

## Annex 6

### Specification for a directed enhanced service in England: towards practice based commissioning

1. In June 2004 The NHS Improvement Plan indicated, “from April 2005, GP practices that wish to do so will be given indicative commissioning budgets”. Guidance issued by the Department of Health in December 2004 set out the initial steps to deliver practice based commissioning, and reiterated the drivers for change resulting from system reform across the NHS, including:
  - **Choice** – the importance of patient choice as a driver for empowerment
  - **Resources** – changes to the financial regime through Payment By Results offer opportunities for the development of alternative services. Where practices are able to provide or commission services locally, the funds will follow
  - **Care of people with long term conditions** – practices or localities will be able to direct funding into packages of care that best support patients with long term conditions.
2. Practice based commissioning supports and enables primary care teams to assess health needs, plan services and secure delivery of care for patients within the practice. Through greater clinical freedom in primary care, it presents an opportunity to innovate and redesign care pathways and services in primary and community care settings as well as improve management of finite resources.
3. Many PCTs and practices have already been working together to develop practice based commissioning. PCTs are supporting this development by providing practices with referral information, activity and expenditure analysis to encourage stronger demand management and robust patient referral arrangements. In some parts of the country indicative budgets have been devolved to practices.
4. This specification outlines a scheme for engagement in practice based commissioning to encourage those practices that have either yet to engage in developing the initiative, or yet to finalise their plans to do so ahead of the Department of Health national target for universal coverage of 31 December 2006. The DES provides a set of incentives around the key areas that will be important to focus on initially. Where PCTs and practices agree additional workload for practices, additional resource to this DES should be made available. It complements guidance issued by the Department of Health in January 2006. It also encourages practice engagement through guaranteed resources where deficits in local health

economy budgets make the prospect of savings even against reduced activity unavailable.

5. The incentive payments to participating general practices are for 2006/07 and will comprise two components:
  - **Component one:** An early payment in response to the practice and the PCT agreeing a plan for the implementation of the practice based commissioning DES and specific objectives. For 2006/07 the total available for Component one is 95p per patient. This payment is to cover the time needed by the practice to implement the plan.
  - **Component two:** This will be paid at the end of the financial year providing the practice successfully meets the agreed objectives in the plan. This will be a minimum of 95p per patient.

### PCT responsibility

6. This one year DES directs PCTs to offer this enhanced service to all their General Practices from April 2006. There are two components to the scheme. This specification sets out how PCTs will validate practices' activity in order to make the payments. Practices will only be eligible to earn component two of this scheme if component one is payable.
7. It is accepted that there will be similar or alternative schemes already in place and agreed between PCTs and practices that include funding to practices. Where this is the case, the level of funding outlined in this specification must be the minimum made available to all practices. Where the aims and preparatory funding criteria are met through an earlier scheme this DES will fund its provisions. Where such locally agreed funding exceeds that of this DES, then the higher level of funding should be honoured. In essence:
  - Practices will be entitled to the equivalent of component one of this DES when an acceptable plan has been agreed with the PCT. The payment in part one reflects the practice time involved in developing and implementing the DES practice plan.
  - Practices who deliver the agreed plan and its objectives will be entitled to either component two of this DES or other freed resource made against an agreed budget. Component two will not be available in addition to other freed resource that already exceeds the value of component two.
8. For support and guidance, Appendix 1 includes a template for a practice plan.

## Component one: Planning and Redesigning Patient Flows

9. Payment of this component is in recognition of the preparatory time and effort that the practice will need to invest to engage in and develop the practice's DES plan. It also includes funding to implement and monitor the DES plan throughout the year. For any activity above and beyond this DES plan, which the PCT and practice agrees, additional resources should be provided. The emphasis will be on the need for clinical time to be invested alongside non-clinical support time in managing this change. The plan will set out the practice's aims and how they link to the PCT's strategic plan, as well as details of the activity proposed and the practice time to effect change. Once agreed with the PCT, the practice will receive component one of this DES. The plan will provide the basis on which the PCT will monitor the practice's activity and delivery.
10. Practices can take up this DES at any time during 2006/07. Ideally this should be before the end of April 2006. The expectation is that practices' DES plans will be agreed and therefore component one payments awarded by the end of the first quarter 2006/07. Where this is not possible, for example because a new practice is set up mid year or there is a delay by the PCT in providing relevant data to the practice, PCTs and practices will agree a date to finalise the DES plan as soon as possible.
11. PCTs should ensure that any new practices established mid year are invited to take up this DES. Those practices will be entitled to a payment in respect of component one if they develop a plan within a timescale agreed with the PCT, as will they be entitled to component two (or freed up resources) upon achievement of the agreed objectives. Where practices split, merge or close within the year, it will be for the PCT to decide whether and how a payment should be made.
12. The expectation is that PCTs will support their practices to develop their approach and plan in the following way:
  - The PCT will provide relevant information to practices about their use of health services and national/local priorities and commitments. Information to be provided is for local discussion and should include as a minimum:

### Benchmarking data

- Referral rates
- Admission rates
- First outpatient appointment attendances

- Follow up rates

Activity and financial information for NHS and non NHS activity

- Elective data – inpatient and day case
- Non elective admissions inc. length of stay
- First outpatient appointments, and follow up appointments
- Use of diagnostic tests and procedures
- Consultant to consultant referrals
- A&E attendances
- Prescribing
- Community and mental health services
- Primary care particularly essential and enhanced, GMS, PMS, APMS and PCTMS services
- Attendances at other services such as walk-in centres.

Practices will also benefit from receiving information about the needs, demands and demographics of the local population.

Where practices believe these data to be inaccurate the PCT should work together with the practice to ensure an accurate data set is agreed.

- Clearly, there are aspects of care which are not suited to being included in the scheme. These include areas of low volume, high cost treatments, which are usually commissioned through specialist regional groups and are not suitable for pathway redesign at practice level.
- PCTs will need to make available a summary of strategic and local priorities which have been included in planning assumptions and which practices should be aware of in developing their plans. Some of the targets at PCT level may be sensibly quantified at practice level (for example plans to reduce emergency admissions to hospital). PCTs may already be engaging practices in activities that can be reflected in the plans such as local service re-design priorities (e.g. orthopaedics bottle necks and practices' role in patch-wide solutions.) Other plans may include longer-term commissioning agreements, for example through the Independent Sector Treatment Programme.
- Other locally agreed and financed arrangements, for activities such as data verification by practices, are not precluded by this DES.

13. Working with the information provided by their PCTs, practices will be able to produce a plan which should demonstrate a strong

commitment to improving the quality of care for patients including managing patients in primary care through improved or extended services, ensuring the most appropriate use of secondary care.

14. The practice's plan will include information about how the practice based commissioning DES is to be implemented, including:
  - Details of practice clinical engagement, including identifying a clinical lead, and proposed activity including clinical areas that will provide a focus for activity in the practice.
  - Proposed improvements to be made relating to reasonable and achievable objectives that are relevant to the practice's existing circumstances; achievement of these objectives will result in payment of component two (in the absence of an equivalent level of freed up resources). The objectives might relate to for example, redesigning care pathways, reducing the level of referrals made into secondary care, or a reduction in unplanned admissions. It will be for the practice and the PCT to agree the specific targets.
15. Managing the level of acute referrals and admissions is dependent on redesign and/or development of services to support patients in the community. A key expectation within practice plans will therefore be the plan to manage care differently for patients with long-term conditions, in particular, in line with national and PCT commitments. For practices, this is likely to involve investment in primary and community services and engagement with the PCT, providers, and locality arrangements in planning and redesigning care pathways. Clinical engagement and participation in these discussions should therefore be reflected in plans.
16. Practices will be expected to work with other relevant local stakeholders, especially community staff and social services in the development and implementation of their plans.
17. The practice may choose to work alone or with other practices and with support from the PCT in developing commissioning and service redesign arrangements and in producing a plan. However, commissioning and redesign plans must fit with the overall strategy and be approved by the PCT. Where there is a composite plan drawn up by more than one practice, each practice will still remain eligible for component one of this DES, as will they for component two (or freed up resources).
18. The practice should expect PCT support on:
  - Clinical reviews of appropriateness of provider activity, as well as emergency admissions, for example, to help identify where inappropriate activity takes place in relation to the national tariff, such as unnecessary A&E admissions.

- The delivery of national priorities such as patient choice, access and clinical targets, and reducing health inequalities as set out in *Choosing Health*.

## Component two: Demonstrating Success

19. GP practices, through practice based commissioning, will be able to improve the range of services delivered in the community and ensure that the right care is delivered to patients at the right time and in the right place.
20. For practices to be eligible for component two, they will need to have met the objectives agreed with the PCT, as identified in the practice plan.
21. Practices will be expected to invest component two in practice activity designed to ensure continued or improved achievement against the objectives agreed in the DES plan.
22. Payments for component two will not be available in addition to resources freed up from the practice based commissioning budget. Where these resources do not meet the minimum level set out in component two of this DES, the difference should be met by the PCT if agreed activity targets have been met. Component two is the minimum that the practice will receive.
23. In reaching agreement on objectives the PCT and practice will need to ensure account is taken of local circumstances, which may include, for example:
  - i. Significant changes to practice populations
  - ii. Changes which are reflected at national level (e.g. flu outbreaks)
  - iii. Changes to coding or counting practice
  - iv. Taking into account patient and public views
  - v. Additional activity required to achieve improved waiting times as per national targets (e.g. 18 week target).

# Appendix A

## Practice plan template

1. Practice name and details and if joint plan with other practices.
2. Agreed scope of services covered by indicative budget. Description of specialties and nature of service (acute/elective) which practice is to redesign in order to improve services to patients and/or the nature of activity/planning to be undertaken by practice to achieve more appropriate hospital usage.
3. Method by which quality of the redesigned services will be assured/ demonstrated.
4. Agreed baseline of referrals and/or admissions by speciality for 2005/06.
5. Agreed threshold for meeting the objectives in this DES plan to trigger the award of component 2.
6. Agreed information and monitoring requirements by PCT and practice.