GREENWICH LOCAL MEDICAL COMMITTEE MEETING

PART I

To be held at 1.30pm – 2.30pm on Friday 2 March 2012 at
The Old Sorting Office, Greenwich Park Street, Greenwich SE10 9LR

AGENDA

1.0 Apologies:
1.1 To receive apologies

2.0 Declaration of members’ interests
2.1 Members to declare any conflicts of interest in connection with any items on the agenda or in the light of subsequent debate

3.0 Minutes and matters arising
3.1 Minutes of previous LMC meeting on 20 January 2012 (page 3-7)

4.0 LMC Business
4.1 LMC Membership update
4.2 To receive an update from the Chair on local and Cluster issues
4.3 To receive updates from LMC representatives attending any other meetings

5.0 Items for decision:
5.1 No items identified

6.0 Items for discussion:
6.1 LMC Sub –Group
   • To note the actions from the meeting held on 22 February (page 8-9)
6.2 Once for London principles – to receive the agreed principles for:
   - List Maintenance (page 10-17)
   - Enhanced Services (page 18-34)
   - PMS Contract Review (page 35-48)
6.3 Sessional/Salaried GPs issues - to discuss any issues

7.0 Part two agenda – Borough Standing Joint Liaison Committee (BSJLC)
7.1 To discuss the agenda in particular:
   2012 Olympic Games
8.0 Items to receive:

8.1 • GPC News - January 2012
• Important information on safeguarding practice premises and income
• The M Word issue 6
• GP commissioning – latest news
• Your chance to talk with your GPC representatives and negotiators

8.2 LEAD:
  To receive a list of forthcoming LEAD events (page 49)

9.0 LMC newsletter
  To identify items for the newsletter

10.0 Date of future meeting:

10.1 To note the LMC/BSU meeting dates for 2012

- (Friday 2 March)
- Friday 20 April
- Friday 22 June
- Friday 21 September
- Friday 2 November

Cluster dates for 2012

- Tuesday 3 April
- Tuesday 15 May
- Tuesday 17 July
- Tuesday 2 October
- Tuesday 4 December

11.0 Any other business:
  At least 24 hours notice should be given of matters to be raised under this item
**GREENWICH LOCAL MEDICAL COMMITTEE/ MEETING**

**Part I**

Held at 1.30pm on Friday 20 January 2012 at

The Old Sorting Office, Greenwich Park Street, Greenwich SE10 9LR

<table>
<thead>
<tr>
<th>LMC representatives</th>
<th>Londonwide LMC representatives</th>
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<tbody>
<tr>
<td>Dr Junaid Bajwa</td>
<td>Dr Eleanor Scott</td>
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<td>Dr Raju Chinduluri</td>
<td>Mrs Jane Betts</td>
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<td>Dr Robert Hughes (Chair)</td>
<td>Ms Rebecca Shaw</td>
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<td>Dr Dermot Kenny</td>
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<td>Dr Ruth Marchant</td>
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<td>Dr Subathra Ratnarajan</td>
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<td>Dr Bharati Shah</td>
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<td>Dr Shabina Siddiqi</td>
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<td>Dr Hany Wahba</td>
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<tr>
<th>Item</th>
<th>MINUTES</th>
<th>Action</th>
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<tbody>
<tr>
<td>1.0</td>
<td><strong>Apologies</strong></td>
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<tr>
<td>1.1</td>
<td>Apologies were received from Dr Helen Phillips, Dr Subathira Ratnarajan, Dr Hany Wahba, Dr Marie-Clare Parker, Dr Shabine Siddiqi and Mrs Jenny Foley.</td>
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<tr>
<td>2.0</td>
<td><strong>Declarations of Interest</strong></td>
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<tr>
<td>2.1</td>
<td>There were no new Declarations of Interest highlighted by LMC Members.</td>
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<td></td>
<td>Dr Hughes requested that the opportunity for meeting attendees to raise any Declarations of Interest was added to future Part Two Agendas. The LMC Office undertook to ensure that this item is added future Part Two Agendas.</td>
<td><strong>JF</strong></td>
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<tr>
<td>3.0</td>
<td><strong>Minutes and Matters Arising</strong></td>
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<tr>
<td>3.1</td>
<td>The Minutes of the previous LMC meeting held on 4 November 2011 were confirmed by LMC Members to be an accurate record of the meeting.</td>
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<tr>
<td>3.2</td>
<td><strong>Matters Arising</strong></td>
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*Item 3.2 - Greenwich Six Facet Survey*

Dr Marchant requested an update on activity regarding the Greenwich Six Facet Survey. Mrs Betts confirmed that five practices in Greenwich have received breach notices for non-compliance with the statutory requirements. However, all other concerns previously raised by the PCT have been withdrawn.

Mrs Betts added that this update does not include disabled access requirements, which Ms Webb would be able to update LMC Members on in the Part Two Meeting.

*Item 4.1 - Child Protection Training*

Dr Scott reported that she had looked into the Child Protection Training policies across the London and these vary for each PCT, since there are no national guidelines issued for this matter. She added that she has approached the Londonwide LMCs Strategy Group to suggest the issue is added to the Pan-London Agenda.
Dr Scott reported that Greenwich LMC signed-off a local policy on Child Protection Training in November 2011 and that this has a vague requirement for practices to show that their staff are trained to Level One and that there is an assigned GP Lead for Child Protection who is trained to Level Three. Furthermore, practices should be able to illustrate that they have a policy in place to respond to serious Child Protection cases. Dr Scott advised that she was still looking into the nurse to which nurses should be trained.

**Item 5.1 – LMC Conference**

Dr Bajwa informed the Committee that he was no longer able to attend the 2012 LMC Conference on behalf of Greenwich LMC. Dr Hughes asked the Committee if there were any other members who would like to attend the conference on behalf of Greenwich LMC. No LMC Members expressed an interest in attending. Dr Bajwa undertook to look into whether he could reorganise his diary to enable him to attend the conference and inform the LMC Office by the end of next week.

**Item 6.1 – LMC Sub-Group Update**

Mrs Betts reported that the LMC Sub-Group had not met since the last LMC Meeting on 4 November 2012, but there is a meeting scheduled for next week.
### 5.0 Items for Decision

5.1 There were no items identified for this section of the meeting.

### 6.0 Items for Discussion

#### 6.1 LMC Sub-Group
There was nothing to report.

#### 6.2 Session/Salaried GPs issues
There were no issues raised.

### 7.0 Part two agenda – Borough Standing Joint Liaison committee (BSJLC)

#### KPIs
Dr Shah reported that the accounts for last year’s KPI payments have still not been finalised. Several LMC Members made various comments on the accuracy of KPI Data and reported that they were unsure what is included in the Gynaecology KPI. Dr Kenny commented that there was some confusion between QOF Data and KPI Data, informing LMC Members that the KPI Data for this Quarter Three has not yet been released. Therefore, the data which has been received by practices must relate to QOF, not KPIs.

Dr Kenny voiced concern over the way practices would be paid for KPIs, reporting that practices would only be paid if they were below the benchmark and the benchmark would be moved after six months. He commented that this was not what had been agreed by the LMC, but the LMC had agreed that the benchmark would remain static for 18 months and be based on last year’s performance. Furthermore, he had concerns that there would be delays in payments to practices as a result of the timescales set by the PCT, which he perceived to be unrealistic.

Dr Marchant suggested that practices need to be aware of the process for appealing against inaccuracies with the data before Quarter Three KPI Data is released. Dr Kenny advised that practices have two weeks to challenge the KPI data.

#### QOF
There were no issues raised under this item.

#### Infection Control
There were no issues raised under this item.

#### Business Support Unit (BSU) Issue
Dr Marchant informed LMC Members that she had recently received an incorrect payment for premises from the BSU. The BSU had agreed that they had made a mistake and undertook to reimburse her practice with the funds. The process for reimbursing the funds included the BSU sending a form to Shared Business Services (SBS) who would then carryout the reimbursement. However, the BSU had filled in the form incorrectly and SBS had sent the form back to Dr Marchant’s Practice to rectify, despite it being a BSU mistake. She commented that this was an inefficient process, since she would now have to send the form to the BSU to correct their mistake. Dr Hughes suggested that Dr Marchant raise this issue in the Part Two Meeting.

Dr Shah raised two issues. Firstly, she reported that the PCT owed several practices money, but whoever she contacted at the PCT were unable to advise her of when the money would be paid. Secondly GPs have still not received the GCC Commissioning Intentions from Dr Foster.
Dr Hughes suggested that the Commissioning Intentions query is raised under Item 3 of the Part Two Agenda.

Superannuation Payments
Dr Kenny reported that he had raised the issue of delayed superannuation payments with Ms Webb and she had responded that this had been an anomaly and the payment would be received by practices by the 6 February 2012. He commented that this delay will mean that practices only have seven weeks to process this payment before the end of the financial year.

GP Performance Online Capita Tool
Dr Scott reported that Cluster have contracted Capita to create an online tool to record GP Performance. This would require GPs to log on to the tool and submit declarations that they have specific named policies in place in their practices. Dr Scott voiced concern that the tool requires additional work, since some of the questions asked do not correspond with the agreed requirements. She reported that she was trying to delay Ms Webb from circulating the tool to practices so that amendments can be made. Dr Scott also voiced concern that Ms Webb intended to share the Performance Data with the CCG in the future.

The LMC Office undertook to circulate guidance to practices once the tool is circulated, depending on what is decided in the Part Two Meeting.

ES/JB

8.0 Items received

8.1 LMC Members noted the following items:

8.2 LEAD Events
The forthcoming Lead Events were noted by LMC Members.

9.0 LMC newsletter
9.1 The following items were identified for the next LMC newsletter.
- Guidance on who to contact at Londonwide LMCs for different practice issues.

JF

10.0 Date of the next meeting
10.1 The following meeting dates for 2012 were noted by LMC Members.

<table>
<thead>
<tr>
<th>LMC/BSU meeting dates</th>
<th>Cluster Dates</th>
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<tbody>
<tr>
<td>(Friday 20 January)</td>
<td>Tuesday 7 February</td>
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<td>Friday 2 March</td>
<td>Tuesday 3 April</td>
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<td>Friday 20 April</td>
<td>Tuesday 15 May</td>
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<td>Friday 22 June</td>
<td>Tuesday 17 July</td>
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<td>Friday 21 September</td>
<td>Tuesday 2 October</td>
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<td>Friday 2 November</td>
<td>Tuesday 4 December</td>
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<tr>
<td>11.0</td>
<td>Any other business</td>
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| 11.1 | Communication with the Londonwide LMC Office  
Dr Marchant reported that her practice’s Finance Manager had recently contacted the LMC Office with an issue that affected all practices, but felt that the LMC Office had not supported him. Dr Scott and Mrs Betts apologized that Dr Marchant’s Finance Manager had not felt supported and undertook to look into this issue outside of the meeting.  
The LMC Office undertook to include an item in the next LMC Newsletter regarding who within Londonwide LMCs should be contacted for different types of practice issues.|
|       | Health Checks  
Dr Kenny voiced concern over the growing trend for local supermarkets to offer free health checks to passers-by. He highlighted that the people seen were often told unnecessarily to visit their GP, which as a result was creating extra patients for him who did not necessarily need to be seen by a GP. Dr Hughes commented that this would become more of an issue when Public Health responsibilities are transferred to the Local Authority, since the LMC will have no forum to raise these issues or regulate Local Authority bodies. |

JB/ES

JF

Attendees

**LMC**
Dr D Kenny  
Dr H Phillips  
Dr B Shah  
Mrs J Betts  
Mrs L Williams

**PCT**
Ms J Webb  (Chair)  
Mr G Beard  
Mr N Langford  
Mr N Taylor  
Mr A Thomas

**Apologies:** Ms A Goodlad, Dr Hughes, Dr H Wahba

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<tr>
<th>Item</th>
<th>Action</th>
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<tr>
<td>2.0</td>
<td><strong>PMS KPIs</strong></td>
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<td><em>Delay in practices receiving achievement awards and quality/timeliness of data</em></td>
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<td></td>
<td>Quality of data: confirmed this is GP referrals converted into attendances, with DNAs excluded.</td>
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<td>Agreed process:</td>
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<td>• Practices to be sent monthly flex data, with 2 weeks to review and send annotated spreadsheet to PCT/BSU to organise challenge to 2care. PCT to confirm timelines to practices.</td>
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<td>• Outcomes to be fed back to practices in the freeze data.</td>
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<td>• Note: if 2care has not accepted a challenge, GPs can still challenge the freeze data outcomes, on the basis of the diagnostic data supplied. GPs also to notify BSU if not receiving discharge summaries from 2care.</td>
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<td>To start with practices receiving Q3 data in April 2012, plus month 10 in a separate report.</td>
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**Payments to practices**
J Webb to organise goodwill reimbursement of the 5% deduction for 3 months, with OOH to be clarified. New regime to be launched April 2012, with the first quarter to be seen as ‘preparatory’; this will reduce timelag between work and payments from 6 to 3 months. 5% contract value deduction is calculated from £85 minus the OOH payment per patient.

<table>
<thead>
<tr>
<th>Person/Organisation responsible</th>
<th>Date action is due</th>
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<tbody>
<tr>
<td>BSU NT/AT</td>
<td>Starting April 2012</td>
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<td>J Webb</td>
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8
Agreed payment schedule:
- Payment for Qtr 3 11/12 work to be made in April 2012
- Payment for Qtr 4 11/12 work to be made in July 2012
- Payment for Qtr 1 12/13 work to be made in October 2012
- Payment for Qtr 2 12/13 work to be made in January 2013
- Payment for Qtr 3 12/13 work to be made in April 2013

Note: the annual reconciliation in 2nd year will include some data from the previous year. Data and payments to both be clearly labelled.

**Baseline for 12/13**
The original agreement was for a baseline using 10/11 outturn data for 18 months. In light of slippage, this will be for 15 months.
Note: BSU will need to demonstrate to auditors this is not double payment for same work, including using GP evidence of increased joint working and BSU evidence of link between community and 2care activity.

**Communications to PMS practices**
- PCT to update and simplify letter and produce a short FAQ/guide, checking it with the LMC office before circulation.
- PCT to offer a drop in date when interested practices can receive a presentation and ask questions of PCT staff.
- In parallel, LMC members to contact those practices they know would benefit from this and LMC office to encourage PMS practices to attend by newsletter/e-alert.

**Review date**
Subgroup to reconvene September 2012 (date tbc) to discuss/review for 13/14.

<table>
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<tr>
<th>3.0</th>
<th>QOF QP indicators</th>
<th>not discussed. Will need to set up a working group to agree new QP indicators for 12/13 (eg A&amp;E) across all LMCs.</th>
<th>JW to set up, LMC to find volunteers</th>
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AOB

| 4.0 | PMS payment schedules and statements | Last payment slipped two days. BSU to circulate payment dates to practices (should be 15th of month) and investigate slip. 
Superannuation | NT/AT |
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<td>Adjustments slipped a week: BSU to investigate and ensure it does not happen again.</td>
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<td>NT/AT</td>
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Once for London

The Once for London Project

• The NHS Commissioning Board will have a direct role in the commissioning of primary care services including medical, dental, pharmacy and optometry.

• London’s Primary Care Professional Leadership Group (PLG) are developing unified operating models for the commissioning of primary care services to:
  – Support continuing improvement in the quality and productivity of primary care services as part of QIPP
  – Ensure fairness, equity and transparency in the way general practice services are being commissioned across London
  – Embed best practice approaches across all commissioning organizations

• The output of this work will be a suite of operating principles that can be consistently applied to improve the way we commission key primary care services. Initially this work programme will focus upon:
  – For general practice - List Maintenance, Enhanced Services and PMS Reviews
  – For dentistry - End of Year Process, Performance Approach and Contract Changes

• The expectation is that this programme of work will synchronise with transition towards a single operating model for primary care commissioning nationally. It may therefore extend to looking at all aspects of primary care commissioning and other contractor groups within London both implementing national operating models and influencing the shape of these by sharing local operating principles.

Developing the Operating Principles

• A set of task and finish groups have been established to ensure that there is wide collaboration from across London.

• Approximately 70 primary care leaders have participated in this work to date with representatives from clusters, contractors, LMC, LDC, FHS organisations, clinicians, practice managers, public health, finance and contracting.

• These task and finish groups have provided a forum through which primary care leaders have shared experiences, skills and knowledge to develop a unified approach to a basket of key QIPP challenges.
Operating Framework for List Maintenance

Primary Drivers for Undertaking List Maintenance:

London is a world city, with a diverse population and many health issues. However, London has some of the worst health outcomes in the country in some key areas, and poor performance in prevention activity. Gross inequalities exist across the capital, both in the quality of preventive services and in health outcomes. London is an extreme outlier for all indicators based on GP registrations.

The accuracy of a practice’s registration list is important for:
- the efficacy of ill-health prevention / screening programmes and total population capture
- the assessment of performance and clinical outcomes which are often compared on a ‘per patient’ denominator
- the appropriate use of public funds, as allocations are made on a £ per patient basis

Improving GP list accuracy would:
- reveal the true picture of London prevalence of ill health and public health performance – showing that London is not the outlier it is currently presented to be;
- ensure the design of effective interventions to reach local priority groups and impact on priority programmes;
- contribute to the delivery of regional and local QIPP Health & Wellbeing outcomes;
- have a positive impact on many clinical outcome measures for example, cancer, long term conditions, heart disease, communicable disease, respiratory disease.
Operating Framework for List Maintenance

Why do inaccurate lists occur?

- The patient list is a changing register reflecting population movement. This is particularly true in London where turnover of patients is high and can be marked for some practices serving a transient population.

- Ongoing and effective maintenance of lists is essential to ensure that they are accurate. However, even with the most effective list maintenance procedures in place, a practice list can hold 3-8% of inaccuracy due to patient turnover alone.

- It is estimated that in London the level of list inaccuracy can range from 3-35%. Whilst some of this is accounted for by population turnover, high levels of list inaccuracy have also resulted from:
  - list maintenance being one of many competing priorities for improvement
  - low awareness of the importance of list maintenance and the link to both service outcomes, public health and the use of public funds
  - attention not being given to this over time but list maintenance has become more critical as a result of QIPP

• Practices have an important role to play in maintaining accurate lists. Practices with robust systems in place to verify and record patient details at the point of registration, as well as regular systematic checking of details when patients contact the practice, have more accurate lists.

• Commissioners, patient registration authorities and GP practices will be effective in reducing list inaccuracies sustainably, if they work collectively to address these factors.
Stage 1 of a List Maintenance Exercise

Commissioner identifies cohort of patients and sends details to the practice for verification (see page 7)

Practice identifies any patients that have a record of contact with the practice in the last 15 months, removes them from the cohort and returns list to the commissioner. Practices will have 4 weeks to do this after which time the letters will be sent out. Contact would include an appointment, telephone consultation, collection of a prescription or any other interaction which has been noted in the patient record.

First letters sent to patients that have had no contact with their practice in the last 15 months

No Response

After 4 weeks a second letter is sent

No Response

After 4 weeks an FP69 activated on the practices IT system

FP69 Active

See STAGE 2 overleaf

List action taken by the patient registration authority

Patient Responded

Patient Responded

List action taken by the patient registration authority

See STAGE 2 overleaf
Operating Framework for List Maintenance

Stage 2 of a List Maintenance Exercise

If the practice still believes the patient is an active registration, they have 6 months to establish contact with the patient directly to confirm their registration requirements.

FP69 Active

Practice declares patient resident and eligible for general medical services from the practice

List action taken by the patient registration authority

Patient deregistered by the patient registration authority

6 month long pause,

Commissioners do not hold attendance information. Advance screening of the cohort by practices should minimise the removal of any vulnerable patients on chronic disease registers, as the 15 months time frame coincides with many of the QOF recall standards for patients with chronic diseases.

Commissioners should not request any more than a verified list from the practice – practices should not be required to produce screen shots or other documentation.

Return to sender
The patient registration authority will inform the practice of any letters which are “returned to sender.”

The practice would then be responsible for contacting the patient and establishing their new/correct address.

They should then inform the patient registration authority so that the FP69 can be removed.
Operating Framework for List Maintenance

Pan-London Operating Principles:

- List maintenance processes should be designed with the proactive engagement of commissioners, registration authorities, LMCs on behalf of GP’s and practice managers.

- List maintenance should be undertaken as a continuous rolling programme for example working through the list alphabetically over a one to three year period.

- A rolling programme could also include phased targeting of specific patient cohorts
  
  Examples of this approach include:
  
  i) choosing a patient cohort that supports a screening programme e.g. childhood immunisations, flu or cytology
  
  ii) addresses with apparent multiple occupancy
  
  iii) practices with particular circumstances which dictate a local bespoke approach to maintaining accurate lists e.g. University practices

- A ‘one hit’ approach in which a single practice is targeted should be avoided except in exceptional circumstances. This might include for example; due diligence when transferring a full list to a new practice. In all cases this should be carried out in consultation with the LMC.

- When responding to FP69 flags in the practice IT system, a practice declaration will be sufficient - additional evidence such as screen-shots would be unnecessarily bureaucratic and may breach patient confidentiality. The practice is responsible for ensuring all declarations made are accurate and should be made aware that these can be challenged where any inconsistencies are highlighted through cluster-wide audit.

- A list maintenance exercise is not designed to address performance failures. Where there are reasonable grounds for believing that list inflation is particularly high at an individual practice then concerns about this should be handled separately and in accordance with the performance management directions. Good performance management guidance has been agreed pan-London (weblink to be inserted).
**Operating Framework for List Maintenance**

**Minimising inconvenience to patients**

- Advance screening of the proposed cohort by practices means that less patients will be inconvenienced by having to respond to the letter. It will also reduce postal costs associated with the exercise.

- The commissioner should ensure that where the registration authority disputes the practice declaration, the practice is made aware of the reason why, and is advised of any list actions that have been taken.

- The commissioner should maximise awareness in the patient population of list maintenance procedures an effective patient communications strategy should be in place. The strategy should be tailored to local needs and build upon examples of what has worked well for example:
  - Branded NHS envelopes are more likely to be opened as they are clearly related directly to the patients health
  - Alerting patients to registration checks well in advance – as part of the registration conversation, through display notices in a practice
  - Making the process clear to patients through any letters and posters for example - what the letter looks like, what to do when you get one, the steps in place to minimize de-registration errors, what to do if there is a de-registration error, what to do if a letter arrives for someone not living at that address.
  - Communications tailored for different languages and consideration of other support for patients who’s first language is not English
  - Letters to be addressed to named patients and not the occupier

NHS London will work with patients and community groups to develop recommended templates which provide clear simple accessible messaging on all patient correspondence

- Commissioners should ensure that practices have access to training and IT support to undertake validation - identifying FP69’s and flagged patients on the practices system

- Practices have a crucial role to play in ensuring that their staff access the training, are familiar with the FP69 process and are proactive partners in the list maintenance process.

- List maintenance is also an opportunity to improve other aspects of patient registration including the accuracy of patient information held on the register. Practices should verify the details of patients contacting the practice on a systematic basis as part of routine on going maintenance.

- Practices should always re-register patients who have been removed under this process, but who are still resident, with a minimum of inconvenience to the patient.
Local Enhanced Services
Once for London

The Once for London Project

- The NHS Commissioning Board will have a direct role in the commissioning of primary care services including medical, dental, pharmacy and optometry.

- London’s Primary Care Professional Leadership Group (PLG) are developing unified operating models for the commissioning of primary care services to:
  - Support continuing improvement in the quality and productivity of primary care services as part of QIPP
  - Ensure fairness, equity and transparency in the way general practice services are being commissioned across London
  - Embed best practice approaches across all commissioning organizations

- The output of this work will be a suite of operating principles that can be consistently applied to improve the way we commission key primary care services. Initially this work programme will focus upon:
  - For general practice - List Maintenance, Enhanced Services and PMS Reviews
  - For dentistry - End of Year Process, Performance Approach and Contract Changes

- The expectation is that this programme of work will synchronise with transition towards a single operating model for primary care commissioning nationally. It may therefore extend to looking at all aspects of primary care commissioning and other contractor groups within London both implementing national operating models and influencing the shape of these by sharing local operating principles.

Developing the Operating Principles

- A set of task and finish groups have been established to ensure that there is wide collaboration from across London.

- Approximately 70 primary care leaders have participated in this work to date with representatives from clusters, contractors, LMC, LDC, FHS organisations, clinicians, practice managers, public health, finance and contracting.

- These task and finish groups have provided a forum through which primary care leaders have shared experiences, skills and knowledge to develop a unified approach to a basket of key QIPP challenges.
Local Enhanced Services

Context and Background

• LESs are a key commissioning tool for delivering care closer to home and to shift services out of hospital.

• This document sets out a range of pan-London operating principles for the commissioning of enhanced services. These principles will provide a framework for local bodies to make best use of local enhanced services mechanisms.

• PCTs have commissioned a broad range and number of enhanced services. There is great variation in the number, scope, format and type of Local Enhanced Services (LES) within each cluster as well as across London.

• The benefits and outcomes of many LESs have not often been systematically evaluated for value for money, impact and strategic fit. A number of PCTs are completing reviews of enhanced services as part of Primary Care QIPP programmes.

• Enhanced services can make up to 20% of practice income. The historical variation in PCT commissioning, reporting, auditing and payment arrangements for different enhanced services can be counterproductive and a significant burden for both commissioners and providers.

• Directed Enhanced Services (DES) remain outside of the scope of this document as they have national specifications which cannot be altered and which must be offered to all practices. Commissioners may wish to replace a National Enhanced Service (NES) by developing a LES to make it more locally applicable.

• The document is structured around 4 parts of a cycle that all commissioners of enhanced services need to explore as key elements of the commissioning and contracting process.
Key Enhanced Service Commissioning Principles

• This document provides principles for Clusters, CCGs, Public health and LMCs in the commissioning of Local Enhanced Services

• LESs are a key commissioning tool for delivering care closer to home and to shift services out of hospital.

• LESs should be locally led and developed in consultation with the Local Representative Committee (LRC)

• LESs should have clear notice periods, termination dates and the facility for annual review.

• Clinical engagement in audit and outcomes should be a key part of this process.

• Commissioners should give due consideration to the provision of reasonable notice periods and appropriate contract lengths to facilitate budgeting and planning. Many LESs will be annual contracts, but where a LES may require the purchase of equipment or employment of additional staff, a LES may be commissioned with a contract length of 2 or 3 years as appropriate.

• LESs should be outcome based as far as possible and the costs required to provide a service covered by the income which the LES provides.

• Commissioners should systematically review their LES portfolio for value for money, impact and strategic fit. It may be that there are opportunities to decommission some services of limited value & strengthen the specifications and outcome measures of those that remain. Commissioners should consider opportunities to consolidate their LES into a fewer number to deliver measurable health outcomes within a financial envelope.

• Enhanced services should add value and offer a measurable enhanced level of care and not duplicate services provided under other contractual provision

• For reasons of equity, commissioners should give due consideration to cover any gaps in service so that complete population coverage is achieved. Non-specialist LESs should normally be offered to all practices which satisfy accreditation criteria. Where specialist skills or equipment are needed to provide a LES (such as minor surgery or anticoagulation therapy), it may be that a cohort of appropriate practices are commissioned to provide the service to the local population. Commissioners could also consider opportunities to achieve economies of scale through a network of practices combining to employ particular staff (such as an additional nurse to provide immunisations and vaccinations) or share a piece of equipment.

• The data requirements for LESs should be as simple and straightforward as possible. They should not be onerous to produce or analyse. By involving general practice IT system suppliers early-on, it is possible to develop a set of enhanced service read codes. This places a marker on all enhanced service activity so that searches can be conducted to provide information for audit requirements.
Governance arrangements

It is likely that the new NHS architecture will present commissioners with challenges to ensure there are clear and transparent governance arrangements.

Commissioners must ensure that there are robust and transparent governance arrangements to manage any potential conflicts of interest within Clinical Commissioning Groups (CCGs) in the LES commissioning and provision process, to ensure that services commissioned are genuinely enhanced and that a robust pricing process has been followed which ensures that LES provide value for money.

We do not know the precise nature of roles and responsibilities for enhanced services commissioning post transition but transparent governance mechanisms will need to be in place to demonstrate probity and stewardship.

It is expected that the LMC will have a key role to play in establishing them and that public and lay representation will be involved in this process.

Deciding if a LES is the best contractual vehicle for the service

As part of the process of defining a service need, understanding the options for provision will enable commissioners to decide whether a local enhanced service contract is the right approach.

Considerations such as the time of day and number of days a week the service would be best provided and the skills required may lead the commissioner to consider a range of providers for whom an alternative contractual vehicle would be more appropriate.

For example, local community services or pharmacists may be best placed to provide some services rather than GP practices.
Governance Arrangements

Stage One:
Identify the outcomes to be achieved by the service you are commissioning and the service specification that will deliver it.

Stage Two:
Agree an appropriate financial model for the service specification

Stage Three:
Deciding which providers should provide the service

Stage Four:
Review and Evaluation
Stage One: Identify the outcomes and service specification required by the service

Having identified a health need, the commissioner should consider the outcomes that they wish to achieve, the service required to address it and the service specification to support it.

Service specifications for enhanced services should be based on clearly defined and measurable service outcomes, outputs and processes depending on the service commissioned which should be expressed in clear KPIs.

In order to facilitate impact assessments, service specifications should contain outcome measures where possible. They may also contain some output measures where appropriate. A smoking cessation LES, for example, will pay for the number of smoking cessation consultations held (‘outputs’), as well as the number of quitters achieved (‘outcomes’).

The specification should be appropriately quality assured to fit with the local enhanced services portfolio, including testing quality, effectiveness and efficiency of a specification.

LES services specifications should include:

• What the LES aims to achieve and how that will be evaluated
• Any eligibility and exclusion criteria
• Service outline
• Pricing for the service
• Data requirements and payments schedule
• Length of contract prior to service review and audit
• Monitoring arrangements and audit process (PPV arrangements for example)
• Length of notice required for termination of agreement or variation of agreement (it is recommended that this should not be less than 3 months)
• Arrangements for patient participation/feedback where appropriate

The commissioner should consult with the LRC on all aspects of the specification

For a LES model template see appendix 1
Length of contract

Due consideration should be given to the period of time that the service will be commissioned before review and evaluation. Where a service requires, for example, the purchase of equipment or employment of additional staff, commissioners may consider an agreement of two years or more appropriate as providers may need to make significant investments to provide the service. This should be clearly outlined in the LES specification and SLA/contract.

Notice period for variation and termination

Similarly, the notice period to be given to providers for variation or termination of a LES should be considered on a case by case basis and should usually be no less than 3 months. When considering notice periods, commissioners should take account of the requirements of providing the service and the ability of providers to make necessary operational adjustments within a reasonable time frame, as well as the health and clinical outputs and outcomes. Considerations similar to those given to contract lengths will need to be given to LES notice periods as those which require the employment of additional staff, for example, are likely to require longer periods of notice than those where the operational impact on providers is less significant. Commissioners may also want to include the period of notice providers need to give should they no longer want to provide a LES.

Contract length, notice periods, termination and variation arrangements should be clearly outlined in the service specification and contract/SLA and are subject to consultation with the LRC.

Contract monitoring

The contracting body should carry out suitable audit, such as undertaking regular reviews of payments and activity. Anomalies/changes in patterns of provision should be queried and where there are ongoing concerns, a post-payment verification check may be appropriate. Contract monitoring should also provide assurance on compliance with service delivery and achievement of outcome measures.

Commissioners should carry out systematic post payment verification at a sample of practices as a matter of routine. Arrangements for contract monitoring/PPV should be made clear in the service specification.
Stage 2: Agree a financial model for the service specification

Recorded activity

Recorded activity for local enhanced services should be based on clearly defined, valid and measurable service outcomes, outputs and processes which should be reflected in the service specification and payments.

For example, where a practice provide chlamydia screening, the LES may reward the number of screenings carried out. Smoking cessation may include ‘outcomes’ (i.e. the number of quitters), as well as ‘outputs’ (the number of patients seen).

Where a LES is largely process-focused, outcomes such as health improvement and patient satisfaction may be considered for inclusion.

The service specification will include the methodology for undertaking review and audit locally – outlined in stage four.

Price setting and payments

In determining the price, commissioners may look at a number of considerations. These could include a calculation of the costs to the provider of delivering the service, how that cost compares to any tariff price that it might substitute and benchmarking of prices paid elsewhere for the same or broadly similar activity.

Professional Local Representative Committees (LRCs) must be consulted on the service specification, including the pricing.

Payments for enhanced services should be identifiable on practice budget statements where possible. Where this is not feasible, alternative solutions should be considered such as an annual statement of enhanced service sum totals.

By involving general practice IT system suppliers early-on, it is possible to develop a set of enhanced service read codes. This places a marker on all enhanced service activity so that data searches can be conducted to provide audit/evidence that the service has been delivered according to the specification.
Stage Three: Identify who should provide the enhanced service

Deciding on service providers

The commissioner may wish to offer their local enhanced services to all providers or practices for “generalist” services or for more specialist services to a select group of providers with the necessary skills, staff, equipment or premises.

Having due regard for professional and medical opinion, commissioners should decide if there are any minimum eligibility/quality criteria for the provision of each local enhanced service and, if so, what they are and how they will be assessed.

The process through which providers are selected should be transparent, fair and equitable.

Commissioners could also consider opportunities to achieve economies of scale through a network of practices combining to employ particular staff (such as an additional nurse to provide immunisations and vaccinations) or share a piece of equipment that can be used by a network of neighbouring practices. Commissioners will also need to consider the number of providers required to deliver a LES in order to address the health needs of the population.

All patients should be able to access the service

For reasons of equity, commissioners should have an alternative strategy in place to cover any gaps in service so that complete population coverage is achieved.

Where a practice is not providing a LES, either through choice or accreditation, then whole population coverage for the service can be achieved by commissioning a neighbouring provider to deliver the service to the non-participating provider’s patients.

Commissioners may want to consider identifying host sites for enhanced service delivery with inter-practice referrals so that provision is via a care network.
Stage 4: Review and Evaluation

Commissioners should undertake a regular review, evaluation and update of each of their enhanced services.

LESs should be subject to periodic review and impact assessment. Clinical engagement in audit and outcomes should be a key part of this process. A robust process would take into account a review of the evidence of impact of each LES, its value for money and strategic fit with local and national priorities. The LRC must be consulted as part of this process.

To facilitate this task, commissioners may consider setting-up a group to review their LES portfolio, which includes stakeholders from finance, IT, public health, pharmacy, primary care, contracts, LRCs, GPs and Practice managers. A LES review process may require significant time input from group members and a commissioning resource to oversee the process and deliver any contract changes.

Following the review of a LES, the commissioner may decide to make modifications (for example, strengthening the service specification, payment thresholds, adapting the outcome measures) or to decommission the service depending on the review outcome.

Modifications to LESs should be subject to consultation with the LRC and arrangements made for due process, in line with governance frameworks.

Undertaking a formal review and evaluation of enhanced services can help commissioners to identify opportunities for improving the administration of these contracts. For example, this could include establishing read codes or having a single enhanced services contract to cover a number of related existing enhanced services.
**Enhanced Services**

**Future Roles and Responsibilities**

**Context and Background**
A national operating model for the development of enhanced services post-transition has not yet been designed however the known organisations and their interactions are outlined below.

The precise commissioning arrangements for enhanced services are not yet known.

As we move towards transition CCGs already have an important role to play in deciding on the ability of practices to provide enhanced services and which services should be commissioned and it is likely that their role will broaden further.

Ensuring that the LES offer effectiveness, value for money, quality and impact as well as processes for governance, audit and patient involvement will be a key challenge for the new architecture.
Local Enhanced Service Specification for XXXXXXX

Commencement date – End date

A local enhanced service between [commissioner] and [Provider(s) name(s)].

1. Introduction and Background

The introduction should include:
- Overall scope of service including needs analysis and links to appropriate/relevant guidance/documentation
- Details of length of contract (eg. fixed term, rolling 2 or 3 years etc)

2. Aims

This section should be considered carefully as it will aid evaluation and review of the service as well as criteria decided for routine monitoring. How will you know if the LES has been successful? It should include:
- Projected outcomes/outputs
- Desired efficiencies
- Quality markers

3. Eligibility and exclusions

This should include details of the target population or any specific terms for eligibility of accessing services, e.g. age, gender, diagnosis, etc

If there are any patients from defined criteria that need to be excluded for this service, e.g. long term condition diagnosis with a certain prescribed medication, etc they should be outlined here.

4. Service Specification

This section should be used to describe the service to be commissioned and the minimum contracted requirements. This may differ considerably in size depending on the complexity of the service to be commissioned, however, should still contain the following minimum requirements:
- Description of the service to be commissioned
- Valid and measurable outcomes, outputs and necessary processes
- What is included and what is not included; details on resources required eg staff/consumables – to be reimbursed or already factored into price for service.
- Patient feedback on quality of LES where appropriate

This section should detail any arrangements for providing a service to a network or practices or a neighbouring practice where appropriate.

Set out any reasonable minimum standards of qualifications, equipment required, staff or premises necessary

This section may also include evidencing continuing competency such as inserting minimum number of IUCD per year or number of minor surgical procedures etc

Where a LES is largely processed focused, outcomes such as health improvement and patient satisfaction may be considered for inclusion eg patient feedback metrics
5. Payment Schedule

This section should give clear activity and pricing details and should include:

- Full details of the payment structure, i.e. per head, per intervention, percentage thresholds, per session etc
- The price paid for clearly defined, valid and measurable service outcomes, outputs and processes.
- Associated expenses – premises, staffing costs etc. to be reimbursed or included in price for service

6. Monitoring

This section should be used to outline any routine monitoring arrangements. The data requirements for LESs should be as relevant, simple and straightforward as possible. They should not be onerous to produce or analyse. However the commissioner should carry out suitable audit such as regular reviews of payments and activity.

The section should include:

- Frequency of reporting
- Data required
- Reporting mechanism
- A requirement that all patient specific activity is recorded on the patient record
- Sample post payment verification (including details of frequency and method of selecting cohort for PPV)

7. Review of the Service

Commissioners should use this section to outline:

- The frequency for planned service effectiveness review during the course of the agreement
- The possible interventions that a review may trigger (for example continuation/extension of the service, suspended or terminated activity, alterations to payment thresholds etc)

8. Variation/Termination of Agreement

This section should give a clear minimum notice period for both the commissioner and provider to terminate an agreement (not less than three months) and outline the process for varying the LES and the minimum notice period that should be given to providers (not less than three months).

It should also describe the process and governance arrangements for making the decision to vary/terminate the LES.

This section should also state what steps would be taken if there was a failure on the part of the provider to deliver to the required standard (ie termination due to sub standard performance) and the process that would be followed.

9. Protecting Patient Confidentiality
This section should outline responsibilities for patient confidentiality with due regard to Caldicott Guardianship principles.
Acceptance of Terms: Service Specification for ... [Enter name and contract length]
Local Enhanced Service (LES)

Practice Code………………. Name of Practice: .............................................................

By signing this document the practice agrees to provide the LES according to the specification. This document will become part of the contract documentation between the ... [commissioner] and ... [provider] to provide Enhanced Services. The Enhanced Services the practice has contracted to provide will also be included in the relevant schedule of your contract.

I hereby confirm my acceptance of the terms of this service. Please sign and date below to confirm acceptance:

Signed on behalf of the [provider] by..............................................................................

Print name.......................................................................................... Date: .......................  

Practice Stamp:  

Signed on behalf of [Commissioner].............................................................................

Print name.......................................................................................... Date: .......................
Appendix - definitions

This section may include:

- Any necessary full definitions of abbreviated terms
- Precise definitions of any phrases that are used throughout the document (for example duration of a “session”, definitions of target populations etc)
- Other details such as the date at which lists sizes may be taken if used to calculate payments
Once for London

The Once for London Project

• The NHS Commissioning Board will have a direct role in the commissioning of primary care services including medical, dental, pharmacy and optometry.

• London’s Primary Care Professional Leadership Group (PLG) are developing unified operating models for the commissioning of primary care services to:
  – Support continuing improvement in the quality and productivity of primary care services as part of QIPP
  – Ensure fairness, equity and transparency in the way general practice services are being commissioned across London
  – Embed best practice approaches across all commissioning organizations

• The output of this work will be a suite of operating principles that can be consistently applied to improve the way we commission key primary care services. Initially this work programme will focus upon:
  – For general practice - List Maintenance, Enhanced Services and PMS Reviews
  – For dentistry - End of Year Process, Performance Approach and Contract Changes

• The expectation is that this programme of work will synchronise with transition towards a single operating model for primary care commissioning nationally. It may therefore extend to looking at all aspects of primary care commissioning and other contractor groups within London both implementing national operating models and influencing the shape of these by sharing local operating principles.

Developing the Operating Principles

• A set of task and finish groups have been established to ensure that there is wide collaboration from across London.

• Approximately 70 primary care leaders have participated in this work to date with representatives from clusters, contractors, LMC, LDC, FHS organisations, clinicians, practice managers, public health, finance and contracting.

• These task and finish groups have provided a forum through which primary care leaders have shared experiences, skills and knowledge to develop a unified approach to a basket of key QIPP challenges.
Summary

- In 2006 the Secretary of State for Health requested that all PCT’s undertake to review PMS contracts to establish value for money and to improve access to services.
- There are clear benefits that flow from renegotiating and updating PMS contracts across London to reflect the changing primary care agenda, ensure value for money, consistent quality and better reflect national and local priorities.
- Many PMS contracts no longer effectively incentivise high quality primary care services and do not contain incentives or provide funding support which will facilitate a reduction in the use of hospital services and deliver more services closer to home in a primary care/community setting.
- In many cases PMS contracts have been superseded by the development of QuOF and enhanced services and as a result there is sometimes little difference between the services provided by PMS and GMS practices.
- In 2007/8 an analysis of GP earnings and expenses suggested that the cost paid per patient under PMS agreements was on average 13% higher than the average under the GMS contract.
- PMS contracts do not always offer value for money and PMS practices usually (but not always) receive higher payments per capita than GMS practices which creates a perceived inequity in PMS contracts.
- In the case of many PMS contracts the original objectives and allocated growth funds have not been reviewed and there is significant variation in their per capita payments.
- This paper sets out an approach to review the above issues and realign the PMS contracts to address the needs of the local population in a cost effective manner.

Background

- Personal Medical Services (PMS) Pilots were first introduced in 1998. The current PMS Contracts have been in place since 2004 and are locally determined contracts with specific objectives that should link to local and national targets.
- The contract was an opportunity to develop more flexible and locally responsive services.
- PMS practices were awarded growth monies attached to the delivery of additional capacity and or locally negotiated services to improve access, encourage the take up of screening programmes, increase the level of childhood immunizations, and improve the management of long-term chronic conditions.
- All PMS practices were expected to have an open list and received additional funding for a planned increase in list size or to attract GPs to the practice in locality areas where GP recruitment was difficult.
- This approach brought a wide range of benefits, being used to develop new services for specific populations, to attract doctors and nurses and to improve services for patients.
Key Principles

This paper aims to establish a set of pan London principles which provide an operating framework within which commissioners across London reviewing PMS contracts will operate. The aim is to negotiate equitable PMS contracts which incentivise and reward outcomes which align with local and national priorities and which meet the needs of the community they serve in line with a set of agreed principles.

A summary of the key principles is as follows:

Process

• The negotiation process, roles, formal processes and representation should be defined and agreed at the start of the process and clearly communicated to all stakeholders
• LLMC should provide advice and support; local LMCs should lead on negotiations and represent local PMS Practices as mandated by individual practices and the resulting contract should be offered to all PMS practices
• PMS contract review should be applied to all PMS Practices
• There should be extensive engagement with practices and consultation with LMCs on the renegotiation of PMS contracts and the process, timeframe and reasons for PMS review should be clearly articulated at the outset
• The commissioner should take all possible measures to reach agreement on PMS contract reviews through timely, well communicated meaningful and open engagement. Termination should not be part of the negotiation process and where possible all PMS practices should transfer to the new arrangements. PMS practices should be made aware of their option to return to GMS contracts.

Outcomes

• To provide a consistent framework for PMS contracting
• Funding and pricing should reflect and reward work carried out and represent value for money
• That PMS practices agree and sign up to changes on an individual practice basis

Financial

• Agree an equitable basis for core and enhanced funding, based on services carried out and quality achieved
• Rebasing and funding comparisons and modelling should reflect appropriate, accurate and relevant financial models and assumptions
• Any released savings should be directed into borough Commissioning Strategy Plan (CSP) priorities
Managing the change

That the impact of change will receive facilitation and support from the LMC and the PCT in recognising that practices have a varied start point in capability. Commissioners should ensure that the pace of change allows a move to the new arrangements with a minimum of disruption to practices and patients

Performance Management

Performance management arrangements should be
- Specific, measurable, achievable, relevant, time bound.
- Evidence-based
- Not duplicate other schemes such as QOF
- Not be onerous on data collection
- Minimise KPIs
- KPIs should reflect outcomes, processes, or be hybrid.
### What are we trying to achieve?

<table>
<thead>
<tr>
<th>Where are we now?</th>
<th>What are we trying to achieve?</th>
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<tbody>
<tr>
<td>There are a number of shortcomings with many current PMS contracts which include:</td>
<td>• A set of <strong>pan London principles</strong> which provide an operating framework within which commissioners across London reviewing PMS contracts will operate</td>
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<td>• Many PMS contracts have not been subject to regular systematic review by commissioners and have not been reviewed or amended since their inception.</td>
<td>• Contracts which maximize the capability and capacity of primary care to support a shift of services out of hospital and deliver extended services as part of an integrated care pathway.</td>
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<td>• Many contracts have <strong>objectives which no longer align with cluster/CCG objectives</strong> or reflect their current priorities.</td>
<td>• Contracts which incentivise and reward outcomes which <strong>align with local and national priorities</strong> and which meet the needs of the community they serve.</td>
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<td>• The introductions of both Quality and Outcome Framework (QOF) and Enhanced Services (ES) have superseded some of the original objectives of PMS contracts (although this has been offset to an extent by the PMS quality points offset)</td>
<td>• A set of contracts which provides <strong>value for public money</strong> where greater investment yields measurably <strong>better outcomes and range of services</strong></td>
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<td>• There is potential for practices to be <strong>double funded</strong> for their activity under their PMS contract as well as attracting payment through QuOF.</td>
<td>• A set of broadly equitable PMS contracts which establish a basket of locally relevant high quality services that patients can expect to receive as a <strong>minimum level of service</strong></td>
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<td>• There is <strong>significant variation in the range, quality and type of services provided</strong> under PMS contracts and the payments which they generate.</td>
<td>• Contracts which support and provide for <strong>flexible locally agreed extra service provision</strong> over and above the basket of services where they offer value for money and strategic fit.</td>
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<td>• There are often <strong>significant disparities in the payments per capita</strong> between practices (both PMS and GMS) with little correlation between the value of the contract and the performance outcomes which the practice achieves or the services they are providing.</td>
<td>• Contracts which support the implementation of health care priorities both national and those identified in local JSNAs and Public Health reports</td>
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<td>• In many cases <strong>list sizes have not increased in line with growth projections</strong> and commissioners may be funding patient lists which are significantly less than the contract allows for.</td>
<td>• A set of KPIs, linked to funding, which are simple to <strong>measure, achievable</strong> and a structure for future monitoring arrangements</td>
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<td>• An established <strong>mechanism for adjusting payment</strong> to quarterly changes in the normalised weighted list population</td>
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<td>• <strong>Consultation with individual contract holders and a range of stakeholders</strong> including LMC and borough/cluster commissioners as appropriate, bearing in mind CCGs as their roles and responsibilities are defined.</td>
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## How will we achieve it?

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<th>Action</th>
<th>Summary</th>
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| Commissioner carries out an audit of the current PMS landscape. | A first step will be to confirm that current PMS contracts comply with statutory regulations, that they are up to date and in the same format across all PMS contracts within the health community. Commissioners should complete a comprehensive structured practice by practice audit of what PMS is currently being delivered over and above GMS and the current levels of per capita funding for each practice. This will include:  
- An in depth financial review of each practice to establish the range of per capita payments (using the definitions of what to include in the diagram overleaf). The assessment will also report on the services the practice provides and the outcomes it produces.  
- A focus on local health needs outlined public health intelligence in the borough JSNA  
- Comparative data on quality outcomes and value for money across different contracts (GMS and PMS).  
- Care that comparisons between per capita payments are made on a like for like basis and Clusters should use the Carr-Hill normalised weighted list (which is used to determine GMS Global Sum Payments) for the denominator in the calculation.  
- An audit of additional payments and existing incentive schemes and where there are LIS’s in existence an alternative LES should be considered to ensure there is a proper contractual mechanism in place. |

| Financial modelling | Establishing a robust per capita funding analysis is a crucial part of the process. As part of their financial modelling commissioners should ensure that:  
- Comparative per capita payments are calculated without additional funds such as premises, QuOF and seniority payments (see diagram on page 6 and appendix 2 for an example of a GMS funding per capita equivalent calculation)  
- Determine their commissioning intentions and determine a financial envelope to deliver these intentions which is affordable to the PCT - delivered through a basket of services over and above the core services  
- PMS per capita payments should demonstrate value for money in delivering effective services over and above what an average GMS practice provides. The commissioner should ensure that the services and standards attached to the additional investment in PMS over and above GMS delivers measurable cost effective quality outcomes.  
- Costing should be calculated for each of services in the basket separately. Once clusters build their basket to reflect local needs, CSP priorities and financial constraints they can set a per capita value can be set against the services, setting aside a sum for stretch target payments.  
- PMS practices are provided with financial support to manage the transition to the new arrangements within a 12 month period  
- Deducted QOF points are noted if they are incorporated into the per capita funding analysis, Out of Hours payments are noted as included in the per capita funding  
- There is a clear process for quarterly list size changes  
- Scope of annual reviews is clearly stated |
This model provides a diagrammatic representation of GMS and PMS contracts and the payments made for the same and different work that they undertake.

The basket of PMS services correlates to the £s per patient over Global Sum that all PMS practices receive for providing those services.

GMS practices should be given the option to provide the PMS basket of services as individually priced LES.

Enhanced Services over and above the basket of services are offered to both PMS and GMS practices.

Where PMS practices opt to provide them they become part of the PMS contract.

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| Enhanced Services provided over and above the basket of services by practices wishing to provide these extended services |
| Option for GMS practices to provide the PMS basket of services as individually costed/priced LES |
| Locally agreed additions to reflect the community need |

**GMS Contractual Requirement**
- Fixed GMS per capita Income
- Variable practice income. Outside scope of review.

**PMS Contractual Requirement**
- New PMS fixed practice income. Subject to PMS review.
- Locally agreed additions to reflect the community need

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**Essential and Additional Services**
- Essential and additional services as defined in the national contract regulations. Includes Out of Hours income unless a practice has opted out of its providing it

<table>
<thead>
<tr>
<th>QOF</th>
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<tr>
<td>Premises Payments</td>
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<td>Seniority</td>
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<tr>
<td>PPA Payments</td>
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**Proposed Pricing Model**

- Enhanced services over and above the basket are offered to all practices (GMS and PMS) and are agreed with individual practices.
- Basket of services over which all PMS practices are expected to deliver. These will include KPIs and clear rules for incentives/penalties as a result of performance against them.

| Essential and additional services as defined in the national contract regulations. |
| Includes Out of Hours income unless a practice has opted out of its providing it |

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<tr>
<td>Dependent on actual QOF performance</td>
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<td>Dependent on District Valuer’s valuation and actual cost of rates</td>
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<td>Personal, based on length of service</td>
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<td>Dependent on prescribing activity</td>
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<td>Variable from practice to practice and year to year in both GMS and PMS practices</td>
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<td>Action</td>
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<tr>
<td>Establishing effective collaboration</td>
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<td>Action</td>
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</table>
| Establish a basket of services | PCTs should:  
• Negotiate with their PMS practices to agree a basket of services which their practices should provide and the standards to which they should be provided. These services/standards should demonstrate value for money where practices are receiving payments in excess of Global Sum/Average GMS payments.  
• A percentage of payments should be set aside for stretch target outcomes.  
• Agree the basket as far as possible with all their PMS contractors in the borough  
• The basket should be reviewed annually and should reflect local and national priorities  
• The review should link to the annual Commissioning Intentions process |
| What might a basket of services look like? | The basket of services is for local determination but in order to achieve a more uniform PMS service provision across London commissioners may wish to include some of the baskets of services already adopted across London.  
For examples of baskets of services commissioned across London see [http://www.pathfinders.london.nhs.uk/wider-health-system-information/](http://www.pathfinders.london.nhs.uk/wider-health-system-information/)  
Commissioners should negotiate a per capita payment that reflects individual borough level negotiations and the results in a single sum payment. Ensuring a clear and simple approach is taken by both the management and calculation of the contract value and payment due. |
| Stretch targets | • Commissioners should attach KPIs to the basket of services which are measurable, challenging and outcome focussed. Where services are similar to elsewhere in London similar RAG rating and thresholds should be benchmarked as far as possible.  
• Commissioners should negotiate a percentage of the payment to be dependent on the contractor being able to demonstrate compliance with the KPIs/stretch targets  
• The capitation payment negotiated for the basket of services should be subject to performance outcomes. The percentage of payments for performance is for local determination but should be sufficiently high to reward excellence, drive gold standard performance. |
<table>
<thead>
<tr>
<th>Action</th>
<th>Summary</th>
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| **Implementation** | Subject to the overall cost to commissioners being cost neutral;  
  • Where a practice was being paid less than the negotiated capitation payment their payment should be adjusted upwards  
  • Where a practice capitation payment was in excess of the newly negotiated capitation payment then the commissioner will reduce the capitation payment.  
  • Transitional non recurrent support should take into account the degree to which practices are changing services, contract value changes and infrastructure requirements and ensure that the pace of change allows a move to the new arrangements with a minimum of disruption to practices |
| **Enhanced services and the out of hospital agenda** | PMS contracts allow for significant flexibility and commissioners and providers may decide to negotiate creative and innovative services which integrate with their local priorities depending on the financial envelope available and the strategic priorities of the cluster.  
  The Commissioner will present the opportunities for additional practice income that may be linked to the out of hospital agenda, or enhanced services that sit outside those identified in the basket of services. |
| **Action where agreement is not possible** | • The commissioner should take all possible measures to reach agreement on PMS contract review through timely, well communicated meaningful and open engagement. However where it is not possible to reach a mutually satisfactory agreement it may be that the provider returns to a GMS contract.  
  • The contractor has the right to return to a GMS contract through regulation 19.  
  • There is no legal right for a GMS practice to move to PMS |
The Commissioner will present the opportunities for additional practice income that may be linked to the out of hospital agenda, or enhanced services that sit outside those identified in the basket of services and core services.

Commissioner engages with PMS GP community and outlines their desire to renegotiate PMS contracts in line with QIPP objectives. Commissioner proposes a governance structure and terms of reference.

Committee Structure:
- Expert Advisory Committee
- Project Board
- Set out mandate from practices
- Representation includes Public Health and Business Support Unit, GP’s, LMC, Primary Care Management (Commissioning)

Commissioner carries out an audit of the current PMS landscape. This will include understanding the investment per patient, and will assume premises, seniority and enhanced services and QOF are excluded. Information will present the correlation between performance and investment.

Commissioner sets out commissioning intentions and proposes a core basket of services that reflects national and local priorities. Commissioner negotiates RAG rated KPIs that will be used to evaluate performance.

Commissioner establishes new per capita payment for all PMS practices and sets stretch targets with performance payments using the KPIs negotiated in stage 4.

Commissioner negotiates time frame for normalising PMS capitation payments across PMS practices.

It is recognised that the contracts will be signed by the individual practices and that partners will retain the option of either agreeing the revised PMS contract or reverting to GMS.
Acknowledgements

Thank you to all those who contributed to the creation of these operating principles including:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Sturgeon</td>
<td>Task and Finish Group Chair, Director of Primary and Community Services Transformation</td>
<td>SEL</td>
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<tr>
<td>Greg Cairns</td>
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<td>LMC</td>
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<td>Dr Paddy Glakin</td>
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<td>Senior Contracts and Performance Manager (GPs)</td>
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<td>ONEL</td>
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<tr>
<td>Sean Fenelan</td>
<td></td>
<td>PCC</td>
</tr>
</tbody>
</table>

Documents Referenced

- Greenwich PCT approach to PMS Review
- Harringey PCT Approach to PMS Review
- Primary Care Quality and Productivity Challenge: Good Housekeeping Guide – NHS Primary Care Commissioning April 2010
GMS Baseline Payment Calculation

<table>
<thead>
<tr>
<th>Data</th>
<th>£/patient</th>
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<tbody>
<tr>
<td>GMS Benchmark</td>
<td>64.59</td>
</tr>
<tr>
<td>London Weighting</td>
<td>2.62</td>
</tr>
<tr>
<td>QOF payment</td>
<td>2.66</td>
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<tr>
<td>Total</td>
<td>69.87</td>
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</table>

As recommended by the DoH letter
Gateway Ref: 14380
para 6

http://www.dh.gov.uk/

Statement of fees and entitlements
Section 2 para 2.3

(as this payment is based on actual list size the amount of £2.18 has been multiplied by the relative list size adjustment as per QMAS 1.1.11)

Payments for chronic disease management allowance, sustained quality allowance and cervical cytology payments included in PMS baselines but received by GMS in their QOF payments.
£13,050/5,891 (PMS points deduction divided by national average list size) multiplied by relative list size adjustment factor as per QOF 1.1.11
Learning Education and Development (LEAD)

CURRENT EVENTS FOR 2011/2012

General Practice Nurse and Healthcare Assistant Events

**Family Planning: Contraception**

- Tuesday, 20 March 2012 (1.00-5.00pm)
- Hamilton House Meeting & Conference Centre, Mabledon Place, London WC1H 9BD
- Delegate fee £50.00 for Londonwide delegates and £60.00 for other areas
- Maximum capacity 40

Practice Manager Events

**Employment Law ‘Hot topics’**

- Tuesday, 23 February 2012 (1.00-4.30pm)
- Woburn House Conference Centre, 20 Tavistock Square, London WC1H 9HQ
- Delegate fee £49.00 for Londonwide delegates and £60.00 for other areas
- Maximum capacity 70

If you, or a member of your practice team, are interested in any of these events please contact the LMC office (mvassallo@lmc.org.uk) to register or request more information.

The New LEAD programme for 2012/13 will be available shortly so please look out for it!