Chief Officer Update

1. 360° Survey Results

Prior to authorisation all shadow CCGs were required to undertake a 360° survey in order to assess the quality of the key relationships that would be critical to the success of the new organisation. This information helped to identify where relationships needed to be further developed and similarly confirmed what behaviours had been successful and needed to be continued.

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NHS England has conducted a further survey this year which was designed to allow stakeholders to provide feedback on working relationships with CCGs for two purposes:

1. To provide data for CCGs to help with their on-going organisational development.
2. To feed into assurance conversations between NHS England area teams and CCGs.

The summary of the results is attached at appendix 1 and it can be seen that there are a number of areas where the CCG has performed higher than the national average for all CCGs across the country. We are strongly encouraged by the feedback received and the level of confidence in our ability to commission high quality services that will improve outcomes for patients. However, neither are we complacent. Of particular note were some of the comments from member practices which indicate a concern about the workload in primary care given the context of our plans to strengthen services in the community and reduce the need for care to take place in the acute sector. The full report which includes the detailed response to each question is available on request.

2. Co-commissioning of Primary Care

Speaking at the Annual Conference of NHS Clinical Commissioners in London on Thursday 1 May, NHS Chief Executive Simon Stevens announced a new option for local CCGs to co-commission primary care in partnership with NHS England.CCGs will get new powers to improve local health services under a new commissioning initiative that will give CCGs "greater influence over the way NHS funding is being invested for local populations." Simon Stevens invited CCGs that are interested in an expanded role in primary care to come forward and show how new powers would enable them to drive up the quality of care, cut health inequalities in primary care, and help put their local NHS on a sustainable path for the next five years and beyond.

NHS England has written to all CCGs in England with details of how to submit expressions of interest in taking on enhanced powers and responsibilities to co-commission primary care (see appendix 2). Though they have called this initiative 'co-commissioning' the exact models are open for negotiation. This could range from CCGs simply having greater influence in commissioning decisions, to joint commissioning, to at the other end of the spectrum NHS England delegating commissioning responsibility to CCGs.

The opportunities include making primary care commissioning more responsive and locally sensitive, potentially allowing us to develop flex around local contracts (PMS and APMS). It could also enable primary care commissioning to be delivered in a more coherent fashion to support the integration agenda and Better Care Fund work. However, there is no new resource available to help CCGs take on any extra responsibility and the organisation would have to continue to operate within current and reducing management cost requirements.

The CCG has engaged with member practices and at the time of writing an expression of interest was being prepared for submission on June 20th 2014. This is likely to be supportive

of more formal working relationships with NHS England in relation to primary care commissioning but fall short of requesting delegated authority. However this will mark the start of the process and the CCG is keen to further develop its thinking and explore how it can work both with neighbouring CCGs and also the Local Authority on this important agenda.

3. CCG manifesto from NHS Clinical Commissioners

NHS Clinical Commissioners launched a CCG manifesto for a high-quality sustainable NHS on 1 May. Making change happen: A CCG manifesto for a high-quality sustainable NHS was handed to the Rt Hon Jeremy Hunt MP, Secretary of State for Health and Simon Stevens, at the NHS Clinical Commissioners annual members' event, which was attended by more than 200 CCG leaders from around the country.

The manifesto for change, which speaks for NHS Clinical Commissioner's membership, identifies a series of challenges that clinical commissioners currently face, as they strive to make a real difference to the health outcomes of patients and populations. It requests eight specific solutions from the system in order to enable CCGs to effectively deliver high-quality, sustainable healthcare: free clinical commissioners to act in the best interest of patients; make local system leadership a priority; health and wellbeing boards as the focus of joined-up commissioning; CCGs must not be a risk pool for the NHS; support to deliver large-scale transformation at pace; connecting national and local commissioning; better alignment of local commissioning to healthcare quality and the new inspection regime; and competition in the NHS in the best interest of patients.

4. South Nottinghamshire Transformation

Following a third and final care design event on 5 June involving clinicians and senior managers from across the 12 health and social care partners in Greater Nottingham, the four CCGs in South Nottinghamshire submitted their five year strategy to NHS England on 20 June. NHS Nottingham City CCG has come together with Nottingham West, Nottingham North and East and Rushcliffe CCGs to form a 'unit of planning', to work with Local Authority partners, NHS providers and the third sector to identify the transformation that would need to take place across health and social care to mitigate against and estimated funding gap of around £140m over the next five years. The five year strategy looks at four domains; Children's Services, Urgent Care, Proactive care and Elective Care and includes initial financial modelling to identify where efficiencies might be realised.

5. Non-recurrent funding for operational resilience and referral to treatment

NHS England has published a framework to support planning for operational resilience during 2014/15 which covers both urgent and planned care. All NHS accountable officers and local authority chief executives have received letters setting out NHS England's expectations for how the system will work together to develop robust plans for managing operational resilience through 2014/15.

This is a directive beyond planning for urgent care over winter, bringing this together with planned care to system wide, year round resilience. The guidance sets out best practice each local system should reflect in their local plan, and the evolution of Urgent Care Working Groups into System Resilience Groups (SRGs). CCGs are expected to play a full role in leading these groups, ensuring that all partners across health and social care are included, whether commissioners or providers.

Non recurrent funding for 2014/15 is being made available to support the successfuldelivery of these plans to ensure that resilience planning does not lead to a deterioration in the financial position of member organisations.

6. Choice Policy across South Nottinghamshire and Nottingham City

Most people return home after a period of acute care, some after a period of intermediate care. Increasingly, in line with the policy of supporting independent living, those who are immediately unable to return to their previous place of residence are offered more appropriate extra care housing or other provision.

The South Nottinghamshire health and social care community is working together to develop a model of 'transfer to assess'. The objective of this is to ensure that patients who are having a supported transfer of care from the hospital move within 24 hours of being medically safe for transfer to a suitable environment for them to receive further assessment of their long term needs.

Where a place is not available in the individual's preferred residential or nursing care home or there is a wait whilst packages that will support the citizen from returning home are put in place, remaining in an acute hospital setting is undesirable both for the patient and for other patients trying to access care within that hospital. There are particular risks of increasing dependency and acquiring infections. In addition the acute care provision is needed for those with acute care needs.

The health community has therefore developed a policy to support the timely, effective transfer of care of medically fit patients, ready for discharge from an NHS inpatient setting who need to move into a care home. It is to be used in conjunction with the Hospital Discharge Policy and is for use by all staff with responsibility for arranging the transfer of care for patients. The aim of this policy is to reduce the length of time a patient waits in an acute hospital bed whilst waiting to be transferred to a care home of choice. In particular the policy aims to

a) Be patient centred, aiming to improve the welfare of the patient and minimise frustration and distress.
b) prevent the development of expectation that a person may stay in the hospital indefinitely
c) offer guidance to staff who have responsibility in arranging the transfer of care from hospital of those patients who need to move to a care home
d) ensure that there is a clear escalation process in place for when patients remain in hospital longer than is clinically required
e) ensure NUH inpatient beds will be used appropriately and efficiently for those who require that service.

The full policy will be brought back for consideration at a future meeting of the Health and Wellbeing Board

Dawn Smith
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