FOR HEALTHCARE LEADERS

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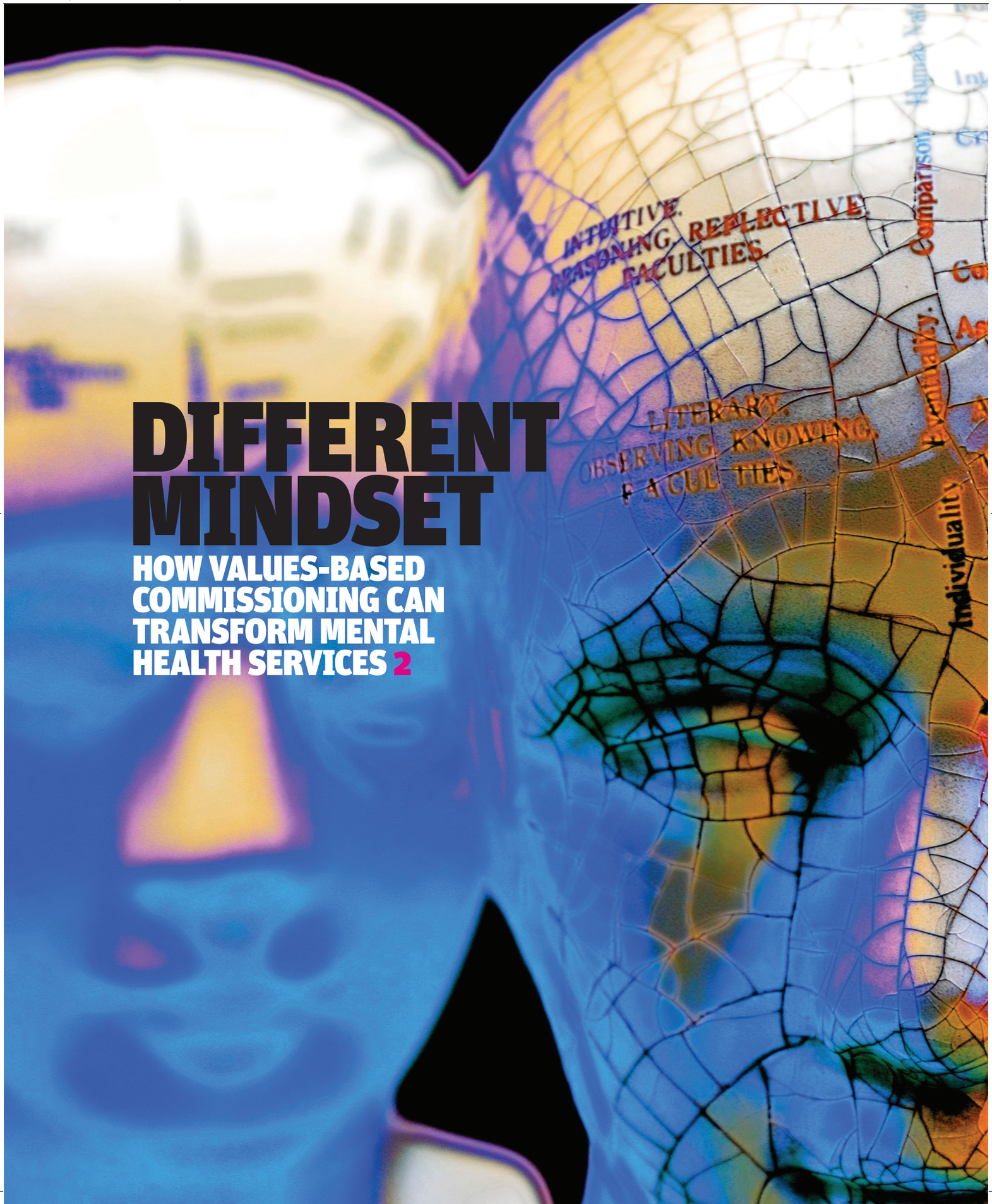

DIFFERENT MINDSET

HOW VALUES-BASED COMMISSIONING CAN TRANSFORM MENTAL HEALTH SERVICES 2

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Getting contracts right will be vital for clinical commissioning groups as they take responsibility for out of hours services. Good service design and thorough specification will be crucial to treating more people in primary care and avoiding perverse incentives for out of hours providers to send people to A&E. Page 10

MENTAL HEALTH

The future of mental health services lies in an entirely new type of commissioning that puts users at its heart. Under "values based" commissioning, service users and carers will work jointly with commissioners to lead commissioning decisions. Commissioners will pay attention not only to evidence based research but also to patients' experiences and perspectives on care. Page 2

END OF LIFE CARE

Far too many people die in hospital when they have no need to be there – and nearly two thirds of people would like to die at home. A lack of joined up working is a key barrier to creating effective, integrated end of life care pathways. Now some trusts are bringing in outside help to lead work across boundaries so that patients do get more choice about where they die. Page 10

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Helped by its network of 8,000 trained volunteers, the British Red Cross is leading the way in rethinking "reablement" services to help elderly and vulnerable people regain their independence and avoid hospital admissions. It aims not just to help them do basic tasks at home such as washing but to re-engage with the outside world. Page 14

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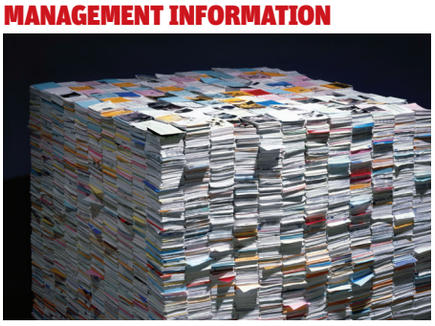

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Joint Commissioning Panel for Mental Health
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NEIL DEUCHAR AND LIZ ENGLAND ON VALUES

The quality of mental health service commissioning has, in the past, been variable. This often led to inequitable services and care, particularly when compounded by a past commissioning tendency to focus on expensive high cost and low volume services, to base service outcomes on numbers and processes, and to commission "one size fits all" service models.

The new NHS landscape offers opportunities to re-examine mental health commissioning in a way which brings together innovation, clinical expertise and patient values, experience and preferences. Treating people earlier with expert input can prevent or minimise more severe and enduring problems. In addition, the system will need to tackle population health and wellbeing and prevention of mental disorder.

To achieve this change, clinical commissioning groups will need to explore new models of commissioning that involve much broader partnership working than traditional mental health commissioning.

In addition, CCGs will need to re-define traditional targets, performance indicators and outputs to reflect patient-relevant outcomes, and focus on issues such as wellbeing, resilience, social integration and looking at physical and mental health together. Commissioners will then need to find new ways of incentivising all the elements of the system to help each other in pursuit of these new goals.

Since the Joint Commissioning Panel for Mental Health was formed two years ago, the 17 leading mental health organisations that make up its membership have worked to produce guides, resources and tools for commissioners to achieve such an approach. The panel – co-chaired by the Royal College of Psychiatrists and Royal College of General Practitioners – has produced 19 guides and a suite of tools that describe what excellence looks like and help those commissioning, providing and using mental health services to achieve it.

Critically, all this work has been premised on a "values based" commissioning (VbC) approach. This process rests on the three equal pillars of patient and carer perspectives, clinical expertise, and knowledge derived from scientific or other systematic approaches to evidence. In doing this, VbC aims to ensure users are involved at every stage of commissioning, as well as at every level of decision making.

Developing NHS leaders, practitioners and CCGs to advocate a VbC approach will create the foundations of a commissioning model with the patient at the centre. This will require changing hearts, minds and the existing dynamic between providers and commissioners. Ultimately a VbC approach is about challenging existing processes and instilling the belief that people can change things for the better.

Neil Deuchar and Liz England are co-chairs of the Joint Commissioning Panel for Mental Health
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MENTAL HEALTH

PIECE OF MY MIND

'Values based' commissioning aims to put users' views at the heart of reshaping services. By Emma Dent

Commissioning mental health is a complex area. Health, social care and the third sector can all play a part. Care may need to be provided across a range of levels. Although 90 per cent of mental health care is provided in primary care, care pathways may involve interaction with a variety of specialist services in secondary care. But these care pathways are far from seamless.

In addition to potentially failing service users, a complex care system that is not fully understood by its commissioners can lead to waste – both economic and of services that are not utilised in the right way. Clinical commissioning groups seeking value for money and good care for their local populations need to get a clear picture of what is happening.

But expertise in mental health commissioning is varied. There has been a widely acknowledged and inevitable loss of organisational memory in the dissolving of primary care trusts and forming of CCGs, and there is no clear national picture of which CCGs actually have mental health leads in place, although around 70 per cent are thought to have one. Those mental health leads that are in place must carry out that work alongside their clinical roles, in a completely new way of working.

"Some places are not getting the support they need, in terms of training about how to commission and in the informatics in what needs to be commissioned, an area where we know mental health falls behind," says mental health charity Rethink's associate director of policy, research, campaigns and advice Victoria Bleazard. "There is a chance they could be overwhelmed."

There are also concerns that the small size of CCGs, compared with that of mental health trusts, many of which cover large geographical areas and population sizes, puts them at a disadvantage.

Sophie Corlett, director of external relations at mental health charity Mind, says

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many CCGs are simply rolling on contracts as it is too early for them to be in a position to challenge the status quo. "Will [CCGs] have the courage to challenge providers on the gatekeeping of services, for example?" she asks.

Guidance on mental health commissioning is available. The Joint Commissioning Panel on Mental Health (JCPMH) – a collaboration set up two years ago between 17 organisations that is co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners – has produced guidance on commissioning specialist areas of mental health including perinatal mental health, rehabilitation services and mental health services for young people.

Values at the core

But ambitions for the future of mental health commissioning go further. What is being taken forward now is a new type of commissioning – which has been dubbed "values based" commissioning (VbC).

VbC aims to challenge the status quo. It takes a step back to see what kind of services should be commissioned and why, with service users and carers working jointly with commissioners to lead commissioning decisions. Instead of looking only to quantitative, evidence based research and

VALUES BASED COMMISSIONING – WHAT DO SERVICE USERS THINK?

Work done so far on values based commissioning in the West Midlands has been evaluated by the National Survivor User Network for Mental Health.

"We were aiming to identify both good practice and barriers in increasing service user participation, and asking service users what impact they wanted VbC to have," says Emma Perry, lead researcher on VbC for NSUN and co-author of a review of the programme.

The review found that, although service users wanted to be equal partners in services – and there was a lot of rhetoric around that participation – in reality this did not often happen, and when it did happen there was a lack of coherence about how.

"It was clear that this kind of co-production and power sharing would require a culture shift," says Ms Perry.

"If there is just one service user on a commissioning panel, they are at risk of isolation; it is not an equal partnership. There also has to be allowances made for the possibility of someone becoming unwell and unable to attend meetings, so more than one service user needs to be on a panel. Ideally carers should be on panels too."

Service users identified issues such as the need for early diagnosis and intervention, swift referral to the appropriate person or place, clear communication, continuity of care and co-care versus a paternalistic attitude by health professionals, as key to a values based system. Overall, they said, service users should be at its heart.

Other barriers to such co-production work taking place included the use of jargon.

"Language was key. However familiar the service users we spoke to were with the process, does the average person actually know what the term commissioning means? It needs to be demystified. Language can also be used to exclude. The use of acronyms was often mentioned when people for our research said they did not know what was being talked about in meetings," says Ms Perry. "Although VbC meant more jargon, they were overall pleased about the direction of travel; at least they were being asked their opinion."

● The NSUN review of VbC was launched at the end of April (available at www.nsun.org.uk). It includes recommendations on how VbC can be applied to the major areas of prevention and provision within mental health and learning disabilities, including addictions, compulsory treatment, dementia and long term conditions.

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clinical experience as a form of reference for commissioning, a more qualitative approach, making reference to patient and carer experience and perspective, is used.

In prioritising service user values and experience, says its champions, VbC aims to address the whole person. Value therefore follows – services can offer real value to the service user while also being cost effective for the service they use.

"It's about creating new models of collaborative care, deinstitutionalising patients, and increasing the ability for people to keep their home, their job, their relationship. Rather than focusing on outputs, this is about outcomes. The service should be measured in terms of the wellbeing and quality of life it results in."

So says Dr Neil Deuchar, VbC architect and champion, JCPMH co-chair and a specialist adviser on commissioning with the Royal College of Psychiatrists, whose day job is as a psychiatrist working in a primary care setting for homeless people in Birmingham.

'Why does a psychiatrist only have to see outpatients in a mental health hospital?'

But for this to happen, commissioners have to change their approach.

"From a commissioning perspective, there needs to be an understanding of the whole of the patient's needs from the beginning. It sounds like a sensible thing to do but does not necessarily always happen," says Dr Deuchar.

He acknowledges that this will require a shift in working style.

"Commissioners need not to micromanage. And health and social care professionals need to work differently to stop patients falling between two stools. Why does a psychiatrist only have to see outpatients in an outpatient setting of a mental health hospital when most mental health care is delivered in primary care? Many come into a primary care setting to work face-to-face with GPs and service users, and to discuss decisions about their recovery and treatment and physical health needs at the same time."

What happens currently is variable.

"I often see a lack of integration between all the different services – who are all providing care for the same patient – on a daily basis," says JCPMH co-chair Dr Liz England, a GP, mental health lead for a locality care group within a CCG, and National Institute for Health Research clinical lecturer at the University of Birmingham.

"We need to move towards a more person-centred model of commissioning. It is about shaping services that are about and for that person and their needs, not just commissioning services as an end point in themselves."

Dr England acknowledges this may be something of a culture shift for some professionals who have spent their working lives fixing, rather than preventing, problems.

She believes some GPs, who have become increasingly au fait with commissioning, may deal with the changes reasonably comfortably. But, for many, seismic culture changes will still be needed.

"Even in primary care, we often have little to do with social care. When we try and get in touch with non health services, half the time we do not know who to talk to. This creates barriers to integrated care," says Dr England.

"I have good relationships with some local psychiatrists and our local crisis resolution team but that is after a lot of hard work on

What do you think? Users are keen to offer their opinions about services

HOW NHS LONDON CARRIED OUT A MENTAL HEALTH COMMISSIONING TRAINING PROGRAMME

Before it was dissolved earlier this year, strategic health authority NHS London realised it had an issue regarding levels of expertise in mental health commissioning across the emerging 32 clinical commissioning groups in the capital. In response, it decided to invite the CCG mental health leads to an intensive training programme on commissioning, in a bid to create a London-wide mental health commissioning network.

Carried out in partnership between NHS London, Lucent Management Consulting and UCL Partners Academic Health Science Partnership, the training took place over 10 days, with five days of self taught study. Trainees "graduated" at the end of April.

"All the attending GPs are really passionate about mental health. We wanted to ask, 'what does good look like?', and to help commissioners decide what the mental health needs in their areas are," says Dr Geraldine Strathdee, formerly NHS London associate medical director and now a national clinical director for mental health.

The training covered issues such as personal and strategic leadership, strategic needs assessment, national and international best practice, and evidence bases around conditions and issues such as psychosis, substance misuse and children and young people, value based service improvement, commissioning tools and techniques, partnership and collaboration, and service user and carer engagement.

City and Hackney CCG mental health lead GP Dr Rhiannon England says that, as a relatively small organisation, being in a CCG can feel like being David to the mental health trust's Goliath. But focused training gave her confidence as a commissioner.

"No one told me how to chair a meeting or go through minutes properly before, so [the training] was fantastic. I didn't know how to commission, how to analyse data or know which data to ask for before. And it was incredibly valuable to be in the same room as all the other London CCG mental health leads," she says. "I now feel much more confident about asking questions [of the mental health trust], and am much better placed as a commissioner."

Each training participant carried out an assignment aimed at tackling a service issue local to them. For Dr Fiona Butler, mental health lead for West London CCG, that was the local urgent care pathway.

"We looked at how to set standards rather than specific services but there were issues around access and response time. We looked at shared communication, assessment response times, communication response times, The training gave us the time and space to push this work forward."

The CCG then held a co-production workshop including local service users and carers and health professionals to develop new standards.

"An implementation plan should now be in place by mid July," says Dr Butler.

London-wide, it is hoped the network will be able to carry out further intensive training – subjects requested by participants for further training include dual diagnosis services, autism, and a masterclass in world class primary care.

And Dr Strathdee believes what took place in London could be replicated elsewhere. "There are pockets of good practice around the country around mental health commissioning but generally the picture is mixed," she says.

both our parts. It is not the standard thing GPs do; traditionally we have been trained differently and we have worked differently. Patient-centred, integrated care based on VbC will be a new way of working."

So how to achieve such change? Though there are significant challenges in putting service users and commissioners on an equal footing, all those involved stress that working with service users and carers – through contacts with local groups, focus groups and workshops – is vital in getting VbC to have any kind of success.

"Any commissioning is at its most effective – when applied at a local level – when local groups and people work with the commissioners and mental health trusts about what works," says Rethink's Victoria Bleazard.

VbC takes this a step further, aiming to put into place services suggested, commissioned and perhaps even run, by service users and carers. The extent to which VbC work in the West Midlands has involved service users has been evaluated.

"Patient power is key," says Dr Deuchar. "There might not be scientific evidence that a patient run respite service will work but if that is what they want, a commissioner should try to make that happen.

"Co-production between patient and carer groups, clinicians and commissioners is vital at each stage of the commissioning cycle. There is evidence to suggest the more involved they are, the more likely it is they will go for a less intensive approach than a professional would opt for. So it's important the values of the patient and the professional are affiliated."

However, Dr England believes there is still often a reluctance at senior board level to take on board patient involvement in service development.

"Prioritising the concept of co-production and co-commissioning, using a VbC approach is key," she says. "In the next two to three years VbC is going to be the 'normalised' or embedded way of commissioning." ●

FIND OUT MORE

➔www.jcpmh.info

The JCPMH guide to values based commissioning is expected to be launched this month

ALAMY

JAMES CLARKE ON UNCERTAINTY

With the long term future of commissioning arrangements for out of hours services uncertain, clinical commissioning groups are faced with the task of commissioning services that may be the subject of significant policy and regulatory change during their term.

Against the backdrop of discharging statutory responsibilities and pressure to achieve greater levels of integration with other services and a reduction in A&E attendances, what does success look like for a CCG approaching procurement and contracting for historically difficult services facing significant change?

The decision to procure should be an easy one, although some wishing to set up their own out of hours services struggle to accept that at present there is no lawful mechanism for GPs to "opt back in" to the 24 hour provision of patient care.

Procurement, although an unavoidable duty, should not be seen as an obstacle to progress or a compliance "tick box" exercise, but as a key tool for a CCG to employ in order to secure precisely the services that patients need at a price that demonstrates value in compliance with statutory duties.

The inherent flexibility in APMS (Alternative Provider Medical Services) contracts means that, with careful specification, it is possible to seek the highest quality and contractual performance whilst securing bids from the widest possible pool of providers.

Some of the better known APMS contract forms of the past, however, have been beset with real practical difficulties. For example, we have seen agreements in impenetrable language, with unenforceable terms, seldom read by those with operational responsibility for services. CCGs now have an opportunity to take a new and positive approach to out of hours contracting by taking control of the commissioning process and making it serve the precise outcomes that they wish to deliver for patients. This means:

- **careful specification design, encouraging best behaviours from providers in terms of quality, value, outcomes and integration;**
- **clear drafting of contractual terms, using the flexibility offered by APMS contracts to the advantage of patients to include appropriate performance management provisions, incentives and enforceable sanctions; and**
- **making the procurement process work for each unique situation – avoiding the unsatisfactory and often legally problematic "off the shelf" approach to procurement peddled by unqualified procurement "experts".**

There is everything to play for in improving out of hours services right now. Adopting a holistic, quality driven approach to procurement and contracting processes gives CCGs a unique opportunity to make a positive impact for patients.

James Clarke is partner in the commercial department at Capsticks
www.capsticks.com

LAW

PUT IN THE HOURS

CCGs must work hard writing out of hours contracts that deliver exactly what they want. By Alison Moore

GP out of hours services are a key part of the broader urgent and emergency care picture: get provision right and the numbers of people attending A&E inappropriately may start to fall. Get it wrong and not only will A&E departments be flooded but some patients will receive poor quality and even dangerous service.

With the demise of PCTs, clinical commissioning groups have taken on the responsibility of commissioning out of hours services. "One would think that this is ideal ground for clinical commissioners to make real improvement," says Rick Stern, a director of the Primary Care Foundation. But he points out that it has coincided with the troublesome implementation of NHS 111.

With contracts coming up for renewal, some PCTs and CCGs chose to roll them over for a few additional months to allow the new bodies time to think about what they wanted – and potentially to look at the interface with the NHS 111 service.

In Sussex, for example, contracts were originally to be extended for six months to avoid them expiring as CCGs took over, but it became clear that different CCGs wanted different specifications and contracts were extended for 12 months to allow extra time to develop and commission these.

But what should be at the forefront of CCG leaders' minds as they start to contract for these services?

They are almost certainly thinking of the two pillars of quality and cost – and how they reconcile them. While good quality care may be costly, so are services which fail to meet people's needs – and lead to them attending A&E instead. In those cases, the CCG will be paying twice. Making use of this opportunity to further integrate urgent care is also likely to be prominent.

The advice from James Reynolds, head of primary care at healthcare law firm Capsticks, is that service design and specification is crucial. A well written specification will help to deliver a quality service. "The first consideration should be what constitutes a safe service and then how do you achieve the aim of treating more people in primary care," he says.

Part of this is likely to be through proper triage, good telephone advice for those patients with more minor conditions, and then access to healthcare professionals, for example through attending an out of hours centre or a home visit.

"People will spend a lot of money on the front end of the contract but not look at the specifications at the back of the contract," says his colleague Duncan Gordon-Smith. "They don't make it work for them."

One example of this is that there can be a perverse incentive for out of hours providers to send people to A&E rather than treating them themselves – unless the contract and specifications are well written. And specifications need to be enforceable and have consequences if achieved or not achieved.

Mr Gordon-Smith recommends involving other stakeholders in thinking about the specification of services and how this can drive better integration.

Right incentives

Some of these specifications can be designed to incentivise the behaviour the CCG wants to see, he suggests. These can include specifying who provides care – such as that any doctors employed by the provider should always be familiar with the NHS and staff should have undergone a detailed induction process. This could help avoid disasters such as the Ubani case – when a doctor who was not familiar with the NHS gave a patient a fatal overdose (see overleaf).

Out of hours services already have national quality requirements, covering everything from how quickly triage should start in urgent cases to auditing patient experience. Providers should be reporting to the commissioners on how they are doing against these.

CASE STUDIES OVERLEAF ▶

Bad writing: there can be a perverse incentive in contracts for out of hours providers to send people to A&E

ALAMY

Some commissioners may want to add in additional performance indicators based on their local situation. But should these be process or outcome based? Process based indicators can be easy to measure – how quickly phones are answered, for example, which is already in the national requirements. But they may not be a good proxy for the ultimate goal of high quality services.

Contracts with demands for too much information can also be an issue, according to Capsticks' James Clarke. Collecting information increases the cost of a contract and if that information is not used by the commissioner to drive improvements it is money wasted.

But measuring outcomes may be harder and can be a blunt instrument – a drop in the number of people attending A&E can be hard to link to changes in the out of hours service, for example, and may only be meaningful if the people who are not going to A&E are those who can be treated more appropriately elsewhere.

In practice, many contracts will include a range of performance indicators covering both process and outcome.

The Primary Care Foundation recently suggested additional ones could include how long patients wait in an out of hours centre; how long it takes for them to be assessed or managed over the phone; and how many cases are identified as urgent or emergency, and how quickly they are responded to.

CCGs may also be concerned about the process for procuring out of hours services. Although such contracts may be exempt from full European procurement, CCGs are still likely to have to go through an extensive procurement process including advertising the contract through Supply2Health and assessing responses against set criteria, says Mr Clarke.

There's nothing to stop local GPs applying for the contract – and they may be in a good position to do so. But there is no guarantee that they will win and they certainly can't be handed the contract on a plate. This can lead to some frustration among GPs, suggests Mr Reynolds.

And, of course, those involved in the decision making process on the CCG side will need to ensure that any conflicts of interest are managed.

But, more generally, CCGs may want to ensure that procurement aids rather than hinders integration. The interface with NHS 111 is likely to be important, together with the need to share information and to ensure that patients don't have to repeat basic details and information without cause. In some areas, procurement of the two services has been run in parallel, allowing for greater integration: but that is not universal.

So there are opportunities for CCGs to seek to improve services through good contract management. The worry for many of them will be the uncertainty around the future shape of out of hours.

Health secretary Jeremy Hunt has not ruled out a return to GP responsibility for out of hours care of their patients. And Sir Bruce Keogh has been examining out of hours as part of his wider review of urgent and emergency care. CCGs contracting for new services will be doing so in a rapidly changing environment. ●

LAW: CASE STUDIES

NEVER AGAIN

The fatal 2008 mistake of a locum from Germany and the financial collapse of an out of hours provider both offer important lessons for CCGs

DANIEL UBANI CASE

There are few cases of individual care which change the way the health system operates: but a fatal overdose of morphine given to an elderly man by an out of hours doctor has done that.

Dr Daniel Ubani, who normally worked in Germany, was on his first shift as an out of hours locum working for out of hours provider Take Care Now in Cambridgeshire when he gave 10 times the maximum recommended dose to David Gray, who had kidney stones. Mr Gray's death in 2008 focused attention on a system which allowed a tired doctor, with little experience and knowledge of the NHS, and limited induction, to treat patients.

The case has led to a general tightening up of regulations around doctors working as locums. Dr Ubani had applied for admission to the local performers' list in Leeds but had been refused. He then successfully applied in Cornwall, and, on the basis of this, was able to work in Cambridgeshire for Take Care Now.

The death of Mr Gray and the analysis of what had gone wrong focused attention on how out of hours care was delivered, managed and monitored.

A Care Quality Commission report on the case highlighted how reporting on performance was not accurate or comprehensive; flawed governance with incomplete and inaccurate reporting to the PCT around the case; and cases where doctors were not available within 50 miles, and nurses and emergency care practitioners had to cover their shifts. PCTs were generally unaware of this practice of shift covering by other staff.

What comes out of the report is a sense that, where there were failings, the PCTs commissioning services would not necessarily be made aware of them. In part this may have been because there was no requirement for them to be told – something which could be addressed through better specified contracts.

For example, there was no requirement to share information on poorly performing GPs employed by TCN. But in other areas what was specified in contracts seemed to have been ignored – for example, the timescale to respond to complaints specified by PCTs was not reflected in the TCN complaints policy until late 2008. And some information, such as around national quality requirements, did not accurately reflect actual performance.

But there was also some evidence that the PCT was not best equipped to manage the contract – for example, not understanding activity figures supplied by TCN. And relationships with TCN were not at the point where mature discussions around problems were possible.

The CQC report looked at how Cambridgeshire and other commissioners were monitoring contracts and found that out of hours had not been a high priority for PCTs and were often not reported at board meetings. The national quality requirements were not necessarily understood well by PCT staff and GPs' views on the quality of service were not regularly sought.

Some of these issues may be overcome by CCGs with their clinical focus and board members who will be aware of out of hours services that are not delivering.

But performance monitoring against specified criteria – whether outcome, process or supplying information – will be key to both raising quality of services and ensuring that penalties can be imposed if they are not met.

After the case, many PCTs tightened up restrictions – for example, by specifying that doctors working for out of hours providers had to be accepted on its local list or one of a nearby PCT. This made it more difficult for doctors to pick a PCT with lighter restrictions to register with – and then to work anywhere on the basis of this.

However, from this April the individual PCT performers' lists have been replaced by a national list, held by NHS England. The position on language qualifications is also likely to be tightened up for EU doctors from next year, through the GMC.

But CCGs who will commission out of hours services will still need to use their contractual levers to ensure that patients receive good quality care. The then national director for primary care Dr David Colin-Thomé looked at how standards could be improved for the Department of Health after the Ubani case and came up with a list of recommendations. These covered:

- ensuring performance management arrangements are "fit for purpose", including quality review meetings;
- locally developed indicators which could be linked to incentive payments;
- the importance of considering feedback from different sources – including patients and other stakeholders – and acting on the results of these, including emerging trends;
- out of hours providers should be treated as

'Performance monitoring – whether outcome, process or supplying information – will be key to raising quality'

Fatal error: locum Daniel Ubani prescribed an overdose of morphine

an integral part of the health economy, and involved in urgent care boards etc;
- robust recruitment and selection processes for clinical staff which cover the skills and knowledge they are likely to need in the local environment; and
- tailored induction processes which are completed before clinicians start work.

Many of these points could be written into contracts, and potentially could be incentivised – or penalised if not carried out.

Capsticks partner James Clarke points out: "Service specification design should never take place in a vacuum – how the specification links in with all of the other parts of the contract, and the procurement process used to put it in place, is vital to securing a stable service which can then be effectively performance managed when necessary."

CAMIDOC INSOLVENCY

Clinical commissioning groups procuring out of hours services need to think about the ability of the new provider to run a service for the contracted time – and one element of that is likely to be their financial stability.

A company in financial problems will face additional challenges in providing high quality services, including investing in improvements and meeting unexpected costs. If things worsen, there is a risk that the provider will no longer be able to provide a service, leaving commissioners to struggle to find alternatives at short notice.

Many contracts are now held by private companies or social enterprises, which may be larger than the old GP co-ops and may have more resilience to short-term pressures.

But some of the problems around contracting were shown up a couple of years ago in north London. Camidoc had been providing out of hours services in the area for some years – not entirely without incident as it was criticised for its clinical supervision following the death of a patient in 2005.

However, in early 2010 it was selected as the provider for four large PCTs – Camden, Haringey, Islington, and City and Hackney – after a procurement process. The new contract was meant to start from October 1.

But in the middle of the year, before the contract was formally started, problems emerged. A confidential independent business report for the PCTs, released over a year later to the joint health overview and scrutiny committees of the local councils, reveals that Camidoc was technically insolvent in May 2010, mainly because of nearly £800,000 in pension contributions due to the NHS Pensions Agency.

The report, by accountants Grant Thornton, said that the proposed contract would allow Camidoc to make a small profit but that this depended on a number of sensitivities and risk. A decrease in the volume of cases it handled or a failure to meet the requirements for incentive payments – or incurring penalties – would badly affect its financial position. It was uncertain whether it could continue to trade into the future without either additional payments from commissioners (it had already received extra payments under the old contract) or renegotiated terms.

But the report also indicated some wider governance and capability issues. It suggested Camidoc needed to invest in managerial capacity to allow it to concentrate on improving productivity and profitability, and it needed a cost improvement plan.

In addition, it needed to supply the PCTs with more information, including monthly reporting packs which the PCTs should include in the new contract and a plan for escalating concerns. The report also raised questions about the ability of the Camidoc board to react in a timely manner.

Part of the problem seems to have been the old contract, which was based on a payment per head rather than activity. This contributed to losses for Camidoc, which had been partly offset by additional funding from the PCTs.

In the summer of 2010 – before the new contract came in – the PCTs said they could not confidently and safely ensure continuity of the out of hours service if they entered into a new contract with Camidoc. An emergency provider – Harmoni – was appointed for a nine month period instead while the contract was reprocured and it was paid set up costs as well as an amount comparable to the proposed contract with Camidoc.

In late 2010, Camidoc was declared insolvent with debts which are thought to have been £1.5m. Harmoni had its contract extended before being given a two year contract in late 2012. A group of doctors also put in a bid, amid claims it had scored higher on quality but lower on cost than Harmoni.

While the problems with Camidoc may not have been avoided by better contracting, they do show the need for contracts to include requirements for information and reporting. Poor performance on these indicators may be a warning sign of governance or finance issues within organisations which should sound warning bells with commissioners.

But James Clarke of Capsticks adds that specifications in contracts should be realistic. He says: "I have seen services procured against a specification which contains requirements relating to insurance that are poorly designed and impossible to comply with. This puts bidders in a situation where they either have to misrepresent their ability to comply, or to submit a non-compliant bid, or attempt to enter into negotiations post-award leading to procurement risks and ultimately undermining the authority of the commissioner – clearly not a healthy start to any contractual relationship." ●

ALAMY

DAWN TAME-BATTELL ON JOINING UP SERVICES

Marie Curie Cancer Care

Too often patients spend their final days in hospital. Indeed 89 per cent of those who die in hospital do so following an emergency admission. However, as a National Audit Office report found, in one NHS trust 40 per cent of those who died in hospital had no medical need to be there. Furthermore the majority of people would prefer to die at home.

Hospital is one of the most expensive places to care for someone at the end of life, with final year hospital care costing the NHS £3.7bn a year. However faced with £20bn efficiency savings and a forecast rise in mortality rates, the healthcare system cannot continue to function as it does at the moment.

There are viable alternatives to hospital care. Shifting care from acute to community settings offers positive outcomes. There are two elements to this.

First it is essential that services are integrated and joined up, with the patient at the centre of both service design and delivery. The evaluation of Marie Curie's Delivering Choice Programme in Somerset found that those receiving an intervention were 80 per cent less likely to die in hospital compared to those who did not receive care from Delivering Choice. Furthermore emergency admissions to hospital in the last month of life were 39 per cent lower and A&E attendances 34 per cent lower for Delivering Choice service users.

Second, there need to be sufficient community services in place. A recent Nuffield Trust report on the Marie Curie Nursing Service (MCNS) found that home-based palliative care can improve care at the end of life. The study found that 77 per cent of those who received MCNS care died at home and 8 per cent died in hospital. In contrast, 35 per cent of a matched control group died at home and 42 per cent died in hospital.

'Final year hospital care costs the NHS £3.7bn a year'

There is less consensus on the financial implications of shifting care from the acute to community setting. We are confident that if this is done at scale, savings can be made. The Nuffield Trust report found total hospital costs for those who received MCNS care were £1,140 per person lower than for matched controls.

The challenges facing the healthcare system are vast but we know transformational change can be achieved through good integrated service design. For end of life patients the solutions are available; it is not what we do but how we do it that will be the test.

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END OF LIFE CARE

HOW TO FIND THE WAY HOME

Helen Mooney on addressing the 40 per cent of patients who die in hospital with no medical need to be there

The figures are telling: according to the latest mortality numbers from the Office for National Statistics more than half of all deaths still take place in hospital. This is despite the fact that, when asked, nearly two thirds of the general population say they would like to die at home and nearly a third would like to die in a hospice. Perhaps even more shocking is the fact that in some areas 69 per cent of people die in hospital.

The government's end of life care strategy published in 2008 stresses that, wherever possible, people should be able to "spend their last days in the place of their choosing".

There is also no question that someone dying in hospital is more expensive for the NHS than the same person dying in a community setting.

Hospital care for those in their last year of life costs the health service around £3.7bn a year with each patient using around 30 bed days. So why can't the NHS manage to move more dying people out of hospital and back home or into a community setting before they die, or indeed keep them out of hospital in the first place?

As with many things in the NHS the issues are numerous, yet the main sticking points are often the same across local systems. First, frequently there are not the staff in place to facilitate a co-ordinated and swift approach to hospital discharge and to getting a patient back home and, second, the fear is that if a patient is discharged to primary and community care, services will not in any case be able to adequately meet their needs.

Dawn Tame-Battell is assistant director of patient services at Marie Curie, which has been in vanguard of driving local programmes to allow more patients to die where they choose.

She says that professionals involved in end of life care have a very similar idea about what an integrated end of life care pathway should look like but that the challenge is making it a reality.

"The challenge is about getting the different elements required to provide the right care efficiently and effectively and in a way that responds to patient need.

"It is about how you pull services together around the patient. However, one thing that is different about end of life care is that time is limited and if services are not provided quickly enough people will die waiting."

She is optimistic that the changing commissioning landscape: the birth of clinical commissioning groups promises to drive more integrated working around end of life care and, if palliative care funding pilots result in a per-patient tariff, providers will in any case be forced to work in a more integrated way.

"CCGs and commissioning support units will have much less capacity [than PCTs] and they will be pushed to buy bundles of services as they won't have the bandwidth to commission lots of bits and pieces of end of life care," Ms Tame-Battell explains.

The numbers say it all. A recent study by the King's Fund highlights that using hospital beds more efficiently could save the NHS at least £1bn a year and deliver benefits to patients.

And a 2007 National Audit Office analysis of patient records in one PCT found that 40 per cent of patients who died in hospital did not have a medical need to be there. Nearly a quarter had been in hospital for over a month.

Ms Tame-Battell says that one of the main barriers to effective locally integrated end of life care pathways is the fact that budgets and resources are in still in "silos".

"People often still approach it from the view of disparate organisations," she says.

"We have to move care from acute to community settings and hospitals will have to surrender resources.

CASE STUDIES OVERLEAF ▶

ALAMY

‘We have to move care from acute to community settings and hospitals will have to surrender resources’

“This is about joining together all providers and bringing together their resources and knowledge to create the same view of this which transcends ‘our bit or your bit’... Let’s start acting as if we are a consortium.”

Ms Tame-Battell says that Marie Curie feels that it can offer the necessary expertise and project management skills to commissioners of end of life care programmes to join up the gaps and work across boundaries so that patients do have a choice about where they die.

A recent Nuffield Trust study examined the hospital use and place of death of over 30,000 patients who had used Marie Curie’s nursing service.

It found that patients using the service were more than twice as likely to die at home and the rate of emergency admissions and A&E attendances was just one third of those not using the service.

Marie Curie has also developed a scheme – the Delivering Choice Programme (DCP) – working across 19 UK sites, to develop its expertise in end of life care service design.

Bridging boundaries

Ms Tame-Battell says that, through DCP, Marie Curie has built up the knowledge and understanding of what it takes to bridge traditional boundaries and work in partnership with different and often disparate organisations to achieve better outcomes for dying patients. She says the DCP helps both commissioners and providers to develop a range of coordinated services for palliative care patients.

These can include 24-hour crisis care and effective case management and coordination so that the right services are in place, especially in the community, when patients and carers need them.

“One of things we do is act as the catalyst; to get an integrated programme in place a catalyst, or experienced and skilled project manager, is needed.”

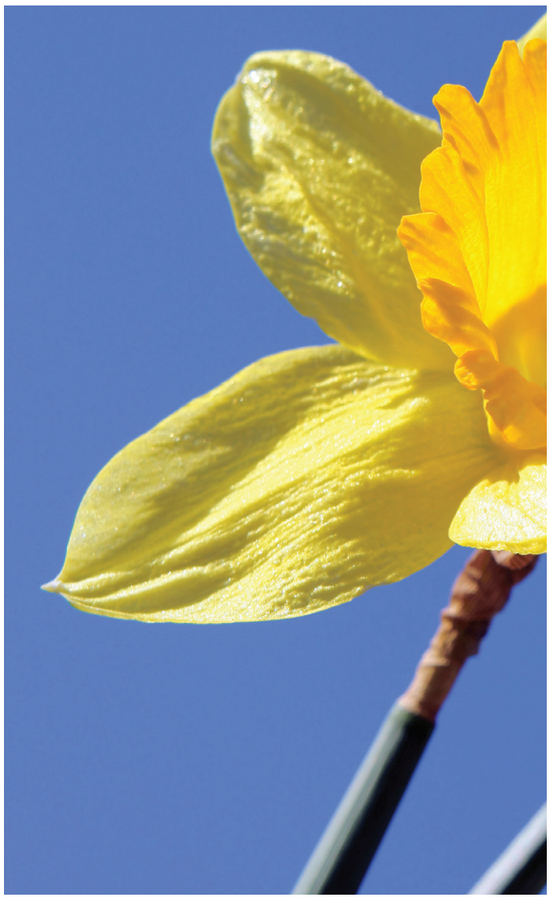
One thing is certain: with budgets already stretched to breaking point, it seems almost impossible that current models of end of life can cope with the predicted 17 per cent rise in deaths in any one year from now to 2030. Something has to change. ●

Marie Curie Cancer Care

END OF LIFE CARE: CASE STUDIES

WHERE THEY WANT TO BE

How partnership working across the country is helping to fulfil patients' wishes to die at home



LIVERPOOL PARTNERSHIP PROGRAMME – END OF LIFE CARE

A partnership between Royal Liverpool and Broadgreen University Hospitals Trust and Marie Curie Cancer Care was set up in 2011 after the realisation that delays in organising care packages were resulting in a higher number of patients dying in hospital, when this was not their preferred place of care.

A high level of unnecessary admissions and occasional shortfall in community care provision, particularly at short notice, led to a disjointed transition from hospital to home.

Rachel Ainscough, Marie Curie's service design manager for the northern region and programme manager for the project, explains that the service that has been set up offers a dedicated integrated team of case managers working between Royal Liverpool and Broadgreen University Hospitals Trust and the Marie Curie Hospice, Liverpool.

It is this team's job to ensure that patient discharge is well coordinated with appropriate levels of care based upon assessed need.

"People at the end of their life in Liverpool had a high level of inappropriate admissions to hospital due to lack of short notice community support and this, as well as delays in discharge, meant there were an increasing number of people dying in hospital," Ms Ainscough explains.

"We now have three case managers, two based in the hospital and one in the hospice, in charge of actively supporting and coordinating discharge on a day to day basis and identifying those who are coming to the end of life and who would like to die at home."

A supported discharge service has also been set up to complement existing resources to care for people at home. Overseen by one of the case managers, Marie Curie health and personal care assistants provide appropriate health and social care to patients during the 72-hour period following discharge.

"Crucially this gives community services a few extra days to organise a package of health and personal care services for the patients," Ms Ainscough says.

"There is both the quality element to this service in that the patient can die where they want to, but it also means that patients are discharged a lot more quickly from the trust which means reduced length of stay, which has an economic impact."

SOMERSET DELIVERING CHOICE PROGRAMME

The Marie Curie Delivering Choice Programme in Somerset was launched in June 2008 in a bid to improve local care and support services so that more people can have the choice of being cared for at home at the end of their lives.

First established in Lincolnshire in 2004 (see below), the Delivering Choice Programme now operates in 19 areas.

Covering a population of around 700,000 people in Somerset and North Somerset, the DCP involved the local NHS, hospices, acute trusts, social care and a number of voluntary and independent sector organisations.

In order to better understand the needs of local patients and carers, the Somerset project first completed a comprehensive review of existing services. Seven workstreams were set up to look at key areas of improvement including information sharing, coordination, communication, professional development and the provision of high quality care whenever it is needed.

New initiatives introduced include end of life care coordination teams, an out of hours advice and response line, discharge nurses, support workers providing health, social and personal care, and an information website.

Karen Burfitt, Marie Curie's head of service design for the west and north of England, said much of the reason for the project's success was the high level of collaboration from senior and frontline staff. "Crucially we had buy-in," she says.

She also believes that the project would not have succeeded without the involvement of the Marie Curie independent project management team.

An independent evaluation by the University of Bristol, published in October 2012, has found that patients using services introduced by the Somerset Delivering Choice project are less likely to be admitted, or to die, in hospital at the end of their lives.

It also looked at the experiences of families, carers and health professionals using these services, and they consistently reported excellent quality, coordinated care.

The results show that, in the North Somerset PCT area, those receiving a Delivering Choice intervention were 67 per cent less likely to die in hospital. The evaluation also found that emergency admissions to hospital in the last month of life were 51 per cent lower and A&E attendances were 59 per cent lower for Delivering Choice service users in North

ALAMY

Somerset, compared to people not in contact with the services.

In Somerset PCT's area, those receiving a Delivering Choice intervention were 80 per cent less likely to die in hospital compared to those who did not receive care from Delivering Choice. The evaluation also found that emergency admissions to hospital in the last month of life were 39 per cent lower and A&E attendances were 34 per cent lower for Delivering Choice service users in Somerset, compared to people not in contact with the services.

LINCOLNSHIRE DELIVERING CHOICE PROJECT

Launched in 2004, the Lincolnshire project was the Marie Curie Delivering Choice Programme's first pilot site. The project introduced pioneering end of life care initiatives, including a community nursing rapid response service, palliative care coordination centre and discharge liaison service.

After completion in March 2008, services were handed over to local partner organisations and are now part of the local delivery plan.

According to independent evaluations by the King's Fund and Lancaster University, the Lincolnshire project provides better patient outcomes at no extra cost.

The King's Fund evaluation found that deaths at home for patients accessing the project's services were 42 per cent compared with non-users at 19 per cent. Importantly, the evaluation revealed no difference in overall cost of care, because the increased community care provided by the programme's new services was offset by reductions in acute admissions, number of GP contacts, 999 ambulance journeys and out of hours visits.

The Lancaster University evaluation reported that 71 and 63 per cent of patients in Lincoln and Boston respectively who used the Discharge Community Liaison Service achieved their wish to be cared for at home. The evaluation also found that the Rapid Response Service played a key role in keeping patients at home until they died. As many as 73 per cent of cancer patients who accessed the service in Boston and South Holland were able to die at home.

GLASGOW PALLIATIVE CARE FAST TRACK DISCHARGE SERVICE

Funded through Marie Curie and NHS Glasgow's "Reshaping Care for Older People Change" fund until 2015, the service brings together Marie Curie, NHS Greater Glasgow and Clyde, the Scottish Ambulance Service, Glasgow City Council Social Work Department and Cordia, a local social care provider. The service aims to enable the safe and timely discharge of patients with palliative or end of life care needs from hospital or hospice to home. It also takes referrals from community services for the purpose of avoiding unnecessary admissions where possible.

Fast-track palliative care discharge liaison nurses based both at the Glasgow Royal Infirmary and the Marie Curie Hospice in Glasgow assess the care needs of patients and arrange support for the period immediately after their discharge home.

'Families, carers and professionals using these services, consistently reported excellent, coordinated care'

A team of Marie Curie senior health and personal care assistants can then support patients at home for up to three days, providing health and social care in one visit.

Diana Hekerem, Marie Curie's head of service development for Scotland, Wales and Northern Ireland explains that the broad aim of the project was to increase the proportion of care provided to people in their own homes at end of life.

"Marie Curie acted as project manager. We come from a culture of collaborative working so it was easy for us – we worked primary care and the acute trust, the hospice and social services," she explains.

She says that it has been important to have a project manager to performance manage and evaluate the service.

Ms Hekerem says that one of the key parts of the jigsaw provided by the service is the period of intensive support that is now provided to patients and carers just after discharge, something that was not available beforehand.

"This, and the fact that we have discharge liaison nurses with an understanding of what services are available in the community, has given the clinicians in the acute trust the confidence that these palliative care patients can be managed in the community and that they can be discharged from hospital," she explains.

So far the figures show that from April to December 2012, 113 patients have benefited from the service. The revenue cost of the service for the current year is £151,330, which includes all staffing costs. The project manager is a volunteer and the service operates from the Marie Curie Hospice Glasgow, so there are no service accommodation overheads. ●

SUE COLLINS ON PREVENTION

Every year the British Red Cross helps hundreds of thousands of people live independently in their own homes for as long as possible.

The charity's dedicated staff and volunteers help elderly and vulnerable people to rebuild their confidence, their resilience, and their health. Its home from hospital schemes support patients who no longer require acute care, but who need extra support in order to be able to cope at home, particularly when simply tackling the cooking and cleaning feels like a daunting challenge.

Its support at home packages help people connect with their communities, make sure they take the right medication, and crucially signpost people to other support from the local diabetic nurse to British Legion clubs or exercise or knitting groups.

These schemes not only make a huge difference to vulnerable people and their families across the country, but are increasingly being shown to make a big impact to commissioners and the health and social care sector in general.

'A study highlighted a return of £1.50 for every £1 spent'

Independent research has revealed that British Red Cross services can save the NHS up to £10,000 per person supported, while another study highlighted a return on investment of £1.50 for every £1 spent by commissioners.

By reducing unnecessary hospital admissions, supporting hospital patients to be discharged as soon as they are medically well and preventing delayed transfers of care, taking the strain off GPs, and enabling people to stay in their own homes rather than care homes, the British Red Cross preventative care services save millions of pounds each year.

Sue Collins is head of health and social care at the British Red Cross
www.redcross.org.uk

Red Cross-funded 'dial a ride' services allow elderly people to go shopping and socialise

SERVICE REDESIGN

TIME TO GO BACK TO THE 3Rs

Integrating recovery, reablement and rehabilitation will be key to cutting hospital readmissions. By Daloni Carlisle

Reablement is one of those ideas that seems like a no-brainer. If people are at risk either of being admitted to hospital or of a delayed discharge because they can't cope at home, then a short, focused, home-based intervention might help.

But with the move of commissioning of reablement from social to health care in April 2013, three questions about the economics and benefits to health are beginning to come into sharper focus.

Does reablement reduce the risk of readmission? Does it avoid delayed discharge? And does it save money? The answers, it seems, are far from clear.

On one side are the findings from a review carried out last year by the think tank Demos. Claudia Wood, Demos deputy director, says: "It's not a particularly well researched subject. The evidence suggests that it does reduce the amount of social care needed after people have been discharged from hospital and that's very important for local authorities. But it does not show a reduced risk of rehospitalisation."

So a person discharged from hospital and given a typical four- to six-week package to settle them in at home is less likely then to need ongoing social support but is at the same risk of readmission as the person who did not have the reablement package. As Ms Wood notes: "Reducing readmission is the big cost saver and the big gain for human outcomes."

It was not clear from the research why this should be. Ms Wood speculates: "It could be that reablement is very much focused on the home, making sure people can wash and dress or make a proper meal. But it rarely seems to be about helping people re-engage with their social networks and helping them to get out of their homes and regaining their confidence to, for example, use a bus or walk to the shops."

There was also a "cliff edge" to the four to six week reablement package with the service abruptly ended and no period of transition.

Which is perhaps why the British Red Cross's reablement schemes are able to show some radically different results. With a network of 8,000 trained volunteers supported by paid expert staff, the BRC is a big player in what it calls "support at home" services that are designed to help people regain their independence and so avoid a hospital admission or readmission (see case studies, overleaf).

"Our services are all about optimising confidence and empowering people to do things for themselves," says Margaret Lally, director of UK service development for the BRC. The services are designed around the needs of the individual. They are time limited but can go on beyond the typical four to six week cut-off.

The BRC has been careful to evidence this, commissioning a review from Deloitte that was published in November 2012.

It looked at five BRC reablement schemes and found that they delivered estimated savings per user in the range of £168 to £704. Patients reduced their length of stay by up to three days. They were less likely to return to hospital and less likely to require social care packages, including both home support and residential care.

In a separate report, called *Taking Stock*, BRC tells the stories of five people who have used its home care support and details the potential savings made by early preventive intervention.

They are both touching and instructive. Take the case of Mr Bains, 68 and using a wheelchair after being diagnosed with multiple sclerosis. Social workers had organised carers and meals on wheels but the Red Cross stepped in as he became depressed and said he felt suicidal.

The volunteer visited him, mentored him

CASE STUDIES OVERLEAF ▶

On the move: the British Red Cross helps patients get out and about

ALAMY

to get in touch with support services including the MS Society which provided a home visitor, and the NHS expert patient programme to help him learn more about how to manage his condition. The Red Cross also gave Mr Bains information about community transport services, local buses with wheelchair access and information on accessible days out locally.

Reconnecting people

As a result he overcame his fear and embarrassment of being seen in a wheelchair, went out with his son and bought an electric scooter that enabled him to get around town again and reconnect with the community.

Potential savings identified included keeping him out of hospital, preventing him needing antidepressants and avoiding the need for cognitive behavioural therapy – adding up to a theoretical saving of somewhere between £7,310 and £10,430.

Margaret Lally feels that the shift of commissioning from local authorities to CCGs is an opportunity to look again at how reablement services are structured. "They need to be based around understanding how we help individuals maintain or regain independence," she says. "They need to be part of integrated care pathways." She believes empowering individuals to connect with support in their local communities is an important factor and it is important that agencies can do that signposting.

'If the patient is discharged early, the saving accrues not to the CCG but to the acute providers'

Amit Bhargava, chief clinical officer for Crawley CCG and a member of the NHS Clinical Commissioners Leadership Group, agrees. "We need to start looking at reablement in a fundamentally different way," he says.

Patients recently discharged from hospital need what he calls "the three Rs": recovery, reablement and rehabilitation. Integrating these three will be key to delivering reduced readmissions and to speeding up discharge.

Reablement services also need to be highly responsive. As Ms Lally points out: "The Red Cross is an emergency response organisation and the people who work for us know that they have to be ready to respond to individual crises." Ms Lally also wants to see longer term planning: "What we have seen time and again is that it takes time to build up the relationships needed to make reablement work but too often we have only six to nine months funding. Commissioners need to be prepared to work with providers for a longer period."

Dr Bhargava senses that CCGs are keen to explore new models but warns that the barrier, as always, may be the cash.

Currently CCGs pay for a hospital admission of, say, five days for a given condition. If the patient is discharged earlier, the saving accrues not to the CCG but to the acute provider.

Dr Bhargava says: "I was talking to one hospital chief executive recently who was happy for us to take away the patients – but not to release the cash. We need to unbundle the tariff. There needs to be intent around this – and that needs to come from the centre." ●

BritishRedCross

SERVICE REDESIGN: CASE STUDIES

YOU'RE NOT ON YOUR OWN

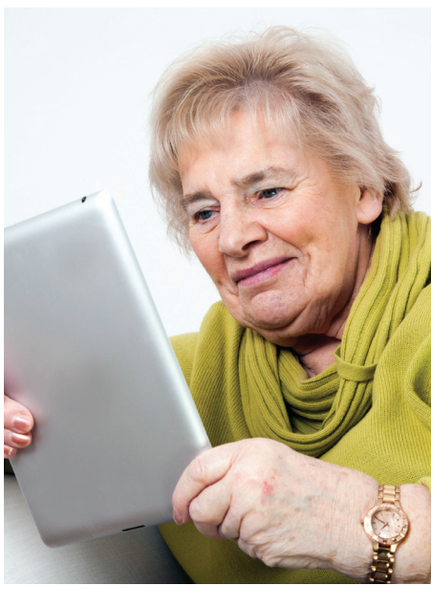
Innovative ways to prevent health problems include using technology to reach out to isolated elderly people and a rethink of traditional home from hospital services

FACELOOK, SUFFOLK

We know that social isolation is a strong determinant for both mental and physical health issues and we also know that more people than ever are living alone with the national demographic changes. As people live longer this is only going to get worse.

"Supporting elderly people living alone to keep them out of hospital is a 'must do' and yet social care budgets have no chance of coping with this ever increasing need," says Suffolk GP John Havard. "Families tend to be more disparate nowadays so we need to use technology to provide some of this social interaction that we know is therapeutically beneficial."

So earlier this year, Dr Havard developed the "Facelook" project to link vulnerable patients to a British Red Cross volunteer and family and friends through the patient's own TV. The Transformation Fund of NHS Suffolk paid for set top boxes with webcams and four balanced microphones to provide "easy Skype" to these patients at home.



The GP practices in East Suffolk have identified patients who need support to remain at home and the BRC arranged the installation of the set-up, helped by a technology engineer from the BT Research Centre at Adastral Park.

The BRC volunteer makes face-to-face contact to get to know the patient and from then on supports them with a mixture of virtual "Facelook" visits and in-person support as needed.

The project was commissioned by NHS Ipswich and East Suffolk CCG and has yet to report on its results. "So these are my early anecdotal findings," emphasises Dr Havard.

First of all, it is very easy to use. "Users can answer a call from their armchair or even their bed, which is a natural way for a normal welfare conversation to take place. Other benefits like witnessing correct tablets being taken and fluids being drunk are inherent in this solution," says Dr Havard.

"Take the case of one of my elderly patients. He had got into medical problems twice already by taking his warfarin incorrectly. His daughter was keen to get involved in his care – but she lives in Australia. So now she calls at 6pm everyday to supervise him taking his medication. She is delighted that she can now play a part in her father's care."

Other applications are old friends who cannot get out anymore but can "Facelook" each other, he adds.

"We have one disabled lady who is quite capable of managing a caseload of elderly isolated people and regularly checking they are OK – this highlights the fact that our ever-increasing elderly have the capacity to be a resource and not a burden."

Dr Havard is looking to the future too. "With the Facelook device and broadband installed in the home then there is capacity to link in a host of other telecare products. We could, in theory, monitor movement, patterns of electricity consumption, toilet flushing and falls detectors to build up a regular daily pattern so a change could be spotted from a remote centre."

This might sound a bit like Big Brother, he admits. "But for many people it might be a choice of Facelook – or institutional care. I can imagine patients currently needing four social care visits a day could have one of these as a virtual visit.

"We need to use technology to triage more effectively to ensure that the on-the-ground carers are directing their attention to where it is needed as well as wasting less time in their cars. And we are using University Campus Suffolk to ensure the project is structured in an academic fashion."

Yet even with all this potential, it can be difficult to persuade patients to participate – even though they get the set-up for free.

"I have taken a tip from the door-to-door brush salesman of old," says Dr Havard. "Their first question was never, 'Do you want to buy a brush?' because the answer tends to

close the conversation. But 'Do you like a clean house?' got a foot in the door.

"So my question is 'How would you like to see more of your family?', rather than asking if they would like regular Red Cross volunteer contact or any of the other add-ons. Of course, once they get to know the Red Cross volunteer, they would not want to give it up for anything."

www.facelook.org.uk

REABLEMENT IN CAMDEN

In Camden, north London, commissioners are keen to develop holistic approaches to care delivery – and this applies very much to reablement.

For a start, long term conditions senior commissioning manager Mousumi Basu-Doyle leads a joint team for Camden clinical commissioning group and Camden Borough Council. As she says: "You have to look at care across the patient journey from the hospital to the transfer to community and how you provide longer term support to prevent readmission.

"So is it is not just about having a reablement team but about having a responsive service that is part of a multi-disciplinary virtual team that enables timely transfer of care of clients from acute settings back home."

The British Red Cross has been providing this reablement team-within-a-team in Camden for the last two years. Ms Basu-Doyle says they are the ideal partners because they are fast, flexible and skilled. "BRC fits very well into our model. Not all social care providers are able to provide reablement," she says.

She explains what the volunteers do – and how it differs from the traditional home from hospital service that the Red Cross had been providing for over 10 years in Camden.

"Home from hospital is a befriending, practical service, making sure there is milk in the fridge or providing companionship. Reablement is more structured involving eight home visits over a six week period that helps clients regain confidence after discharge from hospital."

That might mean helping clients to use new equipment, or helping them access buses, claim benefits or even join a gym. "They might be raising awareness around falls prevention or helping them restart old hobbies," adds Ms Basu-Doyle. "It's about getting their confidence back."

A pilot study over the last year shows that it does reduce the need for social care. Out of 364 people visited, nine in ten were contacted within 24 hours of discharge and visited within 48 hours; 60 per cent needed no further input from social services. Readmission rates were 5 per cent.

All volunteers are trained and CRB checked – Betty Constable and her colleague Joanne Yau, who are employed by the Red Cross to co-ordinate the service – make sure of that.

'This is about how we support people to change their lives to be more healthy'

"We are based in St Pancras rehabilitation hospital," explains Mrs Constable. "We get referrals from everywhere – social workers, A&E, occupational therapy, from UCL [University College Hospital London] and community services."

A large part of the job is being ready for anything and being ready quickly. "You just never know what you are going to find," explains Ms Constable. "One of our volunteers went to see a man and found the front door open, no food in the fridge, no electric and no key to the basement to turn it on."

Very occasionally, she has to turn down clients where she feels there is a risk to her volunteers – whose health, safety and wellbeing she guards fiercely – for example if there are alcohol issues.

Leandra Silvestie is one of these volunteers. Aged 26 and from Brazil, he first volunteered when he was unable to get a job after finishing his university studies. A year and a half later and now in a full time job, he still volunteers because he enjoys it and can see that it works.

Often, he says, the reason stated for the referral is not the real reason people need visiting. "I have just finished working with one lady who said she needed her shopping done after being in hospital but really she was just very, very lonely. I have been helping her get out and meet people."

Ms Basu-Doyle is now writing a prevention strategy in Camden. She wants to see training standards developed for reablement and for the reablement approach – helping people to become independent – to become the default for health and social care services.

As she says: "This is about how we support people to change their lives to be more healthy and give them the motivation, education and skills to do that. Actually this is everybody's business." ●

ALAMY

LIZO NGQOBONGWANA ON DATA

Good information is the lifeblood of commissioning, as commissioning support units (CSUs) will now be discovering. Officially having come into existence on 1 April, their main source of income is generated by working for the clinical commissioning groups driving the NHS reforms. Provider management is one of their key service lines. To effectively support CCGs in encouraging GP engagement in commissioning, the CSUs need access to fully validated, trusted and timely information, to ensure that the books balance on a monthly or even weekly basis, as well as to support strategic decisions such as QIPP and changes in how healthcare is provided.

Commissioning will work best if CSUs can provide the information to enable CCGs and providers to work together, even when some of their objectives may be different, or even conflicting. Historically, commissioners and providers spent far too much time preparing data and discussing its accuracy and trustworthiness – time better spent on resolving real healthcare delivery issues. In our experience, where providers work closely with their commissioners and share trusted information, better outcomes are achieved, using fewer resources. System interoperability is critical to enabling a swift response to demands from GPs for earlier and more accurate pricing information.

'Far too much time was spent preparing and discussing data'

Civica has been part of the NHS commissioning process since inception and its service level agreement manager (SLAM) solutions are now used for commissioning by almost 200 commissioner and provider organisations to process some £40bn of NHS funds each year. We have developed the tools and services to resolve many of the operational issues faced by CSUs, CCGs and GPs. Working in collaboration with both commissioners and providers, through quality assurance, advice and guidance, we have been able to streamline processes so less time is spent preparing information and more on adding value.

The timescale for establishment of the CSUs and CCGs has been challenging, with limited time and resource for them to develop new, robust solutions. Even if this were possible, it is questionable whether these new organisations should be focusing their limited and valuable skills and resources in such an exercise. This is where CSUs, competing in an open market, will need to forge partnerships with organisations (NHS or commercial) which can assist them in their quest to generate real improvements for patients.

Lizo Ngqobongwana is business development director at Civica UK Limited
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MANAGEMENT INFORMATION

FIGURE IT OUT

Those supporting CCGs must work out how to get them useful, reliable data. If they do their job, they could start a new era of benchmarking. By Jennifer Trueland

For the health service's newest commissioning bodies – and those who are contracted to help them meet their goals – it's vital to get information on which providers and commissioners can agree.

It's all the more important – and challenging – when you're a commissioning support unit working with 13 clinical commissioning groups and dealing with a diverse range of providers from acute trusts to community and mental health and even the private sector.

That's why Chris Sharpe likes a service level agreement management system which provides "one version of the truth".

For Mr Sharpe – head of commissioning finance at North of England Commissioning Support (NECS) – giving CCGs the tools to make commissioning decisions which ensure they are meeting local demand, while getting the best value for the public purse, is more than a job: it's a matter of personal pride. And to do this, high quality data flow is crucial.

"It's about getting all contracting and financial information in the one place, reconciling it, and getting it all into the same point before feeding it out again," he says. "We can get our data from a variety of sources – with a good level of granularity – and providers and commissioners know they can rely on it, and are talking about the same figures, at least to within a few pounds. That's really important for the NHS, both for those who are making commissioning decisions and for those who are delivering on contracts."

NECS, which has been more than a year in the making, but formally took up the reins on 1 April, is a business set up to provide support to commissioning organisations across the North of England. Employing around 750 specialist staff (many from the former primary care trusts), its aim is to enable organisations to meet their commissioning goals and to benefit from economies of scale – with the essential ingredient of local knowledge baked in.

The organisation uses Civica's Service Level Agreement Manager (SLAM) to collect, reconcile and manage information for commissioners, enabling them to be sure they are basing their decisions on sound intelligence, both hard and soft.

"There's a huge amount of information in the NHS – one key thing is creating hard intelligence [on finance and activity] – but another important element is soft information, looking at the data and turning it into something useful," says Mr Sharpe. "Working with 13 CCGs there's a massive amount of information and you can start to get really good benchmarking. But it's not just about acute providers – it's about data sets from community providers too."

Meaningful information from the community could include variations in spending on district nurses, for example – if one CCG is spending much more than others, it might want to look at what it's getting from that extra spend to see if it's worth it. "That's the sort of data that gives added value," adds Mr Sharpe.

NECS head of data management Richard McLeod agrees – and would add that as well as information on financial, clinical and demographic factors, it's also important to look at outcomes, such as how many patients are readmitted.

For all of these, and to allow people to focus on the job in hand, properly reconciled, high quality information has to be a given. "You used to find that there was a lot of argument with providers about whose figures were correct. If you can cut out the arguing, by making sure there's one set of figures, that means more time for doing the core part of the job, which is making robust decisions about patient care," says Mr McLeod.

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He recalls working in the NHS before the implementation of SLAM. "There were a lot of information silos – people keeping bits of information in their own ways, so that when they leave, or aren't there, nobody knows how to access it. With this system we have the right information in the right place at the right time – it's a lot more flexible and allows a lot more matrix working."

Making the information meaningful to those who are using it is another important element. "We are providing data to clinicians," says Mr Sharpe. "They don't want lists of figures; they want to know what it means for their practice."

Mr Sharpe says he's confident that the information his organisation provides is easily as robust as could be expected at this stage and already improving in quality, and it is, of course, subject to external scrutiny and audit. There can be a challenge, however, in persuading all CCGs and providers to be open with their data, although part of the solution to this is ensuring that they understand their responsibilities and what they can and can't do with information.

'Clinicians don't want lists of figures; they want to know what it means for their practice'

And after all, the risks of having poor quality data are potentially serious and far reaching. "Take budgets, for example," says Mr McLeod. "If your data isn't sound, how will you know whether you're overspending or even if you have underspent?"

So what are their tips for a successful implementation of a system like SLAM? "Communication, communication, communication," says Mr Sharpe, simply. "It's about making sure that people understand why we're doing it – and making sure that the appropriate checks and balances are in place.

"My tip would be to start at as granular a level as you can," says Mr McLeod. "You can always roll figures up, but there are always cases where someone wants more detail – at a practice level, for example. Building in that level of information may seem onerous at the beginning but it is worth it in the long run."

One of the reasons why SLAM has found favour with Mr Sharpe and Mr McLeod is its flexibility – and the fact that it is developing and improving, building on users' experience. For example, traditionally there had to be human involvement in getting the data in and out, but automation of data flow – with appropriate checks and balances – means that the system is streamlined and turnaround is much quicker. "There's always a demand to get information more quickly, and this is the way forward," says Mr McLeod. ●

PAULINE LAWRANCE ON STEPPING UP AND DOWN

After making the case, over a number of years, for a more joined up approach to health and social care funding, Four Seasons Health Care has welcomed recent statements by the Commons Health Select Committee and Audit Commission regarding the need for a rethink of the way care is delivered.

The independent sector can play an increasingly important role in health and social care provision, particularly for the elderly, that is complementary to the NHS. Larger operators have developed capabilities and have capacity in specialised areas of care such as nursing for frail elderly, step-up and step-down care, dementia care and palliative care.

A number of operators, including Four Seasons, have already contracted specialist care services with both health and social care commissioners for high dependency patients at a fraction of the cost to the NHS and taxpayer, (between 35 and 50 per cent less than NHS tariff rates for hospital care).

This approach to commissioning helps the Department of Health meet spending targets without a drop in quality and arguably provides a better all-round experience for patients. It also helps free up hospital beds and alleviate the situation where between a quarter and a third of beds in acute medical wards are occupied by people, mostly elderly, who don't need to be there. They are there because of widely held misconceptions amongst some commissioners that there is no suitable alternative and in some cases an ideological resistance to the private sector's role in health and social care provision.

'A third of beds in acute medical wards are occupied by people who don't need to be there'

We believe people should be helped to remain at home for as long as it is their wish and in their best interests but there should be informed choice. There is no one size fits all solution. Whilst some people may benefit from additional input in care provision in their own home, others may benefit from a short stay in a residential setting either following hospitalisation or to avoid an admission in the first place. These short stays are far different to the old concept of convalescence but are forward thinking enabling services, such as those described in the case studies, that have appropriate discharge at the forefront of care planning designed to rehabilitate and enable people to return home safely and maintain their independence for longer.

That's why we have developed a range of bespoke models of care to support local health economies in meeting this need.

Pauline Lawrance is managing director of Four Seasons Health Care England West
www.fourseasons.co.uk

Four Seasons Health Care

INDEPENDENT PROVIDERS

MORE THAN JUST A BED

Commissioners are looking at placing frail patients in care homes – with a full care package. By Alison Moore

One of the greatest challenges for the NHS is caring for patients who are too ill or frail to remain at home but don't need to be in an acute hospital bed.

Specialist input can help these patients regain independence or avoid an acute admission. But shortfalls in care which do not meet their needs can result in them remaining in a hospital bed for too long – and not being able to manage at home afterwards, potentially ending up in residential care permanently.

Community hospitals have provided care for such patients for many years. But they have limited capacity and some are no longer fit for purpose with buildings in a poor state of repair. And sometimes staff and financial pressures have meant there has been insufficient focus on getting patients out of hospital and back to normal life.

So PCTs and now CCGs have started to look towards more innovative solutions. And some are commissioning beds and services in private care homes. While using beds in nursing homes has been commonplace for some time, there is now an additional focus on ensuring care is focused on helping patients recover rather than just providing them with a bed.

In 2010, for example, NHS Hertfordshire produced an intermediate care strategy which looked at providing beds in more locations through local nursing homes, allowing patients to remain closer to home but with input from nurses and therapists. It also opened the way to redevelop an existing hospital site and to close an ageing community hospital.

And with an ageing population and people who are admitted to hospital often sicker and frailer than in the past, there is increasing demand for intermediate care to help those who are unlikely to be able to move back home immediately after treatment.

Many care home operators are seizing the baton and see an opportunity to both provide quality care for vulnerable patients and provide cost efficiencies for the NHS, and in some cases they are pushing on an open door.

Pauline Lawrance, managing director of Four Seasons Health Care England West, says that over the last year or two there has been a change with more PCTs and CCGs interested in buying not just a bed but also therapeutic input for patients on an ongoing basis.

"In the past they used to contract beds and provide sessional rehabilitation teams from the community," she says. "But now they are getting more confident and commissioning a full service." For example, one home the company runs operates a unit where all care – including physiotherapy and occupational therapy – is provided by inhouse staff (including some medical input commissioned by the home).

NHS commissioners are effectively commissioning a full package of care, rather than just a bed.

"It is about health and social care integration," says Ms Lawrance. "It has been a case of never the twain shall meet. But now it is about working with both health and social care and seeing the opportunities for both them and us."

Ms Lawrance suggests this has many benefits. "We are, in many cases more cost effective than a hospital bed: in these times of austerity the NHS is becoming more aware of that. We can provide a more homely environment. It is more conducive for rehabilitation, assessment and enabling for the patients than if they were in a big hospital ward. They have their own room and access to kitchen areas as well as a continuous enabling philosophy on the units."

Perhaps most importantly, good targeted

CASE STUDIES OVERLEAF ▶

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care in such units can produce good outcomes with many patients able to return to their own homes, perhaps with a package of care. This can often be achieved within a relatively short length of stay with homes working to key performance indicators agreed with commissioners.

And with community teams often being hard-pressed to care for those already on their books, this can ensure that they are not put under extra pressure.

Ms Lawrance believes that CCGs, with their increased medical leadership, are likely to be interested in what the sector has to offer. GPs obviously have frequent contact with care homes already and an awareness of the sector's strengths.

This can include "admission avoidance" – by diverting patients who otherwise would end up in A&E and would probably be admitted – but also providing extra options when patients no longer need an acute hospital bed but can't simply be discharged. This sort of "step up" and "step down" care is beginning to feature in many CCGs thinking – especially given the pressure the acute sector was under last winter.

'We can provide a more homely environment. It is more conducive for rehabilitation and assessment'

The vast majority of people referred to intermediate or 'step up, step down' units run by Four Seasons are older persons but in principle there is no reason why younger people should not benefit as well, if they need the sort of care on offer, says Ms Lawrance.

But what is holding CCGs back? She suggests that sometimes it is a matter of getting in front of the right person to explain what is on offer – and that this can be more than just "bed and board" in a nursing home, with input from visiting NHS staff such as community-based physiotherapists.

"For the majority of people we are not their first thought," she says. "There are some commissioners who have a vision of what can be provided and others we need to get in front of and say, this is what we can do."

Another barrier is length of agreements. While nursing home beds are usually spot purchased, providers need some form of guaranteed income stream before they will make investments in additional staff and facilities. This is particularly relevant if they are going to offer a full package of care and start to employ physiotherapists and other staff.

But private providers are often willing – and able – to make this investment if they know they will get adequate referrals. Four Seasons invested heavily in its flagship project in Stoke-on-Trent, says Ms Lawrance, and has also looked at issues such as governance and data protection at other units to ensure it fully meets NHS requirements.

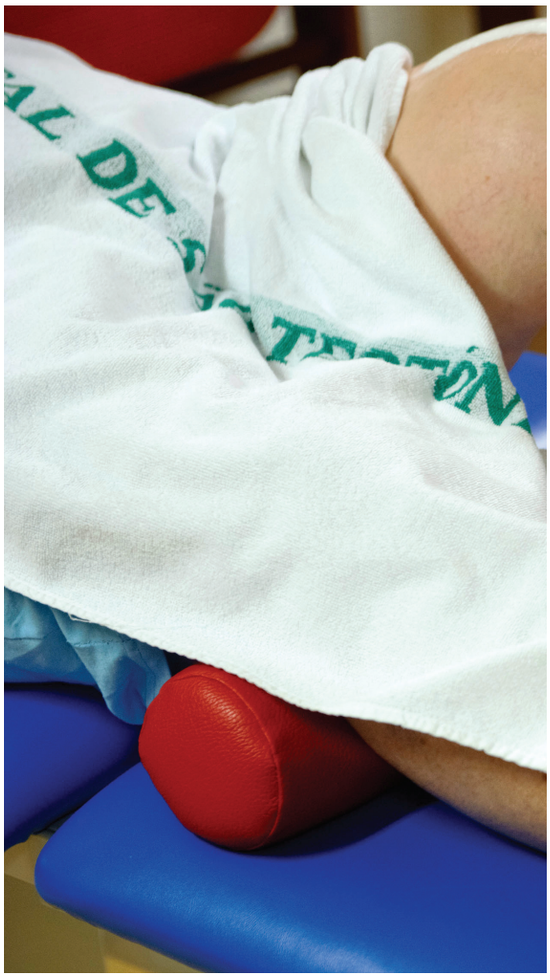
"We are willing to invest, but we do need some sort of long term agreement. In Stoke-on-Trent, for example, we have a two year contract with the option to extend for another year. After that it has to be tendered again," she says. ●

Four Seasons Health Care

INDEPENDENT PROVIDERS: CASE STUDIES

BACK ON THEIR FEET

How care home professionals are acting to restore people's independence after falls and strokes



HILLTOP MANOR, STOKE-ON-TRENT

Getting patients out of a hospital setting and back to an independent life is what Hilltop Manor specialises in – and those patients have included a 104-year-old who was able to return home after a stay in the home.

The 80-bed home in Tunstall, Stoke-on-Trent, has 30 beds which are permanently commissioned by the NHS and four which are available to "spot purchase".

Patients in these 34 beds will either have been admitted from a hospital – sometimes direct from A&E – or will have been referred from the community by healthcare staff.

They are all assessed before coming into the unit to ensure that they are able to benefit from what is on offer. Within 24 hours of being notified of a potential referral, the staff will see the patient and make a decision on suitability. In some cases they will react even quicker – for example, if a patient has had a fall and is going through A&E.

Typically, people referred to the unit will be elderly and may have suffered a fall or had an illness such as a chest infection (it is an old mining and potteries area with many patients with long term conditions from working in these industries). Some will have a level of dementia, although those with very advanced dementia are not admitted. In many cases, they will have lost confidence in their ability to live independently and building up that confidence will be an important part of their recovery. Occasionally younger people are referred as well.

As well as receiving nursing care, the patients will be seen by physiotherapists and occupational therapists and a visiting GP, who attends the unit every day of the week under contract with the home. Within 24 hours of admission to the unit, the patient will be assessed by all of those involved in their care and personalised care plans drawn up which look towards a successful discharge as the key focus.

Weekly multidisciplinary meetings will discuss each patient and set goals for their recovery during the following weeks. Psychiatric input can be important with some patients and this is done through an arrangement with a psychiatrist who will visit to assess patients, when necessary.

"We aim to get everybody back home if possible," says home manager Kath Barcroft. "It is not always possible – sometimes we have to look at nursing or residential care, or sheltered accommodation."

It is important not only to have the aim of getting people home or into more suitable accommodation but to plan towards it. This involves staff visiting the proposed accommodation to assess suitability and recommend any modifications or equipment which would help the patient return there. Hilltop Manor can then arrange for the equipment to be ordered and installed, minimising any delays in discharging the patient.

They will then do a home visit with the patient to see how they cope. Patients can also

be assessed for nursing care and continuing healthcare needs.

Once patients return home or to another setting, they will normally be transferred to local community teams.

Family support and involvement throughout the stay at Hilltop Manor and the transfer to another setting is very important, says Ms Barcroft.

The service has key performance indicators agreed with commissioners, covering average length of stay, patients not being readmitted to hospital within 30 days, days lost to infection, and the "destination" of the patient after treatment. To date the home has continually met all of the KPIs set. Contact with the commissioners and referrers is constant: Ms Barcroft emails the bed availability each day.

Average length of stay is currently 26.5 days – it has been as low as 21, though it obviously depends on the particular mix of patients within the unit at any time.

WESTVIEW LODGE, HARTLEPOOL

Residents coming into the transitional and rehabilitation beds at Westview Lodge in Hartlepool have often had a fall.

'Staff visit the proposed accommodation and recommend modifications to help the patient return there'

In some cases this will not have led to serious injury but might have damaged their confidence and made it hard for them to return home. But in others, they have suffered a fracture such as fractured neck of femur and have had hospital treatment for some time.

The aim of all the staff supporting the 20 beds in the unit is to get them home again or to their previous residence, if possible. Eight of the beds are designated as rehabilitation beds, with support from occupational therapists, physiotherapists and support workers provided by the community team.

Patients admitted to these beds are likely to need relatively intensive input which can be provided throughout the day by the community rehab team who are based at the home – probably more than they would get in an acute hospital setting.

The 12 beds in the transitional unit are also overseen by physiotherapists but those admitted to these beds don't need the same input. There are opportunities for people to move between the different types of bed if their needs change or turn out to be different to the original assessment. A nurse with prescribing rights is also available.

The transitional and rehabilitation beds have been commissioned by Hartlepool Borough Council for the past four years, but the home also has other residents in separate areas who require residential and dementia care.

Home manager Beryl Anderson says that the maximum length of stay is meant to be six weeks but the average stay is about three weeks. However, if further input is needed then this is provided following assessment by the rehabilitation team.

The home has a specially designed gym to help improve patient's mobility and also a kitchen area which is used to help them become accustomed to everyday tasks again.

Figures from 2011-12 show the transitional beds had 123 admissions, of whom 44 per cent came from hospital, 26 per cent from home and 30 per cent from another rehabilitation unit.

Of 111 discharges, 36 per cent were able to return to their own home, 32 per cent were transferred to a short stay setting, 12 per cent went to residential rehabilitation, 15 per cent needed readmission to hospital and 3 per cent were transferred to a setting with extra care. Two per cent died from pre-existing conditions. Average length of stay was 17.5 days.

With the more intensive rehabilitation beds. 85 per cent of the 125 admissions in the same period were from hospitals, 11 per cent from a rehabilitation unit and only 4 per cent from home.

Of these, very close to half were able to return to their own home, 29 per cent went into transitional care, 14 per cent were readmitted to hospital and 7 per cent were transferred to a short stay setting. Average length of stay was fractionally over 18 days.

Ms Anderson says that an environmental visit is carried out before patients return home to assess whether equipment is needed to help them. Coordination with social workers helps to ensure that patients who need a package of care have it ready for them when they are discharged. And the team will ensure they have any medications needed and that their doctor and pharmacist are kept informed.

Not surprisingly, the rehabilitation and transitional beds are usually full, with patients waiting to be admitted from hospital – which sometimes means they have to remain in hospital for longer than their clinical condition demands. "We could do with more beds,'" Ms Anderson says. ●

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KEVIN WATKINS ON QUALITY

IN ASSOCIATION WITH EMIAS

emias independent assurance solutions

There is no doubt that the public's expectation regarding the quality of services they receive has been raised following the publication of findings from reviews by Robert Francis QC and the Winterbourne View investigation.

The financial squeeze that all public sector spending is facing is biting hard at many trusts and their commissioners. Into this arena step clinical commissioning groups, brand new organisations achieving statutory body status just weeks after the second Francis report was published, complete with 290 recommendations. Is this a "perfect storm"?

Maybe not. The evidence from work Emias has completed at 14 CCGs in the Midlands and South Yorkshire, reviewing quality monitoring arrangements, indicates that a solid foundation has been laid down by CCGs in shadow form on which to build a positive response to the Francis inquiry.

The commitment of commissioners to improving quality was impressive – visits to A&E late on a Saturday night to carry out a quality visit are all in a day's work for some chief nurses. It is this commitment which must be harnessed effectively. Passion breeds best practice and as CCG chief nurses and their quality staff respond to specific quality issues, so the potential for a variety of good practices to emerge increases. The quality assurance

'A solid foundation has been laid down by CCGs to build a response to the Francis inquiry'

forum we are initiating in the Midlands will provide a conduit for best practice to be shared, as well as a mechanism for debating difficulties facing CCGs in driving improvements in quality and identifying ways in which these challenges can be met.

CCGs need to learn from each other and in our experience are eager to do so. We have already been able to share best practice across our CCG client base through the production of a number of information papers covering areas such as conflicts of interest and QIPP management. We are also delivering workshops on a variety of subjects that all of our CCG clients are invited to attend to increase the opportunity for networking and shared learning.

As a member of NHS Audit England, we are working with fellow NHS audit colleagues across the country to explore opportunities to extend the benchmarking work we have already undertaken. We firmly believe that the quality assurance forum will prove a significant contribution to something we are passionate about – helping CCGs to be a success.

Kevin Watkins is associate director of commissioning at Emias

www.emias.nhs.uk

ASSURANCE

POSITIVE PEER PRESSURE

CCGs have made a good start to ensuring quality care – and must now learn from each other. By Alison Moore

One of the big challenges for clinical commissioning groups is likely to be ensuring that the communities they serve receive quality healthcare.

For small organisations this process of quality assurance can feel daunting – especially in the wake of the Francis report which has focused attention on failings in healthcare and how they can be detected and prevented. Commissioners are inevitably part of this wider picture.

But the evidence from a survey of CCGs in the West and East Midlands, and Yorkshire and Humber regions, carried out by internal audit and counter fraud specialists Emias, is that CCGs have made a positive start on this.

Already nearly two thirds of CCGs surveyed have their own quality strategy rather than simply inheriting one from a PCT and 80 per cent had designated a lay member as quality lead, with even more having the quality committee designated as a sub-committee of the main board.

With CCGs operating on a limited budget, there is a real determination to ensure that resources and tasks are shared where possible. Half of the CCGs questioned were sharing quality teams and over 90 per cent were involved in collaborative commissioning arrangements, with more than three quarters of these having a formal memorandum of understanding which covers quality assurance.

The CCGs were also drawing on a range of sources to get a picture of quality at the providers they commissioned from: these included CQC reports, local authorities and feedback from patient groups. Generally, they felt they were getting the information they needed to review whether quality included in contracts was being met.

Quality visits are becoming an important part of this picture with commissioners regularly involved in visits, although there is some variation in how they are carried out – for example, whether the provider is told in advance what areas will be visited. But lead and co-ordinating commissioners all had arrangements to allow reactive visits when there were concerns about quality – and had carried out such visits. The picture was more mixed for CCGs which were not leading on a particular contract.

Kevin Watkins, associate director, commissioning, of Emias, says the overall picture is positive, possibly due to the hard work of a lot of committed people and the widespread recognition before the Francis report was out that NHS organisations needed to focus on quality. Quality has also been inherent in the Quality, Innovation, Productivity and Prevention approach and is the focal point of Commissioning for Quality and Innovation (CQUIN) schemes.

"But I have still been pleasantly surprised," he says. "We have found a great deal of evidence of collaborative working between commissioners and providers, and this is beginning to show itself in the CQUINs which are being agreed."

Care home worries

But there are areas of concern. Around 30 CCGs took a three minute survey devised by Emias at last year's NHS Alliance conference. They were unanimous in feeling concern about the quality of care being provided in care homes and less than 20 per cent felt they received sufficient assurance about this. As commissioning of beds by the NHS in care homes has become more common, this has risen up CCG's quality agendas. But this may also reflect the impact of the Winterbourne View case which highlighted failings – and criminal activity – in how some vulnerable patients were treated. Mr Watkins warns that improving quality in care homes through contract monitoring will be a challenge for CCGs.

But CCGs are keen to learn from each

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other in all areas of quality assurance, he says – which is behind Emias's plans for a CCG quality forum which will allow colleagues from different CCGs to discuss common problems and solutions. It is also offering a benchmarking service so CCGs can see how they compare with their peers on key aspects of quality assurance.

With limited management budgets and resources, CCGs don't want to reinvent the wheel and sharing of good practice offers the way ahead. For example, there is variation in how quality visits work and swapping experiences could help CCGs decide what would be best for them in terms of planning and carrying out visits. This could be as simple as how to document visits and ensure that follow-up actions are carried through.

"There is an awful lot that can be learned from getting people together who are in the practice of quality monitoring and getting them to talk about it," he says. "This is the beginning of a process of saying let's share best practice."

The advent of CCGs has also been a challenge to organisations such as Emias. It has reorganised so that key members of staff specialise in CCGs rather than covering all NHS organisations. And it is joining other bodies which provide internal audit services in a collaborative group called NHS Audit England.

'Benchmarking is incredibly useful and sharing best practice offers added value'

Moves to offer these services to CCGs have been met with enthusiasm. Chief officer of Nottingham North and East CCG Sam Walters, says the benchmarking is incredibly useful and sharing best practice offers added value. "It's a smorgasbord of things we can try," she says. "We have less management resources than our predecessors and will have to be slicker."

GPs are often a driving force for monitoring quality, she adds, because they hear from patients every day about their issues with the system. "They want to know that the safeguards are there," she says.

Chief nurse for three CCGs in South Nottinghamshire Cheryl Crocker is enthusiastic about the chance to swap experiences and best practice with peers as it allows everyone to see where they excel but also where they could learn from others who have tackled similar issues. She says working with Emias has given her a sense of where her organisation needs to focus its efforts to provide more assurance; important when CCGs have limited staff and resources.

Positive actions the CCGs have been able to take includes acting on patient feedback to develop CQUIN targets. For example, patients were concerned that X-rays were taking some time to be reported to GPs by an acute provider and they were often making appointments to discuss them – and then finding the information was not available, she said. A CQUIN to encourage speedy reporting has now been devised.

"We have not got time to reinvent the wheel – if someone else has done it, let's adopt it," says Cheryl Crocker. ●

‘Everything has changed’

Getting to grips with the new NHS landscape with the help of speakers including health minister Norman Lamb and NHS England chair Malcolm Grant

COMMISSIONING RETURNS THIS MONTH

The largest national event for commissioning returns in June and will be bigger and better than ever with a line-up of political decision-makers, commissioning pioneers and expert professionals.

Commissioning 2013 will be co-located on 12-13 June with three other conferences covering integrated care, home care and the health and social care sector at Excel, London.

The unrivalled conference programme offers a great mix of best practice case studies, practical workshops and provocative debates to engage with many different kinds of delegate learning styles.

More than 6,000 senior professionals from all over the country will gather to network, join regional meetings and learn from some of the most influential keynote speakers that include Norman Lamb, minister for care and support; Stephen Dorrell, chair of the House of Commons health select committee; Professor Malcolm Grant, chair of NHS England; Andrew Burnham, shadow health secretary; Paul Burstow, former minister for care services; and Bob Ricketts, director of commissioning support strategy and market development at NHS England.

Mike Dixon, chair of the NHS alliance and interim president of NHS Clinical Commissioners, who will chair the conference on June 13, says: “April 1 changed everything and anyone who wants to know what commissioning is really about and wants to be part of it should come to this conference.

“The Commissioning Show will be an event to find out about all the different things that people are doing, what is in the minds of the new commissioners and what the opportunities are for improving patient care.

CCG BUSINESS STREAM

The CCG business stream will examine all the ingredients to running a successful CCG and offer case studies that demonstrate best practice on governance, management, performance, stakeholder engagement, finance and innovation. This stream will be packed with expert advice, innovative case studies and provocative debate on the priority issues for CCGs in their first year.

Speaker stream chair Julie Wood, commissioning development director for NHS clinical commissioners, says: “People should attend this stream because it will give them a very practical hands-on view of what they need to do and how they can be supported to tackle their job as clinical commissioners.”

Highlights of this stream include a presentation by Rosamond Roughton, interim national director for commissioning development at NHS England, on the focus for CCGs during 2013 as they move from authorisation to transformation. Paul Baumann, chief financial officer of NHS England, will give a talk on avoiding financial failure with advice on achieving financial balance in the first year and Richard Gleave, chief operating officer of Public Health England, will discuss key challenges for CCGs in public health.

COMMISSIONING SUPPORT STREAM

This stream will give an overview of the new commissioning support market, what it looks like now and how it is likely to evolve up until 2016 – the point when CSUs become stand-alone bodies – and beyond. Starting with an overview of the commissioning support market by Professor Malcolm Grant, chair of NHS England, this stream will identify the main threats to survival for CSUs and question whether large scale, highly efficient CCGs are the biggest competition of all. Sessions will include a practical look at how CSU staff with an NHS background can be supported to make the cultural shift to working within a quasi-commercial organisation and be proactive in bringing about transformational change.

Dr Charles Alessi, chairman of the National Association of Primary Care and interim chair of NHS Clinical Commissioners, who is described by *Pulse* as “one of the most prominent GP cheerleaders of the Health and Social Care Act”, will chair this speaker stream on June 13.

He says: “Post-Francis there is a new world out there and CCGs are going to have to start thinking in a different way, with a new spirit of openness. We are all learning, there is no manual we can use.

“The Commissioning Show provides an opportunity for people to meet and learn from each other. It creates a real opportunity to utilise what they hear other people are doing and to see how that could be applied in their local situations. The only way we are going to be able to manage this really quite difficult transition is by us all accepting that we can’t all do it on our own and that we need to learn from each other.”

Dr Phil Moore, deputy chair (clinical) for the Kingston Clinical Commissioning Group and joint associate medical director for the borough, is chairing the stream on June 12.

Highlights of this stream include a talk by Professor Malcolm Grant, chair of NHS England, who will give an overview of commissioning support. Tim Kelsey, national director for patients and information at NHS England will offer a vision for a patient-centred NHS and Bob Ricketts, director of commissioning support strategy and market development at NHS England, will discuss the direction of travel for CSUs post 2016.

Dr David Bennett, chair of Monitor will talk about how

commissioners can use competition to improve services and there will be debates on what CCGs really want from CSUs and who is responsible for the delivery of QIPP.

This stream is designed for CSU managing directors and their teams, NHS England and local area teams, CCGs, and private and third sector organisations interested in providing services or partnering with CSUs.

LONG TERM CONDITIONS

This stream will take an overview of the scale the problem long term conditions, which cost the NHS an estimated £77bn a year, pose for the NHS and social care.

There will be case studies demonstrating how commissioners and providers are working together to solve some of the problems through collaboration and integration. Sessions will highlight the key points in the government's long term conditions strategy and key steps to implementation.

Dr Paul Charlson, a portfolio GP who has lived and worked as a GP in East Yorkshire for 25 years, and who regularly appears on the annual *Pulse* list of most influential GPs in the country, is chairing this stream on June 12.

He says: "The discussions in this stream are going to be around what other people have done, what has worked what hasn't worked. People will get some ideas to take back to their own area by cross fertilising and talking to other people."

Dr Rowan Hillson, national clinical director for diabetes, is chairing this stream on June 13.

Highlights include a presentation on the challenges to implementing the government's long term conditions strategy by Dr Martin McShane, director of long term conditions at NHS England, and a panel discussion on how commissioners can improve care for patients with long term conditions with Dr Clare Gerada, RCGP chair; Professor Paul Knight, president of the British Geriatrics Society; and Dr Rowan Hillson, national clinical director for diabetes.

'There is a new world out there and CCGs are going to have to start thinking in a different way, with a new spirit of openness'

This stream is designed for: CCG leads, GPs, health and wellbeing board members, social care directors, public health leaders, community services professionals, secondary care clinicians and managers, commissioners of specialist services, commissioners of primary care, and private and voluntary sector provider organisations.

PRODUCTIVITY THROUGH TECHNOLOGY

Healthcare delivery is changing. New technologies mean that alternative monitoring and treatment methods are emerging. This stream will cover topics from telehealth, telecare and mobile solutions to tools for CCG intelligence and data optimisation. It will focus on key technological innovations and how they are being used by commissioners, providers and patients to improve quality and outcomes and to share knowledge.

Angela Single, BT's global clinical director on telehealth and telecare and chairperson for industry in the 3millionlives programme, is chairing this stream on June 12. Ms Single will be giving an update on the 3millionlives campaign launched by the Department of Health in 2012 to extend the reach of telehealth and telecare to improve the lives of people with long term conditions and social care needs.

Highlights in this stream include a talk about the technological revolution in the NHS by Tim Kelsey, national director for patients and information at NHS England, and a panel discussion about overcoming the obstacles to using technology to transform integrated health and social care services.

Neil Darvil, director of health informatics at St Helens and Knowsley Hospitals, will give a presentation on how to make David Cameron's vision of a paperless NHS a reality and Richard Haynes, a former Department of Health consultant and social enterprise founder, will talk about how to embed telehealth and telecare.

YOUR PRACTICE: ADAPTING TO SURVIVE

Dr Peter Swinyard, national chairman of the Family Doctor Association, who is chairing this stream on June 12, says: "GPs are under immense pressure this year and quite honestly a lot of them are not going to have any time for the commissioning agenda they are just going to be trying to survive with changes in QOF, DESs and everything else. For all but the enthusiasts commissioning is something which is pretty low on the priority list.

"Practices should come to this speaker stream to hear practical ideas about surviving. GPs will go where they think they can hear good speakers and certainly the Commissioning Show has some good speakers. GPs will want to hear about the practical nitty-gritty solution for what they do every day on the frontline. I don't have a guaranteed income as a GP and I don't have a salary so I only survive if I have enough patients and should my patients decide to take a walk I will have no income. If we don't attract the business we don't actually get paid. This speaker stream will address some of these issues."

Dr Nav Chana, postgraduate dean of GP and community based education at the London Deanery and vice chair of the National Association of Primary Care, chairs this stream on June 13.

He says: "For decades the potential for general practice to have a positive impact on chronic ill health has been recognised. Now, with three quarters of the NHS's budget resting with clinical commissioning groups and the general practices they represent, general practice has never been in such an influential position to impact on the long term health of their practice populations.'

Highlights include a talk by Dr Richard Vautrey, deputy chair of the BMA's GPs' committee on how to mitigate the impact of the GMS contract changes and an update from Dr Gavin Jamie founder of the QOF database website on the QOF and the new DESs.

There will also be a panel discussion on the key challenges facing practices from 2013-2015 with Dr Charles Alessi, GP and interim chair of NHS Clinical Commissioners and chair of the National Association of Primary Care; Karen Taylor of the Centre for Health Solutions; and Dr Peter Swinyard, chairman of the Family Doctor Association.

This stream is designed for: GP partners, practice managers, other practice team members, provider organisations, organisations interested in partnership working with general practice, from primary care, community care, secondary care and the private and voluntary sectors, and organisations offering support to practices, including CSUs, CCG leads, and LATs. ●

To find out more about the Commissioning Show visit www.healthpluscare.co.uk