Implementation of Practice Based Commissioning

Lambeth Primary Care Trust

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Summary Report

Introduction

1 In October 2004 the Department of Health (DH) announced moves towards practice based commissioning (PBC). Although PCTs will remain legally responsible for commissioning, setting indicative practice-level budgets and devolving responsibility for working within them is to be encouraged. GP practices that wish to hold such a budget will have a right to do so. PBC became a directed enhanced service (DES) from April 2006.

2 PBC can offer many benefits in the new NHS. In particular, services that genuinely fit the needs of patients may be best designed by those that have the closest contact with them. PBC fits this need and may also help strengthen the primary care sector, manage care pathways, improve the management of chronic conditions and increase clinical engagement. Holding budgets as near as possible to those who make referral and treatment decisions also has some desirable incentive properties, particularly in terms of promoting the efficient use of resources. Since effective commissioning is a key route to securing value for money in the NHS there are good reasons for undertaking much of it at a level where resource allocation can be influenced most effectively.

3 The implementation of practice based commissioning raises a number of difficult questions and challenges. These include how practice-based budgets will be set and what allocation would be ‘fair’, ensuring that PBC and the strategic direction of the PCT are aligned, understanding how PBC fits with the redesign and modernisation agenda and understanding how patients will benefit from the implementation.

4 Failure to manage the transition to PBC and implement this within a coherent strategic framework exposes PCTs to significant business risks. These include failure to deliver the following.

- ‘A patient led NHS’.
- NHS plan targets including:
  - 18 week diagnosis to treatment target by 2008;
  - patient choice; and
  - the government’s aspiration that by December 2006 all practices will be engaged in PBC; and a health service rather than a sickness service.
5 PBC is central to a number of themes and failure risks the ability to achieve:
   • more effective use of the NHS people resource through matching skills to task;
   • Gershon efficiency savings;
   • financial balance and redress historic deficits; and
   • control of supply induced demand.
6 If not well managed there are also risks that:
   • services will be fragmented;
   • inequalities in service provision will be exacerbated;
   • management costs of PBC will spiral out of control;
   • PBC will not provide VFM; and
   • local secondary care services will be destabilised.

Background
7 Lambeth Primary Care Trust commenced the planning for the implementation of PBC in July 2005. As part of the Audit Plan for 2006/07 PBC was judged as a risk for the PCT and it was agreed that the Audit Commission would undertake a review of the implementation between September 2006 and January 2007.

Audit approach
8 Our audit has been focused on five key themes relating to the development of practice based commissioning:
   • strategic fit;
   • financial management;
   • redesign and modernisation;
   • benefits realisation; and
   • value for money.
9 The audit has used the following tools to explore and report on these themes:
   • an initial fact file, incorporating cumulative audit knowledge and experience;
   • interviews with key staff and other stakeholders; and
   • reviews of key documents.
10 Findings in this report reflect the situation at the time of our review and therefore represent a 'snap-shot' at a point in time in the development of practice based commissioning. This approach to commissioning is still in development across the NHS, subsequently the review should be taken in context.
Main conclusions

Strategic Fit

11 The PCT has a clear understanding of how PBC will fit with the overall strategic direction, although some plans have been constrained by the unexpected financial situation the PCT is in, with funds having been top-sliced to rebalance the financial position across the London SHA. Systems are in place to address the key objective of demand management and PBC is seen as a lever to achieve success in this area.

12 The PBC consortia, the Professional Executive Committee (PEC) and the Local Medical Committee (LMC) and the PCT have worked collaboratively to lead local PBC development. This has had the effect so far of ensuring that GPs and practices have remained committed to the process but with little tangible incentives in 2006/07, the PCT needs to ensure it works positively with the staff in the consortia to continue to maintain commitment.

13 Governance arrangements are in place with a transparent and robust system for decision making and a clear line for support and advice. Reports go to the Board and Executive meetings as required.

14 Roles and responsibilities for commissioning are clear, although there is a concern that commissioning and business case development skills among some consortia staff may need to be developed.

Finance

15 Indicative budgets have been set on historical data in accordance with national guidance and agreement with local consortia. Whilst there has been a discussion, there is local agreement to defer a movement to fair shares pending national work on the weighted capitation formula and thus avoid destabilising local healthcare delivery. However, the PCT has developed weighted historical utilisation targets and these will underpin the PBC budget setting methodology for 2007/08.

16 A contingency of 5 per cent has been top-sliced to mitigate against any risks, in line with national guidance. Along with many other PCTs, DES monies have been used to fund management start-up costs. Additional resources to support PBC implementation have been made available. These include incentive schemes for demand management, choose and book and governance. Additional resources have been made available through the provision of Dr Foster software and training, as well as data validation workshops.
Service redesign

There are clear links between PBC and service redesign. A list of key clinical priority areas has been developed based on morbidity and mortality data and cost and volume indicators. Work is now underway with partner trusts in all these specialties to redesign pathways and look at new ways of working. PBC consortia are asked to develop business cases to provide new services and commission others within the envelope of the key clinical areas. All business cases are encouraged to consider equity of access, transferability to other localities and benefits for patients. To date, only one consortium of four has had its business case accepted. This suggests a training need discussed above.

Primary care teams have so far been involved by using individuals from primary care to sit on the Practice Led Commissioning Steering Group and the sub-groups including Finance and Information and Governance. The PBC business case template requires engagement of relevant clinical team involvement, however, little has been done to engage practice and provider arm staff at consortia level in the PBC process to date. PBC may not have the maximum impact expected from it if the full primary health care team is not involved in the process.

Benefits realisation

A benefits realisation plan exists for local PCT priorities, including long term conditions and planned care, both of which are key areas for PBC. The PBC business case documentation directs the applicants to consider benefits in terms of patients, the locality, quality and finance. The next step is to ensure the benefits realised through PBC are captured within the PCT’s existing benefits realization programme.

Whilst the PCT governance processes require patient and public involvement (PPI), there is still a need for consortia to adopt more systematic PPI arrangements, particularly to inform service redesign. Where there is involvement (examples include patients sitting on consortia steering groups), it appears to work reasonably well. However, because this is not systematic, it is not clear what the consortia seek to gain from using patients and the public.

Value for money

A process for performance management is in place and interviews indicate that implementation will commence when service and contractual changes commence in April 2007. The PCT is using the NHS wide finance and activity data sources, however it is recognised these are unwieldy and have significant time delays. Whilst waiting for this to be addressed nationally, the PCT has made Dr Foster available to all practices and has provided advice and training to help practices to understand the data.
PCT performance against PBC performance indicators takes place at SHA level for 2006/07. Interviews indicate that the PCT's performance is strong having achieved both universal coverage and administration of DES incentives. The PCT benchmarks practices on weighted utilisation and providers on key indicators including new to follow-up ratios and uses this data to drive service changes and inform commissioning intentions.

**Recommendations**

Our recommendations, set out in the detailed report and in the action plan at Appendix 1, are designed to guide the PCT in progressing the implementation of practice based commissioning successfully. They are based on the findings of the review under the five key themes noted above and will be added to the Concordat website which is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. Progress in implementation will be reported to the PCT Audit Committee.

**The way forward**

This report will be fed back to the PCT through the Directors of Service Strategy and of Commissioning and an action plan to address our recommendations will be discussed. Once agreed the report will be forwarded to the Audit Committee.
Detailed Report

Strategic Fit

Does the PCT have an understanding of how PBC fits with the strategic direction of the organisation?

25 The PCT has a good understanding of how PBC fits with its corporate direction and annual business plan. By involving the Professional Executive Committee’s (PEC) leadership and Local Medical Committee (LMC), it has ensured that the process is in line with professional and clinical views and plans and has managed to date to keep GPs engaged with the process.

26 The local delivery plan (LDP) states that financial balance is an objective for the PCT through demand management and service redesign. This is supported by the Business Plan which states that PBC is a clear priority for the year 2006/07 and will be achieved through demand management and service redesign. The year 2006/07 is a difficult year for the PCT. Other PCTs and acute trusts across London have fallen into deficit, requiring the SHA to top slice those PCTs in balance (including Lambeth PCT) to address the London financial strategy. This has had an impact on the PCT’s ability to manage PBC as it had envisaged and prevented a number of initiatives coming to fruition at a pace the PCT would have wished.

27 Planning for the implementation of PBC started in 2005. The Commissioning report to the Board in September 2005 notes that local agreement had been reached with the LMC to use 2005/06 as a preparatory year, with the intention of going live from April 2006. At that time the PCT was developing the underpinning policies and framework and analysing activity and finances needed to set indicative budgets.

28 The PEC and the LMC have been involved from the start of the process and ran a number of road shows early on before the PCT staff went out to practices.

29 The impact is that whilst the PCT has been clear about how PBC fits with its overall strategic direction, its plans have been hampered by unexpected financial problems but although this has led to a slowing up of progress, the PCT continues to manage PBC alongside its plans for managing demand and service redesign. PBC is part of a wider organisational plan to change the face of commissioning and stay in financial balance through the redesign of services.

Does the PCT have an understanding of the key practicalities in implementing practice based commissioning?

30 The PCT has an understanding of the practicalities of PBC but will need to ensure that it continues to support consortia as they develop into mature robust commissioning bodies.
The PCT has been working on the impact of PBC since mid 2005 and has developed a Governance Accountability and Operational Framework which sets out a number of priorities for PBC that reflect national priorities. A communications plan was developed in late 2005. It sets out how the process of PBC would be communicated to practices and other stakeholders and aligns itself to the national vision and priorities associated with PBC.

In June 2006, the Practice Based Commissioning Steering Group formally recognised the value in engaging the newly developed local consortia arrangements in local PBC development. In response, the Practice Based Steering Group was disbanded and the Practice Led Commissioning Steering group established. The new group’s terms of reference reflected more consultation and engagement with PBC consortia.

Localities were able to work through the best consortia arrangements for their needs. This has resulted in the commissioning consortia not always following locality lines of demarcation. There are four consortia, some larger than others, covering all but five practices. The PCT aligned support from quality and professional development, public health, finance, service strategy and commissioning and primary and community directorates. Interviews indicate that consortia would appreciate a greater level of support.

The early implementation of a communications plan ensured a clear direction was understood by the practices and stakeholders. It gave practices an opportunity to express their opinions through their PEC and LMC representatives and through communications road shows with PCT staff. The impact has been a clear message throughout to practices and consortia.

Rebalancing the membership of the steering group has given the practices more say and more representation. The public health and finance support continue to be useful; however, jointly agreed training and development processes need to be put in place so that GPs can commission with confidence.

The PBC consortia, the PEC and the LMC have all been involved in shaping developments. This has had the effect so far of ensuring that GPs and practices have remained committed to the process but with little tangible incentives in 2006/07, the PCT needs to ensure it works positively with the staff in the consortia to continue to maintain commitment.

**Does the PCT have an understanding of how PBC will change the face of commissioning arrangements?**

Whilst the PCT is clear about how its commissioning role will change under the new rules, there is a risk that some staff within consortia may not be ready to take on the added responsibility because of lack of training.
Interviews indicate that staff are aware that PBC will change commissioning and whilst the PCT will remain the statutorily responsible commissioner, the PCT will need to ensure PBC informs commissioning decisions. There have been discussions about whether practices in the consortia currently have the breadth of knowledge and skills for this role. There are strategic guides for certain services and potentially, these can act as further support to consortia in their pursuit of successful commissioning.

The PEC is aware that consortia members will need to develop commissioning skills. Interviews also indicate that GPs may well have the skills but are demotivated and do not have the time to take on more activity. There has been some training to use Dr Foster, although five practices are still outstanding and need further training. This is in hand by the PCT.

Developing consortia business cases which describe future commissioning intentions for the implementation of new services has highlighted a training need as only one consortium so far has had its business case accepted. Interviews indicate that consortia staff would appreciate more support in developing the plans.

Consequently, as the practicalities of developing training needs analyses relating to PBC have not been considered yet, there is a risk that some consortia could be unprepared for some of their responsibilities under PBC.

The next step is for consortia to work through best practice for developing business cases.

Has the PCT formulated governance arrangements to ensure efficient commissioning and consistent provision of quality services?

Effective governance processes are developing to ensure efficient commissioning and consistent provision of quality service.

There is a clear governance structure with PBC decisions being made in the PEC sub-committee which is accountable to the PEC and PCT Board. Advice and support is offered from the Practice Led Steering Group, which acts as a 'think tank' and has representation from PBC commissioning consortia, as well as the LMC and PEC. Overall commissioning decisions are overseen by the Commissioning Strategy Group with stakeholder representation from the local authority, and reports go to the executive team and Board as required.

The Governance Accountability and Operational Framework sets out the robust objectives for commissioning intentions. These are:

1. Clear service proposals that demonstrate and articulate:
   - an evidence based approach;
   - a clear service model and care pathway;
   - benefits and outcomes, both qualitative and quantitative, including resources freed up;

Lambeth Primary Care Trust
- a feasibility and risk assessment; and
- an impact assessment – impact on other providers and population.

2 Demonstrate relevant patient and public involvement and how choice will be offered to patients.

3 Demonstrate appropriate quality and clinical governance.

4 Demonstrate financial rigour including affordability and value for money.

5 Consistency with the agreed strategic direction of the PCT and national policy requirements, including existing joint commissioning arrangements.

The fora that guide the implementation of PBC are transparent and robust and there is a clear framework that guides commissioners in all aspects of PBC. These include managing information, performance management, managing risk and governance and accountability. Its use has facilitated the smooth implementation of the process.

**What is the role of the PEC in developing the PCT approach to PBC?**

The PEC has been instrumental in developing the PBC approach in Lambeth PCT. Initially its role was to communicate the process to practices through a series of road shows. More recently, it is the role of the PEC PBC sub-group to approve and sign off the business cases presented by the consortia. The PEC PBC sub group is the decision making and voting body that manages the process of PBC and is accountable to the PCT Board. This system appears to be working well.

The PEC has been involved throughout the process and its decision making responsibilities ensured early clinical engagement in PBC development.

**What arrangements have been made for prioritising and setting a manageable scope of services for the introduction of PBC?**

There has been a clear process to develop a set of priorities for PBC that has involved Public Health, Commissioning, the PEC and key stakeholders such as other PCTs and trusts.

The PCT has been working for some time on its priorities based on morbidity and mortality data. The Public Health department developed an overview in 2005 and advised the development of a number of pathways:

This work was then developed into a list of demand management priorities, based on high volume high cost procedures.

- musculo-skeletal;
- ENT;
- dermatology;
- gynaecology;
ophthalmology; and
• general surgery (dropped from first tranche).

These procedures account for 50 per cent of total outpatient activity.

52 Discussions between the PCT and Guys and St Thomas NHS Foundation Trust have resulted in a senior clinical lead from the Trust working alongside the PCT and PEC to redesign pathways, using checklists. Kings College NHS Hospital and Southwark PCT are now also involved in the process.

53 The consortia are invited to put forward business cases within the scope of the services agreed to redesign services and commission others. The business cases submitted by the consortia are approved by the PEC and outcomes need to demonstrate obvious impact. To date, three of the four have not been approved, largely due to insufficient detail on benefits realisation. This has resulted in delays in the consortia taking forward their initiatives.

How is a balance being achieved? How is the PCT avoiding fragmentation of service delivery and inequitable access to services?

54 Equity of access and service delivery is a priority throughout PBC. Interviews indicate that equity is an objective for the PCT. Out of 53, 48 practices are signed up for PBC. The PCT cites a number of reasons why not all practices are signed up to PBC, which remains voluntary for practices. Reasons include performance issues in some practices as well as reluctance to participate in the demand management elements of PBC and a reluctance to work collaboratively within local PBC consortia for others. The November 2006 Board papers show that the Practice Led Commissioning Group is, developing an action plan regarding the non-participant practices.

55 The PCT is also clear that any commissioning intention business case presented by the consortia has to take account of the needs of the population by demonstrating financial viability, value for money and that if successful, the activity has the potential to be rolled out to other parts of Lambeth.

56 Evidently the PCT is able to demonstrate its commitment to equity. However, there is a risk that approval may be withheld if they were too resource intensive and could lead to longer term inequities. The PCT recognises the need to continue to achieve a balance when considering new proposals from the consortia so that innovation is not lost in the PCT’s visions of achieving complete equity.
**Recommendations**

| R1 | Clarify roles and responsibilities around training needs analyses and delivery to ensure the smooth transfer of commissioning and business case development skills to consortia staff. |
| R2 | Consider what changes to process may have to happen to ensure continued commitment from the consortia despite a withdrawal of incentives nationally. |

**Financial management**

**How does the PCT devolve indicative budgets and manage financial risk?**

57 A robust methodology and process for setting indicative budgets is explicit within the Governance Accountability and Operating Framework. The PCT has been guided by national guidance and has retained actual/historic volume based indicative budgets for 2006/07, rather than start the shift to weighted capitation shares for acute, mental health inpatient budgets. The PCT was a pilot of the Department of Health’s weighted capitation pilot and therefore had early sight of the guidance. Practice based budgets were set in parallel with the local delivery plan (LDP) round for 2006/07.

58 An inclusive process was used to agree a contingency percentage. The PCT had discussions with the LMC and consortia to agree a level of contingency over and above the indicative budgets devolved to practices. This was agreed at 5 per cent in line with national guidance.

59 This suggests the PCT is taking a cautious approach to devolving budgets and managing risk. Whilst this will mean measured but steady progress, it could also potentially demoralise some PBC commissioners who could expect a more rapid resolution.

**How is the PCT planning to achieve fair share budgets by 2008?**

60 Whilst the PCT is working with practices in a proactive way to move to fair shares, a locally determined pace of change is slowing the process.

61 The PCT is working with the PBC consortia in a proactive way to move to fair shares at a locally determined pace. It has assessed fair shares at consortia level and interviews indicate that there is equity according to the 2006/07 weighted capitation formula. 2006/07 practice based weighted utilisation target reductions have been established.

62 With the move to fair shares happening at a locally determined pace and given the limit on expected growth, it is unlikely that fair shares will be managed by 2008.
What systems have been established to meet resource and management costs requirements?

63 Systems have been put in place to support the costs of setting up PBC, including aligned PCT staff, Dr Foster software and training in the form of data validation workshops. In addition, practices have received 2006/07 incentive schemes for data validation, governance and demand management.

64 The PCT has used the DES monies to support management costs. No additional provisions for PBC management costs have been made available to the PCT or practices. The Governance, Accountability and Operational Framework for 2006/07 states that any surplus will be used to supplement PCT funds and only paid to practices when the PCT is in balance. The PCT needs to consider this policy in the light of 2007/08 guidance.

65 Interviews with practice staff indicate a level of concern about the lack of management support, both in terms of financial support and capacity, citing an increase in workload as a result of PBC with insufficient recompense to practices or the PCT to manage associated demands.

66 The impact of the current situation is a potential decrease in practices’ morale and could lead to a lack of commitment on their part. The PCT needs to consider how best to manage the current situation taking into accounts its financial situation as well as the burden of work on the practices.

**Recommendation**

**R3 Clarify what financial and activity information will be collected and used in 2007/08.**

Service redesign

What arrangements are in place for service redesign?

67 There are clear links between PBC and service redesign, specifically demand management. Practices will be responsible and accountable with the PCT for managing waiting times. Five priority areas have been chosen as specialties with high referral rates. Pathways are being redesigned through partnership working with the acute trusts and consortia’s business cases should develop alongside. The business case template facilitates consortia to think through how their commissioning intentions will fit with the PCT’s approach to demand management and strategic direction.

68 The Governance Accountability and Operational Framework makes it clear that PBC is the route to manage demand through referral management and care pathways.
There is a comprehensive approach that links throughout the process between the work of the PCT and the consortia to manage demand.

Has a locality approach to Practice Based Commissioning been considered?

A locality approach been taken to PBC in Lambeth. This was agreed between the practices and the PCT. Lambeth PCT has divided into four consortia. Three are based on geography and patient list size. The fourth has representation from across the patch and is the largest in terms of numbers of practices represented. Consortia are new and working as single entities currently. The impact is that practices are assured as to which consortium they belong to and in most cases work within the patch they know with the same provider (Lambeth Commissioning Group has some practices commissioning across patches).

Is the PCT working with practices to help shift the emphasis from treatment to disease prevention and health promotion?

The PCT is working with practices to move from treatment to health promotion but this is more through the use of quality and outcomes framework (QOF) rather than PBC as it stands. Currently the emphasis for PBC is on managing demand of referrals to secondary care. Targets from the QOF link into the overall PCT strategy and these relate more closely to health promotion.

How does the PCT monitor and manage demand while providing choice under PBC?

Choice is monitored through the patient satisfaction survey. Demand is monitored by information furnished from the acute trusts and reported at performance management meetings.

How does the PCT ensure that practices are working in partnership with other key stakeholders?

Whilst this is a developing process, the increased amount of partnership working is a positive aspect of PBC. The work around demand management requires a high level of partnership working, particularly with acute trust partners. Interviews indicate that a spin-off from the demand management work is that GPs and hospital consultants are renewing old partnerships and work more as a team than in the past. There is also joint work with the neighbouring PCT and some with the local authority, although this is more on a PCT level.

This increased partnership working will have a positive effect on any new initiatives that may be developed between the consortia and the acute trusts.
How has the PCT engaged primary healthcare teams to maximise the benefits of PBC?

75 More could be done to involve other members of the primary care team in PBC at consortia level, so as to broaden the process and achieve commitment from across the team. Currently, the process is GP driven.

76 Primary care teams have been involved in the road shows and are reported to have an understanding of the process of PBC. Community team representation is on the Finance and Information group and non-GP (pharmacy and dental) PEC representatives are on the practice Led Commissioning Steering Group and PEC sub-group respectively. PBC may not have the maximum impact expected from it if the full primary and community health care teams are not involved in the process.

**Recommendation**

R4 Encourage consortia to involve other members of the primary care team in the PBC process as appropriate.

**Benefits realisation**

Has the PCT stated the benefits it plans to achieve at both PCT and practice level?

77 Whilst the PCT is including benefits realisation in its commissioning intentions business case documentation so that consortia demonstrate the benefits for themselves and patients, there is nothing explicit that describes the combined benefits of the PBC commissioning intentions of the PCT.

78 There is a benefits realisation plan for planned care and long term conditions. Benefits are defined in terms of improved health outcomes, reduced inequalities and the financial benefits and cite PBC as an enabler in this process. The PCT has identified the nature, scale and timeframe of benefits it expects to accrue in these two areas.

79 The business case template clearly asks the applicant what impact the change under PBC will have on contract arrangements with the acute sector, financial implications and the impact on the patient.

80 The impact of having benefits stated clearly is that the PCT can have a clear focus on benefits to be derived from PBC and can therefore measure success.
What work has been undertaken to address the challenges of public and patient involvement in PBC?

81 The public and patients have been involved in PBC to a small extent. Interviews indicate that the public are represented on some of the consortia’s steering groups. Consortia business cases also ask applicants for a description of how patient views have been sought. One of the criteria for commissioning intentions cited in the 2006/07 Governance, Accountability and Operating Framework is to demonstrate relevant patient and public involvement and how choice will be offered to patients.

82 There are examples of where the PCT has shown commitment to patient and public involvement in other projects. The ALE work in spring 2006 indicated this and interviews indicate that work on developing renal services has included using a sub group up of five patients and four clinicians. There is also representation on the sexual health group. The next step is to extend this practice into work on PBC.

83 Whilst there is a documented commitment to PPI, there is scope to use patients and the public in a more formal and consistent way across all work streams, rather than in specialties historically proactive in patient involvement.

How will the PCT ensure the PBC benefits the local health population and not just individual patients?

84 It is implicit in the work of the PCT that equity of access to services is a commitment the PCT is signed up to. The business case template specifically asks how the practices’ intentions will affect access and equity of access. Patient choice is monitored through the patient survey annually.

85 The PCT is clear about its commitment to equity of access and the next step is to have a process of measuring its success.

Recommendations

R5 Ensure benefits realisation is integral to business case development.

R6 Encourage the consortia to take a consistent approach to involving patients in the development of practice based commissioning.

Value for Money

Does the PCT have a clear understanding of what it is gaining from delegated indicative budgets?

86 Systems have been approved which should ensure that the PCT has a clear understanding of what it is gaining from delegated budgets.
The PCT is clear about the information it will use to performance manage PBC and these are listed in the 2006/07 Governance, Accountability and Operating Framework. Financial benefits are expected in each of the PBC consortia business cases. Performance monitoring relating to PBC will take place through quarterly reviews involving the Commissioning Strategy Group and the PEC sub-group and is planned to start in 2007. In addition, clear performance monitoring of demand management practice level target delivery is in development. It is important that a robust basis for performance management of practices and consortia is developed for the PCT to assure itself that PBC is being effectively embedded and is achieving its strategic objectives.

Are there mechanisms in place to demonstrate and improve VFM?

Systems to demonstrate value for money are developing. The PCT has been systematic in its approach to managing demand by benchmarking all the specialties and focusing on key priorities. The impact of demand management interventions is monitored by the Demand Management Programme Board and reported at the Commissioning Strategy Group as part of the overall Local Delivery Plan updates. The benefits realisation plans for long term conditions and planned care make reference to the benefits in terms of financial gain. The business case template asks for a forecast of efficiencies gained and the basis for assumptions (examples include first call on resources, distribution between practices and services if more than one service area). The PCT has a good understanding of the current costs of service provision and planned future costs under PBC. However, at this stage in the process their success is difficult to judge against PBC development.

Is accurate data and information available to operate PBC efficiently and effectively?

Whilst data to performance manage PBC is available, finance and activity data used to inform commissioning from NHS wide sources is not current and is unwieldy. The PCT has sought a pragmatic local solution through the investment in Dr Foster and anticipates the NHS wide systems will improve as the data sources move to Secondary Uses Service in 2007.

Data to inform commissioning from the NHS wide data source is subject to time delays. Practices have been able to access information but data is subject to the national quality assurance processes and may not be cleaned for three months. Indications are that this situation has improved in recent months.
Interviews indicate that Dr Foster data enables each practice to undertake data analysis as it provides each practice with the opportunity to report on and investigate recorded completed hospital activity for their patients and assign a national tariff based cost. However, there is no national requirement for acute trusts to provide subspecialty data and thus the PCT and practices cannot view condition specific activity. Therefore, the PCT and consortia are having difficulties assessing health needs and making informed decisions about which services can be moved from secondary to primary care and which ones are needed in the community. The impact of the poor quality and timeliness of the data is that it currently cannot be used to inform commissioning decisions in a meaningful way.

**What bench marking is being undertaken with regard to practice based commissioning?**

Some formal benchmarking is happening on a London SHA level against national targets. Also, the PCT is represented at a South East London sector PBC group, where informal benchmarking takes place between PCTs. There have also been benchmarking exercises with neighbouring PCTs, specifically around referral patterns. The findings were that Lambeth has a low conversion rate from out-patient to in-patient. (Therefore, many outpatients are not admitted, indicating that possibly more services could be provided in the community, reducing the number of secondary care referrals).

Performance management systems are being developed for business cases and the PCT is clear about what data will inform the process but needs to communicate this to consortia so that they too understand the performance management process.

By participating in benchmarking activities, the PCT has a clearer picture about its activity and that of its practices and where best to focus future provision.

**Recommendation**

R7 Review performance management arrangements for PBC to ensure they are fit for purpose in 2007/08.
### Appendix 1 – Action Plan

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<th>Recommendation</th>
<th>Priority</th>
<th>Responsibility</th>
<th>Agreed</th>
<th>Comments</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 R1 Clarify roles and responsibilities around training needs analyses and delivery to ensure the smooth transfer of commissioning and business case development skills to consortia staff.</td>
<td>2</td>
<td>Joint Director Service Strategy &amp; Commissioning</td>
<td>PLC Steering Group 28 February 2007</td>
<td>Joint Directors of Service Strategy and Commissioning to attend regular PBC Consortia meetings to co-ordinate appropriate skills and expertise. GHD Consortia business case shared with all consortia</td>
<td>Process agreed by 28 February 2007</td>
</tr>
<tr>
<td>14 R2 Consider what changes to process may have to happen to ensure continued commitment from the consortia despite a withdrawal of incentives nationally.</td>
<td>3</td>
<td>Joint Director Service Strategy &amp; Commissioning and Director Primary and Community Services</td>
<td>PLC Steering Group 28 February 2007</td>
<td>Proposal to develop integrated practice development plan for 2007/08, encompassing practice based commissioning incentives. PCT to consider other sources of funds eg devolution of Practitioner with Special Interest funding to consortia</td>
<td>31 March 2007</td>
</tr>
<tr>
<td>15 R3 Clarify what financial and activity information will be collected and used in 2007/08.</td>
<td>3</td>
<td>Joint Director Service Strategy &amp; Commissioning and Director of Finance</td>
<td>PLC Steering Group 28 February 2007</td>
<td>As outlined in 2007/08 PBC Governance, Accountability and Operating Framework</td>
<td>Process agreed by 28 February 2007</td>
</tr>
<tr>
<td>17 R4 Encourage consortia to involve other members of the primary care team in the PBC process as appropriate.</td>
<td>2</td>
<td>Joint Director Service Strategy &amp; Commissioning</td>
<td>PLC Steering Group 27 February 2007</td>
<td>Best practice to be shared at future PLC Steering Group. Clinical and Corporate Governance Group to ensure appropriate stakeholder involvement including primary, community and acute at business case approval stage</td>
<td>June 2007 On approval of 2007/08 business cases</td>
</tr>
<tr>
<td>Page no.</td>
<td>Recommendation</td>
<td>Priority 1 = Low 2 = Med 3 = High</td>
<td>Responsibility</td>
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<td>18</td>
<td>R5 Ensure benefits realisation is integral to business case development.</td>
<td>3</td>
<td>SC/SM and LD</td>
<td>PLC Steering Group 28 February 2007</td>
<td>Business case template requires of identification of benefits. Need to work with consortia as per R1 to ensure implementation.</td>
</tr>
<tr>
<td>18</td>
<td>R6 Encourage the consortia to take a consistent approach to involving patients in the development of practice based commissioning.</td>
<td>2</td>
<td>Joint Director Service Strategy &amp; Commissioning</td>
<td>PLC Steering Group 28 February 2007</td>
<td>Best practice to be shared at future PLC Steering Group. Clinical and Corporate Governance Group to ensure appropriate stakeholder involvement including patient and user involvement at business case approval stage.</td>
</tr>
<tr>
<td>20</td>
<td>R7 Review performance management arrangements for PBC to ensure they are fit for purpose in 2007/08.</td>
<td>3</td>
<td>Joint Director Service Strategy &amp; Commissioning</td>
<td>PLC Steering Group 27 February 2007</td>
<td>As outlined in 2007/08 PBC Governance, Accountability and Operating Framework, which reflects National guidance, Lambeth 2006/07 Fitness for Purpose review findings. Provider SLAs to make explicit performance management arrangements.</td>
</tr>
</tbody>
</table>