Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	28 November 2018
Reporting Member /Officer of Strategic Commissioning Board	Dr Vinny Khunger, CCG Governing Body GP Lead Jessica Williams, Interim Director of Commissioning
Subject:	**LOCALLY COMMISSIONED SERVICES REVIEW – 2019/20 COMMISSIONING INTENTIONS**

Report Summary:

The level of funding each General Practice receives is based on the number of patients registered at each Practice. The amount of funding per registered patient is based on a nationally derived weighted formula for General Practice and aims to take into account levels of deprivation as well as other factors.

The majority of funding each year for Practices comes from NHS England, to Greater Manchester Health and Social Care Partnership and then is delegated to Clinical Commissioning Groups (CCG) to distribute for what is defined as "core services" i.e; the minimum level of services which a Practice has to offer its population. CCGs may also decide to invest additional revenue funds into primary medical services to incentivise the delivery of additional services, over and above the core contracted level of service, which are a local priority.

NHS Tameside and Glossop CCG has always chosen to invest additional funds in General Practice to support local delivery of priorities, maintain or increase quality of services and reduce demand elsewhere within the health and social care system. Previous initiatives include Quality Outcomes Framework (QOF), Directed Enhanced Services (DES) and Locally Commissioned Services (LCS).

Locally Commissioned Services (LCS) has been rolled over year on year since 2013/14 and the current contracts expire on 31 March 2019. This report sets out a proposal for reviewing and streamlining the way we manage the LSC funding stream, currently valued at £1.2m per annum. The LCS funding currently enables those Practices who wish to participate, to deliver proactive and preventative services and/or alternative locations to an acute hospital location for treatments.

However, in recent years, LCS payments have remained broadly static and it is possible that Practices will no longer be able to afford to offer these services. This could result in a reduction in local service provision or increased inequity. This report proposes bringing together specific funding streams to create a larger LCS and pay Practices for "bundles" of care rather than individual treatments. With increased clarity of what aspects of care needs to be provided by a Practice or through collective working across a neighbourhood, the aim is to facilitate a cohesive, affordable and high quality population offer.

Our long term vision for General Practice is to reduce variation in the provision of services provided locally, improve equity,

broaden access to services and improve the quality of health outcomes across the population. The proposal set out in this report is a first step towards the delivery of the vision as it commences development of a neighbourhood model of delivery.

Recommendations:

The STRATEGIC COMMISSIONING BOARD to:

1. Note the longer term vision of delivering services at a neighbourhood level and accept this proposal as a transition step on that journey.
2. Approve the continued use of the existing £1.2m resource for the commissioning of LCSs with a two year contract from 2019/20.
3. Approve the addition of the £389k existing Primary Care Quality Scheme budget to the LCS resource from 2019/20.
4. Support the inclusion of the £625k Invest to Save element of the current Commissioning Improvement Scheme, noting this is a Primary Care Delegated Commissioning Resource which has been approved by Primary Care Committee with the requirement set out at 3.12.
5. Approve the full review and refresh of the LCS model (Option 2) through the existing working group, with oversight by Health and Care Advisory Group (HCAG).

Financial Implications:

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

ICF Budget	**S 75 £'000**	**Aligned £'000**	**In Collab £'000**	**Total £'000**
CCG	1,376	-	625	2,001
TMBC	201	-	-	201
Total	**1,576**	**-**	**625**	**2,201**
Section 75 - £'000 Strategic Commissioning Board	£389k CCG Primary Care Quality Scheme budget £987k CCG Local Enhanced Services as detailed in Table A £201k TMBC Public Health Spend as detailed in Table A Recurrent budgets in place for all of the above			
In Collaboration £'000 Primary Care Committee/CCG Governing Body	£625k of the 'Primary Care Investment' budget was used to fund the Invest to Save element of Commissioning Improvement Scheme in 2018/19 as part of delegated commissioning arrangements for primary care. The delegated commissioning budget is recurrent and expected to increase in future years. So resource will exist to fund in future years, but no explicit plan for use of Primary Care Investment budget in future years at this stage.			

	Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparison This business case proposes that the overall funding envelope for locally commissioned service remains the same as in 2018/19. As the improved outcomes envisaged in this business case will be delivered within the current cost envelope, it stands to reason that value for money in increased. While the £389k for Primary Care Quality Scheme (PCQS) is included in budgets recurrently, the national guidance which mandated this spend only applied until March 2019. Detailed planning guidance for 2019/20 is not yet available. Should planning guidance contain a requirement that PCQS is extended, it is important that the Locally Commissioned Services offer is designed in such a way that it addresses national expectations. The star chamber discussed PCQS budgets on 23 October. It was agreed that any Locally Commissioned Services scheme which replaces PQCS would need to include SMART evaluation criteria which would result in money being withdrawn if targets are not met.
Legal Implications: (Authorised by the Borough Solicitor)	Commissioning Intentions provide a basis for constructive engagement between NHS England and providers of specialised services, to inform business plans and contracts. They are intended to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available.
How do proposals align with Health & Wellbeing Strategy?	The proposed approach describes an improved model of proactive and preventative care for patients and delivery of care out of hospital.
How do proposals align with Locality Plan?	This approach will support our locality plan of place based care; with particular focus on the delivery of care close to home.
How do proposals align with the Commissioning Strategy?	This approach will support a system review of provision of services in general practice, improving quality across our practices; this model could incorporate additional outcomes for delivery. This could include elements of the GM Standards, improved delivery of locality priorities and campaigns, and the GP role in the locality approach to the delivery of Place Based Care. This will triangulate with Public Health priorities and the transformation provision through Person and Community Centred Care.
Recommendations / views of the Health and Care Advisory Group:	This report has been developed through clinical discussion at Health and Care Advisory Group (HCAG), through Primary Care Committee and through a working group, with clinical and officer membership. HCAG are supportive of the proposal and the ambition of an increased and consistent provision of proactive and preventative care delivered out of hospital as close to home as possible.

Public and Patient Implications:	The proposed approach aims to increase the proactive and preventative care offer to our population and deliver a consistent set of outcomes across all practices. The model also supports provision of care closer to home.
Quality Implications:	The proposed approach will design an outcomes approach to the commissioning of LCSs and therefore support increased and/or consistency of quality across our practices.
How do the proposals help to reduce health inequalities?	The approach addresses health inequalities by an outcomes focus design, with the commissioning being explicit in describing the practice responsibility for ensuring availability of services in primary care for the registered population. There is recognition that the delivery can be by individual practices or by neighbourhoods where it is not viable for practices to deliver all elements themselves.
What are the Equality and Diversity implications?	There are no equality and diversity issues; the delivery of LCSs is for the total population.
What are the safeguarding implications?	There are no additional safeguarding implications, safeguarding policies in place around existing practice contracts would apply.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no additional information governance implications, the policies in place around existing practice contracts would apply.
Risk Management:	There are no additional risk management issues arising from this proposal over and above management of patients through existing contractual requirements.
Access to Information :	The background papers relating to this report can be inspected by contacting the report writer Tori O'Hare  Telephone: 07920 086397  e-mail: tori.ohare@nhs.net

1. INTRODUCTION

1.1. The core payment structure for all general practice contracts is based on practice list size. There are also a number of additional services practices can opt to deliver; these include Quality Outcomes Framework (QOF), Directed Enhanced Services (DESs) and Locally Commissioned Services (LCSs).

1.2. Our 37 general practices currently deliver a number of LCSs providing proactive and preventative services and/or alternative locations to acute hospital for treatments.

1.3. This report sets out a proposal and timeline for the future commissioning intentions for LCS commissioned from general practice across Tameside and Glossop.

1.4. The aim of this proposed model is to improve quality for the population, by reducing variation in provision across practices and improve health outcomes. As part of a place based model of care this could, in the longer term, include how this can be delivered by a neighbourhood. The proposal set out in this report is a first step towards that vision.

2. CURRENT POSITION

2.1 A number of the LCSs have simply been rolled forward year on year since 2013/14. The detail of the scope of these contracts is included as Appendix A, with the current two year contracts (2017-19) due to expire 31 March 2019. It is therefore essential we review and confirm the commissioning intentions for these services.

2.2 It is timely to carry out a full review of all LCSs within the strategic context of the Care Together programme, the ongoing development of the locality neighbourhood model, the approach to place based care and the role of general practice within this.

2.3 The scope of LCSs recommended by Health and Care Advisory Group (HCAG) for inclusion in this commissioning review is set out in **Appendix A**. The budget figures included in the table are all recurrent.

2.4 It should be noted that the Local Authority Public Health commissioned services included in Table A are for Tameside practices only. Glossop neighbourhood public health LCSs are commissioned by Derbyshire County Council and at this stage are not included in this proposed review but will be considered in the ongoing work to define the Tameside & Glossop LCS offer, working with partners in Derbyshire County Council.

2.5 The commissioning of the Broomwell Community Cardiology Diagnostics service, an element of which is delivered by general practice, has already been approved to continue from 1 April 2019. To ensure our commissioning of services from general practice is aligned, this will remain 'in-sight' of this review however the funding for this service is not included in the recommendations in this report.

2.6 The tariff of the existing LCSs has not been uplifted or reviewed in many years; the date of the last uplift pre-dates the CCG. There is a risk these are now becoming loss making services and therefore that the continued provision of these services is increasingly relying on the goodwill of practices. This creates a potential impact on availability in primary care, which would have an impact on the level of activity in secondary care.

3. PROPOSED MODEL 2019/20

3.1 The current contracts will end on 31 March 2019 and, whilst the timescale is accepted as challenging, the intention is to have an agreed model for LCSs in place for 1 April 2019.

Appendix A illustrates the funding envelope for this review; the recommendation is that this level of investment is maintained. The proposals support an improved approach to the commissioning of Locally Commissioned Services, and delivery of improved outcomes for the population.

3.2 The proposal described in this paper has been developed through clinical discussion at Health and Care Advisory Group (HCAG), through Primary Care Committee and through a working group, with clinical and officer membership.

3.3 A number of options have been explored through those discussions with two remaining in place for consideration.

Option 1 – Revision of Service Specifications and Costing Models

3.4 With this option, the commissioning team would review, and revise where required, the service specifications for the range of services outlined in appendix A. The range of LCSs offered would remain as listed.

3.5 Revised service specifications would include details of any additional accreditation (over and above professional registration/qualification) required to deliver the individual LCSs, and a process by which the commissioners would assess individual practices' ability to deliver the service(s). Alongside the service specification review, a review of the associated tariff would be required.

Option 2 – Full Review and Refresh of the LCS Model

3.6 This option will involve a full review of the LCS model and the content of service specifications and the payment structure; this is the preferred option of the Commissioning Team.

3.7 The range of existing LCS, set out in appendix A, would be mapped into a number of 'bundles'; each with an overarching theme and outcome with a range of indicators or requirements in place. This would mirror the approach adopted from 2018/19 for commissioning improved access to general practice through the Access Outcomes Framework. The proposed "bundles" are:

- Proactive and Preventative Care – Identification and Management of Long Term Conditions;
- Frailty and End of Life Care;
- Out of Hospital Care;
- Quality Improvement.

This would support continued transformation of the model of care in the Tameside and Glossop locality.

3.8 This approach would also allow for a system review of provision and could incorporate additional outcomes for delivery, including for example, elements of the Greater Manchester Standards, improved delivery of locality priorities and campaigns. This could triangulate with Public Health priorities and the transformation provision through Person and Community Centred Care.

3.9 From a patient perspective, commissioning in this way has the potential to improve significantly both the quality of care delivered in primary care as well as the variation in provision across practice performance. This could increase management of conditions in primary care through location, earlier diagnosis and more tailored treatment earlier in the disease progression ultimately leading to improved patient outcomes and contributing to the overall reduction in emergency admissions to hospital and improving integrated care for our population.

3.10 There is potential risk that a 'bundle' offer may result in a practice opting not to deliver the services, which could create an unintended reduction in the level of provision in place. The risk can be mitigated by the commissioning of each LCS 'bundle' being explicit in describing the practice responsibility for ensuring availability of services in primary care for the registered population however that the delivery can be by individual practices or by neighbourhoods where it is not viable for practices to deliver all elements themselves.

3.11 This preferred option offers the opportunity to modernise and streamline the way services are commissioned from primary care, developing an outcomes focus and a holistic model of provision rather than historic item of service arrangements.

3.12 Primary Care Committee discussed this proposal at the 7 November 2018 meeting and supported the proposal with a condition that the additional investment fund a Quality Improvement 'bundle'; mirroring the recognition of Quality Improvement as one of the 10 high impact actions to release time in general practice in the national strategy paper - the General Practice Forward View.

4. FINANCE

4.1 The two options outlined above both require an increase in the resource available for the commissioning of these services. The existing tariff for these services has not been updated for a number of years and therefore there is a level of continued provision based on goodwill. This creates a risk of reduction in delivery as there is a risk of limited resilience within practices for continued provision.

4.2 There is a recurrent budget currently used for the Primary Care Quality Scheme, which ends at 31 March 2019, of £389k. The addition of this to the existing LCS funding would allow for the review of tariff and therefore support the sustained and potential increase in provision of these services.

4.3 The inclusion of 2018/19 Commissioning Improvement Scheme (CIS) projects into the Option 2 model, would require the addition of the CIS £625k investment to the existing LCS resource. The CIS investment is a Primary Care Delegated Commissioning funding to be considered, and approved by, Primary Care Committee.

5. FUTURE COMMISSIONING

5.1 The proposed model described in this paper is a transition period towards a strategy of placed based delivery of care and commissioning from, and delivery by, neighbourhoods.

5.2 This will be explored further through the development of a place based strategy which will be brought through governance for approval in due course.

6. RECOMMENDATIONS

6.1 As set out at the front of the report.

APPENDIX A

Service	Origin	Tariff	2018/19 Budget	2017/18 Spend
Anti-coagulation	CCG	Level 3 In Practice £11.00; Home Visit £14 Level 4 In Practice £15.60; Home Visit £18.60	£600,000	£525,000
Diabetes – Insulin Initiation	CCG	£100 per patient initiation	£9,892	£9,892
DMARDS	CCG	£12.50 per monitored drug per quarter	£73,000	£71,688
In Practice Care (previously HCA LES)	CCG	£1 per weighted patient	£254,638	£260,170
Ring Pessary	CCG	£20 replacement/ refitting	£10,240	£14,309
Hormonal Implants	CCG	£25 insertion fee	£22,000	£27,495
IUCD for menorrhagia	CCG (Glossop)	IUCD fitting - £89.90	£1,000	£809
Contraceptive Implants & Intrauterine Contraceptive DVC	LA	SDI Fitting - £27 SDI Removal - £30 IUCD fitting - £89.90	£87,680	£104,080
NHS Health Checks	LA	£300 to produce 2 x lists 1) all eligible patients not previously invited 2) eligible, previously invited but not had health check £2 for each invitation sent £15 for each health check carried out	£70,000	£98,850
Smoking Cessation	LA	£5 for each registration on the Wellbeing Service and support £5 x each session - max 5 sessions	£40,000	£53,000
Weight Management Public Health	LA	£20 - first appointment £7 each for 3 x further appointments £50 patient weight loss achievement (£91 max payment)	£3,000	£5,260
DVT	CCG	£40 per screening	£16,000	£13,060
TOTAL			**£1,187,450**	**£1,183,613**