NHS Clinical Commissioners

The independent collective voice
of clinical commissioners

NHS Clinical Commissioners response: Developing the long term plan for the NHS

30 September 2018

Key messages

- Clinical commissioners play a crucial role in the NHS. Within the current context of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS), which we understand will continue to play a role in the long term for the NHS, we want to make sure that the expertise and contribution of clinical commissioning is recognised and maintained.

- With ongoing changes, it is vital that we do not lose the clinical leadership that has been embedded within decision making since the formation of CCGs. Keeping a clinical commissioner perspective at the forefront is key for the NHS to deliver the best clinical outcomes.

- CCGs currently perceive barriers when integrating across system and place. We have 5 'asks' which aim to overcome these and should feature in the long term plan (LTP). We believe that the integration of health and social care is key to delivering truly person-centred care and that we must focus on the concept of place-based commissioning. Achieving successful integration is critical to transform care and delivering better outcomes for our populations.

- Given the changing landscape, we hope that the LTP provides clear direction for system architecture. This will help CCGs progress their role as strategic commissioners across larger geographies.

- Our members are also keen to shape the future of primary care, mental health and ensure that governance arrangements are fit for purpose within systems.

- We would also like to understand how the multiple workstream recommendations will be prioritised when the plan is brought together from the widespread engagement that has taken place.

- We are pleased to have been involved in engagement throughout this stage of LTP development – and look forward to continuing discussions. Many of the points we raise will be further expanded over the next few months.

Core values underpinning the LTP for the NHS

Alongside the welcome funding commitment, the Prime Minister announced that "*as the NHS develops the ten year plan we will consider any proposals from the NHS on where legislation or current regulation might be creating barriers.*" We have therefore made the following recommendations specifically to address barriers that CCGs perceive when integrating. Implementing these may not need formal legislative changes (primary or secondary) – it may be possible to reach them by revisiting and clarifying the current Health and Social Care Act.

1. *Responsibility to improve health and health outcomes.* Revise the section that specifies responsibilities of different parts of the NHS to legislate that NHS providers as well as NHS commissioners have responsibility for improving health and health outcomes across a 'place' and system (ICS and/or STP) as well as to their own organisation within that 'place' and system

2. *Regulation and Assurance.* Amend the responsibilities for assurance and regulation so that there is a single process that covers all the health and care organisations across the 'place' to encompass:
   - indicators that are the sole responsibility of a specific organisation within a 'place' but also
   - indicators that are the responsibility of every organisation across the place, so as to mandate 'collective responsibility'.

3. *Payment Reform*. Revise the sections that describe how payment for care will be made so that the payment system is changed to reflect the move towards integration and collaboration across NHS providers within a place. This would include replacing the default to PBR tariff with a mandate for commissioners and providers to mutually agree a contract form with no default. If they can't agree a contract then there is no default position. This should be viewed as a measure of system maturity and mutual agreement should be the expectation, but if necessary could, by exception, be enforced by:
   - Making PSF and CCG uplift conditional on reaching agreement
   - Increase in arbitration fines to both parties to avoid this becoming the new default and to ensure there is a compelling incentive to reach agreement
   - Awarding new 5YFV / Long term plan transformation funding based on systems being able to reach agreement.

4. *Accountability and governance*. Revise the sections that cover accountability and governance to include who is accountable for what functions, including the responsibility to consult and the expectations around governance across the 'place' and system around ICSs and STPs. This needs to clarify NHSEs role as a commissioner and reserved powers in order to avoid the concept of 'double delegation'. Ensure that this also clarifies expectations around the management of potential conflicts of interest particularly at 'place' level. Give providers and commissioners the ability to form joint committees for specific functions, for e.g. to enable integration, reduce inequalities

5. *Procurement, competition and choice.* Strengthen elements within Section 75 of the Act so that procurement is only needed if the commissioner cannot secure the changes needed with the providers working within the 'place' and system. Change the rules around competition and choice so that using competitive and choice levers are only introduced if the commissioner cannot secure the transformative changes needed. Re-look at how 'patient choice' operates by giving responsibility to the 'place' and system to work with its population to secure a mandate from them for the circumstances within which patient choice should prevail, linked to the ICS/STP strategic plan and priorities. Remove the powers of the CMA to make judgements with regard to competition between and mergers of NHS organisations.

Integration and strategic commissioning as enablers of improvement

Clarity of system architecture will be a hugely important component of the LTP. We are supportive of the formation of place-based systems which allow for clinical commissioners to take on more strategic commissioning. As outlined in our '*Steering towards strategic commissioning'* document, each system must continue to have a clinical commissioning function, which:
- Retains strong clinical leadership
- Operates as a high-level decision-making body
- Works with capitated budgets
- Develops sophisticated approaches to population needs assessment
- Retains the role of 'purchaser'
- Is accountable to the local population

- Focuses on outcome-based commissioning
- Operates at a geography larger than a CCG

This retains benefits for the local population by continuing to be accountable and in touch with local needs, as well as providing scrutiny of provider delivery. Our enabling asks above will help to achieve this. It is also important that support is provided to all systems at all levels of development.

Given that these systems should also include services currently commissioned and provided by local authorities, the voluntary sector and other stakeholders, strategic commissioning involves the integration of health and social care.

We would also like to emphases the five lessons from our '*Making strategic commissioning work'* briefing. This identified five lessons:

1. <u>It is right to evolve current systems</u>**.** Experience in England and internationally shows that the gradual, locally driven evolution of the healthcare system rather than "Big Bang" reforms are more effective in developing sustainable systems that meet the needs of patients over the longer-term. Where this is decoupled from national political cycles, local areas are given the certainty, freedom and flexibility to put patients at the centre of planning, transform services to meet local need and deliver long-term sustained quality improvement.

2. *National support for an evolved approach is essential*. Whilst local areas must lead and shape the development of the models for integrated health and care delivery, national clarity on and governmental support on the 'end states' (such as ICSs, with clarity over neighbourhood, place and system levels) for areas to transition towards, will be essential. The nature of national work needs to be enabling and facilitative (in the form of a national framework) for local areas to plan and agree their directions of travel. Internationally no system has been implemented without clear political consensus and a legislative framework to support it on an ongoing basis.

3. *Maintain clinical commissioning leadership and engagement.* When evolving the local health and care system to meet the needs of future populations, it's vital to retain continuity in clinical commissioning leadership at 1) a strategic level and 2) more locally for place-based integrated commissioning. The success of population level planning will depend on the engagement of clinicians in primary, secondary and community care, as well as the wider workforce, in a unified vision for the future. Where systems have done this effectively overseas we have seen increased quality of service delivery, innovation and improved outcomes for patients.

4. *Place the patient at the centre with a focus on quality.* Targets, payment incentives and prescriptive regulation have proved largely unsuccessful in driving system improvement or in ensuring financial sustainability over the longer term. International evidence suggests that strategic approaches to planning and resource management offer an opportunity to refocus the local health and care system on the end user and ongoing quality improvement.

5. *Hold the delivery model to account on behalf of the local population.* A strong strategic commissioning function will ensure a continued focus on quality and improvement within local areas. Competition does not preclude cooperation across systems or the integration of systems, and the development of a closed market has the potential to result in stagnation, with decreases in quality and innovation. The creation of a monopoly of providers who lack incentives to go beyond narrow contractual requirements must be

avoided and therefore the strategic commissioner should hold the system to account for delivery. The health system in Israel shows how this can be retained (albeit at a smaller population level) whilst the lack of contestability is one of the key concerns in the development of accountable care models in the US.

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Sara Bainbridge at s.bainbridge@nhscc.org.

We welcome the opportunity to feed into the long-term plan, specifically on mental health. Our response has been developed from input from our Mental Health Commissioners Network.

The role of the CCG mental health commissioner is important as they hold a considerable amount of the NHS mental health budget, so it is essential that their voice is heard.

Our members believe it is vital that the planning and commissioning of health services are locally and clinically led, so this needs to be reflected in the long-term plan. This is the best way to ensure that the NHS can deliver health services effectively for patients and the wider population.

1. **What are your top three priorities for meeting the mental health needs of people of all ages in England? Over the next five, and ten years?**

Funding that is sustainable and well-invested
Ensuring mental health is properly funded is our top priority. This needs to cover the whole spectrum of services, including prevention and early intervention. The funding needs to be consistent and not 'pump priming' as there is little capacity in the system to divert limited resources to maintain services. It should be used to commission a range of services to meet local needs and these may be from mental health trust, but also primary care and the voluntary sector.

Whilst we welcome the Mental Health Investment Standard (MHIS), we also believe that it needs to be reviewed, as it is not ensuring that investment is made appropriately. Ideally each area's[1] mental health funding needs to be amalgamated (CCG, Local Authority, NHS England, Public Health (local and England) plus elements of primary care where Primary Care Mental Health has been implemented) and quoted per an appropriate denominator (e.g. weighted population or some better measure). It also needs to be compared to outcome measures as some areas may spend less but achieve equally good or better outcomes.

Children and young people's services should be transformed to focus on prevention and early intervention Children and young people's (CYP) services need to move away from the old child and adolescent mental health services (CAMHS) model and increase the focus on and investment in prevention and early intervention to improve mental health and reduce need for specialist mental health services. There should be a national push to adapt the i-Thrive model for the needs of each region and ensure timely access to services.

Core community services
Encouraged by the mental health five year forward view, there has been a (not inappropriate) focus on specialist services for some while but this has left major gaps in ensuring community based services are both integrated and sufficient for the needs of communities. This includes all elements of intervention and recovery services but also crisis care.

At a recent international summit on urgent and emergency mental healthcare, ten recommendations were made (due to be published shortly)[2] and these emphasise the need for community-based solutions:

1. Nations should have an integrated, systematic approach to behavioural health crisis care at the national level – this is seen as the only way to end the current fragmentation of care

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[1] What we mean by area will vary across the country, so could refer to CCG or STP level, depending on how services are commissioned.
[2] NHSCC and RI International (In press) Recommendations from the Urgent and Emergency Mental Health Summit – https://www.nhscc.org/networks/mental-health-commissioners/

2. Each nation needs a single national three-digit crisis hub number that drives easy access in which:
   a. all callers are welcome, and the crisis is defined by the caller, whether this is the user, family, friend or professional
   b. promotion and intelligent social media to get the word out to those who need it
3. Crisis service alternatives to the usual emergency measures of formal assessment and psychiatric inpatient care should be actively developed including:
   a. community crisis response (e.g. mobile crisis teams)
   b. shorter stay crisis facility services (e.g. crisis stabilization, temporary observation, living room models and crisis houses)
4. Significant investment should be identified to deliver these recommendations
5. Special consideration should be included to cater for veterans
6. An integrated health information exchange-capable technology solution should be implemented to enable seamless care across organisations – we can track a parcel worldwide but not the care of vulnerable people!
7. Balanced scorecard dashboards should be developed that display real-time, meaningful data and outcome measures that support continuous quality improvement
8. Users, peers and carers should be embedded in the design and leadership of crisis systems – co-production; peer support staff should be trained and integrated in crisis service delivery
9. The zero-suicide aspiration should be owned by governmental agencies, policy makers and those implementing health and social services
10. Family and friends should be fully engaged in crisis care and inappropriate barriers created by confidentiality or privacy need to be sensitively overcome.

Properly joined up community services would enable proper delivery of physical health care needs for those with serious and enduring mental illness (SMI) and to also to meet the needs of an ageing population with physical health care needs that impact on mental health.

If community-based services are to really be improved, much greater national attention to primary care mental health services must occur. London is one example of leading the way on this and their work forms excellent basis for promoting the important contribution primary care can make to mental health.

2. **What gaps in service provision currently exist, and how do you think the NHS should address them (these can overlap with Q1 but may include a longer list)?**

Lack of treatment provision

- Limitations of therapeutic / talking therapy support across all services including medical and acute to reduce the risk of mental ill health – if we cannot do this within early intervention psychosis (EIP) services now, then the potential of doing this in other areas is extremely limited without investment in workforce and skill base across health and social care
- There are gaps in provision for certain conditions. For instance, a lack of services for people with personality disorders, and medically unexplained symptoms.
- Meet the needs of those with ASD with or without a learning disability. For children there needs to be commissioned service post diagnosis to support whole families to stay together. This will prevent some of the high cost placements and families being separated. Only way this will work is by pooled budgets at commissioning service level not personal level – health/education/social care/work

- For people with ADHD, we need to work across agencies including the criminal justice system and addiction services. Need to consider how to identify early and treat effectively. This impacts on a person's ability to operate within a family, raise children and to seek/maintain employment. It is subject to significant stigma

Joint working
- Guidance from NHSE to help clarify responsibilities for shared care and ongoing treatment/prescribing
- As budgets become tighter across health and social care, the potential for joint working increases but so does the reluctance to share risk – we are failing in areas such as personality disorders, tier 2 and 3 psychotherapy and just seem to be firefighting.
- Holistic approach involving MH services, public health services, LA services, voluntary sector services

Community provision
- Little or no funding for community development to support people with MH and LTC's in their own homes and the need to significantly improve crisis care to avoid relapse and admissions for those at risk of, or who have an admission history
- Need to invest in good quality, robust and life sustaining mental health rehabilitation services in the community, so reducing need for bed-based services.

3. **People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?**

Joint Working
- Change contractual boundaries between acute, community and MH trusts - commission them jointly or co-locate services/staff.
- Joint training and skills mix

Primary care and data
- Our members are concerned about the pressure put on primary care by asking for large amounts of data reporting and the constant admin and bureaucracy. This is leading to many commissioners and managers now spending most of their time writing about the job, chasing reports, searching for data and not actually doing the job itself. Placing unrealistic expectations on different aspects of health and social care, each requiring different reports
  to different departments with much duplication all takes up resources. Trusts are responding with more and more reluctance to provide 'non-contractual' reporting due to lack of capacity meaning for example, A&E won't provide reports on MH unless they are mandated to.

4. **What do you think are the specific challenges that will prevent the NHS from being able to deliver good mental health care, and what should we do to overcome them?**

- Growing demand with less social care and changes as education moves towards academy status which is excluding those who are vulnerable.
- A workforce that is not sufficiently resourced or skilled to deliver the interventions needed in the required amounts and is not able to access easily multiagency packages of support. This also affects retention.
- Lack of funding for mental health generally in the NHS and local authorities.

- Too many initiatives without getting the ones already started completed and delivering. Even worse, drip feeding of resources to 'pump prime' with services closing after the 1 or 2 years due to lack of sustainability.
- Inappropriate lead in times for funding bids resulting in CCG's and Trusts just not bothering as the amount of work involved ins disproportionate to the value and outcomes expected.
- Administrative burden now being placed on CCGs is choking productivity. Some concern about a lack of support from NHSE and that whilst CCGs are undertaking vast amounts of work and feeding in large amount of information and data, there is little or no outcomes to show for it.
- Lack of development for mental health commissioners (like the programme run for children's commissioners).
- Lack of parity of esteem.