Lancashire and South Cumbria Integrated Care Board

ICB Primary Care Commissioning Committee

Date of meeting	14 March 2024
Title of paper	Local Enhanced Services and General Practice Quality Contracts 2024/25 and beyond
Presented by	Peter Tinson, Director of Primary Care
Author	Peter Tinson, Director of Primary Care
Agenda item	6c
Confidential	No

Executive summary

The paper describes the proposed approach to ICB commissioned General Practice Local Enhanced Services (LES) and General Practice Quality Contract (GPQC) for 2024/25 and beyond. It builds on a recent independent diagnostic of General Practice payments.

These proposed changes to LES and GPQC commissioning arrangements for 2024/25 form an important part of the wider ICB commissioning plan and intentions. They are a step towards the ICB overarching vision for a shift to a more primary, community and social care centric model of provision.

The proposed focus on frailty, respiratory and structured medication reviews would deliver improved population health outcomes and a return on investment.

Advise, Assure or Alert

Advise the committee of the work and engagement that has taken place to develop the proposed approach.

Recommendations

It is recommended that the Committee:

1) Agree in principle the proposed approach to LES and GPQC commissioning for 2024/25 identified in this paper, pending Board agreement of commissioning intentions on 10 April 2024
2) Agrees that the Primary Medical Services Group (PMSG) oversees the detailed operational implementation arrangements, including:
    a. Any changes to the review status of individual services, i.e. based on impact assessments and/or feedback that services currently identified to be ceased are either continued or continued and reviewed
    b. Any changes to service specifications based on feedback
    c. Reasonable transitional arrangements from 1 April 2024
3) Receives an update at its next meeting

Which Strategic Objective/s does the report contribute to	Tick

1	Improve quality, including safety, clinical outcomes, and patient experience	X
2	To equalise opportunities and clinical outcomes across the area	X
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	
4	Meet financial targets and deliver improved productivity	X
5	Meet national and locally determined performance standards and targets	X
6	To develop and implement ambitious, deliverable strategies	X

Implications				
	Yes	**No**	**N/A**	**Comments**
Associated risks	X			Transitional risks to be managed
Are associated risks detailed on the ICB Risk Register?			X	
Financial Implications	X			Forecast return on investment

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Business and Sustainability Group	Various	Approach discussed and supported
System and place leadership forums	Various and ongoing	Feedback received and considered

Conflicts of interest associated with this report
Not applicable.

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed	X			For each individual service change
Equality impact assessment completed	X			For each individual service change
Data privacy impact assessment completed			X	

Report authorised by:	Craig Harris, Chief Operating Officer

Local Enhanced Services and General Practice Quality Contracts 2024/25 and beyond

1. Introduction

This paper describes the proposed approach to ICB commissioned General Practice Local Enhanced Services (LES) and General Practice Quality Contract (GPQC) for 2024/25 and beyond. It builds on a recent independent diagnostic of General Practice payments.

2. Context

ICB Commissioning Plan and Intentions

The ICB is developing a clear commissioning delivery plan for 2024-27 which sets out the delivery of its vision and clinical strategy within a financial framework. This plan recognises that the demand for health and care is overwhelming the hospital centric model and major investment is required in primary and social care to better manage demand alongside major clinical reconfiguration (reference ICB *Commissioning Intentions*).

Also, General Practices across the ICB are delivering more appointments than ever with fewer qualified General Practitioners but with bigger multidisciplinary teams. This isn't keeping pace with rising demand and the needs of an ageing population (reference ICB Board *Recovering Access to Primary Care* paper November 2023). Indeed, recent ICB modelling indicates that next financial year an additional 277,000 General Practice appointments are required to meet demand. This equates to 27 full time GPs and 40 other direct patient care roles.

The ICB commissioning intentions for the coming financial year (2024/25) describe the changes that will begin to progress the commissioning plan, involving transformation across the range of services the ICB commissions. This includes primary care and all the changes described in this paper are included in both the commissioning plan and intentions. They represent the beginning of wider work which will seek to ensure that primary care is robust, resilient, and thriving to enable a shift in care and associated investment. Relatedly it is acknowledged that the ICB currently spends less on General Practice than most other ICBs.

A vision for GP is well articulated in the recent NHS Confederation Primary Care Network publication *Empowered, Connected and Respected*. A pictorial summary can be found in Appendix 1.

NHS England (NHSE)

It is recognised that a robust, resilient, and thriving primary care will be significantly influenced by NHSE's approach to nationally commissioned General Practice (GP) services. NHSE commissions or directs about 90% of General Practice funding.

NHSE recently published *Arrangements for the GP contract in 2024/25* which confirmed the contract arrangements for the coming financial year. Whilst simplifying contract arrangements and providing increased flexibility, the communication also includes a planning assumption of 2% for pay growth in the GP contract. It acknowledges that this is subject to the outcome of the Doctors, Dentists Review Body (DDRB) recommendations to Government.

The ICB is aware that General Practice considers this uplift to be insufficient to fund cost increases.

NHSE has also signalled that 2024/25 creates a natural point to take stock of contract arrangements, including consideration of the Carr-Hill global sum payment formula and a new strategic direction for General Practice within the context of the Fuller and Hewitt reports plus the continued ambition to improve patient access. Indeed, the Government recently commenced an open consultation on the role of incentives schemes in General Practice.

3. General Practice Funding

The way General Practices are contracted and funded is complex and very different from other parts of the health and care system.

The funding a General Practice receives depends on a complex mix of different income streams. Most practice income comes from its core contract, which is known as a global sum payment. This payment is based on a weighted sum for every patient on the practice list.

Other income comes from the Quality and Outcome Framework (QOF) or providing enhanced services. QOF is an optional programme from which practices receive payments based on good performance against a number of indicators. Enhanced services are either nationally agreed and known as Directed Enhanced Services (DES) or locally agreed and known as Local Enhanced Services (LES). Both are optional.

4. General Practice Financial Flows Diagnostic

Diagnostic

Earlier this financial year the ICB commissioned Merseyside Internal Audit Agency (MIAA) to undertake a diagnostic of all General Practice financial flows. The diagnostic sought to understand the numerous LES and GPQC commissioning arrangements inherited by the ICB.

The diagnostic was based on the full year 2022/23 former Clinical Commissioning Group (CCG) payments and sought to inform a wider clinically led review of commissioned services. This paper includes the key findings.

Funding flows

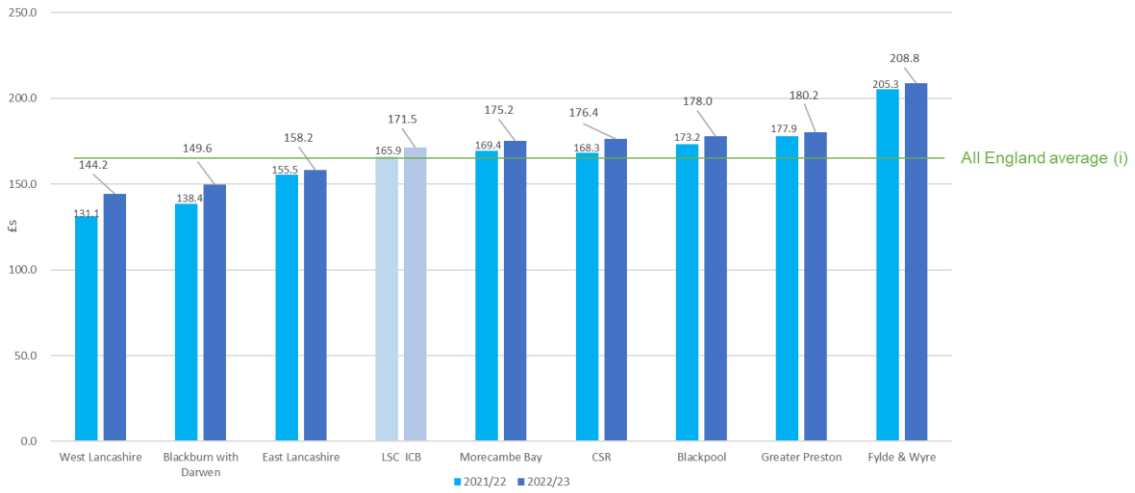
Table 1 below thematically summarises the funding flows.

Theme	£000's	%
Core contract, QOF and DES	243,995	*73*
LES (including GPQC)	33,372	*10*
Premises	21,985	*7*
Prescribing	20,505	*6*
Access	9,610	*3*
Other	4,206	*1*
Total	333,673	*100*

The significant majority of funding (90%) is directed by NHSE.

Payments per registered patient

Chart 1 below shows the total payments per registered patient (weighted) in 2021/22 and 2022/23.

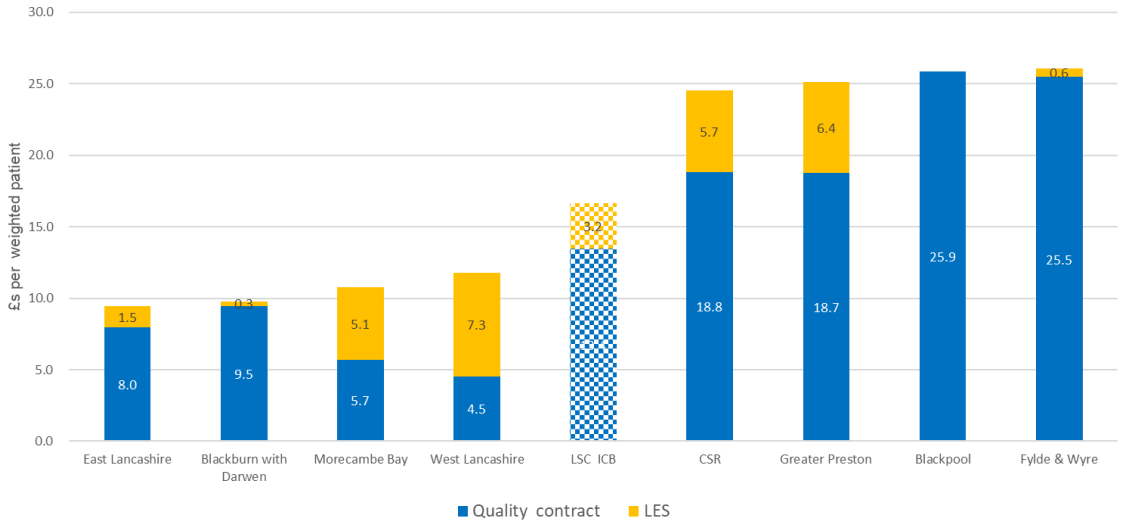


There are two significant thematic reasons for variation:

1) Variation in commissioning decisions, both funding invested and associated services commissioned
2) Variation in provider delivery where payments are based on activity or performance

LES and GPQC payments

Chart 2 below illustrates the variation in former CCG commissioning decisions. It shows LES and GPQC payments per registered patient (weighted) in 2022/23.



LES and GPQC have been shown together as historically some CCGs commissioned both direct service provision and quality improvement schemes via their GPQC and some commissioned them from LES and GPQC respectively. Evidently there is considerable variation in these funding

arrangements. It should also be noted that whilst delivery requirements may have changed, most of these funding arrangements have been in place for more than 10 years and many practices have recurrently invested in additional staffing to support service delivery. Relatedly these payments have not been subject to any inflationary uplifts for more than 10 years (a formal uplift request has been received from the Consortium of Local Medical Committees).

5. LES and GPQC Reviews

Informed by the financial flows diagnostic a clinically led review of all the inherited LES and GPQC requirements was recently undertaken.

The review identified which LES/GPQC requirements:

1) Required further review because they were 'atypical' and served a specific population group, often in a specific facility (they should either cease or be equitably commissioned for all similar population groups across LSC)
2) Required further review because there were different commissioning arrangements, e.g., treatment rooms (a standardised approach to commissioning the service should be agreed)
3) Required wider review because some former CCGs commissioned them from community providers, e.g. phlebotomy (a community services diagnostic was considered essential)
4) Were not considered to represent value for money (and the associated funding could be retargeted)
5) Provided a Quality, Innovation, Productivity and Prevention (QIPP) opportunity, e.g. vasectomies and minor surgery (and business cases should be developed for consideration)
6) Should inform and be superseded by future proposed requirements (specifically frailty and respiratory as later outlined)

This enabled an updated assessment of the funding available per patient for GPQC investment in 2024/25 (former CCG footprints are shown as they currently remain the basis for inherited funding arrangements):

Table 2

CCG	BwD	East	Mbay	Fylde	Central	West
Continue	£0.88	£1.23	£0.13	£0.11	£0.18	£0.18
Review	£2.16	£4.79	£5.77	£7.66	£6.64	£6.64
Reinvest	£11.01	£9.28	£5.31	£18.48	£16.45	£9.14
Total	**£14.05**	**£15.30**	**£11.21**	**£26.25**	**£23.27**	**£15.96**

CCG	BwD	East	Mbay	Fylde	Central	West	Total
Continue	£166,271	£528,138	£51,282	£45,480	£101,503		£892,674
Review	£406,879	£2,053,359	£2,208,093	£3,109,574	£3,659,659		£11,437,564
Reinvest	£2,075,494	£3,974,985	£2,030,201	£7,504,597	£6,967,000	£1,168,690	£23,720,968
Total	**£2,648,644**	**£6,556,483**	**£4,289,576**	**£10,659,651**	**£10,728,162**	**£1,168,690**	**£36,051,206**

A service line summary of the outcome of the clinically led review process has been presented and discussed at numerous system and place based General Practice groups and forums.

<u>Continue</u>

Services proposed to continue would form part of new contract arrangements for 2024/25.

Review

Services proposed to review would be reviewed in 2024/25 either by September 2024 (priority 1) or December 2024 (priority 2), see Appendix 2 for details. The reviews may propose that the requirement/service should:

- Cease and the funding be reinvested in LES/GPQC
- Continue to be commissioned
- Equitably be commissioned across the ICB, including associated investment

Reinvest

Services proposed to cease to enable reinvestment in the new GPQC requirements have been subject to Quality Impact Assessments (QIA). In some former CCG areas practices have raised conerncs about the impact of certain services ceasing. Where concerns have been identified discussions are taking place to review and where necessary update impact assessments and consider the outcome of the clinically led review.

6. Proposed Approach for 2024/25

Design Principles and Options

The design for the proposed GPQC has been informed by several design principles and options which were shaped by key system primary care and population health stakeholders (see Appendix 3).

Two of the key principles and significant challenges were to demonstrably ensure that the GPQC both improved population health outcomes and delivered a return on investment. Consequently, it is proposed that the GPQC focuses on the ICB priorities of frailty, respiratory and structured medication reviews. These priorities have been discussed and agreed by ICB Executives and the ICB Business and Sustainability Group.

Funding Options

Inevitably there has been much consideration of the variation in CCG LES and GPQC funding. Several funding options were explored with key stakeholders, ICB Executives and the ICB Business and Sustainability Group. Thematically there are three main options:

1) Do not change the current funding arrangements
2) Reallocate the current funding based on an agreed place allocation methodology
3) 'Level up' the funding based on an agreed place allocation methodology

It was recognised that options 2) and 3) could take place over a transitional period.

Major considerations included:

- Recognition that CCGs received funding based on the same formula and had made different investment decisions, i.e. CCGs who invested less in General Practice invested more in other services

- Desire to understand any national contract changes in 2025/26, including the funding formula
- Recognition that some CCGs commissioned services from General Practice via a LES and others commissioned the same service from other providers, such as community, i.e. consideration should be given to the totality of the investment in these services
- Desire to increase investment in primary care in accordance with the ICB vision and not simply redistribute existing funding

Consequently, it is proposed that for 2024/25:

- Former CCG investments are not changed
- Practices who receive more funding will proportionally be expected to deliver more
- An 'aspirational achievement' process will be developed whereby should any individual practice identify that they are likely to under deliver, the associated funding will be made available for practices in the former CCG footprints who receive least investment to increase their delivery
- Through the monthly monitoring of the GPQC Return On Investment (ROI), a proposal would be developed to 'level up' funding (and increase the ROI) for 2025/26 onwards

7. Frailty, Respiratory and Structured Medication Reviews (SMR)

Clinically led work has taken place with ICB partners to develop draft Frailty, Respiratory and SMR specifications. They are built on evidence based practice and ICB population health intelligence. The content of each is summarised in the pictorials below.

Frailty

Frailty Bundle	Aim & Outcome Measures
Bundle 1: Population identification and stratification of frailty • Standardise identification and assessment processes across primary care	**Aim:** Practices to identify mild to moderate frail patients on a quarterly basis using the eFI search facility within EMIS and conduct Rockwood Score and holistic assessment **Outcome:** To increase number of frail patients identified and assessed to support individuals to remain safe and well in their home setting
Bundle 2: Supporting people with mild frailty and encouraging them to 'age well' • Proactive care and support to enable a focus on recovery and rehabilitation to prevent progression in functional ability	**Aim:** Promote staff and patient self-management education and promote the range of wider health and wellbeing services to meet personalised needs and identify frail people earlier **Outcome:** Standardise practice staff e-learning, promote local pathways including referral to INTs and support services to address wider care needs of individuals
Bundle 3: Supporting people living with moderate frailty – MDT's & Personalised Care • Establish frailty MDT frailty meetings to co-ordinate personalised care plans to provide the right care, at the right time, in the right place	**Aim:** Embed monthly multi-disciplinary meetings to review frail patients and develop a personalised care plan in response to their wider health and wellbeing needs **Outcome:** Standardise MDT's meetings and prioritise frail patients to develop joint care plans with other organisations to meet on-going wider health and wellbeing needs
Bundle 4: Raising awareness of frailty through education and staff skills • Increase education and training to raise awareness of frailty amongst primary care workforce to ensure that they can meet the changing healthcare needs of the ageing population	**Aim:** To increase primary care staff skills, competency and training on frailty and to develop local 'frailty champions' and networks aligned to workforce development plans **Outcome:** Develop a network of 'frailty champions' who have a key role in promoting a consistent and universal awareness of frailty across health, social care and VCFSE sector professionals

Respiratory

Respiratory Bundle	Aims & Outcome measures
Bundle 1:Improved process for diagnosis of respiratory disease	• Practice/PCNs to work together to provide quality assured consistent delivery of diagnostic spirometry and FeNO to meet minimum staffing, training, and equipment standards. • There will be a high degree of confidence in the quality and consistent coding of newly diagnosed patients in 2024-25.
Bundle 2: Asthma **Provision of optimum asthma diagnosis and management**	• Optimum asthma diagnosis (as measured as % of asthma diagnoses with a positive FeNO result). • 100% of new asthma diagnoses confirmed with a positive FeNO result. • An increased proportion of previously diagnosed asthma cases without FeNO to be confirmed with positive FeNO. • Consistent coding requirement. • Improved prescribed safety following high quality diagnostics.

SMR

Delivery / Outcome

Structured medication reviews

The scheme will pay for additional Structured Medication reviews above the current practice level DES baseline.

The SMR element of the quality contract can be delivered at practice or PCN level, however monitoring and outcomes will be undertaken at practice level.

It is assumed that the scheme will positively impact patient care and focus on those patients in greatest need of reviews to reduce medicines related harms.

The contract requires a standardised way of identifying patients at highest risk of medicines harms, who would benefit most from an SMR:

- Practices will run the Eclipse SMR scoring tool to identify those patients with the highest SMR score. The system will generate a list based on multiple risk factors, ranked by the highest score (see appendix).
- Structured medication reviews must be prioritised by:
  1. Highest SMR scores first, then lower scores
  2. Where patients have not had a review for >12months
- The practice should recall patients for a full structured medication review carried out by a prescribing healthcare professional following national standards
  - NHSE 2023/24 Network Contract DES Specification - Medication Reviews and Medicines Optimisation
    "…ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. The PCN must also ensure that these professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills;"
- Practices will be supplied an EMIS template to complete the SMR
- Following the review this should be coded using the following SNOMED codes:

Description	SNOMED Code
Structured medication review (procedure)	1239511000000100
Invitation for structured medication review declined (situation)	1363191000000100

Return on investment

For each of these specifications work has also taken place, again based on evidence, to identify the cost, savings and return on investment. The services have been 'bottom up' costed based on the current cost of clinical and non-clinical time. Table 3 below summarises the analysis which has also been subject to discussion with ICB Executives and the ICB Business and Sustainability Group.

Total	No of reviews	Service Cost	Service Return
Frailty bundle 1	85418	£10,420,954	£12,088,307
Frailty bundle 2		£489,243	Contributes to bundles 1&3
Frailty bundle 3	10946	£4,925,699	£6,895,979
Frailty bundle 4		£489,243	Contributes to bundles 1&3
Respiratory 1		£978,485	Contributes to bundle 2
Respiratory 2	97228	£2,916,846	£2,948,931
SMR	123475	£3,531,383	£9,605,362
Total	**317067**	**£23,751,852**	**£31,538,578**

The respiratory ROI is subject to further review and the inclusion of reduced demand on secondary care.

The proposed GPQC payment approach mirrors the payment approach for secondary care providers, and is largely based on payment for activity with monthly monitoring (a GPQC delivery dashboard has been developed) and an annual reconciliation process.

Engagement

Whilst discussions regarding the design of the proposed approach have taken longer than expected and delayed the planned engagement, considerable engagement has taken place and continues to take place in accordance with a detailed engagement plan. Initial engagement focused on system wide groups and forums attended by system and place primary care leaders followed by place forums and groups. This initial engagement also focused on the approach. A Frequently Asked Questions and Answers has been produced. Key feedback themes include:

- Variation in CCG investments (see proposed approach in section 6 of this paper)
- Concerns about individual services identified to cease to enable reinvestment (see section 5 of this paper)
- Concerns about the implementation timeframe
- Opportunity to review and provide feedback on the detailed service specifications and their deliverability
- Wider concerns about the financial resilience of General Practice linked to the recent NHSE contract communication

The detailed service specifications were circulated early this month and are subject to ongoing engagement and feedback. Subject to the outcome of this paper, the ICB has also committed to work with practices to agree locally sensitive implementation arrangements to transition to new delivery requirements.

It is proposed that the Committee agrees that the Primary Medical Services Group oversees and finalises the detailed operational implementation of the new GPQC to include any ICB clinically supported changes to the service specifications based on the feedback received.

8. Summary

These proposed changes to LES and GPQC commissioning arrangements for 2024/25 form an important part of the wider ICB commissioning plan and intentions. They are an important step towards the ICB overarching vision for a shift to a more primary, community and social care centric model of provision.

The proposed focus on frailty, respiratory and structured medication reviews would deliver improved population health outcomes and a return on investment.

Key partners involved in the work have commented:

Kate Atkinson, Senior Responsible Officer for Engineering Better Care

> "In 2023-24 healthcare providers from across Lancashire and South Cumbria ICS embarked on a journey in collaboration with the Engineering Design Centre at Cambridge University to test and apply the Engineering Better Care (EBC) improvement framework with teams from across each place locality.
>
> The EBC programme was intended to support healthcare re-design and focused on identifying and implementing system level improvements that would benefit our aging population living with frailty.
>
> The frailty element of the GP Quality Contract, which is focussed on identification of frailty and development of appropriate care plans, is central to driving the outcomes, learning and outputs of the work of the Engineering Better Care programme.
>
> The new quality contract provides a fundamental opportunity to deliver a consistent, equitable and proactive approach to meeting the unmet need of our frail population by providing accessibility and a proactive responsiveness for our frail population. The commissioning of the frailty element of the contract enables a greater opportunity to work together as a truly integrated system and allows these developments and energy to move forward at pace.
>
> The quality contract provides a platform for development of a high quality baseline of support and service provision to our patients but also provides a platform for future strategic development across the wider health and care system."

Adam Janjua, Chief Executive Officer, Consortium of Lancashire and Cumbria LMCs

> "I am broadly supportive of the contract as a means of bringing in much needed funding to practices. I'm cognisant of the fact that each legacy CCG area had their own input into a local Quality contract and the discrepancies we are now seeing in the values for different areas is a result of that.
>
> A well funded and stable general practice will serve to improve the health of the ICB population and have multiple beneficial effects on system partners as well.
>
> I'm therefore looking forward to future years where the GPQC is up levelled and equitable across the ICB footprint."

Sinead Foster, Senior Project Manager, Lancashire and South Cumbria Diagnostic Collaborative

"The collaboration of driving forward the proposed improvements to the respiratory model of care will benefit primary care and secondary care providers and also strengthen a one system approach."

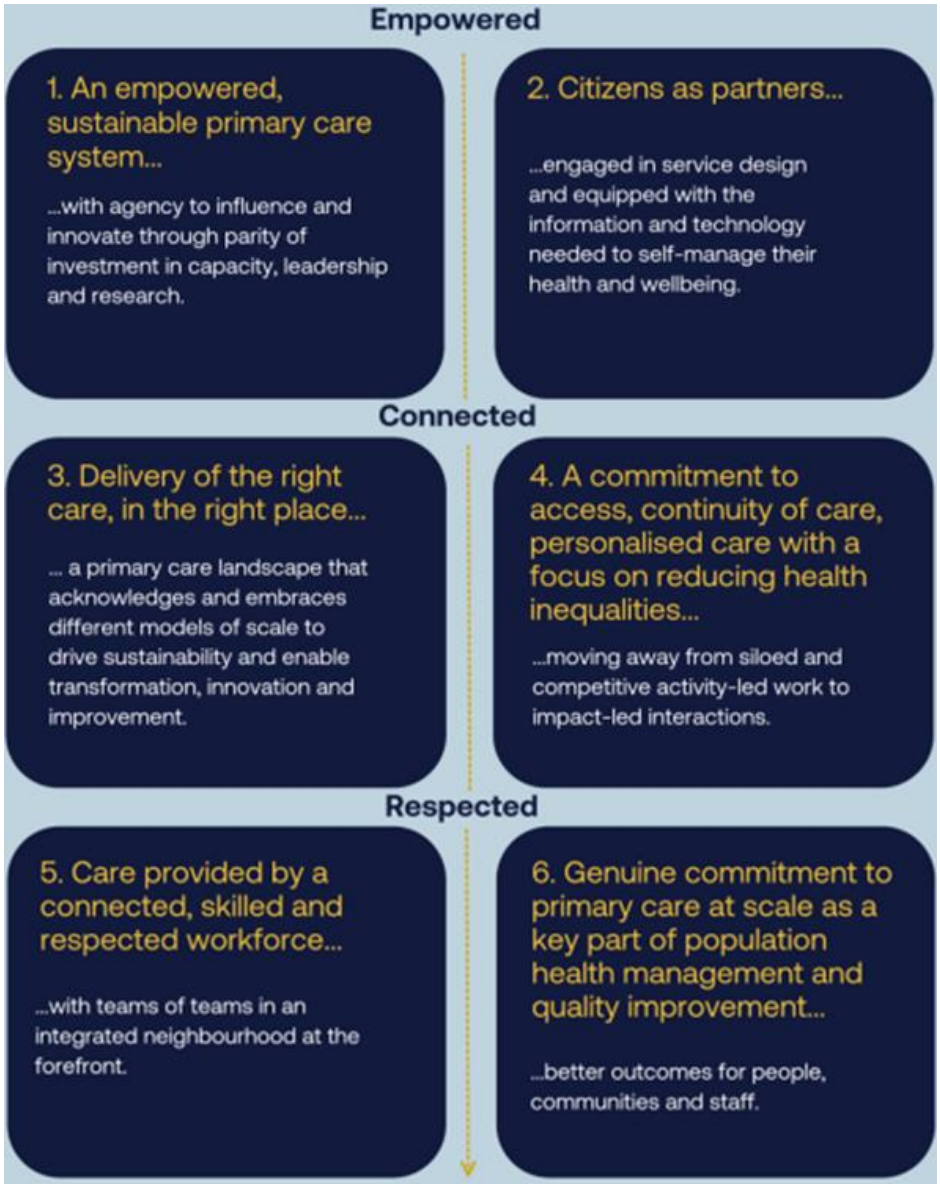
9. Recommendations

It is recommended that the Committee:

1) Agree in principle the proposed approach to LES and GPQC commissioning for 2024/25 identified in this paper, pending Board agreement of commissioning intentions on 10 April 2024
2) Agrees that the Primary Medical Services Group (PMSG) oversees the detailed operational implementation arrangements, including:
    a. Any changes to the review status of individual services, i.e. based on impact assessments and/or feedback that services currently identified to be ceased are either continued or continued and reviewed
    b. Any changes to service specifications based on feedback
    c. Reasonable transitional arrangements from 1 April 2024
3) Receives an update at its next meeting

Peter Tinson
Director of Primary and Community Commissioning
4 March 2024

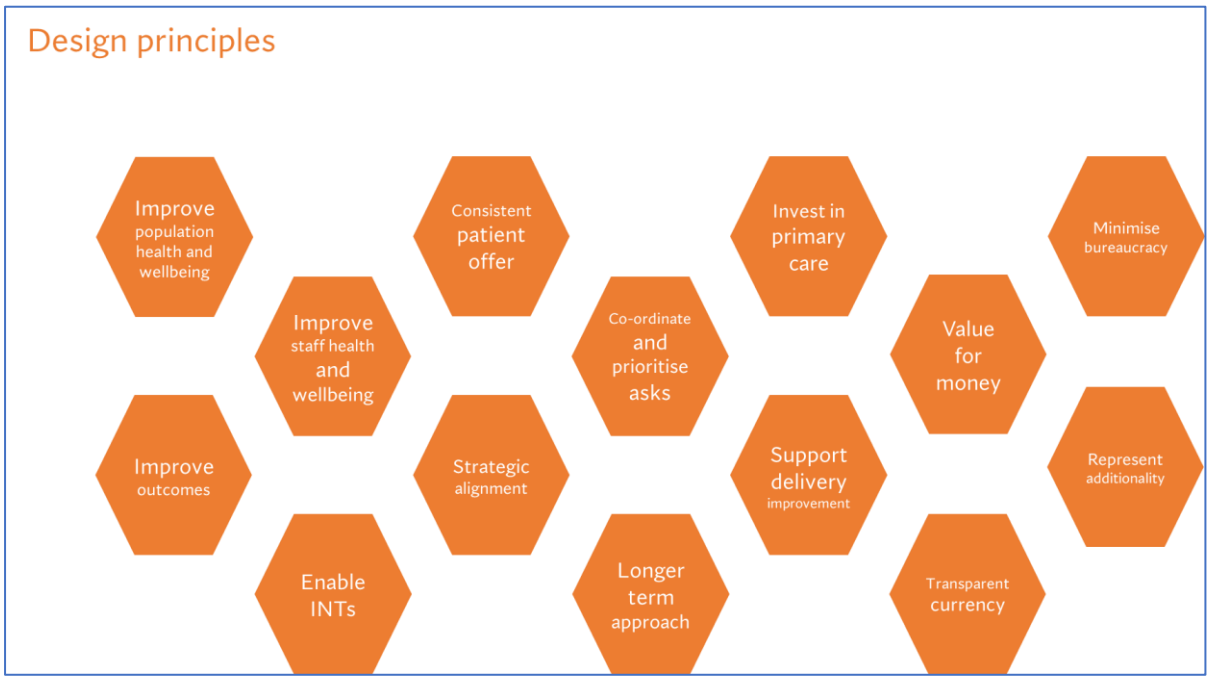
Appendix 1

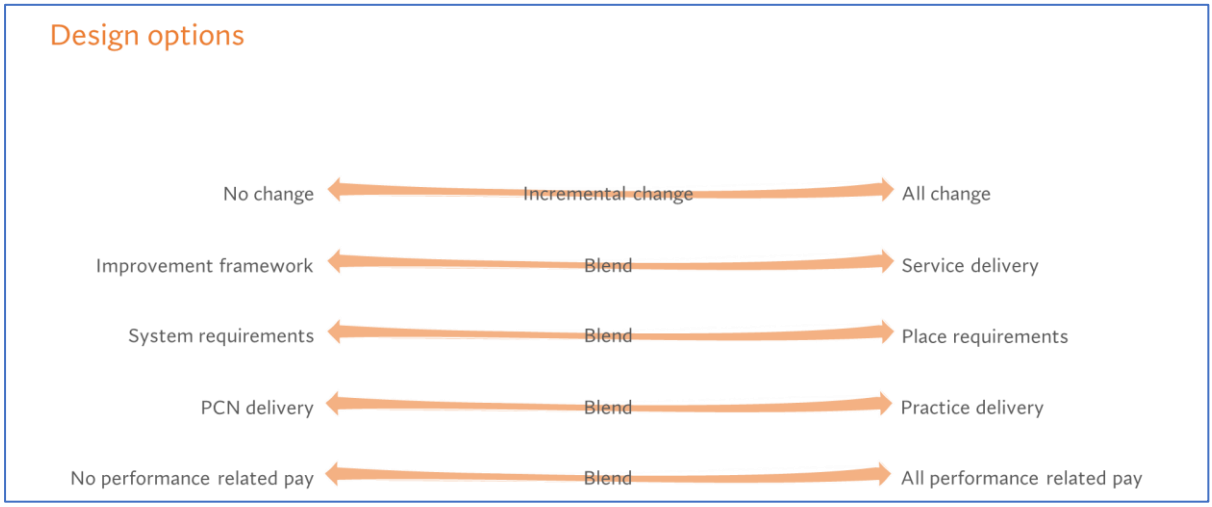

Empowered
1. An empowered, sustainable primary care system...
...with agency to influence and innovate through parity of investment in capacity, leadership and research.
2. Citizens as partners...
...engaged in service design and equipped with the information and technology needed to self-manage their health and wellbeing.
Connected
3. Delivery of the right care, in the right place...
... a primary care landscape that acknowledges and embraces different models of scale to drive sustainability and enable transformation, innovation and improvement.
4. A commitment to access, continuity of care, personalised care with a focus on reducing health inequalities...
...moving away from siloed and competitive activity-led work to impact-led interactions.
Respected
5. Care provided by a connected, skilled and respected workforce...
...with teams of teams in an integrated neighbourhood at the forefront.
6. Genuine commitment to primary care at scale as a key part of population health management and quality improvement...
...better outcomes for people, communities and staff.

Appendix 2

LES Services	Category	Priority Date for completion
Diabetes		1 – 30th September 2024
Atypical populations		1 – 30th September 2024
Community hospitals		1 – 30th September 2024
Rehabilitation units		
Carehomes		2 – 31st December 2024
24 Hour ECGs /ECGS		2 – 31st December 2024
Minor Injuries / Treatment room		1 – 30th September 2024
Phlebotomy		1 – 30th September 2024
Anti coagulation		1 – 30th September 2024
Medicines optimisation		
Near patient testing / secondary care-initiated drugs		
ABPI		1 – 30th September 2024
Assisted fertility		2 – 31st December 2024
Menorrhagia		2 – 31st December 2024
End of life care		2 – 31st December 2024

Appendix 3


Design principles
Improve population health and wellbeing
Improve staff health and wellbeing
Improve outcomes
Enable INTs
Consistent patient offer
Strategic alignment
Co-ordinate and prioritise asks
Longer term approach
Invest in primary care
Support delivery improvement
Value for money
Transparent currency
Minimise bureaucracy
Represent additionality


Design options
No change
Incremental change
All change
Improvement framework
Blend
Service delivery
System requirements
Blend
Place requirements
PCN delivery
Blend
Practice delivery
No performance related pay
Blend
All performance related pay