Health Scrutiny Committee – 21 September 2015

Primary Care Commissioning

When CCGs were established in April 2013, responsibility for primary care (GPs, pharmacy, dentists and optometrists) was retained by NHS England.

On 1 May 2014, the Chief Executive of NHS England announced plans to allow CCGs to develop models for co-commissioning primary care. The benefits these new models of working are anticipated to bring include:

- Improved access to primary care and wider out of hospitals services with more services available closer to home
- High quality out of hospital care
- Improved health outcomes, equity of access, reduced inequalities
- Better patient experienced through more joined up services.

In November 2014, NHS England published the *Next steps towards primary care co-commissioning* document to give CCGs the opportunity to choose afresh the co-commissioning model they wished to assume for commissioning GP services from April 2015.

The scope of primary care co-commissioning in 2015/16 is general practice services only and excludes all functions relating to individual GP performance management. It is anticipated that management of the other primary care professions i.e. dentistry, pharmacy and optometry may be delegated to CCGs from 2016/17

The three proposed primary care co-commissioning models for CCGs were:

I. **Greater involvement** in primary care decision making – "an invitation to CCGs to collaborate more closely with NHS England". No new governance arrangements are required for this option

II. **Joint commissioning arrangements** – enables CCGs to assume responsibility for jointly commissioning primary care medical services with NHS England

III. **Delegated commissioning arrangement**s - an opportunity for CCGs to assume full responsibility for commissioning general practice services using a standardised model of delegation.

NHS England also issued statutory guidance on Conflicts of Interest which set out the governance arrangements particularly in relation to option III – full delegated commissioning due to the conflicts which exist for CCGs as GP membership organisations. This included the establishment of a Primary Care Committee with majority membership of lay and executive members ie not GP members, and with a standing invitation to the Health and Wellbeing Board and Healthwatch to attend for additional public scrutiny and transparency.

In January 2015, all Nottinghamshire and Derbyshire CCGs submitted an application for full delegated responsibility which was approved to take effect from 1 April 2015.

Local Rushcliffe Picture

One of the benefits of full responsibility for commissioning GP medical services is the ability to align primary care with the CCG's commissioning priorities and to progress further the integration of services, practices working together and with their attached community teams.

Patient Survey and Enhanced General Practice Specification

One of Rushcliffe CCG's highest organisational priorities is to transform primary care and general practice. To support this aim we undertook a comprehensive patient survey in April 2014 - a major patient engagement initiative for the CCG, with a questionnaire on future options for primary and community healthcare services posted out to all 66,141 households. The survey included questions about new technologies for communicating with doctors and practice nurses, as well as options for visiting other local practices and receiving specialist care closer to home rather than in hospital.
The questionnaire was also available online, and was widely publicised and promoted through schools, sports clubs, libraries and stakeholder organisations.
The responses were managed by Seymour Research, an independent, external research company, to ensure transparency and impartiality. The response rate was fantastic with more than 14,000 returns, representing a 22 per cent reply rate.
Follow-up focus groups were undertaken by Seymour Research to gather more in-depth intelligence from different patient perspectives: from working people, carers, people with long term conditions, parents, university students and young people.

From the feedback received from the survey we developed and launched our enhanced general practice specification in November 2014.

The specification is being used as the mechanism to improve the quality and consistency of general practice, offering equity for patients registered with a Rushcliffe practice and introducing new investment. It was launched in response to the feedback we received from our comprehensive survey of all households registered with a Rushcliffe GP practice.

Our first objective was that all practices would operate the standard core contract opening hours of 8am to 6.30pm, Monday to Friday. There is also a requirement for all practice receptions to be accessible to patients by phone or face-to-face during lunchtimes from Monday to Friday, and to be able to offer appointments every Thursday afternoon.

One of our main clinical priorities is to provide the best possible long term condition management. This has been incorporated into the general practice enhanced specification and as a result GP practices will take a standardised, systematic, consistent and proactive approach to understanding their patients' risk of developing a long term condition or becoming at significant risk of developing one. Long term conditions can result in, among other things, unwarranted, unplanned and avoidable hospital admissions and readmissions.

Through the specification, practices will also offer patients support in self-management, individual care planning and shared decision making and a named clinician. By May 2015 all practices were utilising clinical risk profiling tools for atrial fibrillation, chronic obstructive pulmonary disease and heart failure to identify 'at-risk' patients, improve patient outcomes, reduce costs and avoid inappropriate treatment. During 2015/16 all patients with a long term condition, if they give their consent, will have the opportunity to agree a personalised care plan with their GP, and we plan to ensure patients will be able to access these online or via mobile tablet devices.

Multi-specialty Community Provider (MCP)

In October 2014, NHS England published the Five Year Forward View, which recognises that the NHS has performed remarkably well despite, over the last five years, the biggest financial challenge in its history. A number of new care models are described in the document, which acknowledges that 'one size does not fit all' and outlines a number of radical new delivery options. One of these options is the multi-specialty community provider (MCP), which builds on the CCG's long history of commitment to integration and care provided out of a hospital setting. The CCG supported the successful application to be a vanguard site and is to be one of 14 MCP sites across the country.

The Principia MCP will see the local health and social care system working as one to focus on proactive healthcare, with commitment and pride in bringing benefits to patients and the professionals who serve them. The result will be a significant culture change, with the health and social care workforce coming together to agree ambitions that are patient-centred and empower people, personalising the care they receive. This new care model will be defined by integrated working and an ethos of mutual accountability for patient experience and outcomes.

Challenges

- Urgent Care system
- Rurality and transport with an ageing population
- Ability for community agencies to recruit – eg Homecare
- Primary Care Estates and significant population increase (30,000)
- Managing an increasing need for services due to an increase in population, specifically an increase in the aging population
- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget.
- People wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals.
- Changes in treatments, technologies and care delivery can transform our ability to predict, diagnose and treat disease.
- Maximising the quality of care in an environment where resources are constrained. A continuation of budget pressures over the next few years meaning that it is unlikely that NHS spending growth could return to the 6%-7% real annual increases.
- To find ways of breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists that get in the way of genuinely coordinated care that people need and want.