

Practice Based Commissioning Fact Sheet

What is Practice Based Commissioning?

Practice Based Commissioning is a Government policy, which largely passes the responsibility for buying local health services from Primary Care Trusts (PCTs) to local GP practices.

Under Practice Based Commissioning, GP practices are given a budget, which they have the responsibility for using in order to provide health services for the local community. This involves:

- Identifying the health needs of the local community
- Designing effective and appropriate health services to meet those needs
- Choosing where their limited budget would be better spent

PCTs are responsible for ensuring that all GP practices receive:

- Information that will allow them to understand how they are doing compared to local and national targets
- An indicative budget covering an agreed range of services
- Support and the offer of an incentive payment (Direct Enhanced Service) or locally agreed payment.

The guidance says that all GP practices taking part in Practice Based Commissioning will include as a minimum:

- All services covered by the national tariff under Payment by Results (1) in 2007/2008
- Primary Care Prescribing

PCTs also ensure that appropriate governance and accountability arrangements for Practice Based Commissioning are agreed.

Why was it introduced?

Practice Based Commissioning aims to give local doctors and nurses' greater control over where they feel money should be spent in order to best meet the needs of their local community.

The Department of Health lists other potential benefits as follows:

- A greater variety of services from a greater number of providers
- In settings that are closer to home and more convenient to patients
- Bringing the decision making process closer to communities
- More efficient use of services e.g. eliminating unnecessary hospital stays
- Greater involvement of front line doctors and nurses in commissioning decisions

However, Practice Based Commissioning also has a role to play in ensuring good value for money and that any savings made are used effectively.

How does Practice Based Commissioning work in South Staffordshire?

The South Staffordshire Primary Care Trust serves a population of around 604,000 people and is located within the boundaries of Staffordshire County. The PCT is responsible for residents registered with a South Staffordshire PCT GP in six of the county's local authority areas, including:

Cannock Chase District Council
Stafford Borough Council
South Staffordshire District Council
Tamworth Borough Council
Lichfield District Council
East Staffordshire Borough Council

For the purposes of Practice Based Commissioning, the six areas are divided between two locality teams covering the East and West respectively. These are broken up as follows:

West Locality – Cannock Chase District Council
Stafford Borough Council
South Staffordshire District Council

East Locality - Tamworth Borough Council
Lichfield District Council
East Staffordshire Borough Council

Each locality team includes a Locality Director, Practice Based Commissioning Leads for each area, Public Health Leads for each area, a Commissioning Manager, a Finance Lead and a Public and Patient Engagement Lead, along with administrative support staff.

GP Practice Based Commissioning Consortiums – How are they arranged locally?

Within each locality area, the majority of GP Practices have come together to create local commissioning consortiums, although some practices have decided to remain independent. Each consortium has its own governing Board and it is these consortiums that are responsible for the commissioning budgets in their areas. Independent practices are responsible for their own budgets.

The GP commissioning consortiums in South Staffordshire include:

Cannock Chase Commissioning Consortium
Stafford and Surrounds Practice Based Commissioning Locality
Seisdon Peninsula Local Commissioning Group
East Staffs Commissioning Consortium
South East Staffordshire Consortia

How are the budgets being set?

All member GP practices are given an indicative budget for the services covered by the national payment scheme, known as Payment by Results (see note below) and primary care prescribing. An indicative budget means that the PCT holds the actual money, but it is the GP practices that choose where it should be spent.

In addition, the consortiums are given an indicative budget for all other services included within the Practice Based Commissioning scheme.

Certain services are excluded from the scheme such as core General Medical Services (GMS)/Personal Medical Services (PMS), specialised services, services commissioned regionally and nationally and national screening programmes.

Subject to the quality of information available and the ability to break this information down to practice level, some budgets for other services may have to be costed at a consortium level initially. If so, further work will be undertaken for these services to be costed at individual GP practice levels.

What happens if a practice runs over budget?

As the budgets are indicative, overspends must be met by the PCT. However, practices are expected to balance their budget over a three-year cycle. In particular, overspends in any one year are expected to be balanced out by under-spends in another. The practice holds the responsibility for managing the financial risk.

If a practice is unable to balance their budget over a three-year period they may lose the right to an indicative budget for three years, although the PCT has the power to waive this rule.

The Department of Health recommended that PCTs “top slice” a small proportion of the budget (in other words keep a proportion of the money back) to hold in a contingency fund which could be used to cover any overspends. This fund would then act as a pool of practice funds to be used for overspends in all practices. If the fund were in credit at the end of the year the funds would be distributed proportionately to those practices that have underspent or balanced their budgets.

In South Staffordshire, the local consortiums have created a “risk pool” that they manage. If one practice overspends and needs to access the pool they have to justify their budgetary problems to the other members of the pool.

How are savings spent?

With the exception of agreed management costs, savings can only be spent on patient services and “should be used to improve clinical services in a substantial way”. This can include buildings where these would enable a wider range of services to be provided or services to be provided to a larger population.

Practices are asked to draw up an agreement for how they intend to spend any savings at the beginning of each financial year.

What is the role of the Professional Executive Committee?

The Professional Executive Committee (PEC) is a subcommittee of the PCT Board and comprises of a group of clinical leaders from a variety of backgrounds. PEC's role is to advise and inform the PCT board using current research and evidence and to uphold patient safety while supporting the delivery of all national and local health plans and initiatives.

It is the role of the Professional Executive Committee (PEC) to oversee the use of management costs and to approve proposals for the use of efficiency savings through the PBC Governance Group. The PEC ensures that all decisions make good clinical sense and are best for patients.

There are extensive guidelines on what PECs should take into account when making their recommendations to the PCT board. A list of these considerations is available in the DoH document “Making Practice Based Commissioning a Reality: Technical Guidance”.

PECs are particularly asked to take into account the extent to which practices have obtained the agreement of other front line staff – for instance, community matrons, district nurses, health visitors, allied health professionals

and school nurses - when making any commissioning decisions that will impact on their patients.

Is Practice Based Commissioning limited to GPs?

No, the guidance states that groups other than practices can hold indicative commissioning budgets. Examples given are nurses or community matrons. The legal mechanism for this is through Personal Medical Services contractual frameworks. However this does not guarantee that groups other than GPs will not be marginalised.

Is this GP fundholding being reintroduced?

There are some similarities between Practice Based Commissioning and GP fundholding (2) but the context and the rules of the two schemes differ:

- GP fund holders were legally autonomous, whilst Practice Based Commissioning exists as part of larger PCT framework.
 - Practice Based Commissioning potentially covers the commissioning of most local health services; GP fundholding covered only limited services.
 - In GP fund holding there was no requirement or minimum standard for patient choice.
 - Fundholders negotiated their own prices for care services – under Practice Based Commissioning; prices will now be determined using new nationally set standard tariffs.
- 1) 'Payment by Results' (PbR) – a financial system where hospitals are reimbursed for the activity they carry out using a tariff of fixed prices that reflects national average costs. Hospitals are paid on a 'per case' basis with treatments and procedures, which are clinically similar and require similar levels of resources, assigned to a 'healthcare resource group' (HRG). Prices for activities in each group are set by the Department of Health and detailed in a national tariff. The same price is paid by commissioners no matter which hospital provides treatment and it covers all the activities involved in the procedure.
 - 2) GP Fundholding - Under the National Health Service and Community Care Act (1990), GPs could apply for fundholding status, which gave them greater control over their budgets. Under GP Fundholding, practices were allocated budgets from which they could purchase certain health care services such as outpatient care, specified inpatient care, hospital direct access services. GP fundholding was abolished in 1999 amid concerns that it helped to foster a two-tier health service with doctors able to use their financial independence to negotiate a better deal for their patients over those outside the scheme. The accusation was made that certain patients got seen quicker at hospitals that had a contract with a GP fundholder.