Expression of interest in co-commissioning of primary medical care by NHS Leicester City CCG

CCG involved

1. NHS Leicester City Clinical Commissioning Group (the CCG) has submitted a formal expression of interest to NHS England to undertake co-commissioning of primary care services. This followed an announcement by Simon Stevens, chief executive of NHS England, that CCGs would be allowed to request the ability to co-commission primary care services with NHS England to provide greater leverage over local health systems and act as enabler for delivering integrated care outside of hospitals.

2. The CCG is currently awaiting a formal response to its application, though we understand that a response is imminent.

Scope of our application

3. In its expression of interest the CCG expressed a desire to take on the full scope of primary care commissioning responsibilities. This would include:

    a. Working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
    b. Designing and negotiating local contracts (e.g., PMS, APMS, any enhanced services currently commissioned by NHS England);
    c. Approving 'discretionary payments', e.g., for premises reimbursement;
    d. Managing financial resources and ensuring that expenditure does not exceed the resources available;
    e. Monitoring contractual performance;
    f. Applying any contractual sanctions;
    g. Deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

4. In each of these areas the CCG would wish to take on full delegated commissioning arrangements, whereby the CCG carries out the functions listed on behalf of NHS England and the area team holds the CCG to account for how effectively it carries out these functions.

5. If successful, the CCG would wish to engage in further discussions with NHS England on the full implications of co-commissioning in terms of the CCG's running costs. However, in principle, the CCG would seek to ensure that arrangements take advantage of synergies with existing areas of CCG activity.

6. Should this expression of interest be successful, the CCG would also wish to work with the area team to fully work through the implications of delegation/transfer of budgets in a way which if practicable and appropriate.

Timescales

7. The CCG recognises that, if successful, transition of responsibilities from the area team to the CCG needs to be undertaken in a way which is safe and appropriate. As such, the CCG would wish to work with the area team to develop a timed phasing of delegation that is acceptable for both parties. We anticipate that is likely to be over a period of six to nine months, commencing during 2014/15 with the expectation up being fully established and operational by the first quarter of 2015/16.

Intended benefits and benefits realisation

8. The CCG believes that co-commissioning of primary medical care represents an intrinsic element in realising our long-term ambitions for health and health services in the city, supporting the delivery of a broader range of services in primary and community settings and reducing over-reliance on acute services. To do this will require radical transformation of current primary care services and the way in which they are now provided.

9. We start from a position of unacceptably low health outcomes in the city, which means that on average patients in Leicester live up to two years less than the national average and up ten years less than some areas of the county. There is also huge variation in the city, with life expectancy varying by as much as eight years depending on whereabouts an individual happens to live. In part this is a result of Leicester's huge diversity, but also the high levels of deprivation. There are particularly high death rates due to CVD and COPD and high levels of disease such as diabetes. However the recorded prevalence rates are lower than would be expected.

10. We also know that the quality of service provision in the city is patchy. While we have some exceptional GPs and high performing practices, there is too much variation and, overall, primary care quality is not as high as it should be. Current perceptions of primary medical care in the city are generally low and perform well below national averages against the majority of benchmarks.

11. Approximately 20% of our 63 GP practices are single-handed. Many struggle to deliver as full a range of services as the larger practices and this is likely to get worse as more community-based services are developed. There are large numbers of local GPs approaching retirement in the coming five to seven years. Recruitment of GPs is proving more and more difficult and retention equally so. Many practices are operating from premises that are small, cramped and not fit for the delivery of modern primary medical services. Patient experience as measured by national survey is poor, with access being

a particular challenge. Put simply, for too long primary care has been at the bottom of the pile when it has come to investment to drive change and improvement.

12. As a result, there is an over-reliance on acute services in the city. This additional pressure compounds issues for a hospital trust that already struggles to achieve satisfactorily against a number of minimum standards for patients.

13. When these health and service factors are combined we are left with a system that is fragmented, unresponsive to the needs of patients and unsustainable in the long-term. It is our belief that these challenges cannot be overcome without material reconfiguration of how local health services work. This required reconfiguration is made more difficult by current commissioning arrangements, which mean the CCG does not have the ability to influence all necessary levers for change across the system.

14. As a result, we believe that co-commissioning of primary medical care by CCGs provides the opportunity to deliver a step change in terms of whole-system integration and improvement.

15. Working on the basis that long-term sustainability for the local health economy is predicated on moving more services out of acute settings and into the community, supported by improved capacity and capability in primary care, putting the CCG in the driving seat of primary care commissioning (under delegated authority from NHS England) enables the strengths of the CCG as a GP-led organisation to be fully leveraged.

16. Peer-to-peer discussions which already take place between Governing Body GPs and member practices, supported by managerial and lay member input, primarily through our Annual Quality Review scheme, will be elevated by being able to take discussions to a contractual level when right and appropriate to do so. Combining this existing supportive peer-to-peer approach with contractual levers will, we believe, prove most likely to lead to positive long-term and sustainable improvement in the primary care sector.

17. The CCG would take the opportunity afforded by co-commissioning to explore appropriate contractual models, KPIs and outcome measures that reflect local priorities and can be implemented across integrated pathways in situations where this would bring efficiencies and improved outcomes for patients and clinicians.

18. Our Better Care Fund (BCF) programme includes investment in new community-based integrated services. These services focus upon a defined cohort of patients (60 years and above; those 18 to 59 with three or more co-morbidities; those with dementia) who are at risk of emergency admission. It is important that GP services complement and support the BCF initiatives if they are to be successful and, in the future, we may wish to explore commissioning along the whole pathway. In the short term, it will be important to explore the feasibility of common KPIs along this pathway. If the suite of BCF services

work as we envisage it will deliver a measurable improvement in the care for the identified cohort of patients, with fewer of them having emergency admissions and more of them being cared for at home or in alternative community settings. Supported by mobile working and the efficiencies that SystmOne delivers, GPs will be better informed about the care that their patients are receiving from the wider primary and community health and social care team whilst the patients, having avoided hospital admission, will experience greater continuity of care.

19. Our key focus is upon the pre-hospital stage of care: prevention of illness; early and accurate identification of conditions; and the delivery of care in a community setting for as many people as possible. This approach is also mirrored in the Better Care Together five-year strategic plans which are being designed across the local health and social care community by providers, commissioners and key stakeholders.

20. Achievement of our vision is only possible if there is a strong primary care sector in place, with sufficient capacity (both manpower and premises) and suitable skills, experience and training in place.

21. To address access, we are exploring alternative and innovative models of care. It is well recognised that the GP-centric model of care is not sustainable and in fact not all patients need to see a GP. We have several local models of care which make use of the skills and capabilities of other health professionals, including pharmacists, nurse practitioners, extended scope physiotherapists and emergency care practitioners. Evaluation has shown that the choice of model needs to be appropriate for the local population but, in some cases, up to 70% of patient contacts have been diverted away from the GP, either to self-care or to other health professionals. We are also exploring an approach used by the Hurley Group of practices in London (with a largely similar population to our own) where a range of methodologies including on-line self-triage has reduced contact with GPs but seen access to appropriate services increase with a concomitant improvement in reported patient experience.

22. Moving forward, the CCG believes that the current number of small practices is unsustainable and that, in time, there will be fewer larger practices. In the short to medium term, we are building upon our current locality groupings of member practices to encourage more formal collaborative working. In some cases this may lead to practice mergers or to formal federations. Models of collaborative working may be the result of various stimuli and one of the major areas is likely to be in the development of enhanced service delivery by some practices, covering patients from other practices which do not have the same skill-set.

23. If we can encourage the adoption of these new models of care and increase collaborative working, the result will be increased primary care capacity coupled with reduced levels of stress for GPs plus access to enhanced primary care services for more patients. We shall need to understand and formulate effective key performance

indicators that allow us to monitor and evaluate the impact that these service changes are having on the primary care system.

24. The CCG already works closely with its member practices and gathers a wealth of hard and soft data about performance and local issues affecting the practice. We want to support our clinicians in developing the capacity and capability to deliver continuously improving services and outcomes to their patients. We believe that by developing innovative models of care including enhanced service delivery by a core of practices, we can improve the overall standards. Our aim is to understand, support and develop practices wherever it is appropriate to do so. Due to our close working relationship we believe we are in a strong position to do this.

25. Such changes would, of course, require patient and public input, which we welcome. The CCG is serving a very complex, diverse population and effective commissioning requires in-depth knowledge of the local cultural sensitivities. We have a strong established network of contacts with local community leaders, public forums and patient participation groups to help shape services that are best aligned to local populations and which can be reflected in local contracts. We also already have in place a high successfully track record of engagement with patients and the public.

Governance

26. The CCG has, and already exercises, powers to commission some services from general practice and other primary care providers. In doing so the CCG has a statutory duty to manage conflicts of interest and have regard to the guidance on managing conflicts of interest published by NHS England. Through our commissioning of Locally Enhanced Services, now Community Based Services, the CCG can clearly demonstrate how the principles of conflict of interest management have been applied successfully.

27. However, as a CCG we acutely recognise the need for more detailed work in this area, particularly in addressing public perceptions of inherent conflicts of GP-led clinical commissioning groups co-commissioning primary medical care and the inevitable shift in dynamics between the CCG Governing Body, and particular board GPs, and member practices. Should the CCG be successful in its application, we propose to engage our primary legal advisors, Browne Jacobson LLP, to work with us ensuring that our systems, processes and policies are robust and appropriate for the level of responsibility delegated to us by NHS England.

Engaging member practices and local stakeholders

28. In developing our expression of interest the CCG has sought initial views from a broad range of stakeholders including member practices, local partners and patients and the public. Engagement activity was deliberately simple and straightforward, asking only a

few key questions to gain insight into the views of stakeholders on whether or not the CCG should take on additional responsibilities.

29. More than 89 responses were received to the survey from partners and patients and the public, while all 63 member practices had the opportunity to give their views through our formal locality meeting structure. Overall, feedback was positive and largely supportive of the CCG taking on delegated responsibility for additional functions.

30. For partners and other stakeholders this particularly included working with patients and the public and with Health and Wellbeing Boards to assess health needs and decide strategic priorities (72%); managing budgets and making sure expenditure does not exceed the resources available (57%); designing and negotiating local GP contracts (55%); and monitoring contractual performance and deciding in what circumstances to bring in new providers, manage procurements and make decisions on practice mergers (both 53%). Stakeholders, patients and the public wanted greater clarity on how the CCG would effectively manage conflicts of interest, particularly in approving 'discretionary' payments to practices and applying any contractual sanctions.

31. Stakeholders, patients and the public were also asked to give reasons for their answers. Typically respondents cited that they wanted to see decisions about health services in the city made locally and by CCGs that understand the local context. An example of this is below:

    "Transferring some of the NHS commissioning functions to the local Clinical Commissioning Group should enable the local healthcare provision to better reflect the needs of patients in the area. This should if administered responsibly reduce wastage of funds on duplication of services whilst ensuring that a wide range of services are available to patients in the area. It must be done in partnership with local GPs and community service providers."

32. In terms of member practices, responses were overwhelmingly positive. 95% of member practices said that the CCG should take responsibility for working with patients and the public and with Health and Wellbeing Boards to assess health needs and decide strategic priorities; 90% agreed that it should take on designing and negotiating local GP contracts; 86% monitoring contractual performance, 81% approving discretionary payments; 77% managing budgets and making sure expenditure does not exceed the available resources; 67% deciding in what circumstances to bring in new providers; and 57% applying any contract sanctions.

33. Comments from member practices particularly cited the advantages of locally developed services based on local decisions, the ability of the CCG to address grass roots problems not identified by NHS England, and avoiding duplication. Main issues of concern raised centred on the need for an effective dispute resolution process between the practice and the CCG should a conflict or disagreement present itself.

34. While a considerable amount of engagement has already taken place, the CCG is committed to undertaking more should this expression of interest prove successful. This will include building upon the findings outlined above by holding further detailed discussions with partners and patients and the public, particularly representative bodies such as Healthwatch, while a formal ballot of member practices is proposed.

Monitoring and evaluation

35. The CCG would wish to work on the basis of 'earned autonomy' as it does for the functions currently delegated to it by NHS England. The CCG is able to demonstrate a significant amount of success during its first year as a statutory body, most notably in addressing some of the wider determinants of ill health in the city. This has included taking innovative approaches to challenges, such as the response to poor uptake of NHS health Checks in the city, which as a result now sees Leicester as the highest performing area in the country.

36. The CCG has also developed a track record for ensuring good governance, and strong working relationships with the NHS England area team. We would expect to see this continue, with formal assurance of the CCG's progress taking place through the existing quarterly review meetings. We would envisage that this would be supported by the development of agreed KPIs commensurate with the responsibilities delegated to the CCG by NHS England.