Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Alternative Provider Medical Services (APMS) Practices - Locally Commissioned Services

F

Primary Care Commissioning Committee meeting

21 July 2016

Author(s)	Rachel Dillon, West Locality Manager with input from finance.
Sponsor	Katrina Cleary, Programme Director Primary Care

Is your report for Approval / Consideration / Noting

Approval

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

Yes financial

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.

We may need to consider another one as and when we understand the health needs more comprehensively in the next six months

PPE Activity

How does your paper support involving patients, carers and the public?
Currently, we have met with GPs and managers within the Contract holders and met with key charities related to Asylum Seekers to discuss their needs and concerns about the Mulberry Practice and have agreed to meet again in the next two months to update them on developments.

We have also met with Darnall Wellbeing to discuss their concerns.

Recommendations
The Primary Care Commissioning Committee is asked to: a) Agree additional funds for the existing specialist service at Mulberry Practice via a locally commissioned service. For 2016/17 this would be £230k pro-rata for six months. b) Agree additional funds to extend the current communities LCS to support Clover Group with its non-english speaking patients.

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1. Introduction

1.1 At its meeting on 1 April 2016, the Primary Care Commissioning Committee (PCCC) received a paper describing the challenges and issues around the Clover Group and Broad Lane Medical Centre under the remit of special cases.

1.2 The Committee agreed to the recommendations for more time to understand the complexities of their population needs and to bring back to committee a final funding and contracting proposal for implementation no later than 1 October 2016.

1.3 This paper provides the funding and contracting proposal, and a detailed description of the work of The Mulberry Practice, provided by The Clover Group in Annex 1.

2. Background

2.1 The APMS contracts for the Clover Group and Broad Lane Medical Centre went out to tender in November 2015. The service specification for the new APMS services only included core services in line with the national equalisation of GP finances. There was a high degree of negative reaction politically and by pressure groups concerned about the services currently provided which would put vulnerable groups at risk if not in the contract.

2.2 Timescales of the tender process were very tight and the CCG agreed that work would begin to identify services currently provided to a significant cohort of patients over and above the core contract and/or not recognised by the Carr – Hill formula which it would be appropriate for the CCG to commission; ie we would adopt a similar process to the Special cases process used for PMS/GMS practices.

2.3 In February 2016 both contracts were awarded to a consortium comprising Sheffield Health and Care NHS Foundation Trust (SHSC) and Primary Care Sheffield Ltd who, from 1 April 2016, will operate the new Clover Group comprising of five general practices

- Highgate Surgery, approx. unweighted 3,800 patients
- Darnall Primary Care Centre approx. unweighted 7,500
- Mulberry Medical Practice approx. unweighted 1,684
- Jordanthorpe Health Centre approx. unweighted 3,500

- City Practice (separate contract previously Broad Lane Medical Centre although the service no longer operates from the Broad Lane premises) – unweighted 4,985 at 1 April 2016

2.4 The timescales and uncertainty regarding the new contract holders did not allow this group of practices to be included in the special cases process which started last August.

2.5 As a result, PCCC agreed to the following recommendations in April:

- To identify the weighted population of each of the sites and turnover. They are currently grouped as one.
- For the contract holder to start collecting data on the numbers of people needing interpreting to assess eligibility for the special case communities LCS
- Understand the services and develop the best commissioning route for the Mulberry Practice.
- A final funding and contracting proposal to be brought back to PCCC for approval for implementation no later than 1 October 2016.
- To delegate authority jointly to Katrina Cleary, the CCG's APMS budget holder, and Julia Newton, Executive Director of Finance, to take forward negotiations to agree an interim financial settlement for six months which acknowledges the potential special cases and maintains some service continuity/stability in the short term.

2.6 The CCG has worked with the contract holders to conclude the work.

3. Key findings of the Population needs of the Clover Group and City Practice

3.1 Work began to understand the patient demographics not met by the Carr-Hill formula when the new contract was awarded in February.

3.2 In summary, the work has determined the following findings:

a. **The Mulberry Practice** provides a national specialist primary care service for asylum seekers, failed asylum seekers and victims of human trafficking. It is one of only two national centres which provides primary care to victims of human trafficking working closely with the Home Office and G4S. Sheffield became the UK's first 'City of Sanctuary' for asylum seekers and refugees in 2007. The practice provides specialised mental health care, infectious disease clinics, specialised counselling, family support, screening, very high use of interpreting services, specialised administration with a significant understanding of the asylum seeking process. Mulberry Practice could actually be defined as a specialised service as the need is national and the numbers of patients are small. Further details of the Mulberry Practice are set out in section 4 below

b. Based on the data submitted so far by the contract holders, **Highgate and Darnall** have similar patient needs as the North Practices, with very high use of interpreting services. Figures to date show that 33% of registered Darnall patients and 20% of registered Highgate patients (with 5% of the

registered Jordanthorpe patients) are non-English speaking. This goes beyond the 10% of total list size threshold agreed by the Primary Care Commissioning Committee last year.

c. Following further analysis by the new contract holder of the patient need at the City Practice (previously Broad Lane Medical Centre), there are no specific special needs akin to those recognised by the special cases premise. Whilst there are a small number of patients with complex mental health issues, it does not substantially impact on the practice and would not meet the 10% of total list size threshold as agreed by the Primary Care Commissioning Committee last year.

d. **Jordanthorpe** appears to have no significant needs from patients not covered by the Carr-Hill formula.

e. PCCC were keen for the contract holders to calculate the weighted list size of each of the practices, to determine how the funding was distributed and to ensure that the 10% rule the PCCC had devised would be met. The contract holders have been unable to develop a weighted population of each practice due to the complicated nature of the national calculation used. The contract holders have alternatively used raw list size, which is described in paragraph 2.3. As at April 2016, the actual list size of the Clover Group excluding City Practice is 16,482, weighted 16,454, so very close overall.

f. Mulberry Practice patients plus patients needing an interpreter based at Highgate and Darnall would make up approx. c.17% of the total registered list which is above the 10% threshold.

4. The Mulberry Practice

4.1 The Mulberry Practice – **key patient groups** not covered by the current Carr-Hill formula.

- Asylum Seekers – approximately 34 new registrations per week, Sheffield is first option for people due to Sheffield's City of Sanctuary' status.
- Victims of Human Trafficking. Recent increased provision due to increased safe housing for male victims of human trafficking.
- Resettlement including increase in numbers for a group of people from Syria this year
- 72% of the patients do not speak English. 40 languages in total.
- Average length of appointment 22 minutes (this is considerably longer for new patient assessments)
- 61% turnover compared to Clover's 13.4%

4.2 The **services** provided include:

- Extensive health screening including Hep B+C and latent TB and follow up
- Quantiferon, which would have been sent to secondary care
- Post Traumatic stress disorder (PTSD) specialist

- Specialist Counselling
- Specialist Health visitor
- Specialist administrative support who deal with language barriers, support, signposting, expertise in the asylum process and can deal with a large concentration of very vulnerable people.

4.3 As a result of the substantial services available in the practice, the rate of A&E attendances and admissions are low. Mulberry's list size represents approximately 10% of Clover total list size yet only shows only 8% of the attendances and no admissions.

4.4. An audit done by Mulberry showed that only 12% of its registered patients have had episodes of care in secondary mental health services, this is perceived as a low number when considering the need.

5. Financial and Contracting Information

5.1 The **costs of the additional service at the Mulberry Practice, considering the additional demand for this vulnerable group are estimated to be £230k**. The detail of this is in Annex 1 pages 14-16. In summary, annually, the total cost of the service at Mulberry Practices is £456,364. The total income is £226,415 including QOF, enhanced services, national funds. This is based on current numbers of patients.

5.2 In additional to the £230k, the proposal is to fund an additional amount for the cohort of non-English speaking patients within the Darnall and Highgate sites in line with the existing communities LCS. This will be agreed within the overall contract offer.

5.3 The total amount via an LCS for 16/17 would need to be calculated on a pro-rata basis given the CCG has agreed an interim solution for the first six months. The duration of the Mulberry specific services will be agreed as part of the overall contract negotiation.

5.4 The CCG is developing a latent TB LCS service, which the Mulberry Practice would benefit from if they signed up to the LCS as they screen all patients for TB. The CCG would need to explore with the contract holders, the appropriate use of funds available to avoid double counting, ensuring the service was supported and ensure that specific data regarding the TB LCS would be captured appropriately to inform national PH initiatives around TB.

5.5 The CCG has been advised that there could be a further 2,500 asylum dispersals into the city. The impact on the Mulberry practice needs to be the subject of further work and consideration in terms of funding arrangements. All practices receive an additional weighting for new registrations to fund the additional work needed. The CCG will explore with NHS England and the Contract holders the financial implications/shared risk management in the event of a sharp increase in asylum dispersals.

6. Conclusions and Recommendations

6.1 There is strong evidence to demonstrate that the Clover Group do have a special case for additional funding for their patients who do not speak English in line with the existing Communities LCS. More importantly, they provide a highly specialist national service at the Mulberry practice which should be treated as such. Both areas are not covered by the revised Carr-Hill formula and meet the threshold of 10% of the weighted list size of the practices.

6.2.**The recommendations which PCCC is asked to approve are:**

a) To agree additional funds for the existing specialist service at Mulberry Practice via a locally commissioned service. For 2016/17 this would be £230k pro-rata for six months.

b) To agree additional funds to extend the current communities LCS to support Clover Group with its non-english speaking patients

Paper prepared by Rachel Dillon, West Locality Manager with input from finance

On behalf of Katrina Cleary, Programme Director Primary Care

12 July 2016

DRAFT

1 July 2016

Introduction

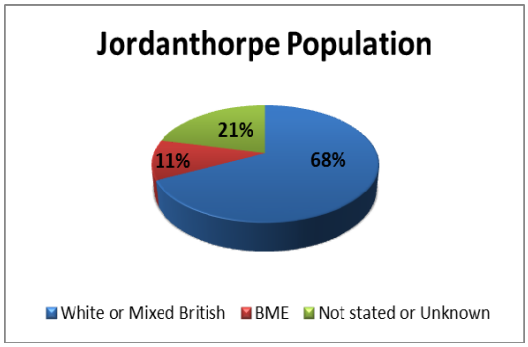
This document has been prepared upon request from Sheffield CCG to discuss the specific specialist work carried out at Mulberry Practice and communicate the differences in that specialist service when compared to any other Sheffield General Practice. The aim of the paper is to help Sheffield CCG understand the scope of the specialist service, the differences in provision of healthcare to the specific population and the effect of the service on the overall health system in Sheffield.

Background

The partnership between Sheffield Health and Social Care FT (SHSC) and Primary Care Sheffield (PCS) runs 2 APMS contracts for Clover and Clover City General Practices. Clover City is a contract that the partnership won in April 2016 having been previously co-located with the Walk-in Centre on Broad Lane and ran by One Medical. The Clover contract was also won by the partnership in April 2016, but had been previously held by SHSC for 5 years following the transfer of the practices from the then PCT under the Transforming Community Services programme. A legacy document was produced as part of the old APMS contract, to detail the areas not reflected in normal core contract and the value of the contract given; this is provided at the Annex for information. The Clover contract is made up of 4 Practices, namely Darnall, Highgate, Jordanthorpe and Mulberry. Three clover practices (Darnall, Highgate and Jordanthorpe) were failed independent contractors for a variety of reasons including financial difficulties and recruitment and retention difficulties and were managed under the PCT upon the dissolution of their respective partnerships. These previous heart-sink practices have been steadily transformed under the PCT and then SHSC to the current position where they now benchmark well with their peers. The Mulberry Practice was established as a specialist service in 2002 following changes to the asylum policy and pressure from local GP's to establish a separate service.

Each site in Clover has an individual and unique demographic and this is reflected in the locally tailored service that is provided by the partnership with an appropriate allocation of resource to that patient group's need.

- Jordanthorpe is a traditional GP practice with a mainly socially deprived Caucasian population. It has a high prevalence of frail elderly patients and a tight grouping of patients surrounding the practice. The unweighted list size is approximately 3,500 patients.



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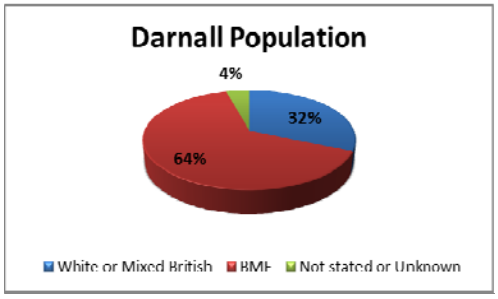
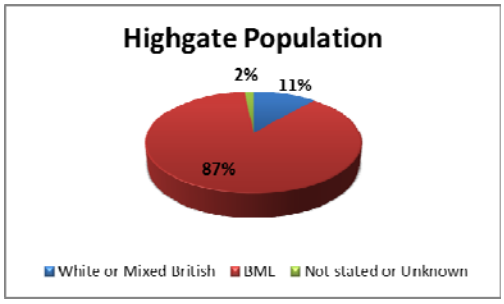
- Darnall has very high levels of deprivation and a high ethnic mix 68% with significant reliance on interpreters. It struggles with access due to the substantial demand. The un-weighted list size is approximately 7,500. The levels of patients from a non-English background who do not speak English are significantly higher than the average GP practice.



- Highgate has an even higher reliance on interpreters with nearly 90% of the population being non-English. The impact of the deprivation and language barrier means that this service is particularly unique compared to the average GP practice. The unweighted list size is approximately 3,800. We have applied for special cases funding in Darnall and Highgate under separate cover in view of the language difficulties.



- Mulberry is a city-centre practice with a city-wide list and is in the unique position of 100% of its population falling into one of three categories, namely:
-
    - Asylum seekers
    - Homeless persons
    - Trafficked persons

  The patient population is made up of multiple ethnicities (over 40 languages are represented currently) and although there is scope to provide a core-only service through the registered list, this service is unlike any other GP practice in the country and has a truly unique remit. There are approximately 1,600 patients (unweighted).

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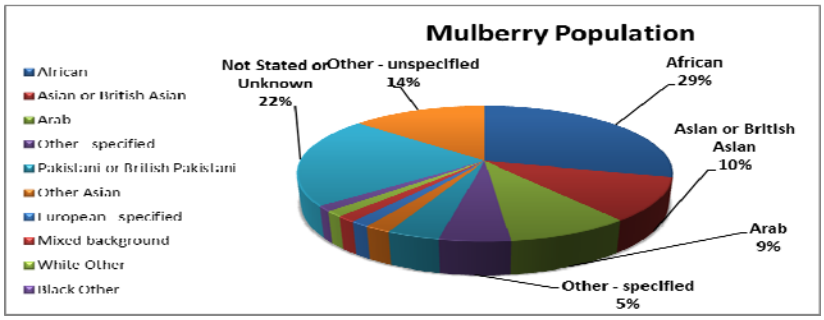

Why the specialist service is not funded under the current APMS contract

Following a request from the CCG to consider whether Mulberry could be funded from the current Clover APMS, we have taken time to deliberate this point. When the Clover APMS contract was transferred to SHSC, it was transferred with a set of KPIs and specialist functions which included being commissioned for the provision of a specialist service at Mulberry Street. When the APMS contract came out to tender in 2016 only the core GP contractual obligations were tendered without any of these specialist functions (confirmed by a clarification questions during the procurement process).

The partnership was concerned about the potential disinvestment to the service and more specifically the affected patient group, but NHSE assured the partnership that Sheffield CCG would commission the service and it was not part of the APMS contract being tendered. Indeed, an interim agreement with the partnership was agreed to provide the specialist functions for the following 6 months, whilst Sheffield CCG had time to commission the service under their new role as co-commissioners. The six month interim arrangement is due to expire on 1st October 2016.

Not only is the specialist service at Mulberry not commissioned or detailed in the APMS contract, it is also important to understand the context against which that wider APMS contract now sits. As only the core GP service was tendered, the value of that contract was reduced to account for the lack of specialist function including some of the other work the Clover Group practices undertakes due to high numbers of non-English speaking populations. The APMS contract for the Clover Group (as with City's new contract) is now based on the principle of equitable funding from the commencement date Whereas the PMS and GMS contract changes were phased in over a number of years, the change to these 2 APMS contracts happened within a single transition on the commencement date for both of 1st April 2016.

The difference financially is a reduction of approximately £1m pa (over 30% of the previous contract value) and the SHSC/PCS partnership has therefore had to take measures to reduce staffing levels and expenditure accordingly. The effect on provision and the impact to service access is being managed through a staged reduction in provision and the delivery of a transformation plan, with the partnership standing an interim significant financial deficit to prevent a potential collapse in patient services.

With the already significant pressures to run a service within a rapidly reduced budget and with concerns over access already, we considered the feasibility of transferring funds from the other sites to bolster the much-needed specialist service at Mulberry. As the value per patient is already weighted nationally to provide an appropriate level of funding for the patient need, we deemed it (after consideration) inappropriate for us to divert that funding

to a city-wide service and thus reduce access to primary care services for our other patients, many of whom are in the highest areas of deprivation for the city. Indeed when we analysed the Carr Hill formula and Mulberry's effect on the Clover contract, it reduced the whole group's weighted list size and already had a negative-impact on the other services (as shown below)

Carr Hill

We are unable to split Clover into its constituent weighted practice lists without NHSE support, but we do know the indices by which the weighting is calculated and can provide comment to them. The indices are: Sex / Age profile, rurality and market factors, turnover of patients, nursing home residents, deprivation and unavoidable costs and additional needs including mortality and morbidity information.

Due to the amalgamation of practice lists, Mulberry's increased issues surrounding mortality / morbidity are lost within the Carr Hill formula; the age /sex profile of Mulberry actually reduces the group's weighting and market forces bear little resemblance to the specific patient cohort that Mulberry sees.

The addition of the nursing home index is not appropriate for the specialist service and deprivation is based upon postcodes and therefore not reflective of our patient cohort's actual deprivation as patients are placed around the entire city.

Neither the patient demographic nor the specific work that has to be completed with the patient group is reflected within the Carr Hill formula. For example, when looking at the turnover of patients the weighting index accounts for normal registration processes and does not take account of the lack of UK health record, immunisation history or previous health interventions.

In view of these financial considerations, and more importantly their resultant effect on the patient cohort's health provision, we felt it inappropriate to move funds from our other sites. The result would be to insufficiently support a city-wide service whilst reducing access for our other vulnerable patient groups. Instead, we feel that we now need to ensure that Sheffield CCG understand the current scope of the service being provided at Mulberry so that they can make an informed decision when commissioning a permanent provision for the city for asylum seekers and victims of trafficking.

Description of the patient Group

Established in 2002, the Mulberry Practice provides specialist primary health care services for people living in Sheffield who are seeking asylum in the UK, victims of trafficking, homeless or living in temporary or unstable accommodation.

Sheffield was the first city in the UK to take some of the 90 refugees the British Government agrees to take each year through the Gateway (refugees who apply for relocation through the International Organisation for Migration from refugee camps to start a new life in participating countries). In 2007, with the support of the City Council, Sheffield became the UK's first 'City of Sanctuary' for asylum seekers and refugees – a city that takes pride in the welcome it offers to people in need of safety.

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The client group of the Practice have complex needs due to their status. All clients have mental health issues, in the main post traumatic stress disorder (PTSD) often arising from torture or rape. Added to this the continuing emotional uncertainty as to whether they will be granted leave to remain in the UK impacts on their psychological wellbeing. Many will also have physical health problems, including illnesses such as HIV, Hepatitis B or Tuberculosis (TB).

The Practice adopts a holistic approach to health and wellbeing, acknowledging that the client group presents with both health and social needs. The Practice has a specialist counsellor and a specialist health visitor as part of the core team and is a nurse-led service, staffed by highly qualified and specialised nurse practitioners. They also receive support from GPs experienced in managing mental health in primary care as member of the core health care team.

Mulberry offers a rapid initial screening service, general primary care and also delivers additional services for patients with infectious diseases and mental health problems that would usually be found in a hospital or other secondary care setting. Mulberry has been a beacon of good practice and other providers in major cities and in other parts of Europe have sought advice on how to emulate the service.

Additional services provided but not commissioned as core General Practice

The following services are currently provided to patients directly via the Mulberry Specialist Service but are not commissioned under the new APMS contract.

New to Country Asylum Seekers

- High volume new arrivals
  The service currently accepts approximately 34 new asylum seekers per week. The registration process takes 40 minutes per appointment and the whole day is spent screening and assessing new arrivals to the Country.

- Essential health screening
  HIV, HEPB+C, Treponema, chlamydia, gonorrhoea and latent TB is required upon arrival for every patient due to the risks associated with non-treatment.

- Quantiferon
  If not provided via Mulberry, patients would be referred to secondary care. Currently this is part of screening, which is followed up by an infectious disease consultant who provides a clinic into Mulberry. This helps to reduce DNAs, as the patients are familiar with where to attend.

- Managing results
  There are significant high numbers of abnormal screening and tests results to be managed –Each patient due to language barriers and basic understanding of health needs for many require a significant amount of time per consultation (average 35 min per patient to screen or give results) due to the nature of the result and required actions that need to be taken to monitor, follow-up or signpost.

- Establishing relationships
  A significant part of Mulberry's role is developing trusting relationships with an individual/family to understand their needs and to help them navigate the basics most of us take for granted for e.g. where they might get their medication or how to walk to the local hospital for someone new to the country these things are alien and daunting. This also supports the reduction of DNA rates in secondary care which results in multiple referrals.

- Signposting and support.
  The new arrival process includes giving and explaining HC2 forms, which show eligibility for free prescriptions, without which patients would not be able to get essential medication, potentially resulting in deterioration in condition and signposting to support groups (clothing bank, ASSIST, City of Sanctuary). All these activities require additional staff time. This is a large part of the role of the staff at Mulberry where the team are usually the first port of call for most issues which go way beyond the role of core general practice staff.

Specialist Mental Health Primary Care Provision

- PTSD specialist.
  As well as generalist support to asylum seekers, the team plays a significant role in delivering specialist mental health support particularly those suffering with PTSD and other serious mental illnesses which are skills that have been developed in-house with the clinical expertise required in managing asylum health. These numbers account for a significant number of the registered population compared to the national average for mental health and reduced referral to secondary care mental health services. These appointments take 40 minutes with a GP and have regular follow-up.

- Specialist Counselling.
  The service currently directly employs a specialist (20 hours per week) in addition to the service provided to all GP practices in the city via IAPT, who acknowledge the specialism required at the Mulberry service.
  This resource is required due to the demand for a counselling service for large numbers of the asylum seeking population and the unique nature of the needs of this population in dealing with torture and trafficking. This was developed as part of the original agreed service provision in developing a specialist service for asylum seekers and not seen as 'core counselling' provision.

Family support

- Specialist Health Visitor (HV)
  The service currently directly employs a specialist health visitor (30 hours) with additional support provided from the Health Inclusion Team at SHSC when there are peaks in activity and increased demand, and holiday and sickness cover. This was developed as part of the original agreed service provision in developing a specialist service for asylum seekers and not seen as core health visiting provision.

  There are significant issues around children and unaccompanied minors new to the UK which requires the team to provide significant amounts of support. There are also high levels of safeguarding complexities.

The HV role looks after the family and includes minors up to the age of 18.

- Multi-agency support
  The team works as part of a multi-agency network of statutory and third sector organisations in support asylum seekers in understanding of stress associated with asylum claim, social isolation issues, mental health and safeguarding.

Victims of human trafficking

Mulberry is one of two national centres for human trafficking. The team works with victims of human trafficking mainly women and children and have knowledge and expertise around the effects of rape as form of torture and supporting people that have experienced multiple sexual assaults and are currently in protected housing. Significant social support is required for this vulnerable group of people requiring extended clinical input from specialist staff within the team. City Hearts have recently increased their provision to include safe housing and support to male victims of human trafficking, resulting in an increase in this patient group.

Resettlement

Mulberry works in partnership with the Local Authority to provide the Gateway programme. The Gateway programme resettles vulnerable refugees from refugee camps into the UK. Mulberry Practice provides advice on estimated secondary care costs for each group; initial screening and any identified secondary care referrals necessary. Follow up for latent TB is provided in house reducing the need for secondary care referrals for this.

The resettlement programme has cohorts have increased this year for Mulberry and a group of Syrians have been agreed to be supported at Mulberry.

Specialist administrative support

- Receptionists undertake the majority of all of the phoning to make hospital appointments for asylum seekers and following this up and offering support and directions. Receptionists also signpost the majority of enquiries to outside support agencies, giving information, directions and working through the majority of which is undertaken through interpreters

- Significant numbers of medical reports that need to be undertaken for asylum seekers are carried out by medical staff and typed by administrative staff. The number of detailed reports that need to be completed in relation to asylum seekers is high and requires a significant amount of clinical and administrative time to complete as well as expertise in the field.

<u>Commissioned Work</u>

The partnership is already commissioned to provide a core General Practice function to the patient group and this includes:

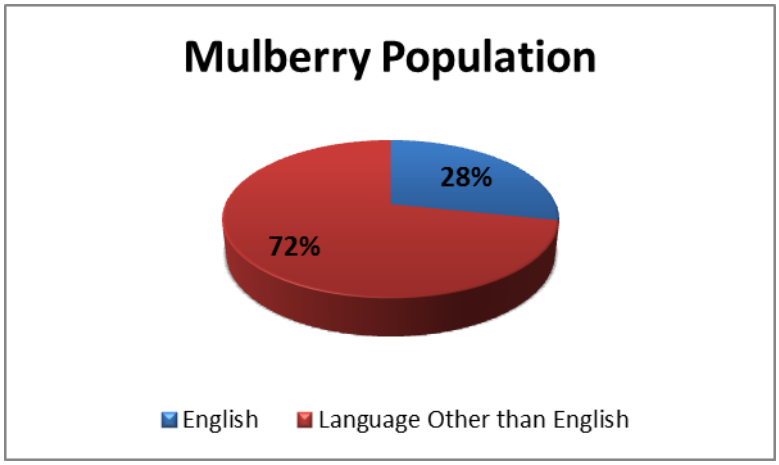
- The provision of essential services for people who are sick, or perceive themselves to be sick, with conditions from which recovery is expected, chronic disease management and general management of terminally ill patients.

- Additional services including cervical screening, contraceptive services, core vaccinations and immunisations, child health surveillance, maternity services and some minor surgery procedures.
- Quality Outcome Framework
- A range of Directed Enhanced Services and Locally Commissioned Services (including the recent addition of the over and above LCS.)
- We also receive a cost-neutral payment for resettlement gateways, a specific service which is detailed below.
- Resettlement grants:
  The practice does receive some specific money for resettlement of asylum seekers into the city. This service is commissioned in order to complete specific work around new arrivals to the country and track their use of the system (including after deduction).

<u>The effect of the patient cohort on the Commissioned Service</u>

We have detailed the effect of the Carr Hill formula on the Clover contract earlier in this document and alluded to the formula's inadequacy when applied to Mulberry's patient cohort. Having described the commissioned services above, it is noteworthy to detail the effect of this patient cohort's impact on these core services which are not effectively accounted for within the current contract.

- Language:
  Less than 0.5% of the list is registered as being born in the UK, those that are, are children born in the UK. It is highly unlikely that any patient at Mulberry has English as a first language and the majority do not speak English fluently, indeed the graph below shows that 72% of the patients do not speak English at all.



The practice uses SCAIS and an audit of that work identified the top languages (from over 40 in total) requested were as follows overleaf:

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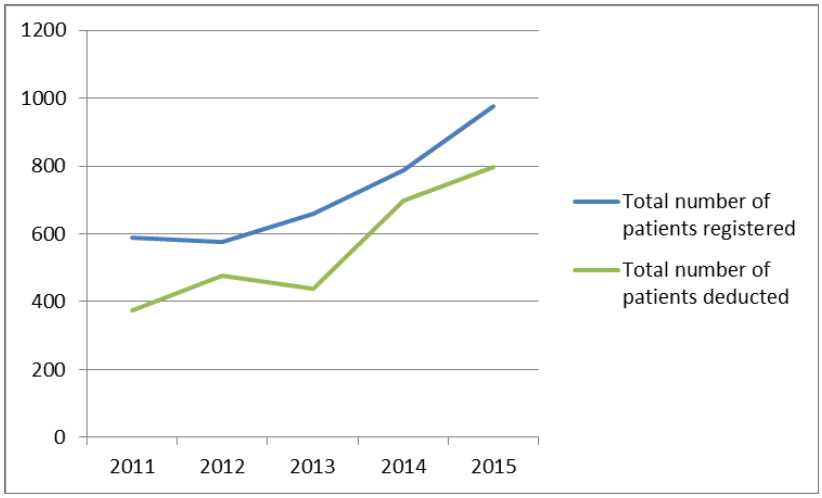
Mulberry	
SCAIS Face to Face 2817	
SCAIS telephone 1524	
4341	
Requests	
Arabic-978	23%
Farsi (Persian)-767	18%
Albanian-370	9%
Tigrinya-360	8%
Amharic-315	7%
French-239	6%
Tamil-186	4%
Punjabi-174	4%
Kurdish (Sorani)-171	4%
Urdu-135	3%
Mandarin-133	3%

- Appointment frequencies:
  The service offered 5,028 appointments over a six-month period between 22 Dec 15 and 22 June 16. If this is extrapolated then we can presume an average of 6 appointments per patient. This is not out of line with the average nationally, what is different is the length of those appointments. When this is taken into account, we show an average length of consultation per patient that is double the national average. Nor does it account for the numerous drop-in questions and requests for support which occur in reception but are not counted in the statistics.

- Length of appointments.
  As alluded to above, when compared to a traditional 10 minute appointment, an internal audit in 2015, showed that the average length of the first consultation (new arrival registration and screening) takes 40 minutes on average and appointments thereafter average 22 minutes. This is over double the national average for all appointments at Mulberry.
  With many practices moving to telephone work to try and manage the demand in General Practice, it is important to note that very few of Mulberry's patients are able to access care via telephone and those that can still require an interpreter and still do not drop to below 15 minutes on average.

- Turn-over
  You can see from the graph below that Mulberry's turnover is extremely high, with a turnover of 61% of the population compared to 13.4 across Clover in 2015. This is far from atypical for the service. Under a single list Carr Hill would apply to bring an

average uplift factor of 1.46 against the list but this is lost against the larger group where it is subsumed as a far smaller percentage turnover. Indeed the 6.5-9.5% range indicates the average Sheffield turnover which is significantly different to the Mulberry figure of 61%.



The turn-over itself is accounted for under the Carr-Hill formula but lost against the whole of Clover as above. What is not accounted for is the work involved under this turnover. The weighting, for example, accounts for patients being registered with an English health record and immunisation record along with a presumption that investigation and treatment for illness will have been started and that chronic conditions have historically been monitored. None of this is true for Mulberry's patients who come to us normally from outside the EU and with little in the way of historic healthcare. What they do have is not in English.

- DNA rate.
  Despite considerable efforts, the DNA rate at Mulberry remains 20-30% of pre-booked appointments. To counter this, we run drop-in clinics daily, but it still impacts heavily on the service.

Advocacy

We provide enhanced support to our patients including advocacy as we feel this is essential as part of their healthcare. We also work closely with voluntary sector organisations to help support the patients.

The detail of these advocacy supports was detailed earlier in the document but comprises;

- Establishing relationships
- Signposting and support
- Specialist administrative support
- Significant numbers of medical reports (that cannot be charged for)

The cost of this service is to prevent inappropriate access to either internal appointments or external services.

Secondary Care Services (not commissioned)

One of the main key differences that has to be highlighted is this patient cohort's in ability to access alternate health and social care provision in the city. For example, they do not have access to:

- Social Workers
- Significant elements of Secondary Care Mental Health
- Health visiting for 5-18 year olds. (The patient cohort's increased risk of safeguarding issues deems this normally un-commissioned service necessary for Mulberry's population.)

Nor do they use (from historical custom and practice agreed with previous commissioners) the city-wide services for:

- Health Visiting for under 5s
- District Nurse services

They also have a very much restricted access to secondary care as they are not entitled to free care and the impact of the invoices and forms results in further work to the practice when a vulnerable patient receives an invoice from the acute trust and attends mulberry for support in processing the next steps.

The practice itself currently provides the provision of

- Specialist Health Visiting (including the settling of a family into new practice areas after they have left Mulberry)
- Specialist Counselling
- Signposting for both health and social services
- Engagement and signposting to wider services along with a much closer link with 3rd sector agencies

Wider engagement

The Practice works closely with the Infectious Disease Clinic at the Royal Hallamshire Hospital. They also work closely with a drop-in service for asylum seekers which is held at the Victoria Hall, a building very close to the Mulberry Practice. The drop-in offers a range of services and stalls include the Refugee Council, Northern Refugee Centre, ASSIST (Asylum Seeker Support Initiative Short Term) Sheffield and other organisations which offer support around education, training, form filling and legal advice etc.

The Practice also works with SOLACE a Leeds'-based charity which provides psychotherapy, complementary therapies and advocacy support to the survivors of persecution and exile living in the Yorkshire and Humber region, many of whom have been traumatised by torture, rape, the death or disappearance of loved ones and often combinations of all of these and other atrocities.

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Savings in unplanned secondary care

Having looked at the service in detail, the knock-on effect from that service should also be examined. For a very vulnerable population with high deprivation and high health and social care needs, the Mulberry service prevents an awful lot of activity in other services. The table below details an internal audit of A&E attendances and Emergency Admissions both across the group and individually.

	Emergency Admissions	A&E attendances	% Total EA for Clover	% Total A&E attendances for Clover
Darnall	84	258	43.08%	46.40%
Highgate	47	146	24.10%	26.26%
Jordanthorpe	64	107	32.82%	19.24%
Mulberry	0	45	0.00%	8.09%
Grand Total	195	556	100.00%	100.00%

The data shows that secondary care costs are extremely low for Mulberry, despite a complex need and high vulnerability. This is not reflected by General Practice's comparator figures for patient groups such as Slovak Roma populations. We believe this is in mainly due to the level of input in primary care and the treatment provided at Mulberry and reliance on the whole primary health care team.

Mulberry's list size represents approximately 10% of Clover total list size, yet it shows only 8% of the A&E attendances and no emergency admissions; this is in contrast to our natural presumption which would be to see a significantly higher than average use of secondary care in an unplanned manner. We believe that the cost to the system of reducing the mulberry specialist service would be to vastly increase the Non-Elective spend and this should not be underestimated when viewing the cost of the service. Traditional primary care teams will not have the capacity to respond to the needs of asylum seekers in the same way.

Savings in Secondary Care Mental Health

The data shows that of the 1,750 patients registered on 6 November 2015, only 264 (15%) have had episodes of care in mental health services, 53 of whom had IAPT contact only, leaving only 12% of current patients who had had episodes of care in secondary mental health services, (inpatient or community). We requested information from mental health on the level of demand on MH services from Mulberry patients, as again, we believe the level of care and specialist interest care provided by the primary care service and staff at Mulberry may in part save on secondary mental health costs. A significant number of Mulberry patients present with mental health needs, as a result of trauma suffered in the countries of origin. This is one of the reasons why the service employs a specialist counsellor.

For a patient group suffering from abnormally high levels of depression, anxiety, PTSD and SMI, spend in secondary care Mental Health services is minimal. Indeed the effect of the in-house primary care support provided by the clinical members of the Mulberry

Healthcare team is believed to be a direct correlation to this, and is worthy of note when demonstrating not just an improved quality of service but also a reduced cost and improved efficiency to the system.

Under normal circumstances many of the patients retained for PTSD care under Mulberry would be referred into secondary care, but they would do not meet the referral criteria whilst seeking asylum as they would not be considered stable and therefore not eligible for treatment. As such their ongoing episodes are managed in-house at Mulberry.

Savings in Elective Secondary Care services

TB is a World Health Organisation priority. Identifying and treating TB is massively cost effective for health services. Mulberry patients are a high risk group. If they do not have good access to services to effectively treat this or other infectious diseases, there are significant risks not only to migrants themselves but also to the indigenous population and also extra cost will be incurred by the NHS.

The life time costs to the NHS of a patient with HIV are currently around £360,000, whereas providing an accessible service, identifying patients and educating them of the risks of HIV transmission costs a tiny proportion of this. Mulberry Practice provides a rapid screening service, a safe place which patients use and trust and has strong effective links with GUM services. (as detailed in Healthcare for asylum seekers and refugees in Sheffield report 22.4.16.)

Mulberry does not currently receive the LCS around TB that some other practices in the city are able to fulfil as the activity was deemed part of the previous APMS contract.

Current capacity and funding

As you can see from the detail below, there has already been significant restructuring of the service in terms of staffing to ensure it runs on the most efficient staffing model. Indeed, since the contract was released from the PCT, 38% of the staffing costs per patient have been removed whilst the service continues to operate 5 days per week 8.30 to 6.00 pm. Despite this, funding levels are still insufficient to cover the costs of this service and it has traditionally been covered by the APMS contract value for the whole Clover group. However, now this contract has been so drastically reduced, this is no longer possible and without significant funding for the asylum service we will be unable to continue providing this level of service. If the service returned to core funding, there would be little more than a part time GP and some small contribution of practice nursing time; it would in no way be able to provide the service currently offered.

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	2008	Now
Contract holder	Sheffield PCT	SHSC / PCS
Patient Numbers	1,367	1,684
Staff (WTE)	0.5 Nurse Consultant 1.5 Nurse Practitioner 1 GP 1 Specialist Health Visitor 0.5 Specialist Counsellor 0.8 Practice Manager (Band 7) 3 Admin / reception staff 2 Family Support Workers 0.11 Rape Crisis Counsellor Plus attached staff	 1.6 Nurse Practitioner 0.77 GP 0.53 Practice Nurse 0.11 phlebotomist 1.0 Specialist Health Visitor 0.5 Specialist Counsellor 1 Support manager (band 5) 3 admin / reception staff Plus attached staff
Staff Costs (under 2016 costs)	465k	357k
Staff costs per patient	£340 per patient	£212 per patient
Mulberry proportion of Non-staff costs*		£99,356
TOTAL COST		£271 per patient or £456,364 total

* Premises income / expenditure not included as 100% reimbursed under actual rent. Cleaners, utilities, consumables etc. are included.

There are other income streams which need to be accounted for, before the financial gap can be apparent. These are:

Income Source	Amount per annum
APMS This figure uses the raw list size, but would be much smaller (300 less?) if it were weighted on Mulberry specifically.	83.84 x 1,684 = £141,186.56
QOF This figure represents a capitated proportion of the overall Clover figures. Again, this would be less if detailed by QOF associated to the specific practice list.	12.38 x 1,684 = £20,847.92
Enhanced Services: • Minor Surgery • Rotavirus • Health Checks • Anticoagulation	£24,381

• Extended hours • DMARDs • Coils • Pessaries • PCV • Zoladex • ACWY • Person Centred Care Planning • Avoiding Unplanned Admissions • Flu and fluenz • Pneumonia • Shingles • Pertussis • Implanon • LDs • Hep B • Over and Above LCS Again, this figure is based upon a capitated proportion of overall achievement excluding the nursing home and not reflective of the funds associated directly to Mulberry.	
Resettlement grants This figure is estimated based on last year's figure of approx. 34k and therefore presumes a slightly higher number of dispersals.	40,000
TOTAL INCOME	£226,415

Funding Shortfall

The difference between the current cost of the service and the current provision of income is **£230,000** without any allowance for surplus. Effectively this is the minimum cost of maintaining the current service with current registered numbers. The expectation of the list growth over the next few months is unknown and the above calculations are based on a replication of the last year's numbers.

However, on talking to G4S they are talking about settling up to 2,500 additional asylum dispersals into the city, so there is the potential for significant change to this cost based on capitation change.

The need for a specialist service to be commissioned

A key question at this point in the document is whether or not a specialist service needs to be commissioned? Given the previous pages in this document, it is clearly thought to be of significant benefit. However, it is worth exploring the impact were such a service not commissioned.

Effectively, at this point Mulberry would revert to a core General Practice the effect would be:

- Sheffield will no longer be a city of sanctuary.
- There will be no specific specialist service which deliberately attracts asylum seekers, trafficked persons and homeless persons in the city.
- There will be no specific access to Health visiting including those up to age 18 for this vulnerable patient cohort.
- We will create a significant safeguarding risk to the most vulnerable cohort of patients.
- We will remove the access to specialist Mental Health provision including PTSD specialist input to the patient cohort.
- There will be no access to routine essential enhanced health screening.
- There will be no primary care access to quantiferon testing.
- There will be no access to specialist and enhanced signposting and support for the patient cohort.
- The patient cohort will be left without access to specialist counselling.
- The patient cohort will be given a reduced multi-agency support regarding stress related to asylum claims, social isolation, mental health and safeguarding
- We will create a possibility that resettlement work may not be viable on its own merit and therefore stopped.
- The patient cohort will be left without specialist administrative support to make hospital appointments, enquiries and signposting for both health and social care matters (and a continuation of no social care support)
- The patient cohort will be left with a potential loss of access to free medical reports
- The patient cohort will be given a reduction in the length of appointments
- The patient cohort will be made to adhere to a stricter DNA policy on attendance of appointments or removal from the list as per core General Practice.
- There will be no commissioned Primary Care involvement in the coordination of 3rd sector organisations surrounding the specific patient group.
- It is highly likely that A&E attendances will increase.
- It is highly likely that emergency admissions and non-elective care will increase dramatically.
- The city will be left without any coordination of TB screening and the potential risk of infection of others.
- The city will lose the rapid screening service for HIV around the patient cohort and potential infection to others.
- City will be left with an uncollated population and administrative burden which will be spread across the whole of primary care in the city.

Conclusion

This document has attempted to demonstrate the difference in patient demographic and demand at the Mulberry Street service when compared to any other GP practice in the city. It further shows the additional needs of that patient group, the non-funded specialist work that Mulberry provides and the effect of the service on not only Clover but also the rest of the health and social care system in the city.

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The increased cost of commissioning the service under its current delivery vehicle is shown to be good value for money compared to the potential increase in secondary care costs and to have significant positive impact and health outcomes on patient care to the most vulnerable patients in the Sheffield.

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Annex to
Mulberry Specialist Service, Clover Group Practice
Dated 1 July 2016

AGREED LEGACY DOCUMENT TO SUPPORT APMS CONTRACT BETWEEN NHS SHEFFIELD (NHSS) AND SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST (SHSC)
April 2012

1. Purpose

The Contract between SHSC NHS FT (for services provided by The Clover Group) and NHS Sheffield is a unique APMS at the point in which the contract was established. Whilst NHS Sheffield commissions other Primary Care services through APMS contracts, the 'Clover Group' contract is the only one APMS @ April 2012 that commissions General Medical Services for registered patients with a Practice. Within the APMS sits an agreed set of KPIs.

This APMS is not comparable to a GMS or PMS on a like for like basis. It is important to understand the different components of the contact value, specifically the elements rolled into the 'core' value of the contract (3.4).

The four constituent practices that make up the Clover Group were, until 2012, PCTMS provided services, which transferred to SHSC NHS FT under the "Transforming Community Services" agenda. Given the changing architecture of the NHS and the possibility that the organisation commissioning this service will change in the future (by both NHS Sheffield and Sheffield Health and Social Care NHS Trust {SHSC}) that it would be helpful to record the unique components of the contract.

This document is intended to ensure that regardless of future commissioning and contracting arrangements, the knowledge, history and value of the service is acknowledged and captured in this document as a 'legacy' to sit alongside the APMS contract.

2. Background:

The Clover Group are an NHS managed salaried GP practice. Nationally the majority of practices operate under a General Medical Services (GMS) or Personal Medical Services (PMS) contract, which is the main contracting model for general practice. From 1 April 2011, SHSC secured a stand-alone APMS contract in relation to Clover Group under "Transforming Community Services" arrangements.

Since 1 April 2011, all of the Clover Group staff including the GP's have been salaried, employed by the Sheffield Health and Social Care NHS Foundation Trust. Prior to this the practices provided services under Primary Care Trust Medical Services (PCTMS) arrangements, a route generally used by PCT's to deliver services in acutely deprived areas where there had been no interest from other GP's.

At the point of this contract, there have been no other examples found of a GP practice, other than the access centres, existing in the NHS following Transforming Community Services.

The four sites that make up the Clover Group. Services at Darnall, Highgate and Jordanthorpe were all at one time delivered by independent GP Contractors. Mulberry Practice however was different in that it was established as a specialist GP practice for Asylum Seekers in 2000. One of the difficulties experienced by these specialist practices working in areas of acute deprivation and ethnic diversity, has been securing and retaining good high quality clinical staff and adequate accommodation. This has not make it an attractive option for Independent Contractors and hence the status of the practices salaried to the NHS since 1997. Up until 2011 these salaried practices had been through 6 organisational restructures/transitions. Continuity and stability are critical for any practice to function properly and the numerous changes had undoubtedly affected the practice's ability to work as efficiently and effectively as they would have liked. The formation and merge of the practices to create Clover Group has significantly strengthened the model and improved the quality of service delivery.

3. Why is this contract unique?

Various complex components of this contract make it difficult to compare the service and cost directly on a like for like basis with GMS/PMS Independent Contractors in Sheffield.

3.1 Practice Demographics

Ethnicity and deprivation are significantly higher for the Clover Group than the Sheffield average. Clover Group provides services to some of the most vulnerable, socially excluded and ethnically diverse patients in the City. These populations include asylum seekers, high levels of frail elderly, and black and ethnic minorities.

3.1.1 Deprivation

The Clover practices are situated in some of the most deprived neighbourhoods/wards in Sheffield. Patients from these areas are likely to be twice the Sheffield average for living with multiple deprivation indicators (graph 1). Many aspects of Clover Group service delivery are socially related as well as health related issues.

Graph 1.

The public health index of multiple deprivation includes

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training
- Barriers to housing and services
- Crime
- The living environment

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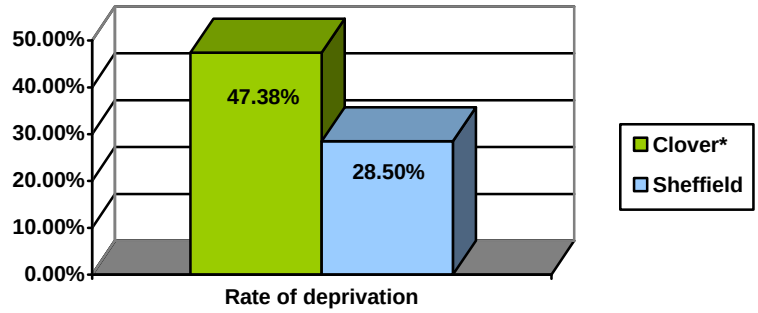


* Excludes Mulberry as not in one geographical area
(Neighbourhood Health Profile, NHS Sheffield Public Health Team, 2010)

3.1.2 Ethnicity

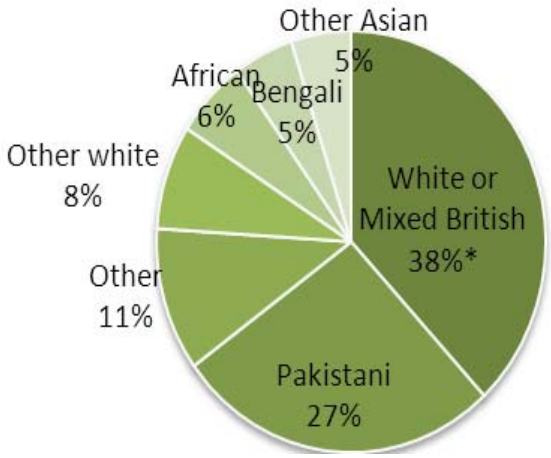
It is significant that 62% of the total Clover registered population are from a non-British background, the remaining 38% are British or of mixed British descent (chart 1).

In Darnall, Highgate and Mulberry more than 65%, 85% and 100% respectively of the registered population are from a non-English background many of whom are also non-English speaking. In recent years, large numbers of EU migrants mainly from Slovakia have registered at Highgate and Darnall and this group has very complex, multiple health and social care needs.

Chart 1.

The practice has approximately 11,000 patients registered from a non-British background (62%), compared to the Sheffield average of 19%.

37% are from an Asian or Asian/British background compared to the Sheffield average of 4.6%**



(*Approx 7% of the 'mixed or white british' are estimated to be of a non-british background.)
(**Neighbourhood Health Profile, NHS Sheffield Public Health Team, 2010)

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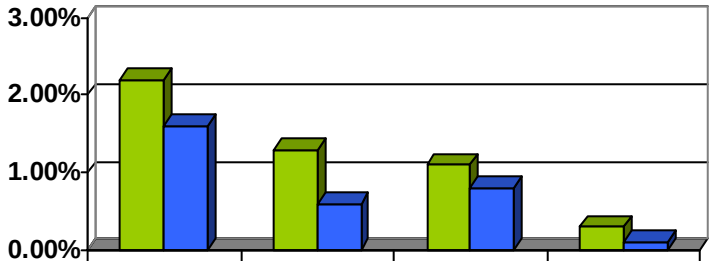
3.1.3 Chronic Disease

The Clover Group practices have significantly higher than National averages for disease burden in all major chronic disease areas. In some disease areas more than twice the national average (graph 2)

Graph 2.



	COPD	CVD	Mental	Palliative
Clover	2.20%	1.30%	1.10%	0.30%
National	1.60%	0.60%	0.80%	0.10%

This has a significant impact on the workload of clinical staff and the numbers of patients requiring regular monitoring for chronic disease and other disease areas that undoubtedly increases the workload of the practice and its clinical staff.

3.2 Specialist Service

The Clover Mulberry team provides specialised services for the asylum seeker population within the city and operates the re-settlement programme for Sheffield. This requires specialist skills in dealing with the issues relating to seeking asylum and the public health associated implications requiring additional health screening.

This element of Clover contract has required inflated contract price due to the investment necessary to provide a specialist service. The practice directly employs pharmacy input, health visiting and a counsellor. If community nursing is required, this function is carried out by the Mulberry clinical staff. At 2012,None of the above is provided by the current respective host organisations and therefore requires additional internal investment from the Clover contract value.

Many asylum seekers and those screened at Mulberry for re-settlement in the UK go through the service very quickly, resulting in high patient turnover. In 2011/12 this was over 700 asylum seekers sand the work required with new patients specifically around asylum and migrant health requires a significant amount of clinical resources and additional screening for public health.

3.3 Agenda for Change

The Clover Group currently employ over 80 staff (approximately 58 WTE), a mixture of clerical staff and multi-disciplinary clinical staff. All staff are employed by Sheffield Health and Social Care NHS Trust and the Agenda for Change (A4C) grading and payment mechanisms therefore apply. Staff are entitled to receive annual salary increments and

uplifts in line with A4C arrangements and salaried GP contracts that are incremental. For GMS/PMS practices A4C is not a mandatory requirement.

3.4 Income Streams rolled up into Core Contract

The Clover Group APMS contract does not provide for any additional payments above the core contract value. Historically the income for these specific service elements was included in the PCTMS contract and this was subsequently rolled forward into the 'core' element of the APMS contract. GMS/PMS practices, on the other hand, are eligible for additional reimbursement or can claim certain items, achievement of some targets and for administering specific drugs.

3.4.1 Specific elements included in the core Clover contract are:

- Personally administered drugs (PAD/PPA)
- Flu/pneumococcal vaccinations (65+ and chronic disease)
- Childhood vaccinations and immunisations
- OOH Development fund
- GP Appraisee fees
- GP Maternity locum cover
- GP sick leave locum cover
- Temporary residents/immediate and necessary
- List size*

*No uplift for change in list size up to 31.12.11.

3.5 Four Site Service

The 4 practices merged to form Clover Group in May 2011. The service continues to operate over 4 sites, inherited from NHS Sheffield. The resource, administration and overhead costs required to manage 4 sites has cost and resource implications that has to be met from within the core contract value.

3.6 Key Performance Indicator Targets

The Clover Group APMS contract contains a set of KPI's that, as at 2012, are not applicable to other GMS/PMS Independent Contractor Practices in the City. There are 22 clinical KPI's and 6 administrative KPI's. A % of the historical contract price is allocated to the achievement of these indicators. Whilst the indicators are new to the Practices, the work required to achieve the indicators must be delivered using historical staffing establishments as this is not additional income into the service. KPI's have been attached to the APMS contract to demonstrate improvements in service quality and value for money for the contract total. The non-achievement of the KPI can result in a reduction to the contract value but does not result in payments above the contract value should achievement levels exceed those designated as excellent.

3.7 Salaried GP Model

The Clover Group employs salaried GP's and follow the BMA salaried GP model contract. Historically GP's attracted to the service have been young female GP's which has meant the Practices have had high levels of maternity leave and access to flexible working applicable to NHS staff (term time working, parental leave policies). The Clover Group

contract does not provide for associated costs for employing doctors to provide cover for such maternity leave, as well as for other types of payment such as seniority allowances or funding for GP appraisal.

The BMA model contract stipulates GP requirements around study leave. A GP that works 7 sessions per week, is entitled to be released for 23 professional study leave sessions a year. This has a significant cost burden on the contract. An additional pressure is the requirement for all employees of the Sheffield Health and Social Care NHS Trust to attend essential and mandatory training sessions per year.

In GMS/PMS practices it is usual practice for Senior Partner GP's to cover additional sessions and study leave would be locally negotiated. Locum costs are therefore only usually incurred after all other possibilities have been exhausted and independent practices are able to insure against GP leave as a contingency towards support with costs. Clearly as an NHS service, Clover us unable to insure against eventualities in GP leave. The salaried GP model has a lot of dependence on the use of GP locums, significantly over and above the standard practice. Locum costs are in excess of 250k per year. All of these costs have to be met by use of core funds.

3.8 Overhead Costs in Overall Contract Value

During the TCS process (referred to in section 2 - Background) there was a mechanism to transfer indirect & overhead costs and 'capital charges' (relating to premises) for every service transferred from the PCT to the Sheffield Health and Social Care NHS Trust. For Clover this amount equates to approximately 15% of the total APMS contract value. This is not funding spent on direct staffing or patient services within the Clover Group. For GMS/PMS practices certain non-direct patient costs are likely to be much lower because certain functions for example, HR & recruitment, are likely to be covered by practice administration staff rather than via the corporate departmental structures that existed within the PCT and now SHSC Trust. Also, the mechanism and allowances for the reimbursement of premises costs are not directly comparable between the APMS contract and GMS/PMS contracts.

3.9 Year End Finance

Due to how NHS finance works currently any additional income generated by the practice in-year is adjusted and paid to the SHSC at year end. The Clover Group as a practice have limited flexibility to re-invest these additional monies within the financial year due to constraints within the NHS. GMS/PMS independent contractors have a much more flexible mechanism in place that enables additional monies to be carried forward in the following financial year. For the last number of years Clover Group has ended the year in profit and these finances are invested into the host organisations financial position. This has resulted in a loss of income to invest the following year.

3.10 Interpreters

Clover Group practices up until 2011 have not been able to access funding for access to language support and interpreters. GMS/PMS contractors have had these costs met by NHSS/PCT. Because of this position the Clover Group had to employ interpreters in the key community languages. This was to reduce spend for telephone and face-to-face

interpreting as this was a more cost effective option. In addition to the employment of dedicated staff approximately £77k of the Clover budget was spent on other language & interpreting services (SCAIS and Language line). This sum was transferred out of the Clover budget to NHSS so that Clover costs are now met from the central budget. However, the service still employs staff with a pure interpreting role to manage the language barriers.

With significant numbers of the registered population from a non-British background having language support on site has been a key priority to provide care to this vulnerable group of people.

3.11 List Size

The practices, since salaried to the NHS have not had a contractual mechanism in place to uplift practice budgets to accommodate changes in the list size. This is also the same for immediate and necessary treatment and temporary resident registrations. This is significant in that in 2008 the practice's combined list size was 14,822 and as at 1.1.2013 was 15,637.

In 2011, a variation in the contract was negotiated to reflect changes in the list size with a trigger for payment set at 4%. However, in order for the practices to achieve funding sufficient to increase clinical capacity the increase would need to be near to 6% approximately 900 new patients.

The population served by Clover is a particularly transient population. In 1 year from 1.1.2012 Clover registered 2532 new patients (cumulatively this only increased the population by over 542 due to deductions). New patients result in a significant amount of clinical work, each patient requiring health screening. This also significantly impacts on the work involved for key performance indicators particularly the practices ability to achieve and maintain QOF and KPI's.

4. Summary

The Clover APMS contract is not comparable to other PMS/GMS contracts due to the unique elements identified throughout this report, and the 'legacy' inherited by SHSC from NHS Sheffield.

It is necessary to understand the nature of the differences when looking at contract values for GP practices in the City.

It has been crucial to establish these services in the way that is described in this report due to the complex nature of the registered population. It is also important to understand the historical difficulties these practices encountered as independent contractors working in areas of high deprivation. The issues surrounding the recruitment and retention of senior clinical staffing working in these challenging environments was and still continues to be a significant problem, as well as previously working from some of the poorest accommodation in the city.

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The Clover Group

Signature…….

Designation …….

Date: …….

Sheffield Health and Social Care NHS Trust.

Signature …….

Designation …….

Date …….

NHS England

Signature …….

Designation …….

Date …….