Clinical commissioning: our vision for practice-based commissioning

Adding life to years and years to life
### DH INFORMATION READER BOX

<table>
<thead>
<tr>
<th>Policy</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR / Workforce</td>
<td>Commissioning</td>
</tr>
<tr>
<td>Management</td>
<td>IM &amp; T</td>
</tr>
<tr>
<td>Planning /</td>
<td>Finance</td>
</tr>
<tr>
<td>Clinical</td>
<td>Social Care / Partnership Working</td>
</tr>
</tbody>
</table>

#### Document Purpose
Best Practice Guidance

#### Gateway Reference
11073

#### Title
Clinical Commissioning: our vision for practice-based commissioning

#### Author
DH/Commissioning/Commissioning & System Management

#### Publication Date
04 March 2009

#### Target Audience
PCT CEs, SHA CEs, Care Trust CEs, Directors of PH, Directors of Nursing, PCT Chairs, Directors of Finance, GPs, Communications Leads, Practice-based Commissioners, Directors of Commissioning

#### Circulation List

#### Description
This document sets out a vision for clinical commissioning, the hallmarks of successful clinical commissioning, the support and entitlements that practice-based commissioners can expect, and the principles underpinning vibrant, productive partnerships between PCTs and their clinical communities.

#### Cross Ref
N/A

#### Superseded Docs
N/A

#### Action Required
N/A

#### Timing
N/A

#### Contact Details
Gareth Probert  
Commissioning & System Management Directorate  
Department of Health  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE

For Recipient’s Use
1 Introduction
The NHS Next Stage Review, built on an unprecedented process of local engagement, established a collective vision for an NHS with quality as its organising principle. Enabling this systematic improvement in the quality of local services means empowering frontline staff to make the changes that are needed, working within a clear accountability framework. This approach is exemplified by our shared commitment to reinvigorate practice-based commissioning.

The NHS Next Stage Review concluded that practice-based commissioning (PBC) has a pivotal role to play in empowering clinicians to shape the health and healthcare of local populations. We have worked with a range of clinicians, primary care trusts (PCTs) and strategic health authorities (SHAs) to produce this document that encapsulates our vision for clinical commissioning, the hallmarks of successful clinical commissioning, the support and entitlements that practice-based commissioners (PBCs) can expect, and the principles that should underpin vibrant, productive partnerships between PCTs and PBCs.
2 Our vision for clinical commissioning

PBC recognises the central role of primary care clinicians – through the hundreds of thousands of treatment and referral decisions they make each day – in using NHS resources to deliver high-quality care for all. PBC gives local clinicians much greater power and influence, working in partnership with PCTs, to shape how these resources are invested so that they deliver better health, better care and better value for local practice populations and for taxpayers. Especially in financially challenged times, clinical empowerment is not a nicety but a necessity.

Our vision for the future of PBC recognises the need for changes to cultures and behaviours as well as processes, and encapsulates the four principles underpinning our approach to implementation of the Next Stage Review:

- We have worked with a range of stakeholders to co-produce the vision, building on the engagement which was central to the Next Stage Review itself
- A core purpose of PBC is to enable and encourage decision-making by local clinicians, ensuring that commissioning decisions are taken at the right level of the system and as close to patients as possible – this is the essence of subsidiarity
- By supporting local clinicians to take on this more active role in commissioning services for their patients, PBC encourages clinical ownership and leadership
- This vision provides clarity about the role of practice-based commissioners and the enabling role of PCTs and SHAs, ensuring appropriate alignment across the system to support PBC.
PBC provides a framework which local clinicians can use to:

- Develop a greater range of more integrated services in community settings, designed around the needs of individuals
- Secure greater investment in upstream interventions that keep people healthy for longer, prevent ill-health and reduce health inequalities
- Drive continuous quality improvement and innovation across the whole system, securing better value for money in the process.

PCT commissioning and PBC should form part of an integrated system where the health investment plans for the wider population dovetail with the health investment plans for local practice populations. The most successful PCTs will secure high-quality care by focusing on strategic outcomes and being able to devolve increasing responsibility to clinicians to achieve these outcomes. The most successful PBCs will inform, influence and complement the strategic direction of PCT and be an integral part of world class commissioning. This requires strong partnerships, based on a shared culture of innovation and health improvement and backed up by new entitlements and systems of PCT and SHA assurance.

“When we restructured the PCT 2 years ago, our foundation was PBC. We saw them as our clinical engine room to take forward new care pathways and we are now seeing a real return on our investment and effort. As we all strive to drive up the quality of our services, PBC ensures active clinical engagement, brings innovation and ensures that strategies are grounded in pragmatism.”

Jan Sobieraj, Chief Executive NHS Sheffield
What are the hallmarks of successful clinical commissioning

At its heart, successful PBC will be characterised by clinicians engaging in the continuous cycle of assessing the needs of practice populations, reviewing how resources are used and services delivered for patients across the system, identifying what needs to change, and working to deliver continuous quality improvement – making sure that patients have convenient access to the right services, in the right place, at the right time.

Successful PBC will combine the local knowledge and professional expertise of GPs and other clinicians with increasingly powerful tools and datasets that give deeper insights into the impact on individual patients of wider changes in services or pathways. PBCs will be able to identify often small changes that can radically improve quality of care for local patients and value for money.

Active clinical commissioners will release and reinvest resources by using their skills and knowledge to challenge ineffective and inappropriate clinical interventions and clinical practice. An estimated 80% of NHS expenditure is committed through clinical decision-making. PBC provides the practical tools and the budgetary flexibilities to match these resources better to patient needs.
Clinical commissioners will also use their local knowledge and skills to develop proposals and business cases for new services, working with the PCT to shape its strategic investment decisions for the local community. For some areas of care (e.g. for a specific condition or pathway), PCTs may discuss with PBCs and agree to delegate direct responsibility for managing ‘hard’ budgets and taking these investment decisions. This must be done within existing PCT powers of delegation1, and providing assurance that PBCs are complying with the Principles and Rules for Cooperation and Competition.

Through reviewing patient pathways, releasing resources for reinvestment and helping shape wider commissioning decisions, PBCs will be able to shift care into more local settings that provide more convenient, integrated care for patients. This is likely to include a greater range of services within general practice itself, in other local settings (e.g. community pharmacies) and in people’s own homes. It is likely to include both specialist care for particular conditions and health and wellbeing services that help people reduce their risk of developing long term conditions. Latest results from the national quarterly PBC survey (December 2008) show that clinicians are having a greater impact on the way services are delivered, with the number of PBCs commissioning

---

1 In accordance with The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000
Successful practice-based commissioning will be rooted in strong systems and cultures of patient and public engagement, ensuring that decisions reflect the diverse needs of local patients.

services rising from 46% to 56%. World class commissioners are likely to look to PBCs to shift resources into local public health activity and may agree that some elements of the budget should be reserved for this purpose. The registered list, if actively managed, is an ideal vehicle for these purposes.

Successful practice-based commissioning will be rooted in strong systems and cultures of patient and public engagement, ensuring that decisions reflect the diverse needs of local patients including those whose voices are less often heard. PBCs will work closely with other community organisations and networks, for instance with Local Authorities and children’s and young people’s trusts.

PBC also provides opportunities for greater clinical and professional collaboration and more integrated working across traditional boundaries, for instance by working with hospital clinicians to review specialist pathways or with community nursing services and social services to review the effectiveness of care for patients with more complex needs.
High-quality PBC needs to rest on a foundation of high-quality primary medical care: PCTs can reasonably expect to see evidence of good quality GP services as a pre-requisite to PBC decision-making. Although PBC budgets do not include the cost of essential primary medical care for registered patients, successful PBC should nonetheless be able to look in the round at quality of care offered for local patients, including the interactions between primary care, community health services and more specialist care. In the same way that we do not expect every GP to become an active clinical commissioner, we do not expect that PCTs will delegate their fiduciary duties to those that have significant improvements to make in providing primary medical care.

Thriving PBCs can act as a driving force for clinical and service innovation, identifying and spreading new ideas that improve quality of care. From April 2009, PBCs have access to the new regional Innovation Funds. SHAs will in turn wish to consider developing an elite cadre of clinical commissioners to push reform further, faster.

“
For the NHS, PBC provides the best and most sustainable means of improving quality, access, integration, cost efficiency and inequalities. For GPs, PBC provides GPs and other clinicians with a new leadership role in determining local services and health initiatives that will enable us to make a real difference for our patients outside the walls of the surgery. For PCTs, PBC is the means of WCC succeeding – the ‘Sine Qua Non’. No PBC, no WCC.

Dr Michael Dixon, Chair NHS Alliance”
4 How do we accelerate progress with clinical commissioning?

Over the last six months, we have engaged widely with clinicians, PCTs and other stakeholders to understand better both what is already working well with PBC and where the potential barriers to further progress lie. What we have heard is that, where PBC is not making sufficiently fast progress, the main reasons are:

a. Lack of a sufficiently strong shared vision between PCTs and PBCs

b. Insufficient support for developing PBC capacity and capability

Sections 2 and 3 of this document set out why there is such a strong mutual dependency between world class commissioning and clinical commissioning. We have designed the world class commissioning system to reflect and reinforce this dependency and to ensure that PCTs give high priority to PBC development. We have established the national PBC development team to help PCTs and clinicians forge common purpose.

c. Shortcomings in the quality and timeliness of information to support PBC – and slow turnaround of PBC plans and business cases

d. Confusion over roles, responsibilities and relationships

Section 5 sets out the full range of entitlements that PBCs can now expect to enhance their skills and capacity, to equip them with the right practical tools and data and to ensure swift decisions on PBC business cases.
e. Concerns over governance and perceived conflicts of interest
Section 6 sets out the key elements of successful local approaches to defining roles, responsibilities and governance, taking proportionate decisions, and developing strong, mutual relationships between clinical commissioners and PCTs. Clinical commissioning and provision should not be seen as conflicting roles but as part of a more sophisticated interplay that involves deploying resources and designing services to best meet population and patient needs.

f. Lack of consensus over the right balance of incentives
Section 7 sets out what we see as the natural evolution of PBC (with the right leadership from both PCTs and from clinicians) where clinicians will have more explicit accountability for financial management and commensurate growth in risk and reward. Where high performance has been established, we envisage world class commissioners increasingly devolving areas of their budget (e.g. for particular conditions or pathways) to clinicians so that they can secure more integrated and preventive care.
PBC gives local clinicians much greater power and influence, working in partnership with PCTs, to shape how resources are invested so that they deliver better health, better care and better value for local practice populations.

5 What support and entitlements can clinical commissioners expect?

**PBC development framework.** We have appointed five organisations as part of a national framework to provide practical, hands-on support to PBCs and PCTs. We have invested £1 million to pump-prime the work of these teams.

**PBC development team and PBC survey.** David Colin-Thomé, National Clinical Director for Primary Care, is leading a small, mainly clinical team, which will visit all regions in spring 2009 to offer support in invigorating PBC. The team will use the quarterly PBC survey to help prioritise where extra support is needed.

**Best practice network.** We have engaged NHS Networks to help rapidly spread innovative examples of PBC. The updated PBC section of the DH website includes a wealth of practical advice on effective practice (e.g. on accountability agreements, local incentive schemes and risk sharing).
Clinical leadership development. The National Leadership Council (NLC) will have a strong clinical leadership focus and will explicitly address how to support PCTs in helping primary and community clinicians take on expanded leadership roles, including as leaders of GP federations, PBC consortia and integrated care organisations.

Entitlements. We have made clear that all PBCs are entitled to:

- **management and financial information**: accurate, timely data and analysis, in particular on budgets, expenditure, referrals, prescribing, activity and, where possible, clinical performance. The PBC budget should contain, as a minimum, all hospital services, prescribing, mental health services, community/locality services and other health initiatives, even if some elements are ‘blocked back’ to the PCT

- **management and financial support**: a package of support that will include, as a minimum, a management allowance, designated support from PCT staff and/or external partners (e.g. from the development framework), and a plan setting out how the PCT intends to support PBC development needs

- **swift budget-setting and decision-making**: every practice should receive their indicative budget and have agreed their management and financial support with the PCT by 1 May each year – with ultimate recourse to the SHA if this is not delivered. PCTs should make decisions on PBC plans and business cases within a maximum of eight weeks

- **local incentive schemes**: every PCT should agree PBC incentive schemes that promote better health, better care and better value in specific areas.

Thriving PBCs can act as a driving force for clinical and service innovation, identifying and spreading new ideas that improve quality of care
The starting point for PBC should be individual GP practices and practice populations. This is the essential building block – and all financial and management information should be produced at this level. Where practices choose to operate as wider groups or consortia, they can choose to aggregate some or all of the information at this higher level. Different practices can legitimately have different types of involvement in PBC.

**PCT assurance.** PCTs will be held to account for the quality of their support through the world class commissioning (WCC) assurance process, which includes 360° feedback from PBCs. The fourth of the eleven WCC competencies is strong engagement of clinicians in the commissioning process. The assurance process is a key opportunity to assess the strength of PCT support and the effectiveness of the PCT’s strategic commissioning plans in helping achieve the PBC vision for local patients. A PCT will not be able to reach level 2 of WCC without strong clinical involvement and support for PBC and PCTs will not be able to reach level 2 of WCC unless the entitlements noted above are delivered.

**SHA assurance.** We will also hold the ten Strategic Health Authorities to account for the development of strong, vibrant partnerships between PCTs and clinical commissioners, as part of their role in developing system management and fostering system-wide collaboration and competition.
Building productive partnerships between PCTs and clinical commissioners

Productive relationships will be built and sustained both through respectful cultures and values and through clear and transparent systems of governance. This will be reflected in the approach to local PBC agreements or compacts. At a basic level, PBC agreements provide clarity about governance, including respective roles, responsibilities and processes, for instance in relation to budget-setting, business case approvals, and handling of savings/deficits. Local agreements can also, however, help to establish the common purpose, values and principles that will underpin the development of PBC.

Local agreements should also include agreed success criteria to enable PBCs to demonstrate how they are improving health, care and value for local populations. As PBCs develop expertise and demonstrate effectiveness, they will be able to take on greater devolved responsibility and accountability.
We continue to get periodic requests for more detailed guidance on governance arrangements, but our experience is that such arrangements only work effectively where they are developed and agreed locally. Good local governance creates an environment in which trust and clinical leadership thrive and in which both PCTs and PBCs have the confidence to make proportionate, evidence-based decisions. This cannot be imposed from above as, ultimately, it is disempowering.

What is clear, however, is that robust governance has too often been mistaken to mean drawn-out approval processes or open tendering for all new services, sometimes linked to simplistic views about commissioning and provision. The PCT is of course the statutory body with accountability for how it uses NHS resources for the benefit of local populations. PCTs need to have clear frameworks for procurement of new services (in line with the Principles and Rules for Cooperation and Competition and the PCT Procurement Guide), including arrangements for declaring and documenting interests and protecting against real or perceived conflicts. It is also essential to ensure that any service is governed by a clear contractual relationship and that there is clear clinical accountability for the service. Where PCTs decide to devolve full budgetary responsibility for a service or pathway, there must likewise be complete clarity about contractual responsibilities and expected outcomes. PBCs must comply with the Principles and Rules for Cooperation and Competition.

---

In accordance with The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000

---

PBC is key to bringing clinical and managerial colleagues together to shift care closer to home, enable integration and continuous quality improvement – and achieve tangible improvements in health outcomes.

Gail Richards, Chief Executive Oldham PCT
A robust system of governance should, however, enable PCTs to meet these requirements whilst drawing strength and power from an enhanced role for clinicians in both commissioning and providing services.

Robust governance should also enable PCTs to take timely and proportionate decisions that balance competition and collaboration. There will be occasions where a single service provider is needed and where it is right to test the market through competitive tender. World class commissioners will, however, increasingly use ‘any willing provider’ arrangements to stimulate a range of providers for more specialist services and extend patient choice into community settings. Where new services are best delivered as an integral part of general practice or other primary care provision, PCTs may commission them through local enhanced services.

"The case for the greater involvement of clinicians in commissioning, through PBC, leading transformational change within local health services remains as compelling as ever. Its effective implementation is dependent on PCTs delegating authority to Practice-Based Commissioners and in Practice-Based Commissioners being prepared for the greater accountability that inevitably will come with this. This effective partnership requires PCTs to provide the practical support that Practice-Based Commissioners require, Practice-Based Commissioners to provide the clinical leadership PCTs require and the creation of a local environment in which the pace of change is only limited by our determination, aspiration and imagination.

Dr Johnny Marshall, Chair NAPC"
7 Where next?
We recognise that not all clinicians want an enhanced role in commissioning role, but we want to make sure that those who do have the support and opportunities to develop as clinical leaders and take PBC to a new place.

PBC consortia are a key element in many of the proposed integrated care pilots due to be launched shortly. Successful PBC consortia or federations of practices are potentially well placed to develop into integrated care organisations (ICOs). A PCT could commission an ICO to take on direct responsibility for an extended budget, as well as providing primary care for a registered population, effectively becoming the ‘primary care home’ for the wider health and healthcare needs of this population. PCTs would hold the ICO to account for quality of care, health outcomes and financial stewardship, leaving the ICO to take ‘make or buy’ decisions about how these outcomes are achieved. This would substantially broaden the offer to members of the public choosing to register with the practices that are members of the ICO. The recently published Constitution makes it clear that PCTs have a responsibility to promote choice and ICO arrangements would take this to a new level.
Although the focus of PBC is rightly on GP practices and practice populations, we believe that PBC will only achieve its full potential – and grow more naturally into ICO-type models – if it brings together a range of clinicians including community nurses, allied health professionals, pharmacists and secondary care clinicians and secures strong relationships with social services, whilst continuing to focus on the practice population.

The development of PBC should also strengthen the role of primary care in helping people take greater control of their health and healthcare through personal health budgets (which we are about to pilot). Primary care clinicians make daily ‘commissioning’ decisions for individual patients through deciding whether to manage within primary care or refer for more specialist care. Personal health budgets will open up new opportunities for clinicians to work as part of an expert partnership with patients to achieve better health, better care and better value at this individual level.

Above all, we want the next stages in the evolution of PBC and clinical commissioning to be shaped by local clinical leaders, working as an integral part of wider systems of world class commissioning. Effective world class commissioning and strong practice-based commissioning infinitely increase the potential for excellent population health, patient care and best value.