The future of commissioning

Simon Stevens, Karen Baker, Gary Belfield, Dr Mark Britnell, Professor Dr Stephen Dunn, Sir Sam Everington OBE, Professor Robert Harris, Dr Axel Heitmueller, Jeremy Hughes, Rt Hon Lord Hunt, Michael Macdonnell, Cllr Jonathan McShane, Clare Pelham, Dr Caz Sayer, Jeremy Taylor
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The conference is kindly sponsored by:

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# The future of commissioning

## Programme

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<td>Welcome and introduction</td>
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<td>13.05 – 13.30</td>
<td>Keynote presentation</td>
<td>Dr Mark Britnell, Partner and Chairman, and Gary Belfield, Associate Partner and Head of Commissioning, at KPMG's Global Health Practice, will deliver a joint keynote presentation on best practice commissioning and the future challenges facing commissioners.</td>
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<td>13.30 – 13.50</td>
<td>Keynote speech</td>
<td>Simon Stevens, Chief Executive of NHS England, will deliver a keynote speech on his vision for the future of commissioning. This will be followed by questions and answers from the audience. Chair – Andrew Haldenby, Director, Reform</td>
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<td>13.50 – 14.40</td>
<td>Delivering new models of care</td>
<td>Innovative commissioning will play a crucial role in supporting the NHS to meet the challenges ahead. The Five Year Forward View set out templates for new, more integrated models of care to cover half of England by the end of the next Parliament. However when “no one size fits all”, there are still a number of questions around what form these models will take. This session will explore the future shape of new models of care and the commissioning levers to implement them. Sir Sam Everington OBE, Chair, NHS Tower Hamlets Clinical Commissioning Group Professor Robert Harris, General Partner, Lakeside Health Partnership Karen Baker, Chief Executive, Isle of Wight NHS Trust Jeremy Taylor, Chief Executive, National Voices Chair – Gary Belfield, Associate Partner and Head of Commissioning, KPMG’s Global Health Practice</td>
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<td>15.10 – 16.00</td>
<td>Learning from new models of care</td>
<td>The commissioning of more integrated, better value care models and pathways has long been a priority, yet proven difficult to deliver at scale. Following the introduction of new models of care, the NHS must quickly and effectively spread the learnings of these “trail-blazers” so the remaining health economies become “fast followers”, rather than lagging behind. This session will explore how the NHS can accelerate the adoption of best practice commissioning and integration across the NHS. Michael Macdonnell, Director of Strategy, NHS England Dr Axel Heitmueller, Director of Strategy and Commerce, Imperial College Health Partners Professor Dr Stephen Dunn, Chief Executive, West Suffolk NHS Foundation Trust Dr Caz Sayer, Chair, NHS Camden Clinical Commissioning Group Chair – Cathy Corrie, Senior Researcher, Reform</td>
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<td>16.00 – 16.50</td>
<td>Commissioning across health and care</td>
<td>There is a growing consensus that care should be better integrated across health and care. The introduction of health and wellbeing boards, the Better Care Fund and Integration Pioneers have given new momentum to this agenda. Despite this progress, there remain a number of profound cultural and organisational barriers to meaningful integration across sectors and agencies. This session will explore the value of commissioning across health and care and the practical steps needed to do so. Jeremy Hughes, Chief Executive, Alzheimer’s Society Cllr Jonathan McShane, Chair, Hackney Health and Wellbeing Board Clare Pelham, Chief Executive, Leonard Cheshire Disability Rt Hon Lord Hunt PC OBE, Shadow Spokesperson for Health Chair – Amy Finch, Researcher, Reform</td>
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<td>16.50</td>
<td>Closing remarks</td>
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The NHS is at a critical juncture. In the face of an ageing population and the rising burden of chronic disease, the health service is struggling to meet demand within the resource available. The need for reform is now widely recognised. As Simon Stevens said earlier this year, “Either we move to something different or we begin to see services run into the sand.”

The Five Year Forward View put forward a compelling vision to deliver better care for patients and value for the taxpayer. As the document set out, “increasingly we need to manage systems – networks of care – not just organisations; out-of-hospital care needs to become a much larger part of what the NHS does; services need to be integrated around the patient.” There is a growing consensus that the NHS must “take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care.”

This has given the NHS a radical blueprint for reform. The health service and their counterparts in local government must now rise to this challenge. Reform is delighted to hold this conference in partnership with KPMG to explore the priorities for commissioning in the next Parliament to drive the pace and scale of change required.

In the first session of the day, we will explore the shape and future delivery of new models of care. These care models will be designed “to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely.” Though “no one size fits all”, a number of templates have been established, including the primary and acute care system and the multispecialty community provider. This Parliament productivity improvements have been through short term squeezes on the tariff and pay at the expense of sustainable reform to services. For these vanguards to succeed where transformation programmes previously have not, the NHS must find the right balance between local and national levers to quickly deliver the step change in productivity required.

The second session will explore the issue of scale. It is striking that many of the chosen vanguard programmes have been in place for a number of years, even decades. The Integration Pioneers this Parliament have demonstrated the benefits to patients and providers. Yet still these innovators remain the exception not the rule. As Simon Stevens said in his maiden speech as Chief Executive of the NHS, “The NHS needs to become the best at harnessing the best – whether spreading good ideas from within, learning from other industries, or cherry-picking from other countries.” NHS England has pledged to do better, with plans to see new care models covering half of England by 2020. History suggests this will be a significant challenge for the health service. For the NHS to “plagiarise” at scale, the spread of new learning must be driven not by national imposition but by local providers demanding to change.

The final session will explore the challenge of commissioning across health and care. Patients’ needs are holistic yet services continue to treat individuals by episode or condition, not as a whole. For the person with dementia or diabetes these divisions in governance, funding and delivery seem meaningless. The introduction of health and wellbeing boards, the Better Care Fund, and recent announcements in Greater Manchester have given new momentum to the agenda to better coordinate across health and care. Yet despite this progress there remain a number of profound cultural and organisational barriers to meaningful integration across the two systems. For initiatives such as integrated personal commissioning to succeed, the next Parliament must see these barriers broken down. As Simon Stevens has argued, the next five years must preside over an unprecedented “blurring of traditional dividing lines” between all public services if the NHS is to achieve high value, person-centred care.
Gary Belfield
We need bold commissioners for challenging times

Healthcare commissioning has undergone relentless change. Despite this, can we confidently say that healthcare commissioning is where we want or need it to be? I think the resounding answer would be “no”. It is becoming increasingly clear that we need to stop tinkering with the mechanics of commissioning and change the focus to the leadership and commissioners themselves.

Since 1990, we have seen ten changes to the organisational form and structure of NHS commissioning. People have been impatient to see success, but with major changes every three to four years, this has not given health professionals enough time to fully embrace initiatives or make a step change improvement in local population health.

Equally, commissioners seldom hold their posts long enough to build the relationships across the health and care system that are vital for long term transformation.

This is part of a wider problem that few people know who their local commissioner is, or what they are supposed to do. Why should they? Unlike hospitals, commissioners seldom make the news, unless they’re closing a service, which usually makes for some negative publicity. But they do need to be in the spotlight. Commissioners spend £80 billion of tax payers’ money a year, so it is only right that communities know where their money is going, just in the same way that they receive a cost breakdown of council spending or how their income tax is spent.

They need to do more to help themselves. Clinical commissioning groups (CCGs) do not always encourage an open door culture. Unlike town halls or hospitals, they do not tend to be physically connected to the local communities they are serving. Frequently, CCGs are situated in business parks or anonymous buildings. This is a mistake for organisations that need to connect with the local population.

If commissioners do not have a relationship with the local population, they are unlikely to be able to stand up and fight for the public’s needs. Some are doing this, such as the award-winning Tower Hamlets CCG, which commissions care for one of London’s poorest boroughs, but for many areas of the country they remain too distant.

I know from my regular contact with CCGs that greater connection into local communities is a high priority. This will be vital to underpin the large scale service changes that are on the health horizon.

The increase of commissioners with a clinical background is certainly a step towards bridging the gap between CCGs and local communities. Their day-to-day contact with the local population gives them a far more holistic understanding of what is required for patients or service users, not only in terms of health but also social and other support services. This is an understanding that previous commissioners with a managerial background have often struggled to achieve.

I know from my work across many parts of the NHS that this clear commissioning leadership will be welcomed. NHS England’s Five Year Forward View encourages new models of care, such as multispecialty community providers, to meet local needs. Commissioners will play a vital role in being the catalyst for this.

Bold commissioners will set out health outcomes that stimulate the local health and care system to work differently to deliver them.

Commissioners can lead the way by linking outcomes and incentives to encourage innovative risk share agreements that take away some of the “win lose” debates that can paralyse a health system.

Full engagement with the public will be a vital element of the outcome development. As healthcare needs become increasingly more complex, the need for bold commissioners to seize the moment is greater than ever. The challenges facing health and care services are profound. With a period of organisational stability and leadership support, I am confident that commissioners can meet these challenges.

Gary Belfield, Associate Partner and Head of Commissioning, KPMG’s Global Health Practice

Learning from new models of care

Dr Axel Heitmueller
How to spread the vanguard

More than a decade has passed since the last significant change of the NHS provider landscape. In 2002 the then Secretary of State, Rt Hon Alan Milburn MP, announced the establishment of foundation trusts to reward successful NHS hospitals with more autonomy. It was a decisively national policy, addressing a relatively limited set of challenges.

While successful in parts, the concept of foundation trusts was not sufficiently transformative to address the complexity of challenges the health economy was, and still is, facing.

Vanguards are decisively local and intended to provide answers to a range of complex and diverse questions. If successful, they will change the NHS at its core. Ignore them at your peril.

Unlike simple structural changes such as foundation trusts, diffusing the outcomes of vanguards will require a more sophisticated strategy.

Firstly, success needs failure. We should expect a large proportion of vanguards to fail, at least in parts. Failure is desirable as long as we manage to capture the reasons. The opposite has happened in many parts of the NHS in the past, where pilots were not allowed to fail. The culture of “success at any cost” has wasted vital opportunities to learn and stopped the NHS taking sufficient risks. If every vanguard succeeds, the programme has also been insufficiently ambitious.

Second, learning requires evaluation. The UK has a very strong tradition in robust academic evaluation. However, much of this evidence turns out to be of less value when it comes to the diffusion of innovation. There are two particular issues. Firstly, the evidence generated is often what the evidence funders want to see rather than the end user. Funders are often academic bodies themselves; for example, the National Institute for Health Research and their interests do not always align with those of end users, such as NHS managers, procurement departments or those needing to implement change.

Secondly, much focus is given to outcomes, which is fair and proper. But little attention is paid to process evaluation and, even where it is, it is rarely written up in such a way that service providers can easily adopt it in their organisations.

Thirdly, we need to reward the “stealing” of ideas. Too much emphasis has gone towards the new and too little towards the adoption of the existing. Maybe it is time for an HSJ award for the most ideas copied by a provider?

Fourthly, and related to that previous point, we need to build an innovation fertile eco-system within provider and commissioning organisations. Today, in most organisations it is no one’s day job to scout systematically for innovation, and many staff feel disempowered to do so. Imperial College Health Partners is actively developing such an eco-system with its members, where we can learn from successful private sector organisations. If we want to spread the lessons from vanguards, we will need to create able and informed customers.

Finally, local innovation is laudable and will generate interesting ideas. At the end of the day, a national policy framework setting out expectations and enablers will be required to support the diffusion of innovation, and here the US Accountable Care experience may be of relevance.

Dr Axel Heitmueller,
Director of Strategy and Commerce,
Imperial College Health Partners
@axelheitmueller
The recently published *Five Year Forward View* (5YFV) sets out a clear and compelling direction for the NHS. It argues that the NHS must take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, and between community services and social care. It argues that we need to see far more care delivered locally, organised to support people with multiple health conditions, not just single diseases.

The challenges that the 5YFV describes are acutely felt in West Suffolk. The population we serve is ageing, long term conditions are increasing and costs as well as public expectations continue to rise. The overall population of West Suffolk is projected to increase by over 7 per cent between 2013 and 2022, with a 38 per cent increase in people aged over 70 years old.

The consequence of this challenge is that West Suffolk faces an increasingly frail and demanding elderly population with a variety of health needs. Currently this is driving large increases in unscheduled attendances and admissions to hospital. Year on year increases of non-elective admissions, for example, have risen by 9 per cent this year.

If these trends continue they will challenge the future sustainability of the overall West Suffolk health system. Our GP practices are concerned about their sustainability, faced by growing patient demand and expectation, and difficulties in recruitment. Our NHS community and adult community services are facing similar challenges. Our CCG is forecasting a small surplus, but has an underlying deficit position due to the growth in demand.

The current model of provision in West Suffolk therefore needs to be transformed. If we change the service model and integrate services across the community and primary care, as well as into social care, then it might be possible to develop a sustainable service model. Our emphasis is upon creating joined up and improved pathways of care through clinical leadership and organisational integration; that is, organisational integration is the vehicle for change, not the aim of the change.

This is why we are looking to develop a primary and acute care system (PACS) in West Suffolk. The principal partners in the model are NHS West Suffolk CCG, Suffolk County Council and West Suffolk NHS Foundation Trust. Our model has been created by a wide range of partners as part of the Suffolk Health and Care Review, including service users, Healthwatch Suffolk, health and care providers, health and care commissioners, voluntary and community sector partners and district and borough councils.

Our strategy has four main objectives, which are aligned to the wider public sector reform agenda in Suffolk. Firstly, people manage their own health and social care with the right support when needed; secondly, our communities are easy and supportive places to live with a health or care need; thirdly, our health and care providers are co-ordinated by one clinically-led organisation (our PACS model) and, fourthly, higher cost interventions are replaced with lower cost.

Our new organisation will combine acute, community, 111 and GP out of hours services into one legal entity and establish governance links with primary and social care. The new organisation, the West Suffolk Health and Care Organisation, will have headquarters co-located with West Suffolk Councils.

Our operating model is locality focused, building on Suffolk County Council’s Supporting lives, connecting communities transformation programme for adult community services. We plan to have six Integrated Neighbourhood Teams of health and care professionals in West Suffolk supported by Neighbourhood Networks (including our voluntary and community sector providers).

Our governance model will support a locality approach by delegating resources to our localities, each with a clinical director, who reports into the System Executive Group and the Board of West Suffolk Health and Care. Primary and secondary care clinicians are in the majority on the executive. The Board has a Council of Governors and public membership scheme to ensure our community and stakeholders have a clear role and voice. Our legal structure for developing the model will be the Foundation Trust to give our community and stakeholders a clear role and voice.

Our financial strategy is based upon a capitated payment mechanism from commissioners. We will move away from performance by results for the West Suffolk GP list based requirements. Choice would still apply – there would be tariff for activity outside West Suffolk – but we aim to repatriate activity. Efficiency would be through prevention, early intervention and the right care in the right place, as well as corporate running cost savings. There will be collective agreement on investment and disinvestment in local services. Using international comparisons we would expect to deliver cost per capita reductions in the region of 15-10 per cent.

Our foundations are strong. We have excellent award winning services in West Suffolk. And if we are going to meet the challenges of the future we need to get on and do this quickly. This is why our timeline is to move to shadow running in 2015/16 and establish the new organisation in 2016/17. So let’s get on with it!

**Professor Dr Stephen Dunn**

**Chief Executive, West Suffolk NHS Foundation Trust**

@Stephen_P_Dunn
CCGs know that they need to do things differently, demonstrate that they add value for patients and play their part in a sustainable NHS. Camden CCG has embraced Michael Porter’s concept of “value”, defined as improved outcomes for every pound spent. We have applied this to every area of our commissioning programme.

An example of how we are doing this is our work around the frail, elderly population. This was identified as one of the CCG’s initial key priorities. The CCG found that elderly people with complex health and social care needs frequently experienced fragmented services that were difficult for them and their carers to navigate. This poorly coordinated care increased the clinical risks in handovers and led to a high rate of admissions and readmissions to hospital that are costly, with limited improvement in outcomes. The CCG’s aim is to deliver integrated services to all patients with complex and chronic mental and physical problems, including the frail and elderly, which improve the coordination and continuity of care for patients.

Bringing together patients and clinicians, we identified that the outcome most important to this population of patients (adopted as our system measure of success) was “number of days spent at home”. We invited providers across health and social care to co-produce with commissioners a model to deliver services that achieved improvements against this outcome. This model focused on the identification of “at risk” patients; care planning and multi-disciplinary team (MDT) management at practice and, in the most complex cases, at borough level was introduced to ensure that all organisations were working towards the same goal. The model is underpinned by clinical governance across the pathway, shared clinical records across health and social care through the Camden Integrated Digital record and the continual measurement and evaluation of system-wide data.

The service commenced in April 2013 and has been a considerable success. 857 patients have been added to the register (92 of whom have care plans). 73 per cent of the most complex patients (212) managed by the borough MDT now spend increased time at home, which has resulted in a 40 per cent reduction in all hospital use. There is evidence from the Nuffield Foundation identifying that hospital admissions reduced for all patients over 75 in Camden. This suggests there is an even wider benefit to be gained from delivering care differently.

36 per cent of those managed by the MDT have dementia. Linked to this work has been increased identification of dementia (prevalence up from 0.29 per cent in 2010/11 to 0.36 per cent in 2013/14 – an additional 253 patients) and investment in memory services and dementia “champions”.

We have applied the same approach, identification of those at risk, standardising pathways, improving quality of services and integrating services around patients’ needs, to a range of areas and demonstrated reproducible improvements in outcomes and reduced costs.

For example, integrated services for children with complex (including mental health) needs and disabilities have achieved 75 per cent of outcomes and a reduction in costs of 35 per cent through less use of high cost settings and out of borough placements. We have undertaken steps to improve the health of our children and prevent future illness. This includes significantly increased childhood immunisations (2nd MMR 51 per cent in 2009 to 89 per cent in 2014), increased school health checks (74 per cent in 2011/12 to 93 per cent in 2012/13), investment in activity parks and a transitions service for 19-25 year olds.

Another priority is care for patients with long-term conditions where early identification is a key factor. Standardising pathways of care through providing education for GPs and support from specialists, along with integrating models of care, have identified 1,000 more people with hypertension and increased by 9 per cent the number of people with atrial fibrillation now receiving treatment. The integrated diabetes community service has resulted in over 1,000 more people being added to practice diabetes registers and reduced diabetes emergency admissions by 7.4 per cent from April 2013 to April 2014. Emerging data suggests patients registered with long-term conditions in primary care are 63 per cent less likely to have non-elective admissions in the six months after being placed on a register compared to the six months before.

Most encouraging of all is data from both GP patient survey (HSCIC) and EQ5D data that shows an increase (60 per cent in 2011/12 to 65.5 per cent 2013/14) in the number of people who feel supported to manage their long-term condition since the CCG started. These are numbers that are falling elsewhere – both nationally and in London – and support the approach that Camden CCG has taken towards commissioning for value.

Dr Caz Sayer, Chair, NHS Camden Clinical Commissioning Group
By common consent, the 2012 Health and Social Care Act is one of the worst pieces of legislation passed in the history of the NHS. Disowned by Downing Street and described by the highly respected King’s Fund as damaging and distracting, it was the last thing our health service needed when hit by growing pressures and an unprecedented funding squeeze.

Ironically, the one piece of the legislation that did get general support – the creation of health and wellbeing boards (HWBs) may lay the foundations for a much more integrated health and social care system where services are built round individual needs. Made up of representatives from councils and the NHS, the HWBs are tasked with assessing the health needs of their local population, promoting greater integration of services through joint commissioning and pooled budgets. They have made a steady rather than spectacular start.

Recent King’s Fund analysis describes the impact of the HWBs to date as variable and limited, with little sign that they provide the collective leadership needed to tackle pressing issues. This isn’t altogether surprising. The current health and social care system is almost designed to put obstacles in the way of effective local leadership and integration of services. A series of different agencies, funding streams and conflicting targets makes working together much harder.

And yet, we know that this has to change. 12 years ago, Derek Wanless’s health review warned that unless we took prevention seriously, the UK would be faced with sharp rises in the burden of avoidable illness. How right he was. That is why our proposals for whole person care are so important. They aim for real integration with joint ownership, budgetary alignment, and accountability through the HWB Board, alongside a much stronger emphasis on helping to improve people’s health.

By asking HWBs to lead local commissioning and by bringing together services to work around people, we will finally be able to link health policy with all the other local level policies that have a bearing on health. Most notably, housing, planning, education, employment, skills and leisure, which by combining forces could do so much more to build up more resilient individuals and communities.

In addition, we shouldn’t ignore the potential link between the work of HWBs and the local economy. As Rose Gilroy and Mark Tewdwr-Jones of Newcastle University have recently pointed out, there is a critical relationship between health and the economy. Indeed, the 2010 Marmot Review identified both a strong case for reducing health inequalities and a compelling economic case. Health inequalities are estimated at more than £30 billion a year in lost productivity and welfare and health costs.

Revitalised HWBs could be crucial in sharpening up commissioning, providing local health and care leadership as well as helping to enhance the local economy.
Clare Pelham
Are you proud to be a commissioner?

I hope so. Because being a commissioner is to play an absolutely indispensable part in caring for people at a time when they really need your help.

A good commissioner of health and social care is just as important to the wellbeing and happiness of people we love as a good nurse or a good care worker. They answer the question “What did you do today at work Mummy?” in exactly the same way. “I made sure that people, who needed support today, got what they needed.” I hope that each and every commissioner is proud of the important work they do.

I start there because every day we see the enormous pressures that commissioners face. Every day it seems that a politician is on the airwaves saying that resources are limited. And equally often frontline care workers and the people they support talk vividly about the gaps and shortcomings in the care that is available. And the place where these pressures collide is in the person of the commissioner. This must – and I think does – put them under enormous personal pressure.

To give just one example, at Leonard Cheshire we no longer bid for homecare contracts containing visits of less than 30 minutes, unless they are a matter of personal choice or for medication checks. We welcome recent guidance from government that councils should not commission 15 minute visits for personal care, however we remain concerned that inadequate funding for social care means flying care visits will remain a reality for too many people.

I could go on. And I’m sure that we could all go on to give examples where health and social care is today less than we would all wish it to be. Whether that is in terms of the esteem in which we hold those who provide the care, or the increasing number of people who receive less care than they need. But the answer is not to blame commissioners.

Integration is certainly part of the answer. It will certainly make the money go further. To ensure a fair and sustainable system it is important that people can access care and support solely on the basis of need and not, as is currently the case, be restricted by whether these needs are defined as a “health” or “social care” need.

But an equally important part of the answer is for us to support commissioners. We cannot leave them alone to reconcile the irreconcilable twin pressures of insufficient funding and increasing numbers of people who need support. They must not go home at the end of every day feeling like all that they have done is make the best of a bad situation. They must be proud of what they have done.

Sometimes it seems to me that the only thing that is holding us back from building more trusting partnerships with commissioners is ourselves. So, perhaps we might begin a small but vital cultural change today. Let’s assume that everybody is trying to do a good job, to provide care that is great for people who need it. A job that we’re proud to do.

We know that commissioners know that care for people isn’t a widget that you buy by the dozen or by the minute. We all want great outcomes. So, let’s trust each other a little more and aim to provide those outcomes together as partners. Let’s have a commissioning process where the partnership and the trust and the transparency between providers and commissioners are the themes.

We would love this at Leonard Cheshire, because we know that great care comes from teamwork. And commissioners are part on the team.

Clare Pelham,
Chief Executive,
Leonard Cheshire Disability
@ClarePelham

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