NHS
East Leicestershire and Rutland
Clinical Commissioning Group

East Leicestershire and Rutland Clinical Commissioning Group Expression of Interest for Delegated Powers Associated with Co-Commissioning of Primary Care Services

June 2014

Table of Contents

Executive Summary

East Leicestershire and Rutland Clinical Commissioning Group welcomes the opportunity to express our interest in assuming responsibility for co-commissioning of integrated care services across the spectrum of health and social care to improve patient outcomes for our local population.

The ability to build on our significant track record of clinical leadership, engagement and pathway redesign, with General Practice at the centre, will enable us to progress innovative approaches to models of commissioning pathways of care.

The local Leicester, Leicestershire and Rutland 5 year strategy and Better Care Fund priorities across Leicestershire and Rutland demand unprecedented levels of integration and strong clinical leadership. The enabler for meeting these demands is a unified and innovative primary care strategy, which can only be fully realised through the joint commissioning of health and social care services.

The CCG is expressing an interest to take the greatest level of responsibility available for the co-commissioning of all primary medical services; however, we understand success will be secure through effective collaboration across health, social care and in partnership with patients, carers and the public.

We believe that the transfer of these services needs to be phased with planning and shadow running prior to assuming full delegation in 2016/17. This will enable the greatest opportunity for a smooth handover complemented by the right level of engagement and involvement of all stakeholders.

The CCG governing body and the vast majority of our members and stakeholders who have expressed an opinion on co-commissioning, support the prospect of taking wider responsibility for commissioning services. We hope that this expression of interest provides the assurance to NHS England that our leadership, vision and track record will drive forward sustainable, quality care in East Leicestershire and Rutland.

1 Introduction

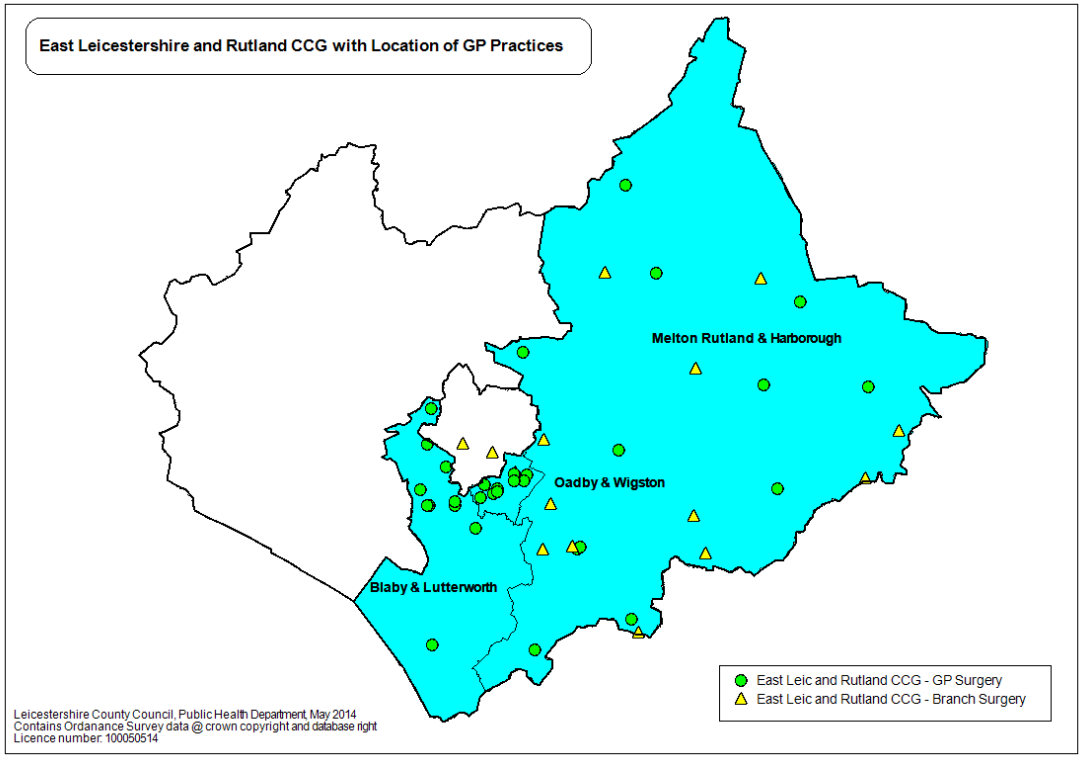
This proposal for co-commissioning of primary care services is presented on a standalone basis by East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG). We believe that commissioning all non-specialised services across the health spectrum, coordinated with social care and the voluntary sector, will be the catalyst for a future sustainable model of high quality care.

Assuming full delegated responsibility for all primary medical services, provides the opportunity to develop a community pathway based model of vertically integrated services, redesigned at scale with general practice at the centre in fit for purpose premises. This whole systems approach will give a renewed focus on outcomes based healthcare, whilst ensuring a sustainable future for primary care within an integrated health and care system.

2 Background

2.1 CCG Membership

ELR CCG is a membership organisation, which comprises 34 medical (GP) practices in three localities: (i) Melton Mowbray, Rutland and Market Harborough; (ii) Oadby and Wigston; and (iii) Blaby District, Lutterworth and surrounding areas. The CCG has a registered population of approximately 320,000 patients.



2.2 CCG functions

The CCG, authorised on 1st April 2013 with no conditions, is responsible for exercising its functions, which are set out in the Health and Social Care Act 2012 and the CCG's constitution. In summary, the main functions relate to:

a) Commissioning health services that meet the needs of: all people registered with member GP practices, and people who are usually resident within the area and are not registered with a member of any CCG
b) Commissioning emergency care for anyone present in the group's area.

Reflecting flexibility within the legislative framework, ELR CCG operates within a Leicestershire, Leicester and Rutland (LLR) unit of planning with Leicester City and West Leicestershire CCGs, with each CCG assuming lead commissioning responsibilities for specific contract areas. ELR CCG also accesses external commissioning support from Greater East Midlands Commissioning Support Unit (GEM CSU) for specific functions.

2.3 Vision, Values and Strategic Aims

The CCG's vision, values and strategic aims have remained unchanged over the last two years and remain at the heart of the organisation's culture, as shown in the figure below.

The CCG's vision is to improve health by meeting our patients' needs with high quality and efficient services, led by clinicians and delivered closer to home.

2.4 CCG primary care strategy

The CCG's existing primary care strategy is designed to build on the high quality healthcare provided by General Practice and to fund continued improvement in quality and outcomes for our patients. The CCG believes that working in collaboration with our providers, partner organisations and members will enable us to exceed the national expectations of high quality outcome focused health care and deliver the key priorities set out in our constitution to:

- Support people to live independently for longer
- Improve outcomes for people living with Long Term Conditions
- Improve quality of life
- Reduce Inequalities in access to healthcare
- Reduce utilisation of the acute sector through integrated community services
- Listen to Patients and the Public
- Live within our means

The health of our local population is generally better than the overall population of England. However, there is a significant number of people affected by ill health, including GP diagnosed coronary heart disease (10,837 people), hypertension (46,917 people), and diabetes (16,145 people). 73% of all deaths within ELR are cancer (31%), cardiovascular disease (29%) and respiratory disease (12%). This presents a significant health challenge in terms of the effective identification, treatment and ongoing management of patients with co-morbidities.

The latest population projections (from the 2011 census) also clearly show that ELR has an ageing population and, with the focus nationally on proactive care of the elderly, our strategy and investment needs to help manage this.

The long term plan is to redesign services and integrate health and social care and increase investment in new community service model, but General Practice is pivotal to its success. The role of the CCG and the aim of co-commissioning is to focus on general practice to act as an enabler to facilitate the changes needed both for improved patient outcomes and new ways of working. This view is shared by the Royal College of General Practice (RCGP) that sets out a vision and six ambitions to promote greater understanding of generalist care, develop new generalist-led integrated services, expand capacity, enhance workforce skills and flexibility to provide complex care (Gerada[1], C 2013).

[1] GERADA, C. (2013) The GP 2022: A Vision for General Practice in the Future NHS. London: Royal college of General Practitioners

In reality, this means that there is a need to reconsider traditional ways of delivering health care and redevelop how the following services / people interact:

- GPs or groups of GPs
- Specialists
- District Nursing / Intermediate Care Team
- Health and Social care co-ordinators / Social Care / Crisis Response teams
- Community / Virtual beds
- Mental Health Services
- Voluntary Sector

The desired outcome is, therefore, an integrated service putting the patient in the middle with shared planning and management by professionals who work together not just within their organisations, with a deliberate plan communicated, shared and developed for and by the patient, creating wrap around care.

3 Approach

This proposal for co-commissioning of primary care services is presented on a standalone basis by ELR CCG.

This approach is consistent with that presented by Leicester City and West Leicestershire CCGs, partners within the established LLR unit of planning for the health and social care community. No hosting arrangements are proposed for primary care contracts between the three CCGs. However, the value of a joint LLR primary care strategy is recognised and is under development by the three CCGs and the NHS England Leicestershire and Lincolnshire Area Team, with particular consideration being given to the transition stage of co-commissioning, sharing of resource and knowledge.

4 Scope

The Governing body of ELR CCG requests that the Area Team of NHS England gives “delegated commissioning responsibility to carry out defined functions on behalf of NHS England and that area teams hold CCGs to account for how effectively they carry out these functions”. In line with the letter sent to CCGs from Barbara Hakin on 9 May 2014.

This is the greatest level of responsibility for co-commissioning of services and would be for the following areas:

- Core PMS/ GMS contracts
- Premises reimbursement and Capital development
- Quality and Outcomes Framework
- Directly enhanced services

It is recognised that NHS England cannot delegate responsibility for commissioning of community pharmacy services or dental services; these services are, therefore, outside the scope of this Expression of Interest, other than in respect of continued engagement with the Area Team as a key local partner with whom the CCG will engage in future planning fora.

5 Intended Benefits and Benefits Realisation

5.1 Strategic and operational plans

The LLR health and social care economy has developed a joint strategic plan for 2014 – 19, which sets out a shared vision to reform health and care services, providing suitable, affordable and sustainable solutions that will improve outcomes for the citizens of LLR. We will do this by developing more integrated services along with increasing quality and efficiency by using the best evidence in class.

This emerging LLR 5 year strategy is readily aligned to Leicester, Leicestershire and Rutland's current 3 Joint Health and Wellbeing Strategies and Better Care Fund (BCF) plans, with an emphasis across the system on reducing avoidable admission to hospital, redesign of alternative pathways and prevention outside of hospital settings. Proposals for co-commissioning are included as a core tenet of our plans to achieve the LLR priority objectives and national ambitions identified in *Everyone Counts*: Planning for Patients 2014/15-2018/19, NHS England 2013.

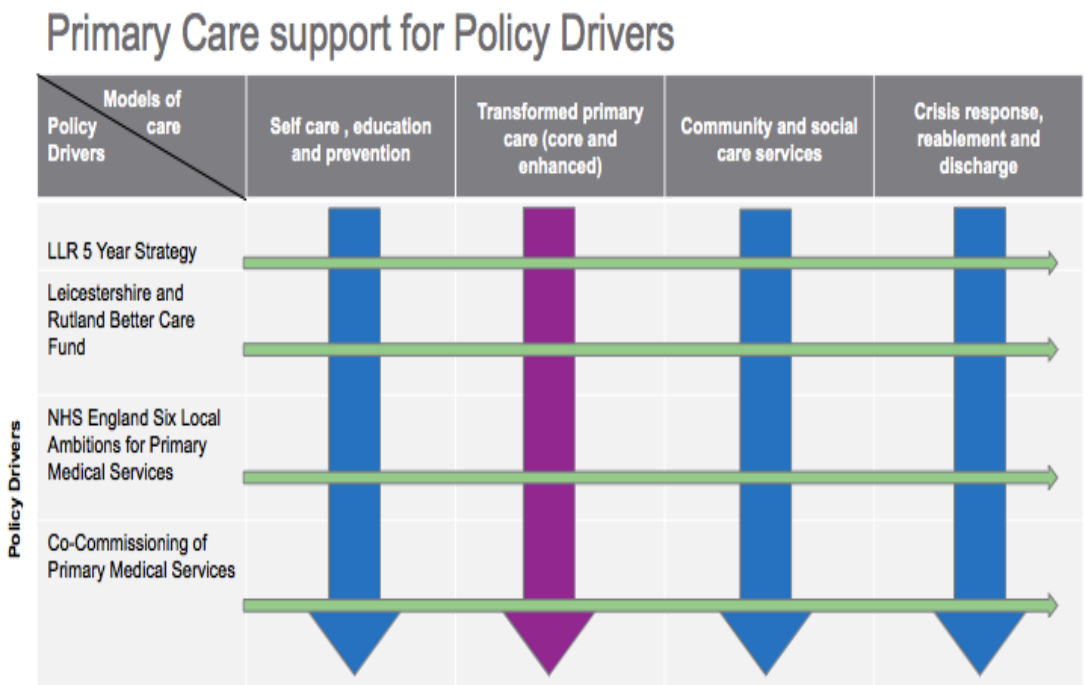
In support of this Strategic Plan, ELR CCG's Operational Plan 2014-16 details the key priorities for the next two years and our intentions to further develop partnership and collaborative working with our local authority partners, neighbouring CCGs and stakeholders in order to deliver the system redesign that is needed to address our local challenges and issues. The key priorities include:

- Driving further integration of health and social care provision to transform care that is strong, sustainable and person centred which enables the health and social care system to meet the future demands;
- Improving services to deliver better quality care and patient experience whilst reducing clinical variation, eliminating waste and delivering better value for money;
- Continuing to focus on the quality of care in our main providers of acute, mental health and community services.

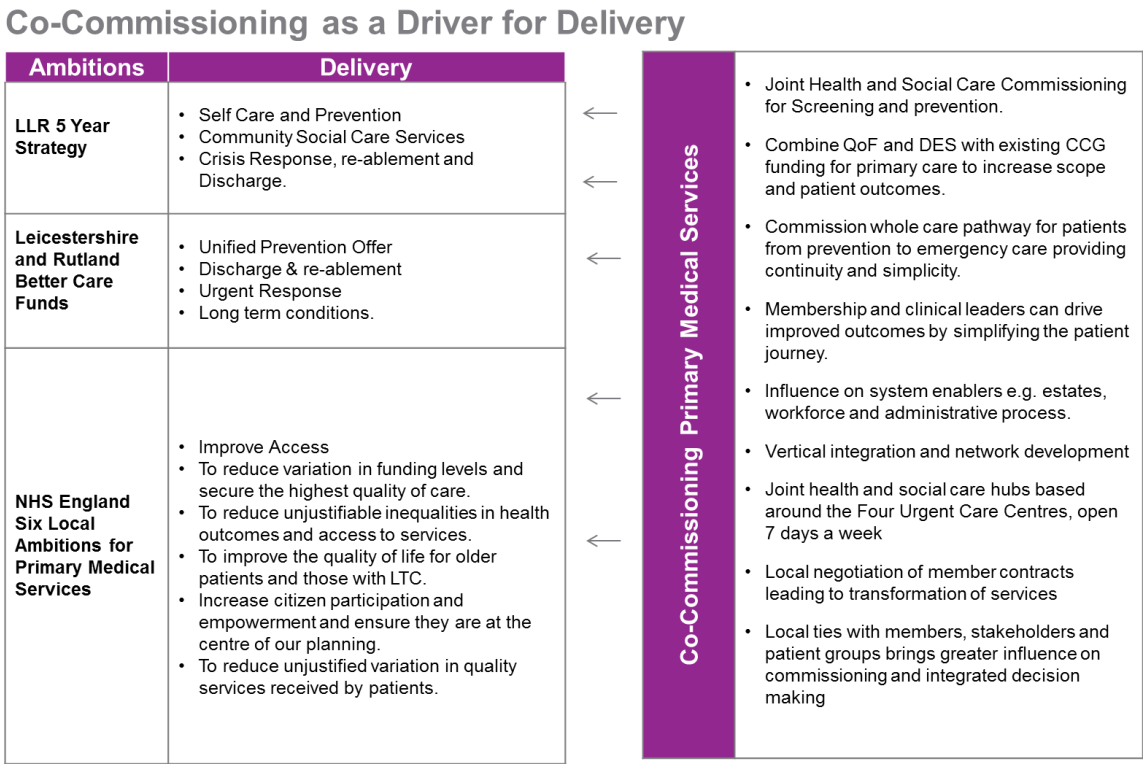
Specifically, we are committed to:

- Continually improving quality of primary medical care services
- Reshaping community services to deliver locally based provision that enables patients to remain independent for as long as possible and have a better quality of life;
- Reducing pressure within our urgent care system to prevent avoidable admissions and reduce length of stay for patients who could be cared for at home;
- Supporting general practice to come together with new ways of joint working to enable primary care health teams to have more time to proactively manage patients with multiple illnesses, at the end of life, in care homes or at risk of admission;
- Continuing to recognise children and their families as an important priority for the CCG;
- Working with our mental health providers, clinicians and service users to improve our acute mental health pathway.

The following figure identifies how primary care relates to the key policy drivers in support of delivery of the core work streams within the Better Care Together programme.



Co-commissioning represents a significant further driver for achievement of the local and national ambition, as shown in the figure below.



5.2 Value added through co-commissioning

5.2.1 Models of care

Ensuring a sustainable model of health care across primary, community and social care services will require a change in the model of commissioning and provider set up to enable integration. The models that will be explored to enable this are:

- **Horizontal:** This can be defined as a strategy linking similar levels of care such as hospitals providing similar services, or a formal merger of two or more organisations producing similar goods to expand market share. The aim is to strengthen the financial position of an organisation, whilst expanding the delivery network.

- **Vertical:** Through vertical integration the CCG would integrate all or parts of the production process as a measure of rationalising its operation and increasing cost control over it. In managing new processes, this could mean that providers purchase or form consortia / alliances with other organisations to gain maximum referral base with the aim of improved coordination between trading partners (Burns & Pauly, 2002[2]) and a hierarchical form of governance created to formalise transactions. This means that a single hierarchy of authority and unity of purpose could be created with integrated delivery systems, which incorporates primary care,

[2] BURNS, L, R. & PAULY, M, V. (2002) Integrated Delivery Networks: A Detour On The Road to Integrated Health Care. Health Affairs Volume 21, Number 4 pp128-143

specialty panels and hospitals (Gaynor, 2005[3]; Robinson & Casalino, 1996[4]). It also provides opportunities to better align with broader services, e.g. community pharmacy.

- **Virtual:** This is an organic form of organisation, which is more flexible than hierarchical or bureaucratic models (Lindstrom, 2000[5]). There is a lesser degree of formalisation at the structural, functional and clinical levels resulting in integration between commissioners and deliverers of health care based on links which do not alter the integral structure of the participating organisations. This has been described as the network approach, where these networks seem to exist alongside and complement hierarchies to accomplish various corporate or institutional tasks. They have often achieved a greater advantage to patients than a series of separate services, which if taken to their conclusion can shift health care responsibility to that of integrated services. The resulting virtual healthcare organisations encompass a multiplicity of relationships between commissioners and providers, supporting cooperation and improving network performance. This is achieved with the flexibility of contracting rather than employing or owning and a transfer of risk away from the organisation to the provider, therefore reducing duplication.

Key to this system is the right estate, which provides outpatient clinics, diagnostic facilities and primary care teams. There are key positives to integrating the NHS system, but there are large risks to introducing integration and creating large geographical and functionally diverse health care provider networks. This is a very difficult mindset for both the public and providers to overcome. It is imperative that these networks are not forced by compulsion, control and centralised design also known as "Controlled Collegiality" (Hargreaves, 1994[6]), but are spontaneous, discretionary and involve voluntary engagement, which allows creativity. Based on this principle, healthcare in England could be reframed as a system that puts emphasis on the relationships over the component parts. This could be achieved by decoupling services, teams and individual professionals from buildings and institutions and ensure that services are available in the most appropriate setting.

5.2.2 General Practice development

To manage both existing and future work load and develop the capacity to take on the task of keeping an ageing population at home, General Practice is

[3] GAYNOR, M. (2005) Is Vertical Integration Anticompetitive? Definitely Maybe (But that is Not Final) Carnegie Mellon University, National Bureau of Economic Research

[4] ROBINSON, J, C. & CASALINO, L, P. (1996) Vertical Integration and Organizational Networks in Healthcare. Health Affairs Volume 15, Number 1 pp7-22

[5] LINDSTROM, R, R. (2000) Towards the Virtual Hospital: An Ecological Approach to Network Development in Health Services. Hospital Quaterly: Spring 2000: Volume 3 Number 3. p18-25

[6] HARGREAVES, D. (1994) The Mosaic of Learning London: Demos

going to need to develop capacity to manage demand, the skill mix of staff, the way they are set up and how to provide services at scale.

To strengthen the role of General Practice as the foundation of the NHS will require practices to collaborate both with other GP colleagues as well as community nursing, social care, voluntary sector, to name but a few. This will support a joined up service for patients, help to improve working environment, improve recruitment and retention and secure funding to protect local services.

This concept is new to most, but the increased workload, expectation of what primary care will offer to patients and the need to secure future funding depends on working together to provide services for patients at scale. This model is clearly the national strategic plan, as is 7 day working and integration of health and social care.

5.3 Benefits Realisation

5.3.1 Integration of health and care services

As noted above, transformed primary care will be central to successful delivery of the LLR health and social care communities' transformational 5 year strategy, as will implementation of the range of interventions outlined in our BCF plans. We have considered which elements of the NHS England primary care function offer the greatest opportunity to lever the change that is required in the primary care system, and believe that this is a significant opportunity to join up the elements currently coordinated by NHS England with those coordinated by the CCG, thereby allowing us to make significant progress, at pace and scale. In having an enhanced level of influence in these areas, we could offer greater flexibility at a local level in delivering our plans.

A CCG Community Services Working Group already exists, established to drive forward the integrated commissioning and delivery agenda across ELR in partnership with Leicestershire County Council, Rutland County Council, Leicestershire Partnership Trust (LPT) and Primary Care. This group is developing an integrated model for community health and social care and has oversight of specific services being developed to deliver both planned and unscheduled care. This will be the forum to develop the future strategy to maximise the benefits of co-commissioning.

Co-commissioning of primary care will act as an enabler to virtually integrate services across health and social care and will provide an added dimension to our existing BCF plans.

Our Better Care Fund plans

Our BCF plans for Leicestershire and Rutland outline how we will maximise the opportunities presented by the fund to lever real transformational change, thereby delivering our 5 year vision.

The fund will be used to drive integration and improve outcomes for patients, service users and carers. People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. Our aim is to provide information, services and support in a coordinated way across agencies and to provide it as early as possible, anticipating future needs as well as addressing immediate needs in the most appropriate setting.

We want people to be able to access a range of support early enough, including through social and community networks, thereby empowering them to take control of their health and wellbeing, live healthier lives and maintain their independence for longer.

By investing in prevention we expect to see a reduction in the number of people accessing services in a crisis or inappropriately, and an increase in the provision of care interventions that offer optimum independence within a supportive community.

We have combined our BCF priorities and activities into the following themes, under which sit a range of services, projects and interventions that will support implementation, including: single point of access, 24/7 services integrated across health and social care, urgent community response services within 2 hours, and case management for over 75s. Our BCF plans support delivery of:

- A unified prevention offer/early Intervention
- Integrated urgent response
- Improved hospital discharge and reablement
- Integrated, proactive care for those with long term conditions

The successful delivery of the projects that underpin these ambitions requires more primary care than ever before, and having the additional flexibilities presented through co-commissioning to align commissioning and contracting approaches would greatly enhance our ability to deliver models of integrated care, with primary care playing a pivotal role.

Integrated Health and Social Care Services

We are working with all of our stakeholders and CCG colleagues towards a fully integrated, coordinated model of service provision for health and social care, delivering 7 day services that put people at the centre of delivery. This is underpinned by the Better Care Fund plan. The aim is to deliver services to the citizens of Leicestershire and Rutland in a co-ordinated way that recognises that people often need support from more than one service, particularly the frail elderly and those with long term conditions, mental ill health or a disability. The new service model aims to reduce and eventually remove barriers that make it difficult for people to navigate between services.

5.4 Quality and clinical effectiveness

5.4.1 Quality

The CCG has a robust, clinically focused and proactive approach to driving up quality across all of our providers. This stems from the leadership shown by the clinical champions on the governing body and manifests itself through unannounced provider quality visits, formal review through the contract squares and investigation of serious incidents. ELR CCG already takes on an enhanced role in monitoring the quality of care delivered to our patients by General Practice. There is a dashboard in place and annual quality visits that gives an opportunity to demonstrate the quality of care our practices deliver in the areas that have been identified as being most relevant to our patients' health needs.

ELR CCG will need to increasingly demonstrate that General Practice is delivering high quality, outcome focussed care. This will form a major part of providing the level of assurance required to understand whether practices have the capacity in their current form to deliver this level of care in a sustainable way.

The CCG already has a process for monitoring quality through a formal committee of the governing body and has an agreed process for sharing information, escalating and joint monitoring of practice quality through the Concordat between LLR CCGs and NHS England (Leicestershire and Lincolnshire Area) for the Sharing of Information and the Management of Concerns relating to the Professional and Contractual Performance of Primary Medical Practitioners.

Quality monitoring of Primary Medical Services

To ensure a robust and quality assured process for ensuring continuous improvement, the CCG will further develop the following areas:

- **Quality Dashboard**: Based on our existing practice profile an improved dashboard of information will be produced including local quality markers, national indices, reports from patient representative groups and significant events. This will include all quality markers against the practice contract and performance against enhanced services, Qof, and community based contracts
- **Complaints process / incident reporting**: A process will be developed that brings together not only all formal complaints, but significant events and incidence of poor quality care. This will provide a breadth of knowledge that can lead to quality improvements. This process will involve not just formal action and escalation, but also a constructive peer review process that leads to evaluation and learning through shared experience.
- **Quality appraisal**: Building on our annual practice quality visit, a pool of skilled GP assessors will be used to undertake a quality appraisal of each practice on an annual basis. This will be focused on patient outcomes and quality improvement and will enable sharing of good practice or formal action plans if necessary. This combined information will form part of the internal and external assurance process.

Clinical effectiveness / added value
The LLR Health economy is facing significant challenge in relation to the quality of other services which interface with primary care – e.g. referral to treatment (RTT) (reduction in variation on in clinical referrals) and A&E performance. We are addressing these through a number of means, including reviewing appropriate access in and out of hours, the development of seven day services, our urgent care review, cancer commissioning and embedding recommendations from local Strategic Clinical Networks, e.g. on the early identification and diagnosis of cancer and cardiovascular disease.

The combination of linking Primary Medical contracts and service at the centre of commissioning new vertically integrated pathways will help to improve performance and provide quality assurance.

We understand our challenge
Between February 2014 and April 2014, members of the ELR CCG Quality Team worked closely with the GEM engagement team and representatives of Healthwatch Leicestershire and Healthwatch Rutland to talk to people across ELR about their experiences and take their feedback on proposed changes to services in the area. The 'We are Listening team' visited 23 locations across the ELR CCG area. These venues included visits to community groups, such as mental health and learning disability groups, or SureStart Centres. We also visited locations highly frequented by members of the public, including leisure centres, markets and libraries. We wanted people to tell us the story of their experience of accessing healthcare from any provider. The questions were deliberately kept as open as possible to allow as full and unbiased a story as possible from the people that chose to talk to us. During the pilot period, 145 people came to speak to representatives at the Listening Booth, resulting in 225 stories of patients' experiences. Overall, 35% of the stories recorded were about positive experiences and 65% were negative. People spoke to us about their experiences of a variety of providers, the majority of stories related to patients' experiences of GP surgeries (35%) or hospital care (30%) (excluding maternity and A+E).

Each story was allocated a theme - negative themes relating to GP practices included; problems in appointment booking systems, staff attitude and difficulties in accessing primary care services. The majority of positive stories about general practice were about feeling supported by doctors. Examples of comments in relation to General Practice:

- Appointments can be difficult to make but good in terms of emergency appointment you can get an appointment at the end of the day. Although it is too small and desperate for an extension due to new housing developments.
- Surgery very good. Telephone system works well but needs more people answering the phone.
- Long waits at Reception, sometimes have to arrive very early for appointment in case you miss appointment as on arrival you have to

queue to inform them you are there. Touch screen appointment system often isn't working.

Co-commissioning will truly enable us to do what is right for our patients, improve quality of care and improve process to provide assurance across pathways.

5.5 Patient and public involvement

ELR CCG is renowned for the excellence of its patient, public and stakeholder communications. We are committed to ensuring that the patient and service user voice is at the heart of everything we do and is an essential part of our brand “Listening. Responding. Delivering.” This was recently endorsed by the findings of the NHS England sponsored 360degree stakeholder feedback. We received our highest ratings for engagement and listening to views (85% responded to say they were engaged either a great deal or fair amount) and acting on suggestions and working relationships (63% strongly or tending to agree that we do act on suggestions, as opposed to other CCGs (51%). Our relationships with others are also highly rated 80% responded very or fairly good.

Should our bid be accepted, we would look to build on these strong foundations, particularly with our patient participation and patient reference groups, which are practice based. These enable us to listen to patients’ views already and help us commission our services. We can build even stronger links to quality of patient care and commissioning, as well as streamline timelines and processes for responding and changing services where we need to, or address patient care or quality concerns.

We have locality lead GPs who chair meetings with Practices every month and we have also strengthened our clinical membership, appointing two clinical vice chairs as well as three locality lead GP governing body members. Our well-established structures and contacts, from Health and Wellbeing Boards, Healthwatch (Leicestershire and Rutland), local councils and political groups, as well as patient groups and voluntary sector will be invaluable as we develop our strategy for co-commissioning.

Our tried and tested techniques to involve people in our development were most recently demonstrated in the development of our urgent care strategy and subsequent consultation. Engagement was a core part of our plans – we embarked on ambitious pre-engagement by hosting meetings, attending events and providing multiple opportunities for our CCG to hear and respond to the views of our patients, either face to face or through email, our website or by letter.

As we develop our plans, we propose a similar strategy: we will engage with our Member Practices, our own staff, our key stakeholders and our patient participation or reference groups using our embedded structures to inform our planning as well as maintaining a continuous informing and listening cycle to ensure our plans are as robust as possible.

Involving and Informing

We have a dedicated strategy for engaging with patients, public, stakeholders, clinicians, Member Practices and staff to ensure they are fully and effectively involved in commissioning decisions. Our strategy uses of a wide range of methods in order to reach and involve the widest range of patients and public, whatever their needs. Just some of our methods are:

- **Be Healthy Be Heard Membership Scheme -** the CCG's membership scheme is a key enabler to engagement. The membership is demographically representative of the CCG's area and consists of nearly 5,000 members of the public. Members sign up to the scheme as a mechanism to feedback into the CCG and have their views heard. They receive a members magazine as well as regular email updates.
- **Patient Participation Groups and Patient Reference Groups -** the majority of the CCG's GP practices now have a Patient Participation Group (PPG) or Patient Reference Group (PRG). The quarterly PPG/PRG Chairs' Network facilitates sharing of best practice and knowledge. To date the network and individual patients and groups have contributed to development of our vision and values, our work to understand patient experience of local services and our commissioning intentions. Under the Involving and Informing Strategy, we will continue to work with the patients involved in these groups to ensure their views are represented in our decision-making.
- **Patient and Public Engagement Group -** the CCG has established the group to help strengthen and improve the way it involves local people in its planning and decision-making and met for the first time in February 2014 and recently in June 2014 to support the PPGs and PRGs.
- **Patient Experience -** in October 2013, the CCG introduced an initiative to take patient stories to the public meeting of the Governing Body, this gives officers direct insight into patients' experience. This is part of a wider dashboard of patient experience data to help give us a fuller picture of our patients' needs.
- **Protected Learning Time –** one of our most important engagement and involvement events, bringing together clinicians and managers from primary and secondary care with our member practices is set piece afternoon events to meet, share information and take part in development sessions, covering various topics to raise quality of care standards as well as foster closer working. We have hosted six of these events over the last 15 months.
- **We are Listening** - staff from ELR CCG worked Healthwatch Rutland, Rutland County Council and First Contact Rutland to visit towns and villages across the county to ensure the voices of Rutland influence health and social care. A Listening Booth encourages the public, patients and carers outside of healthcare locations to speak about their experiences of healthcare, what patients would like to see in their local area and what matters most to people about their healthcare.

5.6 Health inequalities

Health inequalities are defined as the differences either in health status, or in the distribution of factors that affect health between different population groups.

The population of ELR CCG as a whole has relatively low levels of material deprivation, compared to other parts of England. In comparing the various areas where our population lives against the rest of England, ELR CCG ranks overall as 200 out of 212 CCGs for deprivation (where 1 is the most deprived). However, the CCG has developed its equality objectives for 2013 – 2015 to enhance emphasis and attention on the priority equality issues across the CCG focusing on the outcomes to be achieved and improvements required in policy making, service/function change, service delivery and employment

ELR CCG and the specialist public health team for Leicestershire and Rutland County Councils (PH) have a shared ambition to improve the population's health and reduce health inequalities. General practice, with its registered list of patients, has untapped potential to engage in a more proactive approach to improving the health and wellbeing of the local population and reducing inequalities. Such a focus is essential if the NHS is to meet the challenges of responding to rising rates of chronic illness at all ages of the population, during a time of financial austerity. Although there is much that individual general practices and CCGs can do on their own, sustained progress will depend on alliances across health and with local government.

It is fair to say that the potential benefits of integration between primary care and public health have not been fully realised in the new health and social care system derived from the Health and Social Care Act 2012. Since the transfer of responsibilities in April 2013, the Better Care Fund has provided a structured way of delivering integration between the CCG and Local Authority social care. The co-commissioning of general practice by the CCG has the potential to do the same for integration with Local Authority PH and to progress the Better Care Together ambition to transform primary care.

The CCG already has a productive relationship with the specialist PH team for Leicestershire and Rutland. For example, the CCG commissions community services (including CCG mental health and PH substance misuse) from Leicestershire Partnership Trust collaboratively with PH and actively involves PH in its governance structure, including the Governing Body. Co-commissioning provides further opportunities to align approaches to primary and secondary prevention, diagnosis, early intervention and the subsequent treatment and management of disease across pathways of care, e.g. mental health, dementia or cancer.

Regarding primary care more broadly, Bradley and McKelvey (2005)[7] proposed that the importance of primary care to public health lay in four key areas;

1. **Local knowledge and data**: Primary care is the main contact point for the population with the health service (890,000 contacts with a GP or practice nurse each day in England) and this is set to increase with the ageing population and a 'left shift' of activity from acute to transformed primary care. Local data is improving in quality and will be a key source for health profiling and the development of locally appropriate services based on need.
2. **Service delivery**: Primary care provides an important context for the delivery of health improving services, as well as curative services.
3. **Advocacy and collaboration**: Primary care can play an important part in local health advocacy and developing local collaboration. The CCG has wide links with the local community and they, especially GPs, are still held in esteem.
4. **Public health approach**: Primary care has some core approaches that espouse a public health view, for example having a lifelong view of a patient's health, thinking of populations (although only at practice population level) and multidisciplinary working (although often limited to other health and social care workers).

In the context of the Better Care Together programme, the real prize for the future is the potential for the NHS and Local Government to collaboratively commission fully integrated pathways from universal primary prevention services for the whole population through to specialist services for those patients in greatest need. Using physical activity as an example, this pathway could include mainstream leisure services, the identification of physical inactivity and brief advice by frontline staff, GP referral for community-based structured exercise and acute rehabilitation as part of integrated care planning.

An example of how ELR CCG has already worked across pathways to reduce inequalities. There are approximately 4000-4500 gypsies and travellers living in Leicester, Leicestershire and Rutland. These residents experience a wide range of health, accommodation, education and employment inequalities that contribute towards:

- A 10-12 year reduced life expectancy
- High infant mortality, miscarriage and stillbirth rates
- High rates of young adult deaths due to accidents (in particular road traffic accidents)
- 2-5 times more health problems than the settled population.

[7] Bradley S and McKelvey SD (2005). General practitioners with a special interest in public health: at last a way to deliver public health in primary care. J Epidemiol Community Health 2005;59:920–923.

ELR CCG and the public health team at Leicestershire County Council are working in partnership to develop an innovative, multiagency approach to improve health outcomes and reduce health inequalities experienced by travelling families. As part of this approach ELR CCG deliver a number of gypsy and traveller cultural awareness sessions delivered by members of the local travelling community for all members of the practice from receptionists to GPs.

5.7 Enabling strategies

5.7.1 Local flexibility

Unlike the Area Team who is a subset of NHS England and, thus, has to follow a single operating work, the CCG will have local flexibility to amalgamate all forms of investment into primary medical services. This flexibility provides the greatest opportunity to change systems, clinical process and ultimately patient outcomes. There is currently significant fragmentation and duplication in the system, which leads to confusion for practices and unwarranted trips for patients.

The clearest example of this is the separate processes for providing additional services on top of core General Practice contracts. A level of integration would enable practices to direct resources most clearly to, for example, those frail elderly patients least suited to receiving health care through unplanned admissions. Integration would ensure that there is an end to the fragmented approach when responding to subtle differences in national frameworks (QOF, DES, even NICE guidance). Locally derived and directed initiatives could be developed to reflect local health needs where these are different to the national picture.

5.7.2 Premises

The model of GP owned and run premises, reimbursed by NHS funding remains common, but does not act as a catalyst for large-scale investment in new larger health centres, which would provide a hub for modern, integrated care for the local population. This is not to say that the independent contractor status of GPs is not appropriate, but to enable improved outcome for patients through centralised primary care, there will need to be significant investment in premises. This model may require fewer larger GP partnerships, providing at scale specialist, community and diagnostic ambulatory services. The CCG will explore, with local partners, new and innovative methods of investment through public and private routes.

5.7.3 Organisational development

The CCG with its close working ties with member practices has developed an offer to help and support GP practices identify and progress their organisational development agendas to embrace and deliver the changes that are required in primary care. In brief these four key work areas have been embraced by members and will support our future engagement and form the basis for significant education and organisational change management.

Work stream	Activity
Practice OD	Support practices to manage demand, activity and capacity
Training and Education	PLT - Disease education, i.e. AF, diabetes Sharing / maximising other development GP / Practice Nurse education
Joint Working	Define and identify opportunities Grouping and scale Future planning
Workforce	Understand roles and responsibilities of HEE Having a voice at the LETC

This builds on a strong tradition within ELR CCG of clinical training and education of registrars and students.

5.7.4 Investment

The funding crisis within the NHS is well recognised and in particular primary care has seen a tangible reduction with 90% of activity taking place in General Practice with only 8% of the funding. The opportunity that the co-commissioning of primary medical services gives is that the CCG will hold the entire health budget for our population and can now commission and invest across the whole pathway and spectrum of health and social care. This is unlikely to manifest directly into transactional services with single providers, but will allow the increased investment across the totality of health and social care networks.

5.7.5 Information

The key to success is knowing how every intervention within a pathway contributes to an improved outcome. Success is based on patient outcomes, not data input. By using an automated extraction process, it will both simplify work for all providers, in particular General Practice, whilst allowing the commissioner to understand the impact. The CCG is working with colleagues within GEM CSU to develop these processes and the full national budget for GP IT was transferred to CCGs in 2014. This provides the opportunity through Information technology to collect and collate data from across health, public health and social care to add greatest value.

6 Nature of Commissioning

6.1 Collaborative approaches

The guidance provided by NHS England in May 2014 suggested that each CCG could take on a varying level of autonomy, dependent on its confidence to deliver and relationships with their local Area Team. ELR CCG has already developed a productive and collaborative relationship with the NHS England (Leicester and Lincolnshire Area Team), which has helped to influence the development and nature of Primary Medical Services. This collaborative, joint working has been essential in the development of joint strategies, information

sharing and financial planning. Examples of our collaborative arrangements that form a platform for co-commissioning:

- Primary Care Interface group, a joint Area Team/CCG, Quality, Governance and data sharing group that has been running for nearly two years to ensure robust process is in place for monitoring of general practice
- ELR CCG and the Area Team have in conjunction with the LMC, worked together to develop a practice merger policy to enable General Practice Contracts to be combined to improve economies of scale and benefits to patients
- Joint Area Team/ELR CCG process with a troubled practice with contract remedial actions to both support the GPs and practice team and drive up quality of care
- Joint LLR/Area Team/LMC group to assess the impact of FDR and work together to ensure an appropriate solution to a politically sensitive issue. This will morph into a PMS review group with the same robust challenge
- Informal monthly meetings with the Area Team Head of Primary Care to discuss key actions/work streams and particularly issues raised by practices to agree a practical solution
- The three CCGs, following discussion with the Area Team have commenced development of a Primary Medical Services 5 year strategy. This builds on the two workshops held by the Area Team and is a bottom up clinically lead solution to meeting the six local ambitions from NHS England, alongside the need to have a cross-cutting strategy to the Better Care Together Programme.

Recognising that established relationships are only one part of the jigsaw, they set a strong foundation and evidence in managing primary care that will facilitate a smooth transition to CCGs.

6.2 Competence and capacity

6.2.1 Clinical leadership

Fundamental to what makes a CCG different from previous NHS organisations, is the level and involvement of clinicians in the day to day decision making and quality assurance process. ELR CCG has recently increased the number of GPs on the board from 6 to 8 and enhanced leadership with the appointment of two clinical vice chairs. This day to day involvement in the design of health care services in conjunction with secondary care and community clinical colleagues is how the CCG and health system will be able to drive greater innovation and change in the local system. Notwithstanding the assurance required in relation to conflicts of interest, which is covered later in this bid, local clinicians are perfectly placed to understand the needs of their patients and the gaps in the system.

6.2.2 Managing financial resources

The CCG's finance department has a management accounts section dedicated to the effective financial management of the existing Primary Care budgets such as Prescribing and Community Based Services. This also

included the managing of both Qof and DES until 2013/14 when these services were transferred to the AT. The CCG has a very strong relationship with GEM CSU to ensure payments for primary care services. This strength and experience led to a successful year in 2013/14; the External auditors have:

- Given an unqualified regularity opinion on the annual accounts
- Reported that the CCG is achieving value for money
- Not highlighted any control weaknesses

6.2.3 Primary care team

Since the CCG formed in 2012, the focus for General Practice was on managing clinical variation, choice and engagement in peer review. This has evolved to clinical quality and outcomes, engaging with health and social care partners as a 'whole system approach'. The current Primary Care/Operations structure has been refocused to meet the changing needs of primary care and support the integration of health and social care initiatives.

The primary care/operations team is already set up to support the concept of co-commissioning through:

- Locality business and clinical engagement planning
- Practice facilitation and 'first contacts'
- Stakeholder engagement, community nursing, Social Care, District Councils
- Performance of practices around the CCG GP support/investment plan/Practice Profiles and quality information
- Liaise with the NHS England Area Team over service developments and national policy directives
- Corporate reporting on primary care achievements

There are a number of advantages which co-commissioning would bring to the current CCG operations team. Related to the ongoing contract monitoring of primary care this would allow:

- Improved knowledge and understanding of the specifics to the Primary Care Contracts to aid day to day queries
- Allow for joint visits and to highlight contractual and CCG quality improvements
- Locality Managers to assist in the annual contract review process/QOF visits/assurance
- An integrated contracting/commissioning and operations structure would allow for easier and less complex claims process to be implemented

6.2.4 Primary Care Contracting

ELR CCG already has a track record of delivering high quality primary care services through the management and implementation of enhanced services and Quality and Outcomes Framework (QOF) which transferred over to the CCG in 2012 when in shadow form. Some of the key developments and achievements have been:

- A full review of all enhanced services took place through a panel made up of Public health, lay members, GPs and practice managers to provide a clear evidence base for either retaining or ceasing these services. The result was that every service was presented to the joint LLR competition and procurement panel following a market testing process. The outcome was that 90% of the services were tendered on a single provider contract for general practice, with an increased investment in primary care and new quality and performance schedules to improve quality of service for patients using the NHS Standard Contract through the e-contract portal
- Developed strategy for implementing QOF and secured approval from the PCT Primary Care Contracting Panel. Recruited GP clinical assessors to support QOF visits and carried these out for two thirds of practices within the CCG. Designed templates to capture and record QOF achievement and managed disputes on an informal basis avoiding escalation to formal dispute resolution process. This lead to a review of low prevalence and high exception reporting rates within the CCG and formed part of the practice quality visit process.

6.3 Future contracting function

The CCG currently has one primary care contracts manager running all of the community based services and the Local GP investment plan. There are six senior managers within the organisation that have previously worked as primary care contracts managers who provide a wealth of experience to ensure that the future function will be appropriately skilled and staffed. These individuals now work in commissioning, contracting and primary care so have the broader knowledge and skills to link primary care contracts with the wider commissioning cycle and contracting round to ensure that services and pathways are joined up, as well as existing strong personal relationships with member practices to enable seamless transition. This new team will need to work jointly with the Area Team contract managers to ensure a smooth handover and delivery.

There is an acknowledgement that this function is a complex one, especially with the PMS reviews commencing and the lack of national guidance for primary care premises, however with the current relationships with the Local Professional Networks for LLR and the Area Team a strategy can be developed that will enable new service/re-provision of services to be delivered in line with the Single Operating Framework published by NHS England to ensure

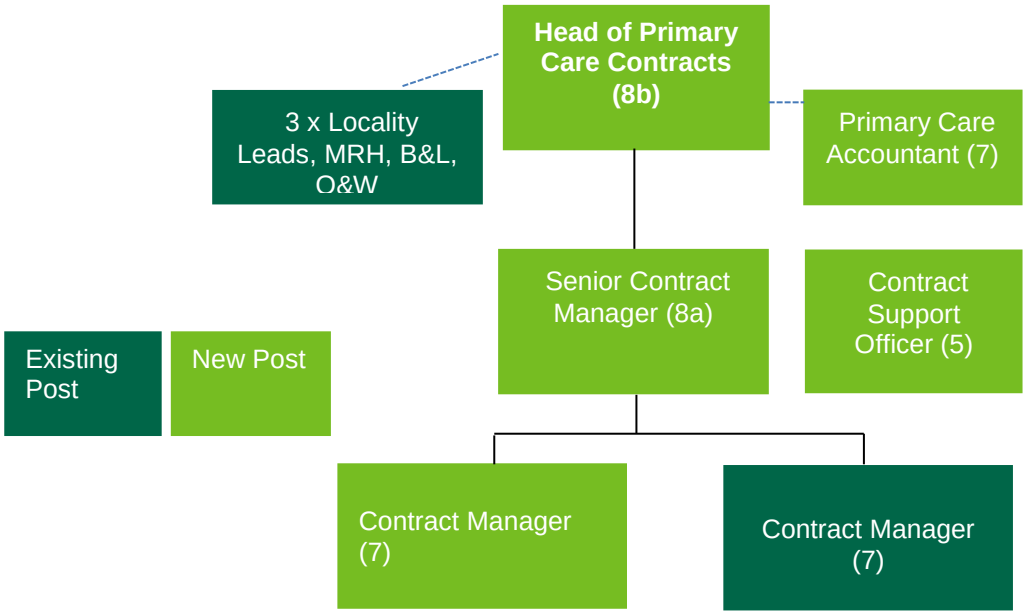
In addition to this framework, the CCG's broader commissioning responsibilities will enable the scope of requirement/commissioning intentions and procurement to enable whole pathways of care to be delivered through joined up contracts.

6.4 Future structure and running costs

The CCG has evidenced that it has the finance, contracting and primary care infrastructure to enhance patient outcomes by managing the entirety of Primary Medical Services. There are, however, gaps in both the specialist knowledge and staffing capacity to ensure continuous improvement.

The initial guidance suggested that this service would need to be taken on and managed within existing management resources. More recently the Local Area Team has suggested that staff will be available to CCGs. ELR CCG welcomes this proposal and will work closely with the AT and other LLR CCG colleagues to work through a process to ensure that the fair share of skills and capacity are transferred. There are a number of options for staff transfer, including a hosted function; however, ELR would prefer to have an embedded team employed by the CCG and have a shared pool of specialist knowledge across CCGs, which could include premises.

Following conversations internally and with the Area Team, our proposed structure planned to not just meet current demand, but enhance the outcome of managing primary medical services can be seen in the following structure chart.



7 Timescales

In order to ensure that this process has a smooth transition of contracts, staffing and funding, ELR CCG is planning a phased approach, as set out in the diagram below.

Phase	Level of Autonomy (position as at end of Phase)	Actions
Phase 1: 2014/15	Full transfer of all DES and QOF and a plan for the transfer of GMS/ PMS contracts and premises	• A joint LLR Co-commissioning transition group, which will need to work through full governance, assurance and monitoring procedures. • A joint plan to ensure that the staffing, financial and contract functions will have a smooth transition. • The CCG will produce a detailed strategy for how co-commissioning will facilitate the achievement of the 5 year strategy and integrate with the BCF • The CCG will produce a vision document on the future models of community and primary care, including premises, capital and procurement plan • The CCG will produce a detailed operational plan for handover and delivery.
Phase 2: 2015/16	Shadow running of GMS/ PMS contracts and premises	• Transfer of staff / shadow running of finances / Delivery of quality and contract assurance
Phase 3: 2016/17	Full transfer of GMS / PMS contracts and premises	• Exploration of new premises / asset management models

8 Governance

8.1 Conflicts of interest

Currently as part of the Health and Social Care Act 2012, Area Teams as part of NHS England, commission primary medical care services. However, CCGs have a statutory duty to continually improve the quality of primary medical care and already have powers to commission non-core contract services from general practice (or from other primary care providers) in their own right through the development of Community Based Services contracts.

As a statutory body, ELR CCG already produces clear and transparent plans on our governance, delivery and strategic direction and this would not change with an expanded role into primary care. The strong oversight role that lay members already play in CCGs, working across the system with Health and Wellbeing boards and NHS England Area Teams, as well as others, means that any perceived conflicts of interests within CCGs can be managed and the public can be reassured that primary care decisions are being made in the best interests of the patient.

ELR CCG has a statutory duty to manage conflicts of interest (Section 140 of the National Health Service Act 2006, inserted by the Health and Social Care Act 2012) and to have regard to the statutory guidance on managing conflicts of interest published by NHS England.

ELR CCG has a Conflicts of Interest Policy and established processes in respect of the following:

- Maintaining a register of interest of the members of our governing body, members of our committees and sub-committees of our governing body, and our employees;
- Our register of interest is published on our website and reviewed and updated on a quarterly basis
- Arrangements are in place to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group, and record them in the registers as soon as they become aware of it, and within 28 days
- Arrangements set out in the constitution for managing conflicts of interest, and potential conflicts of interest in such a way as to ensure that they do not and do not appear to, affect the integrity of the group's decision-making processes.

In addition under the NHS (Procurement, Patient Choice and Competition) Regulations 2013, the CCG is required to:

- Manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been or appears to have been affected by a conflict
- Keep appropriate records of how they have managed any conflicts in individual cases.

The CCG aims to continue to review current arrangements on a regular basis to ensure they remain robust so that the integrity of the decision-making is not compromised and that they continue to adhere to the Nolan Principles; and that processes are in line with any national and local changes.

8.2 Future safeguards

In respect of any functions that the CCG carries out jointly with, or on behalf of, NHS England, the CCG intends to strengthen the current arrangements to ensure additional safeguards are in place to manage actual or potential conflicts of interest.

Systems and processes
The CCG will establish a Register of Interests for our member practices where declarations would be requested in relation to each GP Partner and salaried GP. This would provide overview of potential / actual interests within the practices. Publish the register of members' interest. This will ensure a more proactive approach to seeking to identify and minimise the risk of conflicts of

interest at the earliest possible stage, for instance by considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making roles, and by ensuring individuals receive detailed overview as part of their induction and understand their obligations to declare conflicts of interest. The induction pack will include a range of different situations and scenarios to assist the individuals. Furthermore, a regular training session will scheduled at least on an annual basis for Governing Body members and committee members to attend, with a protected learning time event scheduled for GPs and practice staff. The purpose of the training and awareness will be to ensure individuals understand the processes, feel empowered and confident to be able to make the declarations where required and even if they do not that they have a point of reference to seek guidance.

The CCG will also manage corporate risks in relation to perceived conflicts of co-commissioning are reflected in the Board Assurance Framework and actions to mitigate risks monitored through e.g. external scrutiny committee / Audit Committee and issues reported back to Governing Body.

Commissioning decisions

The CCG will:

- Review procurement processes to ensure they continue to be robust, fair, open and transparent; and stand up to scrutiny and challenge. In addition, review and strengthen the disputes handling process relating to procurement exercise where issues are raised in relation to procurement process and perceived conflict raised.
- Continue to ensure robust patient engagement processes are in place including engagement with public and other stakeholders in relation to appropriate commissioning decisions.
- Refresh the remit of the Primary Care Development Group, which reports into our Strategy, Planning and Commissioning Committee (which is a committee of the Governing Body

Performance and contract monitoring

The CCG will establish a Primary Medical Services Performance Group that reports into our Quality and Clinical Governance Committee (which is a committee of the Governing Body). This group will monitor, review and advise on contracting, quality and premises issues.

It is recognised that the GPs and the Practice Managers on both groups will be conflicted and individuals concerned will be required to declare any perceived and actual conflicts, which will be recorded on the appropriate register and also in the minutes of the meeting. The group would not be a decision-making group, rather it making recommendations to the Strategy, Planning and Commissioning Committee. This committee membership will be reviewed to ensure that the GPs from its sub-group (the Primary Care Development Group) are not the same GPs that form part of the Committee's membership. Existing processes will apply to the Committee in that if the GP members on the Committee are conflicted in relation to any item of the agenda they will absent themselves from the discussion and decision-making

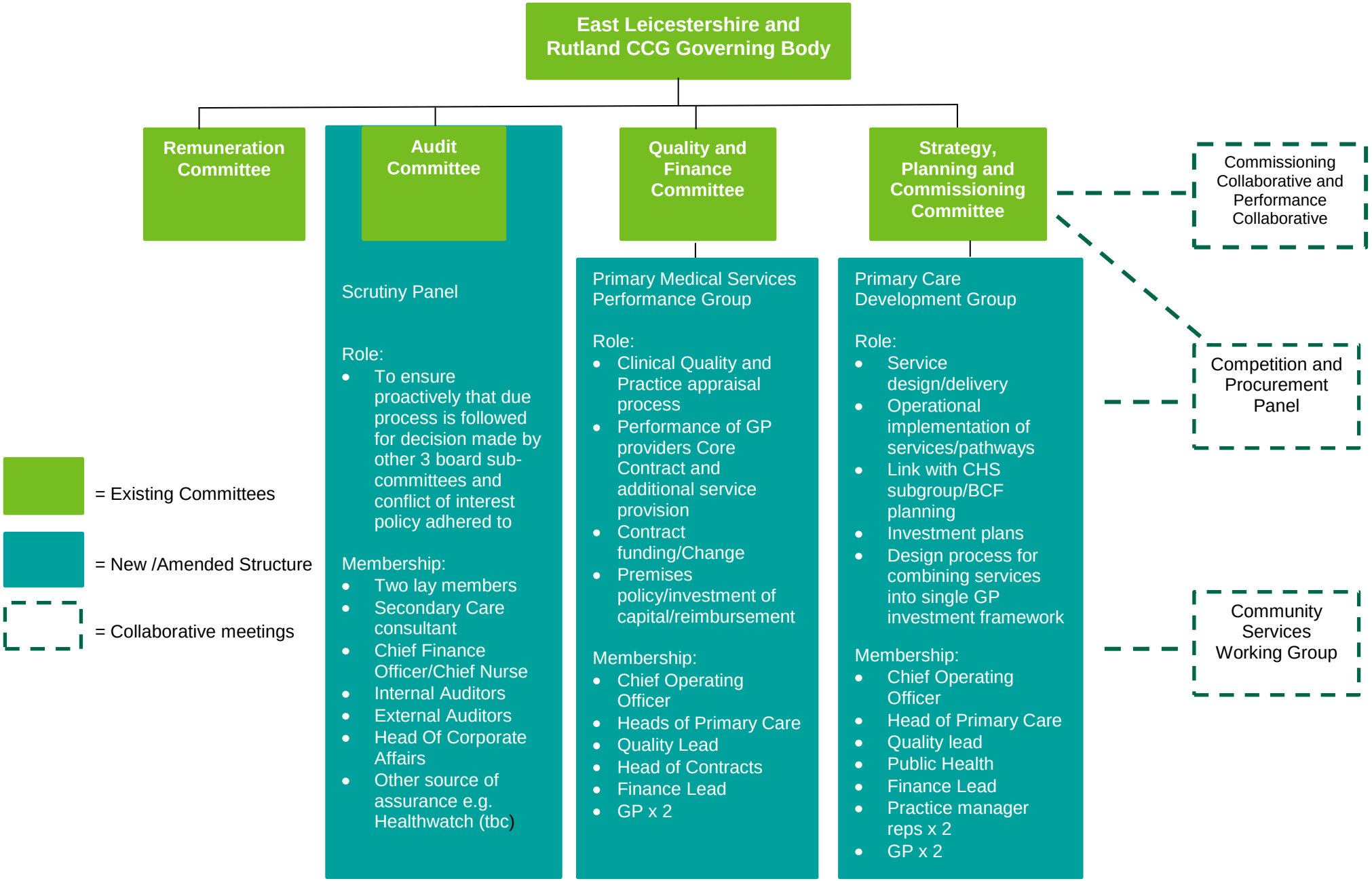
and therefore cannot influence the decision. If this results in the meeting not being quorate the CCG has the facility to co-opt GPs from other local CCGs.

Governance and assurance

In addition to establishing the two groups described above, the CCG will establish a scrutiny committee. At present it is proposed that this role be incorporated into the role of the Audit Committee. The purpose of a scrutiny committee would be to independently review the CCG's decision-making processes prior to reports being submitted to the formal sub committees of the board and provide an independent report to the Governing Body of any potential and actual risks identified in relation to managing conflicts and adherence to Nolan principles. This will include decision-making across the CCG including services across primary care. The Audit Committee membership currently consists of lay members and secondary care clinician. We would look to extending the membership to include: a public health consultant and Healthwatch (Leicestershire and Rutland). The additional members will bring independence and ability to scrutinise and challenge the commissioning decisions made and the underpinning processes of the CCG to ensure that the processes continue to preserve the integrity of the decision-making process.

The future governance arrangements are summarised in the following revised committee structure chart.

Revised East Leicestershire and Rutland Clinical Commissioning Group Committee Structure



9 Engagement

9.1 Early conversations

ELR CCG held early discussions on co-commissioning in May 2014 with its 34 member GP practices through its Practice Manager Forum, as well as in the Rutland Integrated Executive, LLR wide Primary Medical Care Interface Group and Primary Care Development Group, alongside significant informal conversations with the Area Team of NHS England and local GPs.

The concept and opportunity was also discussed by ELR CCG's governing body during its confidential session on 10 June 2014, which resulted in unanimous support for the CCG expression of interest.

Tim Sacks, Chief Operating Officer, held telephone conversations on 11 June with Chief Executives at Local Borough Councils, Rutland County Council and Leicestershire County Council. This was ahead of a one-page summary (Appendix 1) and a link to an online questionnaire (Appendix 2) being sent out to gauge the level of support locally for the CCG taking on the additional responsibilities for primary medical care services and any additional comments. This was sent to the following organisations:

- GP practice managers and Lead GPs
- Local Medical Committee
- Healthwatch Rutland
- Healthwatch Leicestershire
- Health & Wellbeing Board Rutland - chair
- Health & Wellbeing Board Leicestershire - chair
- Rutland County Council – Chief Executive
- Leicestershire County Council – Chief Executive
- Oadby & Wigston District Council – Chief Executive
- Melton Mowbray District Council – Chief Executive
- Market Harborough District Council –Deputy Chief Executive
- Blaby District Council – Chief Executive
- Patient Representative Group (PRG) Chairs of all ELR Member practices
- LPT – Chief Executive
- UHL – Chief Executive.

This equated to 71 Practices, PRGs or stakeholder organisations. In total, 57 (80%) responded to the questionnaire, with 37 voting yes, 3 voting no and 17 voting undecided.

In supporting the bid, comments included the benefits of streamlining and integrating services, centralising, information from one place, good relationships with the CCG and benefits to practices. Positive comments include:

“The opportunity to work in the locality to align budgets and provide services for local people is to be welcomed. This will enable joint working to tackle people's problems in an appropriate way which frees up clinical capacity and budgets to deal effectively with the medical needs and not symptoms or worries resulting from other life or lifestyle issues.”

“It makes considerable sense in the context of health and social care integration if primary care commissioning is undertaken locally and therefore support for ELR CCG is strong.”

“I am impressed by what I have seen of ELR CCG and although usually very cynical do believe that the CCG is managed well and puts patient needs first. The culture of the CCG is in my experience open, well focused, and dynamic. I believe it would organise primary care medical services well.”

It is recognised that others respondents raised concerns around capacity and expertise, conflict of interest and governance. A few people felt that they did not have enough information to reach a decision:

“On behalf of Leicestershire Partnership Trust, we support this move and will be beneficial to integration and local working together to align strategic direction. One caveat would be potential conflicts of interest within the ELCCG board and members providing the commissioned service. eg when the CHS contract goes out to tender and LLR provider org (of which their practices are all member organisations) bid for the service! As long as these arrangements are transparent and clearly articulated from the outset I think this will be a helpful move.”

“This creates an even stronger conflict of interest between GP Board Members and the resourcing of their individual practices. How will this be resolved when individuals commission services from themselves?”

“To me, it seems to be a difficult decision without a comprehensive explanation of what is involved.”

The full spectrum of comments can be seen in Appendix 3

9.2 Future conversations

Engagement with our patients, carers, partners and stakeholders throughout the development of our ambitions will be a key element of our planning. Using our existing mechanisms such as our locality meetings and existing channels and good relationships with practice based patient participation groups we will build comprehensive two-way engagement into our plans, listening and responding to a wide range of comments. This has already started and we are holding a public and patient involvement event on 1 July in Market Harborough which will actively seek people’s views to feed into our plans on co-commissioning.

10 Monitoring and evaluation

The monitoring and evaluation of the success of co-commissioning of primary medical services has the potential either to be overly complex or too simplistic. Key to the success of this venture is to understand from the outset that monitoring contracts in a reactive fashion and retaining the separate functions of individual providers rather than outcomes for patients will be deemed a system failure. To this aim, monitoring and evaluation will be a multi-layered approach.

Practice level

It is vital to ensure that there is a quality assurance process for General Practice and that it remains engaged with the transition necessary in the system. This will be delivered through a three stage practice performance, quality, and engagement process.

- **Contract Management**: Annual Contract Review on a 3 year cycle and on years when a contract review is not undertaken, a self-assessment tool will be used to review and identify any areas of non-compliance, which may lead to a targeted approach using the contract levers, this may mean agreement of an action plan to address and rectify within an agreed timeframe or more formal measures such as remedial/breach notices. Where a change is requested by the Provider a formal process will be followed to allow for review of the proposal in line with the Regulations and the Operating Framework and where approval is given and enactment of that change by way of a formal Contract Variation – this can cover areas such as change in partners, premises, legal status all of which are governed through the Regulations.
- **Quality Appraisal**: Annual practice quality visit by a pool of skilled GP assessors will take place to perform a quality appraisal of each practice. This will be focused on patient outcomes and quality improvement based on the dashboard and will enable sharing of good practice or formal action plans if necessary. This combined information will form part of the internal and external assurance process
- **Member Engagement and Service Development**: An annual practice visit from senior members of the CCG alongside the elected Locality GP. This will provide an excellent opportunity to express practice views/opinions on service delivery and current primary care /community issues and inform the CCG on future commissioning intentions. These visits will also provide an opportunity to develop plans to work collaboratively with other GP practices across networks

Long term change in Primary Care

To monitor any significant change that co-commissioning will have on delivery of services through and by general practice requires a long term study commencing with a baseline. To enable this to take place in a formal and academic fashion, ELR CCG working with the LMC has approached the University of Leicester to work through the possibility of a long term formal study of primary care. This would commence with a detailed analysis of patients, staff, services, funding, ratios and delivery and will over time see how these change to reflect the new systems and models of working

System wide
Key to analyse the extent to which this innovation adds value, there is the need for broad hypotheses for markers of success. These will either be specific or proxy measures for system wide success. Specific examples are:

- Do patients believe that care, access, outcomes have improved
- Did co-commissioning act as a catalyst for new models and networks of integrated care
- Has the CCG succeeded in commissioning system wide pathways across health and social care using alliances / networks
- What proportion of over 65s have an unplanned admission (as a proxy for integrated service delivery)

The complexities of how co-commissioning will deliver change across all areas are as yet not fully defined; however, ELR CCG is committed developing, and agreeing with stakeholders, a detailed and tangible set of measures to evaluate the success.

11 Issues and considerations

There are a number of potential challenges to the success of this transfer of responsibility, based on unknowns and lack of national policy guidance. None of these are insurmountable, but consideration of the following areas will need to be made:

- Freedom for the CCG to design local primary medical services moving away from traditional national strategies such as Qof for the benefit of patient outcomes.
- Pressure on existing primary care budgets and potential financial gap if QIPP has been applied prior to budget transfer.
- Lack of national guidance for premises capital and investment, which is needed to help develop our future strategy
- Availability and skills of Area Team employed primary care staff, for supporting this move
- Ability of the CCG to manage the positive relationship with member practices, in changing and challenging times

12 Conclusion

East Leicestershire and Rutland Clinical Commissioning Group welcomes the opportunity to express our interest in assuming responsibility for co-commissioning of integrated care services across the spectrum of health and social care to improve patient outcomes for our local population.

The ability to build on our significant track record of clinical leadership, engagement and pathway redesign, with General Practice at the centre, will

enable us to progress innovative approaches to models of commissioning pathways of care.

The local Leicester, Leicestershire and Rutland 5 year strategy and Better Care Fund priorities across Leicestershire and Rutland demand unprecedented levels of integration and strong clinical leadership. The enabler for meeting these demands is a unified and innovative primary care strategy, which can only be fully realised through the joint commissioning of health and social care services.

The CCG is expressing an interest to take the greatest level of responsibility available for the co-commissioning of all primary medical services; however, we understand success will be secure through effective collaboration across health, social care and in partnership with patients, carers and the public.

We believe that the transfer of these services needs to be phased with planning and shadow running prior to assuming full delegation in 2016/17. This will enable the greatest opportunity for a smooth handover complemented by the right level of engagement and involvement of all stakeholders.

The CCG governing body and the vast majority of our members and stakeholders who have expressed an opinion on co-commissioning, support the prospect of taking wider responsibility for commissioning services. We hope that this expression of interest provides the assurance to NHS England that our leadership, vision and track record will drive forward sustainable, quality care in East Leicestershire and Rutland.

Appendix 1: Summary Statement for Stakeholders

Summary
NHS England announced on 5 May 2014 that all clinical commissioning groups could express an interest in taking on enhanced powers and responsibilities to co-commission primary medical care services. The responsibility for the contractual elements of primary medical care has sat with NHS England's Lincolnshire and Leicestershire Area Team since the abolition of Primary Care Trusts in March 2013.

Now East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) has the chance to manage primary medical care services and give the greatest opportunity to improve patient care and integration.

The areas of responsibility are:

- Primary Medical Services (PMS) and General Medical Services (GMS) contracts – eg, core general practice services
- GP premises
- Quality and Outcomes Framework (QOF)
- Directly Enhanced Services (DES)

The governing body of ELR CCG voted unanimously this month in favour of taking on the responsibility for all of Primary Medical Care services so as to be at the forefront of developing the right solutions. This decision is optional, however it is the view nationally that primary medical contracts will end up as the responsibility of CCGs. Locally, across Leicester, Leicestershire and Rutland, both West Leicestershire and Leicester City CCGs have indicated they would like to take on the full responsibility for all elements of primary medical services.

What could it mean?
By taking on these responsibilities, we should be able to improve the integration of services in the community, reduce inequalities and improve quality. Importantly we will need to ensure that we maintain and improve our relationship with our member GP practices while holding their contracts and have a strengthened governance structure in place.

Have your say
We want you to tell us if you support ELR CCG taking on co-commissioning for Primary Medical Services, as well as any additional comments you may have. Please click here to tell us your views by 17 June.

What happens next?
We will take your views into consideration before the deadline of 20 June to submit our initial bid.
The Area Team envisages it would take most of 2014/15 to agree the strategy and process if the CCG wanted to take on these responsibilities, allowing time to work through any staffing and funding arrangements and ensure a smooth handover. This is likely to be followed by a shadow year of joint responsibility in 2016/17, with the CCG taking on full responsibility from 2016/17.

Appendix 2: the Survey

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Co-commissioning questionnaire
NHS England announced on 5 May 2014 that all clinical commissioning groups could express an interest in taking on enhanced powers and responsibilities to co-commission primary medical care services.

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Now East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) has the chance to manage primary medical care services to add the greatest value to improve patient care and integration.

Please let us know your views by filling in our short survey below:

1 Do you support ELR CCG in taking on co-commissioning for primary medical care services?
Yes
No
Undecided

2 Please let us know any other views that you may have.

Appendix 3: Survey Results

ELR CCG Co-Commissioning Survey 2014	
Please let us know any other views that you may have.	
Answer Options	**Response Count**
	41
answered question	**41**
skipped question	**16**

No.	Response Date	Response Text
1	**Jun 17, 2014 1:26 PM**	Comments from our practice: It (being CCG managing primary care contracts) might facilitate practices being able to work more closely together under a federating type model. We have to work with the CCG and should support this It is impossible to be sure that it will be better under the CCG, but we have to work with our neighbouring practices.
2	**Jun 17, 2014 1:12 PM**	In theory sounds like a good idea BUT I have major concerns about conflicts of interest. I am worried that resources will be diverted away from the CCG's main functions while attention is focussed on preparation for taking on this new role. I feel disenfranchised- was this letter/survey sent to all GPs as well as practice managers, as I don't think I received the email. From attending the 'breakout session' at the PLT event on 12th June, I got the impression that this change was likely to go ahead irrespective of the views of the grass roots GPs who are supposed to 'own' the CCG.
3	**Jun 17, 2014 11:04 AM**	The opportunity to work in the locality to align budgets & provide services for local people is to be welcomed. This will enable joint working to tackle people's problems in an appropriate way which frees up clinical capacity & budgets to dealt effectively with the medical needs & not symptoms or worries resulting from other life or lifestyle issues.
4	**Jun 17, 2014 8:19 AM**	The ELR CCG has yet to demonstrate that it has made a difference in improving the quality and provision of community health care. I would prefer that the CCG has another year of experience in its present responsibilities before NHS England considers devolving further power or finance to it.
5	**Jun 17, 2014 7:08 AM**	This was discussed at Rutland Integration Executive of the Health and Wellbeing Board. The Local Authority was supportive of the approach as were other partners, it was recognised that the CCG takes the lead on many areas that affect us locally with little involvement from the Local Area Team at the moment, it would be in the best interests of Rutland for the CCG to take on more commissioning responsibility particularly if more local decisions can be made for out of hospital plans. It was recognised that issues

No.	Response Date	Response Text
		particularly around conflicts of interest will need to be thought through.
6	**Jun 16, 2014 3:32 PM**	I support this on condition it leads to a joined-up, accessible, timely, trouble-free service for patients.
7	**Jun 16, 2014 2:15 PM**	One authority which already has strong links with practices is preferable to the existing situation
8	**Jun 16, 2014 2:15 PM**	On behalf of Leicestershire partnership Trust, we support this move and will be beneficial to integration and local working together to align strategic direction. One caveat would be potential conflicts of interest within the ELCCG board and members providing the commissioned service. eg when the CHS contract goes out to tender and LLR provider org (of which their practices are all member organisations) bid for the service! As long as these arrangements are transparent and clearly articulated from the outset I think this will be a helpful move.
9	**Jun 16, 2014 11:15 AM**	How CCG's will link together to avoid any significant differences in services between localities? Yes it is a positive move and should reduce the confusion about who does what in the NHS
10	**Jun 16, 2014 10:26 AM**	Co-commissioning by ELR CCG will give greater opportunity for a more localised perspective into effective commissioning of primary care services.
11	**Jun 16, 2014 7:53 AM**	This creates an even stronger conflict of interest between GP Board Members and the resourcing of their individual practices. How will this be resolved when individuals commission services from themselves?
12	**Jun 15, 2014 2:21 PM**	Anything that can make the NHS more efficient, cost effective and/or give any assessable economies of scale should be welcomed by all, especially if service levels can be standardised
13	**Jun 13, 2014 4:11 PM**	I am impressed by what I have seen of ELR CCG and although usually very cynical do believe that the CCG is managed well and puts patient needs first. The culture of the CCG is in my experience open, well focused, and dynamic. I believe it would organise primary care medical services well
14	**Jun 13, 2014 8:38 AM**	It makes good sense to have this organised from one centre in order to give the public the service they are looking for..
15	**Jun 13, 2014 7:56 AM**	But potential areas of conflict of interest with GPs on the board and in practices. People who have experienced local issues will be involved in making decisions. Need to ensure people are trained and have access to expertise to undertake what is being asked of them. would appear to be removing a layer of management so better and closer communication could be anticipated.
16	**Jun 12, 2014 4:30 PM**	I think it is a good thing to bring responsibilities and decision-making closer to the community.
17	**Jun 12, 2014 1:36 PM**	I believe, that the mindset and governance from The ELR CCG if conducted with the correct acuity and enthusiasm within the guidelines of NHS England and by listening, debating and conforming action with the views of the people,

No.	Response Date	Response Text
		our general public. The ELR CCG will keep both, the Government (NHS England Directives) and its people (The Electorate) content in what services must remain within a locality and in other aspects what relocation needs to be made, in the aspect of what we are trying to debate here currently. By being a good mediator, which I believe you have been conducting well and persevering in not making irrational decisions, you should conclude with the best possible answer also.
18	**Jun 12, 2014 12:56 PM**	It will be better for practices and patients to be engaging with one body. But it is important that all news And changes announced by NHS England are still communicated to and by the CCG.
19	**Jun 12, 2014 8:43 AM**	This is the most absurd consultation yet. The information provided contains only empty statements of ambition and nothing about how structures might change or, most crucially, how this will be resourced. One question. When will NHS structures and policies stop churning, so that something has a chance to embed and make possible some rational and informed decisions about what is most efficient and effective.
20	**Jun 12, 2014 8:33 AM**	As a new Practice Manager it makes sense to have everything under one group with very helpful people on hand.
21	**Jun 12, 2014 7:42 AM**	Are the GP's happy with this? If not what are their objections? It would seem reasonable for decisions to be taken closer to "Home". Will co-commissioning work who takes the ultimate responsibility? What if there is disagreement between NHS England and the CCG?
22	**Jun 11, 2014 9:51 PM**	Transforming out of hospital care will be pivotal in determine rapid progress in service improvement - allowing CCGs to have the necessary levers to maximise incentives and alignment of services will be essential
23	**Jun 11, 2014 9:28 PM**	To me, it seems to be a difficult decision without a comprehensive explanation of what is involved.
24	**Jun 11, 2014 9:26 PM**	It's a no brainer. Congratulations on being offered this great opportunity
25	**Jun 11, 2014 6:38 PM**	Presumably the other party to 'co-commissioning' is NHS England? Extra resources will be needed to undertake the additional duties, where are these to come from? Is there a danger that your current 'lean' approach to running/ managing the CCG will fatten up, and become like the disbanded PCT's. Can you in your enthusiasm avoid this?
26	**Jun 11, 2014 6:12 PM**	When the NHS is struggling to meet its targets due to budget constraints anything that helps stramline services and provide local services is a good thing
27	**Jun 11, 2014 5:09 PM**	Wondering if the people involved will have enough expertise to make the necessary decisions and if this change will in fact benefit the user.
28	**Jun 11, 2014 3:40 PM**	The only worry I have is about the scrutiny , and governance and with The GP Led commissioning group who would have

No.	Response Date	Response Text
		the oversight. I am sure it would be less confusing to the public who have real difficulty understanding the present complex system
29	**Jun 11, 2014 3:34 PM**	How will autonomy remain if CCG are going to be inspecting and evaluating themselves ? Who will monitor the quality of service provided to the public? How will this affect other primary care providers Eg pharmacy , dentistry?
30	**Jun 11, 2014 3:32 PM**	It may not be my business, you do not say what geographical area you cover. My instinct is to say NO. Big is rarely better.
31	**Jun 11, 2014 3:06 PM**	I am a very new PM and as yet I am unsure about what I think. One thing I cannot quite understand is why we have three CCG's across Leicestershire. Would this change mean that there would be one CCG for city and county? I think that would make the most financial sense.
32	**Jun 11, 2014 3:02 PM**	I would need more details on how the ELR CCG would manage primary medical care services. My particular concern is about the integration of patient care taking into account the requirement of more "FULLY TRAINED PROFESSIONALS" and not just course trained nurses who can't cope with the demands made on their time. Patient care is about service provision at the point of need without being on a waiting list. I realize all primary care is not up to standard and ELR CCG management would be a positive step forward but, where primary care has been inspected with excellent results, would their funding be affected and used to bring others into line? As far as I can see more clarity about the actual process is required.
33	**Jun 11, 2014 2:49 PM**	This seems a very sensible step forward and we would look forward to supporting the CCG and the GP's in their work within any changed arrangements.
34	**Jun 11, 2014 2:49 PM**	It makes considerable sense in the context of health and social care integration if primary care commissioning is undertaken locally and therefore support for ELR CCG is strong. It is noted that WL CCG is taking similar steps, which are also supported.
35	**Jun 11, 2014 2:46 PM**	I hope this development will include a meaningful role for the PPGs
36	**Jun 11, 2014 2:43 PM**	It would streamline decision making process. Difficulties encountered during consultation process for urgent care services would apparently be reduced.
37	**Jun 11, 2014 2:33 PM**	I don't feel that the CCG will have the capacity to deal with this. Also concerned about conflict of interest if CCG , which is a member organisation, holds the contract for its members and how that will affect the relationship between the CCG and member practices
38	**Jun 11, 2014 1:55 PM**	I cannot offer view as we do not know enough of the detail as to how this might work in practise.

No.	Response Date	Response Text
39	**Jun 11, 2014 1:39 PM**	The integration of these areas is both sensible and logical. However, in supporting the notion it must be clearly established that this is not simply another tier of bureaucracy that has no authoritative capabilities in its dealings with practices. Core contracts and premises are both highly sensitive areas, and we must all have confidence that these will be taken into the brave new world with appropriate resourcing and levels of expertise in their administration. A shadowing period is essential, as are clear levels of authority and accountability that will be vested in CCGs once they take over fully.
40	**Jun 11, 2014 1:39 PM**	We have a good working relationship with our CCG, I think this co-commissioning can only benefit the Practice rather than the current set which can be a bit distant. I would hope that the much needed new staffing levels had been funded adequately so this new set up does not become an added burden and detriment to our CCG colleagues.
41	**Jun 11, 2014 1:36 PM**	Adequate staff and resources need to be made available to the CCG for this to work properly.