REPORT TO NHS PETERBOROUGH

REVIEW OF PROPOSALS FOR SERVICE RE-CONFIGURATION IN RESPONSE TO THE CO-OPERATION AND COMPETITION PANEL'S REMEDIES NOTICE

Executive Summary

1. NHS Peterborough commissioned CHEC to conduct this independent clinical review of its strategy for primary and urgent care following concerns raised by the Co-operation and Competition Panel relating to the PCT's involvement of clinicians with potential conflicts of interest in its consultation process. CHEC was asked to assess the options put forward in the consultation to ensure that they were clinically appropriate.

2. The CHEC reviewers were Professor Mike Pringle, Dr Christine Johnson, Miss Julie Reid and Ms Jacqui Smith. The review was 'desk based' – a number of relevant documents were read and analysed. A limited number of supplementary questions were answered by NHS Peterborough.

3. The reviewers are satisfied that the three options were fairly expressed and based on clinical logic; that Option 1 (do nothing) is clinically undesirable; that Option 2 (minimal change) would be an improvement of Option 1; but that either the original or the recently revised Option 3 (the recommended change) would be clinical desirable and appropriate.

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The Process of this Review

Remit and Scope for this Review

4. The commission for this review was stated by NHS Peterborough as:

> NHS Peterborough wishes to commission an independent clinical review of its strategy for primary and urgent care following concerns raised by the Co-operation and Competition Panel relating to the PCT's involvement of clinicians with potential conflicts of interest in its consultation process.
> [Document #1]

5. The Cooperation and Competition Panel stated the requirements for this review as follows:

> "i. **An independent panel of clinicians to report to NHS Peterborough's Board:** Prior to making its final decision on the outcome of its 2011 consultation process, NHS Peterborough's board should consider a report from a panel of independent clinicians concerning the clinical case regarding options 1, 2 and 3 consulted on by the commissioner in its 18 May – 18 August 2011 consultation process ('The Right Care at the right Time'). The independent panel of clinicians should be appointed by either of the NHS Clinical Commissioning Community or the RCGP (possibly with the assistance of CHEC). The independent panel of clinicians will have no associations with either urgent care or primary care providers affected by the reconfiguration proposals, no previous involvement with NHS Peterborough's reconfiguration process to date and will have requisite expertise in urgent and primary care. In preparing their report the independent panel of clinicians will consider:
>
> a. NHS Peterborough's consultation documents (and any other documents in NHS Peterborough's possession that the independent panel of clinicians considers to be relevant to understand the clinical case for change);
>
> b. any relevant amendments made by the commissioner to its consultation options; and
>
> c. all feedback provided to the commissioner during its consultation process."
> [Document #1]

6. Further information on the scope of this review was given in the briefing from NHS Peterborough:

> The PCT wishes the review to meet the scope described by the CCP above. To clarify our requirement further NHS Peterborough would wish the review to:
>
> - focus on the clinical elements of the case for change and the proposed strategy

- not include the areas covered by the CCP namely economic case, choice, competition, consultation process, contractual and procurement procedures
- be based on the available information. (Please contact Peter Wightman at the PCT for any points of clarification on the information.) The PCT would welcome evidence and learning from other locations in similar circumstances that the reviewers are aware of.

[Document #1]

7. This report is the response by the CHEC independent reviewers to this remit and scope.

About CHEC (Collingham Healthcare Education Centre Ltd)

8. CHEC is a non-for-profit social enterprise that is registered as a company limited by guarantee. It was pump primed by the precursor of the NHS East Midlands Workforce Deanery six years ago and is allowed to use the NHS logo.

The CHEC Review Team

9. This review has been undertaken by Professor Mike Pringle, Dr Christine Johnson, Miss Julie Reid and Ms Jacqui Smith.

Professor Mike Pringle, CBE MD FRCGP FMedSci
Director of Education, CHEC

Mike is Emeritus Professor of General Practice in the University of Nottingham; Strategic Director of PRIMIS+; former Chairman of the Royal College of General practitioners (1998-2001); ex-member of the General Medical Council; member of the council of the Medical Defence Union; and deputy chair of the board of UK Biobank. He is Medical Lead for Revalidation and Chair of the Trustee Board in the RCGP.

Dr Christine Johnson, FRCGP
General Practitioner

A General Practitioner since 1988, Christine was a full time partner until 2003 when she moved to sessional GP work for Nottinghamshire PCT working with, and supporting, a myriad of practices. As Executive member for Central Notts Clinical Services (CNCS social enterprise) she oversaw the expansion of Out of Hours Care from North Nottinghamshire to incorporate the whole of Leicestershire covering a population of over 1 million. This innovative

development required collaboration with the LMC and all local GPs opting back their OOH responsibility. In addition CNCS established a de-novo practice in Kirkby in 2007 which now has an expanding list of over 5000 patients. Subsequent procurement placed North Notts Walk in Centre within the practice. She continues to be part of the audit team at CNCS. Her work with the National Patient Safety Agency led to annual conferences with the Medical Protection Society sharing lessons from urgent care settings as well as commissioning CHEC to develop Seven Steps to Patient Safety in General Practice. She is in regular contact with the Primary Care Foundation and their benchmarking procedures for urgent care. A Fellow of RCGP and Council member representing Trent consolidates her undergraduate role as Community Sub Dean and deanery role in underperformance both at practitioner and practice level. She has been Clinical Lead for Commissioning at the RCGP

Jacqui Smith, MBA (Health Executive) CMS DCR(T)
Chief Executive, CHEC

Previously an Associate Director in a large acute Trust and a radiographer by profession, Jacqui has over 30 years NHS experience both as a clinician and in management and education. She achieved an MBA (Health Executive) in 2005. Specialising in service redesign and leadership, Jacqui is also a former finalist for CIPFA Public Servant of the Year 2004. Jacqui is an experienced project manager and is a qualified PRINCE2 practitioner. She has previously been responsible for capital projects up to £12m and revenue £23m.

Julie Reid, BA Hons MCMI MIHM
Director and Company Secretary, CHEC

Julie returned to the NHS in 2001 following 6 years general management within warehousing and distribution. She is a former member of a Trent Breast Screening Quality Assurance team, Trent IHM regional committee member and past Chair of the Newark & Sherwood Practice Managers' Forum.
Julie is Practice Manager at the Collingham Medical Practice, Director of Collingham Pharmacy and a former chair of the Newark & Sherwood Health Board. She has experience of practice assessment visits (both provider and assessor) in the PMCPA pilots. She is co-founder of the original CHEC.

Documents Considered in this Review

10. CHEC's role was defined as one of reviewing the available documentation and any supplementary documents that might assist its work. This review, therefore only involved a document review – no interviews or site visits were conducted. The documents provided to and considered by the review team were as follows:

CHEC Doc #	Document Title and date	Main Purpose of document	PCT ref
Briefing documents for this review			
1	Briefing for Independent clinical review (March 2012)	To set out the purpose and scope of this review	NA
Information informing the strategy developed for consultation			
2	NCAT review (March 2011)	Review of draft strategy and business case March 2011	Item 18
3	Business case (May 2011)	Describes case for change, options and recommended option for urgent care and primary care.	Item 35
4	Consultation document (May 2011)	Summary version of the business case for consultation	Item 32
Information gathered during and after the consultation			
5	Meeting notes and written responses (May-August 2011)	Notes of public consultation meetings held and written responses received	Item 48a
6	MRUK report (August 2011)	Independent assessment of the questionnaires submitted during the consultation	Item 48a
7, 8, 9, 10	September Board Paper (main paper and 3 attachments)	Describing the outcome of consultation, key conclusion for primary and urgent care and the revised strategy	Items 47, 48, 49, 50
11, 12	Cooperation and Competition Panel Report and Cooperation and Competition Panel Remedy	Describes CCP assessment of NHSP conduct and includes outcome of economic review regarding choice and competition	(CCP website)
Supporting information			
13	Analysis of attendance at urgent care centre sites	Analysis of urgent care attendances by reason and geography – concludes the alma road service is driven by proximity to the service	Item 65
14	A&E attendances	Attendance in the 3 wards closest to the equitable access centre, indicates no evidence supporting assertion EAC has affected A&E attendance	Item 58
15	Clinical QOF	Latest data for clinical QOF points for practices in Peterborough	Item 62
16	Primary Care Capacity	Illustrates practice capacity is available should EAC close.	Item 72
17	A&E data – potential for management at minor injury service	Outcome of clinical review of minor injury data indicating up to 60% of A&E cases could in principle be managed by an MIU (a lower % shift is used in the modelling)	Item 71

Background to this Review

11. The background to this review, as provided by NHS Peterborough is as follows:

2.1 NHS Peterborough developed and consulted on a strategy for primary and urgent care in 2011. This included a pre-consultation phase (January to March 2011), formal consultation (May to August 2011) and revision of the strategy to reflect comments received during consultation (September 2011). The Board delayed its decision on the strategy in September to allow time for the Competition and Cooperation Panel (CCP) to investigate a complaint it had received, made by 3Well Medical, alleging that the PCT had not followed the Principles and Rules for Cooperation and Competition.

Co-operation and Competition Panel Findings

The Panel concluded their investigation in February and issued a report of their findings.

2.2 The Cooperation and Competition Panel found that NHS Peterborough fulfilled its responsibilities in the following areas:

a. NHS Peterborough followed a process for developing and consulting on its strategy which engaged widely and in a meaningful manner, specifically NHS Peterborough:
   - began the consultation with an open mind;
   - provided sufficient information in the documents for stakeholders to understand and comment on the strategy;
   - provided reasonable opportunity for people requiring language translation to participate.

b. The PCT did not discriminate against 3Well in terms of the management of their contract or considering possible options for the future.

c. NHS Peterborough met its requirements to commission services from those providers best placed to provide the service i.e. it has considered a full range of options and adapted the options following feedback.

d. The strategy appropriately offers patients choice and ensures competition, namely:
   - In hours GP care, for which there will be many choices
   - Urgent and out of hours care – where the PCT intends to run a competitive tendering exercise

2.3 However, the Panel found that NHS Peterborough has not provided sufficient assurance with regard to the management of potential conflicts of interests.
[Document #1]

12. In preparing for this report, the reviews looked at the outcomes from the consultation process. Many respondents were concerned that larger practices would be impersonal with poorer access. However there were many who accepted the case that larger practices, especially in modern premises, could provide a wider range of services.

13. There were also geographical concerns, especially access to the City Centre site for patients who attend the Alma Road Walk-in Centre at present. The flows of public transport to the proposed new general practices were raised and NHS Peterborough has undertaken to negotiate appropriate provision.

14. As the Co-operation and Competition Panel found, the reviewers were impressed with NHS Peterborough's consultation and its response to the consultation's findings.

The Review Findings

15. This report and its findings are based on the following assumptions:

- In this time of transition, NHS Peterborough (the PCT), the newly formed PCT cluster and the emerging Clinical Commissioning Groups are continuing to be supportive of the proposals in Option 3
- The local clinicians, especially the GP community and the LMC, continue to be supportive of the current proposals in Option 3
- NHS Peterborough has the capacity to implement the revised Option 3 within the timescales described in the current board papers, including the financing of new build premises
- The current Option 3 can be implemented as a coherent policy, allowing of course for flexibility as external and local circumstances demand; and that the timing of changes allows clinical continuity to be maintained throughout
- There is a current risk assessment used by NHS Peterborough to inform its management of the changes for the current Option 3
- The planned improvements to transport links are achieved as required by changes in service provision

16. On reading the submitted materials, the reviewers believe that these assumptions can and are being met. However, if any of these assumptions proves to be unrealistic, then the findings of this review will not be secure.

Conflicts of interest

17. This review arose from the Co-operation and Competition Panel's finding that there had been potential conflicts of interest in the conduct of the consultation (18 May to 18 August 2011) by NHS Peterborough on its plans for restructuring of general practice and urgent care services. The key finding by the CCP was:

> We conclude that the commission had not managed potential conflicts of interest in its consultation process appropriately. We found that the involvement by NHS Peterborough of two clinicians in lead, influential roles, in a service reconfiguration consultation process was not appropriate in circumstances where those clinicians were associated with providers that would be directly affected by, and might gain from, the process. Both of the clinicians are partners in GP

practices in Peterborough that will be directly affected by the service reconfiguration, and one of the clinicians also holds a senior position with an urgent care provider in Peterborough that will be directly affected by the service reconfiguration proposals.
Document #11

18. The reviewers have therefore been asked to consider if the clinical proposals for reconfiguration of general practice and urgent care services in Peterborough are coherent and appropriate despite this potential conflict of interest. We will consider the following dimensions:

- Whether change is clinically indicated
- Whether the revised, current Option 3 is compatible with safe, rational best clinical practice, confluent with appropriate values and anticipated health reforms
- General Practice size, quality of services and care, access, number and premises
- The provision of urgent care

Whether change is clinically indicated

19. The presented evidence that much of the general practice services in Peterborough would benefit from urgent improvement is compelling. While some practices provide good care, achieve high QoF scores and offer good access, this is far from universal. There are practices operating from unacceptable premises which restrict the range and potential of their services.

20. The reviewers have seen evidence that the Out of Hours GP service is inadequate for a modern health service in the early hours of the morning. The current services of the two Walk-in Centres are restricted, for example in their use of imaging, and can be developed. Further, having two Walk-in Centres alongside established general practices in one locality allows duplication of services, and promotes the risk of inconsistent and fragmented care.

21. The reviewers are satisfied that the case against Option 1 (do nothing) is cogent on a clinical basis. In terms of risk, we consider the risks to patients of doing nothing to be greater than the risks of disruption through change.

Whether the revised, current Option 3 is compatible with safe, rational best clinical practice, confluent with appropriate values and anticipated health reforms

22. The National Health Service is based upon fair and equal access to health care free of charge at the time of need. Among the key mechanisms for achieving this has been a strong, quality primary care service that manages 9 out of 10 episodes of care and uses high intensity services appropriately.

23. This vision requires strong, effective general practices in appropriate premises with skilled staff. These practices need to be facilitated by the NHS to develop their facilities and services to meet the developing needs of their communities.

24. Patients should expect to receive evidence based, high quality care in appropriate buildings with a wide range of services. They should expect to have good access (including geographically convenient) to primary care advice 24 hours a day.

25. However, most patients value care based on a continuing relationship with a small number of clinicians who they know and respect. The need for urgent care and its provision throughout the 24 hours has to be placed in the context of registration with a practice and most continuing care coming from a skilled, supported primary care team in their practice.

26. In the near future, commissioning of services will occur more locally, involving general practitioners, hospital doctors and local government among others. To ensure clinical leadership, primary care must be encouraged to set itself high standards and to achieve them; to provide a wide range of community based services; and to respond appropriately to the expressed needs of their patients.

27. It is the opinion of the reviewers that the proposed current Option 3 is designed to achieve these values and aspirations.

General Practice size, quality of services and care, access, number and premises

28. The proposals in the revised, current Option 3 for general practice recognise that there are some desirable aspects of small practices – patients often value the very personal relationship and high quality of access that they experience. However, small practices must demonstrate that they can meet the same standards and range of services as any other practice. In particular they can find that their premises are not sufficiently

flexible to allow for current expectations of health care delivery. The desired range of skills and disciplines may not be as easy to achieve in small practices but can be overcome by federating with others.

29. Where premises are not adequate in any size practice, the opportunity can be taken to expand the range of potential services in improved, modern premises. This can mean that the number of patients served from such new premises is of a sufficient size to promote a wide range of provision. Although this review is not concerned with the economic case for these proposals, clearly the benefits for patient care carry a high potential investment requirement.

30. The logic is, therefore, for premises upgrades to be associated with practices working closely together (such as in federations) or practices amalgamating. This is clearly one intention of Options 2 and 3.

31. The evidence is clear that a number of practices in Peterborough have not, in the recent past, provided good access to their services. Better access requires both good practice management and organisation, and clinical availability. NHS Peterborough has addressed this issue with some of its practices and progress has been made. However, Option 3 will provide the physical environment in some practices to improve access further.

32. If any practices are actually closed in the current Option 3 – as appears to be the case – then not only have the other practices to 'take up the slack' but the clinical staff in any closed practices need to be redeployed to maintain local capacity. NHS Peterborough will need to work to ensure that the clinical workforce remains sufficient for short term needs and expands to meet the needs of Peterborough in 2020.

33. As new premises are developed, it is essential that the required changes to transport links are made concurrently. This is a vital way to ensure that these reforms do not exacerbate health inequalities.

The provision of urgent care

34. Clearly the need for urgent care can arise at any time of the day or night. Patients often find the routes into care confusing and difficult to navigate. The simplification away from two Walk-in Centres to one provider on the same site as the Out of Hours service is likely to reduce that confusion. The decision in Option 3 to enhance the range of services available to those of a Minor Injuries Unit, including imaging, is an enhancement in patient care. The reviewers note that the procurement of this service will be through an open tender process – this is appropriate.

35. The increased investment in the general practice Out of Hours service is logically argued for and appears fully justified in the interests of improved patient care. In times of transition in service design and delivery, the commissioners should expect extra demand on urgent care services and this may place stress on the Out of Hours provision. NHS Peterborough needs to take this into account.

36. This proposal will mean that there is a differentiation between the services provided by pharmacists, general practices and the MIU, while all three are operating cohesively. Co-location of the MIU with A&E is not as important as geographical access, but wherever the MIU is placed, the urgent care services must coordinate closely.

37. We note that the provision of a 111 service is proving controversial with some evidence that it generates addition costs and referrals to A&E. We recommend that NHS Peterborough awaits the evidence from the pilots before committing to this model. However, the simplified messages for how patients should access urgent care, with or without 111, will be easier given this proposed reconfigured service. However, telephone triage with patients being pointed to the right service or given self care advice is now an established part of the urgent care landscape.

38. The current Option 3, revised following consultation, includes the provision of in-hours medical cover, rather than nursing cover. NHS Peterborough have also accepted that the current configuration of urgent care services (including the Alma Road Walk-in Centre) will remain until the new service is active.

39. The reviewers therefore consider the current, revised Option 3 proposals for urgent care to be appropriate.

Conclusions

40. This review arose out of a possible conflict of interest in the process by which NHS Peterborough consulted on its proposed changes to service provision in general practice and urgent care in Peterborough City. The reviewers were asked to comment on the clinical elements of the case for change and the proposed strategy, to ensure that any conflict of interest had not distorted the proposals.

41. The reviewers have read the documentation submitted and addressed supplementary questions to NHS Peterborough. We are satisfied that the three options were fairly expressed and based on clinical logic; that Option 1 (do nothing) is clinically undesirable; that Option 2 (minimal change) would be an improvement of Option 1; but that either the original or the recently revised Option 3 (the recommended change) would be clinical desirable and appropriate.

Professor Mike Pringle
Dr Christine Johnson
Miss Julie Reid
Ms Jacqui Smith

11th March 2012