NHS
East Lancashire
Clinical Commissioning Group

Agenda Item No: 5.1

REPORT TO:	**Primary Care Committee**	
MEETING DATE:	**20 July 2015**	
REPORT TITLE:	**PMS Review Report**	
SUMMARY OF REPORT:	This reports provides a summary of the PMS Review Visits and the services provided over and above GMS as a result of the additional resource associated with the 'PMS Premium'	
REPORT RECOMMENDATIONS:	To action the recommendations in the report	
FINANCIAL IMPLICATIONS:	Yes – reduction in PMS Premium will impact on individual PMS practices. Reinvestment of PMS premium to be considered	
REPORT CATEGORY:		**Tick**
	Formally Receipt	
	Action the recommendations outlined in the report.	√
	Debate the content of the report	√
	Receive the report for information	
AUTHOR:	**Lisa Cunliffe, primary Care Development Manager**	
	Report supported & approved by your Senior Lead	**Y**
PRESENTED BY:	**Lisa Cunliffe, Primary Care Development Manager**	
OTHER COMMITTEES/ GROUPS CONSULTED:	Please state if this paper has been presented at any other committees and any decisions / recommendations made	
EQUALITY ANALYSIS (EA) :	Has an EA been completed in respect of this report? Pre-PEAR EA checklist to be completed	**Y**
RISKS:	On Corporate Risk Register	**Y**
CONFLICT OF INTEREST:	Is there a conflict of interest associated with this report?	**Y**
PUBLIC ENGAGEMENT:	Has there been any public engagement associated with this report? This will need to be considered as part of ongoing developments	**N**
PRIVACY STATUS OF THE REPORT:	Can the document be shared?	**Y**

Which Strategic Objective does the report relate to		**Tick**
1	Commission the right services for patients to be seen at the right time, in the right place, by the right professional.	√
2	Optimise appropriate use of resources and remove inefficiencies.	√
3	Improve access, quality and choice of service provision within Primary Care	√
4	Work with colleagues from Secondary Care and Local Authorities to develop seamless care pathways	√

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NHS EL CCG Primary Care Committee
20 July 2015
PMS Review Report

1. Introduction

1.1. This report provides a summary of the PMS Reviews that have taken place across East Lancashire and outlines the findings of the reviews including services that the practices feel are currently provided over and above core services which the CCG may wish to consider as part of its reinvestment plan.

1.2. The CCG needs to ensure any additional investment in general practice over and above core services is clearly linked to enhanced quality or services or the specific needs of a particular population.

2. Background

2.1. NHSE is moving towards a position where all GP practices, whether GMS,PMS or APMS contracted, can expect to receive the same core funding for providing core service expected of all GP practices.

2.2. Any additional funding over and above this core funding will need to be clearly linked to enhanced quality of service or the specific needs of a particular population.

2.3. Core funding for GMS practices is increasing over a seven year period from 1 April 2014 because MPIG payments are being reduced by one seventh every year and the subsequent savings added in to core (global sum) funding.

2.4. In January 2014, NHSE Area Teams were asked to review local PMS agreements over a two year period ending March 2016 to ensure additional investment over and above core funding is used in a way that is clearly linked to enhanced quality or services or the specific needs of a particular population.

2.5. NHSE Area teams need to ensure that any additional investment in general practice services that goes beyond core national requirements meet the following criteria:

2.5.1. Reflect joint Area Team/ CCG strategic plans for primary care and support a more integrated approach to delivering community services.

2.5.2. Secure services or outcomes that go beyond what is expected of core general practice or improving primary care premises e.g. Premium funding that is not tangibly linked to providing a wider range of services, or providing services to a higher quality standard or for a population with specific needs that are not adequately captured by the Carr- Hill formula.

2.5.3. Help reduce health inequalities e.g. providing funding for practices that provide services for populations with specific needs e.g. Homeless people.

2.5.4. Give equal opportunity to all GP Practices. All practices should have an equal opportunity to earn premium funding if they are capable of meeting the required standards.

2.5.5. Support fairer distribution of funding at a locality level

3. PMS Review Principles

3.1. Future use of PMS funding should be jointly agreed between Area Team and CCGs

3.2. There should be a case by case review of all affected practices to ensure they are not serving special populations that merit continued additional funding.

3.3. Resources freed up should be reinvested in general practice services.

3.4. Except were agreed PMS resources should not be deployed outside the current CCG locality.

3.5. PMS should remain a contractual option.

3.6. Any additional investment should reflect joint strategic plans, secure services or outcomes that go beyond what is expected of core general practice, help reduce health inequalities, offer equality of opportunity for all GP practices in a locality and support fairer distribution of funding.

4. Lancashire Approach

4.1. A PMS Project Group was established to oversee the review of PMS contracts in Lancashire.

4.2. The intention initially being for the review process to be led by the Area Team in full collaboration with the CCGs.

4.3. Across Lancashire a seven year pace of change for the equalisation of core GP funding for PMS practices was agreed in line with GMS and this was agreed as a fair and consistent approach by CCGs and the LMC.

4.4. PMS practice in Lancashire were each offered the opportunity for either a face to face review meeting with Area team and/or CCGs or to complete a pro-forma with a view to the Area team and CCGs developing an understanding of the services they deliver over and above core.

4.5. If as a result of these PMS Review visits it is determined that services over and above core are being provided the CCG will be required to decide if it wishes to continue to commission these while ensuring equity of access to patients across East Lancashire.

4.6. Because all review visits had not taken place by the 1 April 2015 when East Lancashire assumed responsibility under co-commissioning arrangements it was agreed that no resource would be removed in 2015/16 in order to allow sufficient time to undertake PMS Reviews and enable the CCG to develop a plan for the reinvestment of any PMS Premium resource released from 1 April 2016.

5. East Lancashire

5.1. In 2011/12 PMS Contracts in East Lancashire were reviewed and in recognition of the additional resource made available through PMS the contract was updated to include the following elements over and above core GMS (See appendix 2 for further detail):

- **5.1.1.** Federated Practice approach
- **5.1.2.** Active Contribution to the Wider Health Economy
- **5.1.3.** Improved Quality of Patient Care including achievement of the RCGP Quality Practice Award
- **5.1.4.** Performance Monitoring

5.2. There are eleven PMS Practice in East Lancashire. Nine out of the eleven opted to have a PMS Review meeting while two opted to complete a PMS Review pro-forma.

5.3. PMS Review visits have taken place across practices in East Lancashire between April and June 2015 with a view to understanding:

5.3.1. What PMS premiums are currently used for
5.3.2. What impact the withdrawal of the PMS Premium will have on practices locally.
5.3.3. Any services over and above core GMS services provided by PMS Practices in East Lancashire.

5.4. A summary for each of the review visits undertaken is available at Appendix 1. More details reports are available on request.

5.5. Summary of findings from PMS Review visits:

5.5.1. **Viability -** Some of the PMS practices feel that withdrawal of the PMS premium without adequate additional re-investment will result in the practice no longer being viable. This has significant implications in terms of the continued provision of primary care services in some areas.

5.5.2. **Workforce –** Any withdrawal of funding without appropriate additional re-investment will impact significantly on the primary care workforce. Many PMS practices see no alternative but to make staff redundant and some are currently holding vacancies as a result of the uncertainties. Recruitment and retention of staff in primary care is a significant issue not just for PMS practices but across General Practice with the increasing use of Locums in primary care impacting on the quality of the service provided and the continuity of care for patients.

5.5.2.1. In addition morale in primary care is currently at an all-time low. Reduced job satisfaction and increased stress levels are likely to begin impacting upon the health of the workforce.

5.5.3. **Enhanced Services –** These are specific services that could be considered to be over and above core GP services and not adequately funded currently through other funding streams such as local enhanced services including:

5.5.3.1. Services to registered patients currently residing in a Homeless Shelter including, counselling and drug and alcohol services.
5.5.3.2. Services to registered patients currently residing in a Women's Refuge
5.5.3.3. Services to registered patients from Gypsy, Roma, Traveller communities
5.5.3.4. Enhanced sexual health and family planning services
5.5.3.5. Enhanced Primary Care Mental Health services
5.5.3.6. Enhanced Diabetes and pre-diabetes management
5.5.3.7. Services to a rural population

5.5.4. **Improved Quality -** These are areas where practices believe they deliver an enhanced level of quality over and above that expected of the core contract compared to less well-resourced practices.

5.5.4.1. Prescribing
5.5.4.2. Continuity of Care
5.5.4.3. Improved access

5.5.4.4. More appropriate use of wider health care services including Secondary care referrals use of A&E/UCC and OOH
5.5.4.5. RCGP Quality Practice Award
5.5.4.6. Gold standard investors in people
5.5.4.7. Data quality
5.5.4.8. Care Navigation
5.5.4.9. Innovation
5.5.4.10. Patient Satisfaction
5.5.4.11. Complaint handling
5.5.4.12. Appropriate management of Significant events

5.5.5. Training – Proportionally more training practices are PMS

5.5.5.1. GPs
5.5.5.2. Medical Students
5.5.5.3. Nurse Practitioners
5.5.5.4. Managerial and administration staff

5.5.6. Special Populations

5.5.6.1. A number of PMS practices provide services to highly deprived, ethnically diverse and culturally isolated populations. These populations tend to have a high burden of disease in a much younger population that is not adequately reflected in the current payment weightings.

5.5.6.2. A couple of practices serve populations with significant numbers of children and young adults with congenital abnormalities often due to co-sanguineous marriages resulting in significantly increase workload.

5.5.7. Active roles within and that support the wider health economy

5.5.7.1. GP Trainers
5.5.7.2. Facilitators
5.5.7.3. Reviewers
5.5.7.4. CCG roles
5.5.7.5. INT/Primary Care Transformation Developments

5.6. Further work is required by the CCG in order to ensure, where appropriate, the additional services provided over and above core GP services by PMS practices

6. Recommendations

6.1. The Primary Care Committee are asked to note the findings detailed in this draft report and agree further work to develop a robust Investment Strategy for Primary Care

Lisa Cunliffe
Primary Care development Manager

Appendix 1

Summary of PMS Review Visits/Pro-forma completion

Practice	What is your premium currently used for?	What impact will the erosion of the PMS Premium have on your practice?	Please detail and particular issues	Other
1	Quality Prescribing Continuity of care (Including a long standing cross cover arrangement with other practices) Training of Nurse Practitioners and Medical Students Minor Surgery (Funded over and above core contract as an Enhanced Service)	**Workforce** Redundancies **Quality** Poorer access Increased waits Reduced quality Fewer Services	Recruitment and retention Increasing demand	
2	Awaiting completed pro-forma from NHSE (Practice chose to complete a pro-forma rather than have a visit)			
3	Salaried GP sessions, Nurse Practitioner and Care Navigator posts Nurse triage Focus on quality rather than activity Continuity Innovation High achieving practice in terms of - Prescribing - Patient satisfaction - QOF etc.. - Play an active role within the wider Health economy	Practice will become unviable. **Workforce** Recruitment and retention Salaried GP has resigned Unable to recruit as a result of uncertainties Use of locums will increase impacting on continuity of care Reviewing affordability of Nurse triage Care Navigator role may disappear Already reviewing skill mix – replacing Practice Nurse with 2 HCAs Business Manager has reduced hours Often only 1 receptionist in the office GP working a 60 hour week **Quality** Reduced access Increase use of secondary care and wider health care system	Increased investment for PMS was based on performance against agreed objectives. Funding shortfall unlikely to be met as a result of reinvestment. Reinvestment in primary care is likely to come too late Work with Primary Care Foundation demonstrated increased demand in East Lancashire compared to other CCGs Considering exist strategies including: - Merger - Reducing list sizes	

		4INT and extended access development at ri5sk **Training** Plans to take Medical Students have been shelved **Morale** Reduced job satisfaction Increased stress with possible impact on health	- Serving notice on the contract Need to seek the views of: - Patients - Staff - Other practices Redundancy costs?	
4	Additional Nursing and Medical manpower to be able to manage: Highly deprived, ethnically diverse and culturally isolated population Significant disease burden in a younger population Large numbers of children and young adults with congenital problems Services to a homeless population	Practice will become unviable **Workforce** Reduction in resource will result in: Loss of medical and nursing manpower Struggling to recruit and retain staff Holding vacancies **Quality** Poorer access Increase use of secondary care Unable to participate in extended roles **Training** Unable to accommodate Medical Students	Current national weightings disadvantage young populations with a high level of health care need.	
5	2 GPs, Practice Nurse and reception staff Introduction of new services and quality initiatives including: - Drug and alcohol services - Mental health services - One stop family planning clinic - Practice based community nurse	**Workforce** Unable to replace retiring GP Haven't replaced Practice Based Community Nurse Increase workload and pressure on remaining GPs Loss of skilled personnel Static wages **Services** Inability to cover all sites List closure	Providing extended access Undertaking mQPA hoping to complete summer 2015 Data Quality Training Practice Working collaboratively with other practices Innovative	

		Branch closure Services withdrawn Only able to offer core services **Quality** Increased referrals to secondary care Reduced attendance at meetings Reduced access Increasing complaints SEAs **Morale** Increase stress levels Increased sickness and absence		
6	Visit planned for 27 July 2015			
7	Recruitment of female GP Extra GP sessions Nursing	**Workload** Unable to replace retiring GPs Unable to replace receptionists Replaced Nursing post at a lower grade Reduced capacity to take on extended roles **Service** Reduction in service **Training** Reduced capacity for medical students **Quality** Reduced number of appointments Reduced access Increased use of OOH/UCC Increase prescribing GP Ward round in nursing homes not possible		

	Nurse Practitioner Supports - Training practice status - Focus on quality and innovation - Sexual health, screening and family planning - Working toward achievement of mQPA - 15 minute appointments - Good working relationships with wider health care team	**Workforce** Ability to maintain strong relationships with wider health care team Need to review skill mix **Quality** Reduced access Increased A&E, OOH **Services** Ability to deliver services	Deprived area Challenging workload	
8	Awaiting completed pro-forma from NHSE(Practice choice to complete a pro-forma rather than have a visit)			
9	Nurse Practitioner Admin and Managerial time Vocational training for GPs including places for extension trainees Drug users Women's refuge	**Workforce** Any reduction to staffing puts into question the viability of the practice Not replaced Nurse Practitioner **Quality** Reduced access Increased waits Increased use of UCC/A&E Reduced patient satisfaction **Training** Reducing staffing further will impact on ability to continue training	Active engagement with deanery as programme director. Cost effective provision of extension programme for GP trainees	
10	GP including extra sessions for MSK and diabetes Nurse Triage Pre-diabetic screening Insulin starts and intensive support	Practice will no longer be viable **Workforce** Loss of triage nurse Loss of HCA Reduced admin hours	Most deprived population/ward in England with associated problems. Large population from South Asian heritage. Increasing numbers of Eastern	

	HCA Care Navigator Training practice RCGP QPA Gold standard investors in people High achieving practice in prescribing MSK and pain management in house	 **Quality** Increase referrals Reduced quality of prescribing Increase in unplanned admissions **Services** Loss of services Training Loss of FY2 Training	Europeans P81736 and P81182 are now working in partnership. These two practice have a similar demographic. Reduction in resource poses a risk to the transformation of P81182	
11	Although not a PMS Practice this surgery is significantly affected by the withdrawal of MPIG funding. The practice has submitted an application for additional resource. Suggest review visit to practice on same basis as PMS			

PART 11[1]

PMS SERVICES

1. This element of the PMS Agreement details the additional contribution that will continue to be made by PMS Practice. This part of the agreement is divided into four main themes or areas of activity.

Federated Practice Approach

2. The principle aims of this approach are to:

2.1. Enhanced co-operative working across federated Practices in East Lancashire
2.2. Provide mentorship and support to federated Practices in East Lancashire
2.3. Improve monitoring efficiency in collaboration with the PCT
2.4. Follow the principles of QIPP
2.5. Share learning and innovation with the wider health economy

155A. The federated approach requires:

155A.1. The PMS Practice to be an active member of the East Lancashire PMS Group. This will be evidenced by:

a. A signed memorandum of understanding
b. Registered attendance at regular Federation meetings
c. A description of the practice members roles, responsibilities and activities in the Federation

155A.2. Terms of Reference that incorporate:

a. Quarterly contract monitoring meetings with the PCT
b. Monitoring of Practice activity against PMS objectives
c. Mentorship and support of Federation members
d. A commitment to sharing learning across the wider health economy
e. A commitment for member practices to monitor and report progress on agreed PMS objectives
f. A requirement for the Federation to report member practices that require escalated intervention to the PCT
g. Removal from the Federation of member practices that fail to progress against objectives despite intervention

Active Contribution to the Wider Health Economy

3. The principle aim is for the practice to:

3.1. Demonstrate activity outside the practice
3.2. Demonstrate added value from the PMS Agreement compared to GMS

156A. The PMS practice will demonstrate a contribution to the wider health economy over and above GMS and Enhanced Services. Examples of contribution include:

a. Undergraduate and postgraduate medical training
b. Nurse and allied health professional training
c. GP Appraiser
d. Clinical Commissioning Group membership

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e. GP Tutor
f. Specific Federation role
g. Clinical leadership role
h. Primary Care research role

156B. The PMS Practice will agree with the PCT and the Federation its level of contribution and this will reflect the skills and capacity of the practice.

156C. The PMS Federation will be able to demonstrate a greater overall proportion of activity in the community than GMS providers.

Improved Quality of Patient Care

4. The principle aims are to:

4.1. Improve levels of clinical governance and reduce patient risk
4.2. Adopt a 'best practice' approach to patient care

157A. The PMS practice will demonstrate a commitment to systems and ways of working that support improved patient care

157B. The PMS practice will agree a formative plan with the PCT to develop systems to improve patient care over an agreed timeframe. This will be evidenced by:
a. Achievement of the RCGP Quality in Practice Award
b. The development of approaches to reduce inequalities in health and service delivery
c. An action learning approach to innovative organisational and service development
d. Participation in research, evaluation and audit
e. Shared learning and innovation in health care provision across the wider community

Performance Monitoring

5. The principle aims are:

5.1. For member practices to monitor their performance against PMS objectives

5.2. To enable the Federation to provide early intervention and support
5.3. To indentify member practices with performance that requires escalation intervention to the PCT

158A. The practice will monitor their own progress against PMS Objectives and report to the Federation at agreed intervals

158B. The Federation will provide the PCT with a summary of performance activity on a quaretely basis

158C. The Federation will formulate development plans with practices that fail to make adequate progress against objectives

158D. The Federation will identify resources and skills that can be made available to support practices to achieve their objectives

158E. The Federation will identify practices that require escalation intervention to the PCT.