



*NHS County Durham and Darlington*

**INTEGRATED BUSINESS BOARD**

**Thursday 25 February 2010**

**Item No: IBB/10/39**

## **NHS COUNTY DURHAM AND DARLINGTON INTEGRATED BUSINESS BOARD**

### **Practice Based Commissioning Governance Framework**

#### **1. Introduction**

This paper presents the governance framework for practice based commissioning (PBC) which is set out at appendix one.

This framework confirms the governance arrangements for PBC for NHS County Durham and NHS Darlington (NHSCDD). The framework has been drafted so as to complement corporate governance arrangements and statutory obligations.

PBC is designed to ensure the involvement of GPs, front line clinicians and patients at a local level in the planning, redesign and commissioning of effective health services. This local perspective must be balanced with national imperatives in terms of policy, strategies and plans. The commissioning intentions, plans and priorities of PBC must be fully aligned with and contribute to the overall strategic plan of the PCT, whilst ensuring that they fully reflect the local context so that local people are provided with accessible and appropriate services.

The PCT remains the accountable body for performance against national and local targets and practice based commissioners must therefore commit to working closely with the PCT to deliver national and local targets through demand management and service redesign.

This PBC governance framework sets out to support the implementation of PBC aims and objectives. It also defines a mechanism for the full integration of practice based commissioning activity.

#### **2. Implications and risks**

<b>Document management</b>				
Version	Date	Summary	Owner's Name	Approved
1.0	25.02.10	Integrated Business Board – Practice Based Commissioning Governance Framework	Louise Okello	

To achieve successful outcomes for patients, it is important that PBC is at the forefront and that frontline clinicians are afforded the opportunity to lead and influence the commissioning agenda. Therefore, it is essential that there is maximum participation of frontline clinicians in PBC activity.

Without adopting an integrated approach to PBC and mainstreaming practice based commissioning activities, there is a risk that the PCT will not be able to demonstrate the achievement of world class commissioning (WCC) competencies.

### **3. Recommendations**

The integrated business board is asked to:

- approve the governance arrangements for practice based commissioning.

### **4. Author and sponsor director**

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Title: Director of Strategy and Involvement  
Date: February 2010

<b>Purpose of paper</b>	Information sharing x Development/discussion x Decision/action x
<b>How does the paper support / have implications for:</b>	
<b>NHS County Durham's 4 strategic aims</b>	Implementing and delivering PBC contributes to all the strategic aims
<b>Our Vision Our Future workstreams</b>	Contributions via the PBC chairs and other practice based commissioners are being made to each of the workstreams
<b>World class commissioning competencies</b>	Competencies 1-6, 8, 10, 11
<b>Standards for better health</b>	NA
<b>Use of resources</b>	KLOE
<b>Targets and vital signs</b>	PBC will support attainment
<b>NHS constitution</b>	No direct impact
<b>Darzi principles</b>	No direct impact
<b>Impact on / involvement of partners</b>	Local authorities, children's trusts, foundation trusts and the voluntary sector
<b>Equality &amp; diversity</b>	No significant impact
<b>Other policies / Issues</b>	



*County Durham and Darlington*

**Practice Based Commissioning (PBC) Governance Framework  
2009-2010**

## Contents

1. Introduction
2. Background
3. Local Context
4. Accountability and Decision Making
  - 4.1 NHS County Durham and NHS Darlington Boards (The Boards)
  - 4.2 Management Executive
  - 4.3 PBC Business Meeting
  - 4.4 PBC Cluster Manager Meetings
  - 4.5 Strategy Development Group (SDG)
  - 4.6 Clinical Programme Groups (CPGs)
  - 4.7 PBC Cluster Infrastructure
  - 4.8 Cluster Accountability
  - 4.9 Practice Accountability
  - 4.10 The PBC Chairs
  - 4.11 Lead Roles of PBC Chairs
  - 4.12 Accountability of PBC Chairs
5. Support to Practice Based Commissioners
  - 5.1 Management Resource
  - 5.2 Financial Support
  - 5.3 Commissioning organisation Support functions
  - 5.4 Training and development
  - 5.5 Information provided to PBC groups by Business Intelligence
6. Financial Management & Budget Setting
  - 6.1 Indicative Budgets
  - 6.2 Use of Freed Up Resources (FURs)
  - 6.3 Interim Financial Management and Budget Setting Arrangements for 2009-10
7. PBC Incentive/Reward Scheme
8. PBC Cluster and Practice Commissioning Strategies and Plans
  - 8.1 PBC Cluster Five Year Strategy and Annual Work Plan
  - 8.2 Practice Specific Commissioning Plans
  - 8.3 Proposals for New services, Improved Pathways of Care or Disinvestments
  - 8.4 Approval Mechanism for PBC Commissioning Plans and Proposals
9. Clinical Engagement
  - 9.1 Clinical Champions and the Clinical Reference Group (CRG)
10. Tendering and Procurement
11. Quality
12. Conflict of Interest
13. Performance Management Arrangements and Measuring the Impact of PBC
  - 13.1 DoH Performance Indicators
  - 13.2 World Class Commissioning Assurance
  - 13.3 Unsatisfactory PBC Performance
14. Risk Management

## **Appendices**

Appendix 1 Table of Chairs Lead Portfolio Responsibilities

Appendix 2 Diagrammatic Illustration of the Lines of Accountability

Appendix 3 Procedure Note for the Management of Conflicts of interest

## **1. Introduction**

This framework confirms the governance arrangements for practice based commissioning (PBC) for NHS County Durham and NHS Darlington (the commissioning organisations 'the CO'). The framework aims to complement the current corporate governance arrangements and statutory obligations.

PBC is designed to ensure the involvement of GPs, front line clinicians and patients at a local level in the planning, redesign and commissioning of effective health services. This local perspective must be balanced with national imperatives in terms of policy, strategies and plans. This means that the commissioning intentions, plans and priorities of PBC must be fully aligned with and contribute to the overall Strategic Plan of the CO, whilst ensuring that they fully reflect the local context so that local people are provided with accessible and appropriate services.

The CO remains the accountable body for performance against national and local targets and practice based commissioners must therefore commit to working closely with the CO to deliver national and local targets through demand management and service redesign.

This PBC Governance Framework sets out to support the aims of PBC to:

1. Engage clinicians with the PBC agenda
2. Develop PBC enabling tools
3. Identify patients' needs and gaps in services
4. Redesign existing services or commission new ones
5. Develop improved patient pathways
6. Improve health and reduce health inequalities

## **2. Background**

The Department of Health (DoH) guidance on PBC Practical Implementation – November 2006 referred to strengthening and clarifying governance and accountability arrangements for PBC, this was supplemented by the DoH's further guidance on PBC Budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance – December 2007.

Any governance arrangements in place to support PBC must be robust and compliant with the CO's Standing Financial Instructions (SFIs), Standing Orders (SOs) and Scheme of Delegation.

### **3. Local context**

County Durham and Darlington (CD and D) have a very strong history of innovative practice in terms of improving pathways of care and service re-design. It is expected that PBC will build on this strong foundation and work with the CO to ensure continuous improvement.

There are six PBC clusters based on former PCT boundaries which came into existence in 2006:

- Durham Dales cluster – 13 practices covering approximately 100,000 patients
- Durham and Chester-le Street – 17 practices covering approximately 154,000 patients
- Derwentside cluster – 15 practices covering approximately 89,000 patients
- Easington cluster – 17 practices covering approximately 101,000 patients
- Sedgefield Cluster – 11 practices covering approximately 96,000 patients
- Darlington Cluster – 12 practices covering approximately 103,000 patients

### **4. Accountability and Decision Making**

#### **4.1 NHS County Durham and NHS Darlington Statutory Boards (The Boards)**

The Boards comprise of non executive and executive directors and one of the PBC Chairs. They are accountable for the system of internal control and effective governance of the organisation in accordance with relevant policy requirements and directions. A key aspect of this role is to ensure the strategic aims, director's objectives and statutory duties are met through effective governance arrangements. These arrangements are reported through the annual statement on internal control. The Boards are led by a chair who is responsible for their effective operation and that of any agreed committees. The chief executive as 'accountable officer' is responsible to the boards for maintaining a sound system of internal control and governance, and with executive directors, delivering the strategic aims and objectives and providing the assurances required by the boards. Non executive directors are aligned to one or more executive directors' portfolio to ensure effective engagement in the business of the PCT's across a range of functions. One of the PBC Chairs attends the Boards to represent the views of practice based commissioners and to provide clinical input. Some of the responsibilities of the boards have been delegated to an integrated business board (IBB).

The Boards have a statutory responsibility to achieve financial balance. The CO remains accountable for all the funds allocated to practice based commissioners and for ensuring fair access to high quality services for the population of CD and D within available resources.

The Boards are also responsible for ensuring that services meet all national and local quality standards and accreditation.

The Boards also have a statutory duty to involve and consult patients and the public when considering new or different service provision. This responsibility

extends to work being carried out by practice based commissioners at cluster or practice level.

The CO is responsible for leading the implementation of national policy at local level. It will work with practices, clusters and other local stakeholders and agencies to deliver on commissioning responsibilities.

The CO provides management support to the PBC clusters to facilitate the ongoing development of PBC.

The CO must ensure that all potential conflicts of interest are addressed particularly when the practice based commissioner is also the provider of the service.

## **4.2 Management Executive**

A Management Executive has been established, led by the chief executive and has delegated authority from the boards within its agreed terms of reference. The Management Executive comprises the chief executive; all directors and the six PBC Chairs are in attendance. The purpose of the Management Executive is to provide a formal mechanism for the executive functions and decision making associated with delivering the strategic direction, plans, strategic aims and directors' objectives as agreed by the boards. Management Executive is accountable through the chief executive to the boards.

## **4.3 PBC Business Meeting**

The PBC Business Meeting is a sub group of the Management Executive which meets monthly. The role of the PBC Business Meeting is to oversee the development and implementation of PBC across the county, to support achievement of the strategic aims of the CO.

Membership includes the Chairs, Director of Performance & Delivery, Director of Finance, Director of Strategy & Involvement, Director of Clinical Quality, Assistant Director of PBC and the Chief Executive.

The remit of the Business Meeting is:

1. To set a direction of travel for PBC.
2. Receive advice from PBC Chairs on PBC developments.
3. To update the PCT's PBC framework incorporating national guidance and national and local intelligence on patient safety, quality and experience.
4. To oversee the implementation of the agreed new approach to PBC and to ensure alignment with "Clinical Commissioning – Our Vision for Practice Based Commissioning".
5. To input into the development of support available to PBC Clusters.
6. To collate and provide advice to Management Executive and the Boards on the development of the PCTs' strategic direction, taking

7. To enable the delivery of high quality and safe commissioned services through effective access to GP and Primary Care Services based on the needs of their populations.
8. To provide a PBC Chair representative to participate in the Clinical Quality Review Groups as part of the performance management of acute and community providers and to act as a link between the Business Meeting and the Clinical Quality Review Groups.
9. To work effectively with the Clinical Reference Group through liaison and participative work on care pathways and the development of business cases.
10. To review performance in:
  - a. Patient quality/experience
  - b. Prescribing
  - c. Finance
  - d. Activity levels
  - e. AOP delivery

#### **4.4 PBC Cluster Manager Meetings**

In order to ensure the effective day to day operational management and co-ordination of PBC both at cluster and county wide levels, there are regular meetings of the six PBC Cluster Managers and the Assistant Director for PBC. This provides an operational link between the clusters, ensuring consistency of approach where appropriate and reports to the PBC Business Meeting.

#### **4.5 Strategy Delivery Group (SDG)**

The SDG is chaired by the Director of Strategy and Involvement. The membership comprises senior managers who report directly to directors including the Assistant Director for PBC. The purpose of SDG is to ensure delivery of strategy and provide technical support and advice to Clinical Programme Groups (CPGs).

#### **4.6 Clinical Programme Groups (CPGs)**

The CPGs provide a framework through which the vision and strategic aims of the CO will be delivered. The CPGs will be built around the eight clinical themes outlined within the five year strategic plan and within "Our vision, Our Future". CPGs have a number of objectives one of which is to ensure planning and prioritisation responds to need at a county wide, PBC cluster and practice level. Membership of each CPG will include a PBC representative being either a PBC Chair (or nominee) who will work with other core members, including a clinical champion, ensuring that PBC is central to the CO's corporate planning processes and that there is clinical endorsement to strategic decision making.

#### **4.7 PBC Cluster Infrastructure**

Each of the six PBC clusters has a PBC Chair (lead clinician) who is supported by a PBC Cluster Manager. Each cluster has different governance arrangements and meeting structures in place.

#### **4.8 Cluster Accountability**

The remit of each PBC cluster is to ensure that the interests of all the registered patient population of the PBC cluster are optimized by practices working collaboratively.

The objectives for each PBC cluster are:

- To ensure collective agreement to the principles underpinning the development of PBC within the cluster
- To ensure that the Annual Operating Plan (AOP) targets are met.
- To ensure the effective management of PBC across all practices including the formulation of a collective five year strategy, an annual work plan together with individual practice commissioning plans,
- To determine and develop patient centred pathways of care.
- To feed into the co ordination and planning of AOP in accordance with the commissioning cycle.
- To advise the CO on strategic, specialist and local commissioning issues.
- To commission patient centred services based upon the health needs of patients at practice, locality and PCT wide levels in line with national and local policies.
- To ensure equity of access to services for patients of all practices in the cluster, taking account of their individual needs, disabilities, cultural and linguistic requirements.
- To ensure that patient choice is maximised and contestability is rigorously tested through an equitable and transparent tendering and commissioning process.
- To ensure that any conflict of interest is identified and declared and that the NHS Code of Conduct, accountability and openness is upheld by practices commissioning services.
- To develop robust quality and clinical governance arrangements, including the preparation of proposals for the development and monitoring of clinical standards in the commissioning process and all of its constituent primary care practices.
- To contribute to the priorities for improving the health of the local population and promoting the public health agenda to tackle the health inequalities.
- To ensure that service users, carers and the public are involved at every stage of the commissioning process.

## **4.9 Practice Accountability**

All practices engaging in PBC must develop a PBC plan. This will set out what the practice wishes to achieve through PBC, i.e. its commissioning objectives.

With effect from April 2010 practice based commissioners will once again have a responsibility to agree an indicative/real defined practice budget as negotiated by the cluster and then manage within that. In agreeing to manage that budget, practice based commissioners are accountable to the commissioning organisation for achieving best value and for delivering their PBC commissioning intentions and will be supported by the cluster to do so.

Practice based commissioners have the ability to redesign services and a responsibility to ensure that patients, as the users of services, are engaged in the decisions about redesign and reallocation of freed up resources. Service redesign through PBC at a practice level should improve health, reduce inequalities and support the achievement of national and local priorities.

## **4.10 The PBC Chairs**

Clinical leads, called PBC Chairs, have an agreed time commitment funded by the CO to support the development of PBC.

Each chair is responsible for:

- Ensuring that PBC activity is fully aligned with the 5 year strategy of the CO.
- Supporting compliance of PBC initiatives with corporate and clinical governance and standards for better health
- Contributing to the strategic development of PBC locally to help shape commissioning policy and primary care development.
- Engaging with all clinical groups and front line clinicians to ensure engagement with PBC.
- Liaising and collaborating with other partners such as provider services, third sector, Local Authorities, Children's Trust Boards and Area Action Partnerships.
- Promoting equal opportunities.
- Supporting the CO's delivery of: National Service Frameworks (NSFs) and the Annual Operating Plan (AOP).
- Ensuring the provision of effective and efficient clinical services from a commissioning perspective.
- Promoting partnership working.
- Helping the commissioning organisations' to ensure best use of resources so as to maximise benefits for patients.
- Helping to ensure PBC delivers on its commitment to involvement of patients linking with: PALs, LINKs and Patient Forums where appropriate.
- Working within corporate and clinical governance frameworks.
- Ensuring full clinical engagement with PBC strategies and plans.

- Ensuring full patient carer and public engagement with PBC strategies and plans.
- Supporting the delivery of financial balance of PBC budgets.
- Supporting the development of the scope of PBC budgets.

The chairs work as a cohesive group, each taking on a portfolio of lead responsibilities in order to deliver the strategic functions of the CO. A PBC chairs' compact underpins the working arrangements of the chairs.

#### **4.11 Lead Roles of PBC Chairs**

The chairs have identified a number of lead portfolio responsibilities which combine areas of clinical focus together with operational, communication and liaison responsibilities. These take account of the eight core Darzi work streams and other key clinical areas as well as the strategic health outcome measures of the CO. The full list of lead responsibilities and how these have been allocated as between the chairs is set out in appendix 1.

#### **4.12 Accountability of PBC Chairs**

The chairs will be accountable to each other for ensuring that each cluster is effectively engaged with the various portfolio areas. The chairs will also be accountable to their local PBC clusters for the effective work of the cluster and to ensure that the cluster is engaged with the full commissioning process. The cluster will be monitored on its commissioning performance against the World Class Commissioning (WCC) competencies.

The chairs will report to the Director of Strategy and Involvement. Each chair will update their commissioning plans for the forthcoming year and will prepare a short summary of their work for the Management Executive, to be escalated to the IBB, on a quarterly basis.

A diagrammatic illustration of the lines of accountability is set out at appendix 2.

### **5. Support to Practice Based Commissioners**

#### **5.1 Management Resource**

A dedicated management resource for PBC has been funded by the CO. This comprises the provision of a dedicated PBC Cluster Manager and admin support for each of the PBC chairs. Each of the clusters also benefits from dedicated fixed term project management and administrative support for specific cluster based projects, initiatives and work streams.

Cluster Managers are accountable to the Assistant Director of PBC and are responsible to their respective PBC Chairs.

The project support staff are accountable to the Cluster Managers.

## **5.2 Financial Support**

The CO provides facilities and resources to support regular PBC cluster meetings to help with the engagement of practices. The Cluster Managers hold a small management allowance, to fund meeting rooms, training sessions and the cost of back fill.

## **5.3 CO Support Functions**

Management and technical support is also provided from other teams within the CO e.g. finance, information, clinical quality, contracting, public health and pathway development to support PBC with the development of commissioning plans, service proposals and in the ongoing management and monitoring arrangements for those services.

The CO is committed to ensuring that activity and finance can be monitored using reliable, robust and timely data (dependent on SUS).

## **5.4 Training and Development**

The CO will continue to work with practice based commissioners, providing them with a range of support programmes including training and development. These training sessions will look to up skilling practice based commissioners in essential skills such as: demand management, commissioning, service improvement, performance monitoring, commissioning commitments and Choose and Book.

## **5.5. Information Provided to PBC Groups by Business Intelligence**

There is a dedicated intelligence analyst for each PBC cluster who provides regular information reports and assessments which are used to develop ideas for service redesign and provision and to improve current care pathways.

The PBC clusters have different areas of focus although there is also some degree of overlap. All clusters regularly receive quality outcome framework (QOF) reports showing disease prevalence with practice and locality level comparisons, benchmarked against the national and SHA levels. A balanced scorecard is also available to all practices, containing secondary care activity and cost data, which enables practices to identify where they are outliers and focus attention on these areas.

Each of the clusters receives a quarterly referral report, via their clinical systems, which is used by practice based commissioners to review referrals made and evaluate their 'appropriateness'.

Information is regularly provided to help support clinical education sessions covering a range of clinically specific topics. The business intelligence team also delivers training and education to practices regarding HRG4 and provides ad hoc training for payment by results (PbR) and Midas as requested. Business analysts also work with clusters on pieces of service specific project work.

## **6. Financial Management & Budget Setting**

### **6.1 Indicative Budgets**

Under national PBC guidance clusters/practices have the right to hold responsibility for a devolved indicative budget. This involves clusters/practices taking on additional responsibilities for managing these resources and redesigning services for patients. Practice based commissioners are accountable to the CO, for achieving best value within their indicative budget and in delivering their PBC commissioning intentions, plans and strategies. The right to hold the budget is subject to:

- Reaching agreement with the CO on how national targets will be delivered,
- Continued active and responsible management of devolved resources
- Willingness to work with the CO on reasonable rectification plans where required
- Working within the terms of this governance framework

In 2009-10 the CO has set indicative budgets as follows;

The scope of PBC budgets will include all aspects of the CO's budget with the exception of specialist commissioning, core GMS/PMS contracts, Drug and Alcohol Action Team (DAAT), services commissioned from other primary care providers e.g. dentists and the management costs of the CO.

Basis of budget apportionment – All clusters will adopt DoH Guidance - 100% historic activity if data available or fair shares if not. Fair Shares are calculated using the DoH toolkit and practice list sizes as at 1 April 2009.

The time period for calculations of historic activity will be 12 months activity January to December 2008 (as provided by business analysts).

There is a contingency fund of 1% of the acute budget with a £20k threshold based on an individual spell of care or multiple spells in excess of £10k each. Exceptional cases will also be considered if they do not meet the criteria.

Practice registered patient list sizes will be reviewed on a quarterly basis in accordance with DoH guidance. However, list sizes must change by +/- 2% to justify recalculation of budgets where apportioned on a capitation basis as all practices within the cluster will be affected by recalculation.

Regular (monthly) financial monitoring information is provided to each cluster and to all practices showing performance against budget in line with the CO's financial reporting arrangements. The clusters regularly review the

performance against budget at both cluster and individual practice level. This enables pressures to be identified at an early stage and actions considered to address any pressures.

PBC activity and expenditure are discussed with practices at cluster board meetings and during practice visits.

The CO will develop, over the course of 2009/10, systems and information to support clear performance management of the financial position and risk through regular reporting to the board of practice and cluster position against budget, principal risks to that position and actions in place to mitigate those risks. Within this framework, the CO will support practices to understand the financial impact of clinical decisions and activity levels and will take action to ensure that financial expenditure remains within budget at a practice and cluster level. This shifts the focus of performance management from the CO to a cluster and practice level and appropriately invests the responsibility and authority in practices to take action to manage financial risk, within a central framework set out by the CO.

Darlington PBC cluster has now moved from budgets based on historic referral patterns to one based on “fair shares” of the baseline of NHS Darlington. The pace of change to ‘fair shares’ has been discussed at length with the five remaining clusters and is still to be agreed.

## **6.2 Use of Freed Up Resources (FURs)**

Under PBC, practices are entitled to use 70% of the savings that are made for reinvestment in patient care. FURs are not practice income but are a non-recurrent commissioning budget that is to be used to commission patient care under the following key principles:-

- FURs must be used to achieve national or local objectives
- FURs can be used to fund commissioning intentions included in the practices’ approved PBC plan (where these meet FURs criteria)
- FURs are to be used to commission new or enhanced patient services

FURs released to practices must be committed within one financial year.

Practice based commissioners will identify the use to which any FURs will be put through the submission and agreement of PBC service development proposals, using ‘Objectives, Goals, Initiatives and Milestones’ (OGIM) and proposed service development standard templates. These standard templates are described in more detail in section eight below.

For proposals for the use of FURs where the value is £10,000 or less, an OGIM must be submitted for consideration and approval by the Assistant Director of PBC.

For proposals for the use of FURs where the value is more than £10,000, then both an OGIM and proposed service development template must be submitted for consideration and approval by a sub group of the PBC Business

Meeting, comprising: the Assistant Director of PBC, the Director of Strategy & Involvement and Director of Finance.

### **6.3 Interim Financial Management and Budget Setting Arrangements for 2009 -10**

There is currently ongoing debate between practice based commissioners and the CO in relation to the content of PBC indicative budgets, the pace of change and the scope and context of FURs. Work is ongoing to resolve this issue. However, for an interim period, agreement has been reached between practice based commissioners and the CO that practices will not hold responsibility for indicative budgets and therefore, for the interim period only, will not be eligible to any FURs.

During this interim period, to ensure continued clinical engagement, the CO has developed a reward scheme (see section 7 below) to provide an alternative interim approach.

During the interim period, the finance team together with business analysts, will work with practice based commissioners to develop more accurate, meaningful and real, rather than indicative, budgets for which practice based commissioners will hold devolved responsibility with effect from April 2010. It is proposed that the focus should initially be on two areas of budget allocation and financial reporting. The first being that budgets should be allocated on the basis of tracking patient expenditure, for example, where services are tariff based and payment by results (PbR) applies. Clusters will be monitored on their performance in relation to these specific service areas. The second will be the establishment of a long term development programme, with a view to refining the ability of the commissioning organisations to track patient expenditure so that more accurate and meaningful budgets can be re-allocated to practice based commissioners, either as real or indicative.

## **7. PBC Incentive/Reward Scheme**

A PBC incentive scheme is offered each year to PB commissioners in recognition of and as a reward for the additional work that goes into carrying out PBC in primary care.

The main purpose of any PBC incentive scheme is to ensure maximum participation of local primary health care clinicians in the commissioning of health care services with a view to improving the health of the local population adding years to life and life to years.

For the current financial year 2009/10, a new reward scheme has been developed which provides an interim alternative to rewarding practices for the management of indicative budgets and resulting FURs payments (see section six above).

The reward scheme sets out the CO's proposals for a new approach to rewarding clinicians for commissioning related activities both on a cluster and county wide level.

Each practice, wishing to engage in PBC activity, has been invited to sign up to the county wide reward scheme. The scheme is divided into three component sections: section one, engagement (mandatory); section two, obesity management (mandatory) and section three, health improvement. This last section focuses on two specific areas of activity, Chronic Obstructive Pulmonary disease (COPD) and diabetes, practices can choose to carry out either one, both or neither of these options.

The reward scheme looks to rewarding practices for undertaking commissioning related activities to improve health and reduce health inequalities, informed by local and county wide health profiling and strategic planning. The ambition is to remunerate practice based staff for time spent towards improving health outcomes, thereby incentivising practices and front line clinicians to become more actively involved in the commissioning process.

Unusually, during this interim period, commissioning related work will involve some clinical provider activity. However, the reward scheme has been developed in such a way as to ensure that any such clinical activity is over and above that required by the QOF or any local or direct enhanced services (LES or DES). In addition, practices are required to produce reports detailing the commissioning outcomes of the work undertaken and identifying the current gaps in service provision and the inadequacies of the current patient pathways. These reports will provide the evidence base for ongoing commissioning intentions for future years and will identify local variations in commissioning needs.

The scheme will have a significant impact on the quality of patient care focusing on areas that have been identified as key health outcome measures, in strategic plans, both on a county wide and locality level. The scheme will also enable the commissioning organisations to make significant strides towards addressing health inequalities for a specific range of vulnerable patient groups.

## **8. PBC Cluster and Practice Commissioning Strategies and Plans**

### **8.1 PBC Cluster Five Year Strategy and Annual Work Plan**

Each of the six PBC clusters is required to produce a five year strategic plan which must be fully aligned with the five year strategy of the CO, whilst also taking full account of local cluster health needs, inequalities and gaps in service provision. This must be developed by the cluster practice based commissioners, supported by the Cluster Manager, they must be able to demonstrate that they have involved and consulted with local patients, the public, partners and other key stakeholders.

Each cluster is also required to produce an annual PBC cluster commissioning work plan which takes account of relevant national and local policies and initiatives.

Cluster commissioning strategies and work plans are dynamic documents which will continue to be refined and realigned on an annual basis to ensure that PBC enables delivery of the corporate agenda whilst maintaining a focus on local needs.

## **8.2 Practice Specific Commissioning Plans**

It is also a requirement that individual practices produce an annual practice level commissioning plan which supports the overall cluster commissioning five year strategy and annual work plan. In developing their PBC plans, practices (in conjunction with other relevant clinical professionals, including district nurses, community pharmacists and health visitors) must establish an understanding of the needs of their populations. Where PBC plans impact on secondary care or other providers, practices should seek the involvement of consultants and wider secondary care clinical teams or other provider staff. The practice commissioning plans are reviewed by the Cluster Manager who will, if required, provide the practice with support to develop the plan.

## **8.3 Proposals for New services, Improved Pathways of Care or Disinvestments**

In order to proceed with their commissioning plans, PBC practices and clusters are required to develop commissioning proposals for each proposed new service or pathway re-design. The proposal should be outlined on a standard 'OGIM' template. This high level OGIM statement must be supported by the development of a more detailed business case using the proposed service development template.

Practice based commissioners will be able to seek technical support with the development of the OGIM and proposed service development templates from their cluster manager and other PCT enabling support functions all of which are represented on the SDG, who will offer to carry out a swift technical appraisal of the proposed service development template prior to it being submitted to the relevant CPG for consideration and prioritisation.

When carrying out the technical appraisal of the proposed service development, the SDG members will consider each proposal, whether for new services, pathways of care or disinvestments, to ensure:

- it is in line with the PCT strategy
- it contributes to demand management and key policies (AOP)
- it provides benefits to patients
- it contributes to wider public health gains
- it is based on clinical evidence,
- has considered patient and other stakeholder views,
- does not adversely impact on other services,

- is safe and clinically effective
- offers value for money
- has identified funding
- is in line with the principles underpinning QIPP (Quality, Innovation , productivity and Prevention).

Once practice based commissioners are satisfied that the OGIMS and proposed service development templates are completed in full and meet the criteria listed above, they will be submitted to the appropriate CPG who will make a recommendation to the Management Executive as to whether or not the proposal should be worked up and implemented.

#### **8.4 Approval Mechanism for PBC Commissioning Plans and Proposals**

The cluster five year strategies and annual work plans must be submitted to the Management Executive, via SDG and the PBC Business Meeting, for approval. Update reports on progress are also submitted to Management Group via the PBC Business Meeting on a quarterly basis. These cluster update reports form an integral part of a comprehensive PBC update report which reports progress on key aspects of PBC development including: risk management, performance and progress with achievement of the corporate PBC development plan, “A New Approach to Practice Based Commissioning”. With effect from October 2009, these quarterly update reports will be escalated to the PCT Board.

Where practices make recommendations for small service changes, these will be agreed with the minimum of restriction.

The Management Executive will be accountable for decisions on proposed service developments for new services having taken account of the recommendations made by the relevant CPG.

Decisions on proposed service developments will be made by the Management Executive within eight weeks of fully completed proposed service development templates being submitted to the relevant CPG.

### **9. Clinical Engagement**

The CO recognises the critical importance of clinical engagement in all aspects of the commissioning cycle and recognises PBC as the key mechanism for achieving this.

The CO has not adopted traditional governance arrangements for clinical engagement and leadership and does not have a professional executive committee to provide clinical advice to the boards. The CO has ensured clinical input by ensuring that PBC is represented on all the key decision making bodies including: the Boards, the Management Executive and each of the CPGs.

They are also represented on Clinical Quality Review Groups and on partnership groups such as Children's Trust Boards and Area Action Partnerships (AAPs).

### **9.1 Clinical Champions and the Clinical Reference Group (CRG)**

The CO has also developed other mechanisms for clinical engagement to compliment the work of PBC. In particular the CO has employed the services of a group of 'clinical champions' and has established a Clinical Reference Group (CRG). Practice based commissioners work closely with clinical champions on specific projects and work streams and one of the PBC Chairs is invited to attend the meetings of the CRG. A reciprocal arrangement is in place whereby a clinical champion CRG member is invited to attend PBC Business Meetings.

## **10. Tendering and Procurement**

The PBC clusters follow the PCT Procurement Policy to determine the need for tendering of services and the relevant procurement processes.

Where the procurement route involves variation to an existing contract, a specification will be developed in the usual way. The PBC cluster will work with the contract management team to consider the implications of and requirements for contract variation.

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 i.e. where an unavoidable service monopoly would be created.

The Standing Financial Instructions and the CO Procurement Policy will be followed in all cases.

## **11. Quality**

Standards for better health sets out the quality framework for NHS services providing a common set of requirements across all health care organisations to ensure that services provided are both safe, have acceptable quality and outcomes and are based on continual improvement.

The standards for better health, core standards, are the means of describing the level of quality that commissioned services are expected to meet. The standards will be used in developing commissioning proposals and in performance management of services to ensure service delivery is equitable, fair responsive and improves health.

## **12. Conflict of Interest**

Conflicts of interest can be many and varied. In this commissioning related context they arise when staff or people/organisations can materially gain from

close working with NHS CD. This occurs if they are closely part of some commissioning activity such as the development of a service specification that can put them at an advantage over other people/organisations. It is important that these conflicts are managed appropriately to safeguard the individuals and NHS CD from external challenge.

A procedure note for the management of conflicts of interest is set out at appendix three.

### **13. Performance Management Arrangements and Measuring the Impact of PBC**

The PCT will work with practice based commissioners to ensure that their patients receive access to high quality services in line with national guidance and that the PCTs financial responsibility to the tax payer are properly carried out.

Performance against the governance arrangements set out in this document will be reviewed at various levels to provide assurance to the Boards that the commissioning duties of the CO, through PBC, are being met.

At a high level PBC performance will be measured against the aims of PBC set out in the introduction to this framework.

The PBC management team will work to the PCT internal performance management framework and to that of each individual Cluster.

#### **13.1 DoH Performance Indicators**

The DoH suggests three main indicators to measure the impact of PBC:

- **Is the PBC framework enabling?**

Clusters will monitor the support provided by the PCT through the arrangements described in this document and report areas of concern to the PBC Business Meeting for discussion. The PBC Business Meeting will in turn report unresolved concerns to Management Executive as part of the quarterly update.

- **Are practices engaging with PBC?**

Clusters will monitor the engagement of practices through attendance and participation at business meetings, input at practice visits, outcomes of commissioning plans and the redesign of services.

Clusters will report to the PBC Business Meeting any issues prohibiting engagement for a wider discussion. Quarterly reports of progress will be submitted to Management Executive as part of the regular update reports. In addition the results of the quarterly PBC survey conducted by DoH will be analysed and discussed at the PBC Business Meeting in order to agree any actions required.

- **Are their new services or pathways and what is their impact on outcomes?**

Services commissioned by clusters or practices will be regularly reviewed using the contract monitoring data as set out in service specifications to measure the impact of pathway changes.

Commissioning decisions will be informed by this data and service review meetings with providers. All newly developed service specifications include a measure of patient experience to ensure service developments are meeting patient needs.

### **13.2 World Class Commissioning Assurance**

The PCT wishes to reward practice based commissioners by offering them increased commissioning autonomy in recognition of their increased commissioning skills and competencies.

To this end, the PCT has developed a PBC specific WCC assurance framework against which each cluster will be assessed on an annual basis.

### **13.3 Unsatisfactory PBC Performance**

If the delivery of key targets is threatened by PBC then the PCT will agree an action plan to rectify the position with the cluster concerned. If after the relevant period, the action plan has not been delivered a recommendation will be made to the Management Executive that the commissioning of services should be handed back to the CO for a specified period.

A performance management framework will be developed for PBC disputes. The PBC practice or cluster will have a right of appeal to the Management Executive. If the practice has its right to commission revoked they can apply for it to be recommenced in the following financial year.

In the case of disputes, the arbitration process will apply through NHS North East. Disputes arising between parties should, where possible, be managed and resolved locally through discussion and agreement.

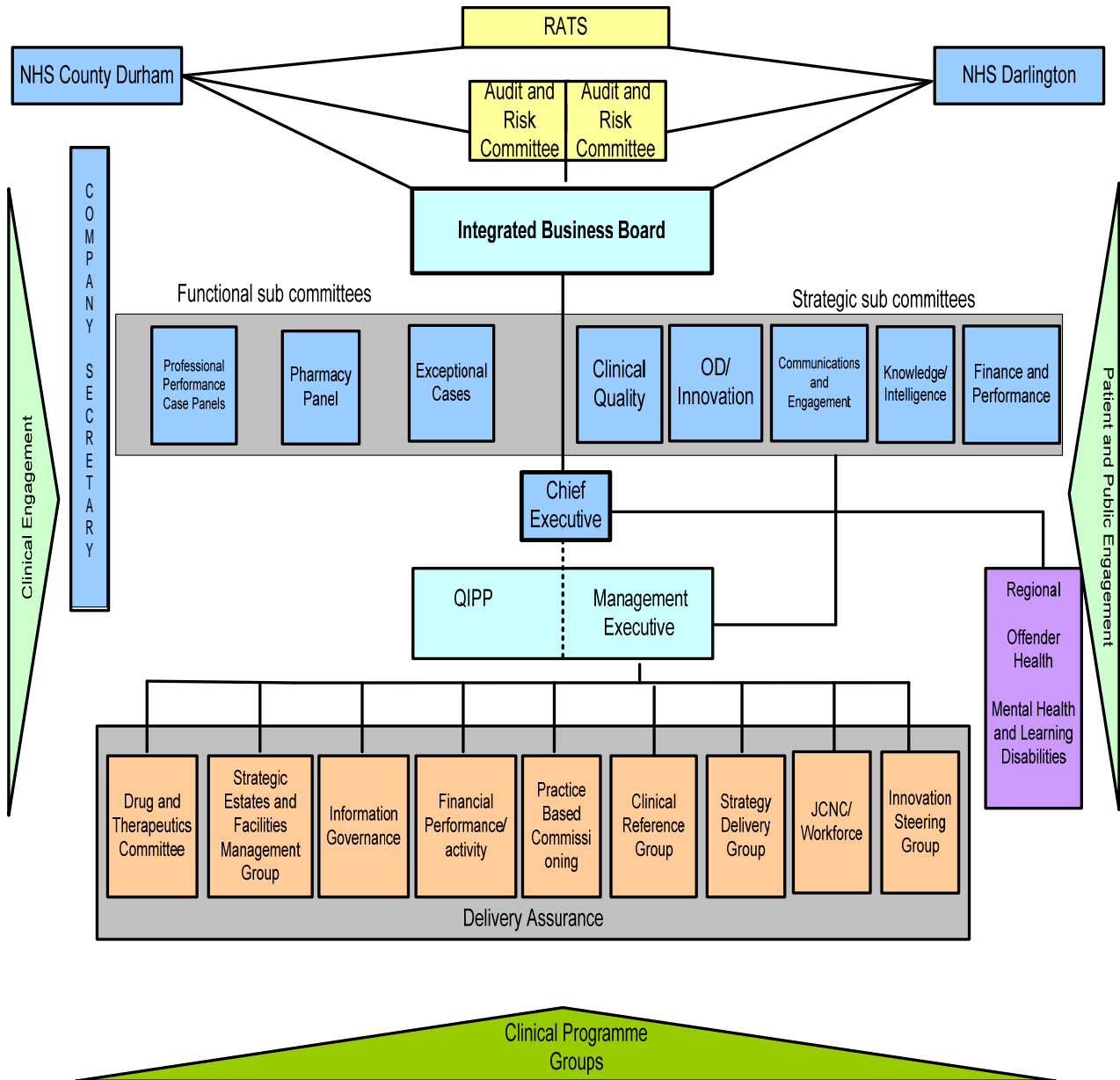
## **14. Risk Management**

Practice based commissioning will be rigorously risk managed at cluster, county wide and corporate levels. Each cluster will keep its own risk register which will be escalated and incorporated within a county wide risk register where appropriate. High level risks will be included in the corporate risk register.

Table of Chairs Lead Portfolio Responsibilities (to follow)

<b>Portfolio lead aligned to the Darzi Workstreams</b>	
Maternity and Newborn Care	Kate Bidwell
Children's Health	Kate Bidwell
Planned Care	Stewart Findlay
Mental Health	Richard Lilly
Staying Healthy	Joseph Chandy
Long-term Conditions	Carol Charlton
Acute Care	Stewart Findlay
End-of-life Care	Dinah Roy
Cancer	Dinah Roy
Cardiovascular Disease	Stewart Findlay
Learning Disability	Richard Lilly
<b>PBC specific portfolio leads</b>	
PCT Board Representation	Dinah Roy (Co Durham)/Carol Charlton (Darlington)
PBC Business Coordinator	Joseph Chandy
Public Carer Patient Engagement within PBC	Dinah Roy (Co Durham)/Carol Charlton (Darlington)
Broader Clinical Engagement and Integration with PBC	Joseph Chandy
PBC Enablers, including Performance, Finance and Information	Joseph Chandy
PBC and Public Health	Dinah Roy (Co Durham)/Carol Charlton (Darlington)
Provider Quality and Patient Safety Development	Stewart Findlay
Innovation	Kate Bidwell
PBC CRG Liaison	Richard Lilly

**Diagrammatic Illustration of the Lines of Accountability**



## PROCEDURE NOTE

### CONFLICTS OF INTEREST

#### Introduction

This procedure note has been prepared to assist NHS County Durham and Darlington (NHSCDD) staff and clinicians manage work situations where conflicts of interest may arise. It is intended that this interest does not preoccupy discussions and so staff should be free to have open and transparent discussions to deliver the specification, workstream, etc.

Conflicts of interest can be many and varied. In this commissioning related context they arise when staff or people/organisations (*or those connected with them by means of a family or business interest*) could materially gain from close working with NHSCDD.

*Examples of conflicts of interest that may arise are as follows:*

- (a) *If a person is closely part of some work (eg developing a specification) that could put him at an advantage over other people/organisations/competitors;*
- (b) *In addition to commissioning of services, this may also include work linked other commercial interests e.g. estates or facilities contracts and schemes.*

It is important that conflicts *of interest* are managed appropriately to safeguard the individuals and NHSCDD from external challenge.

#### Actions necessary

In dealings with staff or external individuals/organizations\*, then any potential conflict needs to be noted (in the meeting notes) at the outset or at any other time when they become apparent.

*If a participator has a conflict of interest he/she shall notify it as soon as reasonably practicable to the chairman of the meeting and/or the appropriate person (eg. line manager). A central log of potential conflicts is maintained by the Company Secretary. The chair should forward the details of the potential conflict of interest to the company secretary. From then, in order to encourage innovation and constructive dialogue, the conflicts or potential conflicts are, so far as reasonably possible, “put to one side” or do not form part of the conversation.*

Only when a *conflict of interest is or becomes material* is a further conversation required about the individual's continued interest in the work area. *Material conflicts of interest must be properly managed to ensure that the integrity of NHSCDD is not called into question.* If this occurs a decision will be taken at that time to ask the individual to resign from the group/workstream. *Any such decision should be properly minuted and/or recorded in writing.*

Any information considered to be confidential needs to be treated in that way and not divulged to other parties not connected with the group.

Any member of the group needs to act corporately as part of the group and continue to abide by NHSCDD's agreed behaviours, policies *and NHS Code of Conduct.*

It is incumbent on the individual initially declaring the interest and the chair/lead for the work area to be aware of these material interests.

It is envisaged that there will be few cases when there is a material or commercial interest as NHSCDD's commissioning business will be offered to a range of providers so that no one provider will be able to gain an *unfair* advantage from being involved in preparing specifications or work priorities . However, there will be occasions when a single provider will be commissioned. In these circumstances, careful consideration needs to be given to who provides clinical advice.

Guidance on interpreting this procedure note or any subsequent potential revisions should be directed to the lead director.

\*Independent contractors (GPs as providers or PBC, GDPs, optometrists, pharmacists), NHS providers, NHS consultants, non NHS providers.