Bath & North East Somerset
Practice Based Commissioning Consortium

Practice Based Commissioning Plan for 07/08

Draft version 1 (22nd June 2007)

Introduction

1. Practices are required to produce an annual PBC commissioning plan for approval by the PCT Board. The plan outlines the workplan and key priority areas for the PBC consortium, representing all the practices in BANES. It should be read alongside the funding arrangements for PBC for 07/08, which are attached as Appendix 1.

Background

2. Practices in BANES believe that Practice Based Commissioning plays a vital role in the reform of health services, providing opportunities for practices to be at the forefront of designing and implementing changes to patient care and experience.

3. The Department of Health paper 'Practice Based Commissioning – practical implementation' (November 2006) explains that the last year has been 'focussed on putting in place the environmental building blocks for PBC, and good progress has been made. Work in 2007/08 must build on that which has been done so far, by delivering practical implementation of PBC that makes a difference to people's lives'.

4. Considerable progress which has been made in establishing PBC in 006/07, both in starting the work of developing new pathways of care and in learning for the Commissioning Executive and Practices. This year has seen the development of the consortium, establishing the commissioning executive and clarification of the role of the PCT- all essential foundations for delivering the practical implementation of PBC. 2007/08 will see the completion of initial pathway changes resulting in benefits to patients, development of new areas of work and greater involvement of practices in PBC.

5. 'Practice Based Commissioning – practical implementation' states that the level of detail in practice based commissioning plans should be kept to a minimum. Therefore this plan seeks to provide an oversight of the main areas of work and pathway development for 07/08.

Practice Based Commissioning in BANES 2007/08

6. The 27 GP practices in B&NES (excluding the PMS practice for the Homeless) will continue to work together in 2007/08 in implementing Practice Based Commissioning. The practices established a Commissioning Executive in April 2006, which was funded in 2006/07 by pooling the DES payments (Component 1) for participation in PBC. The DES was provided to fund time and resources expended by practice based commissioners in engaging and developing PBC plans.

7. The DES payments for PBC end in March 2007, and PCTs are now expected to ensure they continue to provide the necessary support and tools to enable PBC to flourish. BANES PCT will continue to provide incentive funding equivalent to the DES funding for delivery of the PBC plan for 07/08.

8. The basis of the Consortium in 07/08 is summarised as follows:

    - The Consortium will be led by a Commissioning Executive
    - The Executive will be made up of 5 GPs, 1 Nurse, 1 Allied Health Professional and two practice managers.
    - Any new members of the Executive will be interviewed on behalf of the 27 practices prior to appointment
    - Each member of the Executive is required to release the equivalent of 4 sessions (or 2 days) per month to support the delivery of the practices' commissioning plan
    - The Executive will fund additional clinical time from health professionals with expertise in specific areas to undertake project work
    - The Executive will agree priorities for the commissioning plan with all practices
    - The Executive will agree the Commissioning Plan with the PCT
    - Financial risks and savings will be pooled under the consortium arrangement

9. The Executive has produced the following Commissioning plan for 2007/08. The plan supports the PCT's overall strategic direction and is consistent with the PCT's existing priorities. The plan sets out the key priorities for pathway redesign and development of new services, and a framework for the use of freed up resources.

Communication within the consortium

10. The PBC executive will continue to organise quarterly meetings with all practices, and will also develop a web site to aid in communicating to practices, sharing developments and as an access point for relevant papers and best practice information. The website will be maintained by the PBC Executive.

Patient and Public Involvement

11. Patient and public involvement in the commissioning process is a vital part of practice based commissioning. The PBC executive has periodically updated the PPI Forum and the Overview and Scrutiny Committee on its work programme during 2006/07, and will continue to do so in 2007/08.

12. The Commissioning Executive will ensure that users and /or carers are invited to provide input into service re-design proposals as they emerge. Involvement of users, carers and voluntary groups is part of the core methodology for service improvement described in section 12.

Pathway changes and development of new services in 07/08
Criteria for identification of key areas of work

13. Areas for focussed work by the PBC Executive are selected according to the following criteria:

- Significant improved services to patients is likely and achievable
- New services are likely to be clinically effective
- Any new service or pathway change is likely to deliver savings
- The proposal is in line with local health needs, PCT and national priorities. Areas where the PCT is identified as an outlier in benchmarking and productivity matrix information is a priority.
- The resource and effort required to develop the new service is in proportion to the likely benefit to patients and delivery of key priorities

14. In addition to the key areas of work identified in this paper, other areas for alternative provision are likely to be offered by providers during the year, and will be assessed by the PBC Executive against the above criteria.

Methodology for development of new services

15. The PBC plan 06/07 outlined a 7 step methodology to be followed by the PBC Executive in the review services and development of new pathways. This method will continue to be followed for identified areas in 07/08.

- Broad consultation, to include (where relevant) GPs, Community Nurses, Secondary and Tertiary Care Clinicians, Patients, Patient support groups, other Healthcare Professionals, PCT, Voluntary services

- Establishing a project group with interested professionals who are enthusiastic to improve care in the specific area

- Gathering available information and data analysis. To include referral flows, activity levels, benchmarking data. The PCT will support the executive in the provision of this information

- Drawing on published evidence, national service frameworks, NICE guidance etc. Use of public health resource where appropriate

- Identifying best practice, locally and nationally

- Mapping the current service with available information, and identification of areas for service improvement. Use of established tools and techniques for reviewing and improving services

- Development of revised pathways, associated business cases and service specification for submission to the PCT for approval and contracting.

16. The following areas of work are currently either in progress or already being provided. The ongoing development of these priority areas represents the key areas of pathway development work in 07/08. In addition, the executive is working with Social Care to identify key projects for joint working for 07/08.

Pathway development work in progress and planned for 07/08

Development area	**Pathway description**	**Progress to date**	**Next steps**
Musculo Skeletal community assessment and treatment service – this includes Orthopaedics, Rheumatology and Pain Management	Fiona / William Development of a community based triage, assessment and treatment services for musculo-skeletal referrals is a large project which is underway. The intention is to develop a business case for a service which will accept most referrals for rheumatology, orthopaedics, some physiotherapy and pain management. The commissioning executive has successfully implemented a pathway change for prior approval of inpatient pain management referrals, and is working on aspects of the rheumatology pathway.		
Opthalmology pathway	The PBC executive are working with the Ophthalmology SDIG (Service Development and Implementation Group) to identify areas for new services and	?Simon	

Development area	**Pathway description**	**Progress to date**	**Next steps**
	pathways. Three areas for change are a glaucoma pre-referral pathway, developing the use of a lifestyle questionnaire for patients with cataracts to help identify when surgery is required, and cataracts follow ups pathway changes.		
ENT pathway	?Simon The PBC executive are using the skills of a GP with interest and experience in ENT to help identify areas for possible community service development in this area		
Dermatology triage, assessment and treatment service	Jeremy	A business case and commissioning specification has been developed for a community based dermatology service. The proposal has been developed following a process of consultation with other similar services in the area, and in collaboration with secondary care. .	Patient and public input into the model is required.

Managing demand, activity and the budget

17. The Practice Based Commissioning Executive is keen to develop the role of practices as commissioners, and recognises the importance of handing responsibility, accountability and incentives to practices. There are many strands to PBC, including pathway and service development, improving access to patients, providing care in the community and developing practices as commissioners.

18. Although practices are provided with indicative budgets for the whole of the PCT, the reality of practices managing the entirety of the commissioning budget is fraught with complexity. However, the PCT wants to see practices developing in their role as commissioners, and is looking to provide maximum opportunity for practices to demonstrate the benefits of PBC. This includes allocating budgets to allow for identification of freed up resources for reinvestment in patient care in 08/09.

19. In order to overcome some of the issues around full budget devolution, the PCT has recommended that in 07/08 practices, through the consortium, are devolved budgets in defined areas – Outpatients (1st and follow ups), non-elective admissions and Dermatology. Full details are provided in PCT Funding arrangements for PBC (Appendix 1).

20. Practices will establish systems to undertake monthly peer review of referrals sent over the previous month. Practice will record the outcomes and actions from these meetings.

21. [emergency care actions required here]

Appendix 1 PBC Funding Arrangements 07/08

Background

What the guidance says about Incentive Schemes

1. PCTs should develop locally agreed incentive schemes now that the DES for PBC has ended

2. The incentive scheme goes part of the way to funding time and resources expended by practice based commissioners in engaging with and developing PBC

3. The funding made available to practices through an incentive scheme is treated as direct income, to be used as the practice chooses

What the guidance says about Freed up resources

4. Practices are allowed to use a minimum of 70% of freed up resources for reinvestment in patient care (the 30% goes back to the PCT)

5. Practices must have the agreement of the PCT for proposed use of freed up resources

6. Resources released through PBC activity in the previous year should not be deducted from future indicative budget allocations

PBC in BANES in 07/08

7. Full implementation of PBC will take time, and it is helpful to recognise that these funding proposals are part of the gradual implementation of full PBC in BANES, encouraging the full development of practices as commissioners holding and using the commissioning budget

8. The strands of funding (incentive schemes, commissioning executive support, freed-up resources and innovation funding) should be used in each year to encourage involvement and progress towards full PBC. In addition, in the initial years of establishing PBC support is required to enable the commissioning executive to continue to work on behalf of the consortium in developing PBC in BANES.

PART 1

Supporting consortium commissioning executive
Objective: To Support the continued delivery of PBC in BANES through the Commissioning Consortium

9. This recognises that the maintenance of the consortium is key to ensuring the continued development of PBC in BANES. This funding is primarily for the time of commissioning executive members, plus any other training and development requirements.

10. If any practice chooses to cease being part of the consortium during 07/08, the funding for Part 1 will be reviewed mid-year.

PART 2
Incentive Scheme Funding for practices (proposed funding – 95p per patient - registered practice population)

Objective: To encourage practices and the commissioning executive to develop PBC in BANES, ensuring that time and effort is appropriately remunerated. This part covers effort and engagement in the consortium to deliver the commissioning plan.

11. This section is based on the part 2 DES in 06/07, and is distributed to practices, based on an amount per head of population, according to a weighted outcomes framework. For more details see attached appendix 2 attached).

12. Where effort translate into actual measurable results, funding is released as part of Freed Up resources – see part 3.

13. Funding would be released by the PCT directly to practices by June 2008, according to the outcomes delivered in 07/08.

PART 3
Proposal for practice based budget holding and Freed Up Resources

Objective: To allow the PCT and practices to make progress towards full practice based commissioning through gradual introduction of budget holding at a practice level, whilst minimising risk to practices and the PCT.

14. It is proposed that budgets for Outpatients, Non-Elective Admissions and Dermatology are devolved to practices in 07/08 to encourage development of commissioner functions within practices in 07/08. Any freed up resources can be **reinvested in patient care** as agreed by practices and the PCT.

15. If freed up resources are greater than the investment in parts 1 and 2, a proportion of freed up resources will be used to fund either part of or all of the part 1 and 2 investments according to a sliding scale. See appendix 2 for details.

PART 4
Innovation funding for practices

Objective: To encourage innovation and development of new services and ideas. If proven to be successful, developments may be rolled out to all practices as part of the PBC Commissioning plan for 08/09

16. The PCT will set aside funding which is available for practices. The PCT will write to practices and ask for summary business plans, which will be reviewed against a criteria by a panel in July 07. Funding will be for a fixed period of time (normally one year) for successful plans. If the scheme is successful and generates freed up resources then the cost of the implementation would be a direct charge against freed up resources on a sliding scale basis.

Appendix 1
Funding part 2 – Incentive scheme funding for practices 07/08

The following outcomes have been developed from the PBC plan for 07/08.

Outcomes have been weighted to allow for payment to practices based on delivery of the PBC plan. The weighting is expressed as a percentage, and has been applied to reflect the PBC consortium and PCT priorities according to the following broad criteria:

1) Demonstrate that PBC in BANES is becoming established and robust to ensure delivery of effective healthcare to meet the needs of the local population within available resources
2) Provide improved care for patients, providing care in the community as set out in 'Our Health, Our Care, Our Say'
3) Effective practice engagement in commissioning. demonstrating the ability of BANES practices, through the consortium, to effectively manage the commissioning resource

Proposed total =funding available for Part 2 – 95p per patient registered practice population

Funding will be released by the PCT to practices based on both individual practice outcomes (items in section 6) and overall consortium achievement of outcomes (for 1 to 5).

Area		Outcome	Monitoring	Weighting
1. Communication with practices	**1.1**	At least 20 of the 27 practices in the consortium are represented at the quarterly meetings	Meeting minutes	**1%**
	1.2	All 27 practices continue to participate in the consortium	At PCT / PBC Exec review	**3%**
	1.4	Develop PBC website and communication links. Communication and feedback routes promoted to all practices via email, Primary Care News and web site.	At PCT / PBC Exec review	**1%**
			Total % weighting for Communication with practices	**5%**
2. Commissioning Plan	**2.1**	Approval of PBC commissioning plan by PEC and Board, and development of 08/009 plan by March 31st 2007	PEC and Board minutes	**5%**
			Total % weighting for approval and development of commissioning plan	**5%**

4. Public and Patient Involvement	**4.1**	In partnership with PCT, update PPI Forum with PBC update at least twice during 07/08	PPI forum minutes	**5%**
	4.2	Ensure involvement of patient representatives in pathway development work	Pathway development work records	**10%**
	4.3	Develop a PBC patient and public involvement strategy	At PCT / PBC Exec review	**5%**
			Total % weighting for Public and Patient Involvement	**20%**
5. Develop alternative pathways of care	**5.1**	Undertaking pathway development work in at least three pathway areas, following the method described in the commissioning plan, including stakeholder involvement, PPI, benchmarking and implementation of national frameworks and best practice	PBC plan 07/08	**20%**
	5.2	Development of commissioning specifications presented to the in at least two areas. Likely areas to could include Musculoskeletal, , ENT, Ophthalmology	Copies of specification and cases to PCT	**20%**
			Total % weighting for developing alternative pathways of care	**40%**

6. Managing demand, activity and budget	6.1	PBC Executive identified and worked with outlying practices for outpatient referrals and emergency admissions, developing and implementing an action plan where appropriate. Outlying practices able to participate in 6.2 when agreed with PBC Executive. All non-outlying practices are within expected natural variation.	At PCT / PBC Exec review	**0%**
	6.2	All practices within natural variation (see 6.1 above) for 1st outpatient attendances to undertake monthly referrals meeting with peer review of referrals Practice to show evidence of meeting and changes to referral patterns as a result.	Practice meeting notes and actions	**15**
	6.3	All practices within natural variation for emergency admissions (see 6.1 above) to undertake actions – details still to be confirmed. Options could include: Collate and maintain register for high risk patients, in line with BANES long term conditions working group recommendations or Completion of template for any emergency admissions, to cover reasons for admissions, alternatives considered, any other services which might have helped avoid the admission.	Practice meeting notes and actions	**15**
			Total % weighting for Managing demand, activity and budget	**30%**

Appendix 2
Proposal for practice based budget holding and Freed Up Resources

Developing commissioner function at practice level
Devolution of budgets for Outpatients (1st and follow ups), emergency admissions and Dermatology

Introduction

a) The Practice Based Commissioning Executive is keen to develop the role of practices as commissioners, and recognises the importance of handing responsibility, accountability and incentives to practices. There are many strands to PBC, including pathway and service development, improving access to patients, providing care in the community and developing practices as commissioners.

b) Although practices are provided with indicative budgets for the whole of the PCT, the reality of practices managing the entirety of the commissioning budget is fraught with complexity. However, the PCT wants to see practices developing in their role as commissioners, and is looking to provide maximum opportunity for practices to demonstrate the benefits of PBC. This includes allocating budgets to allow for identification of freed up resources for reinvestment in patient care in 08/09.

Proposal

c) In order to overcome some of the issues around full budget devolution, the PCT suggests that in 07/08 practices, through the consortium, are devolved budgets in defined areas – Outpatients (1st and follow ups), non-elective admissions and Dermatology.

d) First outpatients and non-elective admissions have been chosen as areas where there is potential for significant impact by practice level activity, such as referral review and identification of high risk patients. Dermatology has been chosen as practice budget holding is important to support the proposed new pathway.

Implementation

e) The details of implementation and monitoring will need to be described up in a more detailed governance paper.

f) The PCT will provide both the consortium and practices with full activity and financial information for the designated budget areas. This will be in the form of monthly budget and activity information.

g) The PCT will work with the PBC Executive and practice managers to develop the required monthly budget information, and practices will also be encouraged to access specific details from Axiom if required.

h) Individual practices will be provided with monthly budget information for GP referrals, outpatient attendances, follow-ups and non-elective admissions at the RUH, UBHT and North Bristol Trusts. Further performance indicators could be agreed with the Consortium to assist with the effective management of these specialities.

i) The PCT will only monitor some information for the whole of the consortium as this will mitigate against individual practice fluctuations in activity.

Freed up resources

j) Freed-up resources will be defined as reduction in the budget against planned activity. Plan is taken as 2007/08 commissioned activity at all providers.

k) As part of this arrangement, the PCT will ensure that freed up resources are made available for practices to determine use as specified in the PBC Governance Framework 07/08.

l) The PBC Executive and practices will develop a selection of options and funding proposals for the use of freed up resources in 08/09 for reinvestment in patient care.

m) For non-elective care, the costs of planned investments in reducing admissions for 07/08 will be removed BEFORE funding is declared as freed up resource. For example, the allocated investment in Emergency Care Practitioners (ECPs) in 07/08 is expected to reduce emergency admissions. These investments, which are already allocated, will be top-sliced from non-elective admissions freed up resources.

Funding for Commissioning Executive and Practice Incentive Scheme

n) If freed up resources are greater than the investment in parts 1 and 2, freed up resources will fund either part of or all of the part 1 and 2 investments according to a sliding scale below:

Total investment in parts 1 and 2 – approx £400K

Resources Freed Up	70% to practices for reinvestment in patient care	30% to PCT	Return funding for PBC and Practice incentive scheme
£100,000	£70,000	£30,000	£0
£200,000	£140,000	£60,000	£0
£300,000	£196,000	£84,000	£20,000
£400,000	£245,000	£105,000	£50,000
£500,000	£294,000	£126,000	£80,000
£600,000	£350,000	£150,000	£100,000
£700,000	£385,000	£165,000	£150,000
£800,000	£420,000	£180,000	£200,000
£900,000	£455,000	£195,000	£250,000
£1,000,000	£490,000	£210,000	£300,000
£1,100,000	£525,000	£225,000	£350,000
£1,200,000	£560,000	£240,000	£400,000
Further freed up resources to be allocated at 70% to practices, 30% to PCT			