NHS Clinical Commissioners

The independent collective voice of clinical commissioners

May 2019

The changing face of clinical commissioning

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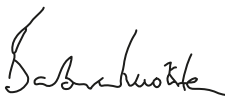
Foreword

The NHS Long Term Plan set out the next steps in changing the way the NHS will work. The aim of triple integration – between health and care, primary and secondary care, and mental and physical health – and new clinical priorities will affect the whole country, but the move to more "streamlined commissioning arrangements to enable a single set of commissioning decisions at system level" will particularly affect clinical commissioners, as neighbouring clinical commissioning groups (CCGs) work more closely or formally merge. Work is well underway to implement the Long Term Plan, and as we look to the future it is also important to reflect on the strengths clinical commissioners have brought to the NHS and to the health of the population over the past six years. These strengths must be retained.

The unique perspective and role of clinical commissioners, as well as their dedication to do what is best for the populations they serve, has seen new ways of working and innovative solutions to the complex challenges within healthcare. As CCGs merge and take a more strategic perspective, it is imperative to retain that strong clinical voice. Clinical input should be felt at neighbourhood, place and system level, as must the collaborative approach CCGs use when working with other organisations in their local area. The examples in this report explore in more depth just some of the ways clinical commissioning is evolving to meet the population's changing health and care needs.

There is still some uncertainty for CCGs as many move to 'typically' one CCG per integrated care system (ICS), not least how many ICSs there will be, and what 'atypicality' might involve. But what we are certain of – and what this report sets out – is the need to retain some commissioning functions separate from the delivery of care, and to allow clinical commissioners to continue to drive real improvements for their populations. In parallel we shall see increased joint decision making between commissioners and providers, at all levels. This collaborative approach will lead to improved outcomes within systems.

This report highlights the strengths and successes of nine clinical commissioning groups in different parts of the country, illustrating the good work happening in health systems across England. It uses these examples to argue that, whatever the changes in the detail, there is a clear need to retain the core commissioning function as well as the expertise brought by the clinical leaders who play a crucial role in getting the best value from the precious NHS pound.



Dr Graham Jackson and Dr Barbara Rushton, Co-Chairs, NHS Clinical Commissioners

Introduction

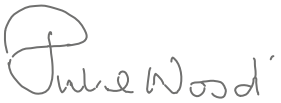
CCGs and NHS Clinical Commissioners, the independent membership organisation representing them on the national stage, have existed since the Health and Social Care Act in 2012. The health landscape has changed a lot since then, but CCGs are still playing a crucial role.

Despite suggestions from some that the development of ICSs signalled the end of the purchaser/provider split, the commissioning role – assessing needs, planning and prioritising, and purchasing and monitoring services – is still seen as important by decision makers. Simon Stevens, chief executive of NHS England, has said that "there is clear benefit from having distinction between the planning and funding functions and the day-to-day delivery of clinical care", and that there still need to be commissioning decisions made in the interests of people living in a specific area. Clinical commissioning fulfils this role, with clinical leadership and expertise – and an insider's knowledge of the local context – feeding into decisions about which services are needed to meet their population's needs.

CCGs will increasingly work across larger populations and more closely with provider and local authority colleagues but the decisions they make should be at the level that is most appropriate, at neighbourhood, place or system level. This principle of subsidiarity means that even as the new NHS landscape emerges, there will be a role for clinical commissioners.

We know that our members are doing things in new ways and will continue to innovate and respond to the changing context. Here we set out what we believe needs to be celebrated and retained as the NHS in England evolves.

We are very grateful to the CCG colleagues who participated in interviews for this piece of work, as well as Brighter Together who authored the report.



Julie Wood, Chief Executive, NHS Clinical Commissioners

Executive summary

CCGs are responsible for improving the health of their populations. They do this by determining the health needs of the people they serve and ensuring there are high-quality services to meet these needs. CCGs are led by accountable officers – with the input of clinical colleagues on their governing body, CCGs have a high level of clinical leadership. These organisations possess many strengths that have led to innovations and improvements across health and social care. They bring together and work collaboratively with other organisations; this role will be even more important as ICSs develop. This report sets out to showcase the strengths that must be retained as NHS and social care systems continue to evolve. To inform it, we spoke to nine different CCGs, exploring their work – these examples provide a snapshot to illustrate the range of great practice taking place across the country.

Clinical commissioners act as respected **clinical leaders** within their communities to promote the best interests of patients while balancing need and resources and driving through change. In Devon the actions of clinical leaders and managers working together saw quality improvements in the CCG's Continuing Healthcare process with a resulting cost reduction of circa £50 million.

Clinical commissioners have no vested interest as a providing organisation – without these constraints, they can take a **system-wide perspective** considering what is best for their whole population and how best to deliver safe and effective care. South Tyneside CCG has worked with partners to align priorities and values and as a result has seen key system-wide outcomes improve.

As well as taking a system perspective, clinical commissioners have **strong links to place** (or local populations) to ensure specific needs and challenges are not forgotten. Leeds CCG has been formed by the merger of three CCGs but recognises the value of working to drive initiatives at a place level – retaining their local relevance.

Clinical commissioners have experience of working with and for their communities and patients over long time periods, providing a **unique perspective**. Wanting to provide a more coordinated service for those with multiple long-term conditions has led Dudley CCG to move towards commissioning an integrated care provider.

Clinical commissioners have a responsibility to **spend their money wisely**, considering the needs of their populations and determining the most effective way of delivering this, both financially and clinically. Blackpool CCG has looked closely at how it spends its resources, choosing to redesign some services such as the musculoskeletal pathway.

Clinical commissioners are motivated by their desire to do best for their patients and are effective at **driving through changes**. Sunderland CCG has facilitated better joint working between providers to transform out of hospital services.

Clinical commissioners recognise the value of **working in partnership** with others for the benefit of patients and have focussed on building relationships. Luton CCG has worked concertedly to partner more closely with their local authority to an extent that budgets and offices are now shared.

Involving patients and the public in their decision-making processes allows clinical commissioners to understand needs and design solutions that are fit for purpose. In Southwark, clinical commissioners have undertaken an extensive patient and public engagement initiative to improve child and adolescent mental health services (CAMHS).

Feedback from their peers allows clinical commissioners to appreciate the issues they are facing and determine if new solutions are working on the ground. For PartnersHealth, a partnership of GP practices providing primary care in Rushcliffe CCG, peer feedback has been an important aspect of their success.

We recommend

As the NHS changes, we need to make sure the following are retained within ICSs and by decision makers:

- tangible 'place' level links and responsibilities – CCGs have formed working relationships with others in their place, especially local government. As they potentially merge to cover larger footprints (to meet the recommendation in the NHS Long Term Plan that there should be 'typically one CCG per ICS'), the important work at place level should not be lost
- 'stewards' and the system perspective – working more collaboratively is important, but having an unbiased view is crucial. CCGs can make sure providers are doing the right thing for their population as they're the only ones without vested interest. Their voices within systems must be heard
- keeping clinical engagement at the core – CCGs have been successful in embedding clinical leaders and the expertise, credibility, and better health outcomes this brings. This must be maintained as we move to more system working.

In 2019/20, NHS Clinical Commissioners (NHSCC) will be working with our members to ensure their role and successes are shared and celebrated. We will be:

- doing more work on 'place' – what this means in practice and how CCGs are ensuring it's retained as they get bigger and work at scale
- helping CCGs understand what the 'typically' one CCG per ICS means in practice, and providing support for those considering merging
- influencing how the NHS England legislative proposals will impact on CCGs – so there is no dilution of their unique perspective even with more collaborative working
- supporting clinical leaders – and their manager colleagues – with delivering the Long Term Plan.

About this report

NHSCC is the independent membership organisation of clinical commissioning groups. We provide CCGs with a strong collective voice and represent them in the national debate on the future of healthcare in England; as well as sharing best practice and learning among our members.

Despite the relatively short lifetime of CCGs and against a backdrop of financial and workforce pressures within the NHS and social care system, clinical commissioning has driven improvements in services and outcomes for patients and delivered value for money for the NHS. The unique perspective and role of clinical commissioners, as well as their dedication to do what's best for their patients, has seen new ways of working and innovative solutions to the complex challenges within healthcare. Within this report we highlight the strengths of clinical commissioning and showcase real case studies of the positive work CCGs are undertaking across the country.

In order to inform this report, we have undertaken a literature review and interviews with nine different CCGs, exploring their work and views on the strengths of clinical commissioning. We thank all those that gave their time and shared their insights and experience.

What is clinical commissioning?

Commissioning is:

- the process of assessing needs
- planning and prioritising
- purchasing and monitoring health services

to get the best health outcomes.

In the NHS in England, commissioning involves a significant level of clinical engagement – and locally is the responsibility of CCGs, which were established in 2012.

CCGs are member organisations made up of GP practices with an elected governing body that includes other health professionals, such as nurses and lay members. There are currently 191 CCGs across England (although this number is likely to change in the future), responsible for approximately two thirds of the NHS England budget.

CCGs contract providers to deliver services for their local populations that include mental health services, urgent and emergency care, many hospital services and community care. The vast majority have also taken on responsibility for commissioning primary medical care from GP practices. Most services they 'buy' are contracted from NHS bodies – like NHS trusts.

Clinical commissioning is a continual process, as commissioners monitor how services are performing and how the needs of their population are changing – as well as what innovation might be needed to improve health. The role of clinical commissioners within the NHS is also evolving, moving towards greater integration and partnership working between all organisations within the health and social care system. This may mean clinical commissioners' roles change as they operate more collaboratively and often at a bigger scale. But their key functions remain, as there will always be a need to assess need, plan and prioritise services, and decide who is best placed to provide a service by contracting them to do so. With this in mind, we wanted to consider the roles that clinical commissioners have played and their key strengths that must be maintained in the changing NHS context.

The strengths of clinical commissioning

Clinical commissioners drive change and improvements across the health and social care system. The role clinical commissioners play, as well as their unique perspective and skills, makes them effective and well placed to deliver these positive impacts for their patients. Alongside this, they work in partnership with other organisations to improve health outcomes across their local area. We explore several of the strengths of clinical commissioning in the case studies that follow.

Clinical leadership

Clinical leaders have the expertise and knowledge to identify and implement the changes that are required across the NHS. They have the credibility and experience that help to bring others with them with the confidence they are trusted by both the public and their clinical colleagues. Evidence shows that engaging doctors, and other health professionals, in leadership drives quality improvement in health services.[1]

Devon

Five years ago, Lorna Collingwood-Burke, chief nursing officer at NHS Northern, Eastern and Western (NEW) Devon CCG, was asked to review the Continuing Healthcare (CHC) process for the NEW Devon CCG because of her background in nursing. Continuing Healthcare allows the NHS to fund social care for some people with long-term or complex healthcare needs. Back in 2014, the NEW Devon CCG CHC budget was financially challenged, and the service needed to be reviewed from a quality and equity perspective.

After undertaking a mini-audit, it became clear that there was variation in the quality of assessments that determined whether a person was eligible for this funding. This was potentially affecting the ability for people to access Continuing Healthcare and raised concerns that it was not an equitable service. Lorna gained agreement that the review of the process needed to be driven by improving quality and not by focusing on finances. The priority was to deliver an equitable and safe service for all people.

"Everyone in the CCG has a focus on quality – led by the executive team and clinical leads. Finance is important but not to the detriment of patient safety and effective care. It is important not to make quick or short-term decisions without truly understanding the quality impact as it may end up costing more in the longer term," Lorna explains. This is why the clinical commissioners in Devon have worked with their quality and finance teams to better understand the impact of high-quality care on finances and vice versa.

Lorna continues: "Quality is about determining the longer-term impacts. These are not always obvious, but you need to consider the longer-term aspects of spending or not spending money. If care is safe and effective, then the patient is more likely to have had a more positive experience of their care and you are more likely to have got that care right first time which reduces the burden on finances."

Lorna believes clinical leadership at the CCG has ensured this focus on quality. When leaders set the values and principles, others will follow.

"The clinical leadership has been absolutely fundamental. They will stand up and talk publicly when changes need to be made and because they are trusted members

1 Policy Research Unit in Commissioning and the Healthcare System (2015), *Exploring the GP 'added value' in commissioning: What works, in what circumstances, and how?*

of their communities they are listened to."

To bring about change to Continuing Healthcare in Devon, Lorna created a 'matrix' team. There is representation from a number of directorates, for example GP clinical leads, nursing, finance, business intelligence and marketing. They meet together once a week and have developed a close working arrangement. A dashboard has been developed and controls are in place around validation of decisions and those assessments that are complex and likely to be of a high cost. As a result of these changes, the Continuing Healthcare expenditure has been reduced by circa £50 million. As far as data suggests, no-one who is eligible for Continuing Healthcare has had their funding request refused.

Leeds

Philomena Corrigan, chief executive of Leeds CCG, attributes their ability to spread change to the involvement of clinical leaders – as they are credible advocates for improvements. In one particularly deprived area of Leeds she has seen GPs working with the voluntary sector introduce initiatives improving the wellbeing of older people with depression who feel socially isolated. She comments:

"Sometimes it takes somebody who is in the same environment with the same background, the same pressures, to be able to stand up and be able to show that kind of real change and demonstrate that it can work."

Her colleague Dr Simon Stockill, Medical Director adds:

"It doesn't happen by accident. We've had a really firm commitment to recognise the value of clinical leadership at practice level, locality level and citywide level. But it's something that's taken a conscious effort, conscious plans, repeated refreshing of our strategy towards identifying clinical leaders, training and supporting them. And that also involves investing in them as well, both in terms of the time available for them to take time out of clinical practice but also to provide them with the skills and support and expertise to continue to do it."

Taking a system-wide perspective

Clinical commissioners take a system-wide view when determining the needs of the people they serve and the best services and solutions to deliver high-quality outcomes. They lead transformative work to identify services or parts of the system which aren't working effectively for patients and, unlike providers, are not constrained by organisational demands to increase income by increasing activity – as some providers may feel pressure to do. Clinical commissioners are motivated to achieve a system where all parties are working together to ensure a healthy population where patients receive the best care and treatment when needed.

South Tyneside

Two years ago, some of South Tyneside's key outcome indicators lay in the bottom 10 per cent in England. Delayed transfers of care (DTOCs) were among the highest in the country and smoking in pregnancy rates were 25 per cent. Today these indicators are in the top 10 per cent, DTOCs have reduced dramatically and smoking in pregnancy rates have dropped to 13 per cent. This impressive turnaround has come about through the CCG working with partners to take a system-wide approach and working together towards shared aims.

Working in this manner began in 2016 when South Tyneside was granted health and social care integration pioneer status and partnered with Canterbury in New Zealand.

"When the CCG was first created, organisations were focused on their own priorities. We were very clear about what we were trying to do, it was to focus on the collective good for our locality and on shifting that behaviour. We could see the inter-connectivity between the work different parts of the system were doing and could see we weren't necessarily spending our money in the most effective way," explains Dr David Hambleton, chief executive officer at South Tyneside CCG.

The CCG followed the lead of Canterbury by adopting the philosophy that all parts of the system needed to succeed together – it would not be possible for one part of the system to work effectively without the other parts also working well – and that decisions should be based on what is best for patients and populations, with the money following afterwards. Rather than focussing on structure and governance, the CCG and partners have worked on developing shared values and behaviours.

The CCG, council, acute trusts and mental health trust chief executives already met regularly. Building on this, key opinion leaders from each of the organisations, the leaders that people would look to, were brought together to create the Alliance Leadership Team. This team has focused on the types of behaviours that they would like to see in the system.

> **"We were very clear about what we were trying to do, it was to focus on the collective good for our locality and on shifting that behaviour."**

David explains:

"Now we talk about doing what's best for patients and for the system. That's in contrast to doing what's best for your organisation. We are essentially asking people to unlearn the behavior they have been taught over the last decade, for example that foundation trusts are businesses that make a profit and generate income. We're asking people to completely change that."

South Tyneside has three system goals. Firstly, to prevent people becoming ill and to ensure they live healthy lives. Secondly, to create good community care as close as possible to people. And thirdly, to provide expert specialist care only when it's needed. Improving delivery of the third goal involved improving the management of finances. The CCG had observed that the system status quo, with payment by results contracts, was not incentivising the right behaviours across the patch, not contributing to keeping people well or delivering care in the community. Changing to a flat block contract arrangement would help to move away from counting activity and shift towards a system that was focussed on the right thing for patients.

"It isn't the block contract itself which is the big achievement, the achievement is changing behaviour of people in the system to focus on doing what is the right thing for patients and for people, and sorting the money out separately. So we've got our hospital chief executive now talking very openly about downsizing the organisation in terms of beds, how we can manage to support people being cared for in the community and how we need to shift the focus to prevention rather than treatment," David adds.

Sunderland

Sunderland CCG has led a move away from transactional principles of providers trying to generate income and commissioners trying to reduce expenditure, to an approach where everyone now works on cost only. The CCG's proactive approach to managing financial and system risk has involved breaking down barriers and making sure everyone is in partnership and not in competition with each other.

Penny Davison, senior commissioning manager at the CCG explains:

"We are talking much more about the system, so providers are no longer worrying about their element of the market and are thinking much more about what is the right thing to do for the system. We have providers saying, 'I may need to make a decision which is not good for my organisation but it is good for the health economy', which is a seismic shift to where they were 12–18 months ago."

From the local to the regional: 'Places' within systems

While clinical commissioners see across healthcare systems and drive organisations to work towards shared outcomes, they also understand the needs and particular circumstances of much smaller, more tangible and local populations within their system's geographical area (sometimes referred to as 'place' but could also be known as a locality). Clinical commissioners work hard to retain their links to these smaller populations or places and ensure this vital insight is not lost. This is especially important as CCGs get bigger and cover larger areas. Often clinical commissioners drive improvements that will benefit populations at a place level, and do this by having working relationships with the right stakeholders in that area – such as local government.

Leeds

In April 2018, the three CCGs within Leeds merged to become one CCG, although the process of amalgamating the three organisations had begun much earlier on.

Philomena Corrigan, chief executive of Leeds CCG, explains the reasons behind the decision to merge:

"There were three CCGs chairs, three CCG governing bodies and three accountable officers and we discussed the benefits of being one organisation for Leeds, partially to do with these decision-making structures, but also for the benefit of our stakeholders, both the council and the providers. We were mindful that actually trying to relate to three separate organisations was difficult. It wasn't the best use of people's time and we thought we could get better benefits and better clinical outcomes by being one organisation."

However, the new CCG wanted to ensure that the links to local populations weren't lost. This was of particular importance to their GP members.

"We've been nudging practices gently over the last few years towards thinking in terms of their obligations to a register, to a collection of registered lists in a locality, to start to bring in that concept of population health management at a local level. And we've been doing that gently by mixing the quality improvement outcomes at both practice and locality level." says Dr Simon Stockill, medical director. "Practices now really value the relationships they are developing with neighbouring practices in their localities and with other providers such as district nurses, matrons, physiotherapists and social workers. As long as that isn't lost in the reorganisation, our stakeholders could see the advantage of a bigger scale citywide organisation."

The CCG is putting in place a partnership executive group across the city with representatives from each locality sitting in the group. This will allow the locality representatives to understand what the system is trying to do and relate that back to practices in their locality, as well as take part in strategic conversations and recognise what needs to done at locality level to implement those strategies. In addition to funding localities for clinical leadership, the CCG also supports the lead GP confederation which has brought together the three federations into one citywide function. Part of the funding agreement for the confederation is to support the delivery of a number of different objectives within the city, one of which is to support practices in the delivery of quality improvement schemes. The

practices receive a payment for this but the network also receives payment for supporting them to do it at scale.

Simon highlights how this is working:

"What we know is that some parts of the city are better at identifying people with major conditions. We're working to close the gap for three major conditions – atrial fibrillation, COPD and hypertension – in areas where we see there is a significant prevalence gap across the city in the identification of these diseases. We've actually identified a series of locality by locality targets and are producing data at a practice, locality and citywide level. Practices in their localities, supported by their citywide confederation, are working to achieve a reduction in unwarranted variation over the course of the next year. This will cut the number of premature deaths and allow people to lead healthier lives."

Luton

Luton is part of the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) which is one of 14 in England. BLMK ICS was one of the pioneers of the Triple Tier Model, the suggestion that the key levels of health and care are locality or neighbourhood (primary care networks), place (local authority) and system or scale (ICS). This has been adopted by the NHS Long Term Plan.

Nicky Poulain, chief operating officer at Luton CCG explains how this works:

"It is our belief that services should be organised as locally as possible, where safety and efficiency allows. As Bedfordshire-Luton-Milton Keynes, we will have some economies of scale (we've got one joint CCG executive team with a joint accountable officer for all three CCGs), and we've got operating officers in each of the three areas, so that the places are sovereign. The role of the Luton chief operating officer with the CCG chair will retain that place focus. The work we are doing to improve services for those with frailty, learning disabilities or mental health conditions is happening at a place level."

Unique perspective

Clinical commissioners have first-hand experience of what is going right and wrong in their community and the challenges both they and their patients face with the health and social care system. They have a local understanding of the population, needs and context and this can aid their decision making to ensure services meet the needs of local people. They also see their population and patients in the round, and not as one condition or set of symptoms, and have an ongoing responsibility for their health. This gives them the ability to take a more holistic and long-term approach to commissioning with an understanding of what is important for patients.

Dudley

Dudley CCG is one of the first to move towards contracting an integrated care provider (ICP). This will see providers collaborating to provide care.

The work began when the CCG considered the needs of their population, whether the way they were organising care met those needs and therefore what their priorities should be. One of these priorities was care for the increasing number of people with multiple conditions. Dudley CCG wanted to create a multidisciplinary primary care and community service to provide better continuity and coordination of care and so resolve the disjointed service which existed for these people. The CCG and providers worked together to develop and implement the integrated care model under the direction of a system-wide partnership board involving the CCG, all providers, the council and voluntary sector. A few years further on, creation of the ICP is the next logical step forward to deepen the extent of integration across the system of care.

Paul Maubach, accountable officer at Dudley CCG, explains:

"That came from our staff and our patients because what our staff are saying is 'we collaborate together, but it would be so much easier if we were one team working for one organisation to one set of shared objectives'. The big emphasis that we've had on developing the ICP is about establishing shared responsibility (between different staff and with the public) for achieving the same shared objectives for the same shared population. It's really all about alignment."

Paul believes that moving towards an ICP will help to shift the thinking of all those working in the system to focus on the outcomes of the whole population, with prevention becoming a much greater priority. One set of patients who will benefit from this shift is the 20,000 people living with diabetes in Dudley. At present, all of those people are managed by their GP with only a small proportion also being seen by a diabetologist. And while the GP practice is contracted to a set of outcomes, the hospital, for which the diabetologist works, is contracted for how many times the patient is seen, regardless of the outcome. At present the clinicians and organisations across the system don't share a responsibility for the wider population of people with diabetes or those people who may be at risk of developing diabetes. In the new system, the diabetologist and GP will work together to manage all patients, supported by shared organisational and contractual objectives to deliver improved outcomes.

Clinical commissioners will still play an important role within this new system: holding the provider to account through the ICP contract

and taking responsibility for the public engagement on what outcomes need to be achieved. Paul explains:

"There needs to be a mechanism whereby someone is engaging with the public about how their needs are changing and therefore what the expectation requirements are on the NHS to deliver those for the local population. And I think there needs to be some separation between whoever does that activity and whoever is providing the services."

Paul highlights that the strengths of clinical commissioners have helped to push these radical changes along:

"The clinical leadership in this CCG has helped us to understand the needs of the population and how that is presenting on a day-to-day basis. GPs bring home the experiences of patients on their life journey and the effectiveness (or otherwise) of healthcare delivery and how it's experienced by patients."

The continual feedback loop from healthcare professionals on the ground about what is and isn't working is also hugely beneficial.

"It enables you to be much more responsive to whether or not what you're doing is working but also what you need to change in order to improve the system of care. It's almost like, it's helping to create a self-improving system and a learning environment because we're getting that feedback all the time. I think that's pretty powerful."

South Tyneside

Dr David Hambleton, chief executive officer at South Tyneside CCG, explains their unique perspective to improving outcomes across their system:

"We do not try and draw a cause to effect line between any of our individual initiatives. The system is far too complex. The output that we see, we never attribute that to one thing, it is more the collective impact of everything that we are doing."

Spending money wisely

CCGs ensure that public money is spent wisely. They have an understanding of what makes a positive impact for their patients and what doesn't and therefore where best to invest. Having close understanding of their local communities is crucial when it comes to making tough and sometimes unpopular choices, which are needed for the benefit of their populations.

Blackpool

Blackpool is an area of high deprivation. Faced with financial pressures, Blackpool CCG has taken difficult decisions to ensure that resources are being used effectively and money spent wisely. The CCG has led a drive to stop procedures of low clinical value, such as the removal of varicose veins and tonsillectomies for some patients who would not derive clinical benefit, as well as restricting the prescribing of medicines that are readily available over the counter, such as paracetamol, or gluten-free food, now commonly found in supermarkets.

David Bonson, chief operating officer, says:

"It's clinicians who are making these decisions and that makes it easier for other clinicians to come on board. It is not always popular with patients but by engaging we've been able to explain to patients and the public the reasoning behind the decision. People do understand that by spending money on some things, we have less to spend elsewhere. If you have an informed conversation, they understand."

In addition, the CCG has undertaken a drive to review and standardise referrals to secondary and specialist services. The CCG has asked GP practices to look at all of their referral processes and review them, and they have built this into the GP contract. The CCG has a process to check providers do not deliver unnecessary procedures and GP practices do not refer in the first place. There is a further check and balance step in the middle, where the CCG eReferrals team confirm that referrals comply with the CCG's referral policies. All practices check each other's data on referrals and there are regular discussions with practices about how they manage referrals and to identify any outliers.

"This has led to a general reduction in referrals and a reduction in variation between practices, so there is a move towards greater standardisation. We are not restricting referrals, we are checking the appropriateness of them by putting processes in and making it more visible for practices and having conversations with them about referrals. Nobody wants to be an outlier, so we are seeing year-on-year improvements in volume of referrals and appropriateness of them."

Another part of the CCG's work has been to redesign musculoskeletal services (MSK). NHS Right Care identified that the CCG was spending a lot on these services and so by looking at patient journeys and engaging clinicians, MSK services have been redesigned as community services, rather than being delivered by the acute trust. The new service is integrated with community and primary care services. The CCG worked with

GPs to understand pathways and developed more flexible contracting and payment approaches.

The new service triages people within the community and then a clinical review identifies those patients who would benefit from an MSK referral in the community or those who need a referral to orthopedics. It has saved significant activity that was flowing into the acute and independent sector. It has also meant that waiting times have improved and patients have been seen in the right setting, in a timely manner. David Bonson explains that partnership has been key to the success of the MSK redesign. At the heart of the scheme's success is:

"The willingness to do it and the trust and partnership built across multiple organisations."

> "People do understand that by spending money on some things, we have less to spend elsewhere."

> "Nobody wants to be an outlier, so we are seeing year-on-year improvements in volume of referrals and appropriateness of them."

Devon

In Devon, the transforming care partnership identified that one solution to meet the needs of one person with a complex learning disability was to buy a property and make specific adaptations – this needed input from finance, commissioning and nursing colleagues. Lorna Collintgwood-Burke said: **"Using money differently is important and can require strong partnership working, communication, flexibility and determination."**

Driving improvements

Clinical commissioners are well placed to see the problems that exist within a health and social care system and the long-term impacts that decisions can have on the health and wellbeing of their patients. This allows them, working with partners, peers, patients and the public, to identify solutions that work for the whole system and that deliver long-term positive outcomes for patients and their families.

Sunderland

"There's been a drive and a commitment to change and take action forward rather than just write a plan and leave it on the shelf." says Penny Davison, senior commissioning manager at Sunderland CCG.

The CCG has led the development of the All Together Better Alliance, which includes the CCG, local authority and providers, all working to transform out of hospital services. The CCG brought together groups of GPs, practice nurses, practice managers, social workers, local authority colleagues and others to develop how they would envisage their locality working and how they want things to change. The CCG has led changes in behaviours by encouraging open and honest dialogue and by the governing body setting clear outcomes to be delivered.

This approach has led to changes in intermediate care (now called 'recovery at home' following patient and public engagement), integrating community care and care homes and setting up a federation of GP practices to enable extended access. Clinical input and clinical perspective have been intrinsic to delivering these improvements, as the clinical leaders have been clear about the changes they wanted to see. Feedback from patients and staff is positive, particularly around creating community integrated teams.

"That deliberate decision to include clinicians in the widest sense from day one has really been the foundation of our work going forward. Taking on that design means the delivery has been more successful."

One improvement has been providers working together to propose a new model of co-locating community-based services with general practices, reducing costs for the CCG, which facilitated these discussions via the alliance and encouraging discussion and shared ways of working.

"Our leadership team really took clinical commissioning to heart and had that drive to change things together. GPs were now executives with the opportunity to do things differently than before."

> “There’s been a drive and a commitment to change and take action forward rather than just write a plan and leave it on the shelf.”

> “That deliberate decision to include clinicians in the widest sense from day one has really been the foundation of our work going forward.”

Rushcliffe

Rushcliffe CCG invested in the development of PartnersHealth, a partnership of all GP practices in Rushcliffe, encouraging the partners to use that investment to build scale, resilience and infrastructure to enable them to operate as a single entity when it is appropriate to do so. They have adopted and adapted a GP specification first used by Liverpool CCG. The GP specification requires a collective effort, with rewards set at the level of the network, not at the practice level.

“The CCG has been a facilitator and understood that actually to deliver its objectives we need a robust, resilient, ambitious and capable primary care sector and we need to create conditions in which primary care can organise itself instead of prescribing how it’s done,” explains Dr Stephen Shortt, chair of Rushcliffe CCG and co-founder PartnersHealth LLP.

Partnership building

Clinical commissioners have the ability to build relationships and partnerships with other key health and social care organisations across the system such as other CCGs, trusts, local authorities and the voluntary sector. They can bring these partners together to enable change or to join up services, promoting a collective view of the system and putting patients at the heart of decisions. This is only possible by developing relationships and working towards common goals.

Luton

"There's always been a common goal to do good for the people of Luton, many of whom face real difficulties and inequalities. But finding the right way to achieve this, when our priorities and finances can be pulling us in different ways, can be tricky," explains Nicky Poulain, chief operating officer at Luton CCG.

For some years Luton CCG and the local authority had been trying to work in a more integrated way. They had faced challenges in ensuring their population received a consistent approach and often found they were potentially duplicating the work they were doing to serve the same cohort of patients. In 2015 the CCG and local authority signed up to become one of NHS England's 'national demonstrator sites for personalisation'.

They began by considering their care of people with dementia, discovering that both the CCG and the local authority had separate dementia strategies. They established joint meetings between the CCG and local authority leadership team to co-create one vision for the people and families with dementia. This triggered a change in culture and way of working, with a shift to both organisations jointly focusing on the population and outcomes.

In 2018, the chair of Luton CCG and the leader of the council jointly wrote and signed a concordat between the organisations. This was followed with a commitment to have one aligned budget to ensure the Luton pound was effectively used. They have now co-located into the same building and have continued to focus on organisational development.

Nicky explains that this has involved building relationships, understanding the other person's point of view and having a shared outcome:

"You've got to build your relationships, you've got to actually find a common goal and you've got to be very kind to each other because you'll make mistakes along the way. But it's actually building that relationship of trust and respect and, in my view, that continual drive to learn and the continual drive to think about the people that you're serving. Whenever we end up having a cross word we say, 'Hold on a second, there's a very vulnerable person we're talking about here, let's not lose the point.'"

The co-location of teams in the same building is a catalyst to joint working. Nicky highlights some of the advantages of working in the same building:

"People can go to the kitchen and talk to the brokerage team, for example, and you find things out that you didn't know. And I've learned, being in this building only a month,

things that I didn't even know about because I wouldn't have been exposed to them."

This joint approach to working has led to new initiatives across the health and care system. For example, the local authority and CCG have joined up their public engagement processes to clarify the offer to a defined cohort of about 800 people who were identified from the frailty register and had had two or more inpatient admissions in the last 12 months. They've seen improvements across the system such as a reduction in the pressure felt in primary care, reduction in hospital admissions, and people and their families feeling better supported.

> **"There's always been a common goal to do good for the people of Luton, many of whom face real difficulties and inequalities."**

Southwark

Throughout the process to review and improve CAMHS, Southwark CCG worked very closely with their colleagues in the council and in South London and Maudsley Trust as part of a whole system approach. The CCG's ability to convene a broad range of partners to consider the issue of children's and adolescents' mental health was a real benefit. The breadth and depth of experiences within the CCG's governing body and broader clinical membership brought a combination of understanding of primary care and insight from working on the ground.

Patient and public involvement

Clinical commissioners understand the value of including patients and carers in commissioning decisions so that services meet the needs of those they serve. This involvement can include identifying the priorities for certain patients and helping to design pathways and services. They also recognise the importance of ensuring their populations understand the decisions they are taking.

Southwark

"It's about how we bring people with lived experience into the actual shaping of the strategic agenda," says Ross Graves, managing director of Southwark CCG, explaining how they worked closely with key partners to run a wide-ranging strategic review into how to improve CAMHS. Involving patients and the public helped Southwark CCG, working in a borough in south London, identify that their current service provision was fragmented and confusing. The review team worked hard to hear from young people who, for example, told them about the challenges of stigma and the importance of where services were located.

Southwark CCG, with their partner Southwark Borough Council, agreed to conduct the review to make sure they were delivering the best outcomes and getting value for money. As well as involving service users, families and carers, it also included the South London and Maudsley Mental Health Trust, local schools, public health, nursing, health visiting, school nursing, acute hospitals and also services provided in a general practice or primary care setting. Patients and the public were involved from the very start.

A range of channels were used to gain people's views. These included a survey, a focus group of head teachers and safeguarding leads, a focus group of young women, a carers' focus group and a parents' focus group. It all culminated in a large stakeholder engagement event, with about 75 attendees, including parents and carers, young people and professionals. This event included presentations, group discussions and prioritisation exercises.

Ross explains:

"What we were seeking to do was to have a range of different channels that we were exploring as part of the engagement. And also to try and get away from a purely health-focused approach. There is always a risk that these reviews become focused on the more specialised, but actually we recognised the importance of young people, communities and schools and social workers, teachers and so on, and actually trying to get that much bigger broader picture."

The CCG's links with the local health communities, and the local authority's links with the local education network meant the strategic review was able to seek the views of users in all parts of the system.

The process of involvement of patients, carers, teachers and the public identified that service users were finding it really difficult to understand different services and pathways and what was available and how to navigate them; the system was fragmented. The patient and public engagement will

continue while Southwark rolls out recommendations from the review, including service improvements and simplifying the pathway.

> **There is always a risk that these reviews become focused on the more specialised, but actually we recognised the importance of young people, communities and schools and social workers, teachers and so on, and actually trying to get that much bigger broader picture.**

Dudley

Paul Maubach from Dudley CCG explains their approach to involving patients in decision making:

"We do a lot of public engagement and our public engagement always includes clinicians as part of that process, because actually patients want to hear from clinicians. They don't really want to hear from managers. When it comes to public engagement, it makes sense to have patients interacting with clinicians because that's the trusted interface. I think we work effectively when we're listening to both patients and clinicians and encouraging them to talk to each other. And for us to listen to the outcome of that conversation."

Peer feedback

Clinical commissioners seek direct feedback from their GP peers within their CCG, both allowing them to hear first hand about the issues that exist at a community level and share learning between GPs. This provides a feedback loop providing an understanding of whether changes are bringing about desired improvements. The King's Fund and Nuffield Trust have found that CCGs have secured better clinical engagement than previous forms of commissioning[2] and are now seen by the majority of their GP members as an influential part of their local health economy.

Rushcliffe

Peer support and feedback from fellow GPs and other clinicians is a key part of the success of PartnersHealth, a network of GP practices providing primary care in Rushcliffe CCG. Good working relationships that have been established and developed over very many years enable the partnership working that continues today.

Incentivised and supported by the CCG, PartnersHealth has taken a life stage approach, identifying clinical leads from wellness to disease prevention and long-term conditions management, mental health and end of life care. There are dozens of GPs involved in leadership positions in a distributed leadership model across the CCG who are supported by CCG managers to help to deliver better care.

Peer feedback is a key part of success. Every month GPs and staff from all practices meet together, to share progress against their clinical strategy and focus on business objectives, discussing what drives their experiences and where there might be opportunities for improvement. They use data to help them, taking into account utilisation metrics, trend information on user resource and audit activity to see what is positive and what is not so positive.

"It's an absolutely critical meeting. The room is crowded, it's buzzy, it's vibrant, it's energetic, and there's good participation. We come together and enthusiastically look at how to solve the problems of delivery, some which are about care pathways and interfaces with the secondary care sector," says Stephen Shortt, chair of Rushcliffe CCG.

Even though Rushcliffe has had significant investment in its primary care funding via the new models of care programme, it is professionalism that has driven change in Rushcliffe. By bringing together colleagues and supporting them to think constructively about being the best clinical professionals they can be, the CCG and PartnersHealth have driven improvements. Other motivations driving the clinicians include overcoming day to day frustrations and enhancing self and peer respect, as Stephen explains:

"One of the positive things around getting together on these monthly occasions is actually to celebrate

2 Robertson R, Holder H, Ross S, Naylor C, Machaqueiro S (2016), *Clinical Commissioning: GPs in charge?* The King's Fund and Nuffield Trust.

that competitive edge. When practices pore over the figures and look at how they benchmark against their peers, it is motivating, it enhances self and peer respect, it encourages us to continue to look forward, to carry on."

In addition, there are dedicated work streams run by different clinical groups, with appropriate management support, so work can continue outside of the key monthly meeting. Stephen comments:

"The ideas come from clinicians, not only GPs, but sometimes, for example, for end of life care, residential home staff, from nursing colleagues and psychiatry colleagues in mental health, but always from the point of view or from clinicians. Clinicians witness every single day experiences of patients and the outcomes of patients in the health and care system and understand how the system is good in parts and can be improved in others."

The result of working together and sharing feedback is the development of more than 50 new care pathways in the last three years and better management of financial resources. They have rolled out self-prescribing, changed the urgent care pathway, invested in health coaches as well as new approaches to mental health, prevention, end of life care service. As Stephen says:

"Fundamentally, our focus is to better understand how system performance can be improved through clinical transformation, as the system's quality, performance and use of resources derives directly from how medicine is practiced and care is delivered and the aggregate of thousands and thousands of care decisions, which take place every day in general practice and community services, and which we try to make better."

Devon

Lorna Collingwood-Burke, chief nursing officer at Devon CCG explains the importance of the relationships clinical commissioners have with their peers:

"All the GPs working for the CCG have a good relationship locally with their counterparts. Those relationships are really important because you can have a conversation that everyone understands and you know you aren't going to have to go and talk to someone who doesn't know you or what you do. Our successes were made because the relationships were always there."

Conclusion

It is clear that clinical commissioners have valuable and unique strengths. Their clinical expertise, understanding of their local communities and patients and their unique perspective presents opportunities to lead changes and bring about improvements across the health and social care system. The NHS Long Term Plan has signalled the need for focus on prevention, supporting people in the community to stay healthy and improving care for everyone. Clinical commissioners are imperative in creating this health and social care service fit for the future. Clinical leadership must continue within the commissioning function at all levels – neighbourhoods, places and system.

By April 2021, if the NHS Long Term Plan is put into practice, then a lot of the 'architecture' of the NHS is likely to be different. Equally, many activities will be different too. It's likely to mean there are fewer CCGs, and they will operate in a more strategic way – something that CCGs have been working towards for a number of years, as we explored in our previous publications *The future of commissioning and Steering towards strategic commissioning*. It also means that CCGs will potentially share some functions and roles with their colleagues across local systems and places as explored in our publication *Driving forward system working*.

When describing their vision for a new, collaborative NHS, we've also heard from the leaders of the NHS that they still see a clear need for someone to make planning and funding decisions. The role of commissioners, and the strengths they bring, must therefore be retained. The snapshot of work from this report shows that CCGs have brought together partners to achieve change. They have embedded clinical leadership, and the ethos of population health management that considers their whole population and uses data to plan and deliver proactive care to achieve maximum impact.

Without a strong voice of clinical commissioners in all places and systems, we will lose a vital perspective when working to achieve better health for all.

Further reading

NHS Clinical Commissioners (2016), *The future of commissioning*

NHS Clinical Commissioners (2017), *Steering towards strategic commissioning: Transforming the system*

NHS Clinical Commissioners and NHS Providers (2018), *Driving forward system working: A snapshot of early progress in collaborative commissioning*

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

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We give 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.

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