NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee

Held in public on Tuesday 24th May 2016, 4-5pm
The Auditorium, Ground Floor, The Brighthelm Centre, North Road, The Brighton Centre

AGENDA

Members:	
Jennifer Oates	Independent Clinical Member - Registered Nurse**(Co-Chair)**
Dr Dinesh Sinha	Independent Clinical Member (Secondary Care Consultant) **(Co-Chair)**
Lola Banjoko	Director of Delivery and Performance
John Child	Chief Operating Officer
Bob Deschene	Healthwatch
Denise D'Souza	Director Adult Social Care, Brighton and Hove City Council
Ian Harper	Local Medical Council representative
Mike Holdgate	Lay member (Patient, Public Participation)
Stephen Ingram	NHS England
Dr George Mack	Lay Member (Governance)
Pippa Ross-Smith	Chief Finance Officer
Peter Wilkinson	Acting Director of Public Health
Soline Jerram	Lead Nurse, Director of Patient Safety and Clinical Quality
In Attendance:	
Natasha Cooper	Head of Commissioning –Primary Care and Community Services
Emma Snowdon	Governing Body Secretary (Minutes)
Apologies:	

Conduct of meetings in relation to attendance by members of the public: Members of the public are asked to note that NHS Brighton and Hove Clinical Commissioning Group Primary Care Committee meetings are meetings held in public, they are not ‘public meetings’ where members of the public can speak at any point. Agendas identify when the Chairman will receive questions and comments from the public. For all other agenda items speaking rights are reserved to Committee members and agreed representatives sitting at the table; members of the public should not speak or intervene in proceedings unless invited to do so. In all matters the Chairman’s decision is final. The introduction by the public or press representatives of recording, transmitting, video or similar apparatus into meetings of Brighton and Hove Clinical Commissioning Group Primary Care Committee is not permitted.

Agenda						
No/ Tab no	**Item**	**Action**	**Lead**	**Paper**	**Page no**	**Time**
022/16	Welcome and apologies	Note	Jenny Oates			1pm
023/16	Declaration of Interests	Note	Jenny Oates			1.03pm
024/16	Minutes from the meeting held in January 16.	Approval	Jenny Oates	✓	P5	1.05pm
025/16	Matters arising	Note	Jenny Oates	✓	P13	1.08pm
026/16	LCS business case development	Note	John Child	✓	P15	1.12pm
027/16	Homeless GP Contract	Note	John Child	✓	P33	1.25pm
027/16	Update on Co-commissioning	Note	John Child	✓	P43	1.35pm
028/16	Approved minutes from the Primary Care Transformation Board.	Note	George Mack	✓	P49	1.50pm
AOB						
029/16	AOB	For information	Jenny Oates			1.55pm
Date of future meetings 2016 (All 4-5pm unless in The Auditorium stated, The Brighthelm Centre)						
	• 26th July 16 • 27th Sept 16 • 22nd November 16 • 24th January 17 • 28th March 17					

Primary Care Commissioning Committee

Draft Minutes

Date: Tuesday 22nd March 2016 **Time:** 1-2pm

Location: The Auditorium, Ground Floor, The Brighthelm Centre, North Road, Brighton, BN1 1YD

Summary of resolutions taken at meeting taken on Tuesday 22nd March

Proposed Resolutions			
Item no	**Resolution**	**Owner**	**Review Date**
18/16	The committee **approved** the budget set out in the paper for communications and engagement work on co-commissioning.	n/a	n/a

Members:	
Jennifer Oates	Independent Clinical Member- Registered Nurse (Chair)
Dr George Mack	Lay Member (Governance)
John Child	Chief Operating Officer
Pippa Ross-Smith	Chief Finance Officer
Richard Woolterton	Head of Primary Care, NHS England
Bob Deschene	Healthwatch
Mike Holdgate	Lay Member (Patient, Public Participation)
Lola Banjoko	Director of Delivery and Performance
In Attendance:	
Lisa Durant	Interim Director of Delivery and Performance
Martha Robinson	Head of Communications and Engagement
Michael Schofield	Former Chief Finance Officer
Emma Snowdon	Governing Body Secretary (Minutes)
Apologies:	
Dr Dinesh Sinha	Independent Clinical Member (Secondary Care Consultant) Co-chair
Dr Tom Scanlon	Public Health Director
Soline Jerram	Lead Nurse, Director of Patient Safety and Clinical Quality
Dr Ian Harper	Local Medical Council Representative
Denise D'Souza	Director Adult Social Care, B&HCC

Item No	Item	Action
12/16	**Welcome and Apologies**	
	Jenny Oates welcomed everyone to the meeting including Lola Banjoko the new Director of Performance and Delivery.	
13/16	**Declarations of any Conflicts of Interest**	
	There were no declarations of any conflicts of interest.	
14/16	**Minutes of the Last Meeting**	
	RW noted p4, the commissioning panel was taking place on 26th Jan, but should read *26th February.* RW noted p5, the quality of the bids would be based on capitation formula, should read *would* not be based on capitation formula. RW noted p5, CCG management allowance of £20 per head should read *£25* per head. The minutes of the meeting held on 26th January were otherwise agreed as accurate. GM referred to p6 and queried whether we should be charging other CCGs for our Director of Performance Role, since we are lead commissioner for Brighton Sussex University Hospital Trust (BSUHT). MS noted that currently we are not charged by other CCGs when they are the lead commissioner. We should not accept lead positions if they tip any balance.	
15/16	**Matters Arising**	
	All other matters arising were either on the agenda or were complete.	
16/16	**Locally Commissioned Service (LCS) Business Case for Primary Care Investment – What good looks like**	
	JC presented the report to the committee for discussion and feedback on the approach that will be taken to developing business cases for investment in Primary Care and highlighted the following points: - The CCG, Brighton and Hove City Council and Public Health have agreed a new approach to commissioning LCSs from GP practices across the city. - These services aim to provide enhanced primary care, beyond the core contracts primary care hold with NHS England and based on local requirements and population needs. The new approach responds to the premature mortality audit and aims to provide more proactive, integrated services. - Clusters of GP Practices have been asked to design and plan business cases with commissioners that will improve health outcomes and reduce inequalities for their registered populations. - Clusters will submit Action Plans covering how they will provide all required elements of current LCS's as well as the additional proposals. - It is anticipated practices will require additional investment to deliver these proposals. - Business cases will include proposed delivery models,	

challenges, issues and economic cases and will come to the May committee for a decision on the proposals.

The committee raised the following points:

- BD queried whether the CCG would be supplying a template with specific headings and asked how would the business cases be evaluated and scored. JC noted that templates are available and will be shared. Commissioners will be working closely with practices and public health to provide support. Business evaluation will as appropriate in line with the CCG governance arrangements.
- BD queried where the patient voice is in the evaluation process. JO noted that a paper confirming how business cases would be evaluated came to the first committee meeting. The detailed discussion and scrutiny takes place at the Primary Care Transformation Board (PCTB) and papers come to this committee with recommendations.
- MH noted discussion taking place at the PCTB does not necessarily mean the patient voice will have been involved in the evaluation. How are we going to measure the impact. We need to know very clearly practices are making the savings put forward in the business cases.
- LB noted that business cases need really clear outcomes.

Action: ES to circulate the evaluation paper which came to the first meeting to ensure all new committee members have had sight of this. [ES]

- BD queried how the 3rd sector are involved in business case development.
- MH raised concern that community strengths and assets are taken into account as well as needs.
- PR-S queried if a community gap analysis has been carried out.

Action: Population data/health needs information which has been provided to clusters and will be re-sent to new members of the committee. [ES]

- MH noted that the data may have come from public health and the CCG but also needs to come from communities as well.
- GM noted that when business cases are evaluated appropriate engagement should be evident. Clusters may need additional support.
- LD agreed that you would need patient engagement in developing the cluster model, but the delivery model is also important. There may be a temptation to go down an alliance route which may not be as formal as you would not want to overburden clusters, but in her view that would be a mistake.

Action: JC to feed back the comments around this to NC. [JC]

JO concluded the key points that the committee had raised:

1) How is the Business Case being evaluated?
2) What's the patient and 3rd Sector engagement in setting the LCSs.
3) What are the outcomes going to be?
4) What is the delivery model including accountability for monitoring and ensuring delivery?
5) Have community assets and patient assets been taken into account as well as patient needs.

Action: JC and NC to respond in writing to the committee prior to receiving the business cases. [JC/NC]

17/16 Update on Primary Medical Service (PMS) Contract

JC referred to the letter which had been sent by NHS England (NHSE) to the Chair Cllr Yates, the Chair of the Health and Wellbeing Board highlighting the following:

- There are five practices across the city who are affected by the Practice Group giving notice on their contract. Four of those have had an extension of their current contract until:
  - The Practice Willow House – until end of Sept 16
  - The Practice Hangleton Manor – until end of Sept 16
  - The Practice North Street – until end of Sept 16
  - The Practice Whitehawk Road – until end of Nov16
- It has been agreed that The Brighton Homeless Healthcare Surgery will be re-procured and that is being extended until 31st Jan 2017.
- There was a panel convened and chaired by NHSE, which some of the members of the PCCC attended. An options appraisal took place in relation to the future plan of the practices.
- Future work needed to be undertaken to include work with patient participation groups to understand the impact on the local community and review the options. The panel will be reconvened on April 25th. A recommendation will then be made following the panel to the Director of Commissioning at NHS England.
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The following points were raised:

- MH noted that it was an excellent piece of collaborative work between NHSE, B&H CCG and the voluntary sector re. patient voice and engagement.
- JC noted there has also been discussions at the last two Health and Wellbeing Boards, plus a Health Overview Scrutiny Committee (HOSC) workshop around the sustainability in Primary Care which was another collaborative piece of work.
- MH noted we need to ensure the demographics of the affected areas are fully taken into consideration.
- BD noted there is an opportunity to move away from smaller models to a larger more sustainable model. JO noted that the clustering and federation models are a driver for this.
- RW noted that discussions are on-going around looking at ways

of providing the back office functions in federations.
- JO noted that if we have delegated responsibility, this committee would have been more accountable for the decisions being made around the 5 practices.

The committee noted the progress.

18/16 Communications and Engagement Plan 2016 – Co-Commissioning

MR presented the report to the committee for review, discussion and approval and highlighted the following:

- Last year the CCG followed the timetable provided by NHSE, and that timescale was tight and we had to work quickly. This year, although we do not know the NHSE timescale we are being proactive and strategic.
- For GP membership we will hold more personalised cluster discussions throughout the year and try virtual forms of communication.
- For the public, the NHSE guidelines have been useful for defining what level of engagement is expected:
    - Tier 1 engagement involves ensuring information is accessible, issues are communicated and people can ask questions. Tier 1 is not about asking for patient experience of services or for a full public consultation.
    - MR noted that a full Equality Impact Assessment is not applicable in this instance because there is no fundamental service change. However we will be applying equalities best practice to all our engagement activities.
    - BD called for more feedback following Governing Body meetings, for people to raise queries and receive responses to their questions.
    - MR noted that the GB meeting is a formal meeting, so will be run in a formal way with formal responses, however the PPG Network meetings will be more bespoke and will be used to communicate and receive feedback.
    - MH also noted that if you hold meetings in the day in town, it discriminates against a whole group of patients who cannot attend daytime meetings. MR noted that any choice discriminates against somebody, so evening meetings would discriminate against people with childcare issues. Hence why on line communication is such an important part of engagement. We can reach people far more easily online. The local media is also an excellent way to get messages out.
    - BD noted that some of the members of the public who attend meetings frequently have an excellent grasp of the whole health system, but rarely get asked for their input. We should make more use of their opinions.
    - MR noted that whatever feedback we receive we cannot say it's fully representative of the B&H population, and the feedback we receive may not influence the final

	decision made, since the decision is being made by GPs. • MH queried how Healthwatch themselves will engage with patients about co-commissioning. BD noted that their role was to ensure the engagement process was thorough enough. The committee **approved** the budget set out in the paper for communications and engagement work on co-commissioning.	
19/16	**Approved Minutes from the Primary Care Transformation Board**	
	GM highlighted the following points: - GM noted that cluster action plans are moving slightly slower than we would like so the meeting concentrated on ensuring there is enough CCG support for clusters. - Similarly proactive care moved slowly to start, however there has been significant progress in getting GP and care coach resources in place for practice care work. It is expected that by the end of April the rest of the clusters will move into the proactice care scheme. - GM highlighted premises. Re. The Primary Care Transformation Fund, there is reluctance for Primary Care to contribute 33%. It is also unclear what the future of primary care premises will be. - Education and training – there are plans to support practices in becoming more self supporting. The committee highlighted the following points: - RW updated on NHSE guidance on Primary Care Estates. A letter was circulated to CCG Chief Operating Officers recently in advance of the guidance coming out. It is expected the guidance and application process will be shared imminently and applications should be submitted by the end of April. The advice is for CCGs to start developing their Project Initiation Document (PID) using last years format. The 33% is being reviewed nationally, and NHSE are waiting for premises cost directions which dictate the structure of development, and rules and rates behind that. - MH queried how our process fits with the Local Authority hub approach to rationalization of community buildings. JC noted that it has been agreed that PR-S will be the exec lead for the estates strategy, and PR-S and JC are meeting with the Head of Planning at the Council, as they are mindful of being linked up. - The committee discussed the funding barriers. - PR-S will update the committee at future meetings.	
20/16	**Any Other Business**	
	The were no calls for any other business.	
11/16	**Dates and Venues of Future Meetings (all 4-5pm in The Brighthelm Auditorium)**	
	24th May 16	

	26th July 16 27th Sept 16 22nd November 16 24th January 17 28th March 17	

Date	Agenda Item	Item Title	Action Required	Member to action	Action Status	Comments
26th Jan 16	06/16.	Local Estates Strategy and PC Transformation Fund	GB seminar re. PC Estates Strategy.	SJ/ES	To be put on the GB seminar forward plan	
22nd March 16	16/16.	LCS Business Case for Primary Care Investment	ES to circulate the evaluation paper which came to the first meeting to ensure all new committee members have had sight of this.	ES	On agenda	
22nd March 16	16/16.	LCS Business Case for Primary Care Investment	Population data/health needs information which has been provided to clusters and will be re-sent to new members of the committee.	ES	On agenda	
22nd March 16	16/16.	LCS Business Case for Primary Care Investment	JC to feed back the comments around LCS business case to NC. JC/NC to respond in writing to the committee prior to receiving the business cases.	JC/NC	On agenda	

Meeting administrators are to keep one "master" copy of the Action Log- adding new lines onto the bottom of the table as each meeting is held, and continuing to update actions as they are completed.

A reduced version of the master spreadsheet, showing only those actions still outstanding/ongoing/for inclusion on that meeting's agenda, should be included within each set of meeting papers. The Chair should go through the Action Log and ask for a verbal update against each outstanding item at the start of each meeting, once the minutes have been agreed.

NHS
Brighton and Hove
Clinical Commissioning Group

Name of Meeting:	**Primary Care Commissioning Committee**
Date of meeting:	**24/05/16**
Item Number:	**26i/16**

Title of report:

Locally Commissioned Services

Recommendation:

To note the response to queries raised by the Primary Care Committee regarding Locally Commissioned Services.

Summary:

At the March meeting, Committee members requested further information on a number of points regarding the development of Locally Commissioned Services. This paper provides a response to these queries.

Sponsor:

John Child, Chief Operating Officer

Author:

Natasha Cooper, Head of Primary Care and Community Services Commissioning

Date of report:

09/05/2016

Review by other committees: n/a

Health impact: n/a

Financial implications:

n/a

Legal or compliance implications:

(Please note the list below is for guidance of the issues which may be included delete those which are not pertinent to the topic) n/a

Link to key objective and/or assurance framework risk:

(Please note the list below is for guidance of the issues which may be included delete those which are not pertinent to the topic)

Locally Commissioned services help us to deliver our strategic objectives for primary care.

Patient and public engagement:

n/a

Equality impact assessment completed:

will there be an impact in any of the following areas:-Gender, Race, Disability, Sexual orientation, Age, Religion/belief

Human Rights

n/a

Locally Commissioned Services

1.0 Background

1.1 The CCG and Brighton and Hove City Council (BHCC) Public Health Directorate have agreed a new approach to commissioning Locally Commissioned Services (LCS) from GP practices across the city.

1.2 These services aim to provide enhanced primary care, beyond the core contracts primary care hold with NHS E, and based on local requirements and population needs. Clusters of GP Practices have been asked to design and plan initiatives with commissioners that will improve health outcomes and reduce inequalities for their registered population.

1.3 At the March 2016 meeting, Committee members requested further information on a number of points regarding the development of Locally Commissioned Services. This paper provides a response to these queries.

2.0 Queries

2.1 *How is the Business Case being evaluated?*

GP clusters have been asked to develop proposals for new LCS interventions, based on a range of evidence, activity and population data. Public Health colleagues are supporting clusters to define and prioritize these initiatives, and will lead on the development of these into business cases. The business cases are the key planning documents that are used within the CCG standard processes and identify the business rationale for any project.

The business cases will be evaluated in line with the agreed CCG PMO processes, to ensure the following areas are addressed:

- What are the objectives of the project/intervention
- What are the outcomes that will be delivered
- What are the outputs and key milestones
- What evidence supports the proposal
- What investment is needed and will there be any savings
- What is the current activity and performance of related services
- Will savings be notional or cash releasing
- What is currently spent for similar services or pathways
- What are the key risks to delivery
- What are the mitigating actions that can be put in place
- Are there any issues which need to be resolved before proceeding

The above process involves representatives across the CCG including finance, business analysts and performance and delivery. Once the group is satisfied there is a sound business case for investing in an intervention, with tangible outcomes and savings, the business case would be presented to the PCCC, with a recommendation to agree the proposal.

2.2 *What's the patient and 3rd Sector engagement in setting the LCSs.*

Engagement has been multi faceted in the development of LCSs. As LCSs usually form part of a wider pathway or commissioning initiative, engagement usually occurs as part of the initial design and wider reviews such as the SMI evaluation completed in 2014. The LCS Outcomes framework and new approach to contracting was the subject of an in-depth engagement exercise with 9 voluntary sector organisations to ask for feedback on how the new contract should be rolled out. This feedback has been incorporated within the evidence and guidance papers that were published October 2015. Clusters have been requested to engage with their PPGs in developing their cluster action plans, which is highlighted in the Patient Participation Guidance published in October. Evidence of this will be required for the plans to be signed off, particularly if a practice/cluster is proposing changes to the delivery model such as one practice providing on behalf of another. Planning for patient engagement is also

underway as part of the development of the business cases on the new proposed interventions being proposed by Clusters. This is being supported by the Head of Engagement and Public Health

2.3 What are the outcomes going to be?

The LCS outcomes framework that was published in October sets out the outcomes the CCG and PH what to achieve for the Brighton and Hove population, across a range of indicators. One of the key aims is to address inequalities of access and outcomes in the city. The business cases being developed for the areas of innovation will identify specific outcomes any additional interventions will achieve.

2.4 *What is the delivery model for proactive care, including accountability for monitoring and ensuring delivery?*

Proactive care is a model of care aimed at improving the identification and management of patients at risk of deterioration in independence and an avoidable hospital admission or care home placement. It is designed to improve the health outcomes for patients based on holistic and personalised care planning, case management, and with a focus on self-management, early intervention and health and wellbeing. In keeping with the available research the proactive service model will be based around primary care with a multidisciplinary team to wrap care around a patient and carer.

To date accountability for monitoring and ensuring delivery has been through the Proactive care steering group. From May a new Performance and Outcomes leadership group is being established with representatives from Clusters, commissioning and clinical leads. The first meeting of this group is 19th May, with the intention to ensure robust plans are in place to deliver the activity and outcomes as detailed in the service specification, and work with partners to design wider system enablers such as shared care plans.

2.5 *Have community assets and patient assets been taken into account as well as patient needs.*

An asset based approach is an important part of developing new ways of working to address inequalities. The Patient Participation guidance published as part of the LCS outcomes framework provides links the community and voluntary sector and encourages cluster to make contact with communities that are already working in an assets based approach such as Hangleton and Knoll multicultural women's group and Portslade Community Art and Craft Group. Individual guidance builds on this such as encouraging referrals to health trainers who empower individuals to make changes and take control of their lives and Young People's sexual health LCS guidance includes signposting young people to appropriate emotional support services (such as connexions personal advisors, youth services, etc) as appropriate. The guidance uses information from consultations to encourage changes in attitude and

understanding such as the mental health LCS recommends GPs listen more to patients and take account of their lived experience. Clusters are also being provided with Cluster needs and provider information sheets. Developed by Community Works, these provide Cluster GPs with information that will support them consider the assets available in their local area.

3.0 Recommendations

The Primary Care Committee is requested to:

To note the response to queries raised by the Primary Care Committee regarding Locally Commissioned Services

Sponsor- John Child, Chief Operating Officer

Name of Meeting:	**Primary Care Commissioning Committee**
Date of meeting:	**24/05/16 (PAST MEETING PAPER)**
Item Number:	**26ii/15**

Title of report:

New Locally Commissioned Services (LCS) indicative budget for outcomes framework

Recommendation:

The Primary Care Committee is recommended to approve principles, model and budget for the new LCS contract April 2016 – March 2019.

Summary:

This paper provides

- a summary of the new joint CCG and public health LCS budget April 2016 – March 2017
- details of the formula that will be applied to the new CCG investment in the new LCS contract. This new budget is indicative and will be used to guide Clusters to develop new and innovative ways to meet their population's needs. Clusters will develop 'costed action plans' to detail what new work they will be doing.

For next year April 2016 – March 2017 it is estimated that the budget for practices is as follows:

CCG Existing LCS services	£1,200,000
Public Health LCS services	£850,000
CCG Proactive Care LCS	£1,812,000
New indicative funding to address population needs at flat rate of £1 per registered list size within the cluster	£309,000
New indicative funding to address population needs based on formula which takes into consideration deprivation	£700,000
Overall Total	**£4,871,000**

The principles for setting the formula for the new LCS investment (£1,009,000) have been discussed at agreed by the CCG LCS Working Group, Primary Care Transformation Board, CCG Senior Management Team, Local Medical Committee and Public Health Directorate Management Team. The principles and model for the formula was also discussed with GP Practice representatives at the locality meeting 17th November 2015.

Public Health colleagues developed and tested a large number of models using elements of the Carr-Hill Formula methodology but removed from the formula the elements related to workload and applied the parameters below:

- *Practice population (the base for all models)*
- Age (% of the registered population aged 75+)
- Premature mortality all causes (standardised rates)
- Limiting long-term illness or disability (standardised rates)
- % of the population in 20% OR 40% most deprived areas in England

The Carr-Hill Formula methodology was originally designed to measure workload within General practice; it was developed for the 2004 GMS contract.

Models that were considered looked at applying the following:

- Ratios compared to city average for different combinations of factors (multiplicative models)
- The factors identified above but normalised (so have the same scale) and averages of ratios used
- A model using deprivation only

The CCG priority was for public health to develop a formula that would most address health inequalities. Following feedback from the Nuffield Trust and further work carried out by public health, the recommendation was for the model to be kept simple and to just factor in deprivation. The rationale for this approach is as follows:

- There is moderate correlation between deprivation, mortality and morbidity
- The Index of Multiple Deprivation includes health as a domain, incorporating health need
- A simple model avoids duplicating the effect of overlap in factors

This new investment, along with current investment would be used by Clusters to plan delivery and submit action plans against the LCS outcomes framework. The indicative budget is intended to support and not restrain Clusters in their ambition to deliver the services and outcomes required in the framework, which may mean Clusters put forward plans that are above or below the indicative amount where the evidence and a business case for this is indicated.

Once submitted Cluster action plans will be developed into business cases which will demonstrate the expected benefits from the additional investment. These business cases will then be reviewed and signed off as appropriate in line with the CCG governance arrangements.

Considerations and risks

There are a number of considerations and risks with implementing the proposed approach that should be considered. These include:

- The risk that clusters or practices receiving proportionally less new investment than others disengage with the LCS contract, jeopardising the approach to improving health outcomes and inequalities and reducing enhanced primary care variation in the city
- The model devised is not a ‘perfect science.’ There may be people deemed to be extremely socially disadvantaged that do not live in the most deprived 20% areas but the way that deprivation is measured and mapped is the most accurate method we have to use.
- Clusters apportioned proportionally larger amounts of the new budget may not have the capacity to implement the large scale changes needed to deliver services, without significant support.
- As this type of approach hasn’t been previously taken in such a way in the city, the outcome is unclear and the planned improved health outcomes will take some time to take effect.

Sponsor:
Natasha Cooper, Head of Commissioning – Primary Care and Community Services

Author:	**Date of report:**
Nicola Rosenberg, Public Health Principal	24/11/2015

Review by other committees: n/a

Health impact: n/a

Financial implications: n/a

Legal or compliance implications: n/a

Link to key objective and/or assurance framework risk: n/a

Patient and public engagement: n/a

Equality impact assessment completed: n/a

Introduction

This paper provides a summary of the new joint CCG and public health LCS budget April 2016 – March 2017 and details of the formula that will be applied to the new CCG investment in the new LCS contract. This new budget is indicative and will be used to guide Clusters to develop new and innovative ways to meet their population's needs. Clusters will develop 'costed action plans' to detail what new work they will be doing.

For next year April 2016 – March 2017 it is estimated that the budget for practices is as follows:

CCG Existing LCS services	£1,200,000
Public Health LCS services	£850,000
CCG Proactive Care LCS	£1,812,000
Estimated new funding to address population needs at flat rate of £1 per registered list size within the cluster	£309,000
Estimated new funding to address population needs based on formula which takes into consideration registered list size, deprivation, age, premature mortality and health need	£700,000
Overall Total	**£4,871,000**

An indicative budget

As described above the indicative new funding formula is a guide to be used by clusters for developing costed action plans. Each cluster will be required to submit two costed action plans, one of which will focus on achieving outcomes and ensuring equity of LCS service delivery. It is anticipated clusters will be guided by the indicative budget to inform this costed action plan and they should consider this is new money to practices – i.e. it is in addition to the funding that they can currently claim against.

The process so far

The process and principles for setting the formula for the new LCS investment were discussed and agreed by the CCG LCS Working Group, Primary Care Transformation Board, CCG Senior Management Team, Local Medical Committee and Public Health Directorate Management Team. The principles and model for the formula was also discussed with GP Practice representatives at the locality meeting 17th November 2015.

Public Health colleagues developed and tested a large number of models using elements of the Carr-Hill Formula methodology but removed from the formula the elements related to workload and applied the parameters below:

- *Practice population (the base for all models)*
- Age (% of the registered population aged 75+)
- Premature mortality all causes (standardised rates)
- Limiting long-term illness or disability (standardised rates)
- % of the population in 20% OR 40% most deprived areas in England

The Carr-Hill Formula methodology was originally designed to measure workload within General practice; it was developed for the 2004 GMS contract.

Considered models were based upon:

- Ratios compared to city average for different combinations of factors (multiplicative models)
- The factors above normalised (so have the same scale) and averages of ratios used
- A model using deprivation only

The CCG priority was to develop a formula that would most address health inequalities.

Following feedback from the Nuffield Trust and further work carried out by public health, the recommendation was for the model to be kept simple and to just factor in deprivation. The rationale for this approach is the following:

- There is moderate correlation between deprivation, mortality and morbidity
- The Index of Multiple Deprivation includes health as a domain, incorporating health need
- A simple model avoids duplicating the effect of overlap in factors:

The formula works as follows:

- It begins with total practice population (July 2015)
- The deprivation factor weighting in the model is calculated as a ratio compared with the city level (city level = 1)
    - So for example across the city 22% of patients live in the most deprived 20% of areas in England, for a practice with 30% of patients their ratio would be 1.4 (30%/22%)
- The practice population is multiplied by the factor weighting to give a new population total
- These totals are then readjusted so that the total population for the city remains the same (for example in this model the population adjusted by the factors gives a new total of 306,694 patients – so all practice totals are multiplied by a factor of 1.01 to readjust the CCG total registered patients to 309,702)

- The funding is then attributed across practices (and summed for clusters) based upon these adjusted population totals.

Proposed funding model to support reduction in health inequalities

The below table provides the outline for budget levels for the model. The CCG Senior Management Team agreed with the recommendation by public health to focus on deprivation.

The model proposed is for the £700,000 proportion of the innovation funding pot. All the funding highlighted below is new money coming into General Practice.

Table 1: New indicative LCS budget April 2016 - 2019

	New Innovation funding (£310K - £1 per head)	New Inequalities funding (£700K – based upon formula)	Total new funding
Cluster 1	£ 58,517	£ 254,353	*£ 312,870*
Cluster 2	£ 46,898	£ 174,412	*£ 221,310*
Cluster 3	£ 47,816	£ 59,736	*£ 107,552*
Cluster 4	£ 48,416	£ 78,298	*£ 126,714*
Cluster 5	£ 47,065	£ 82,203	*£ 129,268*
Cluster 6	£ 60,990	£ 50,998	*£ 111,988*
Total	**£ 309,702**	**£ 700,000**	***£1,009,702***

This new investment, along with current investment would be used by Clusters to plan delivery and submit action plans against the LCS outcomes framework. The indicative budget is intended to support and not restrain Clusters in their ambition to deliver the services and outcomes required in the framework, which may mean Clusters put forward plans that are above or below the indicative amount where the evidence and a business case for this is indicated.

Once submitted, Cluster action plans will be developed into business cases which will demonstrate the expected benefits from the additional investment. These business cases will then be reviewed and signed off as appropriate in line with the CCG governance arrangements.

Reducing Health Inequalities

The Health and Social Care Act (2012) places a duty on CCGs to have regard to the need to reduce inequalities between patients regarding access to health services and the outcomes achieved.

Focusing on the most deprived populations is responding to the evidence outlined in the Marmot review. The report highlighted that health inequalities were derived from social inequalities and called for ‘proportionate universalism’ to tackle inequalities in health across the

social gradient with increased focus on the most disadvantaged. Applying part of the new budget (approximately £300,000) equally to all practices according to registered population ensures action is taken across the social gradient. Weighting the other part of the formula in line with 20% most deprived provides the increased focus on the most disadvantaged.

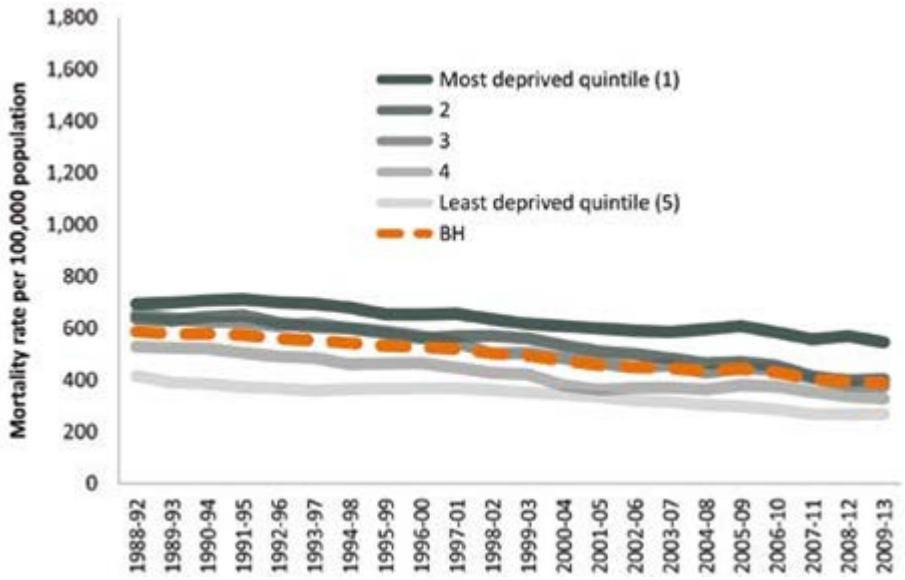
The approach proposed by this paper is also supported by the *NHS England Five Year Forward View* which states

"General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain.....So over the next five years we will invest more in primary care. Steps we will take include:

- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities."*

Health inequalities in Brighton and Hove

The below graph highlights the lack of progress the city is making to reduce premature (under 75) mortality within the city for those living in the most deprived quintile.



The most recent Brighton and Hove public health annual report 2014-15[1] reported the difference in life expectancy between the most and least deprived individuals in the city; it is 9.4 years for males and 6.1 years for females (2011-2013). This compares with a gap of 9.1 years for males and 6.9 years for females across England and is based upon the Slope Index of Inequality. In terms of progress against national equivalents there has been no significant change in the last 10 years.

Each year in Brighton & Hove 500 extra people die, simply as a result of deprivation, with an extra 87 dying prematurely. This means that if all areas had the mortality rates of the least deprived 20% in the city, among those aged less than 75 years (2009-13 data), there would be on average 87 fewer deaths per year.

Queen's Park, Westbourne and Withdean are the wards most affected by this premature

[1] http://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health-2014-15

mortality. There is a clear relationship between deprivation and disability and this relationship appears to be strengthening.

In females, cancer is now the cause contributing most to the gap in life expectancy between the top and bottom deprivation quintiles, increasing from 21% to 25% between 2003-07 and 2010-2012. The contribution of circulatory diseases has more than halved, from 27% in 2003-07 to 12% in 2010-12. As is the case for males, the contribution of respiratory diseases (14% to 19%), digestive diseases (10% to 15%) and external causes (12% to 16%) have all increased slightly. For males, the greatest contributing cause in 2010-2012 remains circulatory conditions (28% compared with 24% in 2003-2007) but the contribution of cancer to the gap in life expectancy has halved from 20% to 10%. Respiratory conditions (8% to 13.5%) and digestive diseases (10.5% to 14.5%) which include alcohol-related conditions such as chronic liver disease and cirrhosis and external causes of death (includes injury, poisoning and suicide) (from 14.5% to 17%) have all increased slightly

In Brighton & Hove, there is a clear relationship between disability and deprivation. People with a limiting long-term illness and disability are significantly more likely to live in more deprived areas and this trend may be increasing. In 2001, 25% of people living with limiting long-term illnesses or disabilities lived in the 20% most deprived areas of the city; by 2011 this had increased slightly to 26%.

Inequalities in mental health and wellbeing are stark, and it has long been established that mental ill health can result in deprivation (loss of employment, housing etc.) as well as result from deprivation (stress is associated with mental illness). In 2012 in Brighton and Hove those living in the most deprived areas had 49% risk of developing depression in comparison to those living in the least deprived who had a 21% risk.

Considerations and risks

There are a number of considerations and risks with implementing the above approach that should be consider. These include:

- The risk that clusters or practices receiving proportionally less new income than others disengage with the LCS contract, jeopardising the new outcomes based approach and aim to reduce enhanced primary care variation in the city
- The consideration that this is not a ‘perfect science.’ There may be people deemed to be extremely socially disadvantaged that do not live in the most deprived 20% areas but the way that deprivation is measured and mapped is the most accurate method we have to use.
- Clusters apportioned proportionally larger amounts of the new budget may not have the capacity to implement the large scale changes needed to deliver services on a higher budget, without significant support.
- As this type of approach hasn’t been previously taken in such a way in the city, the outcome is unclear and the planned improved health outcomes will take some time to take effect.

Recommendation:

The Primary Care Committee is recommended to discuss and approve the principles, model and process for setting the LCS indicative budget for the new LCS outcomes framework.

Services for Cluster One Priority Needs:

Quick Reference Guide April 2016

Priority Needs for Cluster One

Key themes for healthcare are…

- Lifestyles
- Mental health
- Social isolation
- Multi-morbidity

There are more people than expected who…

- die prematurely
- die from heart related issues or cancer and are under 75
- smoke
- are overweight
- drink alcohol excessively
- have mental health issues

There are fewer people than expected who have …

- bowel cancer screening
- heart issues identified
- dementia diagnosed

For more information see Community Insight
http://bit.ly/1wAnF7A

Useful Generic Websites

My Life Brighton and Hove
http://www.mylifebh.org.uk/
This website provides reliable information to residents and professionals in Brighton & Hove, and aims to support those wishing to improve their health and wellbeing. By giving access to both local and national information it aims to help people with a health condition or a social care need, their families and carers, to find the information they require to help with everyday living.

Directory of Health and Wellbeing Services 2015
http://bit.ly/1pKiQMY
Commissioned by Brighton & Hove City Council Public Health Department

It's Local Actually
http://bit.ly/1zeXZm1
Looking for something to do or get involved with in your area? Find an activity perfect for you.

Community Works can help

We want to make sure that voluntary and community action has the greatest positive impact on everyone and that it is integrated with health and social care services. If you want to find out more about voluntary and community sector activities and services beyond those listed here or discuss a need in your community which you think a voluntary or community organisation could respond to, please contact info@bhcommunityworks.org.uk or visit http://bhcommunityworks.org.uk/member-directory to find out more about our 400+ member organisations.

Useful Services and Support for Cluster One Priority Needs

Mental health

Mind in Brighton and Hove
http://www.mindcharity.co.uk/
Works to promote good mental health and empower people to lead a full life as part of their community. Services include advocacy and advice and information for people with mental health issues, their carers and families. Mind also provides peer support and offers a range of volunteer opportunities. Additionally, Mind provides bespoke mental health training.

Brighton & Hove Wellbeing Service
http://bit.ly/1wEZKoA
Offers a range of mental health support for common mental health problems, such as low mood, stress, anxiety and depression. The service is staffed by a team of qualified mental health specialists who deliver evidence based care with an aim to support people to achieve their goals.

We are a primary care service and have clinics in a wide variety of locations across the city, including many GP practices so that our service users are able to access the support in a convenient place. We offer therapy over the phone and a range of courses for service users.

Reducing isolation

Age UK Brighton and Hove http://bit.ly/1o9giGz
Offers a wide range of services, including counselling, a crisis service, help at home, volunteer help before and after hospital visits, information and advice.

Impact Initiatives http://bit.ly/1nqwcwe
From social activities, advocacy or counselling, employment support they provide support to people of all ages to live healthy and fulfilling lives. For projects for older residents **The Hop 50+** offers a range of activities, classes and trips, and has a community café.

Impetus http://www.bh-impetus.org/
Connects people to reduce isolation and improve wellbeing. Services support adults with learning disabilities, mental health issues, physical disabilities, autistic spectrum conditions and older people. The **Neighbourhood Care Scheme** provides befriending support: social visiting, accompanying out, form filling and some practical tasks.

The **Lifelines project - Volunteering Matters**
http://lifelinesbrightonhove.org.uk/
Lifelines volunteers brings together people aged 50+ with the aim of reducing isolation and loneliness by encouraging people to become more physically active and socialise more. Volunteer-led projects include; ballroom dancing, chess/bridge and Tai Chi and mindfulness.

Somerset Day Centre
http://somersetdaycentre.org.uk/
We provide day services for older people to promote independence and enhanced quality of life. We offer social and creative activities, trips and advice as well as minibus transport within East Brighton. We also provide a fully inclusive social club 'Older and Out' for older LGBTQUI people.

Reduce alcohol consumption

Pavilions
www.pavilions.org.uk/contact-us
Pavilions provide adult Drug and Alcohol Services. Support is available to anyone concerned about their drug or alcohol use, or for the families and carers supporting those struggling with substance misuse. Pavilions works to make life better for those affected by alcohol and drugs. It places service users at its heart and recovery as its goal.
Individuals can be referred or self-refer during drop in times: 10 – 4 Mon to Fri, 10 – 7 Thurs, 10 – 1pm Sat.

Lifestyles

Health trainers
http://bit.ly/1SJnggf
Health trainers offer one-to-one advice, support and encouragement. To qualify for free support, you need to be over 18, living in Brighton & Hove and interested in committing to eating more healthily, becoming more physically active, drinking less alcohol or quitting smoking.

Community Navigators – Impetus
http://bit.ly/1UOOjsD
Community Navigators assess patients' non-medical support needs and help them access community activities, groups and social support that can broadly improve their health and wellbeing, and build their support networks.

Be more physically active

Council's Sport and Physical Activity Team
http://bit.ly/1Ro4VTu
Whether you are completely new to sport or physical activity or would like to do a little more each day, the Council's Sport and Physical Activity Team can help. High quality programmes are designed to meet the needs of the City's diverse communities. All activities are provided locally, at low cost or free.

http://bit.ly/1WLZtxs
This Activity Finder A-Z allows you to search for specific sports and provides you with the contacts for the clubs and groups across Brighton and Hove.

Give up smoking

Get smokefree!
http://bit.ly/1RAw9L1
Information from Brighton and Hove City Council including the Stop Smoking Service which is provided by most of the pharmacies and GP practices in Brighton and Hove. This Stop Smoking Service is extremely flexible and tailored to meet the needs of individual smokers.

Smoke Free Me
A six-week programme using scientifically-proven psychological techniques to help you quit for good and claim back your passion for life. You can sign up free online on your phone, tablet or PC.

Domiciliary Smoking Cessation Service for Housebound Smokers
A new service to support housebound smokers wanting to quit, providing one to one behaviour support along with stop smoking medicine.

Cancer Screening and Support

Cancer awareness and early diagnosis
http://speakupagainstcancer.org/
A new service to increase awareness and early diagnosis of cancer from April 2016. The service aims to increase awareness, knowledge and confidence about the signs and symptoms of cancer and number of people attending NHS Cancer Screening Programmes. The service will run campaigns and work with other organisations to increase early diagnosis rates.

Macmillan Horizon Centre
http://bit.ly/1ReZDK4 The Centre will be opening in Spring 2016 and will offer all round support from a team of specialists in a calm, friendly and welcoming environment. It has been designed with input from people affected by cancer to make it the best place to offer the support and services that people in Sussex need.

The **Impetus Cancer Advocacy** service http://bit.ly/1Rw5OZx supports adults in their client groups who are affected by cancer to make informed choices about treatment and care.

Brighton and Hove Cancer Communications Network
BHCC Public health with the CCG runs an active cancer communications network. This group is made up of different service providers in the city aimed at reducing people's risk of cancer increasing awareness and early diagnosis and supporting people to live with and beyond cancer. Contact victoria.lawrence2@nhs.net

Food, Health and Wellbeing

Brighton and Hove Food Partnership
www.bhfood.org.uk
Brighton and Hove Food Partnership provide free 10 week exercise and nutrition programmes and individual sessions with a Dietitian for people above an ideal weight, Eat Well workshops for community groups and cookery courses for beginners and those looking to teach others. They also offer a volunteer referral service for people wanting to get involved in community gardens and run a project called Sharing the Harvest, which helps support people with learning disabilities, or those with experience of homelessness, mental health issues, abuse and addiction to improve their health and wellbeing by growing food. The Food Partnership also gives advice on community composting, reducing food waste at home and on food poverty and support for food banks.

Dementia Support

Alzheimer's Society
https://www.alzheimers.org.uk/
If you or someone you know are worried about or affected by dementia, the Alzheimer's Society is here for you. They have information to help you understand dementia and what to expect, and practical advice and support to help you to live as well as possible with the condition.

You can speak to friendly experts on their Helpline, talk to others affected by dementia on their online forum, and get face-to-face support at one of their community-based services.

Comments and updates?

Contact kaye@bhcommunityworks.org.uk Thanks.

Name of Meeting:	**Governing Body Meeting**
Date of meeting:	**24/05/16**
Item Number:	**27/16**

Title of report:

Brighton Homeless APMS Contract – Update on Re-procurement

Recommendation:

The Committee is requested to NOTE progress with the re-procurement

Summary:

The CCG has identified the needs of homeless people as a commissioning priority and has made this a key element of the Brighton and Hove Better Care Plan. To improve care for this vulnerable group, the CCG (in partnership with Brighton and Hove City Council, health and social care providers, the third sector and service users) has developed a model for integrated care based on a hub and spoke model. The business case was agreed and signed off in December 2015. We are now in the implementation phase of the work. The Council's strategy for Rough Sleeping (due for publication in July) is now adding additional insight and momentum to the work.

The current Homeless Practice contract expires on 31.1.17. Instead of a "like for like" re-procurement, the CCG is planning to use the opportunity to commission an extended primary care service with an explicit role in leading and orchestrating the other elements of the service and the spokes. This will take us a significant step towards the vision for an integrated service.

The Homeless Practice contract is held by NHS England, so the re-procurement process will be NHS England's; however, the CCG is working closely with NHS England to ensure the work is focused on making the ambition set out in the Better Care Plan a reality.

The report sets out the indicative timescales and an outline risk assessment.

Sponsor:

John Child, Chief Operating Officer

Author:	Date of report:
Murray King, Interim APMS Re-procurement Lead	13.5.16

Review by other committees: n/a

Health impact: n/a

Financial implications:

There are no new financial implications to this report. The Homeless Business case that was agreed by the Clinical Strategy Group in 2015 committed additional resources to services for homeless people. The re-procurement process described in this report has an indicative value of £680,000, with approximately £240,000 of this coming from NHS England. (This is the basic contract value and excludes payments for the Quality and Outcomes Framework, Directed Enhanced Services etc.)

Legal or compliance implications:

The process described in the report is compliant with national regulations that govern NHS procurement.

Link to key objective and/or assurance framework risk:

Improving the health and social functioning of homeless people

Patient and public engagement:

Significant user engagement took place during the design phase of the business case/ service specification. This included the establishment of a “Go To” Expert Reference Group and a workshop for homeless people, to ensure that the user perspective played a key shaping role in the design.

User input will form a key part of the tender evaluation.

Equality impact assessment completed:

The service developments described in the report will improve the quality, integration and access of services for this vulnerable group. A formal Equality Impact Assessment will be undertaken as part of the re-procurement process.

Brighton Homeless APMS Contract – Update on Re-procurement

1. Purpose

The purpose of this paper is to:

- Summarise the background to this work;
- Update the Committee on the current situation; and
- Set out the process to be followed and the relevant timescales

(In this paper the term “homelessness” refers to the needs of a continuum of people who are vulnerably housed, ranging from street homelessness to those in emergency accommodation.)

2. Background

2.1 – Assessed Need

Homelessness is a significant and growing problem in Brighton and Hove. The city has a younger than average population, with higher than average mental health and substance misuse issues, both of which are risk factors for homelessness. It is estimated that over 80 people sleep rough each night in the city.

There are approximately 400 single homeless people in emergency accommodation and the city has 272 hostel places for single homeless people, with a waiting list of 125 people. (Source: 2014 Joint Strategic Needs Assessment).

An audit of 302 homeless people in 2013 indicated that:

- 84% had at least one physical medical problem
- 85% had at least one mental health problem
- 40% were current or recovering drug users
- 39% had attended A&E at least once (many several times) and 25% been admitted as an emergency in the last 6 months

The CCG has recognised homelessness as a key local priority for health and social care through the Better Care strategy.

Furthermore, the Council is in the process of developing a strategy for Rough Sleeping in the city. The strategy is currently out to consultation and is due for publication in July 2016. It builds on the foundation of the primary care hub and sets the goal that nobody will have the need to sleep rough by 2020. It proposes, amongst other things:

- A Multi-Agency protocol for all the key agencies commissioning and providing services for homeless people
- A new permanent Assessment Centre with a number of temporary (sit-up) beds to enable service providers to assess the needs of people sleeping rough in a stable environment
- Individual Multi-Agency Plans for all homeless people
- New accommodation for older homeless people with complex needs (following a successful bid to the Homes & Communities Agency for £569,000.

More information is available at:

http://present.brighton-hove.gov.uk/Published/C00000884/M00005932/AI00050035/$20160222151342_008612_0036334_RoughSleepingStrategy2016DraftStrategypremeeting.docxA.ps.pdf

2.2 - New Service Model

In response to this assessed need, the CCG has developed an integrated service model for homelessness as part of the Better Care strategy. The model has both a baseline and an extended primary care service at its core, which are supported by key partner services (from health, social care and the third sector). The business case and re-procurement options appraisal for the new service were formally signed off by the Clinical Strategy Group and the Performance and Governance Committee in December 2015. (A presentation was also given to the Health and Well Being Board.) We are therefore now in the implementation phase of this work.

The total resource to be dedicated to the core and extended primary care element of the service – which constitute the Hub - is approximately £690,000. The other services – which constitute the Spokes – are funded over and above this figure.

2.3 – Dedicated Primary Care Service

Targeted Primary Medical Services have been provided to homeless people in Brighton and Hove for nearly 20 years; the current Personal Medical Services (PMS) contract has been in place since April 2014 (and since 2010 under a previous contractual arrangement). The signatories to the contract are NHS England and The Practice Group. The NHS England 2015/16 outturn value of the core element of the existing contract is approximately £240,000, excluding QOF, DESs etc.

In December 2015, The Practice Group gave notice to NHS England of its intention to relinquish its contract in Brighton, which includes the Homeless service and four other sites. By mutual agreement, the Homeless Service element has been extended to 31.1.17.

3. Current Situation

3.1 – The Practice Group Contract

As stated above, the current contract with The Practice Group expires on 31.1.17. This gives a challenging timescale for the service to be re-procured. The contractual model to be used is Alternative Provider Medical Services (APMS); there is no flexibility to use any other contractual mechanism for Essential primary medical services.

An approach has been made by NHS England to The Practice Group, to see whether a further (two month) extension to the contract can be agreed. This would have the advantages of bringing the contract into line with the financial year and giving two additional months for the procurement process. At the time of writing, these discussions have proved inconclusive.

NHS England and the CCG are therefore assuming that no extension will be possible and are working to the “worst case scenario” – i.e. that the new provider needs to be identified *and the new service mobilised* by 1.2.17.

4. Progressing the Work

4.1 – Re-procurement Process

As stated above, the existing contract is between NHS England and the Practice Group; the contractual re-procurement processes to be used are therefore NHS England's. However, NHS England has given a commitment to work closely with the CCG and to involve it closely in the re-procurement, to ensure that the process is rooted in local need and insight. This joint approach will also ensure that the integrated service model is commissioned through the most integrated possible commissioning process. (It is also worth bearing in mind that the CCG may have responsibility for commissioning and monitoring the service if it applies for and secures fully delegated level 3 Co-Commissioning status in the future.)

4.2 – Contract Value, Term and Outcomes

The core primary care element of the contract is approximately £240,000, excluding QOF, DESs and other additional service elements. This is NHS England funding. As per the agreed business case, the CCG is adding approximately £440,000 to this, to fund additional medical capacity for the system leadership, out-reach and in-reach elements of the service. This sum also covers extra nursing capacity and the engagement workers and primary care hub manager that are required to constitute the hub of the model; the spoke elements of the business case are over and above this.

It is envisaged that the service will be procured for an initial three year term with the option to extend for an additional two years, thus giving a total maximum term of five years. This will provide a period of relative stability for the new provider. However, it is hoped that the first three years' duration of the contract will provide the necessary time to prepare a more integrated commissioning model (e.g. an alliance or prime provider model), to enable deeper integration of the whole "eco-system" of services for homeless people in the city.

The outcomes to be secured from the contract, as set out in the business case, are:

- Improved identification of homeless patients in primary care and acute services
- Increased utilisation of planned health care
- Reduction in the inappropriate use of secondary care
- Delivery of effective preventative health services
- Provision of safe environments that promote physical and psychological well being
- Facilitation of service users to take increasing responsibility for their own health and well being
- Integration through strongly managed co-ordination of services
- Delivery of personalised services
- Support for people to find accommodation

Key Performance Indicators are being developed, to enable these outcomes to be performance managed.

In addition to these, during the re-procurement process we will:

- Agree areas of service that are not currently monitored and where some activity data would be useful; these will be included in the final service specification;

- Introduce a small number of “whole systems” activity/performance indicators, to focus all providers on achieving agreed outcomes that require all the component elements of health/social care to work together

It is hoped that the successful bidder will become an innovation partner and work with us to find the best indicators to challenge the whole system to ensure the best possible services and experience for homeless people in Brighton and Hove.

4.3 - Indicative Timetable

As with all re-procurements, an agreed process and timescales will be used to ensure delivery within the available time. A detailed project plan is currently being drawn up, to set out the key documents, tasks and milestones. These can be broadly summarised as below (although it should be noted that the deadlines are indicative at this stage):

Task	**Indicative Deadline**
Write and sign off suite of documents (service specification, financial schedule, Quality/Key Performance Indicators, requirements for Prescribing/Informatics/HR etc)	24.6.16
Issue Tender	28.6.16
Provider proposals returned	3.8.16
Evaluate responses	30.8.16
Provider Presentations	14.9.16
Sign off of Contract Award Recommendation Report by NHS England	18.10.16
Final contract award	28.10.16
Mobilisation period starts	31.1.16
New service starts	1.2.17

5. Governance

5.1 – Sign Off Process

The final sign off process for the contract and each stage of the re-procurement sits with the NHS England APMS Steering Group. The dates of the group’s meetings will be worked into the more detailed project plan that is currently being written.

The CCG’s contribution to the process will be co-ordinated through the Homeless Delivery and Implementation Team, with an overview provided by the Homeless Board.

The Primary Care Committee will receive regular updates on the process.

5.2 – Management Capacity

Some additional management capacity to assist with the work has been secured by NHS England and the CCG. However, the timescales remain challenging and, given the timing of summer holidays, there is very little “give” in the timetable.

An outline of the key risks and mitigations are attached at Appendix 1. A full risk log will be developed as part of the Project Plan.

6. Recommendation

The Primary Care Committee is requested to NOTE progress with the re-procurement of the existing service.

MK
17.5.16

Appendix 1 – Outline Risks and Mitigations

Risk	Impact	Mitigation
There is a risk that the re-procurement will not take place within the timescales required because of lack of management capacity	Specification is of low quality, leading to service problems in future	Identify additional managerial/admin capacity to ensure delivery on time
There is a risk that the current provider does not/cannot maintain good quality of service in the lead up to the new contract date	Deteriorating quality of service/lack of responsiveness Increase in avoidable use of NHS and social care resources (e.g. A&E)	Work closely with The Practice Group and NHS England to monitor the contract and agree any contract variations with the provider in a planned way
There is a risk that the cost of the newly commissioned service is significantly greater than the existing contract value	Additional resources are diverted to this service and away from other services on an unplanned basis	Work with potential providers and NHS England to secure best possible value for money from available resource. Agree any additional funding in return for best possible impact on other areas of NHS activity (e.g. A&E attendances)
There is a risk that no bidders are available	Service cannot be re-provided, with consequential impact on quality, access and other parts of the system (e.g. other local practices)	Revisit specification and pricing As last resort, agree and commission alternative provision with other local practices
There is a risk that the full range of services is not mobilised by the 1.2.17 start date	Delayed benefits for service users Lack of co-ordination of services within the model	Develop a staged implementation plan for the service, supported by a clear communications plan.

Risk	Impact	Mitigation
There is a risk that the existing premises are not available for the full term of the re-procured contract	The service cannot continue or significant additional costs are incurred	The CCG is seeking an urgent undertaking from Sussex Community Trust, who own the building in which the service is sited, to allow the service to be provided from Morley Street for the full five year maximum duration of the contract term

NHS
Brighton and Hove
Clinical Commissioning Group

Name of Meeting:	**Primary Care Committee Meeting**
Date of meeting:	**24/05/16**
Item Number:	**28/16**

Title of report: **Co-commissioning primary care services**

Recommendation:

To note the functions the CCG would be responsible for under delegated co-commissioning and discuss the proposed process for ensuring the CCG has the necessary capacity and capability in place to undertake these functions.

Summary:

In January 2016, the Primary Care Commissioning Committee received a briefing on the direction of travel around co-commissioning of primary care. The Committee provided views on the direction of travel and following further discussion at the March 2016 meeting, agreed proposals around practice and public communications that will support member practices make a decision in the future about whether the CCG should take on delegated commissioning of primary care services.

This paper provides further information about the functions that would be delegated to the CCG if it was to take on fully delegated responsibility from NHS England, and proposed the steps the CCG should take in preparation for this to ensure appropriate resources and processes are in place.

In preparation of this the CCG will need to fully understand the range of functions that could be delegated and agree its approach to fulfilling these functions, including the role of the Primary Care Commissioning Committee has in decision making and assurance.

Sponsor: John Child, Chief Operating Officer

Author:

Natasha Cooper, Head of Primary and Community Services Commissioning

Date of report:

17 May 2016

Review by other committees: none

Health impact: none

Financial implications: The CCG will need adequate resources to carry out delegated functions

Legal or compliance implications: The CCG will be required to undertake statutory duties that are delegated by NHS England

Link to key objective and/or assurance framework risk:

Sustainable General Practice

Patient and public engagement: The PARC will provide assurance of public and patient engagement in the design and delivery of delegated functions

Equality impact assessment completed: No changes to patient services are proposed

Co-Commissioning Primary Care

1.0 Background

1.1 In 2014 and again in 2015 NHS England wrote to all CCGs asking for expressions of interest from CCG's to take further responsibilities for commissioning primary care.

1.2 This is part of the Five Year Forward View, with the aim of supporting a more collaborative and local approach to designing and developing primary care services, and finding solutions to workforce, premises and IT challenges. This initiative is also seen as an opportunity to achieve greater alignment and integration of health and care services, and support commissioning of new models of care.

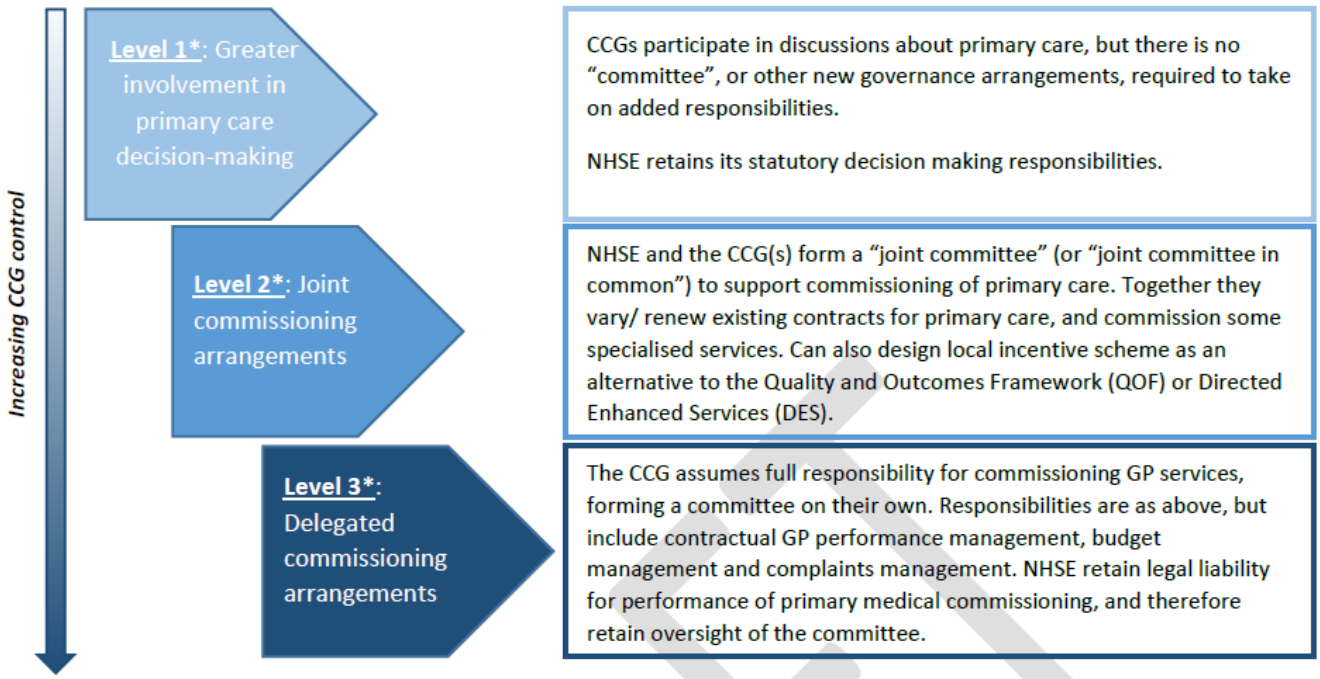
1.3 For both the 2014 and 2015 rounds of Expressions of Interest submissions, Brighton and Hove CCG member practices determined that they did not wish to take on delegated commissioning.

1.4 It is anticipated that another call for expressions of interest will be held in 2016/17, at which point the CCG member practices will need to decide if they want the CCG to take on delegated commissioning.

1.5 If Member practices agree to apply for delegated commissioning, the CCG will need to have plans for how it will fulfil the delegated functions.

2.0 Levels of Co-Commissioning

2.1 There are three levels of Co-commissioning as outlined below. Brighton and Hove CCG are currently at Level 1: Greater involvement in primary care decision making.



2.2 Learning from those that have taken on co-commissioning, and information from NHS England, the CCG would propose to apply for delegated commissioning arrangements if member practices were in agreement.

2.3 As previously discussed, the benefits of co-commissioning include:

- Locally sensitive rather than majority of issues and responses being regionally or nationally defined
- Potentially to increase influence to support GP member practices to improve quality of services
- Influence and shape Primary Care as key component of out of hospital system
- Control over how the primary care budget is spent
- Increased ability to work with practices to develop integrated services in the community and take a whole system or population decisions
- Increased influence in relation to procurements, local contracts and practice changes
- CCG can meaningfully engage with public and patients about primary care in its totality

3.0 Relevant Statutory Duties

3.1 If the CCG did take on delegated commissioning, NHS E would delegate to the CCG the following duties from the Health Act:

- Management of conflicts of interest
- Duty to promote the NHS Constitution
- Duty to exercise its functions effectively, efficiently and economically
- Duty to improve quality of services
- Duties to reduce inequalities
- Duty to promote involvement of each patient
- Duty as to patient choice
- Duty to promote integration
- Public involvement and consultation

4.0 Co-commissioning functions/tasks

4.1 Under delegated commissioning arrangements, the CCG would be responsible for the following:

- List closures
- Practice mergers
- Boundary changes
- Procuring new services through APMS contracts – either existing or new
- Reviews as directed/required eg PMS review
- Discretionary Payments decisions
- Contract performance
- Remedial and breach notices
- Contract terminations eg death bankruptcy CQC
- Contract changes
- Design of local incentive schemes

- Premises Costs Directions
- Needs assessment
- Management accounting and budget sustainability

4.2 Decisions related to the above are determined either by nationally agreed policy or if these don't exist, in accordance to policies set by the local co-commissioning committee.

5.0 Proposed next steps

5.1 Currently we have the Primary Care Commissioning Committee which supports the management of conflicts of interest and enables public voice in decisions related to primary care via its membership, meeting in public, and transparency re papers and decision making.

5.2 The CCG will need to successfully apply for delegated commissioning. As agreed at the March Primary Care Committee we will communicate with our public, patients and stakeholders on the changes and benefits co-commissioning will bring. This will be via multiple channels to:

- Build a positive narrative for our local community on the benefits of progressing to delegated commissioning
- Engage with on how the CCG will prepare for co-commissioning, associated governance arrangements and management of conflicts of interest

5.3 In preparation for taking on delegated commissioning the CCG will need to ensure it has the necessary capacity, capability and processes in place. In preparation for this it is proposed the CCG:

- Re-establish the Co-commissioning subgroup between NHS E and CCG representatives from Commissioning, Quality, Finance and Communications and Engagement.
- Map out in detail the functions and actions/tasks required to fulfil delegated co-commissioning, including where there are nationally agreed policy and what policies need to be locally developed
- Organise an opportunity for the Primary Care Committee to discuss delegation with another committee that is operating under delegated commissioning
- Develop proposals for how the CCG will resource and carry out the range of functions
- Review and agree our approach to contract monitoring, compliance and quality monitoring with member practices
- Develop our approach to public, patient and stakeholder engagement in undertaking the delegated co-commissioning functions/tasks.
- Confirm the decision making and reporting process, including what decisions need to be made by the Primary Care Commissioning Committee and whether some decisions will be delegated to sub-committees or groups

Conclusion

The Primary Care Commissioning Committee is recommended to:

Note the functions the CCG would be responsible for under delegated co-commissioning and discuss the proposed process for ensuring the CCG has the necessary capacity and capability in place to undertake these functions.

NHS
Brighton and Hove
Clinical Commissioning Group

Minutes of the Primary Care Transformation Board Meeting
11.00-13.00, 8th March 2016
Room 1, Lanchester House

Present		
(Chair)	George Mack (GM)	Chair / Lay Member
Attending		
	Mark Cannon (MC)	BICS
	Xavier Nalletamby (XN)	BHCCG Chair
	Michael Schofield (MS)	Chief Finance Officer
	Pippa Ross-Smith (PR)	Chief Finance Officer
	Gary Toyne (GT)	Lead Manager Central
	Clare Marks (CM)	Lead Manager East
	Jane Pavey (JP)	Lead Nurse East
	Jim Graham, Dr (JG)	Central Locality LMG Chair
	Manas Sikdar, Dr (MKS)	East Locality LMG Chair
	Kristina Chapman (KC)	Commissioning Manager
	Katie Stead, Dr (KS)	Primary Care Lead / Sessional GP & Public Health GP
	Natasha Cooper (NC)	Head of Commissioning Primary Care & Community Services
	Julia Powell (JP)	East Sussex LPC
	Soline Jerram (SJ)	Director of Clinical Quality and Patient Safety
	Alison Dean (AD)	Commissioning Manager
	Sarah Murphy (SM)	Senior Administrator (Minute taker)
Apologies		
	Ian Harper, Dr (IH)	LMC Medical Director
	Bob Deschene (BD)	Healthwatch Director
	Lynn Smyth (LS)	Commissioning Support Facilitator
	Jennifer Oates (JS)	Independent Clinical Governing Body Member
	Rachael Horningold (RH)	Public Health Principle

Item No	Item	Action
03/01	**Recording of meeting**	
	Approval was received for the recording of the meeting.	
03/02	**Welcome, introductions, apologies and conflicts of interest**	
	Introductions were made and apologies received for those listed above. The following conflicts of interest were recorded. - JG is a GP with specialist interest in ENT and vasectomy services. - JG is a director at SMC Limited which is a provider for the community ENT service - MKS is a GP at a surgery which is intending to apply for primary care transformation funds.	
03/03	**Previous minutes and matters arising**	
	The previous minutes were reviewed for accuracy. The following amendments were made: Attendees list – CM to be moved to apologies list and SJ to be moved to attendees. **Actions:**	

	SM to amend previous minutes as described above.	***SM***
03/04	**LCS Working Group**	
	KS advised that the working group has not met since the last meeting. RH has joined the team and is working 3 days per week, focusing on LCS. Practices and clusters are developing their cluster action plans and feeding into the areas of innovation. To date discussions that have taken place with the public health support have focused on the innovation areas, feeling is more work/attention is needed to ensure planning is taking place around the LCS "required" elements. This work has revealed that other interdependent or community services that were thought to covering patient groups, may not always be reaching all the patients intended eg House bound reviews. There may need to be some further work on how these services are commissioned from these other providers rather than focusing on primary care providing additional services GM queried if the practices can have different ways of delivering services? KS confirmed that there are a large number of "required" service that it is expected are available to all patients and then there are areas based on population needs and outcomes that clusters have been asked to consider designing and providing an enhanced service for. These innovative areas can be tailored to the needs of the cluster and delivered in different ways. CM commented that clusters are discussing the "required" elements but were not aware that they needed to feed back to the CCG and PH; this can be arranged. It has been noted at practice level that the required elements do not have an educational aspect included in the specification so a query has been raised about whether practices are required to decide what training is needed themselves? KS advised that a discussion can take place at the next LCS meeting in 2 weeks. NC advised that the cluster plans are due on 22 April. For the new innovative areas proposals will then need to be developed into business cases. MS commented that the innovation funds are non-recurrent so it is important to ensure business plans show the pay-back and not just an increase in primary care spending. The business case is being developed by RH working with the practices. It is important to ensure that there is sufficient evidence to support the drawdown of funds. It is important to show the financial savings and demonstrate better outcomes. Support will be needed to achieve it. NC commented that there will be some ideas that are declined as they are not the most appropriate use of money or priority for the cluster population needs.	
03/05	**Proactive Care Steering Group**	
	MC advised that good progress is being made and there are now 11 care coaches that have been recruited to, coming into post over the next month. There has also been some success in recruiting/filling the GP capacity either from locum GP's or GP's who have left practice or new into the city. There was a discussion around the possibility of setting up a GP chambers to support GP's across the city. There continues to be good progress with the better care pharmacists with £200k saved since August 2015. There is an advert in place for another 3 posts and this is a good opportunity to change the bottom line cost. The Patient Centred Outcome Measure (PCOM) and goal planning are	

	being trialled. MC gave a case study showing learning around terminology use. Cluster 1 had a 6 day learning programme. The original question was around what services are available, this has now changed to why are there so many doors to walk through to get to services. The learning will be consolidated and presented at the next board meeting. This is a big change programme but improvements are being made. The following comments and questions were raised. • There are some good ideas coming through and it will be interesting to see what we can or can't do to make Brighton an interesting place to work. Is there any consideration for one off costs for relocation as these needs to be a priority. • Is it just GP's that Brighton needs? Do we also need nurses or admin as well? • Are the savings robust? The concern is around the £1.5m that is being taken from acute services. The business case has been signed off but there needs to be some consideration around reviewing the savings and payback. **Actions:** MC to present consolidated learning from the Cluster 6 day learning events NC to review the KPI's and agree with Proactive Care leads how these will be reviewed to track outcomes and savings.	***MC*** ***NC***
03/06	**Co-Commissioning Working Group**	
	NC advised that NHS England are short staffed at the moment so regular monthly meetings not taking place. Main areas of work is focused on the Practice Group decision to serve notice on its contract in B&H, which affects 5 surgeries A panel met on 1st March to consider the options for the patients registered at these surgeries. JC advised that there will be a further meeting in 6-8 weeks to make a final decision.	
03/07	**Premises and IT Infrastructure Fund**	
	KC advised that the primary care infrastructure is a £1bn national fund for premises and IT innovations. This will be focused on funding the outcomes expected from the 5 year forward view planning and 7 day working. Information is limited at the moment but the CCG will be responsible for submitting and prioritising the bids on behalf of practices. The CCG is working through options with interested practices, ranging from electronic notes to new premises. This is a great opportunity to develop services but there is still work to be done. NC added that NHS England has advised that the finance will be managed by the CCG. Clarification has still not been received around whether the 33% practice contribution will be removed or not. A discussion took place around time-scales and practices being ready to present their business plans. The following questions and comments were raised. • There is some concern that the best bids will come from well-developed practices and not the most needed practices. NC advised that some practices have been given additional support. • Is there information around the support given by other CCG's? Some NHS E local area teams are further ahead in the process than ours	

	and have developed their own guidance. B&H have sight of this guidance and are using it to inform communications with our practices • A discussion took place around NHS England's expectation that the CCG will steer this process and how practices will be able to contribute 33% of the cost. There is concern that solid bids won't be received because of this. **Actions:** KC to provide an update at the next meeting.	***KC***
03/08	**Collaboration of General Practice**	
	NC presented the document regarding the four options available that practices are considering in regards to models of collaboration. EIB have been working with practices and there has been good engagement across the city. The general feel across the practices is that option one is not suitable (as is, informal network arangements), however they will all be discussed at the next locality meeting in more detail on 15th March 2016. It is important to engage all the practices and get a response from everyone. The following comments and questions were raised. • The general feel is positive and most practices are aware of the need to change. • MKS noted that it was really helpful when EIB visited the practices and they made the process really clear. • NC added that there will be a chance to discuss and share views at the locality meeting. • SJ queried if there was a timescale of when a decision will be made? GT asked if there was a possibility of a split of options across the city? NC advised that there will be an implementation plan for the majority decision. • JC noted that there is the option for practices to be an affiliate and simply be kept in the loop for information purposes only. The options are flexible enough to accommodate practices who don't want to join a federation. • There will be discussions around how much support will be available from the CCG and what form this takes. • Will there be allowances for practices to join at a later date? There needs to be clear prescriptive guidance of when practices can join. An annual transfer window was suggested. There also needs to be consideration around how long a practice has been in the federation if it wishes to leave. **Actions:** NC to present the outcome at the next meeting.	***NC***
03/09	**Minor Surgeries DES**	
	AD presented the revised minor surgeries DES and discussed the changes in the document. This needs to be presented at CSG to get approval. AD also presented the revised dermatology DES and discussed the changes in the document. There was a discussion around who will be responsible for the service levels? AD advised that it will be BSUH. This also needs to be presented at CSG to get approval. **Actions:**	

	AD to present both DES documents at CSG for approval by the chair and feedback at the next meeting.	***AD***
03/10	**Finance – Update on LCS spend**	
	Nothing changed since the last report.	
03/11	**Updates**	
	KS advised that RH has started as maternity cover for Nicola Rosenberg. Tom Scanlon is leaving at the end of March to be a GP.	
03/12	**Any other business**	
	None.	
	Date of next meeting	
	Tuesday 5th April 2016, 11.00 – 13.00, Room 1, Lanchester House	

Freedom of Information Act: Those present at the meeting should be aware that their names and designation will be listed in the minutes of this meeting which may be released to members of the public on request.