Commissioning Primary Care Services

1 Introduction

1.1 This paper produced for the Tower Hamlets Health and Wellbeing Board, sets out the arrangements for commissioning of primary care services in the NHS post 1 April 2013.

2 Background

2.1 CCGs commission the majority of NHS services for their populations. CCGs also have a statutory responsibility to support NHS England to improve the quality of primary medical care. Even though they are responsible for local services, in the construct of the reconfigured NHS, CCGs were not granted the rights to commission primary care as this was considered to create a conflict of interests. This passed to NHS England.

2.2 Primary care commissioning is broad and complex. It has been a significant challenge to move from many different systems to a singenational operating model, while retaining vital local responsiveness and sensitivity. It is important that NHS England plans local primary care services in the context of CCGs' commissioning strategies, health and wellbeing strategies, the JSNA and the PNA. Some services, like sight tests from optometrists, will continue to be demand-led and not actively commissioned.

3 NHS England Primary Care Commissioning functions

3.1 NHS England is responsible for planning, securing and monitoring an agreed set of primary care services. These are set out in more detail in **Annex 1**. The following functions underpin this:

Planning the optimum services which meet national standards and local ambitions, ensuring that patients, carers and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;

Securing services, using the contracting route that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration; and

Monitoring, assessing and, where necessary, challenging the quality of services; and using this intelligence to design and plan continuously improving services for the future.

4 Support functions

4.1 The following are also the responsibility of NHS England, discharged in local area teams, through the primary care commissioning arrangements:

- Local responsible officer functions(via Medical Director)
- Local management of the performer lists(via Medical Director)
- Market entry and exit for pharmaceutical services (in London this is managed by a London wide "Control of Entry") team
- Managing individual performance issues for dentists, community pharmacists, GPs and optical providers via Medical Director
- Commissioning occupational health services for primary care providers
- Helping to secure services for patients following a major incident such as fire, flood or similar emergency
- Supporting providers in difficulty to ensure that basic services continue
- Contracts for disposing of clinical waste, including medicines
- Distributing forms e.g. prescriptions, sight test forms.

4.2 NHS England manages the premises reimbursement budgets but delegatesGP IT functions to CCGs to aid integration with broader system development.

4.3 The following matters, carried out by some former PCTs, didnot transfer to NHS Englandand are the responsibility of providers themselves:

- Provision of locums and other temporary or support staff
- Bulk purchasing of equipment and services other than the disposal of clinical waste.

5 Payment and associated functions

5.1 At its most simple, this is payment for contract delivery. However, for many of the primary care payments there is a relationship between them and the resulting net income or pay of individual contractors. For GP payments, this is made more complex, by various sources of contractual income, including payments for weighted capitation ('global sum' for GMS contractors), and practice income from QOFand items like flu vaccinations, premises, etc.

5.2 Payment to GPs is inextricably linked to the patient registration system, which in turn is linked to the system supporting screening and immunisations. Those providing these payment services also process the NHS pension arrangements for some primary care contractors.

5.3 The responsibility for the vast majority of these services for all contractors transferred to NHS England and isdischarged through the primary care commissioning arrangements typically delivered through Family Health Services (FHS) agencies.

5.4 Local Authorities and CCGs are responsible for making arrangements for the payment for primary care services that they respectively commission.

6 Payment services

Dental, pharmaceutical and ophthalmic payments

6.1 The NHS Business Services Authority (BSA) continues to provide a pharmaceutical and dental payments service, as well as contract monitoring data, audit and fraud prevention work.

6.2 NHS Englandis developing a national specification for primary ophthalmic payments. Greater automation will mean efficiency savings for both NHS England as the commissioner and for many service providers. It will also improve post-payment verification and fraud detection.

GP services

6.3 Before reorganisation, there were three methods of GP practice payment and patient registration: directly by the commissioner; a shared service arrangement with other commissioners; or through an external contract.

6.4 GP practice payment, patient registration and other associated functions can be delivered more consistently and efficiently, even more so when paper-based medical records are eliminated. These are delivered through SBS (NE London) and the FHS service based at Stephenson House for the former NC London. A national review of these services is currently underway.

7 The role of clinical commissioning groups (CCGs)

7.1 CCGs have a critical role in providing clinical leadership to commission high quality, responsive and safe services for patients. CCGs are dependent on the unique role of general practice in connecting and acting as the intermediary for most of the care patients receives.

7.2 Practices are central to the new commissioning arrangements as well as providing primary medical services. As providers of care, GP practices take micro commissioning decisions daily with each referral and prescription. CCG member practices need to work together to ensure that these micro decisions are clinically appropriate and deliver best outcomes for patients. Whilst intelligence about these commissioning decisions is of primary concern to CCGs, it is also critical for NHS England to review the performance of individual practices.

7.3 CCGs are best placed to support quality improvement in primary medical care, where necessary in partnership and with the support of NHS England. CCGs are not responsible for contract compliance and should be able to focus on local priorities and supporting continuous development.

7.4 CCGs, working with NHS England, take a quality improvement approach based on:

- Evidence of engagement and involvement with patients and the public
- Benchmarking across member practices of healthcare needs indicators, interventions, and patient outcomes
- Commitments to openness about data and mechanisms to enable information sharing
- Clear approaches to peer review and discussions across member practices
- Self assessment of need, intentions and anticipated impact.

7.5 CCGs should drive greater integration between primary care and other services by commissioning 'wrap-around' community-based services for local populations, so that the services provided in individual practices form part of a broader network of integrated, community-based care for patients, with shared clinical leadership, clinical pathways/protocols, and clinical information systems.

7.6 These wider community-based services could include some services provided by GP practices themselves, subject to CCGs being able to demonstrate that they go beyond the 'core' services expected under the GP contract, that they provide good value for money, have followed an appropriate procurement route, and that they have appropriately managed conflicts of interest.

7.7 CCG commissioning plans, which are based on local joint health and wellbeing strategies, will inform local decisions about access to services and the development of new or replacement services. Some services, like the procurement of a new practice, arethe responsibility of NHS England. Others, like the development of additional community services not necessarily exclusive to GPs, are the responsibility of the CCG.

7,8 Since its inception, staff at NHS England have made efforts to engage with CCG teams about key primary care commissioning decisions (e.g. surrounding the replacement or dispersal of practices falling vacant through retirement, resignation, death of a contract holder, and large new premises infrastructure needs). The teams have worked closely in the development of new 5 year strategic plans.

7.9 Over the past few weeks, CCGs nationally have been invited to submit expressions of interest for new ways of co/joint commissioning of primary care. At the time of preparation of this paper, such a proposal was being worked up by the CCG in collaboration with others locally. The commissioning environment may therefore change again over the months ahead.

8 Specific issues arising from last meeting

i **Information on the new Dental Practice on Ocean Estate** - NHS England will be meeting with the Provider on 24th June 2014, where we will be able to provide more comprehensive details on the service. The current mobilisation position is that the lease has been agreed with and by the Provider and the commissioning team are finalising the specific contractual and service element of the contract. If there is no further clarification from both parties, then service commencement is likely to be agreed for 1st September 2014.

ii **View around seven day working and opening hours** - The national GMS contract is vague around definition of opening hours. It requires practices to deliver services to meet the reasonable need of their patients. It also describes "in hours" as 8.00 a.m. to 6.30 p.m. Monday to Friday excluding public holidays. There is a general intent to improve access across GP services and any widening of the narrow definition is likely to require practices to work together in networks or federations in order to deliver this. NHS England in London is at a forming stage (i.e. prior to consultation and engagement of setting a new range of standards for primary care which at this early stage, include proposals for guaranteed same day access to a GP for "in hours" and generally, 8 to 8 access seven days a week. This will be developed over the summer.

iii **New data on access** – Jane – anything locally?

iv **Confirmation on who commissions Walk-in Centres** – Walk in centres are commissioned by CCGs and generally are part of their urgent care strategies. In some place, walk in activity is still locked in NHS England contracts with GP Led Health Centre providers that were inherited from the former PCTs. Dependent upon the date of expiry of those contracts, the activity and contracts are being separated but only after discussion with the CCG and the provider. It then falls to the CCG to determine future arrangements.

9 Conclusion

9.1 The commissioning of primary care is complex as has been described above and requires close working relationships between all the various agencies and Healthwatch for NHS England to deliver its commissioning responsibilities. Some of those new relationships continue to be developed.

Neil Roberts
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June 2014

ANNEX 1

Scope

The Health and Social Care Act 2012 sets out NHS England's responsibility to commission primary care services for the population of England, including many of the services provided by GPs, primary care dentists, community pharmacists, appliance contractors and optical providers. It allows NHS England to delegate some of its medical and ophthalmic commissioning functions to clinical commissioning groups (CCGs) and places a duty on CCGs to support improvements in the quality of primary medical care. Local authorities also have responsibilities to commission health improvement services and they may wish to commission some of these from primary care providers.

NHS England is also responsible for commissioning community, secondary and urgent dental services.

1. Primary Medical Services Commissioning

Since April 2004, three contracting routes have been available to enable commissioning of primary medical services. The routes are

- General Medical Services (GMS)
- Personal Medical Services (PMS) which includes Specialist PMS (SPMS), and
- Alternative Provider Medical Services (APMS).

General Medical Services (GMS)

This contracting route is provided for by the NHS Act 2006 Section 83, and the NHS (General Medical Services Contracts) Regulations 2004, as amended. It is underpinned by a nationally agreed GMS contract. About 53% of primary medical services nationally are provided under GMS contracts. These contracts are negotiated nationally and their terms are not open for local re-negotiation because the financial impact of any change would eventually impact the income of all GMS contract holders nationally

Personal Medical Services (PMS)

This contracting route is provided for by the NHS Act 2006 Section 92 and the NHS (Personal Medical Services Agreements) Regulations 2004, as amended. PMS contracts are negotiated locally but are underpinned by national regulations. Around 44% of primary medical services nationally are currently provided through PMS contracts. This rate is higher in many parts of London.

Specialist PMS is an additional, local flexibility to help to address unmet needs amongst client groups that traditionally have experienced primary medical services as being more difficult to access, for example, homeless people, prisoners, drug users. There are none of these contract types in London.

Alternative Provider Medical Services (APMS)

APMS contracts are provided under Directions of the Secretary of State for Health. They are time limited contracts. APMS contracts can be used to commission primary medical services from traditional GP practices as well as others such as:

- Commercial providers
- Not-for-profit organisations
- Voluntary and community sector organisations
- NHS Trusts
- NHS Foundation Trusts.

Primary medical services comprise:

Essential services
Every GMS practice is required to provide essential services (or, in PMS, their equivalent) to their registered patients and temporary residents. Essential services cover the:

- Management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally to be expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable
- General management of patients who are terminally ill
- Management of chronic disease in the manner determined by the practice, in discussion with the patient.

Additional services
All GMS and PMS practices have a preferential right to provide additional services (e.g. maternity services). Practices can, however, temporarily or permanently, opt out of providing additional services in accordance with fixed rules. Where opt-outs occur, NHS England is required to commission the services from a different provider.

Out of hours services
Since April 2004 all GMS and PMS practices have had the opportunity to opt out of their responsibilities for securing out-of-hours services for their registered patients. Where that responsibility remains retained by GMS and PMS practices NHS England will be the commissioner as the duty to secure out-of-hours is an integral part of the GMS and PMS contract. Around 10% of GMS and PMS practices retained their out-of-hours responsibilities.

NHS England is responsible for ensuring that all other opted out GP out-of-hours services are commissioned as part of Clinical Commissioning Groups' responsibilities for developing 24/7 urgent care services. Clinical commissioning groups will be responsible for monitoring all NHS commissioned GP-out-of-hours services and assuring the quality of these to consistent standards.

NHS England has delegated authority to CCGs to commission all GP out of hours services.

Enhanced services
Enhanced services are generally understood and defined as

(a) Medical services other than essential services, additional service or out of hours services; or
(b) Essential services, additional services or out of hours services or an element of such a service that a contractor agrees under the contract to provide in accordance with specifications set out in a plan, which requires of the contractor an enhanced level of service provision compared to that which it needs generally to provide in relation to that service or element of service.

The contract regulations (GMS, PMS and APMS) work to allow medical services to be of any type, in any setting, and to extend beyond the scope of primary medical services. NHS England commissions some enhanced services nationally using single specifications. These nationally commissioned enhanced services replaced the arrangements that placed Primary Care Trusts under a duty through legal directions to commission prescribed enhanced services to meet the needs of the population (services known and commissioned as 'Directed Enhanced Services').

NHS England also has the flexibility to commission enhanced services locally to meet the differing primary care needs of local populations. These commissioned services are more tightly defined and managed than those currently commissioned as 'Local Enhanced Services.' Local commissioning reflects the fact that CCGs are largely responsible for the resources attached to current Local Enhanced Service schemes (excluding those supporting defined public health services where responsibility passed to local authorities).

2. Primary Dental Services Commissioning

Since April 2006, the following contracting routes have been available to enable commissioning of primary dental services. The routes are

- General Dental Services contracts (GDS)
- Personal Dental Service agreements (PDS) which includes non mandatory services such as orthodontics and sedation.

GDS contracts and PDS agreements

The GDS and PDS contracting routes are provided for by the NHS (General Dental Services Contracts) Regulations and Personal Dental Services Regulations 2005 (as amended).

Both GDS contracts and PDS agreements are negotiated locally but are underpinned by national regulations. The main differences between GDS and PDS are that GDS contracts are not time limited (PDS agreements are) and that PDS can apply to non mandatoryservices (e.g. orthodontic only) practices.

Community or Salaried Dental Services used to be solely provided by PCTs or NHS Trusts (although increasingly are now provided through Social Enterprise organisations) and are directly commissioned using the PDS contract framework and generally provide services for hard to reach groups.

Primary dental services comprise:

Essential services

Every GDS practice is required to provide a full range of general dental services (mandatory services) plus any agreed non mandatory services. PDS may also includemandatory services and a mix of additional locally negotiated services, but can alsobe agreed for solely non-mandatory services (i.e. with no general dental services). Community or Salaried Dental Services are as defined locally.

All GDS providers and PDS contractors with a mandatory service agreement are expected to provide a full range of primary care dental services to all their NHS patients based on clinical need (limited only by their ability to clinically provide the intervention).

Additional services

All GDS and PDS practices can contract or agree to provide additional services with the commissioner, but they have no right to do so.

NHS England also commissions**secondary care based dental services.**

3. Pharmaceutical services

Arrangements for pharmaceutical services are provided for by virtue of Sections 126 and 127 of the NHS Act 2006 (as amended). Schedule 1 of the National Health Service (Pharmaceutical Services) Regulations 2005 provides for **Essential services**: which must be provided by all community pharmacies and include dispensing, repeat dispensing, health promotion, signposting, support for self-care and disposal of unwanted medicines. Schedule 2 provides for the dispensing services which dispensing doctors are required to provide. Other services which match pharmaceutical services and which are provided by dispensing

doctors would be provided under primary medical services arrangements. Schedule 3 provides for those services which appliance contractors are required to provide. NB There are no dispensing doctors in London.

The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2011 provides for **Advanced services**: which require both the pharmacist and the pharmacy premises to be accredited e.g. medicines use reviews, the New Medicine Service, appliance use reviews and stoma customisation and **Enhanced services**.

Local Pharmaceutical Services
Section 144 of the NHS Act 2006 and the NHS (Local Pharmaceutical Services etc.) Regulations 2006 enable the provision of pharmaceutical services through direct contracting arrangements.

Enhanced services
NHS England also has the flexibility to commission enhanced services locally to meet the differing primarycare needs of local populations.

It is only NHS England which can commission **pharmaceutical** enhanced services. These services will be more tightly defined and will use nationalservices specifications.

However, clinical commissioning groups and local authorities are able to commissionservices direct from community pharmacy providers but cannot call these enhanced services. These arrangements would beoutside the community pharmacy contractual framework and service specifications andremuneration would need to be negotiated by the commissioner and the provider. PublicHealth England may decide to develop standard specifications and tariffs to support thecommissioning of public health services. However, legal provision has also been madefor local authorities to make arrangements with NHS England.

4. Ophthalmic services
Primary ophthalmic services are provided under section 115 of the NHS Act 2006. Under the Act, NHS England must arrange for 'essential' services, i.e. NHS sight tests for those who are eligible. Any suitable provider is able to have a contract to provide NHS sight tests and there are no restrictions on the number of contracts that may be awarded or the number of sight tests they may carry out.

Contractors work to a national contract and the sight test is governed by national regulations. The Act also provides for 'additional' services, which NHS England must arrange. Currently the only additional service is domiciliary sight testing. Contractors providing essential services can apply for a contract to provide the service. The service can also be commissioned from other providers (who do not provide essential services) under a separate contract.

Clinical commissioning groups can commission services from community optometrists for the provision of community ophthalmic services. These arrangements are outside the GOS contract and the service specifications and remuneration would need to be negotiated by the commissioner and provider.

NHS England may also commission enhanced services nationally or locally to meet the needs of the population. These enhanced services would be commissioned using single specifications.