Brent Clinical Commissioning Group (NHS Brent)	**Health and Wellbeing Board** 28 March 2017 Report from NHS Brent Clinical Commissioning Group
For information	
Primary Care - Personal Medical Services (PMS) Contract Review	

1.0 Summary

1.1 This paper updates the Brent Health and Wellbeing Board on the Personal Medical Services (PMS) Contract Review. This is a review of one of three types of GP contract. The paper outlines the background to the review and its objectives, work to date and proposed timelines for completion.

1.2 Three types of contract for GP services exist nationally:

- **General Medical Services (GMS)** – contract for the running of essential GP services. Practices may also choose to provide services against the QOF (Quality Outcomes Framework) and a national list of Enhanced Services. The GMS contract is the foundation and is nationally negotiated by NHS Employers with the General Practitioners Committee (GPC) which is part of the British Medical Association (BMA). It includes the Minimum Practice Income Guarantee (MPIG).

- **Personal Medical Services (PMS)** – builds on GMS to include provision for enhanced services which are locally agreed and aim to support innovation or address particular local need. The additional funding provided for this is known as 'premium funding'.

- **Alternate Provider Medical Services (APMS)** – time limited contract (5 years + 5 years), open to contract signature by other providers including voluntary and commercial organisations. Contract value and KPIs are set and agreed at the point of contracting.

1.3 There are 11 PMS practices in Brent (of a total 62 practices) holding £1.25m in Premium funding between them.

1.4 The PMS Review was initiated by NHS England (NHSE) and originally led by NHSE Area Teams. These teams are currently responsible for the commissioning and contract management of primary medical services (GP services) in England. The review commenced nationally in February 2014 after national guidance was issued.

1.5 The initial requirement was for completion of the review end March 2016; however at this point the review was 'paused' due to incomplete negotiations and the need for further engagement with the Local Medical Committees (LMCs), who represent the interests of NHS GPs.

1.6 The PMS Review in London re-commenced 09 November 2016 with the issuing of a joint letter by NHSE and Londonwide LMCs. In a change to the former arrangement this letter instructed London CCGs to complete the review locally. The commencement date set for implementation of renegotiated contracts is 01 October 2017.

1.7 NHS Brent CCG has commenced work and this paper provides an overview of the requirements, approach, work to date and timelines.

2.0 Recommendation

2.1 The Health and Wellbeing Board is asked to note the review is in progress and comment on the extent to which the approach being taken will achieve the objectives of the review.

3.0 Detail

3.1 PMS contracts were introduced in 1998 alongside a 'Premium' which incentivised practices to move from their existing GMS contract. 'Premium' funding was intended to provide for an additional GP or Nurse to support delivery of services above and beyond the GMS contract. PMS objectives included:

- Testing out innovative ideas for delivery of medical services
- Meeting unmet local need i.e. targeted delivery of services based on local population
- Introduction of proactive management of long term conditions
- Opportunity for nurse-led services and employment of more salaried GPs
- Introduction of more specific targets/KPIs for delivery of services

3.2 Since then there has also been the introduction of QOF and national Directed Enhanced Services (DES) – practice participation is optional but these provide reimbursement for key services and outcomes. The view is this created some overlap with services commissioned / provided under the PMS contract.

3.3 The number of PMS practices in each area, PMS practices as a percentage of all practices locally and the amount of money represented by the 'premium' pot varies significantly nationally. Even in NWL there is significant variation. This is demonstrated in table 1 below. Brent has a relatively low proportion of PMS practices, with Harrow having the greatest proportion:

Table 1: PMS practices in NWL

CCG	PMS Practices	GMS & APMS Practices	Proportion of all local practices which are PMS
H & F	1	27	4%
Ealing	7	66	9%
Hillingdon	9	35	20%
Brent	11	51	18%
Hounslow	12	34	26%
Central	14	19	42%
Harrow	19	14	57%
West	20	25	45%
NWL Total	95	271	26%

3.4 The review was initiated nationally to equalise funding to each GP provider and to ensure services provided to patients are consistent and equitable regardless of which GP practice a patient is registered at. The national objective is equity of funding across all medical services contracts by 2021/22. This should enable all practices to deliver services to the same standard, reduce variation and improve outcomes.

3.5 NHS Brent CCG are (and will remain for 2017/18) joint co-commissioners of GP primary medical services alongside NHSE. Despite this, the CCG has been delegated full responsibility for leading the PMS review to a successful conclusion.

3.6 Key principles for the review have been agreed at Brent and NWL levels. These reflect the original principles developed nationally. The NWL principles are shown at appendix 1. The Brent principles are shown below in table 2:

Table 2: Principles guiding the PMS review

PMS Key Principals – *Brent*
Commissioning Intentions (CI's) agreed locally reflect strategic plans for primary care
Commissioning Intentions (CI's) agreed locally secure services or outcomes that go beyond expectations of core general practice
Commissioning Intentions (CI's) agreed locally help reduce health inequalities by reducing variation between practices
Commissioning Intentions (CI's) agreed locally offer equality of opportunity for GP practices (i.e. all practices are offered an opportunity to deliver extended range of services or meet enhanced quality requirements)
Funding changes will be managed in a way that reduces and mitigated any risk of destabilising practices. Specific steps to achieve this: • PMS Premium funding released as a result of the review should be reinvested in general practice • Reinvestment remains within the CCG area (unless CCGs agree otherwise) • The process should be implemented in a phased way to allow practices to adjust to new funding levels
Services provided currently should remain in place unless the consequence of doing so is an overall reduction in quality and/or destabilisation of the practice.

3.7 The review includes review of the services being provided, the development of a local transition plan that reduces the 'premium' invested in each practice in a managed way over time and the reinvestment of monies released back into practices in line with a set of locally agreed commissioning intentions.

3.8 To introduce some standardisation and equity of approach, the eight CCGs in the North West London (NWL) STP footprint are working together. A NWL PMS Steering Group has been established. The group has no decision making powers but will provide a steer, exploring where a single approach across NWL is desirable, and where a local approach is required. Each CCG maintains sovereignty over key decisions.

3.9 The Brent PMS Steering Group has also been established. Membership includes a Lay Chair, representatives of local GP practices (PMS and GMS), CCG Clinical Directors, Director of Public Health, CCG Officers (senior managers from Primary Care and Finance), NHSE officers and representatives of Brent and Londonwide LMCs. This group has no decision making powers but will provide a steer and make recommendations to the Brent CoCommissioning Committee who will approve key decisions.

3.10 There are a number of key tasks to be completed as part of this review. They include:

- **Review of the PMS baseline contract values** – this differs for each PMS provider and is based on a complex formula. Currently set centrally and managed by NHSE these premiums need to be reviewed and sense checked with individual practices;

- **Mapping of services currently provided** – the services provided by each practice were developed at practice level and each practice has a different definition of what they provide in exchange for the premium. It is important to understand this and to reflect it in impact assessments, contract negotiations and commissioning intentions;

- **Development of the transitional funding model** – transitional funding will be provided to PMS practices for up to four years to enable PMS practices to plan for the change in income and ensure the stability of the practice. Transitional funding will come from the premium released. The amount received and length of the transition will be determined by the overall reduction in practice income.

- **Development of local commissioning intentions** – identification of high impact indicators that align to local need and could be signed up to by each GP practice. Funding released from the review (less transition costs) will be reinvested across GMS and PMS practices where they sign up to these commissioning intentions. Commissioning intentions will span a four year period, in line with the transition plan.

- **Development of the contracting model** – this will be either a variation to the existing contract or a new contract

- **Engagement of stakeholders** – ongoing from the start of the review. Key stakeholders include GP practices (PMS and GMS), LMCs, Public Health and local authority colleagues, Healthwatch and patient groups, others.

3.11 The plan and timeline for the review is shown at appendix 2. To enable equalisation of funding to occur by 2021/22 it is necessary to have implemented the review by 01 October 2017. NWL CCGs are currently working towards this date.

3.12 Progress has already been made in key areas. Work to date includes:

- The CCG has begun to map the number of practices likely to come under each transition path and has begun to meet with local practices and stakeholders.

- The transition model has been developed and reviewed across NWL and we are now seeking final agreement to progress using this financial framework. Transitional funding will be offered to PMS practices over a maximum period of 4 years. The amount received will be dependent on the current PMS Premium received by the practice and the distance to travel to a broadly equal position with other practices. This is shown below in table 3. The transition % shows the % of the premium that would be reinvested each year per practice for the duration of the transition:

Table 3: Proposed transitional funding model

Framework for transition funding	*Forecast change to practice income*
2 Year Transition % Year 1: 90% Year 2: 55%	5% to 10% premium reduction
3 Year Transition % Year 1: 90% Year 2: 70% Year 3: 40%	10% to 15% premium reduction
4 Year Transition % Year 1: 90% Year 2: 70% Year 3: 40% Year 4: 20%	Over 15% premium reduction

- The transition path for the 11 PMS practices in Brent (assuming the transition framework above is adopted) has been identified. Two practices will experience a total change to their PMS premium funding of less than 5% and therefore will not be in receipt of transition support with this change taking effect from October 01 2017. One practice is in line to transition over 2 years. Eight practices are in line to receive transitional funding over four years:

Table 4: Transition path for Brent practices

Change in income – 2016/17 data	Number of practices	No of transitional years	Income changes
Change in income of less than 5%	2	0	3.5- 4.5%
Change in income between 10 – 15%	1	2	8.2%
Change in income over 15%	8	4	17% – 35.1%

- Commissioning intentions and associated KPIs will need to be deliverable and achievable for all Brent practices. We have reviewed the JSNA and local data on variation from the Right Care programme. We have also commenced discussions with Public Health to identify any key areas of need that might be addressed through this review. We refer also to local plans for primary care including for delivery of the GP Forward View and London Strategic Commissioning Framework, the Local Services Strategy and our Sustainability and Transformation Plan (STP). A long list of KPIs has been developed and the Brent Steering Group are reviewing these in the first instance and developing some of the detail (key activities/outputs, outcomes and KPI thresholds). The outline is shown below in table 5:

Table 5: Draft commissioning intentions

Commissioning Intentions	Rationale
Increase Child Immunisation rates for under 1 Year olds to 90%	Reducing variation in primary care for immunisation rates and improve uptake as highlighted in JSNA. Increasing immunisation rate to be introduced on a gradual scale.
Increased uptake for Flu immunisation (over 65 and at risk patients)	Aimed at reducing Excess Winter Deaths as highlighted in the JSNA. Reduce variation and improve uptake across Brent
Increased uptake for Pneumococcal Immunisation rates	Prevent complications from Pneumonia especially in elderly and at risk population
Increase uptake of cancer screening	This supports the CCGs program of work in early detection and treatment of cancers
Improving patient satisfaction with delivery of primary care services	Brent is rated worse than national average for patient satisfaction with primary care services. This commissioning intention would involve collection of data against a small number of patient satisfaction questions which are meaningful locally, with practices working to review feedback from patients, use it to shape services and ultimately to improve satisfaction.
Mainstream existing Local Incentive Schemes (LIS)	Some of the services currently commissioned from practices by the CCG as LIS schemes could be mainstreamed into the core contract and funded from PMS Premium. These are longstanding services and funding through the PMS by October 2017 could release the LIS funding for reinvestment in local priorities as they are developed.

- Further work is being done to consider key areas of the STP including alcohol, tobacco consumption, homelessness and support for carers. The intervention at practice level that would need to be reflected in the commissioning intentions is being scoped.
- The CCG and its partners are considering the steps that might be taken to support practices. There are a number of initiatives progressing locally for all practices. these are:
    - **Provider Development & Resilience** – one of four Primary Care workstreams in Brent. This involves work with individual practices and the Networks / Federation to stabilise and transform general practice locally. PMS practices will be prioritised as this programme can support business planning and financial planning to secure immediate viability and long term sustainability. It can also support new ways of working including partnership / 'at scale' working to deliver new services and alleviate pressure where possible e.g. by rationalising processes and/or costs.

- **CCG Out of Hospital commissioning** - commissioning Out of Hospital schemes to support shift of activity from secondary to primary care. This provides opportunities for practices to increase their income - but it requires creation of capacity to take forward this work for example through reducing administrative burden on GP practices and making better use of technology.
- **Strengthening the workforce and making greater use of a wider primary care team** – we are working with practices to consider the composition of practice teams, the shortage of key roles such as GPs and Nurses and the part that can be played through introduction of a new skill mix and multi-disciplinary working. Roles being considered and developed/trained locally include Medical Assistants, Practice Care Navigators, Health Care Assistants and Clinical Pharmacists. The CCG is supporting introduction of all these roles.

- We are also considering the ways in which we might communicate the review to residents and engage local patient representatives. We welcome patient input into the review to ensure we achieve key objectives around a reduction in health inequalities and improved equity in the service offer across Brent. We have commenced discussion with Healthwatch and will take a steer on how best we communicate and engage from them. Routes for engagement are set out below:

    - **NWL PMS Steering Group** – engaging with the seven other areas in NWL, NHSE and Londonwide LMCs

    - **Brent PMS Steering Group** – engaging local practice representatives, public health and local and londonwide LMCs

    - **Individual practice meetings** - offered by the Brent Primary Care team to all local PMS practices, these meetings (currently underway) are individual visits designed to provide opportunity for a practice level discussion covering:
        - Individual practice update on the review
        - Opportunity to review financial data and proposed transition model
        - Identification/confirmation of services provided in exchange for premium funding practice by practice
        - Practice plan and likely need for/desire for further support
        - Opportunity for the practice to raise questions/comments and feed into the Brent Steering Group

    - **Locality Meetings** - monthly Locality meetings with practices provide a forum for updates on the PMS review and feedback to the CCG. This can also come via clinical directors and clinical leads who chair the localities.

    - **Health and Wellbeing Board** – opportunities for members of the Board to shape and steer the review and to raise any risks or issues for collective mitigation.

4.0 Financial and Legal Implications

4.1 The financial implications of this proposal are still work in progress and will be informed by the final transition path and the associated calculation of reinvestment.

- There are financial implications for the individual practices as outlined in table 4. The net change will be different once commissioning intentions are factored in and we know which practices are signing up to these.

- There should be no cost pressure to the CCG as the funding for the new commissioning intentions should be derived from the released premium however this is not confirmed at this stage and the CCG Finance officer is monitoring this.

4.2 There are some legal implications – at a minimum this will be the legal implications of the contracting process. The approach to contract negotiation and the contracting model is being reviewed at NWL level with expert opinion being sought.

5.0 Equality Implications

5.1 A potential benefit of the PMS Contract Review is improved equity in service offer and service delivery across Brent which should over time serve to narrow health inequalities. However there may be an impact from any associated change to the current service offer. This will be assessed once the transition model and commissioning intentions are confirmed and we have had conversations with each practice about their forward plans.

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Appendix 1 NWL principles

No.	Topic	Description
1	NWL VISION	NWL CCGs have agreed a common vision for primary care in NWL incorporating the London Strategic Commissioning Framework.
2	PACE – NWL alignment	There will be agreement at the NWL level about what aspects need to be completed in unison in order to ensure sufficient alignment.
3	PACE – local determination	n setting this vision, we recognise that CCGs start in different places and will make progress towards this at different rates, reflecting local circumstances and affordability.
4	REINVESTMENT IN PRIMARY CARE	Any money released as an outcome of the review will be reinvested into primary care services within the respective CCG.
5	REINVESTMENT IN PRIMARY CARE - RECOMMISS- IONING (EX-PMS) SERVICES	CCGs will review any extra services currently provided by PMS practices and may decide to re-commission some or all of these to reflect the needs of local populations. Such re-commissioning will be linked to OOH services in CWHHE.
6	OOH ALIGNMENT	Similarity between local enhanced services and PMS service specifications will be promoted as a route to achieving 100% population coverage – for CWHHE CCGs this is in reference to the CWHHE out of hospital contract.
7	LOCAL PRICING	When setting local prices, a minimum consistent offer will be promoted across GMS and PMS practices.
8	GMS EQUALISATION	All services offered to PMS practices as part of the premium contract should also be offered to GMS practices
9	PRIMARY CARE TRANSFORM- ATION	Across NWL, we will aim to increase the average NHSE/NWL practice payment level and this is reflected in our approach to the PMS review.

10	TRANSITION SUPPORT	Where practices suffer a loss of income as a result of the review, transitional support will be made available, so that the loss is phased in over an agreed period of time.
11	VALUE FOR MONEY	Each CCG will have a rationale for current and future investments into primary care which considers value for money.
12	QUALITY AND EQUITY	NWL and individual CCG will assess the impact of decommissioning and re-commissioning services in adherence to their statutory duties.
13	TRANSPARENCY	CCGs will promote transparent engagement with their local practices noting that NHSE will lead on the practice negotiations.

Appendix 2 – Plan and timeline