CO-COMMISSIONING PRIMARY CARE

Richard Armstrong – Interim Director of Commissioning South Yorkshire & Bassetlaw Area Team
Vision for Future Health Care

**COMPREHENSIVE CARE**
- Highly sophisticated centres of urgent and elective care
- 5m-2m population

**LOCAL BASED CARE**
- Active management and diagnosis
- 300-500k population

**PRIMARY CARE**
- Multifaceted care in social context
- 30-50k population

**SELF CARE**
- 30k population

FRANCHISING

INREACHING

OPERATIONAL NETWORKS

GOVERNANCE

Ownership
A Shared Ambition for Better Care

- To help people live longer and healthier lives
  - Prevent illness
  - Screen and diagnose early
  - Enable citizens to self care
  - Manage long-term and episodic care in right setting
  - Manage vulnerable people with dignity
- Consistency in offer to citizen and patient
- To have citizens and patients involved in process of prevention and care
- To maintain stable publically funded physical and mental health and well being prevention and care system
## Shared objectives for improving general practice

General practice to play much stronger role, as part of a more integrated system of out-of-hospital care. It will need to work on a more systematic, collaborative basis with community health services, social care, voluntary/community organisations, community pharmacy and other partners.

1. **Holistic care**: addressing people’s physical health needs, mental health needs and social care needs in the round.

2. Ensuring fast, **responsive access to care** and preventing avoidable emergency admissions and A&E attendances.

3. Promoting health and wellbeing, **reducing inequalities and preventing ill-health** and illness progression at individual and community level.

4. **Personalising care** by involving and supporting patients and carers more fully in managing their own health and care.

5. Ensuring consistently **high quality and value of care**: effectiveness, safety and patient experience.

There is growing support for ‘**wider primary care at scale**’ – for general practice too:

- operate at **greater scale**, for instance through networking, federation or merger, whilst preserving strengths of **continuity of care** and **relationship with local communities**;

- work as a more integrated part of a **wider set of community-based services**.
POTENTIAL BENEFITS FROM CO-COMMISSIONING

- Establish priorities and changes to meet place based needs
- Greater Integration of health and care services
- Developing ‘bigger’ primary and community care – increasing capacity and provision
- Improving quality of primary care provision
- Enhanced clinical engagement in primary care contracting
- Addressing unmet needs and health inequalities

Potential Scope – over time?

- Designing and negotiating contracts to better meet local care system and patient needs
- Shaping investment to increase primary care capacity
- Managing contractual delivery and improving performance
- Development of Primary Care provision
Some of the attributes that may be needed

- Build transformation so sum of small things adds up and is big-enough to make a difference (sustainable and achieves wider system change)
- Alignment of incentives/contract payment model to vision
- Need resources to ‘experiment’/double run
- Workforce – train district general hospital staff to be community orientated
  - Greater role for Primary Care to be coordinators of prevention as well as delivery of new care models
  - Create new ‘generalisms’ to fit the model of managing ‘whole people’
  - Train hospital doctors/nurses to work in (or with) community networks
- Create new organisational forms
  - that focus on population needs/clinical organisations
  - That are not based on buildings
  - That enable the care system and not just themselves
  - Organisational form to follow function
- Single health record with shared access for all
- Capture the gains not the losses
CCGs Expressions of Interest in North Region

- Cat A: Greater involvement/influence – but final decisions remain with NHS England
- Cat B: Joint commissioning arrangements (shared decision making, pooled budgets)
- Cat C: Delegated arrangements and budget (CCG responsibility for decisions)

In North 61 (out of 66) CCGs submitted EOI’s.

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SOME EMERGING PRINCIPLES

• The direction of travel is a ‘place’ based budget, with planning, and decisions on investment done as local as possible so that primary care commissioning best supports a joint CCG and NHS England placed based care strategy.

• Improving quality of provision should be done as local as possible.

• Some plans and decisions need to be consistent across CCGs to support the strategic development of primary care (e.g. approach to joint investment, workforce development, premises and possibly IT infrastructure).

• Address health inequalities by moving money to support better outcomes.

• There needs to be transparency of resources (allocation/investment & management) so those planning services or seeking funding have confidence decisions reached are those that support delivery of strategic plans.

• Data about practices (investment, quality, performance, workforce) to be shared across the AT and CCG commissioner.

• Commissioners must work together to make the most effective use of the scarce management capacity available.
Following is a draft outline of what might be respective functions and activities within the 3 forms of co-commissioning:

- **Category A** – Active involvement and engagement but advisory

- **Category B** – Joint and shared commissioning

- **Category C** – Delegated responsibility
Planning of wider Primary Care services (not medical)
- Assessing needs
- Designing services/models
- Developing strategic direction for services
- Liaison with other service partners

Strategic planning of General Practice
- With HEE of workforce
- Premises, including prioritisation of investment via joint SYB wide governance arrangements
- Reducing unacceptable variation in quality of provision
Cat B – Joint Commissioning

Jointly designing, reviewing and making contract decisions:

- GMS/PMS/APMS contracts
- Jointly deciding appropriate arrangements for practice splits/mergers/replacements
- Joint decisions and setting priorities for discretionary spend on premises and how to increase workforce capacity
- Joint approach to decisions on reinvestment of any released primary care medical spend, based on agreed strategic place based strategy
- Jointly reviewing practice contracts and deciding strategic direction and scope
- Jointly managing enhanced services not delegated to the CCG
- Working collectively together on Primary Care Education & Training
Delegated budget for specific aspects of primary care contracts alongside associated contract management:

- Contract management of specified Directed Enhances Services alongside locally commissioned services
- Explore scope for commissioning of LA led enhanced services

Going forward this could be extended to include:

- Full contract management and budgets (excluding exit and entry)
- Complaints investigation and management
- Full contract design of PMS and APMS contracts
Continuing AT responsibilities in support of co-commissioning

- Provision of practice data containing financial investment/performance/quality
- QOF/Workforce Data in support to CCGs on a monthly basis
- Management of QOF payments (via CQRS and NHAIS Exeter)
- Management of Complaints about GPs (shared with CCGs in support of quality management)
- Technical contract management – issuing of contract variations, amendments, breach notices and application of consequential contract sanctions
- Guidance on handling ‘conflicts of Interest’,
Continuing Area Team Responsibilities

- Core GMS\PMS\APMS contract payments
- Performers List Management
- Responsible Officer
- Revalidation and appraisal
- Provision of statutory primary care returns
- Commissioning of core primary Dental, Pharmacy and Optometry services
- Procurement and system management of primary care
- Clarification of core GMS/PMS provision to underpin CCGs quality and development role
- Sign off CCGs annual, financial and service commissioning plans for primary care
Developing ‘bigger’ primary care

- There is no ‘ideal’ organisational model but plenty of options and opinions
- Ownership and leadership are critical components
- But organisational form should be driven by functions to be delivered
- This is a journey not a destination – what is right for you may not be the same and can be progressed iteratively.
# The vision may drive organisational change?

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<thead>
<tr>
<th>GMS or PMS contract</th>
<th>Federation “some sharing of services and back services – little change to current contractual arrangement”</th>
<th>Additional contractual arrangement for some services</th>
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<td><strong>Single Practice</strong></td>
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<th>Parent Organisation</th>
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<tr>
<td>One organisation with stand alone practices (single or separate)</td>
<td>One Parent organisation with autonomous practices (single joint contract)</td>
<td>Total responsibility and budget for care of Patient</td>
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- **Standards of (clinical) care**
- **Product**
- **Process**
- **Business Model**
- **Education**