Co-commissioning: the architecture of integration

Co-commissioning is a new initiative which could offer the architecture to achieve more cohesive services. Here, Mark Greener reports on recent developments and the likely issues to be resolved in order to improve diabetes care outcomes.

Each year, the National Diabetes Audit makes sobering reading, highlighting ongoing, systemic failures of NHS care, unacceptable variations in quality – especially in primary and community care – and inconsistent service provision. The 2012–13 National Diabetes Audit, for instance, reported that the proportion of adults with type 1 diabetes in England and Wales who receive eight of the nine care processes defined by NICE (excluding eye screening) ranged from 16.4% in the poorest performing clinical commissioning group (CCG) or local health board to 66.1% in the best. The proportion that achieved their treatment outcomes varied from 3.3% to 27.1%. The picture is similar for type 2 diabetes: the proportion that received the eight care processes varied from 31.7% to 79.6%. The proportion that achieved treatment outcomes varied from 28.7% to 50.1%.1

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Co-commissioning describes arrangements when two or more organisations commission health care services. NHS England hopes that co-commissioning will ‘drive the development of new models of care such as multispecialty community providers and primary and acute care systems’.2 Diabetes and other LTCs, which now account for 70% of the health service budget,3 will inevitably attract most of the attention.

NHS England announced co-commissioning in May 2014 and many details are still being ironed out. Nevertheless, NHS England envisages three primary care co-commissioning models:

- Greater involvement in primary care decision-making.
- Delegated commissioning arrangements.
- Joint commissioning arrangements.

In 2015/16, co-commissioning will cover general practice services only.2 The Primary Care Co-commissioning Programme Oversight Group is currently working with CCG leaders to implement co-commissioning.

In the meantime, each CCG needs ‘to consider carefully, and make up its own mind as to how it will respond,’ including whether their co-commissioning arrangements will include diabetes. In November, the Oversight Group published ‘Next Steps Towards Primary Care Co-commissioning’, which, they comment, offers CCGs ‘the opportunity to choose afresh the co-commissioning model they wish to assume’. In addition, the document clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements.2

Against this background, Diabetes UK welcomes the advent of co-commissioning especially as – remarks the charity’s Head of Policy, Robin Hewings – policy initiatives over the last five years generally encouraged the NHS to focus on acute care rather than LTCs. ‘It is hard to integrate the system so that partners work better to improve care of long-term conditions,’ he says. ‘Co-commissioning offers a sensible way to better join up commissioning across the diabetes system that goes across primary, community and specialist care. It was an especially crazy aspect of the NHS reforms that they split up commissioning between NHS England and CCGs. It takes a lot of imagination and leadership to get diabetes care to be integrated across a health economy, so we need to do everything to make it easier.’

**Spreading best practice**

Co-commissioning might mean that commissioning becomes less fractured. If this proves to be the case, co-commissioning could help disseminate best practice through the NHS, which, Robin notes, is increasingly difficult. For example, incorporating NHS Diabetes into NHS Improving Quality in April 2013 resulted in Diabetes UK and other charities taking a greater role in sharing practice. ‘There is a big gap in our ability to learn from each other,’ Robin remarks. ‘In some cases, pressure from Diabetes UK and patients locally have driven improvements in care.’

Essentially, co-commissioning aims to reduce barriers between care providers by joining up their commissioning. However, effective governance and clear accountability are essential. Clinical leads need to be able to account for the delivery of the commissioned services. Such governance is developed locally and some areas now have a single clinical governance structure with staff seconded from primary and secondary care.5 However, Robin adds that ‘there is also a gap in accountability’ nationally. For example, not every CCG acts on the findings of the National Diabetes Audit. Currently, no one holds CCGs to account for short-falls in care. This lack of national accountability might offer one reason why the proportion of people with diabetes who get the essential checks ‘has not greatly changed in the last few years’.6 In 2010–2011, 60.6% of all patients with diabetes in England and Wales received the NICE-recommended care processes (excluding

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Co-commissioning may also overcome issues arising from some current financial incentives that Diabetes UK describes as ‘perverse’. For example, the tariff system for specialist care can create incentives for acute trusts to retain patients who might be better treated in, for instance, primary care. ‘In many cases, commissioners and clinicians have to swim against the tide of national policy to drive improvements,’ Robin says. ‘Co-commissioning may make it easier to develop local payment mechanisms rather than using payment by results. Improving services may mean not taking every opportunity to maximise the income of the acute trust.’

For instance, co-commissioning helps CCGs develop local incentive schemes as alternatives to the Quality and Outcomes Framework or Directed Enhanced Services. Some CCGs have already improved diabetes services by pooling budgets for primary and specialist care. ‘In general, there is good evidence of how a system can work together to improve care for diabetes at little additional cost and, in some cases, even making a saving,' Robin says. For example, in a new report, ‘Improving the Delivery of Adult Diabetes Care Through Integration’, Diabetes UK considers five processes to make the system work for people with diabetes while using limited resources more effectively:

- Integrated IT.
- Aligned finances and responsibility.
- Collaborative care planning.
- Effective clinical engagement.
- Clinical governance for the whole diabetes pathway.

In Derby, for example, £800 000 was saved by better integrating care, reducing admissions and length of stay in hospital – the number of bed days for people with a primary diagnosis of diabetes halved – and improving service efficacy.

To deliver these improvements, commissioners in Derby created a new NHS organisation with a pooled budget that delivers diabetes across the care pathway. Furthermore, Derby – along with Leicester, Portsmouth and Wolverhampton – has introduced locally enhanced service payments to incentivise staff from primary care to attend diabetes training courses and interact more regularly with the diabetes specialist team. Meanwhile, Leicester and Portsmouth clarified responsibility for care delivery in diabetes, including services that must be delivered in hospital. Portsmouth now commissions each of these areas to a distinct service specification, which helps align finances and outcomes.

Historically, initiatives to improve diabetes care originated with clinicians. A growing number of initiatives are led by commissioners, although, Robin comments, most of these are in the early stages. In the Midlands, for example, three CCGs are collaborating to improve service pathways. Robin explains that the initiative focuses on the elements of care that ‘absolutely’ need to be delivered in secondary care – such as management of type 1 diabetes – and ensures rapid access to specialists, who focus on complex or unusual cases.

Similarly, in the ‘super six’ scheme in Portsmouth, diabetologists focus on six types of care: inpatient diabetes; antenatal diabetes; diabetic foot care; diabetic nephropathy; insulin pumps; and type 1 diabetes.

In addition, the diabetologists now also educate health care professionals. GP practices can access consultant support by telephone and email. This gives specialists the confidence to refer cases back into community and primary care, thereby freeing diabetologists to focus on the most specialist cases. A diabetes specialist nurse and consultant visit each practice twice a year to deliver training and support, augmented by a programme of accredited training.

Overcoming barriers
Despite these initiatives, several barriers potentially hinder greater integration in general and in co-commissioning in particular. Robin, for example, highlighted the need for improved IT infrastructure to create a ‘common landscape’ for commissioners and clinicians. Diabetes UK stresses that effective and efficient co-commissioning depends on commissioners and providers being able to join up a patient’s data. For example, an improved IT infrastructure would allow referrals to the most appropriate health care professionals as well as identifying ‘high-risk’ patients.

Again, ‘Improving the Delivery of Adult Diabetes Care Through Integration’ highlights examples of best practice. In Wolverhampton, for example, a central portal extracts data from 49 GP practices. A locally developed algorithm rates patients against the nine diabetes care processes. The algorithm stratifies patients as ‘red’, ‘amber’ or ‘green’ based on their risk of developing micro- and macrovascular complications. According to Diabetes UK, complications are responsible for 80% of the £10 billion cost imposed by diabetes on the NHS each year.

Robin suggests that co-commissioning is easier to implement in some areas than others. ‘Commissioners that have successfully implemented integrated services tend to be towns with one large acute provider. It also helps if the CCG has the same geographical boundaries as the old primary care trust. This means that the hospital and community services had time to develop long-lasting relationships, which makes it easier to build a more integrated system,’ he comments. ‘Developing these relationships and integrating services is much more difficult in large cities, such as Manchester and London, with many CCGs and acute providers.’

Moreover, the Oversight Group recognises that ‘co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest’. In response, they are developing ‘robust new and transparent arrangements for managing perceived and actual conflicts of interest’. After a consultation, NHS England plans to issue statutory guidance on conflicts of interest.

We will never have the perfect system that provides perfect incentives,’ Robin concludes. ‘However, building relationships, adding resources and developing fixes for the issues all help. Co-commissioning offers a sensible architecture allowing commissioners and clinical staff to improve services for people with diabetes.’

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References
References are available online at www.practicaldiabetes.com.
Co-commissioning: a commissioner’s perspective


As the article by Mark Greener suggests, co-commissioning is an opportunity to reduce the fragmentation of commissioning and may enable commissioners to take a system-wide approach to improving care. This is particularly important when addressing the needs of patients with long-term conditions such as diabetes who may require integration of their care with input from both generalists and specialists. The opportunity to pool budgets and to take a broader population approach that it presents may also reduce the silo working and variation in quality of care that have sometimes been driven by the separation of funding streams and the traditional divide between primary, community and acute services.

However, advocates of co-commissioning need to be mindful that these benefits are not a given. As NHS England has committed to allow local determination of the scale and scope of co-commissioning adopted by each clinical commissioning group (CCG), there is likely to be added variation in how commissioners approach commissioning of diabetes services. Those who opt for full delegation of general medical services may decide to develop their own local Quality and Outcomes Framework scheme, creating both opportunities and threats to whether and how diabetes management by primary care is incentivised. Others who opt for joint commissioning will need to work closely with Area Team colleagues who may not have the capacity to engage in such developmental work and, where joint commissioning committees span more than one CCG, providers may find decision making more protracted.

Most commissioners agree that taking a more coordinated approach to system redesign can only be of benefit to improving patient care, but the verdict is out as to whether co-commissioning is required to do this and whether CCGs will have the capacity and capability to deliver full-scale commissioning of primary medical services. Oxfordshire CCG has been working with its providers to develop a single integrated diabetes service with new care pathways which will deliver current hospital based care in locality based community hubs. Such transformative service redesign is possible irrespective of progress on co-commissioning.

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POEMs

Glycaemic control associated with better outcomes in patients with type 1 diabetes

Clinical question
What is the association between glycaemic control and cardiovascular mortality in patients with type 1 diabetes mellitus?

Bottom line
This study finds a strong association between glycaemic control and cardiovascular events in patients with type 1 diabetes mellitus. It also finds a strong association between the presence of type 1 diabetes and earlier mortality. Poor glycaemic control is associated with worsening outcome.

Reference

Synopsis
This Swedish study used data from a national registry of patients with type 1 diabetes, defined as disease onset before the age of 30 years and requiring insulin. The registry tracks medications, complications, and risk factors among adults with type 1 diabetes. These researchers included everyone in the register in 1998 and followed them through to the end of 2011 (or until the patient died). They also identified five control patients from the same county matched to each case by age and sex. Participants were followed up for a mean of approximately eight years.

The researchers divided patients with type 1 diabetes into quintiles by glycated haemoglobin control, from less than or equal to 6.9% to greater than or equal to 9.7%. Patients with worse glycaemic control also tended to have higher levels of low density lipoprotein cholesterol and higher rates of tobacco use (8.9% in the lowest quintile to 23.4% in the highest).

A series of Cox regression models were created, with successive models incorporating more potential confounders.

In the fully adjusted model, cardiovascular mortality increased with increasing levels of glycohaemoglobin, with a relative risk of 2.43 (95% CI 1.7–3.4) for the highest compared with the lowest quintiles. The likelihood of death from cardiovascular disease was significantly higher in patients with type 1 diabetes than in control patients, even for those with excellent glycaemic control.
References


