Subject: Primary Care Strategy for Wiltshire

Executive Summary

The Five Year Forward View states that “The foundation of NHS care will remain list-based primary care. Given the pressures they are under, we need a ‘new deal’ for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years”.

The challenges facing primary care are well documented, including workload pressures with an ageing population and increasing complexity of presenting conditions and multi-morbidities; workforce pressures of recruitment, retention and skill mix; capacity and state of primary care premises; increasing bureaucracy and regulation demands; pressure on practice development; and the national and local resource challenge to maintain the level of high quality services provided by our general practices in Wiltshire.

The details set out in this Report will be factored into the CCG 2016/17 Operational Delivery Plan and used to underpin “placed based” 5 year System Transformation Plans (STPs).

Proposal(s)

It is recommended that the Board:

i) Notes update on the Primary Care Strategy from NHS England South and the Wiltshire CCG response as the Primary Care offer

ii) Notes the update on the arrangements for Joint Commissioning

Reason for Proposal

1. To provide an update on the Primary Care Strategy for Wiltshire
2. To provide an update on progress with joint commissioning arrangements for commissioning primary medical care services between NHS England and Wiltshire CCG.

Presenter name: Jo Cullen
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Wiltshire Council
Health and Wellbeing Board

16 July 2015

Subject: PRIMARY CARE STRATEGY FOR WILTSHIRE

PURPOSE OF THE REPORT

1. To provide an update on the Primary Care Strategy for Wiltshire

2. To provide an update on progress with joint commissioning arrangements for commissioning primary medical care services between NHS England and Wiltshire CCG.

CONTEXT

1. SOUTH CENTRAL PRIMARY CARE DELIVERY PLAN 2016/17

2. This document aims to set out the national and local context for NHS England Public Health Section 7A and primary care directly commissioned services in the South Central area. Its aim is to both provide an overview and detail the 2016-17 strategic commissioning plans of:
   - Primary Care services (including General Practice; Dental; Pharmacy and Optometry).
   - Public Health Section 7A services

3. It is both a strategy document in its own right and a resource document for other commissioners in the South East (e.g. Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). It is anticipated that commissioners will want to factor the plans set out here into their local 2016/17 operational plans and use it to inform “placed based” 5 year System Transformation Plans (STPs).

4. The plans set out underpin the delivery of the Five Year Forward View and articulate how NHS England directly commissioned services contribute to strengthening primary care to ensure elective care continues to meet constitutional standards as requested by “Delivering the Forward View NHS planning guidance 2016/17-2020/21” December 2015. All NHS England commissioning is undertaken in partnership with CCGs and it is expected that there will be strategic alignment across the commissioning system.

5. The NHS England South Central office also plays a key role in the development of ‘New Models of Care’ and is working with the CCGs in the
area testing and developing different ways of working enabled by the Prime Ministers Challenge Fund, Community Pharmacist pilots and the Primary Care Transformation funds to enable whole system change and to help deliver a financially sustainable system.

6. The development of co-commissioning within NHS England directly commissioned services is also a key enabler to allowing a ‘placed based’ approach to service delivery and development tailored to the needs of local populations and flexibly reflecting the ‘assets’ in any given Health and Social Care community. NHS England is fully supportive of CCGs beginning to take on co-commissioning (from Primary Care to Specialised services) to achieve improvements in outcomes for patients and their families.

7. We know that the health needs and expectations of our population are changing and in order to meet these, the whole health and social care sector will need to move away from outdated divisions of care. Collectively, we are moving towards a system of integrated care, where clinicians work together in flexible teams formed around the needs of the patient, their families and the communities in which they live. The aim is to deliver high quality, cost effective and resilient systems of care that achieve best health outcomes for the population of South Central.

8. Primary care is the bedrock of our National Health Service. Therefore, whilst it is necessary to build a vision for out of hospital care in South Central, it is also necessary to have a detailed strategy for the primary care aspects of models of out of hospital care. For the purposes of this commissioning strategy, ‘primary care’ community is defined as general practice, pharmacy, dentistry and optometry.

9. Whilst the quality of most primary care in the South Central area is good, there are variations in performance. We need to reduce unwarranted variation in primary care so our patients, the public and our professional colleagues across the health and social care system are assured that primary care in South Central is consistently of the highest quality. We need to ensure that vulnerable patients are identified to prevent ill health and ensure that their conditions are effectively managed to improve their independence and well-being; reduce unscheduled hospital attendance and admission; and improve health outcomes. As commissioners of primary care, we need to own the quality agenda and take on professional leadership for quality improvement in primary care. We will drive improvements in care and reduction in unwarranted variation by providing clinicians with the timely and accurate data, information and knowledge they need to identify and prioritise areas for quality improvement, ensuring that data is transparent and widely shared with patients and the public. We will ensure this information includes views of patients and their families in order that their views are genuinely listened to and included in improving primary care services.

10. Where inequalities exist, these need to be addressed. Evidence identified in the Local Health Profiles show our most deprived communities are least able to make the necessary changes in their lifestyle. A different approach is required to support these communities: one that better integrates primary
care with social care, housing, education, leisure services and other determinants of health. Primary care is well placed to provide an important leadership role locally in driving this reform.

11. General practice services including practice nurses need to be closely connected with wider out-of-hospital services, including community health services (such as district and community nursing and health visiting), community pharmacy, optometry and dentistry services, services provided by voluntary and community organisations, and social care. NHS England will work collaboratively with CCGs and local authorities to develop a more collaborative approach to commissioning this network of services that are vital for supporting healthy communities and tackling health inequalities. As part of this framework, we are also signalling our intention to move towards delegated commissioning of general practice services by all CCGs in across the patch.

12. NHS England is also responsible for commissioning community pharmacy, dental services and NHS sight tests. We are developing similar frameworks to support the commissioning of these services and will take a comparable approach in supporting their closer integration with wider community-based services.

13. The plan is written within the context of growing demands on the NHS with an ageing population and increasing expectations of accessible healthcare within the confines of finance, workforce and safety.

14. WILTSHIRE CCG RESPONSE: PRIMARY CARE OFFER FOR ENHANCED SERVICES 2016-2019

15. The Five Year Forward View states that “The foundation of NHS care will remain list-based primary care. Given the pressures they are under, we need a ‘new deal’ for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years”.

16. The challenges facing primary care are well documented\(^1\),\(^2\) including workload pressures with an ageing population and increasing complexity of presenting conditions and multi-morbidities; workforce pressures of recruitment, retention and skill mix; capacity and state of primary care premises; increasing bureaucracy and regulation demands; pressure on practice development; and the national and local resource challenge to maintain the level of high quality services provided by our general practices in Wiltshire.

17. The proposal to move to a different and more flexible way of commissioning enhanced services from member GP Practices in Wiltshire from April 2016 is

\(^1\) https://www.somersetlmc.co.uk/outcomebasedcommissioning

\(^2\) https://www.wessexlmcs.com/email3794
being referred to as the Wiltshire Primary Care Offer (PCO). We believe that moving away from providing care in a transactional activity driven model at individual practice level will result in a more efficient and effective use of resources. Developing a single CCG framework incorporating and aligning all of the currently commissioned local enhanced services (potentially including some currently commissioned Direct Enhanced Services by NHS England under joint commissioning arrangements) gives an opportunity to provide more robust, locality based commissioning with patient focussed quality measures and responsive services; adding improved incentives and driving quality initiatives to ensure a reduction in unnecessary variation across our constituent practices and between individual clinicians.

**PROPOSAL:**

- To develop a three year programme 2016-2019 (allowing for transition and some pace of change);
- To transform the commissioning, delivery and monitoring of the CCG commissioned enhanced services from GP Practices in Wiltshire, over and above core GMS/PMS\(^3\) services to deliver responsive, safe and sustainable services;
- To move towards “placed based commissioning” and the CCG vision of integrated out of hospital services;
- To support the development of locality working to deliver primary care services at scale to support increased efficiencies, and to address issues of recruitment and retention of a competent, capable and resilient primary care workforce to deliver high quality services;
- To move towards a "block contract" type arrangement - setting out the total funding available for 2016 to cover the specified services to be delivered to meet the needs of their locally registered population in return for meeting the outcomes required (moving from year 1 with KPIs and agreed metrics towards a full outcome based model by year 3);

\(^3\) General Medical Services (GMS) is a nationally held contract and Personal Medical Services (PMS) is a locally held contract – currently held by NHS England. [https://www.england.nhs.uk/commissioning/gp-contract/](https://www.england.nhs.uk/commissioning/gp-contract/)
- To use 2016/17 as a shadow transition year before delegated commissioning of primary medical services from April 2017.

PRINCIPLES:

i) To reimburse work on a consistent, transparent and fair funding stream (i.e. remove inconsistencies of payment for activity vs capitation, raw vs weighted, geography) so commissioning is based on equity not equality.

ii) To commission certain services to be provided at scale not by individual practices e.g. leg ulcer care, care homes, and Transforming Care of Older People (TCOP) to encourage delivery of sustainable services at scale.

iii) To move towards a full “locality offer” over the next three years, based on capitated or place based budgets including 7 day services, same day urgent primary care hubs, clinical integrated pathways, and agreed estates solutions aligned across the county i.e. NOT 56 practices, and integrated with other out of hospital services.

iv) To support the development of collaborative organisations with general practice at their heart, such as groups of practices, localities, networks or federations – for a resilient new model of primary care service delivery, whilst maintaining the independent contractor status to improve outcomes for patients.

v) To ensure the recording of activity will be proportionate and kept at practice level to ensure records will be available for auditing but minimising the bureaucracy in the system.

vi) To further develop the work programme under Joint Commissioning with NHS England focussing on the key drivers of enhanced services, workforce and flexible estates solutions.

AMBITION:

18. The ambition of the CCG is that services commissioned in primary care under the PCO will:
Maintain the current high quality primary care service across Wiltshire in the face of growing population and demand;
Protect the core values of general practice of contact, co-ordination of care, comprehensive services and continuity of care;
Deliver improved patient safety and clinical outcomes across Wiltshire;
Deliver an improved experience for patients and their carers;
Encompass clinical best practice and reduce variation;
Be sustainable;
Be innovative and promote skill-mix within primary care providers;
Deliver a demonstrable return on investment (financial or otherwise);
Be delivered “at scale” (i.e. at Practice, Locality or Group level as appropriate);
Be monitored and funded on the basis of outcomes achieved rather than of activity.

LOCAL CONTEXT:

19. Wiltshire CCG has developed a clear vision that Heath and Social Care services in Wiltshire should support and sustain independent living and the future system will see:

- Increased personal responsibility to maintain/enhance well-being;
- Care provided as close to home as possible; and
- A reduced reliance on bed-based care.

20. The CCG’s Five Year Plan, and the supporting transformation programmes, place primary care alongside patients, at the centre of the health and social care economy. The aim is that not only will primary care continue to lead the design of the health care system via clinical commissioning, but will also provide a greater range and improve the quality and safety of services delivered to patients. This is essential to our plans for integration (community services, social care, and mental health); moving care out of hospital; and our reconfiguration of community services.

21. Following the Health and Social Care Act in 2012, CCGs replaced Primary Care Trusts (PCT) on 1 April 2013 as the clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. The commissioning of Locally Enhanced Services (LES) from GP Practices was transferred from PCTs to CCGs (whilst others were transferred to Local Authority and the Directed Enhanced Services were transferred to NHS England). In Wiltshire, these LES covered:

- Anti-coagulation monitoring
- Near patient testing
- Basket of Goods
- Care Homes
- Dementia Assessment:
- Insulin Initiation Type II Diabetes
- Level 2 Leg Ulcer Management
- Neo-natal checks
• Ring Pessary fittings
• Venesection
• Homeless (covering one hostel)
• Minor Injury

22. Some of these services were commissioned on an activity basis (such as Anti coagulation and Near Patient Testing) whilst other schemes (such as Basket of Goods for secondary care initiated investigations) are based on capitation (i.e. paid per number of patients registered with a GP Practice). These capitation payments can be made on a raw or weighted list size. Raw list sizes are the actual number of patients registered with a GP practice (taken from the Open Exeter system). The raw list size of the CCG as of 31.12.15 is 483,705. The weighted population, based on the Car-Hill Formula\(^4\) is the number of patients registered with each practice (from Open Exeter system) adjusted for 6 criteria:

- age and sex
- if they live in a care home
- if they joined the practice in the previous 12 months
- if the patient's postcode ward has "Additional Needs" score (from the Ward's Statutory Long Term Sickness and Mortality indexes)
- their rurality which is driven by a combination of population density for the patient's Ward and the distance between the patient's postcode address and the practice's main surgery
- market forces factor (this is GP based and is a cross reference to the GP practice address Ward Code)

23. The GP practice raw list is multiplied by these 6 index values to create a "Practice Weighted List Size". The weighted list size of the CCG as of 31.12.15 is 487,843. The main GMS Contract is based on weighted list size and PMS is currently based on raw; but from 01.04.16 PMS Contract will be based on weighted as per the PMS review changes.

24. The CCG funding allocation is based on a forecast weighted population (not exactly the same weighting indexes as the practice weighted list size from Open Exeter).

25. If the CCG decides to use either weighted list size or raw list size consistently, some practices will lose out significantly (up to 2000 patient difference in the 2 extremes). A pace of change policy could be agreed for practices adversely affected by agreeing a single approach.

26. As part of the contract negotiations for 2015/16, the British Medical Association (BMA) and NHS Employers agreed to re-examine the Carr-Hill Formula with the aim of adapting it to better reflect deprivation. This work began in 2015 and is currently underway. There is still no way to assess properly individual practice workload, so the formula review will be based on an assessment of workload across a sample of practices. The current review will however be able to look at more up to date information to assess

differences in workload at practice level. The review group is likely to report in
time to inform contract negotiations for 2017/18, but implementation will be
dependent on negotiation.

BUDGETS:

27. The funding for Enhanced Services and TCOP for 2016/17 is £9.44m at the
CCG weighted list size of 487,843, giving an indicative price of £19.36 per
registered patient.

28. The CCG will retain 0.5% contingency in line with NHS Business Rules. This
includes all of the CCG commissioned enhanced services and TCOP only,
not those services commissioned from NHS England or Public Health.

29. Budgets for GP Practices under the PCO will be set partly against 2015/16
activity outturn (for those services paid on activity) and partly on capitation; it
will be paid in 1/12 monthly payments to practices from April and based on
the 31.12.15 list sizes. There will be a quarterly reconciliation of activity, as in
the current system, and payments adjusted accordingly. A detailed
spreadsheet setting out funding to individual practice level and built up by
localities, showing variance from 2015/16 and 2016/17 has been developed
and shared.

30. **Financial Controls:** The majority of services and funding streams within the
PCO reimburse GPs for the delivery of clinical services and are monitored on
activity which can be audited to individual patient level. The process is that
funding is made in 1/12 payments and reconciled quarterly on actual activity
with further payment made or withdrawn, as in the current process. Plans and
demonstration of delivery for the locality work (£2 per patient) and the locality
services (£3 per patient) elements of the Group SLA will be agreed through
the three Group Executives and brought to Clinical Executive for approval and
quarterly monitoring.

31. Scrutiny and control will be through the suggested Primary Care Oversight
Group, as in section 9 on Governance.

Wessex Local Medical Committee (LMC) view:

32. The LMC broadly supports the principles of the PCO, in particular securing
the funding for three years, reducing bureaucracy and encouraging the
development of locality based services where appropriate.

33. The impact of the PCO on practices and localities will need to be reviewed
and the PCO refined and modified as necessary during the three year period.
We look forward to working closely with the CCG to do this.
UPDATES ON PRIMARY CARE PROGRAMMES:

Transforming Care of Older People (TCOP)

34. The context for TCOP was the national guidance “Everyone Counts” in 2014/15 where there was a specific focus on patients aged 75 years and over and those with complex needs; and the CCG was expected to support GP practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so.

35. In Wiltshire from 2014, TCOP proposals were assessed and signed off against their ability to meet following criteria:

- The CCG strategic vision;
- Improved care for vulnerable older people;
- Reduced avoidable admissions;
- Continuity of care for older people;
- Improved overall quality and productivity of services;
- Greater integration of health & care services, in particular out of hospital care.

36. Currently, 19 schemes (predominantly locality-based) have been supported and funded since 2014 - subject to successful delivery of the agreed outcomes for patients aged over 75 years. These schemes cover every GP Practice across the whole of Wiltshire. There is evidence of local and clinically-led initiatives with some collaborative working across practices and engagement/alignment with the wider MDTs, reviewing and addressing the individual practice variation and learning from best practice. The nature of the challenge in terms of reducing non-elective admissions in the over 75s meant that many of the schemes were unproven, so at the outset of the funding allocation it was made clear that on-going funding would be subject to successful delivery of the outcomes. That said, the CCG was keen to support locality based schemes that improve care for older people and in particular prevent avoidable admission; and so for that reason the process of project evaluation is to review progress in terms of implementation and outcomes and then work with projects to refine proposals where necessary to ensure the greatest chance of success. Learning from the schemes to date has shown:

- Issues and challenges of recruitment of most groups of clinical staff
- Development of new roles such as the ERP, and new ways of employment (secondment, one practice on behalf of others)
- Links and synergy between TCOP and the Better Care Plan schemes and integrated community teams
- Focus on over 75s, but impact of under 75
- Release of GP capacity and implications of this
- Implications for providing services aligned to primary care at scale, which is a number of practices working together
- Links to other programmes and projects such as work with Care Homes, End of Life, Long term conditions, prevention and Musculo-Skeletal services (MSK)
- Impact of the social care model as in the Leg Club schemes
- Impact of medications reviews on health outcomes and costs

37. The following graphs set out non elective activity access rates by every practice across the three Groups from April 2013 until December 2015 showing that the activity is being generally maintained despite population growth in this cohort of patients.

38. NHS England – alignment of Extended Hours Directed Enhanced Service from April 2016

39. This is a DES commissioned by NHS England and the CCG cannot alter the specification as NHS England has to be sighted on plans to monitor and pay. The specification is to provide 30 minutes of “extended hours” per 1000 patients with minimum 30 min session which can be both routine and urgent and provided by all clinical staff either face to face or via the phone and has to be in addition to core in hours provision. It is funded at £1.90 per pt. (£930K
40. National guidance already states that Practices can deliver this service for their own practice solely or choose to offer as a group of practices.

41. NHS England has agreed that this can be aligned to PCO with locality plans for delivery (could remain at individual practice level) from April 2016.

**42. Joint Commissioning Arrangements**

43. NHS England had previously invited CCGs to apply to take responsibility for delegated commissioning of primary care medical care services from 1 April 2016.

44. In October 2015, a detailed options paper was considered by the Clinical Executive and the Governing Body. This paper set out the options of applying for delegated commissioning responsibility for primary medical care services from NHS England. After in-depth discussion, the Governing Body voted that the CCG would make an application at the beginning of November 2015. However in those discussions, it was identified that there was a possibility that NHS England would not accept the application as the submission pro-forma requires NHS England to sign off on against a number of criteria, including the CCG’s current assurance level (as at Q2 of 2015/16 or equivalent) for each of the five assurance components. At the time the CCG was in Financial Recovery and NHS England confirmed therefore that an application would not be supported. Therefore the decision was taken by the CCG not to make the application for which the deadline was 6 November 2015. As such, it is currently envisaged that the CCG will be expected to take delegated responsibility with effect from 1 April 2017 and work is underway to prepare for that. In the meantime, the CCG will work with NHS England to optimise the current co-commissioning arrangements.

45. From April 2015, the CCG has had a monthly Primary Care Operational Group (previously the Primary Care Programme Board in line with its Programme Management approach) working with NHS England and the Local Medical Committee; and a quarterly Joint Committee meeting in public, chaired by the CCG Lay Member.
46. The Joint Committee reports to both the CCG Governing Body and NHS England Board. The Wiltshire Primary Care Joint Commissioning Operational Group provides assurance to Wiltshire CCG and NHS England Joint Commissioning Committees that there are robust systems and processes in place for monitoring, managing and assuring the quality and safety of primary care medical services and for driving continuous service improvement and delivering the strategy.

47. A jointly developed framework providing additional task detail along with roles and responsibilities is in place to direct / support the work of the Operational Group and this will be supplemented by a Memorandum of Understanding which is currently under development by the NHS England central team.

48. The role of the Joint Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England (and such CCG functions under sections 3 and 3A of the NHS Act as have been delegated to the joint committee).

49. This includes the following planning, securing and monitoring functions:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).
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21.03.16