Report to:	**SINGLE COMMISSIONING BOARD**
Date:	25 May 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**2017-18 COMMISSIONING IMPROVEMENT SCHEME**
Report Summary:	This paper outlines a proposal for a Commissioning Improvement Scheme (CIS) for 2017/18 based on the learning from the 2016/17 scheme and preparatory discussions at Finance & Quality, Innovation, Productivity and Prevention Programme Group. Achievement under the parameters of the 2016/17 Commissioning Improvement Scheme have been calculated and the engagement and innovative thinking of practices and neighbourhoods acknowledged. There is however also learning from the framework of that scheme which needs to be reflected whilst maintaining the spirit in which the initial outline was drafted and the positive engagement and creative thinking the scheme has supported.
Recommendations:	The Single Commissioning Board is asked to support the 2017/18 Commissioning Improvement Scheme proposal, noting the recommendations made by the Professional Reference Group in relation to the following issues: 1. The continuation of the high cost patients risk pool, however with the change for 2017/18 to apply 50% of each high cost episode to the pool. 2. The adjustment to the achievement scenarios in relation to underspends and/or improvements made by practices the percentages to be applied and the inclusion of the neighbourhood element.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

17/18 Budget Allocation (if Investment Decision)	£0 in 2017/18 – any payments due would be made in 2018/19 and 2019/20
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB decision
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoided, Benchmark Comparisons	Deliverable savings & Expenditure avoided.

Additional Comments

A commissioning improvement scheme was in place during 2016/17. During this period GP referrals reduced by 6% relative to the prior year, demonstrating the potential value the scheme has in challenging poor referral practice and contributing to the long term financial gap.

Payments in relation to the 2017/18 Commissioning Improvement Scheme will be made out of budgets in 2018/19 and 2019/20. An indicative budget of £1.5m has been created in 2018/19. From this we will need to make a final payment in relation to the 2016/17 scheme. Value of this is unknown at present, but estimated at around £0.5m. Leaving around £1m available in 2018/19 to fund the 2017/18 scheme.

It is important to note that the schemes proposed in this paper are not capped, which presents a risk to our financial position in 2018/19 and beyond. Payments due under Commissioning Improvement Scheme could be significantly higher than currently allowed for in budget if practice performance continues to improve. While sustained long term reductions in practice expenditure are clearly beneficial to the overall financial position, it is important to appreciate that in the short term the Commissioning Improvement Scheme would not be self-funding because of 'block' contracting arrangements.

Legal Implications: **(Authorised by the Borough Solicitor)**	Without an understanding of the financial implications not yet provided of the proposed Commissioning Improvement Scheme (CIS) it is not possible to assess whether it fulfils the public law test of value for money. Clearly the CIS should support and provide outcomes in line with the Strategies outlined below and within this paper.
How do proposals align with Health & Wellbeing Strategy?	The paper describes a mechanism for continued practice and neighbourhood engagement and delivery of all elements of the Health & Wellbeing Strategy.
How do proposals align with Locality Plan?	The paper describes a mechanism for continued practice and neighbourhood engagement and all elements of the Locality Plan, with primary care being a key link in its delivery.
How do proposals align with the Commissioning Strategy?	The Commissioning Improvement Scheme proposal fully supports the Commissioning Strategy with member practices a key link between our strategy and patient need.
Recommendations / views of the Professional Reference Group:	PRG recommended support of the Commissioning Improvement Scheme in principle and this version of the report reflects the discussion and views of PRG and the subsequent discussion recommended by PRG to be had at Finance & Quality, Innovation, Productivity and Prevention Programme Assurance Group on 17 May 2017.
Public and Patient Implications:	The CIS will not impact on service provision and therefore not impact directly on patients however may highlight areas for consideration through Commissioning Strategy for service redesign. As such any changes considered would be taken through appropriate governance and consultation as required.

Quality Implications:	The principles of the Commissioning Improvement Scheme are to recognise the performance of practices against their devolved unified commissioning budget in comparison to the prior year and therefore maintain and further develop engagement in delivering QIPP (Quality, Innovation, Productivity and Prevention) and securing best use of resources across the economy.
How do the proposals help to reduce health inequalities?	The engagement in the Commissioning Improvement Scheme by each practice will review the activity data and requirements for patients and therefore will address health inequalities within each practice population.
What are the Equality and Diversity implications?	This proposal addresses total practice population.
What are the safeguarding implications?	There are no safeguarding implications; the scheme provides a mechanism for each practice to review the data for their practice against its unified budget. Direct patient care will continue to be delivered through practices contracted route and therefore any safeguarding issues/implications be addressed under that process.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no IG implications; the data provided to practices is pseudonymised. Practices review their own data in line with their own IG protocols.
Risk Management:	Any risks identified will be managed through the neighbourhood support arrangements of Commissioning Business Managers and Neighbourhood Finance Leads.
Access to Information :	The background papers relating to this report can be inspected by contacting Tori O'Hare Telephone: 07920 086397 e-mail: tori.ohare@nhs.net

1. INTRODUCTION

1.1 This paper outlines a proposal for a Commissioning Improvement Scheme (CIS) for 2017/18 based on the learning from the 2016/17 scheme and preparatory discussions at Finance & Quality, Innovation, Productivity and Prevention Programme Group. Achievement under the parameters of the 2016/17 Commissioning Improvement Scheme have been calculated and the engagement and innovative thinking of practices and neighbourhoods acknowledged. There is however also learning from the framework of that scheme which needs to be reflected whilst maintaining the spirit in which the initial outline was drafted and the positive engagement and creative thinking the scheme has supported.

1.2 The principles of the Commissioning Improvement Scheme are to remain, that is to recognise the performance of practices against their devolved unified commissioning budget in comparison to the prior year and therefore maintain and further develop engagement in delivering QIPP (Quality, Innovation, Productivity and Prevention) and securing best use of resources across the economy.

1.3 This version of the scheme proposal reflects the discussion at the Professional Reference Group on 10 May 2017 and the discussion at Finance & Quality, Innovation, Productivity and Prevention Programme Assurance Group on the 17 May 2017.

2. LEARNING FROM 2016/17

2.1
- Budget Setting Methodology;
- Achievement – improvement v underspend;
- Forecasting of achievement payments;
- Parameters for utilisation of achievement payments.

2.2 The 2017/18 proposal recognises these issues and adapts the model to address the concerns raised.

3. BUDGET SETTING

3.1 Practice budgets are calculated annually to devolve to each practice their share of the Clinical Commissioning Group healthcare budgets. In 2016/17 and 2017/18 this includes devolving QIPP across practices. This principle is proposed to remain the same. The scope and mechanism for devolving budgets is for local determination though a national toolkit for calculating fair shares is available. After a comprehensive review of potential budget setting options Finance and QIPP Group have agreed a budget setting methodology for 2017/18 based directly on the national toolkit and utilises its full potential to set budgets at practice level with the exception of the four practices which opened during the source data period of the toolkit and consequently for whom the toolkit is not reliable and therefore a weighted capitation share is to be used as a proxy.

3.2 Opening practice budgets for 2017/18 are being calculated using this methodology. In line with previous years, they will change through the year for the quarterly list size refresh and for changes in Clinical Commissioning Group allocation.

3.3 The 2016/17 practice budgets will also be restated for this change to the methodology for the purpose of accurate prior year comparator. Practices' restated 2016/17 budget will be distributed for information as soon as possible.

3.4 The high cost patients risk pool included in the budget setting methodology for 2016/17 was to hold a £1.5m risk pool topslice and the highest cost episodes of patient level expenditure mapped against this rather than practice budgets. This approach to managing a risk pool will be replicated in 2017/18 however with an adjustment to allocate 50% of the cost of the high cost episode to the risk pool. This approach is felt to allow the resource to be distributed further and therefore support a greater number of practices to benefit from the risk pool.

3.5 The potential for variation in those episodes attributed to the risk pool will be reiterated in the presentation of the data to practices to support practices in the management of their budget.

4. ACHIEVEMENT FRAMEWORK/GRID

4.1 The proposal for achievement under the Commissioning Improvement Scheme in 2017/18 is proposed to follow the same principles as 2016/17 of recognising underspends against budget in year and recognising improvements against 2016/17 when comparing the variance position of each year.

4.2 A point of learning acknowledged from 2016/17 is that the potential for a significant improvement by a practice which resulted in a change from an overspent position to an underspend position was not clearly recognised. This has been addressed in the achievement framework proposed for 2017/18.

4.3 The Commissioning Improvement Scheme proposal for 2017/18 will see practices achieving one of four outcomes:

	Budget Outcome	Achievement Proposal
A	Practice achieves an underspend against their 2017/18 budget and achieved an underspend against their 2016/17 budget	Practice receives an underspend payment of 50% of the value of the 2017/18 underspend.
B	Practice achieves an underspend against their 2017/18 budget and this is an improvement from an overspent year end variance in 2016/17.	Practice receives an underspend payment of 50% of the value of the underspend. Practice receives 15% of the improvement made, the value of the overspend to breakeven position.
C	Practice overspends against their 2017/18 budget however that this is an improvement in comparison to the year end variance in 2016/17.	Practice receives 15% of the improvement value.
D	Practice overspends against their 2017/18 budget and this is not an improvement in comparison to the year end variance in 2016/17.	Practice does not qualify for an achievement payment.

Notes:
- comparison to the 2016/17 variance is the variance restated for the change in budget setting methodology.

4.4 Based on the above percentages a number of worked examples of the achievement proposal are illustrated below:

Practice	16/17 Variance	17/18 Variance	Outcome	Under-spend Payment	Improvement Payment	Total Achievement
A	(£299,958)	£19,407	B	9,704	44,994	54,697
B	£321,430	£60,743	A	30,371	-	30,371
C	(£810,464)	(£578,966)	C	-	34,725	34,725
D	£133,876	(£39,765)	D	-	-	-
E	£251,924	£287,444	A	143,722	-	143,722
F	£687,451	£176,183	A	88,092	-	88,092

5. COST

5.1 The affordability of achievement payments needs to be considered, this would be a commitment in budget setting for 2018/19 as the nature of a Commissioning Improvement Scheme requires achievement payments to be made in the following financial year.

5.2 Sensitivity analysis, varying the rate for each achievement component, was undertaken through the Professional Reference Group and Finance & Quality, Innovation, Productivity and Prevention Programme Assurance Group discussions before agreeing on the above percentages.

5.3 In addition to the above, a neighbourhood payment was supported for inclusion by the Professional Reference Group. This would see a further payment, proposed on the basis of a rate per weighted head of population at 1 January 2018, made to each practice if a neighbourhood underspend is achieved. This is proposed as being payable to all practices in the neighbourhood, if the neighbourhood achieves an underspend, and is not linked to individual practice achievement against the outcome grid. This, based on £2 per weighted head of population, would equate to a maximum further payment of circa £517k. This figure is illustrative based on 1 January 2017 list sizes however would be calculated based on list size information at 1 January 2018.

5.4 The inclusion of a neighbourhood element to the Commissioning Improvement Scheme would support continued sharing of best practice around processes and protocols, peer review and support in each of our five neighbourhoods and would strengthen the commissioning focus within neighbourhood discussions. This would also retain the neighbourhood element of the 2016/17 scheme without increasing the complexity of criteria for improvement payments.

6. ACHIEVEMENT CALCULATIONS TIMESCALES & PAYMENT TIMESCALES

6.1 One of the challenges in year relating to the 2016/17 scheme was the request from practices and neighbourhoods for achievement forecasts. The risk of forecasting a year end position from early months data is significant as there is a limited basis to estimate from, plus the potential for change in the financial position overall and further risk of change in the allocation of the high cost patients risk pool. The benefit of providing this information is however deemed to outweigh this and therefore it is proposed to provide this at least quarterly, with an aspiration to provide this more frequently, however this will be clearly marked and discussed through neighbourhood meetings as indicative.

6.2 The proposal in terms of payments is to continue in 2017/18 of the principle of using an indicative achievement position based on M9 data from which to invite

practices/neighbourhoods to produce business case proposals for utilisation of these resources.

6.3 There is a risk that the month 12 refresh of achievement calculations reduces the amount due to practices. Timing of the month 12 data, available in June, could allow practices to plan a business case based on the achievement calculation forecast with month 9 data however business cases be reviewed in June be after receipt of month 12 data. This would give practices April and May to plan utilisation of their payments, however these figures be refreshed alongside submission of business cases in June so as to ensure affordability within the month 12 achievement figure.

6.4 The payments to be made to practices would be based on the month 12 achievement figures. Again, a 75% part payment could be paid to practices in early in 2018/19, with the balancing payment in 2019/20.

7. UTILISATION OF ACHIEVEMENT PAYMENTS

7.1 Recognising the learning from 2016/17 in respect of utilisation of achievement payments, the panel process for sign off of utilisation proposals will be repeated. This recognises the scale of potential payments and the need for scrutiny of the utilisation of resources across the economy whilst supporting the innovative thinking within neighbourhoods.

7.2 The spend proposal for practice achievement payments will be considered by the Clinical Commissioning Group in line with 2016/17, with a review process in place tiered on the basis of value of business cases. This recognises practices may wish to utilise their achievement funding on a number of schemes. The review process would be as follows:

Business Case Value	**Process**
£0 - £10,000	Email to Commissioning Business Manager and assessment within Single Commissioning Function, to include appropriate neighbourhood finance representative
£10,001 - £50,000	Virtual assessment by the Commissioning Improvement Scheme panel (see below)
£50,001 +	A presentation to the Commissioning Improvement Scheme panel (see below) may be required

The panel will consist of the following members:

- Commissioning Business Manager;
- Finance representative;
- Commissioning Directorate representatives – including the appropriate portfolio lead for the project topic;
- Lay / Patient Participation Group representative;
- Clinical Commissioning Group Clinical Lead for Primary Care.

7.3 Panel dates would be set for June and all practices encouraged to submit business cases to that timescale. There is a recognition that some proposals may require further lead time however a cut off date for all business cases to be submitted of 28 September 2018 proposed. Provisional panel dates will be set to review any proposals to that date.

7.4 As in 2016/17 the proposal is not to restrict the criteria for the investment of the funds through this scheme, but that we would want to see this investment in schemes which align to the strategy across Tameside and Glossop. For example, the delivery across the

economy of the Integrated Neighbourhood and Self Care workstreams and would suggest that practices consider the areas which are a priority for the locality. In communicating achievement, up to date information on workstreams will be communicated to support practices in considering business case proposals. Again the intention will be to enable practices to be proactive and innovative however we would ask practices to be mindful of the non-recurrent nature of the funding if establishing new ways of working (including any ongoing costs of any new equipment purchased) and that they will be going at risk if they proceed on the expectation of a successful outcome and evaluation.

8. RISKS

8.1 Maintaining practice and neighbourhood engagement and drive around improvements in effective use of NHS resources, the sustainability of the economy is crucial and this format of Commissioning Improvement Scheme has proven to be successful to that aim in 2016/17. There is risk around competing priorities and capacity within general practice as across the system and therefore the continuation of a Commissioning Improvement Scheme is a positive step to maintain engagement and focus on the financial challenge in 2017/18 and beyond and to realise the impact of actions and initiatives implemented in 2016/17.

8.2 There is a risk however that the year end impact of engagement by our member practices, alongside the impact of work by officers with the Single Commission and across the economy, cannot be reliably predicted and therefore the likely cost of a Commissioning Improvement Scheme cannot reliably forecast. The risk of not operating a Commissioning Improvement Scheme however, may exceed the risk around forecasting the resources required for achievements.

9. COMMUNICATION

9.1 Communication referencing a Commissioning Improvement Scheme for 2017/18 has already been made to practices in correspondence regarding the 2016/17 achievements, and the Professional Reference Group recommended further communication at the TARGET session on 18 May 2017, and therefore the focus has not been lost despite the timing of sign off of the detail of the 2017/18 proposal.

9.2 Neighbourhood meetings will be used as the communication route and a launch document produced to support this roll out and minimise the potential for some of the confusion and ambiguity of messaging which was seen in 2016/17. In addition, this launch document will be presented at Practice Manager Learning Forum.

9.3 The Commissioning Improvement Scheme launch will be a Single Commission Function and Integrated Care Foundation Trust document, as the success of the Commissioning Improvement Scheme is crucial in the overall system delivery of transformation and efficiencies.

9.4 Alongside the communication of the Commissioning Improvement Scheme, neighbourhood meetings will also be used to communicate the budget setting methodology for 2017/18 as this is a key factor within the scheme and was an area of discussion and challenge in 2016/17.

9.5 The finance agenda item at monthly neighbourhood meetings in year will reference the Commissioning Improvement Scheme, the framework of the scheme and give updates on the overall financial position of the neighbourhood and Clinical Commissioning Group

alongside practice financial and activity data to support practices in managing their position.

10. RECOMMENDATION

10.1 As set out on the front of the report.