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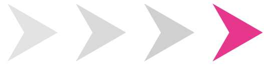

Funding for MS services in England: a practical guide

August 2016

Authors: Amanda Croft*, Geraldine Mynors†, Amy Bowen‡

Introduction

Multiple sclerosis (MS) is the most common condition of the central nervous system affecting young adults. Over 100,000 people in the UK have MS. People with MS live with a complex, variable and often unpredictable condition which can cause a wide range of symptoms. At different points in their disease trajectory they may need input from healthcare professionals spanning multiple disciplines, sectors and providers. These services are funded in a number of different ways. It is helpful for service providers to understand how services are funded when thinking about the commissioning implications of service developments.

This publication from our MS Forward View project, explains how MS healthcare services in England are currently funded through a complex mix of specialised and local commissioning. In developing this guide we found that these arrangements are often not well understood by clinicians, managers or even commissioners, making it difficult for services to identify the economic implications of business cases for service development or improvement. The purpose of this short, practical guide is to help clinicians and managers involved in delivering or commissioning MS services in England to unravel that complexity.

This guide will help you to:

- understand the current mix of specialised and local commissioning in MS services in England
- understand how money moves through the system and the types of contractual models typically used in different care settings
- understand how different types of referral affect who pays for services
- visualise how the patient pathway is funded depending on where services are delivered and how the patient is referred
- identify the economic analysis that will help you write stronger business cases for service developments
- be aware of likely changes to the commissioning of MS services in England

* Policy Officer, MS Trust
† GEMSS Programme Manager, MS Trust
‡ Director of Service Development, MS Trust

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Generating Evidence in Multiple Sclerosis Services
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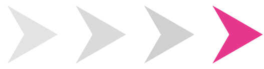

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Policy context

This report reflects the funding arrangements for MS services in England in place at the time of publication (August 2016). However, the policy landscape continues to evolve in response to initiatives arising directly and indirectly from the Five Year Forward View.[1] NHS England is currently setting out a new strategy[2] for specialised services that may culminate in some changes to who has direct responsibility for commissioning MS services. It is possible that fewer MS services will be commissioned nationally by NHS England. The strategy reflects a drive to join up spending on specialised and local services across whole care pathways, and to maximise value by supporting the transition to new models of commissioning and provision that can deliver better outcomes for less.

NHS England will publish its 2017/18 Commissioning Intentions in October 2016. This will categorise the services that should be planned at a national, regional or sub-regional level. The information in this guide is therefore highly likely to change, but presents an accurate picture of how the system is meant to work at the time of publication. We are also aware that local areas may have developed a number of 'work arounds' to address some of the difficulties caused by the complexity of the current system. Therefore, while this is a guide to how the system should work, in reality, local arrangements may differ.

A number of other future developments that will affect MS services in England are discussed briefly in section 5.

1. Specialised and local commissioning explained

This section explains the difference between specialised commissioning, local commissioning and primary care, and sets out the structure currently in place for MS services in England.

The current mix of specialised and local commissioning in MS services in England is a result of the **Health and Social Care Act 2012**.[3] This transferred responsibility for commissioning specialised services to NHS England, with the majority of other health services being planned and managed by local clinical commissioning groups (CCGs). NHS England had to find a way to designate services as either 'specialised' or not. For inpatient care, this distinction can be made through the diagnostic and procedural codes given for individual episodes of care. However, the lack of consistent coding of outpatient consultations in neurology services meant NHS England had to find another way of classifying what counts as specialised. In practice, this means that specialised services are fairly arbitrarily defined by the **place of delivery**.[4]

In recent years, specialised commissioning has grown faster than other areas of NHS spending and in total equates to more than several government departments.[5]

Specialised commissioning

Specialised services are for conditions that affect a **relatively small number of people** but which are often **complex or expensive to provide**. They are typically provided in a small number of hospital trusts that can recruit a team of staff with the appropriate specialist expertise and enable them to develop their skills. To make sure there is access to these services across the country and to pool the high cost of delivering them, it makes sense to plan and fund them on a larger scale. Commissioning specialised services is the **responsibility of NHS England**.[4]

The specialised services budget accounts for approximately £15 billion of NHS spending in England, 14% of NHS England's budget. Local commissioning by CCGs accounts for nearly 67% and primary care for 12%.[6]

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Local commissioning

Non-specialised services are commissioned by **CCGs.** CCGs are clinically led groups responsible for the planning and commissioning of healthcare services for their local population. CCGs are membership organisations of GP practices, led by a governing body which includes secondary care clinicians and lay members. CCGs commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services.

209 CCGs are responsible for **two thirds** of the total NHS England budget.[7]

Primary care

NHS England directly commissions primary care services, delivered through General Practices. In addition, some CCGs now have fully delegated responsibility for the commissioning and contract management of primary medical care.

NHS England specialised commissioning: structure and governance

NHS England is responsible for the commissioning of specialised services. MS services are commissioned regionally through **four regional specialised commissioning teams** supported by a total of **ten specialised commissioning hubs**.

At a national level, specialised services are split into **six National Programmes of Care** (NPoC) which develop clinical strategies and determine the outcomes expected for specialised services. Neurology comes under the remit of the trauma NPoC.

Each NPoC is supported by a number of **Clinical Reference Groups** (CRGs) which provide clinical leadership and expert advice on the best ways to deliver specialised services. CRGs create the tools used by the 10 commissioning hubs to contract services on an annual basis. These include clinical commissioning policies, service specifications, and quality dashboards. CRGs were restructured in 2016. The neurosciences CRG and neurology CRG were merged. MS services fall under the remit of the new neurosciences CRG.

The NPoCs make recommendations to the **Clinical Priorities Advisory Group**, which advises on the services, treatments and technologies that should be prioritised for investment by NHS England.

A **Specialised Commissioning Oversight Group** determines the commissioning implications and available resources, and makes formal recommendations to the **Specialised Commissioning Committee**. This sub-committee of the NHS England board makes final decisions about specialised services commissioning policy and spending.

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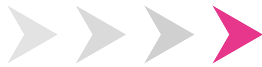


Figure 1: Specialised commissioning structure and governance

4 Regional specialised commissioning teams

Supported by an expert advisory structure of National Programmes of Care and Clinical Reference Groups. Each has regional **specialised commissioning hubs** which commission services at a more local level. The commissioning hubs undertake needs assessments, set priorities, develop and implement local service models with national specifications, lead procurement and contract with providers. They also lead on service reconfiguration and commissioning for value initiatives. For more information visit www.england.nhs.uk/about/regional-area-teams/

North | **Midlands & East** | **South** | **London**

6 National Programmes of Care (NPoC)

Develop clinical strategies and determine the **outcomes** expected for specialised services.

Trauma (including neurology) | **Internal medicine** | **Cancer** | **Mental health** | **Women & children** | **Blood & infection**

Clinical Reference Groups (CRGs)

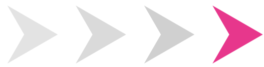
Provide **clinical leadership** and expert advice to each NPoC on the best ways to deliver specialised services. Create the tools used by the ten commissioning hubs to contract services on an annual basis, including **clinical commissioning policies**, **service specifications**, and **quality dashboards**. Chaired by a senior clinician appointed by NHS England and supported by an NHS England **lead commissioner**.

Crosscutting **medicines optimisation CRG**

CRGs in the Trauma NPoC

Neurosciences | **Rehab & disablity** | **Adult critical care** | **Specialised pain**

Specialised ear & opthalmology | **Major trauma** | **Spinal services**



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2. Who pays for what, and how?

MS services are funded through a mix of specialised and local commissioning. The **place of delivery**, **referral route** and the **type of contract** in place all affect how services are paid for.

Place of delivery

Whether services are funded by NHS England through specialised commissioning or by CCGs through local commissioning depends mainly on the **place of delivery**. Broadly speaking, NHS England commissioned MS services are those that are delivered in specialised neuroscience centres and some specialised rehabilitation centres.

Specialised neuroscience centre

A hospital where both neurology and neurosurgery services are delivered. Every neuroscience centre has a multidisciplinary MS team made up of MS neurologists, MS specialist nurses and MS or neuro-specialist allied health professionals (AHPs). There are 25 neuroscience centres in England, as designated by NHS England.[4]

MS prescribing centre

A type of neurology centre not designated as a neuroscience centre by NHS England but which prescribes disease modifying drugs. An MS prescribing centre will have a multidisciplinary MS team made up of one or more MS neurologists, MS specialist nurses and MS or neuro-specialist allied health professionals. Around 60 neurology centres in England are MS prescribing centres.

Neurology centre / district general hospital (DGH)

A hospital which provides general neurology services, but not neurosurgery. Many people with MS will be diagnosed in a neurology centre or DGH by a general neurologist. Their care should then be transferred to a specialist MS neurologist at a neuroscience centre or MS prescribing centre.

Neuro-rehabilitation centre

A centre providing rehabilitation and therapy services to patients with complex neurological rehabilitation needs, with a multidisciplinary team led by a specialist rehabilitation medicine consultant.

Community services

Community services include community nursing and community MS nursing, physiotherapy and occupational therapy delivered outside of acute hospitals, and generalist and specialist rehabilitation delivered in community settings.

Neuro-rehabilitation services and place of delivery

People with MS may require multidisciplinary rehabilitation support on an inpatient or outpatient basis. Rehabilitation services are categorised in levels[8] and the level determines whether the service is funded through local or specialised commissioning.

Level Ia	Hyperacute specialised rehabilitation services for patients with highly complex needs, who will be usually tracheostomy and/or ventilator dependent. Services are led by a specialist rehabilitation medicine consultant working with a multidisciplinary team. There are two Level 1a rehabilitation centres in England, at Salford and Northwick Park.	Specialised commissioning
Level Ib-d	Specialised rehabilitation services for patients with highly complex needs, usually specialising in a particular area of rehabilitation (eg cognitive function) and often linked to a trauma centre.	Specialised commissioning
Level 2a	Specialist rehabilitation services for patients with complex needs. Services are led by a specialist rehabilitation medicine consultant working with a multidisciplinary team.	Specialised commissioning
Level 2b-d	Local specialist neuro-rehabilitation services for patients with complex needs. Services are led or supported by a specialist rehabilitation medicine consultant working with a multidisciplinary team in a hospital or community setting.	Local commissioning
Level 3	Local, non-specialist services which offer general multi-professional rehabilitation in acute, intermediate care or community services.	Local commissioning

Referral route

Not all services delivered in neuroscience centres are funded through specialised commissioning. Since April 2015, the **referral route** makes a difference.

MS care in neuroscience centres – who pays?

GP to consultant referral made after April 2015 = local commissioning
GP to consultant referral made before April 2015 = specialised commissioning

Consultant to consultant referral = specialised commissioning

Whether this is applied in practice depends on the systems in place at each centre. In practice, some centres charge all clinical activity resulting from GP referrals to CCGs, regardless of the original referral date, and only charge NHS England for activity resulting from consultant to consultant referrals.

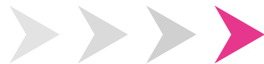
Contractual models

The way that services are paid for also depends on the **type of contract** in place.

Contractual model	Definition	Where used
National Tariff Payment System (NTPS) (previously called 'Payment by Results')	The National Tariff Payment System pays providers for each unit of care a patient receives, based on nationally or locally determined currencies (units that are paid for) and tariffs (prices). Payment is defined by activity. Activity is not reimbursed unless a tariff has been agreed, and the activity is systematically recorded on a patient information system.	Neuroscience Centres Neurology Centres District General Hospitals Outpatient Rehabilitation
Activities not separately reimbursed	Some services that providers deliver are not separately charged for, eg physiotherapy for inpatients on wards, delivering patient education programmes, or interpreting blood tests. The cost of delivering these activities is rolled into an activity for which there is a tariff, such as outpatient attendances with a neurologist or nurse specialist, or inpatient admissions.	Neuroscience Centres Neurology Centres District General Hospitals Inpatient rehabilitation
Block contract	Under a block contract, providers receive an agreed overall sum to deliver a specified service and volume of activity. Block contracts are agreed in advance of the service being undertaken. The value of the contract is unaffected by the actual number of patients treated or the amount of activity undertaken. Unexpected pressures such as increased patient demand or cost of care are not usually paid for, unless (unusually) an in-year change to the contract value is negotiated.	Community services
Capitation payment	Capitation payments are used in General Practice. Providers are paid a lump sum every year based on the number of patients on their caseload. Practices have the flexibility to spend the money providing the services they think will secure the best outcomes for their patients. Practices receive additional payments for meeting Quality and Outcome Framework (QOF) indicators.	General Practice

Understanding the National Tariff Payment System

Of the different contractual models in place, the most complicated is the National Tariff Payment System (NTPS), previously known as Payment by Results (PBR). Under NTPS, providers are paid for each **unit of care** a patient receives, based on nationally or locally determined **currencies** (units that are paid for) and **tariffs** (prices).



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The price that's paid is as follows:

- For activity with a **mandatory national tariff**, there is a set price that is charged in all cases. For inpatient stays, A&E attendances and procedures, and high cost tests (like MRI scans) the tariff is based on the Hospital Reference Group (HRG4) code for the activity. Each episode is allocated to one of around 1,400 codes based on a combination of the diagnostic and procedure codes for the episode, and sometimes the length of stay and a code for whether there were complications.
- Some activities, including neurology consultant outpatient appointments, have **non-mandatory national tariffs** which may be used, but services can choose to negotiate the suggested price locally.
- Some tariffs are **locally negotiated**. Examples include nurse telephone consultations which many MS nurses will deliver.
- The tariff varies depending on whether there are **complications** in the episode of care. This is noted as 'CC' in the HRG description.

A key point to note is that no activity will be reimbursed to an NHS provider under NTPS unless a tariff has been agreed and the activity is systematically recorded on a patient information system.

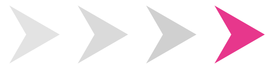
Some of the tariffs are set at a level that does not truly reflect the costs of delivering the activity. For example, the tariff for a specialist nurse home visit is frequently lower than that for a nurse outpatient consultation, despite the fact that home visits are more costly to deliver. The cost of these activities is essentially 'subsidised' by tariffs for other activities.

Examples of tariffs used in MS services

The nationally agreed currencies and tariffs used in MS services can be found in the 2016/17 National Tariff Payment System workbook.[9] Some examples of commonly used tariffs for MS services are given in the table below. These are only for illustration; this is not a comprehensive list and you should refer to the most up to date national tariff workbook if you need to use tariffs in your work.

Example mandatory national tariffs:

HRG4 code	HRG description	Tariff (£)
AA30A	Medical care of patients with multiple sclerosis, with CC (non-elective)	3,332
AA30B	Medical care of patients with multiple sclerosis, without CC (non-elective)	1,974
AA30B	Medical care of patients with multiple sclerosis, without CC (day case/ordinary elective spell tariff)	339
LA04D	Kidney or urinary tract infections, with length of stay 2 days or more, with major CC (non-elective)	3,604
LA04G	Kidney or urinary tract infections, with length of stay 1 day or less (non-elective)	423
WA15O	Respite care with length of stay between 5 and 8 days, with intermediate CC (non-elective)	2,418
RA01A	Magnetic resonance imaging scan, one area, no contrast (19 years and over) (including cost of reporting)	124
RA01A	Magnetic resonance imaging scan, one area, no contrast (cost of reporting)	22
VB06Z	Emergency medicine (A&E attendance), category 1 investigation with category 3-4 treatment (type 1 & 2 departments)	105



Example non-mandatory national tariffs:

HRG4 code	HRG description	Tariff (£)
WF01B	First consultant led neurology attendance - single professional	218
WF02B	First consultant led neurology attendance - multi-professional	218
WF01A	Follow-up consultant led neurology attendance - single professional	125
WF02A	Follow-up consultant led neurology attendance - multi-professional	130
-	Non-face to face outpatient attendance	23

Example locally negotiated tariffs (no national price):

HRG4 code	HRG description	Tariff (£)
WF01D	Non-admitted non-face to face attendance, first	Locally set
WF01C	Non-admitted non-face to face attendance, follow-up	Locally set
WF02D	Multi-professional non-admitted non-face to face attendance, first	Locally set
WF02C	Multi-professional non-admitted non-face to face attendance, follow-up	Locally set
VC12Z	Rehabilitation for other neurological disorder	Locally set

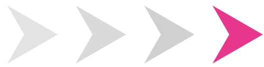
Some episodes of outpatient nursing and AHP led care may not be covered by the mandatory or non-mandatory codes, in particular face to face episodes of non-consultant led care. Payment for these will be subject to local arrangements

Who pays for disease modifying drugs?

The approach to paying for disease modifying drugs (DMDs) highlights the split between specialised and local commissioning of MS services in England.

There are currently 11 DMDs available on the NHS, each with different safety monitoring regimes. **DMD costs are always reimbursed by NHS England through specialised services, regardless of where they are prescribed**. The reimbursement includes, where relevant, the costs of delivery of the drugs to the person with MS. Drug manufacturers will contract with a homecare company, so multiple companies are involved in supplying DMDs. Medicines provided through homecare or community pharmacy partnerships in hospitals do not incur VAT, which lowers the cost of the drugs to the NHS.

Blueteq
Blueteq is an NHS England online system to manage high cost drugs, including disease modifying drugs for MS. Centres which prescribe DMDs must have Blueteq in place in order to demonstrate compliance with the clinical commissioning criteria for each drug. Blueteq enables clinicians to secure prior approval for the funding of the drug by completing an online proforma confirming that the patient meets all the relevant commissioning criteria. If prior approval is not obtained there is a risk that NHS England will refuse to meet the cost of the prescription.



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The costs associated with the **safety monitoring** of DMDs are not included in the amount reimbursed. This includes activities such as phlebotomy, scheduling and carrying out MRI scans or other tests required by the treatment protocol, interpretation and review of test results, and acting on test results where necessary.

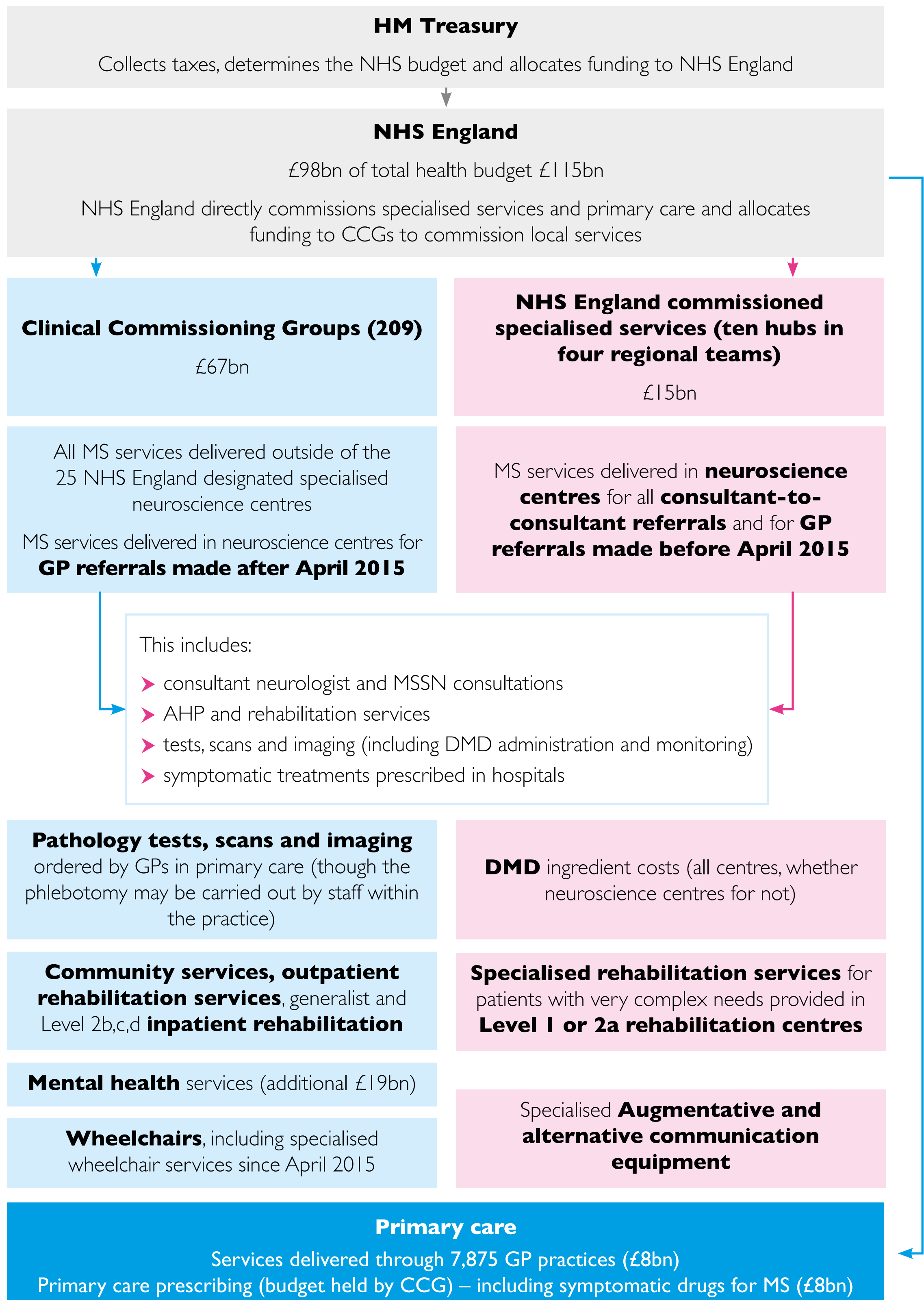
Typically these costs are either absorbed by MS services or are negotiated as shared care arrangements with primary care to improve patient convenience. These shared care arrangements may be formal and therefore reimbursed through contractual arrangements or may be informal, based on goodwill of primary care teams.

Drug administration costs are also not included in the direct reimbursement for DMDs. Administration costs refer to the actual administration of the drugs, for example IV infusions (alemtuzumab and natalizumab) or where protocols require first dose to be monitored (fingolimod).

The vast majority of IV DMD administration is reimbursed through the tariff for elective day case admissions.[10] Monitoring of the first dose of fingolimod is more likely to be treated as an outpatient attendance. Guidance on classifying procedures as either daycase admission or outpatient attendance is available at www.systems.hscic.gov.uk/data/nhsdmds/faqs/cds/admitpat/daycase.

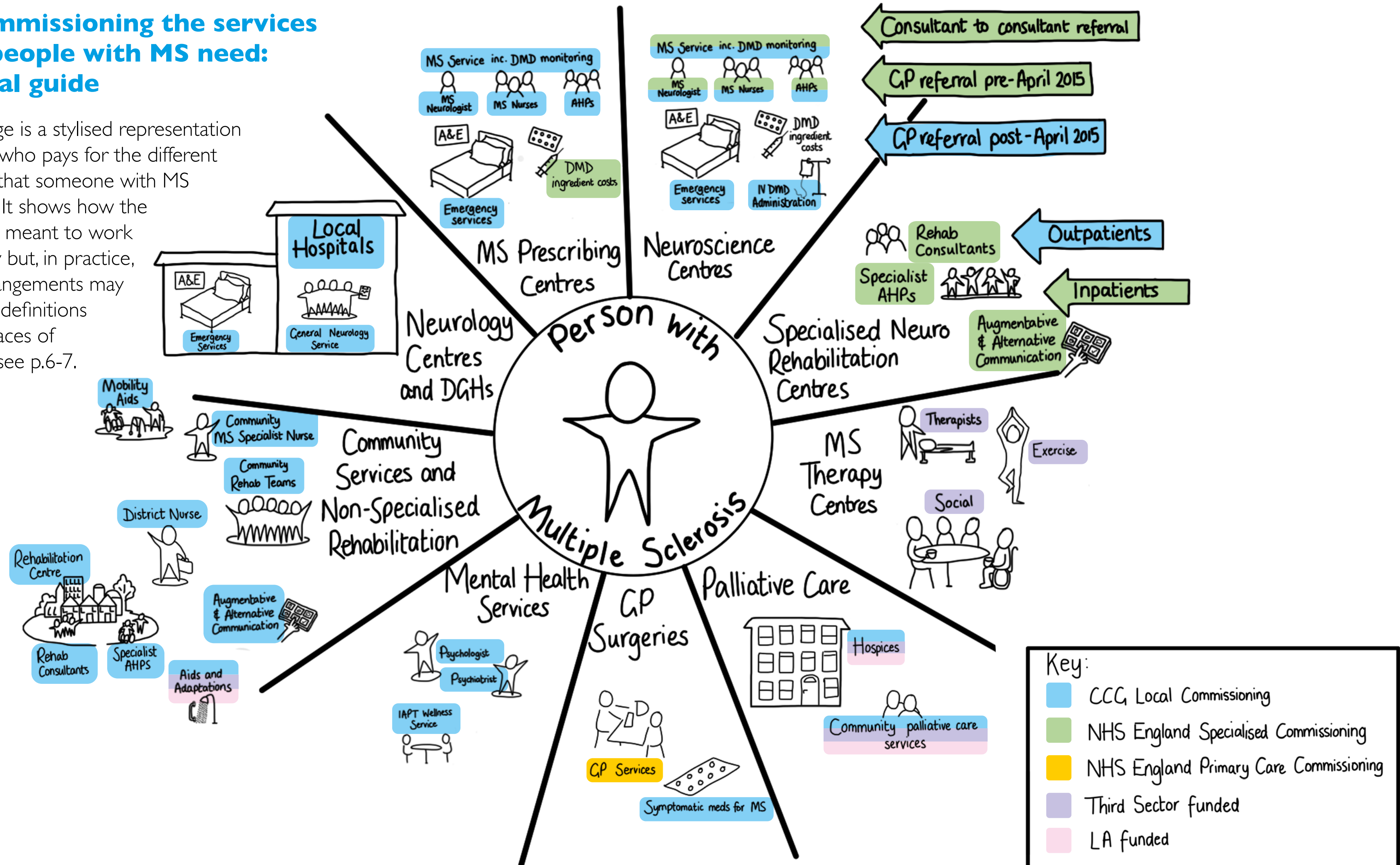
Figure 2: Overview of funding for MS Services in England

*Budget figures are taken from the NHS annual accounts 2014/15[11] and represent the total NHS budget.



3. Commissioning the services that people with MS need: a visual guide

This image is a stylised representation showing who pays for the different services that someone with MS may use. It shows how the system is meant to work in theory but, in practice, local arrangements may vary. For definitions of the places of delivery see p.6-7.



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4. What does this mean for MS service developments?

What impact does this complex mix of funding arrangements have on MS services at the front line? When services are in 'steady state', the answer may be "not much". Contracting and billing takes place largely behind the scenes and may not be immediately visible to clinicians. However, when MS teams want to change or develop their services to make them more efficient, effective or service user oriented, they invariably need to make business case for recruiting new staff, reconfiguring services or some other change. It is here that an understanding of who funds services, and how, becomes important – and can potentially be a barrier to service development.

Questions to ask when developing a business case for service change

Thinking about the service now:

- Which provider(s) incur the costs of delivering the service? Identify all the inputs currently required to deliver the service including staff, premises, materials, medicines, training and travel.
- Which commissioner(s) currently pay for the service, and what type of contract and tariff is used?
- What is currently charged to the commissioner(s) for buying this service?

Thinking about the service in the future:

- Which provider(s) will incur the future costs of delivering the service? As well as looking at how costs are going to change, think about who will incur those costs.
- Which commissioner(s) will pay for the new service, and what will be charged to them? What will be the difference for commissioner(s) after the service change?
- Are there are other consequences of your service change in terms of costs incurred to NHS providers and commissioners? For example, if you believe that your service development may reduce hospital admissions, can you estimate how many will be reduced and how much may be saved to commissioners as a result?

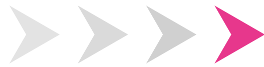
Answering these questions will enable you to work out:

- Who might need to be consulted or convinced about your proposals.
- What economic arguments you could make, in addition to the equally or more important case around service quality, patient experience and fit with strategic goals.
- Whether there are different options to consider in terms of how the service is charged for.

Examples of service development

The following examples show how you might answer these questions for three different types of service development. The MS Trust will be publishing a guide to writing business cases, with a worked example of a case, in autumn 2016 – see www.mstrust.org.uk/gemss for details.

Example 1 (overleaf): A neuroscience centre MS specialist nursing (MSSN) team wants to transfer some of its patients on its caseload to a community based MSSN based at a Community Trust in an outlying area, meaning greatly reduced travel time and greater accessibility for patients living in that area who don't need to visit the main centre for example, for DMD treatment.



	Now	Future
Main direct costs involved	Nursing staff, clinic facility and reception staff, MSSN travel costs for home visits, pathology tests, symptomatic therapy prescribing costs	
Who incurs costs of running the service?	Neuroscience Centre Trust	Community Trust
Who pays for the service?	Mix of NHS England and CCG depending on the source and timing of the original referral	CCG
How is the service paid for? (contract type / tariff)	NTPS tariff for nurse consultation (locally negotiated)	Increase to existing block contract between the CCG and the Community Trust
Other cost consequences / considerations	➤ Care closer to home may mean reduced need for patient home visits and more efficient use of clinic time due to reduced DNA (did not attend) rate, meaning that the cost to the Community Trust of delivering the service may be lower than for the neuroscience centre. ➤ More regular review of patients may lead to reduction in emergency hospital admissions, saving cost to the CCG.	

Example 2: A new consultant neurologist with a special interest in MS is appointed at a neurology service in a District General Hospital in an area where people with MS on DMD treatment currently have to travel long distances to reach a neuroscience centre. The DGH Trust sees an opportunity to establish a local DMD service for people in the area and to 'repatriate' patients from the neuroscience centres.

	Now	Future
Main direct costs involved	Consultant and nursing staff, DMD drug costs, pharmacy, clinic facility and reception staff, pathology tests, imaging, symptomatic therapy prescribing costs	
Who incurs costs of running the service?	Neuroscience Centre Trust(s)	DGH Trust
Who pays for the service?	DMDs (ingredients): NHS England Consultations, imaging and inpatient/day case admissions: mix of NHS England and CCG depending on the source and timing of the original referral	DMDs (ingredients): NHS England Consultations, imaging and inpatient/day case admissions: CCG
How is the service paid for? (contract type / tariff)	NTPS tariff for neurologist and nurse consultations (locally negotiated) NTPS tariff for MRI scans /daycase admissions (national mandatory)	Unchanged, though locally negotiated tariffs may be at different rates.
Other cost consequences / considerations	➤ More regular review of patients may lead to reduction in emergency hospital admissions, saving cost to the CCG. ➤ Agreement from NHS England and establishment of Blueteq in the DGH Trust will be essential before DMDs can be prescribed. ➤ NHS England will also want a forecast of the projected spend on DMDs at the DGH so there can be a transfer of budget from the neurosciences centre to the DGH.	

Example 3: A DMD service provided in a DGH (non neuroscience centre) would like to arrange for regular blood monitoring between consultant / MSSN appointments to take place in local GP surgeries, as this would be more convenient for patients.

	Now	Future
Main direct costs involved	Phlebotomy, pathology testing, interpretation of results and liaison with patients /neurologists if abnormal	
Who incurs costs of running the service?	DGH Trust	Phlebotomy and interpretation / liaison with patients: GP practices Pathology testing : local laboratory with whom the CCG has contracted
Who pays for the service?	CCG	Phlebotomy and interpretation / liaison with patients: GP practices Pathology testing: CCG
How is the service paid for? (contract type / tariff)	PBR tariff for nurse or neurologist consultations (locally negotiated) in which the testing is included	Phlebotomy and interpretation / liaison with patients: no additional payment to GPs Pathology testing: cost and volume contract with laboratory depending on local arrangements
Other considerations:	➤ GPs may feel that they do not have the requisite skills and experience to schedule and interpret these tests, so this will need to be addressed via training and protocols. ➤ Undoubtedly, this type of transfer incurs costs to GPs (though only for consultations, not the tests themselves) so the argument to them is about improvements to care.	

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5. Future models for commissioning MS services

The commissioning landscape in the English NHS is a dynamic one as the system tries to find the right balance between planning at scale with responding to local needs, and to create the right incentives in the system for high quality care. Some of the models on the horizon include:

Collaborative commissioning

A model of commissioning whereby groups of CCGs and NHS England work together across a local area to commission specialised services in a more coordinated way, giving CCGs greater input into decisions about specialised care in their localities. The aim will be to ensure that the pathway for people receiving specialised care is more seamless. For more information see www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/spec-serv-collabrtv-comms-sup-res.pdf

NHS Right Care

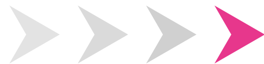
NHS Right Care grew out of the Quality, Improvement, Prevention and Productivity (QIPP) programme. The primary objective of NHS Right Care is to make value the central focus of healthcare decision making and culture. The programme supports commissioners to maximise value by helping local health economies design optimal systems to tackle unwarranted variation in quality and health outcomes. The focus on networked systems rather than organisational structures is a key feature of NHS Right Care. NHS Right Care is now an established programme of NHS England. As part of this programme, a series of Commissioning for Value packs has been published including the 2016 'neurological focus packs' and 'where to look packs' available at www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

NHS Vanguards

Vanguards are local consortia of NHS and care providers that are working together and pooling resources to develop new and better ways of providing care in the NHS. 50 vanguard sites have been selected and the plan is that they act as the blueprints for the NHS moving forward. For more information see www.england.nhs.uk/ourwork/futurenhs/new-care-models/

Outcomes based commissioning

Outcomes based commissioning is an approach to commissioning which rewards providers for delivering a set of outcomes for a population rather than paying individual providers based on the 'countable' activities. The idea is to give organisations incentives to work together to integrate services, reducing duplication and waste. Often the approach involves a lead provider who is responsible for achieving the outcomes and who subcontracts with other providers to deliver particular elements of care. Although we are not aware of any existing outcomes based commissioning pilots in MS care, this may be a promising approach for the future. For more information see www.health.org.uk/publication/need-nurture-outcomes-based-commissioning-nhs



Multiple Sclerosis Trust MS

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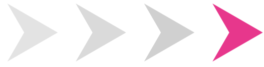
- Clare Mills at Listen Think Draw

About MS Forward View

MS Forward View is a one year project, launched in November 2015 by the MS Trust. It aims to identify key priority actions needed across the MS sector to enable MS services to deliver efficient, effective and equitable services for everyone with MS, in the context of changing treatment paradigms. MS Forward View is looking at how MS services can make better use of current resources and skills for everyone with a diagnosis of MS. We are bringing together clinicians, specialised and local commissioners, professional bodies, industry, multidisciplinary educators, people with MS and patient organisations to produce a sector-wide consensus on how to optimise the provision of evidence-based care for everyone with MS.



About the MS Trust

The MS Trust is a charity which works to make a difference today for the more than 100,000 people living with MS in the UK.

We work to make sure everyone affected by MS can access good quality, specialist care. We do this by providing high quality education and professional development support to MS specialist health professionals so they can deliver an even better service. We support health professionals with online information, publications and updates on the latest research.

Through our innovative GEMSS programme, we support evidence-based service improvement in MS care. Our approach is always to work in partnership with health professionals to improve MS services now and in the future.

We also produce practical, reliable information for people living with MS. Our information is available online and in print, and we offer a telephone and email enquiry service to anyone who needs to know more about MS. Our materials are widely used by MS services across the UK.

We receive no government funding so we rely on donations to fund our vital services.

To find out more about our work, how we can help you and how you can get involved

Visit www.mstrust.org.uk
Call 01462 476700
Or email info@mstrust.org.uk

Multiple Sclerosis Trust
Spirella Building, Bridge Road
Letchworth Garden City
Hertfordshire SG6 4ET

T. **01462 476700**
T. **0800 032 3839**
E. **info@mstrust.org.uk**
www.mstrust.org.uk

Registered charity no. 1088353