

MEMORANDUM OF AGREEMENT

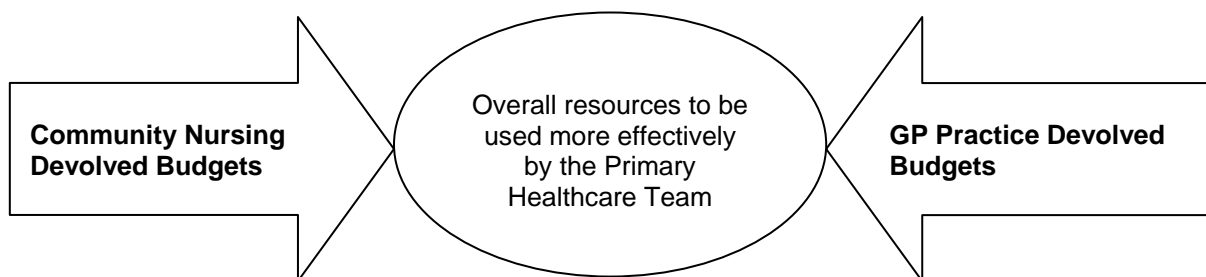
LEVEL 2 PRACTICE BASED COMMISSIONING

FINAL DOCUMENT AGREED BY NORTH BRADFORD LOCALITY PEC ON 11 MAY 2005

1) INTRODUCTION

Practice Based Commissioning (PBC) empowers frontline clinicians to scope services in a way that is most effective to meet the needs of their populations. Under PBC the practice and the community nurse takes on their respective devolved budgets. For the GP practice this means a devolved secondary care and prescribing budget with other unified enhancements attached. The community Nursing team have their own devolved budgets, in particular district nursing and health visitor budgets. PBC provides a platform to bring these two budget holders together to work in partnership to improve the healthcare of their patients.

Practices and their nursing teams are expected to notionally put their budgets together and as equal partners jointly decide how best to use the combined resources.



An overarching principle to PBC is to improve the health care for patients by recycling resources in a cost effective manner.

This document outlines the PBC framework for practices in the North Bradford and Airedale PCT localities.

1a) Options for practices

Practices have two options in terms of their level of engagement in PBC. The document relates to practices choosing Level 2. (See Appendix 1 for detail on the options.)

2) LEVEL 2 PBC - THE FRAMEWORK FOR 2005/6

The overall aim of PBC is to improve patient care. In order to do this the framework for PBC in North Bradford and Airedale will be kept as manageable and practical as possible. There will be a phased approach in terms of size and scope of service reconfiguration. However the framework will provide the flexibilities for individual primary healthcare teams to run at a faster speed should they choose to do so.

Under this Agreement, as a minimum for 2005/6 the practice will be signed up to be actively involved in 7 high impact key areas.

The high impact areas will also form part of the Quality Improvement Incentive Scheme for 2005/6. This means that practices will be rewarded for their efforts regardless of, worse case scenario, they do not manage a saving on their unified budget at year end. In being actively engaged in the 7 areas of work the practice will receive the equivalent of £6,000 per 10k patients.

7 High impact areas of work	Associated Incentive Scheme Marker Worth in total £6,000 per 10k patients <i>(£0.60p per head)</i> Markers to be confirmed once baselines identified
<p>1) Providing services closer to patients - In-house service development</p> <p>By ensuring maximum use of existing skill mix in the practice this can help reduce referrals outside of the practice. Expanding this skill mix further will help manage more patients in primary care and make more appropriate use of secondary care. This will in turn help the practice manage its overall resources more effectively and help align resources closer to the patient.</p> <p>Some practices may choose to develop extended scope clinicians eg GPwSI, nurse-led or therapy-led services in various specialties for their own use and/or for other practices.</p> <p>An example of this would be for the practice to move to evidence based best practice and provide carbon urea breath tests to reduce inappropriate referrals for endoscopy. Therefore improving the patient experience and reducing costs on the budget.</p> <p>Standard reports will be produced as agreed with practices to help inform developments. The management information packs provided to practices monthly can be used to identify potential areas of secondary to primary care shift and also to monitor if such a shift is taking place following the onset of a service development in primary care.</p>	<p>Incentive marker:</p> <p>10% reduction in the overall number of referrals to secondary care or be below the PCT mean</p>

<p>2) Developing patient pathways – improving the quality of referrals</p> <p>In ensuring there is systematic review of referrals in the practice this will help ensure the most appropriate use of services.</p> <p>Evidence shows that in a safe and non-threatening environment peer review of referrals is very effective at improving the quality of referrals and improving the patient experience and outcome of care.</p> <p>The PCT approach to developing pathways is to work with clinicians to identify evidence based best practice. Then work with clinicians and non-medical staff to raise awareness of each individual's role to ensure that overall pathway is achieved. An example of this is the development and use of the Independent Sector Treatment Centre (ISTC).</p> <p><u>In order to facilitate this process throughout 2005/6 all diagnostic activity at the ISTC will be free of charge to practices and day case activity will be at 2/3 of the full cost.</u></p> <p>The management information packs provided to practices monthly will include benchmarking information at practice level and then internal to each practice, at clinician level. Standard reports will be produced for practices.</p>	<p>Incentive marker:</p> <p>Evidence of a systematic peer review of referrals</p>
<p>3) Developing patient pathways – improving outpatient follow-ups</p> <p>At practice/locality/PCT level it will be encouraged to develop an approach to manage follow-ups for secondary and locality services. A collaborative approach will be used to share best practice.</p> <p>Some potential examples of how to manage follow-ups are limiting the number of follow-ups as a prerequisite with the provider then seeking approval from primary care before performing any more; reduce the number of consultant to consultant referrals by referring routine cases back to primary care to determine the most appropriate action; ensure any patients on annual review are discharged to primary care to be referred back as a follow-up should the patient need it.</p> <p>The infrastructure in Primary Care will need to be developed in order to pick up any shift of activity. This is an example of where practices could work together in groups, localities or PCT-wide to ensure best use of skill mix. Realigning funds to reflect any revised pathway.</p> <p>Outpatient activity data will be included in the information packs provided to practices on a monthly basis via email. Practices will be able to spot trends.</p> <p>Standard reports will be produced for practices.</p>	<p>Incentive Marker:</p> <p>10% reduction or be below the PCT mean for follow-ups in the following specialties (Collective figure)</p> <ul style="list-style-type: none"> - General Surgery - ENT - Orthopaedics

<p>4) Case management of patients with complex / high needs</p> <p>The more proactive management of patients who are repeat attenders and/or high users of primary and/or secondary care will help prevent further deterioration of a long term illness. This will in effect improve patient care and help manage resources more effectively.</p> <p>Each practice will receive a full time equivalent Nurse case manager per 10k patients to help them manage this group of patients.</p>	<p>Incentive Marker:</p> <p>Establish a baseline register of patients with complex needs by using the evidence based 6 Yes/No questions (<i>available from the PCT</i>)</p>
<p>5) Improving the quality of patient care through better use of Pathology</p> <p>There is high variation in terms of clinician's use of pathology. By moving to good practice use of pathology from a quality point of view this will in turn reduce spend on this budget.</p> <p>The management information packs emailed to practices monthly will include activity and spend against the pathology budget and show individual clinician activity/use of pathology.</p>	<p>Incentive Marker:</p> <p>10% reduction or be below the PCT mean in overall spend per head for pathology</p>
<p>6) Financial Unified Budget Monitoring</p> <p>In order to manage within budget monthly reviews of activity and cost is crucial. The PCT will facilitate this process by providing monthly information packs to Practice Managers. The management information packs will help practices spot trends or possible variations in activity and spend and therefore inform appropriate corrective action either at practice level or collectively with the PCT.</p> <p>A PCT Manager will be available to help practices monitor their position against contract. Standard reports will be produced.</p> <p>By working together across practices and the PCT this will help each practice manage their budgets more effectively.</p>	<p>Incentive Marker:</p> <p>Evidence of monthly meeting to review the financial position and actions taken</p>
<p>7) Validation of activity/clinical information</p> <p>In sampling activity data via the information packs to identify areas of concern from both accuracy of coding/counting and quality of the clinical information provided it will become apparent where the problem areas lie. Such challenges on data will help with the clinical management of patients as timely accurate clinical data is crucial. Also from a coding and counting perspective there is scope to agree revised costs of activity and therefore make savings on practice budgets.</p> <p>The PCT can then work with secondary care in order to make improvements to the quality of data provided. Any efficiency gained from revised costs to a service area will be made at PCT level and then allocated against each practice's budget on a capitation share.</p>	<p>Incentive Marker:</p> <p>Evidence of sampling, as a minimum, 10% of activity data for accuracy</p>

3) PROTECTED LEARNING TIME (PLT)

Throughout 2005/6 the PCT run PLTs will cover these high impact areas of work by initially providing a workshop to look in detail at each area and then in-year showcasing examples of good practice to ensure further spread.

4) **QUALITY IMPROVEMENT INCENTIVE SCHEME 2005/6**

The Quality Improvement Incentive Scheme for 2005/6 will be split into 3 parts as shown below. The funding is payable subject to performance against the indicators alone and is regardless of performance against the devolved unified budget of PBC.

QUALITY IMPROVEMENT INCENTIVE SCHEME 2005/6		
<i>Note: Part 1 & Part 2 markers to be confirmed once baselines identified</i>		
PART 1	PART 2	PART 3
<p>Focusing on the 7 high impact areas of PBC</p> <p>Voluntary Scheme – Available to all practices</p> <p><u>Indicators</u></p> <p>£ per 10k patients</p> <ul style="list-style-type: none"> • See 7 high impact areas shown in section 2 above <p><i>(Each indicator is worth £857 per 10k patients)</i></p> <p>Worth £6,000 per 10k patients</p>	<p>Focusing on long term conditions, access and acute care</p> <p>Voluntary Scheme - Available to all practices</p> <p><u>Indicators</u></p> <p>£ per 10k patients</p> <ul style="list-style-type: none"> • £2k per annum to agree and implement a 3 year plan on moving the practice to a culture of patients self-care • £2k to reduce A&E attendances by 10% or be below the PCT mean • £3k for 30% of overall day case activity to be performed at the ISTC and overall not increased by more than 2% • £2k to allow pre-bookable appointments to a GP and Nurse of up to 3 weeks in advance <p>Worth £9,000 per 10k patients</p>	<p>Focusing on Prescribing</p> <p>Voluntary Scheme – Available to all practices</p> <p>See Prescribing Incentive Scheme markers for 2005/6 performance indicators</p> <p>Worth £15,000 per 10k patients</p>
<p>Total for achieving all markers £30,000 per 10k patients</p>		

5) PRACTICE ALLOWANCE

PRACTICE ALLOWANCE	
Pre-Practice Based Commissioning	Practice based commissioning
<p>Previously known as the Performance Fund and attached to delivering key objectives.</p> <p>Some of these objectives are now superseded in one form or other these are as follows.</p> <ul style="list-style-type: none"> • <u>Records summarisation</u> Now covered by QOF payment • <u>Collection of referral data</u> Exploring use of clinical system for this, however part of info needed for PBC • <u>Investors in People</u> Optional for a practice to retain status 	<p>Now known as the Management Allowance to be used at the discretion of the practice to manage practice based commissioning.</p> <p>Expenditure needs to be justifiably used on PBC and be auditable.</p> <p>Suggested use of funds:</p> <ul style="list-style-type: none"> • Attendance at PLT and Advisory Groups • Analysis of Management Information • Protected time to plan and develop services
	Worth £50,000 per 10k patients

Throughout 2005/6 the practice allowance will be available to all practices. With effect from 1 April 2006 the Practice Allowance will be payable only to those practices actively signed up to practice based commissioning ie Level 2.

6) AGREEING A BUDGET

There will be a preparatory year in 2005/6 with regard setting and agreeing a unified budget, in particular the hospital services element. This means that for 2005/6 the PCT will carry more risk in terms of an overspend situation. 2005/6 will be used to gain confidence with practices in terms of the accuracy of their budget for 2006/7.

Budgets will be negotiated and agreed with practices prior to signing them off. If a budget can not be agreed the practice will automatically revert to level 1 PBC.

6a) The Unified budget

In signing this Agreement the practice is agreeing to a framework where the unified budget includes the following:

- Usage of Bradford Hospitals Foundation Trust, Airedale NHS Trust and Leeds Teaching Hospitals NHS Trust elective activity
- Locality Services / Secondary to Primary Shift / GPwSI
- Use of Diagnostic and Treatment Centre
- Use of Yorkshire Clinic / York Suite / Nuffield
- Pathology (*Leeds/Bradford & Airedale*)

- Direct Access Services eg physio, speech and Language
- Prescribing budget
- Primary Care Mental Health (*ring fenced for info only in 2005/6*)
- Community Nursing (*ring fenced for info only*)
- Prescribing Advisory Service (*ring fenced for info only in 2005/6*)

Acute activity will not be included in the practice budget in 2005/6 due to the many variances and issues at present. This is an area intended for future years in agreement with practices. Practices will be provided with a position statement against a notional budget for acute for information purposes only in 2005/6.

6b) Setting the budget

Budgets will be based initially on historic usage with a move to capitation over 3-5 years.

During 2005/6 practices will be given for information a weighted capitation budget and with effect from 1 April 2006 start moving at a pace of change to that level of funding. The pace of change will be determined by the size of the variance from historic to capitation.

6c) Virement of funds for service developments

There are mainly two ways of viring funds from the unified hospital services and prescribing budget.

- **Cash flow**

At the beginning of the year, or in-year, a practice may choose to borrow funds from their unified budget. Reasons for this may be to help with set-up costs of a service development in primary care or to top-up the practice management allowance (max of extra £2 per head).

The PCT can release funds in this way to the practice for cash flow purposes only. The amount vired will be subject to agreement of what the funds are to be used for and how the practice plans to manage any risk.

The funds must be repaid to the unified budget line at year end. If in doing so it means the practice has overspent, the PCT will need to invoice the practice for the amount of vired funds or amend the next PMS payment, whichever the practice prefers.

If by paying back the funds to the unified budget the practice has underspent or has broken even the practice will be able to keep the funds for that year only. The practice may then choose to vire the fund again the following year and the process begins again.

If funds have been successfully vired for 3 consecutive years ie the unified budget has not overspent, the funds will then become formally part of the PMS payment and the unified budget will be reset at that lower level.

- **Exceptional virements** (*in effect Additional Enhanced Services*)

There may be some service developments that are evidence based, almost guaranteed to save funds from a specific budget line. Such services could be identified at the beginning of the year, or in-year. In either situation they would need to be signed off by the PCT Executive Group prior to implementation.

An exceptional virement is a service development in primary care where the activity can be charged against the unified budget. An example of such a service is where carbon urea breath testing performed in primary care will reduce the number of endoscopies.

The criteria and process for identifying an exceptional virement is as follows:

- a) Evidence based cost effective in terms of improving patient care
- b) Clinical protocol agreed with regard how the service will be provided in primary care
- c) Agreed activity levels and cost to be charged to the unified budget
- d) Revised secondary care activity level agreed
- e) Year-end data shows successful shift of activity and cost for that budget line

When the above criteria has been met, even if the practice has overspent on the bottom line of their unified budget the funds shifted to primary care will not need to be repaid. These funds will remain in primary care as long as the shift of activity remains cost effective.

For 2005/6 it is agreed that carbon urea breath testing will be accepted as an exceptional virement for any practice who wants to take on this service in primary care.

Exceptional virements are accepted on the basis that the overspend would have been greater if this shift in activity had not taken place.

6d) List size changes

Whilst working to an historic budget alterations for list size changes will only be made where there has been significant increase or decrease. A significant variation will be determined via a shift outside the normal variation pattern of the practice over the last 3 years.

Each practice's situation will be reviewed on its own merits with any additional factors taken into account at that time.

Once moved to a weighted capitation list size adjustments to budgets will be made quarterly.

6e) £8k rule per patient episode

The practice will pick up to the maximum £8k on their budget for any single elective patient spell. The remainder will be picked up by risk sharing across the PCT. This rule applies to a single spell and not a series of spells that equate to £8k.

A risk sharing budget will be created by top slicing budgets based on previous year's activity levels of spells >£8k.

The budget summaries in the monthly information packs will automatically stop the excess showing as spend against the budget. The summary sheet will show how many spells and at what cost have been omitted from the budget spend.

7) EFFICIENCY GAINS

7a) Savings retained at practice level

Practices are entitled to retain 70% of savings that have been made via implementing the 7 high impact tasks. The savings will be calculated at year end based on overall performance against hospital services and prescribing unified budget. Routinely, any savings are payable at year end (*see 6c virement of funds in year*)

7b) Planned savings

Savings will be deemed to be planned when there is evidence of active management of all 7 high impact areas. This will be identified via performance against the indicators in the quality improvement scheme that are attached to the 7 high impact areas and the level and extent of activities the practice has engaged in as reported in a mid-year report.

7d) Unplanned savings

Where a practice has chosen Level 2 engagement in PBC their savings will be deemed as unplanned when performance against the incentive markers attached to the 7 high impact areas is poor and there is little evidence of active involvement as reported in a mid-year report. In this scenario the practice will be deemed to be Level 1 engagement in PBC and therefore subject to the framework for that level, ie retain 25% of savings only.

7e) Use of savings

Any savings from the unified budget must be reinvested to improve patient care. Funds can be spent on direct service development, premises, equipment, training, clinical and non-clinical staff.

A practice may choose to pay themselves to provide a service under secondary to primary shift/local enhanced services. The purchase of any services, either directly provided by the practice or commissioned via an alternative provider would be required to show value for money and meet robust clinical governance measures. Such measures will be developed early in 2005/6.

The practice is required to complete a template showing how they propose to use their savings and improve patient care. This will be signed off by the PEC. A practice can submit a proposal at any point either to pre-empt a saving or when an actual saving has been made.

7f) Savings retained at PEC level

The 30% of savings retained by the PCT will be reinvested as per agreement of the PEC. See section 8) Overspends below with regard how the 30% will be used in 2005/6.

8) OVERSPENDS

The unified budget in 2005/6 will be deemed as preparatory and therefore there will be more flexibility on overspends at practice level. The PCT will carry more risk during the preparatory year of 2005/6 with a view that the framework will be developed further to manage overspends in future years. This will be done in consultation with practices.

PMS funding is ringfenced and practices will not be asked to pay back an overspend from these funds. Paying back an overspend becomes real when a practice has chosen to vire funds from the unified budget. Once vired funds have been successfully managed within the overall budget for 3 consecutive years they become part of PMS and therefore

as long as the service they are funding is still cost effective they are non-returnable to the unified budget line.

During the preparatory year there will be some flexibility in agreeing the year-end position when a practice has overspent. There is scope for negotiation at year end when a practice is able to show evidence that their budget was incorrectly set and/or having tried everything possible to manage within budget events outside their control have resulted in an overspend.

For 2005/6 only the 30% savings retained by the PCT will be used to offset any overspends at practice level. Again for 2005/6 only if any of the 30% funds are left at year end these will be distributed to the practices that made the savings, based on the same % of savings they made.

The PCT reserves the right to take back the management of the devolved budget of a practice in a serious overspend situation.

8a) Managing a potential overspend whilst meeting National and local waiting times

As a last resort to manage within budget, ensuring other avenues have been explored first, there may be need to slow down, reduce or stop the level of activity being performed on a practice's patients.

Such an action would result in the waiting times of the practice's patients increasing to the national and local acceptable lengths. Only patients breaching these times would be treated. This is for routine care only. Urgent and acute care would not be affected.

9) THE RIGHT OF RETURN

A practice can at any time return to Level 1 PBC engagement or to no involvement at all. The process for doing so would be to give formal written notice to the Associate Director of Commissioning at the PCT. The notice period would be 1 month from the date of receiving the letter. The practice would be required to return any funds they had vired and would revert to the framework as outlined in Appendix 1. Funds that had moved across to PMS would not need to be returned as long as the service remains cost effective.

10) SERVICE DEVELOPMENTS

When making changes to service delivery the practice needs do a self assessment against the 7 pillars of CHI to ensure that the new service is an improvement and non of the crucial factors have been jeopardised, eg patient safety, cost effectiveness etc.

Practices will be asked to provide a mid-year report outlining the changes they have made to service delivery and the impact they have found to date. Practices are encouraged to collect data in order to show measurable improvement of the service development. This will in itself provide a business case for the future of that service in terms of securing a payment and spread of good practice to others.

There are several levels of service development ranging from new ideas yet to be tried and tested through to those already evidence based. Some developments may be at practice level others by groups of practices or at locality level. Service developments will also range from those directly provided by primary care through to seeking out alternative providers to commission service from. All service developments must ensure they have robust governance and ways of showing measurable improvements to patient care.

11) PERFORMANCE REVIEW

Performance against the unified budget will be monitored monthly via the practice, PCT Manager and Exec. Reports will be provided to the PEC and Board on a quarterly basis. The quarterly practice reviews will also provide an opportunity to discuss performance.

Performance of the 7 high impact tasks will be monitored via quarterly practice reviews and through work with the PCT Manager. Active involvement will become evident through general discussion in forums and when updating other practices in order to solve problems and identify and spread good practice.

Performance against the associated Incentive Scheme markers will also act as an indicator to practices engagement at Level 2.

A prerequisite of any changes to service provision, either in primary or secondary care, is that National and local wait time standards must be adhered to.

12) SUPPORT PACKAGES

In summary, the following support packages are provided for practices to help facilitate practice based commissioning.

- Practice Allowance
- Quality Improvement Incentive Scheme
- Management Information Packs
- Nurse Case Manager (Unscheduled Care)
- Practice-based Commissioning (PbC) PCT Manager
- Implementation handbook and practical guides
- Workshops, training, PLTs
- Development of Clinical Pathways (Led by Clinical Leads)

13) CENTRAL CONTRACTING FUNCTION

In terms of a central function the tasks provided by the PCT would be as follows:

- Coordination of practices' activity and financial queries with providers
- Challenging data at high level on behalf of practices
- General contract negotiations
- Specific contract negotiations eg need for split tariffs
- Interpretation of Payment By Results (PbR)
- Production of written contracts
- Coordination of service specs (led by Clinical Leads)
- Facilitating service redesign and secondary primary shift

14) SIGNATORIES

Practices are asked to register their intention in relation to the 3 options as shown in Appendix 1 by emailing Julie Winterbottom by **Monday 16 May 2005**. On receipt of the email, in relation to Level 2 PBC, the Finance team will prepare a draft budget for discussion with the practice. The draft budget will be provided by **Monday 23 May 2005**. The aim being to have an agreed budget by **13 June 2005**. At that time senior partners of the practice will be asked to sign the agreed budget.

PRACTICE BASED COMMISSIONING

Practices have two options with regard their level of engagement in practice based commissioning (PBC). A summary of the key elements are shown below.

Elements of PBC	Level 1 PBC	Level 2 PBC
Setting the Hospital Services and prescribing unified budget	Notional budget set by the PCT central team	Negotiated and agreed a unified budget
Performance monitoring	Benchmarking reports to the PEC, Board and peers	Benchmarking reports to the PEC, Board and peers
Savings	Practice retains 25%	Practice retains 70%
Overspends on unified budget without any in-year virement	PCT carries all the risk	PCT carries all the risk
Overspends on unified budget and have vired funds in-year	Virement not feasible	Practice carries the risk of the amount of vired funds.
Exceptional virements for service developments (<i>see page 7 of the Memorandum of Agreement</i>)	As agreed with the PCT	As agreed with the PCT
Quality Improvement Incentive Scheme	Funded for achievement of any markers <i>(In 2006/7 may mean reduced access to markers for level 1 PBC practices)</i>	Funded for achievement of any markers
Involvement in the 7 high impact PBC areas	Passive involvement	Active involvement
Practice Allowance	12mths notice given on this funding (<i>ceases wef 1 April 06</i>)	Recurrent funding

Practices have a 3rd option in that they can choose not to be involved in PBC in any form eg not involved in the Quality Improvement Incentive Scheme, retaining 25% of savings or developing services through exceptional virement of funds.