FOR HEALTHCARE LEADERS
HSJ COMMISSIONING
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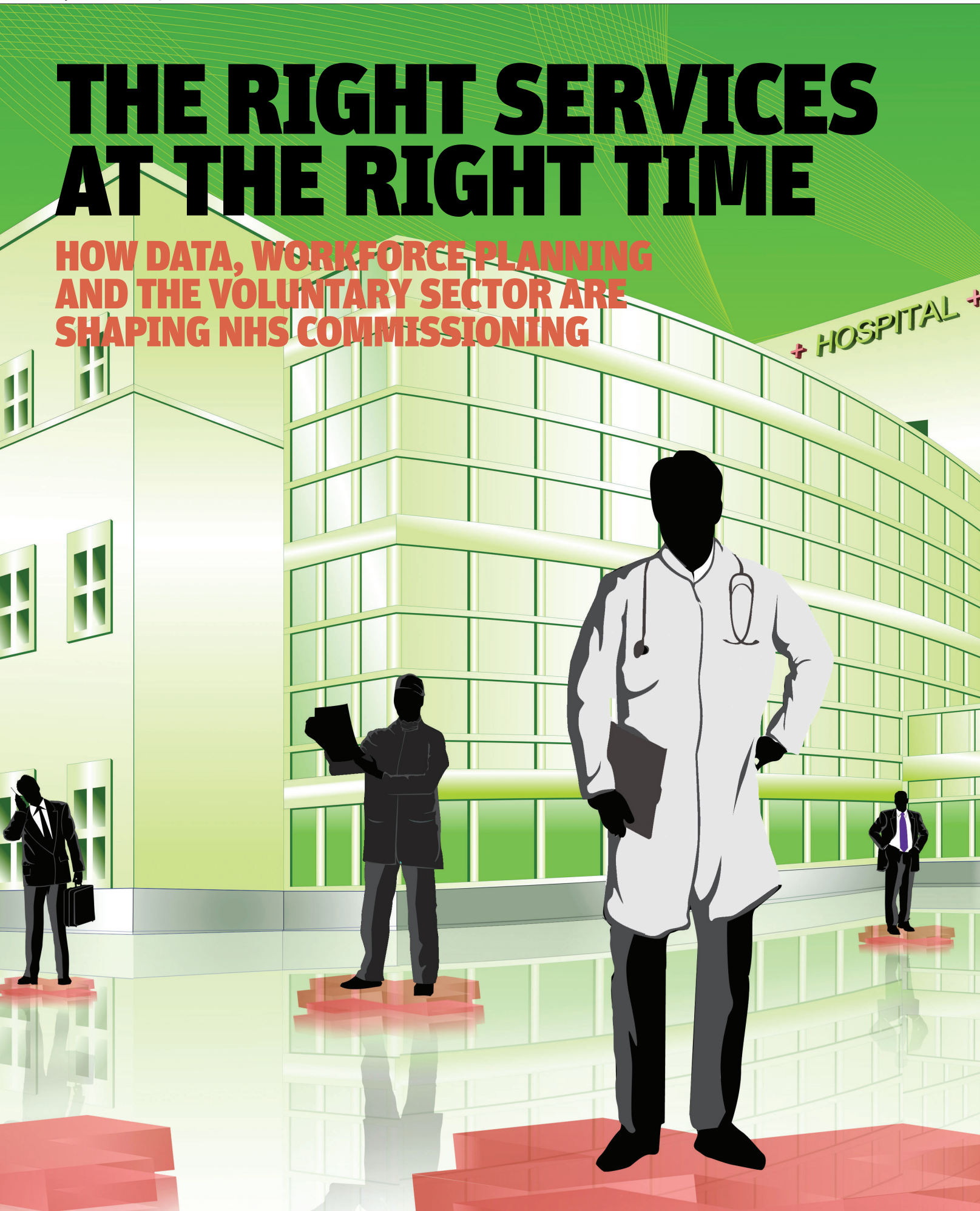
THE RIGHT SERVICES AT THE RIGHT TIME

HOW DATA, WORKFORCE PLANNING AND THE VOLUNTARY SECTOR ARE SHAPING NHS COMMISSIONING



WORKFORCE

NURTURING TALENT

Successful commissioners are aligning strategic workforce planning with staff training and development across primary care. By Jennifer Trueland

When the Primary Care Workforce Commission published its latest report in July, it made clear that change must happen – and that developing the skills of staff was a key part of this.

Indeed, the commission's vision includes the aspiration that high quality education will be available to all staff working in primary care, to give them access to continuing professional development, and provide them with the skills they need.

The commission, however, also lays on the line the challenges that already face primary care and those that are just around the corner.

Increasing workload, an ageing population and increasingly complex medical problems being diagnosed and managed in the community were just some of the issues highlighted in the report, which also points out that investment in primary care has fallen well behind that in hospitals.

None of this will come as any surprise to clinical commissioning groups – but what can be done about it? Taking workforce seriously is a good start.

Capable workforce

Nick Harding, chair of Sandwell and West Birmingham CCG, says that having the right people, with the right skills, in the right place, is essential if the organisation is to achieve its own vision for the future. "We know how important it is to have a fully trained and capable primary care workforce, equipped to deliver the care patients need," he says. "This has become an even higher priority for us since we were awarded full delegated responsibility for commissioning primary care medical services in April 2015."

His organisation has become the only CCG in England to be chosen as a National Skills Academy for Health Excellence Centre, an accolade which brings very welcome investment to help it make the most of its

DEVELOPING EXCELLENCE TO BRING OPPORTUNITIES TO THE COMMUNITY

Sandwell and West Birmingham was the only clinical commissioning group to be chosen as a National Skills Academy for Health Excellence Centre, and one of only six such centres in total. We're delighted to have this opportunity. It will enable us to really develop primary care and, particularly, general practice across our area.

The investment that comes with being an excellence centre will enable us to carry out an indepth workforce and skills analysis. This will help us work with local colleges and education providers to develop tailored education and training for our existing staff and for the workforce of the future. We'll have a very strong focus on young people during the three year pilot but, for the first year, we'll be concentrating solely on general practice. This is an area where we feel co-commissioning gives us the chance to take a fresh look at the support needed as part of the overall primary care picture. We'll work with the National Skills Academy for Health and our training provider partners to:

- develop new and innovative training programmes to ensure a highly skilled and fit for purpose primary care workforce;
- support the recruitment of apprentices into healthcare support roles;
- develop effective training for existing healthcare support workers;
- establish career development pathways supported by identified training opportunities; and
- share best practice, locally and nationally.

This will bring about tremendous opportunities within our communities – for young people wanting to develop a career in primary care; for existing primary care staff who want to enhance their skills; and for older people looking to return to the workplace after taking time out.

Our end goal is to become a self-sustaining regional training hub, working in partnership to provide apprenticeships and tailored training packages for healthcare support workers in primary care, local authorities, and voluntary organisations across the region.

We are not doing this alone. We are collaborating with three other local CCGs – Dudley, Birmingham CrossCity, and Birmingham South Central – covering a population of 1.2 million people. We recognise our partners are all in the same situation with regards to developing primary care and, therefore, delivering this pilot at scale can only bring about quality and workforce improvements for all.

Ultimately, we believe our involvement in this programme will help us improve quality and safety within healthcare, and provide the best possible service for our patients.

Nick Harding is chair of Sandwell and Birmingham CCG.

Taking workforce seriously: Commissioners spelt out their biggest challenges and suggested solutions, many of which related to workforce

present and future workforce (see panel, below).

The excellence centres – there are currently six across the country – will act as a hub to bring together health businesses across a region to encourage more consistent and better quality training through collaboration between employers, and education and training providers.

But this is only one way that the training needs of the healthcare workforce are being addressed, both nationally and locally. Individual bodies, such as CCGs, and wider organisations are looking at their own needs, and those of their local systems, to decide how best to continue squeezing as much as possible out of an often shrinking pot.

Marc Lyall, regional director for the West of England with Skills for Health, which works with employers to support skills development and workforce transformation, says that increasing numbers of CCGs are beginning to recognise the importance of a skilled workforce across primary care. There is a growing awareness, he says, that good commissioning is a process that does not sit within one silo or organisation, but is effectively system wide.

This means that only by getting to grips with the wider primary care workforce – examining its current skills and potential for development – will commissioners be confident that they are u p to the challenges ahead, and indeed, face current barriers too.

Action on crisis

"It's fair to say there's a bit of a crisis in general practice," he says. "[Health secretary] Jeremy Hunt has said he will invest more to get more GPs, but this will take time. CCGs and GP practices know that they need to take action now."

Skills for Health asked commissioners to tell them what the main challenges were and what they wanted to be done about it. There was a tremendous response, says Mr Lyall, with many answers related to workforce – such as the need to develop joined up career plans, and availability of suitable training (see illustration, above).

Commissioners are increasingly talking to Skills for Health about taking creative approaches to make the most of their workforce, says Mr Lyall. This includes being imaginative about all members of staff, not just traditional roles such as GPs and nurses, and using methods such as e-learning and face to face training and education.

This chimes with the commission report, which also highlights the importance of strategic workforce planning, developing new roles, and encouraging better skill mix.

One example is South East London Commissioning Strategy Programme Office, which brought in Skills for Health to develop a healthcare assistant package to standardise skills, training and knowledge across six boroughs of the capital.

The idea was to train HCAs to support practice nurses when capacity in general practice is stretched, which has well publicised knock-on effects on access.

The challenge, however, was that HCA training within general practice was not standardised or regulated, and there were no minimum or consistent standards of HCA skills or training.

Skills for Health, following consultation with stakeholders including the Royal College of Nursing and Londonwide Local Medical Committees, examined the existing landscape, produced a training needs analysis, a standardised role description, minimum standards and a training specification, as well as a training gap analysis.

The South East London Commissioning Strategy Programme Office is now taking the recommendations forward, with the aim of transforming the HCA workforce and reducing pressures on primary care. Similar projects are taking part across the country, says Mr Lyall, often at the instigation of GP practices themselves, that recognise that they need to address issues such as high vacancy rates and an increasing workload transferred from secondary to primary care.

Of course the very issues they are trying to address are among the reasons it is difficult for CCGs, and primary care more broadly, to take this agenda on. In some cases, there is a lack of capacity, confidence and expertise available to develop a strategic workforce strategy and development plan.

"People in the health service are working bloody hard," says Mr Lyall. "But in too many cases they're having to be reactive – unless there is really strong leadership in an organisation, too often people aren't given the time to be creative."

He says there are potentially big wins to be had when CCGs embrace the need to dovetail strategic workforce planning with training and skills development. "It's as much about the process as the outputs, in some ways," he says. "You really learn a lot about your people and organisation, and about the value of collaboration and stakeholder engagement."

In the foreword to the Primary Care Workforce Commission, chair Martin Roland, says that many "exceptional people and teams" had taken opportunities to create new and innovative ways of working, and that the way forward included better and smarter ways of working. The challenge to commissioners is to ensure that what is now regarded as "exceptional" becomes mainstream. ●

Find out more at skillsforhealth.org.uk

'Creative approaches such as e-learning as well as face to face training and education are being used'

NEW POSSIBILITIES

TIM SHEPPARD USE DATA EFFECTIVELY TO COLLABORATE

When so much energy and resource has been channeled into designing a lasting strategy for NHS commissioning, making the leap across the conceptual divide into reality is crucial. It requires many elements: strong leadership, political will and the right technology to name a few.

But to reflect accurately the needs of patients, their families and carers and to act accordingly in an integrated fashion requires more than just a look at data. We need to develop the ability to learn from data what can be changed to affect the system.

How can local health economies, used to working in silos, create a collaborative strategy and put it into action? It will only be through the effective use of data, collected from across organisational care pathways. They will need to look beyond traditional uses of data to capture and measure treatments and interventions – learning from this data means applying more rigorous statistical or predictive models to ensure we understand the "nuggets" of insight that tell us how a change now could impact the service in the future.

Commissioners across sectors, from the NHS and local authorities, will need to collaborate with providers to develop coherent, reliable and efficient patient pathways.

Take diabetes, where it is clear there is a shift in attitude at a strategic level towards prevention rather than treatment, as a means to contain overall spending while improving outcomes. Designing and implementing prevention programmes will require an understanding of not only which patients are at risk, but exactly which types of patients will go on to suffer most from the disease in the long term.

'We need to develop the ability to learn from data what can be changed'

A prevention investment structured, targeted and weighted towards those patients with longer term risk can have more impact for the same spend. To do this means learning from real world histories of diabetic patients, and applying what we learn to forecast the future of disease progression – we can do this now, even at a local level – if we utilise the data we already have in the system, and combine it with models of disease progression in an intelligent way.

Integrated commissioning will only flourish at the local level when there is collaborative working and true visibility across partner organisations, linked with a strong drive and passion to learn and make the most of the data we have access to. The alternative would be a wasted opportunity to put the patient first and reduce inefficiencies.

Tim Sheppard, general manager UK and Ireland, IMS Health.

DATA

THE COMPLETE PICTURE

The NHS is data rich but decision makers do not always have access to it. Collaborative commissioning can help the data 'work for the NHS', writes Matthew Shelley

While collaborative commissioning might well offer opportunities to streamline services and improve outcomes, high quality data is essential to fuel the drive forward.

And therein lies the challenge: the NHS is data rich, but that does not always mean decision makers have access to the readily usable information that is critical for raising standards, optimising patient pathways and achieving sustainability.

This can be tough enough to tackle within a single organisation, but new layers of complexity arise in working across multiple NHS bodies, and arguably even more so between health and social care.

However, commissioners and specialist information providers believe that momentum is building behind collaborative commissioning, alongside recognition that the right data is key.

Julie Wood, director of clinical commissioning group representative body NHS Clinical Commissioners, says there are many examples. She points to developments in Staffordshire where collaborative approaches are being developed for cancer and end of life care.

"Collaborative commissioning offers a lot of potential if commissioners see the value and grab the opportunities," she says.

A firm believer in subsidiarity, Ms Wood regards it as "a useful tool" which can enable decisions to be taken at the right level.

Combatting lung cancer is one area where a pan-organisational approach could make sense.

"You have to look at where you can have the influence, so those commissioning care at the beginning of the pathway and focusing on smoking prevention and cessation are very important.

"Then the CCGs need to look at early diagnosis and referral. When it comes to treatment you may get a group of CCGs working together to commission services for a much larger patch."

Obstacles ahead

But there are obstacles – a clear and accurate picture of the entire patient pathway, which is accessible to all and has commonly understood measures and standards, is vital for successful partnerships.

Common data sets across the NHS are a big plus, but not everyone uses them in the same way. Governance rules mean that not everyone has access to the same information – and then there are the cultural distinctions between the NHS and social care.

Ms Wood says: "Accessing business intelligence can be an issue – are we always comparing apples with apples? It's really important to make sure you are using all the analytical tools available so you can be sure you are having the best impact and are comparing the same things."

Efforts are underway, though, to enable diverse organisations to work together on delivering fully integrated care, and the NHS is increasingly turning to business intelligence organisations to help.

IMS Health UK, for example, is currently involved in projects designed to ensure that collaborators have the quality of data they need and in a form that everyone can understand and act on.

This is seen as the foundation of a shared vision with meaningful agreements on standards and specifications.

Peter Lane, lead on healthcare for IMS Health in UK and Ireland, says: "People need to be able to visualise their patient pathways. If you can't do that then how will you reduce clinical variation, maintain quality and efficiency while delivering the best service to patients?"

An initial challenge is to distinguish between the theoretical and actual patient

journey. "We worked with one organisation on cataracts. There were supposed to be four steps in their pathway, but when you looked at the figures not one patient of the thousands they had seen had actually had four steps. They were astounded," says Mr Lane.

With collaborative commissioning the picture has to be from end to end, rather than just a snapshot of what happens in primary, acute or social care.

This, argues Mr Lane, helps identify what change is needed and lays the groundwork for implementing improvements as well as measuring and monitoring the results.

By creating a complete picture of a patient's journey it is often possible to introduce swift efficiencies and make savings by eliminating duplication and unacceptable variations in treatment.

Beyond that, there are frequent opportunities to take earlier, simpler and cheaper action which benefits the patient and saves money for the NHS. Mr Lane cites analysis that revealed to an NHS organisation how many patients needing a knee replacement would require a second one not long after. They found that a second operation could be avoided or delayed and £500,000 saved if they looked at both knees when the patient first presented.

'The data needs to work for us, and help us to commission the right services for the right people in the right place'

Break down the barriers

Ideas like these are in harmony with the *NHS Five Year Forward View* and its pledges to break down barriers, integrate care and provide the flexibility for local care providers to respond to their own populations.

The prospect of substantial financial savings is clearly a huge attraction in an NHS struggling to close the gap between available resources and patient need.

More than that, the NHS devolution plans for Greater Manchester and Cornwall may create an environment ideally suited to collaborative commissioning.

This is something Mr Lane would welcome: "Collaborative commissioning is the way ahead because it has an impact, not just on individual outcomes, but on population health as a whole and will make services better and simpler."

This is a philosophy that appears to be taking root, for example in initiatives like East Sussex Better Together, which is bringing a more integrated and shared approach across the entire health and social care economy.

Amanda Philpott, chief officer of Eastbourne, Hailsham and Seaford CCG, and Hastings and Rother CCG, and NHS Clinical Commissioners board member, sees collaboration as a way to work through system-wide issues, to reduce waste and design services to suit patients and communities. For her, information is vital, but it has to be useful and has to be usable. "We have a huge amount of data about our [accident and emergency] and emergency admissions, but as it is currently collected, the 'so what' and 'what can we do about it' questions aren't easily emerging from the analysis.

"We need to focus on what we want the data to do. It needs to work for us, and help us to commission the right services for the right people in the right place. The future depends on very good data, sharing that data and working together across organisations, sectors and traditional boundaries." ●

ALAMY

BritishRedCross

PARTNERSHIPS

WINTER PRESSURE RELIEF

After a successful initiative to reduce overflow in A&E last winter, the voluntary sector is all set to provide social support to patients, writes Daloni Carlisle

Early this year overflowing accident and emergency departments became a real problem. Now that winter is just around the corner, it is worth looking back at one of the ways this issue was addressed – with support from the voluntary sector.

The British Red Cross was one of three charities awarded a total of £1.2m in a special initiative funded by the Cabinet Office, developed in partnership with the Department of Health, NHS England and chief executives of the Red Cross, Age UK and the Royal Voluntary Service.

The aim was to get the flow of patients moving by making sure those who needed an "arm around the shoulder" could get home or stay at home safely. Sue Collins, head of independent living for the Red Cross, recalls: "I had been a member of a voluntary and independent sector consortium working with Monitor for the whole of 2013-14 looking at winter pressures and what we had to offer [and] how we could work more collaboratively with the NHS.

"Then in January 2015 hospitals were declaring major incidents and closing their emergency department doors. We were called, with others, to a meeting of chief executives with cabinet secretary Jeremy Heywood to discuss a plan."

Social support

This plan involved declaring 29 (later 30) "hot spots" where NHS trusts were struggling with patient flow. The idea was to put in social support from the Red Cross, Age UK and Royal Voluntary Services to get things moving.

All three already work in hospitals and communities, supporting patient flows. For example, in 2014 the Red Cross reached 74,500 people with its support at home services. All three were ready to scale up quickly to provide additional services.

Together, they agreed to provide 700 volunteers for 12 weeks (subsequently extended to 14) to deliver social support in three ways: at home or in A&E to prevent unnecessary admissions, and on the ward to support early discharge home of patients who did not need a bed for medical reasons.

Within two weeks of agreeing the plan, the three charities had staff and volunteers in place and providing the support.

Nanette Charville, Red Cross operations manager in Cambridgeshire, Suffolk and Norfolk, was on the front line. The Red Cross took the lead at Peterborough Hospital while Royal Voluntary Service took the lead at Addenbrooke's Hospital – the two local hotspots. "We already had a home from hospital service at Peterborough Hospital," she says. "So we already had a working relationship with the hospital."

The first task was to meet with contacts at the hospital and decide the way forward.

"We spoke to discharge managers who told us their main problem was discharging patients over the weekend. We felt we could help by offering support to help patients who need low level support to settle at home.

"We proposed a service running Friday, Saturday and Sunday, based in the hospital. The trust agreed to provide some office space alongside the discharge teams and social workers and to publicise the scheme throughout the hospital."

Ms Charville quickly mobilised a manager who was working in an existing local Red Cross scheme and two paid workers, as the service was likely to be time limited. The Red Cross team worked closely with the discharge team to identify patients who might need "an arm around the shoulder" as Mary Bird, lead nurse for discharge planning at Peterborough Hospital, puts it.

Ms Charville explains the type of help her team was able to offer. "We were insured to take people home by car and make sure they were settled in – turning on the kettle, making them a sandwich, turning on the heating, make sure there is food in the fridge, that kind of thing." The support could last up to 72 hours.

"We were able to chase up medicines that they might need and sign post to other help if we felt they needed it," she adds.

Her team felt very welcomed by the hospital – right from the chief executive who made his support public, through to the

SUPPORT UPON DISCHARGE

Support provided by the three charities include:

- emergency first aid;
- transport;
- following up prescriptions;
- risk assessments at home;
- food preparation;
- emotional support and wellbeing checks;
- shopping;
- safe and well checks; and
- signposting on to other services.

'Arm around the shoulder': British Red Cross volunteers work with discharge teams to identify patients needing support

'We would like to approach this winter in a planned way. We are much more business ready now'

communications department who managed internal publicity material and the ward discharge managers who welcomed them with open arms.

"The three ladies who worked with us were just lovely," says Ms Bird. "They were all round the wards saying, 'how can we help?', and were a pleasure to work with."

She feels they made a real difference – not just to individuals but also to the hospital as a whole. "I've just looked at the evaluation and over 12 weeks they helped 105 people, spent 420 hours on home visits and carried out 372 supporting tasks. "We are a big hospital and 105 patients might not seem a massive amount but these are all people going home over the weekend when, as any bed manager will know, just three or four extra beds makes a real difference."

Would she welcome them back for winter 2015-16? With open arms, she says.

Ms Charville would love to make the service more sustainable. "Once it took off it really gathered momentum," she says. "We did a similar scheme over at King's Lynn Hospital. It was not a hotspot but they saw what we were doing at Peterborough and saw the value. We already had a hospital at home scheme there so we were able to upscale quickly."

Lessons learned

Commissioners agree that this is a service worth the investment. In June NHS Cambridgeshire and Peterborough Clinical Commissioning Group agreed to fund it again for five months over winter 2015-16. Tracy Dowling, chief operating officer for the CCG and chair of the Peterborough Systems Resilience Group, says: "The Red Cross scheme was very effective last winter in providing extra support to the hospital in discharging patients, and was well liked by patients. The SRG was keen to continue this scheme this year, and has made funding available from its operational resilience funding."

Nationally, the initiative exceeded its target of helping 8,862 people – the final total was 9,159 and nearly 500 volunteers joined the scheme. The Cabinet Office has reviewed a national evaluation report and plan to run "lessons learned" workshops this month. Ms Collins met with NHS England chief executive Simon Stevens to discuss them.

One of these is debunking myths about the voluntary sector. Ms Collins says: "The historical divide between health and social care means that not everyone in the NHS is used to working with the voluntary sector and there have been times when, for example, we have had to reassure the hospital that all our volunteers are fully trained and Disclosure and Barring Service checked.

"Debunking myths about the voluntary sector is a major part of the cultural shift we need to see if future such collaborations are to be successful."

In one or two trusts, the message that the charities were there to help did not seem to have filtered down from chief executives to front line discharge managers, she adds. The result was that the services were slower to get going than might have been the case with better communication.

Now the Red Cross wants to get services commissioned sustainably. Winter pressures funding allows the charity to scale up its support to A&Es during a particularly busy period, but ultimately these schemes should be seen more as a core part of patient care.

"Last winter we were highly reactive," says Ms Collins. "We would like to approach this winter in a planned way. We are much more business ready now." To a degree this is happening already. Witness the new contract in Peterborough – other CCGs are considering similar proposals. Last winter's experience led five trusts to create a partnership with the Red Cross to support patient flows. This will not be the last time A&Es across the UK face increased pressures, and it is likely there will be a need for similar support again. With preparations for winter 2015-16 already underway, will this year prove to be the year when early collaboration between the NHS and charity partners finally changes the record on winter pressures? ●

THE RESPONSE IN NUMBERS

£1.2m
Amount spent on the special initiative

30
Number of NHS trust "hot spots"

641
Number of frontline staff and volunteers

9,159
Number of people supported

SIMON RAWLES


HOSPITAL