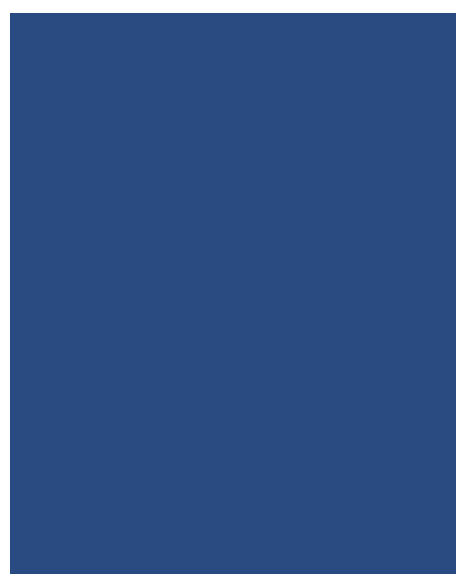


Securing excellence in commissioning primary care

June 2012



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Introduction

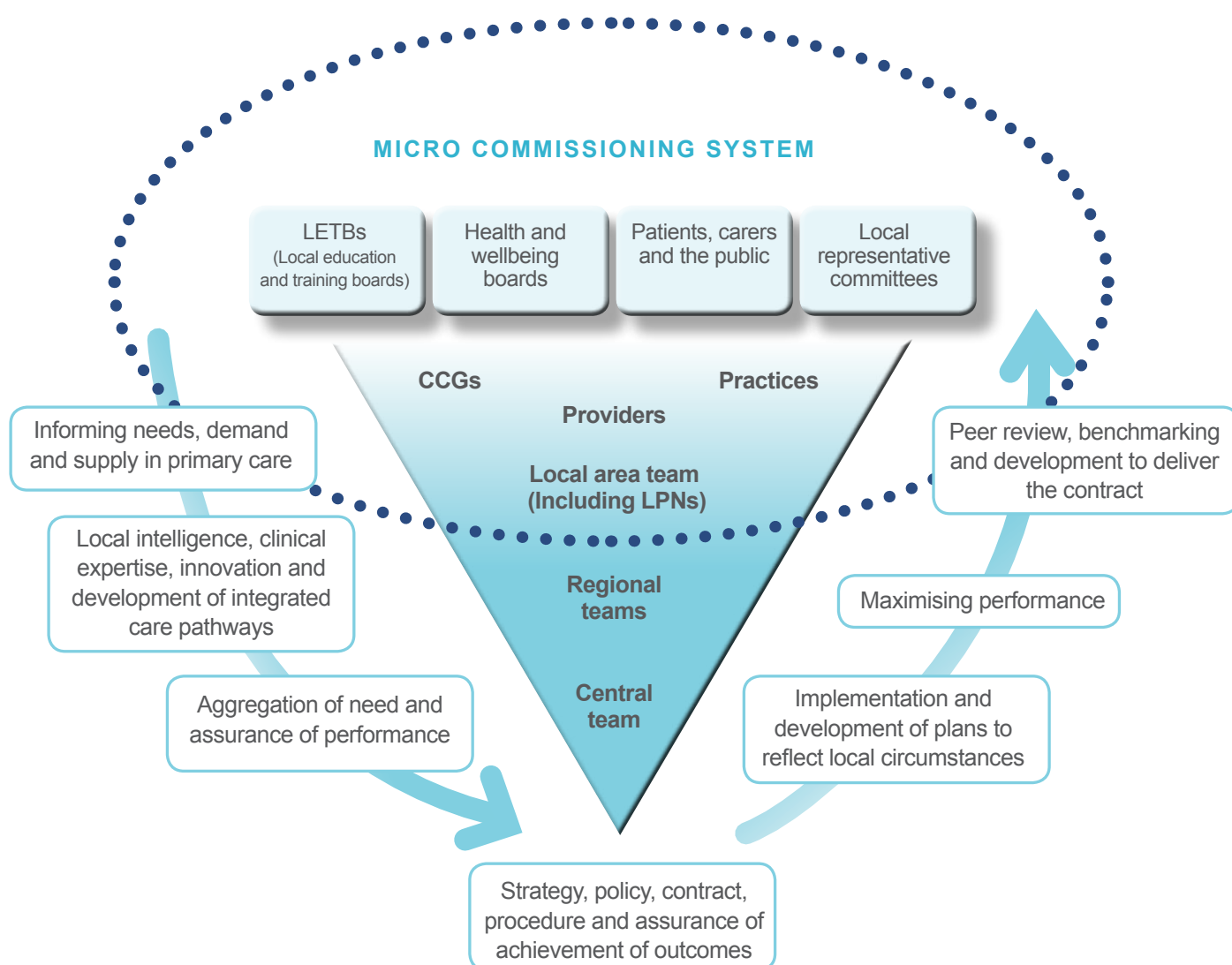
- 1.1 From April 2013, the NHS Commissioning Board (NHSCB) will be established with an overarching role to ensure that the NHS delivers better outcomes for patients within its available resources and upholds and promotes the NHS Constitution. As a single national organisation, the Board will be responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality across the country. The NHSCB will work through its national, regional and local area teams to discharge these responsibilities.
- 1.2 Primary care has a key role to play and we will use the £12.6bn¹ that the NHS spends on primary care to secure the best possible outcomes. We know robust primary care has a positive impact across the whole of the health and social care system. Evidence shows strong and effective primary care services are vital for health economies² and for delivering high-quality health systems and healthy populations³.
- 1.3 Primary care professionals are best placed to make effective preventative interventions and to impact positively on the quality and efficiency of the whole health service. GPs and nurses in general practice see over 800,000 people a day; dentists and dental teams see around 250,000 people a day; opticians provide around 12 million NHS sight tests each year; and an estimated 1.2 million people visit a community pharmacy every day.
- 1.4 Our ambition is to help achieve excellence in primary care provision through excellent commissioning which:
- Delivers a consistent offer to patients of high quality, patient centred services
 - Builds on the very best practice to deliver continuous improvements in health and care outcomes.
- 1.5 This ambition is possible with: the changes to the new commissioning arrangements; our approach to engaging with and understanding our patients; our proposals for strengthening primary care clinical leadership; the opportunities to develop innovative approaches that challenge the ways of the past. These will all enable us to better define excellence in primary care and provide us with a consistent approach to achieving excellence.

¹This excludes drug costs and includes some currently local enhanced services costs

²Starfield Barbara. *Is primary care essential?* Lancet 1994;344:1129-33.

³Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly*, September 2005. Starfield, Barbara; Shi, Leiyu; Macinko, James

- 1.6 Having a consistent approach will also help us tackle unwarranted variation and take positive steps towards raising the overall standard of primary care provision to the level of the best.
- 1.7 At a national level, the NHSCB will work with a range of stakeholders to determine the outcomes expected from primary care and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes, evidence from patient experience and insight, evidence from local experiences, and innovative practice. The NHSCB will use this as a basis for developing national contracts and for developing national frameworks for local contracts and local commissioning.
- 1.8 However, the Government's vision is for decisions about services to be made as locally as possible, involving the people who use them as much as possible. To this end, the NHSCB will work in partnership with CCGs and other local networks; and will ensure that there is a locally responsive approach, supported by joint health and wellbeing strategies, joint strategic needs assessments (JSNAs) and pharmaceutical needs assessments (PNAs).
- 1.9 This new commissioning system aims to be commitment-based, with shared values and behaviours and constant flows of information between local and national teams. By informing the national approach with the views and experiences of those commissioning and providing primary care services and those receiving care, we will ensure local implementation feels both relevant and owned by those delivering it.



- 1.10 Achieving the right balance between national consistency and local decision making will be important. As the contracting body, the NHSCB requires contractual relationships with providers to be managed within a consistent framework. Service developments and improvements must be local and flexible to ensure that they meet the needs of individual communities.
- 1.11 *Developing the NHS Commissioning Board (July 2011)* sets out a number of features that will characterise the culture of the NHSCB. The proposals for primary care reflect these characteristics and key requirements:
- A clear **sense of purpose** focused on improving quality and outcomes
 - A commitment to putting **patients, clinicians and carers** at the heart of decision-making
 - An **energised and proactive** organisation, offering leadership and direction
 - A **focused and professional** organisation, easy to do business with
 - An **objective** culture, using evidence to inform the full range of its activities
 - A **flexible** organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local
 - An organisation committed to **working in partnership** to achieve its goals, in particular by developing an effective and mutually supportive relationship with clinical commissioning groups
 - An **open and transparent** approach, sharing information freely wherever appropriate
 - An organisation with clear **accountability arrangements** and a grip on those things for which it will be held to account.
- 1.12 The purpose of this document is twofold: it describes how we will manage the safe and effective transfer of functions; and it outlines the main components of the new primary care commissioning system and how they will enable us to achieve ambitious improvements in primary care.
- 1.13 Much of that improvement will be driven locally, in partnership with others, and this will take time to establish and become effective. To support this, the NHSCB will provide a framework of common operating procedures, shared values and behaviours within a culture of continuous learning and peer review.
- 1.14 The new arrangements will be kept under review. We will ensure that they are achieving what they are designed to do and, that they remain fit for purpose within the context of the emerging commissioning system.

Our ambition for the new primary care commissioning arrangements is for:

- **A common, core offer for patients of high quality patient-centred primary care services**
- **Continuous improvements in health outcomes and a reduction in inequalities**
- **Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda**
- **The right balance between standardisation/consistency and local empowerment/flexibility**

Primary Care Commissioning in Context

- 2.1 Primary care commissioning is broad and complex. It will be a significant challenge to move from many different systems to a single national operating model, while retaining vital local responsiveness and sensitivity. But establishing relationships and arrangements across the new organisations within the commissioning system will be critical to securing high quality primary care.
- 2.2 CCGs will commission the majority of NHS services for their populations, drawing on the unique role of general practice in connecting with patients and acting as the intermediary for most of their care. CCGs will also have a statutory responsibility to support the NHSCB to improve the quality of primary medical care. Even though they are responsible for local services, to commission primary care as well would create a conflict of interests.
- 2.3 But it is important that the NHSCB plans local primary care services in the context of CCGs' commissioning strategies, health and wellbeing strategies, the JSNA and the PNA. Citizens and communities will have a stronger voice to influence and challenge how health and social care services are provided. Some services, like sight tests, will continue to be demand-led and not actively commissioned.

The task

- 2.4 The scope of primary care commissioning transferring to the NHSCB has already been set out in policy or through agreement that some tasks and functions are integral to discharging this responsibility.

(a) Commissioning functions

- 2.5 The NHSCB will be responsible for planning, securing and monitoring an agreed set of primary care services (see Annex 1). The following functions underpin this:
- 2.6 **Planning** the optimum services which meet national standards and local ambitions, ensuring that patients, carers and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;
- 2.7 **Securing** services, using the contracting route that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration; and
- 2.8 **Monitoring**, assessing and, where necessary, challenging the quality of services; and using this intelligence to design and plan continuously improving services for the future.

- 2.9 The NHSCB will facilitate delivery through supportive frameworks and procedures, managing relationships with providers, sharing good practice and securing essential training, development and support.

(b) Support functions

- 2.10 The following will also be discharged in local area teams, probably through the primary care commissioning arrangements:

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

- 2.11 Expenditure on core GP IT and premises reimbursement is included in the total primary care commissioning budget (the £12.6bn). The NHSCB will manage the premises reimbursement budgets but will delegate GP IT functions to CCGs to help integrate these with broader system development.

- 2.12 The following, carried out by some PCTs, will not transfer to the NHSCB but will be the responsibility of providers themselves:

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

(c) Payment and associated functions

- 2.13 At its most simple, this is payment for contract delivery. However, for many of the primary care payments there is a relationship between them and the resulting net income or pay of individual contractors. For GP payments, this is made more complex, by various sources of contractual income, including payments for weighted capitation ('global sum' for GMS contractors), and practice income from QOF⁴, items like flu vaccinations, premises reimbursement, seniority pay and, for all contractors, enhanced services payments.

⁴Quality and Outcomes Framework

- 2.14 Payment to GPs is inextricably linked to the patient registration system, which in turn is linked to the system supporting screening and immunisations. Those providing these payment services also process the NHS pension arrangements for some primary care contractors.
- 2.15 The responsibility for the vast majority of these services for all contractors will transfer to the NHSCB and be discharged through the primary care commissioning arrangements described in Section 3.
- 2.16 A detailed analysis of the tasks and functions that underpin commissioning, support and payment functions is available in Annex 2 to this document through the following link:
<http://www.commissioningboard.nhs.uk/files/2012/06/task-func.pdf>

The approach

- 2.17 This document sets a clear sense of direction and should guide organisation and people development over the coming months. This will be particularly important for the design of regional and local area teams and as the NHSCB establishes working relationships with bodies such as the Care Quality Commission.
- 2.18 There are a number of interdependencies being considered as part of the overall design of the NHSCB and the future responsibilities of the Department of Health that are critical to the primary care operating model. These include provision of intelligence and information for commissioners, responsible officer regulations, the new approach to patient insight and ensuring patient safety. The model needs to be flexible to respond to these and other emergent strategies.
- 2.19 Designing the new model has enabled us to consider how to embed the equality delivery system⁵ and how to deliver the rights and pledges set out in the NHS Constitution. For example, because the NHSCB will be judged on providers' results, the system has to promote fairness and transparency in dealing with those providers, and local area teams will be expected to adopt a professional and proportionate approach as well as building strong relationships.
- 2.20 We know that clinical engagement and leadership and patient engagement are critical for successful commissioning. There will be a strong clinical community working for and with the NHSCB and we also need to ensure effective relationships between the NHSCB local area teams, CCGs, local authorities and local Healthwatch to enable patients to fully engage with the new model.

(a) Patient-driven improvements

- 2.21 Central to the reforms is ensuring that patients have more choice and control in designing services that respond to their needs. The guiding principle is "no decisions about me without me", which applies to strategic decisions about access to high-quality services as well as decisions about an individual's care or treatment.
- 2.22 Patient insight suggests that it is the basic service offer, whether access to appointments, early diagnosis or effective communication, that makes the most significant difference between a good and bad primary care experience. We want to put an end to unjustifiable variations in services and reduce health inequalities by ensuring that access and provision are consistent and fair.
- 2.23 We will work closely with CCGs to engage patients and the public in commissioning so as to ensure services are responsive, appropriate and consistent. Patients should also be part of the local area team arrangements to improve services such as dental access, use of medicines and preventing sight loss, and through local professional networks (LPNs), described later. Patient insight will be a significant driver of future national strategy.

⁵The Equality Delivery System for the NHS November 2011

(b) Clinical leadership and engagement

- 2.24 We believe that empowering clinicians to drive continuous improvements will also benefit patients through better quality of primary care, better outcomes and a safe and positive experience for them and their carers.
- 2.25 The new primary care commissioning system will be driven by clinical leadership and engagement. We know from PCTs that have invested in structured clinical engagement and ownership, that good clinical leadership can deliver better outcomes in commissioning and improvements in the quality of primary care.
- 2.26 As the NHS Future Forum review in the Spring of 2011 made clear, this clinical expertise needs to extend beyond GPs and CCGs to the wider clinical community and draw on the knowledge and experience of other primary care clinicians in designing, developing and delivering primary care services.
- 2.27 We are testing arrangements which place dental, pharmaceutical and optical clinicians within local area clinical leadership teams. As well as being accountable through the local area teams, these professional groups will also have a professional line of accountability through to chief officers working centrally. They will have responsibility for leading quality improvement locally through the development and implementation of commissioning plans.
- 2.28 The relationship between the local NHSCB teams, local clinicians and CCGs is central to the shared operating model for primary medical care. This will be a new working environment for clinicians and they will need to be supported by high quality management and systems.

Key principles

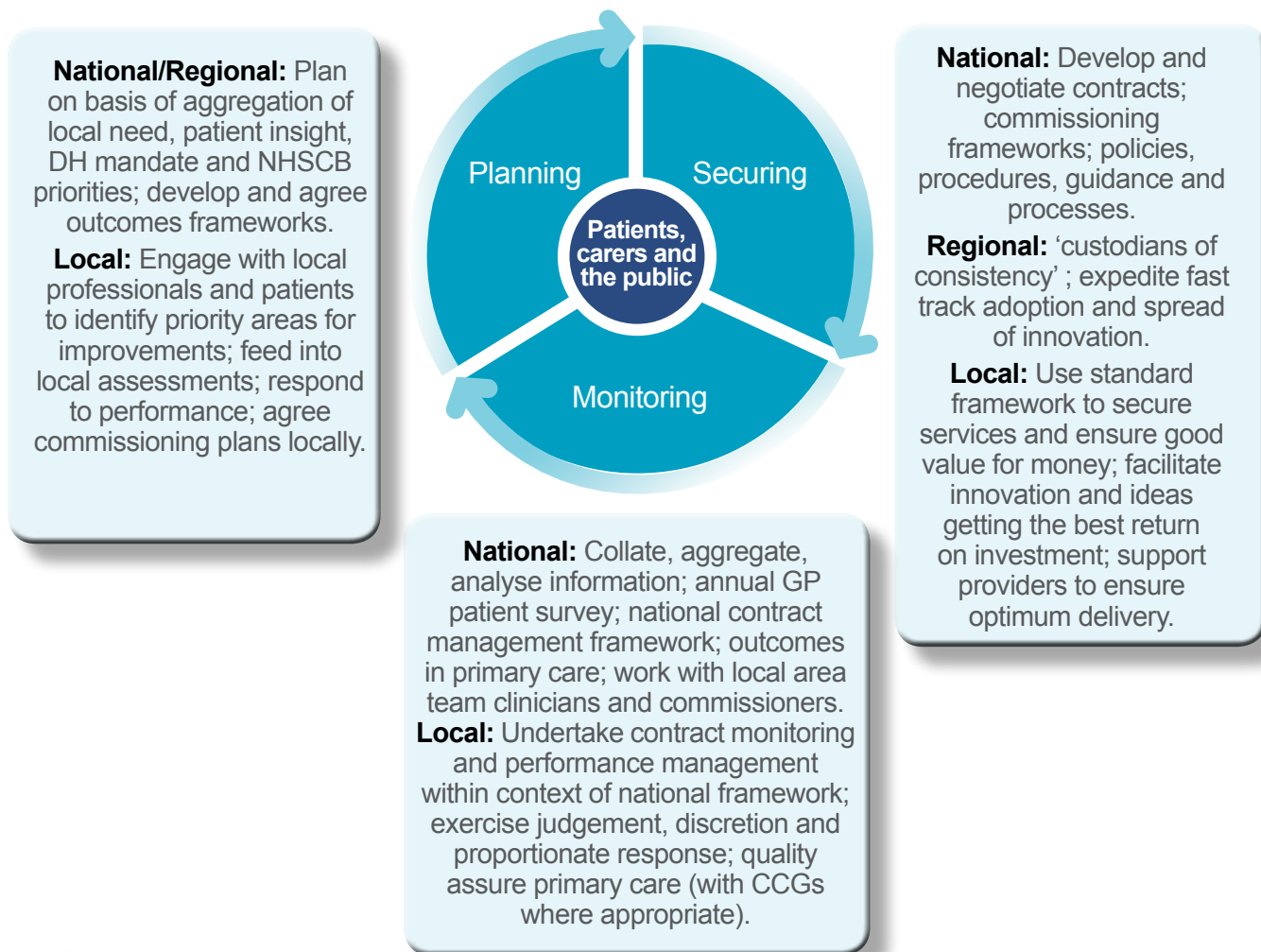
- 2.29 We have worked with stakeholders to define the key principles of the operating model, set out below:
- **Quality will be the overriding principle.** Everyone in the system must focus on clinical effectiveness, safety and patient experience, although their role will differ depending on their job and the area where they work
 - **Patients' experiences** are the main driver of the primary care commissioning arrangements
 - The system will be **clinically led** through a range of mechanisms, including central and local clinical leadership teams, explicit partnership arrangements with CCGs and local professional networks for dental, pharmaceutical and optical services which will include relevant public health clinicians
 - **Teams will work in one system**, but in different ways and with a different focus depending on local circumstances
 - Local primary care teams should strive to **get the best from relationships** by focusing on problem solving and not putting up, or being constrained by, any unnecessary barriers
 - Managing **contractual relationships will be guided by standardised frameworks**, but there remains a need for some local judgement and flexibility. Where standard procedures are not in place, and they cannot cover every eventuality, local teams will use their judgement and be guided by the culture, values and expected behaviours promoted by the Board
 - We will be **judged on outcomes** and this should drive our approach to provider management. We will avoid "clipboard" contract management and concentrate on improvement strategies. We will adopt a proportionate risk-based approach to our relationships with providers based on trust. We will not tolerate sub-standard performance and "support to improve" will come before contractual sanctions unless there are serious breaches or concerns.

The Single Operating Model

- 3.1 Section 2 described the scope of the NHSCB's primary care commissioning responsibilities and the approach needed to get the system up and running and capable of transforming primary care.
- 3.2 This section sets out how this will be achieved, including the functions of the NHSCB and the roles of others such as commissioning support services and CCGs.

The local/central relationship

- 3.3 The local element of the system includes people working for the local area teams of the NHSCB, CCGs, local authorities and health and wellbeing boards. Most commissioning activity will take place locally, close to contractors and close to patients.
- 3.4 These local teams are essential to maintain the effective relationships with contractors built up over many years and vital for effective primary care commissioning. However, the nature of these relationships will change, with a new focus on outcomes across all types of contracts.
- 3.5 The central element will provide the framework to ensure consistency in primary care commissioning.
- 3.6 It will draw on nationwide patient insight and intelligence and include innovation, clinical expertise and the Government's mandate. But just as importantly, it will draw on the experiences and expertise of local clinicians, NHSCB staff and patients.
- 3.7 This will form the basis for coordinating our needs for primary care and working with key stakeholders who will then be able to describe the shape and nature of all the primary care services which will deliver the best quality and outcomes.
- 3.8 This will lead into the negotiations of the national contracts but will also provide the framework which local area teams can use for performance management, managing local relationships and routine quality assurance.
- 3.9 Some supporting systems will be directed nationally but managed locally, such as a national performers (or providers) list with entry and exit managed by local area teams.
- 3.10 All parts of the NHSCB need to work in a fully coordinated and integrated way to ensure that local primary care commissioning activity informs the national strategy and vice versa. To improve outcomes, there must be a strong connection between design and delivery and this requires capacity and capability in regional teams as well as strategic leadership at a national level.



Resources

- 3.11 In February 2012, the NHSCB first set out its national, regional and local structures and the resources available to support them. This was updated further in June 2012.
- 3.12 The cost of running local area teams, including managing primary care commissioning, primary care support and locally-managed primary care payments has been agreed by the NHSCB.
- 3.13 The majority of staff resources in local area teams will be involved in primary care commissioning, including a significant role for clinicians.
- 3.14 Primary care commissioning in local area teams will require strong clinical leadership and support by a team of multi-professional clinicians (including doctors, nurses, dentists, pharmacists and optical providers). There is complementarity in the functions of primary care commissioning and those of the responsible officer.
- 3.15 Managerial resources will be fewer than in PCTs and PCT clusters but there will be different ways of working with the efficiencies brought by common operating policies and procedures. There will be larger geographical footprints and this brings greater opportunities for efficiencies, sharing expertise and for benchmarking performance. We must retain the ability to have face to face relationships with providers as part of our approach to managing risk and gaining assurance of the quality of provision. The need for systematic capture of local intelligence within this context is greater than ever and the clinical leadership arrangements and the relationships with CCGs will be key to securing this.
- 3.16 The potential role of commissioning support services is described later.

Common operating procedures

- 3.17 In collaboration with the four strategic health authority clusters and their constituent PCTs we are developing common operating policies and procedures to support local area teams in the following areas:
- Performance management frameworks
 - Dealing with concerns about individual performance, issues and incidents
 - Managing variability e.g. personal medical services contracts, personal dental services, local service agreements, local pharmaceutical services
 - Operational matters e.g. list cleansing, premises payments, managing disputes
 - Payment policy e.g. maternity, locum, translation
 - Market management e.g. procurement, mergers, boundaries, retirements, branch surgeries, pharmaceutical services market entry and exit
 - Policies relating to the discharge of the responsible officer functions.
- 3.18 Standard procedures will become available in draft from July to September 2012, so we can test them through PCT clusters in preparation for wide spread adoption prior to April 2013.
- 3.19 The most significant task is to standardise the performance management frameworks and processes at practice, provider and individual levels.
- 3.20 This takes place at a time of major change for GPs as they move to a new regulatory framework, including GP practice registration with the Care Quality Commission (CQC), potential professional revalidation and greater transparency of clinical indicators.
- 3.21 Dental providers are already regulated by the CQC and this is being taken into account in developing any performance management framework. The desired shift from monitoring units of dental activity to a more outcomes based approach reflects the dental contract pilot programme currently being undertaken by the Department of Health.
- 3.22 Community pharmacies have to be registered with the General Pharmaceutical Council and their regulatory role will also be reflected within the performance processes being developed.

Commissioning support services

- 3.23. The arrangements for commissioning support are developing as described in *Developing Commissioning Support: Towards Service Excellence (February 2012)*. This is therefore only a broad indication of what the NHSCB might require to support primary care commissioning.

a) Payment services

Dental, pharmaceutical and ophthalmic payments

- 3.24 The NHS Business Services Authority (BSA) will continue to provide a pharmaceutical and dental payments service, as well as contract monitoring data, audit and fraud prevention work. We are discussing how it might manage all payments to dental and pharmaceutical service contractors in the future, given that some PCTs still make local contract payments themselves.
- 3.25 We are in the early stages of developing a national specification for primary ophthalmic payments. Greater automation will mean efficiency savings for both the NHSCB as the commissioner and for many service providers. It will also improve post-payment verification and fraud detection.

GP services

- 3.26 There are currently three methods of GP practice payment and patient registration: directly by the commissioner; a shared service arrangement with other commissioners; or through an external contract.
- 3.27 We believe that GP practice payment, patient registration and other associated functions can be delivered more consistently and efficiently, even more so when paper-based medical records are eliminated.
- 3.28 We believe that there may be further efficiencies from aligning some of the commissioning tasks with payment and other functions. We have studied the arrangements in the North East where four PCT clusters have an integrated approach and believe that this method should be considered as a potential future option.
- 3.29 However, we need to ensure stability during the transition so we will set out clearly which services are included and then, having made any necessary changes, will transfer current arrangements to the NHSCB. Contracts with outsourced suppliers will transfer and, in the short term, single or multiple PCT-based teams should be included in local area team arrangements.
- 3.30 A formal review of these services will consider the best model of delivery and the appropriate procurement process.

b) Business intelligence

- 3.31 To ensure all parts of the system have the same core intelligence to draw comparisons and make decisions, there must be a single flow of standardised information. Locally derived intelligence, including that relating to patient experience, will be processed at national level and fed back into the system to ensure continuous improvement of primary care. For primary medical care this feedback will be delivered through local commissioning support services where it can best support CCGs.

c) Procurement and market management

- 3.32 Support for local area teams in procuring new and replacement services will be sourced centrally by the NHSCB.

d) Support for redesign and development

- 3.33 There is potential locally to share primary care development (e.g. clinical governance support, clinical audit) functions with CCGs and it may be most efficient and effective to secure this through emerging commissioning support services.

e) Provider management

- 3.34 There are no plans to ask commissioning support services to provide primary care contract management, beyond business intelligence requirements.
- 3.35 However, it may be appropriate for commissioning support services to co-ordinate the commissioning of secondary and community dental services.

Local professional networks (LPNs)

- 3.36 Primary care teams of the local area team will be responsible for securing high quality local dental services and many of the pharmaceutical and optical services. Strong clinical leadership and engagement should be integral to the local area teams and the LPN concept is one way of achieving this. This will enable effective service planning and make it possible to translate strategy into implementation.
- 3.37 LPNs of the NHSCB will work in partnership with CCGs, where relevant, health and wellbeing boards, patients and the public and complement and support the JSNA and PNA processes and local commissioning plans. They will:
- Support the implementation of national strategy and policy at local level
 - Work with other key stakeholders on the development and delivery of local priorities, some of which go beyond the scope of primary care commissioning
 - Provide local clinical leadership and, as well as being accountable within local area teams, there will be a professional line of accountability to the NHSCB's chief professional officers.

- 3.38 We are testing the different aspects of establishment by a local area team of an LPN, including practical set up, leadership capacity and capability, relationships with local representative committees and managing conflicts of interests.
- 3.39 LPNs will have three key characteristics:
- A small, clinically-led commissioning team at the core of the network to support the local area team to secure dental, pharmaceutical and optical services
 - Opportunities for more clinicians to get involved in service improvements and redesign work through local (and larger) networks and focussed projects as the need arises
 - Engagement with the wider community of practitioners, practice owners and others involved in providing services.
- 3.40 As the NHSCB develops its strategy for leadership development it will be important to establish what is needed to enable the clinicians working within local area teams to become effective clinical leaders.
- 3.41 LPNs will have the following functions in common:
- **Support the NHSCB in commissioning these services** by ensuring representative and robust clinical input to decision making and leading the profession in peer review and support, maximising performance, addressing inequalities and driving continuous improvement
 - **Provide clinical leadership and facilitate wider clinical engagement** at grass roots, a key principle of the NHSCB. Clinically led local professional networks are probably the best means to do this, as they understand the provider perspective
 - Provide a mechanism for **engaging patients, carers and the public**
 - **Establish solid and productive local commissioning relationships** with CCGs, health and wellbeing boards, LETBs and others to ensure the provision of high quality, appropriate services
 - **Advise and work in partnership with the health and wellbeing boards**, for example, to deliver improvements in oral and general health and to promote healthy living through initiatives like “making every contact count”
 - **Feed into other clinical networks**. Local area team LPNs will be a potential resource for clinical senates and strategic clinical networks and will provide professional development opportunities for clinicians working with the NHSCB
 - **Engage with local representative committees (local dental committees, local optical committees and local pharmaceutical committees)**, and ensure contractors’ perspectives are considered in how best to meet the needs of patients.



Local dental networks will be concerned with the whole dental pathway and could be the commissioning vehicle through which the NHSCB discharges its responsibilities.

Local pharmacy networks will be a source of advice for the local authority and its duty to conduct a pharmaceutical needs assessment (PNA) and could add value to the NHSCB's approach to medicines optimisation.

Local eye health networks' roles in the NHSCB's core responsibilities will be limited to quality assurance and improvement (as these services are not commissioned) but they have a potential offer to the wider health system, working with CCGs.

3.42 Each LPN also has its own unique role.

a) **Local dental networks**

3.43 Commissioning all primary, secondary and community dental services presents an opportunity to integrate dental care pathways. Dentists and other dental care professionals across the NHS can work together to design care that better meets the needs of patients, by placing services in the most appropriate care setting and linking workforce development and dental commissioning strategies.

3.44 Local dental networks, and their area teams, will support practices in making sure day-to-day care is both clinically appropriate and delivers the best outcomes for patients. They will be crucial in developing integrated care pathways, including ensuring the delivery of consistent quality standards across care settings and dental specialties, drawing on local commissioning and clinical expertise to do so. They will also be vital in ensuring the clinical ownership of these pathways necessary for successful local implementation.

3.45 Local area teams through their dental networks will work with local authorities and Public Health England to develop and deliver cohesive oral health improvement strategies and associated commissioning plans specific to the needs of local populations.

3.46 Commissioning more complex care may be best achieved at a larger population level than covered by each local area team. Local area teams could work together in commissioning integrated care pathways that include secondary care and by doing so could have greater leverage and economies of scale. Commissioning support services could provide the vehicle to support local area teams to do this more effectively.

3.47 As part of our design work we have been testing the local professional network concept.

NHS Cumbria has long recognised the crucial role of clinical engagement to support improvements in oral health. Having reviewed their network arrangements to align to the local dental network proposals as part of testing, the first agreed priority was to review the cluster oral health strategy and associated commissioning plan and ensure an effective local ownership of the plans.

The local dental network includes five clinical groups, each led by a clinician and involving other dental clinicians supporting the respective areas of work, covering orthodontics, oral surgery, restorative (endodontics), oral health improvement and a dental reference group (responsible for the QIPP agenda). The work of the respective networks combined to deliver an updated draft strategy, tied to evidence based local oral health need, for the next two years. The local dental network and NHS Cumbria ensured wider ownership and engagement across the cluster footprint by holding consultation and engagement events on the work for all dental health professionals in the cluster, the LDC and the workforce development network, involving the regional deaneries. The next phase of development includes establishing their relationship with health and wellbeing boards and local authorities.

b) Local pharmacy network

3.48 As described earlier, the primary care commissioning responsibilities for pharmaceutical services are concerned primarily with the quality of services provided as well as the general provision of services to meet local needs. However, local pharmacy networks have much to offer the development and improvement of local health services more generally, as well as supporting the commissioning of primary care.

3.49 Medicines are a crucial element of almost every care pathway. Supporting patients and their carers and involving them more in decisions about their medication will help to ensure more individualised care and a better patient experience, as well as improving patient safety.

3.50 Within the context of local area teams, local pharmacy networks will provide clinical leadership in medicine optimisation. They will also be able to develop the role of community pharmacy in supporting self care and in helping patients and carers to manage long term conditions effectively.

3.51 They will work with:

- CCGs to deliver innovative solutions for the safest and best use of medicines
- Public health to develop the healthy living pharmacy concept and promote greater use of pharmacy premises for health promotion
- Local authorities in the development of the PNA, which the NHSCB will use to inform the commissioning of NHS pharmaceutical services (and which local authorities will use to inform the commissioning of public health services from community pharmacies)
- Patients, carers and voluntary organisations to understand local needs, improve services and develop education programmes about medicines use.

NHS Hertfordshire has developed a core ‘hub’ and ‘spoke’ local pharmacy network structure with involvement from the chief pharmacists from the three main acute trusts, local pharmaceutical committee, the university and PCT commissioners.

The network has a number of ‘task and finish’ projects underway and, importantly, is already establishing beneficial partnerships and projects with the local authority and CCGs. The LPN has recently undertaken a scoping exercise with a project group of the local authority overview and scrutiny committee, specifically to look at the use of medicines for older people. The LPN is working with representatives of GPs, CCGs, local authority, patients and Age Concern to establish a common understanding of the issues and with a view to making joint recommendations on reducing waste, improving usage and therapeutic benefit for patients.

c) Eye health networks

- 3.52** It is envisaged that the eye health networks will be regarded as part of the wider health system, whose expertise is drawn on by local authorities and CCGs, and that they provide the NHSCB with a vehicle for the development of vision services that goes beyond its core responsibilities as a primary care commissioner. In this regard, they may need to assume a larger, geographical footprint and relate more closely to clinical senates and networks.
- 3.53** Within the local area team, optical clinicians will need to work closely with patients, their carers and voluntary organisations to understand local needs and improve services. NHS sight tests and domiciliary services are predominantly demand led (and therefore not commissioned as other services) although the local area teams will have an important quality assurance role.
- 3.54** There are three proposed areas of emphasis for eye health networks.
- Reviewing and developing services associated with the existing and emergent pathways for glaucoma, age-related macular degeneration, diabetic retinopathy and low-vision screening
 - Improving primary, secondary and community eyecare services to reduce avoidable visual impairment. This is in line with the new public health indicator being developed by the London Public Health Observatory, which relates to the proportion of visual impairment certificates registered for age-related macular degeneration, glaucoma and diabetic retinopathy
 - Developing a rapid eye care needs assessment approach to support the development of the JSNA.

Of those clusters testing local eye health networks, many have reviewed and built on existing arrangements, enabling a refreshed cluster approach and economies of scale with larger network footprints.

Two key priorities identified by the local eye health network in NHS Sussex have been to establish supporting relationships with CCGs and local authorities as this wider support to commissioners on vision strategies has been identified as a key role of the networks locally.

Local eye health networks are supporting existing work on pathway design and some are using the the national care pathways developed by the optical representative organisations based on best clinical practice as a guide to their work. These pathways have recently been made available to all local eye health networks as part of the testing of LPNs.

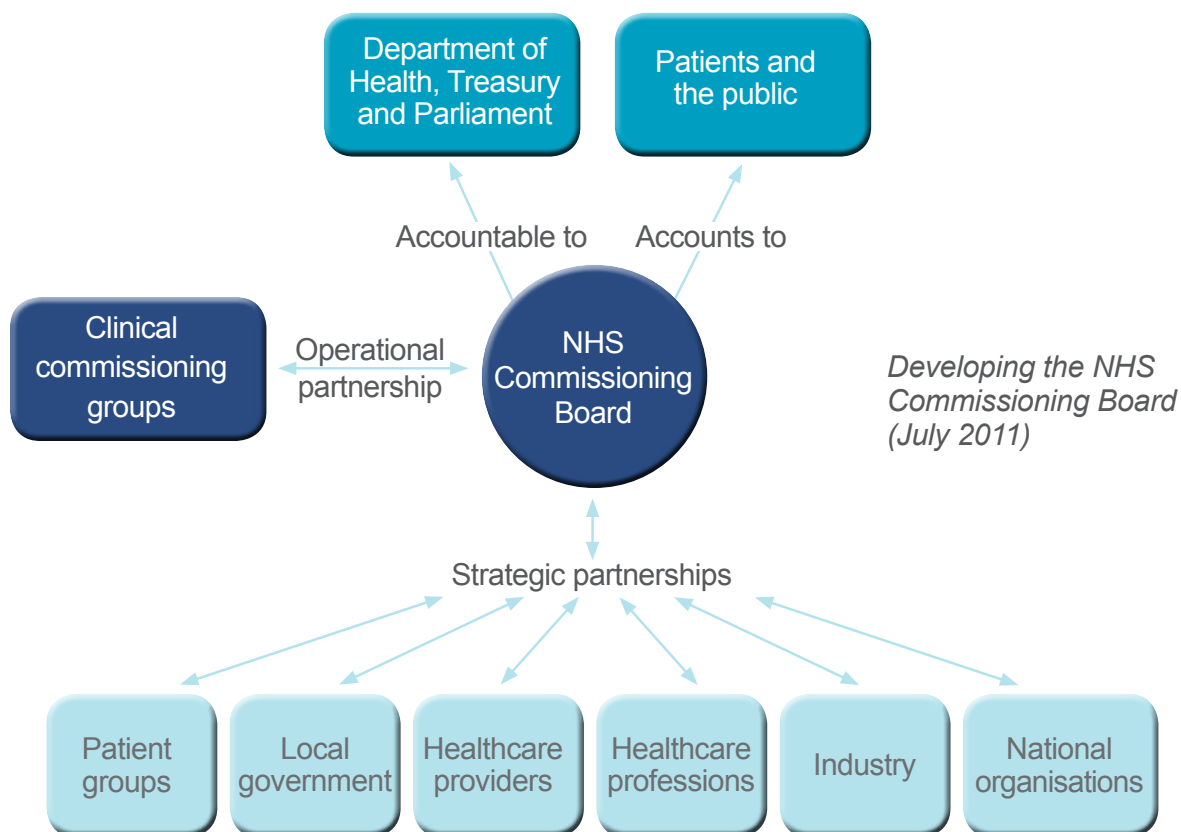
The role of clinical commissioning groups (CCGs)

- 3.55 CCGs will have a critical role in providing clinical leadership to deliver high quality, responsive and safe services for patients.
- 3.56 As described in *Developing clinical commissioning groups – towards authorisation (February 2012)*, CCGs are dependent on the unique role of general practice in connecting and acting as the intermediary for most of the care patients receive. Practices will be central to the new commissioning arrangements as well as providing primary medical services. As providers of care, GP practices take micro commissioning decisions daily with each referral and prescription. CCG member practices will need to work together to ensure that these micro decisions are clinically appropriate and deliver best outcomes for patients. Whilst intelligence about these commissioning decisions is of primary concern to CCGs, it is also critical for the NHSCB to review the performance of individual practices.
- 3.57 CCGs are best placed to support quality improvement in primary medical care, where necessary in partnership and with the support of the NHSCB. CCGs will not be responsible for contract compliance and will be able to focus on local priorities and supporting continuous development.
- 3.58 Our work with CCGs has shown that CCGs, working with the NHSCB, will take a quality improvement approach based on:
- Evidence of engagement and involvement with patients and the public
 - Benchmarking across member practices of healthcare needs indicators, interventions, and patient outcomes
 - Commitments to openness about data and mechanisms to enable information sharing
 - Clear approaches to peer review and discussions across member practices
 - Self assessment of need, intentions and anticipated impact.

- 3.59 CCGs will be able to drive greater integration between primary care and other services by commissioning 'wrap-around' community-based services for local populations, so that the services provided in individual practices form part of a broader network of integrated, community-based care for patients, with shared clinical leadership, clinical pathways/protocols, and clinical information systems.
- 3.60 These wider community-based services could include some services provided by GP practices themselves, subject to CCGs being able to demonstrate that they go beyond the 'core' services expected under the GP contract, that they provide good value for money, have followed an appropriate procurement route, and that they have appropriately managed conflicts of interest.
- 3.61 There is a strong link between CCG clear and credible plans and in particular their role to reduce unwarranted variation and tackle inequalities, and the ambition of the operating model for primary care.
- 3.62 CCG commissioning plans, which will be based on local joint health and wellbeing strategies, will inform local decisions about access to services and the development of new or replacement services. Some services, like the procurement of a new practice, will be the responsibility of the NHSCB. Others, like the development of additional community services not necessarily exclusive to GPs, will be the responsibility of the CCG. Operational working arrangements between the NHSCB and CCGs will need to be aligned with CCG governance arrangements.

Leicester City CCG's member practices are already making an impact on improving the quality of primary care. They have a programme of work to improve orthopaedic knowledge and treatment in general practice as part of an initiative called 3T MSK: Teaching Training & Treatment. This is a mentoring scheme where doctors teach and train their peers in their own consulting room, with their patients, supported by physiotherapists, resulting in better treatment of patients and a reduction of 35% in orthopaedic referrals for high referring practices in the first six months.

Strategic relationships



a) National

3.63 Excellent primary care commissioning relies on building relationships. These may be at a high-level between the NHSCB and national partner organisations (e.g. Health Education England, Public Health England, Care Quality Commission, The Information Centre for Health and Social Care, NICE); national patient organisations; national primary care stakeholder bodies (e.g. BMA, RCGP, National Association of Primary Care, NHS Alliance, Family Doctor Association, British Dental Association, Royal Pharmaceutical Society, Optical Confederation); and national negotiating bodies (e.g. BMA General Practitioners Committee, BDA General Dental Practice Committee, Pharmaceutical Services Negotiating Committee, Optometric Fees Review Committee).

In addition, there will be different relationships with the Department of Health.

b) NHSCB – Department of Health

3.64 There will need to be a strong relationship between the NHSCB and the Department of Health, beyond that covered by the mandate, because of the Department's responsibilities for the legislative framework, including the regulations and directions governing primary care contracts.

3.65 In most cases, where changes to regulations or directions are required in relation to primary care contracts, the NHSCB will be responsible for developing proposals and discussing them with professional representatives.

3.66 The NHSCB's role in commissioning NHS pharmaceutical services will be interdependent with the Department's ongoing role in medicine pricing.

3.67 Other functions remaining in the Department of Health are:

- Legislation governing primary care contracts, including regulations and directions
- Policy on dental and prescription charges, including the level of charges and exemptions and remissions
- Policy on eligibility for NHS sight tests and optical vouchers and on voucher values
- Policy on the new dental contract, including the current pilot programme.

c) Local

3.68 Some of the most crucial relationships will be at a local level. The NHSCB's local area teams will need to manage these within a consistent framework and a set of shared behaviours and values, but they will also need to respond to local circumstances. Local area teams will need to establish relationships with a range of partners including:

- Clinical commissioning groups
- Local Healthwatch, patients and the public
- Health and wellbeing boards
- Local authorities
- Public Health England local units
- Care Quality Commission
- Other regulatory bodies
- Local representative committees – local medical committees, local pharmaceutical committees, local dental committees and local optical committees
- The voluntary and community sector
- Local education and training boards.

3.69 A number of these relationships are described in this document. Some are still emerging. Amongst the most critical are:

d) Care Quality Commission

3.70 We are working to determine what operational protocols are needed to cement the relationship between NHSCB local area teams and the Care Quality Commission, including in support of the primary care operating model.

e) Local representative committees

3.71 The relationships with local representative committees (LRCs) – local medical committees, local pharmaceutical committees, local dental committees and local optical committees - will be particularly important in developing the new system. The NHSCB, through its local area teams, will work to ensure these are strategic, focused and respectful relationships. LRCs can add real value to the consistency ambition by sharing experiences and challenging any inappropriate behaviours. They will have a specified role in the process for dealing with performance concerns and, more generally, should be the best representatives of their members' views and interests.

f) Clinical networks

3.72 Strategic clinical networks will bring together commissioners, multidisciplinary professionals from primary, secondary and tertiary care, with partners from social care, the third sector and patients to support the implementation of evidence-based care. All pathways will engage primary care, across all clinical disciplines, for example with a particular focus on early diagnosis and timely treatment.

g) Public health

3.73 Upper tier and unitary local authorities will have responsibility for health improvement supported by directors of public health and a ring fenced budget. Local primary care commissioners will need to work closely with public health colleagues in two main ways:

- firstly, in supporting local authorities, where appropriate, in commissioning health improvement services, some of which could be provided through primary care
- secondly, through the advice and expertise that public health colleagues will provide to local area teams on how to commission primary care services in ways that best improve local population health and reduce inequalities.

Next Steps

- 4.1 In the coming months, the NHSCB will provide more details about the primary care operating arrangements including:
- The role of the responsible officer
 - How dental commissioning will work
 - The detail of local professional networks
 - Common operating procedures, including contract management
 - GP premises arrangements
 - GP IT arrangements
 - Transitional arrangements for payment and other associated services (FHS).
- 4.2 The NHSCB will also set out further information in due course about its operations which are not exclusive to primary care commissioning, but which are important in how the system will work, including:
- The design of the local area teams
 - Patient engagement, including handling complaints
 - Information and intelligence, including patient insight
 - Financial systems and processes
 - Strategic estates development.
- 4.3 The operating models for prison and offender health, military health and those public health services commissioned by the NHSCB (i.e. screening, vaccinations, child health for 0-5 year olds and public health for people in prisons) will also be published shortly and each will have some implications for primary care commissioning arrangements.

Central work

- 4.4 During the next three to six months, we will fully explore all the interdependent relationships critical for the operating model and take any action necessary to ensure that they will work effectively.
- 4.5 We will continue to work with stakeholders to identify any risk to business continuity, manage the transition and further develop the operating model. As primary care commissioning is a key function for local area teams, it will inform any NHSCB organisational development activity and there will be further opportunities to test the model and make adjustments.

Local work

- 4.6 PCT clusters should discuss this document with emerging CCGs, the local authority, local representative committees and practices and providers. They should consider how this might work in practice and what support and development should be in place during transition to make this operating model a success. We are particularly interested in any models of commissioning support, relationships being established with health and wellbeing boards and how public health commissioning relationships might best work.

Acknowledgements

We are very grateful to the primary care commissioning community, clinical and managerial, for their commitment and hard work in helping to design the operating model; and to national and local stakeholders representing patients, clinicians and others for their feedback and practical support.

Annex 1

Scope

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

The NHSCB will also be responsible for commissioning community, secondary and urgent dental services. These are not covered in this document, but the arrangements for primary dental services will provide the basis of commissioning for the whole dental care pathway.

1. Primary Medical Services Commissioning

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

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

General Medical Services (GMS)

This contracting route is provided for by the NHS Act 2006 Section 83, and the NHS (General Medical Services Contracts) Regulations 2004, as amended. It is underpinned by a nationally agreed GMS contract. About 53% of primary medical services are provided under GMS contracts.

Personal Medical Services (PMS)

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

Specialist PMS is an additional, local flexibility to help to address unmet needs amongst client groups that traditionally have experienced primary medical services as being more difficult to access, for example, homeless people, prisoners, drug users.

Alternative Provider Medical Services (APMS)

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

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

Primary medical services comprise:

Essential services

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

Essential services cover the:

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

Additional services

All GMS and PMS practices have a preferential right to provide additional services. Practices can, however, temporarily or permanently, opt out of providing additional services in accordance with fixed rules. Where opt-outs occur, the NHS Commissioning Board will be required to commission the services from a different provider.

Out of hours services

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

The NHS Commissioning Board will be responsible for ensuring that all other opted out GP out-of-hours services are commissioned as part of Clinical Commissioning Groups responsibilities for developing 24/7 urgent care services.

Clinical commissioning groups will be responsible for monitoring all NHS commissioned GP-out-of-hours services and assuring the quality of these to consistent standards.

Enhanced services

Enhanced services are generally understood and defined as

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

The contract regulations (GMS, PMS and APMS) work to allow medical services to be of any type, in any setting, and to extend beyond the scope of primary medical services.

The NHS Commissioning Board will commission some enhanced services nationally using single specifications. These nationally commissioned enhanced services will replace the current arrangements that place Primary Care Trusts under a duty through legal directions to commission prescribed enhanced services to meet the needs of the population (services currently known and commissioned as 'Directed Enhanced Services').

The NHS Commissioning Board will also have the flexibility Primary Care Trusts currently enjoy to commission enhanced services locally to meet the differing primary care needs of local populations. These commissioned services will be more tightly defined and managed than those currently commissioned as 'Local Enhanced Services.' Local commissioning will reflect the fact that clinical commissioning groups will, subject to appropriate transition arrangements, be largely responsible for the resources attached to current Local Enhanced Service schemes (excluding those supporting defined public health services where responsibility passes to local authorities). Provision could include clinical commissioning groups commissioning local services from existing GPs or other primary care contractors.

2. Primary Dental Services Commissioning

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

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

GDS contracts and PDS agreements

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

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

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

Primary dental services comprise:

Essential services

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

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

Additional services

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

The scope of **secondary care based dental services** will be explored fully in the emerging commissioning framework.

3. Pharmaceutical services

Arrangements for pharmaceutical services are provided for by virtue of Sections 126 and 127 of the NHS Act 2006 (as amended).

Schedule 1 of the National Health Service (Pharmaceutical Services) Regulations 2005 provides for **Essential services**: which must be provided by all community pharmacies and include dispensing, repeat dispensing, health promotion, signposting, support for self-care and disposal of unwanted medicines. Schedule 2 provides for the dispensing services which dispensing doctors are required to provide. Other services which match pharmaceutical services and which are provided by dispensing doctors would be provided under primary medical services arrangements. Schedule 3 provides for those services which appliance contractors are required to provide.

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

Local Pharmaceutical Services

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

Enhanced services

The NHS Commissioning Board will also have the flexibility that primary care trusts have currently to commission enhanced services locally to meet the differing primary care needs of local populations.

It is only the NHS Commissioning Board which can commission **pharmaceutical** enhanced services. These services will be more tightly defined and will use national services specifications.

However, clinical commissioning groups and local authorities will be able to commission services direct from community pharmacy providers. These arrangements would be outside the community pharmacy contractual framework and service specifications and remuneration would need to be negotiated by the commissioner and the provider. Public Health England may decide to develop standard specifications and tariffs to support the commissioning of public health services. However, legal provision has also been made for local authorities to make arrangements with the NHS Commissioning Board.

4. Ophthalmic services

Primary ophthalmic services are provided under section 115 of the NHS Act 2006.

Under the Act, the NHS Commissioning Board must arrange for 'essential' services, i.e. NHS sight tests for those who are eligible. Any suitable provider is able to have a contract to provide NHS sight tests and there are no restrictions on the number of contracts that may be awarded or the number of sight tests they may carry out. Contractors work to a national contract and the sight test is governed by national regulations.

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

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

The NHSCB may also commission enhanced services nationally or locally to meet the needs of the population. These enhanced services will be commissioned using single specifications.

Annex 2

Draft of detailed tasks and functions to support the single operating model:

<http://www.commissioningboard.nhs.uk/files/2012/06/task-func.pdf>