The role of CCGs in healthcare quality: moving from assurance to improvement

A high quality and safe healthcare system is at the heart of everyone’s ambition in the NHS. At a local level, clinical commissioning groups (CCGs) are key partners in shaping the quality of NHS services for patients and populations, and are actively supporting providers of services to go beyond national standards towards safe care on the ground. NHS Clinical Commissioners (NHSCC) believes that the national approaches to quality assurance and improvement could and should benefit more from greater clinical commissioning expertise to build local intelligence and drive improvement.

CCGs are in an ideal position to drive quality locally. They are clinically led organisations, made up of a wealth of experts – from front-line GPs, nurses, lay members and secondary care doctors. They can also draw on the soft intelligence of their GP member practices. Since the formal establishment of CCGs in April 2013, they have fast placed themselves as at the core of local communities – they have both the role and reach within a local area to identify and work with a spectrum of providers make real changes to the quality and safety of services locally.

In October 2014, we gathered ten national stakeholders from organisations including CQC, Monitor, NHS England, Kings Fund and the Health Foundation to sit alongside our Board members and ten quality leads from our membership at a roundtable to hear some examples of the critical role that CCGs play in relation to quality assurance and quality improvement in a healthcare system at a local level – and the difference it makes to patients and populations. We also asked out participants to highlight what they saw as opportunities and barriers to undertaking that role.

This paper outlines some of the key points of discussion at our roundtable and explores themes, messages and challenges for CCGs when undertaking their role within the system. In articulating these points NHSCC wishes to present a CCG led view of the unique role of CCGs in relation to quality at a local level, their potential
to address some of the challenges that whole systems face. For our members we intend this paper to inform and contribute to their work around quality improvement locally.

**Key messages from the roundtable**

- **CCGs are system leaders with a key role to play in improving the quality of care.** Their role as system leaders is to facilitate conversations between clinicians, care professionals, people who use services and other stakeholders, working cooperatively with providers and other CCGs to head off issues quickly.

- **Combining hard data with soft intelligence provides a unique insight into local quality.** Having the right data and triangulating with local knowledge at quality surveillance groups provides a complete picture.

- **Workforce development, education and training enables a culture conducive to quality improvement.** Culture is a barrier to improvement of quality and the wellbeing of the workforce is critical to good culture.

- **Quality care is good financial value in the long term.** Financial pressures can be framed as an opportunity on how we improve quality in the NHS.

**The unique role of CCGs**

CCGs have a recognised space in the quality landscape at a local and national level. They have a statutory role to improve quality, safety and outcomes for their patients:

> Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.

> A CCG must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved and, in particular, outcomes which show the effectiveness of their services, the safety of the services provided, and the quality of the experience of the patient.¹

CCGs are also, at their heart, clinically led organisations – they have a GP membership and leadership in their governing body structures through their GP members, nurse leads, lay members and secondary care doctors.

As organisations they have three unique aspects to their role which make them critical to assurance, and more importantly, continuous improvement in quality.

First, they hold the contracts with providers for acute, mental health and community services (and in some areas will soon hold general practice) – 70 per cent of NHS spend. They can use their contractual levers to both assure quality and provide financial incentives for providers to continually improve quality. Quality assurance through contracts should not be underestimated: well thought through outcomes measurements with clinical input are an important part of assuring quality.

Second, they provide local system leadership and are building relationships with all parts of the health economy, including but not limited to clinicians, providers, local authorities, voluntary and independent sector partners, local patient groups, regulators, co-commissioners and politicians.

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¹ NHS Commissioning Board *The functions of clinical commissioning group* March 2013
Finally, CCGs have the ability to look across the whole system to see where issues in one area may jeopardise quality in another. The biggest risk is when patients are between services: CCGs can assure the whole pathway using their clinical understanding and relationships. They are close enough to providers to work constructively and facilitate changes in quality rather than taking a punitive approach.

The NHS Commissioning Assembly produced a resource pack in July 2014 outlining the role of different parts of the NHS in quality. The resource pack is available here: [http://www.commissioningassembly.nhs.uk/pg/cv_content/content/view/133373](http://www.commissioningassembly.nhs.uk/pg/cv_content/content/view/133373)

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**Stafford and Surrounds CCG**

The governing body of Stafford and Surrounds CCG made a decision to invest a substantial proportion of their running costs into quality assurance and quality improvement. They have a GP lead for quality on their governing body in addition to a Director of Quality and Safety (who is also the Board Nurse) who leads the biggest directorate. The investment was made possible by having a joint management team with the neighbouring CCG, which allowed for freed up resource to be invested in the quality programme. Initiatives have included a cross-economy nursing home quality surveillance group that can look in detail at specific issues such as pressure ulcers. In a multiple provider system the root case analysis can be difficult to understand but by bringing nursing homes together as one group this has helped change culture and encourage reporting as nursing homes did not fear automatically being blamed for reported cases. With the challenges of a distressed health economy, a deficit and the legacy of Mid-Staffs including the dissolution of the local trust, the CCG have found that the investment in quality and clinical leadership are critical.

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**Moving from assurance to improvement**

Following the inquiry and recommendations into the failures at NHS Mid Staffordshire Foundation Trust, there has been much focus on the role of regulation and inspection to build public confidence in the NHS but this has taken focus away from the role of new commissioning bodies in managing care quality at a local level.

It’s clear from our discussion that quality assurance and improvement are not separate activities. Quality assurance offers a baseline for all CCGs: minimum standards with which providers must comply. Quality improvement is anything which goes beyond that, and CCGs have a statutory duty to drive improvements in quality. Assurance and improvement are part of the same piece, because CCGs can’t think about improvement without the baseline assurance, and can’t think about assurance without considering how to raise standards.

The role of the CCG at a local level is complementary to national regulation because together they are part of a strong system to protect patients. CCGs should use CQC’s and Monitor’s assessments of provider quality and governance to assure themselves that providers deliver good care at a local level. This should then drive the CCG’s more ambitious work with local providers to go beyond these standards. The CCG’s role is therefore to be assured of the care quality of its providers but more importantly lead their improvement. It has its contracts, relationships and system role to achieve that.

The areas of overlap between CCGs and regulators is when quality assurance informs the performance management role of a CCG in relation to its contract with its provider. This will require further work as CCGs take on delegated/joint commissioning arrangements with primary care (general practices).
In order for CCGs to develop well-grounded and meaningful strategies for quality improvement across their populations and providers they must always begin with a clear understanding of what high quality care looks like from a person’s point of view. Some CCGs have developed these shared visions of good quality care using patient stories, patient engagement as part of wider transformational approaches and work with their clinical peers.

**Articulating what good looks like**

CCGs should work together with key stakeholders, including patients, to agree what excellent quality looks and feels like. The ‘6Cs’ are core values that mean something to us all: care, compassion, competence, communication, courage and commitment. CCGs have a responsibility to work with all partners to test understanding and language of the values and be clear that while the 6Cs may be articulated in different ways, these are fundamental to putting patients, family carers at the centre of care. They should support empowering patients, family carers and staff to strive for the best, recognise the best, and respectfully challenge when experience and outcomes fall short.

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**South Eastern Hampshire and Fareham & Gosport CCGs – A quality strategy**

South Eastern Hampshire CCG and Fareham & Gosport CCG have developed a quality strategy for 2014 – 2019. The strategy underpins the delivery of one of the five key objectives in the CCGs’ joint 5-year strategy developed earlier this year. Both the 5-year and quality strategy were developed following discussions with patients and the public; the CCGs listened to people about ‘quality’ matters and what quality really meant to them and built the strategy on these foundations. The clinical focus for the strategy was particularly significant, with GP quality leads and CCG quality team nurses contributing and shaping at every stage.

The result is an 18 page document which includes an executive summary on one page – the ‘Strategy on a Page’ (page 3). This describes the difference the CCGs will make to patients and how this will be achieved. The CCG is also planning a short patient leaflet explaining the strategy, which when combined with the Strategy on a Page, will make the CCGs intentions to improve quality and reduce variability in standards accessible to anyone.

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**The CCG role in the system**

As mentioned the CCG role does not sit in isolation. It must work with the national regulators for assurance and work together to improve concerns or failure. The Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority (TDA) all have a role to play in assuring the quality and financial health of trusts and foundation trusts. Their interaction with CCGs is in a number of ways.

**CQC**

The Care Quality Commission (CQC) regulates the quality of care through monitoring, inspecting and rating providers. CCGs should also regularly communicate and raise quality concerns at any time with CQC, so

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2 The one page strategy is available on page 3 here: http://www.southeasternhampshireccg.nhs.uk/Downloads/Corporate%20documents/Joint%20Quality%20Strategy%20Nov%202014.pdf
these can be followed up by CQC as appropriate. CCGs are also involved in the Quality Summits following CQC inspections.

Roundtable participants identified the time patients are between services as the highest risk in terms of quality. CCGs are moving towards outcomes based commissioning and use new contracting methods such as prime provider or alliance contracting to ensure more joined up or integrated care to improve the whole pathway. As these new ways of commissioning and contracting develop, CQC’s regulatory model will adapt to increasingly comment on the quality of care along pathways, for population groups, or in a particular area.

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Quality is everyone’s role

Jonkoping County Council in Sweden set up an in-house centre for learning and improvement for the staff, known as Qulturum. South Devon and Torbay CCG used this model as part of their innovation, education and research facility which formed part of their bid for pioneer status. Attendees at our roundtable were impressed with culture this created, so that every person who works within the organisation has quality as part of their role.

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Monitor and TDA

Monitor has an important role in quality. As the sector regulator it sets tariffs, enforces and supports competition and patient choice, and authorises Foundation Trusts (FTs). Monitor can work with commissioners to set tariffs so they really do work as payment by results – outcomes for patients rather than by activity.

Monitor also works to support commissioners to achieve what they want through procurement processes. To do this, they can support CCGs to get the service specification right, so commissioners can use contractual levers to drive quality forward. They can also support CCGs to select the best procurement route whether that is competitive tender, Any Qualified Provider, or single tender, whichever is best for patients.

Monitor can also support quality improvement by sharing intelligence about what works around rest of the world and publishing meaningful international comparisons. Finally, when Monitor authorises FTs, they should consider how the Board approaches quality, and how that approach translates to the front line.

CCGs and Monitor’s regional leads will know each other and be able to share information through the quality surveillance groups. Monitor uses CCGs’ local intelligence when they monitor existing foundation trusts and when authorising new foundation trusts.

QSGs – local working

Quality surveillance groups (QSGs) have a critical role in bridging national and local working, bringing together the local system on a regular basis to systematically share concerns and developments. They are designed to support commissioners and other stakeholders to combine hard data with soft intelligence across a local/regional footprint - pulling together a broader view of quality. Furthermore, QSGs with concerns about local providers can invite CQC, Monitor or TDA to join the meetings.

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QSGs provide the space for CCGs to work across their boundaries - identifying shared themes, concerns, and areas for joint work across pathways. Our members felt that the quality of QSGs can vary across the country, but having consistent expectations on their function nationally should address that.

**NHS England**

NHS England has a unique relationship with CCGs as it both co-commissions with and assures CCGs. Its assurance and development role is intended to support CCGs in their duty to improve quality. As commissioners, NHS England and CCGs work jointly with providers from whom they both commission services. Finally, NHS England also hosts local and regional quality surveillance groups, as well as attending themselves as commissioners. Through all of these roles, NHS England has a key role in quality throughout the system.

**Health and Wellbeing Boards**

Health and wellbeing boards can facilitate some joint working on relation to the quality of health and social care services. They can be a unique place for all public sector services to develop a population level expectation of what high quality services look like. For example, a CCG sitting on health and wellbeing boards has the ability to use shared intelligence developed with local authority partners, i.e. the Joint Strategic Needs Assessments (JSNAs) to take a whole system view on what changes are needed.

**Challenges for CCGs**

Participants at the roundtable identified some challenges facing CCGs. Supporting providers, financial pressures and the complications or working with other commissioners were all raised.

While everyone is agreed that a good culture and staff wellbeing is critical to quality, it is unclear how commissioners can support providers in developing good culture. Participants observed that quite often there can be a disconnect between a provider’s board and the front-line workforce.

Financial pressures can have an effect on quality, and risk quality in the future. Our roundtable attendees noted the importance of avoiding an ‘every day is a crisis’ mindset. Though challenging to think long-term about quality in the face of much more immediate serious problems, participants noted that in the long term, high quality care is good value care. Financial pressures can act as a catalyst for service change with quality at the heart.

Finally, the fragmented commissioning system means that CCGs must work with other commissioners, both NHS England and neighbouring CCGs, and this can present additional challenges when assuring quality. CCGs who are not the lead commissioner for services must work with their lead co-commissioners to ensure quality. Similarly, CCGs must be aware of the challenges when a provider needs to assure several different commissioning organisations. Finally, CCGs that are not co-terminous with their local authority will need to work with multiple local authority colleagues to drive quality in health and care.

**Enablers and Barriers to the CCGs role**

During the course of discussion at our roundtable we discussed the following enablers and barriers to the CCG role at a local level:

- **Local system leadership is a strong enabler for quality improvement.** The CCG role is empowered when it harnesses the skills and knowledge of local patients, staff and clinicians through meaningfully engagement to understand what high quality care looks like.

- **Data and access to data can be a barrier or enabler.** Some CCGs have been having difficulty accessing patient confidential data, which can be critical to understanding the detailed evidence and risks
in relation to quality. For some CCGs, achieving Accredited Safe Haven (ASH) status is too resource-intensive. In some cases too much data is as problematic as not enough: commissioners need the right type of data and the tools to analyse that data in order to use it intelligently.

- **Local soft intelligence is a key enabler for understanding incidents of safety failure locally.** Alongside their GP membership, clinical commissioners have never been more able to understand better the experiences of their local patients. The challenge is how to accumulate and then triangulate the combination of hard data and soft intelligence effectively to come to robust decisions. The provision of the latter by local Healthwatch bodies across England was discussed as being a valuable source of information to CCGs.

- **A weak Commissioning Support offer in relation to quality improvement is a barrier.** It is not clear what the data and intelligence offer is from Commissioning Support Units (CSUs) in relation to quality improvement is to CCGs. This is a significant gap in the sector as CCGs are looking to find in-house solutions. It would be helpful for CSUs to be less passive in this area and use their unique role across CCG footprints to develop standardised analytical support tools that local CCGs could use to triangulate data and develop shared CCG quality metrics.

- **High quality inspection reports are an enabler.** Inspection reports should not provide CCGs with any surprises, as clinical commissioners should have their own robust assurance process. Rather, these reports crystallise what is already known. Inspectors should be engaging with commissioners to gather evidence. The reports must be used by CCGs to assure themselves that fundamental standards of care are met, and identify what improvements are needed for local organisations to provide good or even outstanding quality of care in their area.

- **Workforce capacity is a barrier to improvement.** Roundtable participants felt that more work needed to be done on workforce planning locally and that CCGs can have difficulties influencing quality improvement when the capacity of the workforce is stretched. Some focused work is required on increasing nursing capacity and to address the skills and capacity of care home staff.

- **Political support is an enabler for tough decisions to be made.** Commissioners can face significant challenges when they need to use their contractual levers to protect patient safety. There may be considerable local and national political pushback when clinical commissioners reconfigure or decommission local services. There is some need to improve the national narrative in this area to support commissioners where they are making a clinically sound decommissioning decisions in the best interests of patients and populations.

- **The misalignment of local and national improvement activity can be a barrier to effective local working.** CCGs are highly aware that their providers are subject to a lot of improvement initiatives at a local and national level – these can lead to a series of action plans that become burdensome and speak to different audiences. There is some need to rationalise these plans at a local level.

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**Practical considerations for CCGs**

In addition to the barriers and enablers – roundtable participants identified some practical learning from their own work in relation to quality and safety. For example, one participant stressed the importance of limiting the number of action plans so they do not become meaningless following serious incidents and finding a single, simpler way to share the learning.

Other suggestions to improve quality included

- Strengthen the nursing and allied health professional role
- Use provider staff surveys as a measure of provider quality, as staff wellbeing affects quality of care
- Focus on the gaps between services, as that is where the biggest risks to quality may be found
- Instilling a culture within the CCG so that all members of staff understand that part of their role is to improve quality
- Using financial challenge as a catalyst for change that improves quality in care
- Investing in workforce ongoing education and training, mental health and wellbeing of workforce in all types of providers, i.e. primary, community, care homes and secondary. i.e. Community Provider Networks or forums bringing together health and social care professionals across the patient/service user pathway

Conclusions and next steps

To summarise, our roundtable identified that CCGs can:

- Encourage and develop system leadership on quality at a local level. CCGs can also collectively aggregate that knowledge nationally to drive improvement nationally.
- Look across providers and to raise unique questions – use the opportunity to highlight gaps in quality between the sectors i.e. secondary care, community and primary care.
- Focus on solving longstanding local issues/concerns about quality and safety i.e. go beyond inspections and look deep into issues in the health economy around care coordination.

CCGs are key to driving improvements in the quality of healthcare, but they can best do this with support of the system. CCGs have a unique role as they are statutorily responsible for improving quality. They hold the contracts with the providers and can use these contractual levers appropriately, and their local clinical knowledge places them as whole system leaders. Quality assessment and improvement are part of the same thing, and to do this commissioners must understand what high quality care looks like from the patient perspective. CCGs can work with organisations across the system to share intelligence, with regular quality surveillance groups able to facilitate this. Key factors can be barriers or enablers but there are practical steps that CCGs can take to support high quality care in their providers, and continue to drive improvement.

Our next steps will be to ensure we support our members to address the challenges they face in their role in relation to quality assurance and improvement. We plan to support members to share best practice and learning across the country through our member engagement channels and we will continue to influence national policy through our senior stakeholder meetings with the CQC, Monitor and NHS England to enable good local working to thrive.

Share your views with us

As a member-driven organisation, we are keen to hear the views of our members on the issues we have raised in this publication. For more information on it, please contact Julie Das-Thompson, Head of Policy and Delivery or Elizabeth Hawley, Policy and Communications Officer, NHSCC, at office@nhscc.org
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