July 2015

NHS Somerset Clinical Commissioning Group

CCG Quarterly Update

Welcome

Welcome to your CCG's July quarterly newsletter. This edition provides updates on the major topics that member practices have asked for and need to be aware of as we enter a period of significant change for the NHS. Matthew Dolman's editorial talks about outcome based commissioning (OBC) which is potentially a game changer for the NHS. Another major issue involving primary care, which is steadily gaining momentum, is the need for GP practices to join together to provide more sustainable services and enable more flexible services for patients. Andy Hill's article updates how the CCG wants to support practices in this aim by proposing changes to the current federation commissioning arrangements.

Both nationally and locally the NHS needs to change how it transacts business and how money flows in the system. Money still needs to 'follow the patient' but there needs to be delivery by health and care organisations for more effective collaboration that improves care for the most needy in our society. This also has to be linked to incentivising organisations to, at last, recognise the common sense in investing 'upstream' in preventive care - an issue highlighted by Simon Stevens in his 'Five Year Forward View'. Outcome based commissioning may well be the system change that enables these to actually happen.

Please remember the next CCG quarterly meeting is on 1st July in Glastonbury, assuming the festival has not overrun! The two topics to be discussed will be OBC and federation development. Details of the meeting can be found on the back page of this newsletter.

Dr Geoff Sharp
Editor

Co-commissioning

First meeting of Joint Committee for Primary Care marks the start of co-commissioning

The inaugural meeting of the CCG and NHS England Joint Committee for Primary Care took place on Monday 15th June. As a meeting in public, the date had been advertised through GP practices, public notices and the media and we were pleased to see some members of the public were able to attend. Chaired by David Bell, the CCG's new Non-Executive Director, the Committee received presentations from NHS England and the CCG covering the current provision for primary care in Somerset and priorities for 2015/2016.

The Joint Committee also received a report setting out the CCG's work programme for improving the quality of primary care. The final report outlined the NHS England proposed approach to undertaking a PMS review in Somerset, which had been based on national direction and discussions across the South.

Due to time constraints, the Joint Committee were unable to agree an approach for undertaking a PMS review in Somerset and further discussions were requested.

Committee Chairman, David Bell

The Joint Committee also approved the terms of reference and agreed to develop a schedule of meetings along with a forward plan. The full papers are available at http://www.somersetccg.nhs.uk/about-us/somerset-primary-care-joint-committee/

Two members of the Joint Committee are currently being recruited to - the Non-Somerset GP principal and the patient representative identified through PPGs. It is hoped that these posts will be in place in advance of the next meeting, planned for September 2015.

Breathing new life into health and social care

The image may be a cliché but its relevance to the current health and care system is absolutely true. We have to find a way to regenerate the way we support people to look after themselves and how we deliver care to people in Somerset and we have to do it in the face of unprecedented pressures. We also have to be tuned into our own wellbeing and ensure in all this upheaval we look after ourselves.

Primary care should be, and has the opportunity to be, central in any new thinking, but that thinking has to recognise the other providers in the system and will be constrained by the fact the money and workforce is stretched to its limit.

There has been a lot of scepticism in the last few months that the ideas talked about by the CCG are too elaborate and lack an evidence base. I will concede that it has been difficult to describe in granular detail what a new Somerset NHS and Care system would look like but that provides the opportunity to design what would work well for Somerset.

The evidence is limited because we are pushing the boundary of health and care thinking. But should that stop us exploring the possible? This is all about the future, our future.

To move the money around providers in a different way, there potentially needs to be a different way of commissioning and that is why we are looking at outcome based commissioning. The amount of work that is happening is significant. A whole work programme is unbundling the complex issues and writing a business case for outcome based commissioning. (A separate question and answer sheet is added for reference.)

There is active daily conversation happening about how to ensure GPs would not be financially compromised in any new flow of money around Somerset, because it is absolutely recognised that there is a fundamental individual level of risk that sits with no other professional group. Engaging with any outcome based commissioning approach would be completely voluntary for primary care but the need to do something for the rest of the system is reaching an imperative.

The Phoenix rises from the ashes. Can GPs and primary care professionals breathe new life into the delivery of health and social care?

I make no apology for being bold and ambitious in exploring a new way of doing business in health and care system thinking, because the stark reality is, every health and care professional in Somerset is working at or beyond their limit and the care of people in Somerset will begin to suffer unless we do things differently as a whole system.

I believe Somerset can lead a new way, the Somerset Practice Quality Scheme (SPQS) showed we can, and there are colleagues across the county who are embracing the chance to describe a new way for primary care, a chance to reshape a professional day that is rewarding and delivers those fundamental values that make primary care so special.

That isn't rhetoric, it is in its infancy, but is happening in South Somerset, Mendip and Taunton Federations. The CCG absolutely supports the LMC paper "collaborate for survival" and will try to ensure that any system changes complement and enhance any collaborative arrangement, simple or complex, that GPs choose to make.

Where will your practice be in five years? How will you be working in five years? Now is the time to ask those questions and now is the time to refresh primary care. It can do more than survive, it can flourish.

Dr Matthew Dolman
Chairman
Somerset Clinical Commissioning Group

Somerset CCG's 2015/16

Financial challenge

The NHS is experiencing unprecedented pressure on its resources moving into 2015/16. This pressure is reflected within the financial position of the CCG and local service providers.

The CCG holds a £690m budget to commission services on behalf of the Somerset population. In previous years Somerset CCG has met all of the 'Business Rules' set by NHS England. These include the CCG achieving:

A budget surplus	1.0% of the CCG's funding allocation
A contingency reserve	0.5% of the CCG allocation
Non Recurrent Spend	1.0% of the CCG recurrent allocation

In 2015/16, Somerset CCG plans to achieve a surplus of £6.5 million which represents 0.9% of its budget allocation; therefore for the first time the CCG will not be fully compliant with the business rules.

This has been a difficult decision for the CCG. However with support from NHS England, it was agreed that additional funding should be used on a non-recurring basis in 2015/16 to improve the performance of local Trusts with regard to the rights and pledges set out in the NHS Constitution and length of time patients might wait from referral to treatment..

The CCG has also planned for a significant QIPP (Quality, Performance, Productivity and Prevention) cost efficiency programme to be delivered in 2015/16. However, £2.7m efficiency savings are still to be identified this year. This risk, along with others such as contract negotiation, in year district hospital performance and prescribing costs means the CCG could face an overall financial risk in excess of £10m against a contingency reserve of £3.5m.

Although significant work has already reduced the level of risks, the CCG remains committed to working with partners to mitigate and resolve the remaining risks over the coming months.

Local service providers are also experiencing a growing financial challenge. At the end of last year, Yeovil Hospital had a deficit of £7 million pounds and forecasts for this year show sizable deficits for 2015/16 for both Yeovil Hospital and Taunton's Musgrove Park Hospital.

Update on SPOS

While national debate about the future of QOF continues, Somerset practices participating in the Somerset Practice Quality Scheme (SPQS) continue to deliver benefits to patients. These come in two forms.

Firstly, GPs report that consultations are more patient-centred as they can respond to the issues that the patient brings. Secondly, some really significant improvements are being developed by GPs and practice managers. For example, in Taunton third sector clinics are now running in primary care. This is a truly collaborative service. Each clinic is open to any patient in the federation. The third sector organisations, including Diabetes UK, Age UK and the Alzheimer's Society provide the services (free of charge) and the federation practices provide the space (again free of charge). In the longer term, the clinics will be managed by the federation long-term conditions specialist service. This will ensure that patients with long-term conditions get all the specialist advice and support they need. The evaluation of SPQS continues, and the team of academics from the South West Academic Health Science Network have been visiting practices to understand what the impact of SPQS on clinical practice has been. We are very grateful to those practices that have hosted visits. An evaluation report will be completed in July, but we are hopeful that by careful use of resources the evaluation can be extended into 2016. This is because we recognise that the reorientation of general practice contracting towards person-centredness is a long-term process and we cannot expect to see instant results.

County-wide service starts September 2015

Early Supported Discharge

Patients in Somerset who have experienced a stroke or acquired brain injury are to benefit from a county-wide roll-out of the county's Early Supported Discharge Service.

Early Supported Discharge (ESD) is a service which enables patients who have had a stroke to be discharged home earlier . Therapy and care is provided by a multi-disciplinary team in their own home or usual place of residence. Physiotherapy, occupational therapy and speech and language therapy are provided, as well as support from nurses and clinical psychologists.

A stroke services review recommended the NHS Somerset Clinical Commissioning Group (CCG) commission a robust ESD service across the county. This built upon the significant evidence from the successful pilot conducted in the Mendip area, which demonstrated improved outcomes and a positive experience for both patients and their carers. The pilot also showed quicker discharges from acute hospitals and less reliance on community hospital beds.

In order to explore the opportunities for aligning rehabilitation for stroke and neurological conditions, Somerset CCG's Governing Body approved a recommendation in January 2015 to commence a procurement process to commission a county-wide ESD model on a 'test and learn' basis. This has been widened to include the rehabilitation for patients who have suffered an acute neurological event and been admitted to hospital as a consequence. The test and learn phase is for 12 months, with a possible 12 month extension. The overarching aim is to explore and understand the benefits of the model in supporting people with neurological conditions other than stroke.

Somerset Partnership NHS Foundation Trust has been awarded the contract to deliver the county-wide ESD service, which will start on the 1st September 2015.

Somerset CCG will work closely with Somerset Partnership NHS Foundation Trust on the transition to the new service. They will also monitor the test and learn, together with other stakeholders, patients and carers. The Somerset Partnership NHS Foundation Trust, who were responsible for the success of the Mendip pilot scheme, have shown considerable experienced in providing community services to the varied demography of Somerset.

Congratulating their rehabilitation staff for the quality of their service, Somerset Partnership Trust explained that the ESD service would be delivered in collaboration with Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

Staff delivering the ESD service will work from three hubs in the county – South Petherton, Dene Barton (Taunton) and Shepton Mallet. To support the service a variety of staff from all professions will be recruited to join the existing teams.

Proposed changes to
Commissioning Federations

Since Somerset's nine GP Commissioning Federations were established in 2012 they have brought a number of important benefits across the system, improving relationships with the public and patient groups as well as nurturing innovation and encouraging leadership.

Federations have also had their limitations. They are dependent upon the goodwill of their members and reliant upon a few key individuals who undertake much of the work. The focus upon commissioning issues has also diverted time from practice priorities like workforce, managing demand and the development of joint working between practices and service providers.

There is now a proposal to retain the overall Federation Commissioning Budget of £450,000 but allocate this differently. (See table)

Members of Somerset CCG's Clinical Operations Group (COG) would like to consult with member practices during June, July and August 2015 and take a report to its September meeting. (The survey will remain open to responses from Somerset practices until 5.00pm on Friday 17 July 2015.) If there is a clear majority in favour of the changes, and subject to approval by the CCG's Governing Body, we will make interim changes from September 2015 and arrange formal changes to take place from April 2016.

Further discussion about the proposals is planned to take place at the next members meeting on the 1st July 2015 as part of the Governing Body visits to federations. You are welcome to discuss the proposals with your COG delegate, the manager supporting the federation or by contacting Andy Hill, Head of Service Improvement and Clinical Engagement, by emailing: andrew.hill@somersetccg.nhs.uk or telephoning: 01935 384096.

Table One: Summary of proposed changes to Commissioning Federations

Proposed Change / budget	Details
A Primary Care Clinical Leadership Budget (£50,000)	A dedicated budget to fund primary care clinicians from across Somerset to be engaged in service development work on an ongoing basis. (Equivalent to around 170 sessions of GP time at £300 per session).
A Practice Provider Development Fund (£200,000)	A dedicated budget to support practices to acquire expert advice or undertake work themselves in developing ways in which they can provide some services together in future..
A streamlined set of Commissioning Functions (£150,000)	For Commissioning Federation to undertake the following streamlined core functions: a) Electing COG members b) Meeting the governing body at least twice per year c) Convening engagement with local public and patient groups via health forums or similar d) Passing information between the COG and Governing Body and member practices and vice versa.
Combine the Commissioning Federations	To reduce bureaucracy and the number of commissioning meetings, it is proposed to combine the current Commissioning Federations into five areas: 1) Mendip, 2) Taunton and area, 3) South Somerset, 4) Sedgemoor, and 5) Crewkerne, Chard and Ilminster
Primary Care Strategy Coordinator (£50,000)	Many of the challenges facing primary Care (like retention and recruitment of staff) can only be addressed by the CCG, NHS England, Somerset Local Medical Committee and others working together. This part of the proposal would fund dedicated management time to support partners to draw up a primary care strategy and action plan and oversee its progress.

Care.data

Somerset CCG is one of just 4 pilot sites in England helping to pilot this exciting national initiative

NHS England and Somerset CCG are working together as a Pathfinder area, and preparing information on care.data for our GP practices in Somerset. We are together developing a Practice Toolkit that will ensure practice staff, and patient representatives, will understand the purpose of care.data and are ready for any enquiries or questions that might arise. A national Patient Information Line is already available to answer queries on 0300 456 3531.

Somerset CCG expects the care.data patient letters (explaining the purpose of the pilot), information leaflet and 'opt out' letters to be sent out in early Autumn 2015. The content and format of these materials have been co-produced by a Somerset Reference Group consisting of patient representatives, GPs, practice staff and CCG project team, working with the NHS England programme team. Two to three weeks before the patient letters will be sent out, Somerset CCG will be working with the local press and media to alert the general public and remind them to look out for a letter through the post, read it and do nothing if they are happy to have their GP coded data gathered by the NHS Health and Social Care Information Centre (HSCIC). One of the benefits of the Somerset involvement in the pilot scheme will be the ability to work with the national team to review the three months of coded data that will be extracted from each medical record by the HSCIC. This will help us to understand how the data will support our understanding of the local needs of our population and in commissioning local services. The national Programme Team have advised that no data will be extracted until national evaluation is undertaken and reviewed by Dame Fiona Caldicott, the National Data Guardian.

The national survey company Ipsos MORI will be doing a survey of a sample of patients in Somerset to see if they have heard of the care.data pilot, received the patient information and understood about their right to 'opt out' if they wish. The patient literature, posters and leaflets will also be evaluated by NHS England's marketing team to see what design and text was most effective and clearly understood by the public. NHS England expects to learn from the care.data pilot areas and incorporate this learning into a national roll out of the care.data programme at a date in the future.

We are aware that there is ongoing national interest in how this Pathfinder phase is progressing, and questions for the national team on process, security and confidentiality continue to be raised through national media. The Somerset Project Team continue to work with practices, patient representatives, LMC, HealthWatch and other local stakeholders, to ensure progress is shared, and further updates are planned for the coming weeks. For more information on local progress, contact Allison Nation. (allison.nation@somersetccg.nhs.uk)

What is the care.data programme?

Care.data is a national initiative which eventually aims to collect and analyse coded data from patients' GP and hospital medical records. This data could help create a picture of the nation's health which would help service commissioners and researchers study issues such as diagnosis, waiting times and patterns of illness or disease. Coded data from patients' hospital records has been collected and analysed by the NHS for the last 20 years.

In the future, NHS England would eventually like to extract coded data from patients' GP medical records, link these with their hospital data before being uploaded to a national database and analysed by the NHS Health and Social Care Information Centre (HSCIC).

Patients who do not want their GP data extracted can choose to 'opt out' of the programme. This will not adversely affect their healthcare.

Quality Accounts

and keeping patients safe

Quality Accounts were introduced in 2009 to strengthen board-level accountability for the quality of services and not just the organisation's financial status. Providers of NHS funded services have a responsibility to submit their Quality Account to the Secretary of State for Health each year and this is subsequently published on the NHS Choices web site.

Somerset Clinical Commissioning Group (CCG) sees the continuous improvement of quality and patient safety to be at the heart of how we commission services and we use the three fold approach based on the definition of quality set out in the Department of Health publication, 'High Quality Care for All', namely:

* "**Clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes

* **Safety** – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and

* **Patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect."

Within this definition, we continue to review quality metrics and strengthen the links with performance and contracting, so that we can be sure the impact on and experience of patients is heard and that improvements are made as a result. Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals, provider organisations, commissioners, system and professional regulators and other national bodies including the Department of Health. The system's collective objectives in relation to quality are:

* to ensure that the essential standards of quality and safety are maintained
* to drive continuous improvement in quality and outcomes for patients

Examples of our monitoring include healthcare acquired infection rates, acquired pressure ulcers and falls.

Reducing smoking in pregnancy

The number of women smoking during their pregnancy in Somerset is falling.

Smoking in pregnancy figures for 2014/15 are down to their lowest recorded rate with just 14% of mums to be continuing to smoke. However, there is no room for complacency and Somerset still aims to deliver a rate of less than 11% by the end 0f 2015.

Over the last two years Somerset County Council's Health and Wellbeing Board and Somerset CCG have been working to make the reduction of smoking during pregnancy a high priority. Both Taunton's Musgrove Park Hospital and Yeovil District Hospital have lead midwives for smoking prevention and all mums to be are offered a carbon monoxide breath test at their first booking and a referral to the Mums-2-Be (M2B) programme.

The M2B scheme is working to increase the numbers of women stopping smoking and this includes reinforcing healthy behavior with incentives such as shopping vouchers.

Better outcomes

for patients through joined up care

The population of Somerset is growing and people are living longer. These changing demographics, during an extended period of financial austerity, will place increasing pressure on the resources of the NHS and Social Care and we need to find new ways to help people stay healthier longer and live independent, purposeful lives.

Outcomes based commissioning is a new approach to commissioning, using contracts based around the delivery of care for a population rather than delivery of care by a provider, and using outcomes as the contract currency. By aligning financial incentives with delivery of outcomes that are important to service users, it creates an economic environment thought to be easier for providers to collaborate and innovate.

As detailed in the March newsletter, Somerset CCG is now mid-way through its assessment of outcomes based commissioning (OBC) as a way of promoting joined-up person-centred care in line with our two and five year strategies. The CCG has partnered with Somerset County Council and the NHS England Sub Regional Team to deliver this programme. Together, the commissioners of Somerset have engaged PwC and Cobic, organisations with significant experience of helping other parts of the country implement OBC, to support this project. They will help in developing a business case outlining the options for how and whether Somerset should move to an outcomes based commissioning approach for the population of Somerset.

Unlike traditional contracting methods, an outcomes based approach can catalyse – rather than hinder – closer collaboration between primary care, community services, hospitals, third sector care and adult social care. It could, therefore, support and accelerate the positive progress of the 'Test & Learn' pilots and the Symphony project. It is, however, a very different way of commissioning care, and the project team is considering if and how it might be undertaken in Somerset, and the potential implications on providers, including general practice. The project team's work to date has focused on:

1. The assessment of options for population segmentation, geographical scale and the scope of services of a contract;

2. The development of an Outcomes Framework to form the basis of incentivising behavioural change and promoting person-centred care;

3. The analysis of capitation levels and potential financial incentive mechanisms to reward the delivery of high value care; and

4. Engagement with stakeholder organisations across the county, including representatives of Somerset GPs, to understand their appetite for, and concerns about, potentially working in collaboration with each other to deliver an OBC contract. The project team's assessment will be presented as a business case to the CCG's Governing Body meeting and Council Cabinet meeting in July 2015.

At this point it is expected that a decision will be made as to whether commissioners will progress with outcomes-based commissioning. If a decision is made to proceed, further decisions will follow based on the options presented in the business case.

Your questions answered on

Outcome Based Commissioning

What is Outcome Based Commissioning (OBC)?

- A new type of commissioning that pays providers for delivering results that really matter for people, patients, carers and communities
- It sets a new type of framework of measures that incentivises providers to deliver results together
- It fundamentally changes the flow of money in the health and care system

Why are we looking at it in Somerset?

- The Somerset health and social care system costs **1 billion pounds a year**
- **160 million pounds** of that is primary care funding (including prescribing), the remaining **840 million is spent** on hospitals, community and mental health services and social services
- Modelling of the future impact of ageing patients using the same care models leaves Somerset short of **212 million pounds** annually after five years
- This year both our acute hospital trusts are predicting financial deficits that, if they are not rectified over the next couple of years, could compromise their national status as independent Foundation Trusts and their ability to deliver national quality standards (specifically waiting times and cancer treatment times)
- Social care has experienced significant financial cuts and is anticipating more
- Primary care is only one part of a struggling set of services
- The impact of OBC on the Foundation Trusts and social care could be fundamental
- The role of primary care would be for individual practices to decide
    - Practices can choose to ignore the OBC developments as providers, they could chose to fit in around the other providers and stay in their current form
    - Engagement as providers would be voluntary
    - The national GP contract is recognised and respected
    - Enhanced services and QOF / SPQS could be used differently in the future
    - There is no expectation on what "unit of primary care" could engage in OBC; individual practice, collaboration, joint venture, whole county

What are the potential benefits?

- The health and care system could begin a 5 – 10 year change programme that aims to deliver high quality care with a combined health and care budget (capitated) for the whole population
- The health and care system could refocus its delivery of care on what matters to people, patients, carers and communities, not on paying for units of activity
- The health and care system could look to create an experience of care that was joined up and underpinned by a common care record with shared IT systems
- Money could be moved "upstream" into the community
- Prevention of illness would be incentivised and the system could be "flipped" to try and reduce the increasing numbers of people with complex illness that is placing unsustainable demand on services
- The combined workforce could be energised by a set of jointly agreed outcomes that allowed professionalism, compassion and quality to come to the fore
- A different type of health and care leadership approach could be realised that recognised the need for a collective and shared style across all providers
- A shared communication to people, patients, carers and communities would shift a responsibility to the individual to understand and develop their own health and wellbeing
- Politicians would be faced with a shared health and care vision that would be compelling and driven by what communities need
- OBC developments would support the "primary care collaboration agenda" at any level
    - Individual practice
    - Collaborative groupings
    - Joint venture options

What are the potential risks?

- The risks of staying with the current commissioning / provider arrangements will produce an unstable health and care system where the quality of care falls. Hospitals and community services will struggle. Social services will retract even more
- Primary care will not be immune from the financial challenge, workforce pressures and political agenda that are becoming critical. Practice teams are on the edge of their ability to function with the current demands, our own individual wellbeing will be compromised and practices will fail
- OBC could take us into uncharted territory from a regulatory perspective but national authorities are keen to be supportive. It has the potential to let us define how organisations work differently
- Staff in the heath and care system could be unsettled but the current environment is hardly stable
- Relationships and the leadership of the system could be strained and legal challenge could be a possibility if appropriate process isn't followed
- The public could resist change

What is the evidence that OBC has worked elsewhere?

No community in the UK has been bold enough to explore a "phased whole population" approach but:

- The best example is an OBC programme in Spain that has been developing over the last 18 years

Your questions answered on Outcome based commissioning … *continued*

- Musculoskeletal care Pennine MSK: Running since early 2000s. Improved patient knowledge and empowerment, reduced follow-up activity, reduced spend by 5% per annum
- Bedfordshire MSK: Running since April 2014. Reduced waiting times. Improved patient choice
- Camden CCG: focused on improving outcomes such as 'days spent at home', with dramatic improvements in, for example, A&E attendances and emergency admissions
- It's also happening in …
    - Older people: Cambridgeshire & Peterborough, Croydon, Mid-Notts, Oxfordshire, Salford
    - Care close to home: NE Essex, Richmond
    - MSK: Bedfordshire, NW Surrey, Sheffield, Halton, Derby, Enfield
    - Plus urgent care, mental health, substance misuse, cardiac

Who has been involved in developing this work locally?

- This programme has been evolving over three years, starting in South Somerset with Symphony
- Teams with clinicians, managers, hospital leaders, area team members, national bodies, GPs, consultants, social workers, allied health care professionals and patients have been working on work programmes to explore ideas about the scale, the scope, the outcomes and how the money might work
- Two years of meetings with health and care leaders has generated real progress with some elements of an OBC model such as outcome measures and a county wide patient level data set
- We have asked PWC and a company called COBIC to support the writing of a business case for the July Governing Body working with a range of stakeholders across the county

Which organisations will it involve?

- We would anticipate all the Foundation Trusts would participate and social services
- Primary care could choose to be involved at whatever scale / combination, on a voluntary basis
- One could imagine other health and care providers would be needed to deliver a more community based preventative set of results
- The involvement of the private sector is a possibility if the NHS and local government organisations can't collaborate

What will it mean for GPs?

- As a GP provider, OBC will be a voluntary opportunity to explore the outcomes framework, on their own or with other providers, and choose whether to engage or not. GP providers will not need to make a decision to be part of OBC before the late autumn
- The Somerset health and care system is creaking and the Foundation Trusts are actively thinking through the possibilities OBC can offer to deliver a sustainable, high quality solution
- OBC compliments "collaborative primary care" options at all levels, it would move new (current Foundation Trust / social care funding) money into the community
- It could support new ways of working for primary care
- It does not impact on the national GP contract unless a practice chooses to explore that
- OOF / SPQS and enhanced services could be used differently through the co-commissioning agenda
- It makes no ask of "property" investments in primary care and in fact may generate further funding options in the longer term
- As a GP commissioner it allows us to set out clearly what our patients and local community need, as we understand our local populations so well
- It would allow engagement in designing new outcomes and measures for Somerset
- It would help keep primary care central to the local system, the patient list is a critical strength of primary care.
- It does not challenge the partnership model unless a practice chooses to explore alternate models which could happen with or without OBC

Is it voluntary?

- It is a voluntary opt in by primary care at any level it wishes
- The time when practices will need to make a decision to be part of the OBC arrangements in not before the autumn

What is the timeframe / What are the plans to progress OBC in Somerset?

- OBC has been worked up over the last three years in Somerset
- Time is becoming a real risk for the stability of the health and social care system as complex health and care issues become the norm and impact on the different services, because the funding is running out
- The current proposal is to take a business case to the CCG Governing Body on 16th July 2015 to provide a set of options around Capitated Outcome Based Commissioning that the Governing Body will have to debate
- If supported at its fullest ambition, notice would be given on the Foundation Trust contracts
- Over the rest of the year, providers in Somerset would then be taken through a controlled process that determines the "most capable provider(s)" of the new outcomes framework. Primary care could choose to be in or out of those negotiations

Somerset's

Test and Learn Pilots

Mendip

The three Mendip GP federations, in collaboration with Somerset Partnership NHS Foundation Trust, Somerset County Council Adult Social Care and the Royal United Hospitals Bath, are working together to design and implement a new model at a local level. The pilot has no additional resource and is predicated on a mutual contribution model, consolidated through a memorandum of understanding between providers.

150 patients have been selected by primary care clinicians against a set of criteria which includes clinical judgment to benefit and three or more long term conditions. They will have access to a wide range of support through care co-ordination and multi-disciplinary working. The first patients were seen in early June and information on outcomes will be available later in the year.

A really special part of the Mendip Test and Learn pilot is Health Connections Mendip. This is commissioned by Mendip federations to provide a peer support and social prescribing service to enable people living in Mendip to improve personal and community resilience. This may be on a one to one or group basis.

Initially trialled in East Mendip the service demonstrated it was possible to improve the ability of patients to self-manage. This is reiterated by similar national evidence.

As a result the service has been developed and expanded to cover the whole of Mendip using the Primary Care Collaborative Fund.

The service is available to adults, including patients who are part of Mendip Symphony (test and learn), who would benefit from non-medical support with health and wellbeing issues. This can include for example learning techniques to better manage a long term health condition, increasing social connectedness or changing health behaviours.

Patients self-refer to the service or may receive a recommendation from any of the health professionals who are providing clinical support.

Health Connectors also work on a one-to-one basis with patients in GP practices in each Mendip federation area. As well as listening to patients' health stories and signposting to local services, they can assist patients to set health-related goals that are meaningful to them, and support them to make changes that last.

Test and Learn Pilots

Taunton Deane

Taunton Deane Federation of General Practices has developed a clear vision of integrated primary, community and acute care with its partners. It has already recruited one keyworker and one nurse with more appointments to follow, including another seven keyworkers.

Somerset Partnership NHS Foundation Trust, as part of the joint venture with the federation, has requested expressions of interest from community matrons in order to provide two care coordinators to the project. The care coordinators are expected to start in June and would see more complex people, possibly those who have a requirement for mental health support.

Taunton and Somerset NHS Foundation Trust is recruiting the clinical lead.
Staff induction is planned, to cover care planning, patient activation, frailty and local service availability.

The first patients were seen and inducted into the service on the 11th of June with a plan to induct a total of 20 patients by the end of June 2015. It is planned that all three of the Taunton hubs will be fully operational by September 2015 with an agreed activity plan to induct just over a thousand patients by March 2016.

South Somerset

The Symphony Complex Care Hub has now gone live and has received positive feedback from patients and staff alike. So far 12 GP surgeries have nominated patients to the hub and four more are in the process of doing so.

77 patients have been nominated to date, and more than 50 have been fully consented and have been met by the team to start the care planning process.
There is a great team of GPs supporting the hub, led by Dr Jo Cummings.
Dr Cummings is one of the Complex Care GPs in South Somerset and brings valuable experience of other care models after spending time working in Australia.

Also working sessions in the hub will be Dr Helena Aisling-Smith and Dr Sarah Ormandy who both have many years' experience as local GPs.

Our GPs are ably supported by two care co-ordinators and three key workers, each with their own area of expertise, including smoking cessation, dementia, falls management, telehealth, therapy support, community hospitals and discharge co-ordination and mental health. Patients are provided with a computer tablet where they can access their web-based care plan, which can also be shared with carers and all health and social care staff involved in their care (with patient consent).

Dr Campbell Murdoch from the Wells Health Centre asks “Could a health and wellbeing person centered approach save us and the NHS?”

Person centred care

Over one year ago when the opportunity to be released from QOF presented there was an easy decision to make. The main driver for dropping QOF for me was because it was frequently at complete odds with providing the best care to my patients within the limited resources at hand. The alternative option, SPQS, had to be a better option, even though I wasn’t sure what it was.

Now we are fifteen months on what has our QOF free, SPQS world enabled. I think at the top of the list has to be professional autonomy. Professional autonomy and the ability to apply critical thinking to patient care were seriously curtailed during my 10 year QOF career.

Autonomy, I think, is an important component of wellbeing. The wellbeing of our patients can be improved by the autonomy that person-centred care provides. Equally person-centred care can provide health care workers with greater professional autonomy which should enhance job satisfaction and thus their own wellbeing.

With the improvement in wellbeing of the health care professional gains can start to be made. Efficiency can improve through improved cognitive abilities (as “the chimp” is resting*). Enthusiasm, energy and innovation can reappear as hope for creating a better future is reignited. Perhaps most importantly, and most topical, improved wellbeing can enable the ability to successfully collaborate. (*The Chimp Paradox by Dr Steve Peters is a book well worth a read. It provides a paradigm that is useful in so many settings including collaborating with colleagues and dealing with worried patients.)

What is “health & wellbeing”?

The Oxford English Dictionary defines well-being as; a state of being happy, comfortable, healthy. I think this is an okay explanation but it doesn’t really help when trying to identify how we may improve wellbeing. There are a number of other definitions of wellbeing that can be found on Google but I couldn’t find one that fitted neatly with a health and wellbeing approach to person-centred care. So I spent some time considering what health and wellbeing components could be used to shape health and social care services for our current population. I came up with the following five headline acts. They are in no particular order and are all intricately intertwined. I have only given the briefest of explanations. Your critique is welcomed.

The Mind – including psychological/psychiatric health, as well as the concept of maximising of the mind. How we may get the best out of the psychological brain.

Social – a huge and broad range of topics covering everything to do with a person and their world.

Movement – our body is designed to move to interact with our world, but we also seem to gain from the simple action of physical activity.

Nutrition – important in its own right. Poor nutrition is having a huge detrimental effect on the population.

The Body – another broad range of topics are covered here. This is where the traditional medical-model of diagnosing and treating pathology sits.

How can a health and wellbeing approach help?

Put most simply, a paradigm shift for the entire population towards a person-centred health and wellbeing model could enable a significant reduction in the unnecessary medicalisation of the population. The benefits of this are known to us all. A system wide person-centered health and wellbeing approach, with the necessary supportive infrastructure, could help to assist individuals in seeking the most appropriate resource / service to meet their perceived health and wellbeing needs.

Put simply, we will stop having to wallop every health and wellbeing issue with a medical hammer...GP practices then survive and the NHS looks rosy again. Phew!

Person centred care

Collaborating to enable a health and wellbeing person-centred care approach. The birth of Your Health & Wellbeing – Mendip.

Over the past four months twelve heterogeneous practices across the Mendip region have been meeting on a monthly basis to…collaborate. These practices cover a population of 100,000 patients. At the start of the process we knew there may be some gains in collaborating. However we were not sure where our collaboration would take us. We started the process with a brain storming session to identify at least one shared goal, and with some surprise we identified many. We also explored what we did not wish to lose if we were to formally collaborate. The headline acts of this meeting were; we wished to collaborate to create sustainability, efficiency and opportunity, but we did not want to lose the individuality, uniqueness and the ownership/autonomy of our GP practices. In essence, to successfully collaborate, our own wellbeing is essential.

Once the hard work of agreeing on the basics was done the next step was to identify what our care model should be. The person-centre health and wellbeing model was the clear answer. This agreement came about relatively easily through our inherent shared GP views.

We were also spurred on by the current projects of the Mendip Symphony test and learn, and also the fantastic development of health connectors who are now embedded in our practices. So, Your Health & Wellbeing – Mendip, has formed. Our next step is to enable sharing of EMISweb for cross-practice working and also develop some quick-wins in process efficiencies, whilst identifying and planning for wider service reconfiguration. We are also creating relationships with the spectrum health and social care providers to start the process of effective inter-organisation collaboration that is needed for true person-centred care.
….one day we really may have in house physios!

My own practice and its developing culture.
I have been asked to give a little information about what we are getting up to in Wells at the moment.
With the recognition that, in order to create the very best organisation the health and wellbeing of the people in the organisation is paramount, we have started to try to apply the health and wellbeing model to our organisational culture.

What have we done? Well, everybody has a copy of The Chimp Paradox! We have established a culture that every individual is an equal. We have outlawed any judgement of a person (whether it is oneself, other staff, or patients) and instead only behaviours or actions can be commented on…this sounds a little simple but it seems to be very effective. We want the best for our staff, whilst recognising that time and money will always be limited resources, so we are trying to enable every staff member to attempt to create a role and environment that provides them with the maximum purpose, passion and job satisfaction.

We are also promoting all the usual activities that create social cohesion (face to face meetings, good communication, and social events).

There is a dream to have an environment that embodies health and wellbeing…..tai chi sessions at lunch time have been suggested. It is early days and the pressures of daily demand on general practice are relentless, but this process to improve wellbeing does feel good.
(Whilst writing this the following TED talk has been released…well worth a watch www.ted.com/talks/margaret_heffernan_why_it_s_time_to_forget_the_pecking_order_at_work

To finish, the next few years in Somerset…
The future is looking like it could be full of opportunity. My hope is, whatever targets are pushed our way over the coming years they don't destroy the enablement of autonomy, professionalism, critical thinking, innovation and enthusiasm that has now been started in Somerset. (And of course General Practice needs to get its fair share of funding otherwise even the tai chi won't save us!)

Quarterly Meetings

with Practices for 2015/16

Autumn/Winter Quarterly CCG Members meetings:

Wednesday 1 July 2015
Glastonbury Town Hall, Magdalene Street, Glastonbury, BA6 9EL (2.00 – 5.00pm)
Light buffet lunch 1.15pm – 2.00pm

Wednesday 23 Sept 2015
Woodlands Castle, Ruishton, Taunton TA3 5LU (2.00pm – 5.00pm) Tea/coffee on arrival
(For map and directions see http://www.woodlandscastle.co.uk/contact-us/)

Fork buffet supper 5.00 – 6.00pm, followed by Somerset CCG Annual General Meeting 6.00pm - 7.30pm

Somerset CCG's Annual General Meeting
Wednesday 23 September 2015 (6.00pm to 7.30pm)
Woodlands Castle, Ruishton, Taunton TA3 5LU

Quarterly CCG Members meeting

Wednesday 9 December 2015
Wynford House, Yeovil 2.00pm – 5.00pm (light buffet lunch 1.15 – 2.00pm)

Links to key documents

Five Year Forward View
http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Primary Care Co-commissioning Guidance
http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

Prime Minister's Challenge Fund
http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

CCG 2 Year Plan and 5 Year Strategy
http://www.somersetccg.nhs.uk/publications/strategies-and-plans/

Making the Most of Community Services
http://www.somersetccg.nhs.uk/about-us/governing-body/meetings-and-papers/governing-body-agenda-and-papers-19-november-2014/

Details regarding Outcomes Based Commissioning
www.cobic.co.uk .

NHS
Somerset
Clinical Commissioning Group

Published by:
Somerset Clinical Commissioning Group
Headquarters, Wynford House, Lufton Way,
Yeovil, Somerset BA22 8HR
Tel: 01935 384000
www.somersetccg.nhs.uk