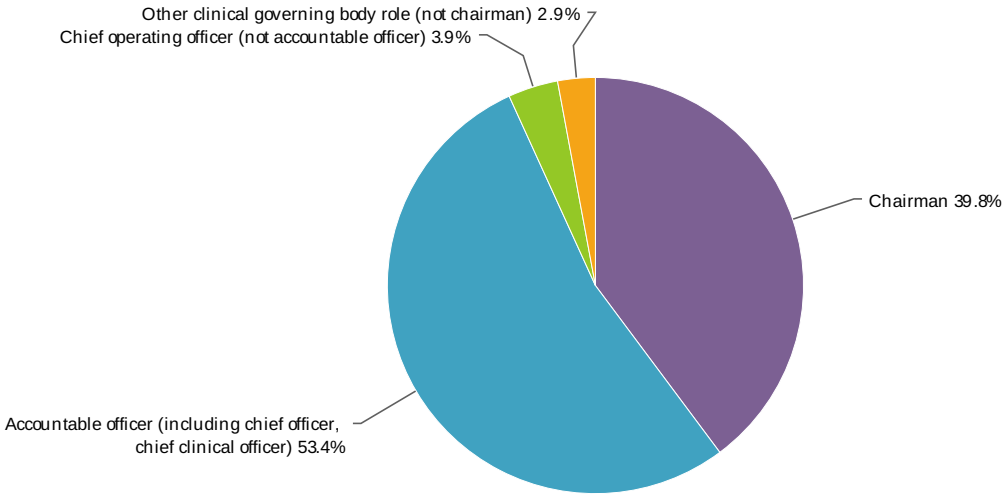
New Summary Report - 05 May 2014

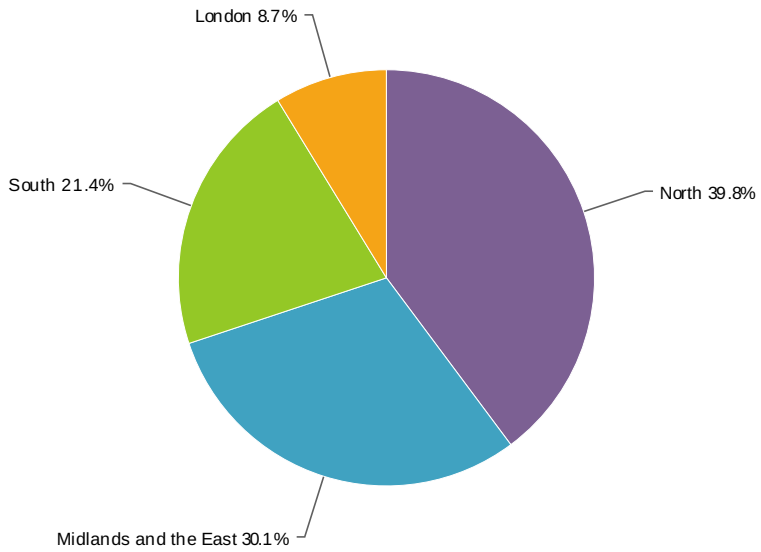
Survey: HSJ Clinical Commissioning Barometer Spring 2013 with PWC

1. What is your role in your CCG (please select best match)?



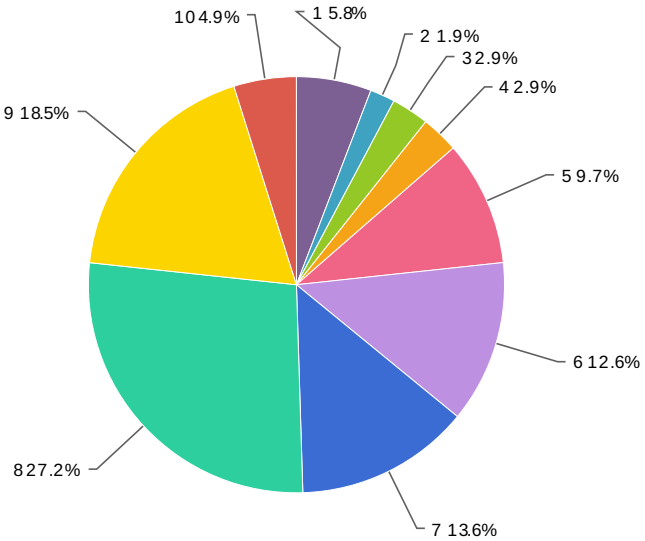
Chairman	39.8%	41
Accountable officer (including chief officer, chief clinical officer)	53.4%	55
Chief operating officer (not accountable officer)	3.9%	4
Other senior executive role (eg finance director)	0.0%	0
Other clinical governing body role (not chairman)	2.9%	3
Governing body lay role (not chairman)	0.0%	0
Other	0.0%	0
	Total	103

2. In which region is your CCG located?



North	39.8%		41
Midlands and the East	30.1%		31
South	21.4%		22
London	8.7%		9
		Total	103

3. Rate your confidence that your CCG can stick to its budget without compromising care quality or access, over the next 12 months (1 is not at all confident, 10 is entirely confident)



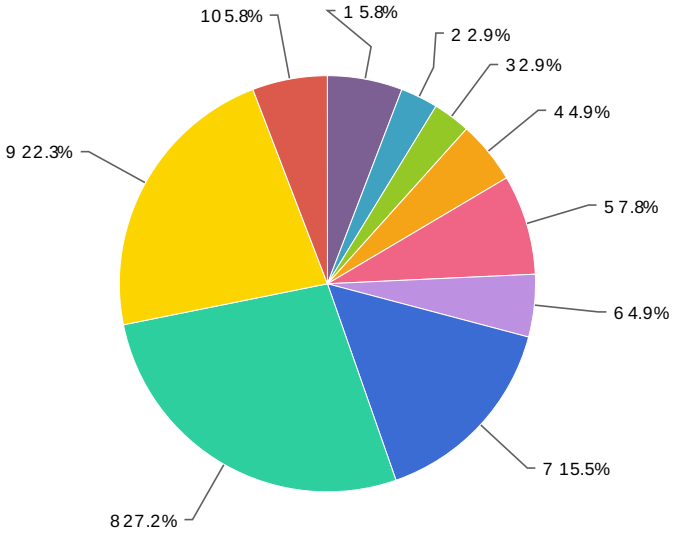
1	5.8%		6
2	1.9%		2
3	2.9%		3

Statistics	
Sum	702.0
Average	6.8
StdDev	2.3

4	2.9%		3
5	9.7%		10
6	12.6%		13
7	13.6%		14
8	27.2%		28
9	18.5%		19
10	4.9%		5
		Total	103

Max	10.0

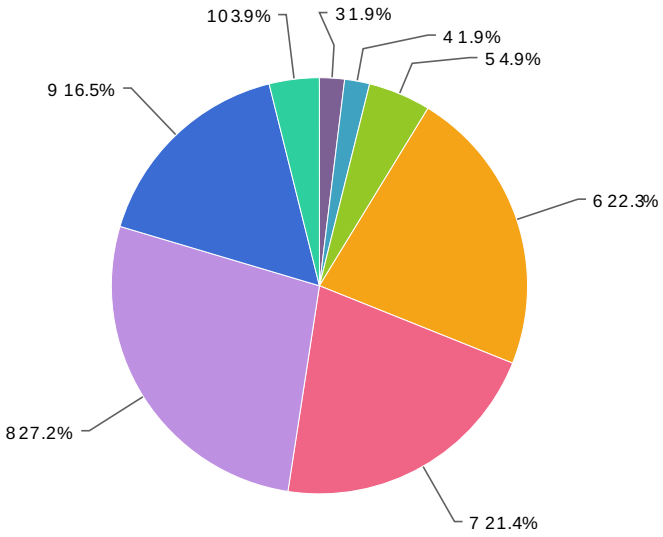
4. Rate your confidence that your CCG will remain in financial balance or surplus over the next 12 months (1 is not at all confident, 10 is entirely confident)



1	5.8%		6
2	2.9%		3
3	2.9%		3
4	4.9%		5
5	7.8%		8
6	4.9%		5
7	15.5%		16
8	27.2%		28
9	22.3%		23
10	5.8%		6
		Total	103

Statistics	
Sum	714.0
Average	6.9
StdDev	2.4
Max	10.0

5. Rate your confidence that the CCG will be able to make significant improvements to health and services this year over the next 12 months (1 not at all confident, 10 entirely confident)



1	0.0%		0
2	0.0%		0
3	1.9%		2
4	1.9%		2
5	4.9%		5
6	22.3%		23
7	21.4%		22
8	27.2%		28
9	16.5%		17
10	3.9%		4
		Total	103

Statistics	
Sum	748.0
Average	7.3
StdDev	1.5
Max	10.0

6. Nearly a year has passed since CCGs became statutory organisations on 1 April 2013. On each of these issues, in relation to your area, please say how these compare to the situation before the government began introducing its clinical commissioning reforms, for example in early 2010:

	Significantly worse now		Worse now		The same		Better now		Significantly better now		Responses
GPs' engagement with design of services	0	0.0%	1	1.0%	6	5.8%	51	49.5%	45	43.7%	103
Ability of NHS to change acute and general inpatient hospital services	0	0.0%	9	8.8%	32	31.4%	52	51.0%	9	8.8%	102
Ability of NHS to change specialist hospital services	15	14.6%	40	38.8%	33	32.0%	13	12.6%	2	1.9%	103

Ability of NHS to change general practice	5	4.9%	22	21.4%	16	15.5%	49	47.6%	11	10.7%	103
Joint working between healthcare commissioners and local authorities	0	0.0%	1	1.0%	9	8.8%	51	50.0%	41	40.2%	102
Ability of NHS to control costs for NHS commissioners	2	1.9%	26	25.2%	45	43.7%	29	28.2%	1	1.0%	103
Ability of NHS to stabilise and reduce hospital activity	0	0.0%	4	3.9%	46	44.7%	48	46.6%	5	4.9%	103
Ability of NHS to support sustainable providers	3	3.0%	34	33.7%	43	42.6%	21	20.8%	0	0.0%	101
Ability to identify major care quality failures	0	0.0%	1	1.0%	25	24.3%	60	58.3%	17	16.5%	103
Ability to create better integrated health and care services	0	0.0%	3	2.9%	7	6.9%	69	67.6%	23	22.5%	102
Public/patient involvement with design of services	0	0.0%	0	0.0%	18	17.5%	50	48.5%	35	34.0%	103
Ability to influence and move activity and costs around the healthcare system	7	6.8%	8	7.8%	38	36.9%	41	39.8%	9	8.7%	103
Ability to improve public health services and public health	10	9.9%	31	30.7%	40	39.6%	15	14.9%	5	5.0%	101

Comments

Count	Response
1	Fragmentation of commissioning between ccgs and NHS England is a disaster.
1	PBR is a perverse incentive and so shifting resources from acute to community is difficult
1	Public Health has been significantly damaged in the reforms
1	The commissioning of GP is particulalry complicated and confused in the new system
1	The commissioning roles of local area teams are an abject failure
1	this year will be crucial in changing general practice and reversing increases in acute spend
1	Cost contro: this is due to fragmentation, not clinical commissioning per se. Sustainable providers: due to continued difficulties in reconfiguration of acutes e.g. OFT rulings, Lewisham judicial review
1	It's taking time to link CCGs with direct commissioning and clinical engagement is dissipated - senate/ networks etc
1	CCGs have significantly engaged with clinicians and local stake-holders including patients to drive improvements in service delivery
1	CCGs are doing really well generaly with good bias for action and change. The rest of the healthcare system still presents in disarray.
1	There is a much more open and honest conversation with the public about how the health and social care service can be delivered within the financial envelope. There is more engagement of grassroot GP's who are beginning to feel they are being listened too and can now influence change for the better. There is also a more adult conversation with providers about the need for real change in the way services are delivered. The local authorities are also getting a better understanding of how health is delivered and why there are the problems we have with the whole system.

1	Some elements of the reforms have had a noticeable impact particularly around joint working with local authority and engagement of GP practices
1	The potential is certainly there, there is a clear change with a willingness even eagerness to integrate and cooperated much more. The difficulty is translating it into action as clinical pressures rise and income reduces especially with the advent of BCF
1	Health and Wellbeing boards were a good idea in theory, but in practice they have either duplicated health scrutiny processes or become forums for political debate about the future configurationb of health services.
1	The fragmentation of commissioning is a real problem requiring urgent action through effective delegation of responsibilities and greater local integration and strategy agreement
1	NHS commissioning primary care- a disaster. Need to combine primary and secondary commissioning urgently within the CCG to develop integrated care and cope with the financial tsunami
1	focus seems to remain on sustainability of NHS providers and trying to do everything. We need a sensible public debate
1	All sems to take far more energy and resource which doesnt bode well given reducing management resiurce and reducing health anf scocial care budgets
1	The process of becoming a CCG has been hugely and overly onerous at a time when need for good stewardship of the NHS was at its highest. NHS England must support development of Primary care if the change to Hospital setting care is to happen. Many of the old perverse incentives for secondary care remain and may yet scupper CCG chance for success.

7. How likely do you think it is that your CCG will employ each of these approaches to changing services and staying within its budget, over the next 12 months?

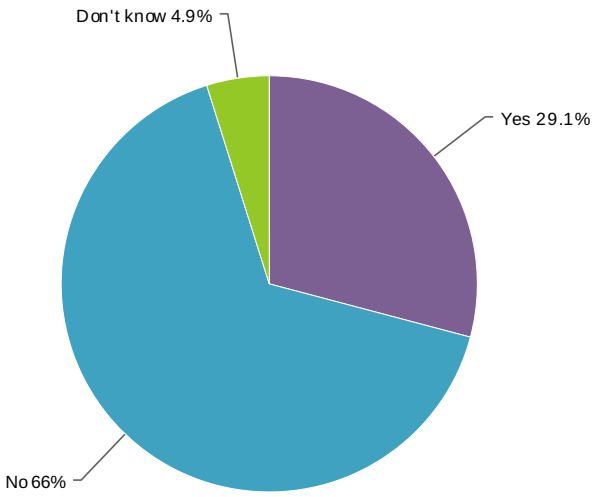
	Very unlikely		Unlikely		Don't know		Likely		Very likely		Responses
Re-contracting a significant amount of services, under an "outcomes based contract"	4	3.9%	23	22.3%	11	10.7%	53	51.5%	12	11.7%	103
Introducing a block contract with risk share arrangement	1	1.0%	21	20.4%	9	8.7%	57	55.3%	15	14.6%	103
Extending the role of independent providers, or competition for or in services	2	2.0%	38	37.6%	24	23.8%	33	32.7%	4	4.0%	101
Encouraging increased integration of existing NHS/GP/social care providers	0	0.0%	0	0.0%	3	2.9%	47	46.1%	52	51.0%	102
A major service reconfiguration, not likely to include downgrading or closing an A&E unit	9	8.8%	35	34.3%	7	6.9%	37	36.3%	14	13.7%	102
A major service reconfiguration, which is likely to include downgrading or closing an A&E unit	22	21.8%	43	42.6%	8	7.9%	12	11.9%	16	15.8%	101
Commissioning significant additional services from GP practices	1	1.0%	11	10.8%	12	11.8%	59	57.8%	19	18.6%	102
Significantly reducing hospital activity and capacity	2	2.0%	20	19.6%	13	12.7%	58	56.9%	9	8.8%	102
Encouraging or telling member GP practices to network, federate or merge	1	1.0%	7	6.9%	1	1.0%	42	41.2%	51	50.0%	102

Bans or limits on some treatments which are not clinically justified	0	0.0%	9	8.9%	7	6.9%	60	59.4%	25	24.8%	101
Bans or limits on some treatments, even when they may be clinically justified	27	26.5%	55	53.9%	12	11.8%	7	6.9%	1	1.0%	102
Implementing robust quality performance regime for primary and second care	0	0.0%	4	3.9%	13	12.7%	68	66.7%	17	16.7%	102

8. Please indicate how much of a barrier you think each of these issues will be to your CCG making significant changes and improvements to services over the next 12 months:

	Don't know		Not a barrier		A small barrier		A significant barrier		Responses
Political opposition to service changes	0	0.0%	11	10.8%	33	32.4%	58	56.9%	102
Inability of CCGs to directly contract "core" GP services	1	1.0%	20	19.6%	34	33.3%	47	46.1%	102
The NHS per-treatment tariff payment system	4	3.9%	11	10.8%	34	33.3%	53	52.0%	102
Capability and capacity of the CCG	0	0.0%	29	28.4%	57	55.9%	16	15.7%	102
Top-down requirement to focus on finance or certain targets/priorities	1	1.0%	6	5.9%	39	38.2%	56	54.9%	102
Resistance from existing hospital/community/mental health providers and their clinicians	0	0.0%	15	15.0%	44	44.0%	41	41.0%	100
Access to data and/or technological solutions to support decisions and integration	0	0.0%	11	10.8%	38	37.3%	53	52.0%	102
Fragmentation from and/or disconnect from other commissioners – CCGs, NHS England, local authorities	1	1.0%	19	18.6%	44	43.1%	38	37.3%	102
Resistance from CCG's member GP practices	0	0.0%	50	49.5%	45	44.6%	6	5.9%	101
CCG is too small to make impact	3	2.9%	73	71.6%	23	22.5%	3	2.9%	102
Lack of commissioning support unit capacity and/or capability	1	1.0%	17	16.7%	42	41.2%	42	41.2%	102

9. Have you, or are you in the process of, inviting competition for a service or services, in instance(s) where you would have preferred not to, if it were not for competition rules or concerns about the rules?



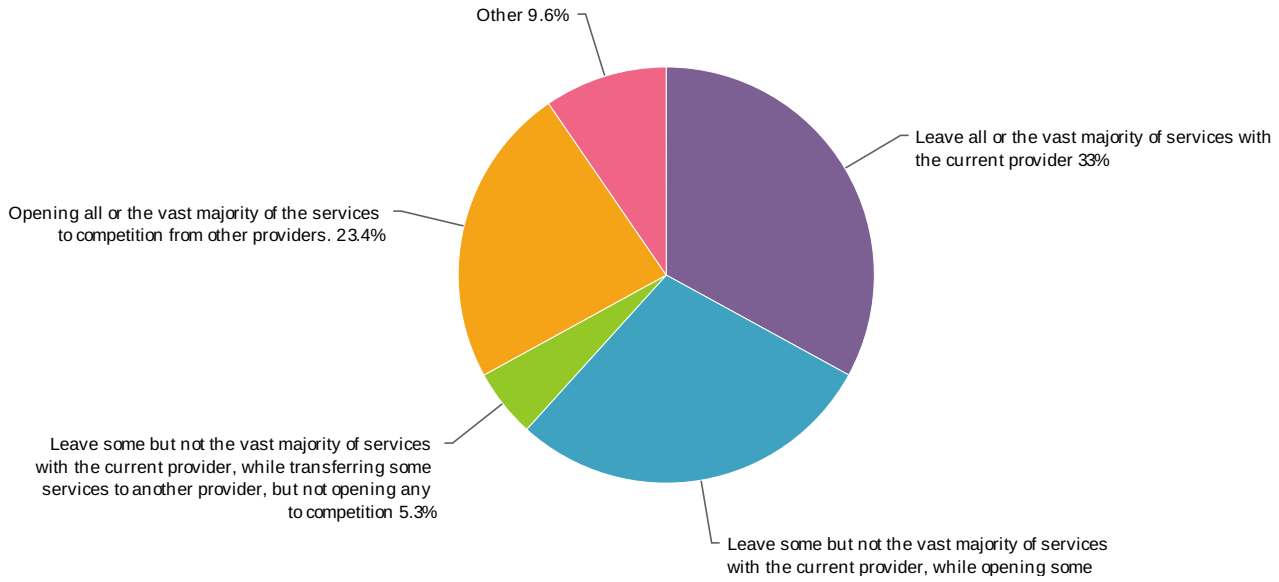
Yes	29.1%		30
No	66.0%		68
Don't know	4.9%		5
		Total	103

10. Please give details

Count	Response
1	AQP for audiology/ultrasound and podiatatry
1	AQP procurements for servies previously delivered via LES arrangements
1	Competition rules are only a barrier for the feeble minded
1	Gp oohs
1	Not yet but it is a real concern when planning services in a rural area
1	Out of Hours contract which has been rolled over too many times
1	Procurement for older peoples services
1	old but redesigned Enhanced Services, pathways for registered populations
1	recommissioning LES contracts
1	tier 2 diabetes service; Out of hours contract nursing home provision CHC
1	urgent care tender pain service tender
1	Invited competition for OOH provider- opportunity to scope alternatives. Have implemented AQP for all physio with now more local access and reduced waiting times at lower tarriff Integrated community Pulmonary rehab and oxygen service - new provider/better service
1	Extended primary care role in Nursing homes providing integrated care - seems crazy to invite competition when the

	service is all about complementing and augmenting primary care.
1	Services in community settings that make most sense being delivered by practices, where AQP applies
1	But I can see that occurring. I have a high performing community provider with no need to re tender but as the service went to an FT there was a stipulation to market test at 3 years. We have slipped by 1 year but this is an unnecessary distraction
1	We have been able to work within the regulations to achieve the procurement processes that make sense locally.
1	PPE contract engagement took a lot of time and effort at not specific reason other than to fullfil the rules and tick all the boxes.
1	Some apms contracts- plebotomy service in general practice. Mad. Patients see this as a core service in general practice.
1	Almost total paralysis in being able to make sensible decisions. Only winner is the lawyers and Monitor has no idea !

11. Many CCGs' contracts for their community health services will come to an end during 2014 or 2015. If this applies to your CCG, are you planning to:



Leave all or the vast majority of services with the current provider	33.0%		31
Leave some but not the vast majority of services with the current provider, while opening some services to competition from other providers	28.7%		27
Leave some but not the vast majority of services with the current provider, while transferring some services to another provider, but not opening any to competition	5.3%		5
Opening all or the vast majority of the services to competition from other providers.	23.4%		22
Other	9.6%		9
		Total	94

Responses "Other" **Count**

Considering all options	1
Not procuring until 2017	1
commission integrated services taking account of the Competition Framework	1
n/a	2
still working though our rationale	1
Taking time with current providers to fully articulate what community services look like beofre deciding how to proceed.	1
looking at most appropraite clinical model for the deleivery of those services then decide the contracting form	1
Community Health services are largely provided by a Community Services NHS Trust going through the FT pipeline. Very unclear at present that FT status will be achieved, so therefore uncertainty regarding hte organisational model going forward. Alongside this, current transformational plans would suggest significant increases in existing community health services along with creation of more specialist community health services, which may be put out to tender, although preferred route is for existing providers to work together to deliver these.	1

12. In relation to the effect of competition and/or procurement rules in the NHS, has your CCG experienced:

	No		Don't know		Yes		Responses
Increased commissioning costs due to procurement, patient choice and competition regulations	28	27.5%	8	7.8%	66	64.7%	102
Formal challenges under competition, patient choice and competition regulations, to commissioning decisions or arrangements	80	78.4%	2	2.0%	20	19.6%	102
Informal challenge or questioning, in relation to competition and procurement rules, of commissioning decisions or arrangements	40	39.6%	3	3.0%	58	57.4%	101
Not being able to change services in the way your CCG would otherwise have wished, due to competition, patient choice and competition regulations, or concern about them	50	49.0%	5	4.9%	47	46.1%	102
Not being able to introduce new single-contract arrangements – such as single "outcomes based" contracts covering a set of integrated services – due to competition, patient choice and competition regulations, or concern about them	70	69.3%	11	10.9%	20	19.8%	101
Plans for the organisational future of providers in your area – such as merging or becoming foundation trusts – being hampered because of procurement, choice and competition rules, or concerns about the rules	54	52.9%	11	10.8%	37	36.3%	102

13. For each of these groups, please choose the phrase which best describes its or their interactions with your CCG

	No relationship		Very good		Good		Neutral		Unhelpful		Very unhelpful		Bullying		Responses
NHS England (commissioning board) national team	37	35.9%	2	1.9%	7	6.8%	42	40.8%	9	8.7%	3	2.9%	3	2.9%	103
NHS England	23	22.3%	5	4.9%	13	12.6%	47	45.6%	12	11.7%	1	1.0%	2	1.9%	103

(commissioning board) regional team															
NHS England (commissioning board) local area team	0	0.0%	37	35.9%	38	36.9%	13	12.6%	11	10.7%	2	1.9%	2	1.9%	103
NHS commissioning support service	3	2.9%	8	7.8%	33	32.0%	30	29.1%	21	20.4%	8	7.8%	0	0.0%	103
Member GP practices	0	0.0%	33	32.0%	60	58.3%	6	5.8%	2	1.9%	1	1.0%	1	1.0%	103
Hospital provider organisations	0	0.0%	26	25.2%	51	49.5%	16	15.5%	7	6.8%	1	1.0%	2	1.9%	103
Mental health provider organisations	0	0.0%	24	23.3%	59	57.3%	16	15.5%	4	3.9%	0	0.0%	0	0.0%	103
Local authorities	0	0.0%	48	46.6%	46	44.7%	3	2.9%	6	5.8%	0	0.0%	0	0.0%	103
Regulators - Monitor, Care Quality Commission and NHS Trust Development Authority	6	5.8%	4	3.9%	27	26.2%	44	42.7%	11	10.7%	10	9.7%	1	1.0%	103

Comments

Count	Response
1	Bringing several in house, rather than to market
1	Going to market is different from changing contracts though
1	In the process of reviewing functions as part of management of change review
1	Mostly in house services anyway - not a factor in our thinking - which is helpful!
1	Programme management IT
1	contracting and service redesign in house already
1	none
1	rather than go to markey the CCG is likely to take " in house"
1	working with our local authority to explore shared services.
1	Will probably wait for the national framework to be complete. Also I am concerned about quality assurance services in the national framework spec, which seem minimalist
1	There are contracts in place but not delivering value for money and there are alternatives which could be better but until notice is served and the rules about competition etc are clarified and simplified there is too much inertia for change

1	What is my real priority - redesigning services with key partners for patients or tendering management support for my CCG? I know which I would choose!
1	Our CSU is expensive and had failed to deliver our requirements, we are considering all our options, if NHS England lets us.
1	We have a new CSU following the frustrating failure of the old. This has slowed our progress to date. The new relationship is growing and needs time to develop. NHS restructuring may be the enemy of the relationships required to make the significant changes the NHS requires
1	many of these services we currently provide in house. We will use CSU mostly for trnasactional support services
1	May be a waste of time as cartels or alliances forming to stifle choice and real competition. Obsession with " stranded costs" in CSUs rather than effectiveness or risk to CCGs from poor CSS

15. Please give any further comments, and highlight issues concerning you which we have not covered.

Count	Response
1	Monitor and TDA completely anonymous.
1	On primary care, NHS England is dumming down general practice to one national contract
1	Politicl interfereence with an up and coming election
1	TDA support of acutes without CCG involvement not helpful
1	premises issues need resolving not appropriate that NHS property company charges unoccupied premises to ccgs multiple commissioner environment is proving to be debilitating NHS england area team relationship is different for differentt services. very very poor on specialised, neutral on primary care and non-existent on strategic planning
1	Significant fragmentation between commissioners and regulators, leading to gaps in assurance of safe services. IG issues make this much worse than previously.
1	There is going to be significant political interference at all levels coming up to the 2015 elections. The ability to be transformative with reduced funds and that interference will be severely restricted unless the rules about judicial review are resolved as every proposed change will be challenged for political expediency rather than patient benefit or system sustainability. The fiscal cliff in April 2015 will hit all providers unless the models of delivery are allowed to change radically and rapidly.
1	The TDA and NHS England will need to work together to ensure a wholesale shift in the balance of power from provider to commissioner if the current vision for the NHS is to succeed.
1	Relationships with the regional team vary. Some of them are excellent but some are dictatorial in an unhelpful manner. NHS England has structural organisational problems which those at the top/center have been unsuccessful in even acknowledging let alone sorting. For example Tier 4 CAMHS and how a central team can add value to what its area teams do, rather than hold them back from tackling local problems. Specialized services commissioning has been a fiasco with no proper financial controls, commissioning or QIPP scheme resulting in overspend. NHS England have completely failed to understand how the de-regionalisation of specialised commissioning has negatively impacted on patients or how they have replaced a postcode lottery with a national commissioner based lottery. e.g. It is not in the best interests of vulnerable children to commission tier 4 CAMHS nationally. These children's mental health is damaged by having to travel hundreds of miles for a bed. No adequate commissioner action has been put in place to manage this issue.
1	The CCG movement has been largely successful and left to develop will continue to thrive. The co commissioning system (specialist, and primary care) has got significantly worse. There are no obvious skills, track record, experience or gravitas in LATs. They are a costly waste of time. The biggest issue will come from Local Authorities who are behaving like rats in a barrel. Cowardly national policy such as BCF has exacerbated this behaviour
1	The relationship with NHS England Area Team varies according to the role they carry out and the different approaches in the hierarchy. Assurance role is bullying at the top and neutralised by the team that we have most contact with. Direct

	commissioning role is ineffectual at primary care level and distant for specialised
1	HWB has blocked a decision to close walk in centres so we need to keep them open for at least a year & with the general election maybe 2. These provide poor quality of care and value for money but their lack if support could have opened us up to legal challenge. Power balance a problem.
1	The public are not aware of the choices being face by NHS and are not being offered real choices eg would they choose increase hours of GP access over increased mental health and emotional well being support to children?
1	Lack of consistency between NHSE, Monitor, and TDA. all talk up integration and quality but are totally disconnected in their approach.
1	Lots of activity, much in response to a continued culture of performance management. I am not clear what real benefit we have added with the new strucutre compared with the old.
1	Appraoch by TDA, NHSE and Monitor "not joined up" with approach taken locally between LA, CCG and Trust(s) Local team very supporting of transformation of primary care, led by CCG
1	answer 12 as it because we have had no experience yet of any challenge because there has been no opportunity
1	NTDA unhelpful and lack the capabilities of Monitor, obsessed with getting money from commissioners. Regime lacks rigour
1	The CCG believes the way to drive transformational change is through a new collaborative approach replacing the previous adversarial relationship between commissioner and provider. This has been embraced by local providers but more work is needed to have a similar shared approach with NHSE as co-commissioners
1	The 5 CCGs i am workinh with have had a financial risk share agrement with us so though we are an underfunded CCG they have supported us. Otherwise I would not be able to stay in balaence similarly my larger size has helped with their management allowwnace we have done this and will continue to do this with no intention of merging or loosing our individual sovereignty
1	I am astonished by the inability to govern a national health service through the dysfunctional relationships and arrangements between the TDA and NHS England. Is it in the patient interest for the TDA to act as a union representative of NHS Trusts at the expense of service improvements and progress. There is a leadership gulf that I trust Mr. Stevens will fill.
1	Our CCG is experiencing severe bullying from both the regional team and the area team which is unjustified as our performance is good and we are not going to overspend and there are no quality issues re our CCG. Robust Peformance management of CCGs is important but it should be based on fair and objective criteria.
1	The system needs to stop top down old style performance management of key targets and focus on sustainability. Cut out the massive duplication in the system by CQC, ccgs, NHS England, monitor, TDA all required to performance manage and all doing it differently. Providers need room to get the job done.
1	We have had to work hard to ensure that TDA work with the CCG not in isolation with regard to quality monitoring. Similarly the CQC has had to be persuaded to work with commissioners rather than entirely independently, even though the CCG has relevant quality information and expertise that would aid their inspections and investigations.