NHS
North East Lincolnshire
Clinical Commissioning Group

Agenda Item 07

Report to (Board/Sub-Committee): Joint Co-Commissioning Committee

Date of Meeting: 26th January 2017

Subject: PMS Reinvestment 2017/18

Presented by: Jill Cunningham, Service Manager

STATUS OF THE REPORT

For Information	☐
For Discussion	☐
For Approval / Ratification	x

PURPOSE OF REPORT:	The attached paper sets out a list of proposed areas for PMS reinvestment in 2017/18, for discussion and agreement. Members are invited to add any other areas that they feel should be considered.
Recommendations:	The Joint Co-Commissioning Committee is asked to: • Review and comment on current proposed areas for PMS reinvestment • Add any other areas that they feel should be considered • Agree the proposed reinvestment for 2017/18 • Agree the increase to phlebotomy payments • Agree the increase to Shared Care (Dementia payments)
Sub Committee Process and Assurance:	The proposed areas for reinvestment have been considered by the Practice Managers Forum, Clinical Leads and GP Development Group.
Implications:	
Risk Assurance Framework Implications:	If these investment areas are not funded services such as phlebotomy and enhanced long term conditions management in general practice will be destabilised placing additional pressure on acute services.
Legal Implications:	None
Equality Impact Assessment implications:	An Equality Impact Analysis / Assessment is not required for this report.
Finance Implications:	PMS reinvestment is phased over 4 years (2015/16, 2016/17, 2017/18 and 2018/19). The CCG has already completed two years of reinvestment (15/16 and 16/17) and we now have to make decisions regarding the next phase of reinvestment for 2017/18.

	The CCG has £1.467k available in total for investment in 17/18, which will also need to cover any recurrent funding committed in 2015/16 and 2016/17, leaving a residual figure of £489k for investment in 2017/18.
Quality Implications:	The quality implications of each of the PMS reinvestment areas will be addressed within the service specification and contracting arrangements for individual schemes. Having these services universally available across the NEL population should improve accessibility, quality of care and patient outcomes.
Procurement Decisions/Implications ***(Care Contracting Committee):***	These are registered list based services and are the responsibility of each Practice to provide to their population. However, in line with GPFV and local strategy these services are expected to be delivered across a minimum 30,000 population to ensure service sustainability and resilience. Recognising that some Practices are further developed than others in determining their collaborative working arrangements, the Enhanced Primary Care Condition Management specification will be offered for 1 year for Practices not proposing to work collaboratively in 17/18. The remainder will be offered a 2 year (plus 1 year) contract for a collaborative delivery model (minimum 30,000 population). Potential procurement implications for this service may need to be considered in future if individual Practices are unwilling or unable to agree collaborative arrangements.
Engagement Implications:	Stakeholders in Primary Care have been engaged in the development of the proposed schemes. As part of the existing specifications for Community Matron SIPs a patient survey is required. Findings of these surveys from previous years show improved patient experience and greater confidence in self-management.
Conflicts of Interest	*Have all conflicts and potential conflicts of interest been appropriately declared and entered in registers which are publicly available? Yes* *Please state ay conflicts that need to be brought to the attention of the meeting.*
Strategic Objectives *Short summary as to how the report links to the CCG's strategic objectives*	*1. Sustainable Services* General practice services are a fundamental part of a sustainable care system. The proposed investments will help to maintain local services and support general practice development.
	2. Empowering People *N/A*
	3. Supporting Communities *N/A*
	4. Delivering a fit for purpose organisation *N/A*
NHS Constitution:	 NHS_Constitution_WE B.pdf *Does the report and its recommendations comply with the requirements of the NHS*

	constitution? Yes
Report exempt from Public Disclosure	No

Appendices / attachments	

PMS Reinvestment 2017/18 – Initial list

The CCG has £1.467k available in total for investment in 17/18, which will also need to cover any recurrent funding committed in 2015/16 and 2016/17, leaving a residual figure of £489k for investment in 2017/18.

The attached table sets out the initial list of potential areas. Thus far, ideas have been generated based on current CCG priorities, GP Forward View and discussion at the GP Development Group and Council of Members.

It is proposed that the remaining PMS reinvestment reflects the GP Forward View commitments, to ensure that the CCG is targeting resources most effectively. Furthermore, NHS England published guidance in 2016/17, setting out how PMS funds should be used. The principles are that this investment:

- reflects joint strategic plans for primary care that have been agreed with the relevant CCG(s)
- secures services or outcomes that go beyond what is expected of core general practice
- helps reduce health inequalities
- offers equality of opportunity for GP practices in each locality (i.e. if one or more practices in a given locality are offered the opportunity to earn extra funding for providing an extended range of services or meeting enhanced quality requirements, other practices in that locality capable of providing those services or meeting those requirements should have the same opportunity);
- supports fairer distribution of funding at a locality level.

Proposed Area	**Comments**
Continuation of 2015/16 services: • Anti-coag level 3 • GnRH Analogues • Post-Operative Care	Proposal to continue, to ensure no de-stabilisation of services
Continuation of 2016/17 services: • Quality Scheme investment • 7 day working • Phlebotomy • Shared Care (Dementia)	Propose to continue Local Quality Scheme. Remove PMS funding identified for 7 day working as other new national funding streams will be available and options are still being developed, in line with the criteria set out within the GPFV. Increase the funding for Phlebotomy to a maximum of £2 per patient based on regular feedback from Practices that the original allocation was insufficient to cover costs. Information has been sought from a number of Practices to demonstrate actual costs of service delivery. Responses to date equate to between £1.50 and £2 per patient and the CCG has sought further information ahead of determining a value. Increase funding for Shared Care and consider options for scheme to cover a wider range of drugs. We are now experiencing issues with some Trusts where other drugs are included in shared care arrangement held by their local CCGs and patients are discharged back to a NEL GP under the misunderstanding that these arrangements are in place locally. Further, the CCG is reviewing the payment under the existing Shared Care (Dementia) Specification following regular

	feedback from Practices that the service is not sustainable. The payment amount for new patient diagnosis and initiation will be reviewed and a new annual payment proposed for on-going monitoring.
Enhanced Primary Care Condition Management (Complex Case Management/ Community Matron Support and Enhanced Skills for Long Term Conditions Management) roles within general practice.	A number of practices/groups of practices currently have these types of roles, all of which have different specifications and contracts, but similar aims; they are targeted at managing individuals with multiple chronic conditions (more complex) and/or housebound patients, including some Care Homes support. These contracts come to an end on 31st March 2017. Reviews, and available data, suggest that this level of support contributes significantly to avoiding A&E attendances and hospital admissions. However, those services with staff employed at individual practice level are less resilient (i.e. dependent on one member of staff and service stops during absence). These are also generally most costly and not affordable in the longer term. Proposal is to offer this out across NEL, on the basis of services covering 30,000 to 50,000 population size, rather than at individual practice level. This is in line with the GP Forward View and evidence that supports community specialist services. The CCG proposes to build the Long Term Conditions model into this spec to reflect the work that is expected to be undertaken primarily by Practice teams. COPD, diabetes and cardiology models being taken forward this year.