Report from the RCGP Clinical Commissioning Champions’ Engagement Event held on 24 January 2013.

1. This event was funded through funding allocated by the Department of Health. The RCGP acknowledges this support.

2. Of our 36 Champions 18 attended the event. Ability to attend was limited by GPs’ workload and lack of resources to fund locum cover.

3. A keynote address was given by Professor Stephen Peckham, Director, Centre for Health Services Studies, University of Kent and Director, Policy Research Unit in Commissioning and the Healthcare System (Speakers’ slides are at appendix 3)

Some key messages:

- Current NHS changes support research in the widest sense
- Research should be seen as informing, through evidence, not dictating system change
- The National Institute for Health Research has overarching role in funding research
- Links to the evolving Academic Health Science Networks (AHSNs) are important.
- AHSNs are key for innovation, research and developing practice and research relationships – this is about increasing the speed with which research has an actual benefit for patients and clinicians
- CCGs should actively seek engagement with AHSCs
- University of Kent can offer advice and help design and put together research proposals

See appendix 4 ‘Help with research – funding sources’

4. Other issues

- Impact upon General Practice of Academic Departments of General Practice being subsumed into Universities
- Challenge to acquire funding for qualitative research – i.e. how patients are affected by Primary Care changes. This is not as straightforward as acquiring funding for a drugs trial.
- Where does Primary Care sit in the wider research architecture?
- Is there a case for seeking increased funding for Academic Clinical Fellows and Clinical Fellows in Primary Care? (NIHR issue).
- NIHR has a Fellowship programme and CCGs should look into this.
- Will the 4th year of GP training broaden the Primary Care research base in the future
- CCGs manage 60% of the NHS budget so they have clout – CCG networks need to influence the NIHR.
- Need a bigger emphasis on research as a tool for quality improvement

RECOMMENDATION
• CCGs are encouraged to join the NIHR network - [http://www.nihr.ac.uk/research/Pages/default.aspx](http://www.nihr.ac.uk/research/Pages/default.aspx)

5. Presentations

5.1 Dr Niraj Patel – Managing the Market (See slides)
• Securing the best value for patients
• EU public procurement law and exemption
• The internal market
• Externalisation of the market
• How to secure best value for patients
• Contract variation
• Procurement options
• Single tender action
• Legal challenge is likely to focus on the process not the outcome

5.2 Dr Agnelo Fernandes – Commissioning – an opportunity to achieve change and improve quality (See slides)

Commissioning is not about General Practitioners – it is about patients.

• A year is a long time in Clinical Commissioning! There have been more changes in the last 9 months than the last 23 years!
• Huge challenges – inherited deficit, organisational restructuring, QIPP challenge, Redesign not cuts, Quality Improvement, Transformation journey
• Commissioning is driving change – small changes can make a big difference, e.g. making access to liquid paracetamol via community pharmacy easier.
• Examples of system change through London 111 Service. Links to End of Life register for London

There are many useful resources:

• RCGP Centre for Commissioning guidance on commissioning urgent and primary care - [http://www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/CIRC/Urgent_emergency_care_whole_system_approach.ashx](http://www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/CIRC/Urgent_emergency_care_whole_system_approach.ashx)
• Urgent and Emergency care Clinical Audit toolkit - [http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Urgent%20and%20Emergency%20Care%20Toolkit.ashx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Urgent%20and%20Emergency%20Care%20Toolkit.ashx)
• Quality standards for care of older people with urgent and emergency care needs: [http://www2.le.ac.uk/departments/cardiovascular-sciences/people/conroy/docs/SILVER_BOOK_FINAL.pdf](http://www2.le.ac.uk/departments/cardiovascular-sciences/people/conroy/docs/SILVER_BOOK_FINAL.pdf)

5.3 Dr Brian Fisher – Community Development, Transformation and Deprived Communities (See slides)

• A new approach to improving population health through community development. This enhances community strength and resilience and can save money through joint funding approach from collaboration by Local Authority and CCG – Health and Well Being Boards
• Good social networks reduce mortality risk – good evidence for this
• Some examples – Health Empowerment Leverage Project – a seven step approach. Partnership led by residents; Operation Goodnight improves services and tackles health inequalities
• Worked examples included cardiovascular disease, crime. A modest social return on investment
See: www.healthempowermentgroup.org.uk

5.4 Dr Susan Stone – Sessional GPs in Commissioning (See slides)

• Project jointly conducted with various stakeholder organisations
• Sessional GPs minimally involved in decision making structures within CCGs
• This means that a huge amount of talent is untapped
• Issues – lack of opportunity, lack of confidence in skill set, interested but not invited or allowed to participate
• Recommendations – CCGs need to ensure they have details of all Sessional GPs; must fully integrate Sessional GPs into commissioning; provide training and support such as seminars and courses
• Some good practice examples identified – one CCG includes all Sessional GPs in voting; some involved in key CCG roles, Deanery led learning sets, supportive Local Medical Committees

The full RCGP report can be seen here:
http://www.rcgp.org.uk/~media/Files/Revalidation-and-CPD/Sessional_GPs_in_Commissioning_Report.ashx

5.5 Dr David Paynton - Refreshing the Commissioning Competency Framework

• Need to review and refresh Framework which was developed in 2011
• Principle of slimming down accepted
• Key roles in new framework – Practice members, Practice Leaders, Commissioners
• Leadership and ‘fellowship’ are essential
• Need for educational development to support embedding of framework
• Centre for Commissioning will do further work on refreshing the framework and share with CCCs.

The current version can be seen here

6. Summary of discussion points

6.1 Big concerns around individual GPs and wider involvement in commissioning activity. Demographic of GPs in present CCG roles is largely white, male and older. How to encourage younger GPs to grasp the mantle of CCG leadership? Current GP training does not adequately cover issues such as the broad structure of the NHS so it is difficult for the new GP to understand. The 4 year GP training programme may offer opportunities to equip new GPs with a range of skills to enable them to be successful in the new world.

6.3 More mentorship is needed.
6.4 Emphasis on work life balance and impact of increasing numbers of female GPs who will need or desire more flexible ways of working.

6.5 What is the role of the Faculty in the roll out of commissioning? Are they more concerned with clinical skills development such as minor surgery, ENT, dermatology than developing skills to enable GPs to work in the new political climate? The CfC is hoping to engage with Faculties and discussions are underway to explore how this may be achieved. Should each Faculty Board have a lead on commissioning? One Faculty has already suggested this should be the case. Could CCCs proactively approach their local Faculty Board offering input?

6.6 Everyone is very busy. The role of CCG Chair or Accountable Officer can be lonely. Can the CfC provide a safe space to talk?

6.7 Practical approaches needed to connect practices with research.

6.8 Some examples of programmes in place to develop skills for new GPs:
  • Kent Surrey and Sussex Deanery has a programme of short attachments of GP trainees to CCGs
  • ‘Leadership Scholar’ programme in Severn
  • Eastern Deanery ST4 Commissioning Fellows

7. Action points

7.1 CfC to collate and share examples of good practice and success.

7.2 RCGP to consider how to influence content of 4th year of GP training to include content around leadership, management and research.

7.3 CfC to explore possibility of Commissioning presence on Faculty Boards – a brief questionnaire will be circulated

7.4 CfC and e-Learning team to progress development of e-Learning modules on End of Life and Community Development – in progress

7.5 CfC to progress refreshment of Commissioning Competency Framework for discussion with Champions – in progress.

7.6 Explore possibility of developing workshops as a package for Faculties to use – not possible at present due to resource limitations.

7.7 Explore possibilities of connection with existing Deanery mentorship schemes.

7.8 Continue to exert RCGP influence at political level NHS CB and Department of Health – ongoing.
Appendix 1

Table of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHSN</td>
<td>Academic Health Science Network</td>
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<tr>
<td>CCC</td>
<td>Clinical Commissioning Champion</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>NHS CB</td>
<td>NHS Commissioning Board</td>
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<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
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<tr>
<td>QIPP</td>
<td>Quality Innovation Productivity and Prevention</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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Appendix 2. Access to CfC website e-learning at 24 January 2013

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Appendix 3. Speaker slides

- Professor Stephen Peckham
- Dr Niraj Patel
- Dr Agnelo Fernandes
- Dr Brian Fisher
- Dr Susan Stone
- Dr David Paynton

Appendix 4. Help with research – funding sources

Appendix 5. Delegate list

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Dr Steve Mowle</td>
<td>College Vice-Chair</td>
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<tr>
<td>Dr Agnelo Fernandes</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Brian Fisher</td>
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<tr>
<td>Dr Niraj Patel</td>
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<tr>
<td>Dr David Paynton</td>
<td>National Clinical Lead, CfC</td>
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<tr>
<td>Professor Stephen Peckham</td>
<td>University of Kent</td>
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<tr>
<td>Dr Su Stone</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Mark Attah</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Awadh Jha</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Paul Charlson</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Kath Checkland</td>
<td>University of Kent</td>
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<tr>
<td>Dr Holly Hardy</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Gary Howsam</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Name</td>
<td>Position</td>
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<tr>
<td>Dr Chris Packham</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Nikita Kanani</td>
<td>Clinical Commissioning Champion</td>
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<td>Dr Christopher Mimnagh</td>
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<tr>
<td>Dr Jacques Mizan</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Jonathan Stead</td>
<td>Clinical Commissioning Champion</td>
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<tr>
<td>Dr Vimal Tiwari</td>
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<td>Joseph Boyle</td>
<td>Commissioning Programmes Manager, CFC</td>
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<tr>
<td>Barry Mitchell</td>
<td>Programme Support Administrator, CFC</td>
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<tr>
<td>Sarah Pallis</td>
<td>Policy Officer, RCGP</td>
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<tr>
<td>Bev Russell</td>
<td>London RCGP Faculty Office</td>
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<tr>
<td>Caroline Turnbull</td>
<td>Head of Education, RCGP</td>
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**Appendix 6: Event evaluation**

50% of delegates returned evaluation forms. These consistently rated the speakers and the overall event as excellent to good -

‘…*useful to get exchange of perspective, clinical, research, educational…*’
Appendix 3 Speakers' slides
Evaluating the changes in the NHS

Professor Stephen Peckham
Director, Centre for Health Service Studies
University of Kent
Director, Policy Research Unit in Commissioning and the Healthcare System
Outline

- NHS reform and research
- National Institute for Health Research
- Health Evaluation Research Programme
- Policy Research Unit in Commissioning and the Healthcare System
- Findings and questions from recent research
- Researching the current reforms:
  - Opportunities
  - Challenges
NHS Research Mandate

- The NHS Commissioning Board’s **objective** is to ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, most importantly to improve patient outcomes, but also to contribute to economic growth.

- This includes duties to promote research and innovation – the invention, diffusion and adoption of good practice;
The NIHR was established in April 2006 to provide the framework through which the Department of Health can position, maintain and manage the research, research staff and research infrastructure of the NHS in England as a national research facility.

**Vision**
- To improve the health and wealth of the nation through research.

**Goals**
- Establish the NHS as an internationally recognised centre of research excellence.
- Attract, develop and retain the best research professionals to conduct people based research.
- Commission research focused on improving health and social care.
- Strengthen and streamline systems for research management and governance.
- Act as sound custodians of public money for the public good.
How NIHR works

- The mission of the National Institute for Health Research (NIHR) is to maintain a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.

- The NIHR is a large, multi-faceted and nationally distributed organisation, funded through the Department of Health to improve the health and wealth of the nation through research. Professor Dame Sally Davies, as the head of DH R&D, is responsible for NIHR.

- The Institute manages its activities through four main work strands:
  - **NIHR Faculty**: supporting the individuals carrying out and participating in research
  - **NIHR Research**: commissioning and funding research
  - **NIHR Infrastructure**: providing the facilities for a thriving research environment
  - **NIHR Systems**: creating unified, streamlined and simple systems for managing research and its outputs.
The National Institute for Health Research

Faculty
- Investigators & Senior Investigators
- Trainees
- Associates

Infrastructure
- Clinical Research Networks
- Clinical Research Facilities, Centres & Units

Universities
- NHS Trusts
- Patients & Public

Research
- Research Projects & Programmes
- Research Schools

Systems
- Research Management Systems
- Research Information Systems
Research programmes

- Efficacy and Mechanism Evaluation (EME)
- Health Services and Delivery Research (HS&DR)
- Health Technology Assessment (HTA)
- Invention for Innovation (i4i)
- Programme Grants for Applied Research (PGfAR)
- Programme Development Grants (PDG)
- Public Health Research (PHR)
- Research for Patient Benefit (RfPB)
- Systematic Reviews (SR)
- DH Policy research programme
- NIHR Fellowships
The Health Reform Evaluation Programme (HREP) was a programme of research to evaluate the reforms introduced by the Labour Government. In 2009 the programme was extended to include evaluation of initiatives set out in the final report of Lord Darzi's NHS Next Stage Review.

The programme comprised three interlinked strands:
- Literature reviews identifying and synthesising relevant research
- Research on the implementation of system reform mechanisms
- Evaluation of local health economies to assess the combined impact of the interaction of the four main reform mechanisms on local health system – patient choice, 'payment by results', practice-based commissioning and diversity of providers.

http://hrep.lshtm.ac.uk/
Main themes emerging from health reforms evaluation I

- Predictions largely confirmed, though some dissonance between local & national data and perceptions
- NHS is still not running as a fully fledged market in all parts though some hospitals seem to be competing on quality
- Implementation varies by area, specialty
- Reforms appear best to ‘fit’ electives & where there is contestability rather than e.g. long term conditions, mental health services;
  - PbR still only applies to 30-40% of hospital services;
  - entry of new providers is modest;
  - patient choice is still often GP-led;
  - need for better information on quality
Main themes emerging from health reforms evaluation II

- No obvious signs of ‘harm’ (hard to measure)
- No evidence of reduction in equity of access to electives or fall in quality though not able to look at all service areas (e.g. chronic care)
- Regulated prices appear to be important for quality
- Other impacts comparatively modest compared with the impact of ‘targets’ (e.g. for waiting), but in the direction expected
- PbR appears to have improved efficiency (↓ LOS, ↑ day case rates) without upward pressure on activity
- Independent contribution of market reforms shown in Anglo-Scottish comparisons
The Policy Research Unit in Commissioning and the Healthcare System (PRUComm)

- Is one of 9 Department of Health funded Policy Research Units
- PRUComm aims to establish an international reputation by bringing together leading academic researchers of national and international standing with existing track records in health services, organisation research and those actively engaged in research on commissioning
- The work of the unit:
  - Focuses on all types of commissioning
  - Utilises and further develops sound and credible methods for researching commissioning
  - Examines commissioning within the context of the health system
  - Is developing strong links with policy makers, health regulators, and NHS managers and practitioners
PRUComm

- Policy Research Unit in Commissioning and the Healthcare System

- Commissioning cannot be studied in isolation from the system within which it operates – especially where policy is concerned
Macro level – DH policy about commissioning

Meso level – new architecture of commissioning

Micro level – Commissioners

How can policy respond to any challenges identified?

How is the new architecture shaping activity?

How is policy being realised?
PRUComm Research Programme

- Literature review on clinical engagement in primary care led commissioning (Completed)
- Review of the international evidence on Personal Health Budgets (Completed).
- Evaluating the commissioning strategies and impact of CCGs (Phase I completed, Phase II in progress)
- Empirical research on the use of contractual mechanisms in commissioning (In progress)
- Exploring the relationship between primary care expenditure, outcomes and overall NHS expenditure (In progress)
Lessons for CCGs from previous research

- If GPs are given sufficient space to innovate, small scale change is likely
- Scope to achieve change in these areas diminished (already focussed on)
- Over time GP commissioners start to engage with a wider strategic focus but initially the focus will be very localised service developments
- Primary and community care are likely to be an area pinpointed for development, especially providing intermediate alternatives in order to reduce use of secondary care services
- Prescriptive guidance re membership may squeeze out GP interest and influence
- Cannot be sure what the added value of clinical leadership (in the wider sense) will be
- Grassroots engagement is key to affecting behaviour of individual GPs but mergers between CCGs may lead to loss of grassroots engagement
Key themes from PRUComm research on CCG development

- History is important – same people but who will be the new leaders?
- Rich variation in size and structure
- Need to explore new external and internal relationships:
  - CCGs with CSUs, NHS Commissioning Board, Local authorities
  - Relationship with new public health structures
  - Relationships between practices, localities and the CCG board – what does it mean to be a membership organisation
- While many claims about the added value of clinicians in commissioning little demonstrable evidence yet
Issues for CCGs

- At a local level, the process of clarifying roles and responsibilities between CCGs and their developing CSS needs to be expedited.
- CCGs to pay attention to their membership, including the developing role of their Locality groups/Council of Members.
- The ability of CCGs to change GP behaviour will depend upon their perceived legitimacy, which in turn depends upon the approach that they take to engaging members.
- Our research suggests that CCGs need to consider:
  - the degree of autonomy devolved to Localities; the role of the members in contributing to strategy development;
  - approaches to quality improvement/performance management;
  - the extent to which the CCG may be a vehicle for the transfer of expertise and resources between practices.
- Need to develop a new generation of clinical leaders, encouraging a model of incremental engagement that builds upon GPs’ commitment to local clinical innovation.
- CCGs need to provide opportunities for aspirant leaders to become engaged in commissioning activities in an incremental way.
Will the effects of the market be the same in future?

- NHS entering 5-7 years of financial stringency
- New system structures:
  - New regulatory systems
  - Multiple commissioners
- Role of CCG as local market manager
- Internal management of the CCG with regard to:
  - GP referral behaviour
  - Prescribing
  - Patient management
- If prices vary, importance of good information on quality rises if market is to improve efficiency
- Prospect of more mergers reducing competition
  - evidence suggests that these should be resisted
- Should competition be between hospitals or between vertically integrated providers, at least for chronic care?
Researching the current reforms

- Evaluation of new developments would be useful to see if they are more successful than the status quo.
- But what should be researched?
  - extending current market structures in the NHS
  - examining the roles of new commissioning bodies
  - examining the impact of the new public health system
  - with more emphasis on community services these need to be accompanied by resource shifts out of hospital (to avoid paying double services)
- And how?
  - methodological challenges
  - shifting context
The only certainty is that the NHS comprises multiple messy, complex settings and contexts that are ever-changing and shifting. Attributing causation is highly problematic which makes conducting meaningful research in such an environment challenging.

As a guide to future policy, research has weaknesses. At best it can provide useful pointers and insights although even some of these are often contradictory or full of paradoxes. Research cannot provide definitive answers despite the claims of some of its authors. Research-informed policy is therefore probably the best we can hope for.

Professor David Hunter – University of Durham
Q: To what extent, if at all, do you agree or disagree with the following statements?

- My local NHS is providing me with a good service: 75%
- The NHS is providing a good service nationally: 65%
- The government has the right policies for the NHS: 22%

Base: Adults aged 16+ in England (c. 1000 per wave)

Source: Ipsos MORI/DH Perceptions of the NHS Tracker
Examples of current research developments

- Current NIHR research:
  - Commissioning for long-term conditions
  - Integrated care
- NIHR calls:
  - Research on long term conditions
  - Examining the role of community hospitals
  - New programme on primary care interventions and services
- NIHR Collaborations for Leadership in Applied Health Research and Care (NIHR CLAHRCs)
- Kings Fund/Nuffield Trust
- Possible new reform evaluation programme
Is research independent?

- Researchers are independent
  - DH liaison officer
  - Involvement in steering groups
- Publication of results cannot be refused:
  “The Contractor shall send one draft copy of the proposed publication to the Authority’s Representative at least 28 days before the date intended for submission for publication. Consent shall not be unreasonably withheld and shall not for any reason be withheld for more than three (3) months from the time the version proposed for publication is first submitted to the Authority. Notwithstanding the foregoing, the Contractor shall always consider any representation from the Authority for the revision of elements of detail in such publications.”
The commissioner role in promoting research and the use of evidence

- Supporting the use, access to, identification of the need for, or generation of evidence to support commissioning
- Promoting research - including developing research culture, capacity and participation among clinicians, managers, patients and the public, as part of efforts to increase the quality of services
- Handling of provider claims for contribution to excess treatment costs for studies
- Participating in, and contributing to, the local Academic Health Science Network, its purpose of identifying, adopting and spreading innovation and best practice and promoting research participation
- Participating in strategic initiatives such as NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRC)
- Work with your local university, NIHR Comprehensive Local Research Networks
- Working with PRUComm (www.prucomm.ac.uk)
Managing the Market

Dr Niraj Patel
Securing best value for NHS Patients

• 1.20. Like the current rules, we are not proposing to prescribe the circumstances in which commissioners should introduce tendering, extend patient choice or harness competition. Commissioners need to decide how best to improve services rather than pursuing choice, competition or other levers as an end in themselves. However, commissioners should always follow transparent, rigorous processes as a necessary step in securing best value and they should always be able to objectively justify their decisions.

• 1.21. As now, commissioners must continue to take their decisions in accordance with the requirements of UK and EU procurement law.
EU Public Procurement Law

• Regulates the purchasing by public sector bodies and certain utility sector bodies of contracts for goods, works or services
• Vehicle to implement treaty principles of freedom of movement and ensure proportionality, equal treatment, non-discrimination and transparency in contract awards
• Enacted in UK law through the Public Contracts Regulations 2006
EU Public Procurement Law Exemption

• An organisation fulfilling a purely social function, its activity based on the principle of solidarity and is not engaging in ‘normal’ markets for goods and services will generally not be subject to EU procurement and competition rules.
The Internal Market

• NHS and Community Care Act 1990
• Purchaser/Provider split
• Changing health authorities' responsibilities by separating the roles of purchaser and provider
• Providers became self governing NHS Trusts
• Purchasers – Health Authorities/GP fundholding
• Competition was key
Externalisation of the Market

• Pro-market policies from 2000
• Payment by Results
• Choice of Elective Provider
• Extended Choice Network
• Foundation Trusts
• Independent Sector Treatment Centres
• Equitable Access to Primary Care (APMS)
• Transforming Community Services
1.9. It will also be for commissioners to decide how best to secure and improve these services. Commissioners can use a range of tools, including managing providers’ performance, extending and varying contracts, widening choice of qualified provider, and tendering. They will need to choose the right tools for different circumstances. Local conditions vary and there is no one-size-fits-all model for raising standards.
DH/NAPC/NHS Alliance May 2012 - Patient choice, cooperation and competition - challenges and opportunities
First steps

• The first step is to assess whether a new healthcare service is required. Where an existing service is not being delivered to the required quality or quantity, your first step will be to secure improvements through contract management. Only after these mechanisms have been exhausted should termination of the contract and its replacement with a new service be undertaken.

• Having established that a new healthcare service is required, you should first consider whether any existing contractual arrangements could be used to deliver the required services.
Contract variation

Incremental change to existing service provision, but only where change was envisaged in the contract and where this change does not materially alter the nature of the contract as originally procured such that it amounts to a new contract. This would be likely to be considered the case where:

• other providers would have been interested in bidding for the contract if the change had originally been part of the specification when the service was originally procured
• the contract would have been awarded to a different provider if the change had originally been included in the original service specification
• the change involves genuinely new services not originally within the scope of the specification covered by the contract or
• there is a significant change in the value of the contract
Where none of these options is available, you will need to consider your procurement options for letting a new contract
Procurement options

• To open the service to Any Qualified Provider (AQP) and enable patients to choose from these providers

• Competitive tendering process to appoint a specific provider, a specified number of providers or collaboration of providers

• Appoint a specific provider or group of providers without competition (Single Tender Action)
Single Tender Action

• Technical reasons, economic reasons and urgent need
• Complex legal area
• Clearly document your rationale
• Will be the vehicle that replaces LESs due to introduction of NHS standard contract from April 2014
It’s the process not the outcome

- Needs assessment
- Stakeholder involvement
- Clear and rational process
- Analysis of the market
- Proportionate and transparent engagement with potential providers
- Full range of options considered
- Objective decision made (Conflict of Interest)
- Meticulous documentation
Commissioning - an opportunity to achieve change and improve quality

24th January 2013

Dr. Agnelo Fernandes MBE FRCGP
A year is a long time in Clinical Commissioning!

“more change and improvements in 9 months than 23yrs as a GP”
Commissioning driving change

• Background of inherited deficit
• Organisational re-structuring
• QIPP challenge
• “Re-design not Cuts”
• Quality Improvement
• Transformation journey
Commissioning driving change

1. Whole System Urgent Care System re-design at pace

2. Transformation at pace of Health & Social Care for elderly and children and families services
Urgent Care Re-Design

QUALITY STANDARDS & MAJOR SYSTEM CHANGES
(Functional & Structural)
Commissioning Urgent & Emergency Care

Guidance for commissioning integrated
URGENT AND EMERGENCY CARE
A ‘whole system’ approach

August 2011
Dr Agnelo Fernandes

- References
- Royal College of General Practitioners Centre for Commissioning
- August 2011
London NHS 111 Service

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<td>ASSESSMENT</td>
<td>London Directory of local skills and services</td>
</tr>
<tr>
<td>APPROPRIATE CARE</td>
<td>Integration with CMC Register</td>
</tr>
</tbody>
</table>

- **ACCESS**
  - 111

- **ANSWER**
  - NHS 111 call advisers

- **ASSESSMENT**
  - NHS Pathways

- **APPROPRIATE CARE**
  - London Directory of local skills and services
  - 999
  - A&E
  - UCC
  - GP in hrs
  - GP OOH
  - MH Crisis services
  - NHSD
  - Midwife
  - Pharmacy
  - Rapid response Nursing
  - Palliative care services, hospices

Integration with CMC Register
CALL 111

111 Call handler triages, takes caller demographics. If CMC flagged up

Public Caller

NHS pathways – disposition as per DOS

111 Clinician

111 Clinician

URGENT
Symptom NOT on CMC care plan

999

NON URGENT
Symptom NOT mentioned in CMC care plan

Symptom pertains to CMC care plan

Select from CMC appropriate Disposition e.g. District Nurse
Commissioning Urgent & Emergency Care

• Redesigning ED (A&E) – Urgent & Emergency Care
URGENT CARE QUALITY & SAFETY

- Royal College of General Practitioners
- Urgent and Emergency Care Clinical Audit Toolkit

- Towards **Consistent** and **Continuous** Quality Improvement wherever Urgent Care is delivered
Paediatric Emergency Care Standards (2012)

www.rcpch.ac.uk/emergencycare

Standards for Children and Young People in Emergency Care Settings

2012

Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings

Representative bodies:
British Association of Paediatric Surgeons
College of Emergency Medicine
Joint Royal Colleges Ambulance Liaison Committee
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health

www.rcpch.ac.uk/emergencycare
Majority of urgent care in primary care setting, an increasing number of older people attending ED’s and accessing urgent health and social care services.

Rapid increase in the number of older people

Lower thresholds for accessing urgent care

next 20 years, the number of people aged 85 and over is set to increase by two-thirds, compared with a 10 per cent growth in the overall population.
Clinically Led Quality Improvement

• Urgent Care Network e.g. schools, pharmacy first, alcohol, dashboard development

• Urgent Care Integrated Governance e.g. sharing/learning, clinical audit of consultations, interfaces

• Clinical Quality Review Groups e.g. Acute Hospital, MH, Ambulance (e.g. ACP’s/Hypo’s), Intermediate Services
Transformation

- Reablement Board
- Service Re-design not enough
- Transformation Board - Health, LA, VS
  - Frail elderly
  - Children & families
- Integrated Care - virtual
- Risk Stratification roll-out
- Aligning incentives (LES, CQUIN)
- Telehealth
Commissioning - an opportunity to achieve change and improve quality

24th January 2013

Dr. Agnelo Fernandes MBE FRCGP
COMMUNITY DEVELOPMENT, TRANSFORMATION AND DEPRIVED COMMUNITIES

Dr Brian Fisher MBE
GP and lead for the HELP project
Chair of the Socialist Health Association
AN OPPORTUNITY

• A new approach to population health through community development
• Wraps around primary care
• Enhances community strength and resilience.
• Saves money – joint funding from LA/CCG through HWBs
• A number of models to choose from
  – HELP
  – Altogether Better
  – Turning Point
CCGs AND COMMUNITIES

• GPs have a strong sense of place. Like councillors
• The new architecture connects LAs, HWBs and practices
• Community budget pilots are beginning

A MARRIAGE OPPORTUNITY!
A BIT OF THEORY
WHAT COMMUNITY DEVELOPMENT CAN DO, ALL AT THE SAME TIME

• Statutory services become more responsive
• Promotes health protection and community resilience
• Helps tackle health inequalities
• Has an impact on behaviour change
• Saves money
CD

Stronger and deeper Social Networks

RESILIENCE

ENHANCED CONTROL

Health protection
Resilience to economic adversity
Better mental health

Can negotiate with services
More strength for self-care
Health inequalities reduce
OUTCOMES – HEALTH

6-Month Survival after Heart Attack, by Level of Emotional Support

Sources of support
- 0
- 1
- 2 or more

Percent died

Men

Women
SOCIAL NETWORKS REDUCE MORTALITY RISK

• 50% increased likelihood of survival for people with stronger social relationships.
• Comparable with risks such as smoking, alcohol, BMI and physical activity.
• Consistent across age, sex, cause of death.

• 2010 meta-analysis of data [1] across 308,849 individuals, followed for an average of 7.5 years

THE HELP PROJECT

- A business case for investment in CD in health
- Small team supporting work in 3 estates in 3 areas - Devon, Wandsworth, Solihull
- Builds on 12 years experience
- Evidence-based, replicable
HELP – THE 7 STEPS

1. Identify and nurture key residents. Establish a residents & service providers learning set

2. Joint workshops and learning to develop skills

3. Organise ‘listening events’ - residents and services

4. Create formal partnership - links with community & service providers

5. Establish monthly public partnership meetings

6. Evidence of change, social capital, organisational, key indicators

7. Embedding sustainability - coordination, facilitation, communications
A RESIDENT-LED PARTNERSHIP

LED BY RESIDENTS
THEIR EXPERIENCE DRIVES CHANGE
FORMAL STRUCTURES MAY BE NEEDED
A CORE REACHES OUT
WHAT COMMUNITY DEVELOPMENT CAN DO, ALL AT THE SAME TIME

• Statutory services become more responsive
• Promotes health protection and community resilience
• Helps tackle health inequalities
• Has an impact on behaviour change
• Saves money
OUTCOMES - RESPONSIVE SERVICES

• Services begin to change within 6 months
• Affects many sectors simultaneously (health, police, education)
• Communities gain confidence and leaders emerge
• Staff enjoy their jobs more
RESPONSIVE SERVICES

- A new dental service established
- Funding of £95k to transform a derelict area into a playpark awarded
- A new GP surgery planned
- Well attended social events and football sessions
- Relations with the housing department improved and tenants more satisfied.
- Summer holiday activities for all ages
- A cooperative plan for social renewal agreed between the community and public agencies
Operation Goodnight
OUTCOMES - TACKLING HEALTH INEQUALITIES

• Strong communities are key
• Health Inequalities are mediated through feelings of lack of control
• Unequal communities have few SNs and lack a sense of control
• More confidence breeds more SNs, stronger more vibrant communities
Before & After
OUTCOMES - BEHAVIOUR CHANGE – NICE

- safer cycling
- improved housing
- reducing alcohol-related crashes,
- improving alcohol-related behaviours
- helping prevent injuries to children,
- promoting a healthy diet in children.
- effective promotion of physical activity through walking.
A WORKED EXAMPLE - CVD

• More trust, cooperation, social and physical activity
  • weight management;
  • smoking cessation;
  • buggy walking route;
  • health trainers;
  • Pedal Power - bikes supplied by Police, aimed at ‘families with complex needs’ (older sibs as well as parents teaching younger sibs);
  • woodland management including coppicing and den building;
  • dance initiatives
• Higher levels of social trust are associated with lower rates of CHD; areas with higher social capital have lower CHD esp amongst people with lower income. Physical activity beneficial
• Indicative 5% reduction in CVD admissions to be substantiated: 12 admissions in n’hood of 4,200, saving £55,000
CRIME – A CASE STUDY

• “This downward trend is more than likely due to the introduction of a permanent PCSO for Townstal and a more regular link with the Dartmouth Community College and the school.”

• “The community involvement of the Townstal Community Partnership giving the residents ownership and a ‘say’ in what they want for Townstal has brought the community together and must be considered as a factor in this reduction of crime.”
  
  • *Townstal Beat Police sergeant*
SOCIAL RETURN ON INVESTMENT

• With modest gains on the eight indicators, the model posits a saving of £559,000 over three years in a neighbourhood of 5,000 people, for an investment of £145,000: a return of 1:3.8

• For £233,655 invested across four authorities the social return was £3.5 million.

• For every £1 a local authority invests, £15 of value is created.
Wanless
And the engaged population

Place-based budgets

Health with roots in the community

Agencies working together, with residents

Engaged primary care
Health Empowerment Leverage Project

www.healthempowermentgroup.org.uk
Sessional GPs in Commissioning Survey Results

Su Stone
Project Stakeholder Group

Funded by Department of Health

**Stakeholder Group:**
- RCGP
- British Medical Association
- Department of Health
- National Association of Sessional GPs
- National Association of Primary Care
- Family Doctor Association
- Conference of Postgraduate Medical Deans
- Committee of GP Education Directors
Demographics of Respondents:

**CCG survey:** 140 out of 281 (50%) of all CCGs

Number of CGGs by SHA Regional Cluster
Demographics of Respondents:

sGP survey - 628 responses (approx 5%)

- Salaried: 256
- Locum: 251
- Mixed/Portfolio: 142
- Retainer: 48
- OOH: 15
- Prison GP: 2
- GP refresher: 1
- Academic: 2
- Medical director: 2

Royal College of General Practitioners
Demographics of Respondents:

sGP survey – 628 represented (approx 5%)

Respondent location by SHA regional cluster

- London: 12%
- North of England: 25%
- Midlands and East: 32%
- South of England: 31%
Are sGP involved in commissioning?

CCG response:

1/3rd: board was representative of whole GP workforce

2/3rds: sGPs can engage in all aspects & invited to apply for roles
Are sGP involved in commissioning?

sGP response:

- 82% understand clinical commissioning
- 43% feel they have the skills
- 9% have a role in their local CCG

- Implementing decisions
- Attending meetings
- Reading communication from CCG
- Practice lead
- Clinical lead
- Board member
- Executive director
- SHA lead
Are sGP involved in commissioning?

Of those NOT involved, reasons cited included:

- Not aware of opportunities 41%
- Don’t feel confident to take on the role 32%
- I feel I lack the necessary skills 32%
- No interest 25%
- Interested but not invited to participate 27%
- Interested but not allowed to apply for roles 7%

- 44% would like to be more involved in commissioning
- 61% would further engage given support and training
Barriers: Communication

CCG survey
- 31% feel they know and communicate with all their sGPs
- 48% communicate regularly
- Email (76%)
- Practice managers (51%)
- Local meetings (48%)

sGP survey
- 37% are kept informed
- 27% receive regular communications
- Email (77%)
- Practice managers (33%)
- Local meetings (24%)
Barriers: Lack of sGP interest

CCG survey

- “sGP choice to opt out”
- “day job mentality”
- “lack of response”
- “won’t free themselves for meetings”
- “they lack the time”

sGP survey

- Of those NOT involved: No interest 25%
- 44% would like to be more involved in commissioning
- “just want to do what we trained for.. diagnosing & treating”
- “overwhelming lack of interest”
Barriers: Lack of opportunity

**CCG survey**
- 97% allow GP partners to vote, but only 65% allow sGPs
- 2/3rds feel sessional GPs can engage in all aspects and were invited to apply for roles
- “must work in practices”

**sGP survey**
- Only 7% feel their CCG holds sGPs in same regard as partners
- “We are considered a second rate group of GPs without any clear voice”
- “no-one seems to want to tap into our knowledge.”
Examples of Good Practice

- One CCG welcomes all GPs including sGP as well as nurse practitioners to vote.

- Another has asked locums to affiliate with a practice to allow communication and voting.

- There were several examples of sGPs in key roles: as vice chair/on boards/locality boards/clinical leads.

- Support offered to sGP by:
  - Sessional GP groups and chambers
  - deanery led learning sets
  - Local LMC
**Recommendations**

- **Robust and comprehensive contact lists:** Accessible to CCG, updated proactively by sGPs

- **Full integration of sGP into commissioning:** both CCGs and sGPs must “make the effort”

- **Education:** seminars and courses for trainees and existing GPs

- **Fair and representative election processes:** facilitated by local sGP groups and chambers

- **Sharing of good practice** from other CCGs
Refreshing the Commissioning Competency Framework

Dr David Paynton
Old version 1

- Practice member
- Practice leader
- Commissioning leader
- Commissioning Director
- Commissioning team
5 Domains

1. Leading people
   Managing self
   Leading a team
   Setting the vision
   Leading change

2. Leading a consortium
   Forging partnerships
   Business leadership
   Media and communication
   Horizon scanning
   Governance

3. Serving a local community
   Partnerships with patients and the public
   Partnering with local authorities
   Partnering with providers
   Evaluating population needs
   Protecting and promoting health

4. Leading commissioning
   Engaging professionals
   Setting priorities
   Shaping demand
   Designing services
   Leading contracting
   Market shaping
   Sharing commissioning

5 Leading improvement & innovation
   Promoting research and development
   Continual quality improvement
   Promoting sustainability
<table>
<thead>
<tr>
<th>ORIGINAL FRAMEWORK</th>
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<tbody>
<tr>
<td>DOMAINS</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Practice Member</td>
</tr>
<tr>
<td>Practice Leader</td>
</tr>
<tr>
<td>Commissioning Leader</td>
</tr>
<tr>
<td>Commissioning Director</td>
</tr>
<tr>
<td>Commissioning Team</td>
</tr>
</tbody>
</table>
New version 1

• On the basis that we are about General Practitioners
• Practice members
• Practice leaders
New version 2

Domains
1. Leading people
   Managing self
   Leading a (practice) team in different delivery models

2. Working in a Consortium
   CCG – provision and commissioning – collective decision making and pragmatism
   Federation – patient focussed models, e.g. COPD

3. Serving a local community - Public is in the context of the GP’s registered list
   Partnerships with patients and the public
   Partnering with local authorities (In the context of individual care planning)
   Partnering with providers (In the context of individual care planning)
   Evaluating population needs (In a limited way in relation to the GP’s registered list)
   Protecting and promoting health (In a limited way in relation to the GP’s registered list)

4. Leading commissioning
   Engaging professionals (At primary health care and community services team level)
   Setting priorities (In the context of care for the individual patient and registered list)
   Shaping commissioning (In the sense of bringing the requirements of the registered list to the discussion)

5. Leading improvement & innovation
   Promoting research and development (Contributing through management of chronic illness in the practice)
   Continual quality improvement- through professional standards and practice
New version 3

<table>
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Sense check?

- Does this ‘slimming down’ seem reasonable?
- We recognise it assumes the CCG as an organisation has responsibility for the other items
Next steps

• Thoughts on how to review and update this shorter list of competencies
• Volunteers needed!!
Appendix 4 Help with Research - Funding sources
Help with research

<table>
<thead>
<tr>
<th>Funding source</th>
<th>Type of research</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIHR Research for patient benefit</td>
<td>Research that directly relates to improvements in care for patients. Must be led by an NHS researcher but collaborating with academic researchers</td>
<td>Regional funding structure</td>
</tr>
<tr>
<td>NIHR Health services and deliver research</td>
<td>Larger grants that are partly defined by the programme and advertised and some are ideas put forward by researchers</td>
<td>Focus on the way services are organised and delivered – range from direct patient services to wider organisation of care issues.</td>
</tr>
<tr>
<td>NIHR EME</td>
<td>A programme for early trials</td>
<td>Helps develop trials</td>
</tr>
<tr>
<td>NIHR HTA</td>
<td>Evaluations of interventions – usually trials.</td>
<td>Large scale research projects</td>
</tr>
<tr>
<td>NIHR Fellowships</td>
<td>Individual grants from PhD to senior fellowships</td>
<td>Very tough competition and need link with strong research orientated academic department</td>
</tr>
<tr>
<td>NIHR Programme grants</td>
<td>Existing NIHR researchers can bid for programmes of research</td>
<td>Usually build on existing research projects</td>
</tr>
<tr>
<td>NIHR Public health research</td>
<td>Evaluations of public health interventions</td>
<td>Fairly wide remit but the focus is on specific interventions</td>
</tr>
</tbody>
</table>

Getting help with research:

Local primary care research network – one in each region Soon to be replaced by the new research networks (based one in each region at a NHS organisation).

Regional research development services (RDS) Help with research development and funding sources

Academic Health Sciences Networks – one in each region to support research and innovation. Regions are also developing CLAHRCs to support research and research capacity.

Link to your local University – primary care department, health services departments.

NIHR website: [http://www.nihr.ac.uk/Pages/default.aspx](http://www.nihr.ac.uk/Pages/default.aspx)