1. Formal details of the paper

1.1. Title of the paper
Developing enhanced health and wellbeing GP services

1.2 Who can see this paper?
All

1.3 Date of Health & Wellbeing Board meeting
March 24th 2015

1.4 Author of the Paper and contact details
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2. Summary

2.1 This paper is presented to keep the Health and Wellbeing Board briefed and to take the Board's feedback on the work to develop and enhance primary care in the city and to ask for support for the overall process.

The Clinical Commissioning Group (CCG) in collaboration with Brighton and Hove City Council (BHCC) is developing a new way of commissioning enhanced services[1] from GP practices. Through this new approach GP practices will work together in clusters (see appendix 1 for current cluster list) covering registered patient lists of approximately 40,000 to improve health and wellbeing outcomes.

The purpose of this work is to respond to the findings from a premature mortality audit, improve the quality and length of life for people chronic conditions, to address inequalities in health and to improve patient experience. The work will include both the CCG

[1] The formal term for these services is Locally Commissioned Services.

and BHCC public health services to join up commissioning and delivery.

This new way of commissioning will be different from how services are individually commissioned at the moment and provide an opportunity for GPs to lead and develop initiatives together to improve health outcomes and reduce health inequalities. GPs will be able to take more of a leadership role in joining up services at community level. There will be more opportunities for GPs to work with others to improve and address patients' health and wellbeing needs.

3. Decisions, recommendations and any options

This paper presents the plans for developing a new way of commissioning enhanced services from GPs for discussion and feedback. The new commissioning approach will be about developing more proactive and integrated primary care organised around clusters of practices to start in all areas by April 2016. It is proposed that an update on the progress of the new contract will be brought back to the Health and Wellbeing Board July 2015.

The new commissioning approach will require a new contractual relationship with GP's, the details of which are currently being developed. It is proposed that contract management will be carried out jointly between the CCG and BHCC.

4. Relevant information

The problems we are seeking to tackle

Poor health

The Joint Strategic Needs Assessment for Brighton and Hove and the recent Preventing Premature Mortality Audit (see supporting document) show that we have a relatively high number of people suffering and dying from preventable causes. In particular, chronic diseases such as diabetes, heart disease, cancer and respiratory disease are causing our residents reduced quality and length of life.

Variable patient access to enhanced primary care:

At present Brighton and Hove CCG have multiple separate contracts with local GPs to provide 15 different enhanced primary care services to their patients: wound closure, neonates, phlebotomy, palliative care, intermediate care, leg ulcers, student health, suture removal, diabetes, depression, Ambulatory Blood Pressure Monitoring, drug monitoring, rabies and proactive care. These services are above and beyond the core services GPs are contracted to provide by NHS England. Practices are paid on

activity of these enhanced services. GPs enter into the contracts voluntarily and so the uptake is variable between practices with some offering their patients only a few enhanced services, often due to space and staff constraints. Until 2014 the CCG budget for these services was approximately £650,000 although not all was claimed for by GPs. Within 2014/15 the CCG budget was increased to just under £3m to introduce a new service called Proactive Care and funding associated with preventing premature mortality.

Brighton and Hove City Council (BHCC) currently commission 8 different enhanced services from GPs: alcohol reduction, stop smoking, NHS Health Checks, HIV, young people's sexual health, contraceptive implants, Intrauterine Contraceptive Devices (IUCDs) and substance misuse shared care.
The annual budget 2014/15 was £758,075. Uptake and levels of a activity of these services is also variable between practices.

<u>Our objectives</u>
Through the new commissioning approach the CCG is proposing to focus on improving health outcomes and bringing all different contracts together into one new contract with practices, invest up to a further £2 million and extend it further to:

- **Achieve universal coverage for all local patients** by requiring GPs to work in groups of practices ("clusters") covering populations of about 40,000 or more[2]

- **Expand GP capacity so there is dedicated GP time to take a more proactive approach to identifying, managing and improving the quality and length of life for patients with complex needs** working with other local organisations to better co-ordinate care around the holistic needs of the individual.

- **Support GPs to develop a greater focus on reducing preventable premature mortality** by taking a proactive approach to identifying patients at risk and working with other organisations to help reduce that risk and keep people as healthy as possible

- **Enable GPs to have dedicated time to improve the health and wellbeing of children and young people, to address inequalities in health and to improve patient experience** of primary care, working with other local organisations

[2] National research and guidance suggests that GPs working together "at scale" provides a more viable structure for integration with other services locally and facilitates a more proactive approach to care.

BHCC is proposing to collaborate with the CCG and to incorporate its commissioned services from GPs within the new proposed CCG contract. It is planned that the BHCC public health commissioned services would form a distinct part of the new joint contract.

Through the new contract the CCG and public health would be supporting each other's aims and ensure as much as possible that the new contract leads to improved health outcomes. Building on and being part of the new contract will result in better use of resources and more joined-up efforts to improve health and wellbeing and reduce health inequalities in the city.

The evidence and rationale behind our proposed approach

The BHCC Public Health Directorate and CCG have looked at research and evidence to find out the best way to commission and contract with GPs to achieve these objectives[3]. Evidence shows this new way of working can be an effective route to commissioning for improving outcomes.

The new commissioning approach will specify outcomes such as reducing deaths from heart disease for people aged under 75 which all parties agree to work together to achieve (see framework in appendix 2). The new contract would be based on the clusters working together to achieve the health and patient experience outcomes as specified by the CCG and BHCC for their whole population of 40,000+.

It is planned that the "clusters" of practices will invest in GP capacity and capability because the evidence shows this will be an effective way to improve the health outcomes. The CCG is currently considering offering a five year contract term to provide the necessary stability of income to enable investment in clusters and to recruit more doctors and nurses to do this work.

The CCG will ensure the new contract mandates appropriate patient and public representation in the decision making structures of the clusters and their collaboration at city level. Information on the performance of the clusters and details of action and investment plans and progress on implementing the new contract will be publically available and actively shared between clusters and elsewhere widely. This "open book" approach is a key feature of the new way of working.

[3] For the research and evidence base underpinning the plans for the new approach see http://www.brightonandhoveccg.nhs.uk/primary-care-transformation-evidence.

There will also be close working with BHCC regarding social care and other services such as housing.

Progress to date and plans

This new way of working is a big change for the CCG, BHCC and for Primary Care. At present the GP practices are starting to form clusters. There are six clusters covering every GP practice in the city. They have all agreed a Memorandum of Understanding about how they will work together, their values and objectives.

It is planned that April 2015 to April 2016 will be the "transition year" for the GPs moving from the old and multiple contracts to the new outcome oriented contract. The clusters will agree Development Plans showing how they will function effectively in order to be ready to deliver the new contract. During this time practices will also be formalising a city-wide collaborative structure for overseeing the delivery of enhanced services through the formation of a new "federated/network" model.

The CCG plans to be able to offer the new contract to GP practices in 2015/16 ready for full implementation April 2016 onwards. In order for practices to take up the new contract, they will need to submit costed action and investment plans and details of how they will implement the services (see appendix 2 for a draft of the commissioning framework with outcomes and targets).

5 Important considerations and implications

5.1 Legal

The current GP contracts for enhanced services called locally commissioned services, have been or are being extended to enable the new model to be developed. The proposal is for GP's to be offered the opportunity to exit from current contractual arrangements and take up the new contract once the terms have been finalised and approved. The procurement implications will need to be addressed once the contractual arrangements for the new model are clear.
Lawyer consulted: Jill Whitaker 05/03/15

5.2 Finance

The CCG will be investing up to £2m or more a year.
The BHCC Public Health budget will be met by the ring-fenced public health grant. It is not expected to significantly change from its current funding levels.
Finance Officer consulted: Michael Bentley Date: 25/02/15

5.3 Equalities

A key objective of the new contract is to develop GP leadership focused on addressing inequalities in health. There are specific targets related to addressing inequalities. As part of the consultation on the new way of commissioning the CCG is working with representatives of vulnerable and / or excluded groups to ensure their needs are met.

This new contract provides an opportunity to incorporate Equality Act 2010 requirements and ensure that protected characteristics and vulnerable groups' needs are adequately addressed and monitored.
Equalities Officer: Sarah Tighe-Ford consulted Date: 25/02/15

5.4 Sustainability

It is proposed that one of the standards for the new contract is that clusters of practices have a lead for sustainability and that the cluster regularly reviews their use of resources such as pathology tests to maximise value.
CCG Sustainability lead: Dr Rachel Cottam, consulted 25/02/15

5.5 Health, social care, children's services and public health

Clusters of general practices will be expected to work in an integrated fashion with other local services including social care, children's services, mental health, housing, the police and education.

This has implications for these services because over time GPs taking a lead role in health improvement activities, will want to work more closely with these colleagues to identify people at risk of deteriorating health and to actively reduce that risk by taking effective action.

6 Supporting documents and information

Background Document:

1) Briefing of the Preventing Premature Mortality Audit report

Appendix 1: Map and list of the GP Clusters for ProActive Care

Cluster	Clinical Lead	Managerial Lead
1	Manas Sikdar	Carol Witney
2	Richard Mitchell and Robert Hacking	Clare Marks
3	Andy Hodson/ Catriona Greenwood	Susan Harries/ Cheryl Palmer
4	Rowan Brown	Rick Jones
5	Tom Gayton	Anne Scott
6	Andy Watts	Gary Toyne/ Steve Cribb
TOTAL		

1

No. on Map	Practice name	GP Code	Responsible Population
30	Albion Street	G81090	6,125
42	Ardingly Court Surgery	G81006	6,230
41	Park Crescent	G81028	13,244
45	Pavilion Surgery	G81054	8,913
24	St Peter's Medical Centre	G81011	11,219
31	Brighton Homeless Health Centre	G81689	1,138
25	North Laine Medical Centre	G81103	4,015
28	Boots North Street	G81020	2082
40	Lewes Road Surgery	G81063	2499
			55,465

2

No. on Map	Practice name	GP Code	Responsible Population
38	Avenue Surgery	G81075	6,772
36	Broadway Surgery	G81669	2,346
35	Ridgeway Surgery	G81642	2,334
33	Saltdean & Rottingdean Medical Practice	G81076	9,564
44	School House Surgery	G81613	4,407
29	Ship Street Surgery	G81694	2,068
32	St Luke's Surgery	G81667	2,296
39	Willow House Surgery	G81661	1,959
37	Whitehawk Surgery	G81676	3,339
34	Woodingdean Surgery	G81065	6,485
46	Regency Surgery	G81656	4,118
			45,688

3

No. on Map	Practice name	GP Code	Responsible Population
23	Beaconsfield Surgery	G81042	10,196

21	Preston Park Surgery	G81018	11,101
22	Stanford Medical Centre	G81038	16,226
19	Warmdene Surgery	G81036	9,174
			46,697

4

No. on Map	Practice name	GP Code	Responsible Population
2	Benfield Valley Healthcare Hub	G81680	5,575
5	The Practice Hangleton Manor	Y00079	2,010
6	Hove Medical Centre	G81001	8,730
3	Links Road Surgery	G81663	5,818
1	Mile Oak Medical Centre	G81073	7,641
4	Portslade Health Centre	G81046	12,186
9	Wish Park Surgery	G81083	5,894
			47,854

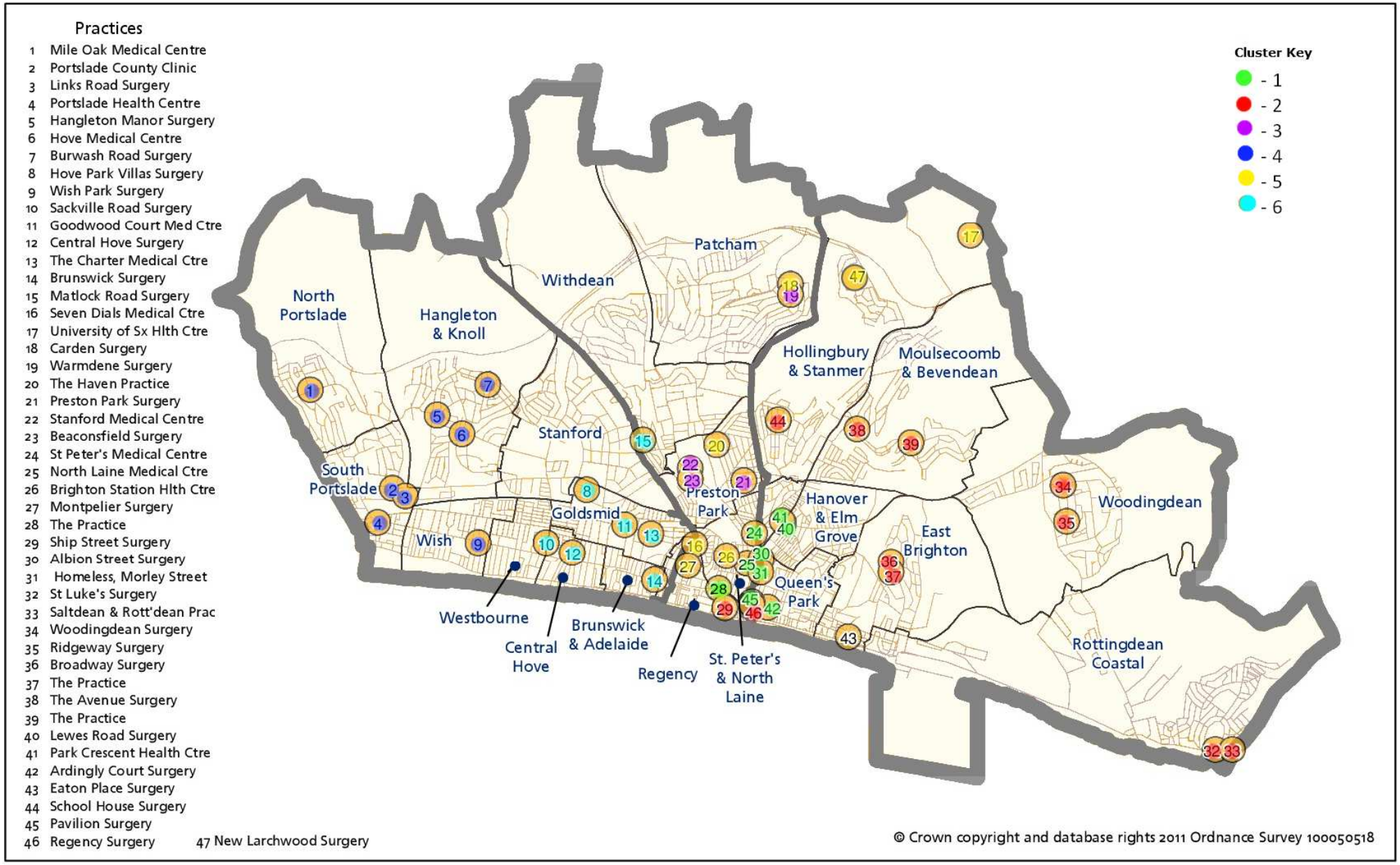
5

No. on Map	Practice name	GP Code	Responsible Population
26	Brighton Station Health Centre	Y02676	5,767
18	Carden and New Larchwood Surgery	G81014& Y02404	5,731& 1,008
16	Seven Dials Medical Centre	G81047	7,848
20	Haven Practice	G81646	3,067
17	University of Sussex	G81071	16,925
27	Montpelier Surgery	G81044	6,101
			49,147

6

No. on Map	Practice name	GP Code	Responsible Population
14	Brighton Health and Wellbeing Centre	G81638	8,188
12	Central Hove Surgery	G81070	5,458
13	Charter Medical Centre	G81034	17,923
11	Goodwood Court Medical Centre	G81687	9,747
8	Hove Park Villas Surgery	G81094	4,473
10	Sackville Road Surgery	G81009	11,289
15	Matlock Road	G81684	2,999
			60,077

Brighton and Hove GP Practices, Dec 2014



Appendix 2: Draft commissioning framework for developing enhanced health and wellbeing GP services

The following tables show the current DRAFT stage of development of the framework for enhanced health and wellbeing GP services. Clusters of GP practices will submit plans which will include their proposed target percentages (replacing the Xs shown in the below framework).

DRAFT Priority Cluster Goals for Enhanced Services	
Reduce premature mortality in key disease areas	Specifically: Reduce preventable premature deaths for the specified patient group by X% in 3 years and X% in 5 years
Deliver proactive care of people with complex needs & "frail" and improving quality of life for people with chronic conditions	Specifically: In the 5 year period: reduce exception reporting of QOF by X% ensuring all high risk patients are actively managed; agree and deliver measurable improvements in patient reported experience outcome measures through integrated multi-disciplinary working; reduce emergency readmission rates by X% and A&E attendances by X% for this patient group
Addressing inequalities in health especially in the above groups	Specifically: Reduce the link between preventable premature mortality in the specified patient group and deprivation by X% by year 5
Improve patient experience for the above groups	Specifically: Deliver the patient experience outcomes agreed with the local community and a comprehensive care approach with continuity where it matters
	Ensuring enhanced access is achieved

Improved health of children & young people	Specifically: Deliver GP led health programmes leading to measurable improvements in sexual health, mental health and reductions in obesity, smoking, alcohol and substance misuse
Addressing inequalities in health especially in the above groups	Specifically: Reduce the difference between the rates of smoking, obesity, alcohol amongst children and young people from deprived areas and non-deprived areas by 50% by year 5
Improve patient experience for the	Specifically: Deliver the patient experience outcomes agreed with the local community (children and young people)

above groups	Ensuring enhanced access is achieved (children and young people)

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from cardiovascular disease	X% reduction or maintenance of under 75 mortality rate for CVD considered preventable X% improvement in estimated percentage of detected CHD per cluster or practice per year X% improvement in CHD patients immunised against flu per year Annual increase of X% of those eligible living within the most deprived quintile receiving an NHS Health Check X% increase in referrals to health improvement services for weight management per year

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from respiratory disease	X% reduction of under 75 mortality from respiratory disease considered preventable X% improvement in estimated percentage of detected COPD prevalence per year X% improvement in exception rate for COPD indicators per year X% reduction of smoking prevalence X% increase in smoking cessation treatment and support offered (certain conditions) per year – *overlaps with QOF* X% more smokers quitting per year X% increase uptake of seasonal flu vaccine 65+ per year - *overlaps with QOF*

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from liver disease	X% reduction of under 75 mortality rate from liver disease considered preventable X% increase in number of alcohol brief interventions per year

REDUCING PREMATURE MORTALITY - Reducing under 75 mortality rate from cancer	X% reduction of mortality rate from all cancers considered preventable X% increase in lung cancer survival at one year X% increase in breast cancer survival rate at 5 years X% increase in prostate cancer survival rate at 5 years X% reduction of cancer diagnosis by emergency routes per year X% increase cancer recorded at early stage of diagnosis per year X% improvement in attendance of Two Week Referral appointments per year X% improvement per year of women aged 25-64 with a record of cervical screening (last 5 years) per year X% improvement in % of men and women aged 60-74 with a record of bowel cancer screening every 2 years X% improvement in % of women aged 47-73 with a record of breast screening every 3 years

REDUCING PREMATURE MORTALITY - Reducing excess under 75 mortality rate in adults with serious mental illness	X% reduction in excess under 75 mortality rate in adults with serious mental illness
	X% increase in % of patients on the mental health register with cholesterol check in the preceding 12 months per year

REDUCING PREMATURE MORTALITY - Reducing excess under 60 mortality rate in adults with learning disability	X% reduction in excess under 60 mortality rate in adults with learning disability
	Implement LD programme for the Cluster

ENHANCING THE QUALITY OF LIFE FOR PEOPLE WITH LONG TERM CONDITIONS	X% increase in proportion of people feeling supported to manage their condition per year
	X% increase in the % of patients reporting their care was joined up around their needs

IMPROVING THE QUALITY OF LIFE - people with COPD	Increase of X% people with COPD and medical Research Council Dyspnoea scale ≤3 referred to pulmonary rehabilitation programme per year

IMPROVING THE QUALITY OF LIFE - People with diabetes	By year 5 80% of people with diabetes have received nine care processes By year 5 80% of people with diabetes diagnosed less than one year referred to structured education X% improvement in estimated percentage of detected diabetes per cluster or practice per year X% of people diagnosed with diabetes receiving an annual review per year

IMPROVING THE QUALITY OF LIFE - Carers	X% improvement in health related quality of life scores for carers in 5 years X% increase in % of carers receiving an annual health check per year

IMPROVING THE QUALITY OF LIFE - People with mental health conditions	Increased access to community mental health services by people from BME groups by X% per year Increased access to psychological therapy services by people from BME groups by X% per year X% improvement in health related quality of life for people with long-term mental health condition in 5 years
IMPROVING THE QUALITY OF LIFE - People with HIV	X% of people with HIV with a personalised care plan and annual review per year

IMPROVING THE QUALITY OF LIFE - People with Dementia	% of people receiving a dementia diagnosis and referred to appropriate services increased by X% per year

HELPING PEOPLE RECOVER EPISODES ILL HEALTH/INJURY	X% reduction in A&E attendances with primary diagnosis recorded X% reduction in emergency readmissions within 30 days of discharge from hospital X% reduction in alcohol admissions and readmissions X% reduction in mental health readmissions within 30 days of discharge

PATIENT EXPERIENCE OUTCOMES - Ensuring people have a positive experience of care	Patient Report Experience Measures (PREMS), Patient Report Outcomes Measures (PROMs), Patient Defined Outcomes Measures (PDOMs) to be developed with the community Achieving an enhanced level of access as appropriate Ensuring a comprehensive care approach for primary care offering continuity where it matters e.g. palliative care, phlebotomy, leg ulcer care

REDUCING AVOIDABLE HARM Reducing medicines related harms and hospital admissions	% increase medicine use reviews conducted for at risk patients, aged over 75

IMPROVING THE HEALTH OF CHILDREN & YOUNG PEOPLE	X% reduction of alcohol related admissions to hospital in 5 years Numbers attending drop in sexual health clinics at practices X% increase per year

PATIENT EXPERIENCE OUTCOMES - Ensuring people have a positive experience of care	Patient Report Experience Measures (PREMS), Patient Report Outcomes Measures (PROMs), Patient Defined Outcomes Measures (PDOMs) to be developed with the community (children and young people) Achieving an enhanced level of access as appropriate (children and young people)