on new pathways being developed.

## **8 PBC ACCOUNTABILITY FRAMEWORK**

- 8.1 This code of conduct was detailed in *Practice based commissioning: practical implementation*, published by the Department of Health.

### **Responsibilities under PBC**

- 8.2 All parts of the National Health Service are expected to conform to the highest standards of honesty, probity and integrity, and to work in partnership in a patient centred inclusive way.
- 8.3 Practice based Commissioners, in accepting an indicative budget, take on additional responsibilities for managing those resources and redesigning services for patients. This means that they should play their full part in meeting national and local priorities.
- 8.4 Practice Based Commissioners should work in partnership with the NHS Somerset, primary care teams, community nurses and health visitors, secondary providers and local authority to develop and implement locally agreed health and service strategies. The NHS Somerset will involve practices in a way that is non bureaucratic and sensitive to the working practices of primary health care teams.
- 8.5 The NHS Somerset is responsible for leading the implementation of national policy at local level. This includes advising, co-ordinating and informing practice based commissioners of the wider implications of their proposed services redesign whilst respecting clinical and management decisions taken by the practice teams on behalf of their patients.
- 8.6 The NHS Somerset has a role in ensuring that patients can choose from a diverse range of providers.

### **Demonstrating Accountability**

- 8.7 Practice based commissioners are accountable to the NHS Somerset for achieving best value within their indicative budget and for delivering their PBC plan. Where local agreement cannot be reached the South West Strategic Health Authority will arbitrate as set out in section 8.18.
- 8.8 Professionals are directly accountable to their patients and to their regulatory body and NHS Somerset (under the terms of their contract) for their standards of clinical practice. In addition, practice based commissioners are responsible for maximising the health and service benefits to patients from their indicative budgets through their proposals for service redesign.
- 8.9 An accountability agreement has been made between the NHS Somerset and WH.C. This document details the roles and responsibilities for each organisation and the performance management arrangements to ensure each organisation is accountable for its responsibilities.

## **Accountability to Patients and the Wider Public**

- 8.10 Practice based commissioners now have the ability to redesign services and with that comes a responsibility to ensure that they involve their patients in developing their plans. Practices should make their plans available for public scrutiny by their practice population and should be included in the annual NHS Somerset prospectus.
- 8.11 The NHS Somerset needs to ensure that the collective plans for all the practice based commissioners are available for scrutiny by the Overview and Scrutiny Committee of the local authority and also by the general public. The NHS Somerset also needs to ensure practices have engaged their patients in service redesign.
- 8.12 All National Health Service organisations are required to ensure they have effective complaints procedures in line with national regulations. The NHS Somerset is required to ensure that any new arrangements for services meet national guidelines on complaints and patient advice and liaison services (PALS).

## **Financial Accountability**

- 8.13 The NHS Somerset has a statutory responsibility to achieve financial balance. Practice based commissioners have a responsibility to agree an indicative budget and then manage within that. The NHS Somerset will monitor practice expenditure and activity against the PBC plan on a monthly basis. The NHS Somerset will discuss with the practice how to operate within this plan and will share best practice to help the practice manage expenditure and activity.
- 8.14 The practice based commissioner must have the agreement of the NHS Somerset for their proposed use of freed-up resources. The NHS Somerset will respond to the practice within 8 weeks.

## **Clinical and Professional Accountability**

- 8.15 All clinicians in the NHS have the responsibility to provide care of the highest standards within available resources.
- 8.16 In addition, practice based commissioners who provide additional services are expected to ensure that their new services meet all national standards of clinical governance including those set out in Standards for Better Health. Practice based commissioners should briefly set out their annual clinical audit plans for such new services.
- 8.17 NHS Somerset is responsible for ensuring that an effective system of clinical governance is in place to approve and monitor services with its health community in line with national guidance and the Healthcare Commission.
- 8.18 While it is not a requirement for practice based commissioners to include developments to the services they provide under their GMS or PMS contract in their business plans, they may wish to. This has the advantage of offering a coherent view of all services to the NHS Somerset and its patients. Such practice may prove useful in helping practices and NHS Somerset's to work together on strategies for developing primary care.

## **Arbitration**

- 8.19 In the event of any disputes, the South West Strategic Health Authority will be expected to establish one or more arbitration groups, depending on demand, and to ensure independence. The group(s) should include practitioner, financial and management representation and will be appointed by the South West Strategic Health Authority. The Local Medical Committee should be involved in agreeing the practitioner representation on the group. The NHS Somerset and practices will be expected to follow the decision of the arbitration group.

## **9 PARTNERSHIP WORKING**

- 9.1 The NHS Somerset will embrace partnership working at every level of PBC implementation and will support practices working in partnership with partner agencies as appropriate.
- 9.2 It is expected that practices will work closely with other primary care clinicians, as appropriate, when developing commissioning plans and business cases. This will include:
- community pharmacists
  - district nurses
  - health visitors
  - dentists
  - optometrists
- 9.3 Working with Social Care partners will be a key element in the development of Commissioning plans. Practices are expected to ensure that partner agencies are fully involved, when appropriate.
- 9.4 Similarly, prevention and reduction of emergency admissions will involve partnership working with the Ambulance Service which practices will be expected to participate in.
- 9.5 The NHS Somerset has a duty to involve and consult patients and the public when considering new or different service provision. Equally patients must be able to express their views on the services currently provided. Practices are expected to ensure that patients, as users of services, are engaged in decisions about redesign and the reallocation of freed up resources. Practices must demonstrate patient and public involvement in any Commissioning plans or business cases submitted.
- 9.6 There will also be a requirement to involve existing providers when discussing specific care pathways.

## 10 PBC INDICATORS

10.1 To understand the implementation and effectiveness of PBC, there will be a set of national indicators for 2009/10. This will allow the NHS Somerset, South West Strategic Health Authority and Department of Health to build an informed view of PBC progress.

10.2 The indicators have been developed around three questions:

- **Is the PBC framework enabling?** Do Primary Care Trusts provide practices with the information, indicative budget and support that enables them to use PBC?
- **Are practices engaging with PBC?** Are practices developing and implementing plans for new pathways through PBC, and do they feel clinically and financially engaged?
- **Are there new pathways and what is their impact on outcomes?** Does PBC result in new pathways for patients and users, and do these improve health outcomes?

10.3 The following indicators will be used to assess PBC progress:

- South West Strategic Health Authority to assure themselves that there is a quality framework in place to support PBC and that high quality practice plans are in place
- the results of the NHS Somerset World Class Commissioning assessment process
- the practice perspective will be captured through an independent quarterly practice survey, covering a sample of practices across the NHS Somerset, to assess practice engagement and the practice's perception of the of the support offered by the NHS Somerset. This will be commissioned by the Department of Health
- the South West Strategic Health Authority will be required to provide an annual report outlining examples of service redesign commissioned by practice based commissioners in their area

10.4 NHS Somerset progress will be assessed by the South West Strategic Health Authority on a quarterly basis and reported to the Department of Health.

## **11 EQUALITY AND DIVERSITY**

11.1 The NHS Somerset is committed to promoting equal rights in all its roles: as an employer, a service provider and as a commissioner. Practices are expected to demonstrate the same commitment to promoting equality and diversity. This should involve:

- understanding the diversity of the population served, in terms of ethnic origin, religious belief, gender, disability, sexual orientation and age
- working to eliminate any form of discrimination on any grounds towards staff, patients and the wider public
- recruiting, developing and retaining a workforce that is able to meet the diverse needs of the practice population

11.2 All new services considered under PBC will require an equality impact assessment to be completed.

**Practice PBC Plan Template**

# WyvernHealth.Com

## xxx Health Centre

### PBC Plan 2009/10

#### 1. INTRODUCTION

This plan outlines the commissioning intentions for 2009/10. The intentions for 2009/10 build on the previous year WH.C plans and support the NHS Somerset's key priorities and commissioning strategic plan.

The commissioning plans fit with the national, regional and local priorities as well as the priorities identified by WH.C which are summarised in the diagram below.

It highlights the need for the practice to support the usage and implementation of currently commissioned schemes, the new care pathway approved in 2008/09 to increase the health of the local population, the quality of care and the efficient use of taxpayers' money in order to generate ongoing savings for developing further local services.

#### 2. CONTACTS

THE WH.C BOARD CONTACT FOR THIS PRACTICE IS .....

The WH.C Manager contact for this practice is .....

The Practice's nominated PBC Lead is ..... who will be expected to:

- attend three WH.C meetings during the year
- disseminate information to the primary care team at the practice regarding PBC developments
- coordinate data validation work required for PBC
- complete the annual practice PBC MORI survey.

The priority areas for our practice are:

- Utilising emergency admission avoidance schemes (*specify which particular ones to focus on*)
- Effectively managing the prescribing budget

AND three from:

- Elective care
- End of life care
- Diabetes
- Mental health
- Wellbeing agenda
- Health inequalities

## Priorities for Somerset Commissioning

### High Level Summary

<b>National 2009/10 Operating Framework</b>	<b>Regional Strategic Framework for Improving Health in the South West 2008/09 to 2010/11</b>	<b>Local Strategic Framework for Improving Health in Somerset 2009/10– 2013/14</b>	<b>PBC Commissioning Plan 2009/10</b>
<ul style="list-style-type: none"> <li>➤ <b>Cleanliness and healthcare associated infections</b></li> <li>➤ <b>Access to personalised and effective care</b></li> <li>➤ <b>Improving health and reducing health inequalities</b></li> <li>➤ <b>Reputation, satisfaction and confidence in the NHS</b></li> <li>➤ <b>Ensuring financial balance</b></li> </ul>	<ul style="list-style-type: none"> <li>➤ Staying healthy</li> <li>➤ Maternity and newborn care</li> <li>➤ Children and young people</li> <li>➤ Long-term conditions</li> <li>➤ Mental health and wellbeing</li> <li>➤ Learning disability</li> <li>➤ Planned care</li> <li>➤ Acute care</li> <li>➤ End of life care</li> </ul> <p>Through:-</p> <ul style="list-style-type: none"> <li>• Developing the workforce for the future</li> <li>• Using technology to deliver improvement</li> <li>• Investing in facilities</li> <li>• Improving clinical effectiveness, safety and the user experience</li> <li>• Improving clinical value and productivity</li> <li>• Integrating care delivery</li> </ul>	<ul style="list-style-type: none"> <li>➤ Improve health and reduce health inequalities</li> <li>➤ Eliminate waiting</li> <li>➤ Improve health services</li> </ul> <p>In clinical areas:-</p> <ul style="list-style-type: none"> <li>• End of Life Care</li> <li>• Acute Care</li> <li>• Planned Care</li> <li>• Long Term Conditions</li> <li>• Mental Health</li> <li>• Children’s Services</li> <li>• Staying Healthy</li> <li>• Maternity &amp; Newborn Care</li> </ul>	<ul style="list-style-type: none"> <li>➤ Shifting care closer to home</li> <li>➤ Improving patient outcomes and experience</li> <li>➤ Investing in primary care services</li> </ul> <p>Contributing to Local Priorities:-</p> <ul style="list-style-type: none"> <li>• Eliminating Waiting: through Flexible Healthcare</li> <li>• End of Life and Long Term Care</li> <li>• Admission Avoidance</li> <li>• Long Term Conditions: Diabetes</li> <li>• Prescribing</li> <li>• Mental Health</li> </ul>

Care Pathway	Actions to be taken by the Practice	Performance Measure and Target	Baseline
<b>Elective Care</b>	<ul style="list-style-type: none"> <li>• Review at least twice during the year the 'elective' referrals tool to identify opportunities to understand clinical practice in the practice for specific specialties and produce an action plan</li> <li>• Where appropriate refer to the dermatology service, acute community eyecare service, musculo-skeletal service, diabetes community based service, flexible healthcare pathways</li> </ul>	<ul style="list-style-type: none"> <li>• County-Wide review of last 20 Rheumatology referrals</li> <li>• Review of 20 referrals to specialty with high practice referral rate)</li> <li>• End of year review of activity in these areas</li> </ul>	<ul style="list-style-type: none"> <li>• Elective referrals / 1,000</li> </ul>
<b>End of Life Care</b>	<ul style="list-style-type: none"> <li>• To support primary and community services deliver palliative care for patients at home where appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Practice will record preferred place of death and actual place</li> </ul>	<ul style="list-style-type: none"> <li>• Collect baseline data</li> </ul>
<b>Emergency Admissions</b>	<ul style="list-style-type: none"> <li>• To improve on the utilisation of SPL</li> <li>• To increase use of the ACGP service and CATUs when appropriate</li> <li>• To refer appropriate patients to the COPD community service</li> <li>• To improve liaison with community matrons, utilising the RISC tool to manage their workload</li> <li>• To identify further opportunities for reducing inappropriate emergency admissions including DVT pathway</li> </ul>	<ul style="list-style-type: none"> <li>• 80% of admissions via SPL or direct to community hospital. (measured in last quarter)</li> <li>• Less increase in acute daytime emergency admission than South West Region average or preferably no increase on 2008/9 rate</li> <li>• 80%of COPD patients with MRC score 3 &amp; 4 referred to COPD community service (measured in last quarter)</li> <li>• Case management plans for high risk patients in place for 0.05% of practice population.</li> <li>• Ensure that Specialist nurses, assistants, locums etc. Are fully aware of emergency schemes and are using pathways.</li> </ul>	<ul style="list-style-type: none"> <li>• Insert SPL usage in 2008/09</li> <li>• COPD community service referrals in 2009/10</li> <li>• Level of care management</li> <li>• Increased use of schemes</li> </ul>

Care Pathway	Actions to be taken by the Practice	Performance Measure and Target	Baseline
<b>Diabetes</b>	<ul style="list-style-type: none"> <li>• Utilisation of diabetes information packs</li> <li>• Guarantee engagement in diabetes pathways</li> </ul>	<ul style="list-style-type: none"> <li>• More packs ordered by practices</li> </ul>	
<b>Prescribing</b>	<ul style="list-style-type: none"> <li>• To effectively manage the practice's prescribing budget</li> <li>• To work with the support pharmacists where appropriate</li> <li>• To action the following prescribing targets: (<i>specific for the practice</i>)</li> <li>• See Section 2.4 of the PBC Framework Document</li> </ul>	See Section 2.4 for more details.	<ul style="list-style-type: none"> <li>• Existing prescribing framework</li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• To refer patients to the Emotional Health and Well-Being (EH&amp;WB) service</li> <li>• To monitor and report waiting times for EH&amp;WB services where possible</li> <li>• To contribute to work on dementia</li> </ul>	<ul style="list-style-type: none"> <li>• Measure referrals to service</li> <li>• Provider responsibility</li> <li>• Ensure secondary care are monitoring patient on dementia drugs according to shared care protocol</li> </ul>	<ul style="list-style-type: none"> <li>• Prescribing costs for appropriate drugs</li> <li>• Waiting times to be seen by a counsellor</li> <li>• QoF register for patients with Dementia</li> </ul>
<b>Well-being Agenda</b>	<ul style="list-style-type: none"> <li>• Engaged in the obesity care pathway by referring patients to the appropriate level in the pathway and in the reduction in levels of alcohol related harm.</li> </ul>	<ul style="list-style-type: none"> <li>• Percentage increase of referrals to local physical activity services;</li> <li>• Percentage increase in referrals to the Turning Point Service.</li> </ul>	<ul style="list-style-type: none"> <li>• BMI data</li> </ul>
<b>Health Inequalities</b>	<ul style="list-style-type: none"> <li>• Review health profile of locality / practice population to identify service gaps and un-met needs</li> <li>• Demonstrate that commissioning proposals link to health needs of the practice population.</li> </ul>	<ul style="list-style-type: none"> <li>• Health needs analysis.</li> </ul>	<ul style="list-style-type: none"> <li>• Locality HNA's undertaken in 2008/09 and 2009/10.</li> </ul>



ALLOCATION OF FUR TO PRACTICES

	Prescribing overspend	Prescribing underspend
PbR overspend	Practice gets no incentive payment and no freed up resources and must put together an action plan for recovery of position within three years. Wyvern Health.Com will help with the recovery plan.	<p><b>Practice gets up to £2 per patient incentive payment out of prescribing underspend.</b> If prescribing underspend &lt; PbR overspend, Practice must put together plan for recovery within three years. Wyvern Health.Com will help with the recovery plan.</p> <p><b>Practice gets up to £2 per patient incentive payment out of prescribing underspend.</b> if prescribing underspend &gt;PbR overspend. A net surplus goes to WyvernHealth.Com for reinvestment in PBC.</p>
PbR underspend	<p>If prescribing overspend &gt; PbR underspend, Practice gets no incentive payment and no freed up resources.</p> <p>If prescribing overspend is &lt; PbR underspend, any net surplus goes to Wyvern Health.Com for reinvestment in PBC.</p>	<p><b>Practice gets up to £2 per patient incentive payment out of prescribing underspend.</b> Any net surplus goes to Wyvern Health.Com for reinvestment in PBC.</p>

Note Net underspend is the FUR (i.e. the underspend less PBC management costs, pump priming of PBC schemes and LES2 and the 70:30 split between WH.C and the NHS Somerset).

**COMMISSIONING PLANS**

The following paragraphs summarise the guidance within “Practice based commissioning: practical implementation” published by the department of Health in November 2006.

Commissioning plans are expected to cover

- services to be provided
- benefits for patients
- expected improvements in efficiency and effectiveness
- management resources required; and
- cost of the proposals and their recovery period

The criteria for assessing commissioning plans will include:

- match against the agreed local statement of need
- evidence-based clinical effectiveness
- clinical safety, quality and governance
- contribution to offering care closer to home and delivery of the national 18 weeks priority
- whether the specific needs of population groups such as disabled people (including those with learning difficulties or mental health needs), people from Black Minority Ethnic communities (BME), the differing needs of men and women and of the diverse age groups, different faiths and sexual orientation of individuals and groups accessing services have been taken into account;
- patient and stakeholder support
- justification/evidence that resources can be released through the substitution of care
- affordability within the current and projected indicative budgets
- Consideration of whether formal tendering is required, which it is envisaged will be infrequent
- assessment of the risks of the development
- procurement route; and
- value for money, including using benchmarked costs to determine reasonable price range for services