Clinically led commissioning – is it making any difference to patient outcomes?

Sarah Price
Chief Officer
Summary

- Haringey and how the CCG works
- What clinical leadership looks like
- Some of the positive changes as a result of clinician involvement
- Moving to a population basis for commissioning
- Success or not?
Haringey: our people

- 255,000 residents (July 2012 census data)
- 276,000 GP registered, 237,000 resident
- Constantly changing population
- One of the most diverse boroughs in London
- 4th most deprived borough in London, 13th in England
- Over 57,000 children live in Haringey
- Over 190 different languages spoken in schools
- 8th highest proportion of children living in poverty in the UK
- Highest homeless population in London
- Life expectancy gap
Haringey: health inequalities

Male Life Expectancy
Source: LHO 2005-2009

Haringey: 76.22
London: 78.12
England: 77.84

Highest Life Expectancy for a man is 81.52 in Fortis Green

Lowest Life Expectancy for a man is 72.46 in Tottenham Green

West

East

Male Life Expectancy

- 79.26 to 81.52 (2)
- 76.99 to 79.25 (6)
- 74.72 to 76.98 (4)
- 72.45 to 74.72 (7)
Our collaboratives—
all GP practices with LA and PH input to each

Central
Population: 46,728 (relatively middle-aged population, 53.7% BME community)
Key issues:
- Late antenatal bookings
- High rates of teenage pregnancy
- High number of drug users
- High prevalence of patients with CHD, COPD and mental illness

North East
Population: 64,405 (relatively young population, 47.8% BME community)
Key issues:
- High birth rates, late antenatal bookings
- Childhood obesity
- Low uptake of childhood immunisations
- High teenage conception rates
- High mortality from cancer and CVD
- Low uptake of bowel cancer screening
- High prevalence of patients with COPD, diabetes and mental health illnesses

West
Population: 88,405 (older population, 64.25% White British community)
Key issues:
- Low birth rates
- Wide range in male life expectancy
- High proportion of patients with cancer
- Low uptake of breast cancer screening
- High prevalence of patients with dementia

South East
Population: 38,923 (younger population, 43.6% BME community)
Key issues:
- High birth rates
- Low uptake of childhood vaccinations
- High teenage conception rates
- High mortality from CVD and cancer
- High prevalence of patients with mental health illnesses, COPD and diabetes
The finances

- The commissioning budget is £320m
- Running cost allocation is £6m
- Approximately £1000 per head of registered population v 1300 per head in Camden
- A lot of the focus is on reducing cost while maintaining or improving quality and outcomes for patients
Breakdown of spend

- Acute and Integrated Care
- Children's Services
- Community
- Continuing Care
- Mental Health & Learning Disabilities
- Other Commissioning
- Prescribing
- Running Costs & Operating Costs
Membership

• The CCG is a membership organisation
• Governance through a constitution that ties decision making back to all member practices
• The Governing Body is elected by the membership
• No two CCGs are the same
• It has implications for delegation
• It means working jointly with others has been difficult to do
• Keeping members engaged is challenging
The Governing Body

- 11 GPs elected from the 39 practices
  - Chair
  - Collaborative representatives
  - Salaried Doctor
- 1 Secondary Care Doctor
- 1 Nurse
- 2 Lay Members
  - Patient and public involvement
  - Audit
- Chief Finance Officer
- Accountable Officer
The role of GP leaders

• GPs have always been involved in commissioning, but not at this scale
• They have the practical, up to date experience of working with patients and other health professionals that they can bring to system design
• They can communicate with practices that can lead to rapid change
• They can challenge clinician behaviour from a position of understanding
GP involvement has meant......

- Care closer to home
- Time to diagnosis reduced
- Maximising use of resources
- Making the clinical case for change
- Rapid Response
  - X% reduction in admissions in 12 months for a very vulnerable group
  - Patients and health professionals positive
- End of life care
Referrals

GP referral volumes - Haringey CCG

- Total referrals for HCCG
- Mean
- UCL (2 STDEV)
- LCL (2 STDEV)
Are there enough GPs?

• The number of GPs coming forward is small
• Balancing clinical commitments is difficult
• Pressure within practices has never been as great
  – Practice income is falling
  – Numbers wanting to take on partnerships is very low
  – Ageing workforce
  – Investment to enable change has disappeared
• Numbers coming into General Practice not high enough
Are we clinically led?

• This isn’t the main role GPs have – the practice comes first
• It is challenging to only consider the commissioning side of things
• Conflicts of interest
  – Co-commissioning
  – Working at scale
• What does leadership mean – setting the strategic direction or making the decisions?
• NHSE – is it tokenistic?
Value Based Commissioning

• Commissioning for populations rather than institutions – it isn’t new but has not been established as the norm
• The system incentivises institutions to increase activity
• Integration is challenging to achieve as there is no advantage to organisations working together
• It makes clinical sense to GPs
How do you define Value?

Value = \[
\frac{\text{Health outcomes}}{\text{Cost}}
\]

To reduce cost, the best approach might be to spend more on some services to reduce the need for others.

Excellent care is frequently the lowest cost.

The full set of outcomes that constitute the quality of care for the customer over the complete care cycle.

Refers to total costs of the full cycle of care for the customer’s medical condition, not the cost of individual services.

VALUE-BASED COMMISSIONING means changing how healthcare is organised, measured and reimbursed in order to improve the value of services.

M E Porter and T H Lee
Working on Value

• Patients, carers, clinicians, commissioners define outcomes which matter to a population group with similar needs e.g. people who suffer from psychosis, diabetes or are frail
• Together we prioritise these outcomes
• We think about what and how we can measure the outcomes
• We cost out a ‘year of care‘ or ‘bundle’ for a patient group (e.g. frail elderly at high risk)
• Providers work together in new ways to deliver outcomes across organisational boundaries (e.g. keeping people well at home)
• Commissioners focus on monitoring outcomes
The North Central London Value Based Commissioning Programme

Who?
The five Clinical Commissioning Groups (CCG) in North Central London (NCL) (Camden, Enfield, Haringey, Barnet and Islington) have embarked upon an ambitious two-year programme to shift the focus of commissioning away from activity, towards delivering improved outcomes for people. This will help us to measure and achieve value (best outcomes for cost).

Why?
The NCL Value-Based Commissioning Programme aims to develop a common purpose across health and social care providers in order to achieve the best possible outcomes for people for every pound spent. Where such an approach has been implemented, as in stroke care across London, significant improvements in outcomes and cost have been achieved.

What?
Initially, the programme will focus on three population segments: Mental Health, Frailty and Diabetes building a common framework of outcomes across each care pathway and looking at new contracting mechanisms that will incentivise providers to work together to improve outcomes and drive out costs.

How?
This work will bring together a broad range of clinical experts, commissioners, providers and patients to define the outcomes that really matter to people. These will then be developed to be included in contracts for 2015-16.
The Process

Cohort

Contracting

Financial model

Outcomes

Service delivery
## Cohort Definition

<table>
<thead>
<tr>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people aged 75+ years and pre-frail and frail</td>
<td>A) Patients under <strong>end of life</strong> care</td>
</tr>
<tr>
<td></td>
<td>B) Patients with <strong>organ system failure</strong> (e.g. end stage renal failure, end stage heart failure)</td>
</tr>
<tr>
<td></td>
<td>C) Patients who <strong>require specialist care teams</strong> (e.g. immediate care following acute event (e.g. MI), surgery related care, psychiatric care, all cancer care)</td>
</tr>
<tr>
<td></td>
<td>D) Patients who are <strong>not frail</strong></td>
</tr>
</tbody>
</table>
Cohort Definition

Initial focus

• 75+ yrs who are also in highest 2% at risk of hospital admission

• Approximate cohort size

Moving towards

• Active identification of 75+ yrs who are frail and pre-frail using eFrailty Index, or other tool

• Approximate cohort size

<table>
<thead>
<tr>
<th>Top 2% at risk</th>
<th>Har</th>
<th>Enf</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages (18 yrs)</td>
<td>4,561</td>
<td>4,198</td>
<td>8,759</td>
</tr>
<tr>
<td>75+ years</td>
<td>2,155</td>
<td>3,108</td>
<td>5,263</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frailty tool</th>
<th>Har</th>
<th>Enf</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail estimated* (15%)</td>
<td>1,605</td>
<td>2,985</td>
<td>4,590</td>
</tr>
<tr>
<td>Pre-frail estimated* (50%)</td>
<td>5,350</td>
<td>9,950</td>
<td>15,300</td>
</tr>
<tr>
<td>Total frail and pre-frail</td>
<td>6,955</td>
<td>12,935</td>
<td>19,890</td>
</tr>
</tbody>
</table>
What could we measure now?

<table>
<thead>
<tr>
<th>Topics</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| 1. Mortality Rate / Age of Death                                       | 1a. A measure of mortality rate  
1b. A measure of average age of death                                                                                                         |
| 3. Patient identified outcomes related to Quality of Life              | 3b. A measure of the feeling of company and contact                                                                                       |
| 4. Evidence-based outcomes related to care process                     | 4a. A measure of the rate of acquired infection rate whilst receiving care e.g. HAP, UTI (with catheter in situ), wound infection  
4b. A measure of the rate of pressure sores whilst receiving care  
4c. A measure of the rate of falls whilst receiving care  
4d. Staying at home after discharge                                     |
| 5. Patient identified outcomes related to care process                 | 5a. A measure of feeling decisions are listened to and acted on  
5b. A measure of feeling in control over care                                                                                               |
| 7. Fragility Fractures                                                 | 7a. A measure of fragility fracture rates  
7b. A measure for the recovery period to previous level of mobility post-fragility fracture                                                 |
| 11. Dementia Specific Outcomes                                         | 11a. A measure of dementia diagnosis rate  
12. A measure of the extent people with dementia/their carer feel supported                                                           |
IPU key characteristics

- We need to define a new Operating Model or ‘Integrated Practice Unit (IPU)’.
- Providers are the key to help design what this new world will look like and how to organise care around patients, irrespective of provider boundaries.

What happens today…
- Services are organised around clinical departments/specialties.
- Cost accounting is driven by ‘charges’ and not ‘cost’
- Patient visits different services, that are not entirely integrated and do not communicate with each other efficiently across the whole care cycle.
- We measure PROCESSES

How is tomorrow?
- Services are organised around patients with similar sets of needs which span professional boundaries
- Cost accounting is driven by “cost” and not ‘charges’
- IPU’s are responsible for the full cycle of care, that is co-located and always coordinated centrally in an IPU.
- We measure OUTCOMES
IPU design proposal

Underpinned by:
Infrastructure issues such as co-location, shared records, workforce development, 7 day working etc.
The IPU: providers and patients

Providers whose services for 75 years+ are in scope for the patient cohort:

Primary care

Core contract

Primary Care

Enfield x 4 localities

Haringey x 4 localities

Acute Providers

North Middlesex

Royal Free (BCF)

Whittington Health

Community Care

Enfield Community Services

Whittington Health

Social Care

LB Enfield

LB Haringey

Other

Housing

Third Sector

The IPU population

<table>
<thead>
<tr>
<th></th>
<th>Haringey</th>
<th>Enfield</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total frail and pre-frail</td>
<td>6,955</td>
<td>12,935</td>
<td>19,890</td>
</tr>
</tbody>
</table>
Contracting options
Contracting options

Option 2: Partial Bundle i.e. bundle just the outcomes

BUNDLED CONTRACT

Primary Care
- Outcomes
- Activity
- Processes

Acute Provider 1
- Outcomes
- Activity
- Processes

Acute Provider 2
- Outcomes
- Activity
- Processes

Community
- Outcomes
- Activity
- Processes

Social Care
- Outcomes
- Activity
- Processes

Different Contracting Mechanisms: E.g. Alliance, Lead Provider, Joint Venture, etc.

Proportion of services contracted on the basis of Outcomes

Proportion of services contracted on the basis of Activity and Processes

Bundled Services
Conclusion

• Having GPs involved has made a difference to
  – what we have focused on
  – the speed of change

• It is not clear that the model is sustainable

• There is some disillusion with the top down NHS approach

• CCGs are making the most of a strong clinical voice

• Changes are happening and clinical leadership is playing its part in that