Appendix 2

WEST GLOUCESTERSHIRE PCT

PRACTICE BASED COMMISSIONING BUDGET SETTING METHODOLOGY 2005/06

SCOPE OF PRACTICE BASED COMMISSIONING

In year one, the commissioning cluster will take responsibility for all budgets, with the exception of:

- Centrally or regionally commissioned specialised services
- Mental health and learning disabilities services
- Emergency ambulance services

In year one, a top-slice will be made of 1% to act as a commissioning reserve across all practice based commissioning clusters/practices. The reserve will be used to offset any overspends within the 2005/6 financial year. Should any of the reserve not be required, the balance will be re-allocated to the contributing practices which have not needed to call on a sum in excess of their contribution to the reserve.

The commissioning cluster will form part of the wider risk share arrangement currently in place across all three Gloucestershire PCTs which risk shares the cost of treatment for any patient which exceeds £50k per annum. Membership of the scheme will be restricted only to treatments falling within devolved budget responsibility and the commissioning cluster's share would be proportionate to the cluster's budget share in the applicable area.

BUDGET SETTING

The method used for setting the Practice Based Commissioning (PBC) budgets is detailed below. The start point for 2005/06 is the budgets agreed by the Board in April which include inflation savings requirements and developments. All practice budgets will be adjusted for:-

1. 1.7% deduction for Cash Releasing Efficiency Savings
2. A share of the remaining £10.2m 2005/06 savings plan based upon targeted savings plans across the whole budget portfolio of the PCT.

The main headings for budgets included within the scope of Practice Based Commissioning budgets for 2005/06 are:-

1. Commissioning Service Level Agreements
2. Non NHS Provider
3. Primary Care
4. PCT Provided Healthcare Services

5. Programme Budgets
6. Administration / Management Budgets
7. Unallocated NHS Funds

Where sufficient practice information is currently available, then this has been used to inform the budget setting process at practice level. The default position, in the event of insufficient practice based information, has been to set the budget based upon a capitation share of available funds. The capitation share has been based upon practice list size information as at January 2005.

PBC budgets have then been set at practice / cluster level using the following methodology:-

1. **Commissioning Service Level Agreements(SLA)**

   a) The initial preparation work (pre June 05) has set budgets based upon a capitation share of the agreed SLA for 2005/06 between the PCT and the provider Trust. From June 05, these budgets will have been recalculated using 04/05 activity data (where available), multiplied by the relevant Payment by Results national tariff price. This will be adjusted to reconcile to the agreed SLA for 2005/06.

2. **Non NHS Provider Services**

   At the present time these budgets have been set using a capitation share

3. **Primary Care**

   Elements of this budget have been set using a capitation share including Primary Care Development monies and IM&T. The PMS / GMS components are based upon practice level contract sums and prescribing budgets based upon the PCT's established budget setting methodology.

4. **PCT Provided Healthcare Services**

   Where it is possible to identify activities by practice or groups of practices, budgets have been set using that information e.g. District Nursing budgets have been allocated to practices based upon the teams in which they work.

5-7. **Programme, Administration/Management and Unallocated Funds**

   These budgets have been based upon a capitation share of the total PCT budget.

PACE OF CHANGE

In years 2-4, the practice based commissioning budget will move in three equal steps to a ‘fair shares’ allocation based on a national formula currently being developed, i.e.

- Year 1[1] (2005/6) – budget based on 100% historic activity usage (or capitation in budget areas where robust practice level activity is not available)
- Year 2 (2006/7) – budget based on two thirds historic activity usage, and one third fair shares using the applicable national formula
- Year 3 (2007/8) – budget based on one third historic activity usage, and two thirds fair shares using the applicable national formula
- Year 4 (2008/9) – budget based on 100% fair shares under the applicable national formula

Note [1] – please note that 'historic' prescribing budgets already represent a mixture of capitation and historical spend in line with the local formula.

BUDGET MANAGEMENT & MONITORING ARRANGEMENTS

Financial performance will be monitored monthly. Where overspends are anticipated, the cluster will discuss the nature (e.g. level and whether it is recurring or non-recurring) and the reason behind the overspend. The commissioning cluster will be required to produce a 'financial recovery plan' and consider the financial risk that the overspend may pose both to the cluster and to the PCT.

The PCT and commissioning cluster will monitor the risk associated with any overspend, according to the following indicators:

- Low Risk – the overspend can be managed in year within the overall financial performance of the cluster (i.e. offset by underspends in other budget areas)
- Medium Risk – the overspend can be managed in a time frame not exceeding one subsequent financial year
- High Risk – the cluster is forecast to overspend with recovery required over more than one financial year.