October 2015

Local solutions to national challenges

Delivering our commitment to patients

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

Foreword: Our ambitions for the future

Since NHS Clinical Commissioners published its first manifesto in 2014, we have had a new government and the publication of the *Five Year Forward View*. We feel therefore that this is the right time to refresh our "asks" of national government and national bodies such as NHS England and to set out how we see the future direction of clinical commissioning groups (CCGs) as they work to the new agenda.

The aims of the *Five Year Forward View* correspond exactly with how CCGs see the future direction of the NHS. The principles of localism in health and social services – working with local partners on sickness prevention, self-care for patients with chronic conditions, health inequalities and care delivered in the community – are those to which CCGs, as local GPs, are fully committed. We have made an excellent start on tackling these issues and we find the possibilities for the future truly exciting. CCGs have the energy and the expertise required to revolutionise our health service.

The themes of this report were developed with our membership and our elected board. The process has highlighted how CCGs have matured as organisations and are established bodies within their local areas. The many case studies in this report demonstrate the benefits of having doctors leading the design and shape of local health services.

What concerns us is how we keep CCGs protected at a time when it feels as though the environment in which they work is moving in an unhelpful direction. Our members highlight ever-growing bureaucracy with top-down priorities, a financial system that feels out of touch with long-term patient needs, and a reporting process that seems oppressive and insensitive to the local context. Here we are asking for some changes that will enable us to concentrate on our strategic role – transforming the health and wellbeing of our populations.

Dr Amanda Doyle OBE, Co-chair, NHS Clinical Commissioners and Chief Clinical Officer, NHS Blackpool CCG

Dr Steve Kell OBE, Co-chair, NHS Clinical Commissioners and Chair, NHS Bassetlaw CCG

Julie Wood, Chief Executive, NHS Clinical Commissioners

Introduction

Fit for the future

Since CCGs were set up nearly three years ago, they have made a significant contribution to patient care. CCGs are now well established, with a growing expertise in commissioning and purchasing local services for our patients and populations.

Clinical commissioners have an unrivalled knowledge of the health needs of their local populations. They are, after all, also on the front line as GPs, seeing patients every day. They know their patch, the resources they have available and the specific challenges of their localities. Doctors who have lived and worked in the same communities for a number of years are making informed decisions for their populations.

The CCG contribution to better patient care is clear: our members can improve healthcare outcomes for our communities using their clinical expertise, change the nature of local services through their commissioning levers and drive efficiencies in order to create a sustainable NHS.

Based on that knowledge then, and in light of the general election this year, our members have identified some refreshed policy "asks" that will help them to perform even better as they work to transform healthcare both now and in the future.

We understand the constraints under which the public sector now operates. The drive for efficiencies and high-quality care is paramount. CCGs have a role in driving that agenda and have a good record of balancing their budgets, targeting their spending on the key priorities. This paper is not then a reactionary demand for ever-increasing resources, but more about being smarter in the way that the system works to support CCGs to be leaders of local change across health and social care. We are not asking for another huge system overhaul, but rather discrete, practical changes based upon our experience of what works.

CCGs are an asset to the NHS. However, they need national support to be as effective as they can be. Here, we set out how those in charge of policy and decision-making can help clinical commissioners as they deliver first-class, modern, cost-saving health services, responsive to the needs of their local populations and fit for the future.

What we need to deliver our commitment to local patients

We have identified five critical asks that will release the potential of CCGs:

1. **Focus on the long-term view**
   Clinical commissioners must be supported to focus on their strategic role and function, which is to transform healthcare at a local level. They need to be freed from centralised reporting in order to work with local partners to prioritise local population health – strengthening community care, sickness prevention, health inequalities and the long-term causes of poor health. This means being able to plan for at least the next five years, rather than on an annual basis; a shift away from the focus on narrow national targets and the daily performance of their hospital providers, all supported by a single national outcomes framework for health, public health and social care.

2. **Realise the potential of localism in the NHS**
   CCGs are looking for a firmer commitment to what is known as "place-based commissioning" – that is, ensuring that NHS commissioning is strongly aligned to local geographies and local populations. For that, they need the centre to recognise that diverse geographies need diverse local solutions; speed up the development of health and wellbeing boards (HWBs); provide resources to develop co-commissioning; fix the fragmentation of the regulators' roles; and allow the CCG role to evolve in the future to meet local need.

3. **Ensure financial stability**
   CCGs can and do manage their budgets but there are stormy times ahead. They face heavy financial pressures. They have identified reforms that will put them on a more stable footing as organisations and also make considerable savings. These are introducing a multi-year financial settlement, which will enable them to invest up front in order to make savings in the following years; the freedom to use different payment methods for different types of care; a reform of the outdated tariff system and the provider objection process; and increased flexibility in how they use their running cost allowances.

4. **Value CCGs as local leaders**
   CCGs' vital knowledge and expertise is being submerged under a top-down approach from NHS England. They need a more collaborative partnership with national bodies, with an end to the ever-increasing micromanagement from the centre; a reporting regime that is proportionate and sensitive to local circumstances; clear support from the centre when they have to make tough decisions; and input into the design of the planned "scorecard" method of measuring their performance.

5. **Provide the tools to support intelligent commissioning**
   CCGs require some practical measures in order to work faster and smarter. Specifically, they are asking for a clear national narrative on the future of commissioning support, with a more flexible Lead Provider Framework, better access to data at patient level and compatible IT systems that allow them to work seamlessly with other sectors of health and social care. They also want a strong national workforce strategy that is fit for purpose and clearer, and simpler rules on competition and procurement.

Focus on the long-term view

> "Clinical commissioning – that coming together of clinicians, managers and patients – can be quite breathtaking in terms of what you can do for your local population, but you need to have the freedom to do it properly. We have a great opportunity; I really don't want to lose it."
>
> **Dr Nikita Kanani, Chair, Bexley CCG**

Health and social care needs have changed hugely over recent years to the point where much of the way that we provide health services is outdated and wasteful. At the same time, spiralling costs mean that the NHS will soon be unsustainable without a radical rethink. And despite all the money and all the efforts, huge health inequalities still persist across the country. We need a different, more long-term approach to the way we plan and deliver healthcare.

We support the direction of NHS England's *Five Year Forward View*, which sets out not only the challenges that we face but also how we can meet them in the longer term at a local level. Working on the ground, clinical commissioners are best placed to understand the needs of their local populations. Together with partners, such as local authorities in HWBs, they are focusing on the *Five Year Forward View* priorities: public health, sickness prevention, self-care, health inequality and care delivered in the community.

We believe CCGs have made an impressive start: some truly innovative services are now delivering first-class care to patients, with far more efficient use of resources. Changing the entire focus of the NHS, however, is a huge, once-in-a-generation task, and much remains to be done. CCGs are more than capable of taking this agenda forward but in so doing they must be allowed to concentrate on the bigger picture. This is about moving beyond immediate priorities to invest in the long-term needs of our populations.

What do we need?

Return clinical commissioning to its strategic role

> "CCGs must be allowed to focus on their role of transforming health services, not diverted by narrow, short-term priorities imposed from the centre."
>
> **Dr Amanda Doyle, Co-chair, NHSCC and Chief Clinical Officer, NHS Blackpool CCG**

CCGs were set up to drive change in the delivery of local health services, building strong community level services for local patients and generally being disrupters in the system. In redesigning health services for future generations, quick fixes do not work. CCGs need to be able to plan strategically for at least the next five years rather than on an annual basis. They also need the government to support them in the strategic aspects of their role by reducing the burden, frequency and duplication of short-term performance reporting.

Our members are increasingly being diverted from their strategic local purpose to focus on short-term national pressures; for example, the daily performance of their secondary care providers on issues such as winter pressures and referral-to-treatment-time targets. This distraction comes from national bodies trying to maintain a grip on the performance of the NHS. As we know, however, the system is broken and needs new solutions. Short-term fixes simply make the problem worse.

Prioritise the CCG role in tackling the long-term causes of poor health, addressing inequalities and prevention – a new national outcomes framework

Issues such as sickness prevention and health inequalities are complex. They take time to address and they cross the divide between the NHS, social care, living conditions and individual lifestyle choices. The link between problems such as poverty, unemployment and poor housing and conditions like heart disease, stroke and lung problems has long been understood, but the problem still persists. CCGs need to be freed from national priorities to work collaboratively with local partners across the public sector.

Our recent work with the Local Government Association (LGA) highlighted CCGs' need for more national government support as, together with local government partners, they can focus on sickness prevention, public health and health inequalities. This is not about creating new structures or local bodies but rather about introducing a single national outcomes framework for health, public health and social care. It should have a limited number of key national outcomes for the whole system, which will enable priorities to be determined locally. A more joined-up national outcomes framework will strengthen the collective priorities of local areas and also ensure that CCGs receive appropriate national support when working with partners to tackle the long-term health problems facing our populations.

CCGs are ready and willing to focus on these issues; many are acutely aware of how needs differ between areas of high deprivation and more affluent areas, for example. Preventing ill health requires investment upfront but its rewards are much greater.

Realise the potential of localism in the NHS

> "We need to be able to implement the national principles in a local context of what will work well. Otherwise we will waste money, time and energy and we won't get the best for our populations."
>
> **Dr Phil Moore, Deputy Chair, NHS Kingston CCG and NHSCC board member**

CCGs are local organisations, designed to work to a footprint, not only based on simple geography but on the profile of their areas. This is their strength. As GPs and as members of other local bodies, they work to provide services tailored to meet the specific, identified health and social care needs of their neighbourhoods. CCGs would welcome a greater commitment to that agenda from central government, regulatory bodies and NHS England, as well as some specific changes that will allow them to make faster progress in developing that strong local focus.

CCGs are looking for a much firmer commitment to what is known as place-based commissioning – that is, ensuring that NHS commissioning works to, and is strongly aligned to, its geography and its population. This commitment to localism must be in the form of national principles, rather than targets, which can be adapted to local needs, strong local levers, adequate resources and a regulatory system that is in tune with local circumstances.

What do we need?

Understand that diverse geographies need diverse local solutions

CCGs must be free to act in the best interest of patients, adopting systems that work best for them and their localities rather than national models. We must move to a place where national government sets out its principles but does not dictate how policy is delivered. This will support different areas in developing different solutions to the health and care needs of their populations. It might involve pooling local budgets with local authorities or devolving some commissioning functions. We want recognised plurality for local areas – local answers to national priorities.

Programmes such as the Better Care Fund (BCF), which centralise attempts to speed up joint local working and the pooling of monies, often meet with mixed reactions because local structures vary. While some CCGs found the BCF helpful, for others the timetable proved a hindrance to effective local working. Sharing financial risk as part of BCF plans (and proportionality of that risk between commissioners) was a key area for negotiation which required space for local decisions to be made.

The approaches to devolution are a move in the right direction. Here local areas, in a bottom-up partnership, agree to work together and produce local mechanisms for doing so. Devolution in areas like Cornwall and Manchester provide interesting examples of how the public sector can work jointly at a local level, but these models will not work for all areas or all CCGs. Policymakers must enable different models and modes of devolution and partnership working to flourish.

Improved services for children with complex needs and their families

In 2014, Barts Health NHS Trust ran a pilot project aimed at improving services for children and young people with complex needs. During the six-month pilot, 20 children and young people were assigned a case manager who played a key part in coordinating care between agencies and services such as community nursing, physiotherapy, occupational therapy, school nursing, teaching staff and community paediatrics. Tower Hamlets CCG is working with the trust to fund an expansion of the pilot to include 50 children and young people, as well as a detailed evaluation to validate the outcomes and build on the achievements so far.

The results:

These are currently being collected by Barts Health NHS Trust. However, early analysis, which will be validated over the next few months, suggests:

- a 59 per cent reduction in A&E attendances for this group
- a 54 per cent reduction in emergency admissions for this group
- better use of hospital admission to manage the children's pain and other symptoms
- introduction of early-stage review of epileptic medications to help prevent uncontrolled seizures
- closer working between health and social services with outcomes such as disclosure of domestic abuse.

Address the variation in the development of health and wellbeing boards

Health and wellbeing boards (HWBs) should be the focus for joined-up commissioning at the local level. For this to happen though, the boards need support in developing the right skills and culture in order to facilitate a more effective partnership between CCGs and local authorities.

We have made the point several times in the past that while local authorities provide a democratic legitimacy to HWBs, CCGs bring the equally essential clinical accountability. Both NHSCC and the LGA recognise that this combination of CCG and local authority accountability is critical to addressing local health and care needs.

However, HWBs are at different stages of development, which can affect the effectiveness of place-based commissioning. NHSCC and the LGA have made a shared commitment to support the sector to improve, as set out in our document *Making it better together*. We know HWBs need clear support to develop their cultures, work differently and become recognised spaces for steering local priorities. Simply adding more national targets, mandated pooled budgets and responsibilities will not make them work better.

"While CCGs are taking on more commissioning responsibilities, they are not necessarily seeing a straightforward transfer of resources from NHS England in order to deliver it, but are instead working with ever-decreasing management budgets"

Further progress on co-commissioning, with resources from NHS England

> "At the moment in my area, some health commissioning is done by the local authority, some by specialised commissioning, some by NHS England and the rest by CCGs. How do we get everyone working together to commission for the whole local population?"
>
> **Fiona Clark, Chief Officer, NHS Southport and Formby CCG and NHS South Sefton CCG**

We believe patients would benefit from a local commissioning system that genuinely focuses on people and pathways of care. We therefore support the principle of CCG co-commissioning and have seen that realised for primary care (or general practice). As we explained in our previous manifesto, *Making change happen* (2014), we see co-commissioning as the most feasible way to join up NHS commissioning at a local level. CCGs have a key role in commissioning out-of-hospital care but it's becoming increasingly apparent that they need the levers to link into other parts of the patient's care pathway, notably wider primary care and specialised commissioning.

However, recent experience from the move to primary care (general practice) co-commissioning shows there are some risks for CCGs in taking on more. The process showed that while CCGs are taking on more commissioning responsibilities, they are not necessarily seeing a straightforward transfer of resources from NHS England in order to deliver it, but are instead working with ever-decreasing management budgets. This creates some nervousness as CCGs move towards a role in specialised commissioning.

With other areas of co-commissioning on the horizon for CCGs, we need a commitment from NHS England that when any commissioning is transferred, the corresponding management budget follows.

> "There are two tests that must be met before CCGs can take on further commissioning functions – the first is they get the budgets and the second is they get the capacity and resource to do the job well."
>
> **Dr Steve Kell, Co-chair, NHSCC and Chair, NHS Bassetlaw CCG**

Better local coordination between the regulators

We welcome the recent merger of Monitor and the Trust Development Authority into NHS Improvement, this should simplify the trust assurance process for CCGs. We would like to see this direction of travel continue, with more joined-up working between NHS Improvement and the Care Quality Commission (CQC). The aim should be for one streamlined process for local areas, with joint inspections and assurance techniques that look at healthcare systems, as opposed to organisations.

Regulatory bodies must, therefore, adapt to new ways of working so that they do not obstruct local commissioners working to improve out-of-hospital care and transform services for their populations. The establishment of NHS Improvement must be swift and the new body must work differently from Monitor and the TDA, looking at the interests of the health economy as a whole, rather than focusing on individual organisations.

CCGs have been experiencing varying levels of engagement with the CQC inspection process – this must be more consistent. The CQC must see CCGs as critical local stakeholders in its work, supporting healthcare to go beyond national standards towards quality 'in the round'. Inspection, like commissioning, can benefit from greater clinical input but must align more closely with local objectives and contexts.

Allow the CCG role to evolve to meet local need

> "We might not all sit within the pure CCG model in the future but that doesn't matter if we are able to deliver a better service for our populations in a more joined-up way. People want a mandate for what the role of the CCG will be, but it's going to be different in different areas."
>
> **Dr Nikita Kanani, Chair, Bexley CCG**

We must remember that when it comes to commissioning healthcare, one size does not fit all. The recognition that different local populations and neighbourhoods have different needs was, after all, the rationale for giving more purchasing power to local CCGs.

As CCGs develop in line with local circumstances and needs, so their structures are diverging. Some are moving towards the model of accountable care organisations: bodies that act as both providers and commissioners of healthcare. Others are developing accountable care partnerships and some full-blown devolution. There are differing views about the future of CCGs and some of the unintended consequences of moving some of the CCG functions to new bodies. Again, we believe that this has to be resolved at local level, taking account of local circumstances. We are keen to work with NHS England to develop a shared narrative for commissioning as it evolves.

Supporting older people in their own homes

Aylesbury Vale CCG's new service, designed and led by a retired GP, supports older people who want to continue living independently. The aim is to avoid crises and the need for emergency hospital admissions. A total of 2,400 patients out of a practice list of 29,000 are aged over 75. All of these patients have been advised of the new service and given a direct contact number.

Nurses carry out a comprehensive geriatric assessment in the patient's home, drawing up a personalised care plan and prescribing medication as needed. In the case of hospital admission, they also assist with discharge planning and coordinate the patient's rehabilitation.

The results: (early indications)

- 20 per cent of patients (480) identified in first stage of project for full review and personalised care plans
- reversal of rising trend in emergency admissions for this group – from an increase of 3 per cent to 8 per cent over the past two years to a drop of 5 per cent during the past six months
- shorter hospital stays, resulting in lower costs – data being collected
- anecdotal increase in patient satisfaction – data being collected.

Ensure financial stability

"If I enable my clinicians to support people with hypertension proactively this year, the evidence shows that over the next three years I can avoid a large number developing life-changing, long-term conditions. The interventions that deliver the greatest return on investment are not recognised because they may deliver in years two and three."

Richard Samuel, Chief Officer, NHS Fareham and Gosport CCG and South Eastern Hampshire CCG

CCGs have made a good start when it comes to operating within their budgets. This is in contrast with other parts of the commissioning system. The specialised commissioning budget held by NHS England, for example, has been overspent by almost £600 million in the last two years. As local purchasing organisations, CCGs fully understand the constraints on the public purse and the importance of achieving the best possible value for money. For them, the £22 billion efficiency target provides a unique opportunity for the sector to show its economic competence.

While CCGs stayed within their budgets over the past two years, they cannot guarantee to continue to do so without the necessary longer-term support and resources. They expect to be hit by several additional cost pressures over the next five years, including increased demand and escalating prices. At the same time, they will be looking to transform services locally, based on an understanding of how health needs are likely to change over time.

CCGs will have to continue to make funding go further while investing in services to meet future needs. This is an even tougher challenge and can only be met with the right government support.

Against this background then, we have identified some changes to the current financial arrangements that will result in considerable savings, particularly in the areas of sickness prevention and community-based healthcare.

What do we need?

A multi-year financial settlement

"If we were to open a community clinic, it might take a year for it to reach its optimum use and for fewer people to go into hospital. We are investing in the long term."

James Rimmer, Chief Finance Officer, NHS Southampton City CCG

The CCGs' current annual spending round militates against services that will make savings in the longer term. Closer monitoring of people with diabetes by GPs or specialist nurses in the community, for example, can prevent complications developing and reduce hospital admissions and expensive treatments. However, such a service might take two to three years to reach its full economic potential. And to close an existing service before a new one is fully established is risky. Obviously, this approach might cost more in the first few months but it will lead to considerable savings longer term. A five-year funding cycle would be much more appropriate and support long-term investment.

Improving the lives of cardiology patients

Heart failure is the most common reason that patients are readmitted to the Royal United Hospital, Bath. Bath and North East Somerset CCG, working with the hospital, set out to reduce readmissions for this group and redesign care around the patient.

Working with patients, carers, cardiologists and specialist nurses, they introduced a community intravenous treatment administered by specialist nurses and produced a *Heart failure passport*. This document, held by the patient, contains key information such as treatment plans and medications. The service was supported by an innovative multidisciplinary team approach where the team's combined skills were crucial in coordination and care planning. New technology also means that patients can monitor their weight and therefore their heart condition.

The results:

- emergency hospital admissions down from 174 in 2012/13, to 131 in the first 11 months of the service
- 94 per cent of more than 2,000 patients said they were likely or extremely likely to recommend the service
- savings of £133,407.

Reform of the tariff

"The tariff is useful in some cases – to reduce waiting times for hip replacement, for example – but it doesn't incentivise long-term prevention or community-based work."

Dr Joe McManners, Chair, NHS Oxford CCG

As we said in our previous manifesto, *Making change happen* (2014), the NHS tariff (as part of the payments system) needs significant reform. Our members feel that the tariff – the system by which hospitals are paid – works against their long-term priorities by concentrating money and resources on hospital activity.

The tariff was introduced at a time when cutting hospital waiting lists was the priority. It therefore rewards on the basis of the numbers of treatments delivered rather than on keeping people healthy and out of hospital. It might have its uses in some parts of the sector but it does not help CCGs to shift care out of hospitals. In fact, it can actively prevent this.

The 2015/16 tariff objection process was a good example of this. While organisations that provide services to the NHS have the right to challenge points in their contracts, CCGs were disappointed that the objections were upheld at the cost of the wider system. In the CCG view, some rebalancing is required if national policymakers really want healthcare to change. We need to see more multi-year tariff arrangements and stronger commissioner and provider negotiation on the annual efficiency factor.

Different payment methods for different types of care

"Care needs to be delivered as close as practicable to the patient; if that's in the community then that's brilliant; if that's in the big hospital because that is the safest, best place, then fantastic. We need financial mechanisms that will help with that."

James Rimmer, Chief Finance Officer, NHS Southampton City CCG

Redesigning how the NHS provides care involves a fundamental shift in how we pay providers. As new models of care come on stream, CCGs need the freedom to use the most appropriate payment models. For example, the Year of Care is an innovative way of delivering care to people with long-term conditions, putting the patient at the centre, encouraging them to self-manage and focusing on keeping them well. The traditional payment model is no longer fit for purpose in this new environment.

Stability in the CCG running cost allowance

"We need to get rid of this arbitrary cap. If you want to invest a greater proportion of your budget on people who are needed to deliver change, you must be able to do that. Give us the freedom to decide where to spend our money."

Dr Steve Kell, Co-chair, NHSCC and Chair, NHS Bassetlaw CCG

To maintain CCGs' long-term stability, there must be no more cuts to their running cost allowances and they must have more flexibility in how they use them. CCGs find it very frustrating that, while they are statutorily responsible for their local commissioning budgets and have, to date, managed them well, their running costs are capped. In 2013/14, their running cost allowance was £25 per head. For 2014/15, NHS England froze the total running cost allocation, which worked out at £24.73 per head. Now for 2015/16, this has been cut even further, by at least 10 per cent to £22.07 per head.

The curb on running costs at a time when CCGs are taking on more responsibilities is a significant risk for them as organisations and to their ambitions for more localism in the NHS. Our members are concerned that further reductions in their running costs will:

- mean CCGs are unable to commission effectively
- leave CCGs unable to support national policy and drive local efficiencies
- reduce transparency through less capacity for reporting
- force smaller CCGs to merge or disappear and lose their local focus.

Help with weight loss

Gloucestershire CCG and Gloucestershire County Council are working together to tackle obesity in a bid to prevent conditions such as heart disease, cancer and diabetes.

People with weight problems are referred to weight loss clinics where the help includes one-to-one sessions on writing and reviewing personal eating plans and a review of patients' progress after six months.

The results:

- 70 per cent of over 6,000 people referred to the scheme have completed the programme
- 62 per cent of those have lost at least 5 per cent of their weight.

Value CCGs as local leaders

"I am very happy to be accountable but we are having demands for a report on this or that almost on a daily basis. That doesn't help us to get on with the day job."

Dr Phil Moore, Deputy Chair, NHS Kingston CCG and NHSCC board member

CCGs must be a recognised, respected voice in the NHS. As we have said, their understanding of the health needs of their local populations is second to none. Yet this vital knowledge and expertise is being submerged under a top-down approach from NHS England that is undermining CCGs as leaders of healthcare.

What do we need?

A mature partnership with national bodies

"We have some very innovative and successful work going on around reducing hospital admissions for frail, elderly patients. Unfortunately, my executive team spend most of their time looking at how long individuals wait in A&E. If only we could lose that micromanagement; all it does is prevent people from doing some proper work."

Dr Caroline Dollery, Chair, NHS Mid-Essex CCG

Our members want more collaborative ways of working with national bodies, in particular with NHS England as a fellow commissioner and as the assurer of CCGs. At present our members feel they are being micromanaged according to the daily priorities of national bodies. A more equal partnership would free up CCGs for the strategic role that they were established to do and that is so urgently required. Indeed, NHSCC has been acting as a check and balance on the centre by highlighting when relationships appear to be changing or the tone or nature of demands are distracting our members from their local role. Our interventions have increased over the past 18 months.

Balanced assurance from NHS England

"The input from national bodies should be supportive and enabling. The focus should be 'How do we solve the issue with you?' rather than 'What are you doing about it?"

Amanda Bloor, Chief Officer, NHS Harrogate and Rural District CCG and NHSCC board member

We understand the need for a robust assurance regime with the right challenge in place, but that process must not be such a burden that it hinders CCGs in their role and goes against the principles of localism. Assurance must be fair and proportionate and recognise the challenges that local areas face. Our members feel that assurance processes are often too weighted towards a CCG's or a provider's financial performance, which is not always within the CCG's control.

The difficulties facing a CCG should be viewed on an individual basis and according to their local context. Too often though the response is a blanket directive or demand across the whole system. CCGs need meaningful, targeted support to help them to succeed.

Fewer hospital stays for people with dementia

Harrogate CCG wanted to improve the detection, diagnosis and aftercare for people with dementia. Working with the local hospital, social services and mental health services, they reorganised memory clinics, made specialist care more accessible to care homes and local hospitals, and improved support for carers.

The results:

- average length of emergency hospital stay for these patients down from 19 days to 10.7 days
- average waiting times for the memory clinic down from 74 to 28 days
- wait for domiciliary care for people with dementia down by 50 per cent.

Accurate information for the public about CCG performance

"CCGs are open to being assessed on their performance and for improved transparency, but we must ensure the system is fair and accurate, otherwise we are giving the public a distorted view."

Julie Wood, Chief Executive, NHSCC

We support the move to greater transparency within the NHS. The public has the right to know how its money is being spent and how its local CCG is performing. However, our work with members shows that CCG metrics are complex. The proposed "scorecard" system for assessing the performance of local health systems through CCGs must compare like with like, align with the existing assurance process and have the right metrics in place in order to produce a fair assessment. We are working with the national bodies to ensure CCGs are able to influence the shape and scope of the final product so that it works well and provides the public with the information they need.

National support for the tough decisions CCGs will make

"We need to talk about how the health service will look in ten years' time. That's the conversation that no one wants to have. But when you say to the public, 'The cake is no bigger, how do you want to cut it?', they do understand."

James Rimmer, Chief Finance Officer, NHS Southampton City CCG

We need senior policymakers and politicians with local influence to work with CCGs to support local healthcare changes that will have a clear benefit for their constituents. We know from bitter experience that closing a local hospital invariably meets fierce opposition. People have an emotional attachment to a service they have known and used for many years and they also tend to see the issue purely in terms of cost saving. Yet when a decision to close a poorly performing, unsafe service is properly explained, people listen. As we improve services, those that are outdated and failing will have to go. CCGs will be leading those decisions and will need support in making the case for change.

"When a decision to close a poorly performing, unsafe service is properly explained, people listen. As we improve services, those that are outdated and failing will have to go"

Fewer calls to the ambulance service

In 2011/12, Blackpool CCG and Fylde and Wyre CCG jointly spent around £86 million on unscheduled care and that amount was set to increase.

Research showed that a large proportion of the healthcare budget was accounted for by relatively few patients and the top 100 callers to the North West Ambulance Service in one deprived area rang 1,100 times over a three-month period.

Frequent callers to the emergency service were phoned and asked about their problems, not about their use of services. If appropriate, they were offered immediate access to local support services for help with conditions such as anxiety, depression and feelings of self-harm and loneliness. When their emotional and social needs were met, the patients' medical problems tended to disappear.

The results:

- 999 calls down by 89 per cent
- A&E attendances down by 93 per cent
- hospital admissions down by 82 per cent
- incidences of self-harm down by 98 per cent
- savings of £2,757,380.

Provide the tools to support intelligent commissioning

In order to deliver innovative new services for their local populations, clinical commissioners require some specific practical measures to enable them to work faster and smarter. They are making key decisions with huge implications for their local populations, and they require modern technology and the appropriate administrative tools to allow them to get on with the job. In the *Five Year Forward View*, NHS England promises to "exploit the information revolution"; CCGs need to be among the beneficiaries of this move. They also need national support around the future direction of commissioning support, procurement and the workforce.

What do we need?

Clarity on the future of commissioning support

To support CCGs' in focusing on their strategic role, they need excellent commissioning support. The transition of commissioning support units to commercial organisations has been disjointed and, at times, difficult for CCGs. Similarly, the recently introduced Lead Provider Framework is often too complex for local purposes. We need a single narrative, shared by CCGs and NHS England, on the development and purpose of commissioning support. As key purchasers of commissioning support services now and in the future, CCGs must have a central role in shaping policy. They are asking for a sensible approach to the Lead Provider Framework, allowing them the flexibility to bring services in-house where this is efficient and the best option for good commissioning for their populations.

"In the Five Year Forward View, NHS England promises to "exploit the information revolution". CCGs need to be among the beneficiaries of this move. They also need national support around the future direction of commissioning support, procurement and the workforce"

Faster care, closer to home for DVT patients

In 2014, Northumberland CCG launched a service to enable patients with deep-vein thrombosis (DVT) to avoid visits to the A&E department and be treated closer to home.

Patients are managed by their GP, who carries out a clinical assessment, arranges blood tests, books the ultrasound scans directly and usually within 24 hours, prescribes anticoagulant medication and carries out follow-up consultations. Only those patients assessed as needing more specialist care are referred to hospital. The medication prescribed requires less monitoring than the standard drugs and has fewer known interactions with food and other medicines.

The results:

Evaluation is still underway but early indications suggest:

- fewer visits to A&E for DVT-related patients
- 150 DVT patients assessed and managed in the community rather than in hospital
- a drop in GP referrals for suspected DVT.

Better care for older people

Since Gloucestershire CCG's GP care homes service was launched in 2013, care home residents have been receiving more planned and proactive support from doctors. Doctors carry out regular planned visits, assessing medical needs, reviewing medicines and looking at the reasons for hospital visits. To achieve this, the CCG worked with a wide range of partners: all GPs, the Local Medical Committee, Gloucestershire Care Providers' Association, community pharmacists, Gloucestershire Care Services' Care Home Support Team and the physician team from the acute trust. They also held workshops to which every care home in the county was invited.

The results:

- emergency hospital admissions of care home residents down by 25 per cent in the first year.

Better access to data and use of IT

> "The information governance issue comes down to one thing: are the right people who need access to a patient's record able to get it? We can't solve that at a local level; it needs a national approach."
>
> **Andrew Pepper, Chief Finance Officer, NHS Wakefield CCG and NHSCC board member**

Confidentially is vital. Doctors, above all, understand this. However, patients' privacy can still be protected, while at the same time providing commissioners with the information they need. This includes the ability to share records with other parts of the system and have access to data at individual patient level. The new 'safe haven' status for patient data is not always working well for CCGs.

CCGs sometimes feel that they are working in the dark, planning essential services without access to some key information. As one of our members explains: "We can tell a GP practice that they have been spending a certain amount on prescribing for a particular group of patients, or what their referral activity may be, but without access to the data behind it, we can't tell them who those people are, which is not helpful."

A seamless service requires seamless IT. As well as access to essential information, commissioners also need the technical ability to enable them to work with other parts of health and social care; in other words, a compatible IT system that follows patients as they move between GPs, care workers, consultants, nurses, allied health professionals and others. This must be a government priority if the integration of health and social care is our shared ambition.

"A seamless service requires seamless IT. As well as access to essential information, commissioners also need the technical ability to enable them to work with other parts of health and social care"

A national workforce strategy appropriate to the new healthcare models

> "CCGs need the right workforce. The system is not training the right people and not using the funding in the most effective way. We need a new type of workforce now; more generic workers who can support rehabilitation."
>
> **Mary Hutton, Accountable Officer, NHS Gloucestershire CCG and NHSCC board member**

At a national level we must address workforce skills and capacity. Delivering joined-up, patient-centred services involves breaking down some of the traditional barriers between staff roles. We need new types of generic health and social care staff who can work more flexibly, carrying out a range of different care tasks, supporting patients with their rehabilitation and helping people to stay healthy and independent. Our members feel that the majority of the workforce strategy from national bodies reacts to demand in the hospital sector.

In particular, CCGs are looking for a strong national workforce strategy to produce more multi-disciplinary working by doctors, nurses and allied health professionals in the community sector. We expect, however, that much of the innovation needed may evolve from the vanguard sites through new models of care.

Clearer, simpler rules on competition and procurement

As we stressed in our manifesto *Making change happen* last year, we believe that competition, used well, drives up quality and efficiency. But the current rules on procurement are cumbersome and unclear, to the extent that they can actually work against cost saving. For example, not every service has to go out to tender, which is useful when a CCG wants to purchase a specialist service from a small local organisation. However, the opting-out process can be as complex as the tendering process itself. We need further clarity on navigating the procurement rules from NHS Improvement and NHS England.

Conclusion

CCGs are now firmly established as key players in delivering quality health services and shaping the long-term future of the NHS. They are local doctors who understand the needs of their areas, focusing on the national priorities of sickness prevention, public health, self-care and care delivered in the community.

No one underestimates the challenge of transforming our outdated health services but CCGs are more than capable of undertaking this task. In so doing, however, they need the full commitment of national government and NHS England: recognising them as local clinical leaders; supporting them in developing the commissioning role as it becomes increasingly diverse and sophisticated, and treating them as valued equal partners, all working towards the same goals.

A note on methodology

To ensure that this document accurately reflects the views and experiences of our board and members, we consulted them widely throughout the writing process. 23 clinical commissioners were interviewed at the start in order to identify the key issues. The resulting writer's brief and the draft document were then finalised by the members of the NHSCC board.

Share your views with us

As a member-driven organisation, we are keen to hear the views of members on the issues we have raised in this publication. For more information on it, please contact Julie Das-Thompson, head of policy and delivery at NHSCC, at **office@nhscc.org**

Contributors

Dr Gora Bangi, Chair, NHS Chorley and South Ribble CCG and NHSCC board member

Dr Alistair Blair, Chief Clinical Officer, NHS Northumberland CCG and NHSCC board member

Amanda Bloor, Chief Officer, NHS Harrogate and Rural District CCG and NHSCC board member

Fiona Clark, Chief Officer, NHS Southport and Formby CCG and NHS South Sefton CCG

Dr Andrew Davies, Chief Clinical Officer, NHS Warrington CCG

Dr Caroline Dollery, Chair, NHS Mid-Essex CCG

Dr Amanda Doyle, Co-chair, NHS Clinical Commissioners and Chief Clinical Officer, NHS Blackpool CCG

Sir Sam Everington, Chair, NHS Tower Hamlets CCG and NHSCC board member

Dr Debbie Frost, Chair, NHS Barnet CCG

Susanne Hasselmann, Lay member, NHS South Eastern Hampshire CCG and NHSCC board member

Mary Hutton, Accountable Officer, NHS Gloucestershire CCG and NHSCC board member

Dr Graham Jackson, Chair, NHS Aylesbury Vale CCG and NHSCC board member

Dr Nikita Kanani, Chair, NHS Bexley CCG

Dr Steve Kell, Co-chair, NHS Clinical Commissioners and Chair, NHS Bassetlaw CCG

Dr Joe McManners, Chair, NHS Oxford CCG

Dr Phil Moore, Deputy Chair, NHS Kingston CCG and NHSCC board member

Dr Tim Moorhead, Chair, NHS Sheffield CCG and NHSCC board member

Dr Ian Orpen, Chair, NHS Bath and North East Somerset CCG

Andrew Pepper, Chief Finance Officer, NHS Wakefield CCG and NHSCC board member

Amanda Philpott, Chief Officer, NHS Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and NHSCC board member

Dr Hugh Reeve, Chair, NHS Cumbria CCG

James Rimmer, Chief Finance Officer, NHS Southampton City CCG

Richard Samuel, Chief Officer, NHS Fareham and Gosport CCG and South Eastern Hampshire CCG and NHSCC board member

Katherine Sheerin, Chief Officer, NHS Liverpool CCG and NHSCC board member

Julie Wood, Chief Executive, NHSCC

Report researcher and writer – Sandra Hempel, freelance writer

Report commissioner and editor – Julie Das-Thompson, Head of Policy and Delivery, NHSCC

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. Our networks provide members with the opportunity to share experience and expertise; and provide information, support, tools and resources to help CCGs do their job better.

Contact us

W: www.nhscc.org
E: office@nhscc.org
T: 020 7799 8621
@NHSCCPress

Stock code: NCC00006

www.nhscc.org

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