

Practice Based Commissioning Operating Framework 2009/10

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Introduction

This document sets out the context in which NHS Rotherham (NHSR) will work with local commissioners through Practice Based Commissioning (PBC) to commission better services for the people of Rotherham. It has taken into account recent policy changes with the 'reinvigoration' of PBC and also the context of World Class Commissioning (WCC), which firmly plants PBC into the heart of commissioning and in particular, clinical engagement.

This document will give an overview of the local arrangements for incentives, indicative budgets, the use of freed up resources and also submission of business cases and development of ideas. The aims of this document are to:

1. Ensure that those who are engaged in PBC are aware of their rights and responsibilities and understand the outcomes expected of them.
2. Ensure that all parties are aware of where to access support for PBC, lines of accountability and reporting structures, including the governance arrangements.
3. Improve co-ordination and planning to ensure the activities of the PBC Consortia and the goals and objectives of NHSR are aligned.

The PCT is committed to the incorporation of PBC into its commissioning process.

1. In order to achieve its strategic objectives, the PCT has adopted a matrix approach to working (see appendix 1). Each of the 'Darzi' areas has been designated as a Programme area, with an identified Programme Manager. It is fundamental that PBC links into each of these areas as developments emerge. It will be the relationship with the Programme areas which will facilitate both small and larger scale projects. The PCT has identified 29 transformational initiatives (see Appendix 6).

This document details how PBC can shape and reflect the work delivered on the strategy, as well as the relationship between plans and business cases developed by PBC groups and the PCT's central planning process.

PBC groups have been involved in the development of this guidance, both historically and currently and it is likely that there will be further developments in their thinking. The key messages which came from clinicians were:

- The PBC incentive scheme should recognise that practices are different and should facilitate smaller practices, particularly single-handers, being able to engage. It should also be noted that each group is different and should not be too prescriptive in how the work is to be done, but be more definite about the outcomes.
- PBC can play a more prominent role in transfer of care into the community, the commissioning of provider services and the PCT's contracting process with providers.

These recommendations were built into the Local Incentive Scheme (LIS) (Appendix 2) along with key messages from the latest DH guidance on PBC, *Clinicians in Commissioning: our vision for PBC* (2009).

The document is structured into the following sections:

1. PBC governance and accountability – Sets out the rights and responsibilities of Practice Based Commissioners and accountability arrangements between Practice Based Commissioners and the PCT.

2. Commissioning services through PBC - Sets out how PBC plans and business cases fit into the PCT's overall strategic commissioning process. It includes details of how 'freed up resources' are made available to Practice Based Commissioners for the commissioning of services, as well as the assessment framework for PBC business cases.

3. PBC Incentive scheme – Details of the PBC Local incentive scheme (LIS), which focuses upon clinical engagement into the commissioning process.

4. PBC Budget Setting – Details how the indicative budgets have been derived.

5. Information for PBC – Gives details of information sources and support available to PBCs to provide the information necessary for commissioning services effectively.

6. PBC Development – Sets out how the PCT will continue to support the development of PBC.

7. Patient Involvement- Sets out how patients have been involved with PBC projects and groups.

Section 1: PBC Governance and Accountability

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.

It is essential that Practice Based Commissioning (PBC) operates within a clear and transparent framework of corporate and clinical governance.

NHSR Accountability

NHSR has a statutory responsibility to achieve financial balance. NHSR remains accountable for all of the funds allocated to them and for ensuring fair access to high quality services for its population, within the resources available to the PCT. NHSR is also responsible for ensuring that services meet all national and local quality standards and accreditation. Appendix 5 details all of the key indicators against which the PCT's performance will be assessed in 2009/10.

The PCT has a duty to involve and consult patients and the public when considering new or different service provision. The PCT must make arrangements which secure that users of services are involved in:

- The planning of the provision of services
- The development and consideration of proposals for changes in the way services are provided
- Decisions to be made affecting the operation of services

The duty applies if implementation of the proposal, or a decision (if made) would have an impact on:-

- The manner in which the services are delivered to users of those services, or
- The range of health services available to those users

The PCT is responsible for leading the implementation of national policy at local level. The PCT will work with practices, groups of practices and other local stakeholders and agencies to deliver its commissioning responsibilities.

NHSR is required to provide Practice Based Commissioners with the following entitlements (ref *Clinicians in Commissioning: our vision for PBC* (2009)):

:

- *Management and financial support:* The PCT is required to agree with practices a package of support that will include, as a minimum, a management allowance (see section 3), designated support from PCT staff (see appendix 3) and a plan setting out how the PCT intends to support PBC developmental needs (see section 6).
- *Management and financial information:* The PCT is required to provide practices with accurate, timely data and analysis, in particular on budgets, expenditure, referrals, prescribing, activity and where possible, clinical performance. The PBC budget should contain, as a minimum, all hospital services, prescribing, mental health services, community/locality services and other health initiatives, even if some elements are 'blocked back' to the PCT (see sections 4 & 5 for details)
- *Swift budget setting and decision-making:* The PCT should issue practices with their indicative budget and agree financial and management support by 1st May each year. PCTs should make decisions on PBC plans and business cases within a maximum of 8 weeks (see section 4 for budget setting, section 2 for business case timescales).
- *A local incentive scheme:* The PCT should agree a local PBC incentive scheme that promotes better health, better care and better value in specific areas (see Appendix 2).

Practice Accountability

All practices participating in PBC have signed up to the terms of the PBC LIS (see Appendix 2), which sets out the minimum requirement for practices participating in PBC. In 2008/9 practices mutually agreed and worked to a PBC commissioning plan, however this has not been adopted for this year, due to the focus for 2009/10 being upon clinical engagement and reinvigoration of PBC. Most of the work done in PBC for 2009/10 has been done in the development of the groups and also clinical engagement into the wider commissioning of NHSR.

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.

Professionals are directly accountable to their patients and to their regulatory body (such as the GMC or Nursing and Midwifery Council) and PCT (under the terms of their contract) for their standards of clinical practice. In addition, practice based commissioners are responsible for maximising the health and service benefits to patients from their indicative budgets through their proposals for service redesign.

Clinical and Corporate Governance Arrangements

To avoid conflicts of interest in the re-provision of services through PBC, there must be clear accountability for Practice Based Commissioning to the PCT Board.

Two separate committees have been established for this purpose (The PBC Approvals Committee and the Rotherham PBC Group). The PBC Approvals Committee is responsible for approving business cases and ensuring that there are adequate clinical governance arrangements in place for any new services developed. The committee is chaired by a Non-Executive Director with membership drawn from the PCT Board and Professional Executive Committee (PE). Clinicians on this sub-committee must exclude themselves from decisions on any PBC business cases in which they have an interest or with which they are associated.

Rotherham PBC group is responsible for providing strategic direction to PBC and integrating PBC into the strategy of the PCT.

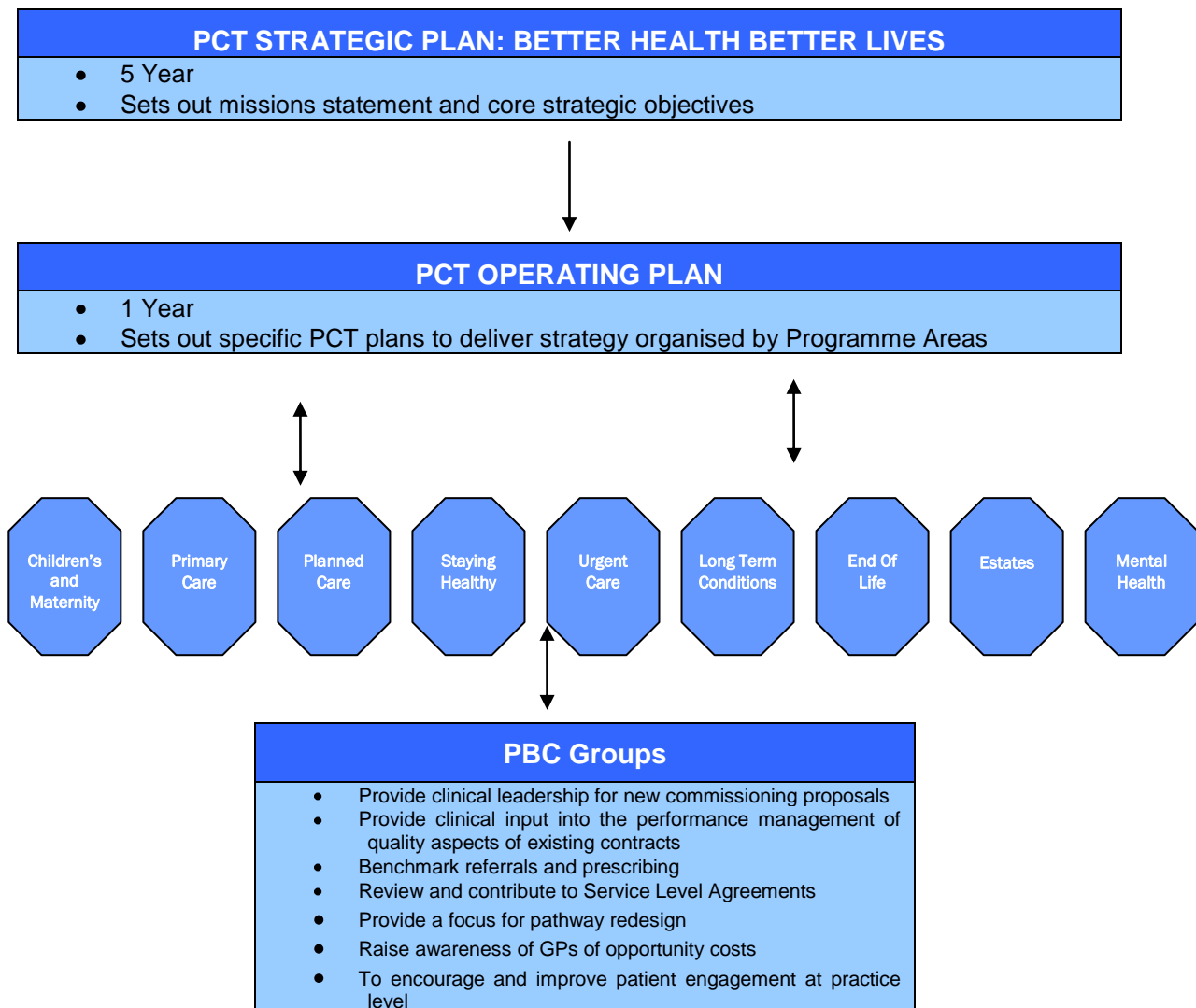
Appendix 3 details the terms of reference, structures and reporting routes within the PCT accountability framework which will meet the clinical and corporate governance requirements related to PBC.

Section 2: Commissioning Services through PBC

Locality Commissioning Plans

'PCT commissioning and Practice Based Commissioning should form part of an integrated system where the health investment plans for the wider population dovetail with the health investment plans for local practice populations' (*Clinical Commissioning: our vision for practice based commissioning, 2009*). This is achieved in Rotherham by making it implicit in the LIS that PBC groups focus on the priorities of the PCT and there are regular meetings of the RPBC group which specifically focus on these areas and feedback from the practices.

The diagram below highlights the relationship:



Locality and individual practice business cases

In 2009/10 the focus has been upon the reinvigoration of the groups, some of which had ceased to function. It was agreed that each group would not submit a commissioning plan, but would ensure that any business proposals were based upon a review of the health needs of their local population. Each consortium was asked to note the following in development of any business cases:

- To develop a greater range of more integrated services in community settings, designed around the needs of individuals
- Secure greater investment in upstream interventions that keep people healthy for longer, prevent ill-health and reduce health inequalities
- Drive continuous quality improvement and innovation across the whole system, securing better value for money in the process.

Consortium plans may be reintroduced in the future, but it is recognised that the plans may not change significantly over the space of a year. NHSR intends to review the framework for PBC in December 2009 in order to inform the operational plan for 2010/11.

PBC Business Cases

Practices and consortia who wish to develop and/or provide a service through PBC must submit a business case to the PCT for approval.

In accordance with the above, PBC business cases are expected to set out how they support the delivery of NHSR's strategic objectives:

In practical terms, this means that practices and consortia submitting a business case should look to identify the key outcomes to be delivered by the new service, and then match these to outcomes that are strategic objectives for the PCT. These include health outcomes prioritised through the world class commissioning assurance process, vital signs and PCT strategic objectives (such as moving care closer to home). The PBC team in conjunction with the Programme Leads can support GPs in identifying how their business case proposals relate to the PCTs strategic objectives.

In addition, it is essential that PBC schemes demonstrate that they are value for money from the perspective of the tax payer and the overall health economy. In practice this means that the non-recurrent investment available for PBC should be used to pump prime initiatives that will release resources in future years, or to deliver improvements in health outcomes that are proportional to the investment required. In the current financial regime it is not acceptable to adopt business cases which will require recurrent investment without subsequent disinvestment being identified.

Business cases from Practice Based Commissioners will be treated on their merits, and in a manner that is transparent and ensures probity. Business cases are expected to cover the:

- service to be provided;
- benefits for patients;
- expected improvements in efficiency and effectiveness;
- level of activity to be provided
- evidence that patients and the public have been consulted and involved
- management resources required; and
- costs of the proposals and the value for money.
- Clinical governance arrangements

The process and the pro-forma are rigorous, however this is intended to ensure that projects are benchmarked and easily evaluated as being successful and commissioning upon a recurrent basis or expansion to the whole area is more easily facilitated.

Appendix 4 sets out the current business case process and the proforma for submission of business cases.

Assessment of Business Cases

Business cases submitted to NHSR firstly go to the working group. Appendix 3 sets out the terms of reference of this group. This group has the explicit task of assessing the case for robustness (ie has all of the relevant information been included), duplicity (ensuring that this is not already contracted for) and also that it meets all of the relevant standards with regard to clinical governance. This team will work with the consortium to get the case to the stage where it can be assessed by the approvals committee.

Business cases submitted to the PBC Approvals Committee will be assessed against the following criteria:

- Evidence-based clinical effectiveness;
- clinical safety, quality and governance;
- SMART outcomes with clear monitoring criteria
- whether the specific needs of population groups have been taken into account; patient and stakeholder support;
- data collection systems are in place to provide reporting to commissioners in line with national guidelines and timescales.
- strategic fit with wider PCT strategies
- justification/evidence that resources can be released through the substitution of care;
- affordability within the current and projected indicative budgets;
- value for money, including using benchmarked costs to determine a reasonable price range for services, and whether the number of patients that will benefit from the service is proportional to the investment required
- assessment of the risks of the development; and proposed actions to mitigate these risks

The ideas for business cases are shared with all of the consortia to encourage joint working and avoid duplication. The outcome of the assessment of business cases is also shared, so that reasons for rejection/approval are clearly understood. Where it is identified that the outcome of an assessment could be reconsidered with amendments to the case or the provision of additional information, the panel will make clear in writing the necessary requirements to the practice/consortium submitting the case.

All business cases, once submitted to the formal process are assessed and a decision communicated to the submitting practice/consortium within 8 weeks.

Business cases that have not been approved will be returned to the PBC and/or consortium with an explanation in writing of the reasons for rejection within **10 working days** of the PBC Approvals Committee.

Practices can appeal decisions made by the PBC Approvals Committee. They can come to the panel to formally present their appeal and are also offered the opportunity to make amendments and to resubmit. There is no right of appeal beyond the Approvals Committee.

The PCT will provide management support to Practice Based Commissioners seeking to commission new services in order to establish whether proposals represent value for money, meet PCT governance requirements and are in keeping with the strategic direction of the PCT. The amount of management support allocated to the development of each individual business case will be agreed by the Director of Strategy and the relevant Programme Manager. Priority will be given to supporting business cases that have a wider application to the Rotherham population.

Determining the available resource for commissioning plans

One of the main purposes of PBC is that, through innovative redesign of services, it enables substantial resources to be released for reinvestment in patient care. It is recognised that the use of freed up resources to commission new services is one of the principle attractions of PBC, and practices who work hard to reduce costs on their indicative budgets and make savings should be rewarded for continuing to do

this. There is a balance required between considering the overall financial position for PBC and continuing to provide an incentive for making savings at an individual practice level.

Since 2007/8 there have been no significant savings made by PBC. This is mainly as a result of the fact that new services have largely been small scale and therefore the impact on secondary care has been minimal. NHSR recognises that some monies must be made available to pump-prime new services and encourage innovation and in order to do this has created an 'innovation fund' of £250K. It has always been made explicit that this is ring-fenced to PBC, however if a big scheme was suggested that could demonstrate savings, this would not preclude the scheme.

Savings that have been made in previous years have a three year time limit for spending and must be upon schemes which can be demonstrated to improve services for patients. Proposals for how 'freed up' resources can be spent have to be agreed by the Approval Committee.

Section 3: PBC Local Incentive Scheme (LIS)

The national guidance on the implementation of PBC states that Practice Based Commissioners are entitled to a local PBC incentive scheme that promotes better health, better care and better value in specific areas. In 2009/10 a budget of £946,000 (approximately £3.70 per registered patient) at NHSR has been set aside for this purpose.

The LIS for 2009/10 is firmly rooted in the achievement of meaningful clinical engagement into practice based commissioning and also World Class Commissioning (WCC). Practices must demonstrate active involvement in this process. The emphasis is upon 'consortium working' in order to facilitate clinical commissioning.

The LIS for 2009/10 will achieve the following:

1. Facilitate clinical engagement across the PCT area, within and external to the PCT: The system should be equitable across practices and make distinction between elements which are based upon practice size and those which are fixed ie will be the same regardless of practice size. It should encourage engagement without being prescriptive about how this is to be achieved. **The focus must be upon outcomes and not process.**
2. Must be in line with the current PCT arrangements with regard to the engagement of clinicians.
3. Should fit in with the current thinking around splitting the current LESs into clinical and a basket of incentives around PBC.
4. Should include incentives which are realistic and attainable. It must not be a vehicle for incentivising unintended behaviour.
5. Should include and identify the management resource.
6. Should be within the existing budget for PBC.
7. Must deliver value for money.

In order to do this consortia are supported by a Commissioning Manager, Commissioning Support Officer and part time administrative officer, with support from the PCT finance team, information team, Public Health team and prescribing team.

The full details of the scheme are set out in Appendix 2..

Entry points into the scheme

All practices should be invited to join the scheme at the beginning of the financial year. For 2009/10 this did not happen until July 09. In future it is intended that applications will be invited in April with a closing date of 1st May. Applications may be made to enter the scheme at a later date and the targets adjusted proportionally.

Exit out of the scheme

The PCT would require three months written notice to the Chief Executive from any practice wishing to exit the scheme. Payments would therefore cease accordingly.

In exceptional circumstances the PCT may wish to limit a practices' participation in PBC, where performance in the delivery of essential medical services is of significant concern and it is felt that involvement in PBC would divert the practice's attention from improving standards. The decision on whether and how to apply limits to a practices participation in PBC will be delegated to the PCT contracting team. Where such limits have been applied the PCT will support practices to enable them to become fully involved in PBC.

If a practice should choose not to become a Practice Based Commissioner, the PCT reserves the right to pass the commissioning responsibility for a practice on to another practice or group of clinicians or the district team. It also reserves the right to offer local enhanced services to another practice and publicise this to the patient population.

Section 4 : PBC Budget Setting

Introduction

Practice Based Commissioning: Practical Implementation set out the Department of Health's expectations for the development of PBC in 2007/08:

- Indicative budgets will be established for PBC groups which may be up to 100% of the PCT budget with funds blocked back for agreed functions.
- 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 will 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 local health economy will be reported for 2007/08.

Building on these expectations in 2008/09 and 2009/10, NHSR will progress with PBC by:

- Enablement - providing practices with the information, indicative budget and support that enable them to use PBC.
- Engaging with PBC - Whether practices are developing and implementing plans for new pathways through PBC, and whether they feel clinically and financially engaged. A PBC Local Incentive Scheme has been developed to reward practices for engaging with PBC. To overcome the constraints of budgetary overspending, a PBC Innovations Fund of £250k has also been made available to "pump-prime" PBC initiatives.

NHSR will take three steps to conclude the 2008/09 PBC process:

- confirmation of the 2008/09 financial outturn and hence what PBC freed-up resources have been generated.
- assessment of practices progress with their PBC plans and hence the award of LES part two payments
- assessment of the small number of PBC business cases received during 2008/09, leading to consideration of these business cases by the PBC Approvals Committee and hence decisions about whether the proposed service developments should proceed.

Practice Based Commissioning budgets

PBCs indicative budgets will include major groups of activity and investment in 2009/10:

- Elective Care – total value £62 million
- Emergency Care – total value £62 million
- Community Services – total value £28 million
- Mental Health Services – total value £23 million
- Prescribing – total value £41 million

PBC budgets will therefore include all the resources for these purposes. Appendix 8 sets out the PBC budgets for each practice, and the methodology by which they have been set.

In view of the substantial work required to fulfill this responsibility, other services and hence budgets be blocked back to the PCT for 2009/10:

- SCG commissioned services (non-tariff)
- Specialised services
- Independent sector services

- Learning disability services
- Drugs and alcohol services
- Intermediate/Continuing care
- Children's services
- COPD (Breathing Space)
- Triage Services
- Out Of Hours Service
- Dental Services
- Pharmaceutical Services

The guidance specifically excludes PMS and GMS services from PBC, which will therefore remain the responsibility of NHSR.

Section 5: Information for PBC

NHSR aims to share information with its PBC consortia on financial and clinical activity.

Information can be supplied on:

- elective activity;
- inpatient and day cases;
- non-elective admissions, including length of stay;
- first outpatient appointments and follow-up appointments;
- consultant-to-consultant referrals;
- A&E attendances;
- use of diagnostic tests and procedures;
- prescribing;
- community and mental health services; and
- primary care.

It also provides benchmarked data on:

- referral rates;
- admission rates;
- first outpatient attendances; and
- follow-up rates.

In addition practices have access to MIDAS, which they can interrogate to look at their own performance.

There have been delays in the production of the information for 2009/10 due to the impact of the introduction of HRG4.

In addition to the monthly information issued by the PCT, practices have access to a number of other information sources. These include individual MIDAS, a tool whereby they can look at their own performance down to patient level, Trust websites, such as Rotherham Foundation trust homepage and also national data sources such as the NHS comparators website (<https://www.nhscomparators.nhs.uk>), the NHS Institute for Innovation and Improvement Opportunity Locator (<http://www.institute.nhs.uk/opportunitylocator/>) and also the Public Health observatory website. (www.yhpho.org.uk).

In order to support practices on information issues the PCT employs provides access to a data analyst and ad hoc access to other members of the Intelligence directorate. The Data Analyst will provide information support to practices in the production of commissioning plans and business cases.

Practices can submit queries on PBC data to the following dedicated email address (PBCinfo@rotherham.nhs.uk).

Section 6: PBC Development

NHSR has taken several steps to increase the engagement of clinicians in PBC, including the formation of Rotherham PBC group to oversee the work of the consortia and also feed into key strategic issues. A clinical lead for PBC has also been appointed, who chairs the Rotherham PBC group as well as having a seat on the Professional Executive (PE). The next step will be to agree the direction of travel for 2010 and beyond.

APPENDIX 1: The Matrix Approach to working.

APPENDIX 2: The Local Incentive Scheme (LIS)

Improving Primary Care/ PBC Local Incentive Scheme (LIS) 2009/10

Outline of the scheme for 2009/10

The Local Incentive Scheme (LIS) for 2009/10 is firmly rooted in the achievement of meaningful clinical engagement into Practice Based Commissioning (PBC) and also World Class Commissioning (WCC). An allocation of £946K has been made available to incentivise this involvement, as well as an innovation fund of £250K. Practices must demonstrate active involvement in this process. The emphasis is upon 'consortium working' in order to facilitate clinical commissioning. The term 'neighbourhood' is to be replaced by consortia or group, which will place the focus upon purpose.

NB Definition of a consortium: A group of individuals or companies formed to undertake an enterprise or activity that would be beyond the capabilities of the individual members.

Following discussion with PBC groups, members of Rotherham PBC Group and NHS Rotherham, a number of suggestions were made. This paper is the result of these discussions. It was endorsed by the PCT Trust board on Monday 15th June 2009.

The groups operate quite distinctly at present, some being self sufficient, some having external management consultancy (funded by pooled group resources), others utilising NHS Rotherham resources. It is not intended to adopt a 'one size fits all approach'.

The LIS for 2009/10 will aim to achieve the following:

8. Facilitate clinical engagement across the PCT area, within and external to the PCT: The scheme aims to be equitable across practices and make distinction between elements which are based upon practice size and those which are fixed i.e. will be the same regardless of practice size. **The focus will be upon outcomes and not process.**
9. Be in line with the current PCT arrangements with regard to the engagement of clinicians.
10. Fit with the current thinking around splitting the 0809 LES into clinical aspects and a basket of incentives around PBC.
11. Include incentives which are realistic and attainable, and avoid incentivising unintended behaviour.
12. Identify the management resource.
13. Remain within the budget for PBC.
14. Deliver value for money.

There are 4 distinct elements to the incentive scheme for 2009/10:

1. Contribution to Rotherham PBC Group
2. Clinical Engagement: At practice and consortia-level
3. Budgetary management

4. Choose and Book

1. Rotherham PBC Group

This is a clinically-led group. The focus of this group is the exchange of ideas between consortia and also NHS Rotherham. Each representative will be responsible for gathering the views of their consortium and representing them in discussions at the RPBCG monthly meetings. Agendas will be focussed upon strategic items, as well as current operational issues. The focus of this group will be clinical commissioning. The agenda will be set jointly by the GP Lead and NHS Rotherham.

Each month a programme area will be chosen (these will be scheduled in well in advance) allowing an annual review of NHS Rotherham's WCC aspirations. Background information will be circulated to every GP and Practice with the aim of stimulating discussion. Views are expected to be fed back up to and discussed at consortium level, and then presented by a representative from each consortium at the PBC Group. Relevant PCT Managers and operational staff active in each area will attend meetings to receive these views in the hope that future commissioning decisions can reflect the priorities of patients as perceived by the Rotherham GP community.

Existing service contracts will also be reviewed in sequence throughout the year, with views sought in a similar manner.

Activity at practice and consortium level will also be reported and shared at the PBC Group meetings to facilitate the spread of ideas and best practice.

Each representative will be paid following attendance (representatives will need to submit an invoice). Each consortium will nominate a lead GP and Deputy GP. A maximum payment of **£341** per session will be claimable by each GP (this includes a 4 hour meeting and 3 hours of preparation time). In the event that neither the lead nor deputy is able to attend the meeting another clinical representative should attend. If a managerial representative attends, this will not be counted as clinical attendance. Clinical attendance must be demonstrated at 80% of the meetings or the payments for clinical engagement for the whole of the consortium (£3,000 per practice plus £1.75) will be reduced.

NB: This directly mirrors the arrangements for other clinical committees such as the Professional Executive (PE).

2. Clinical Engagement: £3,000 per practice plus up to £1.75 per patient.

There are two distinct areas of achievement:

- (i) **Practice Level Working:** Each practice will need to demonstrate engagement with clinical and PCT priorities. This will include:
 - a. Showing active involvement in Programme areas.
 - b. Maintenance of referral logs and use of MIDAS to investigate outliers. Demonstration of 6 practice-level meetings per year minimum.
 - c. Showing that there had been active engagement and investigation into areas of work being brought to the PBC Group e.g. referrals to Ambulatory Care Sensitive Conditions, core Programme areas such as Child Health, as well as areas important to and identified at practice level.
 - d. For 2009/10 a key focus will be upon the improvement of breast feeding data.

It is the responsibility of each practice to ensure that the views of individual clinicians are communicated, by some route, to a designated Lead for the group. It should also be evidenced that the work done at this level is fed into the consortia.

(ii) Consortium Working: Each GP practice should identify a lead GP to represent them at the consortium. *NB it is expected that consortia will meet for a minimum of 6 times per year with formal minutes and action notes kept.*

Evidence will need to be provided of information flow between Lead GP and other practices within the consortium. Business Cases may well originate at practice level but would often be 'worked up' across a group, utilising the PCT management support.

NB Costs for administrative and management support for the day-to-day running of group and practice activities are included in this funding.

Reporting/ Assessment Timetable

Reporting will place on a quarterly basis and payments will be made appropriately. The assessment for payment will be undertaken by a team including Clinical Lead, PBC Manager and Finance Lead. Recommendations for payment will need to be signed off by the Approval Committee. The precise details of evidence will be less important than a clear commitment to the underlying concept of clinician engagement with PCT commissioning priorities.

3. Budgetary Management (25p/pt breakeven Secondary care, 80p/pt Prescribing): **Management_____of Secondary care and prescribing budget.**

As in the 'Improving Primary Care LES 2008/9' this will offer practices that under spend the opportunity to benefit from those savings whilst protecting the overall interests and financial duties of the PCT. The focus of this area is upon active involvement in the budgets and practices that do not achieve breakeven but can demonstrate that they have actively investigated the reasons behind this and can explain why this has happened and how this could be improved may still receive this payment.

As in 2008/9 the secondary care and prescribing budgets will be linked together and grouped across all practices. Practices will continue to receive indicative budgets at practice level, which will be the budgets against which they may wish to develop business cases. These will also be the budgets against which the practices are assessed against for the incentive component in budgetary management.

Should the total PCT pot be under spent as a whole at the end of 2009/10, then 70% of this total under spend will be made available to those practices who have under spent their practice indicative budget (on a pro-rata basis). Should the total PCT PBC pot be over spent at the end of 2009/10, then no freed-up resources will be made available to any practices.

The budget will be broken down to practice level, and any freed-up resources against the total Rotherham PBC budget would be made available to under spending practices on a proportional basis.

Should freed-up resources be achieved by practices, then any payments received either through the incentive scheme or the Innovation Fund will be the first call on the freed-up resources. This is consistent with the treatment of under spends in previous years.

Practices that have under spent their allocated prescribing budget by 5% or greater will receive 0.80p/patient for managing their prescribing budget, 0.60p/patient for an under spend

of between 2.5% and 5%, and 0.40p/patient for under spends of between 0.01-2.5%. This payment will be practice income.

4. **Choose and Book (30p/pt) :**

NHS Rotherham is keen to continue the promotion of Choose and Book, particularly with the likely advent of electronic referral letters.

This element will focus upon utilisation (unique booking reference number –UBRNS) of Choose and Book system for first consultant outpatient appointments over the period July 2009 until end of March 2010.

10p/pt for submission of Practice Application agreeing to achieve a minimum of 65% utilisation and nomination of practice representative for choose and book users group.

10p/pt on achieving 65% utilisation (converted UBRNS) over the period July 2009 until end of March 2010.

10p/pt on achieving 90% utilisation (converted UBRNS) over the period July 2009 until end March 2010.

NB: Percentages will be adjusted to reflect the proportion of referrals that can be made using this system.

Assessment and allocation of rewards

Breakdown of each Element

Component	Overview	Total component	Notes
Consortium working		£3,000 per practice	Paid in quarterly instalments
Practice level working	PCT priorities	£1.75 per patient	Paid in quarterly instalments
(Includes development of business cases)	Programme Areas		
	MIDAS/referrals		
	Rotherham PBC group priorities		
Budget Management	Secondary Care	25p	Paid at year end
	Prescribing	80p	Paid at year end
Choose and Book		30p	Start up and final component
Total		£3.10	

Management Support

Each component is sufficiently resourced to allow for the groups to make their own management arrangements. This includes organising consortia meetings, chasing people up and maintaining information flow. The PCT is providing the following management support to facilitate the Rotherham PBC group, attend consortia meetings (upon request) as well as assist with the development of business cases:

- Commissioning Manager
- Commissioning Support Officer
- Commissioning Administrative Officer
- Access to the Programme Lead and support staff as required.
- Access to PCT staff in finance and information as required.
- Access to representatives from Public health as required.
- Dedicated Prescribing Representative

Further Considerations

Patient / Public involvement: This must be demonstrated with regard to business cases and should be implicit in the development of business cases and also the evaluation.

Practice Feedback

NHS Rotherham will be undertaking a survey to gain practice views. This will form part of the evidence with regard to engagement and all practices will be required to respond.

Fair Shares and budget setting.

This is an area of on-going development.

Review

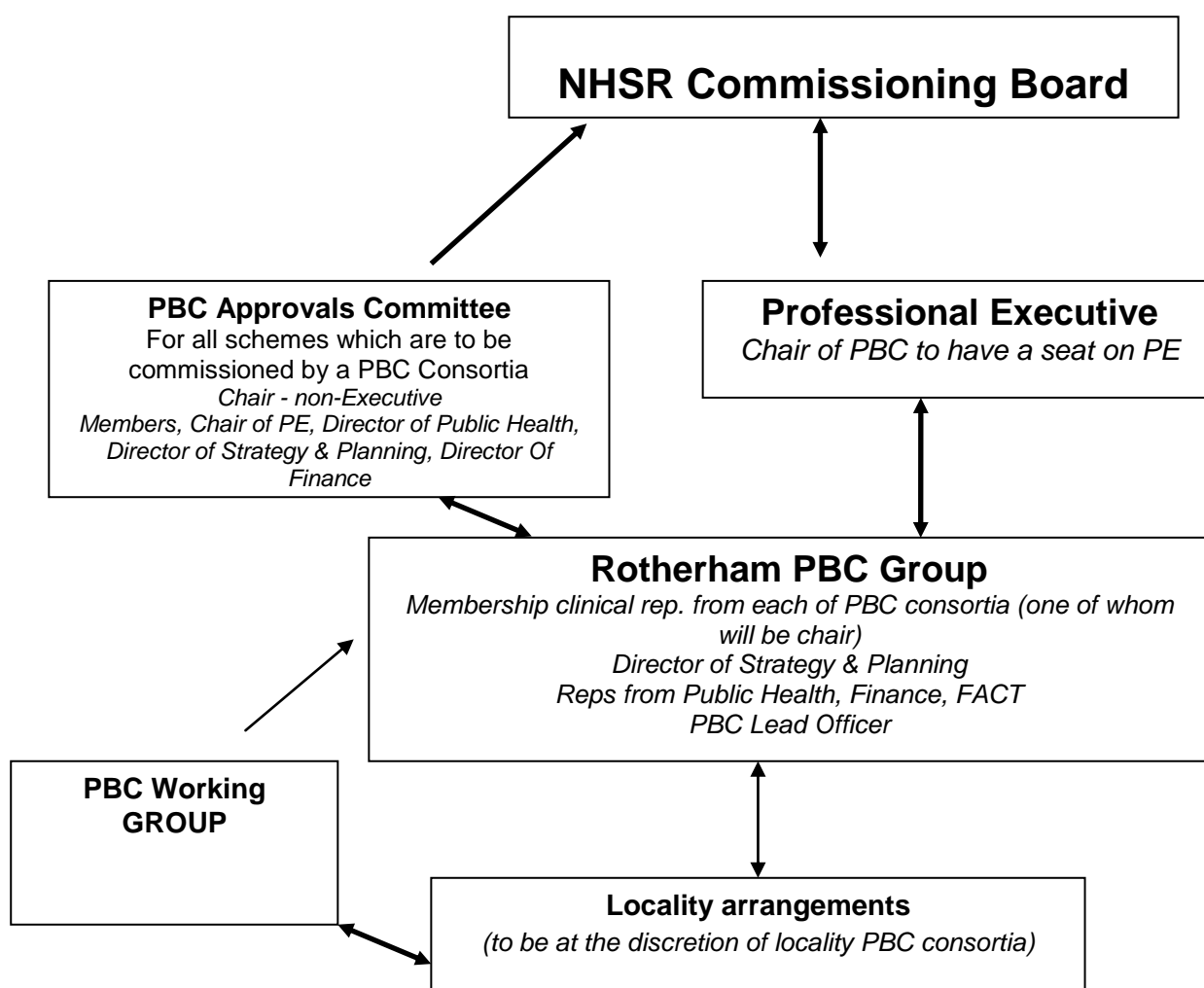
It is planned to review the scheme in December 2009 in order to make recommendations for 2010/11. Quarterly review will facilitate this process.

July 2009.

APPENDIX 3: Terms of reference, Reporting structures and accountability Framework for PBC.

PRACTICE BASED COMMISSIONING GOVERNANCE STRUCTURE

Reporting Arrangements:



Practice Based Commissioning (PBC) Approvals Committee

Terms of Reference – July 09

Purpose

The Approvals committee is a sub-committee of the NHSR Commissioning Board and is specifically charged with the following:

- Considering and approving PBC Plans .
- Recommending PBC Business Proposals to the PCT Board, if they are likely to have a strategic impact on existing health and care commissioning and services.
- Approving PBC business proposals.
- Ensuring that appropriate risks have been considered and mitigated, and that proposals represent best practice and service improvement for the patient.
- To recommend levels of implementation for successful business proposals.
- To monitor performance of PBC initiatives
- To recommend to the PCT/PBC Group the spread of best practice across care pathways
- Operate in line with the PCT Standing Orders (SOs) and Standing Financial Instructions (SFIs).

Membership:

Voting

Robin Stonebridge, Non Executive Director – Chair
Dr Charles Collinson, Professional Executive Chairman
John Radford, Director of Public Health
Kath Atkinson, Director of Strategic Planning
Chris Edwards, Director of Finance.

In Attendance

Dawn Anderson – Commissioning Manager, PBC
Keith Boughen, Associate Director
Dr Stephen Burns – LMC Representative
Julie Burns – Administration

Each voting member will also have a named deputy.

Quorum

To be quorate the meetings must be attended by at least three voting members, including one non-executive director.

Meetings

The committee will meet monthly, as required.

Papers will be circulated to the committee at least one week in advance of the meeting.

Urgent business will be considered without notice, at the discretion of the Chair.

Order of Business

Normal order of business, which may vary at the discretion of the chair will be:

1. Disclosure of any personal interests, financial or otherwise, in that meeting's business.
2. To approve the minutes of the previous meeting as a correct record.
3. To consider any outstanding business from a previous meeting.
4. To consider business on the agenda
5. To receive minutes from the Rotherham PBC Group.

Minutes

The decisions of the committee will be recorded and submitted to the next committee meeting for approval. Where decisions are made with regard to business proposals these decisions will be communicated to the submitting author within 7 days of the meeting.

Copies of the draft minutes, once approved by the Chair will be submitted to the NHSR Commissioning Board and Professional Executive.

Agendas

Any items for discussion on meeting agendas are to be submitted at least one week in advance of the meeting.

Accountability

The Approval Committee will be accountable to NHSR Commissioning Board. The lines of accountability are shown in diagram 1.

The committee will submit review documents to the NHSR Trust board on a biannual basis.

Voting

It is expected that matters will be resolved by consensus and that votes will only be taken when necessary. The Chair will be empowered to exercise a casting vote.

Administration

Administration will be undertaken by the PBC Commissioning team. This will include the agreement of the agenda with the Chair and collation of papers.

Taking the minutes and keeping a record of matters arising and issues to be carried forward.

Review of TOR to take place in December 2009.

TERMS OF REFERENCE PRACTICE BASED COMMISSIONING ROTHERHAM PBC GROUP AND WORKING GROUP

April 2009

Overview:

The PCT is committed to ensuring that Practice Based Commissioning (PBC) offers a vehicle for Clinical Engagement and input into its commissioning processes. The PCT has developed a process for agreement of PBC governance and business proposals which is efficient, transparent and fair. The process must also be robust in ensuring that any proposals meet required corporate and clinical governance standards, and are in line with the priorities of the Rotherham health economy as a whole.

The following sets out the structure for process of governance issues and business proposals, and provides the terms of reference for the PBC Groups.

TERMS OF REFERENCE: ROTHERHAM PBC GROUP

Purpose of the Group:

1. To provide Clinical leadership for new commissioning proposals.
2. To act as a driver for change in line with the Better Health Better lives Strategy
3. To provide clinical input to the performance management of the quality aspects of existing contracts
4. To continue to benchmark referrals and prescribing between both clinicians and practices
5. To provide a focus for pathway redesign
6. To encourage and improve patient engagement at practice level.
7. To ensure that the views of other community clinicians are represented where appropriate.
8. To raise awareness with general practice of the opportunity cost of clinical decisions
9. To Consider and work up the development of a referral advisory service.
10. To ensure that PBC commissioners feel engaged in the process of improving commissioning.
11. To ensure that PBC is recognised both locally and nationally.

Frequency of Meetings

Monthly for 4 hours

Role of Providers

This Group is a commissioning group which will engage with a range of providers as and when required for purposes of clarification.

Review Date: December 2009

Membership of Rotherham PBC Group:

Title:	Main Purpose:	Name:
GP Chair	Main communication link between PBC group and PE. Post to be reviewed on an annual basis	To be confirmed
Representative from each consortium	Ensure wider clinical/management engagement from consortia and outside of PE and the LMC.	Dr Naresh Patel – Central North Dr Srinivasan – Wentworth South Dr Simon Mackeown – Health Village Dr Ian Turner – Wath/Swinton Dr Leonard Jacob – Central Two Dr David Tooth – Rother Valley South Dr Chandran – Rother Valley North Dr Avery – Maltby/Wickersley
Director of Strategic Planning & Development	Ensuring that PBC initiatives fit with wider PCT strategies.	Kath Atkinson
Director of Finance	Ensuring financial and contracting issues are represented.	Chris Edwards
LMC Representative	To maintain effective communication links into and from the LMC	Adrian Cole
PCT Medical Advisor	To input on any wider issues that may affect a business proposal	David Plews
Public Health	Broad Health promotion function and linkages to Area Assemblies	Joanna Saunders
Commissioning Manager	PBC linkage to Consortia	Dawn Anderson
Consultant in Public Health	Engagement and advise on clinical information. Advise on change of clinical practice e.g. NICE	Robin Carlisle
PE Nurse/AHP Representative	Represent the view of clinical non medical primary healthcare team on PBC group.	To be confirmed By invitation only
Local Pharmacy Committee	Represent Community Pharmacists	To be confirmed By invitation only

NB Chair of PE to have open invitation to attend as Observer.

Minutes Distribution List:

- All attendees
- PBC Consortia Clinical leads
- PBC Consortia Practice Managers (including the Gate)

All ratified minutes to be put on line.

TERMS OF REFERENCE : WORKING GROUP

Purpose of the Working Group:

- To ensure inter-directorate communication on PBC
- To agree inter-directorate working processes
- To provide advice to consortia prior to submission of business cases.
- To review and make recommendations to the Approvals Group around specific business Proposals
- To advise the Rotherham PBC Group and Approvals Group around ad hoc PBC issues
- To provide clinical governance checks in the reviewing of business proposals
- To comment upon corporate governance issues prior to being sent onto PE
- To advise Approval Committee of any operational issues regarding PBC

Frequency of Meetings

Monthly, depending upon number of submissions.

Membership of Working Group:

Following to attend Working Group meetings (at least one representative covering each responsibility).

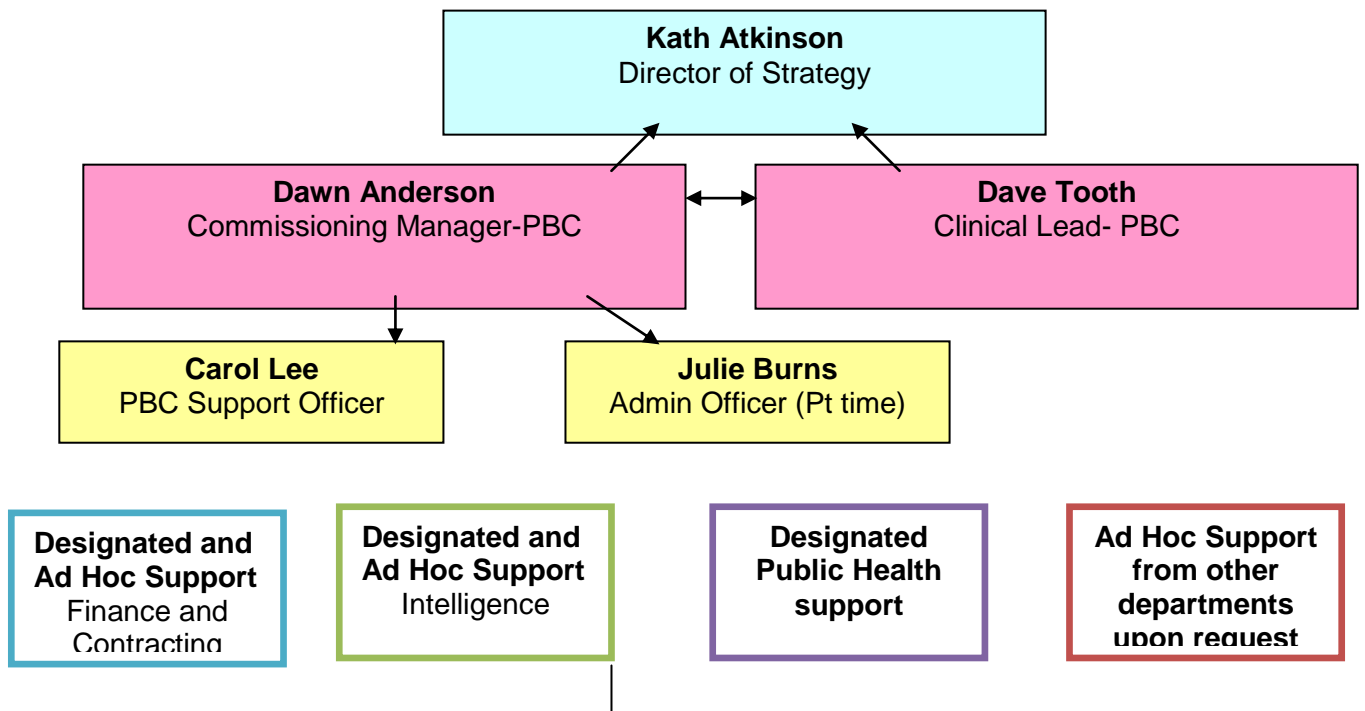
Responsibilities	Main Purpose:	Name:
Finance	FACT lead responsible for the delivery of financial, budgetary data and management information except Public Health info.	Chris Edwards/Joanne Sarsby/John Doherty
Contracting	Analysis of PBC business cases and placing of all contracts.	Mike Ireland/Nigel Parkes
PBC Implementation and Consortium Support	Responsible for implementation of PBC within and across consortia and supporting practices in the production of business cases.	Dawn Anderson
Public Health	Public Health lead responsible for the delivery of all Public Health information requirements for PBC and lead on area assembly involvement within consortia.	Joanna Saunders
Prescribing	Lead on all Rotherham wide prescribing matters	Stuart Lakin/Sue Wright
Information Services	Responsible for delivery of all information requirements e.g producing activity reports as per practice requests. Available to discuss information systems and management of consortia requests.	David Jenkinson
Clinical Governance	To advise on levels of governance required to achieve consortium initiatives.	Yvonne Sambrook

Further invitees to attend working group only where necessary:

Practice IT Systems	To assist in understanding what systems practices have available to them in producing specific reports/compiling data.	Bet Rudge
PPI Engagement	To advise on PPI best practice	Helen Wyatt

Review date for all terms of reference: December 2009.

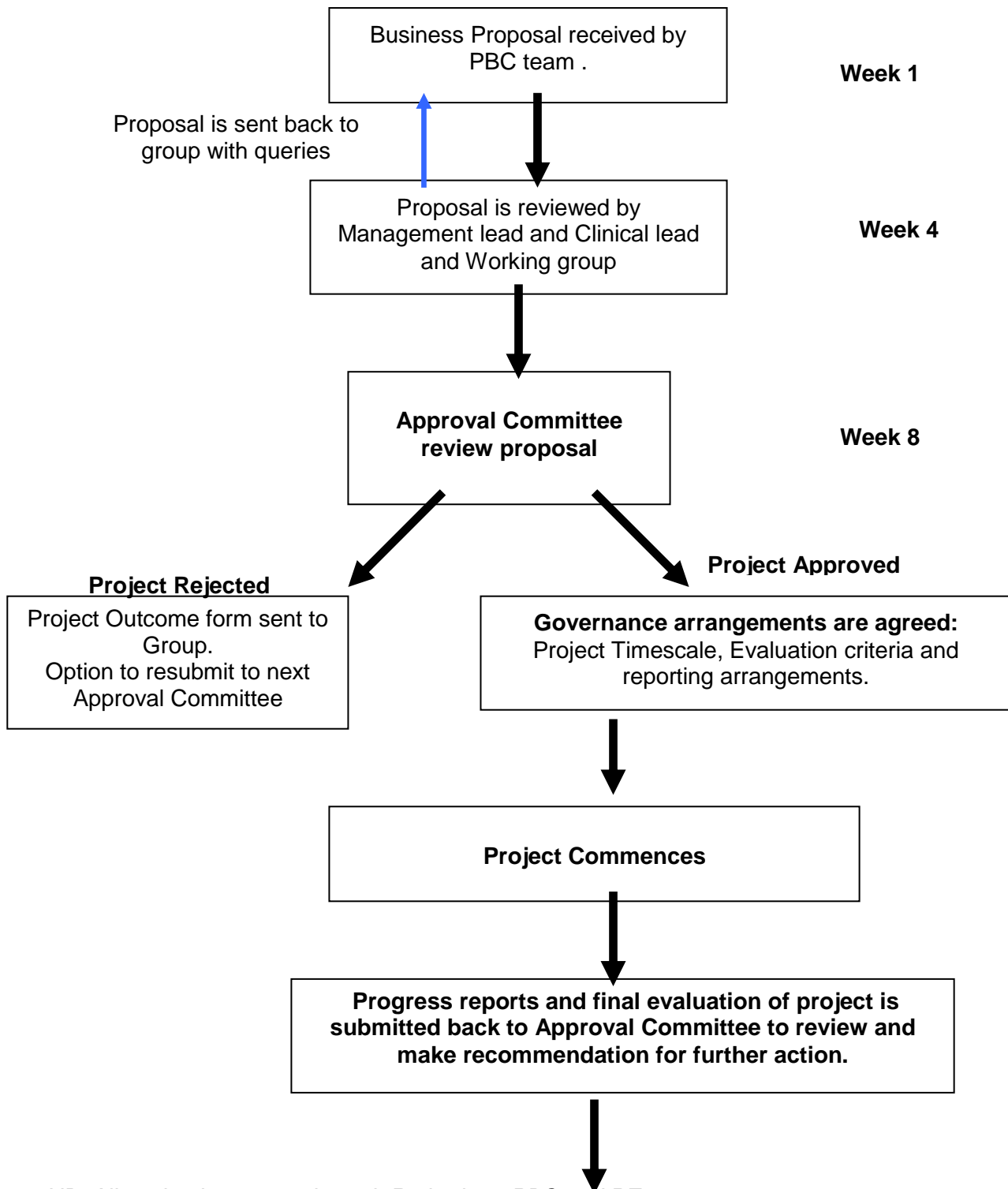
Practice Based Commissioning PCT Structure



Appendix 4 Business Case Process and Proforma

Practice Based Commissioning

Evaluation of Business Proposals For Schemes delivered within Practices



PRACTICE BASED COMMISSIONING

COMMISSIONING AND PROVIDING A QUALITY SERVICE

BUSINESS PROPOSAL

For office Use

Is the proposal DRAFT or FINAL	Date Submitted	Date Received	Reference Allocated	Status
--------------------------------	----------------	---------------	---------------------	--------

PROPOSAL TITLE		
Proposal Summary (No more than 300 words)		
Practice(s) involved:		
Total list size		
Numbers of patients involved:		
Duration of project:		
Impact Assessment Summary	<i>to be completed by provider</i>	
Benefits to patients:		
Improvements in efficiency and effectiveness		
Financial impact: costs per annum. <i>Recurrent or non-recurrent</i>		
Financial impact : savings per annum		
Proposed By:	Name	
	'Phone No	
	Email Address	
Clinical Lead		
NHS Rotherham Programme Manager/ Link Person		

SECTION ONE: Needs Assessment

1. Justification of need

Eg Identified commissioning priority, health need, gap in current services, patient experience, number of people with capacity to benefit.

2. Evidence to support identified need (WCC6, WCC5)

Eg benchmarking data, local patient information, nationally recognised evidence.

3. How does this proposal fit with strategy?

ie National Policy, NHSR Strategic Plan, Darzi

Please tick all of the relevant areas that this project will address

Better access to services/ bringing care closer to home ☐

Extending patient choice ☐

More cost effective ☐

Better patient experience ☐

Improved clinical safety ☐

Relevant programme area:

4. Clinical Engagement/Stakeholder Support (WCC 1,2,4)

Evidence of stakeholder support, including evidence of consultation with other relevant professionals, and where applicable other providers. Evidence that this has been discussed with all of the relevant clinicians and disciplines involved.

SECTION TWO : Proposed service improvement/outline of project

5. Background to the proposal

This should make reference to relevant local and national information

6. Overview of the current service provided to patients

7. Aims and objectives of the new service/proposal

This should make reference to care pathways and protocols and how it fits with other services/pathways

8. Patient engagement/Support (WCC3)

Involvement in planning, management and delivery of services. This should include evidence of patient and public support including consultation with patients and users, as appropriate.

9. Health inequalities (WCC6)

Please outline how the development would impact on health inequalities ie within Rotherham and/or the national average. Has an equality Impact assessment been completed?

SECTION THREE : FULL DESCRIPTION OF SERVICE/PROPOSAL

10. Location

Where will the service take place and are the premises suitable: size, location, privacy, special needs such as sound proofing.

11. Operating Hours**12. Staffing of the service**

Names, roles and whole time equivalents. This should include clinical and support staff.

13 Equipment

What equipment is needed? Outline the equipment required and available and include costs of purchase in the finance section.

14. Target patient/Client group

This should include indications of patient numbers, max and minimum.

15. Referral Processes and Criteria

How will the service receive referrals? How will patients be advised of appointments? How will outcomes be communicated? How will patient choice be maintained.

16. Communication Mechanisms

(Information about new service to potential patients, practices, PCT etc.)

SECTION FOUR: CLINICAL QUALITY AND GOVERNANCE

17. Measurable quality outcomes and clinical standards of the service

18. Clinical Protocol

A clinical protocol has been drawn up (to be enclosed) which outlines the patient pathway and includes quality standards.

19. Evidence base

There should be clear evidence of the clinical effectiveness of the proposal

20. Arrangements for clinicians delivering the service, including supervision, accreditation and CPD.

21. Management of patient records

This should include how patient attendance will be recorded, where records will be kept and arrangements for security, access and confidentiality.

22. Who will have the ultimate responsibility for any failings within the service?

SECTION FIVE: FINANCE AND CONTRACTS

23. Full breakdown of costs

Non-recurrent and recurrent and comparison with current service costs. How will this represent value for money? What is the cost per patient and how does this compare to other providers?

24. Activity

Expected in comparison with current service. Are there national targets to benchmark against?

25. Expected efficiency gains and timescale for achievement

26. Best Value

Arrangements for reviewing service against potential different models of providing same service.

27. Value for money

How will the project demonstrate value for money? Eg benchmarking, quality of life, resources released elsewhere.

SECTION SIX: IMPACT ASSESSMENT, PERFORMANCE MONITORING AND EVALUATION

Performance indicators and outcome measures

This section must include the key success criteria and monitoring mechanism. How will the project be evaluated?

28. Clinical Indicators

29. Activity measures and benefits

What will the activity deliver and what are the benefits?

30 Quality Outcomes (WCC8)

What quality indicators are to be used and how will outcomes be measured?

31. Patient experience

How will this be measured?

32. Monitoring processes and timescales

Including evaluation of service and review period

33. How will the patient pathway be evaluated?

SECTION SEVEN- RISK MANAGEMENT

34. Impact of proposal on other people, organisations, services and budgets in development of services

(Commissioners , other providers-reduction in anticipated activity flows, other providers, increase in support services, local authority, wider population, professional leads

35 Assessment of risks to delivery of service and management of those risks:

Financial risk

Service risk

Clinical risk

Appendix 5

Care Quality Commission Performance Indicators for PCTs 2009/10

Indicator Name	Existing Commitment	National Priority
18 week referral to treatment times		✓
Access to GUM clinics	✓	
Access to primary care		✓
Access to primary dental services		✓
All age all cause mortality		✓
All cancers: one month diagnosis (decision to treat) to treatment (including new cancer strategy commitment)		✓
All cancers: two month urgent referral to treatment (including new cancer strategy commitment)		✓
All cancer: two week wait		✓
Breast cancer screening		✓
Category A calls meeting 19 minute standard	✓	
Category A calls meeting 8 minute standard	✓	
Category B calls meeting 19 minute standard	✓	
Cervical screening for women aged 25 to 64 years		✓
Childhood obesity rate		✓
Chlamydia screening		✓
Commissioning a comprehensive CAMHS		✓
Commissioning of crisis resolution/home treatment services	✓	
Commissioning of early intervention in psychosis services	✓	
Data quality on ethnic group	✓	
Delayed transfers of care	✓	
Diabetic retinopathy screening	✓	
Experience of patients		✓
Four week smoking quitters		✓
Incidence of <i>Clostridium difficile</i>		✓
Inpatients waiting longer than the 26 week standard	✓	
NHS staff satisfaction		✓
Number of drug users recorded as being in effective treatment		✓
Outpatients waiting longer than the 13 week standard	✓	
Patients waiting longer than 3 months (13 weeks) for revascularisation	✓	
Pregnant women: 12 week maternity appointment		✓
Proportion of individuals who complete immunisation by recommended ages		✓
Prevalence of breastfeeding at 6-8 weeks from birth		✓
Reductions in <75 cancer mortality rate		✓
Reduction in <75 CVD mortality rate		✓
Stroke care		✓
Teenage conception rates per 1000 females aged 15-17		✓
Time to reperfusion for patients who have had a heart attack	✓	
Total time in A&E	✓	

Appendix 6

Priorities and initiatives	Strategic Priorities and Transformational Initiatives			
	○			
	First Class Primary Care Services <ul style="list-style-type: none"> ○ Accessible high quality ○ Effective Prescribing ○ New and innovative Community Health Centre (RCHC) ○ Two new GP Practices 	Healthy Pregnancy and Birth <ul style="list-style-type: none"> ○ Increasing Breastfeeding ○ Reducing smoking in pregnancy ○ Reducing teenage pregnancy 	Healthy Childhood <ul style="list-style-type: none"> ○ Improving services for the emotional and MH needs of all children & young people ○ Improving services to support children with complex and continuing healthcare needs ○ New and innovative programme to reduce childhood obesity ○ Dramatically Improving childhood immunisation coverage 	Staying Healthy <ul style="list-style-type: none"> ○ Reducing smoking ○ Reducing harm from alcohol ○ Improving sexual health ○ New and innovative programme to reduce adult obesity ○ Screening for CVD risk
	First class service <ul style="list-style-type: none"> ○ Implementing robust admission and discharge criteria ○ Reducing the numbers of healthcare acquired infections ○ Improving access and choice ○ Commissioning first class stroke services 	Better Services for people with Long term conditions <ul style="list-style-type: none"> ○ Accessible high quality intermediate care ○ Better prevention and treatment of falls ○ Improving diabetic services ○ Implementing the COPD care pathway 	Better Mental health <ul style="list-style-type: none"> ○ Improving mental health promotion ○ Accessible high quality psychological therapies ○ New mental health wards to enable modern therapeutic care 	End of life care <ul style="list-style-type: none"> ○ Improving services and choice for end of life care

Appendix 8

Indicative Practice Based Commissioning Budgets 2009-10- at Practice Level

		Secondary Care					Prescribing	TOTAL
Practice Code	Practice Description	Final Allocation per DH PBC Toolkit	Community Geriatricians top-sliced	Mental Health Fair Shares	Community Services Fair Shares	Total Secondary Care Budgets	Prescribing Budget	PBC Budgets 2009/10
	CENTRAL 2							
C87006	DR AHMED & PARTNERS	3,936,674	-8,805	731,977	888,958	5,548,804	1,202,739	6,751,543
C87018	DR HIRST & PARTNERS	3,900,540	-7,338	725,259	880,798	5,499,259	1,158,578	6,657,837
C87023	DR IQBAL	1,068,849	-6,848	198,740	241,361	1,502,102	347,423	1,849,525
C87608	DR GONI & PARTNERS	1,880,014	-1,468	347,191	424,534	2,650,271	609,819	3,260,090
C87611	DR JARJIS	1,016,901	-6,848	189,081	229,631	1,428,765	361,218	1,789,983
C87617	DR JACOB	647,940	-489	116,805	146,314	910,570	186,916	1,097,486
	CENTRAL NORTH							
C87003	DR COLE & PARTNERS	5,853,017	-17,122	1,088,298	1,321,696	8,245,889	2,050,176	10,296,065
C87012	DR PATEL & PARTNERS	6,542,145	-26,906	1,217,209	1,558,315	9,290,763	1,957,580	11,248,343
C87020	DR COLLINSON & PARTNERS	2,206,212	-20,057	397,938	498,195	3,082,288	848,784	3,931,072
C87603	DR HUSAIN & PARTNERS	1,324,651	-9,294	230,750	283,048	1,829,155	459,074	2,288,229
	HEALTH VILLAGE							
C87005	DR OWEN & PARTNERS	9,990,864	-10,273	1,857,682	2,256,081	14,094,354	2,902,100	16,996,454
C87017	DR PECKITT & PARTNERS	6,326,806	-978	1,176,394	1,428,684	8,930,906	1,992,002	10,922,908
	MALTBY							
C87015	DR REDDY & PARTNERS	3,483,221	-2,446	648,076	786,988	4,915,839	1,108,690	6,024,529
C87016	DR BROWN & PARTNERS	5,032,064	-5,870	935,652	1,136,313	7,098,159	1,640,484	8,738,643
C87031	DR SHRIVASTAVA & PARTNERS	1,745,189	-978	324,497	394,089	2,462,797	595,886	3,058,683
C87606	DR KHAN	841,769	-489	156,517	190,084	1,187,881	308,789	1,496,670
C87616	DR SHELTON & PARTNERS	2,805,265	-5,870	521,605	633,469	3,954,469	916,754	4,871,223
C87618	DR ZUBAIRU	691,131	-489	128,508	156,067	975,217	234,617	1,209,834
C87620	DR VAN DER LIJN & PARTNERS	2,545,226	-978	473,254	574,749	3,592,251	953,491	4,545,742
	ROTHER VALLEY NORTH							
C87007	DR BURNS & PARTNERS	5,553,843	-7,338	1,032,671	1,254,138	7,833,314	1,878,337	9,711,651
C87009	DR VENKATRAMAN & PARTNERS	3,633,952	-2,446	675,690	820,599	5,127,795	1,088,883	6,216,678
C87014	DR PRASAD & PARTNERS	2,828,485	-3,424	525,923	638,713	3,989,697	915,593	4,905,290
C87610	DR GANGULI	949,428	-489	176,647	214,511	1,340,097	232,842	1,572,939
C87612	DR BADER	698,596	-1,468	121,693	149,274	968,095	189,487	1,157,582
C87621	DR KACKER	834,752	0	155,212	188,499	1,178,463	319,023	1,497,486
	ROTHER VALLEY SOUTH							
C87002	DR BARLEY & PARTNERS	9,144,701	-978	1,700,348	2,065,005	12,909,076	3,174,648	16,083,724
C87004	DR SAY & PARTNERS	5,260,080	-1,468	978,673	1,252,932	7,490,217	1,821,419	9,311,636
C87008	DR TATTON & PARTNERS	7,253,969	-978	1,348,789	1,638,051	10,239,831	2,447,948	12,687,779
C87022	DR SIMPSON & PARTNERS	3,105,394	-489	577,411	701,243	4,383,559	1,036,347	5,419,906
	WATH/ SWINTON							

C87019	DR RAHA	1,263,342	-1,468	229,832	285,281	1,776,987	411,622	2,188,609
C87029	DR POLKINGHORN & PARTNERS	3,928,642	0	730,484	887,144	5,546,270	1,237,144	6,783,414
C87030	DR VENABLES & PARTNERS	4,581,737	0	798,125	979,015	6,358,877	1,638,492	7,997,369
C87601	DR KHIDIR	950,808	-489	176,791	214,706	1,341,816	308,160	1,649,976
	WENTWORTH SOUTH							
C87010	DR VASAN & PARTNERS	3,061,366	-978	542,902	691,301	4,294,591	835,090	5,129,681
C87013	DR ALEXANDER & PARTNERS	3,131,965	-978	582,351	707,243	4,420,581	1,032,266	5,452,847
C87024	DR THAKKAR & PARTNERS	1,925,445	-489	358,014	434,793	2,717,763	620,440	3,338,203
C87604	DR PAGE & PARTNERS	2,485,070	0	462,069	561,165	3,508,304	868,250	4,376,554
C87609	DR BHIMPURIA	1,008,862	0	175,741	215,571	1,400,174	406,687	1,806,861
	THE GATE							
C87622	THE GATE SURGERY	542,358	-489	100,845	122,472	765,186	109,428	874,614
	TOTAL	123,981,271	-157,515	22,915,644	28,051,030	174,790,430	40,407,226	215,197,656

- (a) Secondary Care Budgets have been set using historic budgets rolled over from 2008/09, uplifted by 1.7%, with movement towards fair-shares using the DH toolkit with a 1% pace of change and 10% threshold.
- (b) Mental Health and Community Services fair-shares have been calculated using the DH toolkit.
- (c) Prescribing budgets are set based on ASTRO-PU weighted population.