

Practice Based Commissioning (PbC)

An Overview

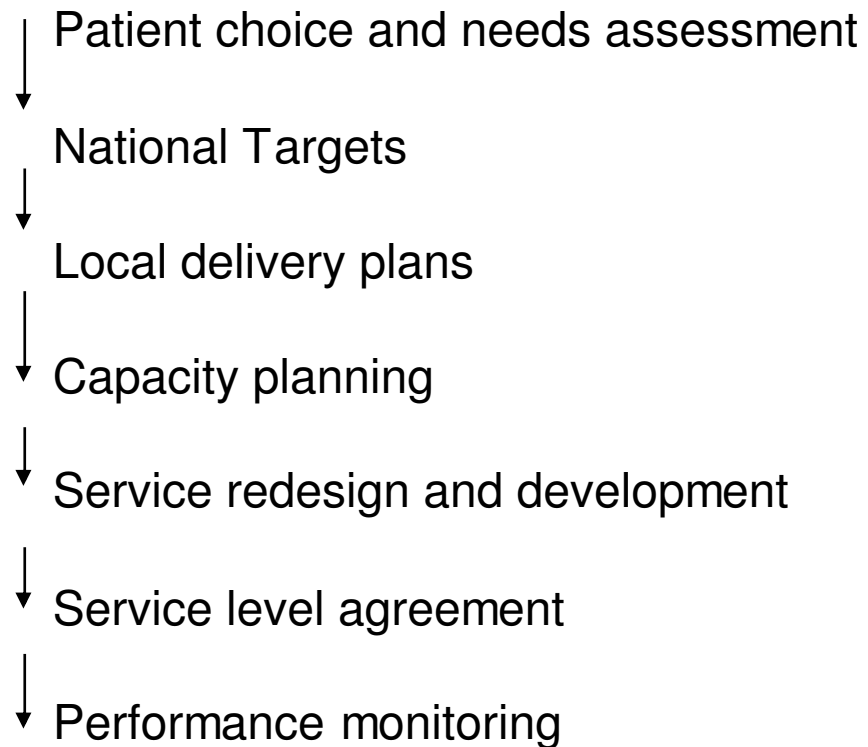
Opportunities for Substance Misuse Services
in Primary Care

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Context

The Traditional Commissioning cycle



Policy Direction – “*Commissioning and patient led NHS*”

Four underpinning policies

1. Devolution

- Shifting balance of power
- NSFs
- delegation to foundation trusts within a locally focussed organisational structure national regulatory environment
- PCTs have three year spending rounds and greater flexibility to develop service in accordance with population needs

PBC fits into this underpinning principle

Policy Direction – “*Commissioning and patient led NHS*”

2. Patient choice

3. Plurality

4. Investment

PBC supports all three of the remaining policy directions

The Vision: -

That through PBC there will be: -

- genuinely personalised care (choice is “real” for patients)
- wider configuration of providers
- greater innovation at provider level
- promotion a wider range of styles of provision
- wiser use of NHS resources

Perceived added value of PbC

- Seen as means of patients getting more personalised care
- Better suited to management of long term conditions
- Will achieve greater GP engagement initially in the commissioning of hospital care (*which follows could also mean more involvement in commissioning T3 and T4 services locally*)

Which areas are likely to develop PbC first and why? (1)

- Localities where there was previously a lot of total fund holding (GPFH)
- Where PMS is concentrated– these practices will have developed mechanisms of ongoing monitoring which could be easily augmented to become the monitoring systems for PBC
- Areas where there are established practitioners with a special interest (PwSI)

Which areas are likely to develop PbC first and why? (2)

- Areas with access to neutral and generic facilities e.g. community hospitals – apparently encourages growth of special interest practitioners
- Natural geography – natural practice clustering
- Available Staffing, Capacity and Expertise – these are needed to help PBC develop
- Finance, information, commissioning, contracting expertise

Things that PCTs will have to take into consideration

PbC decisions cannot be made in a vacuum.....

- ***Financial climate, foundation trust status, NPFIT, Choosing health implementation, Choose and Book, patient choice, current and future LDP planning priorities for areas of need, practices capability agendas, LAA's, ISIPS, local culture, inter-practice working, current and predicted service pressures and areas of need, local incentives to innovate, LES, NES, QOF blah blah blah.....***

Potential barriers to PBC implementation

- Lack of skilled practitioner capacity
- GP focus on QoF
- Risk sharing arrangements
- Availability of good quality information to PCTs
- Existing local commissioning – PBC will potentially create mixed models of commissioning on different levels
- PCTS must not lose sight of targets in respect of health promotion and the wider public health agenda?
- Lack of practice engagement or the creation of ‘neutral ground’
- Lack of management funds

Seeing things through GPs eyes

- PBC MUST be part of a whole systems commissioning approach
- Practices and GPs will have to get *involved* in commissioning
- PCT and LDP operates like a “golden share” whereby national priorities have to take priority
- Allows GPs opportunity to influence resourcing decisions in a “different” way
- Care not to overemphasis potential for savings although if generated they can be one way of developing primary care
- Practices will need clear guidelines as to what will be made available to them for practice input

GP fund holding vs.. PBC

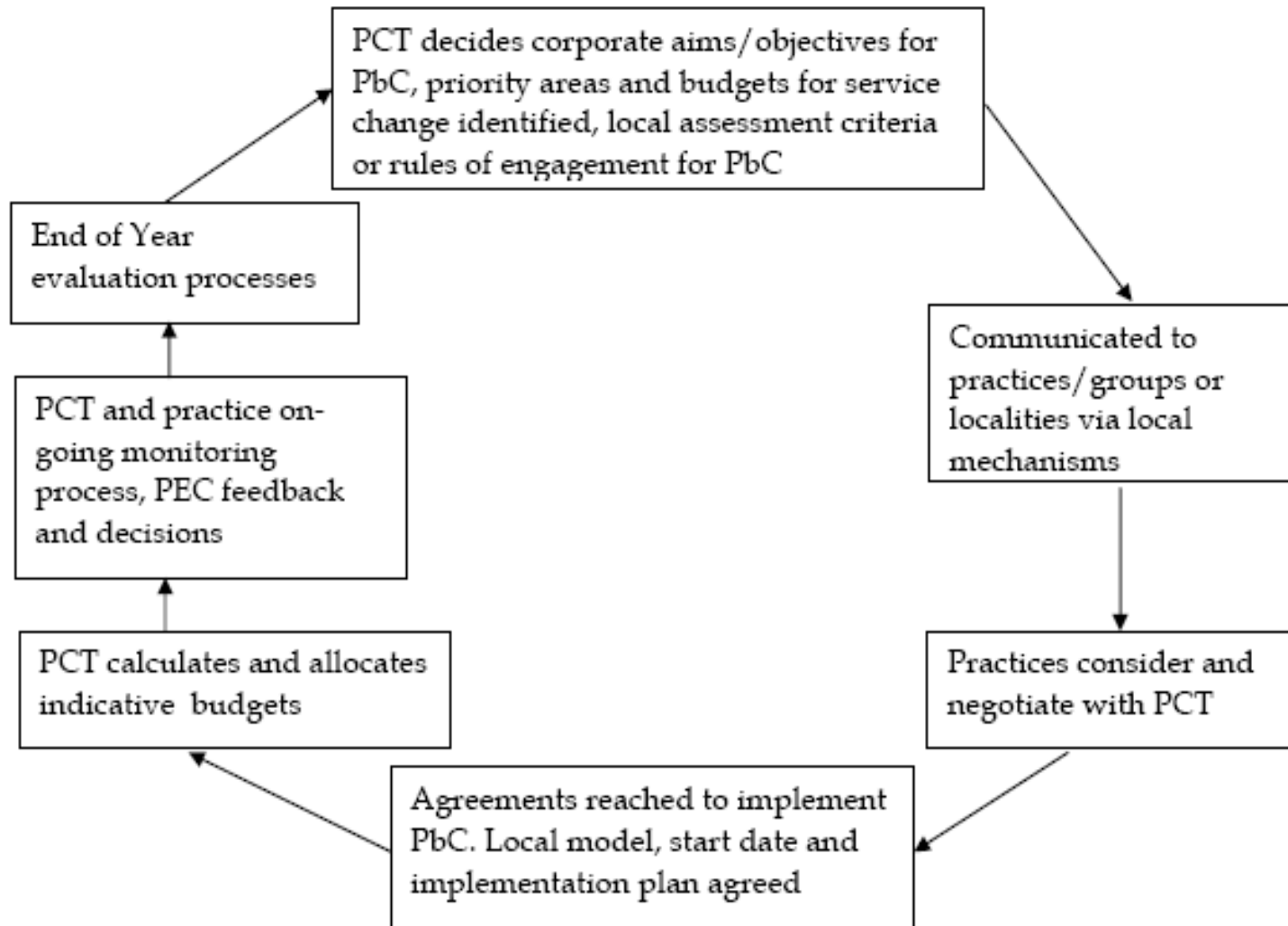
Area	GPFH	PbC
<i>Scope of commissioning</i>	Set list of goods and services which could be purchased by Practices	No centrally directed "menu". Practices and PCTs able to determine range
<i>Budgetary coverage</i>	Prescribing and community nursing a mandatory requirement	Practices and PCTs not obligated to include either prescribing or community nursing budgets
<i>Contracting and monitoring</i>	Direct contracts between practices and secondary care. Monitored at practice level	Responsibility of the PCT, based on need as identified in conjunction with practices. Negotiated and monitored at PCT level to minimise financial risks and administrative bureaucracy

<i>Management costs</i>	Fixed amounts set at a national level with maximum thresholds for clinical time	PCTs and Practices able to agree appropriate levels of resource
<i>Currency</i>	No fixed price for secondary care services	Under Payment by Results (PbR) there is a common currency and fixed price for secondary care
<i>Use and treatment of savings</i>	Centrally directed.	Central guidance emphasises that any resources freed must be reinvested in patient care
<i>Political context</i>	Supported by national legislation and central incentive funding eg. <u>computing reimbursement</u>	Independent of national legislation with no central incentive funding attached
<i>IT and software</i>	Nationally defined "bolt on" software	In the short term PCTs will provide Practices with information as required with the DH driving forward an integrated solution in the future.

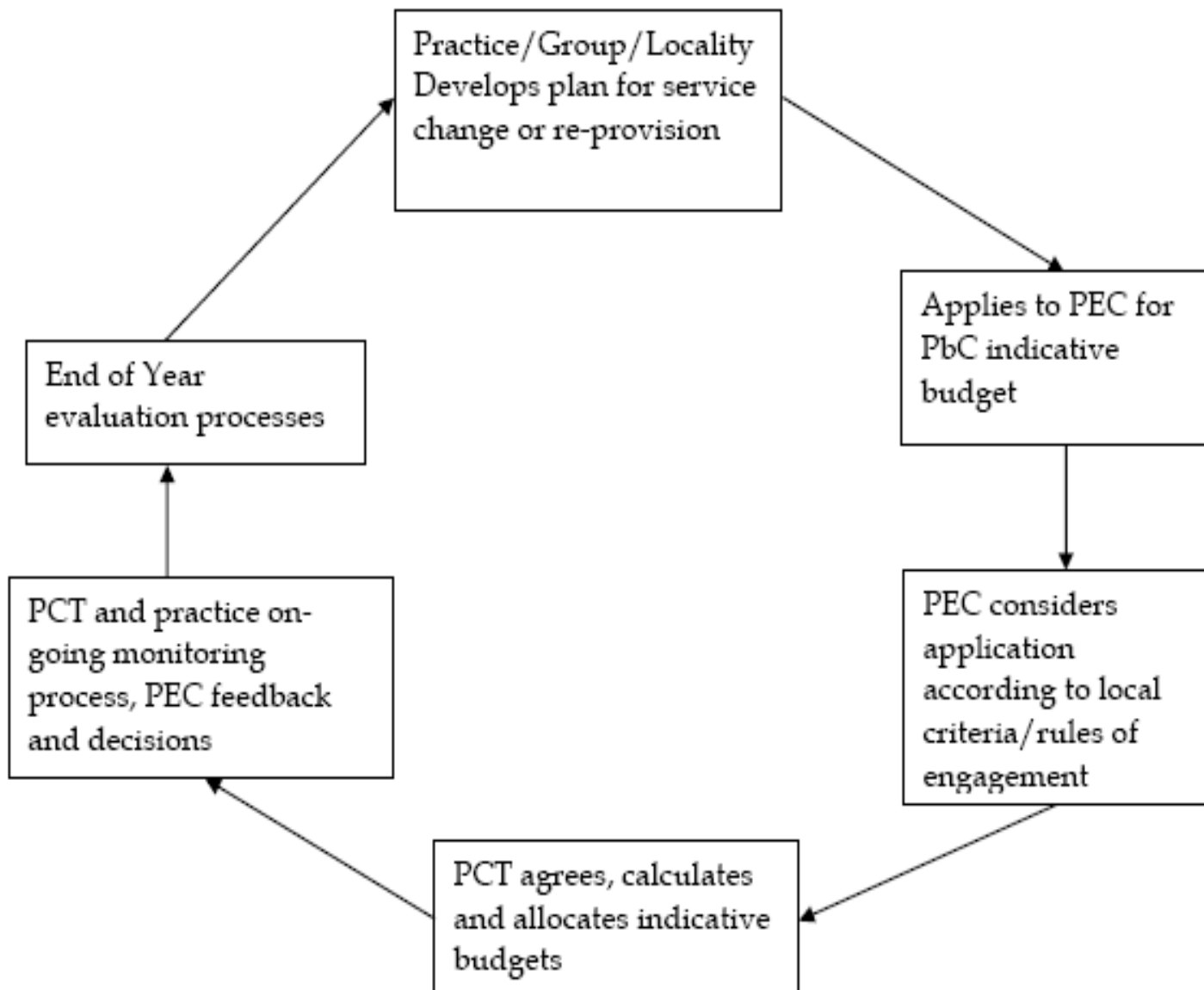
How will PbC be implemented

- Top down
- Bottom up
- As a 'Continuum'

Top-Down



Bottom-Up



Principles of a continuum approach

- Follow the traditional commissioning cycle
- Embrace, patient choice, plurality of provision and resource shift into primary care
- Be locally sensitive - Local PBC solutions likely to be highly dependent on historical and physical factors
- Understand that it might not be perfect first time
- Be aware of local competing interests which will affect pace of implementation
- Some practice backfill and admin support **WILL** be needed to ensure GP involvement

Preparatory work for PCTs

- Need to revise management structures
- Invest in efforts to engage with clinicians
- Key individuals being tasked with introducing PbC
- Financial modelling being undertaken to look at impact of PBC in context of foundation trusts
- Modelling of impact on wider services

Accountability

PCT is accountable for PBC implementation

- Engage and develop local clinicians in the wider commissioning agenda and local plans
- Engage other staff and stakeholders in commissioning redesign and reprovision
- Developing local processes and ensuring high quality provision across primary and secondary care

Information that practices need from PCTs

- National and local aims and objectives
- Sources of funding for PBC
- How payments will be made to practices
- Advice on assessing risk
- Referrals and activity information to practices
- Budget and contract monitoring support (negotiation, documentation, monitoring)
- Training

The role of the PEC

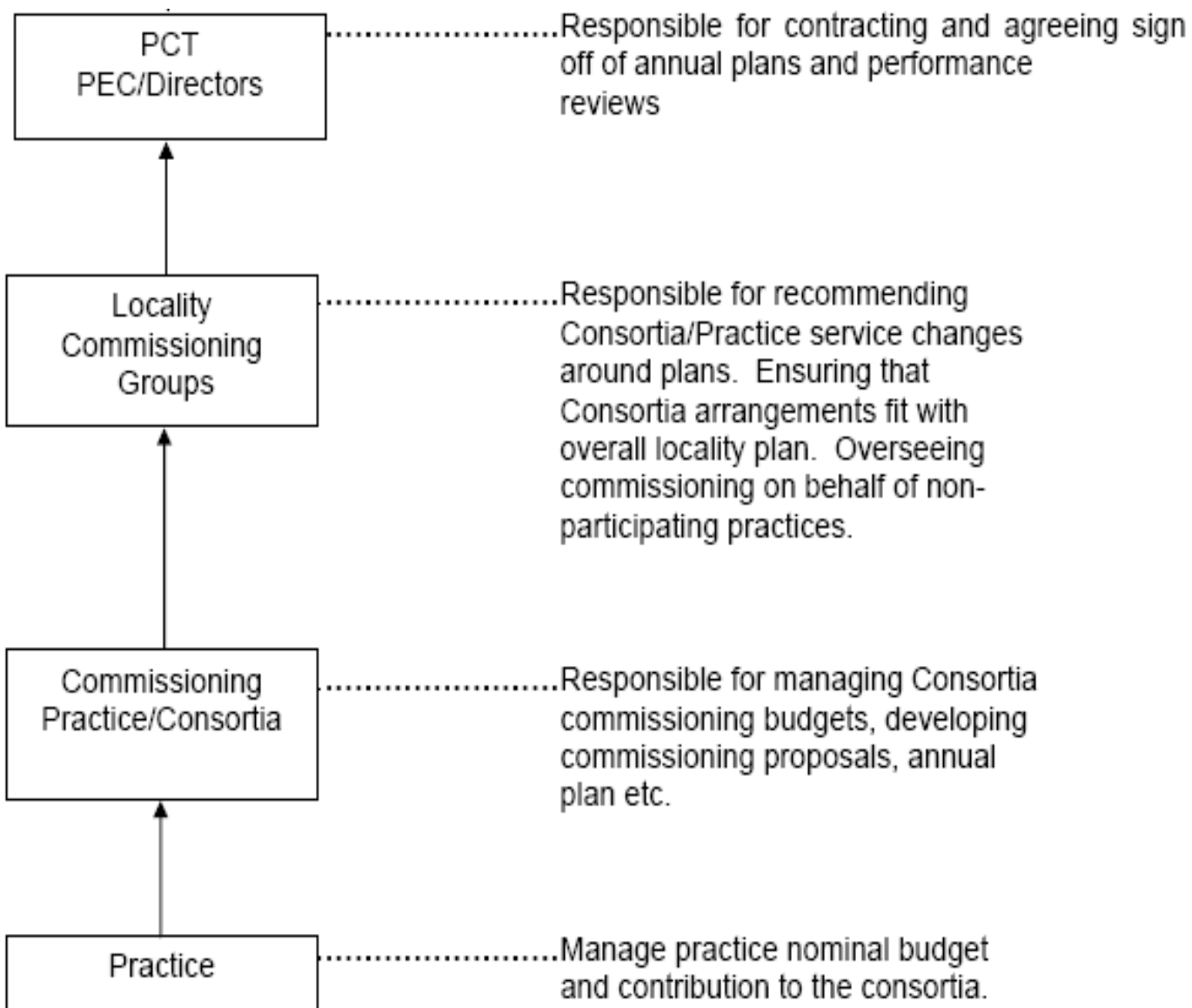
- Sets direction for PbC
- Help devise clinical pathways of care
- Oversee appropriate use of admin costs
- Make recommendations to the board as to use of any freed up resource
- Ensure probity and transparency in process
- Monitor levels of activity and spend

PEC has role in benchmarking success against the following

- The contribution of any new service to demand management and key policies
- Patient benefits
- Wider public health gains
- Demonstration of whole system solutions
- Value for money
- Provision of appropriate and effective care
- Key stakeholder support
- The involvement of patients and frontline staff

The role of the PCT Board

- Considers recommendations from the PEC
- Signs off processes
- Consider impact of PBC on wider opportunities for modernisation and health improvement
- Ensure no conflicts of interest – e.g. when a provider is also a Practice based commissioner
- Key responsibility to ensure patients and public are integrally involved in PBC



What will be commissioned through PbC first?

- The 'quick wins'
- The ones that practices are most keen to explore
- Ones that would be beneficial to GPs on a day to day basis
- Are most efficient in terms of practice/PCT managerial capacity
- Give greatest patient reward and potential for freed up resource as early as possible
- Offer opportunities under payment by results
- If the PCT offers incentives

Craven, Harrogate & Rural District PCT	General Surgery Orthopaedics Urology Oral Surgery Ophthalmology ENT Elderly care medicine
N. Kirklees PCT	Mental health Teenage pregnancy
Newark & Sherwood PCT	Minor surgery Outpatients / therapy areas Long term conditions and end of life care
Gedling PCT	Dermatology ENT Orthopaedics Ophthalmology Geriatrics Non-elective services eg suspected DVT
East Devon PCT	Specialist Orthopaedic Physiotherapist Dermatology Vasectomy ENT Gynaecology Mixed Fracture/Minor Surgery Community DVT

What will influence the choice of PbC

- **Permission** to develop new ideas and begin implementation
- **Information** – accurate, up to date activity, demand capacity, and financial
- **Support** for clinical practice, day to day backfill and gain greater understanding

How will PCTs know if they are ready to develop shared care as a PBC service (1)

- Does the GP commissioning cluster contain a GP champion or GPwSI
- Is there an established relationship or collaboration between the PCT and the interested GP commissioning group
- Does the group contain other relevant contractors (e.g. pharmacists)
- Is there an identifiable management resource
- Is this a PBC where there are clear aims and objectives and links to LDP and national targets

How will PCTs know if they are ready to develop shared care as a PBC service (2)

- Is this an area where there is transparent resource mapping and clear budgets
- Have financial risks been identified and quantified
- Has agreement been reached in terms of use of freed up resource
- Can appropriate and timely data be collected and shared with practices
- Is there in built evaluation for the PBC service

How will you determine whether or not a practice or group of practices are prepared?

- Have good understanding of PCT commissioning agenda and LDP processes
- Sound information systems
- Critical mass of patients in the model
- Good systems of clinical governance and risk assurance No disputes with PCT or high levels of complaints or debts
- Can enter into unambiguous agreements with the PCT and other practices
- Demonstrate a commitment to patient and public involvement

Timetable for implementation

- PCT invites practices to make an application (or practice makes an application)
- Application assessment tool applied to determine suitability
- Develop a **shared agreement** between practice and PCT

Shared agreements – what should they contain?

- State high level aim of the PbC locally
- State objectives of the application (SMART)
- Define the parties to the agreement these could be: -
 - Pct (or PCTs)
 - Locality of group
 - Individual named practices
 - Local service providers (as agreed)

Shared agreements – what should they contain?

Key headlines in shared agreement: -

- Description of the key services
 - Those commissioned by the local scheme
 - Those provided by the local scheme
- Accountability and Governance arrangements
 - Named lead personnel and clinical leads
 - Systems of governance service and financial
 - Links to other agreements (PMS/LES)
 - Review notice and termination
- Data transparency and quality
 - Systems of data quality, validation and confidentiality
 - Description of how data will be used including any incentive schemes, rules around budget setting and freed up resource

Key headlines in shared agreement

Performance management

- Locally agreed indicators

- Framework and timescales

- Rules in respect of under or over performance

Contract monitoring and reporting

- Systems and timescales

- Key personnel involved

- Systems for reporting through to PEC

Key headlines in shared agreement

- Financial management
 - Calculation of budgets and contract values
 - Criteria for use of freed up resources
 - Systems for dealing with overspends and financial recovery
 - Risk management and agreed contingencies
 - Review periods
- PCT and practices roles and responsibilities
 - PCT agrees to
 - Practice agrees to
 - Locality group agrees to
 - PCT and practice collaborative and shared management arrangements

Shared care lends itself to inter practice agreements

- Need to define lead personnel and lead clinicians
- Need to define the system of accountability and governance
- Need to define the shared financial agreements

Finance and monitoring

- Current guidance limited but supports local determination of PbC
- There is technical guidance that allows PCTs to calculate a “default budget for practices but currently only applicable to elective in patient care and day case treatment
- Management costs including clinical backfill to enable GPs to get involved in financial planning and data quality for the PbC will require careful negotiation practice level
- Contingencies will be needed – top slice and activity based methodologies are suggested

IT

- Congruence needed between PCT and Practice solutions
- There will be a need to combine national solutions (Connecting for Health) with local ones

Summary

- There is a need for commissioners and clinical leads to develop an understanding of how PbC could be used as a successful vehicle to increase GP engagement in the provision of services to drug users and enhance and innovate
- As an exercise practices could apply the application assessment tool to determine their readiness to offer a PbC solution

Next steps

- The RCGP Substance Misuse Unit in partnership with SMMGP is keen to support the governance arrangements underpin PbC substance misuse services
- Briefing guidance on making the most of PbC for GPs with an interest substance misuse will be published later in the year
- GPs are encouraged to use SMMGP and the SMU Regional Clinical Leads as a means of sharing good practice and information on PbC