The People's Inquiry: One Year On

Evidence presented by Professor Dr Mark Rowland (MR), Peter Kohn (PK) and Barbara O'Connor (BC) from the London Clinical Commissioning Council

Tuesday 16 December
Central Hall, Storeys Gate, London SW1H 9NH

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
Thank you very much for coming to see us. We are picking up on the Inquiry we published last year in which we made a number of recommendations. We are re-visiting that in the light of really quite a lot more pressures and events. Please tell us a bit about who you are. The London Clinical Commissioning Council – perhaps you'd give us a little bit about how that all weaves together.

MR:
I've been a GP in South-East London, in Lewisham, fairly close to Louise [LI] for 37 years now. I have worked there most of the time. I've done various things over the years and got involved in various things. I joined the CCG when it was being set up, I was elected on to the CCG as a clinical director, then September last year I became chair – the last chair said he found it too difficult to continue with the workload – I took it over from that point. From 1 October (so I am quite new to this particular job) I became chair of the London Clinical Commissioning Council.

Basically what we are is a coordinating group of the 32 CCG clinical leads – chairs, clinical leads, it's a slightly interchangeable term – and if you want to engage with the CCGs across London, engaging with each of the 32 is really difficult. So the idea was to provide a voice that people can communicate more easily with for all 32. The idea is I attempt to channel that and for the [NHS England] London office to supply some base to give feedback and help contact, particularly with NHS England, but also with organisations.

It was the LMC and NHS England who set it up, and that's the role.

PK:
I'm the director of the office of the London CCGs. Barbara [BC] and I are the London office of CCGs, which is small but perfectly formed. I've been in the NHS since 1978. I started as a nurse. I've been a manager for the last 25 years in almost every sort of capacity. I've been doing this job for two and a half years now and essentially set up the office of CCGs as a way of London CCGs being able to coordinate with each other. We've got the most complex commissioning set-up, with something around about 50 contracts with different bodies and so on. With 32 CCGs, the capacity for that being a mess is infinite! So that's a lot of the stuff that we do: making sure that the work of the CCGs is focused and that we coordinate all of the things they want to do together. We don't get involved with what the CCGs do individually. Subsidiarity is the name of the game. But obviously things that happen on a pan-London basis we get involved with.

BC:
I came in almost at the same time as Peter. What we do is, as Peter says, we work with all of London CCGs on things they want to do together. We coordinate their meetings so along with Mark we

coordinate meetings with the chairs for the chief officers and for the chief financial officers, so all their network groups we have coordinated for the last couple of years. We have very good representation for that. People value our input and come to us. We like to be the go-to place. So if CCGs have got a problem or an issue they will come to us and we will talk it through and help them liaise with NHS England as Mark said, and with various other bodies as well.

RL:
I know there will be a list of things you want to go through, and I want you to do that. But we have found consistently with the evidence that we've had from other witnesses that there is an absence of a strategic interlocutor and overview within the London framework. We've been trying to think whether or not we should make recommendations about that. It seems that you kind of just got on with it, and have done it really, because there is a need for a strategic overview and you are providing that. To the extent to which you are robust enough to do it with two people.

MR:
I would give a lot of praise to Howard Freeman, my predecessor, who used to chair at Merton [CCG]. He was really very instrumental in setting this up. I took over from him. It means that we are able to get a place in things, like I have just come from joint chairing the Primary Care Transformation Committee with London Board with NHS England, with Claire Gerada, and Tom Coffey and Rebecca Bosen and all sorts of excellent people.

We have a place there to put the views for the CCGs and also to represent them at all kinds of levels up. Also, I have been to the GLA committees and we work with the various London Council committees as well. So there are all sorts of places where we can try and coordinate and try and develop an overview. Yes, you are absolutely right.

RL:
With Peter, I got the impression that there was some delicacy, though I may be wrong, in that you're representing the views of 30-odd organisations, you have to be careful not to supplant a view, and it was a bit of a diplomatic dance around the handbag. I'm not saying that's bad, it's just how it looks. I'm just wondering if the two of you see this developing into a more robust, a more significant role?

PK:
I wanted to come earlier because I wanted to hear what else you were hearing. I would have a different perspective from the perspectives that you've heard most of the time right through the morning. The reason we wanted to come is that we suspected that would get a set of negative perspectives about London's ability to act strategically.

My view is that actually the very key relationship going into the future is that between local authorities and CCGs. The two most vulnerable groups, those at either end of the age spectrum, rely on a very close relationship between social care and health and therefore that's where you need to put the majority of the effort. That's where all the relationships need to be maintained and so on.

We work on the basis of aggregation up. You aggregate up to do things that you need to do, either at a sub-London level or at a pan-London level. I wouldn't say that we were not robust. I think we're very robust. It's interesting that you pick up the different roles, because actually there are times when I'm the servant of the CCGs and we organise the various meetings. There are times when we are acting as advocates for CCGs and there are times when we are putting forward our own ideas about what needs to be done and trying to get those through. It's an interesting role, and the CCGs pay for us by a top-slice. All of the CCGs pay for the office.

MR:
I don't have a huge feel about what's my identity, I wasn't exactly clear on what you'd want, so I've not done a massive slide presentation.

RL:
Thank goodness!

MR:
So we're just going to run through things, touching on things like *Better Health for London*, and Simon Stevens' *5-year Forward View* and how it impacts. I'm very happy not to go through these things if you wish.

RL:
No, please do. We are particularly interested in the *5-year Forward View* I think.

MR:
Ok. *Better Health for London*. We're very happy with most aspects of that. The CCGs worked with NHS England to respond. There's a commissioning system design group at NHS England, which is like a small part of the Primary Care Transformation Board – and I'm sorry for the terms, I don't make them up – and various points like that, so perhaps we'll change what's happening in primary care at the moment.

The Health Commissioner for London aspect, not sure about that. We're reflecting on that. I think it works quite well in New York, but we have a completely different local authority structure here and I am not too sure if that's what we need.

PK:
I think you were referring to the Commissioner. They proposed a Commissioner.

MR:
Improved links with primary care groups are excellent. In Lewisham, from my experience of that, we are working very closely with Voluntary Action Lewisham and all sorts of aspects like that are coming on really well. There may be other points you wish to pick up on that.

Simon Stevens *5-year Forward View*: it's very interesting if you start to put it together, particularly now with the strategic commissioning framework for primary care in London – and again, I don't invent these things, that's what they are titled – I presume you've had people come back to you on that.

RL:
Yes. On the *5-year Forward View*, just referring to the executive summary, I think paragraphs 8-10 are the key paragraphs. Eight is the multi-specialty future, not multi-disciplinary, I think that's a careful use of that word. Paragraph 9 is about vertical integration, lets' make no bones about it – hospitals running primary care. Paragraph 10 is the extent to which primary care and out of hours are revamped around perhaps the ambulance services running them, perhaps a different role for GPs, perhaps this whole thing is triaged in hospital and we forget out of hours. I'm sure you have a view on those three important things.

MR:
My personal wish would be for primary care to develop and take over and become proper strong provider units based very much in their communities and linking. Whether that's going to be through

super-partnership models or whether that's going to be through federated models I don't know. I want it to be geographically based, and I would very much like it to be linked in with the populations. I have some reservations about whether it should actually be run directly by the local authority, because my experiences in South-East London is that the six CCGs work together beautifully; the local authorities in South-East London do not work together beautifully and I have reservations which I've put along those lines.

RL:
We were very impressed with the new leader of Hammersmith & Fulham Council, Steven Cowan.

PK:
We meet with Martin Smith, who is the chairperson of Ealing local authority. He has a number of roles in connection with health. He is the chair of the local authority chief executive's health group, there are six of them. As the chair of that he is on the collaborative for integration that we've been running for the last year, and a number of other things. Mark and I meet with him on a fairly regular basis.

There is quite a deep relationship with London councils. There is a meeting called the London Health Chief Officer's Group, which we both attend, which has got five local authority chief execs on, ourselves from the CCGs, a couple of chief officers from the CCGs, the GLA and health education.

RL:
We've not found much evidence for the Better Care Fund but I imagine that would be the forum where you would be discussing better care?

MR:
It's more at the CCG than local council level. I'm still not clear in my mind how much that's been very useful in forcing people to look at the joint budget and how much it's been a bit of a distraction. I'm still trying to form a view on that. I was kind of hoping you wouldn't ask me about that!

PT: The point is, you can't find it. Where is it? Where's the money?

PC:
There are detailed plans in each of the CCG-borough set-ups. They vary between things that are adding much more into the pot and those that have basically re-cast what they doing. I think Mark's right, we don't know what the outcome's going to be yet.

RL: It's more granular obviously.

JL:
We've just had Trevor Shipman from CNWL Foundation Trust talking about this. A question I would raise more generally is how is the interaction between you mainly working with the commissioners and the local authorities, and working with front-line providers on the Better Care Fund? Because they don't appear to be getting it at all.

MR:
In Lewisham we meet together, we have our main provider – always attending at high levels – and we have the council and ourselves, and it's a very, very good debate.

JL:

We had someone who was a Finance Director covering the whole of North and West London. He is completely unaware of what the BCF plans are: we asked him and he hadn't found out.

MR:
I think there are big variations. It's interesting that Lewisham Council is inspected by the local authority whoever it is who inspects them, and I was asked to talk with them. That inspection team was really impressed that we actually talked with each other. That, as you are saying, isn't normal.

PT:
We found that last time. Part of the experience of everything you been through pulls you all together. There is a unity there that is quite rare. What we're finding and what I am hearing from various places is a different tension, which is less about local authorities but a tension between you and the providers. They are saying 'you keep tightening the screw, you keep shortening the odds, you keep expecting us to do more – because there's more and more demand – for less and less' and there is a lot of resentment there. You seem to be holding on to money, debts are accumulating with them, surpluses with you [the commissioners]. So the resentment against CCGs is quite strong. Yet I'm not hearing any of that from any of you.

PK:
Yes, I was listening to Trevor and thinking it's a partial view. The surpluses is a partial view. Generally in London if you look at the outer London ring, the outer London ring is in more financial difficulty than inner London. There is no doubt that inner London has had better allocations over the last several years.

I sympathise entirely with the providers. The pressure is on. There is no question that the pressure is now on the providers. The only way out of that is transformational change. In my view, first of all we have to set up primary care in a much more robust fashion so that it sucks the work in rather than pushes the work on to secondary care.

PT:
But there's not a lot of evidence that there are lots of people in secondary care who shouldn't be there. We've heard of the pressure on the beds, there's the problem of getting people out once they are in there.

PK:
The rates of people going into hospital have not increased over the last year in London. It's unlike anywhere else in the UK. Actually it's pretty flat.

MR:
Attendances are up 0.4%, admissions 1%.

RL:
We've had an advanced copy of the Health Foundation report which is due out next week. It does support what you say about the numbers, the problem is more the acuity of the patients.

MR:
But the evidence again is that if you keep people away from hospitals they are not as acute, if you see what I mean. The minute you bump up – I even know in sending someone to Lewisham, sending someone to King's – they will have endless MRI scans, they will never leave without a few thousand pounds' worth of investigations, even if I know darned well it's because their marriage is in trouble. The minute you bump up there, hospitals have a box of tricks, they will go to that box of tricks, in

each speciality, and you will never escape until you've had that lot done because they can't rest assured.

As a good, experienced GP – I hope Louise will back me up on this – you can often hold and contain things. But when the GPs are stressed, when people are going to A&E because the services aren't working the way people expect it to, you will always increase these other things. In fact there is very clear evidence. The classic is Barbara Starfield's work in America on putting the emphasis on primary care physicians as opposed to secondary care physicians. There's really good evidence on that.

SR:
I just want to bring to your attention and see what your thoughts are, specifically with what's happening at the moment with the five CCGs from North-Central London and contracting for a combined NHS 111 and out-of-hours contract. There's a lot of dismay amongst the population certainly in Islington and in Camden – I'm less sure about whether Haringey, Enfield and Barnet share this. But it seems as though it's just not possible to pull the system together so that, what most people agree, in the future we will have an extended primary care system taking responsibility for that. We can't actually bring it about in this case.

The contract's been extended for a year so that there's a bit of leeway but certainly in the case of Islington CCG which I have a bit to do with there's no sense really of taking responsibility for making the market. Islington GPs might follow the example of Hackney GPs, in themselves bidding for the out-of-hours contract, because clearly integrating out of hours and those same patients in primary care is the best way of achieving a good standard.

How do we get from here to there? We know in 3-4 years' time we're going to be there. But here we are now faced with this problem with nobody quite sure who's got responsibility. Would it be meaningful if the CCGs actually did go out and facilitate their GPs to bid? Linking it anyway with 111 is probably a bad idea but they feel forced into it by NHS England. What's your advice?

PK:
That's a list of about 10 different things! The first thing I'd say is that we tend to deal with things on a pan-London basis so we may not know the detail of each of the things, but what I do know about North-Central is that they have been pursuing outcomes-based commissioning for the last 18 months, so how do they move to an outcomes-base rather than an activity basis? I suspect that what you are describing comes from that.

What I would say is that the development of primary care as providers is one of the critical things that we're doing at the moment. So much so that we had a project in the office called the General Practice Development Project, which has been running this year, which is about supporting four federations to develop. I think those things they will develop and those that are successful will become the multi-speciality practice.

The key thing in London is that we develop primary care provision so that it contains the workload and that it sucks workload towards it rather than pushing it into secondary care. That is not going to be a quick fix but it's something that we are very actively pursuing. There isn't a part of London now that isn't in some way exploring federation.

MR:
It needs to develop the proper provider units, GP providers, into units that can actually in-reach into the hospitals, so it's not hospital out-reach it's actually care based in primary care and should be

using hospitals appropriately. Instead of the way now where the hospitals just get bigger and bigger, the whole process just sucks more and more in.

The trouble is the change around. We're experiencing this in all sorts of things. There are going to be difficult times and that's why you are going to end up with some rather interim-level and possibly poor arrangements temporarily. That is I think a lot of what you are hearing, there's going to be a lot of unhappiness and misery. GPs are here like midwives, yet many are going and coming back.

RL: To what extent are these grand plans going to be disrupted?

MR:
It could head that way. In London it used to be something like 150% applications [for each job] and now we're down to just about filling posts. In the Midlands and North-East you're up to 60% joining the schemes so it really is quite difficult. We want to get partners, it's just about beginning to come through that you can't get partners very easily but you are getting locums.

RL:
Just to jump to the mood of your colleagues. The whole idea of primary care is that it's local, everyone pops to see their doctor, but now they're all going to be working in super-clinics because half the premises aren't capable of being repaired, extended or getting planning consent. The whole thing is changing. We'd lose the intimacy of family doctoring. What's the mood amongst your colleagues?

MR:
Firstly I would challenge you on that because it depends on the way it's done. Yes there is a severe risk that we could go that way, but also you have to accept the fact that GPs are not complete super-creatures who can do everything. Like everyone is saying – as Cathy Warwick says – GPs should be much more involved with maternity. They should be much more involved with everything. They can't.

I don't know quite how that will work out. It could almost reach a point where it's difficult to see the GPs actually there to hold all this together. Because the knowledge that I need to do my day-to-day job to be really a good enough to doctor all the time is becoming quite a struggle. That's ignoring the fact I'm doing this stuff on the side. That is the difficulty.

If you look at other models in England, the classic super-partnership model would be Vitality, which is in North-West Birmingham. A pretty poor area. They are developing a real super-partnership, 30 clinical partners, two non-clinical partners. They are working in way that they have only just branded the surgeries they have taken over as being Vitality[1], because they thought their brand was well enough respected to do that.

You can put practices together and patients won't even notice the difference. They still come through the door, they still see Louise and me every day, but there will also be that we can send them to someone who had more specialist knowledge in something. You have extra clinics there, you might link in. If they want a late-night appointment it might not be at might not be at my clinic it might be at somebody else's clinic. But they would know it was still within the setting.

We're not going to be able to deliver the care of seventies, eighties, nineties, which is what I was brought up in and I loved it. You were focused one to one, entirely intimate relationship. That has to

[1] https://www.vitalitypartnership.nhs.uk/about-us/articles/birmingham-people-enjoy-extended-access-their-gps

change. We can't do that in modern times. People want more out of hours, they want more Skyping, e mailing, telephoning, and all that. This is achievable, but you have to bring the patients along slowly. Also you have to bring the GPs along. At the moment they are just feeling very battered, very sad, overwhelmed, income dropped by 20-30%, workload going up by 20-30%. They are getting in at 7 in the morning they are not going home until 8-9 at night. People are not coping with that.

Also with the emotional drain of doing this, which if you do it properly it's really exhausting. Sorry, I've cantered over a little bit what you were saying there.

RL:
Our concern here is we're trying to overlay change and more responsibility: 'We're going to give primary care more to do because the hospitals are busy'. But primary care *is* busy. It doesn't make any sense diverting flow: that doesn't make it less busy.

MR:
But NHS England have at last got that message and that's the only reason I'm here now. I would not be doing this job if I didn't believe there was an attitudinal change occurring. They have now got the message that primary care cannot cope as it is, they are going to have to put fairly large sums of money in to primary care, and there will have to be double running. There will have to be all this expenditure. How all the sums work out I don't know. I admit this worries me. This could be interesting.

RL: There's no pot of gold.

RW: No.

PK:
In terms of London, you know from the London Health Commissioner recommendations that there was a huge concentration on primary care, and the development of primary care. Probably the biggest bill in that is for primary care estate. Much of it is converted domestic premises and therefore not good enough. The consequence of that in terms of finance is about the revenue consequences of capital. These new buildings are going to be more expensive, and we will need to be switching money between what we currently spend in secondary care and what we currently spend in primary care. As you say, there is a single pot of money and that's got to be the solution.

RL:
There's one point something billion, isn't there? £250 million a year coming in to sort out GP premises, which is coming from the LIBOR fines. Please God the banks continue to pay the LIBOR fines and rip us off!

Even then, if you look at the practicalities of it, if you are going to change some GP premises, you have got to get a design, you've got to get a planning consent, you've got to go out to tender. No one has gone to local authorities and said 'look, if a practice wants to come in with a planning application, give it red route access, can we have a yes or no in 3 weeks'. I just don't see how it's going to make the difference that we need to be made on Tuesday, next week, now.

MR: The property stuff in London is really difficult. I am at a health centre that is run by Propco. We haven't sorted out the bill after a year. The inefficiencies are there to start with are unbelievable.

RL: They have just been given a gargantuan task. They've just had a lorry-load of leases. You are the first people who have given us a glimpse of optimism!

MR:
We do not live in a fantasy world: if we don't positively try to make it all work, it is going to crumble anyhow. That's why we want to get in there and try and make it work as best we can. That's our attitude. The co-commissioning, again it was given back to NHS England, they basically screwed it up and over-spent by £1.2-2 billion. They are now trying to off load the commissioning back to the CCGs.

I'm very happy for that. But I have grave worries we are not getting enough support to do it, and they will shave off a few per cent when it comes back and it will become extremely difficult. But the principle is great, because we can then start to do some of these transfers within one budget. I am quite positive about that.

LI: Does co-commissioning mean the specialist commissioning that NHS England was doing, or does it mean you also commissioning GPs?

MR: I was dividing the two. I described specialised commissioning to push that a bit to one side.

The GP commissioning again has to come under the same budget. There are a lot of positives to it. There are conflict of interest aspects, but I think they are quite surmountable, I don't think they are unsurmountable.

If we can start to bring this together and build up structures and give a lot of head space to work on it, there are chances to make this really work, and again in South-East London we have a very collaborative approach. We work very well and you can see this is beginning to build into something where you start with practice units that work well. You build it to CCG units. You then build it to SPG units, specialists planning group – basically sectors like South-East London – and then we can go to South London and make it work at whatever level we need to, or national.

RL: We've overrun but I think it was worth it. Thank you for us encroaching on your time.

JL:
Do feel free to send across anything in written form that might be helpful from work you are doing, because when we come to write up the report, I have to confess to total ignorance until you contacted me and told me of your existence! I just wrote to NHS England London Area Team – I think it was Anne Rainsberry I actually wrote to, and to Mark Spencer who we were keen to talk to about North-West London – neither of them replied. But you did which was very nice.

MR: We are working together and they are seeing us now as co-workers with them.

RL: Thank you so much.