Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Equalisation of GP Finances - Special Cases

C

Primary Care Commissioning Committee meeting

18 February 2016

Author(s)	Rachel Dillon, Locality Manager, West
Sponsor	Katrina Cleary, CCG Programme Director Primary Care

Is your report for Approval / Consideration / Noting

Noting

Are there any Resource Implications (including Financial, Staffing etc)?

Yes, via a Locally Commissioned Service

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?

2. To improve the quality and equality of healthcare in Sheffield

4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality Impact Assessment

Have you carried out an Equality Impact Assessment and is it attached? An equality impact assessment was carried out as part of the original Governing Body decision making process. The result of the EIA helped determine the need for a special cases process. I

PPE Activity

How does your paper support involving patients, carers and the public?
Currently it is the GPs within the practices identified as Special Cases that the CCG is predominantly working with

Recommendations

The Committee is asked to note this progress report.

NHS
Sheffield
Clinical Commissioning Group

Equalisation of GP Finances - Special Cases

Primary Care Commissioning Committee meeting

18 February 2016

Introduction

1. At the CCG governing body extraordinary meeting on the 16th July 2015 on equalisation of finances, the CCG agreed that in addition to a series of uplifts per patient to all practices, it would create a process for practices particularly facing significant financial loss to put in a 'special case' to the CCG for consideration to support and on what basis.

2. On the 18th November 2015 the Primary Care Commissioning Committee met to consider the applications from practices facing significant financial need. The main consideration was whether there was a level of patient need not fully recognised by the current Carr-Hill formula. Decisions were made, and the committee delegated authority to CET to manage the process to conclusion.

3. This paper provides an update on progress and next steps following a discussion at CET on the 19th January.

Background

4. The Primary Care Commissioning Committee agreed that four practices demonstrated a special case and were written to on the 20th November. These were Devonshire Green and Hanover Medical Centre, Upwell Street Surgery, Page Hall Medical Centre and Sheffield Medical Centre. Although Devonshire Green and Hanover Medical Centre is not a PMS practice, it faces a significant withdrawal of MPIG funding and therefore was included in the special cases process.

5. It was made clear in the letter to all practices that the financial value awarded would not necessarily be equivalent to what the practices were going to lose through the equalisation process.

6. In addition, a health needs overview was produced for people registered with Page Hall, Firth Park, Pitsmoor and Upwell Street surgeries identifying possible patient need not met by Carr-Hill to inform the decision making process. There were clear indications that there was a possible patient need and are now included in the process.

7. Also brought into this process is the Clover Group. Clover Group is being re-procured by NHS England. Although this is a different type of contract, the drivers and solutions are similar to this programme.

8. The committee needs to be mindful of the review of the interpreting services currently provided by the Sheffield Health and Social Care Trust because the highest using practices are also within this programme - Pitsmoor, Page Hall, Upwell St, Firth Park, Mulberry and Highgate, both part of the Clover Group.

9. Nationally, there is a review taking place of the Carr Hill formula of which the outcomes might affect our process.

Progress to date

10. Since the committee meeting in November, every practice has been visited to further understand the non-core services the practices provide to meet the needs of patients' needs not met by the Carr-Hill formula. There is commonality across all of them. The patients' specific needs are:

    a. High numbers of patients needing interpretation.
    b. High numbers of new arrivals needing interpretation and have multiple illnesses.
    c. High numbers of people including children with multiple complex physical and/or mental illness which are most commonly found in older people.
    d. Roma-Slovak specific needs.
    e. Significant oral health needs

11. The additional/different services which the practices provide to meet the needs of the above are:

    a. Longer and more frequent consultations which comprises of interpretation, opportunistic screening, public health education, larger families, complex illness, act as conduit between primary and secondary care.
    b. Increased and longer consultations for new registrations.
    c. Drop in/walk in sessions to ensure patients get access to primary healthcare.
    d. Undertake more multiple MDT meetings especially with schools, social services, police, secondary care, mental health services.
    e. More engagement and activity within the communities to help try and support the communities' health and care needs.
    f. Staff who are bi-lingual

12. It has also been recommended that we include Burngreave Surgery at this time to see whether they also have the same demands as its surrounding practices. To summarise we are now looking at eight practices.

CET discussion

13. CET at its meeting on the 19th January agreed to a proposal based on the above findings, to commission an LCS starting from the 1st April 2016 for two years, extending it, subject to review. The LCS will look to cover the services 'over and above' the existing contract which provide for the needs of patients not covered by Carr-Hill where there is significant demand. The committee should note that this is in addition to and complementary to the work we are doing on the redesign of the interpreting service. To be clear, this is a primary care service to meet the needs of this patient group and not an interpreting service.

14. In order to commission the LCS, we need a transparent and simple funding criteria and light touch specification and will develop this with the practices involved, LMC and colleagues within the CCG/Locality. It will reflect the common needs listed above and in addition reflect the patient needs specific to some practices, and not all, which were noted in the visits, e.g Roma Slovak community, Asylum seekers and city centre needs.

15. CET agreed that the work needs to be concluded quickly and will consider and approve an approach at CET on 1 March 2016.

16. CET recognised that some of the practices involved have already lost funding as part of the PMS equalisation arrangements and that a delay in formally offering the LCS until 1 April 2016 could have an adverse impact on the practice. As a result, CET agreed to explore an offer of a "one off" non recurrent payment in 2015/16 to practices who have already lost funding. It was agreed that we would be in a position to advise on this once we have a more detailed understanding on the LCS value and how this compares with the phasing of financial losses through transition.

17. Subject to the consultation, an LCS will be put in place for 1st April 2016.

Risks and Challenges

18. CET noted that there is not enough funding to compensate for the loss of funding practices are facing. Practices are aware of this but we will still need to manage the sensitivities and challenges around this. This is why it is important that our approach is consulted on and open and transparent.

19. It is imperative that the separate funding streams for the equalisation and interpreting services are used to maximise efficiency by both the CCG and practices.

Current Position

20. The above CET discussion and actions have been communicated to all practices involved and we are now starting to work with practices and LMC to consult and develop the funding approach to the LCS.

Summary

21. The Committee is asked to note this progress report.

Paper prepared by:

Rachel Dillon, Locality Manager West

Katrina Cleary, Programme Director Primary Care

February 2016