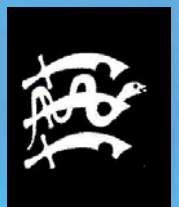


# North & South Essex Local Medical Committees

**PRACTICE BASED COMMISSIONING**  
**A BRIEFING NOTE FOR PRACTICES**



# What is the LMCs' View?

The two Local Medical Committees have considered the subject of Practice Based Commissioning with a view to determining how best to advise practices. The Committees also arranged two Seminars in February with representatives of PCOs to explore ways in which the organisations and practices could work together in introducing any new arrangements.

The view of the LMCs at the present time is that they should offer support and advice to practices who wish to become involved in Practice Based Commissioning but at the same time they should continue to protect the position of practices

who have no wish to participate. (This may change in the future - see page 3.)

This Briefing Note has therefore been produced to assist practices who feel that Practice Based Commissioning offers real advantages to themselves as providers/commissioners of services and to their patients. The document highlights what the LMCs consider to be some of the key issues and principles and [includes some recommendations on important areas such as management costs, savings and risk management arrangements.](#)



## Sources of Reference

In producing this Briefing Note for practices, reference has been made to the following documents:-

Practice Based Commissioning - Technical Guidance

Practice Based Commissioning - GPC Guidance for GPs and LMCs - March 2005.

Practice Based Commissioning - Promoting Clinical Engagement.

The Nuts and Bolts of Practice Based Commissioning - a guide for Practices and GPs - NHS Alliance

10 Steps to Practice Based Commissioning - National Association of Primary Care

Commissioning a Patient-led NHS - 28th July 2005 - DoH

All these documents other than the one produced by the NHS Alliance are available on the LMC Website - [www.essexlmc.org.uk](http://www.essexlmc.org.uk)

# Commissioning a Patient Led NHS - 28th July 2005

**A**t the time of writing this guidance, Commissioning a Patient-led NHS has just been issued by the Department of Health. This document details significant changes in the way in which services are to be commissioned in the NHS.

Practice Based Commissioning is seen as being crucial to the success of these proposed new arrangements. [The Department of Health has confirmed that it "expects to see PCTs make arrangements for 100% coverage of Practice Based Commissioning by no later than the end of 2006. Individual practices will have the option to take on commissioning to a greater or lesser extent depending on their wishes and capabilities"](#).

Under Practice Based Commissioning, practices or groups of practices will have the following main functions:-

*Designing improved patient pathways;*

*Working in partnership with PCTs to create community based services that are more convenient for patients;*

*Responsibility for a budget delegated from the PCT, which covers acute, community and emergency care;*

*Managing the budget effectively.*

This recent document, and its implications for general practice, has totally altered the way the NHS will function in the future. There is now a real opportunity for practices to be part of the solution to the commissioning problem.

**The pace of change towards Practice Based Commissioning is sure to increase. Practices must ensure that they have ownership of what is being proposed and are properly resourced to be able to commit the necessary clinical management time that Practice Based Commissioning will require.**



# Background

- General Practice currently accounts for more than 80% of NHS patient contacts. In doing so it either directly or indirectly commits the majority of NHS resources.
- Practice Based Commissioning gives practices the ability to

influence commissioning and provide more services in a primary care setting.

- Practices will be able to ensure that funds transfer from secondary to primary care to accompany the change in the pattern of service provision.



# Who Can Take Part

- **All practices are entitled to request an indicative budget to commission health services.**

- **PCTs are not able to refuse unless there are clear reasons why**

**the practice(s) is/are unsuitable.**

Practices may choose to take part on their own or in groups/clusters. The decision rests with practices.

It is not for PCTs to determine localities for the purposes of Practice Based Commissioning.

# Service Planning

- The range of services to be commissioned is for practices to determine following discussions with PCTs. It is envisaged that some practices may start with a limited range of services, eg high volume elective care.

- The LMCs' proposals on management costs (see page 5) reflect the fact that the pace of change

is likely to be different throughout the county.

- Practices must agree with the PCT how national targets will be met and how their Commissioning Plans meet the PCT's priorities, clinical governance requirements and quality standards.



# Budget Setting

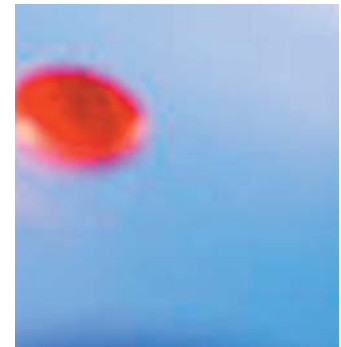
- Legal Accountability for budgets remains with the PCT.

- Budgets will initially be calculated using historical activity data. From 2006/07 funding will be based on a weighted capitation formula ("Fair Shares").

- The timescale for moving to a system based on "fair shares" will need to be agreed between PCTs and practices.

- Practices will be expected to balance their budgets over three years. Failure to do so could result in the budget being

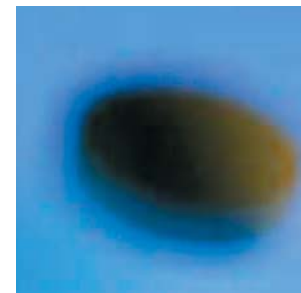
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# Default Budget

- As a minimum in 2005/06 practices are entitled to a Default Budget. This relates to elective inpatient and day-case activity only and will use 2003/04 activity as a baseline.

- The default budget for 2005/06 will be uplifted to reflect increased demand.



# Choose & Book

- Practices need to demonstrate their intention to implement Choose and Book. It appears likely that Choose and Book may well change significantly in the near future.



# Patient Involvement

- Patients will need to be involved in the Practice Based Commissioning process. This applies particularly to decisions made about the range and location of services to be commissioned.
- Now PCTs will be larger and more distant 'Authorities' and PBC is the opportunity for clinicians and patients to make real changes to their local NHS.

# Managing Risk

- Practices and PCTs will need to work together to agree arrangements for managing the financial risk. PCTs are likely to want to top slice practices' budgets to create a Contingency Fund to meet overspends.
- Practices must ensure that any top slice is not excessive. [2% is suggested as being reasonable.](#) Any Fund should only be used to cover overspends of participating practices.

# Payments

- Payment by Results will be the system of payment used in Practice Based (and other Acute care) Commissioning.
- Under this system each episode of care provided for a patient is paid for at a nationally agreed tariff.
- Payment by Results is designed to stop Hospitals from cost shifting between procedures. It [does not apply in primary care](#) and in effect practices can therefore undercut tariff prices.
- Practices, as budget holders, will need to make sure that charges made against their budget are correct. [This validation process would greatly improve commissioning and should be encouraged as a mutual form of PCT/ practice co-operation.](#)

# Savings/Efficiency Gains!

- Practices can keep up to 100% of any savings (less management costs) subject to PCT approval.
- Spending plans must be agreed with PCT Professional Executive Committees (PECs) and PCT Board.
- In PCT areas where financial deficits exist, it may be unrealistic for practices to retain 100% of savings. A compromise needs to be agreed between practices and the PCT. [It is suggested that practices should retain not less than 50% of any savings.](#)

# Management Costs

- The funding of adequate management costs by PCTs is essential if Practice Based Commissioning is to succeed.
- Management Costs must include payment for the clinical time necessary to plan, implement and monitor changes in service provision.
- Devising an appropriate management structure and administering any associated recruitment process is the responsibility of practices.
- PCTs must provide management costs at the onset of the project and these need to be agreed with practices.
- **Where practices group together individual management allowances may be subject to reduction following negotiation between practices and the PCT.**

- Practices will be expected to have in place audit trails to demonstrate that monies have been spent appropriately.

- Areas where expenditure on management costs would be appropriate include:-

*Costs of clinical management time which may include locum costs*

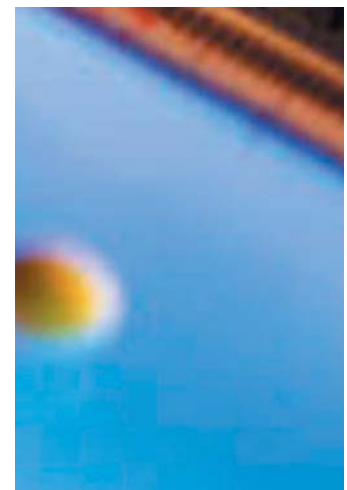
*Data validation/general management costs*

*Training, including workshops, Conferences etc*

*Specialist advice*

*Capital costs. Any capital items purchased must relate to the administration of commissioning arrangements.*

*Cost of developing services, including relevant research.*



*The following is recommended by the Local Medical Committees for 2005/06 Each practice management allowance of £25,000 pa plus a capitation payment as follows: -*

<i>Where 0-25% of eligible services are being commissioned</i>	<i>£1.25 per patient pa</i>
<i>Where 26-50% of eligible services are being commissioned</i>	<i>£1.50 per patient pa</i>
<i>Where 51-75% of eligible services are being commissioned</i>	<i>£1.75 per patient pa</i>
<i>Where over 75% of eligible services are being commissioned</i>	<i>£2.00 per patient pa</i>

*The figures above would provide adequate total resources across Essex. The balance between management allowance and capitation, and any restrictions on the use of allowances are for further discussion.*

- An outline of anticipated expenditure on management costs will need to be discussed annually between the practice and the PCT.
- **The agreed amount of management costs will be paid in full to practices at the start of the financial year.**

# Arbitration

- Wherever possible disputes should be **managed and resolved locally**. The LMCs are available to assist practices and broker resolutions with PCTs.

- Where local resolution is not possible,

a formal system of arbitration exists that is overseen by the Strategic Health Authority. An LMC representative is included on the Committee constituted as part of these arrangements.

- Arbitration should normally be resolved within one month of notification.

## Next Steps for Practices?

**S**uggestions include:

- Decide whether the practice wishes to work on its own or with other practices to commission services. For smaller practices, working together and sharing expertise and clinical management may be the best approach.

- Agree what services are to be commissioned.

- Agree a budget with the PCT.

- Ascertain whether any of the practice team or other primary care performers have skills that could be used and funded under practice based commissioning.

- Involve local pharmacists in discussions. The new contract arrangements provide an opportunity for GPs and community pharmacists to work together to provide services differently.

- Identify possible areas for improvement. Put in place arrangements to obtain and validate hospital data.

- Determine the level of resources, and particularly the clinical time necessary, to support practice based commissioning.

- Agree how patients and/or their representatives will be included in the commissioning process.

- Determine how any savings will be spent and if the project involves more than one practice how these will be apportioned.

- Initiate discussions with the PCT about your proposals, including a start date.

- Access other sources of advice, including the LMCs and obtain information from practices already involved in practice based commissioning in other areas.

- Keep up-to-date with developments. Further advice is expected from the Department of Health, eg Management Costs, expected this month!!