

1 October 2013

Briefing:

Routes into health

Clinical commissioning groups and commissioning support units

Summary of key points:

Clinical Commissioning Groups have replaced primary care trusts as the commissioners of most NHS services, and now control around two-thirds of the NHS budget. This briefing will:

- give an overview of the structure and governance of CCGs, with a sense of who has most influence
- provide information on the types of services CCGs commission and their relationship with NHS England and the Commissioning Support Units
- highlights ways to engage with CCGs and the types of housing association activity they might be interested in.

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1. Introduction

Clinical commissioning groups (CCGs) are at the centre of the Government's health reforms. In April 2013, these newly established, clinically led organisations replaced primary care trusts as the commissioners of most services funded by the NHS in England, and now control around two-thirds of the NHS budget. The CCGs give clinicians and other health professionals the lead on purchasing health services to meet the needs of their areas. Each of the 8,000 GP practices in England is now part of a CCG and there are 211 CCGs altogether, commissioning care for an average of 226,000 people each¹.

This briefing is one of four documents entitled *Routes into health*, which together aim to explain health commissioning structures and NHS providers to housing associations. This work is part of the National Housing Federation's [Health Partnership project](#).

2. Context

All general practices in England are legally obliged to be a member of a CCG. CCGs have decided themselves what geography they will cover and therefore in some local authority areas there is now more than one CCG. They are managed by an executive team and wider support team, who are employees of the CCG. Most have some form of member council that comprises either all practice representatives (in smaller CCGs) or locality representatives (in larger CCGs). They are responsible for representing the membership and liaising with the governing body and executive team. Every CCG has a governing body, with an elected GP chair and includes a combination of member representatives (most commonly GPs), members of the executive team, lay members and representatives from other local partners. They are overseen by NHS England, which ensures they have the capacity and capability to commission services for their local population.

CCGs are tasked with delivering a sustainable health care system in the face of one of the most challenging financial and organisational environments the NHS has ever experienced. They are commissioning services at a time when an ageing population and increased prevalence of chronic diseases will require a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well coordinated and integrated². If nothing changes in the NHS, the result will

¹ The King's Fund website: www.kingsfund.org.uk/topics/commissioning

² *The NHS Belongs to the People: A Call to Action*, NHS England, 2013

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be significant unmet need and threats to the quality of care³. The mandate to NHS England⁴ highlights where the Government expects to see improvements to health outcomes.

3. Who has the most influence in the CCG?

As a membership organisation, CCGs are generally understood to be owned by their members: clinical leaders are elected to the governing body by member practices. However, despite an understanding that members' councils would play an instrumental role in setting the direction taken by the CCG, in reality these boards are sometimes underdeveloped and the governing body has a greater influence over decisions being made⁵. Member GPs, who all carry out their commissioning role in addition to their day job, sometimes don't have capacity to access the necessary information, which leaves them feeling decisions are made without their involvement⁶.

In general, the accountable officer and the chair have the best overview of the CCG and the greatest influence at this stage, particularly as they have steered CCGs through the authorisation process. If CCGs have assigned leads for aspects of commissioning, it may be easier to engage those leads on their specialism rather than the chair. If you are struggling to make a connection, use any relationships you already have in the health sector as CCGs will already have relationships with many health professionals. It is worth bearing in mind that GPs all have individual passions and motivations. Being able to build relationships with a GP who can act as a 'clinical champion' for the housing sector is very helpful. Given the volume of new information, word of mouth and peer recommendation goes a long way in getting housing association services recognised.

4. What types of services do CCGs commission?

As of 1 April 2013, CCGs are responsible for the majority of the NHS budget – more than £65bn of public money. CCG's use their understanding of their own patients, and their relationships with doctors, nurses and other healthcare professionals, to commission the services that best meet their patients' needs. They have two important, but distinct, roles.

Firstly CCGs are responsible for commissioning secondary care services for their local populations. This includes planned hospital care, rehabilitative care, urgent and emergency

³ *Ten priorities for commissioners*, The King's Fund, 2013 (revised edition)

⁴ *A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, Department of Health, 2012

⁵ The King's Fund and Nuffield Trust, 2013

⁶ The King's Fund and Nuffield Trust, 2013

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care (including out-of-hours), most community health services, mental health and learning disability services. They are guided by the NHS Outcomes Framework⁷, which has five domains:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Ensuring that people have a positive experience of care
4. Helping people recover from episodes of ill health or following injury
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

There is a separate CCG Outcomes Indicator Set⁸. This will not in itself set thresholds or levels of ambition for CCGs, it is intended as a tool for CCGs to drive local improvement and set their own priorities. As statutory members of their health and wellbeing boards, CCGs are legally required to use the joint strategic needs assessment (JSNA) and joint health and wellbeing strategy, developed with the health and wellbeing board, when drawing up their commissioning plans. NHS England has produced information packs at CCG level that set out key data to inform the local position on outcomes⁹.

All CCGs have now published their commissioning plans for the next three years, which set out the key outcomes they want to achieve, how they will deliver this and the funding available. Housing associations should use the information to inform their approach and offer to CCGs, alongside the health and wellbeing strategy and any local intelligence they have collected. CCGs will be refreshing their plans in early 2014 so there are still opportunities to influence the content and the priorities.

CCG's second role is to improve the quality of general practice, which will be challenging for them to fulfil, particularly as GP services are commissioned by NHS England through its 27 area teams. However, many of the key priorities they address will call for change within primary care and the way in which primary care relates to the rest of the system. To achieve this, clinical commissioning groups will need to work closely with NHS England area teams. NHS England not only takes responsibility for commissioning primary care (£13bn) through its 27 area teams, it also commissions specialised services (£12bn), such as services for members of the armed forces and for offenders in institutional settings.

⁷ NHS England's website has a useful tool for CCGs, helping them to break down the challenges within each of the domains of the NHS Outcomes Framework:

<http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-1/>

⁸ CCG Indicator set: At a glance. <http://www.england.nhs.uk/ccg-ois/>

⁹ For details of the CCG packs, visit <http://www.england.nhs.uk/la-ccg-data/#ccg-info> These have now been developed into an outcomes tool: <http://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/>

5. How to engage with CCGs?

If housing associations want to influence service provision, it is best to consider individual care pathways, using the financial imperative of QIPP (quality, innovation, productivity and prevention) programme to highlight how housing associations can improve individual outcomes. Delivering QIPP is a top priority for the health service. The QIPP programme is expected to improve the quality of care the NHS delivers while making up to £20bn of efficiency savings by 2014/15, to reinvest in frontline care. The QIPP framework is a major driver of reform within the NHS and the QIPP themes are a way of focusing commissioners and providers delivering big efficiency savings, while sustaining or improving quality.

For any housing offer to be of interest to health, it should improve patient experience and productivity, add value not cost, and be replicable across similar settings. Particular areas highlighted for further innovation in the health sector are:

- improving and extending life expectancy;
- using telehealth and telecare to improve long term conditions;
- bringing services closer to the customer, in their home and community;
- supporting carers for people with dementia service integration.

There are a number of organisation set up to support CCGs, which could be useful for housing associations looking to challenge CCG priorities and redesign care pathways.

a) Working with Commissioning Support Units (CSUs)

The CSUs can support CCGs in carrying out commissioning functions, such as leading change and service redesign, as well as actual commissioning functions, such as procurement, contract negotiation and information analysis¹⁰. There are currently 18 CSUs across the country, many of which have evolved from primary care trusts, set up as social enterprises. CSUs are currently hosted by NHS England, but from 2016 they are expected to become freestanding and compete for business. Each CCG has been given an allowance of £25 per person in that locality to spend on management. However, many CCGs would rather bring commissioning support in house¹¹.

Depending on their relationship with the CCGs, some CSUs will be useful links for housing associations as they can help to support the development of sustainable and effective local relationships with CCGs¹². At their best CSUs will support commissioners to deliver large scale

¹⁰ *Clinical Commissioning: A Guide for the Voluntary and Community Sector*, Regional Voices 2013

¹¹ <http://ccginformation.com/category/commissioning-support/>

¹² For a list of all the current CSUs and names of managing directors visit

www.england.nhs.uk/appointments/csu/

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improvements in efficiency and quality. They will provide commissioners with an understanding of what works so that they can meet their significant local QIPP challenge – ensuring resources are released to meet demographic and other pressures. Therefore, they will be an eager audience for any housing association that can demonstrate services have succeeded in making efficiency savings to the NHS. However, many will simply provide back office functions, with the CCG taking on most of the procurement risk.¹³

b) Clinical Senates and Networks

The new commissioning system encourages a range of networks performing different functions. These include clinical senates and strategic clinical networks. The clinical senates, in 12 areas around the country and hosted by NHS England, provide multi-professional clinical advice on local commissioning plans, particularly on topics where GPs may not have specialised knowledge such as seven-day services, diagnostics and maternity services¹⁴. The strategic clinical networks advise on single areas of care and whole care pathways such as cancer, cardiovascular disease, mental health, and dementia. They will support and improve integration across primary, secondary and social care¹⁵. The strategic clinical networks, in particular, will be key for housing associations working around specific clinical areas such as mental health and dementia. The regional public and patient involvement leads at NHS England will be a useful route in¹⁶.

6. Are you ready to partner with health?

CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities, or private sector providers. However, they must be assured of the quality of services they commission, taking into account both the [National Institute for Health and Care Excellence \(NICE\) guidelines](#) and the [Care Quality Commission's \(CQC\) data](#) about service providers. In order to bring scale and impact, some housing associations may need to work in partnership with other providers.

The focus and membership of CCGs will mean they have a strong focus on clinical services. However, as part of their general duties set out in section 26 of the Health and Social Care Act, CCGs have a duty to promote integration to improve quality and reduce inequalities. Some CCGs

¹³ *Towards commissioning excellence: a strategy for commissioning support services*, NHS Commissioning Board, 2013. Find this and other useful resources on CSUs here: <http://www.england.nhs.uk/resources/css/>

¹⁴ *The Way Forward: Clinical Senates*, NHS Commissioning Board, 2013

¹⁵ *The Way Forward: Strategic Clinical Networks*, NHS Commissioning Board 2013

¹⁶ *Regional Voices 2013*

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are devolving commissioning responsibilities to local authorities. They could choose to commission services jointly or outsource the commissioning to local authorities or other public bodies with clear expertise and experience in achieving the outcomes they seek. CCG's approach to integration could include commissioning health-related services that deliver locally prioritised outcomes. For the purposes of the act community services like housing and housing-related support would be 'health-related services'.

As part of the agenda to increase patient choice, clinical commissioners may identify specific services which they will open up to all providers which can demonstrate that they meet agreed quality and service standards¹⁷. The organisations which achieve Any Qualified Provider (AQP) status will receive a 'fixed price' for providing services when selected by the patient¹⁸.

Therefore, when a patient is referred (usually by their GP) for a particular health service, they should be able to choose from a list of qualified providers who meet NHS quality requirements and price. The move to AQP may in the future provide opportunities for many housing associations to open up services like telecare to those who might not otherwise have accessed them. However, CCGs are currently prioritising areas like podiatry and hearing aids.

7. What is the housing offer to CCGs?

Most CCG members will not know about housing associations, or the support they provide to people in the community. In developing an offer, it is important for housing associations to provide clarity over their role as a care and support provider. Be clear about your clients' needs and how your organisation meets those needs. CCGs will be interested in your size, turnover, physical assets and connection to the local community. They will want to know whether housing associations only provide services to their tenants or the wider community. CCGs will be interested in the ways in which the sector innovates and diversifies its offer to meet local needs.

Research suggests that CCGs' top ten priority areas include:

- managing long-term conditions;
- developing effective emergency or urgent care;
- recovery services for mental health;
- efficiency/finance/value;
- promoting integrated care;
- elective care;
- providing more effective primary care services;

¹⁷ <https://www.gov.uk/government/publications/operational-guidance-to-the-nhs-extending-patient-choice-of-provider>

¹⁸ For more details on how to achieve qualified provider status, see *Understanding the reforms...Choice and any qualified provider*, British Medical Association, 2013

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- giving children or young people the best start; improving access to community services;
- and driving up quality of services¹⁹.

Where people have settled accommodation and access to support, not only can significant savings can be made but, most importantly, they can be supported to live more independent lives. Unsuitable housing, or a lack of suitable housing-related support, can lead to an escalation in care needs, potentially triggering admission to hospital, residential or other institutional care.

Below are some suggested pathways where housing associations could add value. The more housing associations can demonstrate beneficial outcomes and value for money the better. This includes how many people receive, or could benefit from, the service, what difference it makes to them and how much it will cost and save. However, this evidence should be based on the NHS outcomes framework and be clearly linked to the clinical commissioning group's identified priorities for that area.

a) Effective recovery services through hospital discharge practice

Integrated reablement services, intermediate specialist housing and short to medium term support services are key to helping people recover quickly from illness or injury and preventing avoidable readmissions. The CCG outcomes indicators highlight the importance of reducing emergency admissions and readmissions after 30 days. They specifically reference particular diseases such as stroke, where they have identified a clear need to improve recovery services and prevent premature death. There is also an indicator for helping older people recover their independence after illness or injury, as well as an indicator to improve health gain after an elective procedure, such as a hip replacement.

b) Supporting people with a long-term condition to self-care

Many CCGs will commission secondary care service that support people to manage a long-term condition. Housing associations should look at how specialist housing and support enables people to self-care, provides an alternative to residential and institutional care, and prevents avoidable admissions, particularly for those with dementia. The emphasis on long-term conditions is also an opportunity to support integrated care planning through local GPs, which could identify future housing and support needs earlier. This type of triage could be supported by co-locating GPs within specialist schemes.

¹⁹ Health Services Journal, 'Analysis: Big gap between priorities of CCGs and 'rising star' wellbeing' boards, 19 September, 2013

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c) Enhancing quality of life for people with mental health

Housing associations can help to improve access to community mental health services and psychological therapy as they have access to traditionally excluded people. Combining clinical, housing and support service can provide an alternative pathway for people with mental ill health, helping to reduce emergency admissions for acute conditions that do not require admissions.

8. Useful links and resources

- *Providing an Alternative Pathway*, National Housing Federation, 2013
- *Dementia and housing: finding housing solutions*, National Housing Federation, 2013
- The King's Fund website pages on commissioning contain a number of useful resources: www.kingsfund.org.uk/topics/commissioning, including Ten priorities for commissioners, The King's Fund, 2013 (revised edition)
- *The NHS Belongs to the People: A Call to Action*, NHS England, 2013
- *Towards commissioning excellence: a strategy for commissioning support services*, NHS Commissioning Board, 2013. Find this and other useful resources on CSUs here: <http://www.england.nhs.uk/resources/css/>
- Regional Voices has produced a number of useful resources for the voluntary and community sector on health commissioners and providers including a guide on clinical commissioning for the voluntary and community sector, and a guide to who's who in health and care. These are available on their website: www.regionalvoices.org.uk
- For details of the CCG information packs, visit <http://www.england.nhs.uk/la-ccg-data/#ccg-info> These have now been developed into an outcomes tool: <http://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/>
- Ben Gowland, the Accountable Officer at NHS Nene CCG has produced a useful blog on key priorities for CCGs www.ccginformation.com/category/commissioning-support/
- NHS England's website has a useful tool for CCGs, helping them to break down the challenges within each of the domains of the NHS Outcomes Framework: <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-1/>
- *A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, Department of Health, 2012
- *A Healthier Perspective*: a very practical toolkit to support commissioners and the voluntary sector understand how they can work together in commissioning health services by RAISE
- *Towards More Effective Commissioning*: examples of commissioners and VCOs working creatively to co-produce solutions to entrenched health difficulties by Voluntary Sector North West (VSNW)

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