NHS
North Yorkshire
Clinical Commissioning Group

Title of Meeting:	**NY CCG Primary Care Commissioning Committee**	**Agenda Item: 6.5**
Date of Meeting:	**27 January 2022**	
Paper Title:	**Update on Primary Care LES (Local Enhanced Services) Review**	

Session (Tick)	
Public	X
Private	
Development Session	

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Purpose – this paper is for:

Decision	Discussion	Assurance	Information
		X	

Has the report (or variation of it) been presented to another Committee / Meeting?
If yes, state the Committee / Meeting: Yes
Clinical Executive and Transformation and Financial Recovery Group December 2021
Executive Directors Group January 10/1/2022

Recommendation:
The PCCC is asked to receive this paper for assurance that a robust review of LESs has been conducted in year.

Executive Summary

This paper sets out the process that has been undertaken to review the Local Enhanced Services Schemes (LES) Primary Care Contracts in year.

The process has been undertaken with clinical and financial input and is set out in detail below.

In 21/22 LES income has again been subject to activity validation for Q1 and Q2 however due to increasing pressure on primary care in the second half of the year and the bringing forward of the booster vaccination programme has resulted in a further income guarantee of LES income for Q3 & Q4.

Consideration regarding standardising primary care contracts across North Yorkshire has been part of the review. The contracts can be separated into 3 types:

1. Contracts similar or the same across NY CCG where prices differ.
2. Contracts similar or the same across 2 previous CCGs.
3. Contracts very different across all 3 previous CCGs.

Recommendations to improve consistency have been discussed at Clinical Executive and Directors meetings.

In preparing for organisational change the Governing Body has agreed to extend current LES contracts for a further year from 1.4.2022 to 31.03.2023 to ensure stability as the CCG ends and the ICB begins.

Any subsequent recommendation to make any changes to LESs will be considered as part of CCG planning for 22/23 once allocations are known and will be properly engaged upon. No such changes are recommended at this point.

i. Introduction

NY CCG inherited the legacy Local Enhanced Services Schemes (LES) from the 3 merged CCGs.

The schemes have been clinically reviewed by Dr Emma O'Neil from a clinical point of view to understand the differences in consideration of harmonisation. Dr Bruce Willoughby also assisted with some of this work.

Kathryn Shaw-Wright has undertaken a financial review of the schemes in terms of differences in pricing structures.

A report on progress has been received by the Clinical Executive and Transformation and Financial Recovery Group and a set of recommendations considered.

The LES contracts have been split into 3 types for review from a financial, access and health equity perspective.

Type 1 contracts: Activity based schemes available in all localities where prices and specifications are similar and could be most easily aligned.

Includes: Amber drugs, Anti Coagulation monitoring, MIU services, Insulin initiation, IUD, Complex Wound Care

Type 2 contracts: Activity based schemes not consistent in all localities. Activity based schemes that are not consistently funded or delivered across the patch.

Includes: Ring Pessary, PSA, DVT, GP in hours triage, Mgmt benign prostatic hypertrophy, neo-natal checks

Type 3 contracts: Where significantly different contracts exist across each locality primarily funded through PMS reinvestment funding and £1.5 per head of population funding made available by the original CCGs as agreed at the time. It should be noted that each CCG made decisions based on circumstances which existed at the time with relevant primary care engagement. These decisions are a matter of historic record.

Includes: Frailty, Minor injury, post hospital wound care and suture removal, phlebotomy, ear syringing, spirometry, ECG,

ii. Review Process

In terms of considering any harmonisation process the following issues need to be taken into account:

iii. The complexity of schemes
iv. Limited financial resources
v. Differing needs of areas across NY
vi. Capacity in general practice
vii. Interface capacity with secondary care providers

Any proposed changes and harmonisation would need to ensure:

viii. That the overall budget for NY CCG is not exceeded
ix. That harmonisation across NY is maximised and with VOY where possible
x. Clinical views in terms of population need and localisation

A review has been conducted by finance and clinical leads to understand the contracts, costs and specification differences.

All 3 types of contracts were reviewed by the Clinical Executive and Transformation and Financial Recovery Group and the following issues points noted:

xi. For the CCG to move to a consistent price for Type 1 contracts the cost would be circa £53.5k.
xii. To move to consistent prices and availability of Type 2 contracts across the whole of NY would cost circa £62.5k
xiii. For type 3 contracts:
    a. These contracts had been funded and agreed more locally based on population need and local GP priorities.
    b. The £ per head of population of these LESs are similar. For comparability purposes where contracts are conducted by community services these have been included. Comparative £s per head show:
        i. Harrogate £3.20 per head
        ii. HRW £3.02 per head
        iii. Scarborough £3.24 per head
    c. This suggests that where health inequalities are highest, in Scarborough, allocation is weighted towards that area.
    d. There are a number of options that could be considered in terms of Type 2 contracts
        i. Look to continue with local differences and allow local areas to decide how to use the funding in future which may lead to changes in what the funding is used for now.
        ii. Look to work on a few of these contract specifications one at a time to try to make progress towards increased consistency. It was noted that to simply adopt all of these contracts consistently would cost circa £1m which is not possible in any single year given the financial plan.
    e. There is an opportunity to review whether schemes need to be activity based or could be blocked and administration time for practices and CCG reduced.
    f. The summary below shows that £ per list size of comparable schemes is comparable across the CCG area at circa £6.16. This includes some community services costs to ensure full comparability of services between localities.

	19/20			
	HARD	HRW	SR	TOTAL
Table 1	392,362	382,999	322,487	1,097,848
Table 2	78,944	88,557	-	167,501
Table 3	531,400	439,430	431,377	1,402,208
Total	**1,002,707**	**910,986**	**753,864**	**2,667,557**
List size April	166,165	145,375	121,675	433,215
£ per list size	6.03	6.27	6.20	6.16

Conflict of Interest and Next Steps
In view of the inherent CoI of GP CCG decision makers the following next steps were agreed:

1. Clinical Executive Group GP Members agreed to consider further the issues raised with regards to Type 3 contracts at the next meeting of the Clinical Exec and Transformation and Financial Recovery Group in January following engagement with colleagues and reflection
2. The pricing recommendations with regards to Type 1 and Type 2 contracts would be considered by the Executive Directors Group and will be considered in terms of prioritisation of initiatives in the 2022/23 planning round. Allocations to the CCG are as yet not known.
3. In view of the work undertaken on the LESs a recommendation would be sought from the Governing Body (GB) to extend current contracts for a further year from 1.4.2022 to 31.03.2023. This recommendation has subsequently been approved by the GB.
4. Any significant changes will require engagement with the LMC.

Monitoring
LES schemes are monitored through activity based data collection on a regular basis.

CCGs Strategic Objectives supported by this paper

	CCG Strategic Objective	X
1	**Strategic Commissioning:** • To take the lead in planning and commissioning care for the population of North Yorkshire by providing a whole system approach and to support the development of general practice. • To make the best use of resources by bringing together other NHS organisations, local authorities and the third sector to work in partnership on improving health and care. • To develop alliances of NHS providers that work together to deliver care through collaboration rather than competition.	X
2	**Acute Commissioning:** We will ensure access to high quality hospital-based care when needed.	
3	**Engagement with Patients and Stakeholders:** We will build strong and effective relationships with all our communities and partners.	
4	**Financial Sustainability:** We will work with partners to transform models of care to deliver affordable, quality and sustainable services.	X
5	**Integrated / Community Care:** With our partners and people living in North Yorkshire we will enable healthy communities through integrated models of care.	
6	**Vulnerable People:** We will support everyone to thrive [in the community].	
7	**Well-Governed and Adaptable Organisation:** In supporting our objectives we will be a well-governed and transparent organisation that promotes a supportive learning environment.	

CCG Values underpinned in this paper

	CCG Values	X
1	Collaboration	
2	Compassion	
3	Empowerment	
4	Inclusivity	
5	Quality	
6	Respect	

Does this paper provide evidence of assurance against the Governing Body Assurance Framework?

YES		NO	

If yes, please indicate which principle risk and outline

Principle Risk No	Principle Risk Outline

Any statutory / regulatory / legal / NHS Constitution implications	Contracting guidance to be adhered to
Management of Conflicts of Interest	GPs in practice and who benefit from LES income are conflicted in the matter of this item.
Communication / Public & Patient Engagement	LMC engagement as required where significant changes are being considered
Financial / resource implications	As set out in the paper. Consistency will cost circa 110k for a significant number of contracts to be available at the same prices across NY CCG. There are other significant contracts which remain locality based and therefore different.
Outcome of Impact Assessments completed	

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