Assignment Title Page

Outcomes Based Commissioning and the Redesign of Cardiology Services within Appleton

Project Rationale:

The NHS is unique in providing free healthcare at the point of access regardless of wealth or background. However, it is currently under considerable strain whilst struggling to meet escalating patient demands, manage the needs of an ageing population and deal with a workforce crisis and widening financial deficit (Forward View 2014).

Appleton CCG serves a population with a high life expectancy and the highest proportion of elderly people living alone in the region – a situation anticipated to increase considerably over the next decade (Appleton CCG 2015). Naturally, this has led to a higher incidence of long term health conditions and complex care needs (Appleton CCG 2015 and Sands et al 2016) which has made the delivery of proactive, holistic, joined up care a priority within the borough (Appleton CCG 2016).

Unfortunately, the way in which current services are commissioned and organised by different bodies often means that we work in silos with little intra-operability or integration between community services, secondary care, primary care and social services which, in turn, impacts the quality and experience of patient care (The King's Fund 2015). National policy in recent years has tried to incentivise the delivery of more integrated health and social care (Dickenson et al 2013) with pooled budgets such as the Better Care Fund, forums such as health and wellbeing boards and joint strategic needs assessments (JSNA) between CCGs ,councils and public sector partners (Appleton CCG 2015). Despite this, both patients and professionals remain frustrated that the healthcare system is fragmented and difficult to navigate, making a compelling case for change (Appleton CCG 2016).

In view of the above, Appleton CCG and the council want to move towards a relatively new way of contracting and commissioning called outcomes-based commissioning (OBC) for health and social care services. The idea behind this is to incentivise providers to maintain whole population wellbeing and health by using a capitated payment structure which rewards them for the delivery of the outcomes that patients say most matter to them rather than single episodes of treatment (Appleton CCG and Appleton Council 2015; Taunt, Allcock and Lockwood 2015). This is in stark contrast to the current PbR contracts used in acute trusts which can reward activity and preclude organisations working collaboratively to deliver integrated care (NHS Confederation 2014; BMA 2015; Marshall 2014; The King's

Fund 2015). PbR tariffs can also lead to perverse incentives for hospitals to see more patients and carry out more procedures, even if these are not entirely necessary (BMA 2015) and they do little to incentivise prevention and health promotion. In the same vein, the block contracts used for the majority of community services do little to promote innovation and offer little incentive for the providers to increase efficiency or activity (Marshall 2014 and BMA 2015).

The overarching aim of the move towards OBC is to deliver an integrated Out of Hospital Health and Social Care service model which reduces hospital admissions and length of stay, treats people close to home, invests in prevention and proactive care and supports patients to live independently as far as possible in their own homes (Appleton CCG and Appleton Council 2015).

Work was done in 2014 and 2015 to collate a set of overarching patient outcomes and to select a group of "most capable" providers (MCP) to deliver the whole population OBC contract. This group comprised the local GP federation (GPF), our 2 nearest acute hospital trusts and PurpleRain which is our largest community provider. There is considerable evidence to suggest that promoting a collaborative, integrated approach between organisations in this way rather than forcing them into direct competition with one another is beneficial on a number of levels (Dickinson et al 2013; Taunt, Allcock and Lockwood 2015).

The MCP group had planned to focus on 5 priority clinical pathways and workstreams which were: cardiology, respiratory, diabetes, frail and elderly and end of life care. Of these, cardiology was identified as being the highest priority for the CCG and we hence began work in conjunction with the MCP in 2016 to design a new end to end pathway in line with OBC whilst wider contract negotiations were ongoing.

The rationale for focusing on this as a priority area was multi-fold. Drivers included the high burden and prevalence of cardiovascular disease in the borough contributing to an estimated 25% of deaths with a cardiology condition affecting 16% of patients – the latter estimate was based on the Quality Outcomes Framework (QOF) 2014-15 figures and is likely to be much higher in reality due to undiagnosed cases. In addition, 3% of the CCG's overall acute spend was found to be on cardiology with it also having the highest outpatient spend during 2014-15 and referrals still being on the rise. It was felt that significant QIPP savings could be made in the area due to numerous inefficiencies in the way cardiology services were delivered.

The quality of cardiology care within the borough was also a concern. Due to the ageing population in Appleton as highlighted above, the prevalence of heart failure and ischaemic heart disease are both increasing. National Institute of Clinical Excellence (NICE) guidance states that supervised exercise---based rehabilitation programmes with a psychological and educational component should be offered to these patients along with a multi---disciplinary approach to monitoring and treatment (NICE 2011). Despite this there are currently no specialised heart failure nurses and a very minimal cardiac rehabilitation service (0.4 wte) available to residents in the borough which, by extrapolation, would significantly increase morbidity and reduce quality of life for patients. In turn, this is likely to impede the delivery of NHS outcomes such as preventing premature mortality and enhancing the quality of life for those with long term conditions as defined in the NHS outcomes framework (NHS Outcomes Framework 2014-15).

NICE has also produced guidance specifically for commissioners suggesting that "appropriate referral pathways are in place and that a multidisciplinary specialist chronic heart failure care pathway is integrated with other services including primary, secondary and social care, and that the care pathway is seamless across services" (NICE, 2011). Again, it was abundantly clear that this was lacking within Appleton and that action needed to be taken urgently.

In view of all the above factors and flaws in the current system, work commenced with the MCP group to design a new, integrated cardiology service for Appleton patients.

<u>Commentary on key activities carried out:</u>

<u>OBC Contract Neogiations:</u>

I was responsible for providing clinical input, leadership and oversight as a general practitioner to enable the CCG and MCP group to move towards an OBC contract.

I attended weekly meetings as part of a working group involving colleagues from finance, public health, contract management and the consultancy firm BlueShirts. This was to discuss current issues, assess progress and predict and mitigate potential risks and barriers to the programme being successful (appendix 2). I was also a member of an OBC programme board which met monthly as part of the governance process to make higher level decisions related to the programme (appendix 3). The membership included the CCG

chair, chief officer, chief financial officer, 2 governing body GPs, the director of public health, a cabinet member and Healthwatch.

I participated in and contributed to 2 OBC stakeholder engagement events. The first one was an event for patients only to brief them about our plans and to invite them to ask questions about the process and how it may affect the locality and services they received. We then invited 2 patient representatives from the attendees to sit on the evaluation panel as described below. The second event was much bigger and promoted by Healthwatch. Healthcare colleagues from the acute trusts, general practices and community as well as the public were invited to attend, watch a presentation delivered by the MCP group and ask questions of them and the CCG. I was on hand to ensure the event ran smoothly, answered questions from patients and public and also used the opportunity to strengthen relationships with the chief executives from the provider groups. Stakeholder engagement is widely recognised as extremely important prior to commissioning any service so these events were in line with good practice (Williams et al 2012).

The MCP group were required to demonstrate that they had the required capabilities to deliver the system wide change required and they were to be assessed with an interim checkpoint review followed by feedback in October 2016 and a formal evaluation in December 2016. I was a member of the evaluation panel on both occasions and scored the presentations given by all 4 providers and their progress against 4 broad categories: vision and delivery, organisational development, legal and governance and finance planning (appendix 4). In addition to giving my own feedback, I was also responsible for collating the feedback from other evaluation panel members including colleagues from the local authority, governing body GPs, the CCG chief officer, CCG finance officer, and members from the OBC working group. I then worked with the OBC programme director to present this feedback back to the MCP highlighting key areas for improvement (appendix 5). The progress they had made was not felt to be satisfactory overall and hence the timelines were extended and a 3rd assessment and evaluation scheduled.

Cardiology Re-design:

I began work on the cardiology clinical redesign in line with OBC while wider contract negotiations were still ongoing. I worked closely with a group from the CCG and a wider OBC sub-group consisting of stakeholders including consultant cardiologists from our two local acute hospitals, colleagues from the GP federation and local cardiology patients to design, agree and develop a new cardiology

pathway. Working collaboratively with providers in this way is considered good commissioning practice (Smith et al 2013, Dickenson et al 2013). This work began in January and Another gave notice intending to terminate provision of the existing community service from the end of March meaning that we had to consider how we could replace the services being offered there with some urgency.

I mapped out the current availability and provision of cardiology services within Appleton including referral trends from the general practices. I produced a written summary and flow diagram depicting this (appendix 6) and presented this to colleagues from the working group including commissioning and finance managers and clinicians. I invited comments and corrections although there were only minor revisions to this high level mapping. The work was, however, effective in highlighting problems and stimulating discussion around issues such as a huge variation in referral practices, lack of clear pathways and an awareness gap amongst GPs regarding where to refer patients. We subsequently held a bigger meeting with cardiology patient representatives, providers and commissioners to map out the “as is” issues in more detail and identify key areas for change.

I was also able to identify the services offered at the community clinic which would soon end including diagnostics such as ECGs, 24 hour blood pressure monitors, echocardiograms and holter tapes. It was decided that further data around activity and cost was also needed. This work formed part of the monitoring and evaluation of current services and the strategic planning for the new services going forward as recommended by widely published commissioning cycles (appendix 1).

It transpired that although the majority of patients were being referred to our local hospitals, less than half of the general practices were referring into the community service which operated on a block tariff and offered a considerably cheaper option to the acute PbR tariffs. Engagement with the wider GP community revealed that there was a lack of awareness amongst colleagues regarding what pathways were available and the respective costs. There was also a disproportionate number attending tertiary GreenTrust hospitals which were not at all local. The reason for this was thought to be due to GreenTrust having been commissioned as a provider to run the community service in Appleton which lacked specialist services and was intended to be a one stop clinic – as a result the consultants would bring

patients back to their own hospitals to see them again. Unfortunately, we also discovered that such follow ups were being charged as new acute outpatient appointments with a higher market forces factor due to their location. Furthermore, even basic diagnostics such as ECGs were being charged as a 1st outpatient appointment.

I subsequently analysed the cardiology HRG codes from our secondary care trusts and was asked what we could move into the community. I held an independent meeting between myself, the CCG cardiology GP lead and the medical director and consultant from Yellow Hospital to discuss what was feasible, practical and safe (appendix 7). Heart failure services, hypertension, atrial fibrillation, anticoagulation, ECGs and echocardiograms were identified as possible services to move from secondary care into the community. The specialists highlighted that stress echocardiograms and more advanced diagnostics were best performed in secondary care as they needed highly skilled electrophysiologists to perform them which we were unlikely to be able to recruit to the community. They also emphasised the importance of having heart failure nurses and cardiac rehabilitation available in the community to reduce complications and adverse events in this population.

I identified that ECGs and 24 hour blood pressure monitoring were tests that were usually readily available within general practice and that there could be a potential huge cost saving in reducing the referrals to secondary care as well as not replacing these services when they ceased at the community clinic (appendix 8). I spoke directly with the business manager of the GP alliance requesting that they enquire which of the Appleton practices had access to these tests (appendix 8). This allowed us to identify that 5 practices had no ECG machine, some practices had them but did not use them due to a lack of confidence in interpreting them and some practices had them and interpreted ECGs but could not link the ECG to the patient record. 9 practices had no access to 24 hour blood pressure monitoring in house. The data showed that over 2000 patients a year were referred to community and secondary services for these investigations.

I subsequently undertook a detailed piece of work around the options for ECG provision and interpretation. I began by raising awareness and highlighting to the governing body GPs and GP alliance that there would be no provision other than in secondary care for ECG diagnostics and interpretation from the end of March 2016. I also invited proposals for any solutions and discussed these in more details with the cardiology lead GP (appendix 9).

I undertook a benchmarking exercise and spoke to the lead commissioners for cardiology in the neighbouring boroughs of Orange and Yellow about what community cardiology services they were offering, the associated tariffs and problems they had encountered (appendix 10). Orange had found a supplier to provide portable ECGs for all the practices in the locality, which could link to all the computer systems and be uploaded easily for interpretation by cardiologists in secondary care.

I contacted the supplier for more information on ECG machine pricing and logistics (appendix 11) but the CCG did not feel that they could spend so much on kit for all the practices. Instead a hub sharing arrangement was discussed and I met with the GPF separately to discuss the possibility of organising buddying arrangements for this and incorporating it into a locally commissioned service (appendix 8). This involved negotiating the difficult topic of money – the GPF were concerned that they didn't have the resources to do the scoping work and, whilst very keen to provide all the services in primary care, seemed cynical when I told them about the prices offered by secondary care in other boroughs. We also discussed with them the cardiology services which we would like moved into the community and they requested that we provide them with detailed pathways which they could work up.

I took on the responsibility for designing the heart failure and hypertension pathways (appendix 12) and used the recommendations from NICE and current guidelines from another CCG to develop these. I went on to show these to the specialists from our acute trusts and was able to modify them in light of their advice, highlight opportunities for up skilling GPs in general practice and also agree that community services could be nurse delivered with access to a consultant if needed rather than regularly pulling the consultants out of their hospital bases where they had responsibility for many other areas. It was agreed that having a diagnostic work up prior to seeing a cardiologist should enable most patients to be seen just once by a specialist with a detailed management plan back to their GP – this would lead to significant costs savings. While we had initially agreed at previous meetings that consultant triage of referrals would help to ensure that patients had a full work up in primary care, one of the consultants now expressed reservation about this saying that he would not be happy to take the risk of bouncing back referrals in case something adverse happened to patients as a result.

I have since forwarded these pathways to the GPF (appendix 13) and more detailed work and financial modelling is due to be undertaken to see how they can be delivered. In addition, a business case for a full cardiac rehabilitation service is currently being worked up.

Evaluation:

Certain activities have been done well to date in line with good commissioning practice and others could be improved upon. The move towards outcomes based commissioning and the redesign of cardiology services with an emphasis on integrated, seamless, joined up care was in line with the strategic commissioning priorities as stated in the Appleton Council market positioning statement and Health and Wellbeing Strategy (Appleton CCG 2016). The commissioners did try to work together with all the local providers to review the existing services and agree and redesign the new services. This is in keeping with the principles of effective clinically-led commissioning (RCGP 2011). However, the interaction with the providers was often fragmented with the representation from the GPF often being absent at meetings and us having to meet providers from general practice, the community and the acute hospitals separately. This meant that there was considerable duplication of crucial discussions and that progress could often not be made in a timely manner. Hence, the process was not truly as collaborative as it should have been. As OBC was designed to incentivise providers to work together to meet the needs of the whole person (Addicott 2015) the above way of working has not quite achieved this.

The Royal College of General Practitioners' advises that effective commissioning should be "community focused and engage local people and communities throughout the commissioning cycle and prioritise the needs of patients and the public" (RCGP 2011). Whilst we did engage with a handful of patient representatives and invite them to some of the subgroup meetings, it felt more like a tokenistic gesture than true co-design or co-production that OBC advocates (Ham 2015).

It can certainly be noted that clinicians were at the heart of the redesign and used evidence based practice to influence this which is in line with the purpose of CCGs and good commissioning practice (Naylor 2013). However, there was a lack of experienced commissioners driving the process and organisational leadership was also a problem. The director of commissioning, the head of planned care and the commissioning manager allocated to the OBC cardiology redesign were all relatively

new in post and were still getting to grips with the organisation. Getting the necessary data was a problem and led to a lack of accurate, detailed and timely financial modelling. As an example, it took 3 months to get a breakdown of the number of ECGs carried out in the local hospitals and the community service along with the respective costs. It was unclear where to go for the answers which considerably hindered progress on multiple occasions. The relatively new head of planned care was replaced by an interim several months into the process resulting in us needing to almost beginning again which was counterproductive. A lot of time was spent in the planning and design stages of the widely depicted commissioning diagram (appendix 1) but very little implementation or delivery took place. Due to issues with safe patient data transfer and a lack of IT intra-operability, we were unable to even have a provisional service running in the community as originally planned to replace the one which ended in March. Hence, this activity ended up being diverted to the acute trusts on PbR tariffs arguably leaving patients less well off than when we began and certainly without any transformative change having taken place.

Another important point to note is that although the cardiology work was intended to be undertaken as part of the wider, whole population move towards OBC no cardiology specific outcomes have been discussed or introduced to date which seems slightly short sighted. However, it could also be argued that this may be more appropriate after the clinical pathways have been agreed and implemented. Moving ahead with the clinical work while an OBC contract is still being discussed and negotiated has been difficult with a lot of uncertainty surrounding the work. The latest development has been that the acute trusts do not feel ready to take such a risk at the present moment and backed out of signing a formal contract at the last moment. Instead, they plan to still be actively involved and perhaps join more formally in 2 year's time. The contract is hence going to be between a joint venture (JV) consisting of the community provider PurpleRain and the GPF. There is now ongoing dispute about how much the acute providers should be allowed to influence the clinical redesign going forward when they are not going to be a part of OBC. The GPF certainly feels that their involvement should be minimal but this could be a reckless attitude to take given that cardiology especially is a very acute speciality. In essence, patients will still continue to attend the acute hospitals for emergencies and communication to improve patient care and deliver as much of it as possible in the community will be difficult to achieve without their help.

Finally, the key principles of OBC are to provide integrated, person centered, holistic care which is proactive and focuses on prevention and keeping people well at home (Taunt, Allcock and Lockwood 2015). The cardiology redesign process has been successful to an extent in looking at prevention opportunities and involving public health in the discussions. The need for a comprehensive cardiac rehabilitation service to reduce morbidity and mortality has been highlighted and presented as a business case which is a very positive step. The need for better detection of hypertension and atrial fibrillation to avoid stroke and cardiovascular disease has been discussed but still needs to be worked fully into the pathways. However, there has been very little integration or even discussion around how to join up pathways with the other clinical workstreams. It would be advisable to pay attention to this going forward as there will be considerable overlap between the diabetes, frail and elderly and respiratory pathways being developed and there is a high risk of further silo working and unnecessary duplication otherwise.

Personal Development and Learning:

This journey has been a steep learning curve and enlightening experience for me both professionally and personally. Having been a clinician in the NHS for the last 10 years, this was my first experience of working in an organisation such as a CCG and, indeed, my first direct experience of commissioning.

Up until now, I had been used to being known and respected by colleagues in light of my clinical work without having to make much extra effort beyond simply doing my job well. I had had very little experience of even attending let alone giving opinions at and participating in discussions at such high level meetings. To begin with, I was largely a silent observer and avoided contributing much for fear that I didn't know my facts or would say the wrong thing. I soon began to realise that I would never gain any credibility or be actively involved in any projects unless I began to speak up and I began made a more concerted effort to do so. Reflecting on this, I became more aware that I intuitively like to think things through alone and consolidate my thoughts before sharing these with others. Working this way can have both advantages and disadvantages and, while I feel that my approach was always measured and rational, I do feel that it took longer to establish my credibility and presence in the organisation. Interestingly, my confidence in contributing to meetings and discussions became much easier when I moved from the work around the broader OBC contract negotiations to the clinical redesign work – this was largely because I have a lot of clinical expertise both in primary and secondary care

and genuinely believed that I was well placed to lead change in this area. I have learned that, when attending large meetings dealing with subjects I am less familiar with, reading through past meeting minutes and understanding the subject ahead of time allows me to contribute more confidently having had chance to process the information in advance.

I was rather surprised at how little benchmarking and learning from other organisations took place during this process of trying to arrange an OBC contract. Whilst OBC is a relatively new concept, there are still many organisations nationwide which have tried this in some form or another (Taunt, Allcock and Lockwood 2015). While some of the published work was reviewed, at no point did anybody have a direct one-to-one conversation with others who had been involved in planning, co-ordinating and delivering this approach elsewhere in order to benefit from their insight. I learned so much from speaking to our neighbouring CCGs about community cardiology services they had tried to commission and the knowledge regarding the problems and pitfalls they had encountered was particularly helpful. As a result, we were able to plan for and mitigate similar problems in advance saving considerable time and resources. This is something I believe I will now incorporate into any strategic work I undertake in the future or even in trying to run a successful practice as a GP partner.

This work also allowed me to develop a real insight into the importance of building and maintaining strong relationships between commissioners and providers which has also been emphasised in other organisations (Smith et al 2013). I observed that each of the provider organisations and the CCG sometimes had very different agendas and priorities, which could be conflicting and hence hinder progress. An example of this is the CCG needing to make certain QIPP savings by moving work out of secondary care while the acute trusts were struggling with big financial deficits which could be made worse by such a shift. Discussions became more productive when we identified clear shared goals, a vision for the future and risk sharing agreements. Whilst the process seemed to start with an “us vs them” mentality, trust has gradually been built up between the organisations and the culture slowly seems to be moving to one of transparency and openness which will hopefully foster more collaborative working. In the future, I think that I would put in more work at the beginning of any project to identify these shared aims and come back to these during times of friction to keep the pace and momentum moving forward.

I also realised the importance of building and retaining a sustainable workforce with the relevant skills and capabilities to achieve the strategic aims and priorities an organisation sets. I observed an extremely high turnover of staff within the CCG with a high number of interim managers both at lower, middle and senior management levels. People were often changed to different projects without much notice or explanation and could spend a lot of time doing pieces of work which were then not taken forward. This sometimes led to low morale and demotivation meaning that staff disengaged at times. Several people left the CCG and it felt frustrating and disempowering from my own perspective due to the lack of consistency and communication. The benefit of this was that I was exposed to a lot of different work streams and gained an excellent overview of everything that happens in a CCG including governance processes. Trying to make progress in a dysfunctional organisation is difficult and one way to perhaps improve things would be to up skill permanent staff members and help them to develop the capabilities needed rather than constantly swapping them onto different projects and hiring more interims at great cost for short periods.

In summary, although my projects have not gone entirely to plan, not always followed traditional good commissioning practice and taken much longer than the anticipated timescales the learning experience has been invaluable regardless. I have learned to deal with uncertainty, have become more resilient and I have learnt a lot about the importance of fostering good relationships and ensuring there is consistent and reliable leadership throughout the course of a project. I feel that I have a much greater understanding of the commissioning cycle and the basis for the recommendations for good practice – seeing what happens when these are not followed has reinforced the importance of these principles even further.

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Appendices

Appendix 1:

Commissioning cycle, NHS Information Centre for health and social care, *accessed at www.ic.xxx.uk/commissioning on 6th June 2016.*

Appendix 2: Thoughts re. risks of OBC contract not being in place by planned start date sent to OBC programme director and discussed subsequently in the working group.

Appendix 3: Minutes from OBC programme board meeting (see page 3 attendance log)

Appendix 4: My individual feedback post MCP presentation to evaluation panel

Appendix 5: collated feedback from all evaluation panel members

Appendix 6: Cardiology mapping "as is" - Cardiology in Appleton and Current Services: Current Situation

Appendix 7: Meeting to discuss shifting of work into the community based on HRG codes.

Appendix 8: Discussion with GPF re ECGs and 24 hour BP machines in primary care.

Appendix 9: Email chain iniated by myself discussing re. no community facility for ECG interpretation from April 2016.

Appendix 10: Benchmarking and discussion with Yellow CCG and Orange CCG.

Appendix 11: Discussion with ECG supplier re. purchasing machines.

Appendix 12: Outline of planned heart failure and hypertension pathways.

Appendix 13: Email sending above pathways post discussion with cardiologists to GPF for confirmation and further scoping.

Appendix 14: Suggestions for inclusion in the new cardiology service specification