

SURREY PCT

PBC Incentive Scheme 2007/08

1. Objectives of the Local Incentive Scheme for PBC

- 1.1 *Health reform in England: update and commissioning framework (para 3.9)* states that PCTs should operate an incentive scheme to engage practices in service redesign, previously this was DES for PBC, with additional local incentive schemes subject to PCTs individual circumstances.
- 1.2 With the DES incentive scheme for PBC ending at the end of March 2007, PCTs are now required to implement a locally based incentive scheme for PBC. This must (*Practice based commissioning: practical implementation, para 4.13*) be clinically appropriate, affordable and cash releasing. This paper sets out the Local Incentive Scheme for PBC across Surrey PCT for the financial year 2007/08.
- 1.3 It was considered that the scheme should:
- Be Simple!
 - Be measurable and auditable and avoid scope for misinterpretation
 - Be capable of encouraging all practices across Surrey to engage in PBC.
 - Ensure that practices are not financially disadvantaged by their GPs and practice staff participating in PBC.
 - Ensure that practice/group PBC plans and commissioning and re-design energies are focused on the national and local priorities with specific reference to the 18 weeks target work and the NHS Better Care, Better Value Indicators as identified by the NHS Modernisation Agency (as defined in www.productivity.nhs.uk/definitions.asp) and more locally in support of Turnaround Plans for 2007/08 (a reminder of these are set out in Appendix A).

2. Scheme Outline and Assumptions

- 2.1 The PBC Incentive Scheme has three major elements, one rewarding **engagement**, the second rewarding **delivery** and the third supporting **innovation and service redesign**.
- 2.2 The PBC Incentive Scheme sits outside the agreement reached with the PCT around the ability to retain savings generated against PBC budgets. The approach to budget setting and budget savings is described in a separate paper.
- 2.4 In addition to the financial incentives described below the PCT will provide dedicated management support to practices and clusters in the following areas:
- Dedicated Cluster and project manager

- Information and Financial analysis capacity
- Primary Care Development support
- Service Redesign and Innovation support
- Prescribing support
- Public Health support
- PPI

3. Rewarding Engagement

3.1 PBC Group Level

(More detailed list of expectations of PBC Groups and Group Clinical Leads in return for the funding of this clinical time are outlined in Appendix B).

This element will enable nominated GPs and other practice staff to play a lead role in practice based commissioning within their PBC group and play a role in commissioning across Surrey.

An Annual Allowance of **£40,000 per 100,000 population** will be paid to the group. Group populations exceeding 100,000 will be rounded to the nearest 1,000 with an additional 40p per capita per rounded 1,000 being payable.

- 3.2 Smaller groups could be considered for a pro rata share of the above subject to size and the agreement of their respective Associate Director of Commissioning.
- 3.3 PBC Groups will be free to negotiate with the PCT (through the Associate Director for the locality) and their respective governance arrangements, how they wish to use this funding.
- 3.4 The number of PBC groups has yet to be agreed between practices and the PCT, but it is anticipated that the reward level specified above would equate to approximately £450,000 across Surrey.
- 3.5 Deliverables required of the group will be broadly defined and agreed between the PCT and practices, but it is envisaged that they would include for example:
 - ensuring appropriate governance arrangements within the group
 - ensuring practices deliver on their deliverables and performance manage appropriately
 - attendance at local and cross Surrey commissioning meetings as required (to include SLA meetings with local providers)
 - ensuring attendance and participation of relevant cluster nominee in 18 week working groups
 - ensuring engagement in the implementation of the Medicines Management strategy in Surrey, including involvement in important committees or groups relating to Medicines Management.

3.6 The PCT will provide administration support to group meetings as part of their centrally provided and funded support to PBC.

3.7 Practice Level

Individual practices can earn the entitlement to various elements of the incentive fund earmarked for engagement as described below. A practice demonstrating that it has engaged or delivered on all of the elements could earn the **maximum payment of £1.25 per head of population**.

3.8 In accordance with the Department of Health guidance on PBC (*Practical based commissioning: practical implementation, para' 4.13*) any incentive payments should be regarded by practices as income.

3.9 The incentive payments, requirements of practices, proposed timing of the payments and the arrangements for measuring engagement are detailed in the table below.

	DEMONSTRATION OF ENGAGEMENT	PAYMENT PER HEAD OF POPULATION £	TIMING OF PAYMENT	ARRANGEMENTS FOR MEASURING
1	Sign up to PBC budget to timescale required by PCT	0.10	Month following sign off	Recorded by cluster manager and reported to PBC Sub Committee
2	<p>Production of a practice plan for PBC for 2007/08 which is: consistent with the defined priorities of the PCT, covers minimum requirements as specified by the PCT and produced to the timescale specified by the PCT.</p> <p>Practices may choose to produce a PBC plan on a group basis. This will be acceptable provided that all practices have signed it off to demonstrate their commitment to it and accept that performance will be measured at a combined level, not at individual practice level.</p> <p>Practices to demonstrate regular review of performance against business plan.</p>	0.40	Month following receipt and acceptance by PCT	<p>Plan submission Minutes of PBC Sub Committee</p> <p>Evidence of review by the Group or individual practice</p>

	Outturn report at year end (May 2008) identifying progress and achievement against objectives of the plan. This may be an aggregated report for the group.			Report submission
3	Nomination of a practice lead for PBC. Representative from the practice to be present at a minimum of 6 PBC group meetings per annum where the practice are undertaking PBC as part of a group.	0.20	Two instalments, first (April – Sept) payable by 31 st Dec, second instalment (Oct – March) by June of following year.	Minutes of group meetings.
4	Regular (and demonstrable) in practice review of referrals, diagnostic tests and unplanned admissions	0.30	As above	Evidence of review by the Group or individual practice
5	Monthly validation of hospital charges and feedback of anomalies to PCT in required format by agreed flex and freeze dates (a detailed schedule of the dates and process will be sent to practices shortly)	0.25	As above	Cluster manager/HIS records

3.10 The maximum payable for full engagement in PBC deliverables will be **£1.25 per head**. This will be paid direct to individual practices unless groups propose and agree (with the Associate Director and through their governance processes) an alternative arrangement. Calculation of population size will be based on practice registered population at 1 April 2007.

4. Rewarding Achievements

4.1 Achievement of the objectives (or demonstrable performance to the satisfaction of the PCT) as specified in the practice or group PBC business plan will be rewarded as follows:

- Achievement of **prescribing targets** incorporated within the business plan to a maximum of **£0.35 per head** as outlined in Appendix C. Payment made for achieving up to 4 targets, i.e. 25% of possible payment for each target achieved, although practices may wish to include all 5 targets within their plans if they wish.
- Achievement of **non-prescribing objectives** incorporated within the business plan at **£0.75 per head**. This will include participating in

regular review meetings throughout the year with the PCT to discuss progress against the plan focusing on identifying further areas for development and sharing best practice, and demonstrating measurable achievement against the specific objects of their plans as evidenced by their end of year evaluation report to the PCT.

4.2 The above sums will be payable no later than June of the following financial year.

4.3 Again, this sum will be paid to individual practices unless alternative arrangements are agreed with PCT.

5. Encouraging Innovation and Service Redesign

5.1 The PCT recognise that in order to encourage service redesign and innovation it may be necessary for practices to have access to funding to “pump prime” the change. The PCT will make provision for a fund of £500k to be available for pump priming, subject to the approval of the business case for the redesign being proposed.

6. Summary

6.1 The above scheme offers practices the above maximum financial incentive per head of population for full engagement and delivery of business plan objectives:

	Maximum per head £
Engagement	1.25
Delivery	1.10
Total	2.35

6.2 In addition to the above there is funding of approximately **£0.40** (section 3. refers) per patient to enable GPs and practice staff to lead on practice based commissioning in their groups.

APPENDIX A

Reminder of National Policy, 18 Weeks target and Surrey PCT Turnaround Plan 2007/08

1. NHS Better Care, Better Value Indicators

Clinical productivity

Reducing length of stay
Increasing day case surgery rates
Reducing pre-operative bed days
Managing variation in surgical thresholds
Managing variation in emergency admissions
Managing variation in outpatient appointments

www.productivity.nhs.uk/definitions.asp

2. 18 Week Target Redesign Pathways:

ENT	Recurrent sore throat (Tonsillectomy) Reduced hearing – adult (Sensorineural hearing loss) Reduced hearing – child (Glue Ear)
Gastroenterology –	Indigestion (Dyspepsia/ Dysphagia) Rectal Bleeding Change in bowel habit
General Surgery	Lump in groin/navel (hernia pathway) Upper Abdominal pain +/- jaundice (gall stones pathway) Varicose Veins
Ophthalmology	Gradual sight loss (Cataract) Chalazion (cyst)
Orthopaedics	Knee pain (OA Knee) Hip pain (OA Hip) Back pain Shoulder pain
Oral Surgery	Dental Pain (Wisdom tooth/ other tooth pathway) Mouth Lesion
Plastic Surgery	Skin Lesion Reconstruction of breast

Urology	Blood in urine (Dip Stick Haematuria/ Microscopic Haematuria) Difficulty passing urine (lower urinary tract symptom LUTS) Male contraception (Vasectomy) Female incontinence
Gynaecology	Heavy periods (Menorrhagia) Prolapse Women requesting irreversible contraception (Sterilisation) Miscarriage Abnormal Smear
Neurology	Persistent/atypical headache TIA transient ischaemic attack) Blackouts Dizziness Parkinson's Disease
Dermatology	Skin Lesion
Cardiology	Chest Pain/ angina Breathlessness/ heart failure Palpitations (atrial fibrillation)

Surrey PCT has established a programme for managing the implementation of the 18 week target and will be seeking engagement from Clinicians in primary care to support this work and ensure it reflects GPs view and complements local systems.

TURNAROUND SCHEMES 2007/08

It is not envisaged that PBC Groups and Practices will be heavily engaged in all of the schemes above, although the PCT will be seeking firm commitment to some of the schemes, for example reducing GP referrals.

However, it is recognised that practices will be interested in the way that the PCT approaches and implements most of the schemes as they will have some impact of varying degrees on Primary Care. Practices and PBC Groups may wish to support and engage more actively with some of the schemes.

ACUTE WORKSTREAM:

UNSCHEDULED CARE:

URGENT CARE CENTRES

SINGLE ASSESSMENT / TRIAGE SYSTEM

PARAMEDIC IN PRIMARY CARE

A&E ATTENDANCES AVOIDED – SASH

RSCH A&E / WiC STAFF INTEGRATION

REDUCE '0' DAY A&E ADMISSIONS

TARGETED DISCHARGE REDUCING 2 DAYS LOS TO 1 DAY

EMERGENCY ADMISSION AVOIDANCE:

COMPLEX ELDERLY e.g. UTI

ISCHAEMIC HEART DISEASE / ANGINA (included in Complex Elderly)

CELLULITIS (included in Complex Elderly)

DVT (included in Complex Elderly)

ASTHMA (Care call and Telecare and included in complex elderly)

COPD NURSE (Care call and Telecare and included in complex elderly)

DIABETES MANAGEMENT (Care call and Telecare and included in complex elderly)

CHF (Care call and Telecare)

CARECALL

END OF LIFE CARE/ PALLIATIVE CARE

NON ELECTIVE ADMISSIONS (WATU)

PRIMARY CARE SPECIALIST (TARGETED DISCHARGE)

MEET & GREET NURSE

COMMUNITY MATRONS

FALLS

DEXA SCANS

OUTPATIENT REDUCTIONS:

DERMATOLOGY

UROLOGY

CARDIOLOGY

MINOR SURGERY

TNNF OUTPATIENT REDUCTIONS (GENERAL SURGERY)

ORAL SURGERY

ORTHOPAEDICS

OPHTHALMOLOGY

PAIN MANAGEMENT

GYNAECOLOGY

ENT

NEUROLOGY

RHEUMATOLOGY

ADDITIONAL 'CAS' SERVICES

GP REFERRAL RATES

CONSULTANT TO CONSULTANT REFERRAL RATES

COMMISSIONING RULES - FIRST TO FOLLOW UP RATIOS

WARFARIN / INR

ICAT SCHEMES (EDICS / MEDICS)

RETINOPATHY SCREENING

AMBULATORY BLOOD PRESSURE MONITORING

ELECTIVE CARE:

DAYCASE REPROVISION IN COMMUNITY FACILITIES (e.g COBHAM)

PBC GROWTH REDUCTION & ELECTIVE INTERVENTION RATES

COMMISSIONING RULES - LOW PRIORITY PROCEDURES

OTHER ACUTE:

COMMISSIONING RULES - WELSH RULES

COMMISSIONING RULES - ANTE-NATAL

COMMISSIONING RULES - 9 OUTPATIENT PROCEDURES

COMMISSIONING RULES - A&E ATTENDS & SHORT STAYS

COMMISSIONING RULES - Emergency Readmission

DIAGNOSTIC TARIFF UNBUNDLING

ACUTE DATA VALIDATION

LOCAL PRICING

IMPACT OF 18 WEEK RTT 2007/08 INVESTMENT ON 2008/09 SLA

HIGH COST PATIENTS

APPENDIX B

Expectations of PBC Groups and Clinical Leads

1. To be Clinical Lead for their PBC Group, supporting the development of PBC with all constituent Practices.
2. To chair the PBC Group meetings, with the support of relevant PCT staff, in line with the agreed terms of reference, and inter practice agreement.
3. To oversee the delivery of agreed Group work streams, advising the PCT on the level and type of support required enabling practices to achieve specific commissioning responsibilities, and engaging practice leads to deliver agreed tasks, sharing learning across practices.
4. To be a champion for the successful implementation of PBC across the Group, working with both Practices and the PCT to ensure optimum communication between the bodies, and successful development of PBC.
5. To support, with the PCT, the development of improved understanding of commissioning processes and responsibilities amongst Group primary care staff.
6. Together with the PCT, to lead performance management of the Groups use of financial resources as measured against indicative delegated Practice level PBC budgets, so as to support, as far as possible, the delivery of all key targets for the Group
7. To work collaboratively with the PCT Commissioning Executive to secure services that are equitable and responsive for local people, and undertake service redesign where appropriate to achieve this.
8. Where the current commissioning of patient services is not adequate or best practice, to support the Group to develop and clearly articulate commissioning aspirations and objectives to the PCT.
9. To ensure clinical engagement in 18 week work-streams by identifying individual clinicians to participate in work-stream development and implementation in their area as part of the overall 18 Week Referral to Treatment Programme within Surrey.
10. To ensure clinical engagement in the implementation of the Medicines Management strategy in Surrey PCT, by identifying clinicians to participate in committees or groups relating to Medicines Management.

The above is not exclusive. It is envisaged that a budget plan for the PBC Group element of the incentive scheme will be agreed locally.

APPENDIX C

FIVE KEY TARGET AREAS THAT ARE EXPECTED TO BE ADDRESSED THROUGH THE PBC INCENTIVE SCHEME 2007/08

All targets will be based on review of ePACT.net data for the period January to March 2008. Full details available in the PCT Prescribing Turnaround Plan 2007-08

Therapeutic Area	Description	Target	Potential Surrey-wide savings (full year effect) if whole PCT reaches target
<p>Target 1.1 Quick Wins</p>	<p>(a) Maximising the potential of generic prescribing for 3 drugs recently off or due to come off patent:</p> <ul style="list-style-type: none"> ➤ finasteride, ➤ risperidone, ➤ sumatriptan <p>(b) To switch to cost-effective formulations or similar chemical substances of the following (where appropriate):</p> <ul style="list-style-type: none"> ▪ ramipril tablets to ramipril capsule ▪ Lansoprazole fas-tabs to Lansoprazole capsules ▪ Omeprazole tablets / dispersible tablets to omeprazole capsules ▪ Amlodipine besilate to generic amlodipine ▪ desloratidine to loratidine ▪ levocetirizine to cetirizine ▪ Tamsulosin XL tablets (Flomaxtra®) to tamsulosin capsules ▪ Diclofenac potassium to diclofenac sodium 	<p>95% generic prescribing for selected drugs</p> <p>Achievement of a minimum of 6 out of 8 individual switch targets to preferred choice:</p> <p>95% ramipril items as capsules</p> <p>95% lansoprazole items as capsules</p> <p>95% omeprazole items as capsules</p> <p>95% amlodipine items as generic amlodipine tas</p> <p>80% desloratidine / loratidine items as loratidine</p> <p>95% levocetirizine / cetirizine items as cetirizine</p> <p>93% tamsulosin as generic capsules</p> <p>95% diclofenac sodium or diclofenac potassium items as diclofenac sodium tablets</p>	<p>£750,000</p>

<p><u>Target 1.2</u></p> <p>Management of Hyperlipidaemia</p>	<p>Promotion of low-cost generic statins in line with NHS Better Care Better Value indicators.</p> <p>To include switching from high cost statins where appropriate in line with local guidelines.</p>	<p>69% of all statins (including ezetimibe / Inegy®) as simvastatin or Pravastatin</p>	<p>£1,000,000</p>
<p><u>Target 1.3</u></p> <p>Proton Pump Inhibitors</p>	<p>Promotion of low cost generic PPIs (lansoprazole and omeprazole) in anticipation of proposed NHS Better Care Better Value indicators,</p> <p>To include switching from high cost PPIs where clinically appropriate.</p>	<p>87% of all PPI prescribing as lansoprazole capsules or omeprazole capsules</p>	<p>£250,000</p>
<p><u>Target 1.4</u></p> <p>ACE Inhibitors / Angiotensin 2 receptor blockers (ARBs)</p>	<p>Promotion of ACE inhibitors as first line agents in anticipation of proposed NHS Better Care Better Value indicators,</p> <p>To include switching from ARBs to ACE inhibitors where clinically appropriate, and switching to more cost-effective drugs within class.</p>	<p>70% of combined ACE / ARB prescribing as ACE inhibitors</p> <p>(Note: Practices who prescribe above 30% of ACE inhibitors as perindopril will be expected to review their current practice)</p>	<p>£500,000</p>
<p><u>Target 1.5</u></p> <p>Osteoporosis</p>	<p>Promotion of alendronate 70mg weekly as the 1st line bisphosphonate.</p> <p>To include switching from other bisphosphonates where clinically appropriate</p>	<p>70% of all bisphosphonate prescribing as alendronate 70mg weekly</p>	<p>£300,000</p>

Note: If, when published, the proposed NHS Better Care Better Value indicators set targets that are lower than indicated above then the targets will be adjusted accordingly. If they are higher, then the original target will remain.