Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Primary Care Enhanced Services Review

Governing Body meeting

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9 January 2014

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Key messages

- CCGs are required to review their current Local Enhanced Services on offer to primary care providers and determine their future commissioning arrangements
- The review process needed to be cognizant of procurement rules; local priorities and service risk

Assurance Framework (AF)

Assurance Framework Number 4.1

How does this paper provide assurance to the Governing Body that the risk is being addressed?
Governing Body can be assured that due process has been followed and that an appropriate audit trail is in place.

Is this an existing or additional control:
Existing

Equality/Diversity Impact

Has an equality impact assessment been undertaken? No

Which of the 9 Protected Characteristics does it have an impact on?
Not applicable

Public and Patient Engagement

Not applicable at this stage

Recommendations

The Governing Body is asked to discuss the contents of this paper and approve the recommendations therein.

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1. Background

Historically, Primary Care Trusts commissioned a range of services from all GP practices (and other Primary Care Providers) under a contractual framework known as 'Enhanced Services.' These services are effectively appendices to a provider's core contract which require an enhanced level of care for patients, attracting additional funding.

Under the new arrangements, NHS England is responsible for commissioning GPs' core contract and Directed Enhanced Services. All other Local Enhanced Services (LESs) have been delegated to either CCGs or the Local Authority, ostensibly via Public Health.

National guidance (http://www.england.nhs.uk/wp-content/uploads/2013/04/pri-med-care-ccg.pdf) was published in April 2013 outlining a CCG's wider powers to commission services from primary care providers, subject to following an appropriate procurement route and managing conflicts of interest appropriately. Further NHSE guidance (September 2012) stated that Clinical Commissioning Groups (CCGs) should have reviewed their existing Local Enhanced Services to decide in principle whether and how they should be commissioned for 2014/2015 and put in place any necessary procurement processes. The procurement process might vary depending on the service in question (Any Qualified Provider or single tender).

A key focus of the review process was to determine whether current service provision offers value for money and this is in line with one of our four strategic aims of ensuring a sustainable, affordable healthcare system in Sheffield. In determining our final position we should also be mindful of how our approach will also help meet the other three aims of:

- Improving patient experience and access to care;
- Improving quality and equality of healthcare in Sheffield
- Reducing health inequalities in Sheffield.

2. Services Subject to Review

For Sheffield CCG the following enhanced services were reviewed:

- Anti-coagulation Monitoring

- Administration of GnRH agonists Triptorelin, Leuprorelin or Goserelin (ZOLADEX)
- Monitoring of patients on Methotrexate, Azathioprine or Leflunomide (DMARDS)
- Ring Pessaries
- Additional support to homeless patients
- Primary Eyecare Acute Referral Scheme (PEARS)
- Glaucoma Referral Refinement (GRR)
- Contact Applanation Tonometry (CATS)
- Child Eye Screening (PRR)
- Minor Ailments
- Medicines Management Support to Care Homes
- Not dispensed Scheme

It should be noted that there are other Local Enhanced Service/Locally Commissioned Services which are offered to practices but which were not part of the scope of this work – namely the Care Home LES and the Care Planning Locally Commissioned Service. The detail relating to the new GP contract and, in particular the management of patients over 75, will help determine the future of these services.

3. Objectives and Results of the Reviews

The reviews were chaired by one of the Medical Directors supported by a Senior Commissioning Manager. Members of the group included Locality Managers and a practice manager. Clinical Governance, Finance and Medicines Management were also represented.

This enabled closer liaison between clinical, community, locality, portfolio, quality and finance leads to ensure a joint commissioning and contracting approach and considered the following:

- The quality of each service, patient outcomes (where measured), clinical risk, safety and equity of access;
- To look at the services' links with the CCG organisational strategy in areas such as care closer to home;
- To look at current price, financial issues, activity and monitoring arrangements and consider the financial benefits or costs of continuing to provide the services in primary care;
- Coverage and practice issues; and
- Suitability for offering as Any Qualified Provider (AQP) (if required).

The broad findings from the reviews was that all of the services should continue in community settings as they provided appropriate clinical care closer to home with current alternatives being care provided instead in secondary care, there were no quality concerns (patient satisfaction or clinical) and that, generally, the services offered good value for money. However, it was clear to the reviewing panels that coverage should be increased across the city to ensure equity of care and availability to all patients.

These findings were presented to the Commissioning Executive Group in November and, as a result, some further refining work was requested, particularly seeking further clarity in regard to the rationale for recommendations.

4. Procurement of Primary Care Services

When making decisions regarding procurement of primary care health services, the CCG must take into account the requirements under the NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 (the '2013 Regulations').

These procurement requirements do not mean the CCG must always follow a competitive procurement process when awarding commissioning contracts. CCGs can award contracts without a competitive process if they are satisfied that there is only one provider capable of providing those services.

The CCG should also be mindful of the transaction costs of testing the market for services of relatively low value, particularly if the transactions costs are likely to be more than the cost of the service itself, as such an approach does not represent value for money.

5. Other Issues for Consideration

a. **Ensuring a Smooth Transition**
Technically all enhanced service contracts will cease from 1 April 2014, unless arrangements are made for alternative/continued provision, including extension of existing contacts. Practices, in particular, have raised with the CCG the fact that there are a number of patients in receipt of these services and will expect to continue to do so post 1 April. An immediate imperative therefore is to ensure appropriate continuity of service.

b. **Universal Coverage**
A key concern highlighted from the review is the lack of universal coverage in some services. The proposed 'basket of services' approach should help overcome this service deficit,. Including, where appropriate, enhanced services in the basket would support the universal coverage requirement.

The recent GP Association Development Programme provided an opportunity to consider these issues and, currently, there is an appetite for working together to secure full sign-up of the services to be included within the basket.

6. Phase Two Review

The findings on the initial review were presented to the Commissioning Executive Group in November and, as a result, some further refining work was requested, particularly seeking further clarity in regard to the rationale for recommendations.

Consequently, a group led by the Programme Director and including the Clinical Director and representatives from commissioning, finance, medicines management

and contracting was convened to enable update on progress to be given; promote further challenge and discussion and to agree recommended next steps for each service.

Contracting colleagues requested that where services needed a temporary extension of contract to enable further work to be done that the extension period be the same for all services. This approach would not only help make the workload more manageable for staff involved but also would help current providers with their own contract management processes.

7. Output of the Group

The key elements of the discussion are included within Appendix 1 of this paper. However, the LESs fell within four categories of progress:

- For inclusion in the Basket of Services offer to general practice from 1 April 2014 (recurrent):
  - DMARDS
  - Ring Pessaries

- Roll-over of existing services (recurrent):
  - Homeless

- Further work up needed:
  - Anti-coagulation: a 12 month extension to the existing contract is being requested, during which time either an AQP or Primary Provider model will be explored, with a recommendation being presented to CET in January and the preferred option being actioned thereafter;
  - 4 Optical Services: a 12 month extension to the existing contract is being requested to enable an AQP process (one AQP exercise with 4 chapters) to take place.

- Further clarity required:
  - 3 Pharmacy schemes: the Commissioning Support Unit (CSU) to advise if, due to the rules relating to pharmacy, whether AQP is an appropriate route in order to determine if a recurrent extension or short term extension with AQP is appropriate. CSU has now advised that, due to the regulations around pharmacy, AQP is not appropriate, that the CCG already offers patient choice where appropriate and therefore an extension of the current contract is legitimate.
  - Zolodex: Via the commissioning intentions process a business case is being developed around follow-up of prostate cancer patients in community settings, rather than Zolodex delivery only. CET took the view that until this case had been considered and agreed upon that the existing arrangements with regard to the Zolodex LES should continue.

CET accepted the outputs of the group and were happy to recommend to Governing Body that the suggested actions be approved.

8. Recommendations

Governing Body is asked to:

- Discuss the content of this paper;
- Approve the next steps way forward for each service, including where requested the extension to existing contracts.

Katrina Cleary, CCG Programme Director

December 2013

APPENDIX 1

Service Area	Key Discussion Points	Longer Term Preference	Interim Suggestion	Other
Anticoagulation: Currently povided by general practice and some community pharmacies. Universal coverage in community setting not delivered.	Want to commission a 'Stable Warfarin Service' Registered list not essential, though decognised at being dependent on practice list. Providers of services will need to demonstrate links with general practice Delivers care closer to home. Current spec generally ok. May need to refine in terms of required outcomes Service may be slightly more expensive in primary care thought this is hard to determine and will depend on follow-up price agreed for next year	Either AQP; Or Outcomes based prime provider model Either way market testing likely	Contract extended to current providers for a 12 month period - K Gleave to action Alastair Mew to produce for CET end January a scoping paper of both options with recommended preferred option and identified lead management arrangement	D Mason issuing a contract query to determine numbers still in secondary care suitable for transfer K Gleave looking to determine the follow-up price for next year
Pessaries: currently provided by General Practice. Universal coverage in community setting not delivered	Want to secure universal coverage in the first instance. Costs relatively low Want to get as many stable patients as possible from hospital setting	Include in 'Basket of Services' Approach as means of securing universal coverage	Include in basket discussions	R Oliver to develop guidance for transfer of stable patients into Primary Care
Homeless	Small cost to save considerable sums in terms of inappropriate use of hospital services	Might want to consider expanding to include more providers. Need discussions with Public Health about any unmet need due to geography of current providers. Urgent portfolio should consider whether to take this forward as part of its invest to save workplan for future	Extend contract with existing providers	
Zoladex: Universal coverage in community setting not delivered. Considerably more expensive in primary care (prescribing costs) than in secondary care	Plan being developed as part of a wider business case to support primary care follow up of stable prostate cancer patients as part of CCG Commissioning Intentions.	To be determined via commissioning intentions	As a minimum extend exisiting contract	

DMARDS (including DMARDS Gold)	Possible extra 600 patient suitable for transfer from secondary care. Co-morbidities suggests need for general practice provision and therefore suitable for basket of services approach	Include in 'Basket of Services' Approach as means of securing universal coverage	Include in basket discussions	

4 Optical Services (PEARS, Glaucoma Referral Refinement, Contact Applanation Tonometry Service, Paediatric Referral Refinement)		1 AQP with 4 Chapters within	Extension of existing arrangements for further 12 months to enable AQP process	Project Lead: Linda Lyddament supported by A Mew

2 Pharmacy Services (Minor ailments, Not dispensed) Medicines Management Support to Care Homes	CSU advice re pharmacy regulations states AQP not appropriate. Schemes include all pharmaciest so local choice secured		Extension to existing contract Extension to existing contract	