NHS

DH Department of Health

Practice based commissioning: achieving universal coverage

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Foreword

We are now half way through the NHS ten year plan. The first five years have concentrated on increasing capacity – more staff, more hospitals, more use of the independent sector – and changing ways of working. The results of this are evident in shorter waiting lists, improved services, lower mortality rates and patients and carers who are more satisfied with the service that they have received. In the next five years, the focus will be on reforming other parts of the NHS system.

These reforms aim to create a patient-led NHS which works with people to give them the support and help they want to lead healthier lives, coupled with greater choice of fast, effective treatment and higher quality care. Commissioning has a crucial role within the overall programme of reform. We need better commissioning to ensure that the NHS delivers a high quality service for patients, achieves a balance in the range of services available and that these services are delivering value for money for the taxpayer. Practice based commissioning is a critical part of this agenda. This document aims to embed it in 2006/07 and is very much focused on this first year of extensive practice based commissioning.

Alongside strong PCTs, we need GPs and other primary care professionals including practice and community nurses, midwives, dentists, pharmacists, optometrists, and allied health professionals with more freedom to get the services that their patients and users need. With that freedom, of course, there is more accountability for the public money they are spending. Practice based commissioning gives primary care professionals more freedom to innovate and to reshape the boundaries between primary and secondary care. It allows them to look critically at all of the care pathways that patients and users follow. If there is an alternative that is better for the patient and better for the NHS, then practice based commissioning provides the basis on which they can change the way that services are delivered. Alongside this document we will shortly be publishing a more clinically-focused document written by professional leaders showing where clinical gains for patients can be made at an early stage.

We will have universal coverage of practice based commissioning by the end of this year. This is a significant and worthwhile ambition. We want practices to adopt practice based commissioning quickly and we have put the support mechanisms in place to help PCTs work in partnership with practices and other health professionals to achieve this. The expectations that practices can have of PCTs in 2006/07 for practice based commissioning are clearly set out in this document.

But this is only the beginning and we want 2006/07 to be a springboard year from which practice based commissioning can expand its activities more widely. I hope that PCTs, practices and healthcare professionals will seize the opportunity to use practice based commissioning to innovate and in doing so to provide better and more diverse services to their patients in their own communities. This document, produced with the help of the BMA's General Practitioners Council, NHS Confederation, NHS Alliance, National Association of Primary Care, Royal College of GPs, National Primary Care Development Team and health and social care representatives will, I hope, provide a good foundation for practice based commissioning.

Norman Warner
Minister of State for Health

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Introduction

1. This guidance follows *Practice Based Commissioning: Promoting clinical engagement* (December 2004) and *Making Practice Based Commissioning a Reality: Technical Guidance* (February 2005). The principles of the former documents are still relevant, but a year on, this guidance replaces the detail of the technical guidance. It should also be read in conjunction with the *NHS in England: the operating framework for 2006/07* (January 2006) and the forthcoming White Paper on improving community health and care which will be published shortly.
2. The great majority of patients who receive either elective or emergency treatment in a hospital have been referred by their general practice. Patients build up long term relationships with their local practice, which is at the heart of continuity of care in the NHS. Primary care professionals, including GPs, community nurses and others with whom they work such as dentists, pharmacists and optometrists, are often closest to the needs of their patients and understand how best to access healthcare services. Practice based commissioning places these professionals, with patients, at the heart of decision making.
3. Recent health reforms have changed the way that healthcare is commissioned. Under reforms such as payment by results and patient choice, clinical decisions are now direct drivers of financial resources. Primary care professionals commit NHS resources as a matter of course through their clinical decisions. In this way, all practices are already in some form, such as in their decision to refer patients, engaged in commissioning.
4. Within this environment, the Secretary of State for Health has an obligation to help and encourage primary care professionals to commit these resources appropriately, both to ensure clinical quality and to ensure that resources are spent optimally.
5. The freedoms and flexibilities of practice based commissioning give front line professionals and managers the information, levers and incentives to improve services in response to the needs of their patients and local populations. It will facilitate clinical engagement, improve access and extend choice for patients and help restore and maintain financial balance.
6. This guidance addresses the key questions practices and PCTs want answered for the next year.
   - What does universal coverage mean?
   - What information is needed to make practice based commissioning work well?
   - How will budget setting and financial management work?
   - What is the governance and accountability framework for practice based commissioning?
   - What support will be available to practices and PCTs to ensure that patients benefit?
7. A further publication will follow shortly which provides some good practice guidance and early wins for practice based commissioning and in the summer a comprehensive commissioning framework will be made available.
8. Throughout, our intention is to maximise clinical innovation and quality by giving new freedoms to practices; but within a support and accountability framework, which ensures proper and efficient use of public money on behalf of the taxpayer and helps to provide the tools to make change happen.

What is practice based commissioning?

9. The current health reforms are giving a greater say and choice to patients. Hospitals and other providers are becoming more responsive to patient needs. To reinforce this, money is moving with the patient. Practice based commissioning is pivotal in supporting these reforms.
10. General practice is the bedrock of continuity of care for patients. The public has high satisfaction with, and trust in their GP, local teams of district nurses, health visitors and other community health professionals. Patients will look to practices for advice. Practices and community professionals understand the issues of quality and improving care pathways. The forthcoming White Paper will signal the shift of services into primary and community settings.
11. Practice based commissioning gives practices and professionals the freedom to develop innovative, high quality services for patients. This is good for patients. The accountability and support we are putting in place will ensure the best and fairest use of public resources. This is good for taxpayers.
12. To achieve these aims we need to have the right mechanisms in place. These are:
    - fair budgets;
    - excellent information;
    - freedom to move resources around in the interest of patients;
    - freedom to develop new and better patient care pathways;
    - good support and quality assurance;
    - no bureaucracy and transaction overheads; and
    - strong, transparent governance and accountability.
13. This document sets out how PCTs and practices should work together to deliver practice based commissioning using these mechanisms.

Achieving universal coverage

14. Our priority is the recruitment and development of practices such that the NHS has achieved universal coverage by the end of December 2006. PCTs are now charged with putting in place the arrangements for universal coverage of practice based commissioning.
15. To achieve universal coverage by the end of the year, PCTs will be responsible for ensuring that the following arrangements are in place.
    - All practices are receiving information that will allow them to understand their clinical and financial activity compared with local and national indicators.
    - All practices have received an indicative budget covering an agreed scope of services.
    - All practices are receiving support from the PCT and the offer of an incentive payment (the Directed Enhanced Service (DES) (see paragraph 60) or locally agreed payment) to support practice based commissioning.
    - Governance and accountability arrangements for practice based commissioning are in place and these are agreed in partnership between the practice and the PCT.
16. PCTs are accountable to Strategic Health Authorities (SHAs) and will be performance managed against these arrangements for 2006/07.
17. Practice based commissioning remains voluntary for practices. However, our expectation is that every practice, either working alone or in a group, will have the opportunity and the potential to use practice based commissioning to improve patient care. The administration and bureaucracy around transaction and payments will be managed for them so that they can focus on directing resources to maximise clinical benefit.
18. The uptake of practice based commissioning by practices will be measured through uptake of incentive payments. PCTs are expected to submit through their SHA, to the Department of Health, details of practices taking up the DES, or participating in other locally agreed incentive schemes.
19. This data will be collected in April (for the baseline) through the SHA annual report and again in January 2007. Further details on the content of the annual report will be available shortly at www.dh.gov.uk/practicebasedcommissioning
20. Whilst it is important to provide an assessment of progress in the uptake of practice based commissioning, we recognise that uptake is a crude measure. Practice based commissioning is a means to an end not an end in itself. What is most important is whether the aims of practice based commissioning – to drive up quality of services, improve the patient experience, reduce inequality and provide value for money – are being achieved. We are considering more appropriate outcome based measures for the future.

Information

21. All practices will receive information that will allow them to understand the implications of their clinical decisions. They will be provided with information about their historical referral patterns, historical spend and how these compare with other practices both in the PCT and with the national average.
22. To enable practices to make better informed recommendations, PCTs are expected, from April 2006, to provide as much relevant information as possible to practices. Practices can expect to receive monthly information packs from their PCT. A template will be provided to assist PCTs to provide this information and to ensure that all practices receive information in a consistent format. This will be available by the end of February at www.dh.gov.uk/practicebasedcommmissioning
23. The DES requires that PCTs should provide practices with benchmarking information and financial and activity information. Ideally, practices should be able to identify all the PCT unified allocation attributed to them. Even if much of it (those areas where practices have little or no control) is attributed on a weighted capitation basis this will help to manage the risk across all practices.
24. We expect PCTs to provide practices with activity and financial information for their own practice on:
    - elective activity – inpatient and day case;
    - non elective admissions, including information on length of stay;
    - first outpatient appointments, and follow up appointments;
    - use of diagnostic tests and procedures;
    - consultant to consultant referrals;
    - prescribing;
    - community and mental health services;
    - primary care including essential and enhanced PMS and GMS services; and
    - accident and emergency attendances.
25. PCTs are also expected to provide benchmarked data to practices that enables them to compare themselves with other practices in the PCT area and with the national average. Practices can expect benchmarking data on the following areas:
    - referral rates;
    - admission rates;
    - first outpatient attendances; and
    - follow up rates.
26. Practices will also benefit from receiving information on the needs, demands and demographics of the local population. This will enhance the ability of the practice to make informed clinical decisions, improve the public's health and set the context within which those decisions are made. For example, the first annual round of child health mapping data collection is underway and information from this will be made available to practices. Practices and their PCTs will wish to work with other agencies and use this information to help improve the outcomes for children.

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Information

27. PCTs are expected to standardise the information they provide to practices. In putting together information packs, PCTs have a responsibility to ensure that the data are accurate and up-to-date. Where the PCT is commissioning services from non-NHS providers, contracts require these providers to supply this information to the PCT. Data quality will improve over time and PCTs should not delay sharing data with practices because of concerns about complete accuracy.

Budget setting and financial management

28. PCTs will provide practices with indicative budgets by April 2006. Practices and PCTs will work together throughout the year to ensure resources are properly controlled and that resources which are freed up are effectively redeployed to benefit patients locally.

Budget setting

29. PCTs will provide practices with information on their share of the PCT's overall resource that is devoted to the practice's patients. Practices will also be provided with information on their target fair share of the PCT's resources. This will show practices whether they are receiving the appropriate level of resource given the relative needs of their registered population.
30. Over time we expect to see progress towards target fair shares at practice level. To support PCTs, the Department of Health has developed a toolkit that allows the use of the national resource allocation formula to calculate indicative weighted capitation budgets at practice level. The tool, and a supporting technical note, can be found at www.dh.gov.uk/practicebasedcommissioning

Coverage of the practice level indicative budget

31. Practices will need to decide which elements of health care services they wish to include in the indicative budget. This indicative budget will be used as the basis for determining the scale of resources that the practice has freed up for reinvestment.
32. Practices will develop a practice based commissioning plan for the services in their indicative budget, which will include the practice's proposals for improving services and reallocating freed up resources. While the practice will be free to determine the range of clinical redesign it engages in, its indicative budget against which freed resources will be measured must include as a minimum:
    - all services covered by the national tariff under payment by results in 2006/07; and
    - prescribing.
33. Practices should also consider including community services and mental health within their indicative budget. This is particularly relevant where practices plan to shift services out of secondary care into primary care. Any pooled budget commitments under Section 31 of the Health Act 1999 and Section 10 of the Children Act 2004 may also be included in the indicative budget if appropriate.
34. Certain services are excluded from the scope of a practice's indicative budget. These are:
    - core GMS/PMS services;
    - specialised services, services commissioned regionally and nationally and national screening programmes.
35. Services commissioned by PCTs from other primary care providers (i.e. primary care dentists, community pharmacists and optometrists) and secondary care referrals by primary care dentists or optometrists cannot be changed without full consultation and consent with other professionals.

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Budget setting and financial management

Setting the indicative budget

36. For 2006/07, PCTs should take the following approach to setting practice based indicative budgets:
    - provide, for information, the practice's share of the PCT allocation. This should be based as far as possible on historic (2005/06) activity, current formulae (e.g prescribing) and weighted capitation where there is no other methodology;
    - agree with the practice the scope of services to be included in its indicative budget (the budget against which the practice wishes to redeploy resources); and
    - calculate the indicative budget on the basis of:
        - actual 2005/06 activity (based on data available at Jan 06), converted into 2006/07 prices;
        - current formulae for prescribing including the appropriate inflationary uplift;
        - weighted capitation for any services within the agreed scope for which no historic activity data is available; and then
        - any uplift to meet agreed additional activity over 2005/06 (this will depend on the practice's current use of resources compared to their target fair share; and on the overall financial position of the PCT).
37. This approach should ensure each practice receives a budget that is fair, and ensures that, as a minimum, their purchasing power is maintained. Over time, practice budgets will move towards a fair share. PCTs will determine the pace of change for 2006/07.

Financial management

38. Practices and PCTs will work together throughout the year to ensure resources are properly controlled and that resources which are freed up are effectively redeployed to benefit patients locally.
39. The PCT will retain its accountability for its allocation, and its statutory financial duty to break even. The PCT and its practices will have to work together to ensure the PCT achieves financial balance, or runs a small surplus.

Risk management

40. It is important that no patient or practice is disadvantaged because of high cost individual care. PCTs therefore need to have robust arrangements in place to manage unplanned in-year variations in activity and cost.
41. PCTs may consider the following options to manage risks:
    - the retention from indicative budgets of a PCT held contingency fund. This should be a small proportion and we would suggest that such a fund should be between three and five percent of indicative budgets;
    - setting a threshold value for treatments. Costs which exceed this threshold would be funded by the contingency fund;

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Budget setting and financial management

- removing responsibility for particular high cost, low volume treatments from the scope of an indicative budget. This would leave resources and decisions with the PCT, or group of PCTs; and
- encouraging practices to come together in consortia to consider the redesign of services collectively.

42. PCTs, in close collaboration with their practices, will need to agree on the purpose and process for managing unplanned in-year variations and will need a transparent and fair methodology for calculating the contingency fund and for determining calls against the fund, with any unspent contingency returned to practices at year end.

Resources freed up

43. Under practice based commissioning, practices are entitled to make recommendations about how to reallocate resources freed up from their indicative budget made from service redesign and more cost effective treatments.
44. Resources freed up must be used to fund services for the benefit of patients locally. Resources freed up may be spent on equipment, training, clinical and non-clinical staff. They may also be spent on premises development with specific PCT board approval. PCTs are expected to agree a local process to ensure the sensible and upfront distribution of resources freed up. The PCT retains responsibility for the procurement of new services from freed up resources.
45. Practices will use their practice based commissioning plan to identify what service improvements will be made, how this will free up resources and the subsequent use of such resources. The plan should be developed with the PCT and other practices to ensure that national and local priorities are properly taken into account and that practices are fully aware of the local opportunities for partnership working and local development. Practices will take into account the priorities agreed in local action plans such as the Local Delivery Plan agreed with the SHA, and Local Area Agreements agreed with local partners.
46. Practices will look to identify gaps in existing services and pathways that need improvement. Not all service improvements can be organised by one practice on its own. Practices will want to work together, either locally, or in networks of practices with similar interests, to achieve this. For this reason it may be appropriate for freed up resources to be shared across a wider group of practices to support changes that would benefit a wider group of patients.
47. We recommend that for 2006/07 individual practices should be entitled to access and redirect at least 70 percent of any freed up resources; the remaining 30 percent to be used by the PCT to meet a wider need across the whole PCT area.
48. In the event that overspending or deficits management cannot be contained within the contingency fund and recovery plan arrangements, as a last resort, these resources may be used to cover PCT overspends. These arrangements will be reviewed for 2007/08.
49. Where practices make recommendations for small contract changes, or relatively small purchases, these should be agreed with a minimum of bureaucracy by the PCT. The PCT board

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Budget setting and financial management

will be used to ensure that the resources are committed appropriately and in line with the criteria for practice based commissioning.

50. Where practices make recommendations involving larger sums, or which require upfront investment in order to deliver savings, PCT agreement will be needed on the basis of a business case. A simple proforma to help practices and PCTs take on this process will be available by the end of February 2006 on www.dh.gov.uk/practicebasedcommissioning

51. The business case will be expected to cover:
    - the service to be provided;
    - the benefits for patients;
    - the expected improvements in efficiency and effectiveness;
    - the management resources required; and
    - the costs of the proposals and their recovery period.

52. The PCT board will be accountable for decisions on business cases for new services within reasonable timescales in accordance with local governance rules. This should not exceed eight weeks from receipt of the business case. The criteria to be used for assessing business cases will include:
    - evidence based clinical effectiveness;
    - clinical safety, quality and governance;
    - contribution to offering care closer to home;
    - patient and stakeholder support;
    - justification/evidence that savings can be made by the substitution of care;
    - affordability within current and projected budget;
    - consideration of whether formal tender is needed (in accordance with PCT standing financial instructions);
    - assessment of the risks of the development; and
    - value for money.

53. The PCT is expected to clearly identify its reasons for not supporting any business case and parameters or actions which would resolve this.

Contracting

54. PCTs remain responsible for the decisions and contracting arrangements for new services agreed. They will take forward preparation, negotiation, agreement and management of contracts. Increasingly they will do so on the basis of the advice and recommendations they receive from their practices. PCTs will continue to ensure that due process is followed when awarding NHS contracts. Guidance can be found in *Health Service Circular 2002/07: Securing Service Delivery: Commissioning Freedoms of Primary Care Trusts* available at www.dh.gov.uk/publications

55. Where practice recommendations lead to proposals to contract with independent sector providers PCTs should take account of guidance included in the *Alternative Provider Medical Services Toolkit* available at www.pasa.nhs.uk

Support for practices

56. PCTs will be expected to have arrangements in place to provide support to practices, to enable them to successfully engage with practice based commissioning. Support should be targeted to meet practice needs and requirements.
57. Practices will also benefit from peer support where more experienced practices can offer advice and clinical leadership to practices with less experience. Nationally, the Primary Care Contracting Advisors are on hand to support PCTs through workshops, commissioning networks and access to expert advice. Further details can be found at Annex B.
58. Commissioned by the Department of Health, the National Primary Care Development Team (NPDT) has begun a programme of support available to all PCTs and their practices to help them become practice based commissioners. Further details of the programme, which includes preparation for practice based commissioning, assessment of readiness and learning from other PCTs, is included in Annex A and on www.npdt.org
59. We will be publishing a document of good practice examples, including suggestions for service redesign for practice based commissioning early in February. Other support available is detailed in Annex B.

Practice based commissioning Directed Enhanced Service

60. To encourage practices to engage with practice based commissioning a Directed Enhanced Service (DES) for 2006/07 has been agreed with the BMA's GP Committee. It entitles practices to 95p per registered patient in recognition of the engagement required (particularly clinical) of practice staff in developing and implementing a locally agreed plan that will include ways that the practice will redesign care. The production of an agreed practice based commissioning plan between the practice and the PCT, which will include information on the services to be redesigned, will trigger the award. The DES applies to all practice based commissioners, not just those from GMS practices.
61. If practices achieve the objectives set out in the plan, practices are entitled to retain for reinvestment in patient care or other practice activity which supports the continued delivery of objectives, a minimum of 95p per patient from the resources that their plan will have released. This minimum guarantees practices access to released resources in PCTs with financial difficulties that might otherwise absorb that resource.
62. Many PCTs and practices will, however, already have arrangements in place for delivering practice based commissioning and agreements for the handling of released resource that will go beyond the specification of the 2006/07 practice based commissioning DES. Furthermore, local incentive schemes may already exist which focus on driving up clinical quality and value for money. The DES is not intended to override any such arrangements and PCTs will consider whether any supplementary resources are required.
63. PCTs retain legal accountability for commissioning services and will be expected to reallocate resource in line with practice recommendations in response to the appropriate plan. Where the PCT is unable to do so, practices should receive a full explanation of the reasons and, where appropriate, a plan and timetable for addressing the obstacles.
64. The DES will be available shortly on the Department of Health website at www.dh.gov.uk/practicebasedcommissioning

Accountability and governance

65. Under practice based commissioning PCTs remain accountable for all the funds allocated to them by Secretary of State and for ensuring fair access to high quality services for their populations, within the resources made available to them. PCTs are also responsible for ensuring that services meet all national and local quality standards and accreditation, especially specific controls assurance standards on patient safety. PCTs are accountable for this to the Secretary of State via SHAs.
66. PCTs have a duty to involve and consult patients and the public when considering new or different service provision. Practices are encouraged to ensure that patients, as the users of services, are engaged in decisions about redesign and the reallocation of freed up resources.
67. PCTs will work with their practices, groups of practices and other local stakeholders and agencies (e.g. local authorities, children's trusts) to deliver their commissioning responsibilities. Effective relationships between PCTs and practices will underpin successful commissioning. Practices will need to consider all their stakeholders when making decisions around service redesign.
68. To support practices' engagement in practice based commissioning, PCTs will put in place clear and transparent governance arrangements. These will help to provide consistency as PCTs undergo reconfiguration. The governance arrangements will cover the following:
    - dissemination of information to support practice based commissioning;
    - budget setting and financial management arrangements;
    - support for practices including incentives;
    - process to agree practice based commissioning plans;
    - process for approving business cases for resources freed up; and
    - criteria for reaching decisions.

Performance

69. PCTs will work with all their practices to ensure that their patients receive fair access to high quality services, and that the PCT's financial responsibilities to the taxpayer are properly discharged.
70. Support from the PCT should be targeted according to the specific needs of practices. Where a practice demonstrates that it is managing its indicative budget appropriately, and has a track record of delivering change which is effective and releases resources, then the practice should be able to earn a considerable degree of autonomy, and would require less support. Conversely, some practices may need additional support to analyse their referral and spending patterns and to provide advice about where changes to clinical decision making could free up resources for reallocation to alternative services. Other practices may be freeing up resources in some areas but not others, and may need specific support in these areas.

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Accountability and governance

71. The extent of PCT engagement with individual practices will also be related to their performance. Where practices are actively engaged in practice based commissioning and delivering improved services they can expect a lighter touch from their PCT. Equally where practices are struggling to meet the demands of patients, or their financial responsibilities, PCTs will pay closer attention.

Arbitration

72. It is expected that practices and PCTs will agree local application of the national framework for practice based commissioning. If practices and PCTs cannot agree local interpretation of the framework, the issue will be referred to the SHA.
73. SHAs will be expected to ensure one or more arbitration groups depending on demand and to ensure independence. The group should include practitioner, financial and management representation and will be appointed by the SHA. Decisions will be on a pendulum basis, i.e. either/or and not a compromise. PCTs will be expected to follow the decision of the group.

Conclusion

74. Achieving universal coverage of practice based commissioning will see practices and PCTs working together to shape services and clinical pathways to improve services for patients. Practices will be provided with information and indicative budgets to enable them to work within the framework of governance and support to redesign services in response to the needs of their patients and local populations.
75. Practice based commissioning will facilitate clinical engagement, improve access and extend choice for patients and will help restore and maintain financial balance. Practices benefit from greater influence over the services that are commissioned, PCTs benefit from greater clinical support in their commissioning decisions, and above all patients benefit from high quality services that are responsive to their needs and located in a range of more convenient settings.

Annex A

National Primary Care Development Team support programme

1. The Department has asked the National Primary Care Development Team (NPDT) to support PCTs with the rollout of practice based commissioning. The programme will help to make this a reality by providing a faster timeframe than if each PCT or individual practice set about it in isolation.
2. The programme will do this by sharing learning from those who have already done it, by training people in the use of quality improvement tools to take advantage of good practice identified elsewhere and by placing clinicians in the driving seat. The programme capitalises on clinical engagement by ensuring that practice based commissioning is viewed as a means to an end and not an end in itself – and that end sought is an improvement in the services provided for patients.
3. The programme aims to support:
   - engagement with local clinicians in the redesign of services (with a focus on both unscheduled and scheduled care);
   - re-design of commissioning systems to support improved service delivery;
   - faster universal roll-out of practice based commissioning; and
   - support the development of PCTs and practices to deliver practice based commissioning.
4. NPDT's experience has shown that to achieve major change you need to do more than inform people of 'what' to do, you actually need to change peoples' behaviour. Changing behaviour needs a completely different approach – a methodology of behaviour change that presents the 'how' as well as the 'what'. NPDT has substantial experience and results in this area.

Structure of the Programme

5. Based on earlier learning from other programmes, including the Primary Care Contracting Collaborative, the NPDT has built upon its original collaborative model to offer additional, integrated support for the NHS. There are a number of phases to this programme which include:
   - A parallel learning process that will allow any NHS organisation to engage in web casts, simulation events and learning exchanges. Any PCT can also self-evaluate using the NPDT practice based commissioning Assessment Framework accessible from www.npdt.org
   - A preparatory period to ensure PCTs and practices have their data, informatics and finance structure and functions in place so they are ready to take advantage of the collaborative process;
   - An assessment point using the Assessment Framework to determine the PCT and practice readiness to progress; and
   - A collaborative process to engage local clinicians in the practicality of practice based commissioning as a means of delivering improved services (focusing on scheduled or unscheduled care)
6. The timeframe for this programme is for all PCTs to be engaged in the process within eight months of the starting point through three waves (by December 2006).

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National Primary Care Development Team support programme

Waves

7. Wave 1 (national wave): The aim is to recruit initially one PCT site per current SHA area, providing each SHA with a practice based commissioning exemplar site. These 28 PCTs will form the national wave that will develop the worked examples of practice based commissioning. These sites will need to be able to make improvements quickly and will therefore need to be areas that have already done some work on practice based commissioning, e.g. indicative/real budgets are in place, practices are keen to get involved etc.
8. Waves 2 and 3 (regional waves): Recruitment of the remainder of the PCTs in the country in the spread phase will be carried out by the 11 local NPDT centres working with all the SHAs. Within two waves all PCTs will have been offered an opportunity to take part. These waves will give sites a longer preparatory period to help practices and the PCT to start working effectively together and will be run shortly after the national wave commences.

What is a site?

9. A site will consist of a PCT and up to five practices formally participating on the programme, either individually, as clusters/localities or as representatives of localities, and that are interested in working on the chosen service areas and wish to implement practice based commissioning.
10. For further information please contact Jacquie White, NPDT Programme Director, on 0161 236 1566. Alternatively, details are available on the NPDT website at www.npdt.org

Annex B

Further useful resources for practice based commissioning

11. A number of the professional bodies are providing specialist support for their members.
12. The National Association of Primary Care is operating a practice based commissioning helpline and web page resource. It is also collecting and will be disseminating best practice. It will be running further conferences on practice based commissioning and NHS Foundation Trusts throughout 2006. For more information contact Maggie Marum on 0207 636 7228 or maggie@napc.co.uk and www.napc.co.uk
13. The NHS Alliance supports and represents current and aspiring practice based commissioners through the NHS Alliance Federation for practice based commissioning, which provides information, advice, a comprehensive database and monthly newsletters for member practices and practice clusters/localities. There will be 15 regional practice based commissioning conferences this spring and the launch of a practice based commissioning 'flying squad' for practices and PCTs. Practice managers, PCT commissioning managers, PEC chairs, specialists, nurses and allied health professionals can also directly access help with practice based commissioning through six national networks created specifically for these clinician/manager groups. For more information contact Kaye Locke on 01777 869080 or office@nhsalliance.org or visit www.nhsalliance.org
14. The General Practitioners Committee (GPC) of the BMA continues to offer advice on practice based commissioning to Local Medical Committees (LMCs) and individual GP practices. It has produced guidance for LMCs and GPs on the initiative and plans to issue further guidance following publication of this document. For more information contact Sally Al-Zaidy at sal-zaidy@bma.org.uk or alternatively visit www.bma.org.uk/ap.nsf/Content/Hubpracticebased commissioning
15. The NHS Confederation has produced briefings which will assist commissioners to understand the design principles that could be used to develop practice based commissioning organisations that are fit for purpose. The series of papers 'Shaping the Future of Community Health and Care for Patients' provides commissioners at PCT and practice level with service design principles and covers key issues which will support the planning of services. For further information visit www.nhsconfed.org or contact: Jo Webber, Deputy Policy Director at jo.webber@nhsconfed.org
16. The Primary Care Contracting Team has produced a practice based commissioning toolkit and is producing briefing sheets on specific subject areas. It can also provide details of the local primary care contracting advisor who can provide local expert knowledge and support. For more information contact sean.fenelon@pcc.nhs.uk and rebecca.thornley@pcc.nhs.uk alternatively visit www.primarycarecontracting.nhs.uk

Continued overleaf…

Further useful resources for practice based commissioning

17. The Royal College of Nursing (RCN) is running a series of masterclasses throughout 2006 for senior nurses and workshops for all clinicians who wish to further develop their commissioning knowledge. These high quality events are free to RCN members and can be accessed via the RCN Regional Office. Further work will be taking place to support senior nurses who will have commissioning roles to enable them to share and learn from each other and build their commissioning capability. The RCN primary care and public health web site contains specific guidance on commissioning and supporting nurses through changing roles. For more information contact Lynn Young on 0207 647 3740 or email lynn.young@rcn.org.uk or visit www.rcn.org.uk/pcph
18. The Department of Health's own website has some useful resources and links relating to practice based commissioning. For more information visit www.dh.gov.uk/practicebased commissioning You can also email your questions or concerns to pbc@dh.gsi.gov.uk