The Future for Commissioning nurses  
Nurses Forum Meeting

10:00-15:00 – Wednesday 10\textsuperscript{th} January 2017  
NEW VENUE: BMA House, Tavistock Square, London WC1H 9JP

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<th>Time</th>
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<tr>
<td>09:30-10:00</td>
<td>Registration – Tea and Coffee available</td>
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| 10:00-10:05 | Welcome and introductions  
The chair of the NHSCC Nurses Forum, Lorna Collingwood-Burke will welcome members to the meeting and introduce the themes for the day. |
| 10:05-10:45 | Royal College of Nursing update  
Lara Carmona, Associate Director of Policy and Public Affairs (U.K. and International), RCN  
During this session representatives from the RCN will provide an update on relevant work they are undertaking nationally. This will include discussions with government around the removal of the pay cap for nurses, supporting the workforce through addressing wider recruitment and retention issues and ensuring a voice for the nurse in the developing commissioning system. |
| 10:45-11:30 | The future of clinical commissioning  
Julie Wood, Chief Executive, NHSCC  
NHSCC as the membership organisation of CCGs, are working closely with NHS England and others as this new commissioning landscape is being defined. During this session, the future strategic commissioning landscape and the commissioning nurse role within that will be discussed. |
| 11:30-12:30 | NHS England update  
Stacey McCann, Head of Nursing Strategy and Commissioning, NHS England  
This session will provide an update on the NHS England strategy for nursing in the evolving commissioning system, the role of commissioners in supporting practice nursing and delivering Leading Change, Adding Value. |
| 12:30-13:15 | Lunch and Networking |
| 13:15-14:30 | Forum updates  
- Review of Actions from last meeting  
- Update on CHC project  
- Chair meeting with Jane Cummings – Topics for discussion  
- Outcome of Nurses Forum survey  
- Safeguarding |

Paper 1  
Paper 2  
Paper 3
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| 14:30-15:00 | **Next steps for the Nurses Forum** | - Future of the Forum  
- Revised Terms of Reference  
- Proposals for programme of work for 2018/19  
**Paper 4** |
| 15:00  | **Close**            |                                                                          |

**2018 Meeting dates**
- Wednesday 11 April 10:30-15:30 TBC, London  
- Wednesday 11 July 10:30-15:30 TBC, London  
- Wednesday 10 October 10:30-15:30 TBC, London
Making strategic commissioning work

Lessons from home and away
**Introduction**

Clinical commissioning is entering a new phase. Improving the health and care of our populations, both now and in the future, is a task that clinical commissioning groups (CCGs) are keen to embrace. Their clinical leadership, insight and readiness for change has meant they have already evolved into organisations that can work at scale and at pace.

Strategic commissioning is seen by CCGs as their future destination. It’s acknowledged that the specific design and delivery of the function will vary by place, but at its core is the ambition to create a more person-centred and sustainable NHS. Our membership is therefore keen to shape the development of the strategic commissioner role to ensure the right enablers are in place at a local and national level to create a smooth transition towards it.

This briefing has been developed to better understand which enablers can support the transition toward strategic commissioning and some early lessons for its implementation going forward. It therefore builds on our publication *Steering towards strategic commissioning: Transforming the system*, which sought to define the function and highlight a number of national asks in relation to the changing commissioning landscape.

The content for this briefing has been developed from:

- interviews with a combination of our members, national stakeholders within health and social care and representatives from sites further ahead in the development of accountable care models.
- debate amongst our wider membership at our national event on 2 November 2017, which was themed on strategic commissioning. Around 120 CCG leaders attended, with speakers from across the national bodies, CCGs and the accountable care models.
- desk-based research on international examples of high performing place-based systems of care that have developed in New Zealand, Sweden, Spain and the United States, as well as a number of other countries reviewed on an individual basis. The full case studies are available for download on the NHSCC website.
Five lessons from home and away

Our work has identified several high-level lessons which we believe national bodies and clinical commissioners need to be aware of when transitioning towards strategic commissioning arrangements.

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

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

3. **Maintain clinical commissioning leadership and engagement.**
   Having some continuity in clinical commissioning leadership is vital to retain at strategic and tactical commissioning levels when evolving the local health and care system to meet the needs of future populations. The success of population level planning will depend on the engagement of clinicians in primary, secondary and community care, as well as the wider workforce, in a unified vision for the future. Where systems have done this effectively overseas, we have seen increased quality of service delivery, innovation and improved outcomes for patients.

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

5. **Hold the delivery model to account on behalf of the local population.**
   A strong strategic commissioning function will ensure a continued focus on quality and improvement within local areas. Competition does not preclude cooperation across systems or the integration of systems, and the development of a closed market has the potential to result in stagnation, with decreases in quality and innovation. The creation of a monopoly of providers who lack incentives to go beyond narrow contractual requirements must be avoided and therefore the strategic commissioner should hold the system to account for delivery. The health system in Israel shows how this can be retained (albeit at a smaller population level) while the lack of contestability is one of the key concerns in the development of accountable care models in the US.
The current challenge when evolving to accountable care models

The bottom up evolution of accountable care models (ie, accountable care organisations (ACOs) and accountable care systems (ACSs)) and the devolution areas in England has meant that to date there have been differing approaches to local implementation. There have also been differing interpretations in relation to the level of engagement for partners, commissioner and provider roles, the activities and functions of existing and emerging local structures, leadership styles within emerging models and the approach of the national regulators, and the overall scale of the models themselves. This is to be expected at this current stage, but there appears to be some concern that this level of permissiveness going forward may be difficult to legislate for and may create inconsistencies in formal governance structures and accountabilities across local areas.

In Steering towards strategic commissioning: Transforming the system, some challenges are identified by CCGs as they plan their future journeys. Many of our members feel they are caught between the execution of their existing statutory functions and the immediate need to plan for new ones at a much broader scale. This is most recently demonstrated at our 2017 national event where, of those surveyed:

- 58 per cent identified that time, resource and capacity was the biggest need to deliver the evolution of the commissioning system (the next highest, an improved regulatory framework, was at 16 per cent)
- 44 per cent requested increased support and capacity to deliver a sustainable and transformed system (the next highest, money and collaboration of national organisations were both at 20 per cent).

Our national event highlighted that in the future the term 'commissioning' may become less visible in our vocabulary as local areas focus more on ensuring they have the right planning functions and accountability structures in place to undertake population level health and care.

Internationally, the strategic function is described in terms of planning and resource management, distinct from the more transactional functions that would usually be housed in the integrated provider delivery system. In New Zealand, strategic planning is undertaken by the local planning and funding team operating across district health boards (responsible for delivery of services), in the US it is undertaken by the health insurance fund, while in Spain, Sweden and other Scandinavian countries, these functions are delivered by local authorities who hold the responsibility for health service delivery in local areas.

Defining strategic commissioning

Clarification of the strategic commissioning role is essential for the evolution of place-based systems, as it is a function that has the potential to bring a more locally devolved and accountable approach to population health and care management.

Broadly speaking there are two levels of commissioning that are emerging within the sector:

- **Strategic commissioning** is system-wide leadership and service planning across a defined area, involving the development of an understanding of needs and requirements at a population level, monitoring system performance, redesigning the system architecture and repositioning services to better meet local need. This looks to deliver improvements over the longer term and across a wider area. Our publication Steering towards strategic commissioning: Transforming the system highlighted eight core strategic commissioner functions that our members felt must be retained for managing population healthcare.

- **Tactical commissioning** is focused on individual relationships with providers, the procurement of services, sub-contracting, and the management of the provider chain against specification and performance criteria. This would usually be focussed on the short-term and annual cycles. Connections with the population are based on a locality/neighbourhood approach. This would operate at an accountable care level.

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We have also found there are some differing views on where the strategic commissioner function will reside going forward, some suggest the sustainability and transformation partnership (STP), others the ACS and some the ACO. However, in some areas there is more than one ACS in an STP footprint. This difference in views is in stark contrast to the consensus view that the tactical end of commissioning would reside in an accountable care organisation. Clarification around the movement of commissioning functions may require further national work and some increased engagement with all CCGs to understand it more fully.
National enablers for strategic commissioning

Through the research for this briefing we have identified several national enablers that were perceived to support the development of an effective strategic commissioner function both now and in the future. These are as follows:

### National clarity on the ‘end states’ and support for local directions of travel

CCGs are taking a lead role at a local level in the transformation of care delivery through the development of accountable care models. While there are benefits in allowing local variation, further clarity would be welcomed by CCGs on what the ‘end states’ of the commissioning landscape are likely to be, the anticipated roles and responsibilities of commissioners and providers and the role of national bodies, especially for assurance purposes.

This clarity would support areas to know which commissioner functions should transition to accountable care models, which are retained at a strategic level and where they sit in the broader architecture, that is at ACS level or STP level or both. Further, it should be accompanied by additional resources to enable the double running of systems and support those areas that are falling behind to catch up.

In international systems, such as the US, Estonia and New Zealand, while local areas have been able to develop healthcare delivery models to meet local challenges, this is within the framework of an overall direction of travel and priority setting from governmental organisations followed by subsequent empowering legislative change.

Our members are supportive of the development of guidance by way of a national framework. They are clear however that this must not be too prescriptive to limit local development, but should provide sufficient clarity to allow them to plan with certainty.

### A strategic role for clinical commissioning leadership

Our research suggests much of the early focus in transitioning the clinical commissioning leadership role has tended to be in relation to accountable care models or the tactical end of commissioning. However, there is a strong view in our membership that strategic commissioning must build on the progress that CCGs have made to create groups of primary care clinicians who also work as commissioning leaders. This means existing and future clinical commissioning leaders need bespoke support through the current transition. This will require some specific competency-based leadership skills, change management and GP development into commissioning roles.

Alongside this, there is a need to embed multidisciplinary clinical leadership across health and social care to take accountable care forward. This should be driven in the main by primary and community care which will be the focus of NHS service delivery in the future. In all the international models that we reviewed, including in Spain, the US, New Zealand and Sweden, clinician leadership at a local level has been central to the development of place-based systems of care.

On the broader theme of clinical leadership, our interviews identified several clinical leadership roles evolving at home. The first could reside at a strategic level, and the second and third in accountable care models as they mature. These roles are outlined as:

- **Medical director or shared leadership model.** Some areas in England are looking to explore the role of clinical leadership in the performance management of clinical colleagues in the accountable care models – underpinned with agreed clinical practice, protocols and expected standards of practice. This would be similar to medical director roles within hospitals. Others are looking to develop shared leadership approaches with the clinical leaders from across primary and secondary care coming together to form a joint leadership role.

- **Clinical network leadership.** This would entail leading networks within the multidisciplinary team on specific areas to: agree care priorities, determine how services should run to meet local needs, set clinical and patient experience standards, develop care pathways, monitor unwarranted variation (which can only be explained by differences in health system performance), and manage outliers. This will require subject specific experts.

- **Locality and representative clinical leadership.** Clinical locality leadership would provide a way for primary care practices to escalate issues and act as a conduit for local consultation and engagement. The principle, although most relevant to primary care, could be applicable to the wider multidisciplinary neighbourhood team. This will require skills in engagement and member representation.
Strengthen local decision-making

Successful strategic commissioning requires more local decision-making with reduced oversight and intervention from arms-length bodies. As well as devolving budgetary control to local areas, those at the centre must take a permissive approach to both the development of systems and the management of those in local areas. We see most progress on this in some of the devolution deals in England. Internationally, local autonomy has been central to the development of effective health systems, usually at a local authority level as in Sweden, Spain and Denmark.

The move towards strategic commissioning offers the opportunity to successfully integrate social care to develop place-based approaches to health and care services. It was clear from our interviews that nationally supported devolved working must learn from the challenges in bringing different organisational cultures and accountabilities together. This has been most felt through health and wellbeing boards who have lacked the sufficient leverage to affect impactful changes in local areas. Internationally, the evidence suggests that where social insurance models are utilised, more comprehensive coverage is provided of health than social care needs, however, the gap between the two is less stark than in England.

Nationally, there must also be recognition that the development of effective relationships that will drive a local approach takes time and cannot be accomplished overnight. In New Zealand, the development of the current system began in 2007, in Sweden stability of leadership over 18 years locally allowed the Jönköping system to develop, in the Netherlands system development has taken over 20 years, and in South Korea the process has taken closer to 30 years.

Develop strategic commissioning skills and capacity

New skills and increased capacity will be required to ensure the effectiveness of strategic commissioning in developing and monitoring service delivery and implementing an outcomes-based approach. These should enable an increased understanding of the needs of local populations and, most significantly, population level impact of interventions over time.

While some of this capacity can come from external organisations, such as Academic Health Science Networks (AHSNs), to be truly effective this must be developed in-house to allow for rapid monitoring and real-time interventions to be undertaken. Such skills include the data analysis of patient level information to develop clinical pathways, identification of developing long-term trends and assessment of impact based on both national and individual patient-level determinants of success to drive action. Additionally actuarial and contractual skills are needed to hold the system to account for delivery.

In New Zealand, secure medical records are shared across district health board areas and clinical and process guidance is developed centrally based on analysis of this data. In Spain, real-time data displays allow for monitoring of outcomes and the impacts of interventions.

One approach to system assurance, regulation and governance

There needs to be some national work to develop a single assurance and regulatory framework which is coordinated at a system level to mirror the strategic commissioner and accountable care models locally. Our interviews identified there is a risk that without this single approach, there will be multiple layers of reporting for the strategic commissioner to undertake which will divert senior attention away from their population level roles. We have already seen this within the current landscape for CCGs.

Our national event highlighted an appetite for more integrated working between the national assurance and regulatory bodies (NHS England, NHS Improvement and the Care Quality Commission). NHSCC members also felt that without further clarity on the governance arrangements needed to support accountable care models, strategic commissioning will lack a robust framework for decision-making, which is required to establish it in the first place.
Map the risks and challenges – mitigate them early on

To get a smoother transition to strategic commissioning, there needs to be some national work with CCGs to identify and map the risks and unintended consequences when developing accountable care models, as well as to take potential mitigating actions. These include the delegation of commissioning functions, governance, and the management of conflicts of interest, current and future statutory duties, and risk share approaches to handle provider fragility.

It is vital that we learn from international systems and the challenges that they have faced. These include the development of a robust allocation methodology that is flexible enough to respond to changes in demography, sophisticated enough to predict where these changes might occur and yet robust enough to allow for certainty and effective planning over several years, a challenge experienced in New Zealand and elsewhere.

The system should also take steps to minimise the risk of provider market capture that results in the decrease in quality and financial sustainability due to a lack of strength in the commissioning sector, as seen in provider-led models such as in Spain. In the US, evidence shows that consolidation of provider and local physicians can result in an increase in prices, therefore strong local levers must be retained to manage costs.

Share learning on the design and development of the accountable care models

Our national member event highlighted that evolving systems need to share knowledge in real time. It’s clear there are some pioneer areas developing accountable care models that are defining the strategic and tactical commissioner functions. These areas are sharing their experiences and expertise as a community and to some extent are perceived as ‘innovating in isolation’. It can be frustrating for areas not part of these communities to access the knowledge and intelligence they need to develop their approaches to accountable care and in effect kick start their journey in an informed way. This knowledge needs to be shared across the clinical commissioning community consistently and on a regular basis at a national level.

Local enablers for strategic commissioning

The international case studies and the interviews with those areas that have made most progress in developing strategic models in England revealed a number of local enablers that should be considered when developing strategic commissioning systems.

Taking a person-centred approach

The strategic commissioner, although working at a population level, should maintain the primacy of the individual within commissioning decision-making. This approach is perhaps most advanced, although not uniquely, in Sweden where “Esther” is a figurative representation of older people who have complex care needs that involve a variety of providers. The system collaborates and has designed services based on “What is best for Esther?” This person-centred approach ensures that commissioning decision-making is grounded in the perspective of the end-user and that the system prioritises the population it serves above other considerations.

In a public structure with one central source of funding and the requirement to remain in budget rather than deliver profits, this should be more easily achievable than when delivering care across competing commercial interests or through insurance-based payment methods. Involvement of community care, public health and social care within a local system, where considered appropriate, would enable a holistic approach to be developed.

Being accountable to the local population and clinical community

The development of true accountability to local populations for decisions reached, through a formalised structure of engagement and involvement is essential to the effective development of both strategic commissioning structures and the transformation of health and care delivery that they are building. While existing patient and public engagement mechanisms are currently being embedded into accountable care models in England, international models suggest that this engagement could go further. In New Zealand, individuals are elected from the local population to sit as representatives on the local district health boards and plans for service redesign is undertaken with a patients’ or public council.

By involving the local authority within accountable care systems, greater accountability can be achieved for the local population. However, this should not be a bolt-on style of working and must be a joint process of planning from the outset. It was not clear in our interviews if local authorities are fully embedded into the developing accountable care models.
As noted above, while CCGs are currently accountable to their local clinical community through their practice membership, as strategic commissioning develops, consideration will need to be given to how to achieve accountability to the wider clinical community (for example, primary and secondary care clinicians and nurses) and how to achieve mechanisms for representation.

**Finding the appropriate geography**

To maximise the potential for strategic commissioning, the appropriate footprint for delivery must be identified. This will remove duplication across local systems, but also ensure that the principle of subsidiarity for service delivery is maintained. This will only be successful if clear lines of communication are developed and maintained across and between local areas, rather than taking an isolationist approach based on historic or current organisational boundaries. We have seen from international approaches that there is not a specific level at which all services can be delivered or commissioned, and local areas should decide what is appropriate based on the determination of local need.

Our interviewees felt that that strategic commissioning could be undertaken at a large population level, some suggested up to two million. Some CCGs are already collaborating to cover a larger geography due to the need to maintain their statutory functions and create scale, but are also developing the STP and ACS structures for some greater commissioning leverage and reconfiguration.

When commissioning at different geographical levels, our interviews found:

- **Some care pathways are thought to be more effectively commissioned at a strategic level.** For example, learning disabilities (with social care), inpatient mental health, genetics hubs, some pathology services, and some specialist and secondary care services (e.g., cardiovascular and trauma services).

- **Some services were considered to fit a bigger regional footprint.** Examples included the commissioning of 111, population-based health protection, public health/prevention and ambulance services.

- **Some services needed integrated delivery.** Here services such as maternity, end of life and oncology were cited as those that required an integrated delivery and commissioning approach.

The strategic level was also considered to be useful to bringing coherence to local workforce planning and working with local Health Education England (HEE) teams to purchase training and education for the future clinical workforce at scale.

There are clear opportunities for carrying out some commissioning functions at a larger population base than a CCG, but as areas define which elements are tactical and which are strategic it seems the principle of subsidiarity and local assessment must be applied when planning where strategic commissioning functions reside.

**Involving the local clinical community**

A key feature of successful international approaches to strategic commissioning, especially in New Zealand and the US, is the involvement of local clinicians across primary, secondary and community care in the development of whole-system patient care pathways, service improvement and system development. In Canterbury, New Zealand, for example, clinical leadership across the system is essential to the delivery model and the development of cross-organisational patient care processes. Clinicians can utilise their clinical skills and local knowledge to identify requirements ensuring that appropriate solutions are developed for defined populations in planning the contracting and implementation process.

Without the engagement of this community in the development of systems and processes which are embedded in the reality of local service availability and need, strategic commissioning cannot be effective. We have heard about the establishment of clinical training programmes or academies in the developing NHS system that are encouraging clinicians within primary, secondary and community care to take ownership of system delivery and empowering them to redesign services based on clinical effectiveness.

In the US, Intermountain Healthcare has focussed on developing clinicians in leadership knowledge and improvement methodology through an advanced training programme, while in Sweden, there are regular cross-system clinical and managerial meetings to discuss challenges and propose solutions.

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1Please note this will vary by place and is only indicative.
Having a shared vision

In the most successful areas, including in New Zealand, the US and Sweden as well as in developing systems in England, a strong vision and its underlying principles has been agreed at an early stage. As strategic commissioning is at a larger scale and with longer-term ambitions than the annual tactical commissioning cycle, it is vital there is clarity about the system that accountable care models are expected to deliver and the challenges that will be addressed, built upon local understanding and experience of using services. The strength of this shared vision can then shape the conversation at a national level. The permissive approach currently adopted offers an opportunity to the system to develop processes where there is a clearly articulated vision that can then inform national guidance and legislation.

Planning for effective data sharing

Clean, reliable and prospective data must be available for strategic commissioners to make effective decisions about the delivery of services in local areas, be assured that actions are being taken to address identified needs and that agreed interventions are influencing patient outcomes. This would require agreements to share information across organisational boundaries. Some of this may require national support to ensure the consistency of data sharing. Alongside clinical engagement, a common factor that we have seen across successful international systems of place-based care has been the development of integrated systems for data sharing, particularly medical records, between organisations. New Zealand and the US offer examples of where this been done effectively, but this has taken both time and tireless leadership focus to achieve it.

Defining clear outcome measures

The outcomes against which system performance is measured must be linked a shared vision, agreed across the system and sufficiently responsive to identify problems in real time if not pre-emptively. However, they should also retain some flexibility to adapt to changing circumstances and population needs. Where these outcomes are too specific they can be unwieldy for the commissioner to utilise effectively, remove focus as it is dispersed across several competing priorities and function only as local performance management, rather than driving system improvement, as in the US where one network held four ACO-like contracts which contained 219 performance measures. Conversely, where outcome measures are too high level then the strategic commissioner may find it challenging to have effective oversight of service delivery and monitor service quality. A concern from observers of the provider-led Spanish system is the impact that a weak oversight function may have on the long-term quality of service delivery.

Focusing on quality

The distinction between strategic commissioner and delivery organisation in terms of quality assurance is essential for services to improve, especially with the development of an integrated provider and reduced market access. Competition does not impede the integration of systems, and the development of a closed market has the potential to result in a decrease in quality and innovation. The creation of a monopoly of providers who lack incentives to go beyond narrow contractual requirements must be avoided and therefore the strategic commissioner should hold the system to account for delivery.

Internationally contractual agreements are fairly sophisticated. They extend for between ten to 15 years and have incentivised positive behaviours such as provision of additional funding for organisations or personal incentives for achieving quality outcomes for senior leaders or clinicians, as seen in Portugal, the US and Spain. This can be in both secondary and primary care.

Other areas, particularly Scandinavian countries, have adopted a national focus on quality improvement that permeates throughout the health system structures. In Israel, the central focus on quality, with the publication of comparative data on specific issues, along with a highly competitive system has driven considerable improvements at a national level. To exploit economies of scale and thereby improve quality on a larger footprint, competitive pressures can also force providers to cooperate more closely across disciplinary boundaries than they otherwise would.
Conclusion

We are experiencing a rapid period of change. The move to more strategic and population-based commissioning is the future destination for CCGs. This briefing shows there are a number of lessons in the form of national and local enablers for supporting the evolution of the current commissioning structures into the next phase. These are drawn from international evidence and the perspectives of those implementing and developing policy around the new care models.

The task of transitioning is not an easy one for CCGs, but our members know it is necessary in order to do what is right for the populations they serve and to ensure the NHS is as sustainable as it can be for future years. The evolution of current commissioning into more place-based systems of care offers the opportunity for CCGs to innovate both in the planning and resource management of health and care but also to drive quality to a scale never seen before in the English NHS.

It is important that national bodies and CCGs work together on the enablers outlined in this briefing to achieve the same end goal which is to create effective local systems that improve the health and wellbeing outcomes of populations, but also support people when they are at their most vulnerable and need it most.
Acknowledgements

If you would like to speak to NHS Clinical Commissioners about this briefing, or any of the case studies within it, please email office@nhscc.org.

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Freelance researcher

We would like to thank the individuals we interviewed for the briefing:

• Dr Alistair Blair, Clinical Chair, NHS Northumberland CCG, ACO Lead, Northumberland

• Dr Amanda Doyle, Chief Clinical Officer, NHS Blackpool CCG, Lead, Lancashire and South Cumbria Sustainability and Transformation Partnership

• Ben Dyson, Executive Director of Strategy, NHS Improvement

• Ivan Ellul, Director of Commissioning Development and Planning, NHS England

• Dr Claire Fuller, Senior Responsible Officer for Sustainability and Transformation Partnership, Surrey Heartlands

• Anthony Hassall, Chief Accountable Officer, NHS Salford CCG

• Dr Graham Jackson, Clinical Chair, Aylesbury Vale CCG, Buckinghamshire ACS

• Michael Macdonnell, Director for Health System Transformation, NHS England

• Robin Miller, Deputy Director, Health Services Management Centre (HSMC), University of Birmingham

• Sarah Pickup, Deputy Chief Executive, Local Government Association

• Richard Samuel, Lead, Hampshire and Isle of Wight Sustainability and Transformation Partnership

• Ruth Robertson, Senior Fellow, The King’s Fund

• Cathy Winfield, Chief Officer, NHS Berkshire West CCGs, ACS Lead, West Berkshire

• Julie Wood, Chief Executive, NHS Clinical Commissioners

Additional resources

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

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

NHS Clinical Commissioners (2017), Supporting strategic commissioning: Collaborative working between CCGs and AHSNs.

NHS Clinical Commissioners webpage, Sharing learning from new care models.


The King’s Fund (2017), Accountable care organisations (ACOs) explained.

The NHS England website has information on accountable care models, including case studies and contract service conditions: www.england.nhs.uk

The full list of international sources can be found on the NHSCC website: www.nhscc.org
NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We’re giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, Parliament and the media. We’re building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.
Clinical commissioning groups established

Place-based commissioning to the fore, the Five Year Forward View, devolution deals

Health and social care act

Integrated health and social care

The move to ACS, ACOs, next steps on the five year forward view

Steering towards strategic commissioning
Transforming the system
What is strategic commissioning?

The next phase of commissioning must retain the strategic functions of managing population healthcare at a local level. Our members believe this means:

- Operating as high level decision-making body
- Developing sophisticated approaches to population needs assessment
- Being accountable to the local population
- Operating at a geography larger than the CCG
- Retaining strong clinical leadership
- Working with capitated budgets
- Retaining the role of a purchaser
- Focusing on outcome-based commissioning

"We want to preserve the value of clinical leadership and input into commissioning. Clinicians bring a level of credibility to a plan or objective that otherwise wouldn't be there."

"…we’ll need a strategic commissioning function, including needs assessment, setting expected outcomes that would also make sense to the population, resource allocation, strategic procurement and holding the delivery system to account."
What do clinical commissioners need?

NHSCC has identified six asks for national stakeholders to support CCG readiness for the future commissioning landscape.

1. **National clarity on the direction of travel.** For CCGs to evolve, they need to understand the range of ‘end states’ for clinical commissioning and therefore which functions remain, which work at scale and how they interact. The current policy landscape is perceived as permissive, and while this opens opportunities, it also creates risks for CCG governing bodies which are trying to execute their existing functions.

2. **Sharing best practice.** CCGs have a strong appetite to learn from each other and from areas pioneering the development of ACOs and ACSs. They ask that national bodies work with NHSCC to share learning more consistently and frequently.

3. **Support clinical commissioning leaders to manage change.** CCG leaders have fairly high morale at present. However, there are concerns about succession planning and resilience in the context of such large change programmes. It’s important to ensure existing leaders are equipped with bespoke skills in keeping resilient and collaborative in changing times. They also need to be supported as networks of leaders.

4. **Time, resource and space to transform.** CCGs need less burden from centralised reporting to ensure they can confidently plan for the future. Our members would like stronger commitment and clear policy steer on their role in transformation from the national bodies, to support the delivery of longer-term change.

5. **Capabilities to support strategic commissioning.** CCGs need national support to gain the capability to commission at a larger scale for population health. Skills and tools needed to support readiness of the sector are identified as data gathering and analysis, predictive modelling, succession planning and organisational development.

6. **An improved regulatory framework.** CCG leaders feel that the pace of change towards ACOs and ACSs was fast, but their confidence in the regulatory framework’s ability to catch up was low. CCGs would like a single regulatory framework which will mirror the way integrated provision will work on the ground, ie as one system. For strategic commissioning specifically, our members are clear the assurance process would need to be lean and high level.

To read the full research report visit [www.nhscqc.org](http://www.nhscqc.org)
The challenges

Our members envisage significant risks in the current pace of change. These include a perception that the national regulators are not keeping up with the volume and complexity of developments, that there is little clarity for CCGs on the direction of strategic commissioning or ‘end state’, and concerns about provider readiness.

Legislative framework

Concerns that the national bodies will not be able to adapt current regulation to the pace of change and collaboration needed. While STPs are potential catalysts, our members are concerned about their accountability.

Untried models

Concerns that many of the emerging landscapes are as of yet untried models in the UK context and this could have unintended consequences if they are not closely monitored or supported.

Skills gap

For CCGs to be ready for more strategic working, they need skills in data gathering and analysis, navigating the legislation, organisational development, succession planning, collaborative leadership.

Capacity

Our members believe their CCG does not currently have the capacity to undertake strategic commissioning.

Readiness for integrated working

Concerns about managing legacy debt and the current fragility of providers across primary, secondary and social care.

Time

Managing the pressures of today with planning for tomorrow.
<table>
<thead>
<tr>
<th>ACTION</th>
<th>STATUS</th>
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<tbody>
<tr>
<td><strong>Steering Group meeting: Wednesday 11 October</strong></td>
<td></td>
</tr>
<tr>
<td>LC to be invited to attend future meeting of the forum and update on</td>
<td>COMPLETE – attending 10.01.18</td>
</tr>
<tr>
<td>the college’s progress in addressing issues at a national level.</td>
<td></td>
</tr>
<tr>
<td>RL to make amendments following feedback received from members prior</td>
<td>COMPLETE – Revised version 10.01.18</td>
</tr>
<tr>
<td>to further discussion at the roundtable. Revised version to be</td>
<td></td>
</tr>
<tr>
<td>shared with Forum in January for publication in January.</td>
<td></td>
</tr>
<tr>
<td>NHSCC to hold teleconference with Department of Health on revision to</td>
<td>COMPLETE</td>
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<tr>
<td>the National Framework on 30th October. Members invited to attend to</td>
<td></td>
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<tr>
<td>share views.</td>
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<tr>
<td>TM to revise terms of reference based on feedback for ratification at</td>
<td>COMPLETE</td>
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<tr>
<td>inaugural full Forum meeting in January.</td>
<td></td>
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<tr>
<td>NHSCC to work with CO to produce NHS voices blog on nursing</td>
<td>COMPLETE</td>
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<tr>
<td>workforce pressure.</td>
<td></td>
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<tr>
<td>NHSCC to work with CO’B to produce blog on CHC challenges to coincide</td>
<td>COMPLETE</td>
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<tr>
<td>with publication of CHC document.</td>
<td></td>
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<tr>
<td>NHSCC to include ‘safeguarding’ as a hot topic for discussion at the</td>
<td>COMPLETE</td>
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<tr>
<td>January meeting of the Forum.</td>
<td></td>
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<tr>
<td>NHSCC to invite HEE to attend next meeting to discuss workforce</td>
<td>Unable to attend 10.01.18</td>
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<tr>
<td>issues.</td>
<td></td>
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<tr>
<td>CO’B invited to share GPN 10-point plan that had been developed</td>
<td></td>
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<tr>
<td>locally.</td>
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<tr>
<td>Discuss membership of the Leading Change Adding Value working group</td>
<td>COMPLETE - Meeting 15.01.18</td>
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<tr>
<td>at meeting with CNO in new year.</td>
<td></td>
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<tr>
<td>CO’B invited to send through details of QWG meetings.</td>
<td></td>
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<tr>
<td>NHSCC to undertake registration of member’s area of interest to</td>
<td>To be included in Jan bulletin</td>
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<td>ensure that future work was appropriately allocated.</td>
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<tr>
<td><strong>Steering Group meeting: Tuesday 4 July</strong></td>
<td></td>
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<tr>
<td>NHSCC to invite NMC and HEE to attend next meeting to discuss Nursing</td>
<td>Ongoing – Unable to attend 10.01.18</td>
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<tr>
<td><strong>Steering Group meeting: Tuesday 4 July</strong></td>
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<tr>
<td>NHSCC to highlight new A-EQUIP model in July Nurses Forum bulletin</td>
<td>COMPLETE</td>
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<tr>
<td>NHSCC to review Nurses Forum terms of reference</td>
<td>COMPLETE</td>
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<tr>
<td>NHSCC to survey members on current challenges and engagement in development of new commissioning models</td>
<td>COMPLETE</td>
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<tr>
<td>Chair to speak at forthcoming Nursing Times Director of Nursing Conference</td>
<td>COMPLETE 05.10.17</td>
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<tr>
<td>Chair to discuss regulatory structure for new commissioning system and involvement of commissioning nurse in future article/blog</td>
<td>COMPLETE</td>
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<tr>
<td>Members invited to share job descriptions of director of quality with nursing at its core in July Nurses Forum bulletin</td>
<td>COMPLETE</td>
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<tr>
<td>NHSCC to revise future group meetings to align with NHSCC Board meetings, alter timings and engage with NHS England Nursing Directorate for regular attendance at future meetings.</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>NHSCC to ensure that NHS England nursing directorate representative is invited to attend future meetings</td>
<td>COMPLETE – to attend next meeting</td>
</tr>
<tr>
<td>NHSCC/Chair to send letter to Chief Nursing Officer to request meeting</td>
<td>COMPLETE – meeting date finalised</td>
</tr>
<tr>
<td>MA-E to share standard letter to demonstrate commissioning nurse requirement to act as registered nurses</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>NHSCC to advise Nurses Forum members to contact pension agency to request pension statement</td>
<td>COMPLETE</td>
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<tr>
<td>NHSCC to include CHC survey in forthcoming issue of Connect</td>
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NHS Continuing Healthcare: Effective commissioning approaches

Introduction
NHS Continuing Healthcare (CHC) is a package of care funded, commissioned and case managed by the NHS for individuals who have a 'primary health need'. Assessment and provision of CHC follows the process set out in the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (Revised 2012), underpinned by the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 as amended by The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013). Clinical Commissioning Groups (CCGs) commission and are statutorily accountable for the delivery of CHC in local areas.

Continuing Healthcare assessment process
- Patients are screened to determine if they should be assessed for CHC through a nationally prescribed Checklist, and an equity monitoring form is completed (Department of Health 2012, 2013).
- A nationally prescribed Decision Support Tool (DST) is completed to determine if an individual is eligible (Department of Health, 2016).
- The decision is checked and verified by a commissioner lead and only in exceptional circumstances is the recommendation not followed e.g. The quality of the care package does not meet the care needs of the individual.
- If the individual is eligible for CHC the commissioner arranges and funds the care placement.
- Individuals with a rapidly deteriorating condition that may be entering a terminal phase may require a Fast Track to CHC, so that they can immediately receive CHC.
- The commissioner is responsible for ensuring that there is ongoing case management and regular reviews of CHC.
- If the individual does not agree with the eligibility decision they can follow a resolution and appeals process which can include an independent review undertaken by NHS England outside of the CCG.

Why is this a priority area for CCGs?
**Increasing cost and expected savings** – CHC accounts for 4.9% of the total NHS budget. There was a 16% increase in spending on CHC between 2013-14 and 2015-16. NHS England expects delivery of £855m of savings by 2020/21 from reducing administration assessment costs and the overall cost of CHC provision.

**Variation and opportunity** – There is significant variation between CCGs in both the number and proportion of people assessed as eligible for CHC that cannot be explained by local demographics or local core services alone. This suggests that there are considerable opportunities to deliver efficiencies. Within CCGs the percentage of the local budget that is spent on CHC varies from 2.1% to 10.4%.

**Meeting the needs of the local population**– An ageing population and an increasing number of people living with multiple co-morbidities means that CHC is a priority for the populations that CCGs serve. There are considerable opportunities to improve processes to ensure that individuals needs are met more efficiently and effectively. The Continuing Healthcare Alliance report *Continuing to care? Is NHS continuing healthcare supporting the people who need it in England?* outlines some of the issues that patients experience in accessing CHC funding.

This document outlines key learning points from those CCGs that have achieved significant improvements in delivery of CHC in their local area and the national support that could be
provided to local decision-making. The document was informed by a series of interviews with high performing areas, with direct quotes included, and a roundtable with representatives from CCGs, Association of Directors of Adult Social Services (ADASS), the Continuing Healthcare Alliance and NHS England.

**Best practice approaches to delivering CHC locally**
The optimum commissioning approach is to reduce the need for CHC by commissioning effective health services to support long-term conditions and end of life care to allow people to live in an optimised health condition for longer. Due to a lack of capacity, financial pressures and a range of other issues this is not always possible.

The following approaches and practice were observed to improve the efficiency, effectiveness and patient experience of CHC:

1. **CCG leadership prioritising CHC** - Those areas that have made most progress in delivering CHC effectively have benefited from strong sustained leadership supporting changes, a clear vision and a balanced approach to the underpinning principles.

2. **Ongoing case management** - CCGs have improved the delivery of CHC through locality case management approaches and integration with core provider services.

3. **Collaboration with social care** - Joint working at an operational level with the organisations responsible for care delivery has ensured a better experience for patients and delivery of cost efficiencies.

4. **Develop positive relationships with families** - It is essential to communicate clearly and compassionately with individuals and families, ensuring that there is an understanding of the process and that expectations are clearly established at the outset.

5. **Control of process and appropriate metrics and measures** - CHC can be most efficient and effective when there is CCG control of the processes at an appropriate local level, where refined metrics are utilised, and where there is a focus on process improvement.

6. **Appropriate skill mix, capacity and capability** – The appropriate skill mix within the CHC team was found to provide opportunities to free up clinical and social care professional time. CHC teams at scale allows for increased competency and consistency in assessments, efficient management, release of cost savings and the development of specialist skill sets.

7. **Develop an in-depth understanding of the Framework and quality assurance** - Many issues around CHC can be prevented and easily resolved by ensuring that there is an in-depth understanding of the Framework and a robust evidence-based assessment of individuals’ care needs within local CHC teams.

8. **Complete the checklist at the right point and monitor unintended consequences** - CHC is a highly complex and nuanced process and CCGs should look to mitigate possible unintended consequences of incentives and support the completion of high quality checklists in order to improve efficiency.

9. **Rapid Fast Track validation** - A dedicated CHC fast track validation process is useful in ensuring that the appropriate referrals receive timely care and a full CHC assessment if appropriate, however, this is still used in many areas for urgent, perhaps inappropriate, discharge.
10. **Population level commissioning** – There are opportunities to improve the patient experience of CHC and the care delivered, as well as addressing increasing costs, through population level approaches.
**National support**
Alongside adoption of best practice approaches from CCG colleagues there are several actions that can be taken by the national bodies to support local delivery:

1. **Recognise and value the CHC workforce**
   NHS England should define the scope of the CHC workforce roles, the skills required and share examples of effective team structures. The RCN must provide appropriate professional support for CHC nurses and a national CHC specialist forum should be established.

2. **Address workload pressures**
   Only around 18% of checklist screenings lead to an individual being assessed as eligible for CHC, however, this consumes a vast amount of workforce resource, not only with the CCG but also across the wider provider nursing and social care workforce. NHS England should develop a pre-checklist process to manage the number of claims that proceed to assessment or consider changing the checklist and threshold to ensure a more equitable and effective use. This should be coupled with a national information campaign to ensure that the public’s expectations are managed.

3. **Develop national guidance that supports local process**
   There are several areas where NHS England can provide national guidance or adjustment of current process which would support the effective delivery of CHC processes locally. These include:
   - Incentivise assessment following an acute phase rather than a specified setting.
   - Develop a consistent national approach to assessing care package costs, and national specifications for care homes and domiciliary care packages.
   - Clarify the process around responsible commissioner arrangements for out-of-area placements and develop a process for dispute resolution. This should include incentivisation for closer collaboration between the NHS and local authorities.

4. **Establish a national process for sharing legal advice where appropriate between CCGs**
   Our members report considerable variability in legal advice provided at a local level. This acts as considerable additional cost pressure for CCGs and for the wider NHS. NHS England should facilitate the sharing of endorsed legal advice between CCGs to reduce variation between local areas.

5. **Establish a policy feedback forum to ensure effective communication with those responsible for delivery**
   The Department of Health and NHS England should ensure that CCGs are represented throughout the CHC policy review process and there should be an opportunity for CCGs to feedback live issues as they arise. NHSCC should establish an informal forum of CCG CHC leads and hold an annual conference to promote sharing of best practice and discussion with national organisations.
NHS Continuing Healthcare: Effective commissioning approaches

Members identified ten characteristics that improve the overall process of CHC delivery for patients and CCGs in local areas.

1 CCG leadership prioritising CHC

“CHC is viewed as an integral part of the CCG’s provision of care with the aim of providing proactive and ongoing case management of CHC patients. The team has a clear emphasis on quality and a personal approach to CHC. The CCG views CHC as inextricably linked to the nurse leadership and improving quality agenda.”

Where CHC teams have the full support of senior leadership within the CCG, with either direct reporting or close links to the chief nurse and quality directorate, they are more likely to feel integrated within the CCG and core services, continually seek to improve the patient experience and effectiveness of CHC, and contribute more widely to the quality agenda. Consideration must be given to the maintenance of the executive nursing role in the evolving commissioning system and the link with delivery of quality services, especially given that this is such an increasing cost for CCGs. However, ownership for effective delivery must be CCG-wide, rather than seen as the sole responsibility of the executive nurse.

Where CHC works well there is often a balanced approach to the inter-related delivery principles underpinning CHC. There are several core delivery principles that should underpin CHC including meeting individual patient need, delivering quality and well managed care, ensuring positive relationships with individuals, families and providers, safety, compassionate working practices, provision of patient choice and equity, and cost effectiveness.

2 Ongoing case management

“The CHC nurses are viewed as end to end case managers, in which acting as a CHC nurse assessor is just one component of their role.”

The national framework outlines that there must be “ongoing case management”, That can be undertaken as a yearly review and reassessment. However, where there is more regular contact and effective case management there is more likely to be effective assurance that care packages meet patient needs, more robust contract and provider management, and improved communication and relationships with individuals, families and providers.

Several CCGs have adopted a tiered approach to CHC reviews as opposed to undertaking these on an annual basis. The tiered approach works well when coupled with ongoing case management of the individual and their care package, so that there is regular contact with individuals and families and an in-depth understanding of changes in situation and conditions. The tiered approach is based on a determination of complexity and likelihood of changing care needs – where conditions are non-improving and well-managed there is a lower tier assessment through desk and phone based collation of evidence and reassessment. The next tier is assessment by a CHC nurse for less complex cases that are unlikely to have changed, and then through to full MDT reviews for those cases that are likely to require changes to eligibility or care packages. This ensures more effective use of health and social care resources and more appropriate reassessment. However, this approach only works if CHC is viewed as a core CCG service and individuals are connected into mainstream services that can highlight significant changes if needed.

The CHC case coordinator role

Some CCGs are beginning to implement a robust case management approach to CHC, based around local joint working with core services and social care. Where this works well, CHC case coordinators provide an end to end service based on a geographical area through ongoing management of a case load of individuals throughout the process: from the
checklist referral; eligibility decision making; booking care; and then through to ongoing monitoring of care packages. They establish care packages within existing services where possible, but if this is unsuitable then they would also commission care if required. Where this has been introduced the case coordinator is a generally employed at Agenda for Change Band 4 and is part of an integrated health and social care neighbourhood team, linking to nursing staff when care needs change. They can also be allocated to specific care homes providing a point of contact for that home enabling ongoing relationship and contract management and ongoing checks to identify good practice as well as flag areas of concern.

The CHC coordinator role also provides CHC teams with more fulfilling roles, as they stay closely involved and work with patients, families and providers to monitor and adjust packages of care to meet patient needs and expected outcomes. This can improve recruitment and retention for CHC assessment roles which is an ongoing challenge for CCGs.

3  Collaboration with social care

“Many CCGs are moving towards closer working with social care around CHC. This is a result of increasing recognition of the opportunities to provide a better experience for patients and to achieve cost efficiencies through pooling resources, reducing duplication, and ensuring that the most suitable and cost-effective packages can be identified.”

CCGs reported that the approach local authorities take to working with health colleagues to support individuals strongly influences the CHC process. Where there has been effective collaboration around CHC and joint packages of care, CCGs reported that there were often existing good relationships, trust between organisations and a clear leadership from the top of organisations. This takes both time and commitment from senior leadership to establish and it is only through working collaboratively that long term cost disputes can be resolved.

Joint working at an operational level, with leadership that supports these arrangements, is essential to provide a better experience for patients and achieve cost efficiencies. This includes streamlining assessments across health and social care, having clear contact points for individuals, pooling resources, reducing administrative duplication, brokering care packages, and joint ongoing case management.

Joint packages of care

If an individual does not qualify for CHC the NHS may still have a responsibility to contribute to that person’s health needs either by directly providing services or by part funding the package of support. Where a package of support is provided by both the local authority and NHS, this is known as a ‘joint package.’

The funding split of joint packages for individuals can be a potential point of tension between health and social care, as well as with individuals and families. Openness, transparency, consistency, evidence based decision making, empathy and clear communication are essential for effective determination of joint packages of care. The most effective approach may be a fully integrated model and pooled budget, although most health and social care budgets are separate with policies to agree funding splits for individual patients. These policies should be developed collaboratively by the CCG and local authority and ratified through appropriate governance structures.

Joint packages of care work well when there are positive and mature relationships between health and social care and when there is trust and delegated authority for lead nurses and social workers to decide on the package for individuals (usually below a certain cost level), often with the more easily identifiable health and social care cost components allocated accordingly and then the remaining component costs split equally between health and social care. A process for senior review and sign-off all joint high-cost packages for individuals.
ensures that care needs are met, that all options for care provision have been explored and there is increased consistency across the local area. This can also form the basis for the development of effective relationships, for example, one CCG found benefit in the CCG chief nurse and social care director reviewing and quality assuring decisions regarding eligibility and cost-splits for each case at the start of implementation. Then, as the system became more established and trust developed, the authority to make decisions on funding splits was delegated to the CHC team and social care colleagues, with senior review of more complex cases or cases over an agreed threshold.

**Joint commissioning**

Whereas joint packages of care are for individuals, joint commissioning arrangements are the broader systems and processes underpinning the purchase of care packages. Some CCGs are adopting a form of joint health and social care brokerage for commissioning care home places and domiciliary care to ensure price comparability – asking providers to tender for care packages, which are not specifically identified as coming from health or social care, and having a single shared health and social care system to purchase the final care packages.

Some CCGs have also worked with local authorities to commission domiciliary care on a locality basis to streamline provision. This involves a tender for a single ‘prime’ provider to contract for a specified number of guaranteed monthly hours. The prime provider is one that covers a set geography and either develops a workforce with the capacity to meet demand and/or holds contractual relationships with smaller providers and sub-contracts to them. This has been most successful when there is assurance that the prime provider is able to effectively engage and co-ordinate subcontractors and when implementation is undertaken during a relatively low demand and high capacity period.

4 Develop relationships with families

“At the point of undertaking the checklist, it can be an incredibly emotive time for the patient and their family - maintaining compassion, empathy and clear communication to manage expectations is critical.”

A positive relationship with patients and families is crucial to effective delivery of CHC. Positive relationships and communication enables issues to be resolved rapidly and prevents an escalation of problems and complaints. There is considerable value in maintaining a consistent point of contact for the public and to signpost those who are ineligible to mainstream services and patient organisations.

This can only be achieved by the development of a confident, professional, stable and empowered workforce that is able to manage expectations and be assured in their approach. Some CCGs have found benefit from providing a rolling programme of monthly joint NHS and Local Authority training sessions on CHC. These have been found to improve the appropriate use of the Checklist and reduce inappropriate submissions, as well as promote staff awareness of the need for consistent communication to patients and families about CHC to manage expectations. A named CHC contact for each GP practice has also been found to reduce inappropriate referrals and increase understanding.

CCGs have developed dedicated teams to address initial complaints from individuals following a failed assessment. They undertake a reappraisal of the evidence of the ineligibility decision if cases are particularly complex. Informal resolution has worked well where there is a clear emphasis on preventing escalation and a compassionate approach is adopted. The engagement of front-line clinicians in developing an understanding of the overarching eligibility criteria to ensure that realistic discussions regarding eligibility are undertaken in the first instance has been shown to reduce the number of ineligible claims and is especially effective when led by the senior team in the CCG.
5 Control of process and appropriate metrics and measures

“We have worked to get tight control over the process with weekly control room meetings with key CHC staff which offers fifty-two opportunities to get it right. The meetings have ongoing short smart actions to continually improve the process.”

CCGs have found that CHC can be more efficient and effective when there is tight control of systems and processes and consistent leadership focused on improvement. CCGs have found retaining responsibility for CHC in-house resulted in better “grip” of the process and allowed for improvement in processes and data quality as well as future modelling and planning. Where the CHC assessment and review process was in a Commissioning Support Unit (CSU) there is a risk of fragmentation of the process – particularly as local authorities, providers and individuals find it difficult to determine the lead for CHC for a specific CCG.

CCGs reported that national statistics on CHC do not provide a useful or accurate platform to understand local CHC issues, and a more refined approach is required that does not rely on crude conclusions for what is a highly complex area. The effectiveness of approaches can only be determined through more refined assessments and understanding of local arrangements including benchmarking cases, individual feedback mechanisms and collation of patient stories, complaint rates, and resolution approaches and outcomes. Effective benchmarking across the system act as an effective mechanism to ensure quality and consistency.

6 Appropriate skill mix, capacity and capability

“Reviewing the skill mix and delivering CHC at scale can release clinical time and result in a more supported process.”

CCGs are increasingly developing comprehensive CHC teams that comprise staff with the expertise and knowledge to complete assessments for the range of individuals requiring CHC funding. These specialist staff develop relationships with individuals and providers and extend their roles to support improvements in case management and service delivery. Many CCGs are also moving towards increasingly closer working with social care supporting secondments of social workers to the CHC team or providing joint posts.

There are considerable benefits in operating a CHC team that covers a larger population, potentially across an STP footprint, rather than an individual CCG level. These include improved consistency and quality assurance across the area, effective peer support and review, access to greater administrative resource, enabling increasing specialisation of CHC roles, release of workforce efficiencies, opportunities to develop a CHC career pathway and the development of a team structure which empowers senior nurses to act as leaders of teams of case coordinators. There is also potential to release considerable administrative efficiencies by operating at a larger scale.

7 Develop an in-depth understanding of the Framework and quality assurance

“If CCGs followed the Framework then a lot of variability would be avoided. There are instances where assessors are following the decision support tool, without referencing the Framework and legal context.”

Many challenges that CCGs experience around CHC could be prevented and resolved by ensuring that there is an in-depth understanding of the Framework and robust evidence-based assessment of individuals’ care needs. When a decision is made the assessor must have a detailed knowledge of the Framework, case law and an in-depth experience of CHC to ensure consistent and fair application of the Framework. National support for the CHC
workforce will act as a key enabler for the development of this understanding as will the retention of experienced individuals.

Peer support and review is viewed as a critical component in terms of ongoing quality assurance and sharing learning, as well as for supporting nurses following challenging cases and situations. Some CCGs undertake bi-yearly education and peer support away days, where they review case law, the Framework and issues that have arisen in the locality. This can support increased consistency and mitigate the effects of isolation of CHC nurses. Other CCGs have a monthly peer review process where a nurse undertakes observation of another CHC nurse in the team, with feedback exchanged. A further approach has been the establishment of internal verification panels, where two or three CHC assessors review all the Decision Support Tool (DST) assessments and evidence and decision-make collectively, this reduces the vulnerability of individual assessors and results in a clear and consistent CCG decision making approach. The non-eligible assessments are also reviewed, to ensure that these decisions are quality assured.

8 Complete the Checklist at the right point and monitor unintended consequences

“Many CCGs are increasingly recognising the need to ensure that the checklist is initially used at the right point in the patient’s recovery – after appropriate rehabilitation or reablement services.”

The Checklist must be completed by someone with a clear understanding of the CHC process. Subsequent assessments after a positive Checklist referral should be undertaken in a timely manner so that a care package can be put in place for individuals that are eligible. Completing the Checklist after a period of rehabilitation is recognised as best practice. There are targets in place for CCGs to complete assessments in the community at the right point in a patient’s recovery. However, these focus on setting and could be better focused on assessing after an “acute phase” – regardless of location (hospital, care homes or at home). CCGs should be mindful of the potential for unintended consequences in local relationships or patient experience if crude targets for completion are the focus of local CHC process.

9 Rapid Fast Track validation

“Dedicated CHC fast track nurses provide rapid validation to ensure that the appropriate referrals receive timely care and that cases requiring full CHC assessment are handed on. The fast track nurse aims to visit and assess all referrals within two days and then undertake rolling reviews to ensure that patients are receiving a care package that meets their needs.”

Some CCGs have a dedicated internal CHC nurse to provide rapid validation of Fast Track referrals, ensure that the appropriate referrals receive timely care and that cases requiring the full CHC assessment are appropriately managed. This validation function has been implemented in response to increasing referrals that have been submitted to by-pass the full CHC process.

10 Population level commissioning

“CHC is an individual process and results in individual decision based on that patient’s clinical need. However, there are opportunities to improve the patient experience of CHC and the care delivered, as well as cost improvement, through robust analysis to determine patient cohorts and to commission and develop services to meet cohort needs – particularly for end of life care.”

CCGs are exploring new models of commissioning and delivery of services to populations, whilst maintaining assurance that individual assessed needs are met. They are also increasingly looking to integrate CHC more closely into core community services particularly
where there is a concern that CHC is being used to fill service gaps in urgent care and end of life pathways. This is an inefficient approach to CHC, as it is based on a purchase of care package for individuals, whereas the analysis of population need, pathway design and purchase of services to meet cohort needs is more efficient.

Although CHC eligibility is based on a case by case assessment, there are opportunities to improve the patient experience of CHC and the care delivered, as well as releasing cost efficiencies through robust analysis to determine patient cohorts within CHC and to strategically commission and develop services to meet those cohort needs. For example, commissioning flexible frailty services and end of life care services in the community that can in-reach into other provider services - rather than spot purchase commissioning on a case by case basis for Fast Tracks. In one area, the Fast Track process has been embedded in the mainstream end of life care service, with palliative care experts undertaking the assessments for ratification within the CCG and providing care packages for individuals nearing the end of their life – this approach has led to more effective provision of services and a 50% reduction in the number of Fast Tracks assessments in a year.
National support

1 Recognise and value the CHC workforce
The role of the CCG CHC nurse and assessors has been stretched to encompass a range of tasks, whilst lacking the national recognition or support afforded to other sectors of the nursing profession. With responsibility for the effective delivery and management of nearly 5% of the NHS budget there is a clear need to ensure that this workforce is effectively supported. The Royal College of Nursing should recognise this as a distinct role undertaken by a nurse and provide appropriate collegiate support. NHS England should seek to define the scope of the role, the skills required and the potential structures of local teams building on best practice approaches developed in local areas. This should also include support for the current workforce through the development of a CHC specialist forum or network. There must also be clarity on the special class status for CHC nurses.

2 Address workload pressures
CCGs want to ensure that those eligible for CHC are appropriately identified in a timely way; however, thresholds in the Checklist are calibrated at a relatively low level, which results in many referrals going through to the CCG that are then subsequently unsuccessful. It is estimated that only about 18% of Checklist screenings in 2015-16 led to the individual being assessed as eligible for CHC. CCGs reported that conversion rates from Checklist to eligibility as ranging from 13% - 40%. Given the nursing and social care resource required to assess individuals, a review of the Checklist threshold must be undertaken. NHS England should develop a pre-checklist process to manage the number of claims that proceed to assessment.

Referrals from Checklist screening raise patient and family expectation and then result in complaints when referrals are unsuccessful. The number of referrals found ineligible and subsequent appeals and complaints was found to place significant resource and emotional strain on CHC teams (each assessment was reported to take at least 25 hours of nursing time), and results in backlogs of assessments and ultimately delays for those patients who will be eligible for CHC. NHS England should deliver a national public information campaign to manage the expectations for CHC claims and reduce the burden on local CHC teams.

6. Develop national guidance that supports local process
There are several areas where NHS England can provide national guidance or the adjustment of current process that would support the effective delivery of CHC processes locally and reduce variation. These include:

- Incentivise assessment following an acute phase rather than a specified setting in recognition that individuals can be in an acute phase in hospitals, community beds and/or at home. Incentives should be based on a specific number assessed for a CCG on an individual basis, rather than a standard percentage. This will address unintended consequences of incentivising assessment in specific settings.

- Develop a consistent national approach to assessing care package costs, and national specifications for care homes and domiciliary care packages. There is currently considerable variability in charges to CCGs and level of service delivered.

- Clarify the process around responsible commissioner arrangements for out-of-area placements and develop a process for dispute resolution. Our members find it challenging to provide ongoing case management at distance; some placements can be hundreds of miles away leading to a lack of robust oversight and co-ordination of care provision, with only yearly reviews being undertaken. This can lead to a more difficult relationship with individuals and families as the CHC team can lack up-to-
date knowledge of the individual’s care needs as well as a lack of clarity of responsibilities between the commissioning and local CCG.

6 Establish a national process for sharing legal advice where appropriate between CCGs
Currently CCGs seek legal advice on points of clarification within the CHC system and for specific individual cases. This creates a significant cost pressure for CCGs and is felt nationally in the total cost of CHC delivery. This has also led to inconsistency as local legal firms can give differing advice and often seek to support the CCGs proposed approaches to policies and individual cases rather than offering robust challenge. NHS England should encourage sharing of legal advice where appropriate between CCGs, and establish a central repository of endorsed approaches.

7 Establish a policy feedback forum to ensure effective links with the reality of delivery on the ground
CCGs highlighted the value of the NHS Continuing Healthcare National Policy Advisory Group as a source of consistent advice and guidance on policy areas and as a forum for raising issues and ideas. The Department of Health should ensure clear links between CCGs and this group, ensuring that information is shared on a two-way basis through the establishment of a formal policy feedback forum hosted by NHSCC. NHSCC should establish this forum and hold an annual meeting of CHC leads to facilitate sharing of best practice. NHS England should test policy proposals with this group and seek their advice in the development of national guidance.
Acknowledgements
If you would like to speak to NHS Clinical Commissioners about this report please email office@nhscqc.org

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- Tom Brown, National Lead Officer, London Borough of Bexley
- Alison Cain, CHC lead, NHS West Leicestershire CCG
- Tracey Cole, Head of Continuing Healthcare & Complex Care, Cheshire and Wirral CCGs
- Mary Currie, Governing Body Nurse, NHS Bexley CCG
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- Susan Grose, Head of Commissioning and Transformation (CHC), NHS Brighton and Hove CCG
- Rebecca Hulme, Chief Nurse, NHS Great Yarmouth and Waveney CCG
- Jim Ledwidge, ADASS
- Marina Lewis, IPA/CHC Clinical Lead, Midlands and Lancashire CSU
- Jane Lunt, Head of Quality/Chief Nurse, NHS Liverpool CCG
- Christine Morris, Director of Nursing & Quality Telford & Wrekin CCG, NHS Telford & Wrekin CCG
- Dawn Newman, CHC lead, NHS Great Yarmouth and Waveney CCG
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- Debbie Sanders, Clinical Manager - Adult Continuing Healthcare, NHS Gloucestershire CCG
- Matina Loizou, Chair, Continuing Healthcare Alliance
- Louise Spencer, CHC lead, South Eastern Hampshire/Fareham and Gosport Hampshire CCG Partnership
**Additional Resources**


NHSCC Nurses Forum
Terms of Reference

Date of ratification: TBC – January 2018

This document presents the terms of reference for the NHSCC Nurses Forum, a network of NHS Clinical Commissioners (NHSCC).

Aims
The NHSCC Nurses Forum is the independent voice for the commissioning nurse. Those that are involved in the strategic commissioning of services across a place, for example, as an executive nurse within a CCG, as a lay or independent nurse on the CCG governing body or as a Director of Quality or similar.

The aims of the Nurses Forum can broadly be divided into three areas:

1. Supporting members and sharing best practice
2. Strategic influencing of national policy
3. Strategic leadership for the CCG nursing community

Functions
The functions of the Nurses Forum are:

• To act as the independent voice for the commissioning nurse at a national level
• To influence national policy relevant to the commissioning and quality assurance of services related to members’ roles
• To disseminate relevant information to the wider forum on a regular basis to improve networking and development.
• To share learning between members and provide a safe space to discuss issues affecting them.
• To work closely with external stakeholders to progress the national policy priorities for commissioning nurses

Policy Areas
The forum has identified three areas of work that will be the focus of the forum:

1. Transformation
2. Quality
3. Challenges & Conflicts of the CCG Nurse role

Further details of these policy areas can be found in the Annex below
Membership

Membership of the network is open to all nurses employed by a CCG whose CCG is a member of NHSCC (as of January 2018 over 90% of the CCG community). A list of NHSCC members can be found on the NHSCC website. Members will be invited to share their areas of policy interest so that members can be deployed appropriately nationally.

Governance

The chair of the Nurses Forum will be the representative nurse on the NHSCC board. The nurse member for the NHSCC board must be on their CCG governing body and be a nurse.

The chair from July 2017 will be Lorna Collingwood-Burke, Chief Nursing Officer, NHS NEW Devon CCG.

The chair will be invited to select a deputy from amongst Steering Group members who can attend meetings and perform other representative functions on the chair’s behalf.

The deputy chair from July 2017 will be Jo Harding, Director of Nursing and Quality, NHS Leeds CCG’s Partnership

Meetings

The Nurses Forum hold full forum meetings which all members are invited to attend. These will be arranged on a quarterly basis aligned with meetings of the NHSCC Board. These meetings will be held in person to facilitate effective discussion and allow for stakeholder meetings to influence national discussions. A minimum of 10 members will need to have indicated an intention to attend in advance in order for the meeting to be quorate and proceed.

The meetings will be held in London, with one meeting a year held outside of London.

Operating Model

The network will operate through a combination of face-to-face meetings, supported by web-based and email communication. The Nurses Forum bulletin will be circulated on a monthly basis.

Stakeholder relationships

Several stakeholder relationships will be required to support the work of the Forum. Examples include the Royal College of Nursing, Health Education England, the Care Quality Commission and Council of Deans of Health. The network will also seek to develop relationships with national bodies and the Department of Health.
Annex

Each of the three policy areas is considered below in relation to the priorities and issues raised by members of the group:

1. Transformation

   - As the commissioning system evolves, it is essential that the voice of the nurse at a strategic level is maintained. The forum will work to influence national policy to ensure this is enshrined in any future operating model.
   - Leading the practice nursing progression. A key function of the group will be establishing and promoting the value and development needs of practice nurses.
   - Support for commissioning nurses struggling with the role and its evolution. As the lead independent voice for commissioning nurses, the forum will act as a focus for those nurses to gain greater understanding of their role and provide a safe forum to raise and express concerns as these arise.
   - Learning and development for commissioning nurses. The forum, through the secure member area, will allow the sharing of best practice and facilitate shared learning amongst members.

2. Quality

   - The importance of quality in service delivery. The evidence for ensuring quality to improve patient outcomes are widely known, however, the focus of this work is on the accountability that an executive nurse usually holds at a national level.
   - What does quality look like? Through the sharing of best practice and case studies of effective local approaches
   - As new commissioning systems are developed and structures established it is vital that sight is not lost of the role of the executive nurse in ensuring quality.
   - The role that CCG commissioning nurses play in quality assurance and surveillance of Providers with particular emphasis on independent sector nursing/care homes.

3. Challenges & Conflicts of the Nurse CCG role

   - Finding a balance between the Professional Nursing and the commissioning parts of the role. This has proved particularly challenging, sharing of best practice and discussion in this area would be beneficial.
   - Ensuring clarity for members on how Revalidation requirements can be met by commissioning nurses.
   - Ensuring a strong nursing and Allied Health Professionals voice in commissioning. As the independent representative body for commissioning nurses, the Nurses Forum plays a key role in voicing the concerns of the nursing community in relation to commissioning.