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26 June 2009

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Dear Christine

**PROPOSED INTEGRATED CARE PILOT SCHEME BETWEEN CITY HOSPITALS
SUNDERLAND NHS FOUNDATION TRUST AND CHURCH VIEW MEDICAL PRACTICE**

Please see below the views of **City Hospitals Sunderland NHS Foundation Trust** on the issues you outlined as requiring consideration by the Co-operation and Competition Panel in your email of the 15th June 2009

Foreword

The basis for integration is to retain the current practice surplus within the local health economy to reinvest in patient care. The goal from the City Hospitals Sunderland NHS FT (CHS) perspective is to improve the delivery and co-ordination of care and thereby reduce the number of unplanned admissions from Church View Medical Practice (CVMP). This is an innovative way to pilot new ways of working and to develop new, or streamline existing, care pathways

CHS and CVMP have proceeded with the ICO project on the basis that they can be legally joined as one entity. If this is not possible it would make it difficult to deliver the full benefits expected within the ICO project and therefore would necessitate withdrawal from the DH ICO pilots.

Patients' best interests

CVMP and CHS have been developing proposals to deliver integrated care and the shared goals are; -

- To remove current organisational and contractual barriers in order improve patient care.
- To improve communication between primary and secondary care to help prevent avoidable admissions, facilitate discharge and help prevent re-admission.
- To ensure full utilisation of the resources available across primary and secondary care.
- To develop a care model that co-ordinates the input from the local health economy including Social services, the local authority and the 3rd sector.
- To explore new models of working together.

The central aim for integration is to support the above goals and hence to improve both patient care and patient experience.

Joining to become one integrated organisation will facilitate multidirectional information sharing between CHS, CVMP, primary and social care providers allowing more balanced and holistic care to be provided on the basis of multidisciplinary discussions/decisions having access to complete clinical records. Integration would also allow medical and nursing staff at CVMP to concentrate on treating patients by relieving them of the burden of many administrative tasks.

The main patient benefits from the ICO project include:-

- Active management of long term conditions leading to holistic care with improved quality of care and life for patients
- Reduction in use of unplanned out of hours services, A and E, emergency admissions and readmissions
- Reduction of inappropriate planned visits to existing hospital and primary care services
- With patient agreement, extending patients lives, delaying their transition to “frequent fliers” or supporting dignified end of life care.

Key performance indicators of benefit to patients for the ICO project include:-

- An improvement by >20% in the number of positive patient experiences.
- A 20% Decrease in emergency admissions for the selected cohort.
- A 20% decrease in re-admissions within 14 days of an unplanned admission for the selected cohort.
- A 20% decrease in number of contacts in primary and community care for the selected cohort.
- Any surplus reinvested into improving healthcare.

and it is anticipated that these types of KPI will be developed during the lifetime of the project and applied to other patient groups and services when appropriate

Success for the integration of the two organisations and for the pilot would deliver:-

- A defined group of patients having an improved patient experience, which is holistic and patient centred and delivered by a truly integrated care service.
- Increased patient involvement in choosing what care path they wanted to follow.
- Defined processes and systems that could easily be rolled out across the city and health economy and expanded to cover significantly more patient groups and conditions.

Absolute success would be achieving the above but at a lower overall cost so that the surplus could be reinvested into patient care.

The joining of the two organisations and the ICO project should increase the level of care provided in the community, reducing the distance that patients will need to travel and the number of health professionals that patients will need to deal with.

The CVMP Patient Forum has been involved in the development of these proposals and wholeheartedly supports the aims and objectives of the pilot and the transfer of the PMS contract to CHS.

Patient Choice, Primary care provider

The joining of CHS and CVMP will in no way restrict or change any patient's choice of primary care provider. CVMP (6300 patients) will remain open for patients to join and there are two practices (Colliery Medical Group 5520 patients, Dr Joshi 3929 patients) based in a modern medical centre not 50 yards from CVMP. Both of these practices are established, have open lists and are well regarded with Dr Joshi scoring 1000 QOF points and Colliery medical group scoring 998 QOF points compared to CVMP at 998.7 QOF Points.

If patients wished to move further away for a GP there are another 3 practices, with open lists, within a 1 mile radius of CVMP.

If any patient was unhappy with the transfer of the PMS contract from CVMP to CHS, or their care at CVMP, it would be a relatively simple process for them to transfer to another practice if they so wished.

CVMP/CHS would work in partnership with its PBC colleagues in the Sunderland Commissioning Network to take up appropriate LES/DES schemes, or work on pathway development with other practices etc.

CHS/CVMP would also be willing to work with the PCT or other practices on new pathway developments resulting from the Darzi review process.

Tax Payers Best Interests

The integrated organisation would be willing to demonstrate value for money on an annual basis using local data that will have come under intense independent scrutiny from the DH, Ernst & Young and RAND

Integration of CHS and CVMP would mean that any surplus generated at CVMP is kept within the local health economy and will be available to improve patient care.

CVMP will be monitored as a separate service line within the CHS SLR/SLM process. This will allow CVMP to be run as a segregated budget with a clearly defined Income and Expenditure account. Sign off of CVMP invoices etc would be carried out by the Practice Manager at CVMP with countersignature within CHS.

CHS and CVMP are focused on both reducing the amount of unplanned care that patients receive and the number of emergency admissions that are required. Emergency care is expensive for commissioners and stressful for patients so any reductions achieved should produce economic benefits for the health economy and improve both the quality of care and the experience for the patient.

The aim would be to deliver more effective care with the attendant reduction in overall long term health and social care costs.

The delivery of the service would still be via a PMS contract which would fall within the control of the PCT as commissioners and be subject to the normal National standards of the PMS contracting process, PMS review process and any VFM criteria that the PCT would wish to apply or develop.

The aim of the ICO project is to improve both patient experience and quality of care. The DH, RAND and the employed consultants, as well as CHS, will be continuously monitoring the outcomes of the

project, both financial and clinical, over the next 3 years. The CVMP/CHS ICO project has been selected by the DH as one of only 6 “deep dive” sites which means that it will come under even more intense scrutiny with respect to both financial and clinical performance/outcomes.

The long term aim of the project is to provide seamless integrated care which will eventually include social care with the involvement of Social Services, the local authorities and some 3rd sector organisations. Whilst this centres on improving both patient care and experience the overall costs of delivering this enhanced care will be closely monitored to demonstrate value for money.

Gatekeeper function

CHS is more than willing to be bound by reasonable contractual safeguards to prevent both constraint of choice and supplier induced demand.

The GP’s at CVMP are ethically bound to providing the best clinical care for their patients regardless of their employer and all but one of the current GPs are already salaried.

The aim of the integration of CHS and CVMP is to improve patient care with, at worst, no increase in gross secondary care costs per patient. It is possible that outpatient referrals and costs may increase in the short term but this should be more than balanced out by a long term reduction in costs associated with both unplanned admissions and attendances.

All referrals would continue to be made on the basis of clinical requirement and following the appropriate regional or local pathways. The vast majority of these would be made using the choose and book process available within CVMP and fulfilling or exceeding any contractual requirements or performance standards that are applicable

The GPs at CVMP will refer patients for elective or outpatient treatment on the basis of clinical need and the patients will be provided with full and fair information to enable them to exercise their right to choice. It will be made clear via displayed notices and individual letters to all patients that CHS own CVMP and this will be reinforced at consultations if any referral to a secondary care provider is required.

CHS would be more than willing to comply with any contractual requirements or monitoring systems equivalent to those set out in the equal access tendering programme.

Supplier Induced demand

The GPs at CVMP will transfer under current terms and conditions and are likely to transfer into agenda for change terms in due course. Neither of these terms and conditions offer any financial or commercial advantage or incentive for clinical or administrative staff to refer to CHS in preference to any other secondary care provider. As part of the transfer of employment process employees will be asked to sign a declaration stating that they have no perceived conflicts of interest. It should also be noted that one of the GPs already works some sessions for another local FT.

A baseline audit covering financial year 2008/09 has been carried out using the PCT commissioner’s information to establish current referral patterns, rates and trends both for outpatient and elective inpatient activity, by hospital. These referral rates and patterns will be compared to the other similar GP practices in Sunderland to identify any changes or trends in referral pathways or rates. If closer scrutiny is required there are two GP practices located within 50 yards of CVMP which could be used for direct comparison.

Referral information/ analysis would be sent on a monthly basis to the PCT and a quarterly review session will be set up between CHS and the PCT commissioning arm to analyse and review both referral and admission patterns and trends. The work that CHS has already done means that referral rates and patterns to all hospitals are known and have been clearly established using PCT data. This level of analysis, scrutiny, monitoring and management will be both robust and transparent.

Any significant changes (plus or minus 5%) would be investigated and:

- ratified as being observed in other practices,
- justified on the grounds of overall secondary care costs,
- selected for ongoing monitoring ,
- the variation judged unacceptable.

If any changes were judged unacceptable, CHS would expect the commissioners to provide comparative evidence to support their position and the issue would be reviewed and resolved as part of ongoing monthly contract discussions.

CHS is more than willing to be bound by reasonable contractual safeguards and resolution processes to monitor and prevent supplier induced demand. CHS would be willing to adopt a model that would allow the PCT to run a separate Choice Advisor or equivalent if the PCT considered that necessary.

The baseline audit clearly shows that between 82% and 90% of CVMP patients already choose to use CHS services. See tables 1&2, Charts 1&2 and graphs 1&2 for more detail.

The Lead GP at CVMP would have clinical and operationally responsibility for referral management and choice administration. CVMP will remain as a separate Unit but be managed within the Care of the Elderly Directorate in CHS. The clinical lead for CVMP would always be based at Church View and CHS would ensure that they would have no similar responsibilities for any aspect of secondary care delivery.

The Performance Director within CHS has overall Clinical and operational responsibility for referral management and CHS are willing to ensure that this demanding role is not combined with a similar role at CVMP. Equally CHS is willing to ensure that anyone at CVMP with Clinical and operational responsibility for referral management will not be given any similar responsibilities within CHS.

It should be noted that the aim of the integration and the pilot is to reduce unplanned admissions/attendances to CHS and to reduce inappropriate referrals or treatment plans. The main KPIs for CVMP would remain in line other practices e.g. meeting the requirements of the PMS contract, QOF, enhanced services etc.

Patient Choice, Secondary care provider

The integrated organisation would comply with all national and local requirements/standards relating to the use of choose and book and the national and local choice agendas.

Patient Choice would at a minimum remain at the level it exists within the current GP Practice. The last GP access and choice survey indicated that CVMP's performance on choice is more than comparable to the other GP Practices across the Sunderland Region.

The choice process would start with a discussion regarding the referral between the patient and the doctor supported by the provision of written information such as the local PCT's "Choosing Your Hospital" Booklet and advice regarding accessing the NHS Choices website and the type of information that can be obtained.

Once given full and fair information, patients will then be able to book an appropriate hospital and time via the GP, Surgery receptionists or via provision of a reference number which the patients can use to choose and book after they have taken the time to research their choice, discuss with family and friends and choose the appropriate hospital at their own pace.

Use of the Choose and Book process would electronically document patient's choices and this information would be reinforced by analysis of, and action plans from, National Patient Surveys, Access and Choice surveys etc.

The Picker Institute 2007 Report indicates that patients make their choice on the basis of:-

- Location
- Length of Operation
- Travel arrangements
- Waiting times
- Quality of care
- Convenience for family and visitors

Although other factors such as reputation, infection rates, cleanliness transport etc may be the deciding element for many patients none of these factors will be changed materially by the joining of CHS and CVMP.

CHS would also provide "Choose and book" awareness training for all clinical and administrative staff involved with any aspects of the choice and booking process.

GPs and Surgery staff will give particular help to vulnerable adults (and their carers) and for those where English is not their first language in order to assist them in making the best possible choice for them. The "choosing a hospital" booklet from the PCT will be kept in the practice in a variety of languages and formats for easy access or ordered directly from the PCT if necessary.

Annual patient audits would be carried out to assess patients levels of satisfaction with the choice process and this will include questions such as:

- Did your health professional/ administrator state a conflict of interest before advising you on choice?
- Did the practice provide helpful information enabling you to make your choice?
- Were you provided with a range of hospitals to make your choice from unless your doctor explained that there were a limited number of hospitals offering the treatment you needed?
- Do you feel the staff in general help you to make your choice?

The results of these audits will be shared with the PCT to demonstrate that the practice is actively promoting and supporting patient choice in line with all local and national guidance.

In terms of raising general awareness of choice, we would use the practice notice boards, practice news letters and the patient forum to raise the level of awareness of patients regarding their rights and the choice agenda.

In terms of secondary care providers, there are five acute trusts ranging within 3 and 18 miles of CVMP. (See map 1 for more detail)

From CVMP it is 3.4 miles to CHS and 11.8 Miles to both South Tyneside District Hospital (STDH) and University Hospital North Durham (UHND). STDH is a small DGH with a limited range of services and some services (e.g. Haematology, Urology) provided on site by CHS. UHND is medium sized DGH some services (e.g. Urology, Ophthalmology, ENT, and Dialysis) provided on site by CHS. UHND also provide the Dermatology service on the CHS site as a Prime contract.

It is 12.9 miles to The QE hospital (Gateshead Health NHS Foundation Trust) which is a medium sized DGH. CHS provide ENT and other services on the QE site and Gateshead run the regional breast screening service.

It is 18miles from CVMP to the Freeman Hospital, part of the Newcastle Hospitals Trust which is approximately twice the size of CHS and offers a full range of services including many on a regional or tertiary basis.

All the hospitals are well regarded with all being in the CHKS top 40 Hospitals Award 2009 and all but Gateshead achieved double excellent in the 2008/9 Annual Health Check.

Other local hospitals are available within the choice menu but the distances and travel times are almost doubled at approximately 35 miles and 50-60 minutes by car.

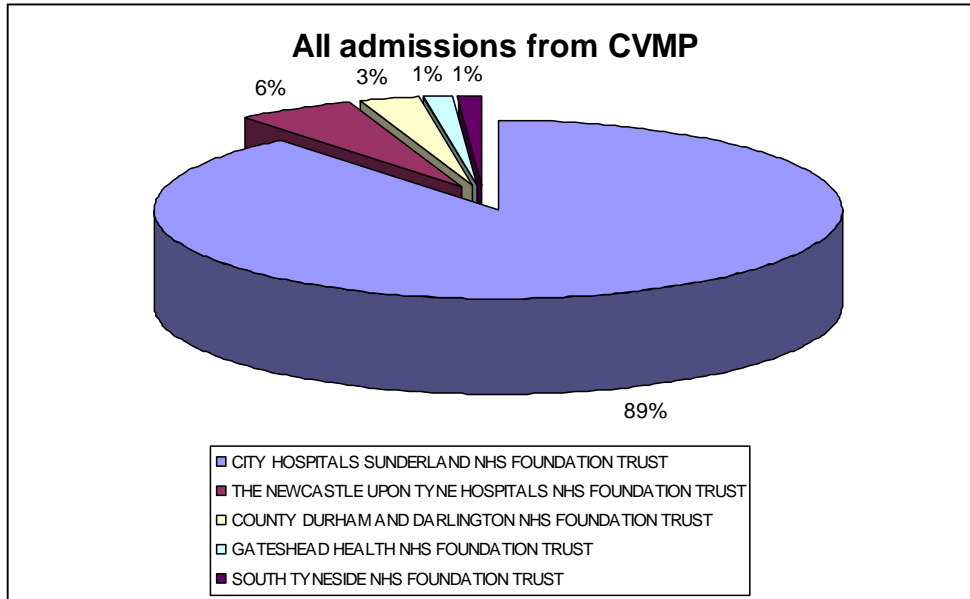
Given the geographic ties of the area and the difference in travel time/ distance, coupled with similar levels of performance, it is no surprise that CHS is the preferred choice for the majority of CVMP patients.

The actual percentage of Inpatient admissions/ day cases from CVMP are:-

Table 1

HOSPITAL ADMISSIONS	ELECTIVE	NON ELECTIVE	MATERNITY	OVERALL
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	85.9%	93.7%	92.0%	89.2%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	6.6%	3.6%	6.5%	5.6%
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	4.1%	0.9%	0.8%	2.7%
GATESHEAD HEALTH NHS FOUNDATION TRUST	1.8%	1.1%	0.0%	1.4%
SOUTH TYNESIDE NHS FOUNDATION TRUST	1.6%	0.6%	0.8%	1.2%
OVERALL	55.9%	33.2%	11.0%	

Chart 1



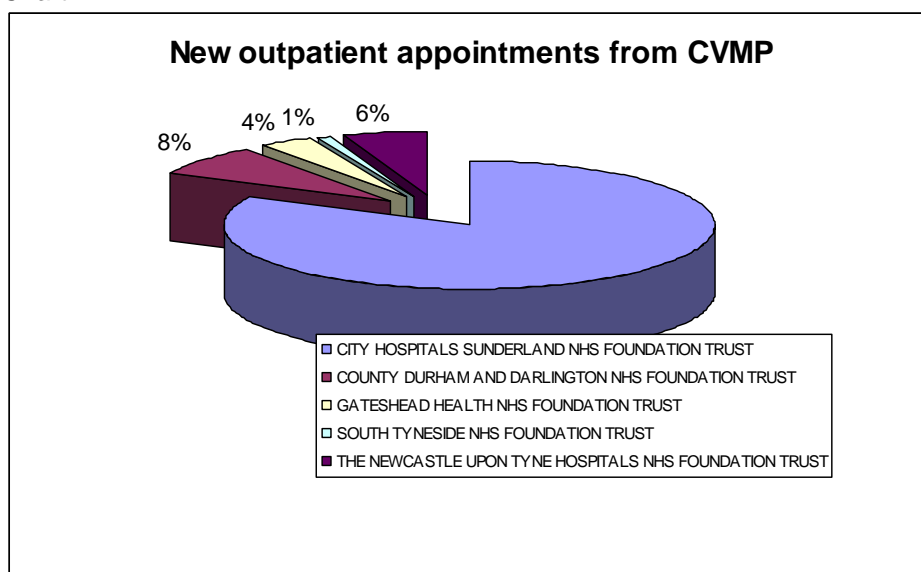
The actual percentage of new Outpatient referrals are as follows

Table 2

PROVIDER	NEW %
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	82.1%
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	7.8%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	5.5%
GATESHEAD HEALTH NHS FOUNDATION TRUST	3.6%
SOUTH TYNESIDE NHS FOUNDATION TRUST	0.9%
TOTAL	

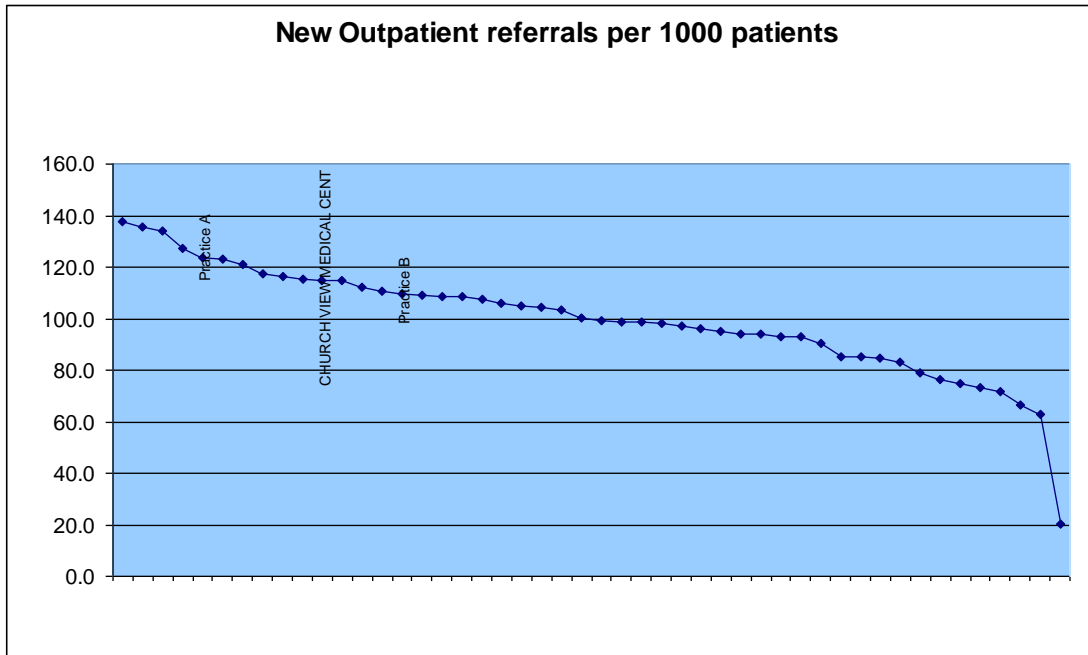
Note County Durham & Darlington FT provide a dermatology Outpatient service on the CHS site

Chart 2

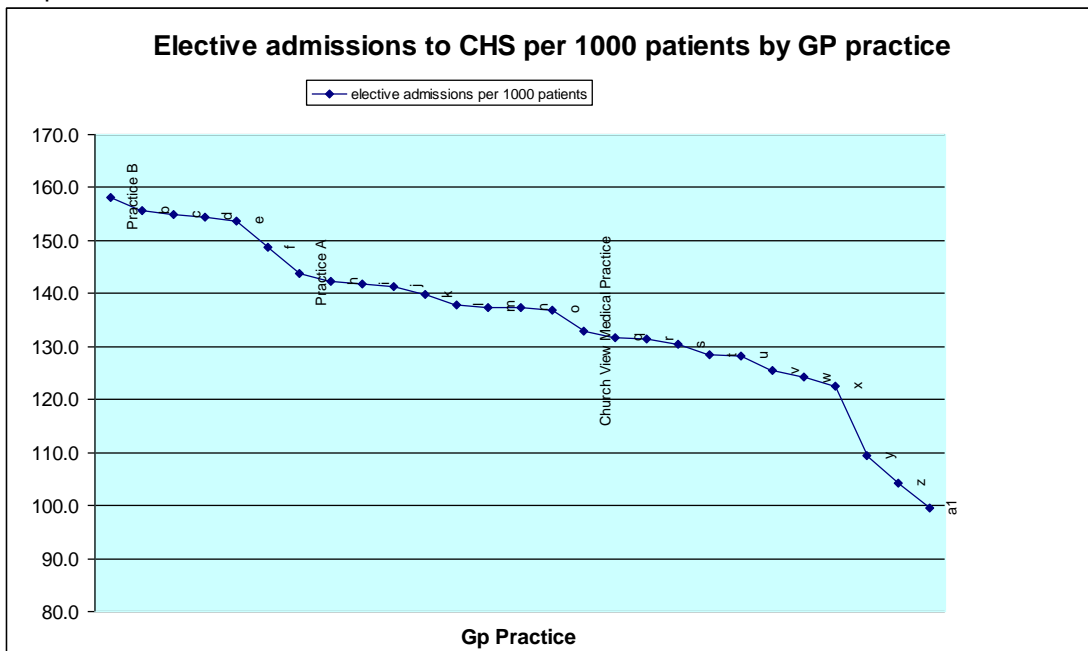


Graphs 1 & 2 below show the level of outpatient referrals and elective admissions to CHS per annum per 1000 patients for CVMP compared to the two closest GP practices and the rest of the practices across Sunderland. The audit data covers the financial year 2008-2009 and practice A and Practice B are practices close to CVMP.

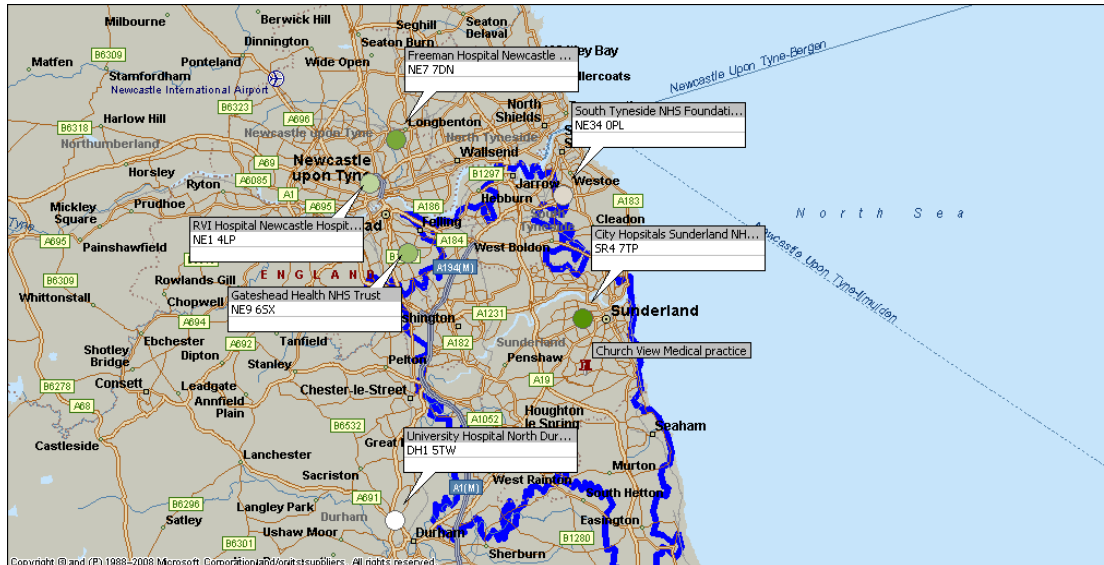
Graph 1



Graph 2



Map 1



The blue enclosure is a 15minute drive time limit.

Further information

In response to the specific question you raised by telephone, we are not aware of any material service overlap between CHS and CVMP.

We hope that the CCP finds the above information useful and if you have any further questions, please do not hesitate to contact Tom Dodds

Yours sincerely

Dr Mark Smith
Executive Director Of Strategy & Service Development