

NHS Clinical Commissioners

The independent collective voice
of clinical commissioning groups

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Transforming healthcare in England's core cities



Foreword

Health inequalities, integrating care more effectively, ensuring parity of esteem for mental health: the issues that keep commissioners in England's core cities up at night will be familiar to colleagues across the country.

What is unique, however, is the scale of the challenges being faced in these highly complex urban environments. Just take equity of care: in Bristol, early death rates from cancer, heart disease and stroke are above the average for England; in Liverpool, there is a difference of male life expectancy of over ten years in different parts of the city; in Newcastle, levels of child poverty were almost 10 per cent above the national average in 2011.

Through a series of case studies, this report explains how core cities commissioners are addressing such challenges. It is grouped around four key themes:

- equitable care
- partnership working
- improving wellbeing
- changing healthcare.

Projects highlighted include:

- an innovative, large-scale social prescribing programme in Newcastle
- the pooling of health and social care budgets in Sheffield
- a scheme which ensures all patients in Birmingham receive the same standards and services from their GP – regardless of which practice they attend
- the strong partnership working in Manchester which is laying the foundations for devolution.

Together, these and other case studies show how clinically-led commissioning is driving constant improvements in care. However, they also highlight how commissioners in our core cities – complex environments with acute needs – are sometimes stymied by unhelpful central intervention. It suggests changes which could accelerate existing work, and make further improvements possible.

Dr Amanda Doyle OBE

GP and Chief Clinical Officer, NHS Blackpool Clinical Commissioning Group
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Introduction

As chair of NHS Clinical Commissioners' Core Cities Network, I regularly hear about the excellent work being done by the healthcare commissioners in eight of England's largest cities outside of London. It is a real pleasure to introduce a report which will share that work with a much larger audience.

The report demonstrates how commissioners in Nottingham, Leeds, Sheffield, Bristol, Newcastle, Birmingham, Liverpool and Manchester are addressing profound health challenges. It also highlights how clinically-led commissioning is making it possible to deliver healthcare focused on the needs of specific populations. And it shows that, in many instances, the core cities are at the forefront of the transformational change demanded by the Five Year Forward View.

We hope that these examples will prove inspiring to our colleagues in other parts of the country, and that there is good practice here which they may be able to adopt.

We also hope, however, that this report serves to highlight the differences between core cities and other areas. Commissioners in metropolitan areas do face incredibly complex environments, and we believe that there are actions national bodies could take to help us in navigating these. This report highlights some of those.

CCGs are all aiming to deliver excellent care for their very distinct populations. These pages describe how we are already doing that in the core cities – and how we could be supported to do even more.

Dr Tim Moorhead

Chair, NHS Clinical Commissioners' Core Cities Network,
and NHS Sheffield CCG

Equitable care: Delivering high-quality care to all

Reducing inequalities and meeting the needs of specific communities: Liverpool, Bristol and Leeds

"When we came into being as a CCG, we were absolutely clear that we weren't just going to be a good operational commissioner – we wanted to use the resources that we were responsible for to engineer real change in the system." So says Katherine Sheerin, chief officer of Liverpool CCG. One of the main priorities: addressing health inequalities.

"If you compare the city to the rest of the country, we're worst or second worst nearly always. But even within the city itself, there are phenomenal health inequalities – so three times more likely to die of cancer in one ward than another ward; a difference of male life expectancy of over ten years in different parts of the city. As a CCG, we wanted to absolutely face these challenges head on," she explains.

The outcome is the Healthy Liverpool programme, an overarching initiative to improve the health outcomes of people in the city. Led by the CCG but in partnership with the local authority, local providers and NHS England, it seeks to create first-class services that are clinically and financially sustainable. It will incorporate changes to hospital services, urgent care and community services – the last will be centred on 18 health and social care teams based on neighbourhoods.

Each stream of the programme has a clinical lead drawn from the membership of the CCG's governing body, which Ms Sheerin feels is crucial. "They see patients day in and day out, so they've got a credibility that managers don't have. Most of our GPs, and probably all of the GPs on our governing body, have lived and worked in their community for a long time, so that gives them credibility."

It also gives them knowledge of the specific needs of local people. In Bristol, for instance, a special clinic has been set up to care for women who have undergone female genital mutilation (FGM). The Rose Clinic is based in a GP surgery in inner Bristol, home to many women from FGM-affected communities.

"The service started in October 2013, and it came about as we had a lot of feedback about the lack of services to support women, because FGM is quite a taboo subject and so many felt uncomfortable going out into secondary care," reports Vicky Ledbury, community and partnerships commissioner for Bristol CCG. "The did-not-attend rates in secondary care were higher than they were for other services. So our clinic is in a GP surgery, and closer to the women."

Ms Ledbury says that involving the communities served by the clinic has been crucial to its success. "We have quarterly performance meetings with the service, and those include a representative from FGM-affected communities. She's really


important to us, and we work really, really closely with her – she's our link to those communities, to ensure that what we're doing still meets the needs of the people who want to use the service."

Understanding the specific needs of specific groups has also been important to a health initiative in Leeds. A city-wide bowel screening programme launched last year, with a view to increasing the early identification of the second biggest cause of cancer deaths.

There has been a particular focus on the south and east of the city, where there are more people with bowel cancer than the UK average and fewer people taking up the free screening offered to all 60–74-year-olds every two years. Community health educators have been identified to speak to harder-to-reach groups, including black and minority ethnic communities.

"We know there are a wide range of reasons people avoid taking the test, so we have taken different approaches to meet those challenges. For many, they're fairly straightforward concerns around how the test works and whether it will be difficult or uncomfortable," reports Martin Earnshaw, community manager at Leeds South and East CCG.

"It's crucial, therefore, that we work closely with partners in Leeds to speak to people directly, find out what the barriers are and how we can help them to overcome those barriers. Whether that be our community health educators working with harder-to-reach groups in the community, or our practice champions who work with GP practices to encourage their patients to take the test."



"Led by the CCG but in partnership with the local authority, local providers and NHS England, the Healthy Liverpool programme seeks to create first-class services that are clinically and financially sustainable"

Partnership working: Joining with councils and the voluntary sector to provide better, more seamless care

Leading the way: Manchester

Leaders at the three CCGs that cover the city of Manchester have become used to being asked about devolution. In February 2015, plans were announced to give Greater Manchester full control of its health and social care spending. The questions about what that means for local CCGs haven't stopped since but, as Nick Gomm explains, the answers are still developing.

"Devolution is great, but it's very early days," emphasises Mr Gomm, head of corporate services for the three city CCGs: North, Central and South Manchester. "People assume it's doing all kinds of things already, but really we're still working out exactly how it links to the local area, because we're only one of ten localities in Greater Manchester (GM) that are part of the devolution deal."

What is clear, however, is the extent to which organisations in the area have already constructed a local care economy: one which is breaking down traditional boundaries between health and social care, and between different parts of each system.

"Certainly the culture of our CCG is partnership working," reports Dr Mike Eeckalaers, chair of Central Manchester CCG. "Developing relationships and then, through that, looking to tackle some of the longstanding problems that our population faces."

"One of my key roles is to maintain relationships. It's more complicated than ever now, because we have the CCG – our relationships with our practices and the hospital – but we also have our city-wide relationships, and now of course we've got the Greater Manchester relationships which have become more important."

It is the strength of existing relationships that is giving confidence that devolution can and will work. Indeed, there have already been successes at the GM level: Healthier Together, for instance, through which plans to reconfigure local hospitals have been agreed. In addition, an agreement on access standards means seven-day primary care services will be in place across the area by the end of 2015.

In the city itself, meanwhile, the Living Longer, Living Better initiative will improve the integration of community-based care. Soon each of the 12 main areas in Manchester will have a care team made up of an array of health and social care professionals. They will be based around existing GP practices, and the aim is to move the focus from organisations to places and to people rather than diseases.

"The idea is that the teams will really have an understanding of their local communities," says Mr Gomm. "So while they'll be working to a standard specification, they'll be able to vary their services according to local needs."

The first such services will be in place by April 2016, and there is a sense that devolution is making speedy change possible. "Devolution has created this pace of change," suggests Dr Eeckalaers. "The landscape's changing, but if you build on the partnerships that are there already, [then you] see this as something that galvanises all of that and just gets us there quicker; gives us the pace that we need to go at if we're going to transform the system."

What would help:

Allow genuine independence

Ed Dyson, chief officer at Manchester Central CCG, describes himself as a "devo-optimist". But he expresses concern about whether the area will be given sufficient freedom to simply get on and make changes.

"To an extent it's about how much central government and NHS England are willing to be hands off. You hear a million times about liberating the NHS, Jeremy Hunt talking about not letting out his inner Stalin and so on. But it depends what happens in practice."



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Creating coordinated services: Nottingham

Jo Williams says there has long been a focus on delivering care in Nottingham's community rather than in its hospitals. That has meant a range of services, but not always a joined-up approach.

"We started to recognise that we were commissioning a lot of different interventions, but that they weren't very coordinated," explains Ms Williams, assistant director of health and social care integration at Nottingham City CCG.

"We tended to commission wherever we identified a gap but what we didn't do was necessarily join it up as a coordinated approach – it was just a lot of different interventions. We started to sense that, for the people receiving the services, there was a lot of duplication and not only that but a lot of confusion around how to access the right kind of support."

The Connecting Care programme was created to redress that. It launched three years ago, with the aim of integrating adult health and social care services. That includes intermediate care – the support for those who no longer need to be in hospital, but who need additional care to be at home. Traditionally, both social services and healthcare services were providing this service.

"Each had a slightly different emphasis, but were essentially offering the same things," says Ms Williams. "So we're in the process of integrating those two services, so that we have one service offer. We found that when we had the two services, the offer to individuals was very much based on where the capacity was as opposed to what the level of need was.

"We had a gold standard service, which was the health intermediate care service, then a bronze standard service which was the local authority with care workers, and what we really needed was something in between – something that offered the right level of support at the right time. And so to integrate those two services and just have one service offer with one route in would almost guarantee us an equity across the population, which we were really struggling with."

The integration has been easier said than done. "It sounds very straightforward to integrate two services, but it's been an incredibly complex piece of work. Because one of them is a local authority in-house provider service, we hit all those blocks around procurement rules – we can't procure an in-house local authority service. All of these things have been really complex to manage."

As a result, the CCG and local authority have decided to collaborate on a model which offers one service while maintaining two separate providers. "In terms of delivery on the ground, it will be one service offer but offered by two organisations. We're working up the operating model of what that means, but obviously the aim is that we will be able to deliver efficiencies because we'll have joint management services, and so limit duplication."

It is a success which Ms Williams attributes in large part to a strong partnership between the CCG and council. "Our relationship with the local authority has always been really positive – we work very collaboratively in a lot of areas, and I think without question that's been a really strong driver for the success of this work."

Work which has seen Nottingham City named a national integrated care pioneer by NHS England. Recently the CCG also became one of the Five Year Forward View vanguard sites, chosen to fast track the development of a new care model for residential homes. Both place the area at the forefront of transformational care and, says Ms Williams, facing the obstacles that can be associated with that.

What would help:

Give us flexibility to deliver transformation

"There's a real challenge that I don't think NHS England are addressing well, and that is that if you're trying to do something transformational, business as usual maybe can't continue in the same way – you have to be flexible," suggests Ms Williams.



"There has long been a focus on delivering care in Nottingham's community rather than in its hospitals. That has meant a range of services, but not always a joined-up approach"

Pooling budgets: Sheffield

In Sheffield, the local council and CCG have pooled £270 million in their Better Care Fund. That's more than the £200 million required by national rules, and represents what Tim Furness says is a shared vision of the future.

"We started from a place of saying wouldn't it be better if we had a single budget for health and social care in Sheffield, and that pre-dated the Better Care Fund by a year possibly," explains Mr Furness, director of business planning and partnerships at Sheffield CCG.


"It was an agreement between the governing body and the council cabinet that that's what we ought to be moving towards, so we can integrate services and make better use of the Sheffield pound. And that's really why we ended up with a Better Care Fund that's £270 million."

He says the roots of those shared understandings lie in meetings of the local health and wellbeing board, created at the same time as CCGs. "When we started meeting, there was a real meeting of minds; a real connection between the GPs on the CCG governing body and the cabinet members in terms of what mattered to them – so health inequalities, and keeping people well and so on."

The Fund incorporates a seventh of the CCG's budget, and most of the local authority's social care spend with the exception of social workers themselves. The challenge now: how to progress that work. Mr Furness suspects support may be needed.

"We got to a point about six or seven months ago when we thought we're really clear about where we're trying to get to, but we're not quite so clear about how we're going to get there," he reports. "We commissioned some external support to help us with that, to review what we were doing and how we were working and to help us draw up the medium- to long-term financial plan, and I think that really helped us."

"But I don't think itself it's got us to where we want to be yet. It seems to me that there's a lot of organisational development work that we need to do to really make this a joined-up approach to the problems that people are trying to address through the BCF."



"The roots of those shared understandings lie in meetings of the local health and wellbeing board, created at the same time as CCGs"

Increasing physical activity: Liverpool

In the north west, similarly strong local partnerships have made for good progress with the Better Care Fund. "Getting it arranged really wasn't hard for us," says Katherine Sheerin, chief officer of Liverpool CCG. "We recognised that the local authority has real problems because of its social care cuts, and we needed to work with them on that. Having that strength of relationship meant we could work things out together."

Indeed, the relationship is so strong that the local authority is heading the implementation of a central stream in the CCG-led Healthy Liverpool programme.

"One of our key goals is to become the most physically active core city," explains Ms Sheerin. "Our partnership with the local authority is absolutely critical in this – it's how do we get the people of Liverpool to be more physically active. And it's not just about getting them to go to gyms, it's about how do we make walking the easier thing to do rather than getting in the car or on the bus; how do we get people to build this type of activity into their everyday lives."

"So we've got a joint physical activity programme set up with the council, to which the CCG has just committed over £2 million of investment."

Working with the voluntary sector to reduce social isolation: Manchester

In Manchester, an innovative funding arrangement is helping increase wellbeing. A year and a half ago, the city's three CCGs allocated £600,000 to a grant fund for projects designed to reduce social isolation among older people. The fund is managed by Macc, the local voluntary and community sector support organisation, on behalf of the CCG.

"We said: here's the money, we'll say what we want to commission, and then Macc would bring in the potential voluntary sector providers and decide which of those would provide services," explains Dr Mike Eeckelaers, chair of Central Manchester CCG. "It just became a much simpler way of providing this commissioned service rather than having to write and monitor 30 different contracts."

Diverse projects have now been set up across the city, including singing groups, cookery classes, and lessons on how to use an iPad. According to Mike Wild, chief executive of Macc, it has been a case of capitalising on the expertise that is already around – expertise which he suggests the health service isn't always best placed to reach.

"The key message out of all of this is that the organisations that are generally best able to reach the people you want to get at are probably going to be very, very small, very informal, and never in a million years be interested in filling out an NHS tender," he suggests.

The scheme has now been extended for a further year.

Improving wellbeing: Reducing the impact of long-term conditions and helping people live better for longer

Improving emotional wellbeing in schools: Leeds

Half of all mental illnesses begin by the age of 14. Untreated, they can lead to reduced educational attainment and employment, as well as greater use of unplanned health services.

In Leeds, there is a determination to intervene early by supporting the emotional and mental wellbeing of schoolchildren. Local schools have come together in 25 'clusters', pooling resources to help buy additional services for their pupils. That includes a service to identify and care for young people who are struggling with emotional or mental health problems. Funding comes from the CCGs, the council, and the schools themselves. But, importantly, while the CCGs provide support to ensure a quality service, they leave it to local clusters to decide exactly which service to provide.

"One of the strengths we have is that it's a procurement model," explains Jane Mischenko, who is lead commissioner for children and maternity services at the three Leeds CCGs. "So the funding is there, and there is guidance for the clusters on what standard to be looking for when they procure, but it is based on local needs. We've found that maybe 30 per cent have gone to the NHS child and adolescent mental health service (CAMHS) and have done a kind of CAMHS in school model. But the vast majority have gone to the third sector."

Evaluations of the project show measurable improvements in mental health; very good feedback from young people, their parents, and their teachers; and improvements in school attendance. The CCG has now made a further investment of £1.5 million in the scheme. "We're testing how adding additional investment at the front end of the pathway impacts on demands at the specialist end," explains Ms Mischenko.



"Funding comes from the CCGs, the council, and the schools themselves. But, importantly, while the CCGs provide support to ensure a quality service, they leave it to local clusters to decide exactly which service to provide"



Social prescribing at scale: Ways to Wellness, Newcastle

Dr Guy Pilkington, chair of Newcastle Gateshead CCG, admits that in some ways the city's social prescribing programme is far from revolutionary. Through the Ways to Wellness service, GPs can refer patients with a long-term condition to a practice-based link worker. That individual can in turn refer the patient to community-based activities that might improve wellbeing in the broadest sense – anything from a local gardening club to smoking cessation services. "Lots and lots of people all over the country are interested in these ideas and these models," reports Dr Pilkington.

What is unique, he suggests, is the programme's scale. "We are putting in significant investment: it's £4.65 million over the life of the project. Fundamentally, that's quite radical. And it's more radical when you think about the way in which it's been set up; the way in which those funding streams are being provided. Initially, we're putting other people's money behind this with the intention of demonstrating that this is a really sustainable and sensible way for a health commissioner to think and invest."

That money is coming from the Big Lottery Fund, the Cabinet Office and Bridges Ventures. More notable still is that the set up of the contract is results based. The CCG will make payments to the organisation managing the service – a standalone body, also called Ways to Wellness – based on outcomes. The team believes the work is the first example of a social impact bond in healthcare: using money from social investors to fund a service, and then using an outcomes-based model to in effect pay them back.

Two key measures are being focused on in Newcastle. The first: the extent to which users of the programme report improved wellbeing. "Every patient who enters the Ways to Wellness scheme carries out a wellbeing star with their link worker," explains Philippa Dodds, delivery project lead for Newcastle Gateshead CCG.

"The star has got eight arms, and it's all about how the individual feels: what impact is housing, finance and so on having. And the patient basically says: 'I think I'm a three on that, a four on that one' and that gives you an overall score.

"So the patient will do the wellbeing star at the first appointment, and then they will do it again every six months. And one of the outcomes we're measuring is what we hope will be an improvement in the wellbeing star scores between the initial appointment and six months down the line."

The second key outcome is hospital usage. "Essentially what we're hoping is that patients going through the Ways to Wellness service will feel better in their holistic being, which means they hopefully won't be using hospital-based services as much compared to a matched cohort who aren't using the Ways to Wellness service," explains Ms Dodds.

Ways to Wellness formally launched in July, and the intention is that it will care for between 4,500 and 5,500 patients at its peak. Each will be supported by a link worker for 18 to 21 months. There is little doubt about the scale of the need and the potential benefits of the programme: about 15 million people in England have a long-term condition, accounting for 70 per cent of the annual expenditure of the health service.

It is a need which GPs fundamentally understand, suggests Dr Pilkington. "Every day they see their patients living with long-term conditions having things done unto them, and they know that the solution isn't another tablet – it's something else, it's something about their lives."

It is therefore perhaps unsurprising that he feels the introduction of clinical commissioning has "absolutely" made a difference to services. "We started this work while we were still practice-based commissioning groups, but the traction gained by the creation of the CCGs is a quantum leap." Which is not to say there have not been any challenges. For one, the difficulties of using standard contracts not set up for this sort of transformation.

"I know there are moves in upper echelons to work on a contract you could have with voluntary sector organisations that isn't as clunky as the NHS standard contract. That is something I wish we'd had, because the standard contract probably added a good six to nine months on in terms of negotiations that I'm sure we could have got past if we hadn't had to use that mechanism.

"The way the voluntary sector moves has been a bit of an eye opener to me, because they don't have the lumbering NHS side of things to carry with them," she adds. "If they want something done, they'll just go out and get it done. Ways to Wellness did a procurement for the sub-contractors in about six weeks – I did one for a pulmonary rehabilitation service that took about a year from idea to procured service. They can move a lot faster than we can, and I just don't think we are currently using them to the best of their abilities."

In Newcastle, the hope is that the Ways to Wellness scheme will change that.

What would help:

Allow us to use simpler procedures to get new projects in place

"We've been obliged to put an NHS standard contract in, because the Big Lottery money flows through the CCG through to Ways to Wellness," explains Ms Dodds. "And it's just not flexible enough to deal with what we're trying to achieve here."

Changing healthcare: Finding new and better ways to provide healthcare services

Reshaping mental health services: Bristol

In October 2014, a completely redesigned suite of mental health services launched in Bristol. The change was the result of a dramatic choice by Bristol CCG: to put all non-inpatient mental health services out to tender.

It was not a decision taken lightly, but one that was grounded by staff's understanding of the specific needs of the city's population. Richard Lyle, programme director for community, partnerships and patient and public involvement, explains: "Bristol is served by a large mental health trust: Avon and Wiltshire Mental Health Partnership NHS Trust.

"As the name suggests, they cover a broad area in the west country, and we're the urban centre. I think it's fair to say that demographics, culture, prevalence of mental ill health are quite different than in, say, the more rural area," he says.

"There is always a tension, understandably, between the trust trying to run models of care across the whole organisation and keeping five or six CCGs – and previously primary care trusts – happy, and then trying to be bespoke and focused on the needs of individual communities. And the feedback from GPs and users and carers in Bristol was that the current model wasn't working."

According to NHS England, more than a third of GP consultations are now linked to mental health issues. Yet it has long been acknowledged that the NHS has failed to give mental wellbeing equal priority to physical wellbeing. In Bristol, concerns included the ability for GPs to receive speedy clinical advice and liaison from specialist mental health services.

"That was something [the GPs] felt they really wanted to develop and improve. There was a lot around making sure that people who had a mental illness, and who were essentially at the limits of a GP's knowledge and competence, were able to access an alternative service in a timely manner. These are inner city GPs with different demographics [from other geographic areas], very focused on meeting the needs of their populations, and they were feeling that maybe services hadn't quite kept up in those terms."

The new model is focused on moving services closer to primary care. For instance, the city now has two crisis houses, which offer an alternative to inpatient admission. There is also a day crisis house, Bristol Sanctuary, which opened in April 2015. "It's not residential, but it's somewhere people can go to get support rather than ending up in the emergency department or suffering in silence," explains Mr Lyle. "It gives the ability to get some trained and

appropriate support, and if staff feel the risk is high or the person needs other input, they can obviously make further onward referrals."

Many services are still provided by Avon and Wiltshire Mental Health Partnership NHS Trust. But there are partnerships with voluntary sector organisations as well, and a new-to-the-area provider trust is responsible for dementia wellbeing services – working with the Alzheimer's Society.

It is a scale of change which Mr Lyle feels was greatly aided by the advent of clinical commissioning. "The GPs on the governing body were obviously getting direct feedback from their peers, and were seeing some of the positives and negatives of mental health services in their daily practice. I think from a managerial perspective, you might have looked at all this extended effort and the time it would take and thought, yes, we could do this but it takes will. And I think what the GPs brought was will to achieve it.

"I think if you've got the will, it will happen," he continues. "What is more complex is making sure that you are able to deliver against that, and I think that's where a manager might say: there's risk. It's the credibility as a clinician to say: actually, I hear what you're saying, but I still think the clinical benefits to my patients outweigh those risks."

Breaking down boundaries in primary care: Birmingham

There are over 100 separate GP practices in the city of Birmingham. But whichever practice local residents visit, they can expect the same standards and services. That's because each and every practice in the area has signed up to Birmingham CrossCity CCG's ACE (Aspiring to Clinical Excellence) Foundation framework.

Through the scheme – running since 2013 – practices are financially incentivised to meet a set of minimum standards established by the CCG. "ACE Foundation was really about how we improve the core quality of primary care," explains Dr Barbara King, the CCG's chief accountable officer. "It was setting standards of care that really everybody should be able to attain as an individual practice."

It was also about creating a more 'grown up' relationship with general practice, encouraging GPs to be less concerned about tickboxes and more concerned about demonstrating true engagement in improving services. "We've moved to a high trust, low bureaucracy situation," reports Dr King.

"It's not just about hitting targets. And that was quite anxiety inducing for GPs in the first instance, because people weren't given those absolute targets, but it was more about proving you've engaged, you've developed this, you've done that, you've focused on this. There was something about getting away from the concept of paying people to come to meetings – attending meetings doesn't equal engagement."

There have been multiple improvements as a result. For instance, the number of patients vaccinated against flu has increased. So too have the number of people identified as carers – now 3,000 names are on a formal register, making it easier to identify those who may have extra needs by virtue of caring for someone else.

“With immunisation, we actually asked practices to set their own targets in terms of where they thought they could improve, and set a plan around how they would achieve those targets,” explains Dr King.

“So rather than the CCG saying this is a blanket target, again going back to that more adult relationship and saying: this is where you are benchmarked, what do you think is a realistic target that you could get to? And again in terms of carers, we didn't set an absolute target, but we did quite a lot of work around saying why it was important to identify carers, so that people aren't just viewing it as a target in isolation but more of a whole package around improving the quality of care.”

Following the success of ACE Foundation, the CCG has introduced ACE Excellence: a set of enhanced general practice services which, again, practices are financially incentivised to offer. The idea is to increase the number of patients who can be cared for out of hospital.

“We recognised that if you can't go to secondary care and say that, universally across this area, all GPs will operate to this level of care, then you can't expect secondary care to discharge patients into the service,” explains Dr King. “So ACE Excellence came out so that we had a universal offer that we can go to secondary care with, and say this is a step up in the level of provision across general practice.”

She continues: “We now have a leaflet we're distributing to patients to say: this is what you should expect as a patient in Birmingham CrossCity. This is the level of care you should expect. And I think that's really important – this is about saying to our patients that, wherever you live in the city, this is the level of service you should expect from your general practice.”

ACE Excellence, to which all but four practices in the city have signed up, has served to break down the gaps between practices in another way. To deliver the level of care it requires, it has been necessary for surgeries to work together in groups or federations.

“So it's really provided a springboard to launch us into further development along the new models of care described in the Five Year Forward View,” says Dr King. “We've got 17 ACE provider groups now across the city: so from 117 practices to 17 provider groups.”

What would help:

Better information sharing

“Sharing patient information across practices is something that needs some national focus and resolution,” suggests Dr King.

Responding to patient engagement: Sheffield

Musculoskeletal disorders are the most common cause of disability in the UK, and each year 15 per cent of a GP's patients will visit with a problem affecting their joints, tendons or muscles. When Sheffield CCG created a new contract for non-emergency musculoskeletal (MSK) services, staff wanted to make sure the wishes of their many users were right at the very centre.

“The new approach to contracting that we have taken for musculoskeletal services – a payment for outcomes based approach – has presented us with a fantastic opportunity to co-produce desired service outcomes with patients, carers and providers,” reports Alastair Mews, head of commissioning for the CCG.

A range of key themes emerged during conversations with service users – the need for good quality information, for instance, and for care that recognises the diversity of patients. “We have taken those key themes and built them into the documentation for each service element that sits under the overall MSK contract,” explains Mr Mews.

“This means that every project and service under the MSK contract has to demonstrate how they have addressed the key considerations of patients and the public.”



“There have been multiple improvements as a result. The number of patients vaccinated against flu has increased. So too have the number of people identified as carers – now 3,000 names are on a formal register”

About the Core Cities Network

The Core Cities Network is a peer-led network representing clinical commissioning groups (CCG) from the eight core cities in England outside London. It is hosted by NHS Clinical Commissioners, the independent collective voice of CCGs.

The Network's reach stretches across Nottingham, Leeds, Sheffield, Bristol, Newcastle, Birmingham, Liverpool and Manchester. We meet with one purpose: to improve the health outcomes of populations that live in complex city environments.

Our members are keen to be involved, influence and innovate. We aim to:

- raise awareness of the distinct needs of commissioners in the core cities, and the common issues we face
- influence national policy, ensuring it takes into account the distinct needs and common issues of commissioners in the core cities
- bring together commissioners in the core cities, and allow them to share information and learn together.

If you would like any further information or to get in contact with the Core Cities Network, please e-mail office@nhsc.org

About NHS Clinical Commissioners

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

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice to the wider NHS, national bodies, government, parliament and the media.

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

For more information, visit www.nhsc.org

Further information and acknowledgements

If you would like to speak to NHS Clinical Commissioners about this report, or any of the case studies within it, please e-mail office@nhsc.org

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