

High Quality Care For All



Primary Care & Community Services:
Improving GP services

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Primary Care & Community Services:
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Section 1 Introduction

Introduction

What is the purpose of this guide?

This is part of a series of supportive guides to help Primary Care Trusts (PCTs) become world class commissioners of primary care services. They have been co-produced by NHS East of England, NHS Primary Care Contracting (NHS PCC), and the Department of Health.

This first guide focuses on improving the quality of commissioning GP services, by which we mean list-based primary medical care, including both GP practices and health centres. The guide provides practical advice on how PCTs can:

- assess their current performance
- identify their vision for the future and
- commission services that meet the needs of their local communities.

This is part of a rolling programme of practical guides that also includes guides on commissioning primary dental services and pharmacy. The guides will be supported by a series of regional events to help PCTs address the strategic, leadership and operational challenges in driving up the quality of primary care commissioning.

Alongside this suite of guides, we are developing a series of practical advice and tools, including:

- How to benchmark primary care services and assess how far they reflect local health needs
- How to measure quality improvement in primary care, including developing 'quality scorecards' or 'balanced scorecards'
- How to commission accessible and responsive GP services
- How to undertake a pharmaceutical needs assessment
- How to support improvements in primary care premises
- How to improve primary care for socially excluded groups.

Who is this guide for?

This guide has been developed for senior managers responsible for commissioning primary medical care. An accompanying briefing sets out key issues for PCT Boards.

Why change?

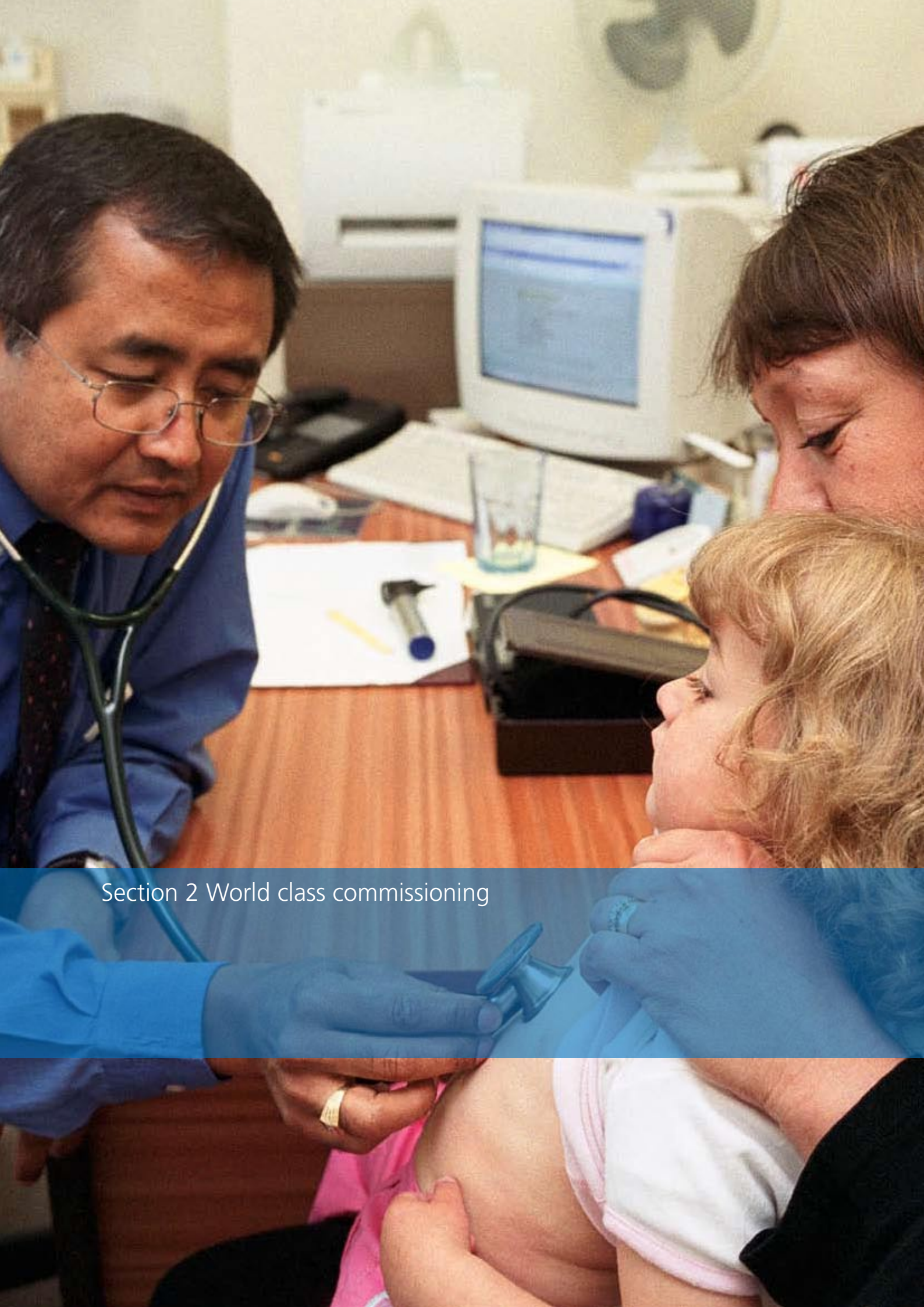
The final report of the NHS Next Stage Review, *'High Quality Care for All'*¹, sets out the strategic direction for driving improvements in the quality of care across the health service. *'Our vision for primary and community care'*² draws together the main conclusions of the Next Stage Review for community-based NHS services, including GP services, and sets out a strategy based around four key areas:

- shaping services around people's needs and views
- promoting healthy lives and tackling health inequalities
- continuously improving quality
- ensuring that change is led locally.



1 Lord Darzi and Next Stage Review
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

2 Our vision for primary and community care
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937



Section 2 World class commissioning

World class commissioning

The world class commissioning programme sets out a framework to support PCTs in developing the competencies needed to commission high quality services that improve health outcomes and reduce health inequalities.

This includes strong engagement and partnership with the public, NHS staff and other healthcare professionals, and other local partners. As world class commissioners, PCTs will be in regular dialogue with their communities about what is good about local services and what needs to change. They will have a deep understanding of local health needs and the services and interventions that will be effective in meeting these needs. They will actively manage the provider market, rewarding and encouraging providers that continuously improve quality and bringing in new providers where services are unresponsive or there is limited choice.

Information for world class commissioning



Delivering world class commissioning of primary care

The effective commissioning of primary care services is central to improving quality and implementing the regional visions for health and healthcare developed as part of the Next Stage Review. The NHS spends around £100 billion per year on health care in England – and a large proportion of that sum is spent, or committed, by clinicians in primary care through either direct treatment, prescribing or onward referral.

It is essential that PCTs understand how resource is committed, the value that can be gained by investment in primary care, and how to work with clinicians to achieve continuous improvements in patient experience, safety and the health of individuals. This requires a proactive and strategic long-term approach to shaping the nature and range of services provided by GP practices and other primary care providers.

Effective PCT commissioning of primary care also provides a strong foundation for practice based commissioning (PBC). PBC brings clinicians to the heart of commissioning so they have a greater say and accountability in designing services that will improve health outcomes for their local communities. As PBC is based around GP practices, it is essential that there is both a robust and transparent process for commissioning the primary medical care provided by these GP practices.

In commissioning GP services, PCTs will clearly need to look in the round at the full range of community-based care in their area, including district nursing, health visiting and other community health or social care services, and the opportunities for providing more joined-up services that improve patient experience and health outcomes. Commissioning strategies for GP services should therefore be consistent with local strategies for commissioning community-based services.

As part of the world class commissioning (WCC) programme, every PCT is developing a five year strategic plan, which sets out its vision, its priorities and how these will be delivered. The plan will include the high level patient offer, which sets out what the PCT is accountable for delivering to its local community. Strategic plans will explain what services will be provided, where they will be available and who will provide them. In addition, each PCT will prepare an annual operating plan, outlining how it will implement its strategy in the coming year. Both the strategic plan and the operating plan should address how the PCT will improve primary care services.

World class commissioning competencies and assurance process

To commission primary care effectively, PCTs will need to develop and display each of the eleven competencies defined by the WCC programme. Section 8 shows how these competencies relate to commissioning GP services.

The annual cycle of the WCC assurance process will hold PCTs to account as they move toward world class levels. The Department is exploring with SHAs how best to reflect commissioning of primary care services in the development of the assurance process.



Section 3 About GP services

About GP services

The services provided in primary care are at the heart of the vision for the NHS. Evidence shows that high-quality health systems and healthy populations require strong and effective GP services.

Key facts

Most people's contact with the NHS is through their GP services:

- 99% of the population is registered with a family doctor
- GPs and nurses in general practice see over 800,000 people a day – that is around 300 million people every year
- the NHS invests around £8 billion in GP services each year, 9% of the overall NHS budget
- GP prescribing in 2007/08 accounted for a further £8 billion of the NHS budget.

People greatly value these services and the staff who provide them. The public trust their GP more than any other profession and they have strong bonds of trust with other primary care staff. The personal ties between GP practices and patients, as reflected in the system of patient registration and list-based care, mean that GP practices are uniquely placed, working alongside other primary and community clinicians, in supporting greater patient choice and empowerment.

Alongside other primary and community clinicians, GP practices play a crucial role in helping to coordinate NHS care, particularly for people with long-term conditions, and in helping patients to access wider or more specialised NHS services. This means ensuring that patients get access to the most appropriate care in the most appropriate settings and helping ensure that NHS resources are used effectively. This is reflected in turn in the key role that GP practices play in practice-based commissioning. GP practices provide a key local insight into identifying local population sensitivities and needs. They are often well placed to support the engagement of the local communities they serve.

Get the commissioning of GP services right and the benefits will extend to the commissioning of wider NHS services, including hospital care.

What are the distinctive features of commissioning primary care?

The commissioning of primary care is complex. Some factors are broadly common to all primary care contractors (i.e. GP practices, dental practices, community pharmacies and optometry practices); whilst others are unique to GP services. Some of these factors can make commissioning GP services more challenging, but they can also provide greater opportunities to make sure that services meet people's needs.

Challenges and opportunities

The following lists some of the challenges you will be familiar with when commissioning GP services. Alongside each we suggest how, as a world class commissioner, you can address them. Further detail is provided in Sections 4-6 of this guide.

Feature	Challenge	WCC response
Large number of small providers.	The local knowledge held by providers can result in diversity of service provision, sensitive to population needs, which could contribute to reducing inequalities in health but can also place extra demands on commissioning services.	A plurality of providers can help PCTs to commission a broad range of services that meet the local community's needs (see Section 4) and support patient choice (see Section 6.6). Be sure to invest appropriate resources in commissioning from this range of providers (see start of Section 6).
Providers are legally independent entities.	Most primary care services are provided by independent businesses over which the NHS has less direct influence than some other NHS services.	Encourage and stimulate independent providers to develop their own business models for responding to patient wishes and PCT commissioning.
PCTs provide some support services direct to providers.	By providing support to small organisations that need help with clinical governance and estates/capital planning, PCTs may be concerned that they are distorting the market or creating barriers to entry for new providers.	DH's <i>principles and rules for cooperation and competition</i> ³ makes it clear that commissioners have a legitimate role in directly supporting providers, provided that the approach is transparent and non-discriminatory. You need to be clear about your own responsibilities, those of the provider, and the level of direct support you will provide (see Section 6.3 for more information).
Pattern and mix of services can be outdated.	In many areas, the location, size and make-up of GP practices reflect historical business decisions made by GPs and do not adequately meet current needs.	By comparing local needs with current services, you can identify what needs to change for services to meet local needs (see Section 4).
Processes that encourage competitiveness are not fully developed.	In general, there are underdeveloped systems and incentives to promote choice and competition. This reflects a range of factors, including inequities in the current GP funding system (with money not fully following patients if they switch practice), the limited number of practices with which some patients can register and lack of comparative information for the public.	PCTs need to consider how to promote greater patient voice and patient choice, in order to promote responsive primary care services (see Section 6.6). PCTs also need to consider how to develop the primary care market to promote greater diversity, innovation and patient choice (see Section 6.7).

Feature	Challenge	WCC response
Different contracts.	GP practices work under different types of contracts – for example, GMS contracts are nationally negotiated and do not have a fixed duration, PMS agreements allow greater local flexibility, and APMS contracts allow the greatest degree of flexibility.	PCTs need to have a detailed working knowledge of the different types of contractual forms so that they can use them to their greatest benefit. See Section 6.2 for key issues on managing contracts and Section 6.7 for contracting new services using APMS.
Contracts are not regularly reviewed.	PCTs often do not have an annual contract cycle for commissioning primary care (compared to the commissioning of other providers such as acute trusts).	See Section 6.2 for guidance on developing a performance cycle.
Marked variability in primary care capacity and quality.	PCTs in more deprived areas tend to have fewer GPs and practice nurses per weighted head of population. Clinical quality and patient satisfaction can also vary widely both within and between PCTs.	PCTs need to secure a consistently high level of clinical quality and patient experience in commissioned services and address relative shortfalls in capacity. See 'Clinical quality' in Section 4 and Section 6.4 on supporting quality improvement and Section 6.7 on developing the market.
GP practices typically have a dual role as providers of list-based primary medical care and as key participants in helping shape commissioning decisions.	In their practice-based commissioning role, GP practices (alongside other clinicians) may play a key role in recommending the development of new primary care services that they may then play a part in providing.	PCTs need to ensure that PBC plays a key role in helping shape high-quality services and improved health outcomes. In doing this, PCTs also need to ensure there are fair and transparent rules governing decisions on what new or additional services should be commissioned and the process through which they should be commissioned (e.g. local enhanced services, 'any willing provider' services, or competitive tenders).



Section 4 Mapping the baseline

Mapping the baseline

Before you can begin to make improvements to primary care services, you first need to establish a baseline of where you are now.

There are three key stages to this:

- assess needs
- map existing services
- identify what needs to change.

The Department of Health is working with several PCTs and with expert input to develop a tool that will help you to collect, benchmark and analyse this data.

Stage 1 Assess local needs

The first stage in the commissioning cycle is assessing the health needs of the local population. This is usually done through the Joint Strategic Needs Assessment (JSNA), carried out with the local authority. The JSNA will:

- give a complete picture of the populations involved and how needs differ
- identify specific communities with particularly poor health, such as travellers, migrant workers, people with learning disabilities, those living in disadvantaged areas or demographic groups
- give a clear view of unmet needs
- enable comprehensive benchmarking of health needs against comparable populations.

The JSNA will highlight a number of areas where improvement is needed. Obtaining patient feedback and evaluating levels of patient satisfaction is an essential part of the commissioning process. It is then up to you to identify which of these needs could be met by improvements to GP services or by more effective working between GP services and other providers.

Stage 2 Map existing services

Next, you need to understand how services are currently being provided and identify any gaps that can be addressed by commissioning new or different services. You will need to draw together a number of different strands of data, which can then be benchmarked.

1. The PCT's overall indicator should be benchmarked against national or, if more appropriate, cluster averages. This will highlight commissioning issues that affect the PCT as a whole.
2. Each practice should be benchmarked against the PCT, as well as cluster and national averages. This will highlight commissioning issues that affect a particular locality or practice.

3. PCTs will also record trends i.e. risk management for example, a practice judged to be meeting minimal standards may actually be falling in its performance – this can then be linked with the escalation process in Section 6.

So what kind of data are you looking for? If you are to build a complete picture, you need to know about:

- Capacity
- Quality
- Access and responsiveness
- Patient choice
- Value for money
- Premises
- Demand
- Enhanced services

PCTs may be concerned about the accuracy of some of the data and this will need to be taken into account when conducting the analysis. However, experience suggests that the best way of driving up data quality is to make sure it is used to inform decision-making.

Capacity

Capacity can be mapped using a number of indicators, such as:

- number of GP consultations per 1,000 weighted population
- length and quality of all primary care consultations
- average patient list size per GP practice
- number of WTE GPs and other clinical staff (e.g practice nurse, nurse practitioner, health care assistant) per 1,000 weighted population.

Armed with this data, you can identify potential shortcomings in overall capacity (compared with other PCTs), as well as particular hotspots where capacity needs to be enhanced.

Quality

As part of 'Measuring for Quality Improvement', PCTs should work with GP practices and other clinicians to develop a range of metrics to measure quality in primary care, encompassing organisational quality (including safety), effectiveness and patient experience. Clinical quality can be mapped using a range of indicators in these three areas, including:

- Organisational quality (including safety)
 - practice accreditation
 - premises
- Effectiveness
 - achievement in the clinical domain of the Quality and Outcomes Framework (QOF)
 - QOF exception rates and comparisons between reported prevalence and expected prevalence of long-term conditions
 - local data, e.g. prescribing, referrals, clinical governance

- Patient Experience

Patient experience is a key element of overall service quality. It is not just GPs, but practice nurses, reception staff, communications systems, parking, quality of premises and so on, that all combine to make up the overall experience. PCTs can use a range of ways to measure and benchmark patient experience, in addition to the indicators for access and choice discussed below, including:

- the results of the wider questions in the new GP patient survey, for instance on quality of GP and practice nurse consultations, helpfulness of reception staff and quality of the physical environment
- the results of local patient surveys or other forms of patient feedback, such as issues raised in deliberative events, by Local Involvement Networks (LINKs) or patient participation groups
- analysis of the complaints that are received, both at a practice level and by PCTs.

This provides you with a starting point to compare quality of provision with that of other PCTs and to identify both the best and the weakest providers.

Access and responsiveness

Accessibility and responsiveness are key measures of quality and performance. Poor access, for instance, discourages patients from seeking medical help and advice. It can also have a negative effect on the quality of consultations. You will need to view the specific guide to improving GP access and responsiveness, and its related tools, to assess the baseline and improve existing services.⁴

.....
 4 *Improving GP access and responsiveness* guide to be published shortly at www.dh.gov.uk/en/Healthcare/primarycare/index.htm

You can measure access in a number of ways, including:

- levels of patient satisfaction (as measured through the national GP Patient Survey) with opening times, 48 hour access, advance booking, telephone access, and seeing a specific GP
- practice opening hours for clinical appointments
- disability access
- consultation languages
- choice of male and female GPs
- uptake of extended opening hours
- use of premium rate telephone number
- attendance at A&E or walk-in centres as a proportion of list size.

Patient choice

Patients should be able to take control of their journey through the healthcare system and make choices about the type of care and support they receive. GP practices have a very important role in empowering patients and supporting patient choice.

The following indicators provide a useful starting point:

- use of choose and book system and NHS choices website
- survey results on offer of choice of hospital
- results of new GP Patient Survey questions on GP practice support for personalised care planning and self care support.

Patients should also have an informed choice about which GP practice they register with. Possible indicators include:

- proportion of the local population within practice boundaries of at least two or three GP practices
- proportion of practices whose lists are open and accepting new registrations
- the number and location of people who need to be allocated to a practice list within the PCT.

This guide focuses on list-based primary medical care, but choice also encompasses people's ability to access GP services in other ways, like when they are away from home or their practice is closed. There are already a range of quality indicators for out-of-hours (urgent) GP services, but you will need to develop your own for measuring the effectiveness of open-access services provided by GP-led health centres.

Value for money

By measuring value for money, PCTs can identify areas of higher spend that are not justified by a higher level or quality of service, as well as areas of under-investment.

You can use the following measures to gauge whether public resources are being spent efficiently:

- GMS spend per head of population
- PMS spend per head of population
- Value for money prescribing indicators, such as the Better Care, Better Value indicator for low cost statin use or generic prescription rate
- Number of urgent and elective referrals per 1,000 weighted population.

Premises

Patients should be seen in premises that are pleasant, accessible and meet relevant national standards.⁵ This is not always the case. Often the poorest premises are in the areas with the highest health needs. To help you develop your Strategic Services Development Plan (SSDP) to improve the primary care estate, you should map compliance with standards for premises across your PCT.

Demand

Gauging demand will help you assess whether you are commissioning enough secondary care and if there is scope for refocusing this work in a community setting.

Indicators include:

- emergency referrals/spells per 1,000 weighted population
- A&E activity per 1,000 weighted population
- activity within out of hours settings, particularly for routine or planned care
- Better Care Better Value indicators for ambulatory care sensitive emergency admissions
- Better Care Better Value indicator on surgical thresholds
- Better Care Better Value indicator on out-patient referrals⁶.

5 The National Health Service (General Medical Services – Premises Costs) (England) Directions 2004 – see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4078585

6 See NHS Institute dedicated site on the NHS Better Care, Better Value Indicators – <http://www.productivity.nhs.uk/>

Enhanced services

Enhanced services are specific services over and above the normal range of essential and additional services. They also include a higher specification than normal for some essential and additional services, such as vaccinations, cervical screening, antenatal/postnatal care and some minor surgery.

Directed enhanced services (DEs) are commissioned under national directions and PCTs are usually required to commission them for their whole population, or to offer all primary care providers the opportunity to deliver the service (for an agreed price). By contrast, local enhanced services (LESs) are decided locally, and examples include minor surgery, long-acting reversible contraception, and Chlamydia screening.⁷

PCTs specify the key performance indicators for each enhanced service and collect the data from providers. By mapping their availability, you can see the extent to which patients have convenient access to enhanced services that address the needs highlighted by the Joint Strategic Needs Assessments (JSNA). An aggregation of the number of patients using the service compared to known need, further informs the JSNA.

Stage 3 Identify what needs to change

Comparing your needs assessment with an analysis of current provision will highlight what needs to change.

Every PCT will be different, but action areas may include:

- misalignments between those segments of the population that have the highest health needs and the existing pattern of investment in GP services
- areas that have poor access to services or widespread patient dissatisfaction
- communities that have limited choice, either in terms of providers or in the nature of services available
- practices/providers that are falling short on quality standards
- investment in additional services not targeted on areas of greatest need.

⁷ The Department has commissioned a number of primary care service frameworks (national model contract specification) developed by NHS Primary Care Contracting available at <http://www.pcc.nhs.uk/themes/serviceframeworks>



Section 5 Developing the vision

Developing the vision

You should have a vision of what GP services will look like in the future. This will be informed by your five year strategic plan, known national priorities, the baseline mapping exercise (see Section 4) and the ongoing involvement of patients, clinicians and other local partners.

There should be two parts to this vision:

- patient offer
- strategic service model.

The 'patient offer'

Your patient offer should be outlined in your strategic plan and described in the PCT's Guide to Local NHS Services. It should clearly state the range of services available and what patients can expect to be provided at their local GP practice or health centre or an associated community facility. This may include what additional or enhanced services people can expect in primary care, such as:

- contraceptive and other sexual health services
- minor surgery
- diagnostic services, including imaging, pathology and physiological measurement services
- mental health services
- enhanced care of long-term conditions (eg asthma clinics, diabetes clinics).

The offer is also likely to include minimum expected standards for:

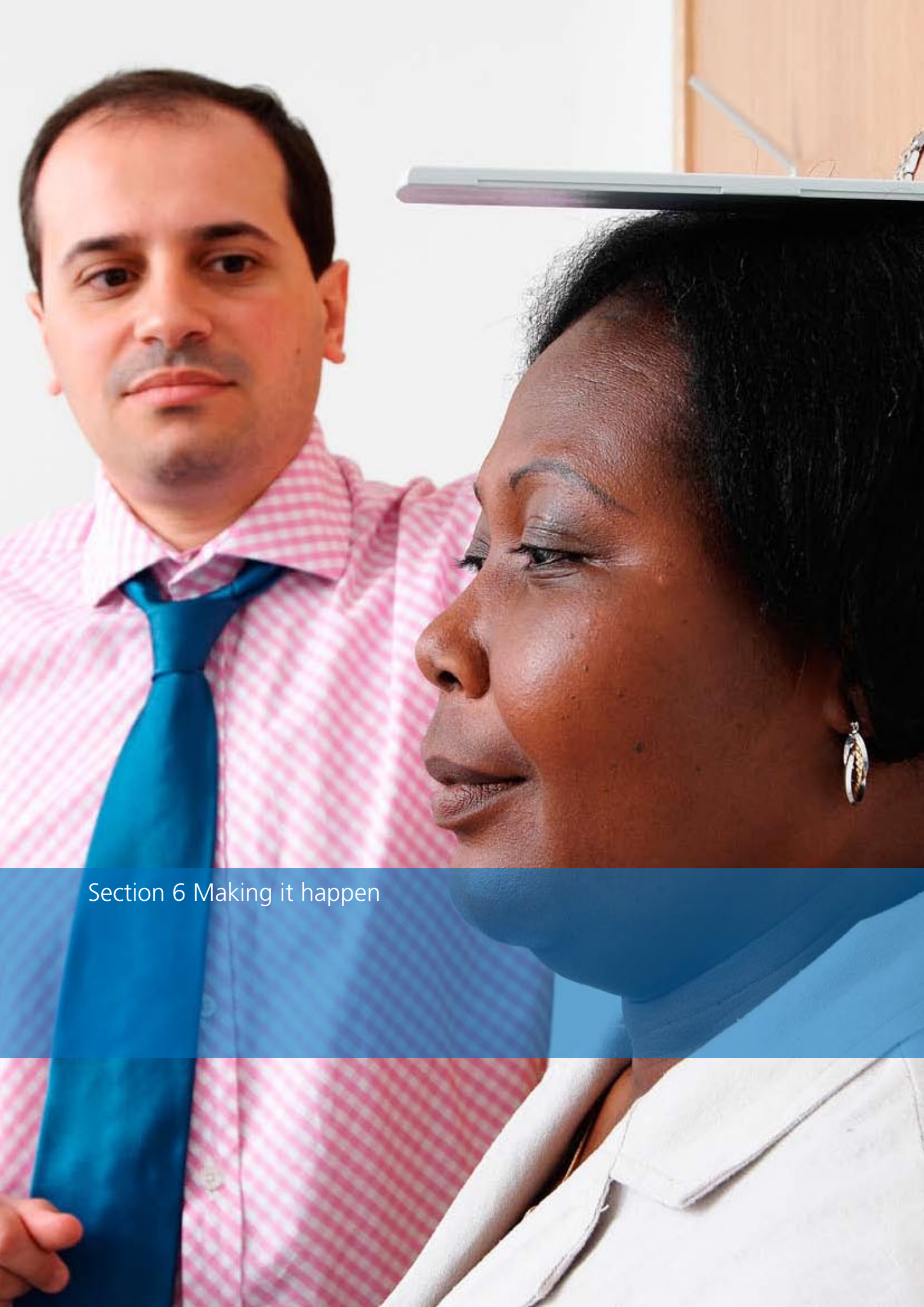
- access (eg opening hours, 48 hour access, advance booking)
- clinical quality (eg QOF indicators)
- patient experience
- premises.

The strategic service model

Your strategic service model describes how you will make your patient offer real. You should map existing practice provision against need, taking into account the quality, economic viability and long-term sustainability of each practice.

Each PCT's strategic service model will be different, but they should all include your approach to:

- defining geographical access standards, such as the maximum distance patients are expected to travel to their GP practice, or the number of practices from which they can choose to register with
- providing services in community settings, such as in primary care 'hubs'
- commissioning more integrated delivery of services, with hospitals providing services in the community and vice versa; greater co-ordination of community health services (such as district nursing and health visiting) with GP services; and more integrated delivery of primary care, social care and wider local government services
- commissioning open access services for both urgent and routine care
- commissioning specialist primary care providers (eg for long-term conditions)
- promoting greater integration or federation between GP providers to increase critical mass and reduce the isolation of smaller practices
- promoting more integrated delivery of other primary care services, such as pharmacy, dental and eye care services
- promoting self-care and self-referral for certain conditions or patient groups, including the use of personal budgets.



Section 6 Making it happen

Making it happen

You have a range of powerful commissioning tools and levers at your disposal. Knowing how each of them works, will enable you to combine them in the most effective way possible to deliver the changes you want.

We have grouped these tools and levers under ten broad headings

- Transparent use of information on quality and performance
- A comprehensive approach to managing performance
- Supporting improvements in quality and performance
- Information for patients and the public
- Assuring minimum standards
- Promoting patient choice
- Developing the market
- Commissioning additional capacity
- Improving premises and estates
- Practice based commissioning (PBC).

The precise combination of tools used will vary according to your individual PCT's circumstances, priorities, and the changes you want to make, but we would expect all PCTs to use the first two tools – transparent use of information on quality and performance and implementing a comprehensive approach to managing performance. These are the basic processes that enable every PCT to understand how well each practice is performing, and determine what needs to happen to support improvement.

All of these commissioning levers and processes need to be underpinned by:

- Board-level oversight and leadership
- senior accountability to the PCT board for commissioning of primary care
- expert clinical advice and clinical leadership
- regular engagement with GP practices and wider clinical engagement
- regular engagement with the public and representatives of patients and carers.

To take the comprehensive approach described in this guide clearly also requires capacity and capability. Where PCTs need to invest more resources in their primary care commissioning teams, this could be achieved by:

- increasing the size and capability of the core team
- pooling resources across PCTs or collaborating on particular topics
- buying in additional support, for example through the use of FESC or NHS PCC Building Foundations programme.

6.1 Transparent use of information on quality and performance

Without good comparative information on the quality of the services provided, PCTs cannot effectively manage performance (see 6.2), support quality improvements (6.3), or provide information for their patients and the public (6.4).

In line with the principles of 'Measuring for Quality Improvement' (see letter from David Nicholson and Sir Bruce Keogh to NHS Chief Executives of November 2008), you should make sure that you have a robust and balanced set of quality measures in place for primary care. These should be developed in collaboration with local clinicians.

A quality framework or 'scorecard' can draw together and triangulate data from a variety of sources, including national data (eg on QOF performance, GP Patient Survey results) and local data (eg data on prescribing, referrals, premises, patient feedback).

Together, this balanced set of data:

- enables PCTs and practices to reach an objective and rounded view of performance
- suggests the key metrics to be used in structured performance reviews
- encourages self-assessment and peer review – providers can use benchmarked quality metrics to compare their performance with that of their neighbours
- signals the indicators that will be used to keep the public informed about quality and performance.

The process of developing a quality scorecard is itself extremely valuable. It stimulates focused discussion with providers about current performance, existing strengths and weaknesses, and priorities for the future. To help you with this, NHS Primary Care Contracting (NHS PCC) has developed a step-by-step guide to creating a quality scorecard. A separate guide on measuring for quality improvement, incorporating key elements of the NHS PCC guide, will be published shortly.

6.2 A comprehensive approach to managing performance

As world class commissioners, PCTs will need to invest considerable time and effort in developing a close working relationship with every GP practice. Otherwise you won't have a clear view of the practice's performance, or what you need to do to help it improve. Likewise, practices won't be clear about your expectations.

Central to this is developing and implementing a comprehensive approach to managing performance. There are four key components:

- transparent, documented approach to contract management
- developing a performance cycle
- measuring performance
- escalation.

Transparent, documented approach to contract management

You should work with providers to agree a formal process for managing their contract. This process needs to be clearly documented and publicly available. It should enable providers to answer the following questions.

- What standards are we expected to meet?
- When and how will our performance be reviewed?
- What will happen if our performance is below the agreed standards?
- What support will you offer to help us improve?
- What action will you take if we fail to improve?

Standards fall into two categories.

- Minimum standards that must be met. Many of these will be contractual standards. Failure to meet them will usually trigger a formal intervention.
- Aspirational or developmental standards to be worked towards. These will set out what you would like providers to deliver. You will want to consider what developmental support is available to providers.

Developing a performance cycle

A clear performance cycle sets out what will happen and when. Every agreement will be different, but the key components are likely to include:

When	What	Outcome
Jan – Feb	Negotiate objectives and development plan for the next year, ensuring that there is an appropriate blend of qualitative and quantitative objectives. Agree any contract variations. Objectives linked to your PCT's strategy, such as incentives to tackle high priority areas like CHD, will be common to all providers. Others will be specific to individual practices (e.g. extend opening hours from x to y, or increase patient satisfaction by x %).	Draft agreement for each practice.
By Mar 31	Sign off agreement/contract variations with every practice.	Written plan/contract variation, signed by both parties.
May	Formal, senior level accountability review with every practice, assessing performance over previous 12 months. Ensure any balancing payments/claw backs relating to the previous year are agreed.	Annual letter to practice, to be shared at PCT Public Board meeting. This could include an overall 'traffic light' assessment of performance. Practice to receive clear statement of performance.
July	Publish Q1 key performance metrics for each practice.	Data published on PCT website.
Oct	Formal mid-year review with every practice. Publish Q2 key performance metrics.	Letter outlining main points of review meeting. Data published on PCT website.
Nov – Dec	Review of performance framework and metrics.	Revised framework (if appropriate) published.
Jan	Publish Q3 key performance metrics.	Data published on PCT website.
April	Publish Q4 key performance metrics.	Data published on PCT website.

The current practice of risk-based performance cycles, with good performers receiving fewer reviews, needs to change. As a world class commissioner, you will be expected to work just as intensively with your best providers as you do with your weakest to help them develop further as outstanding providers of GP services.

Measuring performance

A robust and balanced quality scorecard (see 6.1) enables everyone to reach an objective and rounded view of performance. It can also provide the basis for regular performance reviews.

Escalation

A clear escalation process sets out what you will do if performance slips below agreed standards. This should clarify:

- how you will respond to different kinds of challenges, such as:
 - clinical issues
 - organisational problems
 - breach of minimum standards
 - failure to reach developmental standards
- how ongoing performance will be monitored more intensively, for example through more frequent reviews or recovery plans that set out actions and milestones
- the period during which a practice will be monitored more intensively before further action is taken
- what support you will provide.

As a world class commissioner, you should do everything you can to help practices recover and meet the required standards as quickly as possible. You should therefore set out what additional support you will consider providing, such as temporary support or consultancy. Further detail is provided below in 6.3.

If providers objectively and continually breach agreed quality standards, delivering poor or unresponsive services to patients, PCTs can use the following formal contractual levers:

- decommissioning enhanced or additional services
- issuing breach or remedial notices
- terminating contracts.

You should seek legal advice before invoking any of these contractual levers.

6.3 Supporting improvements in quality and performance

As a world class commissioner, you are expected to help all providers to improve. As noted earlier, there may be concerns that direct support will distort the market or compromise a PCT's role as commissioner.

The *principles and rules for cooperation and competition*⁸ make it clear, however, that commissioners have a legitimate role in directly supporting providers, provided the approach is transparent and non-discriminatory. Direct support should be explicitly linked to the overall approach to managing performance described above and PCTs should clearly define the circumstances in which they will provide support.

PCTs can offer a number of different kinds of support. These may address a specific issue, such as difficulties with appointment systems or poor quality premises, or be a broader package of support to help practices develop as organisations. Examples include:

- PCT staff with specialist skills (eg finance, estates planning, public health or information) working directly within practices
- sharing best practice examples from other providers
- establishing local learning networks across providers
- brokering support from support agencies
- commissioning external consultancy support (the NHS Institute for Improvement and Innovation⁹ holds a list of relevant providers).

You will want to incentivise providers to improve quality in a number of areas. These might include:

- treatment of a particular condition, such as primary prevention of heart disease or diabetes
- developing services for a particular group, such as services for substance misuse
- setting higher standards for a specific group, such as people living in particularly deprived areas, the homeless or travellers.

In line with commitments given in the NHS Next Stage Review, The Department of Health is consulting on proposals for a new, independent process (to be led by NICE) for reviewing and developing QOF indicators. One of the proposals is to allow the process to form the basis for local quality incentives, which might potentially help resources to be better targeted to local needs.

8 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

9 <http://www.institute.nhs.uk/>

You can already use other contractual mechanisms to incentivise providers. These include introducing a Local Enhanced Service for contractors, or building the requirement into the core specification for PMS and APMS contracts.

When developing local incentives, which can be either long-term or short-term, you should make sure that:

- you are not paying twice for activity that should be provided as part of the core contract
- incentives support reductions in health inequalities, eg by focusing on those members of the local population who have the greatest need for specific interventions
- you are not creating a culture in which contractors expect additional payment before implementing good or effective clinical practice or improving service delivery.

6.4 Information for patients and the public

When you commission GP services, you are investing public funds. That is why the information you hold on individual practices about the nature and quality of their services needs to be made available to the public. This information also enables people to compare GP practices and decide which one to register with. *High Quality Care for All*¹⁰ sets out proposals for making all providers of NHS care legally accountable for the quality of care that they provide through the publication of 'Quality Accounts'. These accounts will be reports to the public on the quality of services provided.

Working with local patient groups will show you what information is most useful to people. This is likely to be a combination of the services provided and information on quality (taken from the quality metrics used for managing performance and supporting quality improvement). It might include:

- basic details on location, opening hours, car parking and transport
- size of practice
- quality of premises
- consultation language, child friendly facilities, GP gender
- detailed description of services offered, including any areas of special expertise
- patient satisfaction scores, including by group and trends over time
- ratings on clinical quality, encompassing QOF, screening performance, etc
- the practice's performance against the key metrics used for performance management (eg some PCTs band providers according to their performance against a balanced scorecard).

10 Lord Darzi and Next Stage Review

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

You will need to present this information in an accessible way and keep it up to date. NHS Choices will provide an increasing amount of information on individual practices, but it is up to you to supplement this with the other details the public want or need.

You also need to make sure that the public are aware that this information is available. You can do this:

- through links in the PCT Guide to local NHS services
- by making sure that public bodies, such as libraries, display the information
- by developing proactive ways of distributing this information, for example, through links on house moving and utility switching websites or mail shots to new additions to the electoral roll.

Practice accreditation

The Department of Health is supporting the Royal College of General Practitioners (RCGP) to develop an accreditation scheme for providers of GP services. This is likely to be a valuable addition to the range of information available to measure quality and quality improvement, both for practices and members of the public. You should encourage providers to take part in the scheme, and work with them to address areas where there is scope for improvement.

6.5 Assuring minimum standards

The Next Stage Review strategy: *Our vision for primary and community care*¹¹ proposes that GP practices will have to register with the Care Quality Commission to make sure that they meet minimum requirements for quality, including patient safety. Without this registration, they would be unable to hold a contract to provide primary care services. Subject to final decisions on the scope of registration, PCTs will need to establish a close working relationship with the Care Quality Commission, sharing and receiving local intelligence on GP services and rapidly following up any service problems revealed by their assessments.

The Care Quality Commission is looking at options for when registration should be implemented for GP practices, but it is likely that the earliest practical date for registration will be April 2011. In the run-up to registration, there is likely to be an important role for PCTs, working with GP practices, to provide the Commission with information to support the registration process. This will be helped by working with GP practices to develop local quality metrics (see Section 6.1) and by encouraging practices to participate in the RCGP practice accreditation system (see Section 6.4), assuming it is rolled out more widely following the pilot.

11 *Our vision for primary and community care*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937

6.6 Promoting patient choice

Patient choice means a number of different things for GP services. These include:

- giving people a greater and more informed choice of which GP service they can register with
- giving people additional ways of flexibly accessing GP services – such as GP health centres offering open-access services to any member of the public, 12 hours a day, 7 days a week
- giving patients greater choice about the pathways open to them – for example, by commissioning extended services from community pharmacies or direct access to some AHP services
- giving people greater choice about the type of care and support they receive, for instance in relation to managing long-term conditions
- giving people greater choice in how they access services at their GP practice (eg telephone consultations, internet booking, arrangements for repeat prescriptions).

Here, we look at the first of these – giving people a greater and more informed choice of which GP service they can register with. At present, patients have some choice about which practice they register with, but it is often between providers that offer broadly similar services at similar times. Increased choice should lead to providers seeking out patient views and responding to local preferences, so that they attract patients and can flourish and prosper.

At national level, the Department of Health and NHS Employers are working with the BMA to continue the move to a fairer funding formula for GMS practices where money follows the patient registration. This should provide stronger incentives for GMS practices to attract and retain patients and thereby support patient choice. However, greater choice will also rely on PCTs tackling a wider range of local issues. The same principle and funding should similarly apply in local PCT contracts with primary care providers.

Some of the issues around patient choice and how you can address them are outlined below. Further detail and practical advice will be provided in a follow up guide.

People need good information if they are to make an informed choice.

- See 'Information for patients and the public' above – 6.4.

Some GP practices may be reluctant to accept additional patients, despite having 'open' lists. Narrow practice boundaries may also limit local choice.

- A fairer GP funding formula (with money following the patient if they switch practice) should encourage providers to attract new patients.
- Consider using 'expanding practice allowances' (see 'Developing the market' below) to provide pump-priming for practices that want to expand their practice list but need help with building costs and/or the transitional costs of staff recruitment. You could also support the expansion of practice boundaries.

- Regularly review whether providers with open lists are accepting new patients, for example by using 'mystery shopper' techniques.
- Consider using open procurements to commission additional GP practices, where necessary, to provide additional choice.
- Monitor the degree of choice available to different parts of your local community (ie for a given section of the population, the number of GP providers with open lists with which they can register).

It is difficult for people to move their registration between providers.

You can help by:

- enabling patients to move their registration online (the Department is looking at how this might work nationally)
- developing a call centre or service centre to support patients with registration
- developing and publicising a short 'How to move your registration' guide.

6.7 Developing the market

As described in Section 4, you will want to analyse the capacity and quality of primary medical care provision, and the extent to which they match local patient needs, including the degree of patient choice and competition. You will also want to consider how far both existing providers and other providers would potentially seize opportunities to develop new services.

Together with neighbouring PCTs and the SHA, you should have a quantitative and qualitative understanding of the provider market. Your analysis should include the viability of infrastructure, especially premises, that can be used to support service provision. You should consider:

- volume of potential patients for any new services – whether for a registered list or for other services
- sufficiency of the current and future workforce – including the extent to which incumbent and potential providers will contribute to the training and development of the current and future workforce
- the viability of infrastructure, especially premises, that the PCT can utilise either directly or through the potential provider market to support service provision
- sustainability of the services required. Do the identified needs and the proposed service models provide enough opportunity to sustain the range of providers for at least the length of the contract, ensuring an appropriate degree of competition remains
- the provider's viability – at least for the duration of the potential service contract.

You will need to develop a strategy for ensuring that the provider market can meet identified needs, both now and in the future. This strategy should not be limited to the current models of service provision or levels of integration.

6.8 Commissioning additional capacity

You might decide to commission additional capacity for a number of reasons. These include:

- where your needs assessment and mapping exercises show that you need to increase the capacity of core primary medical care services, either across your whole PCT or in particular localities
- where your contract management cycle reveals that you need additional capacity, either in the form of a new provider to create greater choice and competition, or by encouraging one or more existing providers to expand
- periodic replacements, such as when a partnership dissolves, a GP retires, when you terminate a contract, or when a time-limited contract, such as APMS, expires.

You can commission additional capacity in one of three ways:

- commission an entirely new practice
- encourage an existing practice to expand
- commission an alternative service.

First, you will need to develop a clear policy, which sets out when you will openly tender for new providers, the factors you will consider in reaching your decision, and when you will expand the existing market.

The *PCT Procurement Guide*¹² identifies four criteria that you must consider when deciding whether to issue a formal tender:

- value – the greater the value of the contract, the stronger the case for tendering
- market interest – the larger the number of potential providers, the stronger the case for tendering
- protected services – where it is clear that a particular provider is providing essential public services that need to be preserved
- appropriateness of competition – if only one provider has the technical skills required or if capacity is needed urgently, a tender may not be appropriate.

12 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance

You may also want to consider local circumstances, such as:

- whether existing providers' services meet the quality standards required by the commissioner, including the standard of premises
- existing providers' capacity to expand or to deliver a revised service model
- whether there are specific unmet needs (eg homeless people, asylum seekers) that need to be addressed.

Commissioning new providers

Commissioning new providers gives you the opportunity to:

- specify exactly what you are looking for
- stimulate ideas
- seek innovative proposals from the full range of providers.

There are also contractual advantages to using a locally negotiated, time-limited contract.

So what is next? A comprehensive procurement process has been developed as part of the Equitable Access to Primary Care programme. This includes:

- market stimulation
- consultation
- advertising
- pre-qualification questionnaires
- invitation to tender
- tender evaluation
- contract award
- mobilisation.

A range of support materials is available. This includes an interactive procurement plan, a 16-step guide to managing procurement and various templates. To-date, PCTs using this best practice process have seen large numbers of providers coming forward, often with innovative proposals.

The APMS contract gives you the flexibility to introduce additional capacity and adapt traditional models of service delivery to local needs and priorities. You have greater control over the length of the contract and how it is performance managed. The APMS route also gives greater scope for making sure that tenders are contestable and contracts awarded to providers offering the best quality and value for money.

Strong public and clinical engagement is key to the procurement process. You should always ensure that overview and scrutiny committees, public/patient groups and local clinicians are involved in the process.

Expanding existing practices

Instead of commissioning new providers, you might want to expand existing services. Any decisions you make must be transparent and based on objective criteria.

Designed especially for this purpose, the Expanding Practice Allowance (EPA) model enables PCTs to provide practices with a one-off grant. This is used to increase their infrastructure – usually additional staff – in anticipation of increased list sizes. It is one way of overcoming the time delay between additional patients actually registering with the practice and increased capitation-based payments. EPAs are granted at your discretion, so you should develop suitable eligibility criteria for any allowances agreed locally.

Commissioning an alternative service

Traditional models of primary care are not for everyone. They might not meet the needs of particular communities or groups, such as travellers, the homeless, or areas with very poor transport.

The PMS and APMS contractual models have been specifically designed to help you target these groups and areas. A word of caution though – be careful not to establish new services that largely replicate existing provision. Otherwise you risk causing confusion for patients, and exposing the PCT to paying twice for the same service.

6.9 Improving premises and estates

Contractors are obliged to make sure they operate from adequate and suitable¹³ premises. This is in itself a significant commissioning lever.

Where premises do not meet basic requirements, the NHS Directions require providers and PCTs to agree an action plan to bring them up to at least minimum standards. A failure to deliver the necessary improvement is a breach of contract and could trigger a Breach Notice. Failure to comply with the terms of the Breach Notice could be grounds for terminating a contract.

Premises issues should not be treated in isolation, but as part of your service strategy. You can use premises incentives, for example, to do more than just enforce minimum standards.¹⁴ You can use them to drive changes in the pattern of primary medical care provision, and to help you implement new models of provision.

Further detail will be provided in a separate guide to premises issues.

13 A definition of “suitable” is contained in Schedule 2 of the NHS (GMS – Premises Costs) Directions, 2004

14 Developmental standards for premises have also been developed – go to www.primarycarecontracting.nhs.uk/243

6.10 Practice-based commissioning

The PCT and practices should understand and be able to articulate their respective roles in commissioning, whether for individual patients, specific conditions, practice populations, community or locality areas or for the PCT population as a whole. You should have clear, proportionate and timely governance and support arrangements to ensure that clinicians, practices and clusters can fulfil their roles effectively, including:

1. clear separation between the procurement process and Practice Base Commissioning (PBC) functions with a documented policy on conflict of interest and ground rules for engagement
2. rules for delegated authority to PBC consortia
3. ensuring that contracts are awarded only to practices meeting appropriate quality standards for core primary medical care.

PBC and GP services are linked. PCTs will need to ensure that practices explicitly understand the relationship between the quality of primary care they provide and the referrals and prescribing decisions they make to the 'delegated' PBC budget.

Where PCTs decide to invest in enhanced primary medical care services, as a result of recommendations by PBC consortia they will want assurance that these decisions are based on robust clinical advice. The PCT board will also want assurance that any vested interests of individual practitioners providing this clinical input are well documented with appropriate governance in place.

You should ensure that the provision of information to support PBC includes transparent and benchmarked information regarding levels of investment per head of population for primary medical care, access measures, QOF registers, exceptions and achievements, prescribing data and secondary care utilisation.

You may wish to expand the services available in primary care either to provide wholly new services or as part of a strategy of shifting services away from hospitals. These enhanced primary care services should only be delivered by practices that exceed locally specified minimum quality standards. Practices will need to demonstrate how they intend to deliver a new service without compromising existing standards. The commissioning of these services can be used to support federated working of groups of practices if deemed appropriate by the PCT.

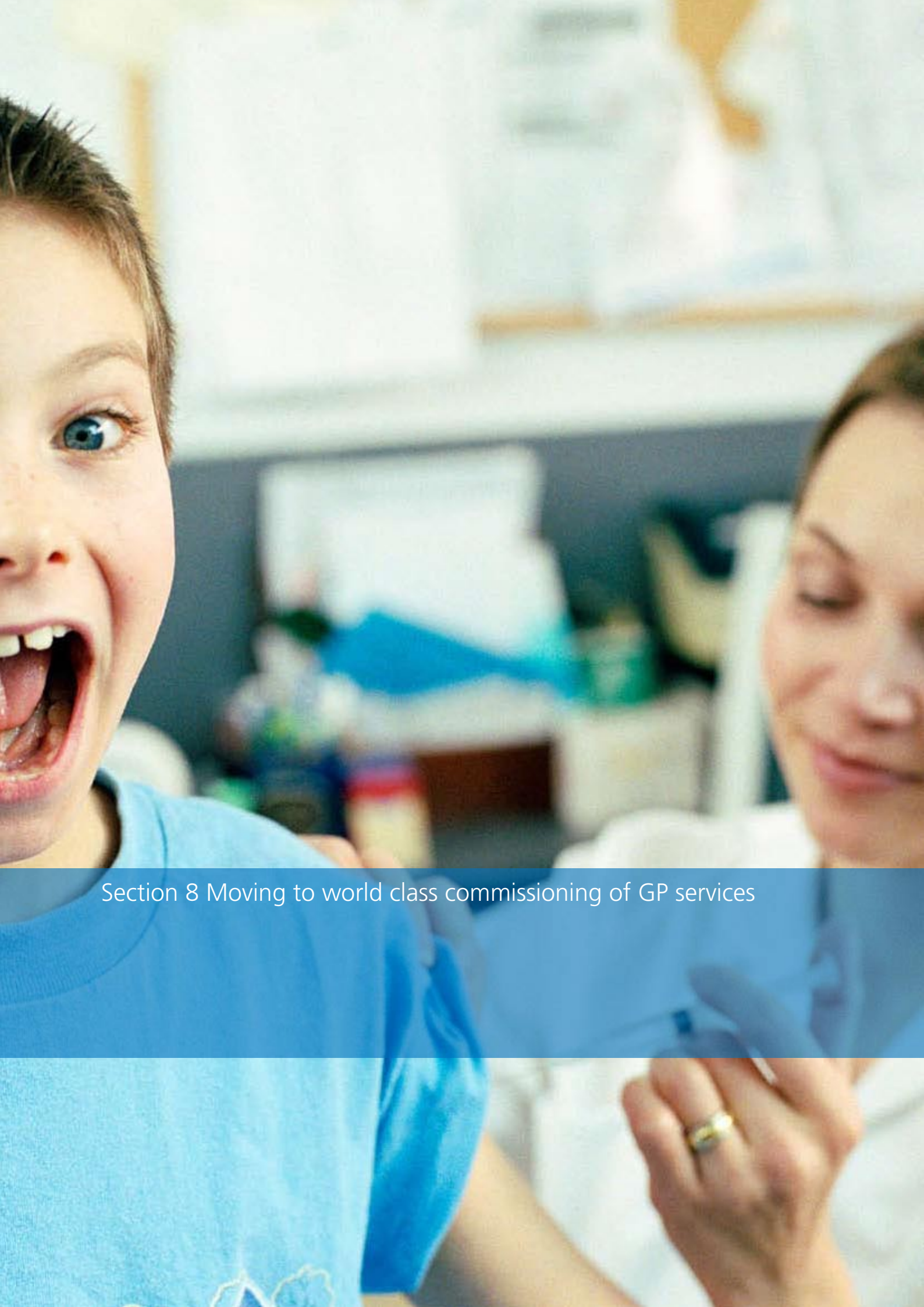
Commissioning of alternative providers of new or shifted services may be needed to stimulate the market, or may better meet the needs of the local population.



Section 7 Questions for the PCT Board

Questions for the PCT Board

- Is there a named board member with responsibility for primary care including general practice?
- Do non-executive board members have a good understanding of the relationship between the PCT, its GP practices and their roles in the PCT's commissioning agenda?
- What is the PCT's vision for the strategic service configuration for primary care services?
- What is the PCT's approach to the support and development of individual providers of primary medical care?
- Does the PCT have clear ways of engaging with the public and local population to understand needs and demand and to help shape services?
- Does the PCT have a good picture of how current investment in family doctor services is deployed and the levels of access, quality and health improvement that this provides?
- Does the Board receive regular reports on primary medical care performance?
- Does your primary care commissioning team have appropriate capacity, skills and support from Directors? Does the team have easy access to suitable clinical advice and financial expertise?
- Does the PCT have a clear strategy and policy on procurement of new or replacement enhanced services and practices?
- Does the PCT have systems in place for managing primary medical care contract performance effectively?
- What is the PCT's strategy for communications and stakeholder engagement on primary medical care issues?



Section 8 Moving to world class commissioning of GP services

Moving to world class commissioning of GP services

The previous chapters have described the steps that all PCTs will want to follow to become competent strategic commissioners of GP services. As with many complex areas a systematic approach supported by a high level of competence and professionalism will lead to significant improvements. These will be seen in the quality and availability of services, improvements to health and reduction in health inequalities.

The aspiration to become world class commissioners will apply to the commissioning of GP services as to other aspects of PCT's strategic commissioning. This section describes under each of the world class commissioning competencies what level 4 might look like in relation to GP services.

This will evolve to reflect what we hope will be growing evidence of best practice and innovation, and the Department will continue to work with SHAs, PCTs and other stakeholders to capture and disseminate this evidence.

Commissioning GP services and world class commissioning competencies

	Competency 1 local leadership	Competency 2 collaborative working	Competency 3 – public/ patient involvement	Competency 4 clinical engagement	Competency 5 needs assessment	Competency 6 prioritising investment	Competency 7 stimulating the market	Competency 8 innovation and configuration	Competency 9 procurement	Competency 10 manage systems and providers	Competency 11 – sound investments
Mapping the Baseline											
Needs assessment		✓	✓	✓	✓						
Mapping current services		✓	✓								
Developing the Vision											
Patient offer	✓	✓	✓	✓		✓					✓
Service model	✓	✓	✓	✓		✓	✓	✓			✓
Making it Happen											
Performance review		✓	✓	✓						✓	
Supporting improvement		✓		✓		✓		✓			
Use of information		✓	✓	✓	✓						
Patient choice		✓	✓								
Additional capacity		✓	✓		✓	✓	✓	✓	✓		✓
Registration and accreditation		✓		✓						✓	
Premises		✓				✓		✓			✓
Practice-based commissioning		✓	✓	✓	✓		✓	✓			✓

COMPETENCY 1 – local leadership

Reputation

- GPs and their practice teams strongly agree that you are the local leader of the NHS.
- People see continuous improvements in the quality of GP services – particularly in the accessibility and responsiveness of services.
- You actively participate in the local authority agenda, including ward level dialogue regarding how wider plans relate to primary care provision.

Change leader for local organisations

- Providers of GP services recognise and respond to you as the commissioner of the services they provide.
- Providers of GP services strongly agree that the PCT significantly influences their decisions and actions.
- Providers of GP services recognise your clear vision and strategy for the future of services provided in a local setting.

Position as the employer of choice

- PCT staff and the Board describe their roles and responsibilities in relation to primary care.
- Your commissioning team is appropriately staffed with highly motivated individuals who understand and can use the full range of commissioning levers for GP services.
- You can attract a substantial field of suitably experienced and qualified staff for roles within primary care commissioning.
- You have good arrangements for succession planning and organisational memory in relation to commissioning of GP services.

COMPETENCY 2 – Collaborative working with community partners

Creation of Local Area Agreement (LAA) based on joint needs

- Your strategic objectives for primary medical care are rooted in wider objectives for health and wellbeing reflected in Local Area Agreements.
- The LAA and other strategic partnerships include objectives to improve GP services. Decisions made by other parties take this into account.

Ability to conduct constructive partnerships

- You have identified key partners for primary care commissioning. This includes explicit arrangements for how clinicians can play an active part in improving primary medical care.
- There is evidence of cross-fertilisation between the PCT's primary care strategy and wider community strategies, eg for social care, education, employment, transport, housing and leisure. For instance, there are clear arrangements to define the role of primary care in contributing to safeguarding of vulnerable adults and children; or (conversely) that bus routes take account of the location of GP practices, health centres and community pharmacies.

Reputation as an active and effective partner

- You support new provider ventures that involve community leaders and services to reach specific groups.
- Key stakeholders strongly agree that the PCT is an effective partner in improving GP services.

COMPETENCY 3 – Continuous and meaningful engagement with public and patients Influence on local opinion and aspiration

- You describe what patients can expect from GP teams in terms of minimum acceptable standards.
- Patient and community groups are involved in commissioning processes at a PCT level, eg by participating in assessment panels for procurements of new primary care services. PBC also has clear and visible mechanisms for seeking and acting on patient and public views.
- PBC clusters have direct access and regular contact with ward-based councillors, local community safety and police officers and education establishments, ensuring the greatest connection with the population they serve.

Patient and public engagement

- You actively use LINKs and other mechanisms to reach different community groups. Social marketing is also used to engage a wide variety of patient groups. Practices and PBC have access to these same skills, ensuring a joined-up approach to engagement with patients and the public.
- The general public see you as a champion of the patient and public interest in primary care.

Improvement of patient experience

- You have identified practices with poor patient experience and can demonstrate improvement to satisfactory levels.
- You have published a 'patient offer' with minimum guaranteed standards. Information on how each GP practice matches up to these standards is published on NHS Choices and is widely available to the general public. PBC clusters and the PCT Board regularly review the benchmarking information to ensure a consistent approach to performance development.
- You demonstrate that your PCT consistently achieves 'patient offer' guarantees in every practice.
- You regularly seek public views on GP services. Practices and PBC consortia use this information to make rapid improvements to the services.
- You have a clear strategy for working with GP practices to support the use of personal budgets for identified patient groups (subject to the outcome of piloting) to give them greater control over their health and healthcare.

COMPETENCY 4 – Lead continuous and meaningful engagement of all clinicians

Clinical engagement

- Local clinicians aspire and prepare to be local or PCT clinical leaders. You have well developed plans to support their development towards these roles.

Dissemination of information to support clinical decision-making

- Together with local practices, you can demonstrate real improvements to services that have been driven by clinicians in commissioning.
- Quality reports to practices and PBC consortia include recent clinical evidence, benchmarks and changes in clinical practice with respect to GP services.

Reputation as leader of clinical engagement

- Primary care clinicians recognise your clinical leadership role. All primary care clinicians understand how they link to the PCT clinical leadership team and its relationship to other clinical leadership roles, such as PBC.
- Transformational clinical leadership and practice based commissioning are rewarded by earned autonomy and increasing opportunities for responsibility with accountability.

COMPETENCY 5 – Manage knowledge and undertake robust and regular needs assessment

Analytical skills and insights

- The PCT and PBC use risk stratification to understand the needs of practice populations at individual patient and ward level. You ensure that appropriate disease and case management registers are in place at each practice. You are able to aggregate these registers to different population levels.
- The PCT and PBC group use predictive modelling to test future scenarios based on demographic changes – and practices apply this methodology to help shape existing and new services.

Understanding of health needs trends

- You are able to identify any disadvantaged sub-groups in each practice and any specific gaps in service.
- You can identify populations that require a specialised primary care service, such as travellers, offenders or asylum seekers.
- You map practice information, QOF data and other quality metrics with population health data and prevalence from PHO tools to identify health inequalities and inform the JSNA and the PCTs primary care commissioning strategy.

Use of health needs benchmarks

- You continuously benchmark each practice against relevant PCT and national targets to create ambitious improvement trajectories.
- You use business processes built on information from registered lists and from registers for specific patient groups to shape bottom up needs assessment.
- You publish a health needs assessment for each practice/cluster, which informs the JSNA, to support practice/cluster priorities for PBC plans.

COMPETENCY 6 – Prioritising Investment according to local needs

Predictive modelling skills and insights

You have, and effectively use, predictive modelling of practice demographics and disease patterns to identify future commissioning requirements.

Prioritisation of investment to improve population's health

- You have a clear understanding of current funding arrangements for primary medical care, including variations in the weighted capitation price for the provision of core services. You also have a developed plan for moving all practices, whatever their contracting route, towards the fair funding allocation as agreed by your Board and informed by the JSNA.
- You have a needs based investment plan in place across primary care services. You have also planned how to reallocate investment to reflect the needs of communities.
- You undertake economic analysis and have a methodology for assessing health gain against investment for Local Enhanced Services, Quality and Outcomes incentives, premises improvements, etc.

Incorporation of priorities into strategic investment plan

- You have a succession plan in place for all current primary care providers. This includes a shared view on the most desirable strategic configuration of services, as well as plans to achieve this over a specific period.

COMPETENCY 7 – Effectively stimulating the market to meet demand and secure required outcomes

Knowledge of current and future provider capacity and capability

- You have identified your future capacity requirements for primary medical services. This includes when you will procure new capacity and when existing services will be offered the opportunity to expand.
- The PCT Board has a clear view of when it will seek to expand or test the market through open procurement and when existing market arrangements provide the appropriate level of quality and choice. The Board has clearly documented processes for agreeing when to commission new services through Local Enhanced Services, through Any Willing Provider arrangements or through competitive procurements.

Alignment of provider capacity with health needs projections

- You have aligned your estates, premises and strategic service development plan with your requirements for future primary medical care capacity. You have a pipeline for future primary care procurements, including the use of tendering for specialised primary care services. There are quantified requirements for relocation of hospital services into primary care settings, including the procurement pipeline.
- You have a dedicated resource for primary care improvements. This is available to practices identified as requiring further support.
- You have AWP arrangements in place for a number of Local Enhanced Services, including the use of non-traditional providers for some services.
- You are aware of the potential provider market for potential new services or changes in configuration of services and engages with the market to communicate your future intentions.
- You understand the role of your practice-based commissioners as current and potential providers of services and support this market appropriately.

Creation of effective choices for patients

- You provide multi-channel information to the public on the quality and availability of services including a range of ways for how to choose a new practice (when moving to the area) or change the practice with which they are registered.
- The local public has real choice over which GP practice they register with.
- There are no practices with 'open but full' practice lists.

COMPETENCY 8 – Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration

Identification of improvement opportunities

- Clinical pathways clearly identify the services to be delivered through primary medical care providers. They also specify the appropriate key performance indicators included within contracts.
- You have a clear strategy for securing continuous quality improvement in primary care. This quality strategy is sensitive to the specific needs of specific patient groups, eg homeless people, people with learning disabilities, university students etc.
- You have a clear strategy for your preferred service model for different communities – hub and spoke across a rural community, for example.

Implementation of improvement initiatives

- Together with practice-based commissioners, you have documented integrated care pathways. Patients know how and when to access services and the choices available to them.
- High performing practices and PBC clusters receive regular recognition.
- Improvement initiatives include clear arrangements for audit and evaluation, including (where possible) patient-reported outcome measures.

Collection of quality and outcome information

- Tracking data from clinical pathway improvements is incorporated in the local quality metrics for primary care.

COMPETENCY 9 – Secure procurement skills that ensure robust and viable contracts

Understanding of providers' economics

You have benchmarked each individual practice on quality and value-for-money.

You have identified any practices where long-term viability is a concern.

You are able to construct target costings for LES schemes and tenders for primary medical care services.

Negotiation of contracts around defined variables

PMS and APMS contracts contain local quality and value for money improvement targets and you can demonstrate that agreed improvements have been delivered.

You have secured value for money in GMS contracts, particularly in practices with residual MPIG payments.

You have agreed consolidation strategy for practices with long-term viability challenges, including merging of practices where appropriate.

You can demonstrate measurable delivery of improvement through these contracts.

Creation of robust contracts based on outcomes

You can demonstrate documented annual cycle for negotiating continuing improvement in the local specification for PMS and APMS contracts, particularly with reference to clinical outcome, patient safety and patient experience criteria.

You can demonstrate documented annual cycle for negotiating quality improvements in GMS contracts, particularly with reference to LES schemes, discretionary disbursements and the local elements of QOF.

You can demonstrate your minimum standards that must be met by providers and your aspirational or developmental standards.

COMPETENCY 10 – Effectively manages systems and work in partnership with providers to ensure contract compliance

Use of performance information

- You have a balanced scorecard for each primary care provider. This information is published regularly to all contractors and the public. The scorecard includes near real time patient experience data. You are able to collect real time data, which both you and individual practices use to develop proactive patient management and inform commissioning.

Implementation of regular provider performance discussions

- You have a documented annual cycle for in year face-to-face performance reviews with each primary medical provider.

Resolution of ongoing contractual issues

- You specify intervention thresholds within your primary medical contracts and have a documented escalation procedure in place for when performance is poor or deteriorating. You issue warning and termination notices where performance fails to reach a satisfactory level. You also act swiftly when concerns about quality are raised.
- Providers are aware of your performance development role. You are satisfied that this is a legitimate role in ensuring that there is a continued market for the services you commission.

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If you have found this guide useful, have ideas for future topics that should be covered or would like to share an example of good practice in relation to any primary care service then please get in touch with the Primary Care and Community services team at pccsteam@dh.gov.uk or your local primary care contracting advisor at pccenquiries@pcc.nhs.uk



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