Briefing August 2020

Creating a new normal for CCG business as usual

Preparing for system by default in 2020/21

NHS Clinical Commissioners
The independent collective voice of clinical commissioners

Introduction

Members and colleagues from NHS England and NHS Improvement (NHSEI) have told us that moving to streamlined commissioning has been galvanised by the COVID-19 crisis, with clinical commissioning groups (CCGs) supporting providers at place. At system level, the focus is to coordinate key activities such as capital bids and population health management approaches, which are best done at scale as we accelerate towards `system by default'.

As we move to phase three of the NHS's response, there is increased pressure for non-COVID-19 health services to return to near normal activity levels, while there is a clear willingness from clinicians and managers alike not to return to the old ways of working that created layers of transactional bureaucracy.

Beyond contracting and procurement, commissioning is often not well understood across systems. If we are to achieve truly integrated working, then CCGs need to ensure system partners are clear on which commissioning functions should be retained, which could be leaner and then lead the collaborative work to define whether these are at place, system or neighbourhood level.

As part of our new 'Evolving Commissioning' series, NHSCC has developed this learning tool to help commissioners capitalise on the recent opportunities for improved system working as they review their core functions in light of the next phase of the COVID-19 response. Based on CCG and ICS feedback, this document pulls together pointers and examples of how CCGs and partners can redesign some core functions over 2020/21 to build a bridge to more system and place working, without compromising their legal duties, taking into account recent guidance from the NHSEI phase three letter. It presents some of the opportunities, as we see them, for CCGs as they move towards streamlining their commissioning functions over the next year. The examples are intended to be helpful prompts which can be tailored to your local circumstances and pace of change.

We hope this tool can help your journey to work differently as strategic commissioners at system and place level, as well as being a useful reference for wider system members as to where commissioning functions might sit in the future. The COVID-19 crisis has allowed us to rapidly redefine functions to enhance patient care for the populations we serve; we must grasp this opportunity and ensure we don't revert back to business as usual in 'yesterday's world'.

Lou Patten
Chief Executive
NHS Clinical Commissioners

Dr Graham Jackson
Chair
NHS Clinical Commissioners

Points to consider **Improving the quality of services for patients**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• A single system level approach to quality monitoring, embracing all organisations delivering NHS commissioned services at system, place and neighbourhood level – a 'do it once, but do it well' approach. • A system wide single governance framework that reduces transactions and concentrates on quality improvement (QI) cycles. • Single shared view/vision of patient experience as they pass through different organisations for their care. • This system will have one version of the truth. • Default of self-regulation and a common QI approach across all partners.	• Consider creating or building on place-level groups/ networks around quality which are cross provider. Develop a set of principles for cross-provider working that reduces repetition and fulfils quality monitoring requirements for all organisations through one reporting process. • Focus on patient experience as they journey through the various provider services for their care. • Build a culture of trust and self-regulation among all providers at place level – embed the principles of QI (agreed at system level but executed locally). • Seek to engage early with regulators (CQC and NHSEI) on specific areas of work at place level, such as service reconfiguration and consultation, primary care, care homes. • Encourage bottom-up problem solving and mechanisms for soft intelligence gathering from providers at place and neighbourhood level. • Develop common system-level principles for QI that can be embedded at place and neighbourhood levels; consider investing in training of key influencers in place to help embed these. • Seek to ensure patients' lived experience is fed into all discussions about quality at system, place and neighbourhood level.	• Consider developing a system wide quality monitoring board that includes NHSEI and monitors only those areas of quality that make sense to do at scale; this would need to include specialised commissioning. Use this platform to quality assure any new ways of working that have developed since COVID-19. • Establish a culture of openness in reporting that uses incidents and issues as system learning opportunities. • Once developed, the system quality board could develop a single quality framework agreed by all partners. This would create one version of the truth and move to less transactional assurance. • Ensure an early conversation with regulators (CQC and NHSEI) to ensure the framework fits; work together to develop new system measures. Consider using the CQC system review indicators that views patient journeys through systems. • Consider taking on devolved responsibility for the leadership of quality surveillance groups from NHSEI. • Seek to establish consistent complaint processes that cover the system.

Points to consider **Financial governance and performance**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• A system financial framework means members focus on a cost-reduction model of total spend. Budgets are delegated wherever possible and linked to outcomes. Contracting, if necessary, is light touch to reduce transaction costs for reinvestment in clinical services. • There are measures of success developed by local communities and a more self-regulated approach to performance. Standardised monitoring across place and neighbourhood levels enable aggregation at ICS level. • NHS Estates will be coordinated at system level, will include primary care and be a significant partner for local authority infrastructure and housing planning.	• Understand and embrace the provider alliance working under the simplified block arrangements during COVID-19 that has enhanced integrated working. Consider how delegated decision-making can move from commissioners to local providers, such as through lead provider and alliance contract models. What would a move to risk share and aligned incentives look like? How can voluntary and third sector partners be aligned? • Embed robust business processes to enable the delegation of budgets that really empower local providers. • Establish local measures to demonstrate that integrated working at place is achieving value for residents and patients. • Expand the current estates portfolio to include primary care and third sector; what are the implications on space requirements given the move to remote working?	• Explore how existing CCG financial governance can bring a system focus on cost control and productivity. Consider how historic contract activity baselines should be adjusted, given the changes in care delivery models. • Look towards developing a single risk management and reward approach across system partners. This would create one version of the truth and move to less transactional assurance. • Establish joint accountability and oversight of COVID-19 expenditure and health and care outcomes. Develop a process for measuring COVID-19 costs that can be used in future major disruptive health issues, to achieve prompt reimbursement. • Establish a timetable of leaseholds and breaks to enhance efficient space sharing across all organisations; develop a single system remote working policy.

Points to consider **Clinical leadership**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• An agile, multidisciplinary, clinical and professional network exists with involvement operationally at place and strategically at system level. • Advice feeds into local governance and scrutiny meetings. • Transformation and improvement remain clinically led and co-produced with the local population.	• Establish a clinical and professional network that draws on the right capability for the task required, so membership is different on various areas of work. • Ensure robust, shared clinical representation from across your providers at place level to support local prioritisation and clinical effectiveness.	• Be clear on how the various clinical leadership models work together at scale. • Ensure clinical leadership and advice is strengthened through support from academic partners. Consider social care professional involvement to ensure the local government care voice is heard. • Ensure that people with lived experience are part of service redesign and transformation at system and place level.

Points to consider **Primary and community care**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• Primary, community and social care provision together with third sector support is greatly enhanced in order to keep patients out of hospital and provide emergent rehabilitation post COVID-19. • Primary care networks (PCNs) are supported to further integrate with community, social care and voluntary care services via ICPs and place-level working. • Primary care is viewed as a collaborative of 24/7 services, including community and with seamless integration of in and out-of-hours services. • Place-level commissioning and delivery are aligned to local authority to jointly influence the local agenda on prevention, population health and the local economy.	• Focus significant effort on supporting PCN development (including the wider community services aspirations in the NHS Long Term Plan) to establish a local robust out-of-hospital collaboration of providers that supports new ways of working. • Seek to establish a population health management (PHM) approach that embraces all facets of local government measures for wider determinants of health in order to comprehensively tackle health inequalities. • Enable PCN clinical directors to focus on what only clinicians can do: leading development of integrated community mental health care, care home support and out-of-hospital rehabilitation services. • Provide support for clinical leadership development and distributed leadership approaches, focusing on patient pathways through the local system. • Embed robust business processes to enable the delegation of budgets that really empower local providers; how could a 'risk and reward' system operate at place level? • Review membership of local health and wellbeing boards to facilitate local engagement and planning with stakeholders. • Support PCNs and community services to coordinate their collective voice at the health and wellbeing and system partnership boards. • Establish a single collaborative framework for 24/7 primary, mental health and community services provision that seeks to offer seamless handover between services and develops a shared approach to demand management.	• Share best practice on managing conflicts of interest as CCGs focus on supporting PCN development. • Develop system measures linked to reducing health inequalities as metrics for successful CCG and PCN out-of-hospital collaboration. • Ensure there is a system plan to support providers in sharing data beyond the temporary measures brought in under the 2002 regulations; think about a robust communications plan to ensure all providers are clear on procedures and that they feel supported. • Think about a system level coordination of the winter 2020/21 flu vaccination programme that targets the population's most vulnerable and BAME members. • Ensure new ways of working from the COVID-19 response are built upon in primary care and best practice shared. How can self-referral and remote triage free up clinical time for the most vulnerable? • Encourage a single standardised approach to performance dashboards and local delivery models at primary and community care level. • Support all CCGs in the system to develop a consistent approach to primary care contracts – Local Incentive Scheme (LIS) and Locally Commissioned Services (LCS) – and Direct Enhanced Service (DES) delivery. • Develop a consistent response to improving general practice resilience.

Points to consider **Jointly commissioned services with local authorities**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• Single shared intelligence framework around communities, including citizen feedback and health inequalities analysis. • Joint collaboration by default, with pooled and aligned budgets delegated where possible.	• Clarify what an integrated population health approach looks like at neighbourhood, PCN and local authority levels and what information is available. Ensure the right data is gathered to measure increased inclusion as described in the phase three letter. • Develop a joint collaborative approach to drive down cost and increase quality in continuing healthcare, personal health budgets and end-of-life care. • Map all current support and consider a joint local offer for care homes and domiciliary care to build resilience. • Embed blended approaches at place level to access mental health therapies across health and social care (all ages) – both digital and face to face. • Ensure there is read across between mental health support for children and young people and those with special educational needs and disabilities to the wider education sector through joint appointments or oversight. • Explore joint oversight of quality, outcomes, capacity and risk so that the impact of actions by a single organisation is understood across all place members.	• Encourage closer working with local authorities on PHM; develop a clear framework for what is managed or commissioned at the different levels of population. Consider pooling data analytic support. • Develop together a set of 'success measures' that will demonstrate improvement in health inequalities and inclusion and that are understood by citizens and health and wellbeing boards. • Encourage more joint appointments or joint programmes of work in key areas such as learning disabilities, health inequalities, public and mental health. • Collaborative market management with local authorities for mental health and learning disability/ Autism support, care homes and home care services, and the voluntary and community sector, building on previous work but also COVID-19 experience to strengthen the market.

Points to consider **Unplanned care**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• A system-wide strategy for unplanned care across acute, community and primary care, tailored to what works at place. • Demand and capacity planning understood for all parts of the system. • The system works collaboratively to manage high demand and free up capacity. • Integration across all points of urgent care access.	• Develop a clear understanding of the local urgent response to COVID-19; what in terms of locality hubs worked well and should be kept, what should stop. • Develop measures to understand primary, community and social care capacity and report it as part of system urgent care preparedness. • Embrace the learning from CCGs where collaboration with fire and police capacity has been successful. • Facilitate clinical collaboration that focuses on the patient journey between providers; include wider services such as hospices and third sector by using place level thematic programmes.	• Learn from the COVID-19 system cell operations; consider retaining the single approach for winter planning, flu delivery and adoption of best practice. • Maintain and build on the infrastructure that has been put in place as part of the COVID-19 response, such as mental health crisis support accessed via 111. • Establish cross-cutting programmes of work with local government services that can enhance support or resource to place and neighbourhoods. • Capture the innovative clinical collaborations and link to system level evaluation and roll-out.

Points to consider **Planned care**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• Have a system-wide evidence-based approach to clinical pathways, reducing unwarranted variation at all levels of delivery. • Operate with a single version of the facts around monitoring and performance. • Provider networks work to manage capacity in planned care, including system level waiting list management.	• Consider how collaboration between primary and secondary care providers can be strengthened to facilitate the work on priority pathways (i.e. cancer treatment and diagnosis). • Ensure the partnership board (as described in the phase three letter) has the information to monitor progress of actions to support patients who may have unequal access to diagnostics and/or treatment. • Develop improvement programmes to spread knowledge and learning. Consider how these can be communicated across place. • Ensure regular dialogue and exchange of information between clinical and professional networks; how can opportunities and constraints be reported up to the partnership boards for action. • Support providers to develop provider networks to share capacity, ensure models are clearly understood by GPs and other referring clinicians. • Embed the Evidence Based Interventions (EBI) programme and principles of self-care into place and neighbourhood level delivery.	• Consider expanding your local recovery cell, developed during the COVID-19 response, to develop service models for recovery and reset, coordinated by the CCG, fed by clinical or specialist cells (such as discharge cells) and organisational recovery leads. • Work with all mental health providers at system level to ensure funding decisions are made in partnership and is allocated to the main Long Term Plan (LTP) priorities. • Adopt a consistent Choice and Access Policy across the system. • Act as the coordinator for change between now and winter. Broker agreements between providers to share waiting lists and encourage the appropriate use of digital technologies to support wider services. • Aim to make more resource allocation and prioritisation decisions in line with system plans and strategies and assessment of clinical outcomes value; ensure allocative efficiency. • Seek system-level ambition to implement phases one and two of the EBI programme by not reinstating procedures deemed to be clinically unsafe. • Look to build upon existing networks of providers across the system to address capacity and encourage integration. Seek to maximise alternative capacity such as voluntary sector provision and alternative pathways of community-based care. Avoid reverting to a reliance on out-of-area placements for mental health. • Identify priority pathways at CCG level and system level to ensure resources are directed to those in most need. • Build on the COVID-19 experience to set up a system demand and capacity cell to provide management capability and support planning processes (including mental health). • Start to embed develop outcomes-based incentives for groups of providers which allow for personalisation and dovetail with personal health budgets.

Points to consider **Corporate functions**

Your desired end state or destination	Actions you can do now to build a bridge towards this end state or destination	
	…at place level	….at system level
• Places and system have standardised corporate business processes and a single system-level strategy for estates, workforce and digital that enables aggregation at ICS level. • There is clarity on what tasks are undertaken at place and scale. • Organisations are united in their approach to achieving best outcomes for their populations.	• Develop a clear roadmap for each CCG function; what could be undertaken at place level via integrated providers, what can be stopped and what could be undertaken at greater scale. • Develop a standardised approach to reporting at organisation and system levels. • Consider deploying CCG staff at place level to support key functions such as provider-led contract management, PCN development, service improvement and transformation work. • Clarify what local specialist support and input is required at place level, for example around infection prevention and control, care home specialist support that supplements local arrangements. • Support workforce planning at place level: gather workforce data to mitigate capacity issues or future supply shortages, develop staff passports across partner organisations and support flexible working.	• Actively participate in the system-level partnership board, develop clear plans to streamline commissioning arrangements to an ICS or STP approach in line with the phase three guidance. • Consider aligning CCG commissioning functions resource to support system plans and clinical strategies. • Develop consistency of approach to local specialist support – such as for out-of-area treatments, evidence-based interventions, and medicines optimisation – building on the good work that has been undertaken nationally by NHSCC and NHSEI for CCGs on the priority prescribing programme. • Develop a single people strategy and overarching digital strategy at system level. • Consider rapid adoption processes for new ways of working and sharing best practice. • Ensure organisational development and training is in place for staff around the move to strategic commissioning; support teams across place and system working.

NHS Clinical Commissioners is the independent membership organisation for clinical commissioners.

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