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# Making change happen

## A CCG manifesto for a high-quality, sustainable NHS

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

## Introduction

At the heart of the NHS reforms in 2012 was a simple idea – that clinicians use their unique relationships with patients and their clinical insights to lead new approaches to healthcare that put patients and local communities at the heart of the NHS.

Clinical commissioning is already making a positive difference: improving outcomes for patients and empowering clinicians, but there is a growing urgency to enable it to achieve much more in light of the challenges currently facing the NHS.

As the membership body for clinical commissioning groups (CCGs), NHS Clinical Commissioners has produced this manifesto for national and local government, system leaders, policymakers and politicians to give confidence that local commissioning works. We want to outline what we see as critical asks from the system to ensure CCGs are supported to realise their potential and create a truly transformational NHS.

This manifesto comes from CCG leaders. It's in their words, it's honest, open and it seeks solutions from the system.

## Empowering clinicians throughout the NHS

CCGs are ambitious, clinically-led organisations striving to improve the health of their local populations.

Clinical commissioning is not just about empowering GPs, but about empowering clinicians throughout the NHS. The clinically-led conversations now taking place between CCGs and providers are strengthening the ability of provider clinicians to secure service improvement and new ways of working.

Dr Guy Pilkington, chair of NHS Newcastle West CCG, says the key difference is that conversations are now going on between commissioner and provider clinicians on clinical value: "When we have conversations about the hard choices that have to be made or the new models [of care] that we want to see emerge, it is easier to have conversations taking patient experience and outcomes as the starting point.

"That doesn't mean the conversations are always easy, but many of the conversations we have with consultant colleagues include how we move to prevention, how we diagnose conditions early, and it all resonates. Therefore our commissioning is based on a shared understanding that starts with that clinical conversation."

Dr Ann Bowman, chair of NHS Greater Preston CCG, stresses that high-quality services require clinicians to influence key decisions throughout the system "at a strategic level down to how individual practices care for their patients, and everything in between – and that's what clinical commissioning brings.

"If you keep clinicians in the driving seat it keeps everything focused all the time on 'what does this mean for patients?'"

## The need for urgent action

CCGs are already securing demonstrable advances in service quality and care pathways that are improving outcomes for patients, local populations and saving money. While relatively young organisations, they have strong ambition to achieve much more.

One year after CCGs were established, despite the early ambitions of the reforms, we see a system that is still embedding and adapting to new ways of working, with new commissioners, which include NHS England as direct commissioner, and local authorities taking a lead on prevention.

We know the NHS in its current form faces a number of critical issues – it is financially unsustainable, unable to meet the service demands of a growing and ageing population and is suffering from low public confidence in recent times around the quality of care.

CCGs are a valuable asset to the NHS. We want to give confidence to national and local government, system leaders, policymakers and politicians that local commissioning works and that CCGs are up for tackling the challenges we collectively face.

While we understand that the system is slowly adapting to the reforms, we also see a need for some urgent action to support CCGs make change happen. We need to act now to create the right environment for locally enabled clinical commissioning to work – giving it the best chances of succeeding and making a real difference to the health outcomes of the populations they serve.

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## A manifesto for change

We have identified eight critical asks that will enable the potential of CCGs:

1. **Free clinical commissioners to act in the best interests of patients**. CCGs are locally mandated organisations who commission for populations. We would like national politicians and NHS England to have faith in localism and uphold the ambitions of the reforms. This is about ensuring that the new system allows for mutual respect, building new ways of working between national and local structures that foster local innovation and the space to make local decisions. We would like to see NHS England demonstrate real confidence in the decisions CCGs make with their area teams, free up its burdensome assurance processes and support more mature conversations with CCGs as co-commissioners.

2. **Make local system leadership a priority**. Ensuring patients get the best possible care against unsustainable finances is one of the biggest issues CCGs face. Empowering localism to deliver better outcomes requires commissioners to work with providers, to co-commission and build relationships with organisations in their system. Clinical commissioners are part of a whole system, and must not be seen as a short-term solution to 'fill the cracks'. This means strong system leadership from CCGs, their providers, local authorities and NHS England (area teams and regional teams) to find ways to collectively plan, share risk and innovate.

3. **Health and wellbeing boards as the focus of joined-up commissioning**. The power of place is a critical driver for CCGs and local authorities. Health and wellbeing boards must become the focus for joined-up local decision-making, a space where CCGs, local government and NHS England build strong relationships and examine their commissioning intentions in the round. It is vital that each part of the system understands the consequences of decisions made in order to reduce risk and deliver meaningful change.

4. **CCGs must not be a risk pool for the NHS**. Poor financial planning is undermining the reforms that CCGs were put in place to deliver. The system must stop raiding the CCG budget and find more long-term system solutions to the impending financial challenge. CCGs need much more mature conversations with NHS England about the way financial risk is delegated and to be part of the process to find solutions.

5. **Support to deliver large-scale transformation at pace**. We want all parts of the system to be open and honest with the public about what transformation of the health service entails. We need national and local political support if CCG plans are to succeed. To support the mechanics, the system must also put the right financial incentives and tools in place at a national level to support commissioners to create change. This means making financial incentives align with outcomes improvements through national frameworks/pooled budgets that reduce risk locally. Regulatory bodies (Monitor and the Trust Development Authority) must adapt their processes to new ways of working so they do not obstruct local transformation plans.

6. **Connecting national and local commissioning**. CCGs must be seen as the strategic driver for commissioning out-of-hospital and non-specialised care, yet be joined up to all other care pathways, i.e. co-commission with NHS England around specialised services and primary care and local authorities for social care and public health. We believe patients would benefit from having a commissioning view that stretches across pathways and is not fragmented. CCGs must be involved in national decision-making on the relative priority of spend in relation to specialised services and spend on acute, primary care and community services.

7. **Better alignment of local commissioning to healthcare quality and the new inspection regime**. Discussions on quality and safety need to move on from inspection to improvement. The Care Quality Commission (CQC) must see clinical commissioners as key partners in their work, supporting healthcare to go beyond national fundamental standards towards quality in the round, i.e. against the needs of a local health economy and using local clinical expertise. Inspection, like commissioning, should benefit from greater clinical input.

8. **Competition in the NHS in the best interests of patients**. CCGs can only succeed if the rules and regulations governing their work enable them to do what is best for patients and help them realise their ambitions for their local communities. Often the rules around procurement and competition seem like a distraction from improving services and saving money. Monitor and NHS England must support CCGs to navigate the rules by providing more evidence and examples of how CCGs can effectively use competition laws.

## Free clinical commissioners to act in the best interests of patients

It is widely acknowledged that a major weakness in the NHS has been its command and control culture, which has inhibited commissioners and providers from doing the right thing for patients and local populations. The advent of clinically-led commissioning was intended to usher in an era of much greater local autonomy and a much lighter oversight, with the presumption being that GP commissioners rather than the NHS centrally would know what is best for their patients.

As the mandate from Parliament to NHS England for 2014/15 stresses, the health secretary and NHS England have legal duties to promote the autonomy of local clinical commissioners. However, the reality can feel very different on the ground. CCGs often feel the burden of national assurance processes upon them. A very recent example is the guidance produced for annual reports. It was dense and moved CCGs from a plan on a single page to 100-page-plus plans with significant detail.

The day-to-day relationship between NHS England and CCGs is managed through its area teams. During their first year, many area teams have developed an increasingly collaborative relationship with their CCGs. But their ability to support commissioners in reforming the local health economy is frequently stymied by the requirement to seek permission from NHS England for flexibilities such as local variations to the tariff or the Quality and Outcomes Framework.

"Joined-up systems need strong leadership, because individual organisations, and particularly acute trusts, are being asked to balance their financial interests with the wider interests of the healthcare community. Joined-up systems need CCGs to lead the way in reaching assent on common goals, including risk sharing across the system"

Dr Steve Kell, chair of NHS Bassetlaw CCG (and co-chair of the NHSCC Leadership Group), stresses the importance of every part of the NHS respecting the value that each partner brings: "This needs to be a whole-system approach, including respect for others when you make decisions. People see clinical commissioning as part of the solution, but not always an equal player in the system. We are often seen as organisations that fill the cracks."

Fiona Clark, chief officer at NHS Southport and Formby CCG and NHS South Sefton CCG, supports the message of mutual respect: "Everyone needs to respect the roles that we each hold. That respect is moving in the right direction but there is a way to go with real trusting relationships, supported by system leadership at a local level."

We would like politicians to have trust in localism and uphold the ambitions of the mandate. They need to trust that place-based approaches to healthcare work. Local innovation needs to be encouraged by a more permissive approach to local structures and governance. NHS England and the Department of Health could help innovation enormously by not presuming that the status quo is likely to be the best approach, and respecting local clinical knowledge. If there is not a convincing reason to say no, the answer should be yes.

Local solutions and meaningful change require NHS England to have more confidence in CCGs and area teams, agreeing effective processes and policies without the need for central authorisation. This light-touch approach would encourage innovation and speed up decision-making. This is about ensuring that the new system works maturely, with the right relationships developing between national and local structures that foster innovation and the space to make local decisions.

## Make local system leadership a priority

The overwhelming message from CCGs is the importance of enabling local system leadership to address the challenges the system faces.

System leadership is about a clearer understanding of the roles and responsibilities of the CCG as a network – working closely with each other and local partners to achieve a set of shared aims for a population.

As Dr Sam Barrell, chief clinical officer, NHS Torbay and South Devon CCG, explains: "Joined-up systems need strong leadership, because individual organisations, and particularly acute trusts, are being asked to balance their financial interests with the wider interests of the healthcare community. Joined-up systems need CCGs to lead the way in reaching assent on common goals, including risk sharing across the system."

However, time is an issue and CCGs must be enabled as soon as possible, as Fiona Clark explains. "This type of system leadership needs to mature relatively quickly to optimise the benefits."

Of course this local system leadership must also be matched by national organisations thinking more broadly about system solutions for complex problems within the entire NHS.

## Health and wellbeing boards as the focus of joined-up commissioning

Localism is what brings CCGs and local authorities into one place. The establishment of health and wellbeing boards was intended to provide a focus for joined-up decision-making in the interests of populations. We ask that CCGs, local authorities and NHS England work together to ensure health and wellbeing boards become the strategic focus for more joined-up local system leadership, a space where the NHS and local government see their commissioning intentions in the round.

The operation of the £3.8 billion Better Care Fund from 2015 will be a tough test of the ability of the NHS and local government to collaborate and share resources. CCGs are determined to bring together providers and local authorities in developing local programmes for the fund, which will meet the objective of investing in long-term change to provide integrated care, not short-term financial fixes for trusts or councils that are under pressure.

Given flatline funding in the NHS, the Better Care Fund has had to come from existing spend (largely from acute hospital spend), and securing this has been very hard. It is essential the Better Care Fund creates change and delivers better outcomes for local populations.

CCGs must not be seen as funding existing services affected by reductions in local authority funding: it needs to be more transformative spend. These changes need mature relationships. CCGs must be central to decisions taken and work in partnership to deliver change.

It is clear that clinical commissioners are still adapting to their relationship with local government and vice-versa. Some are finding it tough, with communication over the reconfiguration of services to transform care outside of hospital proving difficult, while other commissioners feel more positive about engaging with politicians and the public and convincing them of the need to change.

The importance of joint working and connectivity between CCGs and local government cannot be underestimated. Allan Kitt, chief officer, NHS South West Lincolnshire CCG, says: "If people are genuinely engaged with the health and wellbeing board and the health scrutiny committee, and put the effort into working with the public, you have the tools to make change."

Many of the high-level outcomes the NHS needs to deliver rely upon the CCG and local authority relationship working. CCGs believe that effective public health is vital if we are to reduce morbidity and mortality and must be seen as a key factor in creating a sustainable NHS.

We want more connected local decision-making in order to enable the better integration of health and social care. Where the health and wellbeing board is working well, this system leadership is beginning to enable more creative and innovative thinking and solutions together as one voice. This type of joint working must be enabled.

## CCGs must not be a risk pool for the NHS

In order for CCGs to make a real difference to the health outcomes of their populations, they must have transparency in the allocation of their finances and more system-led solutions around financial risk. We believe that financial and resource allocations have to be transparent and enable deeper penetration at a local level.

Several times over the past year, NHS England has made planned – but generally undiscussed – raids on CCG finances. These in-year budget cuts, and particularly the manner in which they are managed, not only cause dissatisfaction among CCG leaders, but also create real difficulties for CCGs to both manage their finances and plan local allocations of resource to fund population health improvement.

Examples include funding an NHS England overspend in the specialist commissioning budget; compelling CCGs to set aside £250 million for a risk pool to cover legacy costs from 'continuing healthcare' in breach of a pledge by the health secretary about PCT debts; and payments to the NHS property company PropCo.

The overspending in the specialist commissioning budget and the uncertainty in the way costs were allocated to CCGs caused particular concern. "We went from being assured that the transfer would be a cost-neutral exercise to it suddenly became an in-year deficit," says Dr Sam Barrell.

She stresses it is not just the cost but the uncertainty caused by these unplanned cuts that causes problems: "You are having to hold back this, that and the other ready for when the next bill for specialist commissioning or the next legacy bill [from PCTs] comes and you have no idea how much it will be."

This is forcing CCGs to surrender money set aside from tight budgets to fund investment in system reforms: "You have no wriggle room for the investment you need to do to create transformational change. I feel it is absolutely wrong to assume that you can do transformational things in your community without some kind of investment upfront."

Dr Shane Gordon, chief clinical officer for NHS North East Essex CCG, has had a similar experience: "I've got £15 million on deposit from efficiencies, and in a year where I really need it for transformation programmes I'm told I can't have it because they've already banked it against the specialist overspend. That's carelessness."

So poor financial planning at the centre is undermining precisely the system reforms that CCGs were put in place to deliver.

## Support to deliver large-scale transformation at pace

We feel all parts of the system need to be open and honest with the public about what service improvement entails, and commissioners need support – particularly from ministers and NHS England.

Most CCGs have yet to deliver large-scale transformations moving care from hospitals into the community and focusing more on prevention. Many reconfigurations need to be carried out across regions or sub-regions, which requires highly effective collaboration between CCGs in addressing both clinical and political issues.

Collaborating on strategic change is one of the biggest challenges clinical commissioners face in a time of financial pressure. It's also at a time when they are still developing the relationships within their own patch. There is a pressing need for them to build relationships with adjoining areas in developing what are likely to be highly contentious plans for change.

It is a complex process to go through and as Tom Jackson, chief finance officer, NHS Liverpool CCG, explains: "We need to ensure we execute change successfully, we need to ensure all providers are reconfiguring as part of a broader plan for the needs of our population, otherwise it won't work".

Dr Phil Moore, deputy chair, NHS Kingston CCG, believes that CCGs are performing but the next big thing to deliver on is working together strategically for big reconfigurations. "We are not going to achieve that if politicians keep undermining it. We've got evidence that we need to reconfigure for patient safety and to save lives, but local politicians will not accept that and will still fight for the status quo. That will undermine the development of a healthcare system that is sustainable and safe for patients."

Local commissioners are as aware as anyone of the passions aroused by plans to merge, move or close services. But until national politicians – whether in Government or opposition – offer political support and leadership on this issue, then service changes vital to the long-term sustainability of the NHS will not happen.

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"If you are going to say you are going to have 25 to 30 specialist centres across the country you actually have to articulate what that means and stand behind your NHS commissioners, not then say 'oh we are not going to close anywhere'," says Dr Ann Bowman, chair at NHS Greater Preston CCG.

### Putting incentives in the right place

For many CCGs, an urgent priority is to reform the funding system so that the flow of money acts as a driver of transformational change focusing on outcomes as opposed to activity. CCGs want to see a national framework for pooled budgets, and national endorsement of risk-share agreements so that individual organisations do not feel they have to go out on a limb if they are to act in the interests of the wider system. This may involve a pin-up system – which prevents one part of a care pathway taking an unnecessary hit.

Provider organisations also need the flexibility to deliver financial balance over a longer period than 12 months. Differing options for contracting and a longer contracting round, of five to seven years, will also be essential in driving transformational change.

Currently "the biggest thing that gets in the way is the financial system. Payment by Results (PbR) does not incentivise any sort of joined-up working," says Dr Sam Barrell.

Dr Guy Pilkington agrees: "PbR allows the acute FTs to be almost immune from efficiencies or cost pressures, because if activity grows then income grows. It has become a mechanism for growth for the hospital sector as opposed to withdrawal. What we need is a focus on local solutions and outcomes."

Increasingly, commissioners are working with providers to agree local variations to the tariff, such as block payments supporting outcomes, but these are cumbersome stop gaps rather than solutions. As Dr Sam Barrell explains: "There are local workarounds you can do, but they are hard work. It is quite difficult to get people to sign up to those systems when they're not the national model. There is always the excuse of 'we've got PbR to fall back on'. It would be good for someone to come up with a system that backs up what we want to do at a local level."

All these issues, which undermined the work of PCTs, have yet to be resolved. If the architecture and political support for change is put in place, then CCGs can act on reconfiguration.

### The role of regulation in supporting local transformation

Innovation is key to local transformation plans. Some CCGs and local authorities would like to establish single commissioning units for both health and social care, while other areas would like to vary the primary care Quality and Outcomes Framework. Many areas are looking at local variations to the tariff system to drive different system behaviours, such as investing in prevention and moving care into the community.

Ian Atkinson, accountable officer, NHS Sheffield CCG, believes regulators could do more to help local services manage risk. "Their threshold for 'I'm a bit worried' is very low. We have got this duality where we are being encouraged – and pressured really – to take risks and be innovative for the benefit of patients, but when you look at the regulatory system it is frozen in time."

Tom Jackson reinforces the point. "A regulatory model that is based on a predictive provider-level three-year financial plan and quality measures to go with it is not going to work in the current environment… I'm not sure the provider regulator model at the minute provides for the large-scale changes we are planning for."

Ben Gowland, chief executive of NHS Nene CCG, believes it is about ensuring "regulation operates more in a system-wide context. Unless regulators are involved in local system redesign work, they will end up blocking it."

Dr Steve Kell believes that blocking out local knowledge creates command and control ways of working. "We've now got the real clinical leadership in local areas, with clinicians in provider organisations talking to clinicians in commissioning, but there is a danger the regulatory system misses that local knowledge. People talk a lot about local leadership being the answer but it's different to how it feels sometimes."

The experience of another CCG offers a good example of this. "It felt like a unilateral decision by the Trust Development Authority to block our plans, which didn't involve the health economy as a whole. Their view was quite clearly that 'we are the regulators of the trust, the area team are the regulator of CCGs, and we speak regulator to regulator – we don't speak directly to CCGs'. The Trust Development Authority needs a more direct relationship with CCGs. They need to understand that institutions have dual accountability."

This relationship is equally true of foundation trust mergers, as Dr Amanda Doyle, chief clinical officer for NHS Blackpool CCG (and co-chair of the NHSCC Leadership Group) explains: "If your local foundation trust has Monitor heavily involved they tend to become very inwardly focused on finance and feeding Monitor, and the health economy tends to suffer.

"It is important that the regulator works with commissioners and has a very clear understanding of what our priorities are, what the plans are and how the health economy as a whole is going to be approached. A provider's financial problems are likely to be related to problems in the wider health economy, and often it's a health economy solution. Often the way the regulator focuses [on the provider] makes things more difficult."

She stresses that in recent weeks there have been signs of Monitor's approach becoming more collaborative, but it needs to go further.

## Connecting national and local commissioning

Every part of the commissioning system, NHS England and CCGs (through collaboration), needs to work together to strategically plan and jointly commission for populations.

Integrating services is a key government objective and a mantra for the entire NHS and care system, but the disjointed approach to commissioning primary, acute and specialist services is preventing clinical commissioners taking a system-wide view of patient pathways. CCGs only commission acute and community services, while NHS England is responsible for commissioning both primary care and specialist services. This fragmentation means local clinical commissioners are unable to oversee and coordinate services across the whole-care pathways. CCGs need to examine the whole pathway and not focus on individual services if we are to reduce the number of patients needing specialised services and improve clinical communication.

Katherine Sheerin, chief officer of NHS Liverpool CCG, believes this problem arose in part because "in the transition to the new structures there was a lot of time put into building confidence in the ability of CCGs, but no attention was paid to the biggest risk in the system, which was fragmented commissioning. To overcome the gap we need a mutual relationship with NHS England."

Dr Phil Moore stresses that now "we've got to work very effectively – hand in glove – with NHS England because this commissioning system that we've now got, where they do bits and we do bits, doesn't help in terms of quality. If we want properly integrated quality we've got to commission in an integrated way."

### Maximising the potential of primary care

Clinical commissioners regard having a far greater role in the development of primary care services as key to ensuring a high-quality, sustainable NHS. As Dr Amanda Doyle puts it: "There is urgency to get the systems and governance in place to allow CCGs to have a much bigger role in primary

care. It is absolutely integral. We are not going to take the amount of capacity we need out of acute services unless we do something with primary care, and at the moment it's not happening."

Dr Shane Gordon says the separation of primary care development from clinical commissioning "was not thought out. We have got a primary care strategy in Essex that makes statements about the coalescence of GP practices, the importance of access, the importance of [primary care] estate, and makes promises and value statements about primary care that they're completely unable to fulfil."

Overstretched NHS England area teams are struggling to provide the vision and leadership required to develop primary services that will ensure prevention and early intervention while reducing demand for hospital services.

Dr Sam Barrell says NHS England's area teams are contracting – rather than commissioning – primary care: "You need a whole reform model [for primary care]. That needs a lot of dynamism and energy and engagement and relationship building – all the things for developing a good commissioning strategy – and that isn't happening."

There are two challenges for whole-scale change. Most CCGs have 'levels of ambition' that are hospital based – most of the commissioning focus is on hospitals. Some CCGs are finding that even modest plans to expand community-based services are being undermined by pressures from overspent trusts. Secondly, the model of primary care delivery is broken: general practice is under pressure both in terms of capacity and sustainability.

Maximising the potential of primary care involves defining an effective way for CCGs, NHS England area teams and GPs to work together on primary care commissioning, while ensuring accountability to the public through governance, openness and transparency.

The solution is far closer collaboration between CCGs and area teams, including sharing staff time. One approach would be for CCGs to use their primary care expertise and local knowledge to determine the overall strategy and be responsible for implementation and primary care improvement, while the area team is responsible for leading the commissioning process and ensuring effective oversight. With CCGs involved in the strategy they are also able to ensure primary care fits into their wider transformational plans – i.e. long-term planning for out-of-hospital care.

We are positive about the early work underway with NHS England around some co-commissioning options for CCGs and we know CCGs are already developing primary care strategies with their area teams as a result of some work we undertook last year with national stakeholders. We are keen to see a rapid evolution of primary care commissioning.

## Having more say in the commissioning of specialist services

NHS England is responsible for commissioning around £12 billion of specialist services, such as cancer treatments, haemophilia services and bone marrow transplantation. At present there is an artificial divide between specialist commissioning and the rest of the commissioning system. Patients using specialist services are, of course, also dependent on services in other parts of the system, yet it is proving unnecessarily difficult to take an integrated approach to delivering what should be integrated services.

This is causing confusion for trusts. For example, bariatric surgery such as gastric band and gastric bypass procedures is commissioned nationally, while weight management services that act as a gateway to bariatric surgery are commissioned locally by local authorities. The disconnect between the two services has led to some patients being unable to access surgery.

While CCGs recognise NHS England is well placed to commission services that often operate regionally and nationally, there needs for closer collaboration with local commissioners. CCGs perceive two major weaknesses with the way specialist services are commissioned. It is failing to integrate specialist services with the rest of the care system, and decisions about spending are not being balanced against other priorities outside the specialist commissioning budget.

Dr Amanda Doyle says the separation of specialist from acute commissioning means that CCGs are carrying out needs assessments and prioritisation without the ability to make specialist services an integral part of that: "There is so much overlap in [acute and specialist] clinical pathways that unless we get some joint commissioning around specialist services, or CCGs have a bigger input into the planning and decision-making, things are only going to get more difficult.

"If you're taking an area and looking at need, unless specialist services are at the table and part of the deliberation and prioritisation then the system is going to lose out. It is as important that we co-commission specialist services as it is that we co-commission primary care."

CCGs question whether the £12 billion allocation for specialist services is proportionate to the benefits they deliver. They would like to be at the table during national-level conversations on the prioritisation of total NHS spend.

Dr Sam Barrell says: "I'm not convinced the specialist commissioning teams have enough generalist clinical input. I'm not sure they're thinking about the universal pot for the NHS and the impact of what spending a bit more does to the rest of the system.

"If I was looking at the whole system and thinking 'where could my money have the most effect overall?' you would be saying it was upstream services and so on, not specialist

tertiary niche services that only serve a tiny proportion of the population. I'm worried that they go away with their pot, overspend on it, but are they really making that decision in the round?"

## Better alignment of local commissioning to healthcare quality and the new inspection regime

The debate on quality and safety needs to move on. The inquiry led by Sir Robert Francis QC into Mid Staffordshire NHS Foundation Trust stressed that "responsibility for driving improvement in the quality of service should rest with the commissioners through their commissioning arrangements. Commissioners should promote improvement by requiring compliance with enhanced standards that demand more of the provider than the fundamental standards [set out in the NHS Constitution and regulations]."

Since then, however, the Government has focused on the role of inspection and regulation in rebuilding public confidence. Dr Phil Moore says: "The Government are looking at inspection for the answers, which is post hoc. If things have gone wrong it's too late, and if things have gone right it's a waste of time. Commissioners, with a real-time awareness of what's happening, are in a much better position to work with providers to drive up quality."

The CQC's new detailed inspections can be valuable to CCGs, but their effectiveness is undermined by the fact that inspectors rarely even tell commissioners they are planning a visit, let alone ask them for their perspective on the provider.

"The CQC rarely talk to us at all. That means that they lose out on our perspective and our long experience of monitoring quality. They don't ask us what we think, they don't involve us. That just seems daft. It must surely be in the interests of what they're trying to achieve to get all the information that's available," says Dr Amanda Doyle.

"If you're taking an area and looking at need, unless specialist services are at the table and part of the deliberation and prioritisation then the system is going to lose out. It is as important that we co-commission specialist services as it is that we co-commission primary care"

Dr Phil Moore adds: "It's ridiculous for the CQC to go into any provider and not ask the commissioners for their [insights], but they're doing it. They aren't going to get the intelligence they need to turn over the right stones." He acknowledges that there is a willingness among the CQC leadership to cooperate more closely with clinical commissioners, but it is taking a long time for the message to get through to all the inspectors.

CCGs believe that the risks of serious failures going unchallenged will be substantially reduced as clinical commissioning increases its effectiveness and grows in confidence. While regulators assure the system of minimum standards, CCGs are able to focus on enhanced standards, self-regulation and patient experience – through their local relationships with providers and their membership's relationships with patients. The GP membership of CCGs is far better placed than commissioners under the old system to pick up evidence about poor care and act on it. This is about the inspection regime tapping into clinical expertise and benefiting, as commissioning is right now.

Clinical commissioning is another powerful lever for assuring the quality of care locally. The health secretary, the Department of Health, NHS England and CQC need to put commissioning at the heart of policy debates about the future of the NHS. CCGs believe the public will respond to this; clear messages about the link between their GP and the public accountability of local services will reassure patients and relatives that their voice can be heard.

## Competition in the NHS in the best interests of patients

CCGs can only succeed if the rules and regulations governing their work enable them to do what is best for patients and help them realise their ambitions for their local communities. Used appropriately, competition between providers can help commissioners improve service quality and value, freeing up funds to be used elsewhere.

However, commissioners have found there are a number of practical difficulties with the current system when clinical commissioners try to secure the best outcomes for patients. It is sometimes unclear to commissioners whether they are simply free to commission from a market, or whether they have to commission in order to make a market operate.

As such, the rules around procurement and competition often seem like a distraction from – and even an impediment to – improving services and saving money.

Health minister Lord Howe gave clear commitments in the closing stages of the debates around the Health and Social

Care Bill that commissioners would be in control of the use of competition. It would be invaluable if ministers clarified aspects of how competition policy works – if necessary through legislation – to ensure that commissioners are able to work in the way the Government intends.

Dr Ann Bowman stresses that the problem is not competition per se, it is the inflexibility. As she puts it: "We should be able to choose [when to use it]."

In theory, commissioners can demonstrate that they don't need to tender a service. But in practice, doing so is convoluted and time consuming to the extent that it barely seems less arduous than tendering in the first place, while being much more open to challenge. Uncertainty and lack of experience over how the competition laws will play out under the pressure of legal challenge means that many CCGs are playing safe. But it is not what they want to do.

As Dr Phil Moore explains: "As CCGs we are still finding our level on this. The notion that you have to procure everything is a nonsense. Procurement is costly, time consuming, energy consuming and should be used sparingly where you think you need it for the quality and the service you're going to obtain. If all you need to do is maintain the current level of service locally, I don't think you should be obliged to go out to tender all the time."

It would be helpful for the system to provide examples and evidence of where it sees competition working in the best interests of patients – where commissioners can navigate the rules following local need as opposed to unnecessary legal process.

"The GP membership of CCGs is far better placed than commissioners under the old system to pick up evidence about poor care and act on it. This is about the inspection regime tapping into clinical expertise and benefiting, as commissioning is right now"

NHS Clinical Commissioners is committed to working with NHS England and the national regulators to develop a system that truly puts populations first and allows CCGs to focus on their core duties.

## NHS Clinical Commissioners: our commitment for the year ahead

We know that clinical commissioners are already working hard to improve local services by making responsible, clinically-led decisions in partnership with GPs, patients and providers, but we also know that they are doing this in a system that is currently not set up to work for them.

NHS Clinical Commissioners will continue to represent the voice of CCGs in the national debate, but we will be turning up the volume of that voice.

We will be pushing key stakeholders such as NHS England, Department of Health, Monitor, CQC and others to work with us to find solutions to those issues that our members have told us, to ensure that they can deliver the best possible care for their patients and local populations.

We will be highlighting the good work that has already been done by CCGs in their first year, supporting them to share best practice across the country, but we will not shy away from tackling those bigger political, financial or operational issues that are holding them back.

## Background to the development of the manifesto

As the membership body for CCGs, NHS Clinical Commissioners has produced this manifesto report for national and local government, system leaders, policymakers and politicians to show that local commissioning works. It also outlines what we see as critical asks from the system to ensure CCGs are supported to realise their potential and create a truly transformational NHS. The report is developed through a series of interviews with CCG leaders from our membership.

We also developed our core messages through a roundtable discussion we hosted in January 2014 with system stakeholders – the Local Government Association, Monitor, Department of Health, NHS England, NHS Confederation and Care Quality Commission, alongside representatives drawn from foundation trusts and commissioning support units.

## 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, senior policy manager at NHSCC, at **office@nhscc.org**

## Acknowledgements

We would like to thank the following individuals for their participation in our work, both through our roundtable and participating in interviews to develop the content of this report.

### Interviewees

| | |
|---|---|
| Ian Atkinson | Accountable Officer, NHS Sheffield CCG |
| Dr Sam Barrell | Chief Clinical Officer, NHS South Devon and Torbay CCG |
| Dr Ann Bowman | Chair, NHS Greater Preston CCG |
| Fiona Clark | Chief Officer, NHS Southport and Formby CCG and NHS South Sefton CCG |
| Dr Amanda Doyle | Co-Chair of Leadership Group, NHS Clinical Commissioners and Chief Clinical Officer, NHS Blackpool CCG |
| Dr Shane Gordon | Chief Clinical Officer, NHS North East Essex CCG |
| Ben Gowland | Chief Executive, NHS Nene CCG |
| Tom Jackson | Chief Finance Officer, NHS Liverpool CCG |
| Dr Steve Kell | Chair, NHS Bassetlaw CCG |
| Allan Kitt | Chief Officer, NHS South West Lincolnshire CCG |
| Dr Phil Moore | Deputy Chair, NHS Kingston CCG |
| Dr Guy Pilkington | Chair, NHS Newcastle West CCG |
| Katherine Sheerin | Chief Officer, NHS Liverpool CCG |
| Report author | Richard Vize, Public Policy Media Ltd |
| Report editor and commissioner | Julie Das-Thompson, Senior Policy Manager, NHS Clinical Commissioners |

### Roundtable participants (January 2014)

| | |
|---|---|
| Dr Charles Alessi | Chair (Interim), NHS Clinical Commissioners |
| Geoff Alltimes | Associate, Local Government Association |
| Dr Alistair Blair | Chief Clinical Officer, NHS Northumberland CCG |
| Helen Buckingham | Chief of Staff, Monitor |
| Dr Michael Dixon | President (Interim), NHS Clinical Commissioners |
| Ian Dodge | Director of Policy, Department of Health |
| Ivan Ellul | Director of Partnerships, NHS England |
| Mike Farrar | Independent Consultant |
| Andrew Foster | Chief Executive, Wrightington, Wigan and Leigh NHS Foundation Trust |
| Ed Jones | Special Advisor to Secretary of State, Department of Health |
| Dr Steve Kell | Co-Chair of Leadership Group, NHS Clinical Commissioners and Chair, NHS Bassetlaw CCG |
| Dr Phil Moore | Member of Leadership Group, NHS Clinical Commissioners and Deputy Chair, NHS Kingston CCG |
| Andrew Ridley | Managing Director, North and East London Commissioning Support Unit |
| Richard Samuel | Chief Officer, NHS Fareham & Gosport and NHS South Eastern Hampshire CCGs |
| Jill Shepherd | Chief Officer, NHS Bristol CCG |
| Dr Nigel Sparrow | Advisor, Care Quality Commission |
| Julie Wood | Director, NHS Clinical Commissioners |

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. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.**

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