NHS England

Primary care Commissioning Intentions 2014/15

London Region

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Background

NHS England is a national organisation and as a consequence, a number of issues that are required to be addressed through these commissioning intentions are prescribed for us nationally. That ensures that at the heart of core primary care services, the arrangements in place are the same throughout England. This means that where for example, changes to national contracts are negotiated and agreed, there is an obligation on the London region primary care commissioners to ensure that these are delivered as 'must do's'.

London's population growth and complexity are placing unprecedented levels of demand on general practice and the current service is struggling to respond effectively to rising health needs. Practices claim that finances are declining in real terms, exacerbating their inability to invest in service improvements and causing some to experience difficulties.

London CCGs are leading ambitious proposals to reconfigure local services to improve care that hinge heavily upon the ability to increase the capacity and capability of primary care services. Across London, there is significant variation between practices for key aspects of diagnosis and treatment. This variation represents a challenge to prevent more people being ill, dying early, and being hospitalised. Patients in London are less able to see their preferred GP than elsewhere in England.

Practices across London operate variable access options for patients with Londoners reporting wide variation in patient satisfaction. Access impacts on patient experience and the quality of care they receive and also matters to practices whose workloads can become unmanageable if access is not managed in a systematic way. If patients find it hard to access their general practice then their diagnosis and treatment may be delayed, or they may elect to go to A&E because it is open and available.

Stark health inequalities exist across London. Many London boroughs are doing worse than the England average on key preventative measures and need to find new ways of responding to high levels o f population migration and deprivation. Health promotion and primary prevention by general practice working in partnership with others will be key to reducing morbidity, premature mortality, health inequalities, and the future burden of disease in the capital.

Most practices remain small, with little access to economies of scale or scope. The small size of the typical practice limits career opportunities for many GPs and London has an especially high number of single-handers and GPs nearing retirement.

The work emerging from the Case for Change for primary medical services will likely see us moving towards larger contracts with GPs with doctors choosing to work in different ways making use of a variety of different models for such. London will actively support work with practices to develop federated models of delivery where GPs choose to do this.

As stated above, access to primary care services continues to be problematic for many Londoners. We are sure that the reaction and response to Call to Action will enable us to develop plans to improve access and the patient's experience of access. Already, as part of the GP contract settlement for 2014/15, we will see a number of changes designed to improve access:

Choice of GP practice. From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. Area Teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

Friends and Family Test. There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.

Patient online services. GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments.

Extended opening hours. The extended hour's enhanced service will be adapted to promote greater innovation in how practices offer extended access.

Through our continued and systematic use of the Primary Care Assurance Framework, we will strive to reduce the variation in the quality of GP services delivered across London. This work will focus first on those practices where that variation is at its widest.

We do need to be cognisant of the 'Fairer funding' equalisation agenda in primary care. We know that there will be greater weight given to deprivation factors and that work with GPC and NHS Employers to identify whether it is possible to update the existing deprivation factors in the Carr-Hill formula from April 2014 to ensure that the formula reflects the most up to date information on deprivation. NHS England is also working with the GPC to develop changes to the formula to be implemented from April 2015 to give greater weight to deprivation.

There will be a phased approach to reducing current expenditure on seniority pay and reinvesting these resources into global sum payments. We and the GPC will monitor the funding released during 2014/15 and, in light of this, will agree how to reduce funding by 15 per cent a year.

Additionally, as part of last year's GP contract settlement the Department of Health decided to phase out MPIG payments over a seven year period. From April 2014, as planned, MPIG payments will therefore be reduced by one-seventh every year for the next seven years, with funding recycled into global sum payments so that funding more fairly reflects the numbers of patients served by each practice and the health needs of those patients.

We expect these arrangements to be mirrored into PMS contracts. This, taken with the combined impact of changes to CCG allocations, may lead us to see a reduction in total commissioning budgets in parts of London.

There is an ambitious programme of work for dental service commissioning and reform signalled in this document. We expect a significant flow of work relating to pharmacy services to become apparent from the London primary care case for change being launched on 28 November.

It should be noted that the Commissioning Intentions for North West will be reflective of the outputs from 'Shaping a Healthier Future'. The intentions in South and North Central will be inclusive of any transformation activity that is ongoing.

Service Specific Issues

Dental Services

Pathways will define, regardless of setting, the grading of complexity and procedures across all levels of care. Services will be commissioned with a view to providing a consistent environment and equipment standards, consistent clinical outcomes, quality standards and patient reported outcomes (PROMS) including the Friends and Family Test.

Secondary care dentistry

Nationally we said…	**1. NHS England will work with LPNs, providers, clinicians and commissioners across England to develop consistent care pathways in all dental specialities, to ensure that patients are seen in the clinical setting most appropriate to their health needs.** **2. 14/15 secondary care contracts will be expected to be less that 13/14, following the introduction of a suite of dental care pathways which are in development**
London wide this means…	1. LPNs will be appointed and become operational with an agreed work plan for 2014/15 2. Commissioners will require secondary care dental providers, through CQUIN, to improve the quality and detail of acute dental data. This will be made available to commissioners and LPN members to inform the local development and implementation of care pathways. 3. Secondary care dental providers will be advised that 14/15 contracts will be expected to be less that 13/14. Changes to pathways will be initiated by the finalisation and publication of nationally designed care pathways. It is anticipated that the pathway for Minor Oral Surgery will be finalised first, and schemes already in place in London will be reviewed against national requirements. Pathway implementation will be supported by referral management services which will include independent triage. Consultant-led clinical governance will support the appropriate transfer of services from secondary care to primary care settings. 4. Some areas have no defined pathways, but the team will start to work on reviewing these where possible, and working with partners to develop detailed pathways

	5. Pathway redesign and implementation will extend into 15/16 and beyond with the associate adjustments to acute contracts being managed through the commissioning round.

Prior approval for secondary care dental care

Nationally we said…	**1. Where NHS England's commissioning policies or service specifications state access criteria, prerequisites or clinical thresholds for treatment, these constitute a group prior-approval for the purpose of authorising treatment. Clinicians at providers who are commissioned to deliver the relevant prescribed services may treat patients without recourse to commissioners for advice.** **2. Adherence to policies and access criteria will be assured through clinical threshold audits undertaken in year from April 2014 onwards.** **3. It is not in the interest of a sustainable health system for providers to undertake care for which they not are eligible for payment.** **4. Where clinicians believe an individual who does not comply with the access criteria would derive benefit by virtue of exceptionality individual prior approval is required, through use of the Individual Funding Request process.**
London wide this means…	1. These requirements will be made clear to providers in the 14/15 contracting round. 2. In order to preserve finite funding for patients who meet the clinically evidenced thresholds for treatment, NHS England is unable to fund treatments provided to patients who do not comply with the criteria in clinical policies. 3. Advance notice of the adoption of this approach by NHS England is designed to ensure providers take prompt preparatory action to put in place systems to ensure compliance to clinical policies prior to the rollout of clinical threshold audits to ensure that all treatment and care undertaken is eligible for funding. 4. The IFR process will be made clear to teaching providers.

Individual Funding Requests

Nationally we said…	1. **During 2013/14, IFR responsibility for secondary care dental treatments transferred to four regional teams who manage the process on behalf of the 27 Area Teams working to a national NHS England IFR Policy and Standard Operating Procedure (SOP). The current management process, the Policy and SOP will be reviewed and revised for 2014/15, strengthening national consistency. A training programme for panel members, commissioners and potentially for providers will be available.**
London wide this means…	1. The policies etc. will be revised nationally and training provided to Panel members in order to achieve greater national consistency. 2. The Dental team are working with London Regional IFR team to implement the emerging policy consistently. Clinical advice from Public Health England's Consultants in Dental Public Health has been identified. 3. Specific focus will be extended to the 4 teaching hospitals in London where the need to balance teaching of complex treatment with a consistent offer to patients needs to be achieved.

Secondary care dental CQUIN

Nationally we said…	1. **There should be an appropriate CQUIN for 2014/15 with particular focus on patient experience for secondary care dental providers.** 2. **Providers will be asked to publish how the resources earned from CQUIN performance are being deployed into the relevant service areas to secure improvements in quality, and may wish to incorporate this into Quality Accounts.**
London wide this means…	1. London will wish to agree with secondary care dental providers an appropriate set of CQUINs for 2014/15 which will include patient experience. The desire is to focus on a small number of CQUINs with limited / no additional reporting requirements on the providers that will enable more effective and efficient commissioning. 2. Monitoring of CQUIN performance will be supported by the development of a dental quality dashboard for acute providers.

	3. Providers will be asked to publish how the resources earned from CQUIN performance are being deployed into the relevant service areas to secure improvements in quality, and will be asked to incorporate this into Quality Accounts.

Community dental services

Nationally we said…	**1. We will review current contracts with specialist community dental providers. We will review case mix and activity and NHS England will look to including the Friends and Family Test in contracts.** **2. NHS England will wish to review the contract KPIs to align with our aims to provide personalized care for frail older people and others with complex health conditions, address increasing demand for domiciliary care, and reduce reliance on secondary care dental services.** **3. Services will be commissioned to a consistent standard**
London wide this means…	1. Current Special Care Dental Services (SCDS) providers will wish to note our intention to review current contracts. There are currently nine providers in London using a primary care contracting model. Contracts will be reviewed for efficiency, value for money and contracting type. Providers should be aware of the need to review SCDS estate, and rationalise as necessary. 2. Providers will wish to note that we will review current activity, to ensure the appropriateness of the caseload. Inappropriate activity intended for the General Dental Services (GDS) will be repatriated as necessary. 3. General Anaesthetic (GA) lists for children will be audited as necessary, to ensure appropriateness of treatment planning as well as ensuring double-counting does not occur against secondary care tariffs. 4. Local piloting of the case mix model will take place, as a potential future national alternative tariff to Units of Dental Activity (UDAs). 5. Providers should be aware of the need to take part in national epidemiology and school screening programmes, as per the relevant statutory instrument. 6. Services will be commissioned to a consistent standard for environment and equipment, infection control/decontamination (HTM 01-05), consistent clinical outcomes, quality standards and patient reported outcomes (PROMS).

PDS Orthodontic services

Nationally we said…	**1. NHS England will work to ensure that there is a completed population orthodontic needs assessment to underpin orthodontic commissioning decisions.** **2. We will undertake a review of existing providers and their services by benchmarking against the quality and value framework, and consider contract extensions and/or procurement exercises in light of a number of key principles including the need to maintain continuity of care for patients. NHS England will introduce a standard approach to performance and quality arrangements for orthodontic providers.**
London wide this means…	1. NHS England will extend existing PDS orthodontic contracts for a further 2 years. Providers will be assessed against nationally agreed quality and value indicators to determine length of future contract extensions in order to phase the process to bring these time-limited contracts to the market. 2. NHS England will further develop the needs assessment for orthodontic services, to ensure the correct service specification is developed 3. A review of providers will be completed to ensure value for money and service compliance. 4. Alternative contract forms, including the NHS Standard contract will be piloted as an alternative to the PDS contract framework for orthodontic provision in a primary care setting.

PDS + contracts

Nationally we said…	**1. NHS England will work with LPNs, providers, and clinicians, to consider the range and scope of key performance indicators associated with PDS + contracts. Opportunities to rationalise and align KPIs with local priorities will be explored including supporting 7 day working/extended availability for primary care dental services.** **2. Services will be commissioned to a consistent standard for environment and equipment, consistent clinical outcomes, quality standards and patient reported outcomes (PROMS).** **3. NHS England will look to including the Friends and Family Test in contracts, and will describe consistent coding and pricing measures for each pathway.**

London wide this means…	1. London will review the service, performance and value of its current portfolio of PDS Plus contracts in line with the emerging national methodology. 2. Opportunities for variation of existing agreements will be considered where appropriate. 3. Those contracts that are due to be re-tendered will be commissioned according to a consistent specification which will include new quality indicators such as FFT.

Dental contract reform programme

Nationally we said…	**1. The new dental contract reform programme is led presently by DH but will have a significant impact on achieving the wider objectives for primary care dental services, specifically, development of appropriate quality metrics and implementation of care pathways.** **2. NHS England will seek equity of access to mandatory and non-mandatory services, and improved data collection to inform the Outcomes Framework, specifically from primary care dental practices**
London wide this means…	1. London will shape and pilot the transfer of the contractual and performance management of Dental Contract Pilots to Area Teams 2. Commissioning intentions across the dental pathway cannot be considered in isolation of the emerging dental contract reform agenda in primary care.

Dental out of hour's services and Dental Nurse Assessment service

Nationally we said…	**1. NHS England will conduct a review of current dental OOH service and through a working group reporting to the National Dental Commissioning Group; consider developing a core service specification, setting standards for access, monitoring outcomes and patient experience.** **2. Dental OOH services whilst commissioned by NHS England will be reviewed in the context of the local commissioning strategy for out of hours and unscheduled care.** **3. As part of the dental OOH service, NHS England will review the provision of the dental nurse assessment service.**

	4. During 2013-14 NHS England will conduct a review of the current DNAS service with the intention of identifying opportunities to achieve efficiencies through economies of scale, and ensuring a strong provider platform upon which to take forward service developments. A number of options will be considered and tested before a formal procurement is undertaken.
London wide this means…	1. London will take the opportunity of contract expiration dates to commission future urgent care arrangements according to a consistent model. 2. London's model for urgent care out of hours brings together call handling through the 111 provider system, underpins this in the out of hours periods with Dental Nurse Assessment, and directs patients appropriately to a number of community based providers in groups of boroughs. 3. Patients will not be limited by geographical boundaries but will be directed to services according to need. 4. Remaining walk-in provision with be reviewed with a view to increasing clinical triage. 5. Availability of next day slots will be reviewed and increased.

Primary Medical Services

Personal medical services

Nationally we said…	**1. NHS England will seek to align PMS contracts with local emerging primary care strategies arising from discussions informed by 'a call to action' to achieve better access and better outcomes for patients, and offering best value for money** **2. NHS England will be engaging with PMS practices and their representatives to seek to agree the best way forward for PMS contracts, taking into account the results of the desktop review and contract disaggregation exercise undertaken by area teams in August 2013**
Locally in London this means:	1. Review of all PMS contracts for size and volume to align to national process. The preferred model is for larger / federated PMS contractors to bring benefit and economies of scale 2. Once reviewed, PMS contracts should be aligned to ensure consistency of service and access. This will include indicators for quality and service, and should be linked to CCG and Local Authority Quality Strategies where appropriate.
Locally in North, Central & East London this means…	
Barnet, Enfield, Haringey, Camden and Islington	Reviewed in 2013 Figures not available yet from Finance Dept.
City & Hackney	7 PMS contracts Reviewed in 2013 Figures not available yet from Finance Dept.
Barking & Dagenham, Havering and Redbridge	14 Redbridge contracts reviewed in 2007 Barking and Dagenham, Havering – reviewed 2010 Figures not available yet from Finance Dept.
Newham, Tower Hamlets and Waltham Forest	Newham reviewed 2012 Tower Hamlets not reviewed 22 contracts in Waltham Forest reviewed in 2007
Locally in North West London this means…	
Inner – Central, West London, Hammersmith & Fulham, Hounslow, Ealing	60 PMS contracts Average £95.29 per weighted patient No known reviews apart from Hounslow in 2010 – a range core requirements and optional premium services introduced KCW reviewed premium enhanced services introduced
Outer – Brent, Harrow, Hillingdon	41 PMS contracts Average £86.96 per weighted patient No known reviews
Locally in South London this means…	
South East – Lambeth, Southwark, Lewisham,	198 PMS contracts Average £81.23 per weighted patient

Greenwich, Bexley, Bromley	Mostly reviewed in last 3 years
South West - Croydon, Wandsworth, Richmond, Merton, Sutton, Kingston	143 PMS contracts Average £79.69 per weighted patient Mostly reviewed in last 3 years

APMS contracts

Nationally we said…	1. **NHS England will be engaging with APMS practices and their representatives to seek to agree the best way forward for APMS contracts, whilst understanding the impact of closures of these centres on patients and on choice and competition.**
Locally in London this means:	1. London Region is systematically reviewing its time limited APMS contract portfolio which includes 73 primary medical services and 24 GP Led Health Centres. 2. The review is being undertaken with CCGs in the case of GP Led Health Centres, in recognition of the shared commissioning responsibility and London Region intends uncouple the unscheduled care element of these contracts. 3. The result of these reviews is that contracts will either continue, or be re-procured, renegotiated or terminated, as appropriate. 4. London, in collaboration with NHS England National Primary care Support Team, is developing a standard APMS contract. This will include a standard specification, price per weighted patient and KPIs for London. Once complete, this will be used to ensure consistency across new APMS contracts within London – both in terms of quality and access to services. 5. Any significant changes to services , both in terms of access and services provided will be subject to appropriate consultation and engagement of key local stakeholders and Equality Impact Assessments

Enhanced Services

Local Enhanced Services

Nationally we said…	1. **Any outstanding Local Enhanced Service (LESs) carried over by NHS England through transition will cease from 31 March 2014. Where CCGs wish to commission services from primary care providers, they will have the option of:** • **commissioning services in their own right and contracting for these services through the NHS Standard Contract** • **developing shared commissioning strategies with NHS England (through Area Teams) and commissioning enhanced services under delegated authority from NHS England**
Locally in London this means…	1. Any remaining LESs will be migrated across to CCGs for future commissioning. These should be evaluated by the CCG to

	understand the future commissioning intentions. 2. By April 2014 there will be clarity on the services that CCGs are continuing to commission locally using the national contract form or as LIS delegated by NHS England 3. Potential impact on Primary Care should not be overlooked during future contracting, as the short term nature of the current contracts can impact on investment in the workforce. 4. NHS England will continue to work with Area Teams to ensure there is no duplication of commissioning

Direct Enhanced Services

Nationally we said…	**No mention of DES in national commissioning intentions**
Locally in London this means…	1. NHS England Primary Care team will continue to commission Direct Enhanced Services (DESs) 2. By April 2014, all Minor Surgery DESs should be evaluated and standardised to comply with NICE guidance. This will be monitored throughout the year. 3. By April 2014 there will be clarity on the services that CCGs are continuing to commission locally using the national contract form or as LIS delegated by NHS England 4. By April 2014 all National Enhanced Services (NES) commissioned by the AT will have been reviewed and a decision taken on whether to continue with them or decommission them for re-provision by the local CCG.

Optometry Services

Optometry Services

Nationally we said…	**1. NHS England will seek to progress eGOS payments, adopting learning from the outcomes of current pilots. We will seek to reduce bureaucracy associated with payment processes, and look to identifying opportunities to achieve efficiencies through economies of scale upon which to take forward service developments. Options will be considered and tested with a wide range of stakeholders before a formal procurement is undertaken.**
Locally in London this means…	1. Development of local professional networks 2. Facilitate better interface with CCGs and ensure the LPNs are up and running

Pharmacy services

Community Pharmacy Services

Nationally we said…	**1. NHS England will review and refresh additional Pharmacy Local Enhanced Services. Guidance will be published about which pharmacy LESs will continue to be commissioned by NHS England and what may be further developed to take forward service developments in line with the local primary care strategy.**
Locally in London this means…	1. Each existing Pharmacy LES will be evaluated to ensure a consistent offer of pharmacy service across London 2. The LES's will be monitored for compliance to the revised guidance document published nationally. 3. The two LES schemes NHS England will focus on are Minor ailments (MAS) and Compliance/Medicines optimisation (MO) 4. Linking in with Local professional networks
Locally in North, Central & East London this means…	Transferring pharmacy enhanced services (including funding) commissioned by PCTs currently sitting with CCGs to NHS England. A once for London approach to be taken in service development wherever possible and a pragmatic approach to be taken with services that are heavily integrated in larger care pathways.
NC London Group	5 boroughs - 3 of the boroughs commission MAS. 2 commission MO. Other LES's commissioned within NC London are Palliative care and Specials services.
BHR	3 boroughs - 2 of the boroughs commission MAS. Other LES's commissioned within BHR are Palliative care and care homes services.
WELC	3 boroughs - 3 of the boroughs commission MAS. Other LES's commissioned within WELC are care home services.
City	1 borough - MAS and MO commissioned
Locally in North West London this means…	Transferring pharmacy enhanced services (including funding) commissioned by PCTs currently sitting with CCGs to NHS England. A once for London approach to be taken in service development where possible and a pragmatic approach to be taken with services that are heavily integrated in larger care pathways.
NW	8 boroughs - 3 commission MAS .1 borough commissions MO. Other LES's commissioned in NW are palliative care and 'Not dispense' schemes.
Locally in South London this means…	Transferring pharmacy enhanced services (including funding) commissioned by PCTs currently sitting with CCGs to NHS England. A once for London approach to be taken in service development where possible and a pragmatic approach to be taken with services that are heavily integrated in larger care pathways.
South East	6 boroughs - 1 borough commissions MAS, 2 commission MO.
South West	5 boroughs - 4 boroughs commission MAS. 3 commission MO. Other LES's commissioned in SW are palliative care, Domiciliary MURs and Care home services.

Support services

Translation and interpretation services

Nationally we said…	**1. During 2013-14 NHS England is conducting a review of current translation and interpretation services providing support to primary care contractors. During 2014/15, NHS England will consider establishing a core service specification, setting standards for access, monitoring outcomes and patient experience.**
Locally in London this means…	1. NHS England (London region) will work with the national team to develop a core service specification for translation and interpretation services 2. In addition we will work to ensure the funding for this service is allocated appropriately and that consistent service frameworks are used 3. NHS England would commission a core service offering related to the core specification; dependant upon the contracting model developed and the expanse of the core specification, it is possible that CCGS may wish to supplement this core offering to assure access to these services for other clinical services that they commission, sensitive to the local demographics of their areas.

Occupational health services

Nationally we said…	**1. During 2013-14 NHS England is conducting a review of current occupational health services. NHS England will consider the future configuration of occupational health services during 2014/2015 with the intention of establishing a core service specification, clarifying criteria for access, and monitoring outcomes and user experience.** **2. In 2014/2015 NHS England will review current configuration of services and identify opportunities to achieve efficiencies through economies of scale.**
Locally in London this means…	1. NHS England holds the occupational health liability for dentists and GPs. In turn, dentists and GPs hold the occupational health liabilities for their staff. 2. NHS England London Area teams will work to develop a core service specification and framework across the region and its current six (6) occupational health providers in London to ensure consistency of service is offered. This is envisaged that

	it will include the use of a call off list from a single framework, therefore identifying potential economies of scale. 3. The core service for London would include; new starter checks, immunisations, sharps injuries, referral management, counselling and health assessments for the contactors and those that contractually NHS England are contractually obliged to provide.
Locally in North, Central & East London this means…	1. North East and Central London will align GP occupational health services so they are identical to those used in South London.
Locally in North West London this means…	1. A consolidation exercise will take place to standardise contract specifications between North West and South London areas.
Locally in South London this means…	1. A consolidation exercise will take place to standardise contract specifications between North West and South London areas.

Clinical Waste services

Nationally we said…	**1. During 2013-14 NHS England is conducting a review of current provision of clinical waste disposal services from primary care premises. We will consider the future configuration of waste disposal services during 2014/15 with the intention of identifying opportunities to achieve efficiencies through economies of scale, and ensuring a strong provider platform upon which to take forward service developments. A number of options will be considered and tested with a wide range of stakeholders before a formal procurement is undertaken.**
Locally in London this means…	1. A consistent Pan London solution has been proposed for waste contract management for all independent contractors (GPs and Pharmacies) based on efficient single contract approach with robust management processes. 2. The objective is to deliver a high quality waste disposal service to patients and providers by ensuring consistent legislative compliance and service quality assurance whilst also achieving significant annual savings on across London. (These savings have been modelled on the cost savings previously achieved in one of the LAT's in London on waste contracts for GP and Pharmacies). 3. Project support has been put in place to source waste contract information, link in with the NHS England Procurement and lead on the procurement process. The Procurement has been advertised in OJEU and PQQ's have been received and are currently being reviewed. It is planned that the solution and new contract will go live in the first quarter of 2014.

Premises

Nationally we said…	**1. We are developing a strategic framework to support joint work with healthcare providers, CCGs, local authorities and other community partners to ensure that local strategies for out-of-hospital care include appropriate strategies for premises development.** **2. NHS England will work with other commissioners and with healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties. NHS England will seek to develop an abatement policy to ensure that payments made under the GP rent and rates scheme appropriately support primary medical services; understanding the range of non-core services currently reimbursed under the Premises Directions and how these should be managed in the future.**
Locally in London this means:	1. NHS England will need to work with partners, including healthcare providers, CCGs, Local Authorities and community partners to develop the premises required to deliver the strategy for primary care 2. In 14/15, this will require scoping around the needs for premises across the London region, taking into account the future changes planned for primary care and the out of hospital agenda. This will include an assessment of the space required, in what location and with what equipment to deliver the strategy. It should also link to facilities requirements and potential IT solutions, to provide a single premises strategy for the future of primary care 3. Additional consideration will need to be given to the best way to procure space, both within an expensive property market in London and the long term risks associated with building and maintaining property.

Primary Care Support Services (FHS)

Nationally we said…	**1. There are national negotiations with private and other PCS/FHS providers to bring their services and costs into line with future NHS-managed services. There are also national reviews of medical records, performer lists, ophthalmology payments, and screening services systems to see how they can be made more efficient, although these proposals will take longer to develop and introduce.** **2. Whilst the improvement programme is being led nationally, many of the plans are being developed (and will be**

	delivered) by three regional teams (one for London and the South working together, one for the Midlands and East, and one for the North) so that they reflect local circumstances. **3. NHS England will need to review services in light of practitioners' changing needs as they take advantage of new opportunities to improve health outcomes and the quality of care, and as developments such as fully computerised medical records are introduced. PCS/FHS services will need to reflect these changing needs.** **4. NHS England will progress work through 2013 into 2014 to achieve a safe transition in PCS services**
Locally in London this means:	London & South have agreed to develop a joint offer which brings the service inline with the £1.08 challenge. There will be a differential impact across London depending on historical levels of provision and providers. The focus of the proposal is to consider the preferred option which requires the shifting of services to locations that are more cost effective in terms of premises and staffing and the streamlining of systems and processes to reflect best in practice. An OBC has been developed to support the above approach which would offer best in class provision and deliver the required savings within a safe transitional timeframe. This was submitted to the national team on Wednesday 6th November. Further work is underway to scope gaps in the current OBC which include: 1. Clarification on the impact of the national time lines/critical path and next steps 2. Scope of national work streams and the subsequent division of labour (national v regional) 3. Resources to be provided regionally 4. Financial assumptions to be made Following national launch of the options for each region London has embarked on a comprehensive consultation process. This is in line with the national programme. 5. An implementation plan to assure safe delivery of the changes is being developed in anticipation of next steps.

Additional services

These sections are not mentioned in the national commissioning intentions but should be considered in London as part of the commissioning intentions.

Regeneration

Locally in London this means:	Across London, there are significant regeneration programmes taking place which will result in the both the relocation of existing London residents and the establishment of new populations. 1. Primary Care Commissioners are working with local stakeholders, including Local Planners and Health & Well Being Boards to ensure developments include proper consideration of primary and community services infrastructure. Access to section 106 (s106) or Community Infrastructure Levy (CIL) funding will be paramount to support the affordability of these developments for London Area Teams, and to enable NHS England to discharge its statutory responsibility to ensure all London residents are able to access primary care services

Homeless and Unregistered

Locally in London this means:	2. London has a large and growing problem with people who are homeless. This includes rough sleepers and people in temporary accommodation. This population is more likely to be associated with physical and mental ill health and have drug or alcohol misuse problems. In London we have 6 primary care services (offering combinations of all GP, Dental and Eye services) dedicated to offering services for this population. 3. In London we intend to review how we commission these services and to develop a single commissioning model based on successful outcomes that addresses the needs of this population and recognises the need to develop care pathways that meet their needs and lifestyle. This will involve collaboration with LA's, CCG's and the third sector. 1.

Access – commuter / choice populations

Locally in London this means:	1. London has the largest commuter population in country with many people experiencing long commutes in and of the capital 2. Demand for a "choice" of GP is likely to be high in parts of London with large commuter populations and this needs to be managed. 3. We intend to scope the impact on practices using findings from the existing pilots to establish whether there is sufficient capacity to absorb this population or if additional capacity needs to be developed in parts of London.

	4. We shall assess the risk to providers, patients and commissioners from this increased demand and ensure that our services are prepared for these changes

Work Arising from the Case for Change COMPLETE POST LAUNCH ON 28 NOVEMBER

Locally in London this means:	6.
Locally in North, Central & East London this means…	
NC London Group	
BHR	
WELC	
Locally in North West London this means…	
NW1	
NW2	
Locally in South London this means…	
South East	
South West	
City	