London Primary Care Commissioning

THE NHS CONSTITUTION
the NHS belongs to us all

Plan on a page 2014/15 onwards

NHS England

Vision

Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Form

Objective One
Co-ordinated Care

Objective Two
Proactive Care

Objective Three
Accessible Care

Function

Objective Four
Collaborative models of delivery

Quality Standards and Outcomes
- Ensuring consistency of service across London
- Performance management

Premises
- Making best use of the assets available
- Borough based strategic planning to inform investment decisions

Workforce
- Ensure the services we commission maintain a diverse workforce that supports collaborative 24/7 working

Technology
- Joined up working that meets the needs of patients
- Integrated systems and better data sharing

Commissioning and contracting
- Managing the provider landscape
- Redesigning incentives
- Primary care contract that delivers national consistency which enables programme of change in local context

Stakeholder engagement
- Ensuring ongoing engagement of patients, healthcare providers and other key stakeholders in service design and programme of change

Change management
- Organisation design
- Clinicians and organisations collaborating to deliver integrated care for patients

Governance arrangements
- Overseen by the Primary Care Programme Board
- Borough based accountability – via the SPGs?

Success criteria
- Enables effective delivery of out of hospital care
- Demonstrable improvement in:
  - Outcome standards across all London CCGs
  - Public confidence in NHS England's ability to address and act upon poor quality (premises, clinicians, systems)
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Primary care system that prevents ill health and supports healthy lifestyle choices
- Patients and stakeholders are at the heart of commissioning decisions

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Engagement with key stakeholders will be crucial to ensuring the success of this strategy
- Finance – investment required to support the transformational change over the next 5-7 years

Six High-Level National Objectives

General practice will play a much stronger role, as part of a more integrated system of out-of-hospital care. It will need to work on a more systematic, collaborative basis with community health services, social care, voluntary/community organisations, community pharmacy and other partners.

Six underlying objectives for general practice:

1. **Proactive co-ordination of care** (or anticipatory care), particularly for people with long term conditions and more complex health and care problems.
2. **Holistic care**: addressing people's physical health needs, mental health needs and social care needs in the round.
3. Ensuring **fast, responsive access to care** and preventing avoidable emergency admissions and A&E attendances.
4. Promoting health and wellbeing, **reducing inequalities and preventing ill-health** and illness progression at individual and community level.
5. **Personalising care** by involving and supporting patients and carers more fully in managing their own health and care.
6. Ensuring consistently **high quality and value of care**: effectiveness, safety and patient experience.

Commissioning Primary care for the local systems in London

- Currently NHS England (NHSE) is solely responsible for commissioning primary care services. However we don't do this in isolation and we have an agreed process of consultation which takes into account local stakeholders.

- NHSE London primary care does not work to a single strategy for primary care commissioning. We have an agreed framework for improving primary care performance and for decision making around commissioning and decommissioning of services but the final decisions about commissioning are made within the context of the local health economy. For North West London (NWL) this means taking account of Shaping a Healthier Future (SaHF) and NHSE officers work closely with CCGs to ensure commissioning decisions support the SaHF ambitions.

- Co-commissioning with CCGs will formalise this arrangement and ensure primary care commissioning has a cohesive and transparent framework from which to make commissioning decisions. The development of co commissioning sits with the CCGs as they must decide what level of responsibility they wish to take on. NHSE will work with CCGs to develop the governance around their chosen model.

Model for decision making when a practice closes.

Over recent years on average the number of practices that close their contracts in NWL has been 4-5 each year (less than 1 per borough). With the current emphasis on improving the quality of primary care and the significant shift in demand that primary care providers are dealing with it is possible that this number could increase. Funding from practices that close is always recycled back into primary care but this can be done in one of two ways either of which can be right for a specific practice population.

1. Dispersal of the list
2. Procurement

A range of factors is taken into account when making the final recommendation, these include

- The views of all stakeholders (patients, OSC, health-watch, CCGs and others as identified, although the patient views are always paramount)
- Local out of hospital strategy, including the ned to co-locate services etc (for NWL this is SaHF)
- Condition and quality of available estate
- Quality and capacity of provision nearby
- Any unique needs of the local population
- Any other specific local issues, for example the impact of the decision on other local practices.

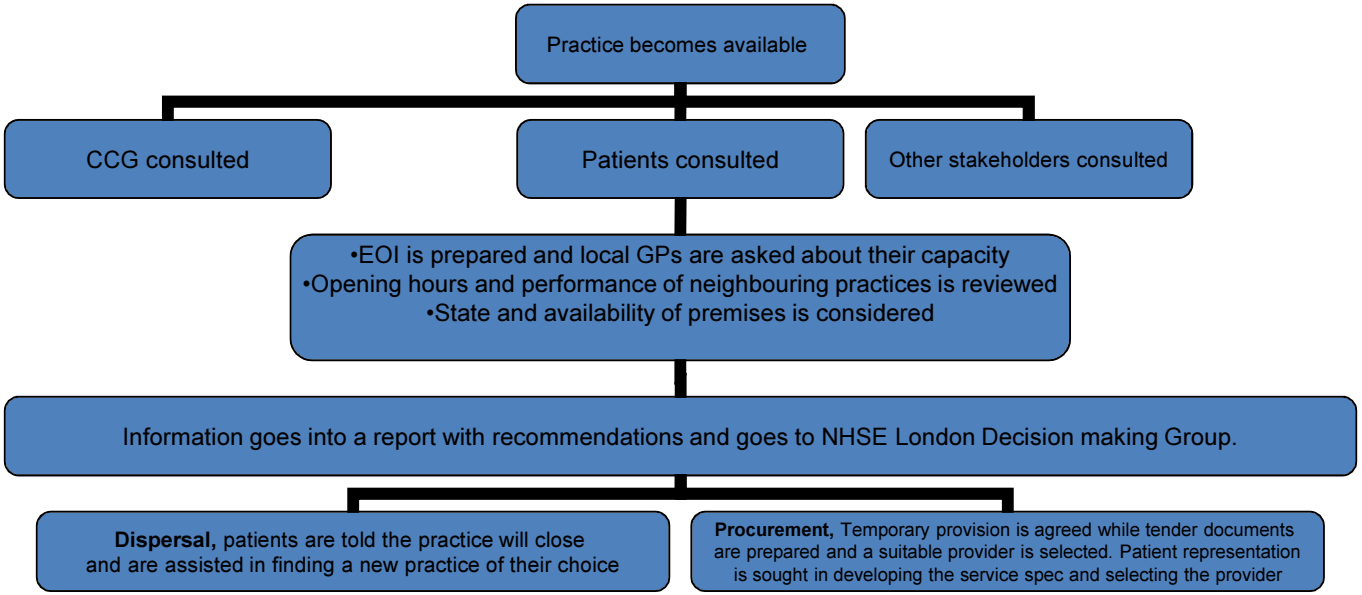
There is a nationally agreed standard around the time given to consult after which a paper is presented to the London Primary Care Decision Making Group (DMG) with recommendations.

Commissioning a GP Practice.

New contacts can only be let when a current practice contract becomes available. There are two options when this happens, to disperse the list or procure a new contract. There are benefits to both and both options are considered within the context of other available provision and local need.

Dispersal: Often small practices are not able to offer patients the full range of services that are available in larger practices and opening hours are less flexible. By dispersing the list neighbouring practices are able to expand and the extra funding that follows the patient can support the development of more comprehensive services in these practices.

Procurement: This would be the option of choice when the list is too large to safely disperse, the neighbouring practices have no capacity to expand or there are unique needs of a specific population that need addressing.



Payment mechanisms for GPs

There are three contract types available for the provision of GP services:

1. GMS: this is the national contract and is predominantly funded by the patient list, practices are paid a fixed price for the number of patients they have on their list (circa £66). This is nationally agreed each year. In addition practices are reimbursed for certain infrastructure such as IT and premises. Finally practices can increase their income by providing extra services usually called 'enhanced' services such as minor surgery. GMS contracts have no end date and only become vacant if the partner/s retires or relinquishes their contract. The contract holder must be a GP.
2. PMS: this contract is locally negotiated and again the main source of funding is the patient list. However the price per patient is agreed based on local factors to recognise the particular needs of the population. In NWL this price ranges from £65 to £135. PMS contracts usually have additional KPIs to recognise local need. These contracts have the opportunity for additional funding as above. Again there is no end date to these contracts but NHSE is able to give notice to terminate or vary these contracts if required. The contract holder does not need to be a GP although GPs must be employed in the practice.
3. APMS: this contract is also locally negotiated and has similarities to the PMS contract in terms of how they are funded. However infrastructure costs are normally wrapped up into the price. APMS contracts are tendered with an end date (normally 5-10 years depending on the service) and also frequently have additional services that would be offered to the wider population. An example would be a practice that also had a walk in centre. The contract holder does not need to be a GP although GPs must be employed in the practice.

Personal Medical Services (PMS) reviews (currently on hold awaiting national decision)

Nationally we said…	**1. NHS England will seek to align PMS contracts with local emerging primary care strategies arising from discussions informed by 'a call to action' to achieve better access and better outcomes for patients, and offering best value for money** **2. NHS England will be engaging with PMS practices and their representatives to seek to agree the best way forward for PMS contracts, taking into account the results of the desktop review and contract disaggregation exercise undertaken by area teams in August 2013**
In London this means:	1. Review of all PMS contracts for size and volume to align to national process. The preferred model is for larger / federated PMS contractors to bring benefit and economies of scale 2. Once reviewed, PMS contracts should be aligned to ensure consistency of service and access. The premium will be aligned to the London 'standards'.

Locally in North West London this means… **Ensuring any premium is also offered to GMS practices to create parity.** **Ensuring any premium deducted from higher rate practices is reinvested into primary care in NWL.**	
Inner – Central, West London, Hammersmith & Fulham, Hounslow, Ealing	60 PMS contracts Average £95.29 per weighted patient Previous reviews: Hounslow in 2010 – a range core requirements and optional premium services introduced KCW reviewed premium enhanced services introduced

Alernative Provider Medical Services (APMS)

Nationally we said…	**1. NHS England will be engaging with APMS practices and their representatives to seek to agree the best way forward for APMS contracts, whilst understanding the impact of closures of these centres on patients and on choice and competition.**
In London this means:	1. London Region is systematically reviewing its time limited APMS contract portfolio which includes 73 primary medical services and 24 GP Led Health Centres. 2. The review is being undertaken with CCGs in the case of GP Led Health Centres, in recognition of the shared commissioning responsibility and London Region intends uncouple the unscheduled care element of these contracts. 3. The result of these reviews is that contracts will either continue, or be re-procured, renegotiated or terminated, as appropriate. 4. London, in collaboration with NHS England National Primary care Support Team, is developing a standard APMS contract. This will include a standard specification, price per weighted patient and KPIs for London. Once complete, this will be used to ensure consistency across new APMS contracts within London – both in terms of quality and access to services. 5. Any significant changes to services , both in terms of access and services provided will be subject to appropriate consultation and engagement of key local stakeholders and Equality Impact Assessments
Locally in NWL this means:	The re commissioning of APMS contracts in NWL must be aligned with the SaHF programme. We have a schedule of when contracts are due for renewal and work closely with the CCGs to decide what is required before going out to the market.

Improving performance

- There is a rolling programme to tackle the bottom 10% of practices in London as defined by the quality Outcome Framework (QOF), High Level Indicators (HLI) and the GP Outcome Standards (GPOS)
- Under these measures 39 practices across NWL have been identified for review.
- The Primary care performance team are working with practices to develop improvement plans.
- Exit strategies will be developed for those practices not able to improve
- Close liaison with CCGs to ensure any market opportunities this creates reflects SaHF strategic and transformation plans
- There is a London wide quality and governance system to ensure consistent approach across London
- There is a 5 year aspiration to raise the number of achieving and higher achieving practices in line with or better than the national average.

Premises

Nationally we said…	**1. We are developing a strategic framework to support joint work with healthcare providers, CCGs, local authorities and other community partners to ensure that local strategies for out-of-hospital care include appropriate strategies for premises development.** **1. NHS England will work with other commissioners and with healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties. NHS England will seek to develop an abatement policy to ensure that payments made under the GP rent and rates scheme appropriately support primary medical services; understanding the range of non-core services currently reimbursed under the Premises Directions and how these should be managed in the future.**
Locally in London this means:	1. NHS England will need to work with partners, including healthcare providers, CCGs, Local Authorities and community partners to develop the premises required to deliver the primary care element of out of hospital strategies 2. In 14/15, this will require scoping around the needs for premises across the London region, taking into account the future changes planned for primary care and the out of hospital agenda. This will include an assessment of the space required, in what location and with what equipment to deliver the strategy. It should also link to facilities requirements and potential IT solutions, to provide a single premises strategy for the future of primary care 3. Additional consideration will need to be given to the best way to procure space, both within an expensive property market in London and the long term risks associated with building and maintaining property.
For NWL this means:	For NWL our proposal is to work with CCGs and NHSPS to agree a 5 year premises estates strategy which will be managed via a steering group acting as a gateway for schemes going to FIPA.

The benefits of working with H&WBB

The Health and Wellbeing Board, may like to consider:

1. How the Health and Wellbeing Board should seek to support and influence primary care commissioning to ensure it reflects local need, when exercising their role in providing local system leadership

1. How the Health and Wellbeing Board can work with NHSE and CCGs to monitor and improve the quality of primary care

2. How to maximise the opportunities that might be available through the introduction of co-commissioning of primary care services between NHSE and CCGs