



Practice Based Commissioning

A Practical Guide
for
LPCs

June 2007

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Introduction

This document aims to help Local Pharmaceutical Committees think through the action they should be taking to assist community pharmacy contractors understand and engage with Practice Based Commissioning (PBC). As well as providing background information on the place of PBC in current policy, it provides practical suggestions for action.

- The first Section describes commissioning and practice based commissioning including the commissioning cycle.
- This is followed by a Section setting out the policy framework within which PBC has developed, key issues in the implementation of PBC, and the impact of recent PCT re-organisation.
- Opportunities for community pharmacy are covered in Section Three and considered within the three areas of preventing admissions, effective prescribing and redesign of care pathways.
- Section Four covers the role of the LPC in ensuring engagement, helping to establish the environment for pharmacy engagement, and providing support to contractors in achieving engagement with PBC.
- Section Five looks at developing a robust business case.
- Examples of documentation, sources of information and a reading list are included in the Appendices.

It should be remembered that PBC is not mandatory and is one of several methods which can be used to commission local services.

Background

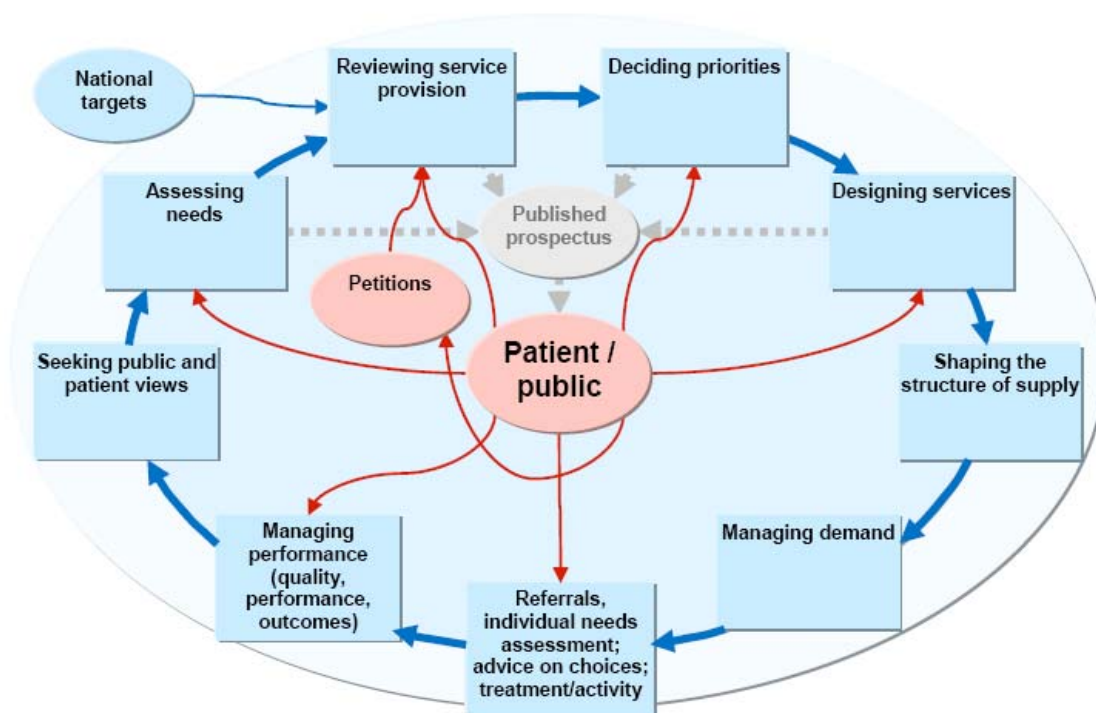
Commissioning

Every Primary Care Trust (PCT), working in partnership with practice-based commissioners, is responsible for commissioning the full range of health services for its population. Effective commissioning makes the best use of allocated resources to achieve the following goals:

- improve health and well-being and reduce health inequalities and social exclusion;
- secure access to a comprehensive range of services;
- improve the quality, effectiveness and efficiency of services; and
- increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs.

Commissioning consists of a multitude of separate but interrelated processes, ranging from needs assessment, through service review, decisions on priorities, contracting and procurement, to feedback on the services provided. Taken together these are described as the commissioning cycle¹ and more detail is provided in Appendix 1.

Figure 1 - The Commissioning Cycle



PCTs, as statutory bodies, have a responsibility for securing the best possible services for their population, whilst remaining within their allocated resources. Their responsibility for the commissioning function cannot be delegated to anyone else.

Practice Based Commissioning

Practice based commissioning (PBC) is a key element of the overall NHS reform programme to improve health and local health services.

Overlaying the population level processes that make up the commissioning cycle are the millions of individual clinical decisions made every day about provision of care and the commitment of resources. PBC aligns the clinical decisions made by GPs - *which drug do I choose for this patient? should I refer this patient?* - with the financial consequences of their actions to the NHS. By devolving money to a local level, PBC provides engagement of primary care clinicians in commissioning decisions and prompts the redesign of services to better meet patient needs and make better use of health resources.

Under practice based commissioning individual practices^a are allocated an indicative budget. The PCT is responsible for ensuring that practices receive an indicative budget that reflects the needs of their population as accurately as possible. As a minimum this should include all hospital-based care covered by Payment by Results² (PbR), prescribing, community services and mental health costs. No actual transfer of resources take place and the overall responsibility and accountability remains with the PCT, who continue to hold contracts for services with providers.

For 2006/07 and 2007/08 budgets have been allocated as a practice's share of the overall PCT allocation. For 2007/08 these were calculated on the basis of:

- actual activity for the last six months of 2005/06 and the first six months of 2006/07, converted to 2007/08 prices;
- current formulae for prescribing budgets include the appropriate inflationary uplift; and
- weighted capitation for any services within the agreed scope for which no historic activity data are available.

In 2008/09 budget setting will start to move to a "fair share" budget-setting methodology to enable the needs of neighbourhoods and practice populations to be more accurately reflected and health inequalities tackled. The Department of Health is working on options for this process.³

PCTs notionally allocate their full budget to practices. Funding to cover central management and support overheads is then returned to the PCT, who will normally provide these services directly. In exceptional circumstances practices can negotiate a budget to procure these services themselves.

Practice Based Commissioning Plans

PBC is not mandatory and practices must decide whether or not to take part. All practices taking part in PBC must agree a practice based commissioning plan

^a The terms practice, PBC consortia, PBC group and PBC cluster are used interchangeably throughout this document to refer to individual practices and groups of practices operating collectively within PBC.

with their PCT, which sets out their commissioning objectives. To avoid burdening practices with bureaucracy the level of detail required has been kept to a minimum. A template is available from the Department of Health website and has been included as Appendix 2. Where practices have grouped together to form a PBC consortia, a single plan can be submitted on behalf of the group.

The PBC plan needs to cover the following:

- how the practice will respond to the particular needs of their population and their experience of local healthcare;
- how the practice intends to contribute to meeting national priorities by redesigning services, and identifying resources that could be released from the indicative budget; and
- areas where the practice believes that a more collective approach to service redesign and improvement is needed.

In order to formulate their PBC plan, practices need to work with other clinical professionals, including community pharmacists, district nurses and health visitors, to develop an understanding of their population's needs.

PBC plans are then submitted to the PCT for approval. The PCT must confirm that they are consistent with national and local priorities. The aggregated PBC plans then form the basis of the PCT's overall commissioning plan and are used to inform strategic planning.³

Commissioning and Procuring Services

PCTs are encouraged to commission from a wide variety of providers, in order to ensure innovation, quality and value, and to offer real choice to people who use services. By operating a process of open tendering any provider willing to provide the service is free to compete. This includes providers from the public, private and third (voluntary) sectors. The "any willing provider" model allows the PCT, through a contract, to give permission for providers to supply services to their population, with no guarantee of volume or payment.

The prospective provider has to satisfy the PCT of its ability to deliver the service and comply with quality standards. This model can be used for routine elective services and enhanced primary care services, where the range of providers could include GP limited companies, third sector organisations, community pharmacies and private companies.

The principle behind this model is that by including as many groups as possible the greatest innovation and variety will be encouraged. In turn, having more service providers should increase levels of competition resulting in improved efficiency and service and greater choice for patients.

Practices who wish to develop and provide a service through PBC must submit a business case to their PCT for approval. A template is available from the Department of Health website and has been included as Appendix 3.

Incentives

One of the key principles behind PBC is that it provides the freedoms and incentives to exercise devolved responsibility in redesigning services to better meet the needs of patients.

Under PBC, practices are entitled to access and redirect at least 70% of any resources released from their indicative budget as a result of service redesign and the use of more cost effective treatments. These can be used to fund services for the benefit of patients locally and may be spent on equipment, training, clinical and non-clinical staff. The potential use for any freed up resources should be covered within a practice's PBC plan, taking into account national and local priorities. The remaining 30% is for the PCT to use at their discretion.

In order to ensure that no patient or practice is disadvantaged by episodes of high cost individual care, robust contingency arrangements need to be put in place.

The Policy Framework

Key Documents

The concept of practice level commissioning is not a new one. The 1997 White Paper *The New NHS*⁴ acknowledged that, despite its limitations, many innovative GPs and their fund managers had used fundholding to sharpen the responsiveness of hospital services and extend the range of services available in their own surgeries. The document stated that “over time, the Government expects that ... [PCTs] will extend indicative budgets to individual practices for the full range of services”.

The publication of the *NHS Plan*⁵ in 2000, followed by the *Wanless Report*⁶ in 2002, saw the start of a ten-year programme of reform. These reports identified the need for sustained investment in the NHS, and for radical reform of the way in which it operated, to ensure that it could deliver its core aim of providing high quality care for every patient, responding to need not ability to pay. Both reports also made clear the need for value for money; to consistently achieve the best use of resources in a taxpayer-funded service.

The initiatives that were introduced are now well known:

- patient choice;
- a wider range of providers;
- more freedom for hospitals;
- stronger commissioning;
- new payment mechanisms; and
- independent inspection of quality.

In June 2004, the publication of *The NHS Improvement Plan*⁷ described a need to balance improved responsiveness and expanded capacity with mechanisms to ensure that referral and treatment thresholds did not fall thereby resulting in unnecessary hospital admissions and investigations. The report signalled that the NHS should provide as much care as appropriate outside the hospital setting. Whilst part of this was about making better use of information and care pathways to promote the appropriate use of services, a further strand was to be the devolution of commissioning to GP practices. The report indicated that “from April 2005, GP practices that wish to do so will be given indicative commissioning budgets”.

In October 2004, the Department of Health published its first detailed proposals for involving GP practices in commissioning health care services.⁸ Following feedback from the NHS a framework for the local implementation of practice based commissioning was published a few months later.⁹ This highlighted that PBC would produce the following outcomes:

- a greater variety of services, from a greater number of providers in settings that are closer to home and more convenient to patients;
- increased support of clinician-to-clinician dialogue about improving and developing care processes;
- early and continuing involvement of practitioners in service development; and
- an additional set of levers to aid demand management.

At this stage PCTs were only required to encourage their practices to take on budgets for commissioning. *Promoting Clinical Engagement*⁹ indicated that there were no targets, simply an aspiration that all practices would be involved in PBC by 2008.

However in December 2005 a framework was published for taking forward the further development of NHS reform during 2006/07. *Health reform in England: update and next steps*¹⁰ indicated the rapid acceleration of PBC, introducing the requirement for “universal coverage” by December 2006. This message was reiterated in the *Operating Framework for 2006/07*¹¹ and in specific guidance on *Achieving Universal Coverage*.¹²

In order to achieve universal coverage PCTs had to ensure that the following arrangements were in place:

- all practices had to receive information that would allow them to understand their clinical and financial activity compared with local and national indicators;
- all practices had an indicative budget covering an agreed scope of services;
- all practices to receive support from the PCT and the offer of an incentive payment (the Directed Enhanced Service (DES) available within the nGMS contract or a locally agreed payment) to support practice based commissioning; and
- governance and accountability arrangements for practice based commissioning in place and agreed in partnership between the practice and the PCT.

All PCTs achieved universal coverage by December 2006, and data published by the Department of Health indicates that in March 2007 ninety-six per cent of general practices have started to engage in PBC (measured by the take up of an incentive payment).¹³

In January 2006 the Government published the White Paper *Our health, our care, our say*¹⁴ setting out the next stage of the NHS reform programme. Acknowledging that many of the reforms implemented so far had concentrated on improving hospitals and stabilising social care, the document moved attention to reforming and improving community services. It placed emphasis on prevention, promoting health and well-being, providing care in more local settings, and providing services that are flexible, integrated and responsive.

By enabling GPs to commission the right services to meet their patients' health care needs PBC is seen as a key tool in order to achieve these aims. The report emphasised that GPs and community-based professionals are closest to individual users and patients, and that through PBC have greater freedom to commission health care services for the individual person. The White Paper also identified the opportunity provided by the Payment by Results (PbR) tariff system for commissioners to seek out providers who offer better quality care, or to develop local alternatives that deliver, safely and effectively, the services that people want, closer to home.

Six months later more clarity was provided on how PBC would empower GPs to develop new service with the publication of *Health Reform in England: update and commissioning framework*¹. An annex to the document provided the overarching vision for the commissioning role of PCTs working in partnership with practices to promote PBC. Alongside choice, individual social care budgets and PbR, PBC is seen as providing commissioners with the tools to support the delivery of patient-centred care. The framework also provided clarity on the approach required on procurement and tendering for services within PBC.

Recognising that good progress had been made in putting in place the right environment for PBC, new guidance was issued in November 2006 and *Practical Implementation*³ superseded the guidance from ten months earlier.¹² Whilst the direction of travel remained unchanged the new guidance addressed the issues of governance and accountability, and budget-setting. The *Operating Framework 2007-08*,¹⁵ published the following month, continued to emphasise the importance of PBC.

In March 2007 a *Commissioning framework for health and well-being*¹⁶ was published, which continues to build on the principles set out in *Our health, our care, our say*. It calls on commissioners of services to improve health, well-being and independence by focusing on the outcomes that people want for themselves and their communities, with a particular focus on partnership. Using the flexibility provided by PBC is identified as one of the steps to achieving more effective commissioning.

ACTION POINT:

Make sure that you are familiar with the content of the key documents before you approach other stakeholders to discuss pharmacy's role in PBC.

Copies of the documents can be downloaded from the DH and Primary Care Contracting websites (see Appendix 4).

Implementing PBC

PCTs continue to be charged with ensuring that PBC flourishes and the following expectations have been placed upon them:

- a locally agreed incentive scheme will be developed and offered to all practices;
- the scope, timeliness and access by practices to activity and financial information relating to their practice will be addressed in line with practice preferences;
- PCTs to provide practices with the tools and support they need to effectively discharge their commissioning responsibilities, either directly or through agreed alternative arrangements;
- A combination of indicators to help take a balanced view about progress towards implementation and the impact that PBC is having across the health economy will be reported for 2007/08.

Governance and Accountability

Following consultation on proposals for a governance and accountability framework for PBC as part of the commissioning framework,¹ the final version was set out in November 2006.³ This aims to balance public accountability for the effective use of taxpayers' funds with minimum bureaucracy for practices and maximum freedom for clinicians to innovate to deliver improvements for patients.

The guidance makes it clear that in order to avoid conflicts of interest in the re-provision of services through PBC (for example where clinicians may be involved in the assessment of PBC business cases in which they may have a direct interest), there should be clear accountability to the PCT Board through a committee or sub-committee of the PCT, chaired by a non-executive director.

Clinicians must exclude themselves from decisions on any PBC business case in which they have an interest or are associated. The guidance emphasises that all parts of the NHS are expected to conform to the highest standards of honesty, integrity and probity, and to work in partnership in a patient-centred, inclusive way.

Practices acting as practice based commissioners also have a responsibility to ensure that they involve their patients in developing their plans. Practices should make their plans available for public scrutiny by their practice population. PCTs need to make the collective plans for all the practice based commissioners available to Overview and Scrutiny Committees and the general public.

Practice based commissioners who provide additional services are expected to ensure that their new services met all national standards for clinical governance, including those set out in *Standards for Better Health*.¹⁷

ACTION POINT:

LPCs will wish to monitor that appropriate governance and accountability measures have been put in place (as well as mechanisms through which to place formal complaints) to minimise the risk of conflict of interest in the consideration of commissioning plans and proposals for service development.

Procuring Services

For services developed through PBC, tendering will normally only be required when the intention is to create a monopoly by awarding a contract to a single provider rather than grant approval to providers who reach the required standard.

This “any willing provider” model has already been described in an earlier section of this document (see page 4). Whilst this at present is primarily intended to relate to routine elective services, the same approach could be extended to the development of enhanced primary care services through PBC.

The responsibility for placing contracts remains with PCTs, who should only award a contract to a single provider in exceptional circumstances as this inhibits patient choice and contestability.

ACTION POINT:

LPCs will wish to monitor local procurement processes to ensure that these principles are followed.

LPCs should ensure that contractors are aware of services for which they could be considered as ‘willing providers’ and support contractors who wish to become ‘willing providers’ to achieve standards required.

Monitoring

In order for the Department of Health to monitor the national implementation of PBC, a series of indicators have been put in place. These have been developed to answer the following questions:

- is the PBC framework enabling?
- are practices engaging with PBC?
- are there new pathways and what is their impact on outcomes?

An independent quarterly practice survey is being commissioned by the DH, covering a sample of practices from each PCT to assess practice engagement. SHAs will be required to submit an annual report providing examples of service redesign commissioned by practice based commissioners. This will also contain details about the numbers of business cases submitted and approved by PCTs and the total resources freed up and re-invested. The DH is developing a scorecard of impact indicators.

SHAs will use the indicators to assess PCT progress in the implementation of PBC, in terms of enabling, engagement and impact.

PCT Re-organisation and Fitness for Purpose

*Commissioning a Patient-led NHS*¹⁸ saw the reconfiguration of PCTs as the first stage in delivering a robust infrastructure from which to strengthen the commissioning function of PCTs. As a result the number of PCTs in England reduced from 303 to 152 on 1st October 2006.

Stage two of the process focused on ensuring that these new PCTs have the internal capacity and capability to discharge their new functions, in particular leadership ability. All PCTs have now undergone an independent diagnostic and benchmarking assessment to ensure that a development programme is put in place which is appropriately targeted. As part of this **Fitness for Purpose** programme, a commissioning capability diagnostic tool was developed to allow PCTs to be benchmarked against best practice commissioning. This considers the areas of:

- strategic planning;
- care pathway management;
- provider management; and
- monitoring and remediation.

Practice based commissioning is specifically covered within the section on care pathway management (see Appendix 5). More information on the Fitness for Purpose programme can be found on the DH website at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134656.

ACTION POINT:

Make sure that you are familiar with the PCT's Development Plan which resulted from the Fitness for Purpose programme, particularly those areas relating to commissioning and PBC.

Opportunities for Community Pharmacy

The philosophy behind practice based commissioning is looking at innovative, more efficient and cost effective ways of doing things, and includes an emphasis on prevention and giving patients choice. Potentially there are many opportunities for pharmacists to become actively engaged in PBC, both in terms of commissioning and redesign, and as providers of services.

Practice based commissioners will be keen to prevent unnecessary hospital admissions as this will have a direct impact on their indicative budget. Likewise any initiative which results in more cost effective use of medicines, and releases resources from the prescribing element of their indicative budget, is likely to be of interest. Finally savings can be made as a result of redesigned care pathways which provide a community-based alternative to hospital treatment.

Preventing Admissions

Poor compliance with medication can jeopardise treatment, and increase the risk of admission or re-admission to hospital. A number of studies have implicated the occurrence of adverse drug reactions with admission to hospital, particularly in elderly patients. These have shown that between 5% and 17% of admissions are likely to be drug-related.¹⁹⁻²⁴

The increased incidence of long-term conditions such as diabetes, asthma, arthritis, heart failure, chronic obstructive pulmonary disease and dementia, presents a huge challenge to the NHS. Improving care and service for people with such conditions will have not only an impact for the individual, but also a beneficial impact on secondary and emergency care, and positive implications for social care.²⁵ Half of all bed-days are accounted for by less than 3% of medical conditions, most of which are chronic diseases, and 5% of inpatients account for 42% of overall inpatient days.²⁶ As many as 80% of patients may not be taking their medicines as intended^{27,28} and wastage due to inequivalence of repeat prescription quantities has been estimated to account for 6 - 10% of total prescribing costs.²⁹ Better management of long term conditions helps to prevent hospital admission.

Elements of the community pharmacy contractual framework are already designed to support patients with long-term conditions in the community and help reduce unnecessary hospital admissions. These include Medicines Use Review (MUR), disposal of unwanted medication, support for self-care and repeat dispensing.

Therefore these services, whilst already funded within the pharmacy contract rather than being opportunities to develop new services, provide a good starting point for discussions with local practices. From there it may be possible to broaden discussion to enhanced services which the practice could commission, such as medication review (full clinical review, EN7), medicines assessment and compliance support (EN6) or supplementary prescribing (EN11).

EXAMPLE:

From 2002 to 2007 Community pharmacists in Hillingdon delivered a primary care diabetes management service, seeing each patient at least six times a year. In addition to improvements in blood glucose and cholesterol levels, blood pressure and body mass index, patients felt that they were better informed about their condition and medicines.³⁰⁻³²

Research in 2003 showed that up to 8% of attendances at A & E could be treated in a community pharmacy as people often present with minor ailments, requests for pain relief or needing urgent further supplies of their regular medication.³³ It is likely that this situation will have been compounded since the introduction of the nGMS contract as most GP surgeries are now closed for the entire weekend. Prevention of A & E attendance can be supported by commissioning from community pharmacy minor ailment services (EN8), emergency hormonal contraception services (EN11), and out of hours (access to medicines, EN9).

In addition more than 150 million GP consultations each year are for conditions that are potential self treatable.^{34,35} By transferring the treatment of more minor ailments to community pharmacy, general practice is able to concentrate on the management of long-term conditions and patients with more complex conditions.

EXAMPLE:

In Harrow community pharmacists operate a rota to supply a pre-determined list of medicines from midnight to 9am every day when required by an out-of-hours provider³⁰

One of the most frequent reasons for unscheduled hospital admission is respiratory disease. Pharmacy-based stop smoking schemes (EN4), targeted at patients with asthma and COPD can help to reduce the number of unplanned admissions for these conditions.

EXAMPLE:

Community pharmacists in Harrow provide counselling, support and provision of NRT to people who want to quit smoking. The service is community pharmacy led and GPs no longer prescribe NRT on NHS prescription.³⁰

The specifications for these enhanced services can be downloaded from the Pharmacy Contract section of the PSNC website at www.psnc.org.uk.

Effective Prescribing

More than £8bn is spent on drugs in primary care each year, and despite activity for more than a decade to try and maximise the efficiency of prescribing a recent report by the National Audit Office found that more could be done to improve efficiency, reduce wastage and ensure value for money.^{36,37}

The report identified that at least £100m a year could be saved by reducing wastage. Pharmacy-based services such as MUR and repeat dispensing are ways in which community pharmacies can ensure prescribed medicines are used properly rather than being disposed off.

By working in concert with the PCT prescribing team, which may be much smaller as a result of PCT re-organisation, community pharmacists can help practices with the management of their prescribing budget. Examples include:

- switches to generic prescribing;
- therapeutic substitution, e.g. changing to a different statin or proton pump inhibitor;
- changes in course length, e.g. five days of antibiotics rather than 7 days where appropriate;
- reduction in quantities of acute “prn” medication supplied, e.g. 50 rather than 100 co-dydramol; 100ml rather than 300ml of simple linctus; and
- encouraging patients to purchase simple remedies for self-care (coughs, colds, simple analgesics).

A number of useful publications are available to provide ideas and support³⁸⁻⁴⁰ and the recent NAO report is accompanied by a communications plan for prescribing advisers.³⁶

Ten top tips recently issued by Primary Care Contracting include linking QOF with PBC and prescribing.⁴¹

Redesigning Care Pathways

Redesigning a particular clinical pathway need not be massively complicated. Many of the examples given in *Practice based commissioning: early wins and top tips*⁴² have involved only small changes to the overall care pathway and have been relatively easy to implement.

Similar small-scale changes in pathway design could involve the movement of one element of the patient’s care to a community pharmacy setting. Community pharmacists can take on tasks previously undertaken in the GP surgery (such as blood glucose and cholesterol tests, blood pressure monitoring), or within a hospital setting (such as anti-coagulation monitoring, Chlamydia screening), freeing up the time of other healthcare professionals to concentrate on more complex tasks. Delivering an 18 week patient pathway from GP referral to the start of treatment by the end of 2008 is a key objective for the NHS.

EXAMPLE:

In Manchester patients with cardiovascular disease or diabetes are offered point-of-care HbA^{1c} and cholesterol tests when collecting their medicines at the community pharmacy.^{32,43}

A pharmacy-based anticoagulant clinic has been running in the North East of England for many years, as an alternative to a long journey for patients to the local hospital.³⁰

The Role of the LPC

Engagement

Although encouraged to develop their PBC plans in conjunction with other clinical professionals including community pharmacists,^{3,44} many general practitioners will not automatically think to take a multi-professional approach in doing so.

As representatives of community pharmacy it is important that Local Pharmaceutical Committees understand the PBC agenda and are familiar with developments both nationally and locally. In order to do so it is likely that LPCs will need to allocate resources to support community pharmacy engagement in both the commissioning and service provision aspects of PBC.

The LPC will, hopefully, already have a well developed relationship with the Local Medical Committee (LMC). It is important to influence the messages that LMCs are communicating to the members about multi-professional involvement in PBC.

Some LPCs have already appointed an officer or member of staff who is responsible for PBC liaison. An example job profile is included as Appendix 5.

ACTION POINT:

If the LPC has not already done so, consider what resources (e.g. time, money, training, a specific post) need to be devoted to PBC if pharmacy is to become fully engaged.

Consider how the LPC can support participation of community pharmacists in the commissioning and planning activities of PBC, as well as identifying opportunities for service provision.

Make contact with key members of the LMC and agree joint messages on the involvement of community pharmacists in PBC processes.

Encourage community pharmacy contractors to develop good relationships with their local GP practice.

Establishing the Environment

In order to be able to support community pharmacists working with their local practices and PBC consortia, the LPC needs to be aware of what is happening with PBC locally.

As a result of recent re-organisation, many of the individuals with whom the LPC has developed relationships over the last few years may have changed. Even where there have been minimal staffing changes at a senior level, individual's responsibilities may have changed.

ACTION POINT:

Find out who, within your PCTs, has responsibility for taking forward the development of PBC. Make contact and find out the PCTs approach to PBC and commissioning.

Review the PCT's PBC plan and identify any opportunities for local contractors to become willing providers.

The introduction of the new community pharmacy contractual framework may have been primarily led by PCT pharmacy advisers or by staff with responsibility for primary care services.

The staff responsible for commissioning and practice based commissioning will probably not be that familiar with the new pharmacy contract, or even with primary care services provided by non-GP contractors. In many PCTs, commissioning staff historically come from a background of commissioning acute services, rather than from working with primary care services.

ACTION POINT:

Establish good relationships with PCT commissioners and pharmacy advisers.

Make sure they are familiar with the pharmacy contract and highlight areas in which community pharmacies can contribute towards provision of cost effective services

Professional Executive Committee

Alongside the re-organisation of PCTs, the Department of Health commissioned the NHS Alliance to undertake a public consultation on the future role of PCT Professional Executive Committees (PECs).⁴⁵ As a result new guidance, *Fit for the Future* has been issued to PCTs on the roles and function of PECs.⁴⁶

The new guidance moves away from the prescriptive approach of the past, where the composition of the PEC was set out in Statutory Instruments and Directions with a specified maximum number of members and minimum requirements for certain professional groups.^{46,47} This led to most PECs being dominated by general practitioners and nurses, although a significant proportion had a pharmacist member and some were chaired by pharmacists.

PCTs will now have the flexibility to determine how PECs should operate according to local circumstances, reflecting the diversity of PCTs in terms of their population size, demography and health needs. The PEC is expected to provide the PCT with clinical leadership, working jointly and equally with the senior management team, and PEC members should be practicing clinicians. The PEC also has close links with PBC and has an important role in governance.

Appointment will be made by interview against defined roles set out in a job description on the basis of suitability against a person specification and competencies, and members will not be appointed to represent their profession.

ACTION POINT:

Work with community pharmacists to identify and support application by suitable candidates for PEC membership.

If there is no pharmacist on the PEC then make sure that a PEC community pharmacy champion is identified.

Needs Assessment

Since 2005, the contractual framework for community pharmacy and changes to the control of entry regulations have required PCTs to undertake and regularly review a pharmaceutical needs assessment (PNA) so that they:

- understand the pharmaceutical needs of their population;
- take stock of the current community pharmacy services provided;
- consider the potential of community pharmacy in redesigning services; and
- take a rational approach to commissioning services from community pharmacy.

The re-organisation of PCTs means that the pharmaceutical needs assessments in place in predecessor organisations will need to be brought together providing an opportunity to refresh and update them in the light of PBC. A revised PNA toolkit will be available from Primary Care Contracting during summer 2007.

In drawing up their PBC plan, practices need to develop an understanding of their population's needs. As well as participating in pharmaceutical needs assessment, community pharmacy can make a contribution to assessing the overall needs of the local population. Community pharmacists have an almost unique opportunity to access people who are well, those who are seeking to manage their own health, those who are ill, and those who don't yet realise that they are ill.

Therefore they are likely to develop a good understanding of the local populations needs and can also act as a conduit through which the views of patients and customers can be collected to feed into local health needs assessment to inform PBC.

ACTION POINT:

Work with the PCT to refresh and update the PNA, taking the opportunity to link this into overall needs assessment as part of commissioning and PBC.

Community Pharmacy Strategic Commissioning Tests

The introduction of the nGMS contract and the community pharmacy contractual framework has each been accompanied by a set of strategic commissioning tests. These are intended as a tool for commissioners and SHAs to assess implementation.

The strategic tests for community pharmacy⁴⁸ have recently been updated to ensure that they focus on:

- ensuring community pharmacy is fully integrated into the commissioning process;
- ensuring that community pharmacy is used as an enabler in service redesign;
- ensuring that community pharmacy is delivering specific NHS outcomes; and
- ensuring that a “fit for purpose” pharmacy related infrastructure is in place to enable the above.

They are also designed as a prompt to PCTs and practices to take account of relevant published documents and to set community pharmacy in the context of the 2007/08 Operating Framework,¹⁵ PBC guidance^{3,12} and the Commissioning Framework.¹

PCTs will need to consider their performance against the commissioning strategic tests, and how the actions of practice based commissioners measure up to these test. SHAs may also review the action plans developed by PCTs in response to the tests.

ACTION POINT:

Work with your PCTs to ensure that there is an effective planning framework for primary care services, including pharmacy, in the commissioning process.

Establish good relationships with SHA commissioning, performance management and pharmaceutical leads and raise awareness of the community pharmacy strategic tests.

Service Redesign

Redesigning the way in which health services are delivered is critical to the long term success of the NHS, and the cornerstone of current policy. The real success of PBC will be in developing about developing new care pathways, especially for long term conditions, that result in more services being provided in primary care.

Some examples of successfully redesigned patient pathways were published in 2006 in *Practice based commissioning: early wins and top tips*.⁴² These have a common theme of redesigning services so that they were provided in the community instead of in a hospital setting, often with the involvement of a practitioner with special interest (PwSI).

Examples cited included changes which had made a rapid difference to patients with chronic obstructive pulmonary disease (COPD), dermatological conditions, heart failure, mental health problems, long-term conditions, ophthalmic problems, orthopaedic cases, diabetic foot problems, and haematuria.

Primary Care Contracting has produced a PBC Bulletin about service redesign and delivery⁴⁹ which can be downloaded from their website (see Appendix 4).

ACTION POINT:

Establish good relationships with PBC consortia leads

Try and ensure pharmacy representation on local PBC consortia planning/strategy groups.

Engage with local GPs and PBC groups to find out what care pathways are being redesigned and what services practice based commissioners are considering developing in primary care.

Emphasise the contribution that community pharmacists can make to care pathway redesign, both around prescribing and medicines management, and around broader service provision.

Request representation on the PBC Delivery Group/Steering Group to overview the progress across localities and contribute to service redesign if it is not done effectively at local level.

The Community Pharmacy Contractual Framework

The community pharmacy contractual framework provides opportunities to support PBC. Essential services, provided by all pharmacies and including support for self-care, signposting and advice on healthy lifestyles, can help reduce demand on local health services.

Participation in repeat dispensing can free up the time of general practitioners to treat more serious cases, who might otherwise have been referred to hospital. MUR allows pharmacists to identify problems that patients are having in taking their medication and help resolve them before they become more serious, potentially preventing avoidable hospital admissions.

In addition to the contribution which Essential and Advanced pharmacy services can make, the new contractual framework provides the opportunity for additional services to be commissioned as Enhanced services. Examples include:

- minor ailment services;
- stop smoking schemes;
- needle and syringe exchange;
- supervised administration of medication (e.g. methadone);
- supplementary prescribing by pharmacists;
- medication review (full clinical review);
- emergency hormonal contraception service;
- care homes;
- medicines assessment and compliance support;
- out of hours (access to medicines).

Primary Care Contracting has produced a PBC Bulletin about the role of pharmacy³⁰ which can be downloaded from their website (see Appendix 4).

ACTION POINT:

Ensure that local practices understand the structure of the pharmacy contract, what services it covers, and the contribution these can make to service redesign and achieving local and national targets.

Ensure that practices understand Medicines Use Review and its potential benefits.

The Improvement Foundation (IF) is running a two year PBC development programme, funded by the Department of Health. The programme consists of:

- Parallel Learning process that will allow any NHS organisation to engage in web casts, simulation events and learning exchanges;
- 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;
- Assessment Point using the Assessment Framework to determine the PCT and practice readiness to progress; and
- 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).

The IF has also put together a range of resources to help front line staff get more out of PBC. These include three events during June and July 2007, in conjunction with Primary Care Contracting designed for pharmacists and practice based commissioners. More information can be found on the IF or PCC websites (see **Error! Reference source not found.**).

ACTION POINT:

If practices in your area are involved in the IF development programme make links with the Improvement Foundation leads.

Contractor Support

In order to be a credible contender within the “any willing provider” model community pharmacy needs to be seen as able to deliver.

Implementation of the new pharmacy contractual framework has provided the opportunity for community pharmacy to show that, given new challenges, this is indeed the case. This means that contractors need to be delivering high quality Essential services, and for as many as possible to become engaged in the delivery of Advanced services. Given that GPs have a significant influence as practice-based commissioners it is important that information being provided to

GPs as a result of MURs is seen as relevant and clinically useful, especially if trying to interest them in extending the medication review role of pharmacists.

PCTs will now be embarking on their second round of monitoring pharmacies for compliance with the requirements of the contractual framework, usually by an annual visit to the pharmacy premises (or other similar mechanism). It is important that community pharmacy can demonstrate that it has taken maximum advantage of the new contractual framework and is delivering what it requires. In undertaking its regulatory and governance roles it is likely that PCTs will expect compliance as a pre-requisite to the engagement of any provider.

ACTION POINT:

Make sure that contractors are fully engaging in the new services provided by the pharmacy contractual framework.

Encourage contractors to work more closely with their GPs, and help them develop the confidence to discuss the benefits of the new services, especially MURs.

Many PBC consortia have in place steering groups or professional fora at which commissioning plans are discussed. Even individual practices operating within PBC should have some form of discussion forum.

The need for multidisciplinary input into the development of PBC plans was emphasised in the most recent guidance³ and was the subject of an earlier bulletin by PCC.⁴⁴

ACTION POINT:

Try and ensure that PBC groups are seeking the involvement of other clinical professionals.

Support contractors to join PBC groups as community pharmacy representatives.

Earlier this year Liverpool PCT and nineteen practices comprising the South Central PBC Consortium became the first in the country to advertise through the any willing provider model for community-based dermatology services. Tenders were invited in the Health Service Journal of 8th March 2007, with a closing date of 23rd March.⁵⁰

Kingston PCT has stated that it will publish willing provider service specifications on its website and will maintain a list of potential willing providers to whom it will circulate specifications. It has adopted a policy where any organisation may bid to be designated as a willing provider for a particular service.⁵¹

In Derby City PCT the commissioning group is preparing to seek willing providers for diabetes and dermatology services.⁵²

Pharmacy needs to be ready to and able to respond to timescales of the kind required by Liverpool PCT. In order to do this, LPCs and individual contractors need to be regularly scanning the types of places where tenders will be sought,

aware of the approach that their local commissioners are intending to take, and have proposals prepared in advance so that they only need final refinement in order to be able to respond to such tight deadlines.

ACTION POINT:

Make sure that you are aware of the approach that your local commissioners are taking. Be familiar with where invitations to tender or register as a willing provider will appear.

Work with your contractors to have proposals already well developed so that when they are required they only need final polishing.

Identify contractors who are willing to act as willing providers and support them in submitting proposals.

Unless they are actively involved in a PBC group or a member of a PEC, practice based commissioning may seem a remote concept to many community pharmacists.

However this is a policy which is constantly evolving, and will have significant implications for community pharmacy, especially if the profession does not become engaged.

The LPC has a key role in capturing information about what is happening across its area, benchmarking the scope and pace of development and keeping community pharmacists up-to-date and involved.

ACTION POINT:

Make use of your LPC newsletter or website to keep contractors up to date with local developments.

Encourage contractors to feed back intelligence to the LPC so that best practice, and concerns, can be shared and discussed. Encourage them to keep their staff updated and involved.

Make PBC a standing agenda item at your meetings.

How to Develop a Robust Business Case

Preparing a business case to develop a new service need not be a difficult process but does require considerable preparation to be successful and may take a significant period of time.

A number of articles have been published which provide advice to pharmacists about developing bids.⁵³⁻⁶⁰ These provide a useful starting point if you are considering putting together a business case.

The most important part of preparing a business case is to make sure that a need exists and can be demonstrated. Make sure that what you want to offer links in with the key issues such as NSF standards, the QOF, local LDP targets, PBC business plan, PCT prospectus etc. Any proposal must link with commissioners' needs, rather than being about what pharmacy wants to provide.

All PCTs should have a pharmaceutical needs assessment (PNA) in place, although it may be in need of updating as a result of PCT re-organisation. Make use of the information that it contains to identify gaps in service.

Before investing too much time in preparation it is sensible to do some groundwork:

- approach local stakeholders for feedback on your ideas; exactly who will depend on what you are hoping to develop, but they are likely to include your local PBC group and relevant PCT commissioners;
- consider obtaining the views of some of the patients who may benefit;
- make sure that you have the evidence you require to demonstrate a need - do a small scale pilot if necessary, or audit current practice to collect data;
- unless what you are proposing is very innovative, make sure that you use peer-reviewed evidence of best practice as the basis for what you are proposing. Carry out a literature review, or if you can't find any published data, try the PSNC database.

Keeping Ahead

The PSNC produces regular LPC Briefings and holds examples of best practice and relevant which can be adapted to suit your local circumstances. Service specifications for the Enhanced services within the pharmacy contract can be downloaded from the PSNC website.

The "What's New" section of the Department of Health's website and the weekly Chief Executive's Bulletin are particularly useful for keeping abreast with key issues nationally. These can be found at:

www.dh.gov.uk/en/News/DH_4015576 and

www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/Chiefexecutivebulletin/index.htm.

Points to Cover in a Business Case

Wherever possible use the locally agreed template for submitting a business case. Your PCT or practice may ask you to use the business case proforma available from the PBC section of the Department of Health website (see Appendix 3). Make sure that all elements are completed as fully as possible. If it is not clear what is required in a particular section of a proforma, ask someone.

Scope of the Service and why Proposed

Outline what is proposed. Will this be a new service or an existing service (or part of a care pathway) that will be provided in a different way?

If the service is not needed a bid will be rejected so it is important that all proposals are supported by evidence that demonstrates a need. This may be collected by undertaking a small-scale pilot or by identifying gaps in service through a local health needs assessment. This would need to cover the following:

- what is the population being assessed ?
- why is the assessment topic a priority ?
- what is driving the process ?
- what are the fixed points and is there sufficient work to be undertaken ?
- what is happening locally that is relevant ?
- who should be involved in what is happening ?
- what are the resource implications ?

Benefits to Patients

Clearly document the impact that you expect implementation to have on local services, and more importantly, if you can, try to demonstrate the impact on patient outcomes. Base these assumptions on published data wherever possible, including references.

Make sure that the benefits that you quote are achievable and meaningful in the local context. Don't be tempted to make claims that can't be realised.

Identify the target population (e.g. people with diabetes, older people, patients with a specific long-term condition). Make it clear whether this is a proposal that relates to the practice population of one practice, a number of practices or the whole PCT. Include estimates of the number of patients that the service is likely to cover. Make sure that proposals are focused on areas of care where improvement is needed or a change would be beneficial - don't take a generic approach.

You may be able to access relevant data from the PCT's Annual Report or public health department. Also consider using the Hospital Episode Statistics (HES) if you are considering a service targeted at reducing emergency admissions (see Appendix 7).

National and Local Priorities

Make sure that you can relate the proposal you are making to the key issues for the particular organisation. Make the links to the relevant national priorities such as NSFs, NHS Plan targets, QOF, PCT performance indicators or local priorities identified in PBC plans or PCT commissioning plans. The emphasis you place on what you are proposing may need to be adjusted depending on whether this is a service intended to assist a practice achieve its commissioning plan, or a proposal for the use of freed up funds to be reinvested in service development.

Demonstrate that relevant stakeholders, including patients and users have been consulted in the development of your proposals.

Your proposal needs to be presented as a solution to the organisations' problems, not another problem for staff to think about.

Clinical Effectiveness

Demonstrate that your business case is based on the best clinical evidence and include references wherever possible. Ensure that the relevant training needs have been identified and that the proposals demonstrate how these will be met.

Risk Assessment

Incorporate clinical governance principles into the business case to make sure that the services are safe, appropriate and efficiently delivered.

Decide at the outset how you intend to monitor the service and what data on patients, interventions or referrals will need to be collected? How will this be collated and outcomes measured? Timescales and a review process will also need to be incorporated.

Make sure that you know what quality standards the PCT or practice will expect to see built into any new service.

Value for Money and Pricing

The price that an organisation will be prepared to pay for a service will be related to the value of the outcome to that organisation. Discussions therefore may need to be based on benefits not purely cost-driven pricing.

Identify what resources will be saved as a result of implementing your proposals. Over what timescale will these be released, and what are the parameters needed (for example patient numbers) to ensure resources can be released?

Multidisciplinary approach

A business case for the development of any service is likely to be more successful if it demonstrates a clear understanding of how pharmacy can contribute in relation to other elements of the NHS, and makes appropriate links with other professionals.

For example think about the links between what you are offering and the single assessment process (SAP), community matrons, case management etc.

Presenting Your Case

Be ready to make either formal or informal presentations. Try to make any presentation as professional as possible using presentational and word processing software as appropriate. Prepare a summary of points (no more than 1-2 pages) to use as an executive summary and leave with the commissioners.

Make sure that you can produce relevant references to back up your claims; somebody is sure to ask for the details to satisfy themselves.

Be prepared not to succeed quickly; you may need to try several approaches before something is successful. Don't be disheartened if a proposal is rejected - learn from the experience and be persistent.

Costing Services

Less expensive services are more likely to be funded; however that is not necessarily a reason to exclude a more comprehensive, well thought out service.

A toolkit for costing Enhanced services has been developed by PSNC and endorsed by NHS Employers (the employers' organisation of the NHS Confederation).⁶¹ It is intended to be used by LPCs and commissioners to assist in the agreement of the costs that will be incurred in relation to a particular service.

You need to be confident to be able to discuss your costing in detail and to be able to back up your assumptions.

So... Making it Happen

To start with, try to keep it simple, start with small discrete projects or developments which can be introduced within a relatively short timescale, and if these are successful move on to more ambitious plans. If applying to provide Enhanced services which a PCT wishes to commission much of the groundwork will already have been covered in that there will be a service specification detailing exactly what you are expected to provide.

Commissioners will want to see that the outcomes you are contracted to provide are delivered so expect to be asked to provide regular monitoring information on performance indicators for the service. These may be crucial to ensuring that a service is sustained over a period of time as regular review will occur within the commissioning cycle to ensure that commissioners are getting what they expect from the service you are providing and therefore remain willing to continue to commission the service.

The following checklist will help you make sure that you don't overlook anything.

- ✓ Make the relevant links between what your business case is for and NSF standards, QOF, PBC plans, PCT Local Delivery Plan and other national and local priorities.

- ✓ Identify a need for the service and how what you propose to do can assist the commissioners to address its key issues.
- ✓ Make informal contact with individuals who you think will be able to give you support and feedback on your ideas.
- ✓ Identify any learning needs that you may have, and consider whether there is further training that you need to undertake to be in a stronger position to provide this type of service.
- ✓ Make sure that you are familiar with the current issues in the relevant service area.
- ✓ Identify the key individual within the PBC group or PCT to whom you should make a formal proposal. This will vary from one organisation to another. Draw up a formal business case to provide services in your locality. Ideally the proposed service should be multidisciplinary involving integrated care plans and working in partnership with other professionals.
- ✓ If you are submitting a business case to provide an enhanced service make sure that you are completely familiar with the service specification, how you can meet its requirements and what you will be expected to provide to the commissioners in terms of performance monitoring.

Conclusion

By the end of March 2007 more than 95% of general practices were recorded as having taken up the incentive payment offered for signing up, in principle, to PBC.¹³

However a survey of GPs and practice managers undertaken by the King's Fund and NHS Alliance showed that the majority of respondents thought that the policy has not yet improved the quality of patient care.^{62,63} The report noted that although PBC receives widespread support, implementation has been slow and concluded that, in practice, an environment has been created in which PBC *could* flourish rather than one in which it *is* flourishing.⁶⁴

Alongside this, the BMA has advised its members to remind PCTs of GPs entitlements under the PBC guidance⁶⁵ and that there is a provision for practices to negotiate a budget from the PCT to procure these services independently.³

Some PCTs have already started to advertise for willing providers, and many more are likely to do so over the next few months. Many of the organisations coming forward at present involve local GPs.⁶⁶

Speaking at the NHS Alliance spring conference the Secretary of State for Health indicated that support for practice based commissioning will be a priority for the NHS during the coming year.^{67,68} She announced the availability of a new tool for commissioners - the Disease Management Information Toolkit. The toolkit is intended to support commissioners gain a better understanding of which of nine major long-term conditions have the greatest impact in terms of emergency bed days in their locality and models the effect of possible interventions.⁶⁹

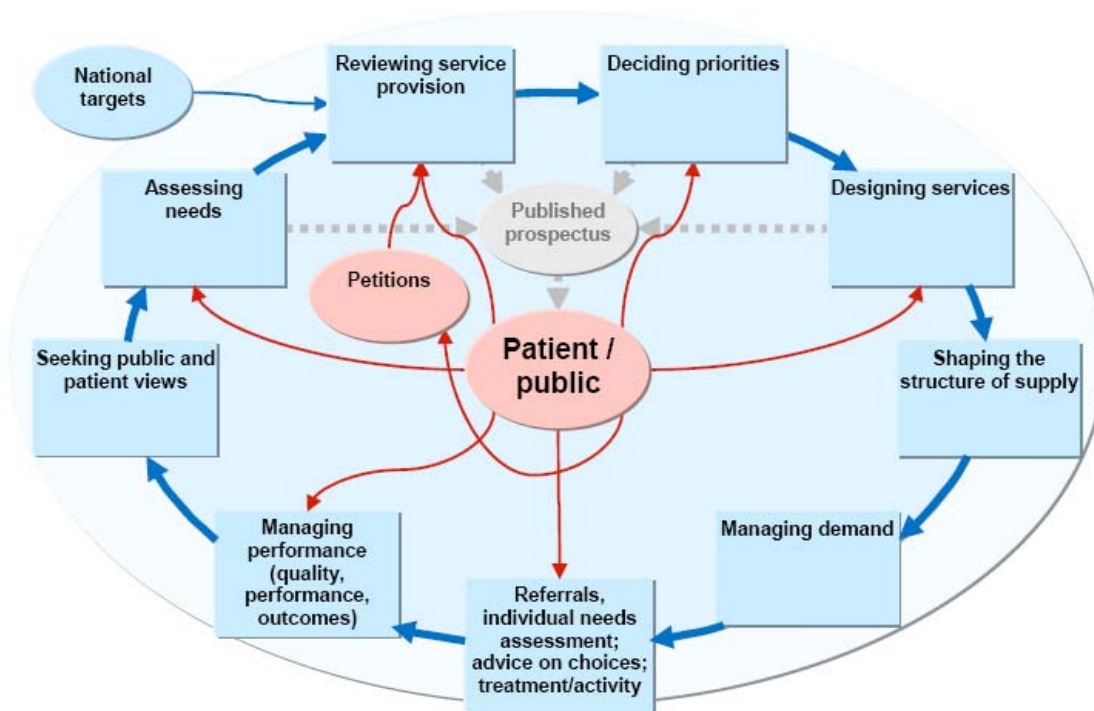
It is clear that the emphasis on practice based commissioning is not going to reduce in the near future, and that many GPs are keen to see the further development of the system, feeling that they are currently being held back by PCTs.

If community pharmacy does not want to be left behind in both influencing commissioners' plans, and acting as providers of services, it is crucial that LPCs and individual contractors do not see PBC as another policy fad which will pass and become actively engaged in the process now.

Appendices

The Commissioning Cycle

Source: *Health reform in England: update and commissioning framework. Annex, the commissioning framework, DH, July 2006*



Assessing needs

This will increasingly be based on more rigorous analytical approaches involving population segmentation and risk stratification and will involve public health professionals, local authorities, GPs and patients and the local community.

Reviewing service provision

Practices will identify gaps and the potential for improvements in existing services. PCTs will use the aggregated intelligence of their practices and their local needs assessment to identify gaps or inadequacies in provision, as well as broader requirements for service development.

Deciding priorities

The PCT should produce a strategic plan for the health community based on data on needs assessment collated from practices and on the clear choices patients are making. Practices and PCTs should work collectively to reinvest resources that have been released through service redesign where these would achieve greater impact. PCTs should ensure patients and the local community, as well as local government and other partners, are properly involved in the process of deciding priorities.

Designing services

Practices will work individually, or in groups, to develop strategies and service models to improve healthcare services and address the priorities of the public.

PCT prospectus

The PCT prospectus will signal the strategic direction for local services, highlighting commissioning priorities, needs and opportunities to service providers, offering a focus for discussion with patients and local community and an opportunity to open dialogues with potential providers.

Shaping the structure of supply

PCTs will be clear about the services and service specifications they and their practices and patients want to see developed and will give strategic support to proposals where necessary. They will seek to develop new services and will work with NHS Trusts and Foundation Trusts, expanding GP practices, neighbouring PCTs and private and third sector providers to ensure the best services for local people.

Where appropriate, PCTs will encourage practices to offer services locally and also attract private sector and third sector providers to offer services in line with identified needs and priorities. Incentives and levers will be available to PCTs to stimulate the supply of services.

PCTs will agree contracts with local secondary care providers within a new national contracting framework, with the involvement of practice-based commissioners. For a few, very specialised services, contracts will be held at national level. For other specialised services, PCTs will group together to set contracts.

Managing demand and ensuring appropriate access to care

Practices and PCTs will establish strategies for care and resource utilisation to ensure that patients receive the most appropriate care in the right setting, ensuring that healthcare resource is maximised.

Clinical decision making

Individual practices and clinicians undertake individual needs assessments, make referrals and advise patients on choices and the treatments available to them - each referral is effectively a micro commissioning decision. Practices will work with social services and other agencies where appropriate to assess the needs of their patients. It will be important to facilitate the opportunity for patients to make their choices with the benefit of good advice from their GP. PCTs and local authorities should work together to develop this environment in which integrated working between practices and social services is the norm.

Managing performance

Practices will seek to manage their indicative budget to maximise the benefits from the resources available to them. To help them, PCTs will provide a support programmes including training and development, and will develop systems to allow practices to monitor the services their patients receive through accurate,

relevant and timely data. PCTs will be responsible for the aggregated financial position and for ensuring financial balance overall.

Patient and public feedback

PCTs will be responsible for measuring and reporting on patients' experience. Practices will also want to monitor patients' satisfaction. Robust mechanisms for collecting and understanding patients' views will need to be developed by PCTs and made available to practices. Throughout, PCTs will ensure that the public voice is heard in the development of priorities and shaping services.

Appendix 2

Practice Based Commissioning Plan Template

This template is to assist practices in developing a practice based commissioning plan to agree with their PCT. Agreement of the plan by the PCT will trigger the award of the incentive payment. This may be the nationally negotiated DES or a locally agreed alternative.

Where alternative templates have been developed locally, these may be used. In addition, this template can be amended for local use. Further examples of locally developed plans are available from the Primary Care Contracting team and at www.primarycarecontracting.nhs.uk

The practice based commissioning plan should be drawn up in the context of the accountability and governance framework agreed between the practice and the PCT.

Practice name and contact details, including details of the practice lead for practice based commissioning.

--

Details, if applicable, of other practices within the consortia. The incentive payment will be made to individual practices, however practices subsequently working together is strongly encouraged.

--

Where practices are redesigning or reproviding services as a group of practices, details of the interpractice agreements in place.

--

Scope of services covered by the indicative budget as agreed with the PCT. As stated in the DH guidance *Practice based commissioning: achieving universal coverage*, this is expected as a minimum to cover PbR tariff services and prescribing.

--

Details of links to local and national priorities.

Details of how the practice intends to manage expenditure within the delegated budget. The practice should demonstrate the steps it will take to manage financial risk and ensure that overspends do not occur.

Scope of the services to be redesigned and how these services will be provided in the future. This will include whether services will be redesigned or reprovided by a single practice or with other practices. Further details of the new or changed service will be set out in the business case for PCT approval, however an outline should be included here.

Method by which the quality and safety of the redesigned or reprovided service will be assured.

Estimate of the value of resources freed up through redesign or reprovion of services.

Outline of how these freed up resources will be reinvested in patient care. Further details will be included in the business cases for new or redesigned or services submitted for PCT approve.

Indication of how patients and users will be involved in redesigning or reproviding services. Further details will be provided in the individual business case proposals submitted to PCTs.

--

Indication of how other professionals and stakeholders, including providers, will be involved in redesigning services. Further details will be provided in the individual business case proposals submitted to PCTs.

--

Indication of how the impact on other services will be considered in the redesign or reprovision of services. Further details will be provided in the individual business case proposals submitted to PCTs.

--

Indication of other services that the practice considers would benefit from redesign or reprovision, but that are not included in the objectives of this plan. These may be services where a larger group of practices or the PCT might consider leading the redesign.

--

Summary of objectives. The achievement of the objectives set out here will trigger payment of component two or entitle the practice to access freed up resources.

--

Details of any arrangements to measure progress agreed with the PCT.

--

Business Case Proforma

These proforma provide templates for use by practices submitting business cases for new services to their PCT for approval. Use of these particular proforma is optional, and where there are local alternatives in place, these may be used instead.

Practices should submit business cases to their PCT for all new services or existing services provided differently. As stated in *Practice based commissioning: achieving universal coverage* (January 2006), where practices make recommendations for small contract changes, or relatively small purchases, these should be agreed with a minimum of bureaucracy by the PCT. In these cases, the business case will be very straightforward.

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. In these cases, the business case will be more detailed. Two proforma have been developed.

The first proforma is for proposals to change services within a single practice and the second is for the development of new services for patients across more than one practice.

Both proforma will need to be considered by the PCT in the context of the governance and accountability framework agreed between the practice and the PCT. Examples of locally developed accountability and governance frameworks can be obtained from the Primary Care Contracting team at www.primarycarecontracting.nhs.uk

Proforma for changes to services within the practice

Practice name and contact details.

--

Outline of proposed service change.

--

Benefit to patients.

--

Estimated number of patients the service is likely to cover, also including an indication of the minimum and maximum numbers.

--

Costs of the proposed service.

--

Links to and any impact on local and national priorities.

--

Likely value of any freed up resources and over what timescale.

--

Proforma for development of new services across more than one practice

Practice name and contact details

--

Outline of proposed service change.

--

Benefit to patients.

--

Estimated number of patients the service is likely to cover, also including an indication of the minimum and maximum numbers.

--

Evidence to support clinical effectiveness of the proposed service.

--

Evidence of patient support, including consultation with patients and users.

--

Evidence of stakeholder support, including evidence of consultation with other relevant professionals and where applicable other providers.

--

Costs of the proposed service, including details of any upfront investment required. Detailed costs should be set out in the contract for the new service, but an overall estimate of the cost should be included here.

--

Likely value of freed up resources and over what timescale. Overall value should be included here with further detail provided in the contract.

--

Links to and any impact on local and national priorities.

--

Assessment of risks of the service, including consideration of whether there are other local similar service providers.

--

Key Documents

Information on all aspects of PBC can be found at the Department of Health Practice based commissioning website at

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/Practice-basedcommissioning/index.htm

To make sure that you are up-to-date with the current guidance on PBC read the following documents:

Practice Based Commissioning: Practical Implementation (DH, November 2006)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062703

Health reform in England: update and commissioning framework (DH, July 2006)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137226

NHS in England: operating framework for 2007-08 (DH, December 2006)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063267

To understand the background and development of PBC the following documents are useful reading:

Practice Based Commissioning: Promoting Clinical Engagement (DH, December 2005)
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4098565.pdf

Practice Based Commissioning: Achieving Universal Coverage (DH, January 2006)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127125

Practice Based Commissioning Bulletin (Primary Care Contracting, 2005 - 2006)
www.primarycarecontracting.nhs.uk/126.php

- No 1 - Preparing for PBC
- No 2 - PBC and Governance
- No 3 - Multiprofessional involvement in PBC
- No 4 - Service Redesign and Delivery
- No 5 - Pharmacy and PBC
- No 6 - Patients and the Public

Practice Based Commissioning: Early Wins and Top Tips (DH, February 2006)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4128102

To fit PBC into the wider policy context read:

Our Health, our Care, our Say: a new direction for community services (DH, January 2006)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4127552

Commissioning framework for health and well-being (DH, March 2007)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Fitness for Purpose Programme

Extract from the Care Pathway Management Diagnostic Tool

<p>Scorecard (enter check marks in appropriate box)</p>	<p>1 Does not meet minimum standards</p>	<p>2 Meets minimum standards</p>	<p>3 Good to best practice</p>
<p>1</p> <p>Does PCT have formal systems for engaging with practices on PBC?</p>	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> PCT has an individual or group of individuals responsible for communicating and coordinating with practices on PBC Practices feel engaged about PBC from both a financial and clinical perspective and the PCT has an informal or infrequent mechanism to measure practice attitudes 	<ul style="list-style-type: none"> PCT has a 'PBC Board' or equivalent structure for working with clinicians to design locally relevant PBC scheme and engages the majority of local practices in planning for PBC Practices feel engaged about PBC from both a financial and clinical perspective and the PCT has a systematic process (e.g. regular surveys) to measure practice attitudes
<p>2</p> <p>Has PCT clearly and sufficiently defined PBC rules and guidelines in an accountability and governance framework?</p>	<ul style="list-style-type: none"> Does not meet minimum standards 	<p>PCT has clear policies governing:</p> <ul style="list-style-type: none"> Who bears financial risk Unit of analysis (e.g., practices, localities) Scope of services covered How freed-up resources will be calculated How freed-up resources will be shared between practices and PCT How clinical quality will be ensured How freed-up resources can be spent Incentives to support PBC (e.g., DES payments) 	<p>In consultation with practices, PCT has developed clear and detailed policies governing</p> <ul style="list-style-type: none"> Who bears financial risk Unit of analysis (e.g., practices, localities) Scope of services covered How freed-up resources will be calculated How freed-up resources will be shared between practices and PCT How clinical quality will be ensured How freed-up resources can be spent Incentives to support PBC (e.g., DES payments)
<p>3</p> <p>Have PCT and practices explicitly allocated responsibility for care pathway management initiative?</p>	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> PCT's care pathway management strategy clearly defines which tasks will be undertaken by PCT and which will be undertaken by practices 	<ul style="list-style-type: none"> PCT and practices have formally discussed a comprehensive care pathway management strategy and worked together to define clear responsibilities for each party in planning, implementing and monitoring these strategies

Scorecard (enter check marks in appropriate box)	1 Does not meet minimum standards	2 Meets minimum standards	3 Good to best practice
4 Has PCT actively communicated with practices about PBC?	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> PCT has produced or adapted existing written guidelines and advice on the PBC scheme and disseminated to all practices 	<ul style="list-style-type: none"> PCT has actively engaged with practices, sending written documentation, convening learning sessions and dialogues on PBC and creating forums where questions and issues can be raised and addressed
5 Have practices taken up PBC?	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> Half to three quarters of practices have developed PBC plans and are actively implementing these plans for PBC PCT and clusters are finalising a business case for a LES 	<ul style="list-style-type: none"> More than three quarters of practices have developed PBC plans and are actively implementing these plans for PBC (e.g., have taken up DES/ LES Part 1) PCT and clusters have agreed a LES and services and implementation is taking place
6 Are there arrangements in place to support practices in implementing PBC?	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> PCT provided DES payments to participating practices to support the implementation of PBC PCT encourages peer-to-peer knowledge sharing and support among practice-based commissioners 	<ul style="list-style-type: none"> PCT has provided initial DES funding and has offered written management support, advice and guidance for practices wishing to adopt PBC PCT proactively promotes transmission of good practices with formal support for peer-to-peer knowledge sharing between practice-based commissioners (e.g. workshops, newsletter, working groups) PCT has a mechanism for considering business cases submitted by practices? PCT can articulate financial impact of PBC

Scorecard (enter check marks in appropriate box)	1 Does not meet minimum standards	2 Meets minimum standards	3 Good to best practice
7 Has PCT created indicative budgets that have been shared and agreed with all practices?	<ul style="list-style-type: none"> ● Does not meet minimum standards 	<ul style="list-style-type: none"> ● PCT has developed indicative budgets in accordance with DH guidance on calculating practice fair shares and has made practices aware of their 'fair share' budget 	<ul style="list-style-type: none"> ● PCT has developed indicative budgets consistent with DH guidance, has made practices aware of their 'fair share' budget and has ensured in consultation with practices that calculations address locally specific demographic and clinical issues ● PCT budgets are acceptable to practices and are accompanied by supporting information at a practice level.
8 Is PCT providing benchmarking, utilisation and monthly cost data?	<ul style="list-style-type: none"> ● Does not meet minimum standards 	<ul style="list-style-type: none"> ● PCT provides data consistent with minimum standards described in Exhibit ● PCT has systems in place to identify financial issues early and to raise them with the practice ● PCT benchmarks within its area 	<ul style="list-style-type: none"> ● PCT provides data consistent with best practices described in Exhibit ● PCT has systems in place to identify financial issues early and to raise them with the practice ● PCT benchmarks across its own and other PCT clusters ● PCT passes such information to clinicians at least quarterly
9 Has PCT modified its financial systems to support PBC, so budgets are not manual and time intensive?	<ul style="list-style-type: none"> ● Does not meet minimum standards 	<ul style="list-style-type: none"> ● PCT tracks practice or practice cluster budgets on at least a quarterly basis and reports on financial implications for PCT ● Payment policies and systems have been designed to release a proportion of freed-up resources to practices 	<ul style="list-style-type: none"> ● PCT tracks practice or practice cluster budgets on at least a monthly basis and reports on financial implications for PCT ● Payment policies and systems have been designed to release a proportion of freed-up resources to practices

Scorecard (enter check marks in appropriate box)	1 Does not meet minimum standards	2 Meets minimum standards	3 Good to best practice
10 Has PCT identified clinical and financial risks and developed a mitigation strategy?	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> PCT has identified clinical and financial risks of implementing PBC and identified strategies to mitigate them 	<ul style="list-style-type: none"> PCT has identified and sized clinical and financial risks of implementing PBC and identified strategies of sufficient scale and scope to mitigate them in consultation with local clinicians and other stakeholders
11 Is PBC changing PCT commissioning to deliver better patient care and / or better value for money?	<ul style="list-style-type: none"> Does not meet minimum standards 	<ul style="list-style-type: none"> Clusters are obtaining and using some form of patient or public input Clusters have translated strategic plans into actual changes to patient care, e.g. shift of some care out of hospital or set up new services Clusters have achieved financial savings (of at least 1% of budget) from introduction of PBC related schemes which has been reinvested in care 	<ul style="list-style-type: none"> Clusters are systematically obtaining and integrating patient and public input to re-shape service delivery Clusters have translated strategic plans into at least 3 care pathway changes with initial evidence of superior patient experience or outcomes Clusters can demonstrate savings of at least 3% from PBC and are starting 'invest to save' schemes to accelerate PBC opportunities with any savings reinvested in superior care Practices are comfortably on track to earn DES 2 money, or will access freed resources PBC plans are explicitly reflected in the PCT's commissioning plans

Appendix 6

PBC Liaison Manager Job Profile

(Source: Essex LPC)

Accountable to the Chief Executive / Secretary of the Local Pharmaceutical Committee.

Main Responsibilities

1. Develop working relationships with commissioning groups, and with PCT commissioning managers across PCTs.
2. Promote the involvement of community pharmacy within each group.
3. Attend locality pharmacy / LPC meetings to update contractors on PBC developments.
4. Using PSNC, NPA and other information resources to help community pharmacies develop bids for services.
5. Liaise with the LPC so that the committee is fully informed of opportunities and threats.
6. Maintain a database on PBC groups, leads, board members, priorities and service developments.
7. Working with the LPC training, and PBC leads, to organise training events for pharmacists directly involved with PBC groups.

Key Attributes.

A suitable candidate should have highly developed skills in the following areas:

- Good communication skills
 - Able to communicate with healthcare professionals
 - Able to influence key PBC decision makers
 - Able to deliver effective presentations
- Local knowledge of healthcare organisations.
- Is able to understand clinical pathways, and referral processes.
- Able to make connections between the clinical skills base that community pharmacists possess, and PBC groups plans.
- Can develop a business case.
- Uses negotiating skills to produce a desirable outcome

Information Sources and Useful Websites

Pharmaceutical Services Negotiating Committee (PSNC)

The PSNC website has a wide range of resources including details of the pharmacy contract, nationally agreed enhanced service specification, examples of good practice and case studies, commissioning, including PBC and FAQs, and supporting publications.

Website: <http://www.psn.org.uk>

Department of Health

Website contains all relevant guidance, tools and templates, case studies, and links to the PBC support programme.

Website:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/Practice-basedcommissioning/index.htm

Improvement Foundation (IF)

Host of the DH sponsored PBC development programme. Many resources, including webcasts on key topics, and examples of service redesign, are available from their website.

Website:

www.improvementfoundation.org/View.aspx?page=/topics/health/practice/default.html

National Prescribing Centre

Variety of publications, including MeReC, available for pharmacists involved in medicines management; maintains a database of prescribing advisers. Website includes conference proceedings covering PBC.

Website: www.npc.co.uk (search using the term “practice based commissioning”)

Primary Care Contracting

A number of resources on PBC are available from their website. These include an initial Toolkit and a series of PBC bulletins, including one on PBC and Pharmacy.

Website: www.primarycarecontracting.nhs.uk/99.php

NHS Alliance

The organisation plays a major part in supporting and developing Primary Care Trusts and other primary care organisations and in providing opportunities for them (and the individuals within them) to network and exchange best practice. A number of documents about PBC are available from their website.

Website: www.nhsalliance.org/documents.asp?subsection=pb

National Association of Primary Care

Membership organisation whose main focus of support is General Practice and all its staff.

Website: www.napc.co.uk/pub-view.php?pubID=31

National Pharmacy Association (NPA)

The NPA NHS Service Development Department has a wide range of resources on service development and access to extensive examples of good practice. Nationwide details of current and past local projects are available along with individualised advice on relevant NHS policy and service developments.

Website: www.npa.co.uk

Other Useful Websites

British Medical Association	www.bma.org.uk www.bma.org.uk/ap.nsf/Content/pracbasedcomm1204
Royal College of General Practitioners	www.rcgp.org.uk
Royal College of Nursing	www.rcn.org.uk
NHS Confederation	www.nhsconfed.org
Royal Pharmaceutical Society of Great Britain	www.rpsgb.org.uk
NHS Networks	www.networks.nhs.uk
Kings Fund	www.kingsfund.org.uk/resources/publications/index.html http://www.kingsfund.org.uk/resources/briefings/index.html (Filter by Topic “Commissioning”)
Hospital Episode Statistics (HES)	http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/HospitalEpisodeStatistics/index.htm www.hesonline.nhs.uk/Ease/servlet/ContentServlet?siteID=1937 (Use the “Self Service” option under “Accessing the Data”)
Disease Management Information Toolkit	http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_074772
Delivering the 18 week patient pathway	www.18weeks.nhs.uk

Abbreviations and Glossary

Alternative Provider of Medical Services (APMS) - a type of contract that Primary Care Trusts can have with primary care providers, particularly designed to bring in new types of provision, such as social enterprise and the voluntary sector.

Choice - since January 2006, patient are offered the choice of at least four hospitals and a booked appointment when they need a referral for elective care. By 2008, they will be able to choose any healthcare provider that meets costs and quality requirements.

Commissioning - the full set of activities that local authorities and Primary Care Trusts undertaken to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively.

Elective Care - planned care for a pre-existing illness or condition.

General Medical Services (GMS) - services provided by family doctors and their staff, as defined in the General Medical Services Regulations 1992.

General Practitioner with Special Interests (GPwSI) - GPs who supplement their generalist role by delivering a clinical service beyond the normal scope of general practice.

Health Economy - health authority and the primary care organisations, main NHS trusts, and social services department(s) that are co-terminous with it.

Independent Sector - an umbrella term for all non-NHS bodies delivering healthcare, including a wide range of private companies and voluntary organisations.

Local Delivery Plan (LDP) - a plan, covering a three-year period, that every Primary Care Trust prepares and agrees with its Strategic Health Authority on how to invest its funds to meet its local and national targets and improve services.

National Service Frameworks (NSFs) - documentation bringing together the best evidence of clinical and cost-effectiveness with the views of service users to determine the best ways of providing particular services.

Payment by Results (PbR) - a scheme that sets fixed prices (a tariff) for clinical procedures and activity in the NHS whereby all trusts are paid the same for equivalent work.

Personal Medical Services (PMS) - alternative type of contract for the provision of general medical services, negotiated locally between the Primary Care Trust and primary care provider.

Pharmacist with Special Interests (PhwSI) - pharmacists who supplement their core generalist role by delivering an additional clinical service beyond the normal scope of their core professional role.

Primary Care - the collective term used for all services which are people's first point of contact with the NHS.

Primary Care Trust (PCT) - free-standing statutory trust responsible for delivering healthcare and improving health services in a geographical area in England. They commission or directly provide a range of community health services as part of their functions.

Provider - general term for an organisation that delivers a healthcare or care service.

Secondary Care - the collective term used for services to which a patient is referred after first point of contact. Usually used to refer to a hospital in the NHS offering specialised medical services and care (outpatient and inpatient services).

Service Level Agreement (SLA) - a formal written agreement made between a provider and the commissioner of a service. It specifies in detail how and what service will be provided, including the quality standards to be met.

Social Enterprise - businesses that have primarily social objectives. Their surpluses are reinvested principally in the business or the community.

Specialist Provider of Medical Services (SPMS) - one type of contract that Primary Care Trusts can have with primary care providers. Patients do not have to be registered with the provider to receive specialist care. It is particularly designed to give Primary Care Trusts and providers the flexibility to deliver services to people whose needs may not be fully met by other primary medical services options.

Strategic Health Authority (SHA) - the local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and that Primary Care Trusts are performing well.

Third Sector - the full range of non-public, not-for-profit organisations that are non-governmental and “value driven” (i.e. motivated by the desire to further social environmental or cultural objectives rather than to make a profit).

Voluntary and community sector - an umbrella term referring to registered charities as well as non-charitable non-profit organisations, associations, self-help groups and community groups, for public or community benefit.

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